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

7 March 2019 11:00 - 7 March 2019 14:00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Location: Boardroom, Chelsea and Westminster Hospital
Date: Thursday, 7 March 2019
Time: 11.00 – 14.00

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence	Verbal	Chairman
11.03	1.2	Declarations of Interest, including register of interests	Report	Chairman
11.05	1.3	Minutes of the previous meeting held on 10 January 2019	Report	Chairman
11.07	1.4	Matters arising and Board action log	Report	Chairman
11.10	1.5	Chairman's Report	Verbal	Chairman
11.20	1.6	Chief Executive's Report	Report	Chief Executive Officer
	2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**		
11.30	2.1	Patient/Staff Experience Story	Verbal	Chief Nursing Officer
11.45	2.2	Quality Improvement update	Report	Chief Nursing Officer
11.55	2.3	Serious Incidents Report	Report	Chief Nursing Officer
12.05	2.4	Health & Safety Matters	Report	Chief Nursing Officer / Director of Clinical Governance
12.15	2.5	Mortality Surveillance Q3 Report	Report	Deputy Medical Director
12.25	2.6	Integrated Performance Report including: 2.6.1 Workforce performance report	Report Report	Chief Operating Officer Chief Financial Officer
12.35	2.7	NHSR Maternity 10 Point Plan	Report	Chief Nursing Officer
	3.0	**STRATEGY**		
12.45	3.1	Business planning 2019/20 *(Board action 10.01)*	Pres.	Chief Financial Officer
13.00	3.2	Cancer changes from Long Term Plan *(Board action 10.01)*	Report	Chief Operating Officer
	4.0	**GOVERNANCE**		

13.10	4.1	Risk Assurance Framework Report	Report	Chief Nursing Officer
13.20	4.2	Equality & Diversity material	Report	Chief Nursing Officer
13.30	4.3	Guardian of Safe Working Report	Report	Chief Medical Officer
13.35	4.4	Audit and Risk Committee review of effectiveness including Terms of Reference	Report	Nick Gash, NED Chair
13.40	4.5	Revised SFIs and SOD	Report	Chief Financial Officer
	5.0	**ITEMS FOR INFORMATION**		
13.45	5.1	Questions from members of the public	Verbal	Chairman
13.55	5.2	Any other business	Verbal	Chairman
14.00	5.3	Date of next meeting – 2 May 2019, Room A, West Middlesex Hospital		

Board of Directors Register of Interests – updated 25 February 2019

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 Visiting Professor at the Institute of Global Health Innovation, part of Imperial College
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; 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 – Assistant Chief 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; Patisserie Holdings PLC; Hospital Topco Limited (Holding Company of BMI Healthcare Group) 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) Linear Healthcare UK Limited (9299681) Ramsay Health Care Leasing UK Limited (Guernsey) Guernsey (39556) Ramsay Health Care (UK) N0.1 Limited (11316318) Clifton Park Hospital Limited (11140716) Ownership or part-ownership of private companies, businesses or consultancies: A & T Property Management Limited (04907113) Exeter Medical Limited (05802095)

	Independent Medical (Group) Limited (07314631) Other relevant interests: Board member NHS Partners Network (NHS Confederation)
Liz Shanahan Non-executive Director	Owner of Santé Healthcare Consulting Limited Shareholder in: GlaxoSmithKline PLC, Celgene, Gilead, Exploristics, Official Community, Park & Bridge, Captive Health, Cambrex, Illumina, Vertex, MPX bioceuticals, some of whom have an interest in NHS contracts/work Director and shareholder: One Touch Telecare ltd Trustee of CW+ Charity
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
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)

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)
Iain Eaves Director of Improvement	
Martin Lupton Honorary NED, Imperial College London	Employee, Imperial College London
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
Sheila Murphy Interim Company Secretary	
Ayshea Richards Acting Director of Communications	

Minutes of the Board of Directors (Public Session)
Held at 11.05 on 10 January 2019, Meeting Room A, West Middlesex Hospital

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Non-Executive Director	(SG)
	Eliza Hermann	Non-Executive Director	(EH)
	Rob Hodgkiss	Chief Operating Officer	(RH)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Andy Jones	Non-Executive Director	(AJ)
	Pippa Nightingale	Chief Nurse	(PN)
	Zoe Penn	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)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Kathryn Mangold	Lead Nurse for Learning Disabilities and Transition	(KM) (item 2.1)
	Sheila Murphy	Interim Company Secretary	(SM)
	Julie Myers	Company Secretary	(JM)
	Ayshea Richards	Acting Director of Communications	(AR)
	Colleen Roach	Care Quality Commission	(CR)
	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. Apologies for absence had been received from Martin Lupton.
1.2	**Declarations of Interest** It was noted that Jeremy Jensen had recently been appointed to the Board of Patisserie Holdings PLC as a non-executive director and Chair of Audit Committee. THH declared, with reference to page 30 of the NHS Long Term Plan, that Helpforce had been asked to scale up volunteering within the NHS during the Plan period. THH reminded the Board that he was Chair of Helpforce. **Action: VD to add JJ interest to the Directors' Register of Interests**.
1.3	**Minutes of the previous meeting held on 1 November 2018** The minutes of the previous meeting were approved as a true and accurate record of the meeting.

1.4	**Matters arising and Board action log** The action log was noted. LW noted that all actions were on track and that the clinical strategy would be brought to the March public Board meeting.
1.5	**Chairman's Report** The Chairman reported: • that he had met the Secretary of State for Health and Social Care and that the Minister had been complimentary about his visit to the Trust • that the Senior Advisor to the Mayor of London was keen to see how greater use could be made of volunteers in the community, particularly in a preventative public health context • that a firm message at a recent dinner of NHS Improvement (NHSI), NHS England (NHSE), Care Quality Commission (CQC) and a number of Chairs of bodies in the health system was that there was unlikely to be any further monies for the health system from HM Treasury (HMT). The message was that at the end of this period of investment, the UK would have one of the largest spends on health as a proportion of GDP. JJ asked for clarification on the statistic regarding health system spend, including whether the comparator included the USA, when European comparators were more valid. THH indicated that he had been advised that the UK position was that spend would have risen from 8% to 14%. **Action: The Executive were asked to clarify the statistics as regards GDP and the international comparators for the next Board meeting**.
1.6	**Chief Executive's Report** The CEO wished all attendees a happy new year and confirmed that she had extended warm thanks, on the Board's behalf, to all staff who had worked over the Christmas and New Year period. She noted the following: • that there had been significant **media coverage**, including of a variety of VIP visits, and that these had all really helped to lift spirits. • the new **appointments** to senior positions and the number of **awards** both internal and external that Trust staff had received. • the **appointment of Sir David Sloman** as Regional Director for London, as a consequence of changes at NHSI and NHSE, and the range of work that Trust Executive Directors were already working with NHSI/E colleagues on. In response to a question from THH, LW confirmed that the Regional Director for London was akin to the historic role of 'London Regional Office' lead ie one office that sets the strategic direction for London, looks at performance across the region, articulates London issues to the centre and vice versa. In addition, the role would also be looking at learning and development issues and making sure the workforce is developed to meet the needs of the service now and in the future. Significant issues would always need to be discussed with the Regional Director first although there would inevitably be issues, such as specialist commissioning, that would need to be considered on a cross-regional basis. In response to a question from SG, LW explained that there was not always a strong correlation between the seven Regional Directors and the STPs. For instance, London encompasses five STPs, each of which has a Senior Responsible Officer (SRO). LW confirmed

that there is an understanding that Sir David Sloman will meet the SROs and the Accountable Officers (AO) for the Clinical Commissioning Groups (CCGs) every two weeks to look at whole of London matters. LW added that there was an expectation that bringing a degree of alignment to STPs would be beneficial, not least in terms of financial savings.

- work continued on the **Integrated Care System (ICS) in Hounslow,** with relationships very constructive.
- the submission of a joint proposal with Imperial College, Imperial College Healthcare Trust and other partners on an **alternative proposal to the move of Royal Brompton's services** from the Fulham Road to St Thomas' site. The full proposal was available on the Trust's website.
- the establishment of a **Brexit Committee** at executive level, chaired by the Chief Financial Officer, to ensure the Trust was alert to and following all essential guidance from the centre.

SG referred to the summary of NHSI Board papers appended to the CEO report which referenced a £700m potential saving from the outpatient improvement programme and asked how this translated to a Trust level. LW indicated that, for NWL, this was expected to be circa £40m but that this was based on assumptions in modelling. Great progress has, however, been made on the outpatients improvement programme in NWL. IN particular: every Trust has agreed to use the same pathways; the first five of these have been rolled out; GP referrals will need to follow agreed pathways and would ultimately be referred back if they did not; circa 10 – 30% of patients were anticipated not to meet the pathway criteria.

JJ asked about progress on ambulatory care further to the business cases that had been reviewed by the Finance and Investment Committee (FIC). RH confirmed that ambulatory care had opened at the Chelsea site in December 2018. Work was underway to develop the same services at West Middlesex but this was on a longer timetable due to the PFI and the need to relocate a number of services from the site of the new service. In response to a challenge from JJ regarding measuring anticipated impact, RH noted that the service has only been open a short time to date but that it was proving helpful albeit not in a way that could yet be quantified.

Action: Impact of ambulatory care to be reviewed by FIC.
Action: Patient experience of ambulatory care to be reviewed by Quality Committee.
Action: Impact of ambulatory care to return to public Board in May 2019.

NHS Long term plan (LTP)
LW provided her reflections to the Board on the recently published LTP, noting that work recently undertaken by this Trust and across NWL aligns well with the LTP. In particular alignment was noted:

- in terms of aspirations to see more patients in primary care than in secondary and tertiary;
- focus on disease and prevention of disease;
- focus on women's and children's;
- mental health focus;
- innovation and digital technology;
- care across a patient's life.

LW advised that the Trust would be arranging workshops with a) the Board b) staff and c) Governors and the public to show how the Trust's strategy aligns with the LTP.

In response to a question from THH, LW expressed her view that for London, it was unlikely that current geographical boundaries eg NWL would get smaller.
In response to a question from NG regarding implications for the estates strategy, LW noted that

	there was agreement across NWL that there should be a single estates strategy but proposals still needed to be developed and agreed by respective Boards. In addition, she confirmed that Trust control totals were expected to remain but that there would also be a STP control total. JJ opened discussion on the implications for governance and the role and responsibilities of a Foundation Trust Board. He expressed excitement about the potential for eg ICS but cautioned that resources could only be released to such initiatives if there was clarity about planning and, crucially, if there was no negative impact on the Trust being able to deliver care that met patient demand. With that in mind, he suggested that early changes may need to be small to see how governance and control operate and to instil confidence in such processes. The Board agreed that it would welcome further discussion on governance matters. In response to a question from AJ, RH advised that the Trust was starting to think about how tariffs would need to change to reflect new forms of care eg how 'admission avoidance' pathways could be remunerated. **Action: The Chief Executive to invite Sir David Sloman to meet the Trust Board as early as possible in his tenure.** **Action: Company Secretary to circulate NHS Confederation briefing on NHS Long Term Plan to Board and Governors.**
2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**
2.1	**Patient/staff experience story** The Board welcomed Kathryn Mangold, Lead Nurse for Learning Disabilities and Transition who leads the Trust's involvement with Project SEARCH. KM explained that Project SEARCH originated as an idea in the US 22 years ago and supports people with learning disabilities and autism into paid employment. The programme involves support from a mentor and the learning of skills. The Trust's programme started in September with eight interns and is a joint project with Kingsmill School, and funded by the London Borough of Hammersmith and Fulham. Four members of staff are employed to support the project which involves interns working in four main job roles over a year-long programme. KM commenced the support given to the programme by ISS, Trust contractors. KM played a video which showed the eight interns studying and performing their job roles. The Board welcomed Nathan, one of the Trust's Project SEARCH interns who explained: why he joined the project; what he found hardest; what he had done on the programme; how his mentor had helped him; and what he had enjoyed the most. The Board thanked Nathan and his fellow interns for all of their hard work and thanked KM and all Trust colleagues who provided support to the programme.
2.2	**Improvement update** PN presented the Improvement Programme update noting that: • The Trust has identified 86% of its Cost Improvement Programme savings and that circa 80% of the schemes were 'green' • With regard to the Getting It Right First Time programme (GIRFT), real progress was being made under ZP's leadership. • There were no 'red' actions outstanding from the Care Quality Commission (CQC) inspection 'should do' actions. In response to a question from THH, PN confirmed that none of the

	outstanding actions were of concern but that a number had longer lead times and that it was important to do them right rather than quickly. • The deep dive programme was critical in ensuring grip was maintained. • The ward accreditation programme continued, with 98 completed in the second year of the programme. Whilst seven areas had slipped back a grading on second assessment, PN noted that the thresholds were now more stretching. EH advised the Board that the Quality Committee (QC) looks in depth at the areas reported by PN. She commended the Trust for using open source improvement tool Life QI so that improvement work can be shared. She advised that the executive had been challenged to provide reports that showed greater depth as to how outcomes and improvements are actually being delivered in practice. In response to a question from JJ, PN advised that the improvement in ward accreditation grade for the patient discharge lounge encompassed estates matters as well as clinical. This had resulted in furniture being replaced, eating facilities improved, and the pharmacy process streamlined – all of which was helping to reduce time to discharge. LW added that the process helped to instil the same approach to patient care irrespective of the area of the hospital. PN explained that the ward accreditation process was now seen as a national exemplar. In response to whether wards see the standards as something to be embedded 'every day', PN confirmed that there was a good understanding of what the standards were and that wards were now sharing best practice and looking to learn from each other. It had become a cultural aspiration to achieve as high a grading as possible and to maintain it. NG asked whether there was reason for concern over five of the seven wards that had dropped down a grading being at West Middlesex. PN said not, noting that many of the wards at West Middlesex had been part of the first wave of accreditation and that the standards were now tougher on second time accreditation. The Board thanked PN for her report.
2.3	**Serious Incidents Report** PN introduced this item, advising the Board that there had been one Never Event submitted in the year to date. This was the retained vaginal swab event reported to the Board previously. A detailed review had been undertaken and an action plan implemented. This was being closely monitored. PN noted that there had been five Serious Incidents (SIs) in Month 8. Trends had been analysed and work was underway to establish of there were reasons why there were more than double on the West Middlesex site than at Chelsea. The detailed analysis would be interrogated by Quality Committee. Positive news was that the number of pressure ulcers reported was well below the number reported at the same point last year. In response to a challenge from SG regarding the apparent increasing trend of incidents at West Middlesex, ZP advised that the number was a crude measure. More robust analysis was needed to consider alongside mortality rates, adjustments for age and other factors. She noted that the increase was within Statistical Process Control (SPC) limits. LW added that the Trust encourages incident reporting. Additionally, the population was different at West Middlesex than at Chelsea and Westminster, with a larger proportion of emergency and elderly patients. She advised, however,

	that the Executive were alert to the statistics and had discussed whether amendments to senior cover needed to be made. EH confirmed that this was also a matter that had been discussed at Quality Committee. **Action: Quality Committee to review West Middlesex trends analysis.** The Board thanked PN for her report.
2.4	**Integrated Performance Report including:** **2.4.1 Winter plan** **2.4.2 Workforce performance report** RH introduced the performance report noting that the Trust had struggled with the A&E standard: whilst Chelsea and Westminster had managed to be compliant, West Middlesex had not. This had been compounded by breaches at the Urgent Care Centre (UCC) (managed by Greenbrook). A meeting had been held with Greenbrook to discuss the challenges and improvement was being seen. December figures indicated that the Trust had achieved 94.9% which was an increase on November. For the quarter, the Trust was compliant which meant that £1.8m STF funding had been secured. He noted that Referral To Treatment (RTT) and cancer targets had been met in November and December. Overall, it had been a challenging month but performance was still the best in London and one of the best in the UK. RH added that the NHS Long Term Plan included reference to a significant investment in early detection and a consequential shortening of waiting times. He would advise the Board in March of what this might mean for the Trust, once the Plan had been considered in more detail. **Action: Paper at March Public Board on implications of cancer changes from Long Term Plan.** LS sought clarification on the interpretation of the SPC for RTT at West Middlesex. RH noted that the dip on the graph since May correlated directly to the introduction of Cerner EPR and consequential effects. Daily meetings were being held to review data. He advised that he was confident that signs of improvement were starting to be seen but he warned that it was unlikely performance would return to 95/96% for some time, although 93/94% should be achievable. SG asked about medication safety incidents with harm where the Trust's figures looked to be above the national benchmark. RH advised that the figures had stabilised and reduced and that the executive did not have concerns. PN agreed noting that the Trust was not an outlier nationally. ZP concurred adding that the denominator for the statistic was likely to be incorrect as there was a general under reporting of incidents without harm. The Trust would be marking Medication Safety Week shortly. **Patient experience** PN asked the Board to note the positive story told by the patient experience statistics. She noted that the Trust had recently introduced 'comfort packs; including ear plugs and eye shades with the support of CW+ and these had been well-received. Volunteers had been very helpful in increasing response rates to surveys. **Finance report** SE advised the Board that the Trust was £300k ahead of plan at Month 8. The accounting treatment

	of the Sensyne Health shares had had a positive impact. After discussion with NHSI, it had been agreed to adjust the plan and the Trust had received an additional £7.5m funding. Use of Resources score remained at 1. **Winter planning** RH noted that the Board had seen the plan for winter which had included a number of proactive steps, including an increase in senior nursing presence, which had proved very beneficial. **Workforce report** SE asked the Board to note the report and drew their attention, in particular to the Trust exceeding its target for statutory training compliance for six months, with Information Governance training at its highest ever at 93%. She added that the turnover rate improvement had been maintained and was starting to stabilise. The vacancy rate had also stayed low with nursing and midwifery's rate at 8.9% which was exceptional. **Action: A report on the Trust's relationship with the trades unions to be brought to a public Board at a future date, once the new Director of HR was in post**.
2.5	**Mortality surveillance Q2 report** ZP introduced the report which showed Trust statistics for Q2, 2018/19. She explained that the report was considered by the Mortality Surveillance Group which includes representatives from every Division. All deaths where care was an issue are considered by the Group, which then identifies any themes either by individual, by service or on a more generic basis. Key themes identified to date include identifying the deteriorating patient and delay in diagnosis. There is an interface with the SI process and represents an important leg of the Trust's triangulation process. She explained that the report shows HMSR (the relative risk of death) and the SHMI – both of which are 'controlled' statistics and provide a benchmark to enable sites to be compared nationally. The HMSR has decreased on both sites and both show as 'good' against national benchmarks. ZP confirmed that Quality Committee also receives reports from the Group and that it would be considering the report for Quarter 3 in detail at its February 2019 meeting. In opening discussion on the report, NG asked whether the Trust had looked at deaths occurring soon after transfer from care settings and whether these were reported. ZP advised that they were not reviewed systematically but confirmed that there were a number of inappropriate transfers to hospital, typically because patients had not had conversations about where they wanted to die. The Trust's End of Life Group was looking into this and talking to GPs and CCGs about how to ensure wishes about transfer were known and that people were not transferred against their known wishes. LW added that the Trust does report pressure sores and that where a number of patients were seen from a single nursing home, these would be interrogated. I response to a question as to how the Trust compared nationally, ZP advised that mortality review was still a relatively new process and that there was not yet enough information for national comparison. A national system was expected to be developed in 2019/20. EH added that, bearing in mind the Trust's positive HMSR and SHMI scores, it would expect to benchmark well. **Action: Board development session at a future date to be scheduled on Mortality Review process**.
3.0	**STRATEGY**

3.1	**EPR programme update** KJ updated the Board on the progress of the Cerner Electronic Patient Record (EPR) process. He reminded the Board that Ernst and Young had provided the Gateway process for Phase 1 one of the programme and, after tender, had been reappointed for external assurance of Phase 2. THH urged the Board to be alert to the timetable for implementation as against that which had been adopted by Imperial College Healthcare Trust previously: this Trust was proceeding much more rapidly and the Board needed to be alert to the risk. As lead Non-Executive for the programme, ND confirmed that the team was alive to the risks. LW agreed, noting that these were not trivial. The implementation programme represented a significant risk and was recognised as such. NG asked for confirmation that the implementation of phase 2 would not supersede outstanding work still required to implement fully the benefits of phase 1? KJ and RC confirmed that there remained real focus on phase 1, and agreed that it was important to do everything possible to complete the implementation. This would also have positive benefits for the cutover period also. ND and RC confirmed to the Board that the programme was receiving sufficient senior team focus. The Board noted the report.
	The Board paused to allow the presentation of gold ward accreditation status to the following areas: • **Outpatients five** • **Outpatients four** • **Endoscopy** • **Outpatients six**
4.0	**GOVERNANCE**
4.1	**Committee terms of reference** JM advised the Board that Committees had recently completed a review of effectiveness and that, as a consequence, three Committees had proposed revisions to their Terms of Reference: Finance and Investment Committee; People and Organisation Development Committee; and Quality Committee. The Board approved all of the changes to the Committee terms of Reference.
5.0	**ITEMS FOR INFORMATION**
5.1	**Questions from members of the public** A member of the public involved with patient matters from an STP perspective, noted the significant amount of change going on in the health sector, and in this Trust, and stressed the importance of these changes being talked about in terms that members of the public would understand. Specifically, communications needed to be patient focused ie to talk about how change might affect them not just talk in terms of strategy. LW responded and confirmed that the STP does have a Communications Group comprising all Communications Directors from all member bodies. She agreed that this Group needed to translate 'strategy' matters to what it all means for patients. She reaffirmed that, as provider lead for the STP, it was her absolute intention that this would happen. A member of the public noted a recent tender for Dementia and Stroke Services in Hounslow and asked whether West Middlesex Hospital has a dementia lead. LW confirmed that she would

	investigate. **Action: LW to identify dementia lead at West Middlesex Hospital and confirm to member of public and at next Board**. Governor, Anna Hodson-Pressinger remarked on the impressive number of volunteers that had come forward following the Christmas media campaign but reported anecdotal concerns about whether clinicians had sufficient time to find constructive activity for them. She also asked whether volunteers were routinely encouraged to consider healthcare careers. LW responded and confirmed that volunteering was often a route into a formal career in health or a way of testing whether it would be. Regarding the anecdotal concerns, LW advised that concerns of this type had not been raised in this Trust although she noted that they had appeared in some media. She confirmed that this Trust is committed to investing in volunteers and reiterated the important contribution they would be making to patient care. IN this Trust, the volunteering programme had started in areas where there was a real commitment and this had been beneficial in demonstrating how successful use of volunteers could be.
5.2	**Any other business** THH extended thanks on behalf of the Board, to Julie Myers, Company Secretary, who would be leaving the Trust shortly.
5.3	**Date of next meeting** – 7 March 2019

Meeting closed at 13.09

Trust Board Public – 10 January 2019 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
10.01.19	1.2	Declarations of Interest	Action: VD to add JJ interest to the Directors' Register of Interests.	VD	Complete.
	1.5	Chairman's Report	Action: The Executive were asked to clarify the statistics as regards GDP and the international comparators for the next Board meeting.	Executive	The UK spends 9.7% of GDP on health care (under 2011 definition). This is about average for peer group. More specifically it is similar to Austria and Australia but behind France, Germany and Sweden who are at 11% or higher. Elements of social care (eg residential beds) are included in OECD definition which means Long Term Plan is lies to improve out comparative position although the frontier is also likely to change (eg other countries will also shift spending patterns) Source: Organisation for Economic Co-operation and Development (OECD) and Kings Fund Analysis May 2018
	1.6	Chief Executive's Report	Action: Impact of ambulatory care to be reviewed by FIC.	RH	This will be scheduled as part of FIC forward planning.
			Action: Patient experience of ambulatory care to be reviewed by Quality Committee.	PN	This is on forward plan for July Quality Committee.
			Action: Impact of ambulatory care to return to public Board in May 2019.	RH	This is on forward plan for the May Board.
			Action: The Chief Executive to invite Sir David Sloman to meet the Trust Board as early as possible in his tenure.	LW	Sir David Sloman is due to attend the May Board.

			Action: Company Secretary to circulate NHS Confederation briefing on NHS Long Term Plan to Board and Governors.	JM	Complete.
	2.3	Serious Incidents Report	Action: Quality Committee to review West Middlesex trends analysis.	PN	This is on forward plan for July Quality Committee.
	2.4.1	Winter plan	Action: Paper at March Public Board on implications of cancer changes from Long Term Plan.	RH	This is on current agenda.
	2.4.2	Workforce report	Action: A report on the Trust's relationship with the trades unions to be brought to a public Board at a future date, once the new Director of HR was in post.	SE	This will be put on the Board forward plan later in 2019.
	2.5	Mortality surveillance Q2 report	Action: Board development session at a future date to be scheduled on Mortality Review process.	JM/ZP	To be scheduled as part of forward planning.
	5.1	Questions from members of the public	Action: LW to identify dementia lead at West Middlesex Hospital and confirm to member of public and at next Board.	LW	The Trust has a CNS dementia lead at West Middlesex Hospital.
Nov 2018	5.1	Business planning 2019/20	Action: March Board to include sufficient time to review business plan for 2019/20.	SM	Closed. This is on current agenda.
		Membership	Membership growth to be added as a KPI to communications strategy.	AR	Action ongoing.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	1.6/Mar/19
REPORT NAME	Chief Executive's Report
AUTHOR	Sheila Murphy, Interim Company Secretary
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
March 2019

1.0 Performance

January again saw continued growth in non-elective demand and increasing numbers of patients coming through our front doors to its highest volume for any single month and 10% higher than the same month last year. While demand continues to be challenging the Trust has delivered a high level of performance in its Urgent Care pathway with 94.2% within the 4 hour standard. Despite this being a slight deterioration in performance from December the Trust continues to be the highest performing in London and one of the top performing Trusts nationally. This is only possible due to the teams continued hard work and dedication to patients requiring urgent care.

The Referral to Treatment (RTT) incomplete target was again achieved with an improving trend along with on-going compliance against all the Cancer standards. Our 6 week wait Diagnostic position remains compliant, so despite challenges across a number of areas this is a fantastic achievement, demonstrating the continued efforts of all of our staff to ensure we give our patients the very best, timely care.

2.0 Flu Vaccination update

The Trust exceeded the NHSE target of 75% with 80% of our staff being vaccinated.

Attached separately to this report is an update on Health Care Workers flu vaccination programme as required by NHS Improvement.

3.0 Divisional updates / staffing updates

I am pleased to say that James Eaton, Director of Performance and Information has now started with us. All the Divisional Medical Directors are now appointed: Simon Barton for Women and Children, HIV, GUM and Dermatology; Julie Hillier for Clinical Support Services; Dilys Lai for Emergency Medicine and Integrated Care and Jason Smith for Planned Care.

Other notable staffing changes include the retirement of Shan Jones, Director of Quality Improvement, and I am pleased to announce that Lizzie Wallman will be taking up this post.

4.0 Staff Achievements and Awards

Our latest CW+ PROUD award winners are:

- **Planned Care**: Jatinder Kaur, Service manager WMUH
- **Emergency and Integrated Care**: Catherine Sands Head of Emergency Preparedness
- **Women and Children**: Paediatric Services at WMUH
- **Corporate**: IT Team Trust-wide

5.0 Communications and Engagement

Team Brief

January's Team Brief included presentations on the ambulatory care project, compliance of information governance and the launch of the new budget holder manual.

Website

The Trust website had 147,000 visits in January 2019 and 124,000 visits in February 2019. Three quarters of visitors were new and one quarter were returning visitors.

The top sections were 56 Dean St, 10 Hammersmith Broadway and John Hunter clinics, travel directions and contact info, and our clinical services. Two-thirds of our visitors use mobile devices.

Three quarters of users visit our website via a search engine and Facebook remains the key driver on social media. The stats are consistent with this period one year ago.

Social Media

Engagement rates across all social media platforms remained consistent throughout this period. Topics included student volunteering week, as well as promotion of National STI Day, World Religion Day, Holocaust Memorial Day and Young Carers' Awareness Day.

January media coverage

Imperial College London Global study of HIV-associated liver cancer news article. Prof. Mark Bower, Director of the National Centre for HIV Malignancy at Chelsea and Westminster co-authored the study.

https://www.imperial.ac.uk/news/189706/imperial-takes-lead-global-study-hiv-associated/

Chelsea and Westminster Hospital NHS Foundation Trust spokesperson quoted in HSJ news article on the impact of tariff change on London trusts.

https://www.hsj.co.uk/finance-and-efficiency/london-trusts-to-lose-300m-after-tariff-change/7024245.article

6.0 Strategic Partnerships Update

North West London Health & Care Partnership

The Health & Care Partnership (previously STP) has taken responsibility for the oversight of NWL Planning & Contracting model and accompanying submission to the centre. All Trusts have used the core planning assumptions (including referral and activity growth) and we have incorporated these into our 'in parallel' Operating Plan submissions.

The HCP has also been tasked with co-coordinating EU exit contingency plans. The Trust has instituted these arrangements locally with the Chief Financial Officer acting as SRO; and our Divisional Director of Operations for Clinical Support Services as day to day lead. The Trust held a Business Continuity simulation event on 6 February with attendance from local CCGs, Boroughs and NHSE and will co-ordinate lessons learned both internally and to partners across HCP.

The Trust is also taking forward the core principle of consolidation to support best care and outcomes for our population with Imperial College Healthcare Trust. The Joint Executive met on 28 January and are developing an outline proposal for collaboration across identified specialities and care groups where we believe we can improve care and improve the sustainability of services. Any final proposals and supporting governance arrangements will be brought back to Executive Management Board and Trust Board.

Integrated Care in Hounslow

The Trust remains engaged in the development of a business case for a first generation Integrated Care System and has signed the Memorandum of Understanding with the GP Federation, Hounslow & Richmond Community Trust, West London Trust, London Borough of Hounslow and the Voluntary sector collaboration. The proposal focuses on four priority areas:

1. Frequent Attenders
2. Urgent and Emergency Care
3. Care at Home
4. The Deteriorating Patient

Alongside the specific benefits analysis and wider business case development the Trust is focussed on aligning our existing priorities in ambulatory care, Innovate UK Testbed and Home First & Discharge planning with these work-streams.

The current timeline for finalising the business case and seeking approval from constituent partners is May 2019.

Healthier Hearts & Minds (NWL Cardio-Respiratory Services)

The programme supporting the NWL business case to retain and provide cardio-respiratory services continues. Key actions in the period prior to our last report to Board have included:

- Representatives from the Trust and the NWL team attended the NHS England hosted 'Hurdle & Evaluation Event' on 25 February. This event included patient representatives, provider, commissioning and academic colleagues from across London (and beyond) and started to develop 'Must Do' (Hurdle) and 'Should Do' (Evaluation) criteria for the assessment of any options. Once finalised NWL would expect to formally address these criteria in any business case submission.
- Three clinical working groups have been established (Adults, Paediatrics, Cystic Fibrosis) to ensure a clinical quality and benefits focus to our proposals and to add the required detail to our initial vision document (November 2018).
- The Chief Executive has met the incoming CEO for NHSE England (London)

Senior Medical Leadership Forum

The CEO and Medical Director have re-instituted the quarterly forums between the Executive and the senior clinical leadership of the Trust. I met with service leads over all our directorates on 26 February to cover issues from the NHS Long Term Plan, the NWL Health & Care Partnership (STP) and our own strategy and Operating Plan; and the leadership role I expect of them to lead and support our staff. This was a really

positive event and I have received feedback that colleagues enjoyed both the content and the opportunity to network with peers. Our next event is to be scheduled in early/mid June.

7.0 EU Exit (Brexit) planning

Whilst the Government continues to work to secure an EU Exit deal, actions need to be taken now to ensure effective contingency arrangements. In line with the key requirements, set out by the Department of Health and Social Care (DHSC), the trust will take a business continuity approach to preparing for a worst case 'no deal' scenario.

The greatest media interest is around medicines. Key areas e.g. pharmacy and procurement have been in planning for some time. We already have command and control structures and escalation triggers in place; we are ensuring that our Business Continuity Planning (BCP) in each area is robust and that there are accepted and agreed plans in the event of any disruption to service not just in consideration of EU Exit impact.

It is important that we are prepared to respond to any impact e.g. supply disruption incidents that may arise in event of EU Exit with no deal.

National contingency planning has focussed on 9 work streams and the Trust EU Exit Tactical team are preparing an EU Exit Risk Assessment Document in line with these work streams:

1) Medicines
2) Vaccines and other public health issues (PHE)
3) Clinical trials, research and clinical networks
4) Medical devices and clinical consumables
5) Non-clinical consumables, goods and services
6) Blood and Transplant
7) Workforce
8) Reciprocal healthcare and overseas visitors
9) Data

On-going Communication & Engagement by the Trust is as follows:

- Team Brief 6th March 2019 - Trust response to EU Exit
- Operational Plan – with action cards being finalised
- Dedicated EU Exit email account for staff to pose questions and escalate issues
- Dedicated Intranet page being launched 6th March 2018
- Asking for nominated leads from each area as EU Exit champions to link with the EU Exit Tactical Team

8.0 Finance

The Trust is reporting a year to date surplus of £22m at for January (month 10) which is £0.4m favourable to plan. This is after receipt of additional Provider Sustainability Funding (PSF) in relation to an increase in the Trusts planned surplus agreed at month 6 with NHSI.

However, it must be noted that although the Trust is forecasting a year end surplus of £26.8m this includes a number of non-recurrent transactions and without those the Trust would be forecasting a £28.9m deficit. This means the Trust will need to continue to seek efficiencies for 2019/20 as these funding sources will not be repeated in the next financial year.

Lesley Watts
Chief Executive Officer
March 2019

Health Care Workers Flu Vaccination Update

Introduction

This paper provides an update of the flu vaccination programme for front line health care workers as required by NHS Improvement. In April the Trust will publish a comprehensive review of the current flu campaign, including lessons learned and an action plan in preparation for the 2019-20 Flu campaign.

Background

The ambition for the 2018-19 flu season was to achieve 100% compliance of vaccination in front line health care workers. In addition the Trust had a CQUIN target of 75% vaccination for front line staff. The Trust achieved 80% compliance with vaccination which exceeded the CQUIN target.

Total Vaccination Uptake (front line staff)

	Total numbers	Rates
Number of frontline Healthcare Workers	4395	100%
Uptake of vaccine by frontline Health Care Workers	3499	80%
Opt-out of vaccine by frontline Health Care Workers	202	5%

Vaccination in High Risk Areas

NHSI identify a range of high risk areas, in which vaccination rates are required to be reported separately. Of the areas identified as high risk the Trust provide HIV / Oncology / Haematology, NICU and SCBU. The Trust has identified additional high risk areas which are those identified as red in the table below:

Area name	Total number of frontline staff	Number who have had vaccine	% Vaccinated	Number who have opted-out	Staff redeployed? Y/N
HIV / Oncology / Haematology	31	26	84%	1	N
NICU	136	86	63%	5	N
SCBU	38	27	71%	2	N
ED	340	266	78%	10	N
ITU	130	103	79%	4	N
Paediatrics	436	294	67%	8	N

Actions taken to achieve the 100% uptake ambition

The flu vaccination campaign this year has used a multi-faceted approach to achieve the 100% vaccination ambition. This has included:

Occupational Health flu clinics

- Daily and weekend walk round visits to all wards and departments
- Early morning clinics in the Atrium
- Lunchtime clinics in or near the restaurant
- Attending Trust meetings to immunise all present
- Attendance at induction
- Attendance at Christmas fair
- Routine vaccination offer for all staff attending OH for other appointments

Peer vaccinator programme

- Occupational health trained over 150 peer vaccinators in the local clinical areas
- Monthly prize draw for 2 vaccinators and 2 people who had received the vaccine
- Monthly 'flu trolley' offering tea and treats to those who had a vaccination that day

Communications

- Flu myth buster campaign
- Regular tweets and updates as staff were vaccinated
- Early planning and preparation
- Strong CEO and executive team leadership

Opt out Reasons

Reason	Number
I don't like needles	2
I don't think I'll get flu	8
I don't believe the evidence that being vaccinated is beneficial	35
I'm concerned about possible side effects	8
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get the vaccine	0
The times when the vaccination is available are not convenient	0
Other reasons:	
Had a bad experience/side effects/reaction	93
Personal Choice	16
Allergies	23
Autoimmune/Health condition	16
Vegan option required	1

Action – The contents of this interim report should be noted and will be updated with the comprehensive review in April.

All staff briefing

January 2019

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

We want to start by saying a huge **thank you** to all of you who worked over the festive period and wish everyone a happy 2019! Going forward, we will now include an update from each of the divisions in this briefing:

Emergency and Integrated Care

December was a busy month for the Division with record numbers of patients attending our A&E departments. Despite this, we remain one of the top performing Trusts in the country on the 4hr wait target and improved on our performance in December 2017 to secure our Sustainability and Transformation Funding for Quarter 3. This is a reflection of the hard work of all teams in enabling patient flow. To help manage this increasing demand on our services, December also saw the opening of our expanded Ambulatory Emergency Care service at the Chelsea site. Our AEC will now provide a 7 day service with extended opening hours and medical cover Monday – Saturday. This will ensure that patients won't have to wait unnecessarily or for longer than needed in our emergency department, when they can receive their care in AEC and return home on the same day. An expanded AEC at West Mid opens in early 2019. Please contact Project Manager Adele Testa if you have any questions (adele.testa@chelwest.nhs.uk).

Planned Care

Tara Argent joined the Senior Ops Management Team in December 2018 as Divisional Director for Clinical Support Services, acquiring from Planned Care Division the overall management of the Patient Access, Imaging, and Pharmacy Teams. For the remaining directorates within Planned Care (Surgery, Theatres, Critical Care and Anaesthesia), the focus remains on continuing to reduce the number of patients waiting for surgery, thus making us compliant with Referral to Treatment national standards. Although the Trust aggregate position is above the required 92% target, the division has, and continues to require improving its performance. The division is currently reporting 90.2% with action plans in place for compliance within the target by March 2019. We are also presently working on improving theatre utilisation. Will Reynolds, Service Improvement and Efficiency Manager is currently leading a project involving clinical and non-clinical teams to ensure the right patients are being scheduled. The project is also aiming to identify and reduce problems that normally affect start times in theatre and turnaround times between patients.

Women's, Children's and HIV/GUM

As 2018 came to an end, we'd like to take stock of all the things that have been happening across the division. We've opened a new Early Pregnancy Unit on the West Mid site (2nd floor opposite the executive management offices), helping to provide an enhanced experience for our patients. Estates work has commenced on our Labour Ward and Obstetric Theatres at Chelsea to improve the ventilation systems. A room of four chairs has been opened on Starlight/PSSU at West Mid to help support patient flow from A&E during the busy winter months. We have been able to expand our Paediatric Ambulatory Care (PAC) unit at Chelsea by using Saturn Stage 2 space – later this year we will be moving the PAC unit into a new home next to paediatric outpatients. The e-services project for sexual health services in London – supporting patients to not have to travel in to hospital to have standard tests – is progressing really well and the take up is ahead of plan. We've launched a tele-dermatology service at Chelsea which will hopefully support us to meet the increasing demand and referrals we are receiving.

Latest CW+ PROUD award winners

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

- Planned Care: **Jellica Horvatic**, Phlebotomist
- Emergency and Integrated Care: **Maria Mercer**, Lead Clinical Nurse Specialist, TB/Respiratory
- Women and Children: **Alice Green**, Antenatal Teacher
- Corporate: **Paolino Buttaci**, Information Governance Officer

Visit the intranet to nominate a team or individual.

Mandatory and statutory training

The Trust has achieved 93% compliance for the 4th reporting period with all divisions now reaching 93% or above. Current compliance figures (at 31 December) are as follows:

Division	Compliance
Corporate	**96%**
Emergency and Integrated Care	**93%**
Planned Care	**93%**
Women, Neonatal, Children, Young People, HIV/Sexual Health	**93%**
Overall compliance	**93%**

Information Governance compliance is at 94%, the highest ever for the Trust, but is still slightly short of the national 95% target. If you receive an email reminder from the system this means you have 3 months to complete the course. Please ensure you plan ahead to meet the deadline.

Patient Handling is at its highest level since the requirements were aligned across both sites and now stands at 90% due to extra sessions being run at both sites. There are two new topics on Learning Chelwest required for some clinical roles. These are the Workshop to Raise Awareness of Prevent (WRAP) - a government initiative to prevent radicalisation - and the Basic Life Support theory courses for Adults and Paediatrics.

Website updates

The website is a key source of information for our patients and members of the public who want to find out more about our Trust and the services we provide. Departments are responsible for their own content so if you are a lead then please review the information on your pages at www.chelwest.nhs.uk/services and email any updates to communications@chelwest.nhs.uk

February *All Staff Briefing*:

- Tue 5 Feb, 09:30–10:30am—Harbour Yard
- Wed 6 Feb, 12:00–1:00pm—C&WH
- Wed 6 Feb, 14:00–15:00pm—WMUH

All staff briefing

February 2019

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

Emergency and Integrated Care

Our Division is at the forefront of the current winter pressures, with record numbers of patients being seen at both A&E departments. Despite this pressure, both hospitals are performing really well due to the excellent efforts of all our staff – so please keep up the hard work. Lots of recent quality improvements are also helping: Ambulatory Care expansion the Medical Emergency team at West Mid, rapid flu testing and a better, closer liaison with our community colleagues – all helping to achieve safer and quicker discharges to get our patients home. An important focus is this year's Cerner go live at the Chelsea site. Look out for Cerner training events to attend. You can also drop in on 14 February to the 'Road to Cerner' event in the restaurant. Finally, we'd also like to congratulate all of our recent PROUD award winners, our therapy colleagues for their successful strategy launch/dragons den and our stroke teams for their excellent national peer reviews.

Planned Care

Plans discussed and agreed as part of Winter Planning readiness are allowing us to maintain our elective programme. Despite few patient cancellations as a result of needing to operate on surgical and orthopaedic emergency cases, January 2019 has been one of our busiest months for elective surgery. Thank you to all clinical and non-clinical colleagues in Planned Care division for their on-going commitment to improving patient care and access to treatment. We hope you have your winter garments ready as the cold snap is likely to remain. Please make sure you provide patients with extra blankets and do everything possible to keep them ward on our wards.

Women, neonatal, children and young people, HIV/GUM and dermatology

As we ramp up to Cerner implementation at the Chelsea site, it is especially important that all clinicians are actively involved in this. Our Division is working on recruiting an additional two Paediatric Emergency Medicine consultants at West Mid and are working closely with Imperial to repatriate inpatient HIV patients to Chelsea. Our CQC maternal survey was published recently and we have the highest score in NWL with all areas the same or above the national average. Although January is a challenging month, teams across the division have been working fantastically to help deliver the ED, RTT and cancer targets. We have been interviewing for new Service Directors in Paediatrics and have received lots of positive feedback following the recent Hammersmith & Fulham Special Educational Needs and/or Disabilities (SEND) inspection for community paediatrics. Well done to all teams involved.

Clinical Support Services

As we begin 2019, we are developing our business plans, identifying opportunities and recognising that there are exciting times ahead for the new division. Our main focus is building the new team and getting to know each other whilst recruiting two new General Managers, one of which will replace Alan Kaye who sadly retires at the end of March. We will arrange a suitable send off for him.

Latest CW+ PROUD award winners

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

- Planned Care: **Ophthalmology Department**, Chelsea
- Emergency and Integrated Care: **Emergency Department Nurses**, Chelsea
- Women and Children**: Fokru Miah**, Community Paediatrics Coordinator, Chelsea
- Corporate: **Dhivya Kesavan**, Quality Improvement Manager, Chelsea

Visit the intranet to nominate a team or individual.

Mandatory and statutory training

The Trust has achieved 93% compliance for the 5th reporting period with all divisions now reaching 93% or above. Current compliance figures (at 31 January) are as follows:

Division	Compliance
Corporate	**96%**
Emergency and Integrated Care	**93%**
Planned Care	**93%**
Women, Neonatal, Children, Young People, HIV/Sexual Health	**94%**
Overall compliance	**93%**

Information Governance is due to submit the Trust compliance level at the end of March as part of its national annual submission. Please ensure if you've already lapsed or are due to lapse soon that you've schedule in time to complete the online training. The Trust is aiming for at least 95% compliance on this topic.

Cerner EPR

By the end of the year our Chelsea site will be live on Cerner, which will bring the whole Trust onto the same system for the first time. Preparations are well underway and we'll be holding a drop-in event from 10am-4pm in the restaurant at Chelsea on 14 Feb: 'The Road to Cerner EPR.'

Recruitment and retention

The Trust is now reporting a vacancy rate of 8.7% in Nursing and Midwifery, a 6% reduction since October 2017 and one of the lowest in London. We also recently visited the Philippines and India, offering 163 posts to overseas nurses. More close to home, we've recently attended recruitment events at Bournemouth, Bristol, Leicester and London and have further local, national and university recruitment fairs scheduled in the coming months. Our voluntary turnover rates in Nursing and Midwifery are 15.3%, down by 2.6% since the Trust launched our retention action plan in October 2017. We've also recently launched a stay questionnaire to further explore how we can encourage staff to stay at the Trust.

March *All Staff Briefing*:

- Tue 5 Mar, 09:30–10:30am—Harbour Yard
- Wed 6 Mar, 12:00–1:00pm—C&WH
- Wed 6 Mar, 14:00–15:00pm—WMUH

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.2/Mar/19
REPORT NAME	Improvement Programme update
AUTHOR	Victoria Lyon, Head of Improvement
LEAD	Iain Eaves, Director of Improvement Pippa Nightingale, Chief Nurse Sandra Easton, Chief Finance Officer
PURPOSE	To report on the progress of the Improvement Programme
SUMMARY OF REPORT	**Trust-level progress:** **Cost Improvement Programme (CIP)** The Trust is forecasting to achieve a full year forecast of £22.7m – 10% or £2.4m below the target of £25.1m. There is an increase of £310k from the prior month review. **Quality improvement work** Two improvement showcases are planned for April. This is an opportunity to celebrate the improvement work taking place across the Trust and discuss with staff how we take it forward together as part of the Trust's commitment to a culture of continuous improvement.
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.
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	For assurance

This report provides an update on the progress of the Improvement Programme:

1. Summary of Financial Improvement Programme
2. Getting It Right First Time
3. CQC Improvement Plan
4. Deep Dive programme
5. Improvement approach

1. Summary of Financial Improvement Programme – M10

The Trust is forecasting to achieve a full year forecast of £22.7m – 10% or £2.4m below the target of £25.1m. There is an increase of £310k from the prior month review.

- Month 10 – January 2019 shows that the in-month performance has delivered £2.3m against a target £2.23m; this is an in-month over achievement of £0.06m or 3%.
- There is a YTD adverse variance of £2.22m against the target which is largely driven by unidentified projects (£1.48m).
- 94%, or £21.3m, of the £22.7m full year improvement forecast is rated green, with the expectation that these schemes will fully deliver against plans.

2. Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national programme, helping to improve the quality of care and the efficiency of care delivery. The Trust GIRFT Action Group meets monthly, with the national GIRFT team joining quarterly.

The Trust completed the following GIRFT Reviews in Jan – Feb 2019:

GIRFT Visit Date	Name of Workstreams
14-Jan-19	General Surgery
31-Jan-19	Endocrinology
15-Feb-19	Vascular Surgery

The following dates are confirmed for future GIRFT visits:

- 12 March 2019: Intensive and Critical Care
- 19 June 2019: Hospital Dentistry
- 16 May 2019: Radiology

In addition we are awaiting confirmation of dates for Cardiology and Anaesthetics and Perioperative Medicine.

3. CQC action plan

The overall breakdown of the CQC 'Should Do' actions and additional actions are updated for February as below. The number of complete action has increased from 77 to 114, and the number of 'Amber' actions has decreased from 17 to 7 with work ongoing to rapidly move these to 'Green':

CQC Improvement Plan Summary					
Number of 'Should Do' actions	57				
Number of additional actions (extracted from report)	90				
Total number of actions	147				
Progress - August Update	**Red**	**Amber**	**Green**	**Complete**	**Awaiting update**
'Should Do' actions Summary	0	6	8	43	0
Additional actions Summary	0	1	18	71	0

The Divisional Directors of Nursing provide a monthly update on the progress made so far for each of the CQC actions. A 'BRAG' dashboard for each of these is provided for February below:

a) Progress made for 'Should Do' actions:

Division	CQC Domain	Amber	Green	Complete	Total
EIC	Safe	1	-	11	12
	Effective	1	2	3	6
	Responsive	-	-	1	1
	Well-Led	1	-	-	1
PC	Safe	-	-	4	4
	Effective	-	-	1	1
	Caring	-	-	1	1
	Responsive	-	-	4	4
	Well-Led	-	-	4	4
W&C	Safe	-	-	3	3
	Effective	1	1	3	5
	Responsive	1	3	3	7
	Well-Led	-	-	4	4
Trustwide	Well-Led	1	1	-	2
Corporate	Effective	-	-	1	1
	Well-Led	-	1	-	1
Grand Total		**6**	**8**	**43**	**57**

b) Progress made for additional actions:

Division	CQC Domain	Amber	Green	Complete	Total
EIC	Safe	-	2	11	13
	Effective	-	4	9	13
	Caring	-	3	1	4
	Responsive	1	3	7	11
	Well-Led	-	2	3	5
PC	Safe	-	-	15	15
	Effective	-	2	7	9
	Caring	-	-	1	1
	Responsive	-	-	9	9
	Well-Led	-	-	3	3
W&C	Safe	-	-	2	2
	Caring	-	-	1	1
	Responsive	-	1	1	2
	Well-Led	-	1	1	2
Grand Total		**1**	**18**	**71**	**90**

4. Deep Dive programme – March 2019 schedule

The following planned and targeted deep dives have been scheduled for March. These deep dives are key opportunities to identify areas for improvement and the feed into the Trust's overall improvement programme.

Division	Name of Deep dive	Deep Dive Category	Deep Dive *Scheduled*
EIC	**Cancer Services**	Targeted	**05-Mar-19**
Corporate	**Website Development**	Targeted	**06-Mar-19**
W&C	**Private Patients**	Targeted	**07-Mar-19**
EIC	**Respiratory/Thoracic**	Planned	**12-Mar-19**
W&C	**Neonatology**	Planned	**13-Mar-19**

Trustwide	**Temporary Staffing**	Targeted	**18-Mar-19**
Planned Care	**General Surgery (also include GIRFT Action progress update)**	Planned	**21-Mar-19**
Trustwide	**IT Operations Follow Up**	Planned	**25-Mar-19**
Trustwide	**CDIF**	Targeted	**27-Mar-19**

5. Improvement Approach

Two improvement showcases are planned for April. This is an opportunity to celebrate the improvement work taking place across the Trust and discuss with staff how we take it forward together as part of the Trust's commitment to a culture of continuous improvement. Our aim is that feel enabled, enthused and empowered to improve care and services delivered to patients.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.3/Mar/19
REPORT NAME	Learning from Serious Incidents – January 2019
AUTHOR	Shân Jones, Director of Quality Governance Stacey Humphries, Quality and Clinical Governance Assurance Manager
LEAD	Pippa Nightingale, Chief Nursing Officer
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	There is a reputational risk associated with the Never Event reported in December - Unintentional connection of a patient requiring oxygen to an air flowmeter.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	The reduction in hospital acquired pressure ulcers continues
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 Board is asked to note the report.

SERIOUS INCIDENTS REPORT
Trust Board 7th March 2019

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. 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*'.

There have been 2 Never Events reported since the 1st April 2018. The first Never Event was reported in September 2018 (Retained foreign object post-procedure, StEIS reference 2018/22293). The incident involved a 36 year old patient who had a spontaneous vaginal delivery at 38 weeks with an episiotomy due to suspected fetal compromise delivery. The episiotomy was sutured in the labour ward room under epidural analgesia. The retained vaginal swab was found after attending an appointment with her GP. Patient has been reviewed, is systemically well and has been given a course of oral antibiotics. The Trust was informed of the retained swab by the GP.

The second Never Event was reported in December 2018 (Unintentional connection of a patient requiring oxygen to an air flowmeter, StEIS reference 2018/28691). The incident involved a 77 year old patient who was brought to ED following a cardiac arrest. On arrival at ED, patient had a return of spontaneous circulation, however, deteriorated and had a second cardiac arrest. CPR was stopped as it was agreed nil improvements had been noted. On detaching monitors it was noticed the patient's Maple C water circuit was attached to the air-port rather than the oxygen port.

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 January 2019. There were 8 reports submitted. A précis of the incidents can be found in Section 7.

Table 1 – Reports submitted to CWHHE

STEIS No.	Date of incident	Incident Type (STEIS Category)	External Deadline	Date report submitted	Site
2018/24482	24/09/2018	Treatment delay	08/01/2019	08/01/2019	CW
2018/25812	06/10/2018	Maternity/Obstetric incident: mother and baby	23/01/2019	15/01/2019	WM
2018/25213	17/10/2018	Slips/trips/falls	16/01/2019	16/01/2019	WM
2018/26137	10/10/2018	Pressure ulcer	28/01/2019	28/01/2019	WM
2018/25653	24/10/2018	Maternity/Obstetric incident: baby only	22/01/2019	15/01/2019	WM
2018/25744	24/10/2018	HCAI/Infection control incident	23/01/2019	23/01/2019	CW
2018/25799	26/10/2018	Slips/trips/falls	23/01/2019	23/01/2019	WM
2018/26142	26/10/2018	Pressure ulcer	28/01/2019	28/01/2019	WM

Table 2 shows the number of incidents reported on StEIS (Strategic Executive Information System), across the Trust, in January 2019.

Table 2 – Incidents reported by category

Incident Type (STEIS Category)	WM	C&W	Total
Maternity/Obstetric incident: baby only	1	1	2
Maternity/Obstetric incident: mother only	1	0	1
Slips/trips/falls	1	2	3
Treatment delay	0	2	2
Grand Total	**3**	**5**	**8**

The number of SI's reported in January (8) is lower compared to the previous month, December (11). This can be attributed to the reduction in the number of maternity incidents reported to the Healthcare Safety Investigation Branch (HSIB).

Charts 1 and 2 show the number of incidents, by category reported on each site during this financial year 2018/19. WM has reported a significant number more SIs than the CW site. There have been 8 falls with moderate harm on the WM site and these are being reviewed at the falls steering group.

Chart 1 Incidents reported at WM by category YTD 2018/19 = 39

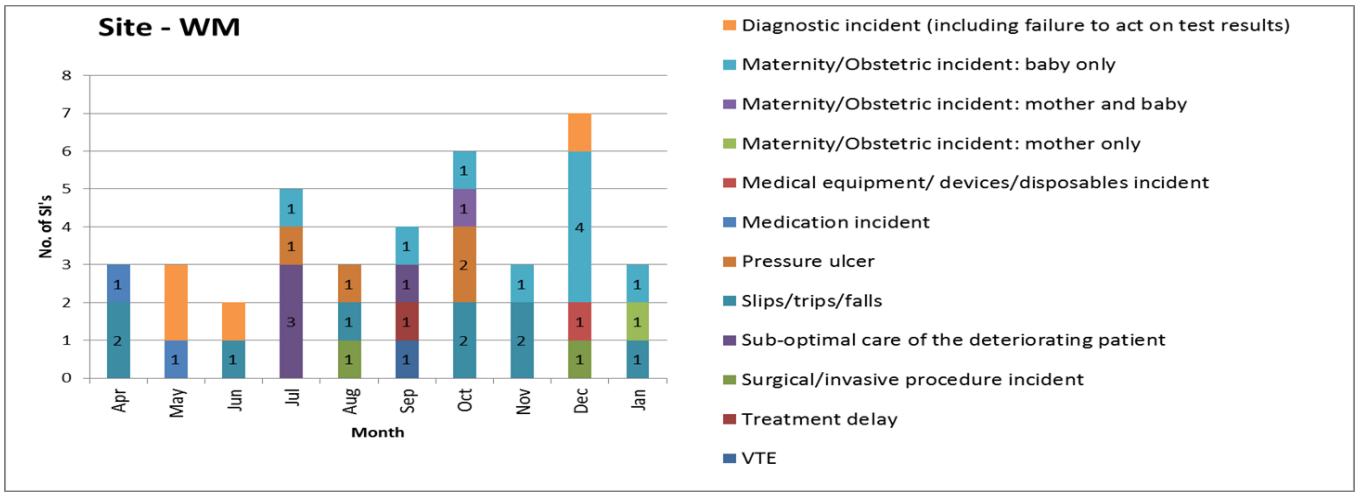
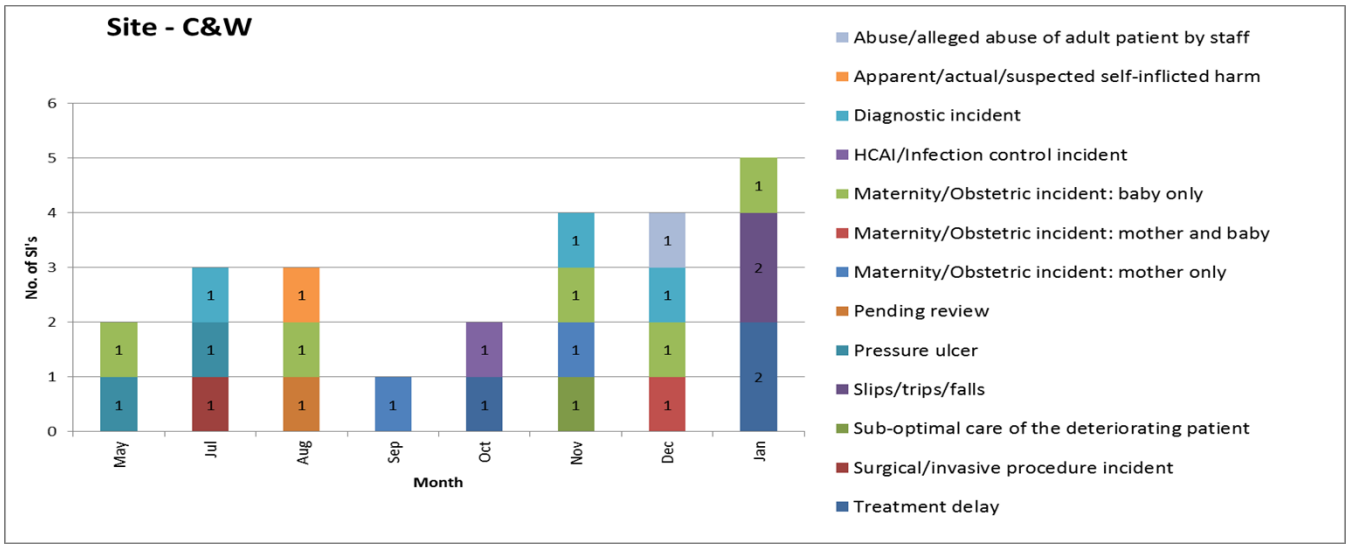


Chart 2 Incidents reported at C&W by category YTD 2018/19 = 24



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

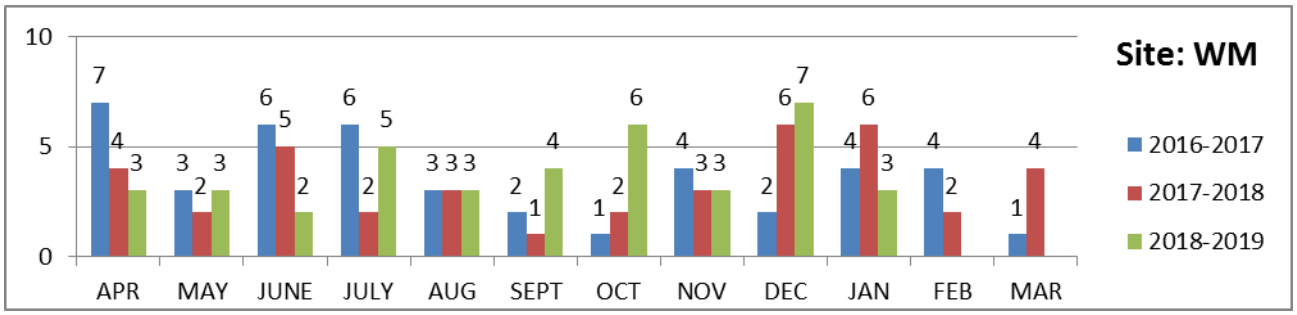
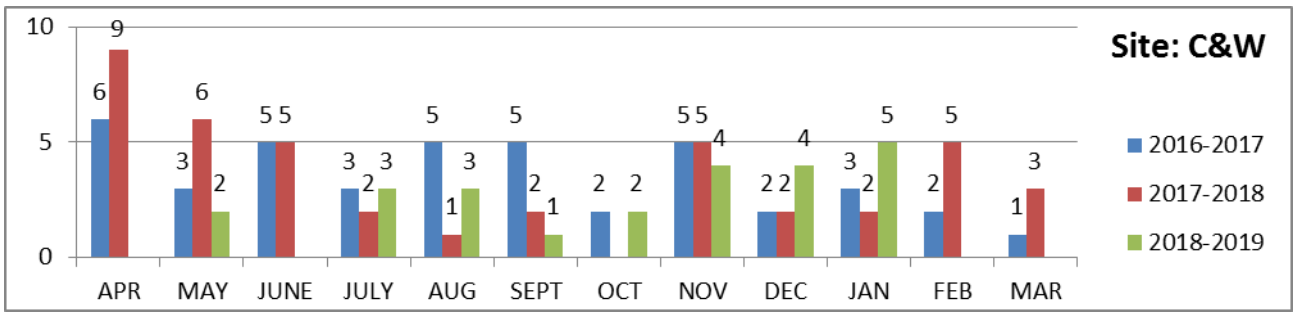


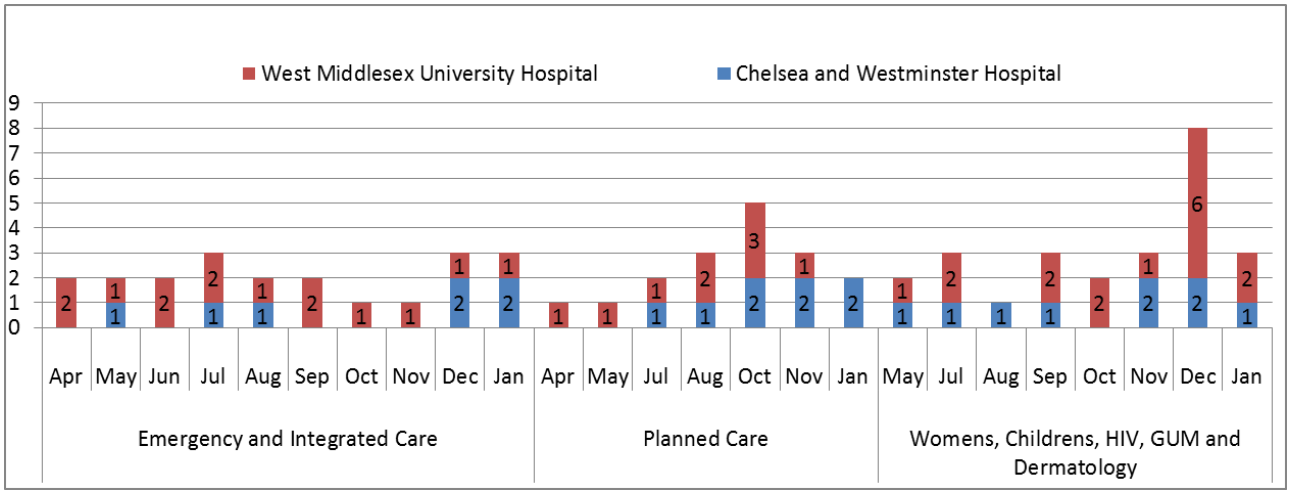
Chart 4 Incidents reported 2016/17, 2017/18 & 2018/19 – C&W



3.1 SI's by Clinical Division and Ward/Department

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 to compare the number of incidents reported by each division.
Since April 1st 2018, the Emergency and Integrated Care Division has reported 21 SIs (C&W 7, WM 14). The Women's, Children's, HIV, GUM and Dermatology Division have reported 25 SIs (C&W 9, WM 16) and the Planed Care Division have reported 17 SI's (C&W 8, WM 9).

Chart 5 Incidents reported by Division and Site 2018/19



Charts 6 and 7 display the total number of SI's reported by each ward/department. On both sites the Labour wards have reported the highest number of SI's. The second most reporting location, again for both sites, is Accident and Emergency departments.

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

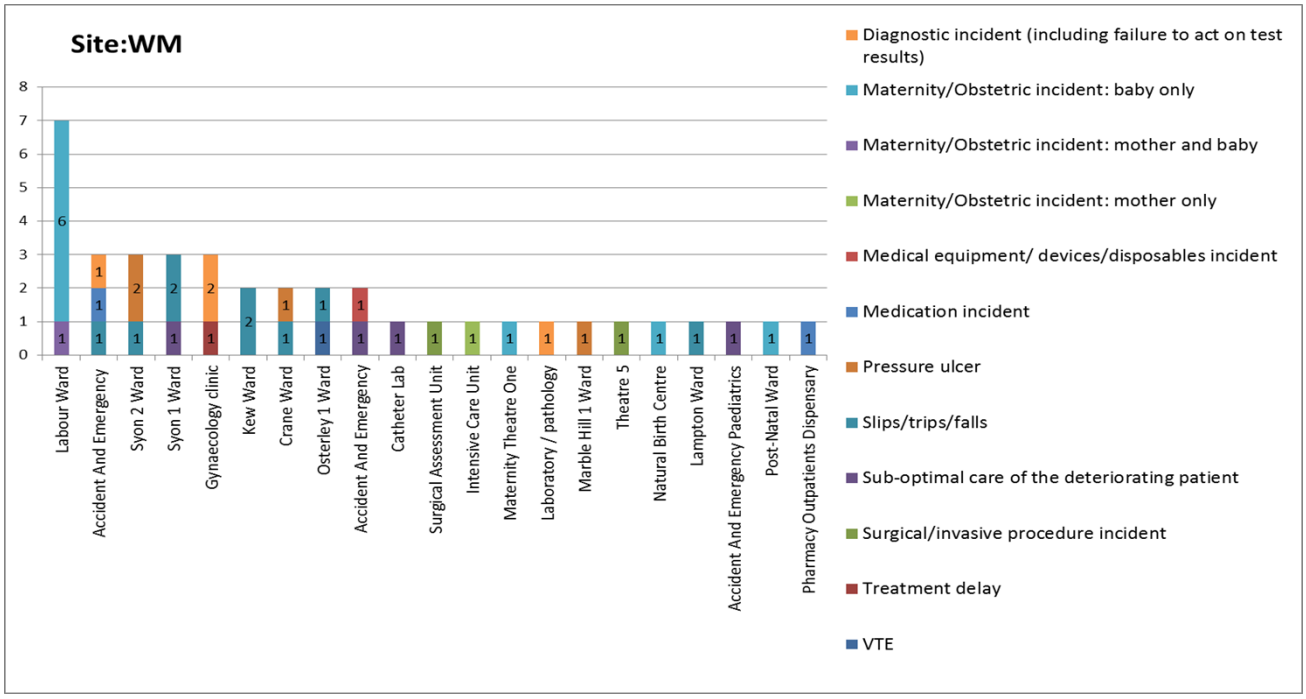
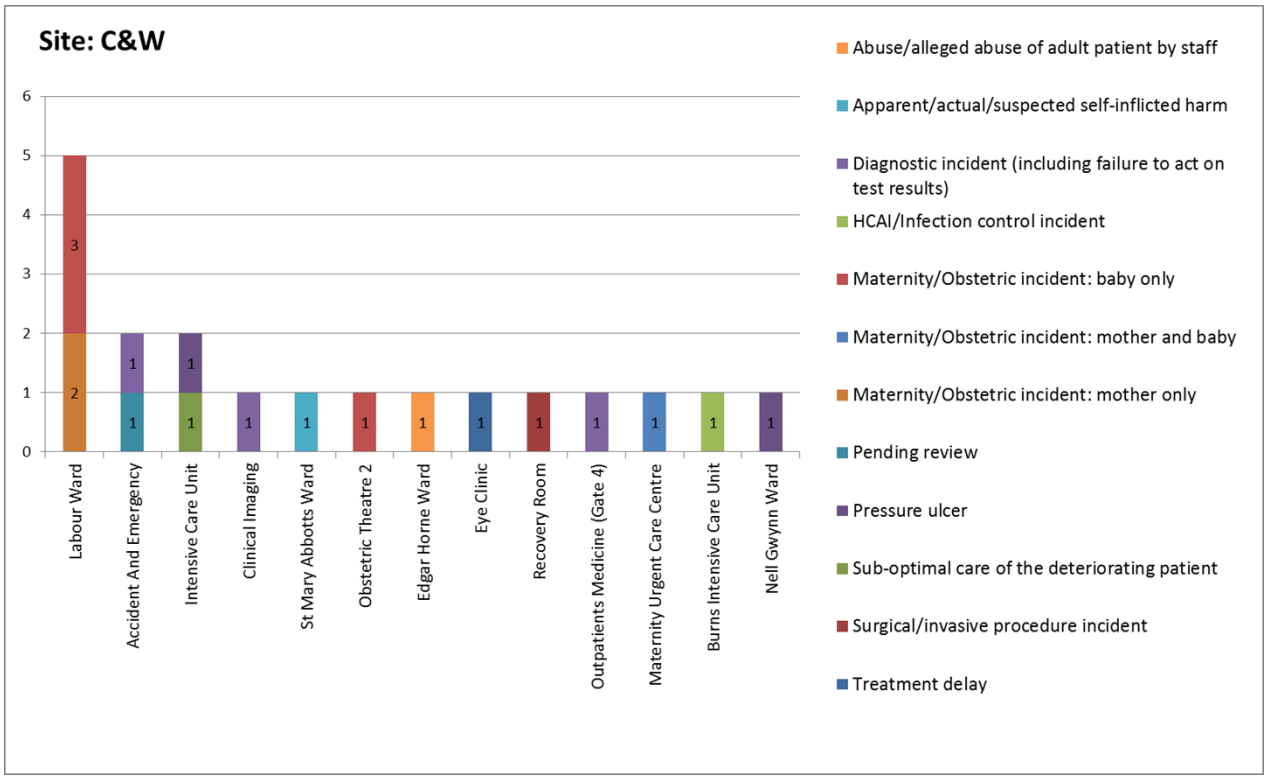


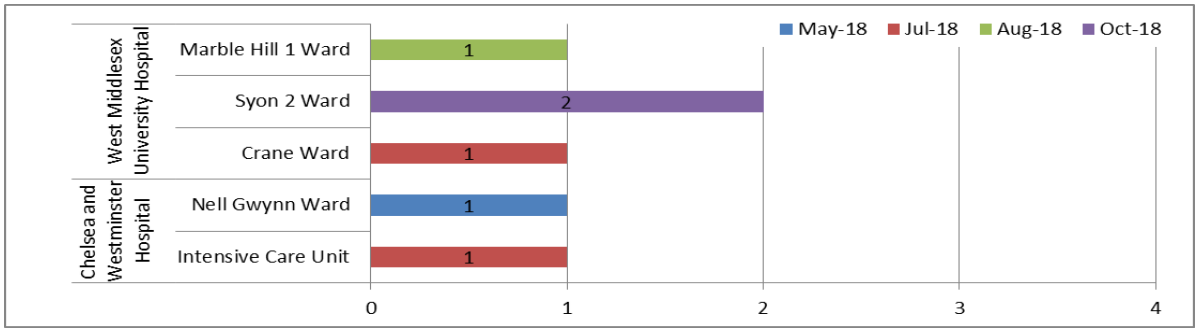
Chart 7 - Incident category and location exact, C&W 2018/19



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 year to date is 6 compared to 12 for the same time period in 2017/18. Very positive reflections that the interventions put in place are working.

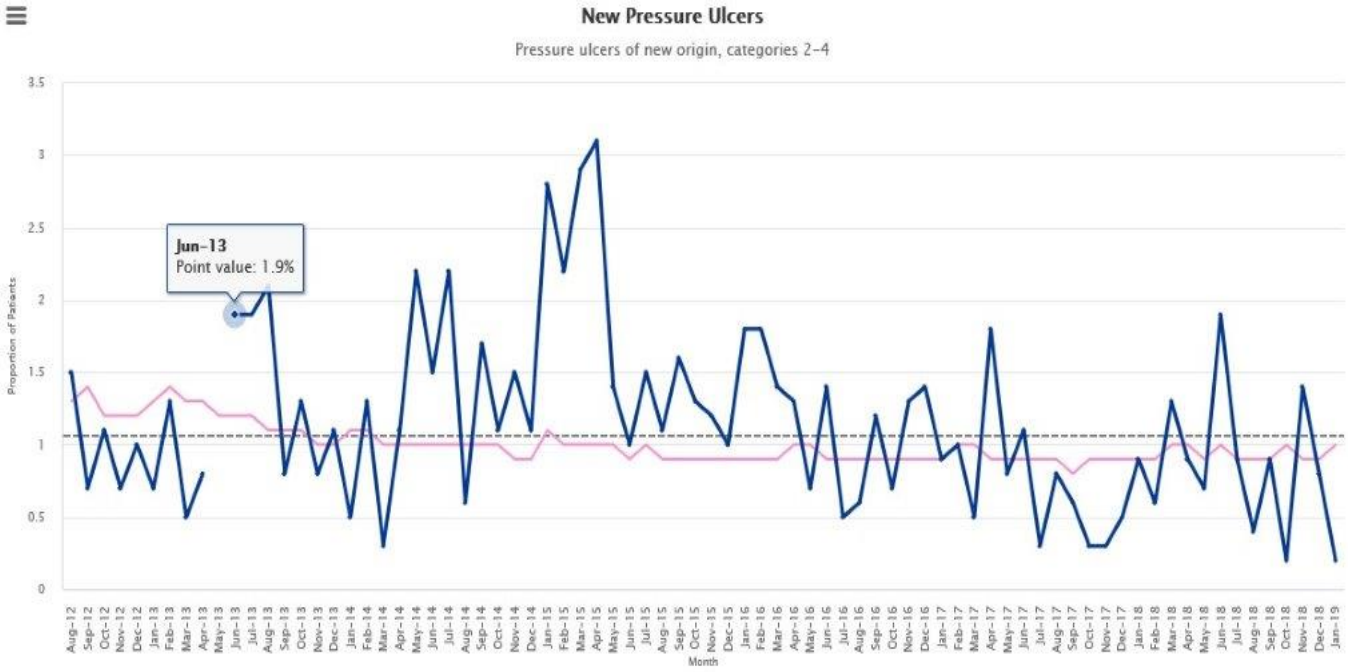
Chart 8 Pressure Ulcers by Location (exact) (Apr 2018–March 2019) YTD total =6



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 January 2019.

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

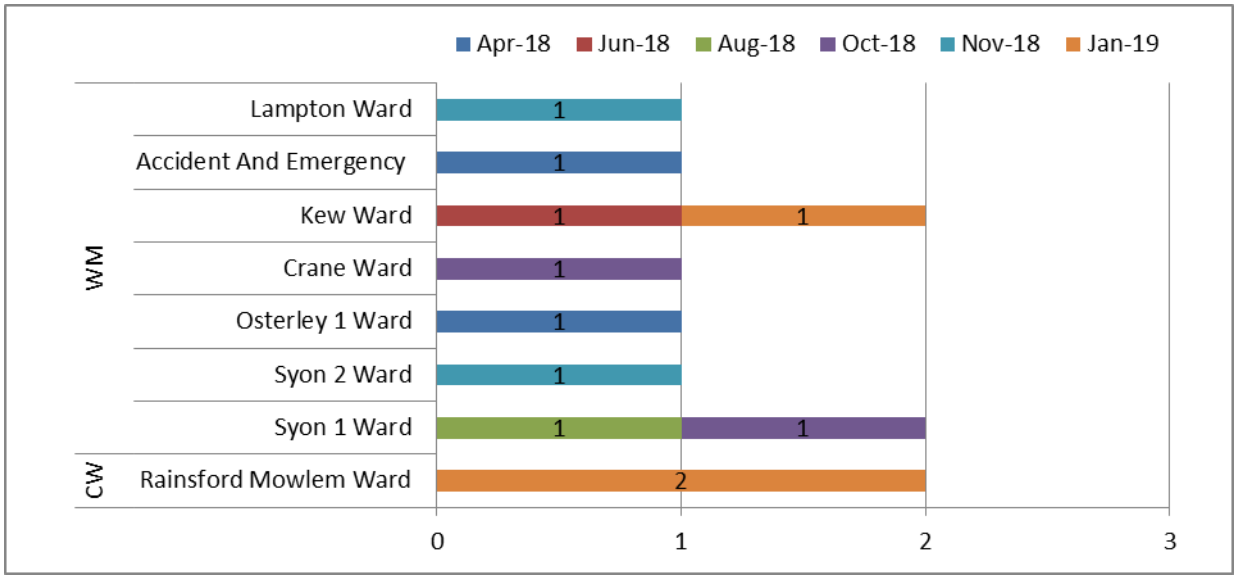


3.3 Patient Falls

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

Since the 1st of April 2018, the Trust has reported 11 patient falls meeting the serious incident criteria. Disappointingly the 2018/19 year to date position is 11 compared to 6 for the same period last year. 9 falls have happened on the WM site, and 2 falls have happened on the CW site. Learning from the SIs will be shared and reviewed at the falls steering group. In addition the falls steering group is reviewing all incidents of falls, not just the serious incidents and the Director of Nursing (WM) is undertaking a review of falls on the WM site.

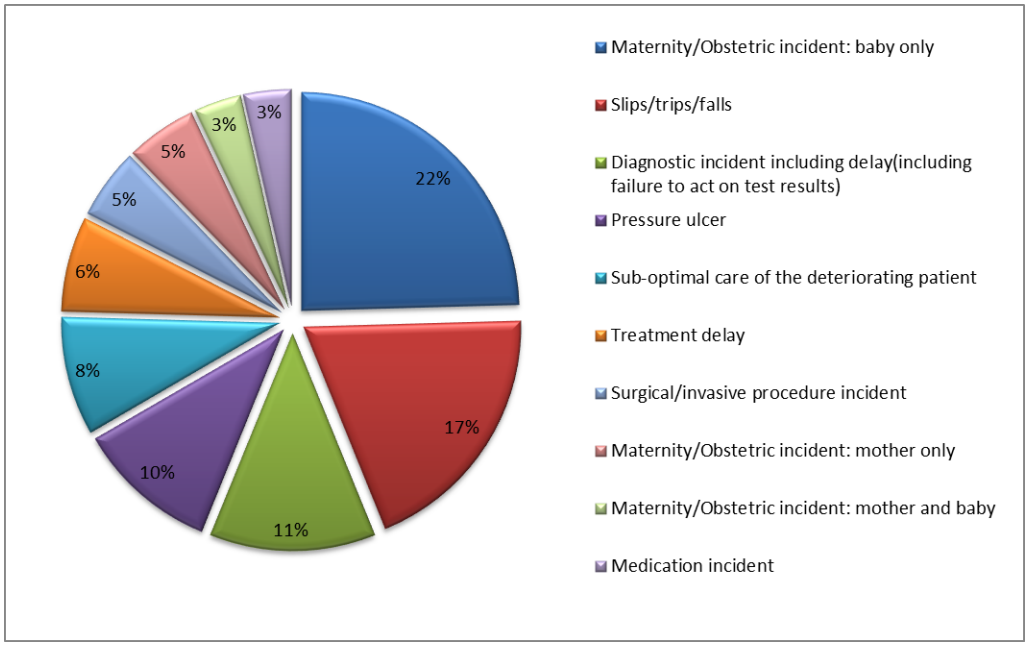
Chart 9 Patient Falls by Location (exact) (Apr 2018–March 2019) YTD total =11



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 16 of the SI categories.

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



YTD Maternity/Obstetric incident: baby only is the most reported SI category. This is followed by Slips/trips/falls and Diagnostic incidents.

3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (27).

Table 3

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Hospital Site	CCG Due date
2018/27968	04/10/2018	PC	Diagnostic incident (including failure to act on test results)	CW	20/02/2019
2018/27241	08/11/2018	WCHGDPP	Maternity/Obstetric incident: baby only	CW	11/02/2019
2018/28461	17/11/2018	PC	Sub-optimal care of the deteriorating patient	CW	26/02/2019
2018/28460	26/11/2018	WCHGDPP	Maternity/Obstetric incident: mother only	CW	26/02/2019
2018/29174	30/10/2018	WCHGDPP	Maternity/Obstetric incident: baby only	WM	06/03/2019
2018/28691	26/11/2018	EIC	Medical equipment/ devices/disposables incident	WM	28/02/2019
2018/29768	21/08/2018	EIC	Diagnostic incident (including failure to act on test results)	CW	14/03/2019
2018/29545	11/12/2018	EIC	Abuse/alleged abuse of adult patient by staff	CW	12/03/2019
2018/30378	22/07/2018	WCHGDPP	Surgical/invasive procedure incident	WM	21/03/2019
2018/30508	12/09/2018	WCHGDPP	Diagnostic incident (including failure to act on test results)	WM	25/03/2019
2019/90	11/10/2018	PC	Treatment delay	CW	27/03/2019
2019/300	02/01/2019	WCHGDPP	Maternity/Obstetric incident: mother only	WM	01/04/2019
2019/1284	16/01/2019	EIC	Slips/trips/falls	WM	12/04/2019
2019/2011	18/01/2019	EIC	Slips/trips/falls	CW	23/04/2019
2019/1629	20/01/2019	EIC	Slips/trips/falls	CW	16/04/2019
2019/2408	26/01/2019	WCHGDPP	Maternity/Obstetric incident: baby only	CW	29/04/2019
2019/2405	29/01/2019	PC	Treatment delay	CW	29/04/2019
2018/29176	*02/12/2018*	WCHGDPP	*Maternity/Obstetric incident: baby only*	*WM*	*06/03/2019*
2018/29348	*06/12/2018*	WCHGDPP	*Maternity/Obstetric incident: mother and baby*	*CW*	*08/03/2019*
2018/29485	*06/12/2018*	WCHGDPP	*Maternity/Obstetric incident: baby only*	*WM*	*11/03/2019*
2018/29760	*12/12/2018*	WCHGDPP	*Maternity/Obstetric incident: baby only*	*WM*	*14/03/2019*
2018/30645	*23/12/2018*	WCHGDPP	*Maternity/Obstetric incident: baby only*	*CW*	*26/03/2019*
2019/719	*06/01/2019*	WCHGDPP	*Maternity/Obstetric incident: baby only*	*WM*	*05/04/2019*

The six maternity incidents highlighted grey are being investigated by the Healthcare Safety Investigation Branch (HSIB). The investigation reports will not be submitted to the Commissioners by the CCG due date, however will be submitted to them once the HSIB report is received. Current timescales for HSIB investigations is 6 months.

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 15 actions overdue at the time of writing this report. The divisions are asked to review these actions in advance of the Quality Committee so verbal update on progress can be provided.

Table 4 - SI Actions

	Month due for completion									
	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Total
Emergency and Integrated Care	2	0	7	2	0	0	0	0	0	11
Planned Care	2	1	6	19	8	0	0	0	0	36
Womens, Childrens, HIV, GUM and Dermatology	1	7	4	17	7	1	0	0	2	39
Total	**5**	**8**	**17**	**38**	**15**	**1**	**0**	**0**	**2**	**86**

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.

Table 4.1 – Type of actions overdue

Action type	EIC	PC	W&C,HGD	Total
Share learning (inc. feedback to staff involved)		2	2	4
Create/amend/review - Policy/Procedure/Protocol			3	3
Personal reflection/Supervised practice			2	2
One-off training	1		1	2
Audit		1		1
Perform risk assessment	1			1
Create/amend/review - proforma or information sheet			1	1
Duty of Candour - Patient/NOK notification		1		1
Grand Total	**2**	**4**	**9**	**15**

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 63 which is significantly less compared to the same reporting period last year and the year before (2016/17 = 77, 2017/2018 = 68). The reduction can be attributed to a reduction in the following categories: Pressure Ulcers, Alleged abuse, Treatment Delay and sub optimal care.

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	2	5	3	4	6	3	7	5			41
	CW	0	2	0	3	3	1	2	4	4	3			22
		3	**5**	**2**	**8**	**6**	**5**	**8**	**7**	**11**	**8**			**63**

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	1		1	13
Maternity/Obstetric incident: baby only		2	1					2		3	2	1	11
Slips/trips/falls					1		2	1	1	1	1	1	8
Sub-optimal care of the deteriorating patient	2	1	1	2					1				7
Treatment delay	1	2	1					1		1	1		7
Abuse/alleged abuse of adult patient by staff			1		1				2			2	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
Blood product/ transfusion incident			1										1
Environmental incident		1											1
Unauthorised absence												1	1
Medication incident			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
Maternity/Obstetric incident: baby only		1		1	1	1	1	2	5	2			14
Slips/trips/falls	2		1		1		2	2		3			11
Diagnostic incident (including failure to act on test results)		2	1	1				1	2				7
Pressure ulcer		1		2	1		2						6
Sub-optimal care of the deteriorating patient				3		1		1					5
Treatment delay						1	1			2			4
Surgical/invasive procedure incident				1	1				1				3
Maternity/Obstetric incident: mother only						1		1		1			3
Medication incident	1	1											2
Maternity/Obstetric incident: mother and baby							1		1				2
Pending review					1								1
Apparent/actual/suspected self-inflicted harm					1								1
VTE						1							1
Abuse/alleged abuse of adult patient by staff									1				1
Medical equipment/ devices/disposables incident									1				1
HCAI/Infection control incident							1						1
Grand Total	3	5	2	8	6	5	8	7	11	8			63

5.2 Site comparative analysis and StEIS reporting versus activity

There is a significant change in the number of SIs each site has reported since the 1st April 2018 compared to the same period in 2017/18. The number of incidents reported by WM has increased from 34 to 39 and the number reported by C&W has decreased from 34 to 24.

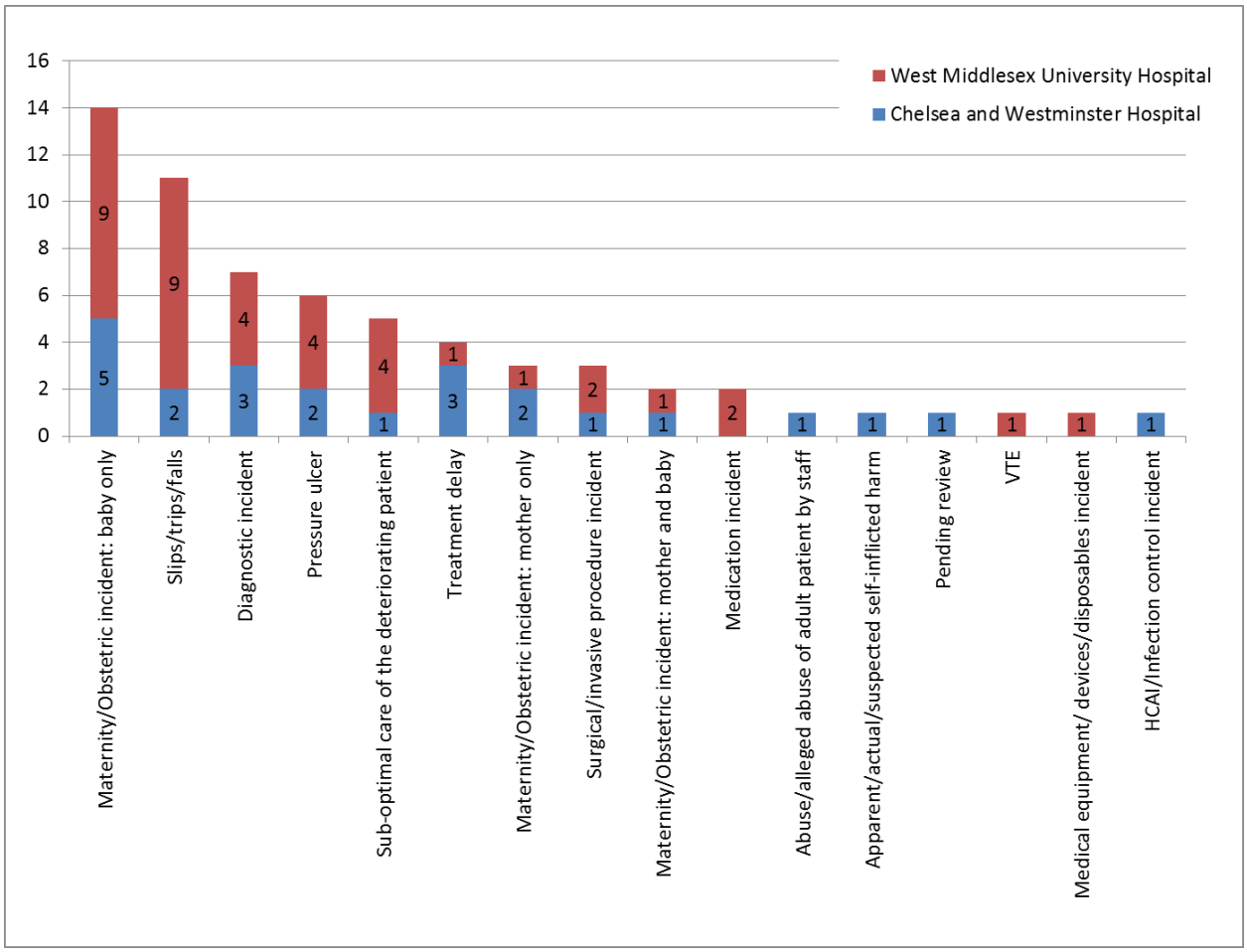
C&W have reported fewer pressure ulcers (-7), treatment delays (-2) and Diagnostic incidents (-2). WM have reported fewer diagnostic incidents (-3) and sub-optimal care of the deteriorating patient (-2) and have not reported any abuse/alleged abuse of adult patient by staff (-3).

WM has seen significant increases in the number of maternity/obstetric incidents: baby only (+6) slips/trips/falls (+4), medication incidents (+2) and surgical/invasive procedure incidents (+2).

YTD C&W's most reported incidents include maternity/obstetric incidents: baby only (5) and diagnostic incidents (3). WMs most reported incidents include maternity/obstetric incidents: baby only (9) and slips/trips/falls (9).

The increase in maternity incidents may be attributed to the agreement with the commissioners to externally report all HSIB investigations on StEIS.

Chart 11 – Serious Incidents reported by category and site (April 2018 – March 2019)



5.2.1 Site comparison – Patient safety incident reporting

Table 9 –Number of patient safety incidents and incident level (reported since 1st April 208)

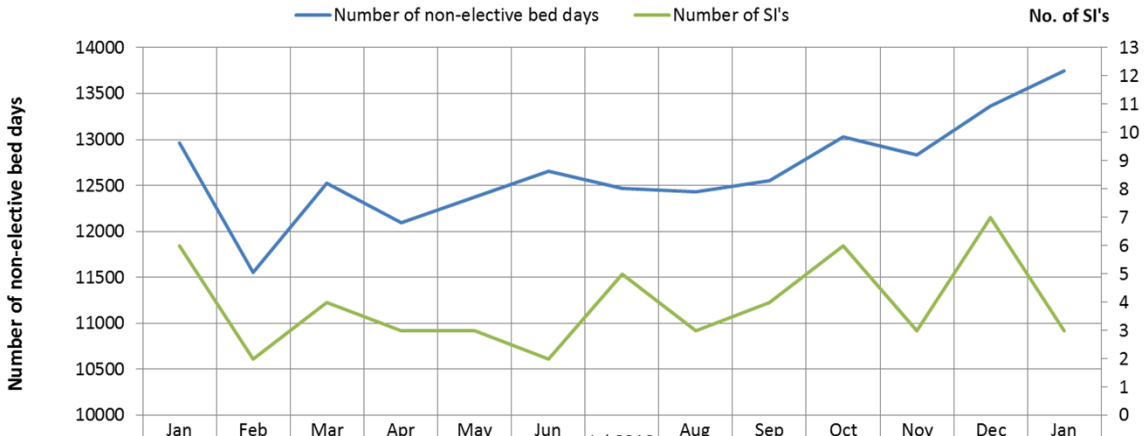
Current Incident level	CWH	WMUH	Total
Level 1 - Not a serious incident	6595	5976	12571
Level 2 - Internal Serious Incident	42	30	72
Level 3 - External Serious Incident (StEIS reportable)	24	39	63
Grand Total	**6661**	**6045**	**12706**

WM have reported a higher number of external SIs and C&W have reported a higher number of internal SIs. All level 2 and 3 incidents are endorsed by the Chief Nurse and/or Medical Director and are disucssed at the Executive Quality and Safety Group.

5.3 Serious Incidents and activity

Charts 12 and 13 provide an overview of the number of SIs reported in comparison to the number of non-elective bed days for each site.

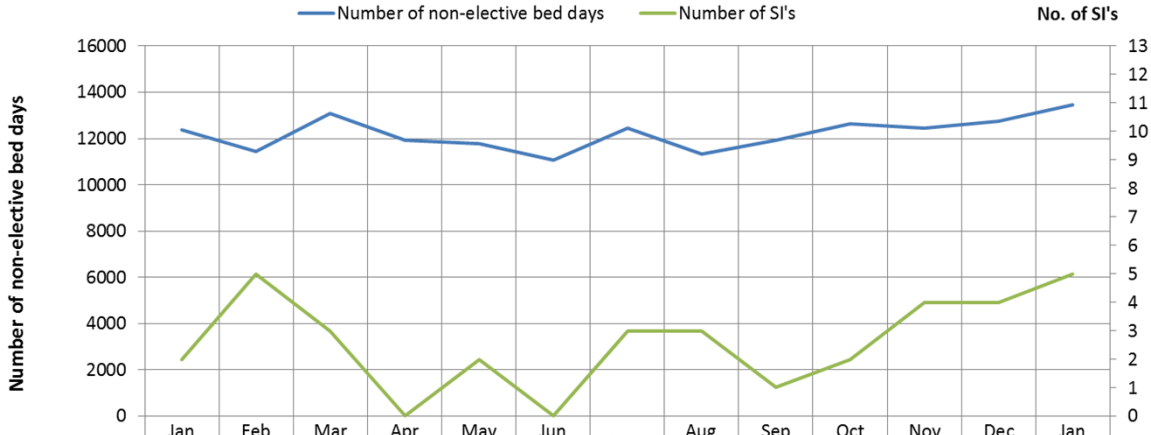
Chart 12 – No. of SI's in relation to the no. of non-elective bed days: January 2018 to January 2019 – WM site



	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019
Number of non-elective bed days	12960	11555	12525	12093	12373	12655	12466	12431	12556	13031	12836	13368	13750
Number of SI's	6	2	4	3	3	2	5	3	4	6	3	7	3
Reporting rate per1000 Bed Days	0.46	0.17	0.32	0.25	0.24	0.16	0.40	0.24	0.32	0.46	0.23	0.52	0.22

The West Middlesex site has an average reporting rate of 0.31 SIs per non-elective 1000 bed days. Since January 2018, the highest reporting rate was recorded in December 2018 at 0.52. 7 SIs were reported in December 2018 of which 4 of them were Maternity/Obstetric incidents.

Chart 13 – No. of SI's in relation to the no. of non-elective bed days: January 2018 to January 2019 –C&W site



	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019
Number of non-elective bed days	12373	11435	13101	11943	11781	11051	12442	11316	11944	12643	12444	12760	13459
Number of SI's	2	5	3	0	2	0	3	3	1	2	4	4	5
Reporting rate per1000 Bed Days	0.16	0.44	0.23	0.00	0.17	0.00	0.24	0.27	0.08	0.16	0.32	0.31	0.37

The Chelsea and Westminster site has an average rate of 0.21 SIs per 1000 non-elective bed days. Since January 2018, the highest reporting rate was recorded in February 2018 at 0.44.

Chart 14 – Serious Incident Reporting Rate per 1000 Non-Elective Bed Days – WMUH

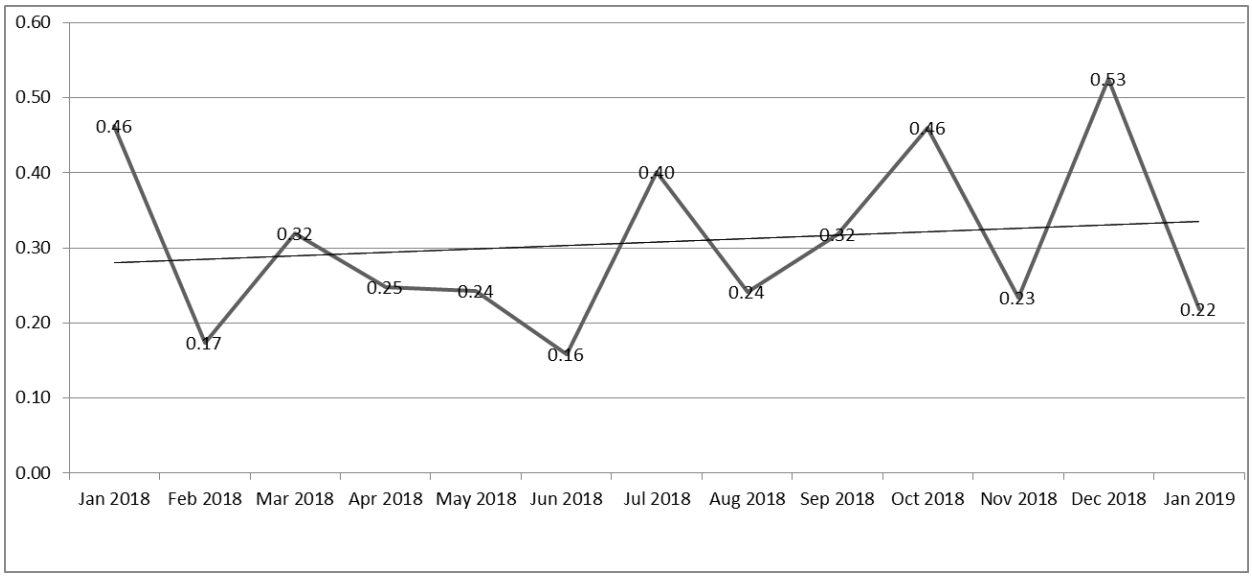
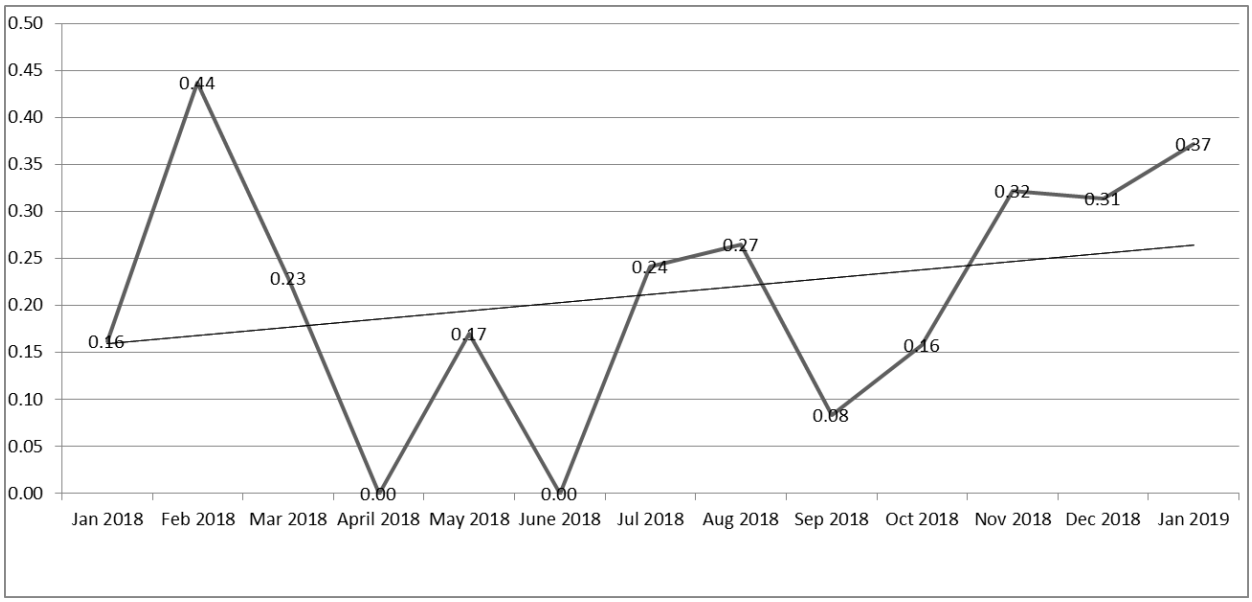


Chart 15 – Serious Incident Reporting Rate per 1000 Non-Elective Bed Days – CWH



The number of non-elective bed days is higher on the West Middlesex site and WM have reported a higher number of SIs. With the exception of February, August and November 2018, the SI rate per 100 admissions exceeds the CW SI rates each month.

It is possible that differences in the population demographic, hospital services (and surrounding health economies have a strong influence on this rate, therefore, it should only be used to demonstrate the differences between the two hospital sites.

6.0 Serious Incident De-escalations

The Trusts has only requested de-escalation for one SI during 2018/2019 (2018/20712 - Maternity/Obstetric incident: baby only) The commissioners declined to grant the de-escalation request for this case, due to the organisational learning that was identified following the investigation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.4/Mar/19
REPORT NAME	Report to the Trust Board from the Health, Safety and Environment Risk Group for period September 2018 – February 2019.
AUTHOR	Alex Bolton, Head of Health, Safety and Risk
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	This report provides assurance to the Board on the work of the Health, Safety and Environmental Risk Group (HSERG) and updates the Board on progress developing, implementing and embedding the Trust's governance arrangements relating to the management of Health, Safety and Risk.
SUMMARY OF REPORT	This report provides the organisation with details of the work of Health, Safety and Environmental Risk Group (HSERG) between September 2018 and February 2019. The report provides the Board with an overview of all key aspects of the HSERG agenda and the subgroups that report to the HSERG.
KEY RISKS ASSOCIATED	• Potential under reporting of staff safety incidents (violence and aggression) at the West Middlesex University Hospital site. • Establishment of Safer Sharps Group
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Managing H&S at ward and department level is of paramount importance to protecting staff and patients.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Delivering high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For comment

Health, Safety and Environmental Risk Group
Summary of business; September 2018 – February 2019

Introduction

This paper provides the Board with a summary of business undertaken by the Health, Safety and Environmental Risk Group between September 2018 and February 2019.

1. National Priorities

1.1 CAS Alerts; Estates and Facilities Notifications

4 Estates and Facilities Alerts were received by the Trust between 1st September 2018 and 22nd February 2019:

- EFA/2019/001, Portable fans in health and social care facilities: risk of cross infection
- EFA/2018/007, Fire risk from personal rechargeable electronic devices
- EFA/2018/006, Vernacare Vortex macerator: potential to contamination mains water supply.
- EFA/2018/005, Assessment of ligature points

The delivery of these safety actions is in progress and all alerts are currently within deadline and on track for closure within required timescales; oversight and assurance is provided by the HSERG.

95% of Estates and Facilities Alerts received by the Trust during financial year 2018/19 have been closed within the required timeframe; one alert relating to the risk of accidental detachment of Integrated Plumbing System (IPS) Panels was not completed by the planned due date. An in-depth review of ISP panels was undertaken but due to scale of equipment review action to fully identify and undertaken required risk assessment was not be achieved within timeframe.

Completion rates and outcomes are monitored by the Health, Safety and Environmental Risk Group on a monthly basis; the group has developed the tracking and reporting arrangements and confirmed membership requirements to ensure awareness and response to alerts supported.

1.2 RIDDOR

13 incidents meeting the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) criteria were identified during this reporting period. No significant variation in the occurrence of RIDDOR applicable events has been identified; 9 cases were reported during the comparable time period 2017/18.

RIDDOR events are reported to the Health, Safety and Environmental Risk Group (HSERG) on a monthly basis to support trend recognition, shared learning and improvement action.

The following RIDDOR applicable incidents were investigated by the local management team with support from the Health & Safety and Occupational Health departments where required:

- Needlestick, Marble Hill 2, WM
- Needlestick, Osterley 2, WM
- Needlestick, Ron Johnson, CW
- Needlestick, Gazzard Day Unit, CW
- Needlestick, Dean Street
- Needlestick, Treatment Centre, CW
- Sharps injury, Imaging, CW
- Splash / Accidental substance release, ITU, CW
- Splash / Accidental substance release, Labour Ward, WM
- Splash / Accidental substance release, ITU, CW

- Slip/trip/fall (staff), Medical day Unit, CW
- Physical assault, Hospital grounds, WM
- Injury when handling/lifting/carrying, Medical Records, WM

Incidents associated with needlestick / sharps injuries and splashes of contaminated fluids are key trends associated with RIDDOR reporting.

- The HSERG is attended by the Occupational Health Manager to support understanding and mitigation relating to needlestick and splash.
- Dashboards, reports and automatic email alerts have been developed within the incident reporting system to ensure staff involved in incidents are offered the appropriate Occupational Health department support in the event they do not self-present.
- Overarching trends and risks associated with these incident types are monitored on a quarterly basis by the HSERG.

2. Incidents affecting staff

The Health, Safety and Environmental Risk Group (HSERG) receive quarterly reports regarding incidents affecting staff. The aim of these reports is to highlight the types of incidents that are being reported across the organisation and the associated learning.

Learning from staff safety incident reporting within Q2 2018/19 was considered by the HSERG in December 2018; of note from this report:

The top three reported incidents affecting staff during Q2 2018/19:

- **Assault, abuse and aggression**: 169 total, top 3 areas; A&E CW (26), David Erskine CW (14), Osterley 2 WM (14)
- **Personal accidents, injuries and illness**: 95 total, top 3 areas; ITU CW (6), A&E WM (5), Osterley 2 WM (5)
- **Staffing issues**: 78 total, top 3 areas; David Erskine CW (12), Labour Ward CQ (7), Antenatal clinic WM (6)

Within Q2 the Trust experienced a 21% increase in the reporting of incidents of assault, abuse and aggression (affecting staff) at ChelWest site and a 3% decrease at WestMid compared to the previous quarter. Accident and Emergency departments are high risk areas for violence and aggression; during Q2 there were 26 incidents associated with A&E at ChelWest but only 3 incidents associated with the WestMid A&E. The HSERG is attended by Divisional representatives and the Local Security Management Specialist to support accurate incident identification and reporting.

There was a small increase in the number of incidents affecting staff reported in Q2 (401) compared with the previous quarter (333) and the same reporting period last year (Q2 2017/18; 325). This increase is predominantly associated with the ChelWest site from which 175 staff incident were reported in Q2 2017/18 compared with 248 in Q2 2018/19 (percentage change of 42%); at WestMid site 144 incidents were reported in Q2 2017/18 compared with 148 in Q2 2018/19 (percentage change of 3%).

The HSERG has considered the potential for under reporting of staff safety incidents and Divisional representatives are engaging management teams to identify occurrences and support staff to report safety incidents affecting them or their colleagues. Reporting trends for Q3 2018/19 will be presented to the HSERG in March 2019 for further action.

Overarching learning from incident investigation is cascaded by the members of the HSERG to their respective Divisional teams.

3. Health and Safety risks

The Health, Safety and Environmental Risk Group provides assurance that risks primarily relating to Health and Safety and the Physical Environment are being appropriately managed and mitigated. This assurance process aims to consider whether; identified risks reflect reality, controls are effective, actions are sufficient, actions are being delivered, risk scores are being updated as new information becomes available, target risk scores are achievable.

There are currently 274 live risks recorded across the organisation of which 28 relate to health and safety and 8 to the physical environment. The HSERG considers controls and planned mitigation actions for all health and safety and physical environment domain risks graded at or above 9 on a monthly basis; there are currently 6 risks meeting this criteria:

- ID48, Violence & Aggression (trust wide risk); mitigation led by Security department
- ID460, Violence & Aggression in the Emergency Department; mitigation led by EIC
- ID300, Non-compliance with FFP 3 (Respiratory Protective Equipment) fit testing; mitigation led by EIC
- ID390, Nitrous Oxide exposure, Maternity cross site risk; Mitigation led by WCHGD
- ID410, Ventilation verification non-conformities; mitigation led by Estates and Facilities
- ID665, Access control to plant rooms; mitigation led by Estates and Facilities

Where appropriate risk items are scheduled for individual agenda items or sub-group consideration to support understanding and delivery of mitigation actions.

Violence and Aggression

The risk of harm to staff due to violence and aggression within the workplace is recorded within the organisations risk register (ID 48); the overarching risk for all staff is currently scored as 9 (consequence moderate 3 x likelihood possible 3). It is recognised that some trust areas operate with higher risks of violence and aggression; a location specific risk is recorded for the emergency department (ID 460); due to increasing occurrence of these events the risk grading for this area is scored 12 (consequence moderate 3 x likelihood likely 4). Controls and actions arising from these risks are recorded within the register and are tracked by the HSERG with themes, controls and planned mitigation actions reported on a quarterly basis via the security group report. The following mitigations to address violence and aggression have been developed since last report to Board:

- Amendment incident categorisation system to support tracking (confirmation of medical factors, aggravating factors and restraint use)
- Introduction of 24/7 security presence in WestMid Emergency Department
- Local Security Management Specialist and Senior Nursing Group working to engage WestMid staff in process of reporting incidents of violence and aggression
- Revision of training provision for clinical staff (250 staff trained to new programme as of December 2018)
- Review of management of violence and aggression policy
- Violence and Aggression Staff Safety Group expanded to better share learning and mitigation actions
- Monthly meetings between Emergency Department management and Security Service providers
- After action reviews of physical assault incidents utilising CCTV and body worn camera footage to support learning and improvement

Non-compliance with FFP 3 (Respiratory Protective Equipment) fit testing

Insufficient front line clinical/nursing respiratory protective equipment fit testers could potentially expose staff to contracting infectious diseases. In February 2019 the HSERG considered updates from the Head of Emergency Preparedness, Resilience and Response on the delivery of fit testing;

assurance of delivery and compliance improvement in fit testing training was noted. Much improved position reported following initial training programme delivery and planning now being developed to ensure competency levels are sustained; risk scored to be reduced and approved by the HSERG in March 2019.

Nitrous Oxide exposure and Ventilation verification non-conformities
A programme of environmental monitoring to investigate the levels of nitrous oxide and other anaesthetic agents (sevoflurane, desflurane and isoflurane) is undertaken to satisfy the requirements of Regulation 10 of the Control of Substances Hazardous to Health 2002 Regulations (COSHH) and provide assurance that staff / patient safety is being maintained. A potential risk of increased exposure levels to nitrous oxide above the workplace recommended levels was identified within maternity areas and the ChelWest MRI scanner room. Based on best available information regarding the risk to staff from exposure and peer organisations response to nitrous oxide monitoring the probability of staff requiring professional intervention or the trust receiving challenging external recommendations is deemed to be low; therefore the consequence described is 'moderate' and the likelihood 'possible' within the standard risk matrix, the risk is therefore currently scored as 9.The following key actions have been delivered:

- Ventilation upgrade within WestMid maternity unit for areas of highest exposure
- Ventilation upgrade within ChelWest MRI room
- Ventilation upgrade within ChelWest maternity and theatres is in process as part of the site development

The HSERG will consider updates regarding the functioning of ventilation systems (ventilation verification) and proposal for re-testing exposure levels in previously identified high risk areas in March 2019; risks scores will be considered for upgrade following results of testing.

Access control to plant rooms
The risk of unauthorised access to critical plant equipment is tracked by the HSERG following identification of deterioration to the electronic door locks for plant within ChelWest site. Interim rectification to damaged doorframes and locks has been provided to secure site and a business plan to provide enhanced security for critical plant that provides a longer term solution is being developed. The HSERG have scheduled a standalone agenda item to consider plant room security arrangements in March 2019.

4. Training compliance

Health & Safety training
Trust wide health and safety training compliance is 96%; the figures below were reported to the HSERG in February 2019:

Health and Safety training (mandatory)	ChelWest	WestMid
Overall	96%	96%
Corporate functions	98%	100%
Emergency and Integrated Care	95%	95%
Planned Care Division	95%	96%
Women's, Children's, HIV/GUM, Derm.	96%	96%

Fire training
Trust wide fire safety training compliance is 92%; the figures below were reported to the HSERG in February 2019:

Fire Safety training (mandatory)	ChelWest	WestMid
Overall	92%	93%
Corporate functions	91%	97%
Emergency and Integrated Care	91%	93%
Planned Care Division	92%	93%
Women's, Children's, HIV/GUM, Derm.	92%	92%

Weekly fire training sessions, fire marshal courses, targeted departmental sessions, bespoke ad-hoc course and online learning are provided to raise awareness and support a coordinated response to the provision of training.

Liquid nitrogen
Liquid nitrogen is used within Sexual Health Clinics, Dermatology, Children's OPD and ACU. The hazards arising from use are; risk of asphyxiation when used or stored in poorly ventilated areas and cryogenic burns. Each area has a Safe Operating Procedure and arrangements for staff training.

For the cohort of identified liquid nitrogen dispensing staff training compliance is 92%, the HSERG were assured in November 2018 that staff who did not complete the training requirements were not being permitting to use liquid nitrogen.

5. Sub-Groups

5.1 Radiation Safety Group

A report was received from the Radiation Safety Group in January 2019. The HSERG noted the 6 CQC reportable radiation incidents occurring between January and December 2018 all of which related to unintended radiation dose (5 plain X-ray / 1 CT). 3 radiation specific risks were flagged to the group relating to availability of drawing up room at ChelWest, aging equipment and process for requesting x-rays before starting theatre cases. Development of, and compliance with, the request process within theatres was considered and divisional representation to support rectification confirmed, updates to be returned to the HSERG at next report. The Policy for Safe Use of Ionising Radiation has been updated to reflect legislation changes.

5.2 Medical Gases Group

A report was received from the Medical Gases Group in October 2018. The report highlighted continuing gaps in the appointment of critical roles that support the work of the group; Engineering Manager for Estates and Authorised Persons (currently only one Medical Gas Approved Person at WestMid site). The group highlighted work in progress to replace Drager medical pendants in order to meet HTM 02-01, at WMUH replacement of hoses all completed supported by Life Cycle funds, at CWH pendants are significantly older and therefore if hoses are replaced, these will not be underwritten by Drager; assessment being undertaken on the benefit in undertaking work to replace all hoses in favour of waiting for all pendants and hoses to be fully replaced in the future.

The report highlighted compliance and learning from patient safety alert NHS/PSA/W/2018/001 regarding incorrect operation of oxygen cylinder controls and provided update on training and policy development / harmonization. Update was provided on the contract for the supply of piped and cylinder oxygen at both sites.

The Pharmacy Department have taken the lead on updating the Trust Medical Gases Policy and harmonising it across both hospital sites with support from on-going sub-group meetings involving key stakeholders.

5.3 Moving and Handling Group

A report was received from the Moving and Handling Group in February 2019. The report highlighted delivery of tailored programme of ward based and off-ward training being offered and request support to ensure staff could be released. Mandatory training compliance reported as; inanimate loads 94% (improvement from 93% previously reported), patient handling 90% (improvement on 81% previously reported). Group noted 61% increase in completion of Patient Handling Risk Assessments (compliance 98.5% WestMid, 84% ChelWest).

HSERG members were updated on the procurement and delivery of gantry hoists and hoverjack devices at both sites and discussed suitable long term storage arrangements to ensure ease of access when required; training and standard operating procedures to be cascaded following equipment delivery.

The group considered learning from moving and handling incidents, themes arising from investigation including; failure to undertaken moving and handing risk assessment prior to patient moves resulting in issues such as allocating the incorrect number of people to support a safe PAT slide transfer, issues with poor manual handling techniques were also highlighted within the incidents. Members of the HSERG supporting cascade of learning.

5.4 Fire Action Group

A report was received from the Fire Action Group in October 2018. The report highlighted the progress made to migrate the old ChelWest fire detection and alarm system the new system and raised challenges / risks posed by; testing of the alarm sounders across the site and the associated disturbance this causes to staff and patients, the identification and correction of faults on both old and new systems, and the passing of responsibility for routine fire alarm testing to new estate contractors JCA.

The group also highlighted learning from 4 fire alarm activations in October that were linked to; steam leaking from a faulty radiator valve, smoking / vaping in lower ground floor WC and burnt toast. Signage regarding smoking has been placed within the toilets affected and security are aware. HSERG members requested to cascade requirement to report any persons smoking or vaping on premises and ensure that toasters are not used in any area of the hospital apart from designated kitchen areas. The Fire Safety Policy is being updated and will be returned to the Fire Action Group and HSERG for ratification.

5.5 Security Group

A report was received from the Security group in December 2018. The report highlighted the impacts violence and aggression had on the Trust's ability to provide a safe and secure environment for patients, staff and visitors particularly within the emergency departments. The group highlighted risks and examples of incidents occurring within the organisation, it was noted that violence and aggression reporting was increasing at ChelWest site and reducing at WestMid, support was requested from divisional representatives to ensure occurrences were logged and investigation outcomes shared.

Developments to the management of violence and aggression policy were presented, the document has been streamlined and divisional support has been provided to improve its usability for staff.

5.6 Safer Sharps Group
The joint approach between Corporate Nursing and Occupational Health to establish and lead the organisations safer sharps group was discussed in January 2019; the HSERG is supporting leadership and attendance to ensure appropriate oversight and assurance is provided for this important area of staff safety. Terms of reference are being updated and quarterly reports will be provided to HSERG.
5.7 Waste and Sustainability Group
The interim Waste Management Policy was presented to the HSERG in December 2018; it was highlighted that the policy would only be in operation until April 2019 by which point the changes to histology / mortuary waste disposal processes would be complete and the new waste processing plant (Sterilewave) would have been installed at WestMid. Update on the installation of the new processing plant and introduction of the offensive waste stream at WestMid will be monitored by the HSERG.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.5/Mar/19
REPORT NAME	Mortality Surveillance – Q3 2018/19
AUTHOR	Alex Bolton, Head of Health Safety and Risk
LEAD	Zoe Penn, Medical Director Roger Chinn, Deputy Medical Director and Chief Clinical Information Officer
PURPOSE	This paper updates the Board on the process compliance and key metrics from mortality review.
SUMMARY OF REPORT	The Trust wide Hospital Standardised Mortality Ratio (HSMR) relative risk of mortality, as calculated by the Dr Fosters 'Healthcare Intelligence indicator', between December 2017 and November 2018 was 74.4 (69.8 – 79.2); this is below the expected range. Ten months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced during the twelve month period to end of November 2018. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust. Mortality case review is undertaken following all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss). The outcome of the Trust's mortality review process, review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG). The group also scrutinises mortality analysis drawn from a range of sources to support understanding and to steer improvement action. The Trust aims to review 80% of all mortality cases within 2 months of death. 297 cases for review were identified within Q3 2018/19, of these 44% have been reviewed and closed. 3 cases of suboptimal care have been identified within Q3 to date. Identified sub-optimal care cases have been discussed at local specialty Morbidity and Mortality (M&M) meetings and themes have been identified at the Mortality Surveillance Group. Key themes this financial year include: Recognition, escalation and response to deteriorating patients, Delays in assessment, investigations or diagnosis, Establishment and sharing ceilings of care discussions, Handover between clinical teams and Medication errors. Learning from deaths dashboard included in Appendix A.
KEY RISKS ASSOCIATED	Engagement: Lack of full engagement with process of recording mortality reviews within the centralised database within 2 months of death impacting quality of output and potential missed opportunities to learn / improve.
FINANCIAL IMPLICATIONS	Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
QUALITY IMPLICATIONS	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Deliver high quality patient centred care
DECISION/ ACTION	The Board is asked to note and comment on this report

Mortality Surveillance – Q3 2018/19

1. Background

Mortality case review provides clinical teams with the opportunity to review expectations, outcomes and potential improvements with the aim of:

- Identifying sub optimal care at an individual case level
- Identifying service delivery problems at a wider level
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

Case review is undertaken following all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss). Learning from review is shared at Specialty mortality review groups (M&Ms / MDTs). Where issues in care, trends or notable learning are identified action is steered through Divisional Mortality Review Groups (EIC) and the trust wide Mortality Surveillance Group (MSG).

2. Relative risk of mortality

The Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHMI) are used by the Mortality Surveillance Group to compare relative mortality risk.

The Trust wide HSMR relative risk of mortality, as calculated by the Dr Fosters 'Healthcare Intelligence indicator', between December 2017 and November 2018 was 74.4 (69.8 – 79.2); this is below the expected range.

Ten months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced during the twelve month period to end of November 2018. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust.

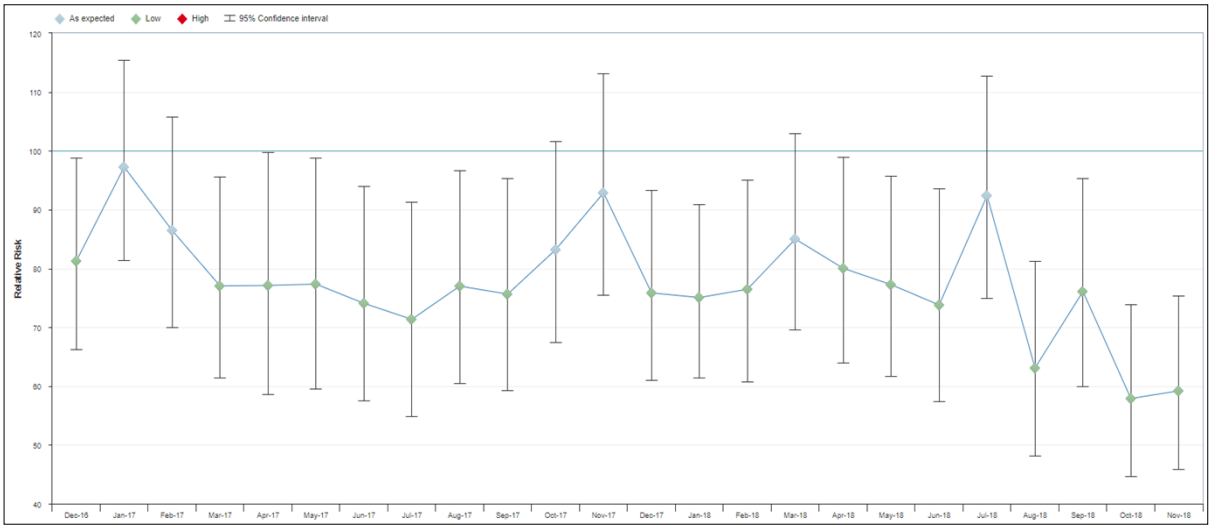


Fig 1: Trust HSMR 24-month trend (December 2017 to November 2018)

Improving relative risk of mortality has been experienced across both sites since March 2017. During the 12 month period to November 2018 the HSMR relative risk of mortality at ChelWest was 69.7 (63.6-76.2); at WestMid it was 75.7 (70.3-81.3), both sites operated below the expected range.

3. Diagnostic & procedure groups

The overall relative risk of mortality on both sites is within the expected range, however, the Mortality Surveillance Group seeks further assurance by examining increases in relative risk associated with procedure and diagnostics groups. Where higher than expected relative risk linked to a diagnostic or procedure group is identified a clinical coding review is undertaken and where indicated comment from clinical team is sought. Following clinical coding review no patient safety concerns have been raised with individual procedure or diagnostic groups during this reporting period.

4. Crude rate

Crude mortality should not be used to compare risk between the sites; crude rates are influenced by differences in population demographics, services provided and intermediate / community care provision in the surrounding areas. Crude rates are monitored by the Mortality Surveillance Group to support trend recognition and resource allocation.

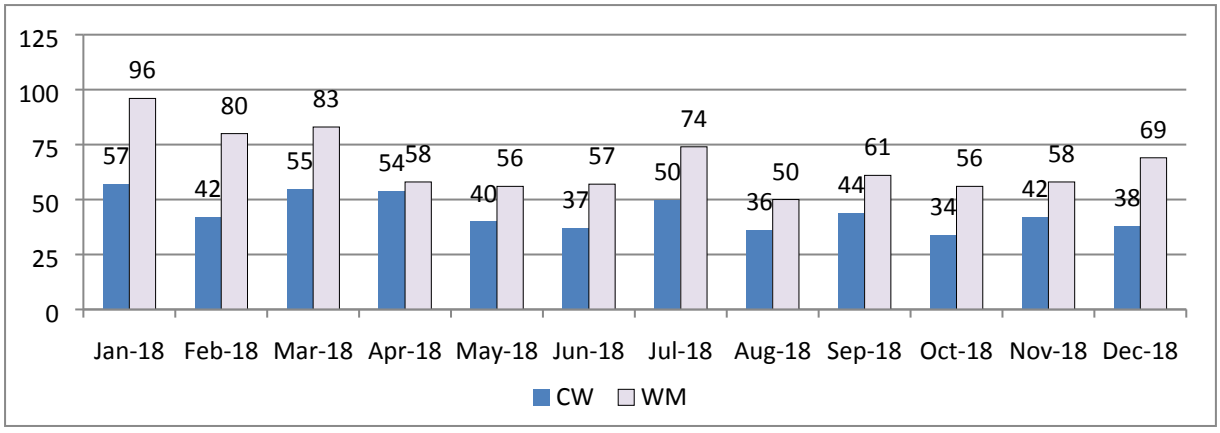


Fig 2: Total mortality cases logged to Datix by site and month, January 2018 – December 2018

5. Review completion rates

5.1. Closure target

The Trust aims to complete the mortality review processes for 80% of cases within two months of death.

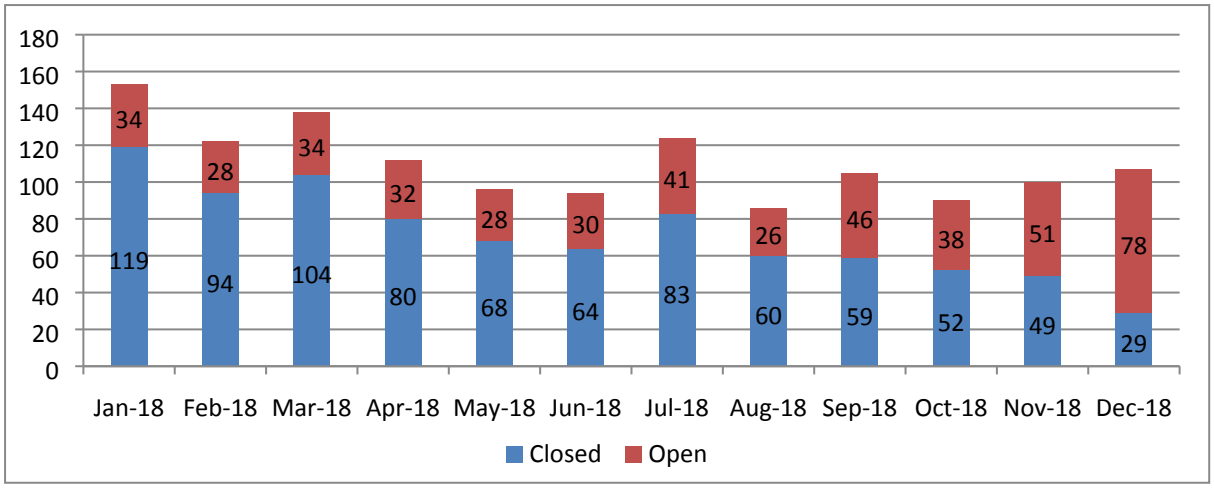


Fig 3: Open and Closed mortality cases by month, January 2018 – December 2018

1327 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period; of these 861 (65%) have been reviewed by the named consultant (or nominated colleague) and closed following specialty M&M/MDT discussion and agreement.

	Q4 2017/18	Q1 2017/18	Q2 2018/19	Q3 2018/19	Total
Total	413	302	315	297	**1327**
open	96	90	113	167	**466**
closed	317	212	202	130	**861**
%	**77%**	**70%**	**64%**	**44%**	**65%**

Table 1: Cases by financial quarter, January 2018 – December 2018

297 cases are recorded as occurring within Q3 2018/19 of these 44% have been reviewed, discussed at MDT/M&M and closed. Clinical teams aim to close cases within two months of death.

	Q4 2017/18	Q1 2017/18	Q2 2018/19	Q3 2018/19	Total
EIC	76%	71%	69%	49%	**67%**
PCD	74%	64%	33%	14%	**47%**
WCHGD	93%	76%	63%	57%	**72%**
Total	**77%**	**70%**	**64%**	**44%**	**65%**

Table 2: Percentage of closed cases by division and fin. quarter, January 2018 – December 2018

The Mortality Surveillance Group has overseen the following actions to promote the review and closure of mortality cases required to achieve the 80% review within 2 months of death target:

- Mortality Surveillance Group monitoring and promoting review process
- Divisional Medical Directors supporting the engagement of clinical teams
- Effectiveness of review arrangements in specialties with low review closure levels being assessed by clinical teams / service directors.
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- Guidance for Divisional / Specialty mortality review practice provided by the Heads of Quality and Clinical Governance

6. Sub-optimal care

Cases are graded using the Confidential Enquiry into Stillbirth and Deaths in Infancy scoring system:

- **CESDI 0**: Unavoidable death, no suboptimal care
- **CESDI 1:** Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **CESDI 2:** Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- **CESDI 3:** Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

CESDI grades are initially scored by the reviewing consultant and are then agreed at Specialty MDT/M&M. All cases of suboptimal care are considered by the mortality surveillance group. Where cases are graded as CESDI 2 or 3 they are considered for Serious Incident investigation.

44 cases of suboptimal care were identified via the mortality review process between January 2018 and December 2018:

- **38 CESDI grade 1**: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **5 CESDI grade 2**: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death).
- **1 CESDI grade 3***:* Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

CESDI grades for closed cases occurring in Q3 2018/19

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3	Total
EIC	107	3	0	0	110
PCD	7	0	0	0	7
WCHGD	13	0	0	0	13
Total	**127**	**3**	**0**	**0**	**130**

CESDI grades for closed cases occurring in Q2 2018/19

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3	
EIC	163	7	0	0	170
PCD	10	1	1	1	13
WCHGD	16	3	0	0	19
Total	**189**	**11**	**1**	**1**	**202**

When reviewing deaths the aligned specialty considers the patient's full episode of care e.g. the mortality review aims to identify sub-optimal care that occurs prior to the reviewing specialty taking on the management of that patient. This ensures that opportunities to improve the services offered by the organisation are identified across the full pathway rather than being limited to leading solely from the care provided directly by the specialty that was responsible for the patient at the time of death.

Maternity / Obstetrics, Acute Medicine and Anaesthetics / ITU have identified the most opportunities for improvement via the mortality review process; the sub-optimal care identified may have occurred within previous specialties involved in that patient's care rather than the specialty undertaking the review therefore this should not be considered a measure of safety. The identification of sub-optimal care provides assurance to the committee that specialties are engaging in the mortality review process.

6.1. Overarching themes / issues linked to sub-optimal care

Review groups discuss the provision of care / treatment; where element of suboptimal care are identified recommendations for further action are recorded. Review themes are considered by the Mortality Surveillance Group.

The key sub-optimal care themes across both sites during 2018/19 relate to:

- The recognition, escalation and response to deteriorating patients
- Delays in assessment, investigations or diagnosis
- Establishing and sharing ceilings of care discussions
- Handover between clinical teams
- Medication errors

The MSG, in coordination with other governance and operational groups, utilises learning from review to develop high level actions designed to improve outcomes, reduce suboptimal care and gather further assurance evidence. Key improvement actions tracked by the mortality surveillance group this financial year are:

- Trust wide planning for the implementation of medical examiners and development of bereavement services, due September 2019
- Review of inter hospital transfer policy, due February 2019
- Review of approach to major haemorrhage process, due February 2019
- Development of registrars with ultrasound competency required to place central lines; action overseen by Clinical Effectiveness Group, due March 2019
- Action plan to address national learning from the Learning and Disabilities Mortality Review programme, completed July 2018
- Introduction of treatment and escalation plans to support end of life care decision making, completed May 2018

7. Conclusion

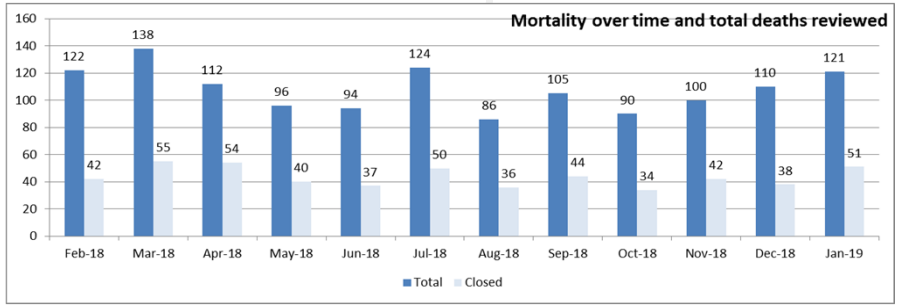
The outcome of mortality review is providing a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality has been experienced since March 2017 and has continued within Q3 2018/19; this is an indicator of improving outcomes and safety.

Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, 2018/19

Summary of total number of in-hospital deaths and total number of cases reviewed (includes adult/child/neonatal deaths, stillbirths, late fetal losses)

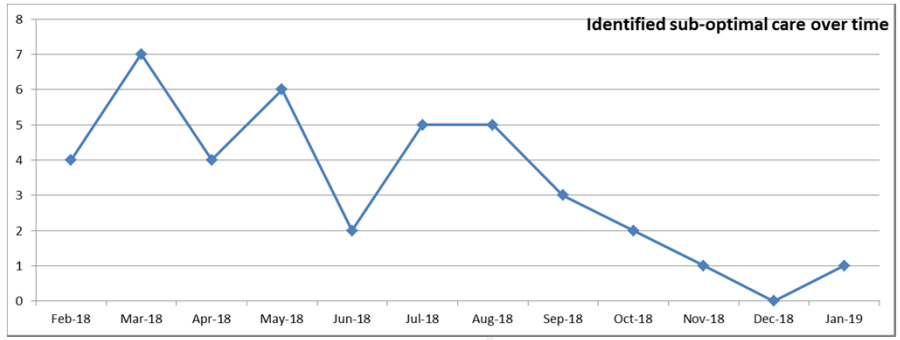
Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)
121	110	24	29	1	0
Q3	Q2	Q3	Q2	Q3	Q2
300	315	114	130	3	13
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
1038	1403	426	1214	29	76



Total Deaths Reviewed by CESDI Grade
Note: CESDI grades may change following in-depth investigation (carried out for all CESDI grade 2 and 3 cases)

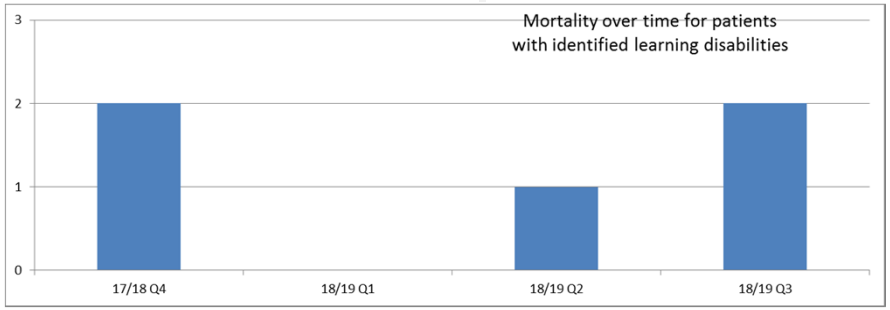
Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome		Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)	
Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)
1	0	0	0	0	0
Q3	Q2	Q3	Q2	Q3	Q2
3	11	0	1	0	1
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
10	12	3	9	1	1



Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodolog

Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care for patients with identified learning disabilities

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)	Last Month (Jan)	Previous Month (Dec)
0	0	0	0	0	0
Q3	Q2	Q3	Q2	Q3	Q2
2	1	1	1	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
3	7	2	7	0	0



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.6/Mar/19
REPORT NAME	Integrated Performance Report – January 2019
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for January 2019 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 January 2019. **Regulatory performance** – The A&E Waiting Time figure for January is showing 94.23% against the 95% standard. This has raised us to be the 4th highest performing Trust nationally and the top performing trust in London against this target, even though there was a 0.69% drop in performance against December. The RTT incomplete target was for the Trust in January currently stands at 92.66% (pre-sign off). This maintains the performance against this metric, which has passed each month but one in the last 12 months. There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue. Delivery of the 62 Day standard is currently meeting the target in January. Each month in 2018/19 to date has exceeded the national target. All other reportable Cancer metrics exceeded the target. There was 1 reported C Diff infection reported at West Middlesex in January. **Access –** The Diagnostic wait metric returned 99.27%. This maintains the trust performance, which has passed each month but one in the last 6 months.
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 2 week, 31 and 62 day waits remains a high priority. The Trust will continue to focus on any Diagnostic Waiting time issues in the weeks to come.
FINANCIAL IMPLICATIONS	The Trust is reporting a YTD surplus of £21.985m which is £10.49m favourable against the internal plan (£000s) – excluding impairment adjustments.

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 January 2019 and to note that whilst some indicators were not delivered in the month, the overall YTD compliance remained good.

TRUST PERFORMANCE & QUALITY REPORT

January 2019

NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.1%	95.0%	94.3%	95.4%	92.7%	94.8%	94.1%	94.6%	93.8%	94.9%	94.2%	94.2%	95.0%		!
RTT	18 weeks RTT - Admitted (Target: >90%)	79.6%	84.3%	80.4%	76.8%	75.4%	72.7%	70.6%	77.1%	77.5%	79.3%	76.5%	76.5%	77.0%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	93.6%	94.6%	94.9%	94.2%	83.4%	82.8%	84.0%	85.8%	89.4%	89.8%	90.4%	90.4%	91.0%		!
	18 weeks RTT - Incomplete (Target: >92%)	93.1%	94.1%	93.9%	92.3%	91.6%	91.1%	91.7%	92.5%	92.5%	92.9%	92.8%	92.8%	92.4%		!
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jan-19) in this report	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	98.6%	98.2%	96.8%	96.9%	95.0%	96.1%	92.3%	91.3%	96.6%	96.9%	94.0%	94.0%	93.6%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	96.3%	96.7%	94.9%	91.9%	96.3%	96.7%	94.9%	94.9%	91.9%		-
	31 days diagnosis to first treatment (Target: >96%)	96.9%	95.3%	96.9%	95.7%	98.3%	98.3%	97.5%	98.8%	97.8%	97.1%	97.2%	97.2%	97.5%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	100%	100%	96.3%	100%	100%	100%	100%	100%	100%	100%	100%	98.9%		-
	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%)	100.0%	92.7%	85.7%	87.9%	88.9%	91.2%	93.6%	90.1%	92.1%	91.8%	89.9%	89.9%	89.2%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	71.4%	100%	100%	91.4%	71.4%	100%	100%	100%	91.4%		-
Patient Safety	Clostridium difficile infections (Year End Target: 15)	1	0	0	7	0	0	1	7	1	0	1	1	14		-
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 – Types 1 & 3 Depts

The A&E 4hr target was narrowly missed in January with a performance of 94.2%. This raised us to be the 4th highest performing trust nationally and the 1st in London again this target. The increase in attendances to our Emergency Departments continues with growth of 10.6% in comparison to January 2018; over 90 additional patients per day.

Cancer

All cancer indicators were compliant for December apart from 31days diagnosis to first treatment; this was due to 2 treatment breaches.

Clostridium Difficile infections

There was one case of healthcare associated Clostridium Difficile in January 2019 at the West Middlesex site. There have been 14 cases year to date against a target of 15.

Self-certification against compliance for access to healthcare for people with Learning Disabilities

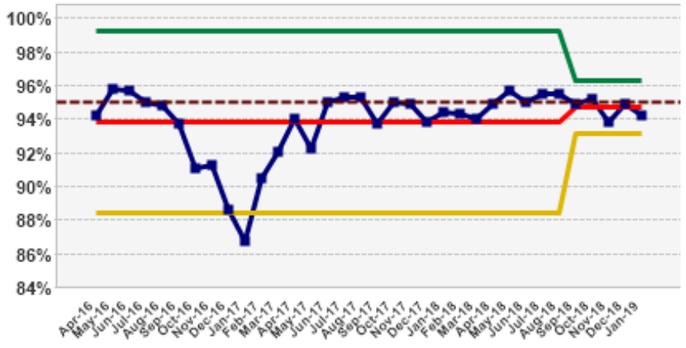
Both sites continue to remain complaint against this indicator.

SELECTED BOARD REPORT NHSI INDICATORS

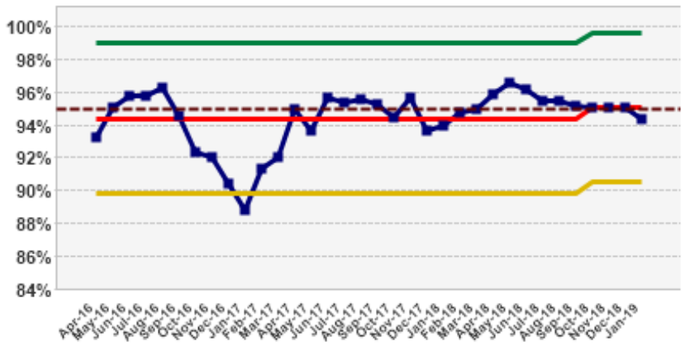
Statistical Process Control Charts for the 34 months April 2016 to January 2019

A&E 4 hours waiting time

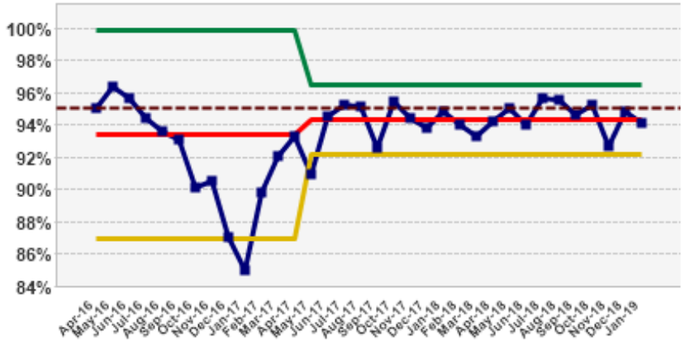
Trust Total



Chelsea and Westminster

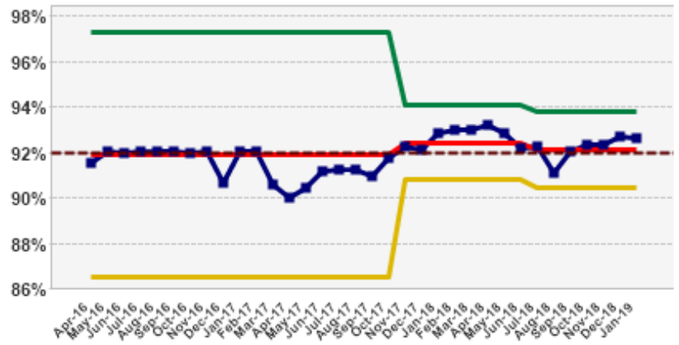


West Middlesex

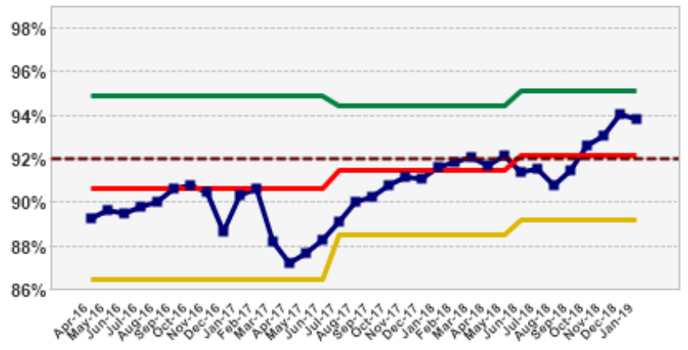


RTT Incomplete pathways

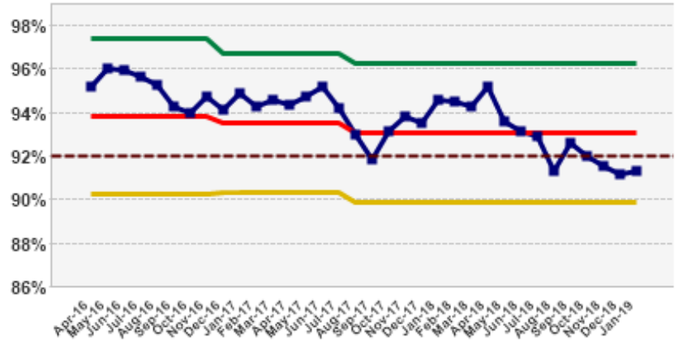
Trust Total



Chelsea and Westminster

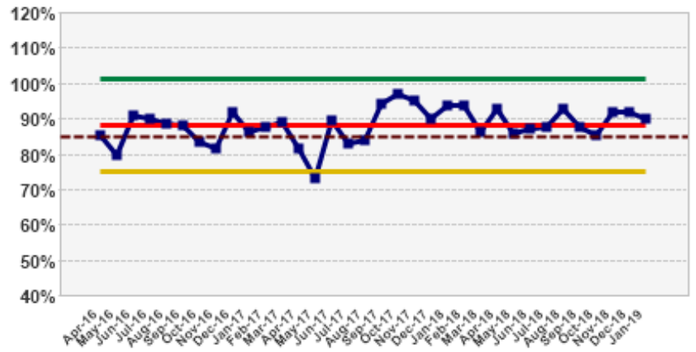


West Middlesex

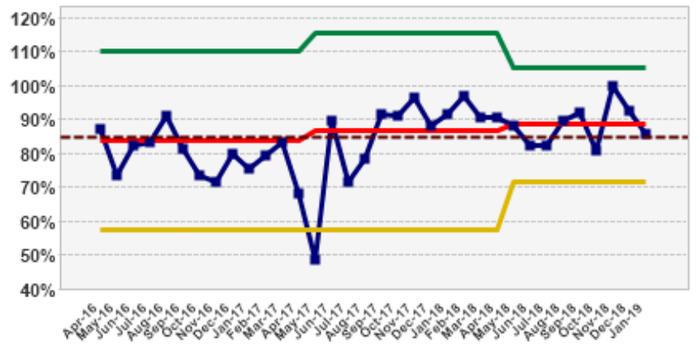


Cancer: 62 day standard

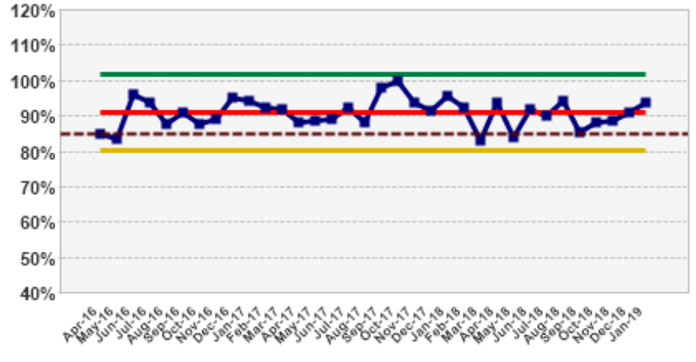
Trust Total



Chelsea and Westminster



West Middlesex



Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	1	0	0	1	2	0	0	1	1	3		-
	Hand hygiene compliance (Target: >90%)	96.5%	96.6%	96.1%	96.5%	80.7%	89.8%	96.7%	90.3%	92.3%	94.9%	96.3%	96.3%	94.6%		-
Incidents	Number of serious incidents	4	4	5	24	3	7	3	39	7	11	8	8	63		-
	Incident reporting rate per 100 admissions (Target: >8.5)	7.5	8.5	8.3	8.2	8.1	8.5	8.4	9.0	7.8	8.5	8.4	8.4	8.6		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.01	0.02	0.03	0.02	0.03	0.04	0.03	0.02	0.02	0.03	0.03	0.03	0.02		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	416.21	541.73	426.88	494.31	286.99	145.91	195.55	243.68	354.43	336.56	314.14	314.14	371.12		-
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	17.5%	7.2%	14.5%	13.3%	25.0%	0.0%	25.9%	13.7%	20.4%	5.6%	18.0%	18.0%	13.4%		-
	Never Events (Target: 0)	0	0	0	1	0	1	0	1	0	1	0	0	2		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	98.6%	95.4%	96.7%	96.1%	95.4%	96.8%	97.5%	95.2%	96.8%	96.3%	97.2%	97.2%	95.6%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	2	0	0	0	4	0	0	0	0	6		-
	NEWS compliance %	98.3%	96.5%	98.2%	97.5%	100.0%	99.3%	99.1%	98.2%	99.0%	97.4%	98.7%	98.7%	97.8%		-
	Safeguarding adults - number of referrals	26	24	41	247	12	14	28	138	38	38	69	69	385		-
	Safeguarding children - number of referrals	27	9	24	287	117	71	86	673	144	80	110	110	960		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80		-
	Number of hospital deaths - Adult	30	29	41	324	43	56	54	518	73	85	95	95	842		-
	Number of hospital deaths - Paediatric	0	2	0	7	0	0	0	0	0	2	0	0	7		-
	Number of hospital deaths - Neonatal	1	1	2	18	0	2	0	5	1	3	2	2	23		-
	Number of deaths in A&E - Adult	1	1	1	16	7	6	9	59	8	7	10	10	75		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	1	0	3	0	1	0	0	3		-
	Number of deaths in A&E - Neonatal	0	0	0	1	0	0	0	0	0	0	0	0	1		-

Trust commentary

MRSA Bacteraemia

There was one case of hospital acquired MRSA Bacteraemia in January at the West Middlesex site. This takes the yearly total to three.

Hand hygiene compliance

Hand hygiene compliance was achieved at both sites in January and the trust performance has increased to 94.6%. Hand hygiene audit completion was 100%.

Number of serious incidents

8 serious incidents were reported in January 2019 compared to 11 in December 2018. 5 serious incidents occurred on the Chelsea & Westminster site (2 patient falls, 2 treatment delays and 1 maternity incident) and 3 occurred on the West Middlesex site (1 patient fall and 2 maternity incidents). The serious incident report prepared for the board reflects further detail including learning from completed investigations.

Incident reporting rate per 100 admissions

Overall performance in January 2019 decreased to a rate of 8.3 compared to 8.5 from the previous month. Both sites fell below the expected target and overall trust performance stands at 8.3. The 2018/2019 year to date position is above the expected target range and is currently 8.6. We continue to encourage reporting across all staff groups, with a focus on the reporting of no harm or near miss incidents.

Trust Commentary (continued)

Rate of patient safety incidents resulting in severe harm or death per 100 admissions

There were 2 incidents resulting in severe harm. These were both reported on the West Middlesex site (1 failed discharge and 1 patient fall incident). There was 1 incident reported resulting in death. This was an unexpected death linked to a hospital-associated VTE that occurred on the West Middlesex site and is being investigated as an internal serious incident. The patient had multiple admissions for episodic painful spasms and was treated for Pregabalin withdrawal-associated symptoms. The patient refused 6 of her prophylactic injections and post-mortem confirmed that she died of pulmonary embolism and deep vein thrombosis. The case is still awaiting its specialty mortality review.

Medication-related safety incidents

82 medication-related incidents were reported at Chelsea & Westminster site compared to 36 at the West Middlesex site. There was also 1 medication related incident reported in the community/nursing clinics (provided by the trust). The Medication Safety Group is working to increase the reporting of medication-related incidents at West Middlesex, particularly around no harm and near miss incidents. During the Medication Safety Awareness week, incident reporting was featured on the stand on both sites to further encourage the reporting of medication-related incidents.

Never events

There were no Never Events reported in January 2019.

Medication-related (reported) safety incidents per 100,000 FCE bed days

The Trust has achieved an overall reporting rate of medication-related incidents involving patients (NRLS reportable) of 314/100,000 FCE bed days in January 2019. This is higher than the Trust target of 280/100,000. There were 434 and 188 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively.

Compared to December, there has been a 23% decrease in the reporting of medication incidents at CW site and a 29% increase in reporting of medication incidents at WM site. A Trust wide Medication Safety Awareness Week took place in the first week of February; its main focus was to drive medication-related incident reporting across the Trust.

Medication-related (reported) safety incidents % with harm

The Trust had 18% of medication-related safety incidents with harm in January 2019. This figure is higher than the previous month and above the Carter Dashboard National Benchmark (10.3%). The year to date figure is 13%. WM site rate for medication-related incidents with harm in January 2019 is 27%. This has increased from 0% in December, which may have been due to the previously low overall incident reporting rate at WM site. All 7 incidents reported at WM site in January 2019 have been of low harm.

There were 9 incidents that caused harm at CW site; 7 with low harm and 2 with moderate harm. Moderate harm incidents (i) missed doses of two oral antibiotics in a patient with infected diabetic foot ulcer and osteomyelitis resulting in raised inflammatory markers and wound deterioration; and (ii) tissued cannula resulting in the infiltration of Parenteral Nutrition to the tissue and subsequent 2nd degree tissue loss.

The common theme for low harm incidents (8/14) at both sites was missed doses, due to missed prescribing, missed administration and supply issues. The Senior Nurse and Midwifery Quality Round 08/02/2019 focussed on teaching regarding the importance of administering “critical medicines” within the prescribed time window, followed by an audit of practice to be reported back to the Medication Safety Group.

NEWS Compliance %

NEWS compliance has improved on both sites this month. We continue our monthly audit to highlight and address any areas of concern.

Safeguarding Adults – number of referrals

Pattern of safeguarding alerts remain consistent with previous reports.

Safeguarding children – number of referrals

Currently working on reviewing social services referrals/notifications to ensure parity cross site.

Summary Hospital Mortality Indicator (SHMI)

The trust is currently showing updated SHMI figures for the reporting period October 2017 – September 2018. The 0.80 performance figure relates to 1666 observed deaths / 2077 expected deaths.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	94.6%	93.2%	94.5%	92.4%	92.9%	95.6%	95.1%	92.1%	93.4%	94.8%	94.8%	94.8%	92.2%		-
	FFT: Inpatient not recommend % (Target: <10%)	2.6%	3.4%	2.3%	3.7%	2.9%	0.8%	0.7%	3.2%	2.8%	1.7%	1.3%	1.3%	3.4%		-
	FFT: Inpatient response rate (Target: >30%)	32.9%	14.8%	25.3%	37.5%	37.1%	16.5%	24.6%	36.3%	35.7%	15.9%	24.9%	24.9%	36.7%		-
	FFT: A&E recommend % (Target: >90%)	91.4%	91.2%	89.5%	90.5%	90.8%	89.7%	92.5%	89.5%	91.2%	90.9%	90.6%	90.6%	90.3%		-
	FFT: A&E not recommend % (Target: <10%)	5.1%	5.6%	6.7%	5.9%	4.7%	6.6%	4.4%	5.9%	5.0%	5.8%	5.9%	5.9%	5.9%		-
	FFT: A&E response rate (Target: >30%)	21.2%	19.5%	20.7%	21.0%	26.0%	19.9%	45.5%	22.6%	22.2%	19.6%	25.9%	25.9%	21.3%		!
	FFT: Maternity recommend % (Target: >90%)	91.6%	91.8%	93.0%	91.5%	96.8%	92.8%	93.1%	95.1%	92.2%	91.9%	93.0%	93.0%	92.0%		-
	FFT: Maternity not recommend % (Target: <10%)	5.6%	5.0%	4.3%	5.2%	3.2%	4.3%	5.6%	2.8%	5.4%	4.9%	4.5%	4.5%	4.9%		-
	FFT: Maternity response rate (Target: >30%)	20.2%	19.9%	22.0%	22.0%	21.1%	17.7%	19.1%	23.1%	20.3%	19.6%	21.7%	21.7%	22.1%		!
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	51	41	59	424	24	22	34	301	75	63	93	93	725		-
	Complaints formal: Number responded to < 25 days	36	29	36	312	18	13	18	205	54	42	54	54	517		-
	Complaints (informal) through PALS	164	121	185	1423	36	28	50	590	200	149	235	235	2013		-
	Complaints sent through to the Ombudsman	0	0	0	5	0	1	3	4	0	1	3	3	9		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	0	1	0	0	0	0	1		-

Trust commentary

Friends and family test

Inpatients - The trust continues to exceed the 90% target and almost achieved 95% this month. The response rate has improved but is yet to fully recover above the 30% target after issues with paper forms uploading last month.

Accident & Emergency - The response rate for ED has continued to improve and an excellent response rate of 45% was achieved in month at the WM site. ED continues to perform above the 90% target.

Maternity - The response rate for maternity services continues to improve and the recommendation score for both services has exceeded 95%.

Breach of same sex accommodation

There have been no same sex accommodation breaches.

Complaints

The number of complaints received this month have increased and compliance with 25 day response has been reduced to 69%. This is being addressed with the divisional teams concerned.

PHSO

There are not new outcomes reported from complaints currently being reviewed by the PHSO.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	3.36	3.49	4.34	3.93	2.81	3.78	3.84	3.03	3.23	3.55	4.23	4.23	3.72		-
	Average length of stay - non-elective (Target: <3.95)	4.16	3.70	3.98	3.92	2.99	3.28	3.06	3.09	3.50	3.45	3.44	3.44	3.44		-
	Emergency care pathway - average LoS (Target: <4.5)	4.74	4.34	4.71	4.47	3.40	3.81	3.34	3.52	3.90	3.99	3.83	3.83	3.86		-
	Emergency care pathway - discharges	226	214	244	2200	381	403	430	3917	607	618	674	674	6118		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	3.66%	4.07%	4.05%	3.85%	8.83%	10.62%	10.40%	10.27%	6.12%	7.27%	7.05%	7.05%	6.91%		!
	Non-elective long-stayers	436	408	438	4219	379	391	394	3801	815	799	832	832	8020		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	83.1%	85.7%	87.2%	84.1%	83.8%	84.5%	87.0%	86.2%	83.3%	85.3%	87.2%	87.2%	84.9%		-
	Operations canc on the day for non-clinical reasons: actuals	9	3	18	106	16	18	20	128	25	21	38	38	234		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.29%	0.12%	0.58%	0.38%	0.99%	1.66%	1.57%	0.98%	0.53%	0.59%	0.87%	0.87%	0.57%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	2	10	0	2	0	8	0	2	2	2	18		-
	Theatre active time (Target: >70%)	70.9%	71.2%	71.3%	72.3%	75.7%	71.9%	73.5%	76.0%	72.5%	71.5%	72.0%	72.0%	73.5%		!
	Theatre booking conversion rates (Target: >80%)	86.4%	86.7%	84.0%	85.5%	92.6%	91.7%	90.8%	91.1%	88.8%	88.5%	86.3%	86.3%	87.5%		-
Outpatients	First to follow-up ratio (Target: <1.5)	1.54	1.63	1.53	1.51	1.50	1.39	1.45	1.42	1.51	1.45	1.47	1.47	1.45		!
	Average wait to first outpatient attendance (Target: <6 wks)	6.9	6.5	7.1	6.8	6.0	5.9	7.1	6.2	6.5	6.2	7.1	7.1	6.6		!
	DNA rate: first appointment	11.4%	12.4%	11.6%	12.0%	11.9%	11.5%	13.0%	12.3%	11.6%	12.0%	12.2%	12.2%	12.2%		-
	DNA rate: follow-up appointment	10.7%	10.7%	10.0%	11.0%	11.0%	11.1%	11.8%	11.9%	10.8%	10.8%	10.6%	10.6%	11.3%		-

Trust commentary

Average length of stay – elective

An issue was identified at the Chelsea & Westminster site whereby patients from the Emergency Department were being admitted as elective. This has resulted in a much higher length of stay compared to the 3.1 days when you exclude these patients.

Daycase rate (basket of 25 procedures)

On the Chelsea & Westminster site, the number of day case procedures continues to increase following some specialty theatre lists moving from PM to AM sessions and allowing patients to recover for longer before going home the same day. Innovations in Trauma & Orthopaedics around partial knee replacements are being done a day case procedures.

Operations cancelled on the day for non-clinical reasons: % of total elective admissions

On the Chelsea & Westminster site, there has been an increase in the number which sees 38 patients cancelled on the day for non-clinical reasons. Of these, 3 were due to no ITU/HDU bed being available, 9 were due to clinical sickness, 10 patients declined the procedure and 9 were due to over-running theatres.

First to follow-up ratio

The Trust maintained an overall compliance for first to follow-up ratio's with an improvement on the Chelsea & Westminster site.

Average wait to first outpatient attendance

The Trust is non-compliant on the waiting time for the first attendances standard. The Trust is assessing the impact of the increase in two week wait referrals on both sites.

DNA rate

The DNA rate on the Chelsea & Westminster site has reduced by comparison to previous months. This is the result of the text reminder service working consistently. At the West Middlesex site, there have been technical issues with the text service which has now been rectified and daily checks are taking place.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	93.2%	89.0%	83.5%	87.1%	91.7%	92.5%	90.2%	88.0%	92.6%	90.3%	86.1%	86.1%	87.4%		-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	81.8%	86.7%	93.8%	93.5%	88.9%	88.9%	90.5%	89.6%	86.2%	87.9%	91.9%	91.9%	91.5%		!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	90.0%	100.0%	96.4%	100.0%	91.7%	90.0%	95.4%	100.0%	90.6%	95.5%	95.5%	95.9%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	94.2%	93.0%	92.7%	93.8%	50.3%	43.3%	44.5%	54.6%	75.7%	71.7%	72.9%	72.9%	76.0%		!
TB Care	TB: Number of active cases identified and notified	4	0	3	27	8	4	9	55	12	4	12	12	82		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

Trust commentary

Dementia screening case finding

Chelsea & Westminster: Work continues on improving dementia screening, including volunteers collecting data and producing ward specific lists to be reviewed at board rounds.

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

Chelsea & Westminster: Only one patient was delayed by more than 36 hours going to surgery in January and this was due to theatre capacity.

West Middlesex: Of the 22 #NOF patients, only one did not achieve the 36 hour target and this was due to the priority of other cases.

VTE Hospital-acquired

Chelsea & Westminster: Interim process in place to address the backlog of identification of hospital associated VTE events. Clinicians are encouraged to report hospital associated VTE events via Datix.

West Middlesex: Potential hospital associated VTE events identified and reported on Datix by responsible teams.

VTE risk assessment

Chelsea & Westminster: Performance has declined compared to previous months. Weekly and monthly VTE performance reports continue to be circulated to all divisions for dissemination and action, with inclusion in divisional quality reports. Lists of patients will outstanding assessments are circulated to medical teams for action.

West Middlesex: Target not achieved as lack of documented VTE risk assessments on RealTime e-system which is not used by medical staff until the point of discharge. The target is unlikely to be achieved due to current IT infrastructure and lack of resources which do not support VTE risk assessment processes. Work is under way to improve the overall compliance with VTE Risk Assessment by using a PDSA cycle to complete a manual assessment. In parallel, we are exploring the use of the CTE risk assessment form in Cerner with the view that it is brought forward and used at West Middlesex. This solution will provide long term improvement and stability for the risk assessment occurrence and completion. This improvement cycle is expected to take 6-8 weeks from 1st February 2019.

TB: Number of active cases identified and notified

There were three cases notified. This is for Chelsea & Westminster only as per the London TB Register. Chelsea & Westminster TB Service also manage TB cases at the Royal Brompton.

Access Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	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%)	99.16%	99.30%	98.61%	98.92%	99.49%	99.53%	99.76%	98.94%	99.38%	99.44%	99.27%	99.27%	98.93%		-
	Diagnostic waiting times >6 weeks: breach actuals	18	22	49	291	22	23	11	496	40	45	60	60	787		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.2%	9.5%	9.1%	9.0%	8.2%	7.8%	8.5%	8.2%	8.8%	8.9%	8.9%	8.9%	8.8%		!
	A&E time to treatment - Median (Target: <60')	01:11	01:04	01:14	01:07	00:51	00:48	00:55	00:49	01:04	00:59	01:08	01:08	01:02		!
	London Ambulance Service - patient handover 30' breaches	23	39	29	168	48	25	34	465	71	64	63	63	633		-
	London Ambulance Service - patient handover 60' breaches	0	3	1	6	0	0	0	4	0	3	1	1	10		-
Choose and Book (available to Nov-18 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	2371	2962	3661	2209	0	0	0	0	2371	2962	3661	3661	2209		-
	Choose and book: capacity issue rate (ASI)															-
	Choose and book: system issue rate	140	145	154	134											-

Trust commentary

RTT Incompletes 52 week Patients at month end

The trust continues to report zero 52 week breaches at either site in 2018/19.

Diagnostic waiting times <6 weeks: %

The combined trust has achieved the diagnostic waiting time standard of 99% tests completed within 6 weeks of referral for the fourth consecutive month. This follows an entirely compliant Q3 and improves the year-to-date position to a marginally non-compliant 98.93%.

For January 2019:
Chelsea site reported 98.61%
West Middlesex site reported 99.79%
The combined trust performance for January 2019 is reported as 99.28%

Diagnostic waiting times >6 weeks: breach actuals

Across both Trust sites, 59 breaches were reported which is slightly higher than recent months.

The CW site was responsible for 49 breaches, the bulk of these were in Endoscopy and Urology who contributed a total of 37 breaches. The remainder were spread fairly evenly across CT scanning, MRI scanning (Imaging), Neuro-Physiology and Paediatric Urology.

The WM site reported 10 breaches; 7 from Endoscopy and 3 from Non-Obstetric Ultrasound.

A lack of consultant capacity is cited as the main cause in Endoscopy; the team has identified the required actions to resolve the situation.

London Ambulance Service – patient handover 30 / 60 minute breaches

The Trust continues to be one of the highest performing in London on ambulance handover times, despite increasing A&E activity and ambulance conveyances.

There was one 60 minute ambulance breach at the Chelsea & Westminster site in January, at a time when there were no free cubicles in the department. This breach has been investigated as an incident and the department's escalation process for managing ambulance handover has been reviewed to ensure appropriate escalation and action to avoid such breaches in future.

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	Trend charts	
Birth indicators	Total number of NHS births	478	501	485	4873	364	399	383	3877	842	900	868	868	8750		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	30.3%	33.7%	35.7%	34.2%	31.9%	30.6%	28.2%	29.5%	31.0%	32.3%	32.4%	32.4%	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%)	99.5%	99.5%	94.1%	97.1%	97.4%	96.8%	96.6%	97.4%	98.6%	98.2%	95.2%	95.2%	97.2%		-
Safety	Admissions of full-term babies to NICU	7	12	10	145	n/a	n/a	n/a	n/a	7	12	10	10	145		-

Trust commentary

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	Nov-18	Dec-18	Jan-19	2018-2019	YTD breaches	Nov-18	Dec-18	Jan-19	2018-2019	YTD breaches	Nov-18	Dec-18	Jan-19	2018-2019 Q4	2018-2019	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Breast	n/a	n/a	n/a	n/a		88.9%	100%	100%	98.9%	1	88.9%	100%	100%	100%	98.9%	1		-
	Colorectal / Lower GI	100%	50.0%	100%	93.1%	2	100%	50.0%	75.0%	89.3%	4	100%	50.0%	88.2%	88.2%	91.0%	6		-
	Gynaecological	n/a	100%	100%	89.3%	1.5	100%	n/a	100%	86.7%	2	100%	100%	100%	100%	87.9%	3.5		-
	Haematological	100%	100%	n/a	100%	0	100%	100%	100%	87.0%	3	100%	100%	100%	100%	90.3%	3		-
	Head and neck	100%	100%	n/a	91.7%	0.5	33.3%	100%	100%	70.8%	3.5	60.0%	100%	100%	100%	77.8%	4		-
	Lung	n/a	100%	100%	76.9%	1.5	n/a	100%	n/a	79.2%	2.5	n/a	100%	100%	100%	78.4%	4		-
	Sarcoma	n/a	n/a	n/a	100%	0	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	100%	0		-
	Skin	100%	100%	100%	97.0%	2	100%	100%	100%	98.7%	0.5	100%	100%	100%	100%	97.7%	2.5		-
	Upper gastrointestinal	100%	100%	0.0%	82.8%	2.5	100%	100%	100%	95.5%	0.5	100%	100%	50.0%	50.0%	88.2%	3		-
	Urological	100%	88.2%	66.7%	75.9%	16	84.4%	81.8%	88.9%	82.7%	18	88.1%	84.0%	75.0%	75.0%	80.1%	34		-
	Urological (Testicular)	100%	100%	n/a	100%	0	n/a	n/a	n/a	100%	0	100%	100%	n/a	n/a	100%	0		-
	Site not stated	n/a	100%	n/a	66.7%	0.5	n/a	n/a	n/a	100%	0	n/a	100%	n/a	n/a	87.5%	0.5		-

Trust commentary

There were 4.5 breaches of the standard: 3 at Chelsea with 1.5 at West Middlesex.

Split by Tumour site the breaches were as follows:

Tumour Site	Chelsea Site		West Middlesex Site	
	Breaches	Treatments	Breaches	Treatments
Breast	-	-	0	6
Colorectal / Lower GI	0	4.5	1	4
Gynaecological	0	1	0	1.5
Haematological	-	-	0	3
Head and Neck	-	-	0	0.5
Lung	0	1.5	-	-
other/not stated	-	-	-	-
Sarcoma	-	-	-	-
Skin	0	6	0	3.5
Upper Gastrointestinal	0.5	0.5	0	0.5
Urological	2.5	7.5	0.5	4.5

CQUIN Dashboard

January 2019

National CQUINs (CCG commissioning)

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
A.1	Improvement of health and wellbeing of NHS staff	Chief Financial Officer	
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	Chief Financial Officer	
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	Chief Operating Officer	
E.1	Preventing ill health through harmful behaviours - alcohol and tobacco consumption	Deputy Chief Executive	
F.1	STP Local Engagement	Chief Financial Officer	

National CQUINs (NHSE Specialised Services commissioning)

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
N1.1	Enhanced Supportive Care	Medical Director	
N1.2	Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy	Medical Director	
N1.3	Optimising Palliative Chemotherapy Decision Making	Medical Director	
N1.4	Hospital Medicines Optimisation	Medical Director	
N1.5	Neonatal Community Outreach	Chief Operating Officer	
N1.6	Dental Schemes - recording of data, participation in referral management & participation in networks	Chief Operating Officer	
N1.7	Armed Forces Covenant	Chief Operating Officer	

2018/19 CQUIN Scheme Overview

The Trust has agreed 12 CQUIN schemes (5 national schemes for CCGs, 7 national schemes for NHS England) for 2018/19. Relative to 17/18, there is a new 1 year CCG scheme replacing a previous 1 year scheme, and the withdrawal of a further CCG scheme was confirmed in the 18/19 Planning Guidance.

2018/19 National and Local Schemes (CCG commissioning)

Payments for Q1 and Q2 were made at 100% in accordance with the agreement reached with Commissioners. Evidence for Q3 has now been submitted. Scheme leads will aim to meet the requirements set out for those schemes within existing resources, but will otherwise prioritise which aspects to work on in line with the agreement with Commissioners to deliver through 'reasonable endeavours'. The forecast RAG rating for each scheme relates only to expected delivery of the specified milestones, not financial performance. The requirements of the Local Scheme relating to Trust engagement with STP planning and development work are expected to be met in full. With regard to 'Improvement of health and wellbeing of NHS staff', the targets for improving scores for key survey questions have so far proven to be challenging for most providers, and the Trust didn't achieve the 17/18 target.

2018/19 National Schemes (NHSE Specialised Services commissioning)

The Q1 and Q2 results, based on assessment by Specialised Commissioning, were confirmed as 100%. Evidence for Q3 has now been submitted. The Trust continues to expect good overall results for the full year, and in line with last year's achievement in the case of the 2 year schemes. The Neonatal Community Outreach scheme is now being implemented in line with the approach agreed with the Commissioner and approved by the Executive board. The forecast RAG rating for each scheme reflects both expected delivery of the milestones and the associated financial performance.

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	97.4%	98.0%	102.6%	94.6%	8.6	3.5	12.1	7 – 17.5
Annie Zunz	98.6%	84.6%	98.4%	96.8%	5.6	2.3	7.9	6.5 - 8
Apollo	91.2%	87.1%	91.3%	25.8%	18.1	2.2	20.4	
Jupiter	124.9%	67.4%	121.2%	-	10.3	1.8	12.0	8.5 – 13.5
Mercury	87.3%	97.8%	83.3%	58.0%	7.2	1.0	8.2	8.5 – 13.5
Neptune	97.1%	84.8%	99.2%	0.0%	9.5	0.9	10.4	8.5 – 13.5
NICU	101.8%	-	98.9%	-	12.0	0.0	12.0	
AAU	103.8%	71.7%	99.8%	100.4%	9.7	2.1	11.8	7 - 9
Nell Gwynn	96.4%	84.9%	107.5%	111.8%	3.9	3.7	7.5	6 – 8
David Erskine	93.3%	91.3%	102.2%	108.2%	3.2	3.0	6.2	6 – 7.5
Edgar Horne	99.2%	96.8%	97.8%	106.5%	3.2	3.5	6.8	6 – 7.5
Lord Wigram	90.8%	91.3%	97.7%	103.1%	3.6	2.5	6.2	6.5 – 7.5
St Mary Abbots	100.6%	91.4%	102.6%	98.1%	4.3	2.6	6.9	6 – 7.5
David Evans	90.4%	83.8%	100.0%	125.9%	5.5	2.2	7.6	6 – 7.5
Chelsea Wing	82.8%	84.9%	100.0%	92.0%	9.7	6.0	15.7	
Burns Unit	104.8%	90.2%	109.5%	90.9%	15.7	2.9	18.6	
Ron Johnson	94.6%	109.7%	96.9%	119.3%	4.6	2.9	7.5	6 – 7.5
ICU	98.1%	-	100.3%	-	25.5	0.0	25.5	17.5 - 25
Rainsford Mowlem	98.0%	92.0%	108.1%	105.5%	3.3	3.0	6.3	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	95.2%	95.6%	92.5%	95.8%	6.9	1.8	8.7	7 – 17.5
Lampton	101.0%	100.2%	102.2%	100.0%	2.9	2.4	5.4	6 – 7.5
Richmond	116.2%	113.1%	126.6%	111.5%	5.2	2.7	7.9	6 – 7.5
Syon 1	94.8%	115.7%	98.5%	148.4%	3.6	2.7	6.3	6 – 7.5
Syon 2	97.9%	111.8%	101.4%	140.5%	3.6	2.6	6.2	6 – 7.5
Starlight	95.7%	131.3%	102.0%	-	9.6	0.5	10.1	8.5 – 13.5
Kew	77.2%	117.1%	100.0%	201.6%	2.9	4.2	7.1	6 - 8
Crane	100.0%	117.9%	100.0%	148.4%	3.1	3.2	6.3	6 – 7.5
Osterley 1	111.5%	124.0%	106.4%	103.0%	3.6	2.7	6.4	6 – 7.5
Osterley 2	107.5%	98.1%	108.0%	99.2%	3.8	3.1	6.9	6 – 7.5
MAU	96.6%	88.4%	90.9%	90.3%	6.0	2.6	8.6	43715
CCU	99.2%	96.9%	100.4%	-	5.3	0.7	6.0	6.5 - 10
Special Care Baby Unit	80.7%	100.0%	78.7%	95.2%	6.0	2.8	8.7	
Marble Hill 1	110.9%	93.1%	123.8%	93.4%	3.9	2.7	6.6	6 - 8
Marble Hill 2	103.5%	122.8%	103.4%	127.4%	3.3	3.2	6.5	5.5 - 7
ITU	112.8%		109.0%	-	24.7	0.0	24.7	17.5 - 25

Summary for January 2019

Increased fill rate for Registered Nurses on Jupiter due to amount of children requiring RMN's. Skill mix reviewed in light of this and number of HCA's reduced.

High fill rates of HCA's on Syons, Kew and Marble Hill 2 due to confused mobile patients at risk of falling and absconding.

Low fill rate for Registered Nurses on Kew due to roster template still being set up for earliest and latest when long days are being used.

Increased number of HCA's booked for Starlight to cover PSSU.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance Dashboard

Month 10 2018-19 Integrated Position

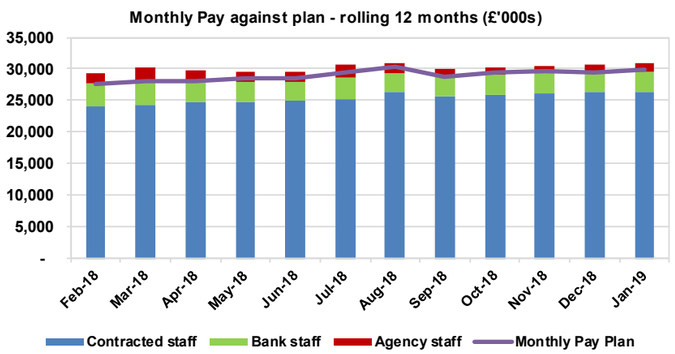
£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	563,115	577,003	13,888
Expenditure			
Pay	(291,947)	(302,491)	(10,544)
Non-Pay	(230,542)	(226,985)	3,557
EBITDA	40,626	47,527	6,901
EBITDA %	7.21%	8.24%	1.02%
Depreciation	(15,533)	(14,975)	558
Non-Operational Exp-Inc	(13,600)	(41,415)	(27,815)
Surplus/Deficit	11,492	(8,863)	(20,355)
Control total Adj - Donated asset, Impairment & Other		30,848	30,848
Surplus/Deficit on Control Total basis	11,492	21,985	10,493

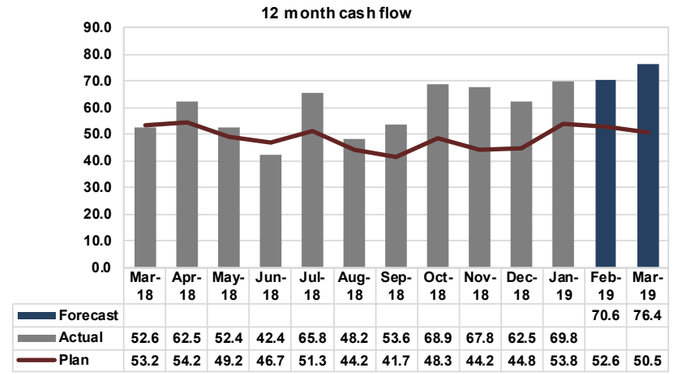
Comments

The Trust is reporting a YTD surplus of £21,985 on a control total basis. The favourable position forms part of a revised plan submitted to NHSI in M7. It should be noted the YTD deficit recorded above £8.86m is due to an impairment charge the Trust incurred based on the revaluation of the Trust's estate. Although this forms part of the operating costs, it does not form part of the control total which is used to measure the Trusts performance.

Income: January saw the highest levels of A&E activity in history, which in turn led to increased emergency admissions. Adult Critical Care, Paediatrics HDU and Outpatient first attendances were the other drivers of the in-month over performance.

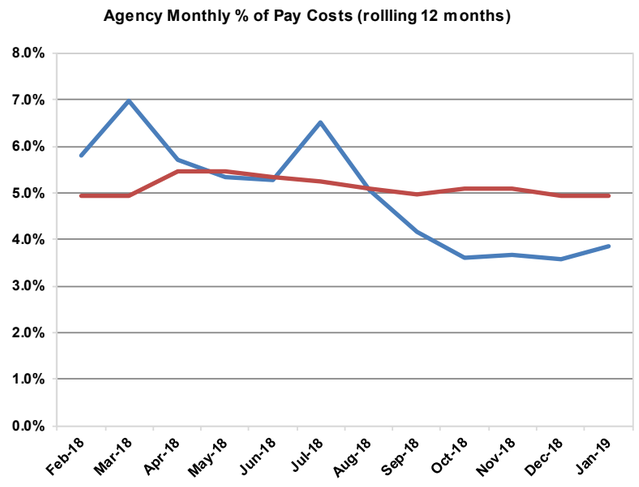
Pay is adverse by £10,544k YTD. The Trust continues to use bank and agency staff to cover vacancies, sickness and additional activity. There has also been supernumery staffing to cover new medical starter post rotation. The largest contributor to this position has been under achievement against CIP targets.

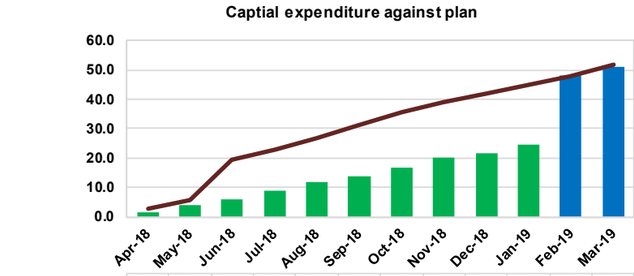




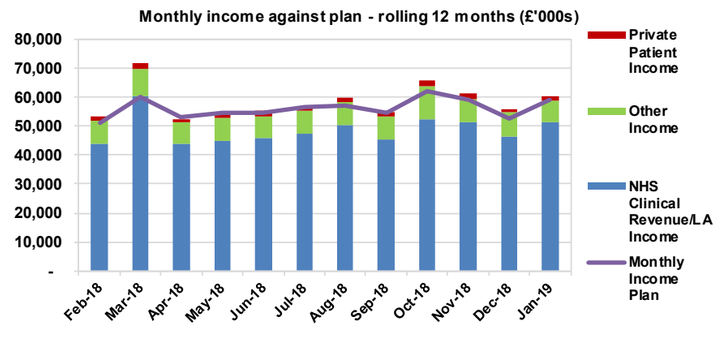
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Forecast												70.6	76.4
Actual	52.6	62.5	52.4	42.4	65.8	48.2	53.6	68.9	67.8	62.5	69.8		
Plan	53.2	54.2	49.2	46.7	51.3	44.2	41.7	48.3	44.2	44.8	53.8	52.6	50.5

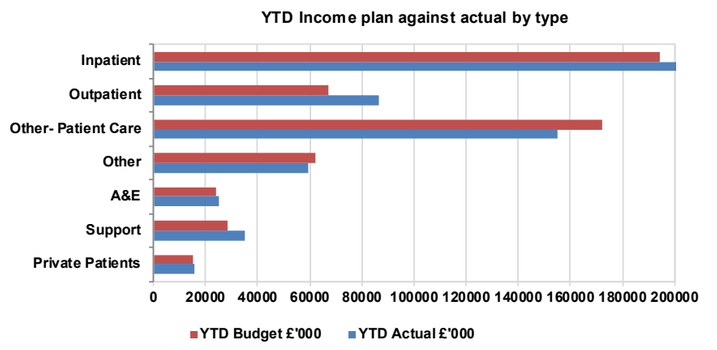
Comment: The higher cash balance (compared to plan) in M10 of £15.9m is mainly additional receipts for PSF, non recurent funding, higher VAT claims and also higher than planned cash settlement of invoiced debt totalling £59.4m. This has been offset in part by higher creditor payments and lower NICU donations totalling £43.5m

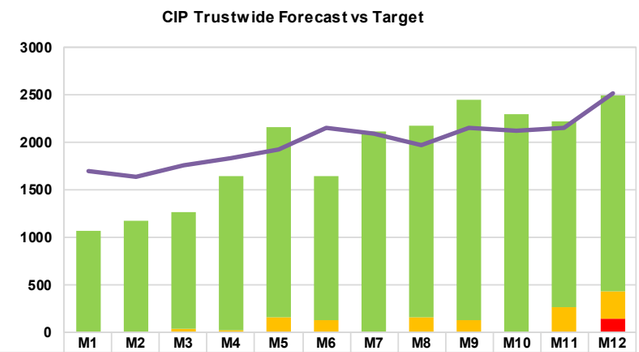




	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	1.7	4.1	6.0	9.0	11.6	13.9	16.7	20.1	21.5	24.4		
Forecast											48.1	51.30
Plan	2.7	5.6	19.4	23.1	26.9	31	36	39	42	45	48	51.90







	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Green	1061	1159	1238	1615	1996	1506	2105	2014	2316	2302	1946	2070
Amber	17	17	38	30	155	137	10	168	132	0	264	281
Red	0	0	0	0	8	0	0	0	0	0	8	153
Target	1700	1636	1759	1840	1926	2164	2090	1976	2164	2131	2159	2516

Comment: Month 10 year to date capital spend was £24.43m (month 9 £21.49m) against planned year to date expenditure of £45.02m (month 9 £41.91m), with a resulting underspend of £20.59m (month 9 underspend £20.42m). Although the Trust's current spend is below planned spend the Trust is forecasting, overall, to meet its revised capital programme of £51.3m for the year.

BPPC % of bills paid within target

Year to Date	Current Month %	Previous Month %	Movement %
By number	90.2%	90.2%	0.1%
By value	83.7%	83.3%	0.3%
Creditor days	101	99	2
Debtor Days	50	50	0

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.6.1/Mar/19
REPORT NAME	Workforce Performance Report
AUTHOR	Natasha Elvidge, Associate Director of HR; Resourcing
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	The People and OD Committee KPI Dashboard highlights current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	The dashboard to provide assurance of workforce activity across eight key performance indicator domains; • Workforce information – establishment and staff numbers • HR Indicators – Sickness and turnover • Employee relations – levels of employee relations activity • Temporary staffing usage – number of bank and agency shifts filled • Vacancy – number of vacant post and use of budgeted WTE • Recruitment Activity – volume of activity, statutory checks and time taken • PDRs – appraisals completed • Core Training Compliance
KEY RISKS ASSOCIATED	The need to reduce turnover rates.
FINANCIAL IMPLICATIONS	Costs associated with high turnover rates and reliance on temporary 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 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 People and Organisational Development Committee

Month 10 – January 2019

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

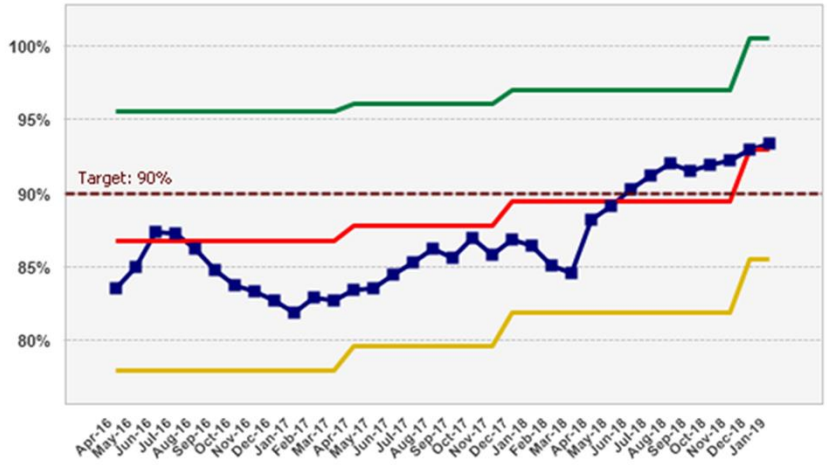
Statistical Process Control – April 2016 to Jan 2019

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

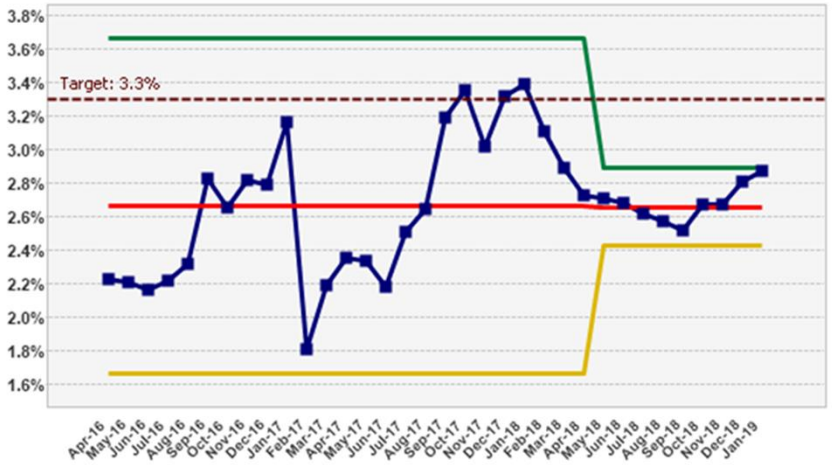
WORKFORCE INDICATORS

Statistical Process Control Charts for the 34 months April 2016 to January 2019

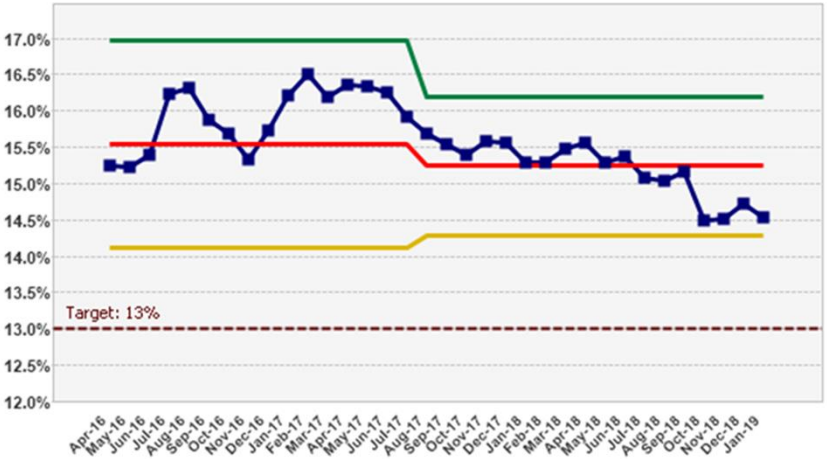
Mandatory Training compliance



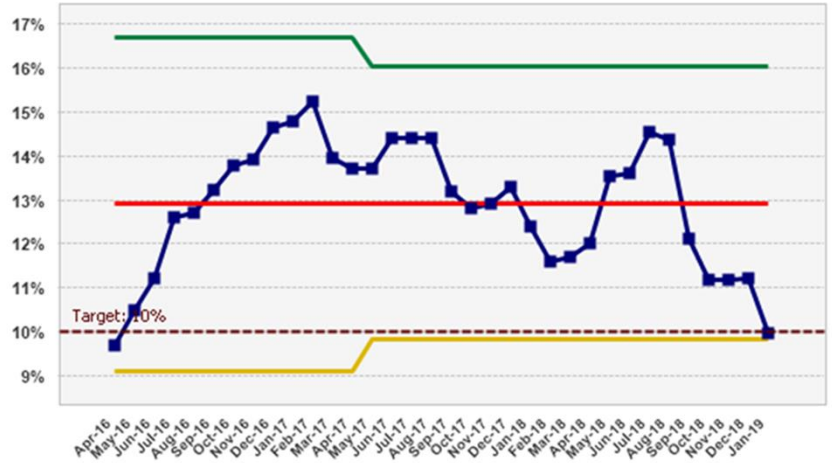
Sickness absence



Staff turnover rate



Vacancy rate



People and Organisational Development Workforce Performance Report January 2019
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

Item	Units	This Month Last Year	Last Month	This Month	Target	RAG Status			Trend
						Red	Amber	Green	
1. Workforce Information									
1.1 Establishment	No.	6112.74	6,284.69	6,226.51					↓
1.2 Whole time equivalent	No.	5354.60	5580.55	5611.73					↑
1.3 Headcount	No.	5826	6062	6115					↑
1.4 Overpayments	No.								↔
2. HR Indicators									
2.1 Sickness absence	%	1.80%	2.84%	2.87%	<3.3%				↑
2.2 Long Term Sickness absence	%		1.25%	1.17%					↓
2.3 Short Term Sickness absence	%		1.60%	1.70%					↑
2.4 Gross Turnover	%	19.23%	19.28%	19.00%	<17%				↓
2.5 Voluntary Turnover	%	15.28%	14.74%	14.55%	<13%				↓
3. Employee Relations									
3.1 Live Employment Relations Cases	No.		118	177					↑
3.2 Formal Warnings	No.		3	1					↓
3.3 Dismissals	No.		1	4					↑
4. Temporary Staffing Usage									
4.1 Total Temporary Staff Shifts Filled	No.		13260	14775					↑
4.2 Bank Shifts Filled	No.		11243	12593					↑
4.3 Agency Shifts Filled	No.		2017	2182					↑
5. Vacancy									
5.1 Trust Vacancy Rate	%	12.40%	11.20%	9.87%	<10%				↓
5.2 Corporate	%	9.66%	9.64%	9.07%	<10%				↓
5.3 Emergency & Integrated Care	%	15.04%	10.15%	8.85%	<10%				↓
5.4 Planned Care	%	11.97%	14.09%	12.63%	<10%				↓
5.5 Women's, Children and Sexual Health	%	11.36%	9.50%	8.00%	<10%				↓
6. Recruitment (Non-medical)									
6.1 Offers Made	No.		113	104					↓
6.2 Pre-employment checks (days)	No.		20.6	30.4	<20				↑
6.3 Time to recruit (weeks)	No.		8.32	10.76	<9				↑
7. PDRs Undertaken (AfC Staff over 12 months)									
7.1 Trust PDRs Rate (AFC Staff)	%	76.85%	83.32%	85.20%	≥90%				↑
7.2 Corporate	%		75.31%	70.78%	≥90%				↓
7.3 Emergency & Integrated Care	%		86.18%	89.88%	≥90%				↑
7.4 Planned Care	%		85.85%	85.74%	≥90%				↓
7.5 Women's, Children and Sexual Health	%		81.08%	85.93%	≥90%				↑
8. Mandatory Training									
8.1 See Appendix 1 for details on Mandatory Training									

Chelsea and Westminster Hospital NHS Foundation Trust

People and Organisational Development Workforce Performance Report January 2019
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

December 18 SICKNESS

Division	Sickness Abs.	RAG Status Target <4%	Available FTE	Abs. FTE	Episodes	Long Term (FTE Lost)	% Long Term	Prev. Month	% +/-
Corporate	1.24%		16210.20	200.64	64	53.84	0.33%	2.14%	-0.90%
Emergency & Integrated Care	2.52%		49018.06	1233.08	304	401.00	0.82%	2.37%	0.15%
Planned Care	3.08%		55821.60	1720.59	369	689.98	1.24%	3.10%	-0.02%
Women's, Children and Sexual Health	3.47%		52691.08	1829.88	377	887.46	1.68%	3.22%	0.25%
Trust	2.87%		173740.95	4984.18	1114	2032.28	1.17%	2.84%	0.03%

January 19 Mandatory Training

Course	Last Month	This Month	Target	RAG Status	Trend
Basic Life Support	87%	86%	<90%		↓
Conflict Resolution	95%	96%	<90%		↑
Equality, Diversity and Human Rights	93%	94%	<90%		↑
Fire	92%	92%	<90%		↔
Health & Safety	96%	96%	<90%		↔
Infection Control (Hand Hygiene)	94%	94%	<90%		↔
Information Governance	94%	95%	<95%		↑
Moving & Handling - Inanimate Loads	92%	93%	<90%		↑
Patient Handling (M&H L2)	90%	89%	<90%		↓
Safeguarding Adults Level 1	94%	95%	<90%		↑
Safeguarding Children Level 1	95%	95%	<90%		↔
Safeguarding Children Level 2	92%	92%	<90%		↔
Safeguarding Children Level 3	84%	86%	<90%		↑

January 19 Vacancy / Bank and Agency Ratio on "Fill Rate"

Division	Budgeted FTE	Staff in Post (FTE)	Vacancy (FTE)	Bank Usage (FTE)	Agency Usage (FTE)	Total FTE Used	Budget minus Used FTE	RAG Status
Corporate	575.89	523.66	52.23	26.67	12.62	562.95	12.94	
Emergency & Integrated Care	1742.68	1588.40	154.28	313.75	79.87	1982.02	-239.34	
Planned Care	2064.78	1804.00	260.78	272.13	78.81	2154.94	-90.16	
Women's, Children and Sexual Health	1843.16	1695.67	147.49	209.50	36.88	1942.05	-98.89	
TRUST	6226.51	5611.73	614.78	822.05	208.18	6641.96	-415.45	

January 19 Voluntary Turnover

Division	Turnover	Prev Month	% +/ -
Corporate	16.66%	17.16%	-0.50%
Emergency & Integrated Care	14.96%	15.54%	-0.58%
Planned Care	12.83%	12.72%	0.11%
Women's, Children and Sexual Health	15.31%	15.36%	-0.05%
TRUST	14.55%	14.74%	-0.2%

Key to Sickness Figures
Sickness Absence = Calendar days sickness as percentage of total available working days for past 3 months
Episodes = number of incidences of reported sickness
A Long Term Episode is greater than 27 days

Chelsea and Westminster Hospital NHS Foundation Trust

People and Organisation Development Workforce Performance Report January 2019

Mandatory Training Compliance :

Our compliance rate stands at 93% against our target of 90%. Compliance has remained above the Trust target of 90% for the previous 7 months. Moving and Handling has reached the Trust target for the first time since the requirements across both sites were aligned in April 2018. The Moving and Handling have created more ad hoc events to be delivered in addition to the planned programmes.

Information Governance is at its highest level of 95%. Q4 has a large number of employees due to lapse on the topic, so the IG team have increased communications re: updates across the Trust.

Planned changes – Starting in April Adult Basic Life Support reporting will be split into Theory and Practical reporting elements to reflect the increased use of eLearning in the new policy and Infection Control reporting will be split into Levels 1 and 2.

Staff Turnover Rate:

The voluntary turnover rate is currently 14.55% a decrease of 0.19% lower than last month. The voluntary turnover rate suggests that approximately 1 in 6 members of staff have left the trust over the past 12 months. The turnover rates are consistent with the London region and are above our trust target of 13%.

This month last year, the voluntary turnover rate (15.28%) which represents a 0.73% decrease year on year. This due to increased productivity and reduction of time to recruit by the recruitment team. Divisional HR Business Partners are working within divisions to improve turnover and we continue to monitor turnover and reasons for leaving and joining via our joiners and leavers surveys.

Sickness Absence: (December)

The trust's sickness rate is currently 2.87%. Our sickness target (3.3%) has not been breeched during the last ten months (this financial year); peaking at 2.89% in April 2018.

The staff group consistently reporting the highest level of sickness over the last seven months is unqualified nursing and midwifery staff whilst medical and dental staff are consistently reporting the lowest level of sickness.

The Women's, Children & Sexual Health Division had the highest sickness rate in December at 3.47% and Emergency & Integrated Care had the lowest sickness rate 2.52% of the clinical divisions.

Vacancy Rate:

The trust has achieved its KPI target with a 9.95% vacancy rate in January 2019. The vacancy rate has decreased (1.25%) as related to the month prior and we continue to maintain a downward trend for over the last 12 months. Our vacancy rate has improved due to increased activity within the recruitment team and robust monitoring and maintenance of the establishment. There has been an increase in establishment over the past 12 months 110.32wte, a gain of 1.76%.

The vacancy rate at West Middlesex is 11.03% and 9.38% at Chelsea and Westminster. The Nursing and Midwifery qualified staff group vacancy rate 7.90% which means we have achieved and maintained our target vacancy for nursing over the past three months.

Our Nursing and Midwifery Qualified staff vacancy continues to be the best in London.

People and Organisation Development Workforce Performance Report
January 2019

PDR's Completed Since 1st April 2018 (18/19 Financial Year)					
Division	**Band Group**	**%**	**Division**	**Band Group**	**%**
COR	Band 2-5	61.42%	**PDC**	Band 2-5	77.76%
	Band 6-8a	68.81%		Band 6-8a	90.82%
	Band 8b +	82.35%		Band 8b +	100.00%
Corporate		**68.77%**	**PDC Planned Care**		**82.90%**
EIC	Band 2-5	87.84%	**WCH**	Band 2-5	79.27%
	Band 6-8a	85.99%		Band 6-8a	85.52%
	Band 8b +	95.00%		Band 8b +	100.00%
EIC Emergency & Integrated Care		**87.16%**	**WCH Women's, Children's & SH**		**83.04%**

Band 2-5	**Band 6-8a**	**Band 8b +**	
79.68%	84.91%	90.58%	**Trust Total** **82.47%**

PDRs:

During the previous financial year we achieved our target of appraisals completed (90%).

At Month 10 / January, we are marginally behind target for the completion of PDRs by our banding windows. The divisions have produced plans to achieve their PDR targets and greater focus and attention to the completion of PDRs within the banding windows have resulted in a 19% increase over the last two months. This PDR target and progress against divisional plans is continues to be monitored at the Workforce Development Committee meeting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	2.7/Mar/19
REPORT NAME	Progress with Achieving the year 2 Maternity 10 point safety plan
AUTHOR	Clare Baker, Deputy HOM/Natasha Singh, Service Director
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	The purpose of this paper is to provide the board with an update on progress in achieving the NHSR Maternity 10 point plan.
SUMMARY OF REPORT	The maternity 10 point plan Came into place in December 2017. This new process replaces the CNST audit programmes and aims to standardise and drive quality improvement nationally across maternity services. Chelsea and Westminster were one of the few trusts that met the 10 point plan in year 1 which resulted in a £1.6m refund in their CNST premium in 18/19. Year 2 plan has changed slightly with a closer focus on meeting Avoidable Term admissions neonatal units (ATAIN standards) as well as midwifery and Obstetric safe staffing measures. To gain compliance NHSR mandates in the programme that the trust board must be informed of progress in meeting the 10 point plan by the end of March 2019 with final submission of compliance with the plan in August 2019. The current benchmark demonstrates compliance with 9 of the 10 actions with further work to do to meet point 3 the new standard demonstrating that you have transitional care services to avoid unexpected term admissions to the neonatal unit, although these sites have this services some work needs to be completed to standardised and update guidelines to meet the national standards. The service is confident it will meet this standard fully by August. The actions to meet full compliance can be seen on the second tab.
KEY RISKS ASSOCIATED	Not achieving high quality care to patients
FINANCIAL IMPLICATIONS	Not receiving the 10% reduction in premium.
QUALITY IMPLICATIONS	Not achieving national maternity safety standards

EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For the board to acknowledge the progress made towards meeting the 10 point safety plan.

Maternity incentive scheme - Guidance

Trust Name
Trust Code

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

Section A : Please choose your trust in the Guidance tab

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	No
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Section B : Please choose your trust in the Guidance tab

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q4 Medical workforce planning	**To be met by**	Q2 2019/20
Work to meet action	*complete medical trainee GMC action plan and present to divisional board CW site*		
Does this action plan have executive level sign off	No	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Natasha Singh*		
Lead executive director	*Does the action plan have executive sponsorship?* *Zoe Penn*		
Amount requested from the incentive fund, if required	-		
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring	GMC and internal medical staff surveys as well as Guardian of safe working reports	Natasha Singh	Q1

Action plan 2

Safety action	Q3 Transitional care	**To be met by**	Q1 2019/20

Work to meet action	*Joint transitional care guideline with admission criteria and SOP in place for both sites*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Mark Thomas*
Lead executive director	*Zoe Penn*
Amount requested from the incentive fund, if required	-
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**		**When?**	
Monitoring	publication of new guideline			May-19	

Action plan 3

Safety action	Q5 Midwifery workforce planning	**To be met by**	Q2 2019/20
Work to meet action	*workforce review complete but Safe staffing NICE guidance red flags need to be recoded via Datix*		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Victoria Cochrain/Clare Baker*		
Lead executive director	*Pippa Nightingale*		
Amount requested from the incentive fund, if required	-		
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring	Reporting via Datix	Lizzie Wallman	Q1

Action plan 4

Safety action	Q8 In-house training	**To be met by**	Q2 2019/20
Work to meet action	*90% complaince in maternity training met but not consistantly in all staff groups*		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Liz Owen/Victoria Cochrain*		
Lead executive director	*pippa Nightingale*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring	training database	HR	Q2

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name Please choose your trust in the Guidance tab
Trust code

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	No	Yes	-	You have missing data in your action plan for this unmet safety action, please check
Q4 Medical workforce planning	Yes	Yes	-	You have met the action as well as submitting an action plan, please check
Q5 Midwifery workforce planning	Yes	Yes	-	You have met the action as well as submitting an action plan, please check
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes	Yes	-	You have met the action as well as submitting an action plan, please check
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**9**	**4**		
Total sum requested			**-**	

You have validations on 4 safety actions. Please recheck tab A (Safety actions) and/or B (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.

Sign-off process:

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:
Position:
Date:

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	3.2/Mar/19
REPORT NAME	NHS 10 year plan - Cancer Services
AUTHOR	Tara Argent, Divisional Director of Operations, Clinical Support
LEAD	Rob Hodgkiss, Chief Operating Officer
PURPOSE	To update the board on the NHS ten year plan relating to Cancer Services
SUMMARY OF REPORT	The purpose this report is to summarise the key points of the NHS 10 year Plan relating to diagnosing cancers earlier and the introduction of the Faster Diagnostic Standard.
KEY RISKS ASSOCIATED	Delivery of the Faster Diagnostic Standard (FDS) turnaround times for access to diagnostic testing, pathology and reporting Workforce
FINANCIAL IMPLICATIONS	Building and developing our workforce to meet the modern cancer & Screening pathway Expanding and optimising our diagnostic services
QUALITY IMPLICATIONS	Delivery of the FDS
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability
DECISION/ ACTION	For information

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

NHS 10 Year Plan

Changes to Cancer Service Delivery

Rob Hodgkiss
Chief Operating Officer

Diagnosing cancers earlier

The headline pledge in the NHS 10 year plan is to diagnose 3 in 4 cancers at an early stage by 2028, this is an important and ambitious commitment, and is key to improving survival.

People are more likely to survive their cancer for longer when diagnosed early. But at the moment, only around 1 in 2 people with cancer in the UK are diagnosed at an early stage. This will require lots of changes in the way we deliver services, and the new 10-year plan includes some positive first steps, including:

- Introduction of the Faster Diagnostic Standard (28 days)
- lowering the age range for bowel screening to 50 with the introduction of new tests
- Introduction of Rapid diagnostic Centers

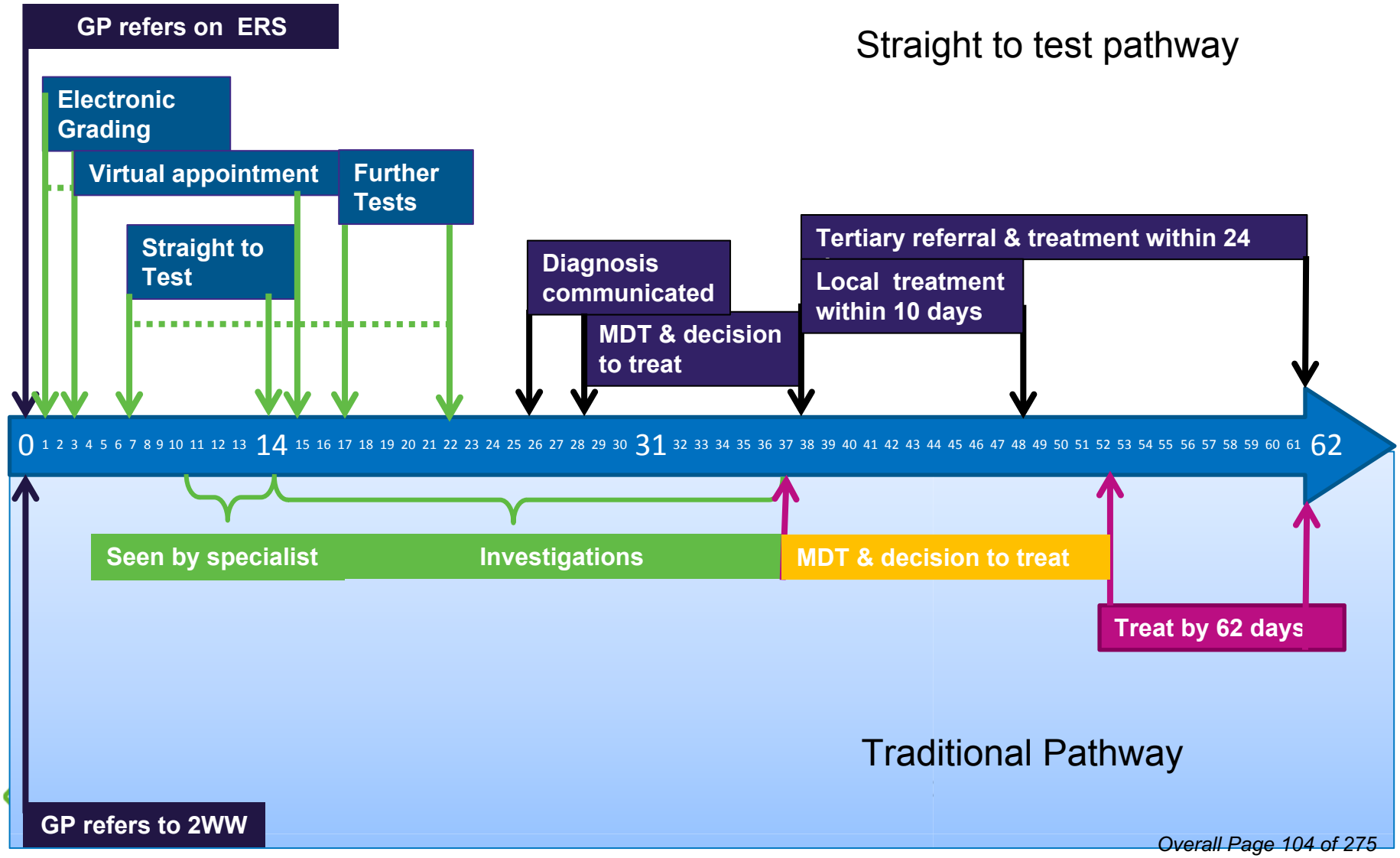
Faster Diagnostic Standard (FDS)

- Reduce time to diagnosis to 28 days: So that patients receive a definitive diagnosis or ruling out of cancer within 28 days
    - Improve communication with patients (reduce waiting time for non-cancer result communication)
- Diagnosis cancers at an earlier stage 75% in stage 1-2 by 2028
- Straight to Test from GP appointment:
    - Patients informed of possible cancer diagnosis by GP
    - Patient awareness of possible Straight to test pathway
    - Patient advised to be available within two weeks
- Improved efficiency of cancer pathways

"We will increase the early detection rate from one-in-two today, to three-in-four by 2028." Prime Minster Theresa May

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

28 day Faster Diagnosis Standard - timeline



Trust Direction of Travel & Cancer Strategy

- Working closer with our partners; via hub and spoke and treatment pathways to deliver **diagnosis** and **treatment** closer to home for our patients.
- Expanding and optimising our diagnostic services, particularly at the WM site, to deliver **earlier diagnosis** for our patients
- Building and developing our workforce to meet the modern cancer & Screening pathway, with a focus on **communication with patients**
- Expand our capacity to offer access to comprehensive local chemotherapy treatment for all patients and **reduce inequality in treatment**
- Work more closely with patients and primary care to **ensure patient experience and quality** remains at the heart of our cancer provision

QUESTIONS?

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO	4.1/Mar/19
REPORT NAME	Risk Register Process Assurance Report
AUTHOR	Alex Bolton, Head of Health Safety and Risk
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	This report provides an overview of the risk register process and the risks recorded within the Trust's Datix risk register system; the spread of risks across operational areas and by risk grading are highlighted to support the provision of risk process assurance across organisational activities.
SUMMARY OF REPORT	There are 266 live risks being managed / mitigated across the organisation, of these one has been identified as an extreme risk: • ID3, Growth in non-elective demand above plan One new strategic risk has been identified since the last report to the Board: • Risk 671, Brexit Implications on Staffing Operational risk register assurance is provided via the Divisional Quality Boards within each clinical Division; these groups ensure the Divisional risk register process is embedded and mitigation actions are undertaken within appropriate timescales. Within the Corporate Functions / Non-Clinical Division individual management teams undertake this responsibility with Executive oversight. Process and mitigation assurance is provided via the committees of the board and sub-groups; risk updates are forwarded to the overarching groups based on risk type or risk grading. These groups ensure that Trust wide learning from risk is cascaded and support risk identification and delivery of mitigation actions. Positive assurance is provided via evidence of; risks identification across all operational areas, recent risk reviews (97% of all risks are within scheduled review timeframes) and the amendment of risk scores demonstrating mitigation control effectiveness or an awareness of increasing risk.
KEY RISKS ASSOCIATED	Patient safety is the most commonly identified risk type.
FINANCIAL IMPLICATIONS	Financial impact relating to risk mitigation actions required
QUALITY IMPLICATIONS	The provision of an effective and comprehensive process to identify, understand, monitor and address current and future risks is a key component being a well-led organisation.

EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Objective 1:Deliver high quality patient centred care Objective 2: Be the employer of choice Objective 3: Deliver better care at lower cost
DECISION/ ACTION	For information

Risk Register Process Assurance Report

1.0 Introduction

The Trust's risk management strategy is designed to provide a systematic method of identifying risks and determining the most effective means to minimise or remove them following a process of risk analysis and evaluation. Practice is supported through the maintenance of an organisation wide risk register; the register is a management tool that promotes visibility, escalation, and provides a repository from which assurance can be offered to the Board that risks are being identified and appropriately managed.

The Trust utilises the Datix Safety Learning System as the single repository for the recording of risk; this system also provides management oversight of incidents, complaints, claims, inquests and mortality reviews. By operating a cross functional recording system information can be more readily triangulated to support risk identification and evaluation.

This report provides an overview of the risk register process and the risks currently recorded within the Trust's Datix risk register system; the spread of risks across operational areas and by risk grading are highlighted to support the provision of risk process assurance across organisational activities.

2.0 Recording a risk on Datix

The Datix risk register is accessed from the Trust's intranet; to record a risk a member of staff requires a Datix login. There are currently 2318 staff accounts covering all staff groups. The largest staff groups with access to Datix are; Doctors, Nurses, Admin / Clerical, Midwives.

3.0 Responsibilities

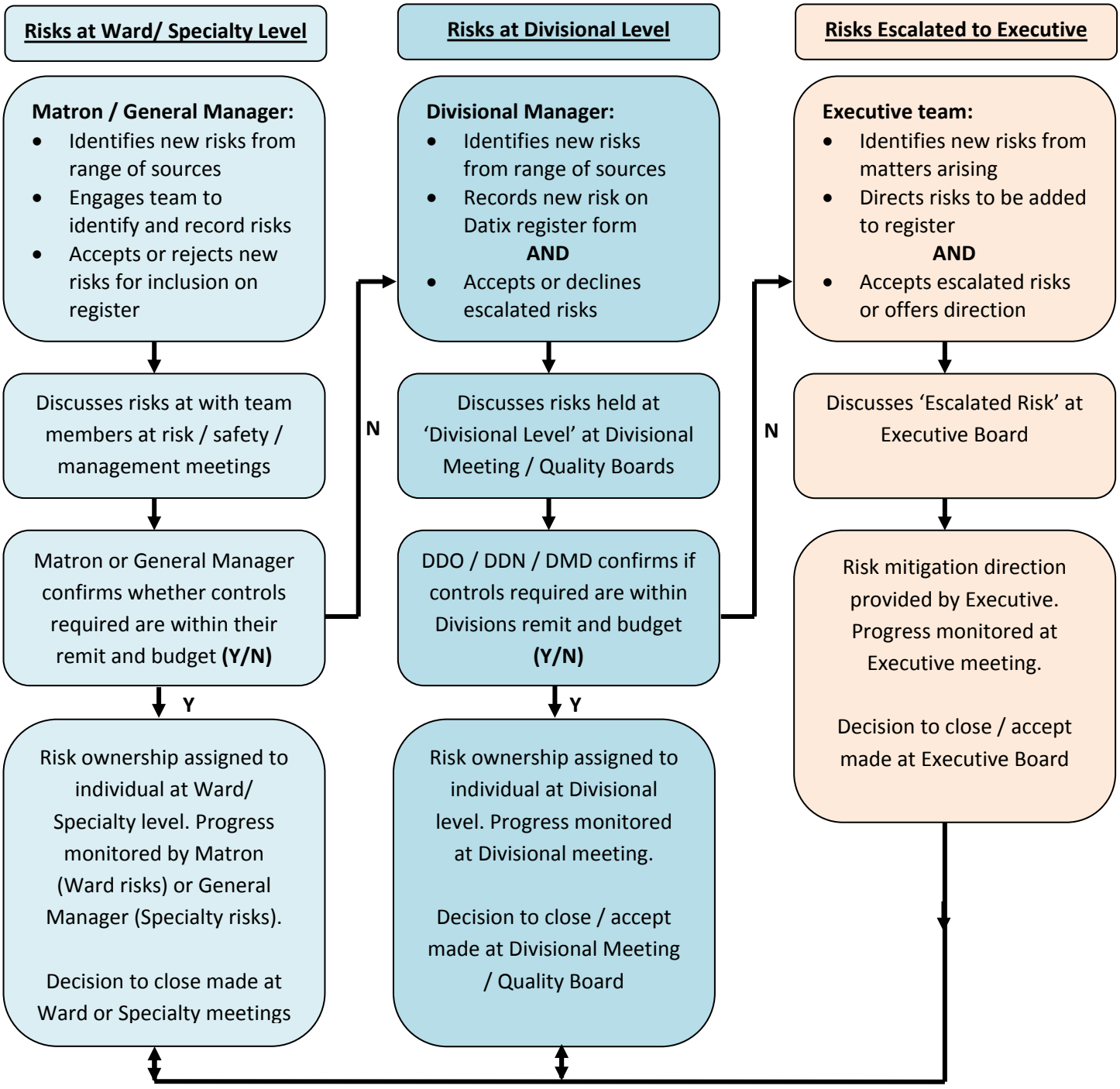
It is the responsibility of all members of staff to engage with the organisations risk management processes and every member of staff with a Datix account can record an item within the Trust's risk register system. Line managers, in consultation with their staff, are responsible for ensuring high quality risk registers are maintained for the areas within their remit and outcomes of risk evaluation are shared with the members of their teams.

- **Individual management responsibility:** Managers at Ward, Specialty and Divisional level are responsible for the maintenance of functional risk registers within their remit e.g. responsibility to identify, record and manage risks.
- **Group management responsibility:** Divisional groups (i.e. Quality Boards) oversee risk management practices across the operational areas within their remit e.g. Group responsibility for evaluating Division wide risks, supporting mitigation action and monitoring progress compliance.
- **Escalation arrangements:** Local, Specialty and Divisional management teams are responsible for escalating risks when the controls required are outside their budget / remit or where the nature of the risk indicates the requirement for higher level management e.g. Individuals and groups responsible for making escalation decisions.

The Quality and Clinical Governance Department: The Quality and Clinical Governance Department will facilitate, support and advise line managers and employees on the management of risk but it is not their responsibility to manage risks identified within a service. The management of risks is a line management function and responsibility. The Head of Health Safety and Risk will provide over overarching risk management advice and facilitation as required and provides assurance in respect of the risk register process.

4.0 Risk register process

To support ownership, engagement and visibility of risk registers the following operational management process is being embedded across the organisation. This process supports a bottom-up risk awareness approach.



5.0 Assurance oversight

5.1 Role of the Divisional Quality Boards

Operational risk register assurance is provided via the Divisional Quality Boards within each clinical Division; these groups ensure the risk register process is embedded across the Division and mitigation actions are undertaken within appropriate timescales.

The organisations Corporate Division is comprised of disparate management teams from non-clinical departments; as such there is no overarching Divisional Quality Board. Risk identification and management action is overseen by the individual management teams and process assurance information will be reported to the Executive Management Board.

5.2 Role of Committees / sub-groups

All items recorded within the risk register system are categorised according to the risk 'subject'; each categorisation is aligned to a Committee or sub-group so that an assessment of the level of assurance provided by the organisations risk management approach can be considered. Members of the assurance committees and sub-groups are asked to consider all items aligned to their risk categorisations that are scored equal to or greater than 12; groups are asked to assure themselves that:

- Identified risks reflect reality
- controls are effective
- actions are sufficient
- actions are being delivered
- risk scores are being updated as new information becomes available
- target risk scores are achievable

Risk assurance information is made available to the assurance groups based on the following risk categorisations:

- **Executive Management Board (EMB):** Aligned to risk types - Quality of Service, Governance Arrangements and Key Performance Target risks. The group will also consider items escalated via Divisional Board or Corporate Functions management team.
- **People and Organisational Development (POD):** Aligned to risk types - Staffing & Staff training risks
- **Finance and Investment Committee (FIC):** Aligned to risk types - Financial management risks
- **Quality Committee**
    - **Patient Safety Group (PSG):** Aligned to risk types - Patient safety Risks
    - **Health safety and environment risks (HSERG):** Aligned to risk types - Health Safety, Physical Estate risks
    - **Infection Prevention and Control Committee (IPCC):** Aligned to risk types - Infection Control risks
    - **Medical Device Group (MDG):** Aligned to risk types - Medical Device risks
- **Digital Transformation Board (DTB):** Aligned to risk types - ICT risks

The greatest number of risks identified across the organisation are aligned to subjects aligned to the remit of the Quality Committee; to ensure sufficient resources is available to monitor and oversee these risks the assurance remit is spread across the groups within the Quality Committee's reporting arrangements. The Quality Committee will receive assurance from the routine reporting up arrangements of its sub-groups, an overarching assurance report that details steps taken by its sub-groups is being developed for the Quality Committee.

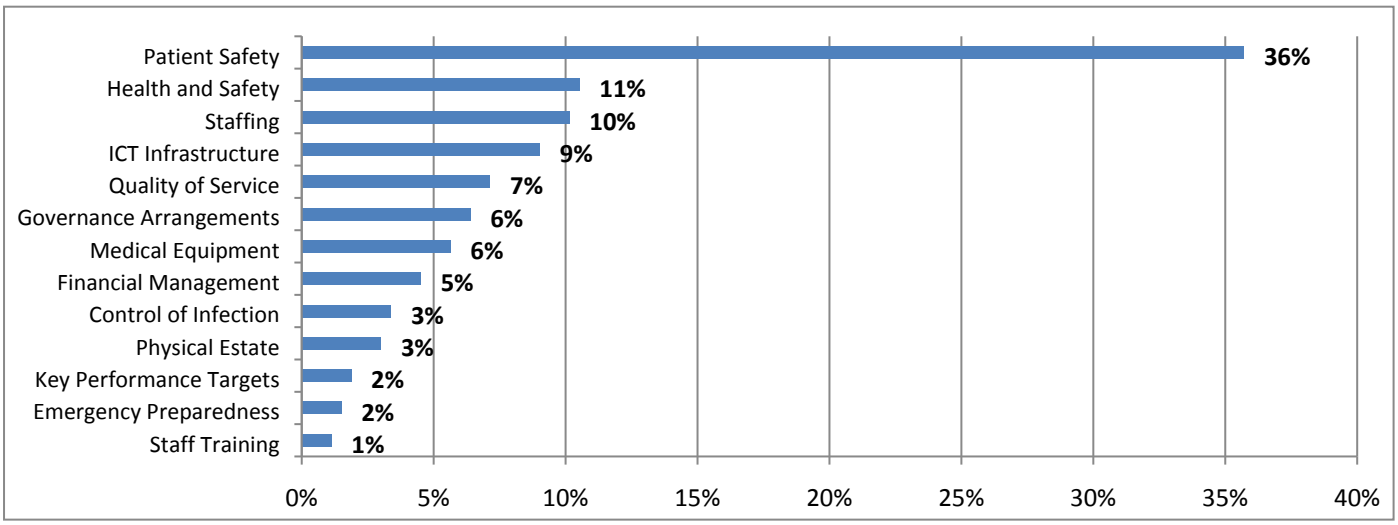
Information Communication Technology risks are well sighted and reviewed across the organisation; a formal process for the extraction and reporting of risk assurance information to the Digital Transformation Board is to be developed.

6.0 Trust wide risk overview

There are currently 266 live risks recorded across the organisation; since the last report to the Board 46 new risks have been identified and 46 risks have been removed from the live register post-mitigation. Risks are graded according to a five-by-five matrix;

	Low Risk (1-3)	Moderate Risk (4-6)	High Risk (8-12)	Extreme Risk (15-25)	Total	% of Total
Corporate functions	2	23	37	0	**62**	**23%**
Emergency and Integrated Care	4	26	33	1	**64**	**24%**
Planned Care	14	47	17	0	**78**	**29%**
Women's, Children's, HIV, GUM and Dermatology, Private Patients	8	24	30	0	**62**	**23%**
Total	**28**	**120**	**117**	**1**	**266**	**100%**

Risks are categorised to support assurance group oversight (as outlined in section 5.2). The highest recorded risk category is patient safety; 95 patient safety risks are being managed / mitigated across the Trust, this is 36% of the organisations total live risks. Assurance oversight of these risks is provided by the Patient Safety Group.



Since the last report to the Board in November 2018 the following key processes indicators have been observed within the Trust's risk register across all operational areas:

- No. new risks added: **46**
- No. mitigated risks closed/accepted: **46**
- No. of live risks re-scored: **48** (10 increased / 38 decreased)
- No. of live risks overdue for scheduled review (at 15/01/2019): **9** (3% of total)

Good Trust wide process assurance is offered that risks are being identified and meaningful review is taking place as risk scores are increased or decreased based on new information availability and the delivery of mitigation actions. Risks show evidence of contemporaneous review; 97% of all items are within their scheduled review timeframes.

7.0 Extreme risks

Extreme risks could seriously impact upon the achievement of the organisation's objectives, financial stability and reputation. Examples of these could include significant harm to patients, service loss / closure, failure to meet national targets, statutory breaches or loss of financial stability.

There is 1 extreme risk identified across the organisation; this is flagged for cross divisional awareness but management / mitigation action is led by the Emergency and Integrated Care Division.

Risk 3, Growth in Non-Elective demand above plan

Date reviewed: 14 January 2019 **Current risk score:** Consequence Major x Likelihood Likely = 16 (Extreme Risk) **Target risk score:** Consequence Moderate x Likelihood Likely = 12 (High Risk) **Aim to reach target score by:** 31 March 2020
Description:
Multiple risks to patient care, service delivery and financial stability due to continuing growth in non-elective demand. External Causes: • Aging population: Between 2003/4 and 17/18, the number of people aged over 85 increased by nearly 40% • Financial constraints: Between 2003/4 and 15/16, the average annual increase in admissions was 3.6%, while funding increased by an average of 3.1% per year nationally • Reduction/removal in seasonal funding 2018/19 onwards • Patient expectation and choice driving additional demand beyond peer organisations • Sector-wide admission avoidance & delayed discharge improvement schemes had limited impact on demand Internal Causes: • Limited physical capacity to expand services / provision of treatment areas Impacts: • Increased operational capacity (routine use of escalation space) • Increase in locum / agency staffing to support additional demand • Sub-optimal care of patients due to demand out stripping resource • Cancellation of elective procedures to support non-elective demand
Controls in place
• Over performance income utilised to offset cost of providing bed capacity. • Ambulatory expansions at both sites – open and available from December 2018 as planned • Trust wide LOS/Bed productivity work stream: Local/daily measures: Red/Green[1] , 2-before-12 (2b412[2]), escalation, discharge, choice policies implemented, Site + discharge team reconfigurations • Stretch CoE & ED/AAU specific improvement schemes for 2017/18+; Emergency Care Transformation Plan being implemented, including a discharge to assess model. • Acute frailty steering group meeting monthly to better manage increased frail elderly attendees • Introduction of senior nurse on call until 10pm weekdays and over weekends to support site teams • Established Medical Emergency Team (MET) and enhanced care area at WM to improve response to deteriorating patients and raise quality of care
Actions to be undertaken:
• On-going work with local partners to improve rates of discharge to community care providers and reduce readmission rates – using AE Delivery Board as 'system' monitoring and leverage • Site expansion plans for West Mid (2019/20) including additional NEL bed base and expanded ED RESUS. • Length of stay reduction opportunities in certain specialties to reduce bed capacity (CoE / Stroke); via LOS / Productivity work stream – on-going Nov-Mar 2019

Assurances:
• Assurance oversight provided by: Executive Management Board, Divisional Quality Board, Ambulatory Programme Board • Management oversight provided by: Divisional management team, Length of Stay/Bed Management Cost Improvement Programme Workstream, Executive/Divisional bi-lateral. • Daily management: Actions implemented and tracked via bed meetings, Delayed transfer of Care/medically optimised daily updates and weekly performance management group

Red/Green[1]: 'Red and Green Bed Days' are a management approach to assist in the identification of wasted time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle.

2b412[2]: Two Before Twelve (2B412) is a campaign to support trust discharge processes. Each ward has to identify three patients each day who are likely to be discharged from an acute bed the following day. This is to ensure that at least two patients are discharged before midday. This excludes intensive care, labour ward and the coronary care unit

The response to this risk is led by the Emergency and Integrated Care Division but is widely shared across the organisation's assurance groups and supported by Executive oversight. Since the last report to ARC the Trust's ambulatory emergency care facilities have been expanded on each site. The expansion of services supports the Trust's response to increasing demand; however it is noted that the majority of drivers for increasing activity are external and as such sit outside the organisations ability to directly control. Key risk controls therefore seek to address the effects of increasing demand rather than addressing the fundamental causes, it is for this reason that the target mitigation score is set as high (12) as further reduction in the current operating environment is not considered to be readily achievable.

1.0 New Strategic Risks

Strategic risks arise from failure to identify, develop and implement strategic plans which are aligned with the external healthcare landscape and economy. Strategic risk which is not adequately mitigated could have a material impact on income, expenditure and capital funds, thus threatening the viability of the organisation. It may also have a material negative impact on the quality of patient care and organisation's reputation. The following strategic risk has been recorded within the organisations risk register since last report to the Board.

Risk 671, Brexit Implications on Staffing

Date reviewed: 8 January 2019 **Current risk score:** Consequence Moderate x Likelihood Likely = 12 (High Risk) **Target risk score:** Consequence Moderate x Likelihood Possible = 9 (High Risk) **Aim to reach target score by:** 31 March 2019
Description:
Risk that the Trust is unable to recruit or retain EU nationals due to uncertainty regarding the national Brexit arrangements influencing staff to seek employment outside the UK. 13% of the organisations permanent workforce are from the EU. Causes: • Uncertainty regarding the UKs Brexit arrangements • EU nationals dissatisfaction with Brexit arrangements when confirmed Impacts: • Increase in staff turnover

- Increased agency / locum spend
- Potential threat to delivery of key objectives / service
- Potential for loss of key or hard to recruit staff
- Falling staff morale

Controls in place

- Trust Brexit plan presented to the People and Organisational Development committee (POD)
- Letter from the CEO to all members of staff from the EU assuring them that the organisation values their contributions and are wish to retain staff. All staff were made aware and encouraged to apply for settled status as part of the home office pilot; Trust has agreed to pay the application cost.
- Staff communication plan re Brexit developed
- Monthly monitoring of leavers taking place and overseen by POD
- POD approved attraction and on-boarding plan developed to increase recruitment opportunities, streamline recruitment process and tailor workforce planning to meet needs and address hard to recuit / retain areas and staff groups.

Actions to be undertaken:

- Workshops for staff to provide information and assurance scheduled
- Manager and staff 'Questions and Answers' and information packs are being developed

Assurances:

There has not been a significant loss of EU staff to date, however, due to approaching Brexit date and continuing national uncertainty the probability of this risk occurring is considered 'likely'. The risk grade will be reconsidered based on outcome of internal monitoring and developing national picture. The risk will be overseen by the People and Organisation Development Committee.

Risks identified at Ward, Specialty and Divisional level are predominantly operational in nature and support a bottom-up reporting process; assurance groups are asked to consider and support the identification of strategic risks.

2.0 Emergency and Integrated Care

Emergency and Integrated Care (EIC) have 64 live risks recorded within the register (24% of the organisational total). Assurance relating to identification and mitigation action is provided via the Divisional Quality Board and a separate monthly Divisional risk group. The division is well represented at the overarching governance groups with a remit for risk (e.g. Trust level committees, groups and sub-groups) as evidenced by attendance tracking.

	Low Risk (1-3)	Moderate Risk (4-6)	High Risk (8-12)	Extreme Risk (15-25)	Total	Review Overdue
Division wide	0	0	2	0	2	**0**
Cancer	0	3	0	0	3	**0**
Emergency Medicine	0	8	12	0	20	**1**
Site Operations	0	3	5	1	9	**0**
Specialist Medicine	3	12	13	0	28	**2**
Therapies	1	0	1	0	2	**0**
Grand Total	4	26	33	1	64	**3**

All EIC directorates (Cancer, Emergency Medicine, Site Operations, Specialist Medicine, Therapies) have identified risks; 95% of which are within the scheduled review deadlines. Where risks are not reviewed support is provided via the local management team and the Divisional Quality Board.

Since the last report to the Board in November 2018 the following key processes indicators have been observed within the EIC Division's risk register:

- No. new risks added: **10**
- No. of risks closed/accepted post mitigation: **9**
- No. of live risks re-scored: **8** (2 increased / 6 decreased)
- No. of live risks overdue for scheduled review (at 15/01/2019): **3** (5% of total)

Since the last report to the Board the Division has escalated two new risks scored equal to or greater than 12 to their highest level risk dashboard (these risks are escalated for Committee / Sub-Group assurance oversight):

- ID 633: Inability to accurately & swiftly process large volumes of patients during a Major Incident

Within this reporting period three items, previously reported as equal to or greater than 12, have been mitigated and removed from the highest level risk dashboard (closure rationale escalated to aligned Committee / Sub-Group):

- ID 134: Intermittent Bleep Issues across ChelWest site
- ID 411: Dementia care provision and strategy
- ID 554: Interface with Cerner and Somerset
- ID 617: Compliance with IV drug administration protocol

Process assurance is provided via evidence of risk identification, contemporaneous review, changing risk scores, and risk mitigation. The Division notes that only 4 low level (scored 1-3) are currently recorded, ward and specialty leads are being engaged to support identification in this area.

2.1 Emergency and Integrated Care; Highest level risk dashboard (items scored 12-25 / items mitigated from dashboard since last report to ARC, October 2018)

Highest risks: These are risks scored equal or greater than 12		Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Assurance Group
3	Growth in Non-Elective demand above plan	Quality of Service	12					◊		●		01/06/2015	31/03/2020	14/01/2019	EMB
2	Delayed Discharge due to lack of specialist beds and nursing homes	Patient Safety	9	◊				●				04/04/2016	25/12/2020	15/01/2019	PSG
136	Pandemic Influenza continuity risk	Control of Infection	16			◊		●				29/07/2016	01/09/2019	07/12/2018	IPCC
373	Mental Health bed provision/Violence & Aggression	Patient Safety	12			◊		●				03/07/2017	31/12/2019	13/11/2018	PSG
417	Allied Healthcare Professional services to NICU / SCBU	Staffing	12	◊				●				25/09/2017	31/03/2019	05/12/2018	POD
449	Root cause analysis (RCA) for hospital associated venous thromboembolism (VTE)	Patient Safety	12	◊				●				01/03/2017	31/03/2019	04/10/2018	PSG
460	Violence & Aggression in the ED	Health and Safety	12			◊		●				04/12/2017	31/01/2019	25/05/2018	HSERG
487	Patient monitors	Medical Equipment	12	◊				●				23/01/2018	01/02/2019	08/01/2019	MDG
616	Medical registrar gaps in AAU/ED on call rotas	Staffing	12	◊				●				18/09/2018	31/12/2019	20/11/2018	POD
633	**NEW RISK** - Inability to accurately and swiftly process large volumes of patients during a Major Incident	Emergency Preparedness	12	◊				●				11/10/2018	01/09/2019	14/01/2019	EMB
134	**MITIGATED** - Intermittent Bleep Issues across ChelWest site *Risk score reduced from 12-8, risk remains live*	Patient Safety	16	◊	● ←							03/10/2012	14/01/2019	14/01/2019	PSG
411	**MITIGATED -** Dementia care provision and strategy *Risk score reduced from 12-9, risk remains live*	Patient Safety	12			● ←						18/09/2017	30/09/2019	14/01/2019	PSG
554	**MITIGATED / CLOSED -** Interface with Cerner and Somerset *Risk score reduced from 12-1, risk closed*	ICT	12	●◊ ←								14/06/2018	14/06/2018	20/11/2018	DTB
617	**MITIGATED -** Compliance with IV drug administration protocol *Risk score reduced from 12-9, risk remains live*	Patient Safety	12	◊			● ←					18/09/2018	31/12/2018	20/11/2018	PSG

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

3.0 Planned Care Division

Planned Care Division (PCD) have 78 live risks recorded within the register (29% of the organisational total). Assurance relating to identification and mitigation action is provided via the Divisional Quality Board. The division is well represented at the overarching governance groups with a remit for risk (e.g. Trust level committees, groups and sub-groups) as evidenced by attendance tracking.

	Low Risk (1-3)	Moderate Risk (4-6)	High Risk (8-12)	Extreme Risk (15-25)	Total	Review Overdue
Division wide	0	3	1	0	4	**0**
Clinical Support	3	10	8	0	21	**0**
Critical Care	3	7	4	0	14	**0**
Patient Access	3	8	2	0	13	**1**
Pharmacy	3	3	0	0	6	**0**
Surgery	2	10	1	0	13	**0**
Theatres	0	6	1	0	7	**0**
Grand Total	14	47	17	0	78	**1**

All PCD directorates (Clinical Support, Critical Care, Patient Access, Pharmacy, Surgery, Theatres) have identified risks; 99% of which are within the scheduled review deadlines.

Since the last report to the Board in November 2018 the following key processes indicators have been observed within the PCD risk register:

- No. new risks added: **11**
- No. of risks closed/accepted post mitigation: **6**
- No. of live risks re-scored: **19** (2 increased / 17 decreased)
- No. of live risks overdue for scheduled review (at 15/01/2019): **1**

Since the last report to the Board the Division has escalated one new risk scored equal to or greater than 12 to their highest level risk dashboard (these risks are escalated for Committee / Sub-Group assurance oversight):

- ID 634: Follow-up appointments in Ophthalmology clinic not tracked

Within this reporting period five items, previously reported as equal to or greater than 12, have been mitigated and removed from the highest level risk dashboard (closure rationale escalated to aligned Committee / Sub-Group):

- ID 4: Identification and Escalation of the Deteriorating Patient
- ID 489: Restricted access to Agfa historical images
- ID 538: Inadequate staffing levels on Surgical wards
- ID 600: Condition of Main Operating Theatres and Treatment Centre
- ID 603: Breach of BOA guideline for follow up within 72hours

The Division's risk register provides good assurance of risk identification across all Directorates and delivery of mitigation actions as evidenced by risk re-scoring and updates; this is an indicator of a well embedded risk management approach.

3.1 Planned Care Division highest level dashboard (items scored 12-25 / items mitigated from dashboard since last report to ARC, October 2018)

Highest risks: These are risks scored equal or greater than 12		Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
37	Backlog in outpatient letters - turnaround delays	Staffing	9	◊				●				01/06/2016	31/01/2019	24/12/2018	POD
38	Non-compliance with RTT performance	KPIs	12	◊				●				01/06/2016	27/02/2019	19/12/2018	EMB
407	Unable to meet overall financial targets as a result of ongoing challenges with EL throughput and NEL demand	Financial Mgmt.	12	◊				●				01/09/2017	29/03/2019	22/11/2018	FIC
508	Radiology Computer hardware and VC equipment not fit for purpose	ICT	8	◊				●				08/03/2018	27/02/2019	27/12/2018	DTB
571	Mammography unit failure	Medical Equip	9	◊				●				28/05/2018	31/10/2019	03/12/2018	MDG
573	Unreliability of dental x-ray units - both sites	Medical Equip	12	◊				●				17/05/2018	01/10/2020	03/12/2018	MDG
634	**NEW RISK -** Follow-up appointments in Ophthalmology Clinic not tracked	Patient Safety	12	◊				●				16/10/2018	01/03/2019	28/12/2018	PSG
4	**MITIGATED** - Identification and Escalation of the Deteriorating Patient *Risk score reduced from 12-6, risk remains live*	Patient Safety	12	●◊	←	←	←	←				01/02/2015	30/06/2019	27/12/2018	PSG
489	**MITIGATED** - Restricted access to Agfa historical images *Risk score reduced from 12-6, risk remains live*	Patient Safety	12	●◊	←	←	←	←				22/01/2018	31/03/2019	23/11/2018	PSG
538	**MITIGATED** - Inadequate staffing levels on Surgical wards *Risk score reduced from 12-6, risk remains live*	Staffing	12	●◊	←	←	←	←				16/05/2018	31/05/2019	03/12/2018	POD
600	**MITIGATED** - Condition of Main Operating Theatres and Treatment Centre *Risk score reduced from 12-6, risk remains live*	Physical Estate	12	●◊	←	←	←	←				14/08/2018	28/08/2020	23/10/2018	HSERG
603	**MITIGATED** - Breach of BOA guideline for follow up within 72hours *Risk score reduced from 12-6, risk remains live*	Quality of Service	12	●◊	←	←	←	←				15/08/2018	14/12/2018	10/10/2018	EMB

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

4.0 Women's, Children's, HIV/GUM, Dermatology and Private Patients

Women's, Children's, HIV/GUM, Dermatology and Private Patients (WCHGDPP) have 62 live risks recorded within the register (23% of the organisational total). Assurance relating to identification and mitigation action is provided via the Divisional Quality Board. The division is well represented at the overarching governance groups with a remit for risk (e.g. Trust level committees, groups and sub-groups) as evidenced by attendance tracking.

	Low Risk (1-3)	Moderate Risk (4-6)	High Risk (8-12)	Extreme Risk (15-25)	Total	Review Overdue
Division wide	1	1	0	0	**2**	**0**
Dermatology	0	0	2	0	**2**	**0**
Gynaecology and reproductive medicine	1	3	2	0	**6**	**0**
HIV / Sexual Health	1	9	8	0	**18**	**0**
Maternity	3	6	13	0	**22**	**0**
Paediatrics	1	4	4	0	**9**	**0**
Private Patients	1	1	1	0	**3**	**0**
Grand Total	**8**	**24**	**30**	**0**	**62**	**0**

All WCHGDPP directorates (Gynaecology and reproductive medicine, HIV / Sexual Health, Maternity, Paediatrics, and Private Patients) have identified risks; 100% of which are within the scheduled review deadlines.

Since the last report to the Board in November 2018 the following key processes indicators have been observed within the WCHGDPP Division's risk register:

- No. new risks added: **17**
- No. of risks closed/accepted post mitigation: **15**
- No. of live risks re-scored: **5** (1 increased / 4 decreased)
- No. of live risks overdue for scheduled review (at 15/01/2019): **0**

Since the last report to the Board the Division has escalated four new risks scored equal to or greater than 12 to their highest level risk dashboard (these risks are escalated for Committee / Sub-Group assurance oversight):

- ID 289: Poor 4 hour performance and delays in review of children in the Paediatric Emergency Department (WM)
- ID 640: Inability to deliver MOH safety improvements at WestMid
- ID 656: Risk of puncturing imported Baxter Nsaline 1 Litre bags containing cytotoxics when spiking
- ID 642: Out of hours operating department practitioners staffing; Obstetrics

Within this reporting period four items, previously reported as equal to or greater than 12, have been mitigated and removed from the highest level risk dashboard (closure rationale escalated to aligned Committee / Sub-Group):

- ID 333: GUM Commissioning - Reduction in Tariff
- ID 367: Security of the QMMU
- ID 507: Temperature Monitoring Solution - No Disaster Recovery / Single Point of Failure
- ID 496: Out dated ultrasonography equipment (early pregnancy and emergency gynaecology unit)

The Division's Quality Board has engaged all areas in the management and maintenance of the risk processes to ensure an accurate risk record is developed and risks are kept current as new controls are introduced; assurance in the areas is provided by 100% of the division's risks being within their scheduled reviewed deadline.

4.1 WCHGDPP highest level dashboard (items scored 12-25 / items mitigated from dashboard since last report to ARC, October 2018)

	Highest risks: These are risks scored equal or greater than 12	Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
289	**INCREASING RISK** - Poor 4 hour performance and delays in review of children in the Paediatric Emergency Department at WestMid *Risk score increased from 6-12, risk escalated*	Patient Safety	12	◊			→	●				05/12/2016	01/01/2020	07/01/2019	PSG
318	Shortage of Sonographers at West Middlesex Hospital	Staffing	9	◊				●				04/04/2017	01/09/2019	10/01/2019	POD
352	Lastword HIV disclosure flags and associated risks	ICT	12	◊				●				23/05/2017	01/04/2019	02/01/2019	DTB
493	Cerner Implementation	ICT	12	◊				●				13/02/2018	04/05/2019	14/01/2019	DTB
565	Handling patients from British Pregnancy Advisory Service (BPAS)	Patient Safety	12	◊				●				05/07/2018	31/03/2019	07/12/2018	PSG
630	Retained swabs	Patient Safety	12	◊				●				04/10/2018	01/01/2020	14/01/2019	PSG
640	**NEW** - Inability to deliver MOH safety improvements at WestMid	Patient Safety	12	◊				●				29/10/2018	31/03/2019	10/01/2019	PSG
656	**NEW -** Risk of puncturing imported Baxter Nsaline 1 Litre bags containing cytotoxics when spiking	Patient Safety	12			◊		●				27/11/2018	18/01/2019	09/01/2019	PSG
642	**NEW** - Out of hours ODP staffing Obstetrics	Staffing	12	◊				●				30/10/2018	30/04/2019	11/12/2018	POD
333	**MITIGATED RISK** - GUM Commissioning - Reduction in Tariff *Risk score reduced from 12-8, risk remains live*	Financial mgmt.	12		●	←						05/05/2017	28/02/2018	02/01/2019	FIC
367	**MITIGATED RISK** - Security of the QMMU *Risk score reduced from 12-6, risk remains live*	Physical Estates	12	●	←							10/06/2017	31/12/2018	11/01/2019	HSERG
507	**MITIGATED / CLOSED -** Temperature Monitoring Solution - No Disaster Recovery / Single Point of Failure *Risk score reduced from 12-2, risk closed*	ICT	12	●◊	←							05/03/2018	30/11/2018	12/11/2018	DTB
496	**MITIGATED / CLOSED -** Out dated ultrasonography equipment (early pregnancy and emergency gynaecology unit) *Risk score reduced from 12-1, risk closed*	PSG	12	●◊	←							22/02/2018	31/10/2018	30/11/2018	PSG

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

5.0 Corporate Function / Non-Clinical Division

Corporate Functions / Non-Clinical Division has 62 live risks recorded within the register (23% of the organisational total). Assurance relating to identification and mitigation action is provided via the individual departments management review.

	Low Risk (1-3)	Moderate Risk (4-6)	High Risk (8-12)	Extreme Risk (15-25)	Total	Review Overdue
Clinical Systems & Information Technology	0	5	16	0	21	**0**
Corporate Governance	1	5	6	0	12	**0**
Estates and Facilities	1	7	5	0	13	**0**
Finance	0	0	1	0	1	**0**
Human Resources	0	2	4	0	6	**0**
Medical Directors Office	0	2	4	0	6	**5**
Nursing Directorate	0	2	1	0	3	**0**
Grand Total	2	23	37	0	62	**5**

The majority of directorates that comprise the Corporate Functions Division have identified risks; with exception of the Communications department. 92% of the risks aligned to the Division are within the scheduled review deadlines. Where risks are not reviewed the Head of Health Safety and Risks engages departmental leads and notifies aligned Executive.

Since the last report to the Board in November 2018 the following key processes indicators have been observed within the Division's risk register:

- No. new risks added: **8**
- No. of risks closed/accepted post mitigation: **16**
- No. of live risks re-scored: **16** (5 increased / 11 decreased)
- No. of live risks overdue for scheduled review (at 15/01/2019): **5** (8% of total)

Since the last report to the Board the Division has:

- Escalated five new risks scored equal to or greater than 12 to their highest level risk dashboard; these risks are escalated for Committee / Sub-Group assurance oversight based on the risk categorisation
- Mitigated six risks that were previously reported as equal to or greater than 12 and removed them have from the highest level risk dashboard; the mitigation rationale is reported to aligned Committee / Sub-Group

Departmental leads have engaged with the risk review process as evidence by 95% of items across the Division being reviewed within the scheduled timeframe; where review timescales have breached (5 items) confirmation has been received that all items are scheduled for update at forthcoming departmental risk group.

Further risk identification sessions are being scheduled by department leads to ensure full and accurate risk register development in continued and processes are embedded.

Corporate functions / Non-clinical departments; Highest level risks (items scored 12-25 / items mitigated from dashboard since last report to ARC, July 2018)

	Highest risks: These are risks scored equal or greater than 12	Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
252	EPR Domain Share with Imperial Hospital Directorate: Clinical Systems & Information Technology	Patient Safety	16		◊			●				08/12/2016	29/03/2019	18/12/2018	PSG
261	Cerner implementation costs may over run in 2019/20 Directorate: Clinical Systems & Information Technology	Financial Mgmt.	9	◊				●				28/11/2016	29/03/2019	18/12/2018	FIC
263	CWHFT and Imperial Health Care Trust Implementation Dependencies Directorate: Clinical Systems & Information Technology	Quality of Service	9	◊				●				28/11/2016	29/03/2019	18/12/2018	EMB
444	Failure to successfully implement the new EPR system (Cerner) Directorate: Clinical Systems & Information Technology	ICT	15				◊	●				10/11/2017	29/03/2019	18/12/2018	DTB
476	Variances in reported activity pre and post go live Directorate: Clinical Systems & Information Technology	Financial Mgmt.	12	◊				●				31/08/2017	29/03/2019	18/12/2018	FIC
659	**NEW -** Income Risk associated with EPR project Directorate: Clinical Systems & Information Technology	Financial Mgmt.			◊			●				04/12/2018	29/11/2019	18/12/2018	FIC
678	**NEW -** Benefits Not Fully Realised from EPR implementation Directorate: Clinical Systems & Information Technology	Financial Mgmt.		◊				●				05/01/2019	30/04/2019	05/01/2018	FIC
69	**INCREASING RISK** - Data Protection Directorate: Corporate Governance *Risk score increased from 9-12*	Governance				◊ →		●				04/07/2016	30/06/2019	28/12/2018	EMB
416	**INCREASING RISK** - Incomplete Information Asset Register Directorate: Corporate Governance	Governance		◊				●				30/06/2017	30/06/2019	28/12/2018	EMB
76	Staffing Capacity Directorate: Human Resources	Staffing	16	◊			◊	●				01/02/2016	30/04/2020	27/12/2018	POD
671	**NEW -** Brexit Implications on Staffing Directorate: Human Resources	Staffing				◊		●				27/12/2018	31/03/2019	08/01/2019	POD
202	MRSA trajectory Directorate: Medical Directors Office	Control of Infection	12			◊		●				05/10/2016	12/09/2019	19/07/2018	IPCC
78	**MITIGATED RISK** - Risk of delivering the 4 year quality improvement journey at pace Directorate: Nursing Directorate *Risk score reduced from 12-9, risk remains live*	Governance	12			● ←						01/02/2016	31/03/2019	07/12/2018	EMB
410	**MITIGATED RISK** - Ventilation verification non-conformities Directorate: Nursing Directorate *Risk score reduced from 12-9, risk remains live*	Health and Safety	12			● ←						14/09/2017	31/03/2019	11/12/2018	HSERG

440	**MITIGATED RISK** - Systems not available as insufficient backups, and on old technology Directorate: Clinical Systems & Information Technology *Risk score reduced from 12-4, risk closed*	ICT	12	10/11/2017	28/02/2018	29/11/2017	DTB
473	**MITIGATED RISK** - Desktop computer and network issues impacting Cerner delivery Directorate: Clinical Systems & Information Technology *Risk score reduced from 12-9, risk remains live*	ICT	12	03/07/2017	29/03/2019	11/01/2019	DTB
572	**MITIGATED RISK** - Strategic partnerships Directorate: Corporate Governance *Risk score reduced from 12-9, risk remains live*	Governance	12	18/07/2018	31/07/2019	15/01/2019	EMB
580	**MITIGATED RISK** - CW Hub utilisation impacting Mandatory & Statutory Training Directorate: Human Resources *Risk score reduced from 12-6, risk remains live*	Staff Training	12	25/07/2018	31/12/2018	08/11/2018	POD

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

6.0 Conclusions

There are 38 risks graded as 12 or above being managed across the organisations risk register; oversight and process / management assurance is overseen by aligned assurance groups.

Since the last report to the Board all organisational areas have demonstrated engagement in the risk identification and review process and are being supported to further embed risk into normal business management processes. Increasing awareness and bottom-up reporting is being encouraged through the introduction of ward based risk registers.

7.0 Next steps

1. Assurance committees / groups terms of reference and forward plans to be reviewed to ensure risk management and processes assurance explicitly planned.
2. Heads of non-clinical / corporate functions departments to establish regular meetings to identify and review risks that could, or are, impacting service delivery and provide positive assurance via the Executive Management Board.
3. Matrons to support the identification of Ward based risks and oversee development of local ward registers.

Appendix A: Risk rating guidance

The consequence of a risk is multiplied by the likelihood to determine the risk score e.g.
Consequence X Likelihood = Risk Score

Determining the Consequence of the Risk

When assessing the consequence of a risk you should consider the harm, loss or damage that would be caused if the risk occurred, this is a matter of judgement but the consequence should be the most probable outcome expected not just the potential worst case scenario. Reviewers should take account of all current controls when considering consequence.

Consequence is scored as follows; Negligible (1), Minor (2), Moderate (3), Major (4), Catastrophic (5)

The guidance on the following page describes examples of harm, loss or damage that may affect patients, staff and the public and indicates which consequence score should be chosen when undertaking the assessment, **see consequence domain guide overleaf.**

Determining the Likelihood of the Risk

Once you have determined the most probable harm, loss or damage that would be suffered if the risk was to occur you must consider how likely you feel it would be for that consequence to actually happen. When doing this you should consider all of the controls and precautions you already have in place and then determine the likelihood that the consequence will still occur.

The table below should be used to assist support decision making regarding likelihood.

Likelihood	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency - How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possible frequently
Frequency - timeframe	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability - Will it happen or not?	<0.1%	0.1 - 1.0%	1 - 10%	10 - 50%	>50%

Determining the risk score

Risks are scored by plotting the consequence of the risk and the likelihood of that consequence occurring within the following matrix, this is featured within each risk register item.

	Consequence				
Likelihood	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
5 Almost certain	**5**	**10**	**15**	**20**	**25**
4 Likely	**4**	**8**	**12**	**16**	**20**
3 Possible	**3**	**6**	**9**	**12**	**15**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
1 Rare	**1**	**2**	**3**	**4**	**5**

Consequence guide: Choose the most appropriate 'domain' for the risk from the top row, then work down the column in to assess the severity of the risk to determine the consequence score on a scale of 1-5. Remember the consequence should be the most probable outcome expected not just the potential worst case

LEVEL	STATUTORY DUTIES	INJURY/HARM/ PATIENT SAFETY	SERVICE DELIVERY	FINANCIAL/ LITIGATION	REPUTATION/ PUBLICITY	BUSINESS INTERUPTION / ENVIRONMENT	BUSINESS OBJECTIVES/ PROJECTS	QUALITY COMPLAINTS AUDIT	WORKFORCE DEVELOPMENT
Catastrophic Extreme 5	Multiple breeches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report	Serious incident involving a large number of patients Incident leading to death	Permanent closure/loss of a service	Loss of >£5M	Removal of Chair/CEO or exec team Long term or repeated adverse national publicity	Permanent loss of service or facility. Catastrophic impact on environment.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met	Totally unacceptable level or quality of treatment / service. Gross failure of patient safety if findings not acted on. Inquest/Healthcare Commission/ombudsman inquiry. Gross failure to meet national standards	Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis
Major 4	Enforcement action. Multiple breeches in statutory duty. Improvement notices. Performance rating low. Critical report	Major injury leading to long term incapacity requiring significant increased length of stay.	Significant underperformance of a range of key targets Intermittent failures in a critical service	Loss of between £501,000 and £5M	National media coverage and increased level of political/public scrutiny Total loss of public confidence	Loss/interruption of >1 week. Major impact on environment	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low performance rating. Critical report	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training
Moderate 3	Single breech in statutory duty. Challenging external recommendations/ improvement notice	RIDDOR reportable incident Moderate injury requiring professional intervention	Sustained period of disruption to services/sustained breach of key target	Loss of between £101,000 and £500,000	Local media coverage with reduction in public confidence	Loss/interruption of >1 day. Moderate impact on environment	5–10 per cent over project budget. Schedule slippage	Treatment or service with significantly reduced effectiveness. Formal complaint with potential to go to independent review. Repeated failure to meet internal standards. Major patient safety implications if not acted on.	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day). Low staff morale Poor staff attendance for mandatory/key training
Minor 2	Breech of statutory legislation. Reduced Performance rating if unresolved	Minor injury or illness requiring minor intervention. < 7 days off work if staff	Short disruption to services affecting patient care or intermittent breach of key target	Loss of between £10,000 and £100,000	Local media coverage	Loss/interruption of >8 hours. Minor impact on environment	<5 per cent over project budget. Schedule slippage	Overall treatment or service suboptimal. Formal complaint. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved	Low staffing level that reduces the service quality
Insignificant 1	No or minimal impact or breech of guidance/ statutory duty	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Less than £10,000	Rumours.	Loss/interruption of >1 hour. Minimal or no impact on the environment	Insignificant cost increase/ schedule slippage	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry	Short-term low staffing level that temporarily reduces service quality (< 1 day)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	4.2/Mar/19
REPORT NAME	Equality and Diversity
AUTHOR	Nathan Askew, Director of Nursing
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	The purpose of this paper is to provide the Trust Board with oversight of three mandated equality and diversity publications which require approval and publication on the Trust external website.
SUMMARY OF REPORT	The Trust are required to publish the following three annual reports: **Modern Slavery and Human Trafficking statement** The Trust statement has been updated and reflects the processes within the organisation in relation to human trafficking and modern slavery. **Patient Equality report** The Trust are required to use this set format to provide information on various aspects of protected characteristics of our patients **Patient equality objectives** The Trist are required to identify areas of improvement from a range of indicators that could make a difference in terms of equality and diversity for our patients. The patient experience committee recommend to the Trust that this work focusses on the following three areas: A – accurate and consistent data collection B – access of information C – using current feedback systems to identify any areas where BAME patients are disadvantaged in their experience of care
KEY RISKS ASSOCIATED	The Trust are required to be compliant with the publication of these reports
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	These publications will improve the quality of care across all patient groups
EQUALITY & DIVERSITY IMPLICATIONS	As stated above.

LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services
DECISION/ ACTION	The Trust board are requested to approve these for publication on the external web site.

Modern Slavery Act Statement

Slavery and Human Trafficking Policy Statement

1. Introduction

At Chelsea & Westminster NHS Foundation Trust (CWFT) we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by CWFT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

2. Organisational Structure

Chelsea & Westminster NHS Foundation Trust is an organisation of over 6,000 staff and is a major, multi--site north west London healthcare provider and teaching hospital consisting of Chelsea and Westminster Hospital situated in the borough of Kensington and Chelsea, and West Middlesex University Hospital, situated in Hounslow.

Our services reach 6 key London boroughs: Hammersmith and Fulham, Hounslow, Kensington and Chelsea, Richmond, Wandsworth and Westminster. The Trust is the largest provider of HIV and Sexual Health services in the UK and in addition to the multiple Sexual Health Clinical sites and are the lead provider for on line sexual health testing across London.

We are also leading Trust for teaching, training and research, with close links to Imperial College London and Imperial College Health Partners, as well as other Higher Education Institutions (HEI's).

Our supply chains enable the procurement of a wide range of goods and services on behalf of our clients and service users.

3. Our Policy on Slavery and Human Trafficking

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures.

4. Due Diligence

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

• Undertake appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff

• Implement a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair Terms of Conditions of employment and access to training and development opportunities.

• Consult and negotiate with Trade Unions on proposed changes to employment, work organisation and contractual relations.

• Purchase most of our products from UK or EU based firms, who may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.

• Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour

• With effect from January 2017, require all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through our purchase orders and tender specifications. All of which set out our commitment to ensuring no modern slavery or human trafficking related to our business

• Uphold professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply

• Where possible and consistent with the Public Contracts Regulations, build long-standing relationships with suppliers

5. Training

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our Safeguarding policies and procedures and our Safeguarding Leads.

6. Board of Directors' Approval

This statement has been approved by the Board of Directors of CWFT, who will review and update it on an annual basis.

Further information about Chelsea & Westminster NHS Foundation Trust can be found on the following website: http://www.chelwest.nhs.uk/

Chelsea & Westminster NHS Foundation Trust

Patient Equality Report 2018

Chelsea & Westminster NHS Foundation Trust delivers specialist and general hospital care at Chelsea and Westminster and West Middlesex University hospitals. Both hospitals have major A&E departments and the Trust also provides the second largest maternity service in England.

Our specialist hospital care includes the burns service for London and the South East, children's inpatient and outpatient services, cardiology intervention services and specialist HIV care.

We also manage a range of community-based services, including our award winning sexual health clinics, which extend to outer London areas

The Trust serves a catchment area in excess of one million people. The Trust's main health commissioning and social care partnerships cover two STP footprints and the following areas:

- West London CCG
- Hounslow CCG
- Hammersmith and Fulham CCG
- Central London CCG
- Ealing CCG
- Richmond CCG
- Wandsworth CCG
- NHS England (NHSE) for Specialised Services Commissioning

The Trust values are now firmly embedded. They demonstrate the standard of care and experience our patients and members of the public should expect from any of our services.

They are:
- **P**utting patients first
- **R**esponsive to patients and staff
- **O**pen and honest
- **U**nfailingly kind
- **D**etermined to develop

The following sections provide an overview of the demographic profiles of our patients who have used the Trust services during 2017/2018. The sections have been divided into 4 services.

A&E
Maternity
Inpatients
Outpatients

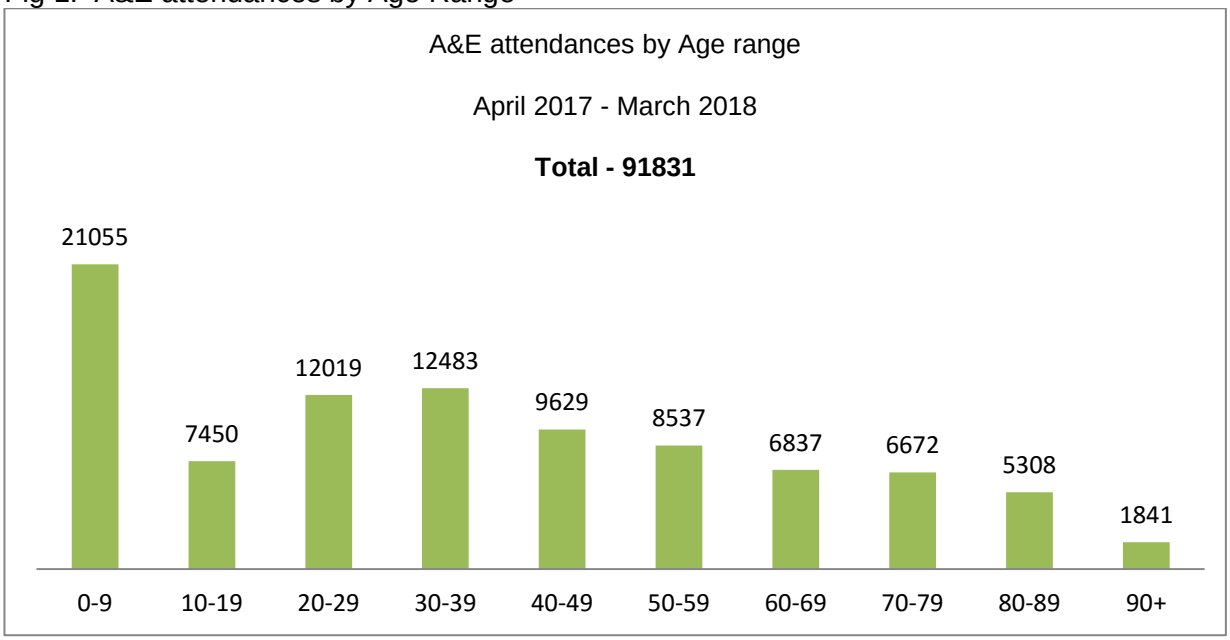
For the purposes of this report, the following breakdown of ethnicity has been used. Non BAME incorporates patients that identify as White British, White Irish and Any Other White background.

BAME includes patients who identify as Asian (Indian, Pakistani, Bangladeshi), Mixed (White Black/Asian), Black (Caribbean, African) and Other (Chinese and Any Other). These are in line with the Office of National Statistics' Census categories.

The Not Stated category also includes those who have chosen not to disclose their ethnic background.

1. A&E

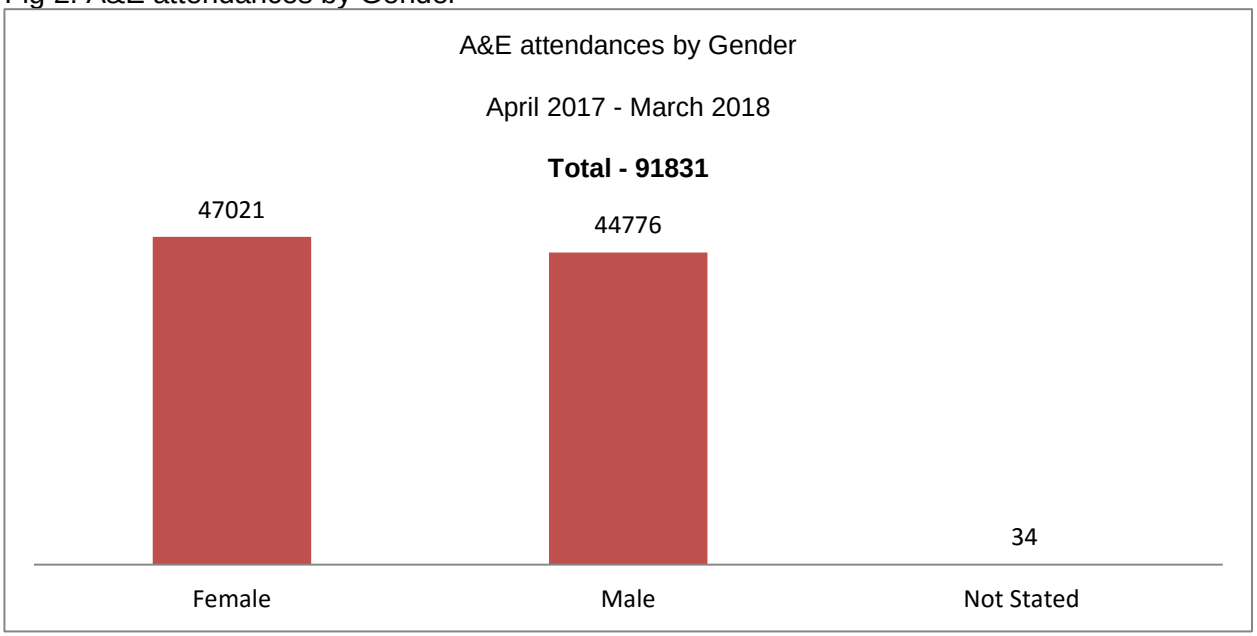
Fig 1: A&E attendances by Age Range



The data shows that there were *91,831 patients who attended one of the Trusts two A&E departments between April 2017 and March 2018. This is a 3.6% increase on the previous year for the same time period. The 0-9 age range makes up the largest single user group of this service at 23%. This data excludes births that occurred during the same period.

The under 60's accounted for 77.5% of overall attendances with the over 60''s accounting for 22.5% of the overall total. This shows no change from the previous year.

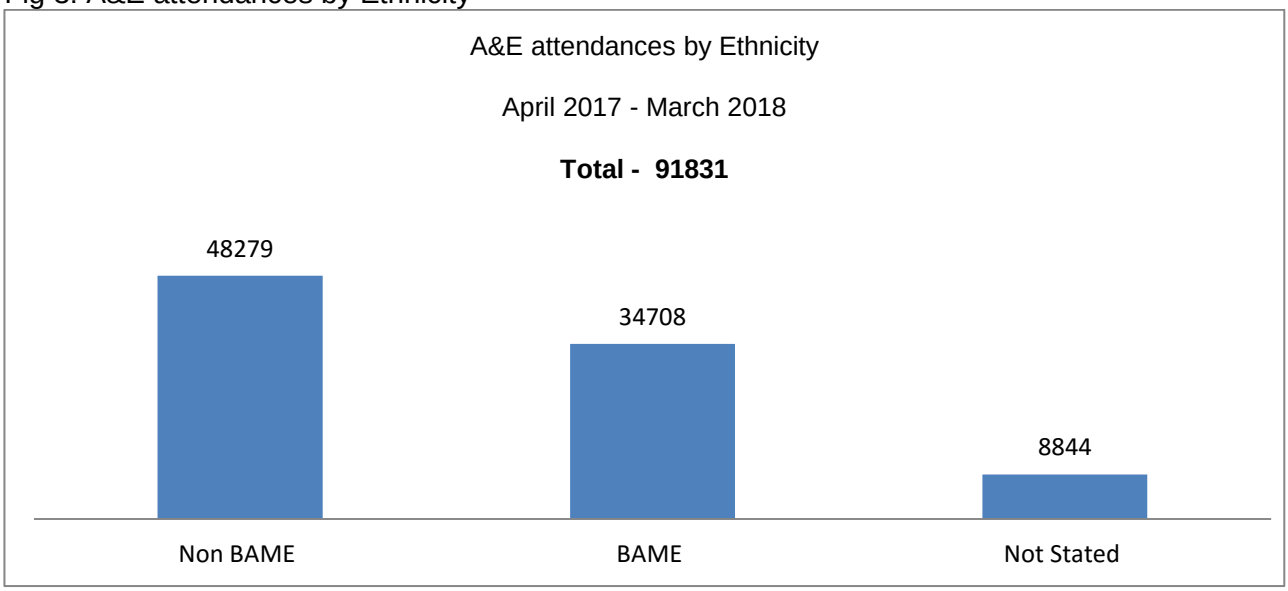
Fig 2: A&E attendances by Gender



The data for A&E attendances by gender shows females at 51% just ahead of males at 48% with not stated at less than 1%. This has remained the same as the previous year.

*The patient data quoted throughout the document is based on the number of patients that accessed Trust services and not the number of times an individual patient attended A&E, was an inpatient or had an outpatient appointment

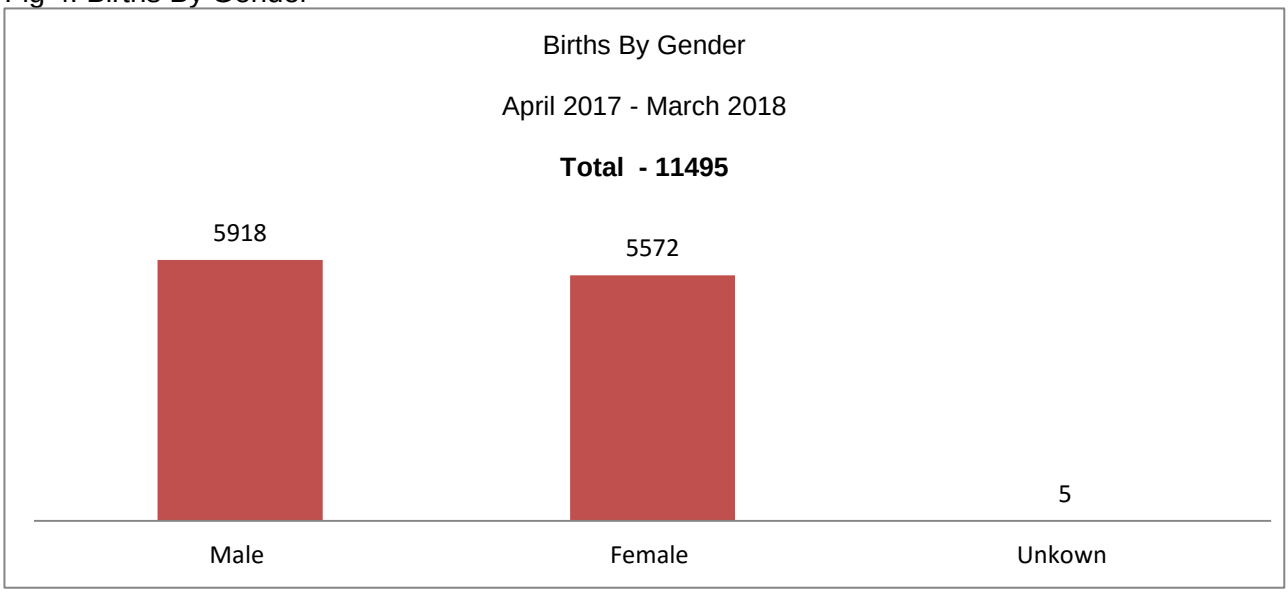
Fig 3: A&E attendances by Ethnicity



The above shows that Non BAME account for 52% of service users with BAME at 38% and not stated at 10%. This is also the same as the previous year.

2: Maternity

Fig 4: Births By Gender

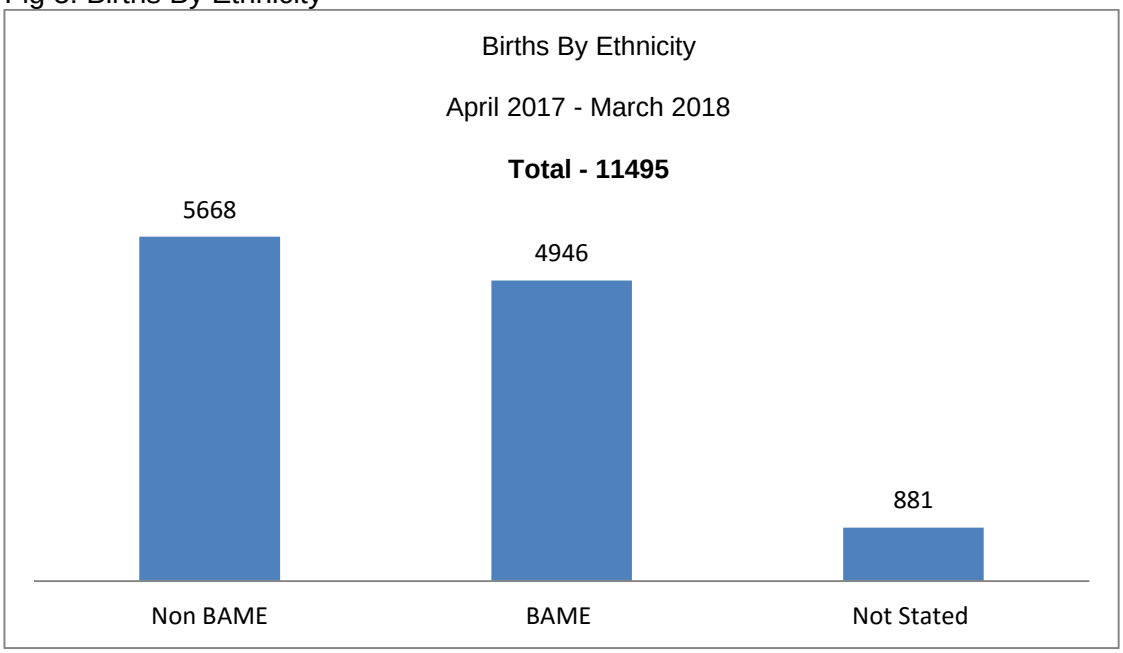


There were 11,495 births across the maternity service between April 2017 – March 2018. This includes home births.

This averages out at approximately 958 births a month which reflects the Trusts position as the second largest maternity service in the country.

There were slightly more male babies born at 51% of the total, with females 48%. There were 8% of births were the gender of the newborn was not recorded.

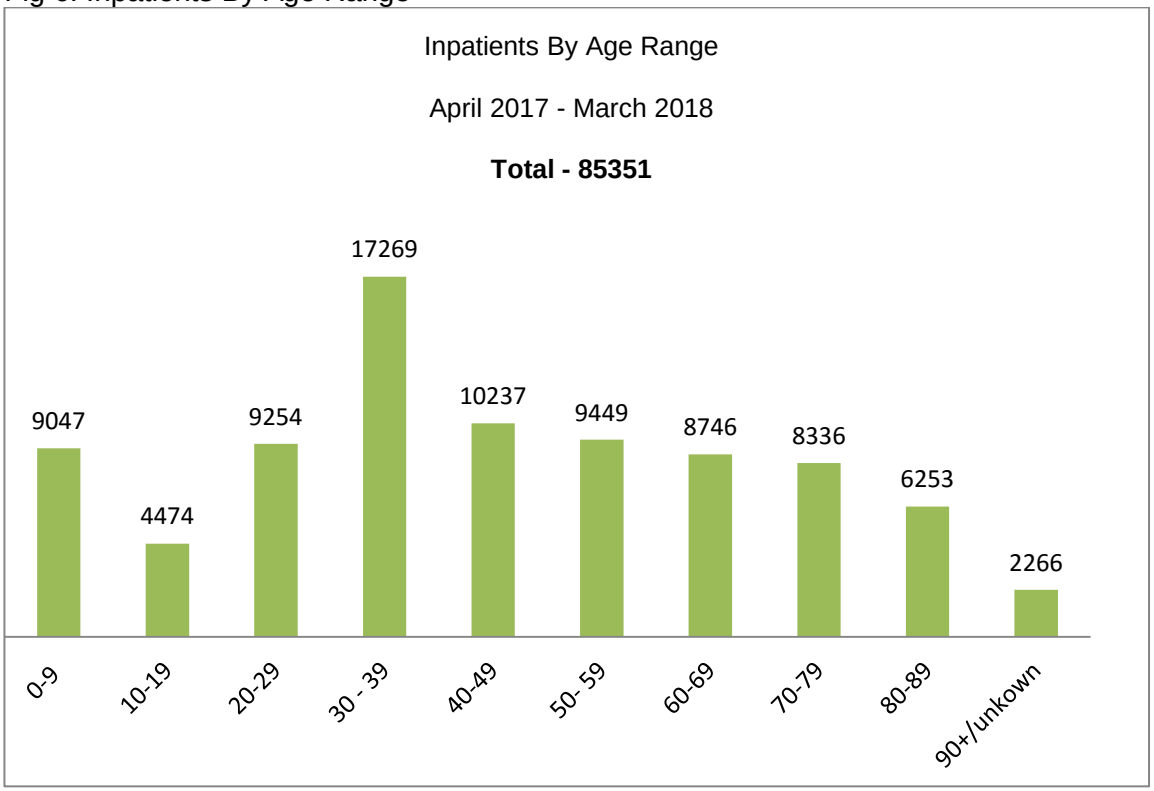
Fig 5: Births By Ethnicity



Of the 11495 births 49% were Non BAME, 43% were BAME and 8% were Not Stated

3. Inpatients

Fig 6: Inpatients By Age Range

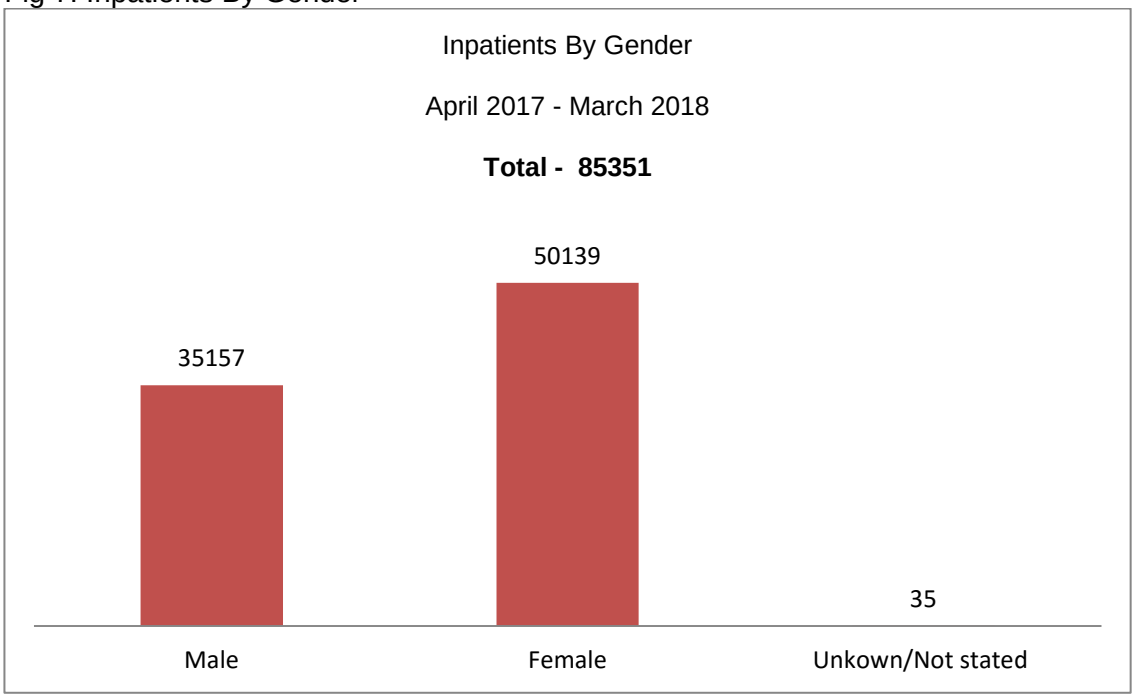


The above shows that were 85,351 inpatient admissions in the period from April 2017–March 2018. This is down on the data reported last year which showed 94,356 inpatient admissions, however last year's data included births which had the effect of increasing the 0-9 age range to be the largest single group at 23% of the overall total. The data has therefore been adjusted to remove births this year.

The information as demonstrated in the graph shows that the 30-39 age group make up the largest single user group of this service at 20% of the total with the 40-49 age group the next largest at 12% of the total.

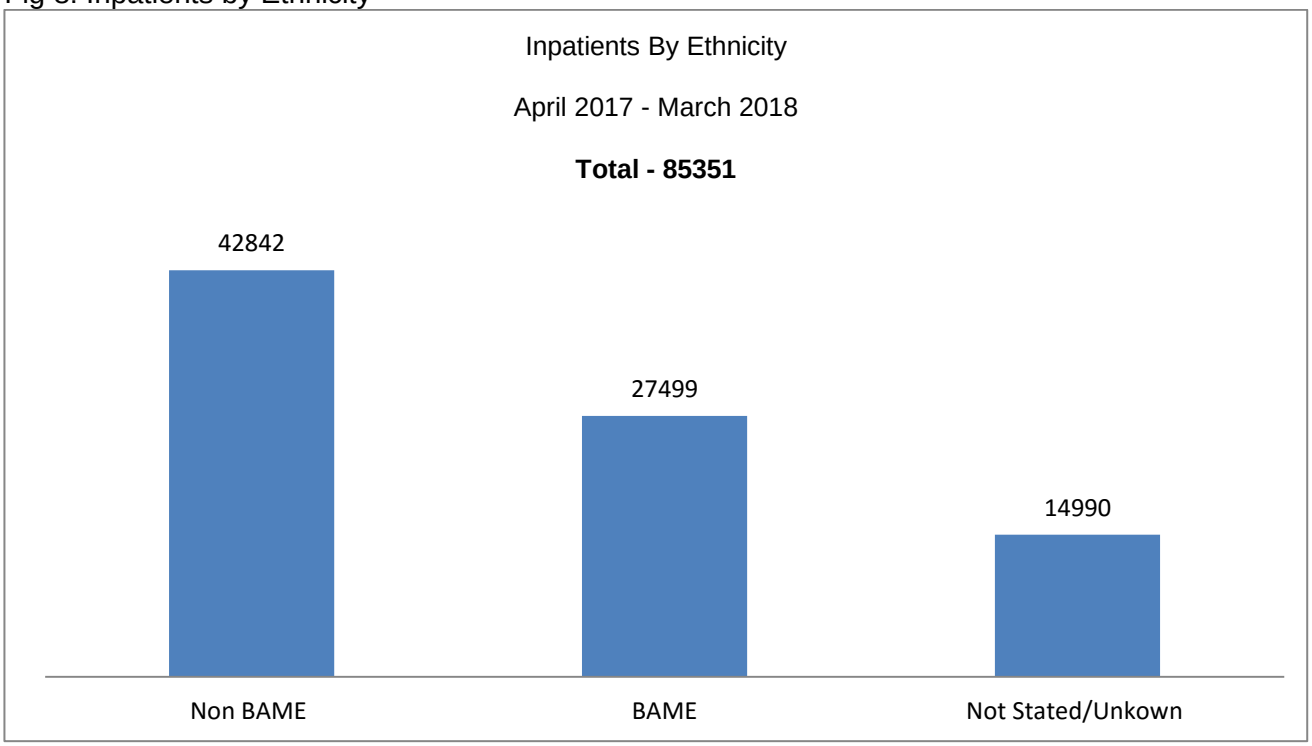
Those aged under 60 years old account for 59% of the overall total patients. Those over 60 years old accounted for 30% of overall total patients which is an increase of 6% on the previous year with the 80-89 age range.

Fig 7: Inpatients By Gender



Inpatient by gender indicates that females at 58% make up the majority users of this service with males at 41%. This reflects the data from the previous year where females were again in the majority.

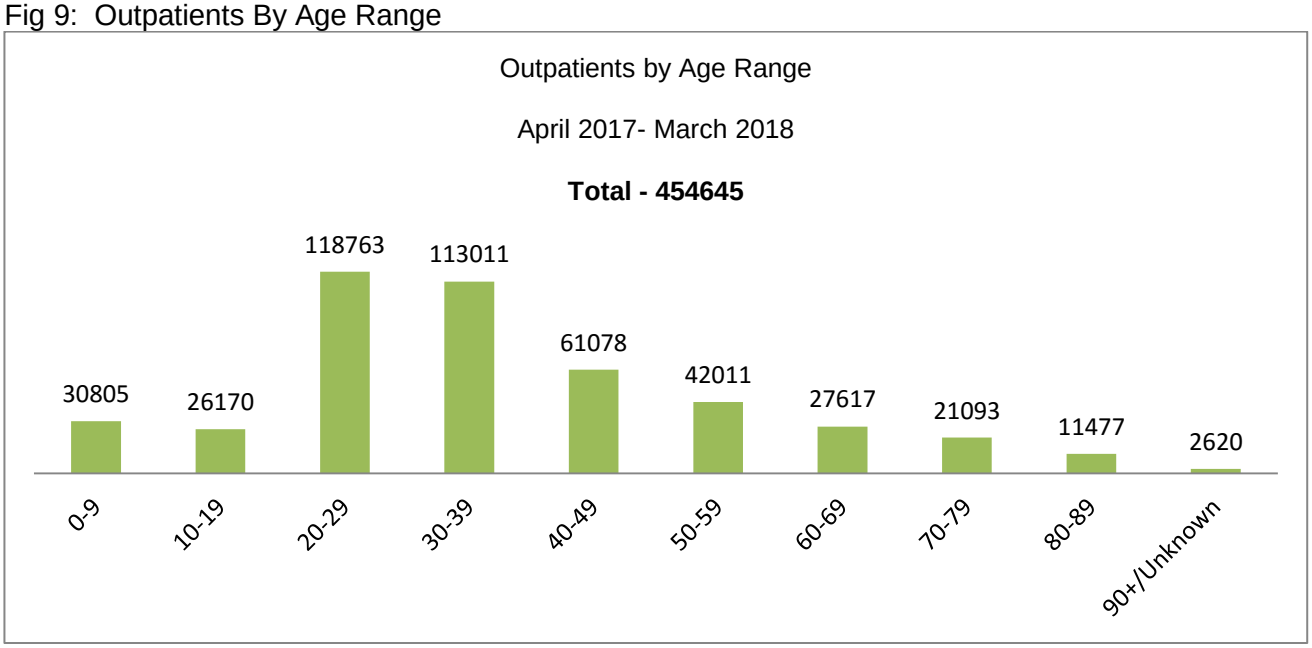
Fig 8: Inpatients by Ethnicity



Non BAME patients account for 50% of overall total of inpatients and BAME 32% of overall total with not stated/unknown at 17% which is on increase of 2% in the data for the previous year.

4. Outpatients

Fig 9: Outpatients By Age Range

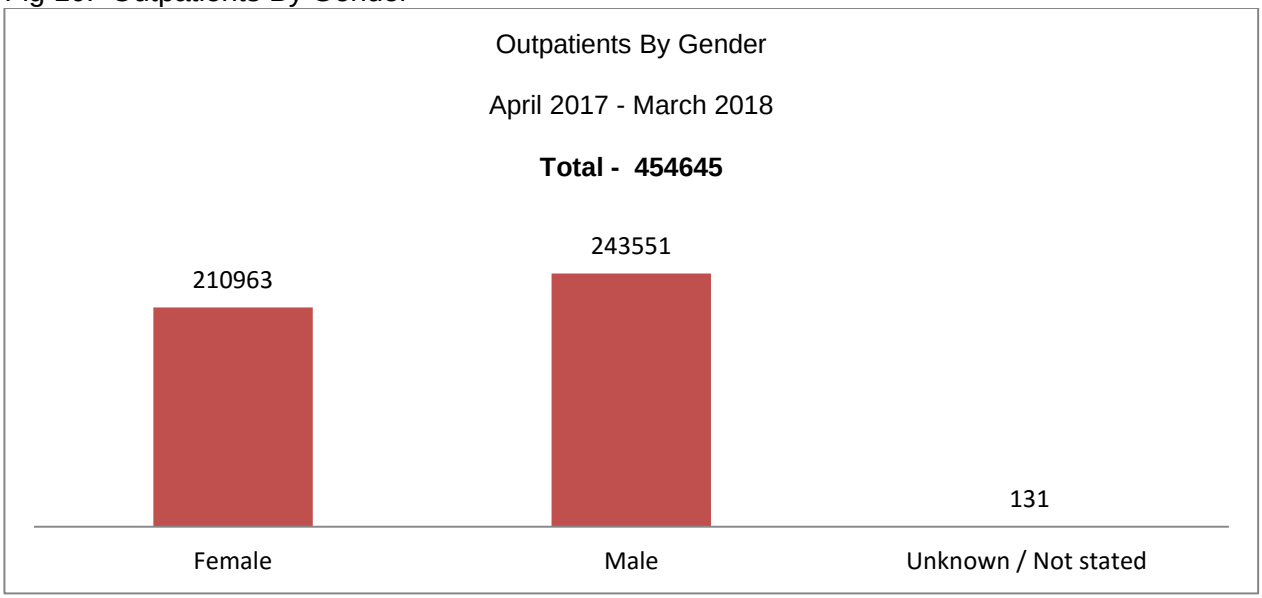


The above shows 454,645 patients attended outpatients' appointments between April 2017 and March 2018 and the distribution of patient age ranges. This represents a 5.4% increase in the number of appointment across the same period the year before.

The information as demonstrated in the graph also shows that in total those aged between 20–39 years old make up the significant users at just under 51% of these services. As a whole those aged

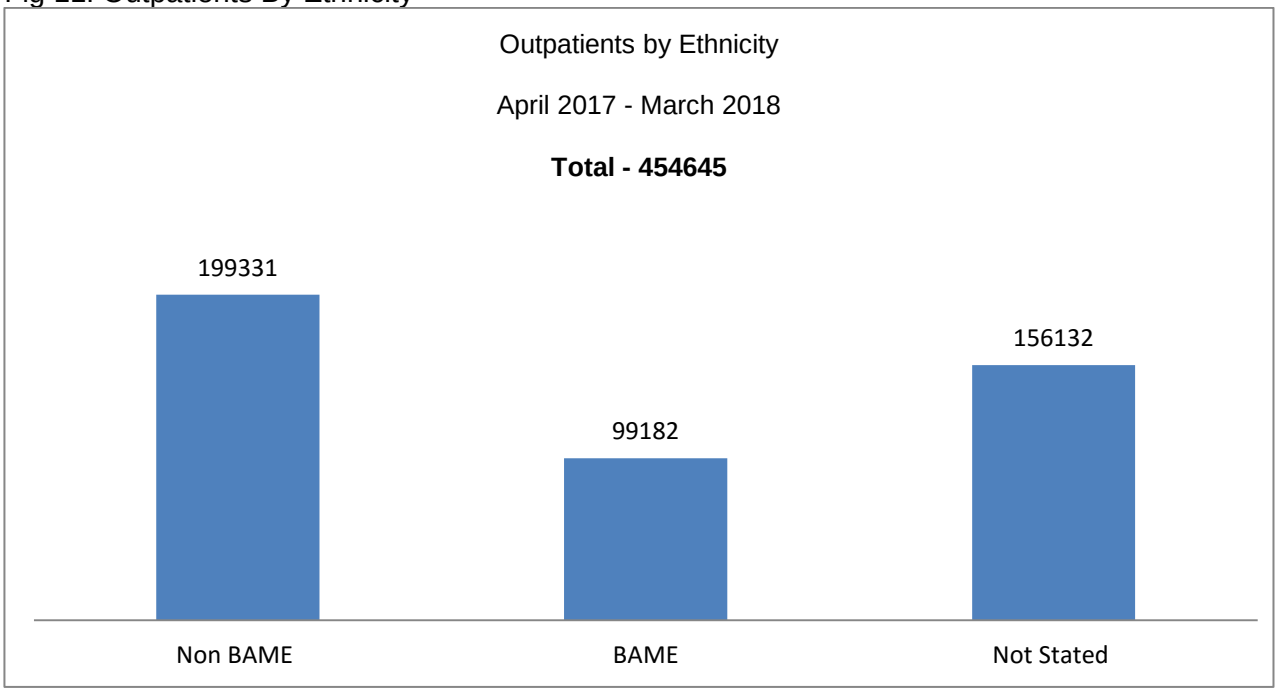
under 60 years old make up 86% of the total with those over 60 years old accounting for 13% of the total. For the over 60's this is a 2% reduction from 15% of the total from the previous year.

Fig 10: Outpatients By Gender



The above shows that males make the majority of the 454,645 outpatient's appointments at 53% with females at 46% which is no change from the previous year. The number of unknowns/not stated is less than 1% of the total.

Fig 11: Outpatients By Ethnicity



The capturing of outpatient patient ethnicity data has improved since last year with the Not Stated at 35% of the total as opposed to 60% of the total last year which is a 25% improvement. This has contributed to a change in the data in the following way.

The percentage of Non BAME patients using these services is now 44% of the total, this was 61% of the total last year. The percentage of BAME patients has decreased from 39% of the total last year to 22% of the total this year. Whilst the percentage of the overall total in both categories has decreased

this has actually led to a 19% increase in the overall numbers of Non BAME data being captured and a 6% increase in BAME data being captured. The implementation of CERNER will continue to improve and support the capture of this data.

Fig 12: Top 10 Religions By Department

Religion	A&E	Inpatients	Outpatients
Christian	3807	4063	9991
Church of England	3521	2820	5432
Hindu	2091	1429	3011
Muslim	5352	3205	6346
Sikh	2031	1175	2163
Roman Catholic	3741	2703	5420
Jehovah's Witness	39	36	78
Jewish	106	119	360
Buddhist	245	199	395
Not Religious /No Religion	8214	4818	8890
Not Declared	60501	4818	407399
Total of all denominations	**85331**	**91831**	**454645**

The Trust collects data on the religious beliefs of patients. 30 different denominations were recorded as well as those who were not religious and the above details the top 10 most recorded religious beliefs by service. There was however high percentages between 65% and 89% across the services were religious beliefs were not declared by patients.

Patient profile by Disability

Analysis of patient usage by disability is too small and no valid conclusions can be drawn from this. Data for patients with learning disabilities is being collected at the CWH sites and recorded on both sites. The introduction of a new cross-site IT system EPR system will enable better data collection in relation to this protected characteristic the CWH site and work is underway to collect this on the WMUH site.

Transgender Guidance

In August this year the Trust Executive Management Board approved new guidance for our staff on providing care to transgender patients. The policy includes key information and helpful sources of advice and information. This has been developed in association with transgender organisations.

Accessible Information Standard

The Trust continues to work towards full compliance with the AIS identifying patients with a communication need and raising awareness to all staff.

Learning Disabilities

Data for patients with learning disabilities is collected at the Chelsea sites. The introduction of a new cross-site electronic patient record system (CERNER) will enable better data collection in relation to this characteristic.

The Trust Learning Disabilities Steering Group, chaired by the Lead Nurse continues to champion high quality care for patients with learning disabilities. This includes effective working in partnership with our community teams and services to ensure a smooth interface and transition of care. The group has Trust departmental representation, local Patient groups and carers of patients with a learning disability.

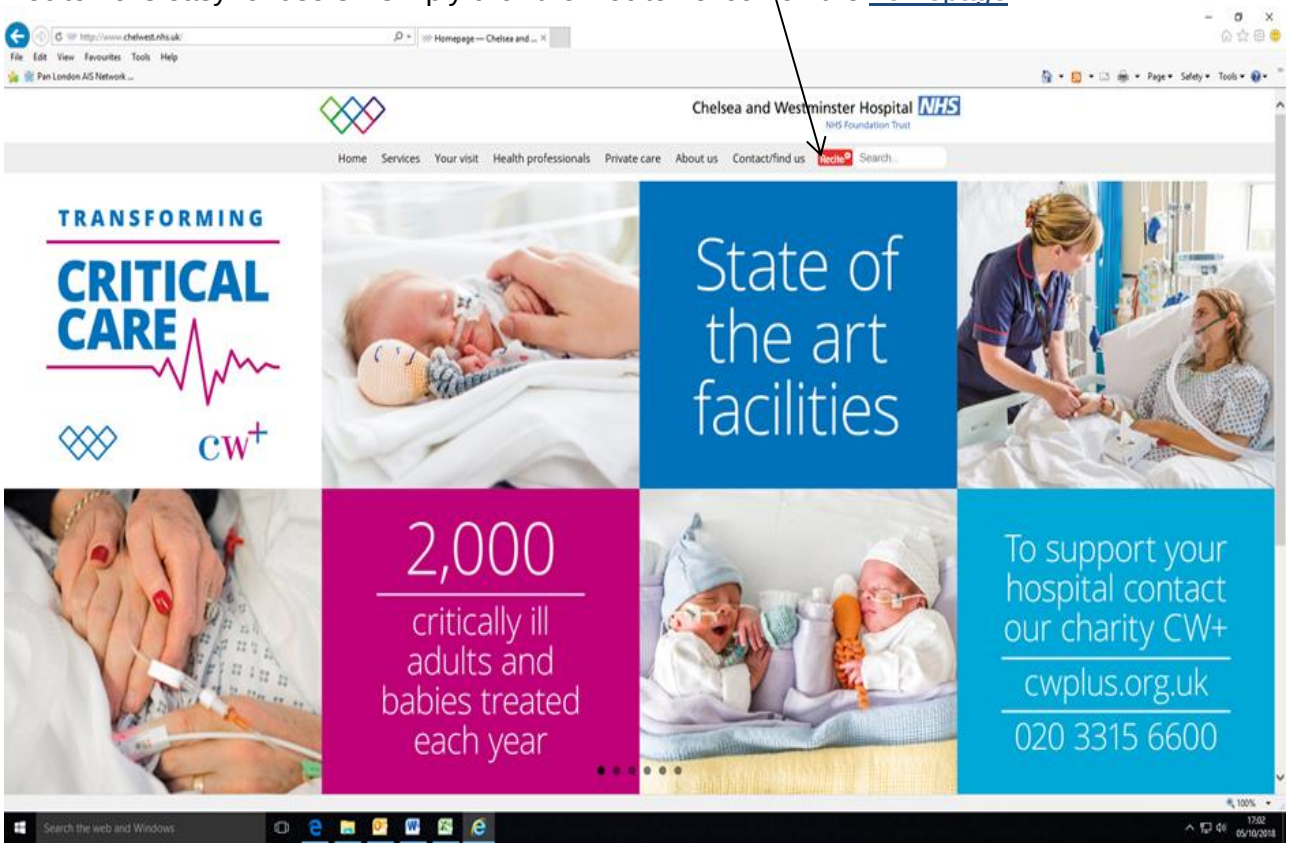
The Lead Nurse has trained over 3,800 Trust staff both in Learning Disability/Autism awareness and Level 2 to training to date and training of staff continues.

ReciteMe
This year as part of its ongoing commitment to reducing accessibility barriers Chelsea and Westminster Hospital NHS Foundation Trust has enabled an innovative new product on the Hospitals main website called ReciteMe.

ReciteMe is a text-to-speech solution that reads all accessible website content aloud in a human sounding voice which can be altered to suit the individual's specific needs. As the text from the website is read aloud words are also highlighted at the same time.

ReciteMe helps people who have literacy problems, learning difficulties, dyslexia, visual impairments and also provides a translation toolbar which translates text and speech into a number of languages for those who English may be a second language.

ReciteMe enables the Trust improve the accessibility of our website for people who may find it challenging to use the site in a conventional way.
ReciteMe is easy for users—simply click the ReciteMe icon on the homepage



GUM - Launch of eServices Contract
Sexual Health London (SHL) is London's new sexual health e-service that provides free and easy access to sexual health testing via the internet and local venues.

Chelsea & Westminster NHS Foundation Trust have been appointed as the lead contractor to deliver this new sexual health service across London from April 2018. The service provides testing for a range of sexually transmitted infections including chlamydia, gonorrhoea, HIV, syphilis, hepatitis B and hepatitis C via samples you can collect at home. Currently 10,000 patients have opted for this service opposed to a face to face appointment.

Interpretation & Translation
Continuing effective patient care depends upon the accurate exchange of information. It is therefore the aim of the Trust to ensure that a range of interpreter and translator services are provided for people whose first language is not English and also those who communicate via sign language. These services are provided by accessing the use of telephone interpreters and where required face to face interpreters within the permitted specialities.

Interpreting; relates to the spoken word.

Translation; relates to the written word (transferring ideas expressed in writing from one language to another).

The tables below indicate the usage of Interpretation and Translation Services between April 2017–March 2018 across Trust services and sites.

Top 10 Face to Face Languages

Target Language	Spoken/Non-Spoken	Total Serviceable Jobs	2017 Usage	Position in 2017
Arabic	Spoken	543	475	1
Spanish	Spoken	278	284	3
Polish	Spoken	239	298	2
Farsi	Spoken	218	199	4
British Sign Language	Non-Spoken	214	2	n/a
Portuguese	Spoken	192	181	5
Russian	Spoken	102	121	6
Somali	Spoken	85	69	9
Turkish	Spoken	71	n/a	n/a
Romanian	Spoken	70	72	7

Top 10 Telephone Languages

Language	Serviceable	Serviced	2017 Usage	Position in 2017
Arabic	288	285	249	1
Portuguese	148	143	101	4
Spanish	136	135	129	3
Polish	129	128	143	2
Romanian	112	111	98	5
Somali	101	101	45	10
Russian	81	81	61	8
Amharic	80	77	n/a	n/a
Farsi (Persian)	77	76	62	7
Punjabi	55	55	n/a	n/a

Top 5 users of Telephone Interpreting by Department

Department	Serviceable	Serviced	2017 Usage
Antenatal Clinic / Ultrasound	250	250	*140*
Dean Street	161	161	*176*
Medicine Outpatients	155	155	*127*
Paediatric Outpatients	98	98	*N/A*
10 Hammersmith Broadway	97	97	*N/A*

Face to Face Bookings by Department

Appointment Type	Total Serviceable Jobs	Total Serviced Jobs
Clinical Support Services	1884	1853
Woman's Paediatrics, HIV &Sexual Health, Derm	559	547
Medicine and Surgery	349	339
Non-Clinical Support	153	151
Other	1	1

There were a total of 2,946 face to face bookings by departments in 2017- 2018 up from 2,689 which is a 9.5% increase.

Patient Equality Objectives 2019 - 2021

Issue	Objective	Baseline	Target	Summary of Work	Owner	Due Date
The Trust does not consistently collect all protected characteristics of patients attending for services	To ensure that the following protected characteristics data is collected for all patients: Gender Ethnicity Religion Disability Communication Needs	Current levels of compliance by service for each characteristic are: **Accident & Emergency** Gender: 99% Ethnicity: 90% Religion: 35% Disability: no data available Communication: no data available **Inpatients** Gender: 99% Ethnicity: 82% Religion: 27% Disability: no data available Communication Needs: no data available **Outpatients** Gender: 99% Ethnicity: 65% Religion: 11% Disability: no data available Communication Needs: no data available	All characteristics listed to achieve 95% compliance	Cerner EPR PAS to be reviewed and characteristics mandated Communication Plan to be developed and rolled out Compliance report to be developed Report to Cerner and Patient Experience monthly	NCIO Head of Coms NCIO E&D Manager	01.10.19 01.07.19 01.08.19 01.11.19

The Trust produce patient information primarily in print form and in the English language	To improve access to health information with a focus on patient information leaflets These will be available in: Digital and print form Various size print A range of languages On the trust external website	Current levels of compliance for each of the objectives are: Digital and print form – unknown Various size print – unknown A range of languages – unknown On the Trust external website – unknown	All patient information leaflets to meet the objectives within one year	Current information leaflets to be reviewed and converted to digital version Website to be developed that is available externally Communication plan to all clinical teams Compliance report to be developed and report monthly to patient experience	Quality Improvement Lead Coms / Quality improvement lead Head of Coms Quality improvement lead	31.03.20 01.07.19 01.07.19 01.06.19

Trust national patient surveys do not demonstrate any difference in experience of care by our BAME patients and non-BAME patients	To use the national data collected to analyse the experience of care by BAME and non-BAME patients for: • Maternity • ED • Paediatrics • Inpatients	Currently this data has not been available	For each survey to be analysed by BAME and Non-BAME patients	Picker data to be obtained by ethnicity Data to be compared to BAME and Non-BAME Differences in experience to be summarised into a report to the patient experience group Local action plan developed for each survey once compared	E&D Manager E&D Manager E&D Manager Local Areas Divisional Directors of Nursing / Midwifery	As each survey results are realised Within 1 month of each release date Within 2 months of each release date Within 3 months of each release date

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	4.3/Mar/19
REPORT NAME	Guardian of Safe Working Report Q1, Q2 and Q3 2018-19
AUTHOR	Dr Rashmi Kaushal
LEAD	Zoe Penn, Chief Medical Officer
PURPOSE	This paper is to provide the PODC with assurance on the process and outcomes of the information gathered by the Guardian of Safe Working, who safeguards the working hours and the safety of those hours for our junior doctors.
SUMMARY OF REPORT	The report shows declining submission of exception reports by junior doctors over the quarter and continues a previous downward trend. The major themes of reports submitted are about reduced staffing levels and increased workload. Rota gaps are a national problem but all vacancies have mitigation and plans against them. There are no 'red flag' specialities and all rotas have been rigorously subject to job plan review in two cycles to assure that they are safe and compliant, with the exception of ENT at WMUH and urology at WMUH, which are still ongoing. Benchmarking of the Trust performance is favourable against other London trusts and we are a lead performer and Beacon site; recognised by Health Education England, the GMC and the BMA. Our junior doctor forums are well attended by juniors and by senior medical staff.
KEY RISKS ASSOCIATED	Non-compliance risks imposition of internal financial fines for divisions and is a reputational risk for recruitment and increased costs for Bank and agency staff.
FINANCIAL IMPLICATIONS	As above
QUALITY IMPLICATIONS	Risk to quality of care b unsafe rotas for junior doctors and reduction in the amount and quality of postgraduate teaching.
EQUALITY & DIVERSITY IMPLICATIONS	None

LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Board is asked to discuss and approve.

Guardian of Safe Working Hours Report

Quarter One: April – June 2018.

1. Executive Summary

All junior doctors training grades employed by Chelsea Westminster Foundation Trust have been successfully transferred to the New Terms and Conditions implemented in August 2016.

The Trust has ensured that all posts have contractually agreed service requirements, training opportunities including Clinical Governance and Mandatory training. Rota design to ensure Safe Working is complaint for all such posts employed by the Trust.

The report follows in three main sections: a report of Exception reporting for the first quarter of 2018, Rota gaps, and the junior doctor Forum.

The key findings of the Exception Reporting process are:

- The number of Exception Reports submitted has been on the decline for this quarter. This can be attributed in part due to better organisation, prioritisation and improved clinical skills expected in clinical training posts.
- Responses to Exception reports submitted have improved significantly with most clinical supervisors responding promptly. This has resulted in timely changes to work schedules with a reduction to the number of exceptions occurring.
- There remains a significant variation of exception reporting across sites and also between the different sub specialities.
- Most Exceptions submitted were as a result of reduced staffing levels and increased work load. The combined effect of rota gaps and zero days is an increase in reduced staffing levels and increased work load.
- Additional hours worked by junior doctors have been remunerated predominantly with payment. Whilst most doctors can expect to be paid within 2 months of management sign off, the introduction of e-pay has resulted in possible delays for this quarter.
- No fines have been levied for this Quarter.
- From August 2018, Exception Reporting systems will change from DRS4 to Allocate.

Rota Gaps continue to be a national problem. It is anticipated that there will be a further reduction of up to 20% as Junior Doctors choose to leave formal training posts in 2018-2020.

Whilst the focus remains on recruiting to posts, the Trust is developing strategies to ensure that clinical care is not impacted. Gubby Ayida is leading on the process of exploring task shifting as well as formal involvement of Physician Associates within the workplace. This should reduce the need for unnecessary agency recruitment. The Clinical divisions have been invited to actively contribute to this process.

2. Rota Gaps:

Rota gaps are a common theme affecting most clinical departments on both sites. The introduction of Zero days as a mechanism to make existing rota's complaint has resulted in a reduction in the total number of doctors in the work place at any time.

Table A: Rota Gaps at Chelsea Site

Site	Department	Gaps for Quarter 1 of 2018	Anticipated Quarter 1 2018	Solutions
C&W	HIV & GUM	1 GP VTS at Dean Street		Filled with Trust SHO Post
C&W	HIV & Gum	4 X SPR posts due to maternity leave and OOPR	4 X SPR posts due to maternity leave and OOPR	Filled with LAS doctors. Recruitment for Aug 2018 has taken place in April 2018
C&W	Paediatrics	2.6 SHO and 1 SPR		Gaps remain unfilled
C&W	General Surgery	FY2 post moved from general surgery to paediatric surgery April 2018		Team are in the process of recruiting to this post
C&W	O&G	1 SPR gap since resignation post CCST		On call shifts have been covered by locum
C&W	O&G	1 gap ST3-7		Remains unfilled
C&W	O&G	0.5 gap ST3-7maternity leave		
C&W	O&G	1 ST3-7 Unable to do on call shifts for medical reasons		On call shifts have been covered by locum
C&W	AAU	ACCS AM gap continues until August 2018		Short term , locum until April 2018 only
C&W	COTE	1 CMT1		Intermittent locum cover only
C&W	Anaesthetics	ST3 on modified duties after a period of sickness		Covered by locum shifts

Table B: Rota Gaps at WMUH site

Site	Department	Gaps for Quarter 1 2018	Anticipated Quarter 1 2018	Solutions
WM	AAU	0.4 SPR		Locum cover when possible
WM	AAU	1 FY2		Gone to recruitment
WM	Respiratory	1 SPR		Work load absorbed by existing team
WM	Respiratory	1 CT1 (Post shifted by the Deanery to COTE)		Work load absorbed by existing team
WM	COTE		FY2 gap (April to August 2019)	
WM	COTE		CMT gap (Feb to August 2019)	
WM	COTE		GPVTS gap (February to August 2019)	
WM	Gastroenterology		FY2 gap (Dec 2018 – April 2019)	
WM	Gastroenterology		2 FY2 gaps (April – August 2019)	
WM	Paediatrics	3.5 x SHO		Out to recruitment
WM	ENT	1 SPR		Out to recruitment
WM	ENT	6 x SHO Posts		Covered by flexi staff
WM	Endo	SPR until Aug 2018		Work load absorbed by existing team
WM	AAU		2 FY2 gaps (August 2018 – April 2019)	Out to recruitment

3. Locum Tap

Locum Tap is a software solution for managing the temporary staffing requirements of hospitals. It is the recruitment tool employed by all the Trusts in London to ensure that rota gaps can be filled as a short term measure. The aim is to enable clinicians to view shifts at Trusts where they are employed or other London Trusts and reduce the barrier of entry for clinicians to provide locum cover.

National rates of hourly pay are uniform and non- negotiable. Shown Below in Table A

Basic Rates	
Effective April 1, includes HCA allowance and 12.07% WTD payment	
Band/Grade	**Flexistaff rates from 9 April 2018**
FY1 standard	**£22.41**
FY1 enhanced	**£28.00**
SHO standard	**£33.62**
SHO enhanced	**£40.00**
ST3+ standard	**£44.83**
ST3+ enhanced	**£56.04**
Speciality Doctor/ Staff Grade	**£50.43**
Associate Specialist	**£56.04**
Consultant – standard	**£67.24**
Consultant – enhanced	**£84.05**

Unsocial Rates	
Effective April 1, includes HCA allowance and 12.07% WTD payment	
Band/Grade	**Flexistaff rates from 9 April 2018**
FY1 standard	**£26.90**
FY1 enhanced	**£30.00**
SHO standard	**£43.03**
SHO enhanced	**£45.00**
ST3+ standard	**£53.79**
ST3+ enhanced	**£67.24**
Speciality Doctor/ Staff Grade	**£60.52**
Associate Specialist	**£67.24**
Consultant - standard	**£80.69**
Consultant - enhanced	**£100.86**

4. Junior Doctor Forum

The Junior Doctor forum has remained very active for this Quarter.

WMUH meetings took place on Wednesday March 11th and Wednesday 20th June.

C&W meetings took place on Wednesday 16th of May and Wednesday 13th of June.

Whilst there are guidelines as to who should be present from management, the junior doctors have preferred attendance from senior management on an invitation basis only. This has been supported by the BMA.

The LNC chairs, GOSW and DME's are expected to attend all the meetings or send an appropriate member of staff to represent them.

The forum dates are selected on the basis of when the Junior Doctors and BMA reps are available to attend. This often makes it impossible to give senior management sufficient notice as dates are set every 4-6 weeks.

There are plans to formalise this process to ensure at least 1 management attended forum for each site per quarter.

5. Exception Reporting

The Exception Reporting data has been broken down to demonstrate a monthly analysis.

April 2018: A total of 56 reports were submitted. **No Guardian Fines Levied**.

Division	C&W: 41 Reports	WMUH: 15 Reports
Emergency & Integrated Care	COTE: 19 (CMT rota gap) Neurology : 12	COTE: 2
Planned Care	General surgery: 9 T&O: 2	General surgery: 7 Urology: 4 ENT: 2

May 2018: A total of 44 reports were submitted. **No Guardian Fines Levied**.

Division	C&W: 17 Reports	WMUH: 27 Reports
Emergency & Integrated Care	COTE: 9 (CMT rota gap) Neurology : 4	COTE: 6 AMU: 4 Endocrinology: 3 Ortho-geriatrics: 6
Planned Care	General surgery 4	General surgery: 3 ENT: 5

June 2018: A total of 32 reports were submitted. **No Guardian Fines Levied**.

Division	C&W: 2 Reports	WMUH: 30 Reports
Emergency & Integrated Care	Neurology : 2	AMU: 5 COTE: 5 Ortho-geriatrics: 11
Planned Care		General surgery: 2 ENT: 6 Urology: 1

Appendix 1-Exception Reporting Analysis:

Table # 1 outlines the costs for each speciality and also the on- going efforts to resolve the issues. It is RAG rated for convenience. The red specialities in need of scrutiny are Ortho-geriatrics at WMUH. This is a complex ward set up which is currently under review by the Foundation school and Royal College Tutors.

Graph and Table #2 presents the variation of exception reports throughout the week. The number of reports submitted due to increased work load, tend to be highest from the start of the week and on Friday's, due to post weekend discharges occurring at the start of the week and an influx of new patients to the wards mid- week. Exceptions to working conditions caused by delays in the Handover Process features daily. This is an on-going problem affecting surgical Handover at C&W which is under review.

Nearly all additional hours have been reimbursed with financial payment. Short staffing levels and busy wards have not enabled many juniors to secure TOIL.

Graph and Table #3 presents the split of themes at the C&W site. The dominant themes remain "Work load", "staffing levels" and "ward rounds". We can also deduce that the average number of hours of individual exceptions is similar across the themes.

Graph # 4 presents the split of themes at the WMUH site. The conclusions are very similar with the exception of "Handover" being significant here.

Graph and Table # 5 compares each speciality across both sites. There has been a significant improvement in the responding to exception reports by clinical and educational supervisors. Actions have been closed without CS/ES response on DRS4 by the GOSW when there is a deadline to submit payment. These reports are closed after receipt of email confirmation by CS/ES grades that the exception has been responded to and payment has been agreed.

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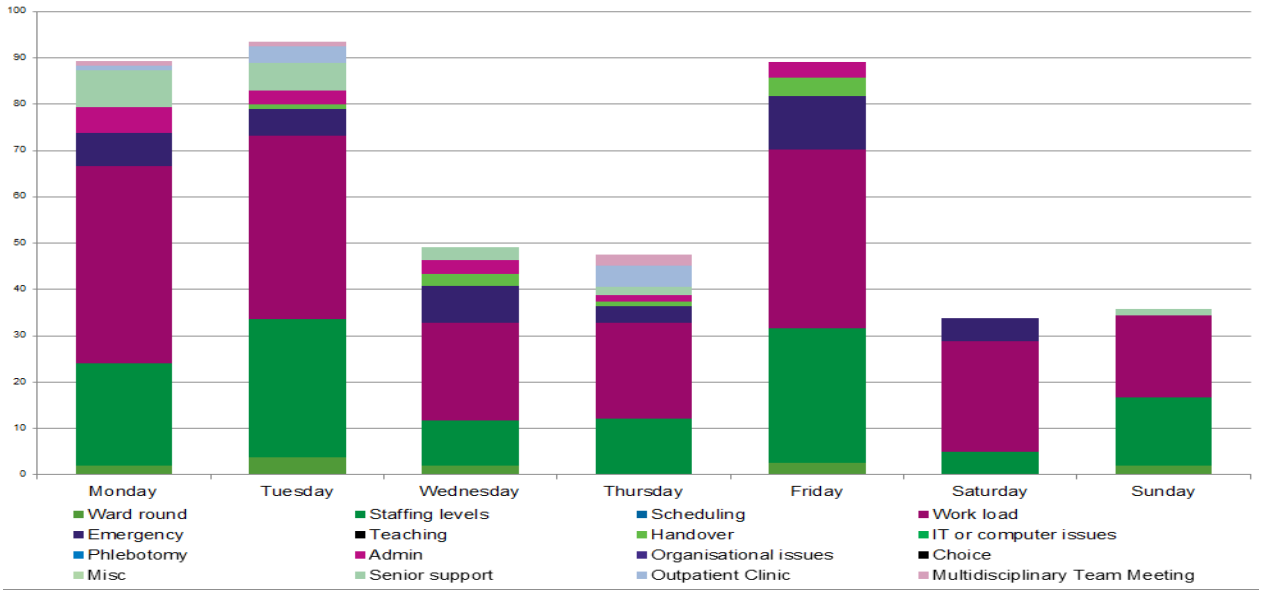
Table 1

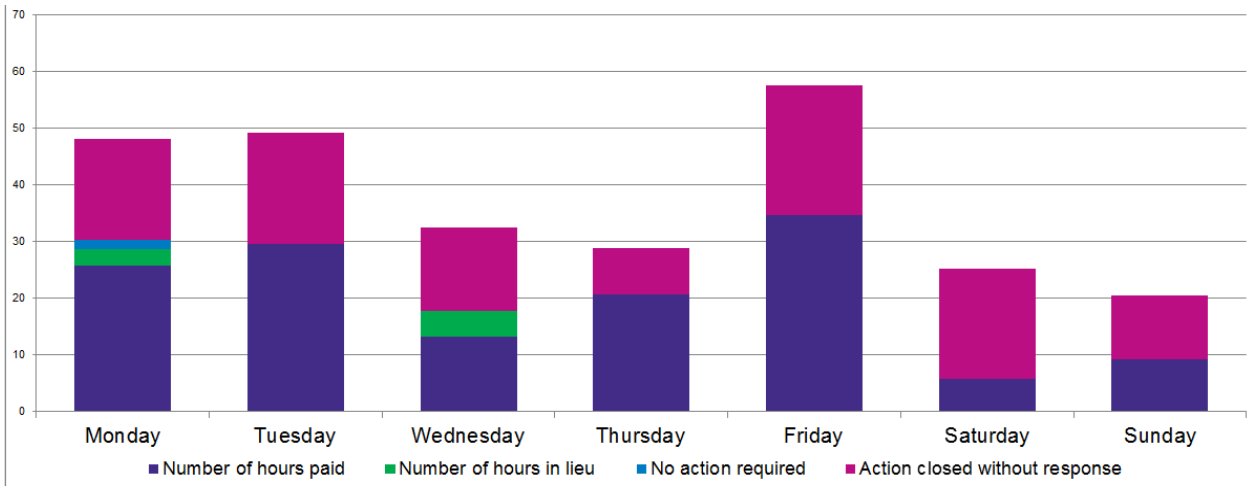
Department	No of reports	Grade	Payment	Fines	Themes	Trends
WMUH Orthogeriatrics	18	FY1	£492.14	£469	Consistent lack of engagment of supervising consultant in Exception Reporting Process. Job schedule reviews delayed as a result.	This has been escalated to the College Tutors and Divisional leads
C&W COTE	28	FY1	£496.23		CMT Rota Gap The entire team have worked hard to absorb the additional work load.	This isue will be resolved in August 2018.
C&W Neurology	23	SPR	£585.51		Short staffing with only 1 SPR available to cover wards and provide service provsion in OPD	Work schedule reviews have taken place
C&W General Surgery	13	FY1, FY2	£220.11		Delayed Handover The impact of Zero days on work laod	There has been significant improvement in working hours. Surgical leads are actively involved with improving the Handover Process
WMUH ENT	13	SPR	£867.63		Cross Site working. Covering Acute service at Northwick Park Hospital	Work Schedule Review process has been urgently requetsed.
WMUH COTE	13	FY1, FY2, CMT	£269.28		Consultant Gap in the Rota	Locum Consultant appointed
WMUH AMU	9	FY1	£351.26		FY1 and SPR Rota Gap	This isue will be resolved in August 2018.
WMUH Genarl Surgery	5	FY1	£253.59		Reduced staffing due to sickness	This isue will be resolved in August 2018.
WMUH Endocrinology	3	FY1	£118.08		SPR Rota Gap	This isue will be resolved in August 2018.
C&W T&O	2	FY1	£38.28		Phlebotomy	Resolved
All other daeparments						

Graph and Table 2 Exceptions Themed per day

Quarter 1 of 2018

Graph and table #2 - Exceptions Themed per Day								WR	SL	SC	WL	EM	TE	HA	IT	PL	AD	OR	CH	OP	MDT	MI	SU
Day of week	Number of reports	Proportion of reports	Number of hours total	Number of hours paid	Number of hours in lieu	No action required	Action closed without response	Ward round	Staffing levels	Scheduling	Work load	Emergency	Teaching	Handover	IT or computer issues	Phlebotomy	Admin	Organisational issues	Choice	Outpatient Clinic	Multidisciplinary Team Meeting	Misc	Senior support
Monday	24	18.2%	48	26	3	2	18	2	22.05	0	42.55	7.25	0	0	0	0	5.5	0	0	1	1	0	8
Tuesday	26	19.7%	49	30	0	0	20	3.75	29.95	0	39.45	5.75	0	1	0	0	3	0	0	3.5	1	0	6
Wednesday	22	16.7%	33	13	5	0	15	2	9.75	0	21.05	8	0	2.5	0	0	3	0	0	0	0	0	2.75
Thursday	19	14.4%	29	21	0	0	8	0	12.05	0	20.8	3.5	0	1	0	0	1.5	0	0	4.5	2.5	0	1.75
Friday	25	18.9%	58	35	0	0	23	2.5	29.1	0	38.6	11.5	0	4	0	0	3.5	0	0	0	0	0	0
Saturday	7	5.3%	25	6	0	0	20	0	5	0	23.75	5	0	0	0	0	0	0	0	0	0	0	0
Sunday	9	6.8%	21	9	0	0	11	2	14.75	0	17.75	0	0	0	0	0	0	0	0	0	0	0	1.25

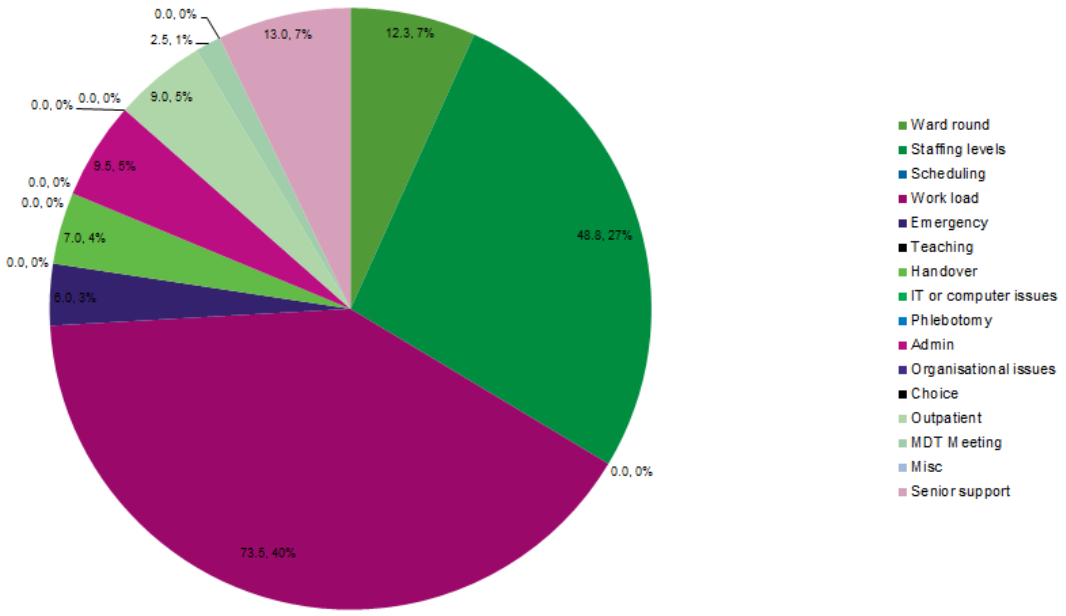




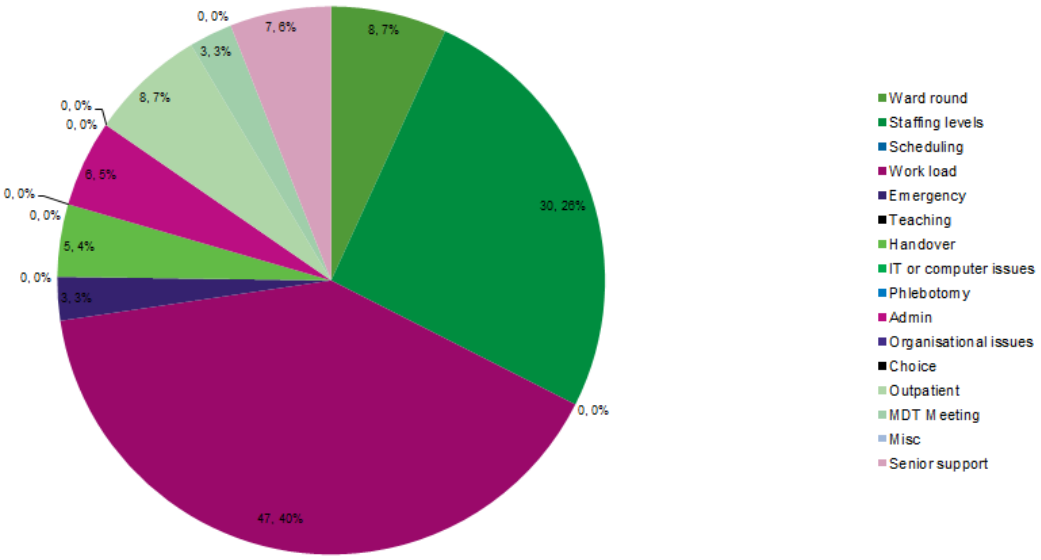
Graph and Table 3: An overview of Exception Themes at C&W Quarter 1 2018

Look up	Long Theme	Short Theme	Count	Percent	Hours	Percent	In lieu	Paid	No action	Action closed without response
WR	Ward Round issues e.g. long or starting late	Ward round	8	7%	12.3	7%	0.0	7.3	0.0	5.0
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	30	26%	48.8	27%	0.0	26.0	0.0	22.8
SC	Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	0	0%	0.0	0%	0.0	0.0	0.0	0.0
WL	Work Load exceeding the capacity of a full team	Work load	47	40%	73.5	40%	1.5	37.3	0.0	34.8
EM	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	3	3%	6.0	3%	0.0	0.0	0.0	6.0
TE	Teaching – either resulting in late stay; or missed at request of consultant	Teaching	0	0%	0.0	0%	0.0	0.0	0.0	0.0
HA	Handover – doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	5	4%	7.0	4%	0.0	4.5	0.0	2.5
IT	IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
PL	Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
AD	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	6	5%	9.5	5%	1.5	8.0	0.0	0.0
OR	Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
CH	Choice – doctor chose to come in early / stay late – not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OP	Outpatient Clinic	Outpatient	8	7%	9.0	5%	0.0	8.0	0.0	1.0
MDT	Multidisciplinary Team Meeting	MDT Meeting	3	3%	2.5	1%	0.0	2.5	0.0	0.0
MI	Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SU	Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	7	6%	13.0	7%	0.0	1.8	0.0	11.3

Hours under all reasons cited

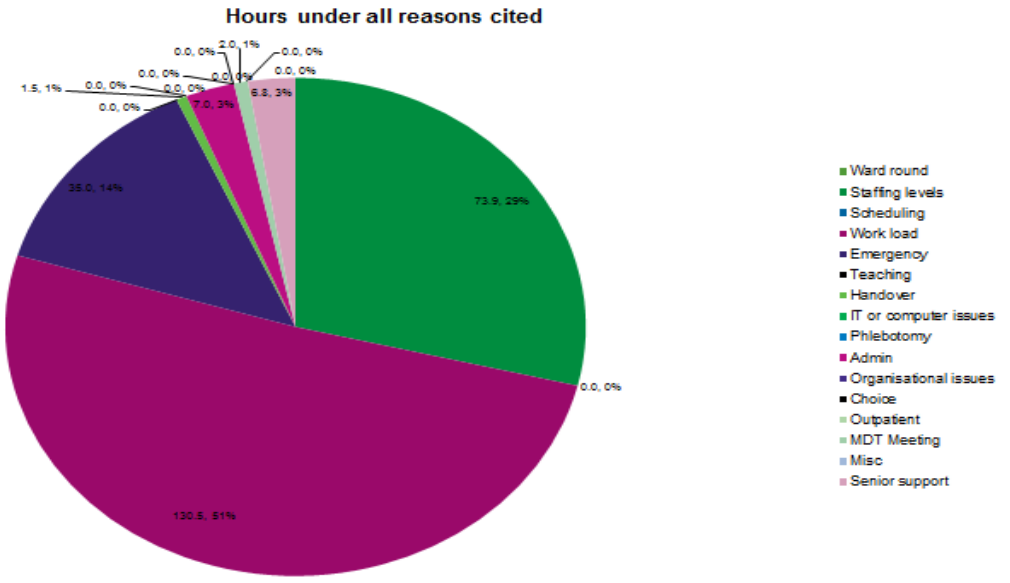


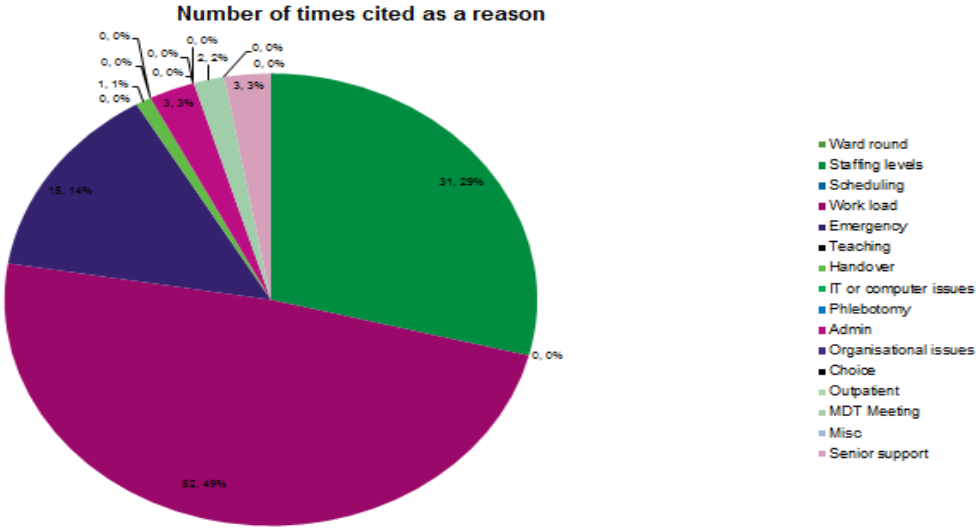
Number of times cited as a reason



Graph and Table 4: An overview of Exception Themes at WMUH Quarter 1 2018

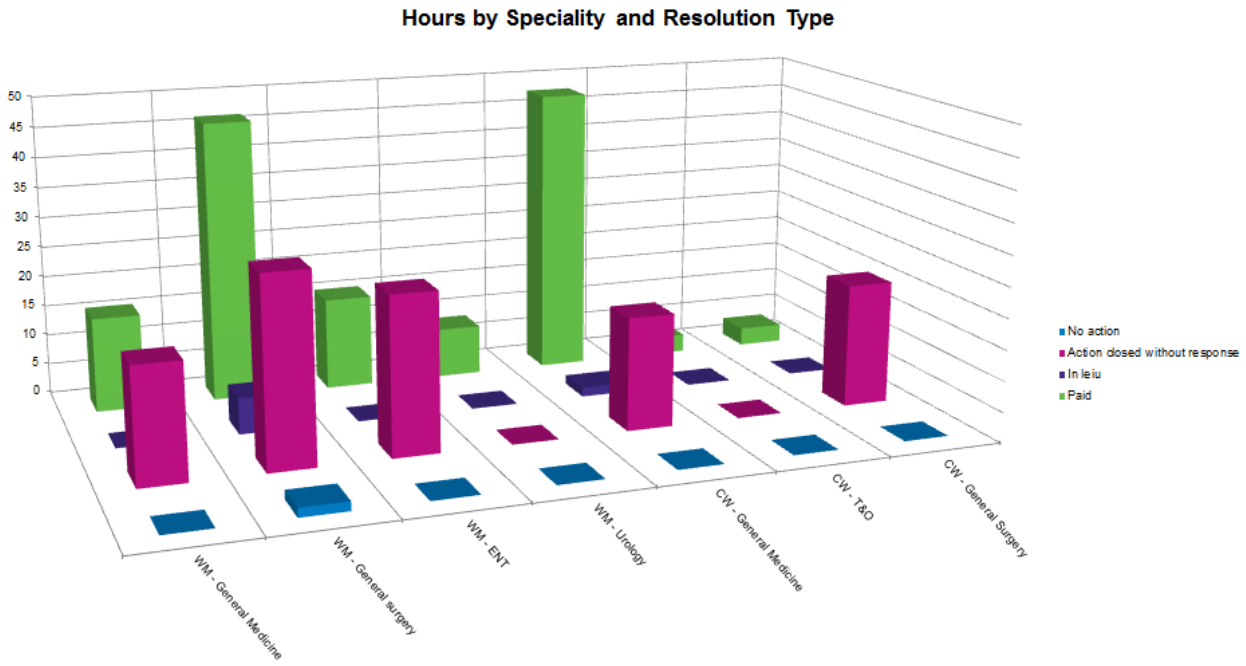
Look up	Long Theme	Short Theme	Count	Percent	Hours	Percent	In lieu	Paid	No action	Action closed without response
WR	Ward Round issues e.g. long or starting late	Ward round	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	31	29%	73.9	29%	3.0	40.1	0.0	30.8
SC	Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	0	0%	0.0	0%	0.0	0.0	0.0	0.0
WL	Work Load exceeding the capacity of a full team	Work load	52	49%	130.5	51%	3.0	69.2	1.5	56.8
EM	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	15	14%	35.0	14%	3.0	18.3	0.0	13.8
TE	Teaching - either resulting in late stay; or missed at request of consultant	Teaching	0	0%	0.0	0%	0.0	0.0	0.0	0.0
HA	Handover - doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	1	1%	1.5	1%	0.0	0.0	0.0	1.5
IT	IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
PL	Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
AD	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	3	3%	7.0	3%	0.0	3.5	0.0	3.5
OR	Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
CH	Choice - doctor chose to come in early / stay late - not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OP	Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0	0.0	0.0	0.0
MDT	Multidisciplinary Team Meeting	MDT Meeting	2	2%	2.0	1%	0.0	1.0	0.0	1.0
MI	Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SU	Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	3	3%	6.8	3%	3.0	3.8	0.0	0.0

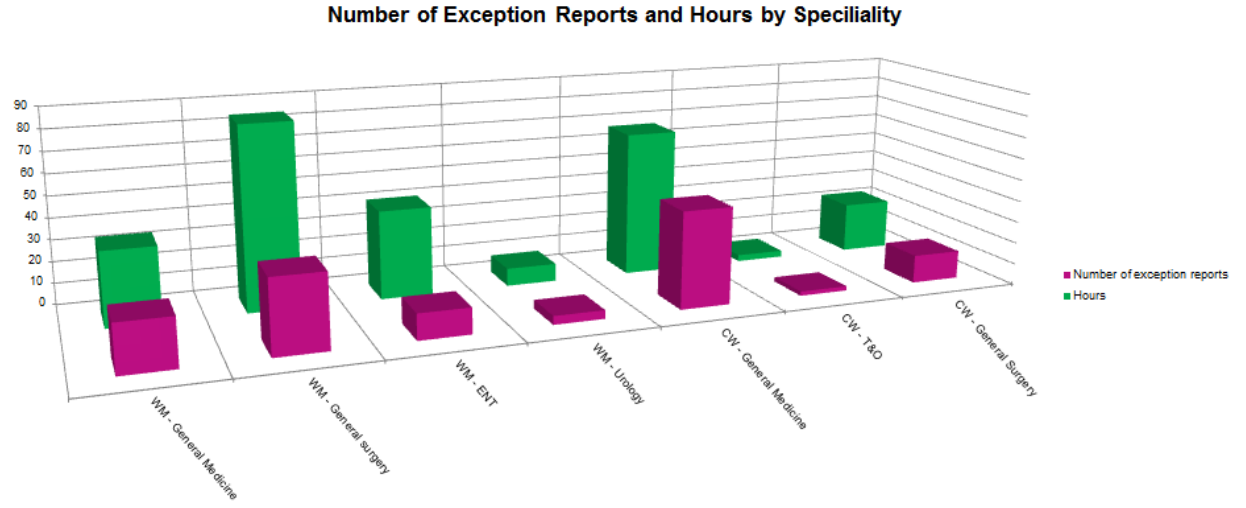




Graph and Table 5: Overview of Exceptions per site and speciality

Site	Speciality at time of exception report	Number of exception reports	Open	Percent	Number of staff on rota	Number of staff submitting reports	Reports per staff on rota	Percent	Hours	In lieu	Paid	No action	Action closed without response
WMUH	General Medicine	22	0	0%	0	5			34.4	0.0	15.6	0.0	18.8
WMUH	General surgery	34	0	0%	8	11	4.3	138%	84.6	6.0	46.3	1.5	30.8
WMUH	ENT	12	0	0%	0	2			41.0	0.0	15.3	0.0	25.8
WMUH	Urology	4	0	0%	1	1	4.0	100%	8.3	0.0	8.3	0.0	0.0
Chelsea	General Medicine	45	0	0%	0	5			67.5	1.5	47.5	0.0	18.5
Chelsea	T&O	2	0	0%	0	1			3.0	0.0	3.0	0.0	0.0
Chelsea	General Surgery	13	0	0%	7	5	1.9	71%	23.3	0.0	3.0	0.0	20.3
WMUH	**Total (of reporting specialities)**	**72**	**0**	**0%**	**9**	**19**	**8.0**	**211%**	**168.2**	**6.0**	**85.4**	**1.5**	**75.3**
CW	**Total (of reporting specialities)**	**60**	**0**	**0%**	**7**	**11**	**8.6**	**157%**	**93.8**	**1.5**	**53.5**	**0.0**	**38.8**





Guardian of Safe Working Hours Report

Quarter Two: July – September 2018.

1. Executive Summary

The report follows in three main sections: a report of Exception reporting for the second t quarter of 2018, Rota gaps, and the junior doctor Forum.

The key findings of the Exception Reporting process are:

- The number of Exception Reports submitted has been on the decline for this quarter. This is an on-going trend that was observed in the first quarter.
- Previous Red Flag areas in Respiratory medicine WMUH and Trauma & Orthopaedics have been resolved by staff expansion in both areas. This has been facilitated by departmental and divisional leads working to ensure an expansion in consultant numbers as well as filling rota gaps for junior grades.
- There is just one current Red Flag area in ENT at WMUH due to on-going problems with cross site working. There has been active communication with GOSW and rota coordinator at Northwick Park to ensure that changes are made for rota compliance. Educational and Clinical supervisors have incurred fines caused by a delay in engagement with job schedule reviews.
- Rota Gaps continue to be a national problem. It is anticipated that there will be a further reduction of up to 20% as Junior Doctors choose to leave formal training posts in 2018-2020. Whilst the focus remains on recruiting to posts, the Trust is developing strategies to ensure that clinical care is not impacted by ensuring rota gaps are filled with active task shifting processes using the skills of other trained medical staff.
- Responses to Exception reports submitted have improved significantly with most clinical supervisors responding promptly. This has resulted in timely changes to work schedules with a reduction to the number of exceptions occurring.
- Most Exceptions submitted were as a result of reduced staffing levels and increased work load. The combined effect of rota gaps and zero days is an increase in reduced staffing levels and increased work load. Active measures are in place to fill all existing and anticipated rota gaps.
- Additional hours worked by junior doctors have been remunerated predominantly with payment. Whilst most doctors can expect to be paid within 2 months of

management sign off, the introduction of e-pay has resulted in possible delays for this quarter.

- The Allocate Exception Reporting system has been live since August 2018. Training for all ES/CS grades was provided by HR and the Medical workforce in August with very poor uptake. The GOSW has worked across specialities to ensure that supervisors are familiarised with the process. Education has also been provided at the Educational Supervisors update at Chelsea Post Graduate centre on October 17th 2018.

2. Rota Gaps:

Rota gaps are a common theme affecting most clinical departments on both sites. The introduction of Zero days as a mechanism to make existing rota's complaint has resulted in a reduction in the total number of doctors in the work place at any time.

Problem areas include General Surgery at C&W and GIM at WM. The latter will be 5 SPR's short during the busier winter months Quarter 3 and 4. COTE WM site has been most impacted by severe staff shortage. This has been addressed and placed on the Risk Register, 6 JCF posts have been added across the medical specialties at WM this year to try and support the wards. 3 of these are filled at present and the remaining 3 starting in December 2018 and January 2019.

There is a Pan-London Cap on hourly rates of pay for Junior Doctors who undertake shifts to maintain adequate staffing. This has been communicated in the previous GOSW report and also by the Medical Director to all consultants and senior management.

The Royal College of Physicians has pioneered benchmarks for medical staffing levels in the UK

At the present time, there is a staggering variation in number of doctors per patient bed and no clear tally on how many doctors, nurses or other healthcare professionals are needed in the acute setting at any point in time.

A template has been produced which can be used by Trusts to assess where they are with their current staffing levels. This is an area that is already under active consideration at this Trust

Table A: Rota Gaps at Chelsea Site

Site	Department	Gaps for Quarter 2 of 2018	Anticipated Quarter3 2019	Solutions
C&W	HIV & GUM	1 GP VTS at Dean Street		Filled with Trust SHO Post
C&W	Paediatrics	2.6 SHO and 1 SPR		Gaps remain unfilled
C&W	General Surgery	1 SPR	**There will be 2 SPR gaps from Jan 2019 and 4.2 SPR gaps from April 2019**. There are 6 SPR's allocated by the deanery for a rota that requires 8 in order to be compliant. Mr Efthimiou and Bonanomi are now sharing an SPR where previously there were 2 SPR posts. 1 SPR on maternity 1SPR leaving to undertake research	RSO posts will be covering until posts can be filled. However, of the 6 RSO posts 2 filled by Anna & Said 4 are being filled ad-hoc by locum's doctors. Danni Browning, Astrid Leusink, Joshua cave, Charlie.
C&W	O&G	1 SPR gap since resignation post CCST		On call shifts have been covered by locum
C&W	O&G	1 gap ST3-7		Remains unfilled
C&W	O&G	0.5 gap ST3-7maternity leave		
C&W	O&G	1 ST3-7 Unable to do on call shifts for medical reasons		On call shifts have been covered by locum
C&W	AAU	ACCS AM gap continues until August 2018		Short term , locum until April 2018 only
C&W	COTE	1 CMT1		Intermittent locum cover only
C&W	Anaesthetics	ST3 on modified duties after a period of sickness		Covered by locum shifts

Table B: Rota Gaps at WMUH site

Site	Department	Gaps for Quarter 2 2018	Anticipated Quarte3 2019	Solutions
WM	AAU	0.4 SPR		Locum cover when possible
WM	AAU	1 FY2	2 FY2(August 2018 – April 2019)	Gone to recruitment
WM	ENDO	1 FY2		Currently filled ad hoc by Junior Clinical fellow who also covers 2 bays on MH2 ward
WM	Endo		1 SPR gap from Feb 2019	
WM	Respiratory	1 SPR has been relocated to Royal Brompton	2 SPR gaps1 (1 SPR due to start acting up as a consultant from January)	Work load absorbed by existing team There will be no Respiratory SPR's from Jan 2019, this has been escalated to divisional leads
WM	Respiratory	1 CT1 (Post shifted by the Deanery to COTE) FY2 is only 80% FT		Work load absorbed by existing team
WM	COTE		FY2 gap (April to August 2019)	
WM	COTE		CMT gap (Feb to August 2019)	
WM	COTE	1 GPVTS only 60% FT 1 GPVTS only 80% FT and now on maternity leave	2 GPVTS gap (Feb to August 2019)	Work load absorbed by existing team
WM	COTE	1 SPR on maternity leave since Oct 2019	2 SPR gaps (1 COE SPR is due to start acting up as a consultant from January 2019	

WM	Gastro		FY2 gap (Dec 2018 – April 2019)	
WM	Paediatrics	1 SHO 1 SPR		Out to recruitment
WM	ENT	1 SPR		Out to recruitment
WM	ENT	6 x SHO Posts		Covered by flexi staff
WM	Endo	SPR until Aug 2018		Work load absorbed by existing team

3. Junior Doctor Forum

The Junior Doctor forum has remained very active for this Quarter.

Meetings occur at 12.30 and last for 1 hour. They take place on the first Wednesday of each month at WMUH site (Doctors mess) and the last Wednesday of each month at C&W site, PGMEC.

Meetings are very well attended attracting interest from Imperial and BMA as the only Trust in London to have an established working junior doctor forum.

The aim of the forum is to inform our junior doctors about the vision of the senior management and how this impacts their development and also service provision. The emphasis is on professional development, supporting, encouraging and coaching more junior grades with sharing of core values and behaviours expected from doctors.

Many junior doctors have wanted to actively engage in quality improvement projects and develop their knowledge of leadership by having the opportunity to speak with senior doctors in an informal environment.

Sessions covered for this quarter

July 2018 GMC liaison presentation: Duties of a Doctor

August 2018 BMA representative election and the role of the LNC

JDF Sept 2018 2018 GMC Survey Results Ms Cotzias DME

4. Exception Reporting

The Exception Reporting data has been broken down to demonstrate a monthly analysis.

July 2018: A total of 34 reports were submitted. **No Guardian Fines Levied**. Warnings issued to COTE C&W and Ortho-geriatrics.

Division	C&W: 9	WMUH: 25
Emergency & Integrated Care	COTE: 4 (CMT rota gap) Neurology: 5	COTE: 1 Ortho-geriatrics 7 Endocrine 3
Planned Care	General surgery: 9 T&O: 2	General surgery: 2 Urology: 11

August 2018: A total of 44 reports were submitted. Fines levied for ENT, Breast and Respiratory (WMUH) and Gastro (C&W) £1,534.55

Division	C&W: 18	WMUH: 26
Emergency & Integrated Care	Neurology : 8 Urology 1 General surgery 2 Endocrinology 3 Gastroenterology 1	COTE:3 Respiratory 1
Planned Care	General surgery 4	General surgery: 2 Urology 16 ENT: 2 Breast : 1 Anaesthetics: 1

September 2018: A total of 65 reports were submitted. Guardian Fines levied for ENT, COTE, Respiratory (WMUH), COTE (C&W) £3,492.18

Division	C&W: 45	WMUH: 20
Emergency & Integrated Care	Neurology :3 COTE : 27 Endo: 1 Gastro: 7 AMU: 5-	Endo: 2COTE: 5 COTE: 1 Gastro: 4 Ortho-geriatrics: 3 Respiratory: 2
Planned Care	General Surgery: 2	Anaesthetics: 2General surgery: 2 ENT:56
Women & Children		O&G: 1

Appendix 1-Exception Reporting Analysis:

Table # 1 outlines the costs for each speciality and also the on- going efforts to resolve the issues. It is RAG rated for convenience. The red specialities in need of scrutiny are Ortho-geriatrics at WMUH. This is a complex ward set up which is currently under review by the Foundation school and Royal College Tutors.

Graph and Table #2 presents the variation of exception reports throughout the week. The number of reports submitted due to increased work load, tend to be highest from the start of the week and on Friday's, due to post weekend discharges occurring at the start of the week and an influx of new patients to the wards mid- week. Exceptions to working conditions caused by delays in the Handover Process features daily. This is an on-going problem affecting surgical Handover at C&W which is under review.

Nearly all additional hours have been reimbursed with financial payment. Short staffing levels and busy wards have not enabled many juniors to secure TOIL.

Graph and Table #3 presents the split of themes at the C&W site. The dominant themes remain "Work load", "staffing levels" and "ward rounds". We can also deduce that the average number of hours of individual exceptions is similar across the themes.

Graph # 4 presents the split of themes at the WMUH site. The conclusions are very similar with the exception of "Handover" being significant here.

Graph and Table # 5 compares each speciality across both sites. There has been a significant improvement in the responding to exception reports by clinical and educational supervisors. Actions have been closed without CS/ES response on DRS4 by the GOSW when there is a deadline to submit payment. These reports are closed after receipt of email confirmation by CS/ES grades that the exception has been responded to and payment has been agreed.

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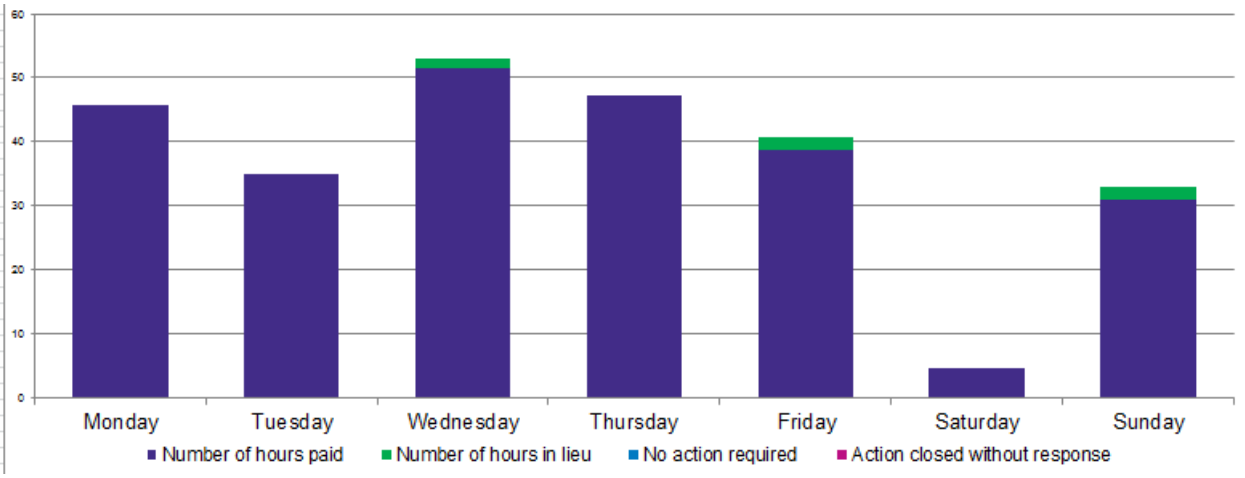
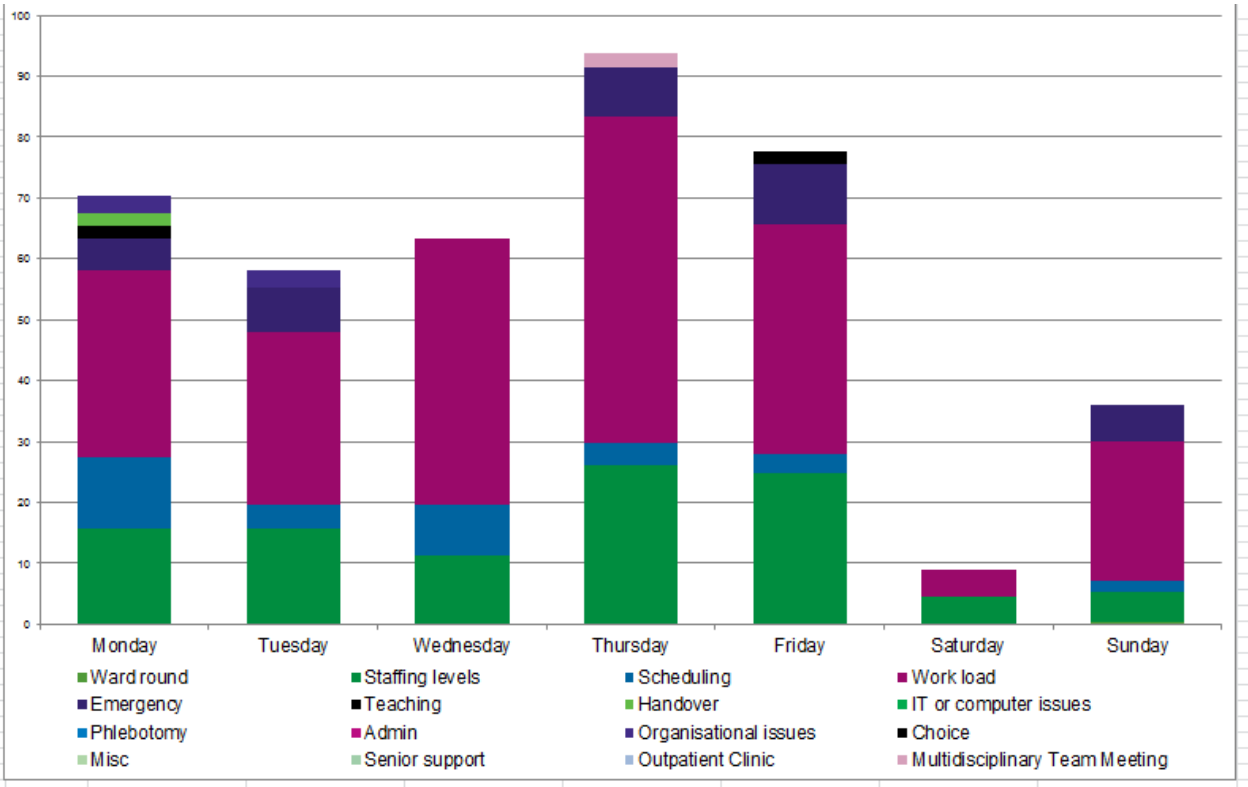
Table 1

Department	No of reports	Grade	Payment	Fines	Themes	Trends
C&W COTE	31	FY1	£910.70	£1,943	Consistent lack of engagment of supervising consultant in Exception Reporting Process. Job schedule reviews delayed as a result.	This has been escalated to the College Tutors and Divisional leads
WMUH Urology	27	FY1	£2,224		Job schedule reviews have taken place.	
C&W Neurology	16	SPR & FY1	£454.31		Short staffing with only 1 SPR available to cover wards and provide service provsion in OPD	Work schedule reviews have taken place
WMUH ENT	7	SPR	£804.89	£2,254.2	Cross Site working. Covering Acute service at Northwick Park Hospital	Work Schedule Review process has been urgently requetsed.
WMUH Orthogeriatrics	10	FY2, FY1	£243.65	£59.53	Late ward rouind start	This has been escalated at Divisoinal level
C&W Gastroenterology	8	FY1 and Senior Trainee	£308.16	£107.15	Three ward rounds occur on the same day utilising the same tarinees. Jobs cannot be completed	Ward Round Review has been requested.
WMUH Respiratory	4	FY1, FY2, CMT	£180.96	£352.30	SPR Gap in the Rota Failure of response for Immediate Safety concern	SPR rota gap continues
WMUH anasthetics	2	SPR	£274.30		Rota Design	Resolved
C&W AMU	8	FY1 SPR	TOIL 8 hours + £198.62		Work load and Rota gap	Resolved for now
WMUH Genarl Surgery	4	FY1	TOIL		Work load	Senior review has taken place
WMUH Endocrinology	5	FY1	TOIL		SHO Rota Gap	Filled with Clinical Fellow
C&WGeneral surgery	4	FY1	TOIL		Phlebotomy	Resolved
All other daeparments						

Graph and table #2 - Exceptions Themed per Day

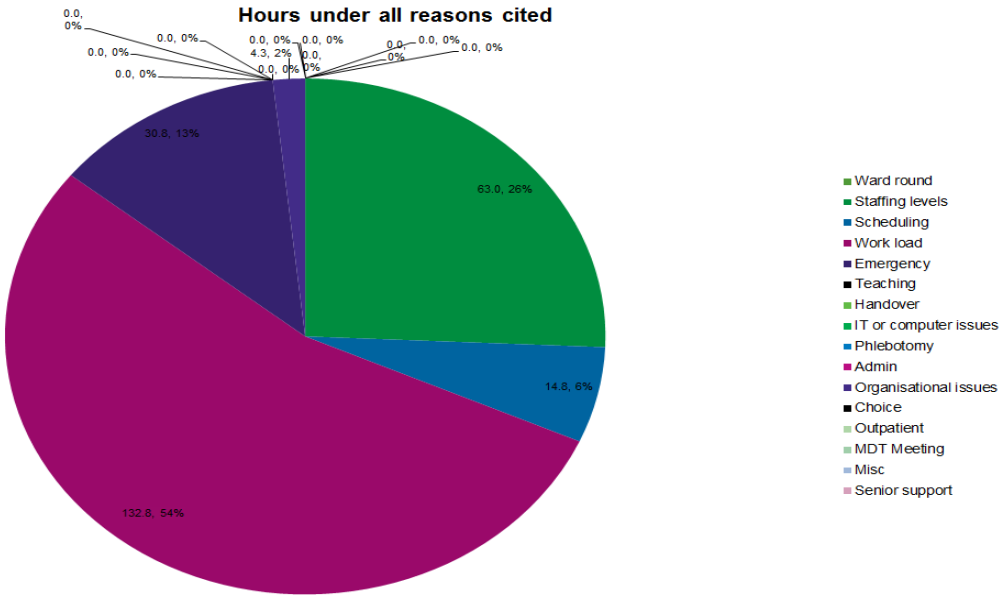
Day of week	Number of reports	Proportion of reports	Number of hours total	Number of hours paid	Number of hours in lieu	No action required	Action closed without response
Monday	23	16.4%	46	46	0	0	0
Tuesday	20	14.3%	35	35	0	0	0
Wednesday	25	17.9%	53	52	2	0	0
Thursday	33	23.6%	60	47	0	0	0
Friday	22	15.7%	46	39	2	0	0
Saturday	3	2.1%	5	5	0	0	0
Sunday	14	10.0%	33	31	2	0	0

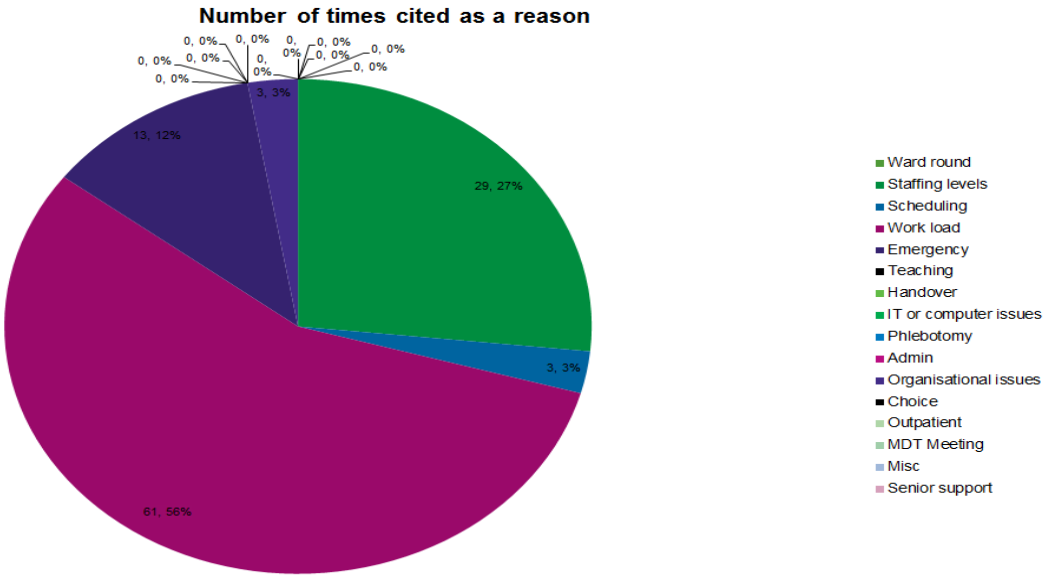




Graph and Table #3 - Overview of Exception Themes - WM

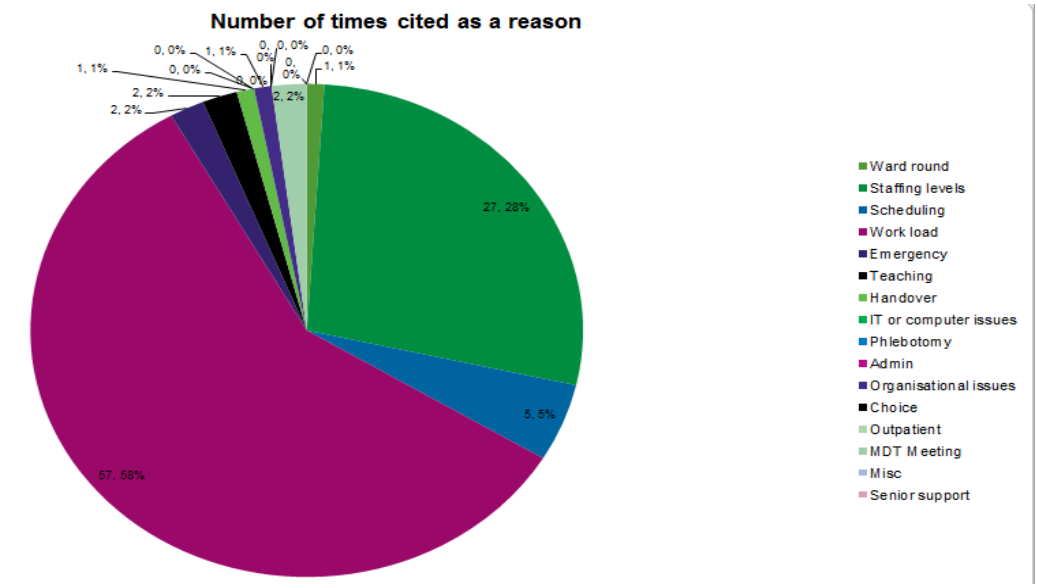
Theme	Short Theme	Count	Percent	Hours	Percent	In leiu	Paid	No action	Action closed without response
Ward Round issues e.g. long or starting late	Ward round	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Staffing Level below agreed template for team or type of cover	Staffing levels	29	27%	63.0	26%	2.0	61.0	0.0	0.0
Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	3	3%	14.8	6%	0.0	14.8	0.0	0.0
Work Load exceeding the capacity of a full team	Work load	61	56%	132.8	54%	2.0	115.8	0.0	0.0
Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	13	12%	30.8	13%	2.0	24.8	0.0	0.0
Teaching - either resulting in late stay; or missed at request of consultant	Teaching	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Handover - doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	0	0%	0.0	0%	0.0	0.0	0.0	0.0
IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	3	3%	4.3	2%	0.0	4.3	0.0	0.0
Choice - doctor chose to come in early / stay late - not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Multidisciplinary Team Meeting	MDT Meeting	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	0	0%	0.0	0%	0.0	0.0	0.0	0.0

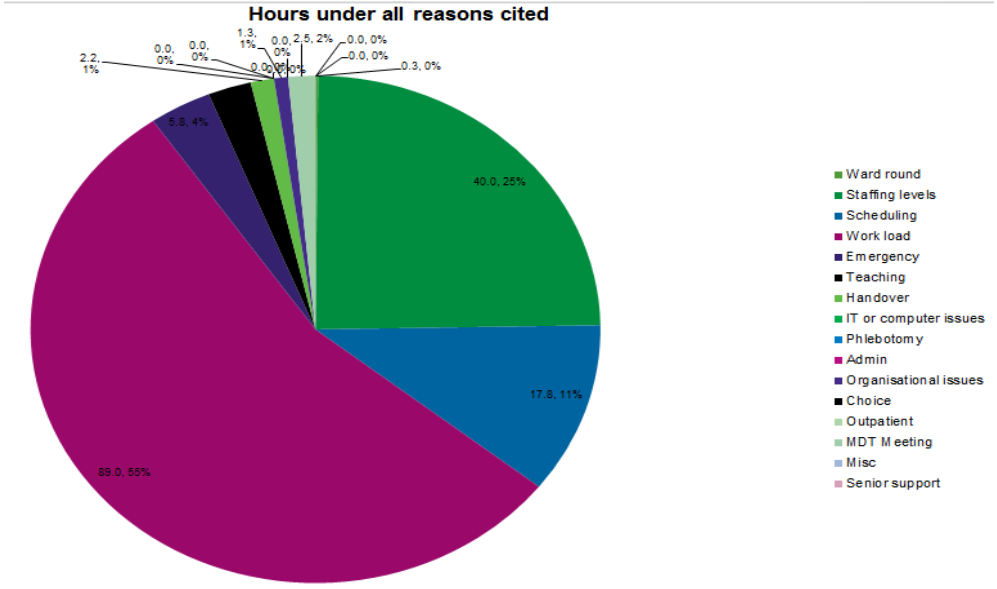




Graph and Table #4 - Overview of Exception Themes - CW

Theme	Short Theme	Count	Percent	Hours	Percent	In lieu	Paid	No action	Action closed without response
Ward Round issues e.g. long or starting late	Ward round	1	1%	0.3	0%	0.0	0.3	0.0	0.0
Staffing Level below agreed template for team or type of cover	Staffing levels	27	28%	40.0	25%	0.0	40.0	0.0	0.0
Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	5	5%	17.8	11%	0.0	17.8	0.0	0.0
Work Load exceeding the capacity of a full team	Work load	57	58%	89.0	55%	3.5	83.3	0.0	0.0
Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	2	2%	5.8	4%	0.0	5.8	0.0	0.0
Teaching – either resulting in late stay; or missed at request of consultant	Teaching	2	2%	4.0	2%	0.0	4.0	0.0	0.0
Handover – doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	1	1%	2.2	1%	0.0	2.2	0.0	0.0
IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	1	1%	1.3	1%	0.0	1.3	0.0	0.0
Choice – doctor chose to come in early / stay late – not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Multidisciplinary Team Meeting	MDT Meeting	2	2%	2.5	2%	0.0	2.5	0.0	0.0
Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	0	0%	0.0	0%	0.0	0.0	0.0	0.0

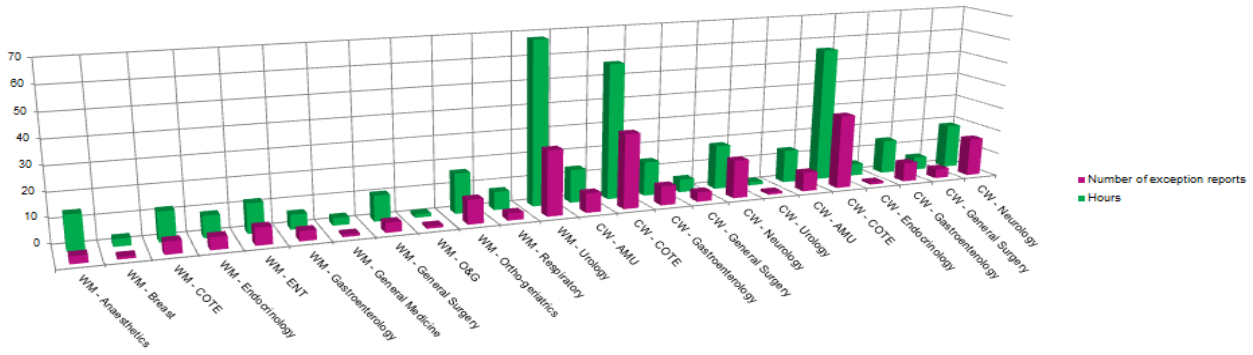




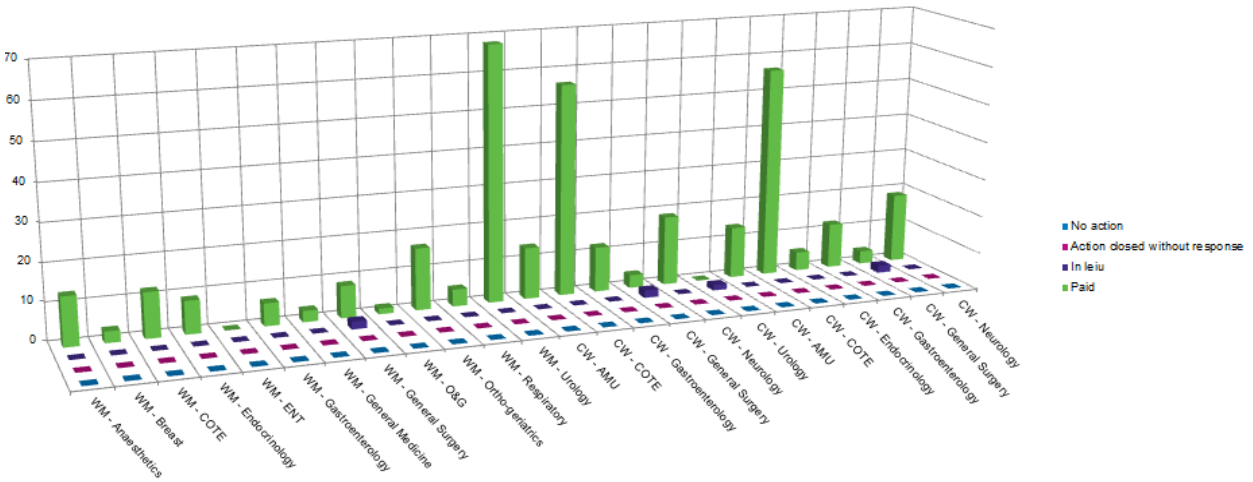
Graph and Table #5 - Overview of Exceptions per Site and Speciality

Site	Speciality at time of exception report	Number of exception reports	Open	Percent	Number of staff on rota	Hours	In lieu	Paid	No action	Action closed without response		
WMUH	Anaesthetics	3	1	33%	0	14.0	0.0	13.0	0.0	0.0	WM	WM - Anaesthetics
WMUH	Breast	1	1	100%	0	3.0	0.0	3.0	0.0	0.0	WM	WM - Breast
WMUH	COTE	5	0	0%	0	12.0	0.0	12.0	0.0	0.0	WM	WM - COTE
WMUH	Endocrinology	5	0	0%	0	8.8	0.0	8.8	0.0	0.0	WM	WM - Endocrinology
WMUH	ENT	7	2	29%	0	12.0	0.0	0.0	0.0	0.0	WM	WM - ENT
WMUH	Gastroenterology	4	0	0%	0	6.0	0.0	6.0	0.0	0.0	WM	WM - Gastroenterology
WMUH	General Medicine	1	0	0%	0	3.0	0.0	3.0	0.0	0.0	WM	WM - General Medicine
WMUH	General Surgery	4	0	0%	0	10.5	2.0	8.5	0.0	0.0	WM	WM - General Surgery
WMUH	O&G	1	0	0%	0	1.5	0.0	1.5	0.0	0.0	WM	WM - O&G
WMUH	Ortho-geriatrics	10	0	0%	0	16.5	0.0	16.5	0.0	0.0	WM	WM - Ortho-geriatrics
WMUH	Respiratory	3	1	33%	0	7.5	0.0	4.5	0.0	0.0	WM	WM - Respiratory
WMUH	Urology	27	0	0%	1	68.0	0.0	68.0	0.0	0.0	WM	WM - Urology
Chelsea	AMU	8	0	0%	0	13.8	0.0	13.8	0.0	0.0	CW	CW - AMU
Chelsea	COTE	31	0	0%	0	56.3	0.0	56.3	0.0	0.0	CW	CW - COTE
Chelsea	Gastroenterology	8	1	13%	0	14.3	0.0	12.0	0.0	0.0	CW	CW - Gastroenterology
Chelsea	General Surgery	4	0	0%	7	5.5	2.0	3.5	0.0	0.0	CW	CW - General Surgery
Chelsea	Neurology	16	0	0%	1	18.5	0.0	18.5	0.0	0.0	CW	CW - Neurology
Chelsea	Urology	1	0	0%	2	1.5	1.5	0.0	0.0	0.0	CW	CW - Urology
Chelsea	AMU	8	0	0%	0	13.8	0.0	13.8	0.0	0.0	CW	CW - AMU
Chelsea	COTE	31	0	0%	0	56.3	0.0	56.3	0.0	0.0	CW	CW - COTE
Chelsea	Endocrinology	1	0	0%	0	5.0	0.0	5.0	0.0	0.0	CW	CW - Endocrinology
Chelsea	Gastroenterology	8	1	13%	0	14.3	0.0	12.0	0.0	0.0	CW	CW - Gastroenterology
Chelsea	General Surgery	4	0	0%	7	5.5	2.0	3.5	0.0	0.0	CW	CW - General Surgery
Chelsea	Neurology	16	0	0%	1	18.5	0.0	18.5	0.0	0.0	CW	CW - Neurology
WMUH	**Total (of reporting specialities)**	**14**	**2**	**14%**	**0**	**37.8**	**0.0**	**36.8**	**0.0**	**0.0**		
CW	**Total (of reporting specialities)**	**136**	**2**	**1%**	**18**	**223.0**	**5.5**	**213.0**	**0.0**	**0.0**		

Number of Exception Reports and Hours by Speciliality



Hours by Speciality and Resolution Type



Guardian of Safe Working Hours Report

Quarter 3 of 2018

1. Executive Summary

The key findings of the Exception Reporting process are:

- The number of Exception Reports submitted continues to be on the decline. A total of 320 reports were submitted for this quarter in 2017 compared to 206 for 2018 despite the Trust experiencing an exceptionally busy winter period.
- The trend for Exception Reporting at Chelsea Westminster Foundation Trust is significantly different from other Trusts in London who have observed the trend of a substantial increase in the numbers of reports
- Most Exceptions submitted were as a result of reduced staffing levels and increased work load. Active measures are in place to fill all existing and anticipated rota gaps
- There are no Red Flag areas to report on. Much of this can be attributed to rigorous Job Schedule Reviews to ensure that Safe Working Conditions and rota compliance are maintained for all training posts. The GOSW has completed a second revision of all training post work schedules and rota designs with the exception of Gastroenterology C&W site (due on Jan 9th 2019), Urology WMUH (escalated to Jason Smith) and ENT WMUH (in discussions with HR at Northwick Park Hospital).

2. Rota Gaps

- Rota Gaps continue to be a national problem. The Trust has responded by ensuring that existing gaps have been filled promptly to ensure patient safety and maintain desired standards of clinical care.
- Most gaps have been filled by Junior Clinical Fellow Posts. There has been active succession planning of such posts to ensure that these junior doctors rotate through varied specialities, have designated Educational Supervisors and are included in the Trust Appraisal process.
- Long term locums have also been appointed to escalation areas such as Marble Hill 1 at West Middlesex site and also in departments where staff ill health or maternity leave have created short term gaps.
- The Trust has previously had posts withdrawn from some specialities based on findings from GMC surveys. This has impacted patient care and staff morale. With the introduction of Internal Medicine Training (implemented in August 2019) the GOSW has started engaging in discussions with college tutors and DME's to ensure that additional posts promised to the London region can be secured for this Trust.

3. Job Scheduling Reviews

- The third quarter of 2018 has focussed on a thorough review of all training post job schedules to ensure that departments can share resources efficiently in the current climate of rota gaps and also to accommodate zero days. This activity has been combined with a review of all rotas to ensure that optimal staffing levels are maintained.

- One to one discussions with all junior doctors who have submitted more than two reports per month and mentoring schemes have been set up for Foundation Doctors to ensure that Junior Doctors educate and support each other in the process of prioritisation and time management.

4. Junior Doctor Forum

- The Junior Doctor Forum at the site is very well attended and has evolved to become a place where doctors can develop a better understanding of the Trust Vision and goals.

- The forum is regarded to be a safe space where juniors can express concerns or anxieties about working patterns with the GOSW, members of HR or the DME's in the form of one to one confidential exchanges.

- The third quarter has focussed on Well- being in the work place with education about dealing with stress, alcohol consumption and the importance of patient centred care.

Presentations:

GMC: Doctors and Alcohol October 2018 C&W

Education Fellows: How to deal with patient complaints and Datix investigations November 2018 C&W

Ms Christina Cotzias, DME, GMC Survey. October 2018 WMUH

Dr Natasha Wiles, Consultant Haematologist: VTS Prophylaxis November 2018 WMUH

5. National and Regional issues

Nationally the GOSW has been an unpopular role with many Trusts having difficulty in recruiting to the post. The additional workload has resulted in many Trusts falling behind on the completion of the contractual requirements.

Chelsea Westminster Foundation Trust has been recognised nationally by HEE, BMA and at The GOSW Body for being a Leading Performer and Beacon Site. This status has been achieved by the visionary and strategic support provided to the GOSW by the Medical Director and members of the strategy teams.

6. Benchmarking

As we observe a downward trend in reports at this site, our neighbouring Trusts (Hillingdon, Northwick Park, Hammersmith Hospital and St Marys) have observed significant increases in the reporting trend. Much of this can be explained by later implementation and the difficulties GOSW colleagues have had with engaging in the Job Schedule Review Process.

Hillingdon: 132% increase in reporting with 80% increase in expenditure .

Trust	Number of trainees	Number of reports per Quarter and trends	Organisational
St George's	633	Q3: 203 reports £6437.46 Fines	Reports are on the increase. Work schedule reviews Commenced in ENT
Guys and St Thomas's	700	Q3: 328 reports £11,000 fines	Change of GOSW Reports have doubled Difficulties with responses to exception reporting
Leeds	422	869 reports £3517.50 fines	58% of reports responded to by GOSW Exception Reporting Process has been active for 12 months

7. You Said, We Did:

We have engaged frequently with the junior doctor body to ensure that working conditions are safe and optimal. Changes made based on what doctors junior doctors have requested include:

This has included refurbishment of the Doctors Mess area at C&W October 2016 and WMUH May 2017. Further expenditure has taken place in 2018. Changes include:

- An entire newly fitted kitchen at C&W, including new floor, new units and 2 large fridges, with complete painting and decorating of the Doctors mess lounge with the hanging of tasteful paintings. New Furniture includes two large leather sofas with reclining armchairs, Coffee table and large flat screen television.

- At the West Mid site, new leather sofa and arm chairs have been purchased with complete refurbishment of shower rooms. New carpet has been laid in on call rooms with painting and decorating of the lounge area. New Fridge and crockery.

Both mess areas have extended Wi-Fi access, additional doctors lockers space and Industrial Nespresso Coffee machine with twice daily cleaning service

Improved working Conditions

- All training post rota's are compliant with New terms and conditions of Safe Working
- Extended phlebotomy service on all surgical wards at Chelsea site December 2017
- Extended phlebotomy service to all acute wards WMUH site December 2017
- Dedicated Handover time taking place within scheduled working hours March 2018
- Computer on Wheels available for ward rounds WMUH August 2018

Social

GOSW Christmas Cheese and Wine both sites December 2017, December 2018

Farewell Medi Cinema event for all FY1 grades on Chelsea site June 2018

Monthly Junior Doctor Forum meetings with lunch and refreshments provided

Rota Gaps

Site	Department	Gaps for Quarter 3 of 2018	Anticipated Quarter4 2018/2019	Solutions
C&W	HIV & GUM	1 GP VTS at Dean Street		Filled with Trust SHO Post
C&W	Paediatrics	2.6 SHO and 1 SPR		Gaps remain unfilled
C&W	General Surgery	SPR: 2.4	**There will be 2 SPR gaps from Jan 2019 and 4.2 SPR gaps from April 2019**. There are 6 SPR's allocated by the deanery for a rota that requires 8 in order to be compliant. Mr Efthimiou and Bonanomi are now sharing an SPR where previously there were 2 SPR posts.	RSO posts will be covering until posts can be filled. However, of the 6 RSO posts 2 filled by Anna & Said 4 are being filled ad-hoc by locum's doctors. Danni Browning, Astrid Leusink, Joshua cave, Charlie.
C&W	O&G	1 SPR gap since resignation post CCST	Deanery allocation to be released on Jan 8th 2019	On call shifts have been covered by locum
C&W	O&G	1 gap ST3-7	Deanery allocation to be released on Jan 8th 2019	Remains unfilled
C&W	O&G	0.5 gap ST3-7maternity leave	Deanery allocation to be released on Jan 8th 2019	
C&W	O&G	1 ST3-7 Unable to do on call shifts for medical reasons	Deanery allocation to be released on Jan 8th 2019	On call shifts have been covered by locum
C&W	AAU	ACCS AM gap continues until August 2018 FY1 gap The foundation school error FY2 CMT		Short term , locum until April 2018 only Locum cover Locum cover
C&W	COTE	1 CMT1		Intermittent locum cover only
C&W	Anaesthetics	ST3 on modified duties		Covered by locum shifts

Site	Department	Gaps for Quarter 3 2018	Anticipated Quarter 4 2018/ 2019	Solutions
WM	AAU	0.4 SPR		Locum cover when possible
WM	AAU	1 FY2	2 FY2(August 2018 – April 2019)	Gone to recruitment
WM	ENDO	1 FY2		Currently filled ad hoc by Junior Clinical fellow who also covers 2 bays on MH2 ward
WM	Respiratory	1 SPR has been relocated to Royal Brompton	2 SPR gaps1 (1 SPR due to start acting up as a consultant from January)	Work load absorbed by existing team There will be no Respiratory SPR's from Jan 2019, this has been escalated to divisional leads
WM	Respiratory	1 CT1 (Post shifted by the Deanery to COTE) FY2 is only 80% FT		Work load absorbed by existing team
WM	COTE		FY2 gap (April to August 2019)	
WM	COTE		CMT gap (Feb to August 2019)	
WM	COTE	1 GPVTS only 60% FT 1 GPVTS only 80% FT and now on maternity leave	2 GPVTS gap (Feb to August 2019)	Work load absorbed by existing team
WM	COTE	1 SPR on maternity leave since Oct 2019	2 SPR gaps (1 COE SPR is due to start acting up as a consultant from January 2019	
WM	Urology	1/1 for SHO, adverts will be out this week		
WM	General Surgery	SPR: 2/10 1/10 for SHO		(long term locum> 6 Work absorbed by remaining team
WM	T&O		Feb 14th 1 out of our 8 SHOs	Out to recruitment

Exception Reporting

The Exception Reporting data has been broken down to demonstrate a monthly analysis.

October 2018: A total of 41 reports were submitted. Fines were levied against: Linda Tsam £308.87, Matthew Foxton: £416.68, Musa Barkeji: £571.39

Division	C&W: 17	WMUH: 24
Emergency & Integrated Care	AMU: 6 Gastroenterology 10	Respiratory 9 Ortho-geriatrics 6
Planned Care	General surgery: 1	General surgery: 5 Breast: 5

November 2018: A total of 7 reports were submitted. No Fines Levied

Division	C&W: 18	WMUH: 26
Emergency & Integrated Care	COTE: 6	AMU: 1

December 2018: A total of 42 reports were submitted. No Fines Levied

Division	C&W: 45	WMUH: 20
Emergency & Integrated Care	Gastro: 15 COTE: 7	
Planned Care		ENT: 5 Urology: 13
Women & Children	Paediatrics: 2	

Appendix 1-Exception Reporting Analysis:

Table # 1 outlines the costs for each speciality and also the on- going efforts to resolve the issues. It is RAG rated for convenience. The amber specialities in need of scrutiny are Ortho-geriatrics at WMUH. The addition of a locum consultant post has seen much improvement although this is a temporary measure until the end of February 2019.

Urology at WMUH has seen itself emerge as a very popular and progressive unit amongst trainees. Job schedule reviews have been imposed due to the number and frequency of exception reports submitted.

Graph and Table #2 presents the variation of exception reports throughout the week. Nearly all additional hours have been reimbursed with financial payment. Short staffing levels and busy wards have not enabled many juniors to secure TOIL.

Graph and Table #3 presents the split of themes at the C&W site. The dominant themes remain “Work load”, “staffing levels” and “ward rounds”. We can also deduce that the average number of hours of individual exceptions is similar across the themes.

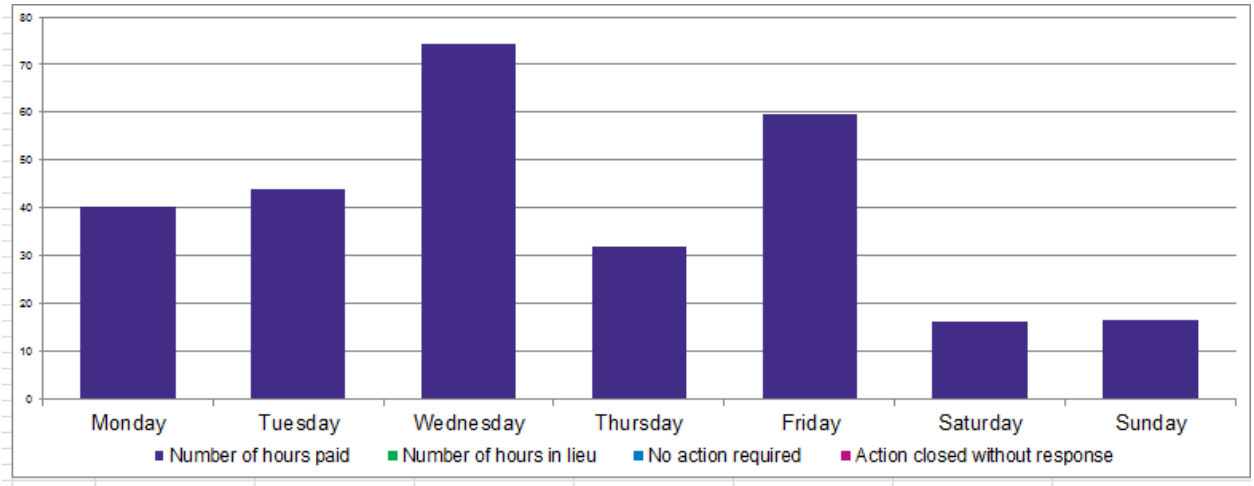
Graph # 4 presents the split of themes at the WMUH site.

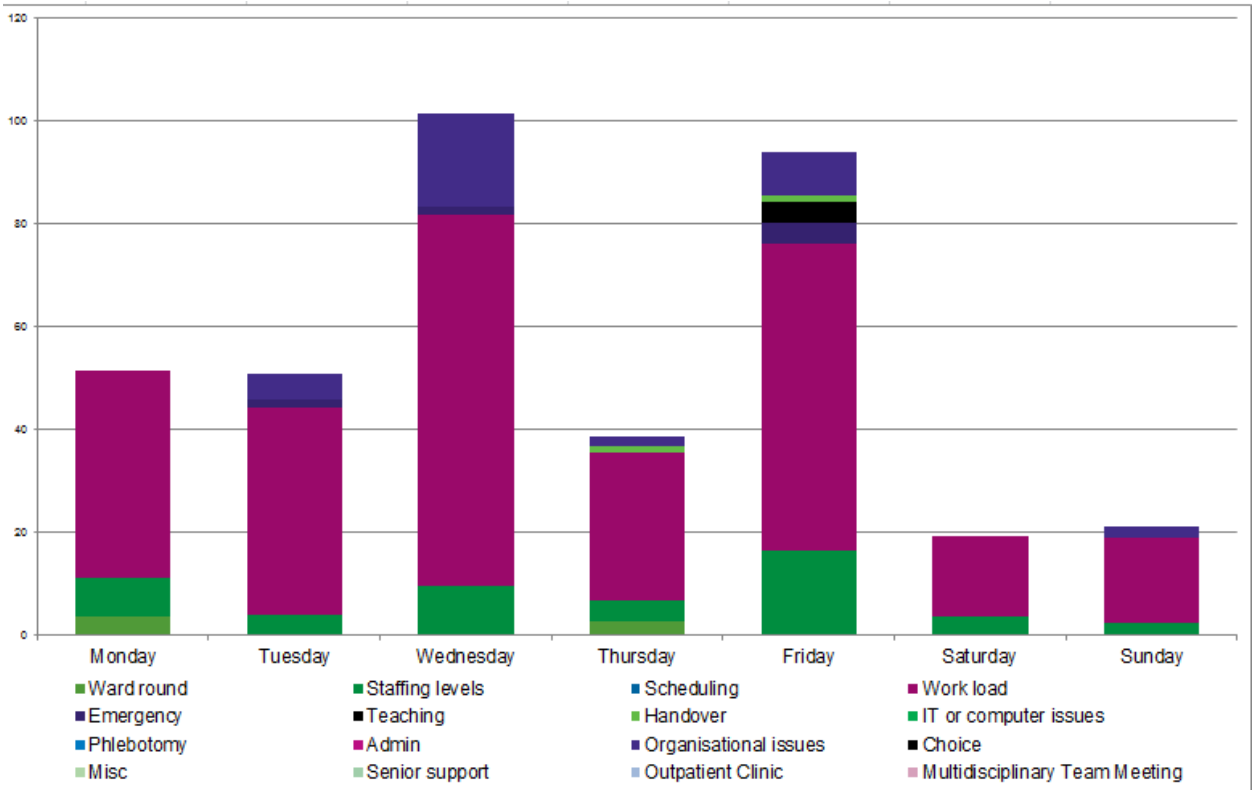
Graph and Table # 5 compares each speciality across both sites. There has been a significant improvement in the responding to exception reports by clinical and educational supervisors. With 100% compliance by November 2019.

Table # 1 Outlines the costs for each speciality

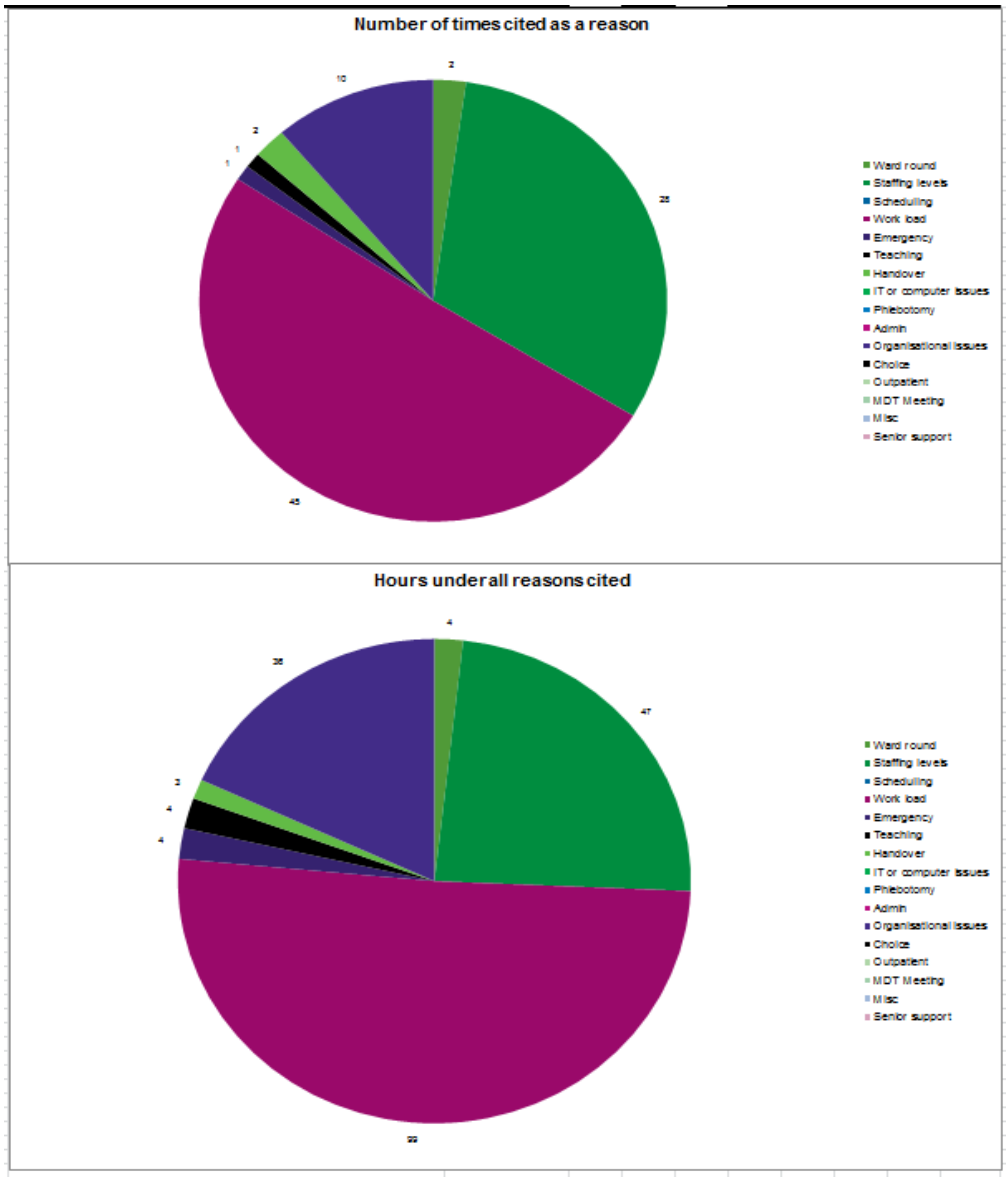
Department	No of reports	Grade	Payment	Fines	Themes	Trends
WMUH Urology	13	FY1	£1701		SHO gap in the rota. Escalated To Jason Smith For Divisional Job Schedule review	Escalated To Jason Smith For Divisional Job Schedule review
WMUH Breast	5	FY1	£228.59	£571.39	Failure pf supervisor to respond to submitted reports	Resolved
WMUH Orthogeriatrics	6	FY2, FY1	£123,51	£308.87	Late ward rouind start	Resolved. Second consultant recruited Until Feb 2019
C&W Gastroenterology	25	FY1 and Senior Trainee	£672.69	£416.68	Three ward rounds occur on the same day utilising the same tarinees. Jobs cannot be completed	Resolved.
C&W COTE	13	FY1	£322		CMT Gap in rota	
WMUH Respiratory	9	FY1, FY2, CMT	£295		SPR Gap in the Rota	SPR rota gap continues
WMUH ENT	5	SPR	£176.28		Cross Site working	Extended Job schedule review in process
C&W AMU	6	FY1	£100.96		Work load and Rota gap	Resolved for now
WMUH Genarl Surgery	5	FY1	£66.68		Work load	Senior review has taken place
WMUH AAU	1	FY1	£33.81		Work load	Resolved
C&WGeneral surgery	1	FY1	£16.51		Work load	Resolved
All other daeparments						

Graph and Table #2 presents the variation of exception reports throughout the week and observed themes.



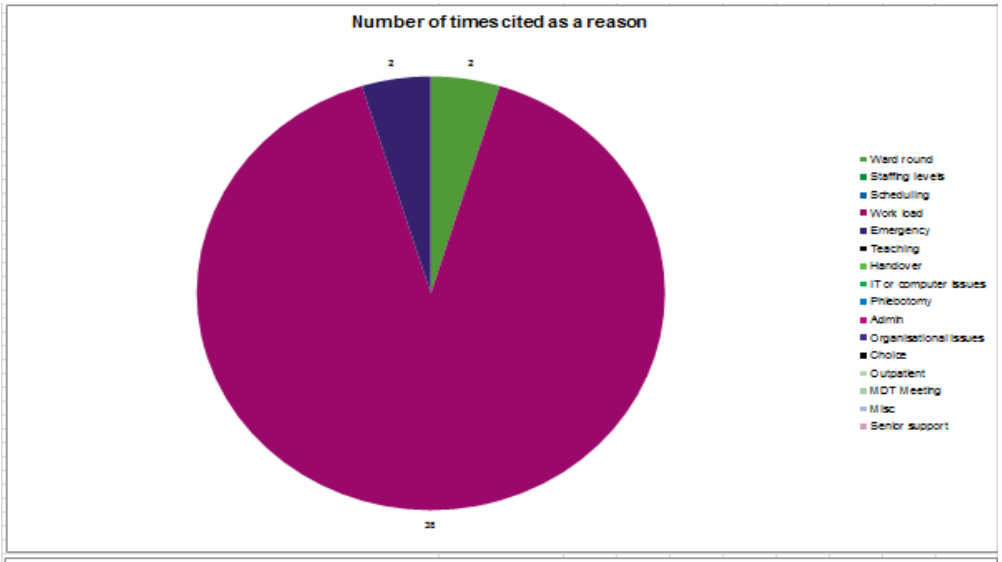


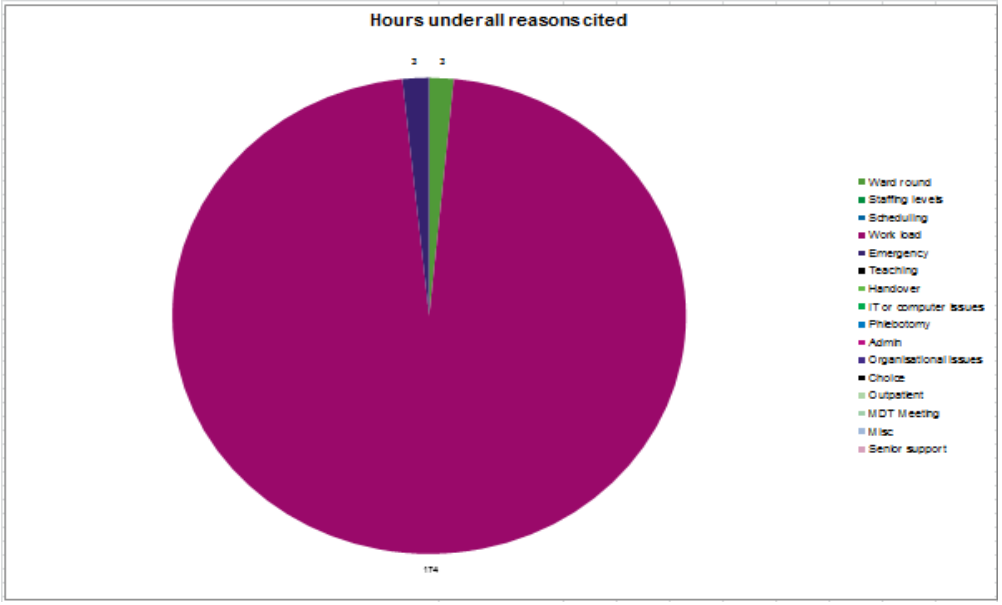
Graph and Table #3 - Overview of Exception Themes - CW



Look up	Long Theme	Short Theme	Count	Percent	Hours	Percent	In lieu	Paid	No action	Action cleared without response
WR	Ward Round issues e.g. long or starting late	Ward round	2	2%	3.5	2%	0.0	0.0	0.0	0.0
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	28	31%	46.7	24%	0.0	0.0	0.0	0.0
SC	Scheduling of duties outside normal working hours (N.B. this includes late	Scheduling	0	0%	0.0	0%	0.0	0.0	0.0	0.0
WL	Work Load exceeding the capacity of a full team	Work load	45	51%	99.5	51%	0.0	0.0	0.0	0.0
EM	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	1	1%	4.0	2%	0.0	0.0	0.0	0.0
TE	Teaching - either resulting in late stay; or missed at request of consultant	Teaching	1	1%	4.0	2%	0.0	0.0	0.0	0.0
HA	Handover - doctor stayed or they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	2	2%	2.5	1%	0.0	0.0	0.0	0.0
IT	IT or computer issues or the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
PL	Phlebotomy issues or the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
AD	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making list etc (please specify)	Admin	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OR	Organisational issues or the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	10	11%	35.5	18%	0.0	0.0	0.0	0.0
CH	Choice - doctor chose to come in early / stay late - not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OP	Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0	0.0	0.0	0.0
MDT	Multidisciplinary Team Meeting	MDT Meeting	0	0%	0.0	0%	0.0	0.0	0.0	0.0
MI	Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SU	Lack of Senior Support or the main cause of the exception (please qualify)	Senior support	0	0%	0.0	0%	0.0	0.0	0.0	0.0

Graph and Table #4 - Overview of Exception Themes



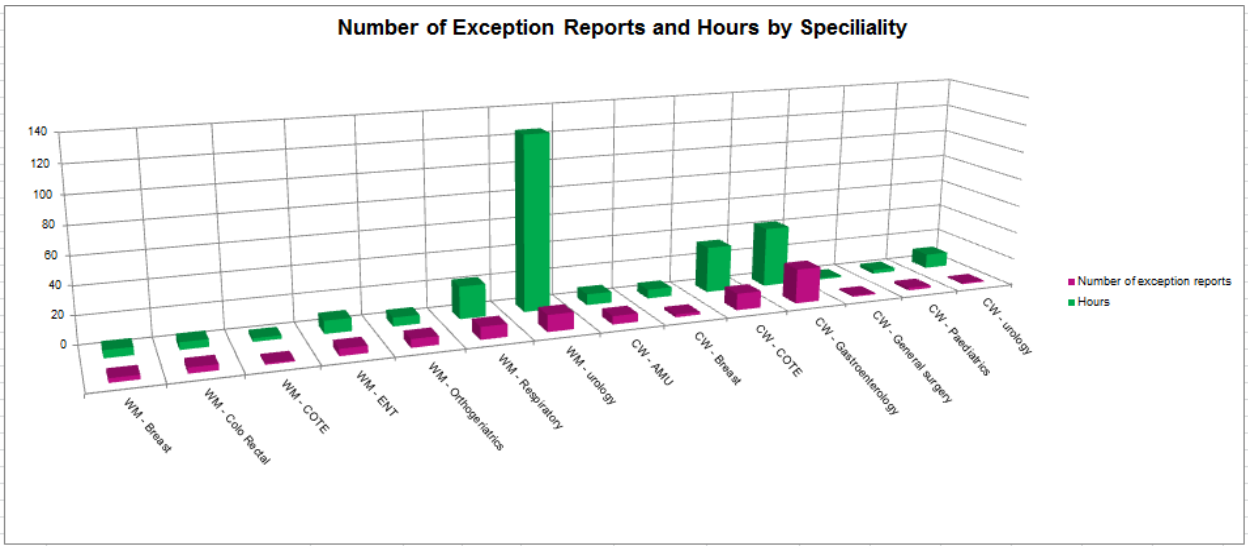


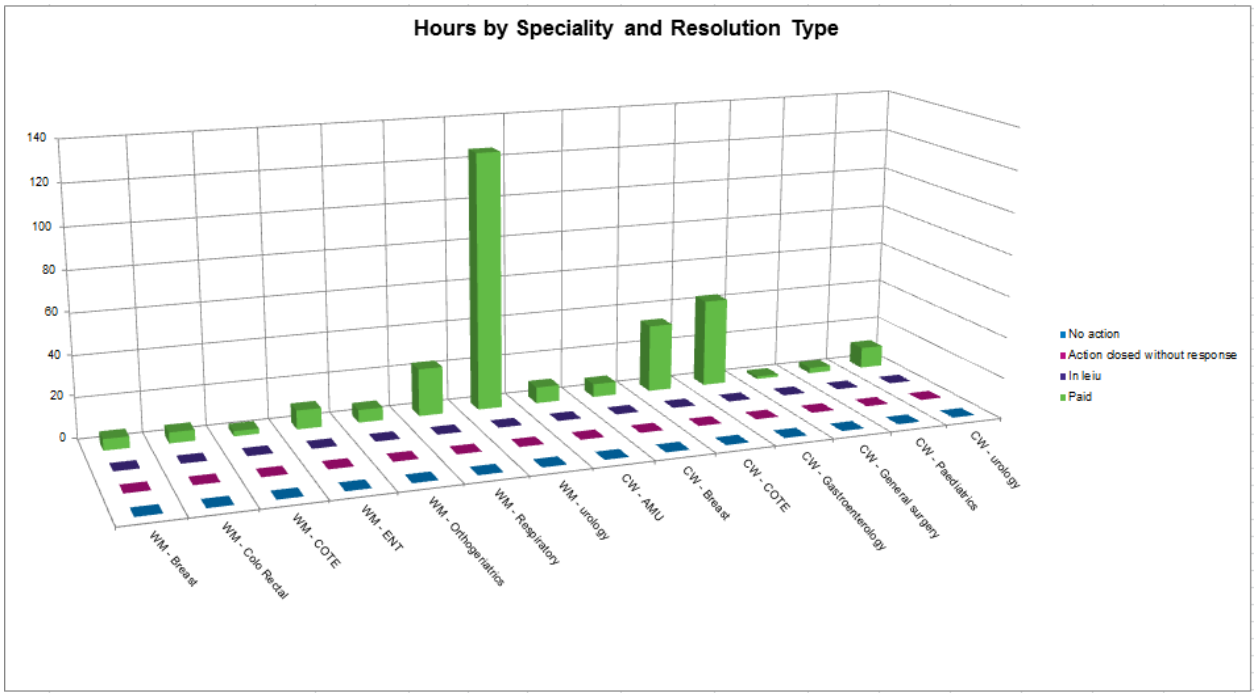
WMUH

Look up	Long Theme	Short Theme	Count	Percent	Hours	Percent	In lieu	Paid	No action	Action cleared without escalation
WR	Ward Round issues e.g. long or starting late	Ward round	2	5%	3.3	2%	0.0	0.0	0.0	0.0
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SC	Scheduling of duties outside normal working hours (N.B. this includes late	Scheduling	0	0%	0.0	0%	0.0	0.0	0.0	0.0
WL	Work Load exceeding the capacity of a full team	Work load	38.00	90%	174.0	97%	0.0	0.0	0.0	0.0
EM	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	2	5%	3.0	2%	0.0	0.0	0.0	0.0
TE	Teaching - either resulting in late stay; or missed at request of consultant	Teaching	0	0%	0.0	0%	0.0	0.0	0.0	0.0
HA	Handover - doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify)	Handover	0	0%	0.0	0%	0.0	0.0	0.0	0.0
IT	IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
PL	Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0	0.0	0.0	0.0
AD	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making hirts etc (please specify)	Admin	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OR	Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high volume of new patients (please specify)	Organisational issues	0	0%	0.0	0%	0.0	0.0	0.0	0.0
CH	Choice - doctor chose to come in early /stay late - not directed by seniors	Choice	0	0%	0.0	0%	0.0	0.0	0.0	0.0
OP	Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0	0.0	0.0	0.0
MDT	Multidisciplinary Team Meeting	MDT Meeting	0	0%	0.0	0%	0.0	0.0	0.0	0.0
MI	Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0	0.0	0.0	0.0
SU	Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	0	0%	0.0	0%	0.0	0.0	0.0	0.0

Graph and Table #5 - Overview of Exceptions per Site and Speciality

Site	Speciality at time of exception report	Number of exception reports	Open	Percent	Number of staff on rota	Hours	In leiu	Paid	No action	Action closed without response
WMUH	Breast	3	0	0%	0	5.5	0.0	5.5	0.0	0.0
WMUH	Colo Rectal	4	0	0%	0	5.3	0.0	5.3	0.0	0.0
WMUH	COTE	1	0	0%	0	2.5	0.0	2.5	0.0	0.0
WMUH	ENT	5	0	0%	0	9.3	0.0	9.3	0.0	0.0
WMUH	Orthogeriatrics	6	0	0%	1	6.3	0.0	6.3	0.0	0.0
WMUH	Respiratory	9	0	0%	0	23.3	0.0	23.3	0.0	0.0
WMUH	urology	12	0	0%	1	125.5	0.0	125.5	0.0	0.0
Chelsea	AMU	6	0	0%	0	8.0	0.0	8.0	0.0	0.0
Chelsea	Breast	2	0	0%	0	6.5	0.0	6.5	0.0	0.0
Chelsea	COTE	12	0	0%	0	33.3	0.0	33.3	0.0	0.0
Chelsea	Gastroenterology	25	0	0%	0	43.2	0.0	43.2	0.0	0.0
Chelsea	General surgery	1	0	0%	7	1.3	0.0	1.3	0.0	0.0
Chelsea	Paediatrics	2	0	0%	0	2.8	0.0	2.8	0.0	0.0
Chelsea	urology	1	0	0%	2	10.5	0.0	10.5	0.0	0.0
WMUH	**Total (of reporting specialities)**	**13**	0	0%	**0**	0.0	0.0	0.0	0.0	0.0
CW	**Total (of reporting specialities)**	**49**	**0**	**0%**	**9**	**105.5**	**0.0**	**105.5**	**0.0**	**0.0**





Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	4.4/Mar/19
REPORT NAME	Review of Committee effectiveness including Audit and Risk Committee Terms of Reference
AUTHOR	Company Secretary
LEAD	Nick Gash, Audit and Risk Committee Chair
PURPOSE	To provide the Board with assurance as to the effectiveness of its Committee structure and seek approval to amendments to the Terms of Reference of the Audit and Risk Committee.
SUMMARY OF REPORT	The paper provides assurance from the Audit and Risk Committee as to the effectiveness of the Board's Committees.
KEY RISKS ASSOCIATED	Board Committees are integral to the effectiveness of Trust governance and the Board needs to be assured that they are delivering to their agreed Terms of Reference. Terms of Reference for Board Committees need to be reviewed regularly to ensure they remain comprehensive and coherent.
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Board is asked to: • note the assurance of Committee effectiveness • approve the proposed revisions to the Audit and Risk Committee Terms of Reference.

Review of Committee effectiveness including Audit and Risk Committee (ARC) Terms of Reference

Background

1. Board committee evaluation is an important feature of good governance and supports compliance with the principles of the UK Corporate Governance Code and the NHS Foundation Trust Code of Governance. Effective evaluation allows the Board, and individual committees, to obtain assurance on how well each committee is performing against its remit, delivering its objectives and in turn contributing to the effective performance of the Trust as a whole.

2. In October 2018, the ARC agreed a questionnaire for use by the Board's Committees built around the following themes:
    - Composition, establishment and duties
    - Administrative arrangements
    - Governance, scrutiny and assurance
    - Scope of work
    - Committee engagement
    - Committee focus
    - Committee effectiveness
    - Committee leadership
    - Committee values

3. Members and attendees of the Board's Committees completed the questionnaire and each Committee reviewed its own results to identify whether it was operating as effectively as possible and in line with prevailing Terms of Reference. Each Committee Chair then provided an assurance report to the Audit and Risk Committee. The Audit and Risk Committee assured its own effectiveness using the same methodology, supplemented by the Committee Chair and Committee Secretary also completing a checklist specifically for Audit and Risk Committees prepared by the Health Finance Management Association.

Assurance status

4. Based on the reports provided by the Chairs of the Finance and Investment Committee, People and Organisation Development Committee and Quality Committee, the Audit and Risk Committee can report to the Board that Committees have undertaken effective self-evaluations of effectiveness and identified appropriate areas for improvement. Terms of Reference for these three Committees are also up to date and fit for purpose in light of the changes agreed at the Board's January 2019 meeting.

5. With regard to its own review of effectiveness, the Audit and Risk Committee reports that its results were broadly positive and did not indicate any need for substantive change to processes and procedures. The Committee seeks the following changes to its Terms of Reference (see attached at **Annex A**):

    - updating for consistency with other Committees
    - addition of a more fulsome overarching aim paragraph (consistent with that used in many other Foundation Trusts)
    - addition of a clause, under method of working, to confirm that assurances from other Committees may be utilised as the Committee undertakes is work.

6. The only Committee yet to review the results of its self-evaluation is the Board's Nominations and Remuneration Committee and that review will take place at the Committee's next meeting.

Matter for decision

The Board is asked to:

- note the assurance of Committee effectiveness
- approve the proposed revisions to the Audit and Risk Committee Terms of Reference.

Annex A

Audit and Risk Committee
Terms of Reference

1. Constitution

The Audit and Risk Committee (~~the Committee~~ARC) is established as a sub-committee of the Board of Directors of Chelsea and~~&~~ Westminster Hospital NHS Foundation Trust (~~the Trust~~CWFT) ~~Board of Directors~~.

The ~~Committee~~ ARC will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any changes recommended to the Terms of Reference will require Trust Board approval~~Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Board of Directors approval~~.

2. Authority

The ~~Committee~~ ARC is directly accountable to the Board of Directors.

The ARC is authorised by the Board of Directors to act within these terms of reference. In doing so, the Committee 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.

3. Aim

This Committee provides the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the foundation trust's activities (clinical and non-clinical), both generally and in support of the annual governance statement. ~~This Committee assures the Trust Board that probity and professional judgement is exercised in all financial and operational areas governance. It is authorised by the Trust Board to seek relevant professional advice and to secure attendance of relevant parties at its meetings.~~

4. Objectives

4.1 ~~To s~~Support the Trust's Values and objectives.~~:~~

4.2 Review the establishment and maintenance of effective systems of internal control, establishment of value for money and risk management including fraud and corruption.

4.3 Assure the Board on completeness and compliance of required disclosure statements and policies.

4.4 Review the Trust's Annual Report, including Quality Report and financial statements, Annual Governance Statement and Head of Internal Audit Opinion and the External Assurance on the Trust's Quality Report and assure the Board on compliance.

4.5 Assure the Board on judgements and adjustments relating to annual financial statements.

4.6 Review the Trust's self-certification as required by NHS Improvement or its successors to comply with any conditions of its foundation trust licence

4.7 Assure the Board on the appropriateness and effectiveness of the internal audit service its fees, findings and co-ordination with external audit.

4.8 Assure the Board on the appropriateness, effectiveness and co-ordination of external auditors, and

the Trust's management response and outcomes.

4.9 Assure the Board on the appropriateness and effectiveness of the local counter fraud specialist service, their fees, findings and co-ordination with internal audit and management.

4.10 Make recommendations to the Council of Governors on the appointment, re-appointment and remuneration and terms of engagement of the external auditors.

4.11 Assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework and of the processes for its implementation.

4.12 Ensure that arrangements are in place for investigation of matters raised, in confidence, by staff relating to matters of financial reporting and control, clinical quality, patient safety or other matters.

4.13 Undertake such other tasks as shall be delegated to it by the Board in order to provide the level of assurance the Board requires.

4.14 Report to the Council of Governors on significant matters where these matters are not notified to the Council of Governors via other means.

5. Method of working

5.1 The Committee will have a standard agenda. At every meeting, the following item headings will be on the agenda:

1. Apologies for absence
2. Declarations of Interests
3. Minutes of the previous meeting
4. Business to be transacted by the Committee
5. Any Other Business
6. Date of next meeting

5.2 All Minutes of the Committee 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.

5.3 In carrying out its duties, the Committee may take account of the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work.

6. Membership

6.1 The membership of the Committee shall consist of:

- Non-Executive Chair
- 2 other Non-Executive Directors

6.2 In Attendance: Chief Executive Officer, ~~Deputy Chief Executive,~~ Chief Financial Officer, Medical Director, Deputy Medical Director, Company Secretary or equivalent, Head of Internal Audit, External Audit representatives and a Counter Fraud representative. Other Directors only when required. Deputies have to attend if the Chief Executive or Chief Financial Officer cannot.

7. Quorum

7.1 The Committee will be deemed quorate to the extent that the following members are present:

- 2 Non-Executive Directors one of whom will chair the meeting

8. Frequency of meetings

8.1 Meetings shall be held quarterly, aligned with Trust Board and Quality Committee and additionally if requested by auditors.

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

8.3 Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

9.1 Minutes and agenda to be circulated by the Company Secretary or equivalent.

10. Reporting Lines

10.1 The Committee will report to the Board of Directors after each meeting. The minutes of all meetings of the Committee shall be formally recorded and submitted to the next Board.

10.2 Matters of material significance in respect of audit 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 Committee minutes.

10.5 The Committee shares some items with the Quality Committee.

10.6 Internal and External Auditors and Counter Fraud representatives report to each meeting of the Committee.

11. Openness

11.1 The agenda, papers and minutes of the ~~Committee~~ ARC are considered to be confidential.

Reviewed by: Audit Committee
Date: 2~~6~~ January~~uly~~ 201~~7~~
Approved by: (to be Board of Directors)
Date: ~~August 2017~~March 2019
Review date: ~~July 2018~~January 2020

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 March 2019

PUBLIC SESSION

AGENDA ITEM NO.	4.5/Mar/19
REPORT NAME	Approval of Standing Financial Instructions and schedule of decisions reserved to the Board and the scheme of delegation.
AUTHOR	Stephen Aynsley-Smith, Deputy Director of Finance- Financial Operations and Julie Myers; Company Secretary
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	Provide an updated Standing Financial Instructions (SFIs) and schedule of decisions reserved to the Board and the scheme of delegation (SOD) for approval by the Trust's Board.
SUMMARY OF REPORT	The Trust has reviewed its SFI's and SOD and undertaken a number of changes to ensure they are closely aligned. The changes to the documents ensure that the SFIs and SOD have clear responsibilities and that all relevant approval values, delegated authorities are correct. In January 2019 the Trust provided the updated SFIs/SOD for review and endorsement by the Trust's Audit and Risk Committee. The Trust's Audit and Risk Committee has endorsed the SFIs/SOD for approval by the Trust's Board.
KEY RISKS ASSOCIATED	Financial Sustainability
FINANCIAL IMPLICATIONS	As above.
QUALITY IMPLICATIONS	N/A.
EQUALITY & DIVERSITY IMPLICATIONS	N/A.
LINK TO OBJECTIVES	Deliver financial sustainability
DECISION/ ACTION	The Board is asked to approve the updated SFIs and SOD.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS			
START DATE:	March 2019~~8~~	**EXPIRY DATE**	March ~~2019~~2020
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE:** Sir Tom Hughes-Hallett	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee	**DATE:** 24 January 2019	
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~~September 2017 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interests and ~~,~~ Anti-Bribery ~~and Corruption~~ Policy • Treasury Management Policy • Raising ~~a~~ Concerns (Whistleblowing) 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
January 2019	14	Chief Financial Officer	Comprehensive refresh and rewrite for ease of use and cross-check with refreshed Schedule of Decisions Reserved and Delegated

STANDING FINANCIAL INSTRUCTIONS

CONTENTS

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st October 2006, following authorisation by "NHS Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued 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) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The Single Oversight Framework details how NHS Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DH GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and any hosted organisations (subject to para 23.2). They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Financial Officer (CFO) must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 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 meeting of the Audit and Risk Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and Delegation

Foundation Trust Board of Directors

1.2.1 The Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

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

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Chief Financial Officer (CFO)

1.2.4 The Chief Executive and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

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

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Chief Financial Officer

1.2.7 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) 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;

d) 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;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) 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;

iv) Developing the Trust's financial strategy including:

- Managing cash resources

- Ensuring a robust system of budgetary control is in place

Board of Directors and Employees

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

a) The security of the property of the Trust;

b) Avoiding loss;

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

d) Conforming to the requirements of NHS Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 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.

1.2.10 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 CFO.

1.3 TERMINOLOGY

1.3.1 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;

1.3.2 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.

1.3.3 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.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with the Constitution, the Board shall 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 external audit and internal audit and counter fraud services;

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

c) Monitoring compliance with SOs and SFIs;

d) Reviewing 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 wishes to raise, the Chair of the Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Independent Regulator, NHS Improvement, in consultation with the Chief Executive.

2.1.3 It is the responsibility of the Audit and Risk Committee, supported by the CFO, to ensure that an adequate internal audit and counter fraud service is provided and the Committee is involved in the selection process when providers are changed.

2.2 Chief Financial Officer

2.2.1 The CFO 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. An internal audit function is required by NHS Improvement's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.5 in relation to fraud, corruption and bribery);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit and Risk Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit plan recommendations;

iv) Progress against plan over the previous year;

v) A strategic audit plan covering the coming three years;

vi) A detailed work-plan for the coming year.

2.2.2 The CFO and 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 members of the Board or employee of the Trust;

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

d) Explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit

and Risk Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.3.2 Internal Audit will review, appraise and report upon:

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 (responsibility for investigation of any suspected or alleged fraud is held by the Counter Fraud Specialist);

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.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.3.3 Whenever any matter arises (in the course of work undertaken by internal audit) 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 CFO must be notified immediately and, in the case of alleged or suspected fraud, the Counter Fraud Service (CFS) must be notified.

2.3.4 The Head of Internal Audit, or equivalent title, will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chair and Chief Executive.

2.3.5 The reporting system for internal audit shall be agreed between the CFO, 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 "Audit Code," the "DH Group Accounting Manual", the "NHS FT Accounting Officer memorandum" and other relevant NHS Internal Audit Standards guidance.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.

2.4.2 Audit and Risk Committee must ensure a cost-effective service is provided and agree audit

work-plans over and above the statutory requirements.

2.4.3 The External Auditor must ensure that this service fulfills the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.4.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.4.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.4.6 Prior approval must be sought from the Audit and Risk Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the CFO is required to authorise expenditure.

2.4.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit and Risk Committee and shall be entitled to meet the Audit and Risk Committee in the absence of Trust employees if they so wish.

2.5 Fraud, Corruption and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority's ("NHSCFA") standards.

2.5.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.5.3 The Trust shall nominate a professionally accredited person to carry out the duties of the Counter Fraud Specialist ("CFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified by NHSCFA implementing their good practice and guidance.

2.5.4 The CFS shall liaise with the CFO 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.

2.5.5 If it is considered that evidence of offences 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.

2.5.6 The Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.5.7 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 CFO and outcomes fed back to the Audit and Risk Committee.

2.5.8 In accordance with the "Whistle-Blowing Policy", the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHSCFA.

2.5.9 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 CFO shall sign-off the annual self-review and authorise its submission to NHSCFA. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant

authority.

2.6 Security Management

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHSCFA's standards.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHSCFA's anti-crime standards.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD), who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust 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.

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

3.1.3 The CFO will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust 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.

3.1.4 The Board shall have regard to the views of the Council of Governors in preparing the forward plan.

3.1.5 The CFO shall monitor financial performance against budget, and report to the Finance and

Investment Committee (the "FIC") and the Board.

3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.7 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the strategic review and annual planning processes. Only approved business cases or expected 'base case' will be included in the annual plan and budget setting. An adjustment to plans will be made in year for those that are subsequently approved. The approval process for business cases is contained within SFI 12.2.

3.1.8 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the CFO, 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;

f) The provision of regular reports.

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

3.2.3 Except where otherwise approved by the Chief Executive, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

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

3.2.6 Clinical Directors, Divisional Director or Service Leads (or equivalent) who are responsible for "trading activities" must ensure the integrity and supply of information to other users. Price increases in such departments shall be monitored by the CFO to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the FIC and the Board in a form approved by the Board containing sufficient information to allow the FIC and the Board to ascertain the financial performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Workforce spend and whole time equivalents ("WTEs");

iii) NHS Commissioners' contractual performance to date;

iv) Movements in working capital including cash;

v) Capital project spend and projected outturn against plan;

vi) Explanations of any material variances from budget and/or plan;

vii) Details of any corrective action where necessary and the Chief Executive's and/or CFO'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 and virements.

3.3.2 Budget holders are not authorised to overspend their budget. Where an over spend occurs, the budget holder must account to their divisional management team or line manager for the over spend and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to phasing.

3.3.3 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 for any purpose other than that authorised, subject to the rules of virement;

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

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS Improvement's risk rating regime.

3.3.5 The CFO will include a written introduction to the Trust's SFIs, SOs and Scheme of Delegation in the induction pack for all Trust induction attendees.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual and DH GAM. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms and returns are submitted to "NHS Improvement." The performance figures to the Board should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, 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 prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

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

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

4.5 The Annual Report and Accounts, including the auditor's report, is submitted to NHS Improvement (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

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 public inspection at the Trust's headquarters and made available on the Trust's website.

4.7 The Chief Nurse will 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 Chair 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.

4.9 The Chief Executive, Chair and CFO, as appropriate, shall sign other documentation relating to the Annual Report, Annual Accounts, Annual Quality Report and financial returns to NHS Improvement on behalf of the Board.

5 BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The Board will review banking arrangements periodically.

5.1.3 The Board shall approve the banking arrangements, including CFO recommendations, regarding the opening or closing of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks

working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.3 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services (refer to the Treasury Management Policy for further details);

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

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

f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit if applicable;

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

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

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

5.5 Trust Credit Card

5.5.1 The Chief Financial Officer has overall responsibility for Trust credit cards including security, approval for issue, authorised use and purchasing limits.

5.5.2 Responsibility for the security and use of an individual Trust credit card is the named holder of the card. Each card must only be used for the purpose for which it is authorised.

5.5.3 Each cardholder must comply with the administrative requirements of the Trust's Purchasing Cards guidance.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for

the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the DH guidance on "Payment by Results" ("PbR") when entering into contracts for patient services where applicable.

6.2.2 The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care ("DH") 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 DH's "Commercial Sponsorship – Ethical Standards in the NHS" shall be followed.

6.2.3 All employees must inform the CFO 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 at SFI Annex 1.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed, should be written off in accordance with agreed procedures for reporting losses in SFI 14.

6.3.3 The following VAT exclusive approval limits shall be applied to individual debt write offs or partial write offs:

Monetary Value	Approval
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 referred to the ~~Board~~Audit and Risk Committee

6.3.4 The following VAT exclusive approval limits shall be applied to packages of debt:

Monetary Value	Approval
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 referred to the Board

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6.3.5 A schedule of all written off debt shall be presented to the Audit and Risk Committee at least annually.

6.3.6 A schedule of debts written off in excess of £100,000 ~~and approved by the Audit and Risk Committee~~ should be presented to the Trust Board for noting at least annually.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt 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 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The CFO shall be responsible for the security arrangements.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received before banking except under arrangements approved by the CFO.

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

6.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses in SFI 14

7 TENDERING AND CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions and Procurement Law

7.1.1 The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders.

7.1.2 The Procurement Department shall maintain standard tendering procedures and documents in accordance with best practice and EU procurement law.

7.1.3 Tenders for building and engineering works will be let in accordance with SFIs, SOs, "Procurement Policies and Procedures" document and NEC/JCT or relevant engineering or construction contracts as authorised by the Director of Estates.

7.2 Thresholds Tender Guide

7.2.1 The formal tendering process is facilitated by the Procurement Department. It is applied 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 line with the procedures in SFI 7.9 below.

7.2.2 If a conflict of interest exists between the tender and the Procurement Department, the Chief Executive shall nominate a representative who will conduct the tender process.

7.2.3 All tendering activity is to be processed through the Trust's e-tendering system, Due North. Paper tenders will not be accepted and will be deemed to be non-compliant.

7.2.4 The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

7.2.5 Where goods, services and/or capital works are to be supplied over a period of time, the threshold limits represent the total value of the contract and include the whole life costs e.g. a 5 year contract of £25,000 per year would be a contract value of £125,000

7.2.6 The tables below detail the procurement thresholds for goods and services

Products and Services Procurement (Revenue and Capital)

Contract Value (Excl VAT)	Quotations/Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	Single quotation may be obtained by end user	1	Purchase Order
£10,001 - £50,000	Quotation. Authorisation required from Procurement prior to obtaining quotes	3 (of which 2 must be returned)	Purchase Order or Contract
£50,001 – OJEU Limit (Currently £181,302)	Tender by Procurement	6 (of which 3 must be returned)	Contract as specified in Tender and Purchase Order
> OJEU limit (Currently £181,302)	OJEU Tender by Procurement	Whole market invited	Contract as specified in Tender and Purchase Order

Building and Estates Engineering Procurement (Revenue and Capital)

Contract Value (Excl VAT)	Tender for Building & Engineering	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	Single quotation may be obtained by end user	1	Purchase Order
£10,001 - £50,000	Quotation. Authorisation required from Procurement prior to obtaining quotes	3 (of which 2 must be returned)	Purchase Order or Contract
£50,001 – OJEU Limit (Currently £4,551,413)	Tender	6 (of which 3 must be returned)	Contract as specified in Tender and Purchase Order
> OJEU Limit (Currently £4,551,413)	OJEU Tender	Whole market invited	Contract as specified in Tender and Purchase Order

7.2.7 In circumstances where the specified number of quotations and/or tenders cannot be obtained (e.g. where there are a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded.

7.3 Placing Contracts

7.3.1 Contract negotiations with suppliers can only be entered into by the Procurement Department.

7.3.2 Agreement of contracts for goods and services are subject to approval in line with the authorisation levels in the table below:

Contracts for Goods and Services

Value	Authoriser
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 or Clinical Director
Contract value up to £200,000	Executive Director
Contract value up to £500,000	Chief Executive or CFO
Contract value over £500,000	Trust Board

7.3.3 Contracts sign off for all goods and services must be facilitated through by Procurement.

7.3.4 Variations to revenue contracts are subject to approval in line with the authorisation levels in the table below:

Variations to Revenue Contracts

Value	Authoriser
Contract value up to £100,000	Non-Board Director or Clinical Director
Contract value up to £200,000	Executive Director or CFO
Contract value up to £500,000	Chief Executive or CFO
Contract value over £500,000	Trust Board

7.3.5 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff and temporary staff and agency staff contracts.

7.4 Electronic Tendering

7.4.1 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal, Due North.

7.4.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.9. Issue of all tender documentation should be undertaken electronically by the Procurement Department through the Due North system with controlled access using secure login, authentication and viewing rules.

7.4.3 No communications will be permitted outside of the Due North system. Any bidders attempting to communicate with staff in relation to a tender outside of this facility may be disqualified from the process.

7.4.4 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time.

7.4.5 A “Declaration of Interests” form must be completed by all participants in a tender process without exception. Procurement will retain responsibility for reviewing forms and excluding participants where a conflict of interest is noted.

7.5 Opening Formal Tenders

7.5.1 The Due North e-tendering system will automatically open the tender once the closing date and time has passed. Details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. Tender responses can then be downloaded and assessed.

7.5.2 The Due North system automatically maintains a full audit trail of all actions and communications by both procurement staff and suppliers. A permanent record shall therefore be maintained to show for each set of competitive tender invitations despatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening.

7.5.3 Except as in SFI 7.5.4 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record will be recorded in the audit trail.

7.5.4 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure set out in Section 7.5.3 above unreasonable.

7.6 Admissibility and Acceptance of Formal Electronic Tenders

7.6.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the CFO or nominated officer.

7.6.2 Tenders received after the due time and date may be considered only if the Chief Executive or CFO decides that there are exceptional circumstances, e.g. where the e-tendering facility does not allow successful uploads of tendering documentation or there is a fault with the system. Each case will be judged on its merits and according to current case law. The Chief Executive or CFO shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

7.6.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Chief Executive or CFO be regarded as having arrived in due time. A record supporting this decision should be logged.

7.6.4 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative after the due time for receipt) should be dealt with in the same way as late tenders under Section 7.6.2.

7.6.5 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

7.6.6 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

7.6.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the CFO.

7.6.8 Where only one tender/quotation is received the Chief Executive or CFO shall, as far as practicable, ensure that the price to be paid is fair and reasonable. All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

7.6.9 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (SFI 7.8 below).

7.6.10 All tenders should be treated as confidential and should be retained for inspection.

7.7 Extensions to Contract

7.7.1 In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Estates and /or Associate Director of Finance-Procurement (ADFP) up to the value of the original contract (including formally agreed variations).

7.8 Quotation and Tendering Procedures

7.8.1 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts and the supply or goods and/or services according to the financial limits specified in SFI 7.2.

7.8.2 The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

7.8.3 Quotations may be obtained by the Procurement Department or requisitioner for single purchases where the estimated value does not exceed £10,000.

7.8.4 No Pre Qualifications stages should be conducted for below OJEU threshold quotations/tenders in accordance with Public Contract Regulation 2015 (Regulation 111)

7.8.5 Where the total contract value exceeds the published OJEU Thresholds then the Trust is committed to EU Regulations and conducting an EU compliant procurement process.

7.8.6 Tender documents will be issued by the Procurement Department using the Due North system and will incorporate standard NHS Terms and Conditions as appropriate.

7.8.7 Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise the opportunity through the national Government Contracts Finder portal and must subsequently ensure the respective award is also published

7.8.8 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

7.8.9 Tender lists for building and engineering works will be compiled in conjunction with the Director of Estates from “Construction Line” the Trust’s approved list of contractors.

7.8.10 Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the CFO for further instructions.

7.8.11 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

7.8.12 After tenders/quotations have been opened, the ADFP will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.

7.8.13 A Contract Approval Document and Ratification Report prepared by the Procurement Team should be submitted to the ADFP for approval or to seek authorisation from the Chief Executive/Trust Board, according to delegated limits.

7.8.14 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

7.8.15 Where a competitive tender ratification process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the ADFP to approve any subsequent lease contract award for the same goods or equipment.

7.8.16 All contract documentation must be finalised promptly after the award of the contract and ideally prior to its commencement.

7.8.17 The waiving of variation of competitive tendering/quotation procedures shall be reported to Audit and Risk Committee meetings.

7.8.18 All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Contract database (ACCORD). Any exceptions to this are at the discretion of the ADFP.

7.9 Waiving of Formal Tendering/Quotation Process

7.9.1 Single tender waivers must not be used for the purpose of avoiding competition, for administrative convenience or to award further work to a consultant original appointed through a competitive process. They must be approved by the CFO or Chief Executive prior to any procurement taking place and can only be sought in the following circumstances:

a) Supply under special arrangements negotiated by the Department of Health which must therefore be complied with;

b) Timescales preclude competitive tendering (cannot apply to OJEU- explicit in Public Sector Regulations);

c) Specialist expertise is sought and is available from only one source (refer to Procurement Department to validate the issue of a MEAT notice if applicable);

d) There is clear benefit from continuity with an earlier project or to complete an existing project.

7.9.2 Tender waivers must be reported to the next Audit and Risk Committee meeting.

7.9.3 Formal competition need not be applied and therefore a waiver is not required as follows:

a) In circumstances after market engagement has been conducted and the specified number of quotations or tenders cannot be obtained (e.g. limited number of suppliers). The reason for receiving a lower number of quotations/tenders must be recorded;

b) The estimated expenditure does not, or is reasonably expected not to, exceed £10,000;

c) The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (e.g. change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor;

d) A direct award to a supplier on a national or regional framework is permissible and recommended according to the rules of the framework. On these occasions a report will require authorisation in accordance with SFI 7.3.2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust;

e) A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

f) A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed.

g) The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute procurement but the nominated Officer must still ensure value for money.

8 CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England, Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health or NHS Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

a) Costing and pricing of services (in accordance with Payment by Results) and the activity / volume of services planned;

b) The standards of service quality expected;

c) The relevant national service framework (if any);

d) Payment terms and conditions;

e) Amendments to contracts and extra-contractual arrangements; and

f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff.

8.1.7 The CFO shall produce regular reports detailing actual and forecast income linked to contract activity with a detailed assessment of the variable elements of income.

8.1.8 Any pricing of contracts at marginal costs must be undertaken by the CFO and reported to the Board.

8.1.9 The authorisation limits for signing service contracts are set out in SFI Annex 1.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where the Trust is a competing body)

8.3.1 Where the Trust participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Divisional Director of Operations	Procurement Steering Group	CEO	Trust Board
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£12.5m	<£25m	>£25m
Annual value	£20k pa	<£5m pa	>£5m<£10m pa	>£10m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to the CFO and Board for noting.

8.3.4 Staff who participate in a tendering exercise must follow the processes as outlined in the Procurement Procedures and the Evaluation protocol

9 TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Nominations and Remuneration Committee

9.1.1 The Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 The Committee will:

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

b) Approve recommendations for the remuneration, 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;

d) Report in writing to the Board on any decisions made and the basis for such decisions.

9.1.3 Trust Board and most Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.4 In line with March 2018 NHSI guidance, the opinion of NHSI, DHSC and the Minister of State for Health must be sought before confirming any senior manager or Director salary at appointment or any increase in salary where the annual salary is £150,000 or above.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Vacancy Control panel(if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) staff should be sourced through Bank whenever possible. The use of bank must be in line with the Trust's procedures for booking temporary staff. If the use of Bank is not possible, staff may be sourced through an Agency. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulations are complied with. Any off payroll engagements must be approved by the CFO prior to contract signature.

9.2.3 All staff employed by the Trust shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be retained by the HR Department.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the Trust intranet.

9.2.6 A leavers form shall be completed via the E-Pay system by the employee's line manager and submitted electronically to HR immediately upon the date of an employee's resignation, retirement or termination becoming known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the line manager shall inform HR immediately.

9.2.7 A "Change of Employment Circumstance Form, available on the intranet, covering changes to the employee's existing contract shall be completed by the employee's line manager and submitted electronically to HR immediately upon the date of change becoming known.

9.2.8 The employee is responsible for notifying HR of changes to personal details such as name,

address or bank details. Changes can be notified online via the ESR (Electronic Staff Record) portal.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its "Managing Organisational Change Policy".

9.2.11 The Nominations and Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.12 The Trust must seek approval from NHS Improvement before commissioning Management Consultants above a cap of £50,000.

9.3 Processing Payroll

9.3.1 The CFO 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 Trust employment contracts, the proper compilation of the payroll and for payments made.

9.3.2 No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the CFO.

9.3.3 All pay records including expense claim forms, supported by vouchers/ receipts where appropriate, shall be in a form approved by the CFO and shall be certified and submitted in accordance with his/her instructions be it in manual or electronic format.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed in advance by the CFO, on the date determined by the CFO.

9.3.5 Payment in full or in part shall not be made in advance of the pay date determined in 9.3.4 above except where prior approval has been obtained from the Chief Executive, CFO or duly appointed representative. In such cases payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.

9.3.7 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) 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.

9.3.8 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. The processes and procedures related to pay related claims and under/ overpayments are contained in the Trust's "Expenses Policy" and "Salary Under/Overpayment Policy".

9.3.9 The "Expenses Policy" sets out that claims for reimbursement will only be paid within 90 days of the expenditure being incurred. Additionally, pay claims in excess of normal contractual hours will only be paid within 90 days of the extra shift/hours. Any claims over 90 days old will only be paid in exceptional circumstances and require CFO approval.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust 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.

10.1.2 The Council of Governors will be consulted on significant transactions – see Annex 3.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 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. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 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 ADFP and/or the CFO shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition for a purchase order (PO) to be raised.

10.3.3 In line with the "Procurement Policies and Procedures", the Trust operates a "No Purchase Order, No Pay" policy. With the exception of items specifically detailed as "exceptions" within the policy (such as agency staff and utilities), all goods and services will be procured by means of a PO in the Trust's e-ordering system, or using the Trust's Credit Card, in which case the order must also comply with the Trust's "Credit Card Policy" (refer to the Procurement Department for further guidance).

10.3.4 Official POs must:

a) Must be uniquely identified by use of an internally approved process;

b) Be in a form approved by the CFO;

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

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

10.3.5 Orders for goods and services listed as "exceptions" in the "Procurement Policies and Procedures" must contain sufficient information to enable the supplier's invoice to be allocated to the correct budget. In line with the policy, the minimum information required on both the PO and supplier's invoice is:

a) Department;

b) Cost centre and account code;

c) Approver's name.

10.3.6 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.

10.3.7 The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.8 The CFO 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 the SFIs and regularly reviewed (SFI 7.2.6);

b) Prepare procedural instructions (where not already provided in the SFIs, Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

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

i) Authorisation:

- A list of Directors and 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:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be 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 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 and are reasonable;

- 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;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

- The account is arithmetically correct and is in order for payment

iii) Payments and Creditors:

- A timetable and system for submission to the CFO, or delegated 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) Financial Procedures:

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

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

10.3.9 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) 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 is unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director and CFO if problems are encountered.

10.3.10 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

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

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;

c) Verbal orders must only be issued by a member of the Procurement Department and then only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked as “Confirmation Order”;

d) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds referred to in 10.3.8 above;

e) Goods are not taken on trial or loan in circumstances that could commit the Trust to future uncompetitive purchase or without appropriate indeminity;

f) No order shall be issued to a firm which has made an offer of gifts, reward or benefit to Directors or employees other than isolated gifts of a trivial nature (e.g. calendars) or conventional hospitality such as lunch in the course of a working visit;

g) Changes to the list of Directors and Employees authorised to certify invoices are in

accordance with the scheme approved by the Board and are notified to the CFO;

h) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the CFO who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Advice on the VAT status of individual transactions will be provided by the Finance Department as required.

10.5 Petty Cash

10.5.1 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO.

10.5.2 Staff reimbursements for expenses incurred must not be made through petty cash but through payroll (see SFI 9.3.2).

10.5.3 Petty cash records are maintained in a form as determined by the CFO.

11 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.1.6 The CFO must prepare detailed procedural instructions concerning applications for loans or overdrafts.

11.1.7 The CFO is responsible for reporting Trust borrowing anually to the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 The amount of Public Dividend Capital at the point in time when the former NHS Trust became an authorised Foundation Trust will become the initial PDC of the Trust to be held on the same conditions.

11.2.2 Any application for an increase in PDC on behalf of the Trust shall only be made by the CFO or their nominated representative and will be notified to the Board or FIC on the Board's behalf.

11.2.3 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and 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.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria approved by the "Treasury Management Policy". The "Treasury Management Policy" will be refreshed and approved by the Audit and Risk Committee on a bi-annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Board through the Audit and Risk Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the "Treasury Management Policy" at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

12 INVESTMENT (CAPITAL AND REVENUE), PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Investment (Capital and Revenue)

12.1.1 The Trust will establish a Capital Programme Board (CPB) chaired by the CFO to oversee its allocation of capital investment and to approve business cases for both capital and revenue investment. The CFO will ensure that there is an adequate appraisal and approval process in place for determining expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.2.2 The CPB will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.2.3 The CFO shall establish systems to ensure that approved investment schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.2.4 The CPB may approve in year virements.

12.2.5 The financial performance of the capital programme, including virements above £250,000, shall be reported to Trust Board, via the Finance and Investment Committee, on a monthly basis.

12.2 Approval of Investment (Capital and Revenue) Business Cases

12.2.1 The Chief Executive shall require that a business case is produced for investment proposals

in line with the Trust's "Capital Governance Framework" and "Business Case Guidance" and NHS Improvement's "Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts."

12.2.2 Business cases must meet the following criteria:

a) Strategic case – Ensures strategic fit with organisational priorities and outlines the case for change;

b) Economic case – Demonstrates that the proposal optimises public value, evaluates options and identifies the preferred option;

c) Financial Case – Evidences that the preferred option will result in a fundable and affordable deal;

d) Commercial Case – Demonstrates that the preferred option will result in a viable procurement;

e) Management case – Demonstrates that the preferred option is capable of being delivered successfully.

12.2.3 Business cases should be developed for all schemes given approval to proceed to business case irrelevant of funding source. The approval for business cases is as per the tables below dependent on whether the investment is capital only (Table 1) or revenue only or a combination of capital and revenue (Table 2):

Table 1 – Capital Only Business Cases

Capital Asset Category	Business Case Value (incl 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 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/Chief Information 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	</ = £200k	Yes	Approved by the relevant	Capital

Capital Asset Category	Business Case Value (incl VAT)	Within Trust Plan	Approval Process	Report to
Equipment			Divisional Board and then approved by Chief Operating Officer	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 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

Table 2 – Revenue Only or Combination of Revenue and Capital Business Cases

Capital Asset Category	Business Case Value including VAT	Within Trust Plan	Approval Process	Report to
Revenue Expenditure only	< / = £50k	N/A	Approved by Divisional Director up to an annual limit of £200k.	
Revenue & Capital Investment	>£50k plus capital investment		Approved by the relevant Divisional Board and then up to an annual limit of £200k 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

12.2.4 Expenditure must not be incurred on any scheme prior to the above approval process unless with the express consent of the Chief Executive or CFO.

12.2.5 Any proposed scheme defined as major within the Foundation Trust Compliance arrangements must be approved by the Board and reported to NHS Improvement.

12.2.6 Investment funded entirely by donations must follow the approval process above.

12.3 Private Finance Initiative (PFI) and Leasing

12.3.1 The Trust should normally test for PFI and leasing when considering capital procurement through its business planning process (See “Capital Governance Framework” and “Business Case Guidance” on the Trust intranet)

12.3.2 When the Trust proposes to use private external finance, the following procedures apply:

a) The CFO shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

b) The proposal, in addition to any requirements under the business case approval process, must be specifically agreed by the Board.

12.3.3 Finance and operating leases must be agreed and signed off by the CFO

12.4 Asset Registers

12.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register, the method of updating and arranging for a periodic physical check of assets against the registers.

12.4.2 The Trust shall maintain an asset register recording both tangible and intangible fixed assets with an individual or grouped value of over £5,000. The register must be adjusted to reflect assets currently in use. The minimum data set to be held within the register shall be as specified in DH and NHS Improvement guidance.

12.4.3 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, architect’s certificates, supplier’s 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;

c) Lease agreements in respect of asses held under a lease and capitalised.

12.4.4 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).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.4.7 The CFO shall prepare procedural instructions on the disposal of assets.

12.5 Security of Assets

12.5.1 The overall control of assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. 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.

12.5.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.4 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 property as may be determined by the Board. Any breach of agreed security practices must be reported.

12.5.5 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 and the requirements of insurance arrangements.

12.5.6 Whenever practicable, assets should be marked as Trust property.

12.5.7 An inventory shall also be maintained and receipts obtained for equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's estate must receive the prior approval of the Capital Programme Board and Trust Executive Management Board. .

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £250,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £250,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £250,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 Any contracts to acquire property must be signed by two Executive Directors, one of whom should be the Chief Executive, subject to any requirement to affix the Company Seal being conducted in accordance with the requirements of the Trust's Constitution at Annex 7 (Standing Orders) Section 11.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £250,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.7 The disposal must be effected in full accord with Estate code.

12.6.8 Disposals of protected/relevant assets (as defined in the Trust's Licence) require the approval of NHS Improvement.

12.6.9 Major divestments as defined in the Foundation Trust Compliance Framework require the approval of NHS Improvement (See Annex 3).

12.6.10 Granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £250,000.

13 INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 All goods delivered to the Trust should be routed via the Goods Receipt Point unless formally agreed in advance by Procurement. In this way goods can be properly accounted for via the electronic purchasing and receipt system and invoices matched and paid appropriately.

13.1.2 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First in first out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.3 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Associate Director of Finance- Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; and the control of fuel oil of a designated Estates Manager.

13.1.4 The responsibility for security arrangements and the custody of keys for all inventory 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.

13.1.5 The CFO, in conjunction with the Associate Director of Finance-Procurement, shall set out procedures and systems to regulate the inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.6 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures for the control of consignment stock;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.7 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.8 The designated manager/ Pharmaceutical Officer shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, 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.

13.1.9 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.10 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.

13.1.11 For goods supplied via the NHS Supply Chain central warehouses, the CFO shall identify those authorised to requisition and accept goods from the store.

13.1.12 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO 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 CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100,000 (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register (See Trust “Losses and Special Payments Guidance”).

14.2.2 The CFO must also prepare a ‘fraud response plan’ that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See “Counter Fraud and Corruption Policy and Response Plan”).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust’s “Counter Fraud and Corruption Policy and Response Plan”.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHSCFA.

14.2.5 The Divisional or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether an insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. The categories for classification of losses and special payments are defined at Annex 2.

14.2.10 The CFO shall report all losses and special payments to the Audit and Risk Committee on a regular basis. Losses in excess of £100,000 approved by the Audit and Risk Committee should be presented to the Trust Board for noting at least annually.

15 INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Chief Executive, 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 General Data Protection Regulation framework;

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 are in place to manage and develop IT systems;

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

e) Ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied 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.

15.1.3 The CFO 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 contract should also ensure rights of access for

audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Information Strategy;

b) Data produced for use with financial systems is adequate, accurate, fit for reporting purposes, complete and timely, and that a management (audit) trail exists;

c) Finance 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.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Trust's ICT Team and outsourced service provider, Sphere. Any quotes to purchase software should therefore be managed through the online Sphere IT self-service portal.

15.1.7 No hardware equipment should be connected to the network without the approval of the outsourced service provider, Sphere. Any quotes to purchase hardware should therefore be managed through the online Sphere IT self-service portal.

15.1.8 ICT business cases for both hardware and software are subject to procedures and limits contained in SFI 12 and the "Business Case Guidance" on the Trust intranet.

16 FREEDOM OF INFORMATION

16.1.1 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.

16.1.2 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.

17 PATIENTS' PROPERTY

17.1 Patients' Property and Income

17.1.1 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. Staff have a duty of care to make every effort to take care of patients' possessions, which are not handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

17.1.2 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, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the

Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

17.1.3 The CFO will 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 it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

17.1.4 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 CFO.

17.1.5 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.

17.1.6 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.

17.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

17.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines.

17.1.9 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.

17.1.10 Funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any patient's monies held by the Trust.

18 STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's "Conflicts of Interest and Anti-Bribery Policy". This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Company Secretary for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for

negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

18.2.1 Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

18.2.2 These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically "Raising a Concern Policy", "Counter Fraud and Corruption Policy and Response Plan" and "Related Party Disclosure Policy" available via the Trust intranet).

18.2.3 The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

18.2.4 Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Counter Fraud Specialist (CFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19 RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS Improvement / DH guidelines. Archives may be held electronically.

19.2 The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, and maintenance of a register shall be as follows:

Document	Responsible
Property deeds	Director of Estates
Building and engineering contracts	Director of Estates
Estate maintenance contracts	Director of Estates
Maintenance and clinical contracts	Assistant Director of Finance - Procurement
Contracts for goods and services other than the above	Assistant Director of Finance - Procurement

Any other contracts not covered by the above which may be held by other managers must be reported to the Director of Corporate Affairs for a register to be maintained.

19.3 Any records held in archives shall be capable of retrieval by authorised persons. Destruction of archived records must only be undertaken by authorised personnel and a full audit trail must be maintained.

19.4 Records and information held in accordance with latest NHS Improvement / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or CFO. Proper details shall be maintained of records and information so destroyed.

20 GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Trust Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) Engendering amongst all levels of staff a positive attitude towards the control of risk;

c) The authority of all managers with regard to managing the control and mitigation of risk;

d) 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 residual risk;

e) Contingency plans to offset the impact of adverse events;

f) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review;

g) 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 Accounts as required by current Department of Health /NHS Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Company Secretary shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.3.3 The Company Secretary shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.3.4 The Company Secretary shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3.5 The Company Secretary shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.3 Clinical Risk Management / CNST

20.3.1 The Chief Nurse shall:

a) Provide a central point of contact within the Trust for NHS Resolution /CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21 LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where NHS Resolution considers it appropriate to do so. Public liability claims carry an excess of £3,000 and employer liability claims carry an excess of £10,000. Any occupier liability cases handled in house by the Trust within the excess of £3,000 will be notified NHS Resolution for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of NHS Resolution with the Trust as the defendant.

Value	External	Internal
< £100,000	NHS Resolution	Company secretary
£100,001 - £500,000	NHS Resolution	Chief nurse/medical director
> £500,000	NHS Resolution	Chief Executive

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Chelsea and Westminster Hospital NHS Foundation Trust, the Act provides that the Trust is exempt from repaying their “own” costs.

22 EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the CFO.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the CFO and the Chief Executive. In certain cases, additional approval should be sought from NHS Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the CFO advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value	Approval
< £30,000	CFO
£30,001 - £100,000	Chief Executive
> £100,001	Trust Board

22.4 NHS Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The CFO, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against legal advice must be approved by the Trust Board.

23 WHOLLY OWNED SUBSIDIARIES, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries

23.1.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

23.2 Hosted Bodies, Partnerships and Collaborations including Joint Ventures and Joint Operations

23.2.1 Hosted bodies are organisations for which the Trust provides services under a service level agreement (SLA).

23.2.2 The Trust also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.3 Dependent on the terms of the SLA, memorandum of understanding etc., these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding etc. should be referred to on a case by case basis.

24 RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, "Attributing the Costs of Health and Social Care Research and Development" (ACoRD DH2012) using the national costing guidance/templates.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 SOs and SFIs apply equally to the undertaking of research including budgetary control, purchasing and contracting, security of assets, and declarations of interest and Standards of Business Conduct amongst others.

24.5 The submission of grant applications to support research shall be signed by the CFO or designated representative.

26.6 The principles governing probity and public accounting shall apply equally to work undertaken through research.

25 GRANT APPLICATIONS

25.1 All applications for grant funding, whether for revenue or capital purposes, must be approved by the CFO or designated representative in advance of submission.

Annex 1: Authorisation Levels

Table 1

Authorisation levels for:

- Requisitioning of goods, works and services excluding pharmaceutical drugs (see table 2);
- Contract approval for goods and services;
- Signing call-off orders against existing contracts;
- Approval of invoices against existing service contracts excluding pharmacy (see table 3);
- Approval of contracts for income*

Table 1	
Value	**Authoriser**
Up to £10,000	Budget Holder
Up to £50,000	General Manager
Up to £100,000	Non-Board Director or Clinical Director
Up to £200,000	Executive Director or CFO
Up to £500,000	Chief Executive and CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

* All income contracts with a value of up to £100,000 must be countersigned by:

- Procurement, in order to review legal aspects of the contract;
- CFO, Deputy Director of Finance, Head of Financial Operations or Head of Management Accounts to review the financial aspects of the contract and ensure budget exists for any related expenditure;
- Head of ICT Operations for ICT related contracts

Annex 1: Authorisation Levels

Table 2

Authorisation levels for requisitioning of pharmaceutical drugs.

Table 2	
Value	**Authoriser**
Up to £10,000	Pharmacy Purchasing Coordinator or; Pharmacy Payments Administrator or; Pharmacy Buying Office and Stores Manager or; Homecare Administrator (for Healthcare at Home only) or; Highly Specialist Pharmacist W&C or; Operational Dispensary Manager
Up to £50,000	Pharmacy Purchasing and Distribution Manager or; Pharmacy invoicing manager or; Lead Pharmacist Clinical Commissioning (NHSE)
Up to £300,000	Lead Pharmacist Procurement or; Associate Chief Pharmacist or; Head of Pharmacy or; Chief Pharmacist or; CFO
Up to £500,000	Chief Executive or CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

Annex 1: Authorisation Levels

Table 3

Authorisation levels for approval of invoices against existing pharmacy service contracts.

Table 2	
Value	**Authoriser**
Up to £10,000	Pharmacy Buying Office Manager or; Pharmacy Payments Administrator or; Operational Dispensary Manager or; Lead Clinical Dispensary Pharmacist or; Chief Technician Technical Services or; Homecare Administrator (for Healthcare at Home only) or; Highly Specialist Pharmacist W&C
Up to £50,000	Pharmacy Purchasing and Distribution Manager or; Lead Directorate Pharmacist Medicine or; Lead Directorate Pharmacist W&C or; Lead Directorate Pharmacist HIV/GUM or; Pharmacy invoicing manager or; Lead Pharmacist Clinical Commissioning (NHSE)
Up to £300,000	Lead Pharmacist Procurement or; Associate Chief Pharmacist or; Head of Pharmacy or; Chief Pharmacist or; CFO
Up to £500,000	Chief Executive or CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

Annex 2: Classification of Losses and Special Payments

Losses and special payments are divided into two different categories:

Category A - Losses which include:

1. Losses of cash:

    a) Theft, fraud, arson, neglect of duty or gross carelessness
    b) Overpayments of salaries, wages, fees and allowances
    c) Other causes for example physical losses of cash due to fire, accident or similar causes

2. Fruitless payments, including abandoned capital schemes, and constructive losses

3. Bad debts and claims abandoned covering cases involving:

    a) Private patients
    b) Overseas visitors
    c) Cases other than private patients and overseas visitors

4. Damages to buildings, their fittings, furniture and equipment and loss of all other equipment and property in stores and in use:

    a) Theft, fraud etc.
    b) Stores losses including expired pharmacy stock
    c) Other causes

Category B - Special payments which include:

5. Compensation payments made under court order or legally binding arbitration award

6. Extra contractual payments to contractors

7. Ex gratia payments:

    a) Loss of personal effects
    b) Clinical negligence with advice
    c) Personal injury with advice
    d) Other negligence and injury
    e) Other employment payments including ex-gratia payments for employment cases
    f) Patient referrals outside the UK and EEA guidelines
    g) Other payments
    h) Maladministration cases, no financial loss

8. Special severance payments on termination of employment (Excludes contractual redundancy payments and MARS)

9. Extra statutory and regulatory payments

Further guidance is given in H M Treasury's Managing Public Money, Annex 4.10 Losses and write offs and Annex 4.13 Special Payments

Annex 3: Significant Transactions

The Trust is obliged to report significant transactions to NHS Improvement (the independent regulator of NHS Foundation Trusts) prior to entering the transaction. Such transactions may take the form of major investments such as PFI's, long term contracts for the provision of services or acquisitions or mergers with other NHS organisations or private sector companies.

The Trust would require both Trust Board and more than half of the Council of Governors voting to approve all significant transactions prior to submission to NHS Improvement, in accordance with the Clause 46 of the Constitution

Significant transactions are defined by NHS Improvement as being equivalent to a 10% change in any one of the following three financial criteria:

1 Gross Assets

2 Attributable Income

3 Capital

The full details of the NHS Improvement guidance on significant transactions can be found in annex 13 of the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts (published November 2015).

RESERVATION OF POWERS AND SCHEME OF DELEGATION			
START DATE:	March ~~2018~~2019	**EXPIRY DATE**	March ~~2019~~2020
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE** Sir Tom Hughes-Hallett	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee	**DATE:** 24 January 2019	
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~~September 2017 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interests and~~,~~ Anti-Bribery ~~and Corruption~~ Policy • Treasury Management Policy • Raising ~~a~~ ConcernS (Whistleblowing) 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
January 2019	14	Chief Financial Officer	Comprehensive refresh and rewrite for ease of use and cross-check with refreshed Standing Financial Instructions.

SCHEDULE OF DECISIONS RESERVED TO THE BOARD AND THE SCHEME OF DELEGATION

~~MAY 2018~~January 2019

~~WIP version January 2019~~

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1	Introduction	
2	Schedule of Decisions Reserved to the Board	
3	Decisions / Duties Delegated by the Board to Committees	
4	Scheme of Delegation of Powers from the Constitution	
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6	Scheme of Delegation of Powers from Standing Financial Instructions	
7	Other Issues to be delegated	
	7.1 Matters not covered by SFIs or SOs	
	7.2 Scheme of Budgetary Delegation	

1. INTRODUCTION

1.1 The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.

1.2 The Board remains accountable for all of its functions; even those delegated to Committees, individual executive directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.

1.4 The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.

1.5 The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated, the Chief Executive remains accountable for that responsibility to the Board. All powers delegated can be re-assumed by him/her should the need arise.

1.6 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 (see 7.2).

1.7 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 Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.

1.8 The Scheme of Delegation is reviewed annually.

1.9 As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

1.10 **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.

2 SCHEDULE OF DECISIONS RESERVED TO THE BOARD

The Board retains the right to determine any matter it wishes in full session within its statutory powers.

Constitution Reference	Decision Reserved to the Board
4	To exercise the powers of the Trust as set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation, or delegated to a Committee of the Board of Directors or to an executive director.
22	Determine the rates for travelling and other expenses payable to members of the Council of Governors.
28.2	Appoint one of the non-executive directors as a Senior Independent Director to act in accordance with NHS Improvement's NHS Foundation Trust Code of Governance, as may be amended and replaced from time to time, and the Trust's Standing Orders (SOs).
29	Appoint or remove the Chief Executive and other executive directors.
34.2	Establish a Committee of non-executive directors to decide the remuneration, allowances and other terms and conditions of the Chief Executive and other executive directors.
38	Make available for inspection by members of the public: • The Constitution • Latest Annual Accounts and Auditor's report • Latest Annual Report • A copy of any notice under section 65 of the 2006 Act.
40	Establish an Audit and Risk Committee.
41	Keep accounts.
42.1	Prepare an Annual Report and send it to NHS Improvement.
42.2 – 42.6	Prepare an annual forward plan and send it to NHS Improvement.
42.4	Receive the views of the Council of Governors on the annual forward plan.
43	Present the Annual Accounts, Auditor's report and Annual Report to the Council of Governors.
44	Authorise the fixing of the Trust seal.
Annex 5 Rule 4	Appoint a returning officer for elections to the Council of Governors
Annex 5 Rule 6	Determine the remuneration and expenses payable to the returning officer
Annex 4, Rule16	Make available for inspection by members of the public the statement of nominated candidates and nomination papers.
Annex 4, Rule 22	Provide the returning officer with a list of constituency members eligible to vote.

Annex 4, Rule 57& 58	Retain documents relating to elections to the Council of Governors and make these available for public inspection, subject to the restrictions in the election rules.
Annex 4, Rule 63 & 64	Compile information about the candidates and publish information about the candidates and the election.
Annex 7 9.5	Agree procedures for resolution of Council of Governors membership queries and any voting or legislation issues.
Annex 10 1	Decide to disqualify a Member of the Trust if they are likely to cause harm or detriment to the Trust
Standing Order Reference (Annex 9 to the Constitution)	
3	Determine the timing and location of Board meetings, including whether these should be held in public, and set the agenda.
3.29 – 3.34	Suspend or amend SOs subject to contravention of any statutory provision or direction from NHS Improvement and criteria within SFIs 3.29 and 3.34
4	Determine the functions to be delegated to committee, sub-committee or an officer of the Trust.
4.5	Approve scheme of delegation
5	Appoint committees subject to such directions and guidance as may be given by NHS Improvement and appoint persons to sit on such committees formally constituted.
5.5	Authorise committees to delegate executive powers to a sub-committee.
5.8	Establish the following committees and approve the Terms of Reference of: • Audit and Risk Committee • Nominations and Remuneration Committee • Finance and Investment Committee • People and Organisational Development Committee • Quality Committee • Any other committee or sub-committee required to discharge the Board's responsibilities.
10.2	Enter into contracts on behalf of the Trust and within its statutory powers
11.2	Authorise use of the Trust seal
12.2	Authorise Chief Executive, Chief Financial Officer or executive director to sign documents on behalf of the Trust
13.2	Review SOs annually
13.4	Resolve disputes arising out of or in connection with the Constitution including interpretation of SOs and procedure to be followed at meetings of the Board of Directors
Standing	

Financial Instructions Reference	
1.2.1	• Formulate the financial strategy • Approve budgets • Defining and approving essential features in respect of important procedures and financial systems • Define delegated responsibilities
1.2.2	Approve terms of reference of all committees reporting directly to the Board.
1.2.8	Responsible for security of Trust property, avoiding loss, exercising economy and efficiency in use of resources and conforming to the Constitution, Standing Orders, SFIs and Scheme of Delegation and requirements of NHS Improvement
2.1.1	Establish an Audit and Risk Committee
2.5.3	Nominate a professionally accredited person to carry out the duties of the Counter Fraud Specialist
2.6.2	Nominate a suitable person to carry out the duties of the Local Security Management Specialist
4.4	Approve the Annual Report and Accounts, including the auditor's report, unless specifically delegated to the Audit and Risk Committee.
5.1.2-5.1.3	Review and approve banking arrangements including CFO recommendations regarding the opening or closing of Trust bank accounts.
6.3.3 – 6.3.4	Approve individual or packages of debt write offs over £100,000.
7.3.2 – 7.3.4	Approve contracts for goods and services and variations to revenue contracts with a contract value over £500,000
8.1.1	Regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.
8.3.2	Approval of tenders over £25m in total or £10m per annum where the Trust is a competing body
9.1.1	Establish a Nominations and Remuneration Committee
10.1.1	Approve the level of non-pay expenditure on an annual basis
11.1.3	Approve applications for loans or overdraft facilities
11.1.5	Approve long-term borrowing
11.3.3	Approve investments in forming and/or acquiring an interest in bodies corporate
12.2.2	Approve the annual capital plan
12.2.5	Approve capital or revenue schemes defined as major within the Foundation Trust Compliance arrangements

12.3.2	Approve proposal to use private external finance for capital procurement including PFI and leasing
12.6.2	Approve estate strategy and acquisition of property, freehold and lease, over £250,000 excluding VAT.
12.6.8	Approve disposal of property over £250,000 excl. VAT
12.6.8 -12.6.9	Seek approval from NHS Improvement for the disposal of protected/relevant assets and major disinvestments.
12.6.10	Approve the granting of property leases where the annual value is in excess of £250,000
17.1	Provide safe custody for money and other personal property of patients.
20.1.1	Monitor risk management policy and procedures.
21.1.2	Approve litigation payments against legal advice
22.3	Approve out of court settlement of Employment Tribunal applications over £100,000.
22.4	Approve out of court settlement of Employment Tribunal applications against legal advice

3 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

Committee	Duties delegated by the Board	
Audit and Risk Committee	See Terms of Reference (available from Trust Company Secretary)	
	SFI 1.1.8	Ratify or refer non-compliance with SFIs for action
	SFI 2.2.1	- Oversee external audit, internal audit and counter fraud services. - Review financial and non-financial systems and processes. -Monitor compliance with SOs and SFIs. -Review losses and compensations and make recommendations to the Board.
	SFI 2.1.3	Ensure adequate internal audit and counter fraud service is provided and participate in selection process when providers are changed.
	SFI 2.4.1	Advise on appointment of external auditor.
	SFI 2.4.2	Agree non statutory external audit work plans and ensure cost-effective

		service is provided.
	SFI 4.4	Approve Annual Report and Accounts, including auditor's report when delegated to do so by the Board.
	SFI 11.3.2	Set the investment policy and oversee all investment transactions.
	SFI 11.3.4	Approve the "Treasury Management Policy"
	SFI 11.3.7	Review and monitor all investments.
Nominations and Remuneration Committee	See Terms of Reference (available from Trust Company Secretary)	
	SFI 9.1.2	- Decide remuneration package and terms and conditions of office of Executive Directors and Company Secretary. - Approve recommendations for remuneration package and terms and conditions of office of senior managers under their remit. - Decide rates at which Directors' travel and other expenses may be reimbursed. - Refer appointment to posts at a salary above £150,000 to NHS Improvement.
	SFI 9.2.11	Approve procedures for determination of pay rates, conditions of service etc. for employees on local contracts.
Finance and Investment Committee	See Terms of Reference (available from Trust Company Secretary)	
	SFI 12.2.3	Approval of business cases: - Over £200,000 not in Trust plan (Capital only) - Over £1m Approval of variations to capital: - Over £1m
People and Organisational Development Committee	See Terms of Reference (available from Trust Company Secretary)	
Quality Committee	See Terms of Reference (available from Trust Company Secretary)	

4 SCHEME OF DELEGATION OF POWERS FROM THE CONSTITUTION

Constitution reference	Delegated to	Authorities / duties delegated
1.4	Chair	Interpretation of the Constitution.
18.1 and Annex 7 Section 2.5	Chair	Preside at meetings of the Council of Governors.
18.3	Chair	Exclude any person from a meeting of the Council of Governors if that person is preventing the proper conduct of the meeting.
29.1	Chair and Non-Executive Directors	Appoint or remove the Chief Executive.
29.3	Chair and Non-Executive Directors and Chief Executive	Appoint or remove executive directors.
36.1	Company Secretary	Remove from the members register the names of members no longer entitled to be a member under the Constitution.
Annex 6 Section 2	Company Secretary	Monitor the eligibility of individuals to serve on the Council of Governors.
Annex 6 Section 2.5	Chair	Casting vote at Council of Governor meetings.
Annex 6 Section 2.6.1	Chair	Invite public and patient governors to put themselves forward for the post of Lead Governor when vacant.
Annex 6 Section 4.1	Company Secretary	Request the appointing organisation to appoint a replacement to hold office for the remainder of the term when a vacancy arises on the Council of Governors.
Annex 7 Section 3.4	Chair or Company Secretary	Call meetings of the Council of Governors including “other” or “emergency” meetings and serve notice to the governors.

Annex 7 Section 3.12	Company Secretary	Determine whether matters should be included on the Council of Governors' meeting agenda if a request for inclusion is made less than 15 days before the meeting.
Annex 7 Section 3.13	Chair	Exercise Council of Governors' powers in an emergency together with at least one-third of the Governors elected from the Patient and Public Constituency combined.
Annex 7 Section 3.20	Chair	Final decision at meetings of Council of Governors on questions of order, relevancy, regularity and any other matters.
Annex 7 Section 3.14	Company Secretary	Determine motions to be included on the Council of Governors' meeting agenda
Annex 7 Section 6	Company Secretary	Maintain Governor register of interests.
Annex 7 Section 9	Company Secretary	Ensure existing Governors, officers and new appointees are notified of and understand their responsibilities as set out in the Standing Orders of the Council of Governors (Annex 7 to the Constitution). Deal with any membership queries
Annex 7 Section 9.4	Senior Independent Director	Mediate a settlement to disputes involving the Chair arising on interpretation of the Standing Orders of the Council of Governors.

5 SCHEME OF DELEGATION OF POWERS FROM STANDING ORDERS (ANNEX 9 TO THE CONSTITUTION)

Standing Order reference (Annex 9)	Delegated to	Authorities / duties delegated
2.8	Deputy Chair	Act as Chair until a new Chair is appointed or existing Chair resumes duty where the Chair has died, ceased to hold office or is unable to perform his/her duties.
3.3	Chair or Company Secretary	Call meetings of the Board of Directors.
3.9	Chair	Determine whether matters should be included on the Board's meeting agenda if a request for inclusion is made less than 10 days before the meeting.
3.18	Chair	Final decision at Board meetings on questions of order, relevancy, regularity and any other matters.
3.19	Chair	Second and casting vote at Board meetings if equality of votes.
4.2	Chief Executive and Chair	Exercise the powers of the Board in an emergency.
4.4	Chief Executive	Exercise on behalf of the Board of Directors those functions of the Trust that have not been retained as reserved by the Board or delegated to an executive Committee or sub-committee. Determine the functions he/she will perform personally and nominate officers to perform the remaining functions.
4.5	Chief Executive	Prepare a scheme of delegation.
4.6	Chief Financial Officer	Accountable for providing information and advising the Board in accordance with statute or NHS Improvement requirements.
6	Company Secretary	Maintain Board register of interests.
8.4	Chief Executive	Report any director's relationship with a candidate of whose candidature the director is aware to the Board
10.3	Chief Executive	Nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

11	Company Secretary	Custody of common seal of the Trust and maintenance of a register of sealing.
12.1	Chief Executive or Chief Finance Officer or Executive Director	Authorised by resolution of the Board to sign any agreement or document on behalf of the Trust.
13.1	Chief Executive or Company Secretary	Ensure Directors are notified of and understand their responsibilities as set out in the Standing Orders of the Board of Directors (Annex 9 to the Constitution) and Trust Standing Financial Instructions (SFIs).
13.2	Senior Independent Director	Mediate a settlement to disputes involving the Chair arising on interpretation of the Standing Orders of the Board of Directors (Annex 9 to the Constitution).
13.5	Company Secretary	Deal with any membership queries.

6 SCHEME OF DELEGATION OF POWERS FROM STANDING FINANCIAL INSTRUCTONS

Standing Financial Instructions Reference	Delegated to	Authorities / duties delegated
1.1.6	Chief Financial Officer (CFO)	Interpretation or application of Standing Financial Instructions (SFIs)
1.2.4	Chief Executive (CE) and CFO	Accountable for financial control
1.2.5	CE	Overall executive responsibility for Trust activities; ensuring financial obligations are met and responsible for Trust's system of internal control.
1.2.6	CE	Ensure members of the Board, employees and new appointees are notified of and understand their responsibilities under SFIs
1.2.7	CFO	• Maintenance of SFIs • Implementing Trust financial policies • Maintaining effective system of internal control • Provision of financial advice to Trust Board and employees • Preparation of accounts and such other documents required to fulfil statutory duties • Developing Trust's financial strategy
1.2.8 – 1.2.9	All directors, employees and contractors	Responsible for security of Trust property, avoiding loss, exercising economy and efficiency in use of resources and conforming to the Constitution, Standing Orders, SFIs and Scheme of Delegation and requirements of NHS Improvement
2.2.1	CFO	• 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. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards. • Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities • Ensuring that an annual internal audit report is prepared for the consideration of the Audit and

		Assurance Committee.
2.3.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies, plans and procedures.
2.3.4	Head of Internal Audit	Right of access to Audit and Risk Committee members, the Chair and Chief Executive and to attend Audit and Risk Committee meetings.
2.5.1	CE and CFO	Monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority's ("NHSCFA") standards.
2.5.2 -2.5.7	CFO	Responsible for countering fraud, bribery and corruption in the Trust including monitoring of work of Counter Fraud Specialist
2.5.5	CFO	Authorise appropriate route for action when the Counter Fraud Specialist considers prosecution is desirable
2.6.1	CE	Monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHSCFA's standards.
2.6.4	Chief Operating Officer (COO) and Local Security Management Specialist	Responsibility for controlling and coordinating security.
3.1.1	CE	Submit to the Board and Council of Governors the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.3	CFO	Prepare and submit an annual budget for approval by the Board .
3.1.5	CFO	Monitor financial performance against budget and report to Finance and Investment Committee (FIC) and Board.
3.1.6	Budget Holders	Provide information as required by the CFO to enable budgets to be compiled.

3.1.8	CFO	Ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.
3.2.1	CFO	Delegate management of a budget to permit performance of a defined range of activities.
3.2.1 – 3.2.4	Budget holders	The management of a budget to permit performance of a defined range of activities that must not exceed total or virement limits set by the Board
3.3	CFO	Devise and maintain systems of budgetary control including monthly reports to FIC and the Board containing sufficient information to ascertain financial performance.
3.3.4	CE	Identify and implement cost improvement programmes and income generation initiatives.
3.3.5	CFO	Prepare written introduction to the Trust's SFIs, SOs and Scheme of Delegation in the induction pack for all Trust induction attendees.
3.5.1	CE or CFO	Appropriate monitoring forms and returns are submitted to NHS Improvement.
4.1	CFO	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Company Secretary	Prepare an Annual Report in accordance with current guidance.
4.5	CFO	Submit the Annual Report and Accounts to NHS Improvement and put forward to be laid before Parliament in accordance with prescribed timetable.
4.7	Director of Nursing	Prepare the Annual Quality Report in accordance with current guidance.
4.8	CE and Chair	Sign the "Statement of Directors' Responsibilities in Respect of the Quality Report".
5.1	CFO	Manage the Trust's banking arrangements and advise the Trust on the provision of banking services and operation of accounts.
5.2.3	CFO	Managing the Trust's Government Banking Service (GBS) and non GBS bank accounts, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made, monitoring the level of cleared funds and ensuring they comply with guidance, and covenants are adhered to.

5.3	CFO	Prepare detailed instructions of the operation of bank accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
5.4	CFO	Review commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.
5.5	CFO	Responsibility for Trust purchasing cards including security, approval for issue, authorised use and purchasing limits
5.5.2	Named Purchasing Card Holder	Responsible for security and use of an individual named Trust purchasing card
6.1	CFO	Design, maintain and ensure compliance with income systems including prompt banking of monies received.
6.2.2	CFO	Approve and review the level of all fees and charges other than those determined by DH or statute.
6.2.3	All Staff	Inform the CFO of income arising from transactions which they have initiated.
6.2.4	Table in SFI Annex 1	Approval limits for approval of contracts for goods and services
6.3.1 and 6.3.5	CFO	Take appropriate recovery action on all outstanding debts and report to Audit and Risk Committee.
6.3.3	Per table in SFI 6.3.3	Delegated VAT exclusive approval limits for individual debt write offs or partial write offs
6.3.4	Per table in SFI 6.3.4	Delegated VAT exclusive approval limits for packages of debt
6.4	CFO	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc. including security arrangements
7	CE	Arrangements for tenders where the Trust is the procuring body.
7.1.2 and 7.2.1	Procurement Department	Maintain standard tendering procedures and documents in accordance with best practice and EU procurement law and facilitate formal tendering process.
7.2.2	CE	Nominate a representative to conduct tender process if a conflict of interest exists between the Procurement Department and the tender.
7.3.1	Procurement	Contract negotiations with suppliers.

	Department	
7.3.2	Per table in SFI 7.3.2	Delegated authorisation levels for agreement of contracts for goods and services
7.3.4	Per table in SFI 7.3.4	Delegated authorisation levels for variations to revenue contracts
7.3.5	CE	Nominate officers with delegated authority to enter into contracts of employment regarding staff and temporary staff and agency staff contracts.
7.6.2	CE or CFO	Decision to accept late tenders or whether re-tendering is desirable. Report to Board.
7.6.9	CE	Approve form of contract including a fluctuation clause for price variations or nominate officer to approve.
7.7.1	Director of Estates and/or Associate Director of Finance – Procurement (ADFP)	Approve contract extensions where optional extensions to contract are outlined at the time of tendering up to the value of the original contract (including formally agreed variations).
7.8.12	ADFP	Arrange for adjudication of tenders/quotations in accordance with SFI 7.7.
7.8.15	ADFP	Approve any subsequent lease contract award for the same goods or equipment where a competitive tender ratification process has already been conducted and approved within the delegated levels.
7.9	CE or CFO	Approval of single tender waivers and reporting of same to Audit and Risk Committee.
8.1	CE	Arrangements for contracts re provision of services.
8.1.7	CFO	Production of regular income reports.
8.1.8	CFO	Pricing of contracts at marginal cost and reporting of same to Board.
8.1.9	Table in SFI Annex 1	Authorisation levels for approval of income contracts.
8.3.2	Table in 8.3.2	Authorisation levels for decisions to bid or bid sign off relating to tenders where the Trust is a competing body.
9.1.3	Human Resources Department	Maintenance of list of applicable posts subject to the requirements of the Fit and Proper Persons Test. Administer the test.

9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment. Regrade employees after consultation with the Human Resources Business Partner and job evaluation has taken place.
9.2.6 – 9.2.7	Employee line manager	Notify Human Resources of any changes in employee circumstances immediately on becoming known.
9.2.8	Employee	Notify Human Resources of changes to personal details.
9.2.11	CE	Determine local contract pay rates and conditions of service and present to Nominations and Remuneration Committee for approval.
9.3.1	CFO	Final determination of pay, proper compilation of the payroll and payments made.
9.3.2	CFO	Approval for monetary payment to staff outside the payroll system.
9.3.5	CE or CFO	Approval of payment of pay in full or in part in advance of the determined pay date.
9.3.6	CFO	Agreement to and management of external provider payroll contract.
9.3.8 – 9.3.9	Managers and employees	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.
10.1.1	CE	Determine level of delegation of non-pay expenditure to budget managers.
10.2.1	CE	Set out the list of managers and their limits for requisitioning goods and services.
10.2.1	Table in SFI Annex 1	Delegated authorisation limits for requisitioning of goods and services.
10.3.7	CFO	Prompt payment of accounts and claims.
10.3.8	CFO	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.
10.3.9	CFO	Approval of prepayments where financial advantages outweigh disadvantages.
10.3.10	CFO	Authorise requisitions/orders for which there is no budget provision.
10.4	CFO	Ensure procedures and systems are in place to account correctly for VAT including payment and recovery.

10.5	CFO	Determine form of petty cash records and issue instructions re petty cash purchases.
11.1.3	CFO	Approve use of loan or overdraft facilities approved by the Board.
11.1.4	CFO	Authorise short term borrowing in excess of one month.
11.1.6 – 11.1.7	CFO	Prepare instructions concerning applications for loans and borrowing and report borrowing to the Board.
11.2.2	CFO	Apply for increase in Public Dividend Capital or nominate representative to make application. Report to Board
11.3.5 – 11.3.6	CFO	Advise Board on investments and ensure that policies and procedures are drawn up for the operation and maintenance of investment accounts.
11.3.7	CFO	Authorise all investment transactions ensuring compliance with “Treasury Management Policy” or delegate responsibility to nominated senior finance manager
12.1	Capital Programme Board (CPB)	Oversee allocation of capital investment; approve capital and revenue business cases and report financial performance of capital programme to Board.
12.1	CFO	Chair CPB and ensure that there is an adequate appraisal and approval process in place for determining expenditure priorities. Oversee development and monitoring of annual capital plan, establish systems to ensure schemes are progressed and budgets and cash flows monitored and approve in year virements
12.2.3	Table 1 in 12.2.3	Delegated limits for approval of capital only business cases
12.2.3	Table 2 in 12.2.3	Delegated limits for approval of revenue only or combination of revenue and capital business cases
12.2.4	CE or CFO	Approve expenditure incurred on a scheme in advance of approval through the business case process.
12.4.1	CE	Maintain registers of assets.
12.4.5	CFO	Approve procedures for reconciling fixed asset accounts in the general ledger to the fixed asset register.
12.4.7	CFO	Prepare procedural instructions on the disposal of assets.
12.5.1	CE	Control and security of assets.

12.5.2	CFO	Approve asset control procedures and manage process.
12.6.3	CE	Approve property purchases, licences and leases up to £250,000 each (excluding VAT)
13.1.3	CFO	Establish systems of control for Inventory Stores and Inventory
13.1.3	ADFP	Control of Inventory Stores and Inventory subject to above. Responsibility may be delegated subject to being entered in a record available to the CFO
13.1.3	Designated Pharmaceutical Officer	Control of pharmaceutical stocks.
13.1.3	Designated Estates Manager	Control of fuel oil stocks.
14.1.1	CFO	Prepare detailed procedures for the disposal of assets including capital assets and condemnations.
14.1.5	CE	Approve disposal of assets valued at over £100,000
14.2	CFO	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments and maintain a register. Prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments. Report all losses and special payments to Audit and Risk Committee
15.1.1	CE and Chief Information Officer	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, having regard to the General Data Protection Regulation framework; ensure adequate controls over data entry, processing, storage etc.
15.1.4 – 15.1.5	CFO	Ensure that financial systems are appropriately procured, tested and that adequate controls are in place.
16.1.1	Responsible Director	Maintain a "Freedom of Information Publication Scheme"
16.1.2	Responsible Manager	Notify the Responsible Director of any new documents to be included in a Publication Scheme .
17.1.2	CE	Inform patients or their guardians that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises.
17.1.3	CFO	Arrangements for the administration of patient property.

18.1	CE	Ensure all staff, volunteers and persons associated with the Trust are aware of and comply with the Trust's "Conflicts of Interest and Anti-Bribery Policy".
18.1	Company Secretary	Maintain register of declarations of interest and hospitality under the Trust's "Conflicts of Interest and Anti-Bribery Policy".
19.1	Chief Executive	Maintain archives for all records, information and data required to be retained in accordance with current guidance.
19.2	Table in 19.2	Delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, and maintenance of a register.
20.1.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and processes and that these are monitored.
20.2.1	CFO	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	Company Secretary	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3.1	Chief Nurse	Provide a central point of contact within the Trust for NHS Resolution /CNST issues and report activity to Board.
21.1.2	CEO and Board	Approve litigation payments against legal advice.
22.1	CE	Approve all employment tribunal settlement agreements.
22.2	CFO	Approve employment tribunal settlement agreements in excess of contractual entitlement.
22.3	Table in 22.3	Approval limits for out of court settlements of employment tribunal applications.
22.4	CFO	Submit business case to Treasury for compromise agreements.
25.1	CFO	Approve submission of applications for grant funding.

7 OTHER ISSUES TO BE DELEGATED

7.1 Matters not covered by SFIs or SOs

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 officer. These are:

Area of Responsibility	Overall Responsibility
Information governance including: • Information Governance Statement of Compliance (IGSoC) • General Data Protection Regulation framework requirement	Chief Information Officer and Head of Information Governance
Health and safety arrangements	Chief Nurse
Caldicott Guardian	Medical Director(delegated to Deputy Medical Director, Women's and Children')
Corporate governance	Chief Executive and Chief Financial Officer
Clinical governance	Medical Director
Accountable officer for controlled drugs	Medical Director
North West London Pathology (NWLP) – Joint Operation	Chief Executive and Chief Financial Officer
Systems Powering Healthcare Limited (Sphere) – Joint Venture	Chief Executive and Chief Financial Officer
Named responsible officer (various)	See separate register (to be prepared and maintained by Company Secretary)
Hosted bodies (various organisations and arrangements)	See separate register (to be prepared and maintained by Company Secretary)

7.2 Schedule of Budgetary Responsibility

This Scheme of Delegation covers only matters delegated by the Board and certain other specific matters referred to in the Constitution, SOs and SFIs. Each Divisional Medical Director and Divisional Director is responsible for delegation in their division and 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.

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.

8.1 FINANCIAL CONTROL

8.1.1 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.

8.1.2 BACS payments transmission

BACS payments transmission of approved invoices is prepared by Accounts Payable and approved in line with schedule 8.1.1 above.

BACS payments transmission of salaries is prepared and authorised by the outsourced payroll provider.

8.1.3 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.

8.1.4 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.

9.1 HUMAN RESOURCES

9.1.1 Engagement of Staff on the Establishment

Authority to fill funded post on the Establishment with permanent staff	Refer to Establishment Vacancy Panel Guidance

9.1.2 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).

9.1.2 Additional Staff to the agreed Establishment

With specifically allocated finance	General Manager/Chief Financial Officer/
Without specifically allocated finance	Chief Executive or Chief Financial Officer

9.1.3 Fixed Term Contracts

Authorisation or renewal of fixed term contracts	Trust Establishment Panel

9.1.4 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

9.1.5 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

9.1.6 Bereavement Leave

Up to 6 days on full pay	*Line / General Manager

*With guidance from Human Resources

9.1.7 Special Leave

Dependents leave	*Line / General Manager

*With guidance from Human Resources

9.1.8 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

9.1.11 Sick leave

Extension of sick leave on half pay up to three months	General Manager and Chief Financial Officer and 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 andor Chief Executive

9.1.12 Study leave

Study leave	General Manager

9.1.13 Redundancy

Redundancy	General Manager and HR Business Partner

9.1.14 Ill Health Retirement

Decision to pursue retirement on the grounds of ill health	Line Manager with Occupational Health and HR Support

9.1.15 Dismissal

Dismissal	Dismissing Officers

9.1.16 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

9.1.17 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

9.1.18 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	Chief Operating Officer
• Estimated sale proceeds over £5,000	Chief Operating Officer / Chief

Financial Officer