Chelsea and Westminster Hospital NHS
NHS Foundation Trust

25 October 2013

Dear Colleagues,

Board of Directors Meeting (PUBLIC)
Thursday, 31 October 2013

Dear Colleagues,

Please find enclosed the Agenda and Papers for the next week's meeting which will be held at 4pm in the Hospital Boardroom.

Please note that the following papers have been 'starred' and will not be discussed unless an advance request is made to the Chairman:

- 3.5 Shaping a Healthier Future Programme Initiation Document*
- 3.7 Register of Seals Report Q2*

Please note that light refreshments will be provided from 3.30pm in the Atrium area.

Yours sincerely,

Vida Djelic
Board Governance Manager

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Chair: Professor Sir Christopher Edwards
Date: Thursday, 31 October 2013 Time: 4.00pm

Agenda

Ref	Item	Lead	Time
1	**GENERAL BUSINESS**		**4.00pm**
1.1	Welcome and Apologies for Absence	CE	
1.2	Declaration of Interests	CE	
1.3	Draft Minutes of the Meeting of the Board of Directors held on 25 July 2013	CE	
1.4	Matters arising	CE	
1.5	Chairman's Report (oral)	CE	
1.6	Chief Executive's Report	APB	
1.7	Council of Governors Report including Membership Report	CE	
2	**PERFORMANCE**		
2.1	Finance Report Commentary – September 2013	LB	
2.2	Performance Report Commentary – September 2013	DR	
2.2.1	A&E/Emergency Care and Winter Plans		
3	**ITEMS FOR DECISION/APPROVAL**		
	QUALITY		
3.1	Assurance Committee Report – July and September 2013	KN	
3.2	Infection Control Annual Report	EM	
3.3	Response to the Francis and Keogh Reports	EM	
	STRATEGY		
3.4	Strategy Update (oral)	APB	
3.5	Shaping a Healthier Future Programme Initiation Document*	DR	
	GOVERNANCE		
3.6	Monitor In-Year Reporting & Monitoring Report Q2	LB	
3.7	Register of Seals Report Q2*	FH	
3.8	Risk Report Q2	EM	
3.9	Health and Safety Policy 2013-14	EM	
3.10	GMC Responsible Officer appointment	APB	
3.11	Donor Recognition	APB	
4	**ITEMS FOR INFORMATION**		
4.1	Audit Committee Minutes – 10 July 2013	JB	
5	**ANY OTHER BUSINESS**		
6	**QUESTIONS FROM THE PUBLIC**		
7	**DATE OF NEXT MEETING – 30 January 2014**		
	CLOSE	**5.30pm**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	1.3/Oct/13
PAPER	Draft Minutes of the Meeting of the Board of Directors held on 25 July 2013
AUTHOR	Fleur Hansen, Interim Director of Corporate Affairs and Company Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	To provide a record of the decisions and actions discussed at a meeting.
LINK TO OBJECTIVES	Links to strategic direction/patient experience.
RISK ISSUES	None in addition to those included in report.
FINANCIAL ISSUES	None in addition to those identified in relevant papers.
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines a record of proceedings of the meeting of the Board of Directors on 25 July 2013.
DECISION/ ACTION	1. The meeting is asked to agree the minutes as a correct record of proceedings 2. The Chairman is asked to sign the agreed minutes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 25 July 2013 PUBLIC
Draft Minutes

Time: 4.00pm
Location: Chelsea and Westminster Hospital NHS Foundation Trust – Hospital Boardroom

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Sir John Baker	JB	
	Jeremy Loyd	JL	
	Prof Richard Kitney	RK	
	Sir Geoffrey Mulcahy	GM	
Executive Directors			
	Tony Bell	APB	Chief Executive
	Lorraine Bewes	LB	Chief Finance Officer
	Zoe Penn	ZP	Medical Director
	Tony Pritchard	TP	Acting Chief Nurse
	David Radbourne	DR	Chief Operating Officer
In attendance	Fleur Hansen	FH	Interim Director of Corporate Affairs/Company Secretary
	Mark Gammage	MG	Director of Human Resources
	Cathy Mooney	CM	Director of Quality and Assurance
	Rakesh Patel	RP	Director of Finance
	Elizabeth McManus	EM	Director of Nursing and Quality Designate
	Susan Young	SY	Director of Human Resources and Organisational Development Designate

1.1 Welcome and Apologies for Absence **CE**

CE welcomed the members of the public to the meeting.

CE welcomed Tom Hayhoe, Chair of West Middlesex University Hospital to the meeting.

CE welcomed Susan Young Director of HR and OD designate, Elizabeth McManus, Director of Nursing and Quality designate and Rakesh Patel who has been appointed as Director of Finance.

CE noted Cathy Mooney's new role as Director of Quality Assurance and Fleur Hansen's new role as Interim Director of Corporate Affairs/Company Secretary.

Apologies were received from Karin Norman.

CE noted that GM had to leave at 5pm.

1.2 Chairman's Introduction **CE**

1.3 Declaration of Interests **CE**

There were no declarations of interest.

1.4 Draft Minutes of the Meeting of the Board of Directors held on 28 May 2013 **CE**

Minutes of the previous meeting were accepted as a true and accurate record of the meeting.

1.5 Matters Arising **CE**

Ref 1.5/May/13 – CE noted that the key was ensuring staff knew what training they were expected to undertake. Key actions: new poster produced, personal learning stems going to each member of staff identifying what training they need to undertake and reports going to managers monthly.

Ref 2.2/May/13 – CE noted that access was the focus for this meeting's performance report.

1.6 Chairman's Report **CE**

CE said there were no particular issues he wanted to highlight.

1.7 Chief Executive's Report **APB**

APB highlighted the following items from his report:

Accountable Care Organisation (ACO): The Trust is committed to taking this model forward and ensuring joint responsible for a population's health with recognition that the current model is broken.

Keogh Report: The executive are analysing this and will report back to the October Board.
Analysis of Keogh Report to be brought back to the October meeting. **TP/EM**

Shaping a Healthier Future (SaHF): APB noted all CEOs had been asked to give evidence to the Independent RP wanted to know what preparation had been made and what the associated risks were from SaHF. APB had highlighted risks related to the failure of the out of hospital strategy and the future use of Charing Cross site. Re the visit, APB said a presentation was given on the redevelopment plans and the Independent Review Panel (IRP) were clearly very impressed with their reception and warmth of staff they met.

Liverpool Care Pathway (LCP): JB expressed concern regarding the removal of LCP and what will be our own paperwork and process for communicating with patients and their families. APB said Dr Sarah Cox was leading a review of our end of life care and had received non-recurrent funding through Directors Den to lead this work.

Royal Brompton Hospital: CE and APB have met with Chair and CEO to discuss joint venture for paediatrics, Rob Hodgkiss, Divisional Director of Operations is leading the project team and APB, LB and DR are looking at the governance issues.

Private Patients: APB said a strategy been taken forward and interviewing for the Commercial Director tomorrow. Amanda Grantham is currently leading for the Trust and will also be appointing clinical and nursing leads.

1.8 Council of Governors Report **CE**

It was noted that terms of office for CE and KN were extended for a further year. The Nominations Committee will be taking the recruitment process for Chair and two Non-executive Directors and had an initial meeting today to review head-hunters and have shortlisted two firms.

Regarding the Francis Report, listening events have been held and membership movements noted.

2.1 Finance Report – June 2013 **LB**

Report is for month 3 and LB noted remain £1.4m behind plan. Key issues:

- identification and achievement of Cost Improvement Programme (CIP)
- areas behind plan on income but noted elective income on plan

The forecast is currently for a £7m adverse variance which is a £2m surplus which would be a Monitor risk rating of 3.

A Trust wide recovery plan has been initiated with formal plans requested from all areas which would bring back the adverse variance to £3m of which half is ensuring get back on plan. There is particular focus on agency spend and a full recovery plan will be operational from the beginning of August. LB said we will also need to review reserves for developments. Noted also the cash variance – £11m behind plan of which the majority is due to NHS debtors due to transfer of services from non-specialist to specialist commissioning – LB said an agreement has now been reached for this. The second element of cash variance relates to monies transferred to local authorities for sexual health and that issues of principle will be escalated to NHSE, specifically related to the CQUIN with agreement being reached though related to cash payments.

RP added we are testing the robustness for delivery of divisions plans and also ensuring these have been quality assessed. By the end of August RP said he would hope to be back in balance but if not will need a more granular approach to taking costs out.

CE asked for an update on clinical coding. ZP detailed the process for clinical coding and noted the key is ensuring coders are physically as close as possible to where procedures are taking place to capture all the elements to ensure we are receiving all the funds we are entitled to. ZP said we have piloted having clinical coders in paediatric theatres and will look to roll out further.

GM noted concern regarding forward projections and planning for future years if this is now the environment. Noted ongoing population and demographic issues but unique issues this year resulting from transition which you would anticipate would be resolved in future years. Also noted sea change in the system and we need to find new ways of organising incentives hence our move to different models of care.

JL asked of the variance, what proportion is income shortfall and what is cost

overrun? RP said it was about a 50/50 split. JB said in this context, an area for concern is OP diagnostic imaging which we have recently invested in due to the planning error resulting from radiology being unbundled from the outpatient tariff resulting in a £500k one off hit.

JL said this position should focus attention on building non-NHS income and the fact that improving this could have a significant impact.

2.2 Performance Report – June 2013 **DR**

DR said that the report continues to evolve and from this month included more trend information and granularity of CQUINs. Noted also addition of the Shaping a Healthier Future slide on p.6 which is work in progress.

DR noted that the Q1 CQUIN was only £3k short of being achieved, that the Trust continues to be compliant with Monitor targets and that the excellent A&E performance continues.

The Board commended the continued excellent A&E performance especially given the constraints of the physical environment. It also noted no additional C. difficile or MRSA cases which is very positive and that the continued revisions of report were making it more useful.

JL noted unacceptable length of Board papers. FH will be reviewing content more closely in the future. Also noted the importance of Health and Safety.
Health and Safety traffic light to be added to front page of the Performance Report. **DR**

Noted that re-booking of outpatient appointments drive cancellation rates so ensuring waits are reduced is very important. DR noted looking at different systems for booking and also ensuring our processes such as cancellation of clinics are adhered to. Suggested looking at increasing notice time for consultant leave. Online booking system has also gone live allowing patients to book their appointments. Is there a potential issue of culture of not respecting agreement for appointment if Trust is re-booking frequently. Increasing numbers of consultant led clinics should help in reduction of cancelled clinics.

Lack of meeting 12 hr consultant assessment highlighted – noted there has been recording issue which has been addressed.

3.1 Patient Experience - Patient Story (video) **TP**

Noted patient's husband needed to go to Charing Cross as they are the HASU but clearly communication issue when transferred from Charing Cross back to C&W for continued care. There was also the issue of ensuring there are sufficient chairs for visitors. **DR to follow up with David Butcher.** **DR**

3.2 Francis Report Update **TP**

TP noted that the Council of Governors were informed at the May meeting that listening exercises were being conducted. These were very positively received and themes are being collated which will be linked back to the recommendations. It was noted that some recommendations will be considered nationally but we will be reviewing all of them. The next steps for the action plan were noted.

Responsibility for taking these recommendations forward sits jointly with the

Board and Council of Governors and the Council of Governors has a key role in being the eyes and ears of the organisation.

JL queried the college's view on the year's HCA work for nurses in training. EM said it was being reviewed by a number of organisations but general consensus that it is not helpful and that it was more important to ensure we have the right training in place locally. EM also said compassion is and should be core part of training instead of adding an additional HCA year to the training programme. Noted that at C&W training is monitored by an onsite clinical tutor with very clear mentorship for HCAs.

3.3 Assurance Committee Annual Report 2012/13 **KN**

3.4 Assurance Committee Report – May & June 2013 **KN**

It was agreed to discuss 3.3 and 3.4 together. Highlights noted:

- change in process for relating to the Committee allowing people to voice concerns including top 5 report,
- the Assurance Committee is yet to be assured over mandatory training
- will need to change the way health and safety is measured and reported on

ZP's top concerns were noted as follows:

- failure to recognise and escalate deteriorating patients. NEWS system rolled out and ZP will monitor on-going performance
- senior staff on the ground over 24 hrs – noted adherence to AES standards for acute services but need to ensure for all areas
- handover monitoring – routine and acute
- delayed outpatient follow up and administrative processes for f/up results
- never events

It was noted that health & safety and mandatory training had been discussed at the closed session earlier and it had been agreed to introduce a process for identifying people who have not undergone training and there will be financial consequences for those who continue not to do so.

GM left the meeting.

It was noted that all aspects of safety should be brought under the quality agenda and will be overseen by the Director of Nursing and Quality.

3.5 Risk Management Strategy and Policy 2012/13 **CM**

This was approved.

3.6 Risk Management Annual Report 2012/13 **CM**

CM highlighted aspects of the report. Noted full reports available on request.

CE expressed a concern regarding a high number of blood related incidences. ZP said this may be due to the need to hand label blood samples which can result in handwriting errors. Process for accepting blood for cross match in a national process – SHOT committee directive. Also noted that 60% comes from maternity. ZP looked at whether an outlier – we are not and are in fact lower.
ZP to update CE outside the meeting. **ZP**

3.7 Complaints Annual Report 2012/13 **TP**

TP highlighted aspects of the report and the top three subject areas for types of complaints. Noted changes in practice resulting from complaints and that all complaints are reviewed and signed off by TP, DR or APB with weekly meetings with the divisions to review progress having been introduced.

CE raised concern re type 3 complaints not dealt with within 50 days. TP said this is often because they are complex incidents that are awaiting further information e.g. from another trust or the outcome of an inquest.

JB said as the general process continues to improve and there is a reduction in type 2 or 3, whether we should move from risk management to a zero tolerance process? TP said would be challenging to achieve zero tolerance but that we need to change culture to early resolution to prevent escalation. Suggested to involve external senior clinical staff early in complaints. – noted each complaint is allocated a senior internal lead but should consider. Clearly need to become more patient responsive rather than process driven. It was agreed the focus should always be to admit any wrong-doing, apologise and determine how to put right.

3.8 Complaints Policy and Procedure **TP**

Noted due for review but propose to wait until national review. This was agreed.

3.9 Review Strategic Objectives, Board Assurance Framework Report and Risk Report Q1 **FH/CM**

Noted strategic objectives being reviewed and BAF will be reviewed as a result – will bring to a future meeting.

3.10 Council of Governors Quality Awards **CM**

This item was starred and therefore taken as read.

3.11 Strategy update **APB**

The update was provided under item 1.7.

3.12 Sustainable Development and Carbon Reduction **DR**

The paper was noted and DR said he was happy to discuss outside the meeting.

3.13 Workforce including E&D Report 2012/13 **MG**

MG highlighted four key points from the report:

- the need to employ a diverse workforce, particularly a younger demographic
- continuing to embed the Trust values through HR processes
- both sickness and appraisal rates have decreased
- a focus on employee relations by reviewing existing processes and their impact on BME staff in particular

The Board noted national recognition that the HR team had received in 2012/13 and the importance of our nursing staff in the success of workforce relations.

The Board of Directors noted and approved the report.

The Board noted it was MG and TP's last Board meeting and thanked them both for their commitment.

3.14 Update on Emergency Department Redevelopment **DR**

DR noted that the report encapsulates recent discussions with the Board, CCGs, Council of Governors and the Finance and Investment Committee and proposes next steps. FIC queried the revenue consequences and noted that the staffing model was being reviewed and would be reported back through the FIC.

It was noted that it is a very important development for the Trust and patients and the current configuration had not been designed for the number of patients currently being seen, in addition to the need to anticipate requirements from *Shaping a Healthier Future*.

3.15 Monitor in-Year Reporting & Monitoring Report Q1 **LB**

Q1 position as required for Monitor was noted.

Board was requested to support the commentary for submission to Monitor and approve the declaration that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months and the governance statement. This was agreed.

3.16 Register of Seal Report **CM**

This item was starred and therefore taken as read.

3.17 Assurance Committee Terms of Reference **CM**

This item was starred and therefore taken as read.

3.18 Finance and Investment Committee Terms of Reference **CE**

This item was starred and therefore taken as read.

3.19 Annual Members' Meeting Proposal **APB**

It was noted that this item was discussed at the recent meeting of the Council of Governors.

The key proposed themes were noted. The format of the meeting was also noted.

4 ITEMS FOR INFORMATION

4.1 Audit Committee Minutes – 23 May 2013 **JB**

This was noted.

5 ANY OTHER BUSINESS

JB noted following visit to maternity and frustrations re IT and ensuring the patient experience is improved via technologies such as apps. FH noted she was taking a personal interest in this and that this work would be taken forward through the Communications Team. **FH to follow up on development of an app for maternity care.** **FH**

6 QUESTIONS FROM THE PUBLIC

Question from Governor re amount of papers in the Board pack. FH responded said she will be reviewing this and looking to reduce going forward.

Question from a Governor re the increase in medicines incidents. TP responded that an IV administration group being set up to review training and process.

Question from Governor re the Keogh report suggesting it is a dispersal of quality oversight – is that the correct definition of the review? Followed up with a query related to the Francis Report and the suggestion of unannounced visits by Governors.
CE noted there will be a discussion on the role of governors at the Away Day and we have spent time exploring how Governors can visit clinical areas with a process now in place. CE was clear that Governors need to be the eyes and ears of the organisation and should transmit concerns but we cannot bring in another regime of inspection for clinical staff.

7 DATE OF NEXT MEETING – 31 October 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	1.4/Oct/13
PAPER	Matters Arising – 25 July 2013
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	To provide record of actions raised in a meeting and subsequent outcomes.
LINK TO OBJECTIVES	NA
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines matters arising from meetings of the Board of Directors held on 25 July 2013 with subsequent actions or outcomes.
DECISION/ ACTION	The Board is asked to note the actions or outcomes reported by the respective leads.

Board of Directors Meeting, 25 July 2013

Ref	Description	Lead	Subsequent Actions/Outcomes
1.7/Jul/13	**Chief Executive's Report**		
	Keogh Report: The executive are analysing this and will report back to the October Board. **Analysis of Keogh Report to be brought back to the October meeting.**	**TP/EM**	On agenda.
2.2/Jul/13	**Performance Report – June 2013**		
	Health and Safety traffic light to be added to front page of the Performance Report.	**DR**	
3.1/Jul/13	**Patient Experience - Patient Story (video)**		
	Noted patient's husband needed to go to Charing Cross as they are the HASU but clearly communication issue when transferred from Charing Cross back to C&W for continued care. There was also the issue of ensuring there are sufficient chairs for visitors. **DR to follow up with David Butcher.**	**DR**	
	Risk Management Annual Report 2012/13		
	CE expressed a concern regarding a high number of blood related incidences. **ZP to update CE outside the meeting.**	**ZP**	
5/Jul/13	**Any Other Business**		
	JB noted following visit to maternity and frustrations re IT and ensuring the patient experience is improved via technologies such as apps. FH noted she was taking a personal interest in this and that this work would be taken forward through the Communications Team. **FH to follow up on development of an app for maternity care.**	**FH**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	1.6/Oct/13
PAPER	Chief Executive's Report
AUTHOR	Tony Bell, Chief Executive
LEAD	Tony Bell, Chief Executive
PURPOSE	This paper is intended to provide an update to the Board on key issues.
LINK TO OBJECTIVES	Strategy and finance is the main corporate objective to which the paper relates.
RISK ISSUES	No
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This report updates the Board on a number of key developments and news items that have occurred since the last meeting.
DECISION/ ACTION	For information

CHIEF EXECUTIVE'S REPORT
OCTOBER 2013

1.0 Strategy Development Update

We have appointed Dr Simon Barton, Clinical Director for HIV & Sexual Health Services and dermatology, as the clinical lead for developing the concept of an ACO in our area and a Public Health Registrar, Abigail Knight, is also in place in order to help identify population health themes that could potentially be addressed by such a venture. We are holding regular meetings with GPs and social care providers where we have agreed a set of objectives and boundaries of involvement.

We will be establishing two groups to undertake detailed analysis to design options for the new clinical and business models required by an ACO.

A clinical summit to be held in December 2013, led by the Medical Director, will amongst other things further explore how we can work with health and social care partners in order to provide the right care, at the right time, to patients in a boundary less way.

2.0 Shaping a Healthier Future

The Independent Reconfiguration Panel have submitted their report into the proposed reconfiguration outlined in Shaping a Healthier Future to the Secretary of State for Health and we await his response to these findings.

3.0 West Middlesex Update

The Trust are close to completing detailed due diligence into a potential partnership with West Middlesex University Hospital NHS Trust and how the potential partnership, with the advice of our clinical and managerial teams, could deliver benefits to patients and improvements in service delivery. A decision will be made by the Board of Directors in November 2013 about whether we choose to develop an Outline Business Case, the next stage required to consider any potential partnership.

4.0 Estates update

Dean Street Express Clinic – Work commenced in September and currently on-track to be open for service at the end of this year.

Midwifery Led Unit (MLU) – Refurbishment of old Annie Zunz Ward to form a 7 Birthing Room MLU and a private (midwife-led) maternity suite for Kensington Wing - started work in September with completion due by the end of December.

Adult Burns – Refurbishment of the Burns Unit to provide better facilities, larger theatre and ITU/HDU capacity – commenced in July and due to be completed in January 2014.

Following on from a query raised by a member of the public at the Annual Members' Meeting, David Butcher, the Director of Estates and Facilities, has been looking at how we can improve access for patients and the public by opening one of the staircases. As the Board will be aware, the staircases were closed to the public following an incident in 2006.

The options, costs and any associated issues for opening all the staircases will be brought to a future meeting for discussion but in the meantime we are proceeding with opening the car park staircase for public assess. This staircase is on the left as you enter through main reception and does not pose the risks associated with the other staircases as it is entirely enclosed and obviously already used for public access to the car park. As has not been open for use for some years some refurbishment is required but should be open for public use by the end of 2013.

5.0 Care Quality Commission (CQC) inspection results

Informal feedback from the CQC following an unannounced inspection earlier this month across a range of clinical services was positive. Thanks to all staff who showcased the excellent standards of care that they provide to their patients. More feedback will be provided once the official inspection report is received.

6.0 NHS Litigation Authority (NHSLA) level 3 achievement

We are delighted to have achieved NHSLA level 3, the highest level awarded to NHS organisations. The standard was awarded after a rigorous two day assessment of our policies and processes, which are in place to manage and alleviate any clinical risk to patients, and ensuring staff are using these policies and procedures effectively.

This achievement illustrates how we work to our Trust values in providing safe, excellent, respectful and kind care to our patients.

7.0 Improving healthcare through research across North West London

The Department of Health has announced that the National Institute for Health Research (NIHR) will provide £10 million to fund the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for North West London to translate research from the lab bench to the hospital bedside over the next five years. Trusts, universities, charities and industry partners across the North West London sector will contribute a further £12 million in matched funding. We will continue to host NIHR CLAHRC and look forward to strengthening our focus on research and education over the longer term.

8.0 'Protect their future: Don't wait to vaccinate' campaign

The Trust has launched an immunisation campaign to help parents understand the importance of childhood immunisation. The month-long campaign, funded by a medical education grant from Pfizer, involves a range of road shows in locations such as Westfield Shepherd's Bush offering parents information and advice from doctors and health visitors on the facts about vaccinations for children. We'd like to thank Dr Kati Hajibagheri, Consultant Community Paediatrician and Clinical Lead for Immunisation, for her tireless work in making this campaign a reality.

9.0 Awards

We have won two prestigious national awards recognising the hospital's commitment to a healthy work-life balance for its staff. The Trust were joint winners of the Best for Childcare award and named in the Top 21 Employers for Working Families 2013 at the 2013 Working Families Awards. Chelsea and Westminster was the only NHS organisation in the Top 21 Employers category.

10. Appointments

We would like to welcome Aiden O' Neill who will join the Trust as Commercial Director on 4 November. Part of Aiden's remit will be the continued development of private patient services within the Trust with a minimum financial aim of doubling our private patient income.

11. Annual Members' Meeting

The Annual Members' Meeting, which was held in September 2013, was very well attended with those in attendance providing positive feedback about the event and associated materials. We'd like to thank all those involved in arranging the meeting and those that provided the very informative presentations on the day.

12. External meetings attended by the Chairman and CEO 19th July – 18th October

CHAIRMAN & CEO	Imperial College Health Partners Board
CEO	Hospital del Vinalopó visit to Chelsea and Westminster Hospital
CHAIRMAN & CEO	Chair and CEO from Royal Brompton and Harefield NHS Foundation Trust
CHAIRMAN & CEO	Independent Reconfiguration Panel site visit
CEO	Central & North West London NHS Foundation Trust
CEO	Managing Director of North West London Health Education
CEO	Chair of West London CCG
CEO	Association of UK University Hospitals
CHAIRMAN & CEO	Foundation Trust Network Event
CEO	Innovation Investment Fund
CEO	Kings Fund
CEO	Dr Foster Global Comparators Leadership Board

CEO	Shaping a Healthier Future Implementation Board
CEO	West Middlesex University Hospital
CHAIRMAN & CEO	Imperial College Healthcare NHS Trust
CEO	Foundation Trust Network Annual Conference
CEO	Department of Health Chief Executive Meeting

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	1.7/Oct/13
PAPER	Council of Governors Report including the Membership Report
AUTHOR	Vida Djelic, Board Governance Manager Sian Nelson, Membership Manager
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	Part A – provides highlights of the Council of Governors meeting held on 19 September 2013. Part B – updates the Board on its membership numbers and engagement activities.
LINK TO OBJECTIVES	
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper highlights the most important issues discussed at the Council of Governors held on 19 September 2013 and reports on the membership numbers for the Trust.
DECISION/ ACTION	To note.

Part A

Council of Governors Report

The Trust held the Council of Governors meeting on 19 September 2013.

1.0 Chief Executive's Report

Governors noted the key points in the Chief Executive's report. The highlights include:

- Shaping a Healthier Future update
- West Middlesex Hospital update
- Royal Brompton Hospital update
- Estates update

2.0 Feedback from Board

Governors received an update on the Accountable Care Organisation model from Geoff Mulcahy.

3.0 Council of Governors Standing Orders – Report of the Task and Finish group (attached)

Governors agreed proposed draft Standing Orders. It was noted that once the constitution has been revised the Standing Orders will be attached to it as an annex.

4.0 Update on election of a new governor

Governors unanimously agreed that Dr Andrew Lomas fills the vacant patient seat.

5.0 Nominations Committee update

An update on the recruitment process and the progress with selecting recruitment firm to facilitate the selection of a Non-executive Director and Chairman was noted. It was confirmed that Saxton Bampfylde was selected by the Nominations Committee following on a competitive procurement process.

6.0 Membership engagement and communication update

The preparation with forthcoming elections to Council of Governors was noted.

7.0 Membership report

It was noted that going forward CCGs would be asking trusts to provide data for a number of different components of the diversity agenda, including sexual orientation and religious belief in order to comply with the Equality act 2010. It was noted that the Trust will have to update the membership application form accordingly.

Part B

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the financial year of 2012/13 and activity for Q1 and Q2 2013/14.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 12 – 31 Mar 13	Current Situation 30 September 13
As at start	**14,858**	**15,268**
New Members	1,811	413
Members leaving or changing constituency	1,401	285
TOTAL	**15,268**	**15,396**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 September 13**
As at start	**5,942**	**5,850**
New Members	225	81
Members leaving or changing constituency	317	152
TOTAL	**5,850**	**5,779**
PATIENT MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 September 13**
As at start	**5,685**	**5,994**
New Members	573	331
Members leaving or changing constituency	264	128
TOTAL	**5,994**	**6,197**
STAFF MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Current Situation 30 September 13**
As at start	**3,231**	**3,424**
New Members	1,013	1
Members leaving or changing constituency	820	5
TOTAL	**3,424**	**3,420**

2.0 Membership Joiners and Leavers April to September 2013

Between April and September 2013 – Quarter Two (Q2), there were 285 members who left and 413 who joined membership. This results in a surplus of 128 new members.

Membership numbers are broken down (below) to reflect patient, public and staff membership representation.

Start Period	01/04/2013	01/05/2013	01/06/2013	01/07/2013	01/08/2012	31/08/2012
End Period	30/04/2013	31/05/2013	30/06/2013	31/07/2012	30/08/2012	30/09/2012

Totals	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Period Start	**15,268**	**15,087**	**15,424**	**15,438**	**15,429**	**15,415**
Joiners	10	356	26	10	3	8
Leavers	191	19	12	19	17	27
Period End	**15,087**	**15,424**	**15,438**	**15,429**	**15,415**	**15,396**

Public	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Period Start	**5,850**	**5,749**	**5,799**	**5,799**	**5,799**	**5,795**
Joiners	3	57	11	3	3	4
Leavers	104	7	11	3	7	20
Period End	**5,749**	**5,799**	**5,799**	**5,799**	**5,795**	**5,779**

Patient	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Period Start	**5,994**	**5,914**	**6,204**	**6,219**	**6,210**	**6,200**
Joiners	7	298	15	7	0	4
Leavers	87	8	0	16	10	7
Period End	**5,914**	**6,204**	**6,219**	**6,210**	**6,200**	**6,197**

Staff	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
Period Start	**3,424**	**3,424**	**3,421**	**3,420**	**3,420**	**3,420**
Joiners	0	1	0	0	0	0
Leavers	0	4	1	0	0	0
Period End	**3,424**	**3,421**	**3,420**	**3,420**	**3,420**	**3,420**

3.0 Public Membership Ethnicity

Figure 1 shows public membership ethnicity. At the end of Quarter 2, 2013/14, the highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

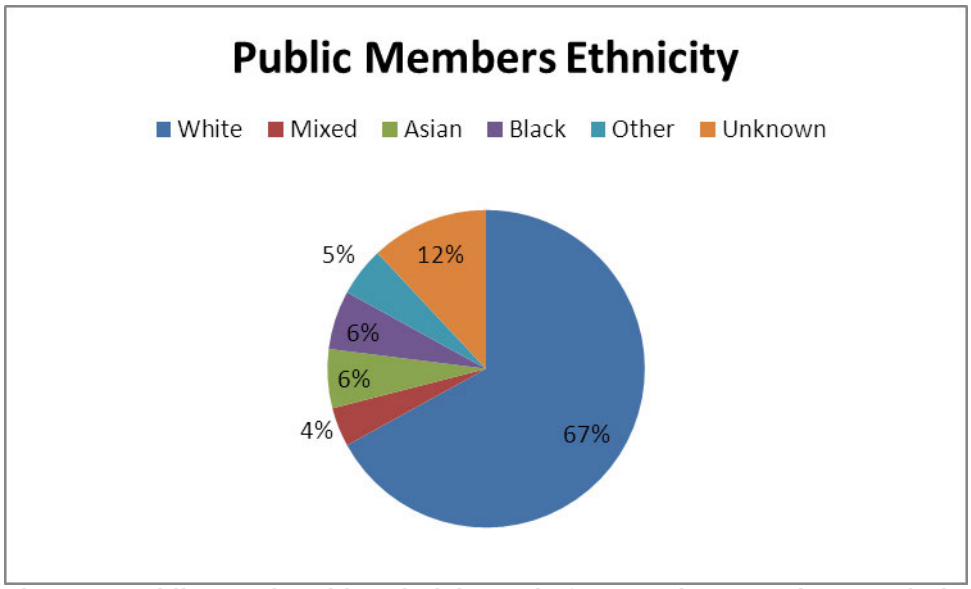


Figure 1. Public Membership Ethnicity end of September 2013 (Q2 2013/14)

3.1. Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Here representation is highest in the White population, and lowest in the Black and Asian population.

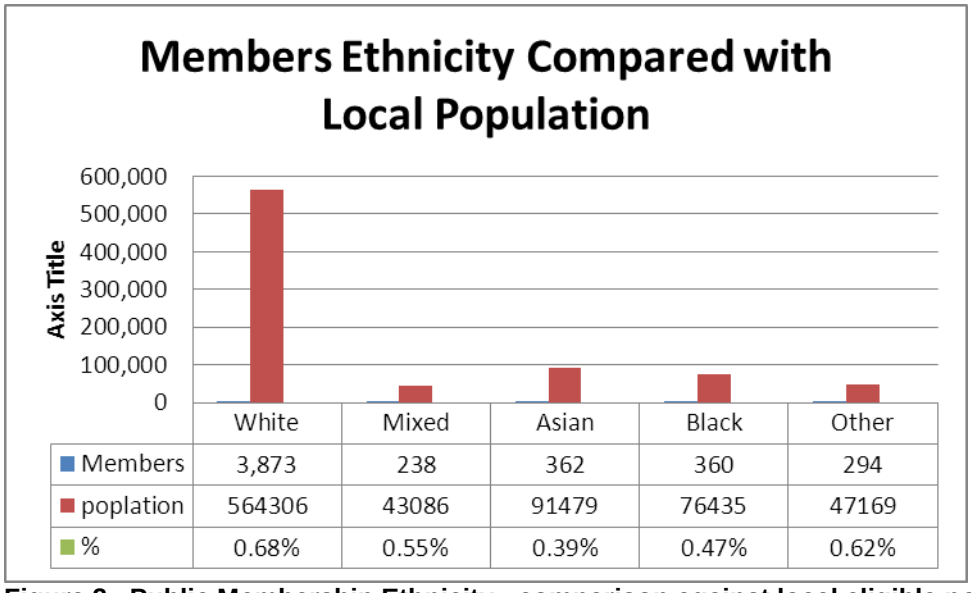
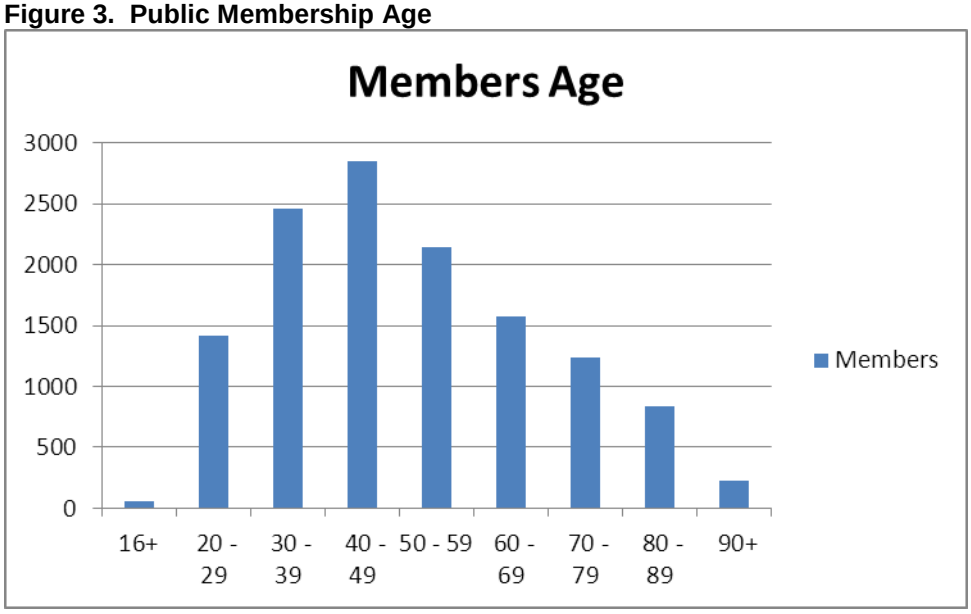


Figure 2. Public Membership Ethnicity - comparison against local eligible population. End of September 2013 (Q2 2013/14).

4.0 Public Membership Age

Figure 3 shows a profile of public membership by age. Public membership representation peaks at age group 40-49 years whereas the lowest age group is those within the 16-19 age group.

Figure 3. Public Membership Age



5.0 Public Membership - Socio-economic grouping

Figure 4. below shows public membership by socio-economic groups. At end of September 2013 (Q2 2013/14) the highest representation remains in the ABC1 category* followed by category E*. There is no representation in the other categories.

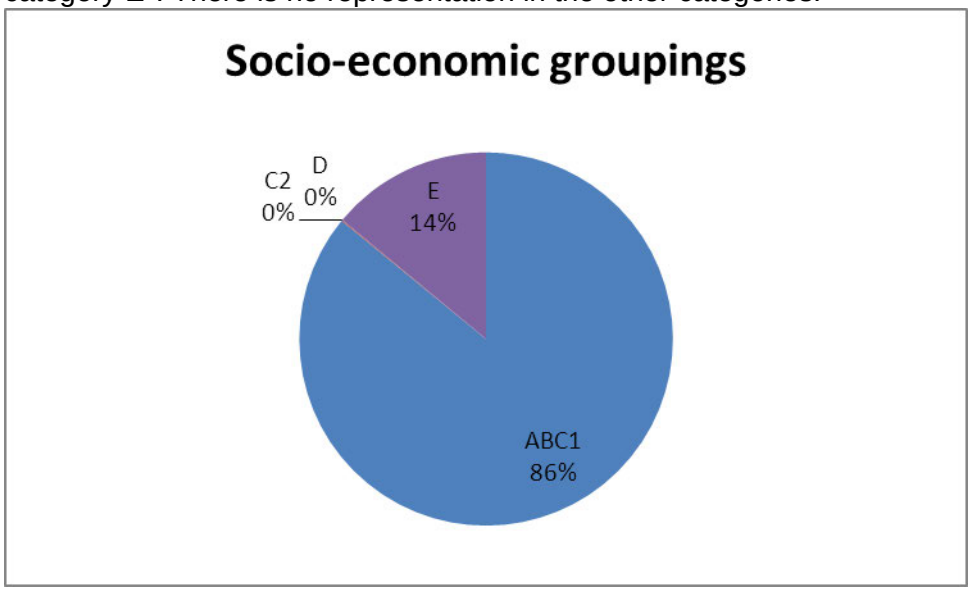


Figure 4 Public Membership- Socio-Economic Groups*

*Social economic grade: A-upper middle class (higher managerial, administrative or professional occupation, B-middle class (intermediate managerial, administrative or professional occupation), C1-lower middle class (supervisory or clerical, junior managerial, administrative or professional occupation), C2-skilled working class (skilled manual workers), D-working class (semi and unskilled manual workers) and E-those at the lowest level of sustenance (state pensioners or widows (no other earner), casual or lowest grade workers).

6.0 Membership Recruitment

Between April and September 2013 – Quarter Two (Q2), there were 285 members who left and 413 who joined membership. This results in a surplus of 128 new members.
This was achieved by a combination of recruitment activities from the Governors who recruited at Open Day and 'Meet a Governor' session and a recruitment campaign outsourced to Capita recruitment services.
A data cleanse is performed each quarter by Capita recruitment before member mailing which removes those not at the same address or who have been registered deceased. In addition Capita is notified monthly for requests of members' removal from the database

6.1. The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership recruitment strategy. Recruitment activity is focused on both maintaining our membership numbers whilst also enabling a diverse and representative membership.

6.3. Governors continue to host 'Meet a Governor' session at the Ground floor Information Zone. Patients, public, staff and members have the opportunity to meet a Governor to discuss issues important to them. This is publicised on the Trust website, and a banner positioned at the hospital's main entrance.

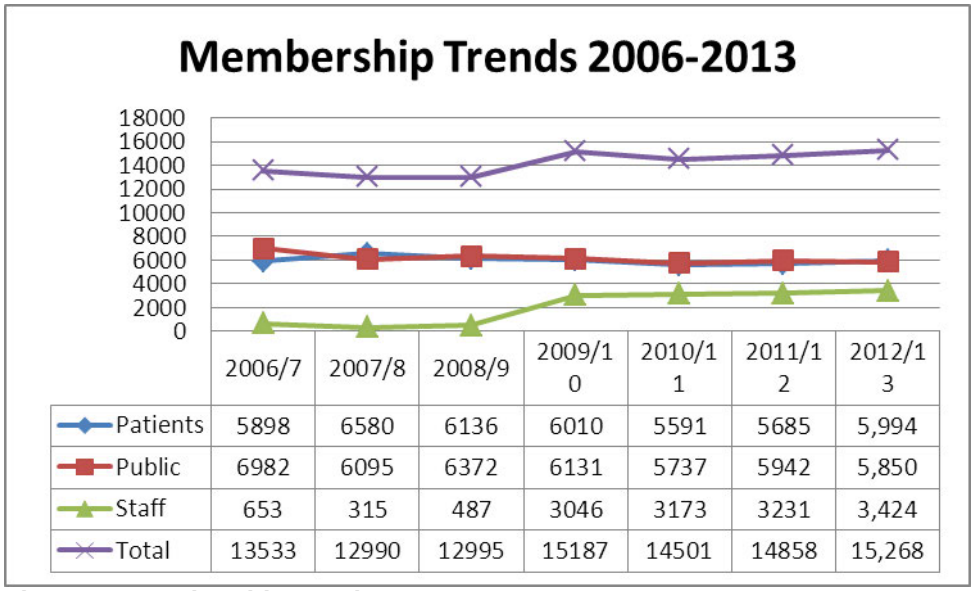
6.4. The Patient Advice and Information Service support membership promotion. Visitors to the PALS office, when appropriate are offered a membership application form. Application forms are sent with patient response letters and the team will continue to actively promote membership.

6.5. The Communications team concentrate on Membership engagement and a plan for membership events has been agreed for 2013/14.

6.6. Membership recruitment campaigns are planned for 2013/14 – the first took place in May 2013, including Open Day and we exceeded the aim to recruit 300 new members (total 355). The second began 15th October – this campaign aims to recruit 200 patients whilst promoting the Governor November Elections. The recruiters are encouraging a diverse range of patients and public residents to nominate oneself as a Governor.

6.7. It is important to recruit throughout the year to ensure membership numbers are maintained. We aim to recruit 900 new members throughout 2013/14.

6.8. Figure 6 shows the trends in Trust membership from 2006-2013.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Patients	5898	6580	6136	6010	5591	5685	5,994
Public	6982	6095	6372	6131	5737	5942	5,850
Staff	653	315	487	3046	3173	3231	3,424
Total	13533	12990	12995	15187	14501	14858	15,268

Figure 6. Membership trends 2006-2013

7.0 Developing a Representative Membership

7.1 Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

7.2 To create equal representation, It is recognised that membership recruitment should focus on recruitment and engagement with Black, Ethnic and Minority groups. Our recruitment strategy will continue to focus on activities which can encourage wider representation within our membership.

7.3 Table 3.1 highlights that although trust membership figures are higher in the white category; ethnic groups are more balanced when compared to the local eligible population.

A proposal, which is supported by Healthwatch will be discussed at the October Membership Sub-Committee. The proposal outlines plans for a listening and learning event – the key objective will be to give patients and local people the opportunity to inform the trust of any issues that affect their patient experience. The event will focus on Black Minority Ethnic Groups and concentrate on the more deprived socio-economic groups in our local communities.

8.0 Summary

8.1 The hospital gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13, 533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.

8.2 We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we have introduced initiatives such as 'Medicine for members' to actively encourage the engagement of members in the work of our hospital.

9.0 Membership Recruitment 2013/14

The below table summarises key recruitment events scheduled for 2013/14

Month	Event	Total Recruited	Report	Funds Approved
May 2013	Members Recruitment Campaign Promotion for Open Day May 2013 And Governor Elections	300 members Achieved	Q1 2013/14	£2,340
September 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	Aim – 150 members	Q2 2013/14	£1170
October 2013	Members Recruitment Campaign and promotion of Governor Elections (Inc. within the community)	Aim – 150 members	Q3 2013/14	£1170

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

STANDING ORDERS FOR PROCEEDINGS AT MEETINGS OF THE COUNCIL OF GOVERNORS

DRAFT 20.08.13

Agenda

1.1 Meetings of the Council of Governors properly convened under clause 11.16.2 of the constitution shall be notified to all Governors at least fourteen days in advance. The notice shall include an agenda specifying the business to be conducted at the meeting. No other business may be conducted at the meeting except at the discretion of the chairman.

1.2 The Agenda Sub-committee of the Council of Governors shall meet with the chairman and chief executive of the Trust to agree the terms of the agenda before it is sent out.

1.3 Individual items on the agenda should be described briefly and clearly. A notional time for dealing with each item should be indicated in the margin, to assist in the timely conduct of the meeting which should not last more than two hours in total. For the same reason items should be listed in two groups, those requiring discussion and decision and those which are for information only.

Chairmanship

2.1 In accordance with s12 of Schedule 7 to the National Health Service Act 2006 the Chairman of the Trust shall chair any meeting of the Council of Governors properly convened under clause 11.16.2 of the constitution. If he is unable or unwilling to do so the Deputy Chairman of the Council shall chair the meeting. If he is also unable or unwilling, the Governors present at the meeting shall appoint one of their number to chair the meeting.

Quorum

3.1 A meeting will only proceed to business if a quorum is present within fifteen minutes of the time fixed for the start of the meeting. A quorum shall consist of ten Governors including not fewer than four public and/or patient Governors, not fewer than one Staff Governor, and not fewer than two appointed Governors. If a quorum ceases to be present during the meeting so that no decisions can be taken the chairman must adjourn the meeting to the same day in two weeks' time.

3.2 If no quorum is present within half an hour of the time fixed for the adjourned meeting, the number of Governors present shall be the quorum.

Presentation of papers

4.1 Wherever possible papers for a meeting should be sent out with the notice and agenda. They may be prepared by Trust staff or Governors. If the paper is for discussion and/or decision, not simply for information, the author should give a brief introduction, not repeating the content of the paper. The author should not contribute further to the discussion until the end, when a response may be required to points made in the discussion.

Form of debate

5.1 Anyone wishing to speak should raise their hand and will be called by the chairman. Their contribution should be brief and to the point, avoiding personal reminiscences. They should not be interrupted except by the chairman if they speak for too long or off the point, when he should call them to order.

5.2 Whilst a person is speaking others present must not make a running commentary on their remarks or hold private conversations. In the case of persistent disregard of the authority of the chair in this respect the offender should be required to leave the meeting.

5.3 If a Governor believes that a speech is contrary to the provisions of these Standing Orders he or she may stand and declare "Point of Order". Discussion shall then immediately stop, whilst the objector explains the objection and the chairman gives his ruling. *See also* **Procedural Motions** *below.*

Ordinary Motions

6.1 All motions should be submitted to the Agenda Sub-committee in writing by the mover and seconded by another Governor.

6.2 A motion:

(a) should begin with the word *That* and be generally affirmative and not negative in form.

(b) must be within the powers of the meeting.

6.3 Amendments to motions can be moved without previous notice provided they are seconded by another Governor, they are relevant to the motion, within the scope of the agenda, and do not involve such a substantial alteration of the motion as to make it a new motion. No-one can move more than one amendment to a single motion.

Procedural motions

7.1 The discussion of an ordinary motion which has been properly proposed and seconded may be interrupted by any one of the following procedural motions, no notice of which is required, need not be in writing, and need not be seconded:

(a) to proceed to next business

(b) to move the closure

(c) to adjourn the debate.

7.2 A "next business" motion if carried has the effect of getting rid of the substantive ordinary motion under discussion without putting it to the vote: If carried, the meeting will proceed to the next item on the agenda. It does not prevent the ordinary motion being proposed again at the next meeting.

7.3 A "closure" motion takes the form "That the question be now put". If carried, the ordinary motion under discussion must be put to the vote immediately.

7.4 A motion to adjourn may be appropriate where discussion has become heated. The adjournment may be to later in the same meeting or to a future meeting. The mover of the original motion is allowed a right of reply to this motion but no further debate is permitted. If the procedural motion is successfully carried the proposer shall have the right to re-open the debate when it is resumed after the adjournment.

Decisions

8.1 Decisions shall normally be reached by simple majority on a show of hands by the Governors present. If the chairman rules that the result is too close to determine there may be a second show of hands. In the case of an equality of votes the chairman shall have a casting vote. The chairman or any other member of the Council may require a written poll of the Governors present. Such a demand must be made immediately after the determination of the show of hands.

8.2 No decision shall be valid if it is opposed by all the Public Governors present.

8.3 Approval of a proposal which requires funding by the Council of Governors shall be dependent on an ordinary motion to approve the expenditure, tabled in accordance with section 5.1 of these Standing Orders.

Minutes of meetings

9.1 The minutes of a meeting must record the decisions taken and the precise wording of any motions considered or passed. There may need to be an explanation of the reasoning for some decisions, but if so it should be brief and concise. The aim should be that a member who was absent from the meeting can fully understand what was done at it.

9.2 Minutes should be circulated as soon as possible after the meeting to which they relate and in any case within 14 days.

9.3 Minutes should record accurately whatever was decided at the meeting, be approved at the next following meeting, and be signed by the chairman after corrections of any inaccuracy are made.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	2.1/Oct/13
PAPER	Finance Report Month 6 – September 2013
AUTHOR	Carol McLaughlin, Financial Controller
LEAD	Rakesh Patel, Director of Finance
PURPOSE	To report the financial performance for September 2013.
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
RISK ISSUES	Risk of Trust not delivering financial plan. Risk Rating: Impact 4 – Major (Loss of between £1m and £4.9m). Likelihood 3 – Possible Total Rating: **Orange**
FINANCIAL ISSUES	The Trust reported a surplus of £1.6m in September, which was £0.3m ahead of plan, with an EBITDA of 11.9% against an EBITDA plan of 11.1%. The year to date position is a surplus of £0.8m, which is an adverse variance against plan of £1.7m; with an EBITDA of 6.7% against a planned EBITDA of 7.8%. The key issues in the month 6 year to date position are: • Un-achieved CIPs (£3.1m) • Under recovery in Private Patient Income (£0.3m), predominantly in adult private patients. • Over recovery on NHS Clinical Contract Income of £3.2m however £2.1m relates to pass through costs for drugs and excluded devices • Continued spending on general clinical supplies above plan (£1.1m); which is under review for budget, price and activity analysis. Following on from the prior month's reserves analysis, further review of investments that could be delayed or avoided without impacting adversely on quality or patient care have increased the total release to £3.2m for this financial year. £0.8m of the Reserves release has been reflected in the year to date position, with the remainder factored into the year-end forecast.

	As part of the recovery plans, controls totals have been set for divisions and corporate departments based on their month 4 forecasts. The recovery schemes account for additional cost savings and income recovery plans that have arisen in year since business planning assumptions were made. Divisions are performance managed against these control totals. There is some slippage to month 6 in the main clinical divisions on schemes in the two months since the recovery plans were implemented. The CIP target for 2013/14 is £18.9m of which there is a forecast shortfall of £4.5m at year end, deterioration from the £3.2m reported at month 5. At month 6 the ytd CIP plan was £7.9m, with delivery of £4.8m and slippage of £3.1m. Therefore the main risk to the year-end forecast remains delivery of the original CIP and additional recovery schemes identified. The forecast position is for a surplus of £7.0m, against a plan of £9.0m, which is an adverse variance of £2.0m. The EBITDA forecast is 7.9% (£28.3m) against a plan of 8.4% (£29.5m), an adverse variance of 0.5% (£2.0m). However the Executive have agreed mitigations around controlling pay and non pay and minimising contractual penalties to recover the position to breakeven against plan. These control mitigations will be reflected in the forecast going forward once detailed plans have been put in place. The Financial Risk Rating (FRR) year to date for month 6 is a 3, which is in line with the planned FRR at the end of Q2. The actual FRR rating has improved to 3.15 year to date compared to 2.85 at month 5 as a result of the improvement in the EBITDA and net surplus position in month. The Continuity of Services Rating (COSR) is being reported in shadow form at Q2 but will be implemented by Monitor from Month 7 onwards. The year to date COSR rating is a 3 compared to a planned 4 due to the impact of the reduced surplus on the capital service capacity ratio. The forecast COSR rating is a 4, which is in line with plan.
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No

EXECUTIVE SUMMARY	**<u>Income and Expenditure</u>** The Trust reported a surplus of £1.6m in September, which was £0.3m ahead of plan, with an EBITDA of 11.9% against an EBITDA plan of 11.1%. The year to date position is a surplus of £0.8m, which is an adverse variance against plan of £1.7m; with an EBITDA of 6.7% against a planned EBITDA of 7.8%. Operating income in-month was ahead of plan by £0.8m. The key income variances in month 6 are an over-performance in NHS Clinical contract income of £0.4m, and Private Patient income was under-plan (£0.1m) mainly within private adult patients, although PMU continues to over-perform as has Overseas in month, reflecting price changes. Within expenditure the pay position is £1.1m adverse in the month, almost entirely due to under-delivery of CIP plans, with an underlying pay position of £0.1m under-spent in the month. Within non-pay, clinical supplies continue to be a pressure on the position and there are in-month pressures in consultancy. However, there was a considerable benefit from the release of provisions (£1.1m), including £0.7m from prior year provisions no longer required; and also a benefit from contractual baseline changes within the Imperial Pathology contract (£0.1m). **NHS Clinical Contract Income** NHS Clinical Contract Income was ahead of plan by £0.4m in September and £3.2m for the year to date, including £2.1m of excluded drugs and devices which are offset by expenditure. The key NHS clinical contract activity and income variances are set out in the table below.

NHS Clinical Contract Income Variances £000

Point of Delivery	Specialty	Annual Plan	In Month Variance	YTD Variance	In month % Income Variance	In month % Activity Variance	YTD % Income Variance	YTD % Activity Variance	Forecast Outturn Variance	Forecast % Income Variance	Forecast % Activity Variance
Elective	Dermatology	1,598	-118	-244	-73%	-84%	-38%	-52%	-511	-32%	-47%
	Bariatric Surgery	1,829	-70	-238	-41%	-41%	-29%	-33%	-784	-43%	-44%
	T&O	7,792	-60	-184	-9%	15%	-5%	-5%	-888	-11%	-12%
	General Surgery	3,351	-52	-38	-19%	5%	-2%	7%	70	2%	10%
	Paediatric Surgery	3,066	-41	-307	-17%	-1%	-23%	-17%	273	9%	6%
	Endoscopy	4,166	6	197	2%	22%	9%	11%	458	11%	12%
	Burns Care	1,223	22	397	23%	47%	74%	67%	642	53%	48%
	HIV	2,346	23	-92	12%	61%	-8%	-7%	-65	-3%	14%
	Paediatric Dentistry	2,215	25	237	13%	46%	22%	24%	568	26%	28%
	Thoracic Medicine	328	38	117	144%	83%	79%	39%	197	60%	24%
	Plastics & Hand Surgery	4,813	53	112	15%	51%	5%	22%	290	6%	23%
	Paediatric Gastroenterology	1,589	57	213	43%	46%	27%	15%	204	13%	6%
	Elective other	14,631	-20	452	-2%	19%	7%	5%	1,831	14%	17%
Elective Total		**47,349**	**-138**	**622**	**-3%**	**-7%**	**3%**	**-4%**	**2,286**	**5%**	**-1%**
Non Elective	Obstetrics	15,571	-192	-320	-15%	18%	-4%	0%	-350	-2%	2%
	General Medicine/ Care of the Elderly	20,408	-98	-200	-6%	24%	-2%	5%	-639	-3%	3%
	HIV	2,423	-98	-350	-49%	-5%	-29%	-18%	-547	-23%	-10%
	Plastics & Hand Surgery	2,458	-13	-144	-6%	-20%	-12%	-22%	-385	-16%	-24%
	Paediatric Surgery	2,687	-35	-126	-22%	-2%	-13%	-15%	-260	-10%	-8%
	Paediatric Medicine	3,634	-37	-216	-12%	1%	-12%	-16%	-393	-11%	-15%
	T&O	2,719	148	73	66%	81%	5%	11%	154	6%	12%
	Paediatric Gastroenterology	831	238	449	348%	-21%	108%	1%	619	75%	0%
	Emergency Care Metrics	-4,843	391	1,742	97%	N/A	72%	N/A	2,351	68%	N/A
	Non-Elective Threshold 30% marginal rate	-2,700	42	250	19%	N/A	19%	N/A	356	13%	N/A
	Non Elective Other	13,337	27	-193	2%	20%	-3%	1%	-603	-5%	-4%
Non Elective Total		**56,524**	**374**	**966**	**8%**	**18%**	**3%**	**-1%**	**304**	**-0%**	**-1%**
Outpatients - firsts	GUM	15,856	-47	108	-3%	-3%	1%	1%	472	3%	3%
	Paediatric Medicine	814	-30	-114	-43%	-60%	-28%	-28%	-47	-4%	-37%
	Gynaecology	983	-25	5	-30%	-29%	1%	1%	-24	-2%	-2%
	Dermatology	669	-2	-25	-4%	-7%	-8%	-8%	-0	-0%	-1%
	Obstetrics	11,711	27	116	3%	20%	2%	2%	232	2%	1%
	Paediatric Diabetes	43	105	106	2898%	-20%	488%	-1%	210	488%	-1%
	Metrics (Internally Generated Referrals)	-1,950	117	179	72%	N/A	18%	N/A	-43	-3%	N/A
	Outpatients other	14,507	9	94	1%	5%	1%	6%	138	3%	8%
Outpatients - first attendances Total		**42,633**	**154**	**470**	**4%**	**-1%**	**2%**	**2%**	**938**	**2%**	**3%**
Outpatients - follow ups (incl diagnostic imaging, virtual clinics & procedures)	Paediatric Ophthalmology	920	-90	-239	-113%	-46%	-53%	-53%	-279	-33%	-24%
	Ophthalmology	1,111	-51	-35	-54%	-12%	-6%	-6%	-9	-1%	6%
	Gastroenterology	772	-46	-146	-61%	18%	-32%	-32%	-159	-21%	14%
	Obstetrics	492	-44	-258	-98%	-87%	-99%	-99%	-489	-98%	2%
	Burns Care	1,180	9	139	9%	7%	23%	23%	284	24%	23%
	GUM	3,997	24	287	7%	13%	15%	15%	810	20%	23%
	Paediatric Dentistry	1,452	60	135	48%	47%	19%	19%	276	19%	16%
	T&O	1,238	67	34	50%	37%	4%	4%	135	8%	12%
	Gynaecology	3,799	94	81	32%	22%	5%	5%	308	9%	9%
	Diagnostic Imaging	4,648	-30	-543	-8%	1%	-23%	-20%	-653	-14%	-12%
	Outpatients other	28,575	136	951	11%	-0%	13%	4%	987	6%	5%
Outpatients follow up attendances Total		**48,184**	**129**	**405**	**5%**	**5%**	**2%**	**3%**	**1,211**	**4%**	**6%**
Other	Accident & Emergency	6,387	14	-30	3%	6%	-1%	-2%	-120	-2%	-2%
	Urgent Care Centre	5,147	-1	68	-0%	-0%	3%	3%	106	2%	2%
	ACU	1,168	17	118	17%	0%	19%	0%	228	19%	N/A
	Burns Critical Care	2,540	-24	-101	-12%	-20%	-8%	-9%	-194	-8%	-9%
	Adult Critical Care	4,511	-33	-92	-9%	37%	-4%	-1%	-92	-2%	2%
	NICU & SCBU	9,511	167	121	21%	13%	3%	5%	391	4%	4%
	Paediatric HDU	2,503	-77	-241	-38%	-3%	-19%	-19%	124	5%	5%
	Excluded Devices	1,652	63	316	45%	N/A	38%	N/A	601	36%	N/A
	Excluded Drugs	52,031	-186	1,829	-4%	N/A	7%	N/A	2,424	5%	N/A
	Chemotherapy	1,072	-46	-294	-51%	N/A	-55%	N/A	-566	-53%	N/A
	U-code provisions	0	-19	-256	0%	N/A	0%	N/A	-164	0%	N/A
	Other	12,283	-63	140	8%	N/A	2%	N/A	-773	3%	N/A
Other Total		**98,807**	**-180**	**1,620**	**-2%**	**-2%**	**3%**	**-1%**	**1,964**	**2%**	**-0%**
Sub Total		**293,497**	**339**	**4,082**	**0%**	**0%**	**0%**	**0%**	**6,703**	**1%**	**0%**
	Prior Year Income	0	0	-407					-407		
	Change in WIP	0	233	225					225		
	Directorate Savings Target	1,332	-191	-742					-1,332		
	Cross Border Activity - to non NHS income	-186	16	73					147		
Grand Total		**294,643**	**397**	**3,231**					**5,336**		

	Elective inpatient activity and income was below plan (£0.1m) in September, which is off trend for the year to date, though remains £0.6m ahead of plan for the year to date. The main in-month deterioration relates to Dermatology (£0.1m) due to the closure of the phototherapy unit during the month for the installation of an additional phototherapy machine. This has resulted in low regular day activity in the month, which is expected to recover in the remaining months of the year. Bariatric Surgery continues to report an adverse variance (£0.1m behind plan in September), which is expected to continue due to changes in commissioning criteria in 2013/14. Other elective income is forecast to continue to over-perform for the rest of 2013/14. Non-elective inpatients overall reported a net favourable variance against plan of £0.4m in September, which was primarily driven by the discharge of a long stay paediatric gastroenterology patient in the month that was previously accrued under work-in-progress and continued over recovery against emergency metrics. The Trust is currently meeting the emergency metrics to reduce admissions from A&E and reduce length of stay for the year to date, but is forecasting a slight deterioration over the winter months in anticipation of increased emergency activity. Outpatient new and follow-up attendances were ahead of plan by £0.3m in September, largely due to over-performance for the paediatric diabetes best practice tariff (£0.1m) and a benefit due to a change in phasing for the internally generated demand metric. This is due to a delayed start date to 1st October 2013 following discussions with North West London CCG commissioners, but with the same total planned impact for the year. There is also a continued over-performance in Paediatric Dentistry outpatient activity to address waiting list pressures. The Trust reported an adverse impact of £0.8m for the new to follow up ratio metric for the year to date, the main impacted specialties continue to be Gastroenterology (£130k), Rheumatology (£92k) and Ophthalmology (£88k) and the clinical divisions are working to reduce the number of follow ups by converting follow up appointment slots to news. Outpatient income is forecast to significantly over-perform for the rest of 2013/14, with a number of specialties forecast to increase over the last 6 months of the year, particularly in GUM due to expected increases in activity in December due to World AIDS Day and the opening of Dean Street Express in November. NHS Clinical Contract Income relating to other points of delivery was £0.2m behind plan in September, but £1.6m ahead of plan for the year to date, mainly as a result of an under-recovery of income in month 6 for excluded HIV anti-retroviral and other excluded drugs (£0.1m), which is offset by expenditure. The Trust has now signed the 2013/14 contract with NHS England (specialised services and directly commissioned services) and is finalising contract agreement and documentation with North West London CCGs (local acute services). Contracts with Local Authorities in North West London for Sexual Health services in 2013/14 are still outstanding. There is now one area of dispute; the application of CQUIN funding, as local authorities are advising that they do not wish to fund CQUIN on GUM services and there is Department of Health guidance advising that this is non-mandatory for local authorities. The Trust has proposed a counter offer of a local incentive scheme to the value of the CQUIN aimed at rolling out postal testing for STIs, which has not been accepted by the local authority commissioners. All other clinical income was behind plan by £0.2m in September with low activity in Adult Private Patients' income (£0.1m), continued poor performance in amenity beds (£0.2m year to date) and provider-to-provider diagnostics contract income; it should be noted that overseas income over-performed in month (£0.1m) as a result of new

increased prices, although a review of the bad debt provision in relation to this is underway. Non Clinical operating income was ahead of plan by £0.6m due to improvements in the SIFT allocations the Trust receives (£0.5m year to date, backdated) invoicing for consultancy costs in relation to the West Middlesex Due Diligence work (offset by expenditure overspends), reduced down by low R&D activity (offset by lower costs).

Pay had an adverse variance in month of £1.1m. Actual staff costs were largely on plan and the over-spend represents CIP slippage of £1.2m, with further reserves released of £0.1m. Although the overall payroll costs were on plan, there were slight increases in nursing agency costs from month 5, with a reduction in bank nursing costs.

Clinical Supplies and Drugs produced an adverse variance of £0.3 in month 6. The majority of this was within general medical supplies & equipment, including the back-dating of procurement CIPs to the start of the year. The continued adverse variance on clinical supplies has prompted a detailed piece of work between procurement and finance to further understand the reasons behind the issues.

Non-clinical supplies were ahead of plan in month 6. The main contributing factors being NHS Bad Debt Provision releases (£1.1m) as outlined above; and consultancy costs for the West Middlesex Due Diligence work, although these were offset by income (funding from the Trust Development Agency).

Forecast

The current forecast for the Trust is a £2.0m adverse variance against plan (£7.0m forecast actual surplus against £9.0m planned surplus). A trust-wide recovery plan process has now been underway for two months with divisions monitored against their respective control total. There has been some slippage on performance, however central benefits from reserves (£3.2m assumed in the year end forecast) and provisions have resulted on the Trust trajectory being slightly ahead of plan.

There are a number of risk factors within the current forecast that will need to be closely monitored over Q3 and Q4, including the overall improvement on trend required to move from a month 6 year to date surplus of £0.8m, to a year-end forecast of a £7.0m surplus (note this includes £2.4m of capital grant income in relation to Burns). And it should also be noted that there are risks around delivery of the activity forecast, which is back-ended in its current trajectory and also the requirement to deliver a high proportion of the CIP plan in the last 6 months of the year.

Overall Financial Risk Rating (FRR) and Continuity of Services Risk Rating (COSR)

The detailed FRR ratings for the YTD position at month 6 are shown below:

Financial Metric	M6 YTD				
	Plan	Actual	Actual FRR	Weighting	Plan
EBITDA margin %	7.8%	6.7%	3	25%	3
EBITDA , % plan achieved	100.2%	88.9%	4	10%	5
Net Return after Financing	0.7%	-0.1%	3	20%	3
I&E surplus margin net of div.	1.3%	0.5%	2	20%	3
Liquidity days	36	34	4	25%	4
Financial Risk Rating	**3**	**3**	**3**	**100%**	**3**

The weighted average FRR for month 6 is 3.15 which rounds down to a 3, which is an improvement on the month 5 year to date actual rating of 2.85. The reason for the improvement in month is the fact that the % of EBITDA plan achieved has improved to 88.9%, which is a 4 (compared to a 3 last month) and the Net Return after Financing has improved to a 3 (compared to a 2 last month). These improvements are due to the increased surplus position in month 6.

Monitor has now published its final Risk Assessment Framework, which means that the FRR will be replaced by the Continuity of Services Rating (COSR) from 1st October 2013. However Monitor has confirmed that the Q2 return will continue to monitor FTs against the Compliance Framework since it remains in operation until 30th September 2013.

The Continuity of Services rating at month 6 is a 3 against a planned 4, and the forecast rating is a 4 as shown in the table below.

COSR Rating	Weighting	M6 Actual	M6 Plan	M6 Forecast
Capital Servicing Capacity	50%	2	3	3
Liquidity	50%	4	4	4
Total Rating		**3**	**4**	**4**

The overall rating is behind plan due to the Capital Servicing Capacity rating being a 2 compared to a planned 3 year to date. The Capital Servicing Capacity metric looks at the degree to which an organisation's generated income covers its financing obligations (financing being defined as loan repayments, PDC dividend expense and interest on loans and leases). The metric is calculated by taking the revenue available to service financing obligations over the total cost of servicing those obligations, with the scores assigned ratings as below:

Capital Servicing Capacity Ratings

1	2	3	4
<1.25x	1.25x	1.75x	2.5x

The Trust's year to date score at month 6 is 1.56x, which is an improvement on the position at month 5 but not as good as the planned score of 1.90x which would have given a 3 rating. The forecast score is 1.86x based on the month 6 I&E forecast.

Loans

The Trust has two signed loan agreements in place that have not been drawn down, one for the purchase of Doughty House (£20m) and one for the SAHF development (£6m). The exact timing of the drawdowns against these two loans is currently under discussion as part of the overall strategic planning around the purchase of Doughty House and SAHF.

The Trust also submitted a new £10m loan application to the Foundation Trust Financing Facility (now the Independent Trust Financing Facility) in relation to the Emergency Department Expansion business case. The loan was requested in order to allow the Trust to proceed with the ED expansion in advance of the implementation of the SaHF proposals, and the ITFF have confirmed that the loan application was approved. It is anticipated that the loan agreement will be signed shortly once the Trust has confirmed the anticipated timing of the loan drawdowns, and the interest rate will be fixed at this point.

Capital

The month 6 capital expenditure forecast is £43.3m against a plan of £49.9m. The reduction of 13.8% in planned capex is mainly due to two building projects: the Emergency department expansion (£3.8m) and the purchase of Doughty House (£3.1m), both of which are loan funded schemes.

Year to date spend is £7.6m against a plan of £7.9m (4.5% behind plan), with spend of £2.2m in month 6. Major building projects in progress are Adult Burns, Dean Street Express, ED Expansion, Midwifery Led Unit (MLU) and Outpatients 3 & Phlebotomy. The Mace contract finishes with the Trust after the completion of the Adult Burns (January 2014). The Midwifery Led Unit (MLU) was re-tendered and Dovehouse has been appointed the new contractor. The MLU project will complete in December 2013. The Dean Street Project construction was awarded to Area Sq. and this project finishes in November 2013. The ED Expansion project is continuing in the planning phase and it is envisaged that the construction works will commence in February 2014 however this is still dependent on the decant programme. The Outpatient 3 / Phlebotomy project construction phases (3 -5) are being tendered for completion in the last week of January 2014.

The IT year to date spend is 3% ahead of plan however the 2013-14 forecast is breakeven. The medical and non-medical equipment is forecast to breakeven.

Capital expenditure by asset category against Monitor budget is shown in the table below:

Asset Category	YTD Budget (£'m)	YTD Actual (£'m)	YTD Var (£'m)	YTD Var (%)	2013/14 Budget (£'m)	2013/14 Forecast (£'m)	Forecast Var (£'m)	Forecast Var (%)	Commitments (£'m)
Buildings	3.103	3.598	(0.494)	(16%)	34.544	28.125	6.419	19%	0.635
Chief Executive Contingency	0.030	0.000	0.030	100%	0.200	0.200	0.000	0	
IT	1.605	1.656	(0.051)	(3%)	8.938	8.923	0.015	0%	0.273
Medical Equipment	2.599	2.216	0.383	15%	4.932	4.911	0.021	0%	0.150
Non Medical Equipment	0.641	0.153	0.488	76%	1.267	0.827	0.440	35%	0.095
Grand Total	**7.978**	**7.623**	**0.355**	**4.5%**	**49.881**	**42.986**	**6.895**	**13.8%**	**1.058**

Cash Flow

The cash position as at 30th September 2013 is £17m, which is significantly below the Monitor plan of £36.5m. The key issues driving the adverse variance against plan are the following:

- The YTD I&E deficit of approximately £1.7m compared to plan.
- Trade receivables (including NHS, Local Authorities and non-NHS) are approx. £17.7m higher than the Monitor plan at month 6 (explained in more detail below).
- Capital creditors are £2.5m lower than plan.

Within trade receivables, Non NHS debt has reduced slightly in month but NHS debt (including Local Authorities) has increased by a further £4.5m. The key factors causing debtors and cash to be behind plan at Month 6 are the following:

- Outstanding debt for GUM activity billed to Local Authorities of @ £4m, relating to months 1-4. All invoices raised have now been sent to the correct level within the LA organisational structure and back up data has been provided, however this debt is still proving very difficult to collect. In addition there is a timing issue that is affecting cash flow this year in that prior to the changes on 1 April 2013 GUM activity would have been paid for in monthly instalments as part of the SLA block contracts, whereas activity is now being invoiced retrospectively. However since closing the month 6 position NW London Local Authorities have agreed to pay in advance going forward, which will improve cash flow.

- In addition to the above a further £3m of GUM activity relating to M5-6 has been accrued rather than billed at Month 6, therefore showing as part of debtors rather than cash at this point.

- Adult Burns funding invoiced to NHS England of £2.4m is still outstanding at M6, together with Burns network revenue funding of £0.7m. This is being actively pursued for payment via the London and South East England Burns network.

- There are approx. £2.4m of invoices unpaid relating to CCG billing for M1-6 as a result of some CCGs arguing that contracts have not been signed. However the majority of contracts have now been agreed, therefore these outstanding payments are being actively chased both via the credit control team and through the contracting team. In addition invoices for over performance for the first quarter remain unpaid in many cases due to data challenges – the most significant value being £1.6m billed to NHS England.

The above issues represent a risk to the forward cash flow forecast, however they are being escalated and it is anticipated that cash flow will improve over the last 6 months of the year. The forecast cash position at month 12 is £30m (£6.2m lower than plan), based on the I&E forecast being £2m below plan and taking the prudent view that NHS debt may be slightly higher than the original Monitor plan due to GUM

	invoicing now being retrospective rather than being included in the monthly block SLA payments. **<u>Investments</u>** As at 30th September the Trust had £6m invested with the National Loans Fund for a period of 14 days, maturing on 2nd October. This will generate interest of approx. £0.9k at an interest rate of 0.39%. As reported in previous months, the Trust is restricting investment activity to deposits with the National Loans Fund due to the change in the PDC dividend calculation.
DECISION/ ACTION	The Board is asked to note the financial position for September 2013.

APPENDIX B

Financial Overview as at 30th September 2013 (Month 6)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

X A

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Mth 6 YTD Var	Mth 5 YTD Var	Forecast
Income	(353,717)	(174,152)	(177,096)	2,944	2,169	(361,058)
Expenditure	320,733	159,593	164,264	(4,670)	(4,233)	329,331
EBITDA for FRR excl Donations/Grants for Assets	29,531	13,558	11,832	(1,726)	(2,064)	28,274
EBITDA % for FRR excl Donations/Grants for Assets	8.4%	7.8%	6.7%	-1.1%	-1.5%	7.9%
Surplus/(Deficit) from Operations before Depreciation	**32,984**	**14,558**	**12,832**	**(1,726)**	**(2,064)**	**31,727**
Interest	829	414	418	(4)	(4)	808
Depreciation	12,907	6,496	6,379	117	112	13,249
Other Finance costs	0	(0)	(8)	8	8	292
PDC Dividends	10,241	5,119	5,207	(88)	1	10,415
Retained Surplus/(Deficit) excl impairments	**9,007**	**2,529**	**837**	**(1,693)**	**(1,946)**	**6,963**
Impairments	0	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	**9,007**	**2,529**	**837**	**(1,693)**	**(1,946)**	**6,963**

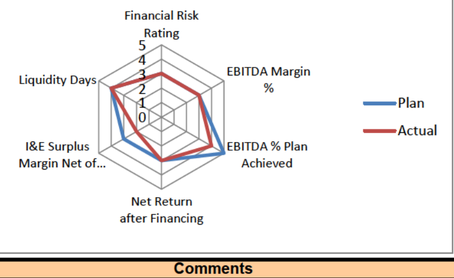
Comments

Risk Assessment
Impact 4 – Major (Loss of between £1m and £4.9m). Likelihood 3 – Possible **Orange**

The YTD position is an favourable variance of £0.8m (EBITDA of 6.7%) which is an adverse variance of £1.7m against plan.

I&E position (£1.7m) includes the following material items:
- Un-achieved CIPs (£3.1m);
- Private Patients Income is £0.3m behind plan;

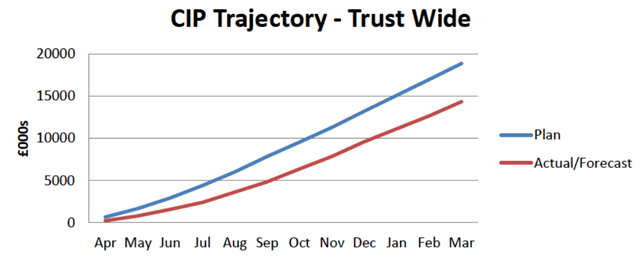
Risk Rating (year to date)



Comments

The weighted average FRR for month 6 is 3.15 which rounds down to a 3, which is an improvement on the month 5 YTD actual rating of 2.85. The reason for the improvement in month is the fact that the % of EBITDA plan achieved has improved to 88.9%, which is a 4 (compared to a 3 last month) and the Net Return after Financing has improved to a 3 (compared to a 2 last month). These improvements are due to the increased surplus position in month 6.
The COSR rating YTD is a 3 against a planned 4.

Cost Improvement Programme



Comments

CIPs 13/14
The CIP target for 13/14 is £18.9m (£16.9m for 13/14 + £1.9m b/f from 12/13).
The year to date position was a plan of £7.9m, with delivery of £4.8m.
Schemes totalling £14.3m have been forecast to achieve in 13/14.

Trajectory
It was proposed that all Divisions should have identified 100% of CIP schemes by 31st May.
Followed by a further detailed trajectory of 100% achievement by 31st Jan 2014.

There is slippage on the CIP plan, that is being offset by additional recovery schemes

NHS Clinical Income (£000)

Division	Directorate	Point of Delivery	M6 YTD Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
CLINICAL SUPPORT	DIAGNOSTICS	Elective	3,378	3,722	344	2,095,411	2,293,869	198,458
		Non Elective	11	15	4	40,028	45,166	5,138
		Other	31,798	30,100	-1,698	1,165,119	1,088,807	-76,312
		Outpatients	14,551	15,069	518	1,280,710	1,350,800	70,090
	DIAGNOSTICS Total		49,737	48,905	-832	4,581,269	4,778,642	197,373
	PERI-OPERATIVE THEATRES & ANAESTHETICS	Elective	4	7	3	26,412	20,049	-6,363
		Non Elective	131	186	55	142,631	190,247	47,617
		Other	1,554	1,533	-21	2,260,965	2,164,658	-96,308
		Outpatients	180	162	-18	15,584	13,933	-1,651
	PERI-OPERATIVE THEATRES & ANAESTHETICS Total		1,868	1,888	20	2,445,592	2,388,887	-56,705
	THERAPIES	Other	21,780	16,006	-5,774	887,090	718,202	-168,888
		Outpatients	21,272	23,374	2,102	1,188,961	1,276,365	107,404
	THERAPIES Total		43,052	39,380	-3,672	2,056,051	1,994,567	-61,484
CLINICAL SUPPORT Total			94,657	90,174	-4,484	9,082,911	9,162,096	79,184
MEDICINE AND SURGERY	MEDICINE	A&E	55,298	55,903	605	5,546,625	5,587,190	40,565
		Elective	2,380	2,642	262	1,424,155	1,768,491	344,336
		Non Elective	9,934	8,882	-1,052	11,279,887	10,890,105	-389,782
		Other	773	420	-353	399,311	276,361	-122,950
		Outpatients	39,543	41,172	1,628	5,974,056	5,861,944	-112,112
	MEDICINE Total		107,928	109,019	1,090	24,624,034	24,384,090	-239,943
	SURGERY	Elective	5,698	6,506	808	10,445,935	10,768,330	322,395
		Non Elective	3,529	3,306	-223	6,543,503	6,469,771	-73,732
		Other	1,363	1,208	-155	1,729,310	1,970,366	241,057
		Outpatients	51,300	53,884	2,584	6,243,838	6,351,012	107,174
	SURGERY Total		61,891	64,904	3,013	24,962,586	25,559,479	596,893
MEDICINE AND SURGERY Total			169,820	173,923	4,103	49,586,619	49,943,569	356,950
OTHER	OTHER	Elective	0	0	0	-21,012	0	21,012
		Non Elective	0	0	0	-2,421,415	-679,869	1,741,546
		Other	372,604	372,413	-191	7,343,715	7,867,173	523,457
		Outpatients	5,833	3,207	-2,626	-1,261,043	-409,426	851,617
	OTHER Total		378,437	375,621	-2,817	3,640,246	6,777,879	3,137,632
OTHER Total			378,437	375,621	-2,817	3,640,246	6,777,879	3,137,632
WNS/CYPS/HIV/SH/Dem	CHILDREN'S AND YOUNG PEOPLE'S SERVICES	Elective	4,114	4,499	385	5,259,485	5,264,341	4,856
		Non Elective	3,194	3,588	394	4,051,688	4,067,581	15,893
		Other	7,574	7,540	-34	7,277,459	7,061,002	-216,457
		Outpatients	27,852	26,212	-1,640	5,198,524	4,766,462	-432,063
	CHILDREN'S AND YOUNG PEOPLE'S SERVICES Total		42,734	41,839	-895	21,787,156	21,159,386	-627,770
	HIV/SEXUAL HEALTH AND DERMATOLOGY	Elective	4,891	2,778	-2,113	1,832,449	1,487,440	-345,009
		Non Elective	419	555	136	1,274,152	912,647	-361,504
		Other	-2,894	864	3,758	106,213	106,576	363
		Outpatients	74,305	78,787	4,481	37,913,661	39,959,729	2,046,069
	HIV/SEXUAL HEALTH AND DERMATOLOGY Total		76,721	82,984	6,262	41,126,474	42,466,392	1,339,919
	WOMEN'S AND NEONATAL SERVICES	Elective	1,297	1,496	199	1,673,881	1,755,839	81,959
		Non Elective	7,589	7,012	-577	8,381,948	8,112,097	-269,851
		Other	75	37	-38	667,318	708,256	40,938
		Outpatients	17,736	18,278	542	8,387,896	8,331,432	-56,464
	WOMEN'S AND NEONATAL SERVICES Total		26,697	26,823	126	19,111,043	18,907,624	-203,419
WNS/CYPS/HIV/SH/Dem Total			146,153	151,646	5,493	82,024,673	82,533,402	508,730
Grand Total			789,067	791,363	2,296	144,334,450	148,416,946	4,082,496

Comments

The table above summarises the NHS Clinical Income position for Directorates/Divisions and POD for month 6 of 2013-14

Key Financial Issues

Key Issues

- Trust forecast adverse variance of £2.0m
- including delivery of recovery plans

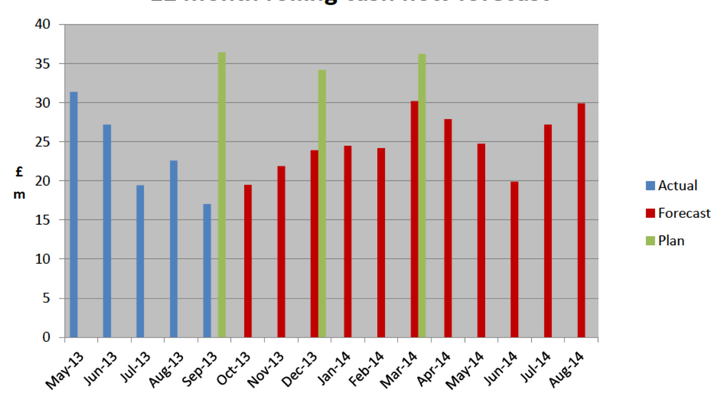
- CIP 13/14 identification and achievement
- including FYE of 12/13 (b/f)

- additional mitigations have been agreed by Execs around control of temporary staffing, non pay and contractual penalties

- GUM Public Health commissioning & payment
- Delivery of the Trust's activity plan
- Achievement of commissioner metrics
- Achievement of CQUIN targets for 2013/14

Future Developments
- Strategic developments e.g. West Midd, SaHF
- West Middx at the Strategic Outline Case stage
- Operationalising the capital plan
- ED capital redevelopment
- Business Planning for 2014/15
- Delivery of increased Private Patient income plans

Cash Flow



Comments

The cash position as at Month 6 is £17m, £19.5m below plan. The key issues driving the adverse variance are the YTD I&E deficit, together with trade receivables being above plan due to issues around collection of cash from CCGs and transfer of GUM commissioning to Local Authorities. Both these issues have been escalated and the cash position is expected to improve going forward.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	2.2/Oct/13
PAPER	Performance Report – September 2013
AUTHOR	Jen Allan, Head of Performance Improvement
LEAD	David Radbourne, Chief Operating Officer
PURPOSE	The purpose of this report is to the summarise high level Trust performance, highlight risk issues and identify key actions going forward for September 2013.
LINK TO OBJECTIVES	This paper reports progress on a number of key performance areas which support delivery of the Trust's overarching aims.
RISK ISSUES	Overall performance in September remains good with all Monitor indicators met for the month. A&E performance against the 4 hour target fell below our internal stretch target of 98% in September but was 98.2% for Quarter 2 and the Trust remains one of the highest performing in England on this measure. Variation at specialty level against the RTT targets has the potential to incur contractual penalties for the first half of the year but the Trust has a robust action plan in progress and remains fully compliant with all Monitor RTT indicators. Contract negotiations continue with North West London CCGs on acute services, and with Local Authorities on sexual health services, which remain a challenge due to the complexity of dealing with many different approaches from individual authorities. The specialised services contract with NHS England has now been signed.
FINANCIAL ISSUES /OTHER ISSUES	None.
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Trust continues to meet all key performance indicators for Monitor and has shown good performance throughout the first two quarters of 2013/14. The NWL CQUIN compliance position for Q1 is confirmed at 99.5% and the draft position for Q2 is presented as 92.5%. A prospective view of Q3

	and NHS England CQUINs is presented which shows some areas of challenge but overall an expectation that the Trust will deliver a high level of achievement and action plans are in place where required. Patient safety and clinical effectiveness indicators align with the ongoing focus on Pressure Ulcers and Dementia within the Trust. On pressure ulcers, an awareness campaign with staff has raised reporting levels, but excellent results have been seen from the high impact project in place on the AAU, and improvement is expected in the second half of the year. The Deputy Chief Nurse with the ward teams is leading on improving dementia care and a report on support to carers of patients with dementia is presented. It has been identified that lower than target performance on meeting our standard of 90% of patients on the AAU being assessed by a consultant within 12hours of admission relates primarily to recording of these assessments and this is being addressed. A&E performance in September reflects an extremely challenging month with peaks of activity, and a focus section is presented on Winter Planning at the end of this report to assure the Board on plans in place for the winter period. Within Maternity the caesarean section rate remains higher than target in both elective and non-elective and we are working with commissioners on an action plan to address this, although the rate has reduced significantly to 32% from a peak of 38% in June. The Outpatient Transformation Project has now introduced a new system to manage hospital cancellations of outpatient appointments which has resulted in a significant drop in key specialties and this will be tracked going forward. The DNA rate is now below target at 10% and further work is being undertaken to embed good practice here, as well as continued work with the Disney programme to improve patient experience. The Friends and Family Test has now been rolled out to Maternity and the Trust has signed up to being an early adopter of the test in Outpatients also. The Trust is meeting all Access standards albeit with some variation in RTT performance at specialty level which is being addressed through an action plan and reflects work to move to a prospective online patient pathway management system. The electronic transmission of information about patients' care to GPs is a key priority for the Trust and focused service improvement work is ongoing to improve processes for Outpatient Letter and Discharge Summary turnaround.
DECISION/ ACTION	The Trust Board is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Corporate Performance Report

Performance to 30th September 2013

At a Glance Performance – September 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Trust Headlines

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Contracts Update

Contract signature

The NHS England contract covering both specialised services and paediatric dental/orthodontics was signed on 14th October. The NWL acute contract remains unsigned due to a delay in final agreement on the metric relating to internal referrals, but is now resolved. Further discussions have been held with the NWL Local Authority commissioners of GU services where progress was made; however the LA's have maintained their stance that they will not pay CQUIN as they maintain this funding was not transferred to them. This represents a reduction in income against the plan for the Trust of around £0.3m for NWL and negotiations are on-going as to whether this could be offset by increasing the funding for growth within our GU services.

CQUIN Achievement

NWL CQUIN achievement for Q1 has now been finalised at 99.5%, and a draft report for Q2 prepared showing 92.5% achievement, which will be presented at the November Clinical Quality Group. This is well above the level assumed in financial plans of 90%, so represents a benefit to the position. NHS England CQUINs are being reported for Q1 and Q2 together due to the late finalisation of the contract. The position is not yet confirmed, however a high level of compliance at or close to 100% is anticipated for the first half of the year. A prospective look forward at Q3 requirements of all CQUINs has been prepared and presented to the Senior Operational Group in order to highlight areas requiring additional focus this quarter. A summary is presented below:

CQUIN Title	Summary	Status	Actions
Friends and Family Test	Roll out to Maternity; increased response rate	On track	
NHS Safety Thermometer	Data collection and reduction in Pressure Ulcer prevalence	Medium risk	Several improvement projects in place
Dementia	Identification/Referral of patients at risk, clinical leadership and supporting carers	Medium risk	Actively managed
VTE	95% patients risk assessed and RCAs completed & timely	On track	
Out of hospital care	Emergency care pathway programme	On track	
GP Real Time Information	Notification, PDDs, DSUMs and OP Letters sent timely electronically to GPs	Low risk	Improvement programme in place
AES standards	Hip replacement LOS reduction and Labour ward consultant cover increase	On track	
Near Patient Testing	Transfer of patients to community clinic for 3 conditions	Medium risk	C&W setting up mtgs. Risk flagged to CQG
Cancer standards	Compliance against LCS for Lung and Colorectal (or action plan)	On track	
HIV	Better comms to GPs, cost reduction on ARVs and model of care	On track	
Burns	Monitoring refused admissions, reducing LOS, ODN development	TBC	Awaiting info from Burns
NICU	Increase % babies receiving breast milk on discharge, and TPN started by day 2	On track	

Performance Headlines

- **A&E waiting times** in September (97.7%) fell below our internal stretch target of 98%, our national target being 95%. This related to a very busy month with particular peaks of activity and high levels of admissions. A focus report on A&E, Winter planning and the emergency care pathway is provided at the end of this paper but year to date performance and Q2 are 98.4% and 98.2% respectively.
- **RTT Waits** remain compliant at Trust level, but there is variation at specialty level. This has the potential to incur contractual fines although for Q1 the Trust negotiated a significant reduction in the potential fine. RTT/Waiting list improvement work is in progress as is Demand and Capacity planning to ensure sustainable achievement going forward
- **MRSA** improved with no cases in September. We are currently negotiating to ensure Trust is not unreasonably penalised for August case (Burns ICU admission value £300k)
- **Pressure ulcer reduction** plans are in place and have been successfully rolled out in AAU; further improvement is anticipated
- **12hr consultant assessment on AAU** requires improvement; analysis has confirmed that this is primarily a suggests this is a recording issue and actions are in hand to secure improvements moving forward.

Monitor Compliance

The trust has maintained compliance against the key monitor indicators for September.

KPI Name	Target	YTD	Sep13
Clostridium difficile cases	<13	1	0
MRSA objective	6	3	0
All cancers: 31-day wait from diagnosis to treatment	> 96%	97.95%	96.00%
All cancers: 31-day wait for second or subsequent treatment Surgery	> 94%	No treatments	No treatments
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	> 98%	No treatments	No treatments
All cancers:62-day wait for first treatment from urgent GP referral to treatment	> 85%	91.41%	92.00%
All cancers:62-day wait for first treatment from consultant screening referral	> 90%	100.00%	100.00%
Cancer: Two Week Wait from referral to date first seen comprising all cancers	> 93%	96.51%	98.90%
Referral to treatment waiting times < 18 Weeks - Admitted	> 90%	90.8%	92.4%
Referral to treatment waiting times < 18 Weeks - Non-Admitted	> 95%	97.8%	98.1%
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	> 92%	93.0%	92.9%
A&E: Total time in A&E < 4hrs	> 98%	98.4%	97.7%**
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant

**The Contractual and Monitor standard is 95%; the 98% is an internal Trust stretch target. The Trust remains compliant on 4hr waits

Month 1-6 Contractual KPIs with financial impact

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

KPI	Target	Application	Performance						Penalty	Potential Negotiated Penalty
			Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13		
18 Week Wait - RTT - Admitted Pathways	90%	Monthly	90.10%	90.10%	91.60%	90.20%	90.40%	92.40%	£49,982	£24,991
18 Week Wait - RTT - Non-Admitted Pathways	95%	Monthly	96.90%	97.70%	97.60%	98.10%	98.10%	98.10%	£534	£267
18 Week Wait - RTT - Incomplete Pathways	92%	Monthly	93.30%	93.20%	93.90%	92.60%	92.20%	92.03%	£37,548	£18,774
52 Week Wait - RTT - All Pathways	0	Monthly	1.00	1.00	0.00	0.00	0.00	0.00	£10,000	£10,000
Diagnostic 6 Week Wait	99%	Monthly	99.96%	99.89%	100.00%	100.00%	100.00%	100.00%	£0	£0
A&E 4 Hour Wait	95%	Quarterly			98.60%			98.20%	£0	£0
Cancer - 2 Week Wait - 1st Appointment	93%	Quarterly			95.50%			97.40%	£0	£0
Cancer - 31 Day Wait - Diagnosis to Treatment	96%	Quarterly			97.70%			99.00%	£0	£0
Cancer - 31 Day Wait - Subsequent Surgery	94%	Quarterly			-			100.00%	£0	£0
Cancer - 31 Day Wait - Subsequent Chemotherapy	98%	Quarterly			-			100.00%	£0	£0
Cancer - 31 Day Wait - Subsequent Radiotherapy	94%	Quarterly			-			-	£0	£0
Cancer - 62 Day Wait - RTT - GP	85%	Quarterly			87.70%			94.40%	£0	£0
Cancer - 62 Day Wait - RTT - Screening Service	90%	Quarterly			-			-	£0	£0
Cancer - 62 Day Wait - RTT - Consultant Upgrade	85%	Quarterly			-			100.00%	£0	£0
No Mixed Sex Accomodation	100%	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
Cancelled Operations - 28 Day Rebook	100%	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
Cancelled Operations - Urgent Cancelled > 1	0	Monthly	0	0	0	0	0	0	£0	£0
Cancelled Operations - Overall Rate of Cancellation	0.80%	Monthly	0.10%	0.40%	0.10%	0.10%	0.50%	0.40%	£0	£0
MRSA	0	Monthly	1.00	1.00	0.00	0.00	1.00	0.00	£329,963	£28,073
Cases of Clostridium difficile	13	Annual							£0	£0
A&E - Ambulance Handovers - >30 minutes	0	Monthly	5.00	5.00	4.00	5.00	4.00	13.00	£7,200	£7,200
A&E - Ambulance Handovers - >60 minutes	0	Monthly	0.00	0.00	0.00	0.00	0.00	0.00	£0	£0
A&E - 12 hour Trolley Waits	0	Monthly	0.00	0.00	0.00	0.00	0.00	0.00	£0	£0
Publish Formulary	100%	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
Duty of Candour	100%	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
Colposcopy - 28 Day Waits	90%	Monthly	95.43%	99.56%	96.33%	99.46%	98.77%	97.04%	£0	£0
Outpatient Referrals - Use of RMS	100%	Quarterly			-			-	£0	£0
TB - Treatment Completion	85%	Annual							£0	£0
TB - 2 Week Wait - 1st Appointment	90%	Monthly	100.00%	100.00%	-	-	100.00%	-	£0	£0
Choose & Book Slot Availability	98%	Monthly	96.20%	98.40%	98.10%	98.80%	97.90%	97.80%	£0	£0
Maternity - 12 Weeks 6 Days Booking (exc Lates)	95%	Quarterly			93.50%			96.30%	£0	£0
Rapid Access Chest Pain	98%	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
Stroke - 90% of time spent on Stroke Unit	80%	Quarterly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	£0	£0
TIA	75%	Half Yearly						81.30%	£0	£0
Serious Incident Reporting - Timely RCA Completion	100%	Monthly							£0	£0
Critical Care Transfers for Non-Clinical Reasons	5%	Monthly	0.00%	0.00%	0.00%	0.00%	0.00%		£0	£0
SHMI	77%	Quarterly			78.10%			82.00%	£0	£0
									£435,227	£89,305

Key

- Met Target
- Did Not Meet Target - No Penalty Applied
- Did Not Meet Target - Penalty Applied
- Target Does Not Apply This Month

RTT

Although the Trust remained compliant against the monitor standards for all RTT indicators there were breaches at specialty level which are liable to a fine according to a nationally set sliding scale. For Q1 the Trust has negotiated not to apply these penalties other than 2 x £5k fines for 52 week waiting patients, as we have a waiting list improvement programme in place. Further fines would be incurred in Q2 most notably in Surgery in August and September but the team will be negotiating with commissioners to reduce this by 50% as part of an improvement trajectory

MRSA

3 MRSA cases have occurred YTD for which the Trust is not paid the cost of the patient's admission. The last case in August related to a Burns intensive care patient and application has been made to NHS England to cap the fine at £10k rather than the £300k value of the admission, on the grounds of reasonableness

Ambulance Handover

A number of breaches of the 30min target during September have occurred. The site has been under pressure but we have a plan to reduce the level of breaches through enacting our winter plans. All patients have been reviewed to ensure no harm occurred from the delay.

Maternity Access

The Trust fell below the required level of 95% patients booked within 12+6 weeks in Q1 but achieved compliance in Q2 and thus no fine is incurred.

Shaping a Healthier Future

Trust Level Monthly Data				
Month/Year	Sep 2013	Aug 2013	Jul 2013	Trust YTD
A&E waiting times (Target: > 98%)	97.7%	98.2%	98.6%	98.1%
Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.78%)	3.47%	3.45%	3.12%	3.22%
On the day cancellations not rebooked within 28 days (Target: = 0)	0	0	0	0
Clostridium difficile infections (Target: = 1.1)	0	0	1	1
MRSA Bacteraemia (Target: = 0.5)	0	1	0	3
Never Events (Target: = 0)	0	0	1	1
Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: >)	0	0	0	0
Patient Satisfaction	Currently unavailable	Currently unavailable	Currently unavailable	Currently unavailable
Friends & Family Test - Net promoter score (Target: > 62)	64	66	66	66
Friends & Family Test - response rate (Target: = 15.0%)	24.8%	23.5%	30.2%	24.1%
Friends & Family Test - Local +ve score (Trust) (Target: = 90.0%)	95.0%	95.0%	94.0%	94.3%
Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 71)	N/A	N/A	N/A	63.96%
Total Formal Complaints (Target: >)	N/A	24	35	153
Formal complaints responded in 25 working days (Target: = 90.0%)	N/A	75.0%	86.0%	81.2%
Complaints upheld by the Ombudsman (Target: = 0.0%)	0	0	0	0
Proportion of people dying at home	Community indicator	Community indicator	Community indicator	Community indicator

Shaping a healthier future Programme update

Ealing Council's request for a Judicial Review into the Shaping a Healthier Future (SaHF) programme has been rejected. We now await the SoS's decision on whether SaHF should proceed and in what form, in response to the report he has received from the Independent Reconfiguration Panel (IRP). The SaHF modelling team are currently refining and inputting new data into their model, and at the end of October will release a better estimate of the activity that Chelsea and Westminster is likely to receive.

This dashboard tracks the sector SAHF indicators in line with the SAHF programme board requirements for North West London, in order that we can track quality, activity and performance metrics during transition.

Patient Safety

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	Jun-13	YTD
Harm	Confirmed Incidents of Hospital Associated VTE (Target: = 0.83)	0	1	0	0	3
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	3.01	3.26	2.42	1.99	2.57
	Incidence - Newly Acquired Pressure Ulcers Grade 2 (Target: <1)	3	9	4	4	44
	Incidence - Newly Acquired Pressure Ulcers Grade 3 and 4 (Target: <3)	4	3	3	8	22
	Safety Thermometer - Newly Acquired Pressure Ulcers Grade 2 – 4 (Target: < 4)	3	7	7	6	29
	Safety Thermometer - Harm score (Target: > 90%)	96.20%	92.30%	93.80%	95.20%	94.3%
HCAI	Clostridium difficile infections (Target: < 1.1)	0	0	1	0	1
	MRSA Bacteraemia (Target: < 0.5)	0	1	0	0	3
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	95.6%	96.0%	97.3%	97.6%	96.5%
	Screening all elective in-patients for MRSA (Target: > 95%)	89.1%	94.9%	96.40%	95.12%	92.60%
	Screening Emergency patients for MRSA (Target: > 95%)	95.8%	97.1%	98.20%	96.48%	97.9%
Incidents	Rate of pt. safety incidents resulting in severe harm / death per 100 admissions (Target: =0)	0.00%	0.00%	0.02%	0.00%	0.00%
	Never Events (Target: = 0)	0	0	1	0	1
Pathways	Stroke: Time spent on a stroke unit (Target: > 80%)	100.00%	100.00%	100.00%	100.00%	100.00%
	Proportion of people with higher risk TIA who are scanned and treated within 24 hours. (Target: > 75%)	83.3%	66.7%	100.00%	100.00%	81.3%
	Fractured Neck of Femur - Time to Theatre < 36 hrs. for Medically Fit Patients (Target: = 100%)	66.7%	100.0%	78.60%	88.90%	84.6%
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 71)			69.3	93.8	82.1
	Mortality SHMI (Target: < 77)	SHMI preview data 82.00 (Apr 12 to Mar 13)				

Commentary on key points

Pressure Ulcers Grade 3 and 4

Four in total, 3 of these were un stageable pressure ulcers related to the use of medical devices on ITU and in theatre/recovery. The 4th was an unstageable ulcer to the sacrum of a critically ill patient in ITU. There is ongoing work to look at device related ulcers and how these can be prevented, including a review of the types of masks and tubing used.

The Trust is currently not meeting the target set in relation to hospital acquired pressure ulcers of grade 2 and above. There are a number of actions underway to address this. A simpler risk assessment has been piloted as a component of the McKinsey led project on AAU and we are liaising with a range of other trusts to identify high impact measures that we can implement here. Work on pressure damage as a result of device related issues is continuing with our procurement team

Elective MRSA Screening

A taskforce continues to meet each month in order to analyse non compliance in the screening of elective patients, and identify actions to improve this. Issues include some patients who fall outside the 3 month screening period, and capturing of screening which is undertaken by GP's.

TIA

The Trust recorded 1 high risk TIA patient not treated within 24 hours in September; due to a delay in receiving the referral during the weekend.

SHMI

Preview data has been released for Apr 12-Mar 13 and the Trust score is 82 which means we would be in the 95th percentile across England. A contract indicator was set by commissioners to maintain the same or better SHMI value as the last data set (where the Trust score was 77). However, the Trust does not agree that this is a clinically meaningful way to assess mortality as the indicator can swing significantly based on a very small number of deaths, similarly to the monthly HSMR indicator. The Trust remains an excellent performer on mortality.

Clinical Effectiveness

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	YTD
A&E	A&E Time to Treatment (Target: < 60)	1:06	00:56	00:59	01:02
	A&E waiting times (Target: > 98%)	97.7%	98.2%	98.70%	98.4%
	A&E: Unplanned Re-attendances (Target: < 5%)	5.78%	6.41%	5.76%	5.89%
	LAS arrival to handover more than 60mins (KPI 3) (Target: = 0)	0	0	0	0
Admitted Care	Day case rate Relative risk (Target: < 100)	101.0	108.3	103.3	101.9
	Elective length of stay relative risk (Target: < 100)	123.5	131.4	115.0	123.9
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	3.46%	3.45%	3.12%	3.22%
	Non-Elective length of stay relative risk (Target: < 100)	83.4	81.9	87.3	84.4
Best Practice	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	97.8%	97.9%	97.2%	97.7%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	87.0%	92.3%	100.00%	95.1%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	87.5%	86.1%	84.60%	84.8%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	98.2%	95.6%	90.70%	95.0%
	% Patients Nutritionally screened on admission (Target: > 90%)	93.0%	91.7%	89.6%	92.2%
	% Patients in longer than a week who are nutritionally re-screened (Target: > 90%)	86.6%	54.10%	65.67%	72.6%
	Access to healthcare for people with a learning disability (Target: = 100%)	100%	100%	100%	100.00%
Best Practice CQUIN	VTE Assessment (Target: > 95%)	95.9%	95.7%	94.40%	95.40%
	Dementia Screening Case Finding (Target: > 90%)	89.0%	88.7%	87.7%	83.3%
	Appropriate referral Dementia specialist diagnosis (Target: > 90%)	Awaiting Sept figures	100.00%	100.00%	Awaiting YTD
	12 Hour consultant assessment – AAU (Target: > 90%)	51.7%	51.6%	43.7%	44.5%

Commentary on key points

A&E Time to treatment and waiting times: Performance dropped in September against the time to treatment indicator to just over an hour (1.06). The main reasons for this decrease in performance relates to activity peaks, some staffing constraints and a lack of cubicle space. We are in receipt of winter pressures funding, which we are investing in, to better align capacity and demand. Performance for October thus far is 98.4%.

A&E Unplanned Re-attendances: Main reasons for re-attendances are patients presenting with a new problem, patients presenting with a deterioration of their original condition, and patients and parents seeking reassurance about their original condition. Marked continuation of the action plans are in place which include, enhanced capturing of planned patients and improved patient information leaflets.

Elective Length of Stay:

Upon analysis of the long stays; many of the patients overstaying have been treated within the trauma and orthopaedic specialty, and later had post operative complications. There are action plans, in place to address increased re attendances. The division is leading a piece of work to systematically reduce length of stay moving forward.

Emergency Re-Admissions within 30 days: Analysis is on-going within Medicine to identify whether this data is representative of real performance. What is known is that when patients are transferred from one ward to another they can be discharged and admitted once again contributing to data quality issues. The Medicine management team do feel there is an issue with performance but not to the extent that current data suggests.

Nutritional Re-screening: Re-screening has been consistently under target, however performance has greatly improved since August and we are now within the amber threshold (87%) just below the 90% target. Improvements have been realised due to more focus and awareness on the rescreens. Out of 82 patients, 11 were unscreened.

Dementia Screening Case Finding: Performance has improved for patients with dementia and cognitive impairments and we are confident that we will achieve the required 90% by the end of October. Regular reminders and teaching for Junior doctors regarding the need to complete the dementia screenings will continue.

Appropriate referral dementia specialist diagnosis: The data for Q2 Appropriate specialist Dementia referrals has not been finalised as we are awaiting completion of the audit.

Clinical Effectiveness - Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Indicator		Goal	Measure	Sep-13	Aug-13	Jul-13	Jun-13	May-13	Apr-13		YTD
NHS Deliveries	Benchmarked to 5184 per annum	420 per month	NHS	393	408	437	422	424	402		2486
Private Deliveries	Benchmarked to 840 per annum	72 per month	PMU	65	52	67	56	61	52		353
Trust Deliveries	Total Maternities (Mother)	492	Trust	458	460	504	478	485	454		2839
Births	Total NHS Births (infants)		NHS	402	415	447	436	431	409		2540
	Home births	6 mth (1.5%)		6	2	6	5	6	6		31
Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)			189	214	204	190	196	185		1178
	Maintain normal SVD rate	52%	SVD Rate	48.1%	52.5%	46.7%	45.0%	46.2%	46.0%		
C- Section	Total C/S rate overall	<27%	reduce by 1%	32.1% **	27.7%	33.0%	38.2%	38.4%	31.3%		
	Emergency C Sections		No. of patients	68	63	70	79	94	64		438
			%	17.3%	15.4%	16.0%	18.7%	22.2%	15.9%		
	Elective C Sections		No. of patients	58	50	74	82	69	62		395
			%	14.8%	12.3%	16.9%	19.4%	16.3%	15.4%		
Assisted Deliveries	Ventouse, Forceps Kiwi		No. of patients	78	81	89	71	65	91		475
		10-15% (SD)	%	19.8%	19.9%	20.4%	16.8%	15.3%	22.6%		
PP Haemorrhage	Blood loss >4000mls		No. of patients	1	0	1	2	1	0		5
	Blood loss >2000mls	<10	PPH>2L	5	4	10	10	3	4		36
Perineum	3rd/4th degree tears	<5% (RCOG)		4	2	7	3	8	4		28
	Shoulder Dystocia					8	4	5	9		26
Stillbirths	Number of Stillbirths			1	5	5	1	3	2		17
	Maternity 12 week access	95%		Awaiting	97.6%	98.2%	95.3%	94.8%	91.0%		
Maternal Morbidity	Maternal Death		Incident Form	0	0	0	0	0	0		0
	ITU Admissions in Obstetrics	In 2 mths < 6	Patients		0	2	2	1	0		5
Serious Incidents	Serious Incidents (Orange Incidents)	0	Incidence		2	1	4	3	1		11
VTE	Assessments	90%		96.3%	97.2%	94.1%	98.1%	97.0%	98.0%		
Trust Level Indicators	Breastfeeding initiation rate	90%		92.1%	91.4%	92.9%	90.0%	91.5%	91.0%		
	Women smoking at time of delivery	<10%		1.5%	2.0%	2.5%	4.7%	2.4%	2.5%		

Commentary on key points

NHS Deliveries:

NHS deliveries in month are below plan and at the lowest level year to date, forecast deliveries look to remain below plan through October. The division is refreshing it's marketing plan to seek to redress this.

Our plans to increase deliveries include:

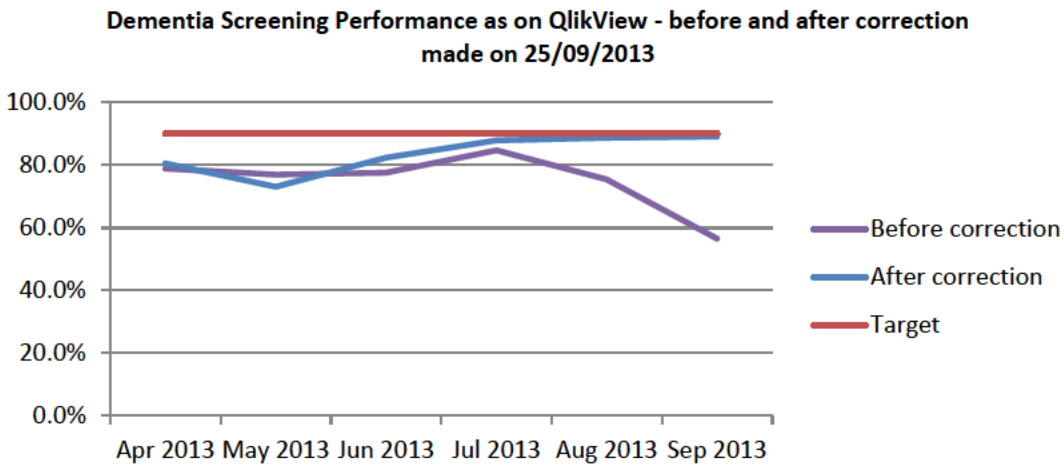
- the opening of the new midwifery led unit with a coordinated marketing strategy
- Increasing work in the Fulham & Wandsworth areas (for postnatal care)

This is against a background reduction in births across the North West London sector

A focus on discharge summaries from maternity triage has seen a considerable improvement in this KPI from August.

** Overall caesarean section rate based on data sourced from local maternity information system.

Clinical Effectiveness – Focus on Dementia



Dementia Screening: We have seen a steady improvement in screening patients for dementia and cognitive impairment and are confident that we will achieve the required 90% by the end of October – we have made significant improvements to the way the information is recorded and reported which has enabled us to have more confidence in the current figures – these figures have been validated against snap shot audits each month which have found a monthly increase in completion of the screenings by junior medical staff. Regular reminders and teaching for Junior doctors regarding the need to complete the dementia screenings continue.

Appropriate referral for diagnostic assessment: We are confident that in September we will continue to be compliant with the requirement to refer people at risk of dementia for onward assessment.

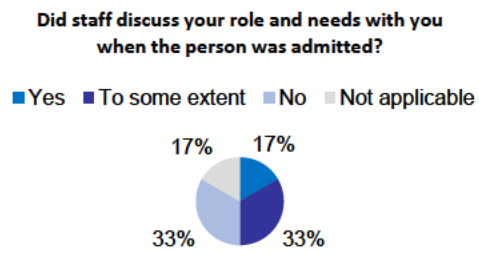
Dementia CQUIN: The Trust continues to focus on maintaining the excellent improvements in managing patients with Dementia. A Dementia Care Nurse Specialist is due to start in October. This CQUIN will form part of their portfolio - they will provide additional support to chase assessments that have not been completed and embed an awareness of the needs of patients with dementia with new junior doctor teams. An enhanced electronic solution is being developed with roll out due to take place at the beginning of October.

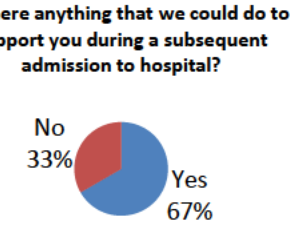
Carers Survey

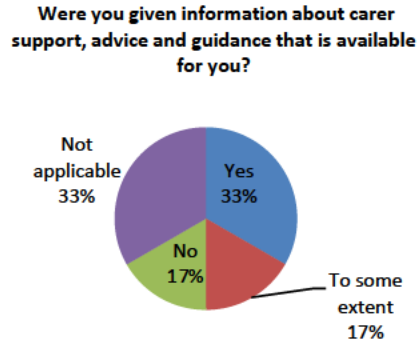
Work to implement a survey for carers of patients with dementia was initiated in April 2013. The drivers for this were the development of our trust Carers Strategy along with a dementia CQUIN focussed on dementia carers support. The survey is conducted for those who are informal carers of patients with dementia who have been discharged from Chelsea and Westminster Hospital. The patient may also have a formal package of care in place. The discharge team are asked each month to identify any patients / carers who meet the above criteria. The Deputy Chief Nurse contacts the carer following discharge to conduct the survey which along with responses gathers free text comments. Between April and August, 6 carers have been identified to complete the survey.

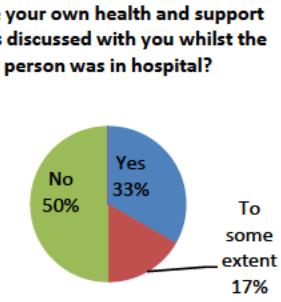
Results of the survey are fed back to the Trust Carers forum and will be integrated to the following developments

- Development of best practice standards for carer support
- Implementation of a carers care plan within inpatient areas
- Development of an intranet folder of carers information
- Development of a trust web site page for carers
- Seminars and awareness campaign to raise the profile of carers and their role in the hospital setting
- Continuing work with Carers UK , Social Services, Healthwatch and carer representatives
- Liaison with therapists and the new dementia case finder to identify wider numbers of carers for the survey









Patient Experience

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	YTD
Complaints	Complaints (Type 1 and 2) - Communication (Target: NA)	10	16	23	113
	Complaints (Type 1 and 2) - Discharge (Target: NA)	2	3	1	13
	Complaints (Type 1 and 2) - Attitude / Behaviour (Target: NA)	7	14	21	91
	Complaints Re-opened (Target: < 5%)	n/a	2.7%	1.2%	2.0%
	Complaints upheld by the Ombudsman (Target: = 0)	0	0	0	0
	Formal complaints responded in 25 working days (Target: > 90%)	n/a	75.00%	86.00%	82.00%
	Total Formal Complaints (Target: NA)	n/a	24	35	153
Cancellations	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	9.5%	9.2%	9.1%	8.5%
Friends and Family Test	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	95.00%	95.00%	94.00%	94.3%
	Friends & Family Test - Net promoter score (Target: >62)	64	66	66	66
	Friends & Family Test - response rate (Target: > 20%	24.8%	23.53%	30.20%	24.1%
	Breach of Same Sex Accommodation (Target: = 0)	0	0	0	0

Commentary on key points

Formal Complaints response rate within 25 days: Performance fell to 75% for August 2013. This is disappointing and the complaint team will continue to work with the divisions to achieve the required turnaround time for responses. We have recently reported our year to date performance on breaches to Trust Execs, from which the Divisional Directors are required to provide an update against any outstanding complaints and to ensure that these are followed up.

Hospital cancellations/reschedules of outpatient appointments: The process of GM authorised cancellation of clinics with less than 6 weeks notice is in place and early indicators show this has significantly improved performance recently. There is a proforma and a centralised clinic cancellation email inbox, which will go live on 14th October. We have reports showing volume of short notice cancellations through which we will monitor a reduction in the HIC rate.

Friends and Family Test: Maternity

The Maternity Friends and Family Test was launched 1st October 2013. The FFT is offered at four touch points during the patient pathway. A variety of methods are being used to deliver the test, as touch points 1 and 4 are mostly held in the community setting. Therefore the following methods are used:

36 weeks Antenatal screening appointment – text messaging
Post-labour ward – electronic questionnaire (i-pad)
Postnatal ward - electronic questionnaire (i-pad)
Postnatal community – paper questionnaire

The first month's data will be available mid-November

A&E response rate:

Accident and Emergency Response
There has been a dip in the A&E response rate during July and August but it was recognised that A&E faced challenges during this time period and clinical care was a priority. Attendances during August and September reflected early winter pressures; there was a changeover of F1 staff during August which caused more clinical burden on nurses.
This has been discussed with the A&E department and it has been agreed to further encourage all staff to offer the FFT. September's results increased to 17% with a Net Score of 71.

Latest results

September Performance
Some wards have challenges above others that prevent the uptake of FFT. For example, Nell Gwynn ward and Edgar Horne. These wards have a patient population that is elderly and have experienced debilitating conditions such as a stroke or dementia which inhibit communication, and therefore it is difficult to offer the FFT. Staff in these areas are encouraged to ask the patients relatives, friends or carers for their feedback. However, all wards during September achieved above the minimum response rate of 15%.

	Actual response	Eligible response	Response rate
A+E	187	1132	17%
Inpatient	412	1288	32%
Overall trust	599	2420	25%

Outpatient Pilot:

Chelsea and Westminster Hospital has agreed with NHS England to pilot some areas of outpatients. The programme will start November and include the following areas:

Treatment Centre (Day Case)
Endoscopy (Day Case)
John Hunter clinic (outpatients – sexual health)
Dean Street (outpatients – sexual health)
West London Clinic for Sexual Health) (outpatients)
Kobler Clinic (outpatients – HIV)

The FFT outpatients and day case will be mandatory in April 2014.

Delivering the questionnaire

An APP has been developed to accommodate the survey in all areas of the hospital: Maternity, Outpatients and Day Cases, A&E and Inpatients.
There are two i-pads in the Maternity Unit and a device for each area of the outpatient/day case pilot. There needs to be early planning for devices in outpatients and day care areas.

In addition, the inpatient wards and A&E should move over to the electronic version of FFT from April 2014 to save costs which are currently spent on external data input/analysis. This would then bring the entire FFT programme onto an electronic version. The long term costs will be significantly reduced by eliminating the need for external data analysis as the data submitted from the electronic questionnaire goes directly to the trust data warehouse and analysed with Click Start.

Monthly Trust Score						
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Patient Satisfaction	92%	96%	94%	94%	95%	95%
Response Rate	20%	22%	24%	24%	24%	25%
Net Score	63	68	69	66	66	64

Access and Efficiency (1)

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	YTD
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	92.4%	90.4%	90.2%	90.8%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	98.1%	98.1%	98.1%	97.8%
	18 week RTT incomplete pathways (Target: > 92%)	92.9%	92.2%	92.1%	93.0%
	RTT Incomplete 52 Wk. Patients @ Month End (Target: = 0)	0	0	0	2
OP	Choose and Book slot issues (Target: < 2.0%)	2.21%	2.09%	1.20%	2.10%
Cancer	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.00%	100%	100.00%	100.00%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	92.00%	100%	92.31%	91.41%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	No Pts.	No Pts.	No Pts.	No Pts.
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	No Pts.	No Pts.	No Pts.	No Pts.
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	98.90%	98.4%	96.22%	96.51%
	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	96.00%	100%	96.43%	97.95%
Referrals	Number of referrals (Target: = NA)	7283	7112	8377	46780
OP/ IP Waits	Average week wait for new outpatient appointment (Target: = NA)	5.8	5.4	5.4	5.3
	Average week wait for new inpatient appointment (Target: = NA)	9.0	7.8	9.4	8.9

Comments on key points

RTT Performance

Whilst Monitor assess each of these indicators at an aggregate Trust level, contractually we are required to meet each indicator at a nationally reported specialty level. Unfortunately, despite headline performance showing that we meet the indicators, there have been a number of challenges meeting them at specialty level.

In Q1, the total potential fine to the Trust could have been £58,385. However, as we have been working closely with commissioners in developing and implementing a recovery plan, they have agreed that they will only apply the fine for the 52 week breaches (£10 ,000)

As the recovery plan continued to be implemented in Q2, performance was planned to decline in August and as a result the potential fine for the Trust would be £88,065. However, we anticipate that commissioners will agree to reduce the fines, due to the continued close working between us.

Meanwhile our work programme to strengthen RTT management progresses well.

Demand and Capacity Planning

The Trust has now started a Demand and Capacity planning project supported by the NHS Intensive Support Team, to roll out a standardised best practice D&C tool across each key service line. The IST consultant will work with General Managers and teams, supported by Information / Performance, to complete the tool for a the highest priority areas over the next 6 weeks and to embed the knowledge and skills to continue the roll out locally. The output of this exercise will support Business Planning in identifying productivity opportunities, excess capacity and need for investment as well as generating a better understanding of our market and demand within the operational teams. The D&C tool can then be use on an on-going basis to support business cases and in-year developments

Access and Efficiency (2)

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	YTD
Admitted	Delayed transfers - Patients affected (Target: < 0)	Under development			N/A
	No urgent op cancelled twice (Target: < 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	0	0	0	0
	Theatre booking conversion rate (Target: > 80%)	88.1%	87.7%	87.40%	87.8%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	80.5%	82.1%	81.1%	82.1%
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	92.4%	91.1%	93.0%	93.3%
GP Real time	GP notification of an A&E-UCC attendance < 24 hours (Target: > 90%)	83.4%	84.1%	98.90%	80.9%
	GP notification of an emergency admission < 24 hours (Target: > 90%)	99.9%	99.7%	99.6%	99.9%
	GP notification of discharge planning within 48 hours for patients >75 (Target: > 75%)	68.6%	62.9%	76.3%	65.9%
	Discharge Summaries Sent < 24 hours (Target: > 80%)	82.6%	77.3%	78.80%	79.6%
	OP Letters Sent < 7 Working Days (Target: > 90%)	84.0%	89.8%	88.0%	89.2%
OP	DNA Rate (Target: < 11%)	10.0%	10.5%	10.30%	10.50%

Comments on key points

GP notification of an A&E attendance within 24 hours of discharge from A&E: Despite a significant improvement in performance in July, this suffered a decline in August and September due to a technical issue which is currently being investigated. A fix will be implemented as soon as possible.

GP notification of discharge planning within 48 hours of admission for patients >75 admitted as emergencies: Whilst there has been a significant increase in the number of patients with a Planned Date of Discharge, attention now needs to be focused on ensuring that this is entered into Lastword as soon as possible, so that it can be communicated to GPs.

Full Discharge summary available to GPs within 24 hours of discharge: The Trust continues to maintain focus on this indicator and regularly communicates the importance of this with clinicians. In order to further improve the discharge process a working group has been set up to look at Best Practice for Discharge Summaries. Having developed the Best Practice Guide staff are being encouraged to give patients their discharge summary before they leave the Trust. We have seen improvement in performance as a result of these efforts.

GP notification of Outpatient care delivered within 7 working days of appointment and with key information headers: The Trust convened a working group to review the current process to improve efficiency. Out of this working group the Trust has developed a best practice guide for clinical and administrative staff to ensure the target is met. Alongside this the Trust has enhanced the system used to create and send letters (Bighand); these developments alongside the other outputs from the working group will be incorporated into a workshop for the medical secretaries. Similarly to above, we anticipate the embedding of best practice will sustain compliant performance in future.

Sub Domain	Month/Year	Sep-13	Aug-13	Jul-13	YTD
HR	Agency Staff % (Target : < 3.65%)	4.6%	4.3%	5.00%	4.7%
	Average Recruitment Time (Target : < 70)	80	68	77	70
	Vacancy Rate (Target : < 8%)	9.74%	9.95%	7.45%	8.43%
	Appraisal completion rate (Target : > 87%)	88%	87%	86.00%	86%
	Sickness Rate (Target : < 3.65%)	3.43%	2.97%	3.22%	3.21%
	Turnover Rate (Target : < 13.5%)	13.52%	14.00%	14.22%	14.28%
	Mandatory Training (Target >75%)	77%	77%	76%	75%
	Staff Engagement (Target Q1: >4*)	4.05	4.15	4.16	4.10

Positives

Sickness Absence - The Trust's sickness absence rate in September 2013 was 3.43% (3.21% ytd). This was higher than previous months, with the early onset of the cold and flu season, however remained marginally lower than September 2012 (3.49%). Following a review of current sickness rates for the year, the sickness target for the year has been reduced to 3.5% and the QIPP project begun in 2012 is continuing in 2013/4 to support this reduction. HR is currently reviewing the issue of non-reporting and will be implementing changes to improve compliance.

Staff Engagement- The Trust commenced its pilot of local staff surveys in April 2013. In September, staff in Anaesthetics, Burns Unit, A&E, HIV/Research, Mercury and Medical Secretaries, were surveyed. As a proxy for staff engagement we will be measuring staff willingness to recommend the Trust either as a place for friends or relatives to receive treatment ('Friends and Family' test) or as a place to work. On a Likert scale of 1-5, where 5 is the most positive; the overall score for staff willingness to recommend the Trust was 4.05 in the September surveys, with a YTD measure of 4.10. This compares favourably with a score of 3.87 in the 2012 NHS Staff Survey.

Red – below both monthly target and 2012/3
Amber – below either monthly target or 2012/3
Green – above monthly target and above 2012/3
*Source 2012 NHS Staff Survey (weighted data)
**Mandatory training represents % of completed relevant training within refresher period.
NB: Year to date figures represent the average metric rate across the financial year to date

Areas for focus

Bank & Agency Usage – The Trust showed an increase in Bank and Agency usage for September, up by 44.02 WTE on September 2012, with an increase in both Bank and Agency usage. Nursing remains the largest cohort of Agency staff at nearly 8.4% of the Nursing workforce, with the Trust having spent nearly an additional £1 million on agency nursing than the previous year. Several workstreams across the Divisions supported by HR and Finance have been established to increase controls for Agency usage in the Trust. The Trust is currently reviewing the use of quota controls to manage the usage of temporary nursing staff, as well as a review of the level of authorisation required for Nursing agency bookings. Staffbank recruitment campaigns are planned for the remainder of the year to increase our pool of available temporary workers.

Vacancy Rate – The Trust's vacancy rates are calculated using the budgeted WTE (based on reconciliations with the Finance department), and the WTE of staff inpost at the end of the month. This represents the 'total vacancy' position. The full Trust vacancy rate for September 2013 was 9.74%, which represents an increase of 1.12% on the previous year. The Trust Executive has recently re-introduced a centralised Establishment panel to review all non-clinical posts to support the Trust Recovery process. It is expected that this will have an impact on the vacancy rate as non-clinical vacancies will only be recruited to by exception. Finance and HR have embarked on a full establishment reconciliation to support the Trust Recovery plans and we expect that some of these vacancies will be eliminated as part of the cost improvement plans.

A truer measure of vacancies is those posts being actively recruited to, based on the WTE of posts being advertised through NHS jobs throughout September 2013. The active vacancy rate is currently 3.22% which is above target. This was due to recruitment of a group of Healthcare Assistants following a Recruitment Open Day. The active vacancy rate remains below target for the year.

Staff in Post – In September the Trust staff in post position stood at 2982.95 WTE (whole time equivalents) with the substantively employed workforce increasing by 58.31WTE (2%) since September 2012. Unplanned turnover (i.e. resignations) stood at 13.52% for the month, although higher than target, this is lower than recent months, and is the lowest rate of 2013. Turnover was highest amongst the Nursing & Midwifery Band 5 and Healthcare Assistant Band 2 staff. The most commonly stated reasons for leaving are due to promotion or relocation. Human Resources has refreshed its exit interview process to help us understand the reasons for this increased turnover better.

Time to recruitment – The time to recruit for September new starters was 80 days (once international recruitment is excluded.) Although this is higher than target and year to date, it should be noted, that the Trust commences recruitment of newly qualified nursing staff for September well in advance to ensure we are able to recruit the best quality staff. This has had the impact of increasing the time to recruit, however this remains in target year to date.

Compliance against trust wide mandatory training September 2013

Division	Total	Clinical Support Services Division	Management Exec & Corporate Services Division	Medicine,Surgery & Private Patients Division	Womens, Childrens and Sexual Health Division
Fire	68%	73%	67%	62%	69%
Moving & Handling	72%	77%	69%	65%	73%
Safeguarding Adults Level 1	100%	100%	100%	100%	100%
Slips Trips and Falls	72%	76%	69%	66%	75%
Harrassment & Bullying	82%	86%	78%	81%	81%
Information Governance	68%	72%	76%	67%	61%
Hand Hygiene	73%	77%	69%	69%	74%
Health & Safety	72%	76%	69%	63%	76%
Child Protection Level 1	100%	100%	100%	100%	100%
Innoculation Incident	73%	74%	42%	88%	76%
Basic Life Support	58%	63%	61%	51%	59%
Health Record Keeping	78%	83%	83%	73%	79%
Medicines Management	86%	89%	93%	85%	85%
VTE	81%	85%	87%	77%	81%
Blood	76%	81%	83%	72%	77%
Safeguarding Children Level 2	81%	83%	80%	73%	85%
Safeguarding Children Level 3	74%	75%	0%	87%	73%
Corporate Induction	73%	74%	42%	88%	76%
Local Induction	69%	80%	62%	61%	65%
Mandatory Training Compliance %	77%	80%	70%	75%	77%

Information Governance

In order for the Information Governance training to be auditable we have refreshed how training will be delivered via Learn Online. We will be securing take up to adhere to our target of 95 %.

Upon this information, we will be contacting the heads of all the Departments directly to provide them with regular updates for their staff, as well as make use of the Daily Communications email to make staff aware of this essential mandatory training. The Trust must achieve 95% pass rate for Information Governance training by the end of March 2014.

Division	Appraisals
Total	88%
Clinical Support Services Division	95%
Management Exec & Corporate Services Division	91%
Medicine,Surgery & Private Patients Division	71%
Womens, Childrens and Sexual Health Division	89%

The Trust has continued to make good progress on achieving it's target of 90% of staff having an appraisal within the last 12 months. Fortnightly updates are provided to the Trust Senior Operational Group, and employees with a due or overdue appraisal have been emailed about arranging their appraisal. Although Mandatory training figures continue to increase, and remain above the London average, further work is being undertaken by the HR and Education teams to increase compliance. During September the Workforce team began roiling out individual Learning Statements to Trust employees, giving them visibility of what training they are required to undertake and advising them how to access the training. This should have the effect of giving employees greater responsibility for their personal training.

Finance Balanced Scorecard

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

APPENDIX B

Financial Overview as at 30th September 2013 (Month 6)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Mth 6 YTD Var	Mth 5 YTD Var	Forecast
Income	(353,717)	(174,152)	(177,096)	2,944	2,169	(361,058)
Expenditure	320,733	159,593	164,264	(4,670)	(4,233)	329,331
EBITDA for FRR excl Donations/Grants for Assets	29,531	13,558	11,832	(1,726)	(2,064)	28,274
EBITDA % for FRR excl Donations/Grants for Assets	8.4%	7.8%	6.7%	-1.1%	-1.5%	7.9%
Surplus/(Deficit) from Operations before Depreciation	**32,984**	**14,558**	**12,832**	**(1,726)**	**(2,064)**	**31,727**
Interest	829	414	418	(4)	(4)	808
Depreciation	12,907	6,496	6,379	117	112	13,249
Other Finance costs	0	(0)	(8)	8	8	292
PDC Dividends	10,241	5,119	5,207	(88)	1	10,415
Retained Surplus/(Deficit) excl impairments	**9,007**	**2,529**	**837**	**(1,693)**	**(1,946)**	**6,963**
Impairments	0	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	**9,007**	**2,529**	**837**	**(1,693)**	**(1,946)**	**6,963**

Comments

Risk Assessment

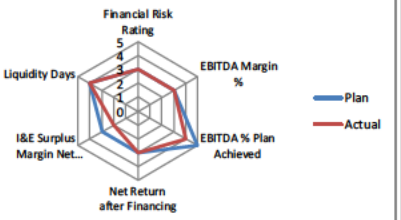
Impact 4 – Major (Loss of between £1m and £4.9m). Likelihood 3 – Possible **Orange**

The YTD position is an favourable variance of £0.8m (EBITDA of 6.7%) which is an adverse variance of £1.7m against plan.

I&E position (£1.7m) includes the following material items:

- Un-achieved CIPs (£3.1m);
- Private Patients Income is £0.3m behind plan;

Risk Rating (year to date)

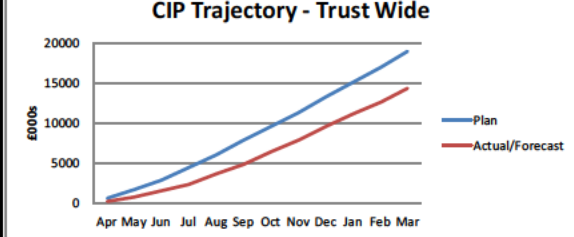


Comments

The weighted average FRR for month 6 is 3.15 which rounds down to a 3, which is an improvement on the month 5 YTD actual rating of 2.85. The reason for the improvement in month is the fact that the % of EBITDA plan achieved has improved to 88.9%, which is a 4 (compared to a 3 last month) and the Net Return after Financing has improved to a 3 (compared to a 2 last month). These improvements are due to the increased surplus position in month 6.

The COSR rating YTD is a 3 against a planned 4.

Cost Improvement Programme



Comments

CIPs 13/14

The CIP target for 13/14 is £18.9m (£16.9m for 13/14 + £1.9m b/f from 12/13).
The year to date position was a plan of £7.9m, with delivery of £4.8m.
Schemes totalling £14.3m have been forecast to achieve in 13/14.

Trajectory

It was proposed that all Divisions should have identified 100% of CIP schemes by 31st May. Followed by a further detailed trajectory of 100% achievement by 31st Jan 2014.

There is slippage on the CIP plan, that is being offset by additional recovery schemes

NHS Clinical Income (£000)

Division	Directorate	Point of Delivery	M6 YTD Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
CLINICAL SUPPORT	DIAGNOSTICS	Elective	3,378	3,722	344	2,086,411	2,293,869	198,458
		Non Elective	11	15	4	40,028	46,166	6,138
		Other	31,798	30,100	-1,698	1,166,119	1,088,807	-76,312
		Outpatients	14,551	15,069	518	1,280,710	1,350,800	70,090
	DIAGNOSTICS Total		49,737	48,906	-832	4,681,269	4,778,642	197,373
	PERI-OPERATIVE THEATRES & ANAESTHETICS	Elective	4	3	-1	26,412	20,049	-6,363
		Non Elective	131	186	55	142,631	190,247	47,617
		Other	1,554	1,533	-21	2,260,965	2,164,658	-96,308
		Outpatients	180	162	-18	15,584	13,933	-1,651
	PERI-OPERATIVE THEATRES & ANAESTHETICS Total		1,868	1,884	20	2,445,592	2,388,887	-56,705
	THERAPIES	Other	21,780	16,006	-5,774	887,090	718,202	-168,888
		Outpatients	21,272	23,374	2,102	1,158,961	1,276,365	107,404
	THERAPIES Total		43,052	39,380	-3,672	2,060,061	1,994,567	-61,484
CLINICAL SUPPORT Total			94,657	90,174	-4,484	9,082,911	9,162,096	79,184
MEDICINE AND SURGERY	MEDICINE	A&E	55,298	55,903	605	5,446,629	5,587,190	40,561
		Elective	2,380	2,642	262	1,424,158	1,768,491	344,336
		Non Elective	9,934	8,882	-1,052	11,279,887	10,890,106	-389,782
		Other	773	420	-353	399,311	276,361	-122,950
		Outpatients	39,543	41,172	1,628	5,974,096	5,861,944	-112,152
	MEDICINE Total		107,928	109,019	1,090	24,524,034	24,384,090	-239,943
	SURGERY	Elective	5,698	6,506	808	10,445,938	10,768,330	322,395
		Non Elective	3,529	3,306	-223	6,643,603	6,469,771	-73,732
		Other	1,363	1,208	-155	1,729,310	1,970,366	241,057
		Outpatients	51,300	53,884	2,584	6,243,636	6,351,012	107,174
	SURGERY Total		61,891	64,904	3,013	24,062,586	25,559,479	606,893
MEDICINE AND SURGERY Total			169,820	173,923	4,103	49,586,619	49,943,569	366,950
OTHER	OTHER	Elective	0	0	0	-21,012	0	21,012
		Non Elective	0	0	0	-2,421,418	-679,865	1,741,546
		Other	372,604	372,413	-191	7,343,718	7,867,173	523,467
		Outpatients	5,833	3,207	-2,626	-1,361,043	-409,426	851,617
	OTHER Total		378,437	375,621	-2,817	3,540,246	6,777,879	3,137,632
OTHER Total			378,437	375,621	-2,817	3,540,246	6,777,879	3,137,632
WNS/CYP&/HIV/SH/Dem	CHILDREN'S AND YOUNG PEOPLE'S SERVICES	Elective	4,114	4,499	385	5,269,486	5,264,341	-4,866
		Non Elective	3,194	3,588	394	4,061,688	4,067,581	15,893
		Other	7,574	7,540	-34	7,277,465	7,061,002	-216,467
		Outpatients	27,852	26,212	-1,640	5,198,624	4,765,462	-433,063
	CHILDREN'S AND YOUNG PEOPLE'S SERVICES Total		42,734	41,839	-895	21,787,160	21,159,386	-627,770
	HIV/SEXUAL HEALTH AND DERMATOLOGY	Elective	4,891	2,778	-2,113	1,832,449	1,487,440	-345,009
		Non Elective	419	555	136	1,274,152	912,647	-361,504
		Other	-2,894	864	3,758	106,213	106,576	363
		Outpatients	74,305	78,787	4,481	37,913,661	39,959,725	2,046,065
	HIV/SEXUAL HEALTH AND DERMATOLOGY Total		76,721	82,984	6,262	41,126,474	42,466,392	1,339,919
	WOMEN'S AND NEONATAL SERVICES	Elective	1,297	1,496	199	1,673,881	1,755,839	81,959
		Non Elective	7,589	7,012	-577	8,381,946	8,112,097	-269,851
		Other	75	37	-38	667,316	708,256	40,939
		Outpatients	17,736	18,278	542	8,387,895	8,331,432	-56,464
	WOMEN'S AND NEONATAL SERVICES Total		26,697	26,823	126	19,111,048	18,907,624	-203,416
WNS/CYP&/HIV/SH/Dem Total			146,163	161,646	6,493	82,024,678	82,533,402	608,730
Grand Total			789,057	791,363	2,295	144,334,459	148,416,946	4,082,486

Comments

The table above summarises the NHS Clinical Income position for Directorates/Divisions and POD for month 6 of 2013-14

Key Financial Issues

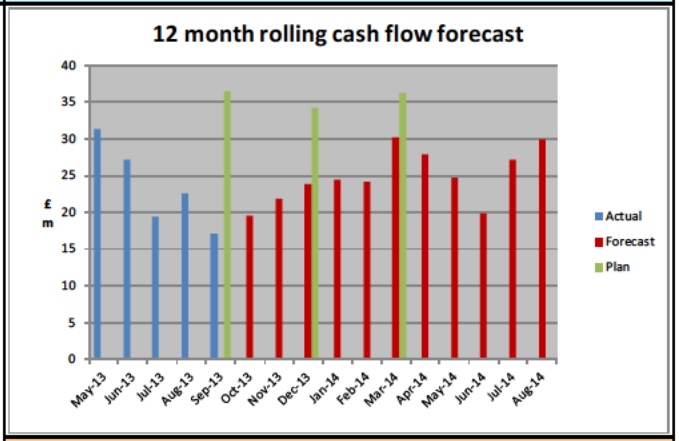
Key Issues

- **Trust forecast adverse variance of £2.0m**
  - **including delivery of recovery plans**
- **CIP 13/14 identification and achievement**
  - **including FYE of 12/13 (b/f)**
- **additional mitigations have been agreed by Execs around control of temporary staffing, non pay and contractual penalties**
- GUM Public Health commissioning & payment
- Delivery of the Trust's activity plan
- Achievement of commissioner metrics
- Achievement of CQUIN targets for 2013/14

Future Developments

- Strategic developments e.g. West Midd, SaHF
- West Middx at the Strategic Outline Case stage
- Operationalising the capital plan
- ED capital redevelopment
- Business Planning for 2014/15
- Delivery of increased Private Patient income plans

Cash Flow



Comments

The cash position as at Month 6 is £17m, £19.5m below plan. The key issues driving the adverse variance are the YTD I&E deficit, together with trade receivables being above plan due to issues around collection of cash from CCGs and transfer of GUM commissioning to Local Authorities. Both these issues have been escalated and the cash position is expected to improve going forward.

Deep Dive: A&E, Emergency Care and Winter Plans

Chelsea and Westminster Hospital NHS Foundation Trust

Context and Aim

The Trust needs to ensure resilience for the coming winter 2013/14, delivering safe and effective care while maintaining high standards of patient experience and performance. A number of initiatives are in place to this end, with winter planning having started pre-emptively through spring and summer with the Emergency Care Pathway Programme. This focus report describes the risks, mitigations, and resulting position moving into the winter period.

A&E performance and Admission trends

C&W has consistently delivered best in class performance on A&E waiting times, but during 2012/13 winter, and already this autumn, significant challenges have been experienced. The Trust remains a top performer with >98% patients waiting less than 4hrs in Q1 and Q2, although performance was 97.7% in September when significant peaks in demand occurred. These challenges are mirrored amongst peers and across the country.

Risks of the winter period

A&E and bed capacity come under pressure during winter due to a number of seasonal factors including:

- A more complex case mix leading to an increase in length of stay
- Reductions in timely discharge of patients due to increased demand on capacity in community / social care
- Increased demand for acute services due to higher levels of infection within the Community; bed closures due to infectious outbreaks
- Unplanned absence of staff due to seasonal illnesses and/or adverse weather conditions

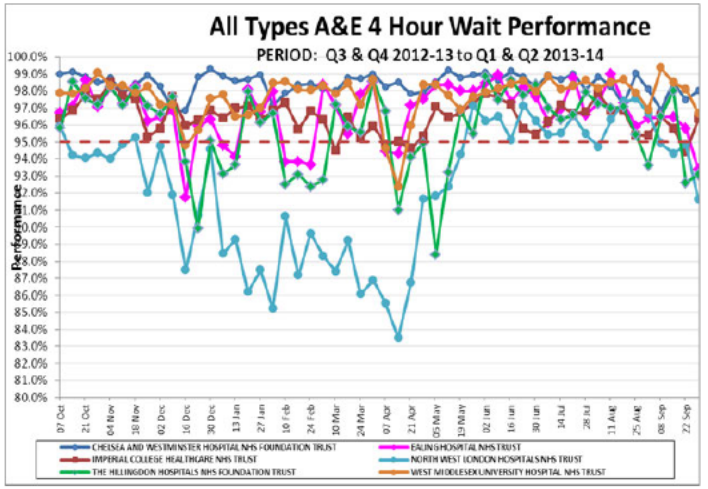
This results in consequences to the Trust which include difficulty managing flow through A&E, wards and critical care, increased outliers, cancelled operations and delays to ambulance handover.

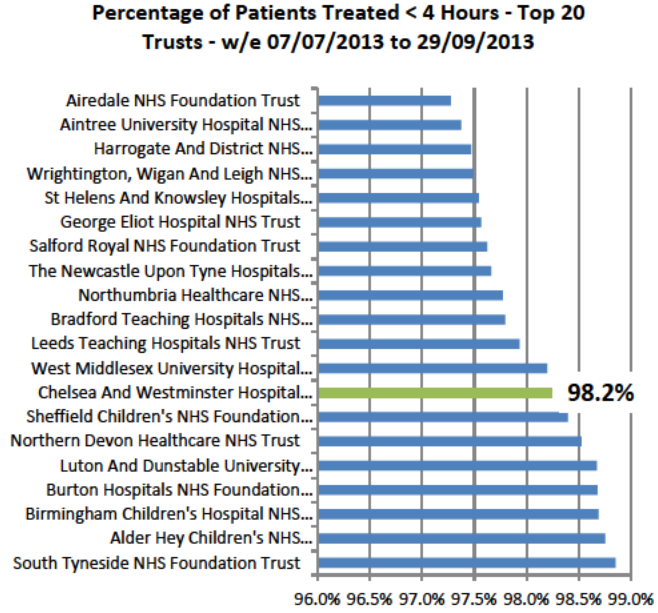
Approach to Winter Planning 2013/14

Significantly, the Trust is moving into winter this year in the context of having no additional acute bed escalation capacity available due to the use of SMA ward as decant for the Burns redevelopment. In previous years there was the ability to open up to 28 beds on an ad hoc basis and this facility was used to manage peaks in demand; it will no longer be available for 2013/14. On top of this the Trust's CIP plans require 10 beds to be closed on NG ward. Within the planning process the Trust also identified that a 4% increase in A&E attendances is expected.

To mitigate these risks the Trust has proactively put in place a strategic programme with community partners through the Emergency Care Pathway work, which aims to reduce emergency admissions and LOS by diverting to community and ambulatory care. GE Healthcare are supporting this programme and a number of initiatives are in place, as described subsequently. The Trust has also taken full part in winter planning with NHSE and NWL commissioners through short stay modelling and the assessment and documentation of risks and mitigations. Building on both the ECP programme and the commissioning assurance programme the Trust has had the opportunity to make proposals for winter pressure funding and has been successful (£340k) in gaining support for a number of areas including senior support in A&E, ambulatory care, and step down beds (£730k).

In terms of learning from previous years, the Trust will be continuing the senior management on-call system for weekdays which worked well, and focussing on ensuring winter pressure schemes are implemented early and escalation processes are robustly implemented, particularly to support in-sector diversion where appropriate. The implementation of A & E step down beds as part their plan represents a change in model and will help us pilot these images in care pathway management.





Emergency Care Pathway Programme (1)

Emergency care pathway programme overview

A transformational change programme has been initiated between C&W, CLCH, CCG Commissioners and social care to deliver a step change to the emergency care patient pathway. Contractual decisions mean that the incentives for these organisations are aligned to improve the emergency care pathway.

The overall aim of the programme is to reduce avoidable attendance and admissions and better manage the flow of emergency patients through and out of the hospital, in order to improve patient care and deliver savings. A summary of the three C&W focussed programme workstreams and initiatives in place is presented below. CLCH the community provider in the Tri-Borough is also working on a 4th workstream which addresses their internal processes and bed capacity requirement.

Front Door: A&E	Acute Flow: AAU/ Inpatient	Back End: Discharge
Frequent attenders (with MH/ Frequent Admission) – identification, reducing impact, new pathways	Virtual ward – transfer of patient home with daily consultant review and fast track access to diagnostics	Discharge transformation – internal process improvement around Board Rounds, DSUMs, Discharge Assessment, and patient info
Community In Reach Team – in A&E and on wards, diverting to community care	Diagnostic fast track – focus on long wait areas	Single point of referral – enhanced liaison with social care to speed discharge
A&E flow – Rapid senior assessment, diagnostics, and specialty pathways	Urgent surgical pathway – ambulatory pathway for acute surgical patients	Continuing care – streamlining referral/assessment process to speed discharge
Hot Clinics – same/next day clinics for acute patients replacing admission and wait for review	Capacity modelling – development of whole hospital flow model to understand bed requirement	Transitional care – development of Step Down bed facilities, use of Medihome

The programme builds on work already in progress within the Trust where new models of care that aim to deliver an enhanced patient experience as well as more effective care, for example:

- The development of a case management model
- The implementation of extended consultant cover and senior decision making in A&E and AAU
- The set up and expansion of ambulatory care treatment services
- The Discharge Transformation project , which is enhancing discharge planning through internal process improvement

Emergency Care Pathway Programme (2)

Emergency care pathway programme metrics

The programme references a number of audits particularly the Day of Care audit which suggested some 25% of patients in hospital beds at C&W could be cared for elsewhere (May 2013). The success of the programme will be measured through a number of means including process measures tracked on a weekly scorecard (see below), contractual metrics which demonstrate a reduction in use of emergency care, and the experience of and success in managing the winter pressure period.

Week Ending	20/10/2013	13/10/2013	06/10/2013	Sep-2013	Trust YTD	Trust YTD Monthly Trends
A&E Attendances (Run Rate)	204.29	230.86	229.43	213.52	221.53	
A&E waiting times (Target: > 98%)	98.32%	98.46%	97.07%	97.36%	98.08%	
Reducing emergency admissions (A&E Conversion Rates) (Target: N/A) *	21.74%	18.64%	18.51%	20.79%	19.51%	
Reducing emergency admissions (Emergency Admns over A&E Attends) (Target: < 23.5%) *	22.16%	22.71%	20.32%	24.55%	23.09%	
Emergency Admissions (Run Rate)	46.71	45.14	39.00	44.97	44.95	
Emergency Discharges (Run Rate)	45.14	48.00	37.71	44.19	44.82	
12 Hour consultant assessment - AAU Admissions (Target: > 90%)	63.29%	63.27%	74.12%	56.49%	50.44%	
Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	N/A	N/A	N/A	N/A	88.5%	
Completion of Predicted Discharge Date within 48 hours of admission (Target: = 100%)	79.25%	69.06%	72.66%	73.82%	78.18%	
Accuracy of Predicted Discharge Date (Target: = 100%)	45.28%	50.36%	46.09%	39.09%	43.33%	
Discharges between 8am and 11am (%) (Target: > 40%)	6.12%	8.64%	4.74%	5.67%	6.23%	
Emergency Re-admissions within 30 days (adults only) (Target: <2.78%)	3.10%	4.70%	3.34%	4.11%	3.75%	
Emergency Length of Stay (Average)	3.50	4.07	5.46	4.55	4.46	
Number of Excess Bed Days (NEL Freeze position) ^	N/A	N/A	N/A	0	1971	
Reduction in Excess Bed Days as a % of Spells (NEL) ^*	N/A	N/A	N/A	0.00%	17.43%	
Reduction in Excess Bed Days as a % of Spells (Contract) ^*	N/A	N/A	N/A	0.00%	9.85%	

Modelling of patient flow and bed changes

A NHSE/NWL modelling exercise and process of winter planning assurance has been undertaken with commissioners in parallel to the Emergency Care Pathway work in order to meet sector requirements. This showed that, in line with strategic direction, there is potential to reduce C&W bed requirements by more effective use of ambulatory care and by right sizing bed capacity between AAU and Downstream wards.

Within our ECP programme, GE have helped develop a sophisticated model which simulates patient flow through the hospital and allows scenarios flexing different variable s to be tested. This has been done for scenarios which reflect the key initiatives within the ECP programme to see their impact on bed requirements as illustrated in the table here. The first section reflects the reduction in beds from 12/13 to 13/14 and the increase in demand driving a “gap” of 12 beds. 4 scenarios are considered including admission reduction, increased use of Ambulatory care, earlier discharge from short stay and reduced LOS. The aggregated effect in terms of bridging the gap is shown, with the RH column showing the likely impact given overlap between the patient affected by the 4 scenarios. I

n summary, the initiatives in progress would be realistically able to largely but not entirely bridge the gap in beds and it is important that the programme addresses inter provider collaboration needed to deliver effective out of hospital care options that enable these initiatives

Acute Bed Type	2012-13 Count	2013-14 Count	Gap to Sustain 2012-13 Congestion Levels	Scenario 1: ED Adm Reduction	Scenario 2: Ambulatory Care	Scenario 3: Onward Transfer Reduction	Scenario 4: LOS Reduction	Total BEST CASE (no overlap)	Total LIKELY CASE (with overlap)
Obser-vation	15	15	2	-2	-2	-1	-1	-6	-3
Short Stay	44	44	0	0	0	0	0	0	0
Down-stream	233	222	9	-3	-3	0	-4	-10	-7
Intensive Care	13	13	1	0	0	0	-1	-1	0
		Totals	**12 beds**	**-5 beds**	**-5 beds**	**-1 beds**	**-6 beds**	**-17 beds**	**-10 beds**

Winter Risks and Mitigations - Conclusion

The risk factors, mitigation schemes and outcome risk ratings for winter 2013/14, given the work described above, are summarised here:

Factor	Risk	Rating	Mitigation Scheme(s)	Supported by	Residual risk / rating
Increasing demand for emergency care Late delivery of OOH schemes Restricted space in A&E	Flow in A&E bottlenecks, delayed LAS handover	High	Additional consultant , SHO and nursing resource in A&E Front end initiatives	Winter pressure funding from NWL Internal improvement through ECP programme	Med-High
No escalation capacity Late delivery of OOH schemes	Outlier patients, cancelled operations, risk of outbreak, diversions	High	Additional nursing and medical support to ambulatory care Acute flow initiatives	Winter pressure funding from NWL Internal improvement through ECP programme	Medium
Complex casemix Ineffective process/ liaison with community and social care Increased demand for same	Increased LOS and patients not cared for in right setting	Very High	Therapies support for wards CLCH Step Down beds at CXH Back end initiatives	Investment of £730k in Step Down beds Internal improvement through ECP programme Collaborative process improvement with community partners	Medium

Conclusion: CLCH step down beds are key for this winter; internal process flow and collaboration with partners are critical for long term successful management of emergency care

The key to success this winter will be the proposed opening of 20 ‘step down/intermediate care’ beds by CLCH, who have been awarded £730k to open these beds assisting both C&W and ICHT to move non-acute patients who await on-going care At any time, these patients can be occupying up to 15 beds on downstream wards (GE analysis), therefore having the ability to transfer would allow for new acute and specialty patients to be transferred on from AAU and significantly bridge the bed gap previously described.

Over the next year the wider ECP programme will need to deliver both internally and externally to support ongoing effective management of emergency care in a financially challenged environment with reconfigurations such as SAHF to be accommodated. This will continue to be a top priority for the Trust moving forward.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.1/Oct/13
PAPER	Assurance Committee Report to the Board for July 2013
AUTHOR	Catherine Mooney, Director of Quality Assurance
LEAD	Richard Kitney, Non-executive Director
PURPOSE	The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed and the Assurance Committee's views on the level of assurance for each issue, where this is possible. The Assurance Committee will also escalate to the Board where appropriate. The paper is for information but also to allow any directors to raise any issues or queries about the matters in the paper.
LINK TO OBJECTIVES	The Assurance Committee assures on quality. The items discussed at the meetings are relevant to the quality objectives.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A summary of the issues discussed at the meeting in July 2013 is attached.
DECISION/ ACTION	For information.

ASSURANCE COMMITTEE REPORT FROM MEETING JULY 2013

1. Introduction

The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed at the July meeting. This paper includes the Assurance Committee's views on the level of assurance for each issue, where this is appropriate.

2. Background

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

3. Items discussed at the Assurance Committee in July 2013

3.1 Facilities Report

It was reported that Norlands are doing a good job and there are no major problems. The current sewage problem was discussed. Deep cleaning has not been successful in eradicating the odour and there have been complaints from staff and patients. Inappropriate products (fabric bandages etc.) have been discarded in toilets blocking the pumps and causing a back flow into ward areas.

Documented procedures for dealing with local electrical failure in in all crucial areas have now been completed. Norland carry out its own Fire Safety training and are encouraged to attend the Trust sessions. 46% of Norland staff have done so.

ISS is performing well. Deep cleaning of all areas is taking place.

It was noted there appeared to be fewer recycling bins at this Trust compared to others. New bins are expected at the beginning of August and a new Waste Manager is commencing 1st August.

The recent transport incident was noted. This is reported separately to the Board .

The Facilities team has been successful in two out of three project bids to the Department of Health relating to Carbon - £1.3m to install LED lighting principally in patient and public areas and just under £1m to install additional waste heat recovery to the boilers to generate hot water.

The Committee noted the report and the good performance from the contractors.

3.2 Monthly report on local quality indicators (May)

The main areas of concern were discussed. This included MRSA, timeliness of complaints responses, compliance with care bundles relating to peripheral line continuing care and pressure ulcers. The measures in place to address performance were also highlighted.

The Committee were concerned at the performance on some indicators but were assured that plans are in place to address them.

3.3 Never Events Assurance Report
The updated RAG status report was attached, focussing on the status of Never Events which have not yet been graded green.

The Committee will continue to monitor assurances around never events.

3.4 Top Concerns from Medical Director and Nursing Director
These were identified to be pressure ulcers and noise at night which is an issue which has been raised by patients. The high level of activity on AAU is proving a challenge.

A key piece of work will relate to issues highlighted by the Keogh report and continuing to work on the responses to Francis.

The committee noted the top concerns of the concerns of Medical Director and Nursing Director and the ongoing work in relation to the Francis Inquiry report

3.5 Report from the Trust Executive Quality Committee, July
This was noted.

3.6 Induction and Statutory and Mandatory Training Annual Report 2012/13
The annual report was presented. Overall compliance has increased to 69% from 61%.

Key achievements for the year include that Individual training records are now more accessible and monitoring of staff compliance by topic is easier to access. Update days are now in place which is an effective way for staff to complete mandatory training. Steps to improve attendance for mandatory training are being taken, with incentives to comply and consequences for non-attendance related to pay. An e learning video for non-clinical staff lasting 45 minutes has been produced.

Areas to work on include staff bank induction and under reporting the attendance of nurses at clinical update.

The Committee welcomed the report and the achievements but remain concerned about overall progress.

3.7 CQC Quality and Risk Profile update Q1
It was noted that none of the reported risks are rated red or amber and that overall we are green or yellow.

The Committee noted the report.

3.8 CQC Standards – Provider Compliance Assessments (PCAs) amber risk
An update on the risks identified from completing the PCAs for the CQC standards was presented.

Remaining risks include discharge and care of the older person and risk of failing to recognise and respond to the deteriorating patient which will not be green until we are confident that all early warning systems are embedded and appropriate escalation is occurring. The Board will also be aware of the 5 day turnaround time for clinic letters for discharge in all areas.

The Committee noted the risks which are recorded on the PCAS and which are being addressed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.1/Oct/13
PAPER	Assurance Committee Report to the Board for September 2013
AUTHOR	Catherine Mooney, Director of Quality Assurance
LEAD	Karin Norman, Non-executive Director
PURPOSE	The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed and the Assurance Committee's views on the level of assurance for each issue, where this is possible. The Assurance Committee will also escalate to the Board where appropriate. The paper is for information but also to allow any directors to raise any issues or queries about the matters in the paper.
LINK TO OBJECTIVES	The Assurance Committee assures on quality. The items discussed at the meetings are relevant to the quality objectives.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A summary of the issues discussed at the meeting in September 2013 is attached.
DECISION/ ACTION	For information.

ASSURANCE COMMITTEE REPORT FROM MEETING SEPTEMBER 2013

1. Introduction

The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed at the September meeting. This paper includes the Assurance Committee's views on the level of assurance for each issue, where this is appropriate.

2. Background

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

3. Items discussed at the Assurance Committee in Sept 2013

3.1 Report from the September Health, Safety and Fire Committee

The report this month provided an update on the controls and assurances in place.

Preparation for the NHSLA assessment identified some gaps in the reporting template as not all the relevant information was being provided and monitored and this would be addressed.

Clinical Support Services presented an excellent and comprehensive review of risk assessments across all their areas at the health and safety committee meeting and it was agreed that this approach would be adopted by all Divisions. This would be labour intensive initially but would be used to populate the on line risk register once it is available and can then be monitored.

All Control of Substances Hazardous to Health (COSHH) risk assessments have been completed and Lone Working risk assessments and spot checks have been undertaken for potential high risk areas.

Measures that the Trust might use to confirm a positive Health and Safety culture were discussed and other sources would be investigated.

The goal is to integrate clinical and non clinical safety, with both reporting to the Director of Nursing and Quality, to merge Health and Safety and Patient Safety and embed as part of the culture of the organisation. The eventual method of integrating the two is work in progress.

The committee noted the continue work on health and safety on which it is still not assured.

3.2 Safeguarding Adults 6 monthly report

The 6 monthly report was presented. Although there are robust controls in place for monitoring and the Trust engagement with multi-agency policy and procedures and that assurance is comprehensive, there is no assurance that the alerting and information sharing system, the Confidential Social Information Log is being used appropriately, and this is being pursued. This would yield information in particular regarding the support of people with a learning disability.

Information is obtained from a number of sources including incidents and complaints and Divisional nurses undertake a valuable role in escalating safeguarding concerns. 80% of alerts are raised by the Trust.

Information regarding Adult Safeguarding is available on the intranet and training is provided.

Any safeguarding allegations are required to be reported externally with the investigation led by social services. In the Trust, all Safeguarding incidents are escalated as orange incidents and a root cause analysis is undertaken for each one. Where an allegation has been made against a member of staff, HR processes are in place.

The Committee noted the report and were assured that robust systems were in place for reporting and follow up of safeguarding alerts but noted the gap with respect to the flagging system.

3.3 Safeguarding Children report (April 12 to June 13)
This report covering April 12 to June 13 was presented.

Training was highlighted and the work that is on-going to improve the number of staff undertaking level 2 and level 3 training.

The report on the CQC/Ofsted visit in April 2012 was noted.

The methods for alerting clinicians to issues were described including a child protection management proforma for inpatients completed by medical consultants which includes history, the name of the parent/carer, child, social worker, school etc.

DNA's (patients who did not attend appointments) are tracked on Last Word and followed up. There are regular audits including ensuring safeguarding issues are noted and a child with safeguarding issues is followed up. There is no centralised system so regular liaison with social services is important.

The audit of the quality of discharge summaries showed that all DSUMs (Discharge summaries) are completed within 24 hours.

The Committee noted the report and the areas of concern – training and liaison with the community.

3.4 Emergency Preparedness 6 monthly report
The overall summary is that there is still work to do. A great deal of planning is being undertaken and 'command and control' has been tested and used on a few occasions and plans and procedures are in place. NHS London and the PCT does now not exist in the new NHS structures and has been replaced with NHS England. Work is in progress to determine the response in the event of an incident.

During the last weekend there was an exercise to assess the response to a large event; lessons were identified and are being addressed.

An audit on CBRNE Decontamination was undertaken in June by NHS England and London Ambulance Service and the Trust's plan was rated well and will be used as a model for best practice.

The potential risks with the move to IP telephony in clinical areas were outlined and the mitigation in place. The risk has been comprehensively assessed, the action plan is robust and an update is expected this week.

The committee noted that there is work on-going but more is required especially with the new NHS structures. It was requested that there was more clarity on available assurances.

3.5 Monthly report on local quality indicators
The areas where performance was rated red and the action to be taken was discussed by the committee. This included hand hygiene audit completion rates, incident reporting rate, pressure ulcers, and the turn-around target time for response letters to complaints, however, a measure of the quality of responses, complaints upheld by the ombudsman is rated green.

The committee were concerned about the number of red areas but recognised some of the targets may be challenging.

3.6 Mortality indicators
The mortality indicators update on the Trust performance against the SHMI and HSMR mortality indicators. Key points were outlined noting that information is very out of date. The results show that the Trust is one of the lowest in the country although not among the top performing London teaching hospitals. However, problems with coding were identified during an audit of Gastrointestinal (GI) haemorrhage mortality cases as there was no evidence of GI haemorrhage in some of the cases. Quality of coding is being addressed e.g. through mortality and morbidity meetings.

HSMR excludes palliative care. If mortality is coded as palliative care it drives down the figures. The Trust is below average in terms of those coded as palliative care on admission and in terms of people who die the Trust is noted as average. This provides some reassurance that our numbers have not been understated (too positive).

A paper is to be submitted to the next Finance and Investment Committee which describes how coding is linked to tariffs and this is another important reason why coding is important.

The Trust will continue to monitor this data until the Department of Health advises otherwise. It is important to use as part of other data.

3.7 Top Concerns from Medical Director and Nursing Director
The only new addition to the current concerns was the inclusion of noise on the wards at night.

3.8 Infection Control Annual Report
This is on the Trust Board agenda

3.9 Learning Disabilities 6 monthly report
The Trust is able to demonstrate overall compliance with the CQC performance standards.

Key items include the appointment of a new lead and the implementation of a new training plan.

The Committee noted the good progress

3.10 Out of hours – is there a risk?
The committee has been interested in data which looks at the risk out of hours. To date, this has suggested that there is not a particular risk out of hours but different data will continue to be looked at until there is a clear picture.

The committee were assured that there is no data to support an increased risk out of hours but agreed that this will be a question we should be asking continually and it should be kept on the agenda.

3.11 Confidential Enquiry Study report
The Trust is participating in 3 national open studies relating to Subarachnoid Haemorrhage, Tracheostomy Care and Lower Limb Amputation and enquiries relating to MBRRACE-UK, Head injury in children, Child health reviews and Suicide and Homicide by people with Mental Illness.

The concerns expressed by clinicians are the resource demands involved in coordination and support required to participate in the studies.

The Trust is adhering to the agreed process for participation in these national studies but the resource demand was noted.

3.12 Report from Trust Executive Quality Committee October
The paper provides a summary of the key issues raised at the recent meetings.

Changes to the Quality Committee are being considered as the agenda is so heavy. This is work in progress.

3.13 Equality and Diversity 6 monthly report
The paper provides a summary of the progress made against the Trust's equality objectives and highlights priorities for the next 6 months.

The legal requirements under the Equality Act 2010 and Public Sector Duty 2011 are highlighted in section 2. The Trust has to demonstrate due regard to the need to eliminate discrimination, harassment and victimisation and promote equality of opportunity.

The progress being made against the equality and diversity objectives was outlined: a work plan detailing progress between March – September 2013 was attached to the paper.

This is an area where the Committee will focus further until assurance is obtained.

3.14 Mandatory Training
A summary progress report on mandatory training was presented. The highlights are that there has been steady increase in the number of staff undertaking mandatory training across the board, with one Division being mainly green at this point. The aim is for 85% compliance by the end of this financial year.

The Appraisal Policy now states that annual increments will be withheld if Mandatory Training is not up to date.

The Committee welcomed the report and the achievements although still felt progress was slow.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.2/Oct/13
PAPER	Infection Control Annual Report 2012/13
AUTHOR	Dr Berge Azadian, Director of Infection Prevention and Control Roz Wallis, Nurse Consultant Infection Prevention and Control
LEAD	Elizabeth McManus, Executive Director of Nursing and Quality
PURPOSE	It has been brought to the Board given the importance of Infection control at the Board level.
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness CQC standards: 8: Maintaining a clean environment and protecting people from infection 4.a Care and Welfare of People who use the service 10. Safety and Security of Premises NHSLA objectives: 4.6 Hand Hygiene Training 4.7 Inoculation Incidents 5.6 Screening Procedures
RISK ISSUES	No
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW	No

REQUIRED?	
EXECUTIVE SUMMARY	An annual report to the Board on infection prevention and control is a statutory duty. The Infection Prevention and Control Team (IPCT) implement the annual programme and policies; makes clinical decisions on the prevention and control of infection and advises other staff. The IPCT ensures that there are processes to manage risks associated with IPC through the statutory requirements of the Health Act 2008, the associated CQC criteria and Level 2 NHSLA Risk Management Standards. This paper outlines the statutory assurance measures related to infection prevention and control, summarises performance against these and provides links to more detailed information within the Infection Prevention and Control Annual Report. What are the main issues covered by the paper • Compliance with Statutory Requirements • Serious Incidents • Antibiotic and Proton Pump Inhibitor (PPI) Prescribing • NHS Litigation Authority (NHSLA) Risk Management Standards: • MRSA Screening • Decontamination • Standards of Cleaning: • Water Assurance • Hand Hygiene • Saving Lives Care Bundles • Education and Training • Body Fluid Exposure • Infection Control Team Activity **What are the controls in place?** Infection prevention and control committee (monthly review of KPI's) DIPC and infection prevention and control team

	Infection Prevention and control link nurses in clinical areas Education and training of staff Synbiotix system for electronic recording and reporting of infection control audits including hand hygiene Root cause analysis of all hospital acquired C diff cased and MRSA / MSSA bacteraemias SUI panel reviews of all MRSA bacteraemias **What are the gaps in controls** (*Where are we failing to put controls/systems in place/where are we failing to make them effective e.g. we know there is insufficient training in place, or a procedure needs reviewing, or the use of a practice is unknown.* **What assurance is there?** Monitoring of; Mandatory targets for MRSA bacteraemias and hospital acquired C difficille MSSA bacteraemias , ecoli and VRE Hand hygiene completion and compliance MRSA screening compliance for elective and emergency patients 'Saving Lives' care bundles for peripheral and central venous access and urethral catheters Alert organism surveillance for MRSA Isolates and Resistant Gram Negative Bacteria (RGNB) Isolates Orthopaedic Surgical Site Surveillance Outbreaks, Clusters, Incidents and Exposures **What are the gaps in assurance? What we are doing to address gaps in assurance?** There are no identified gaps in assurance **Where we have assurance what does it tell us?** The average hand hygiene compliance has increased over the last year from 94% (average compliance 2011/12) to 94.5% (2012/13). The average percentage for MRSA screening was 91.48% for electives and 98% for emergencies against a target of 95% screening A target of 90% was set for each of the Saving Lives care

	bundles. The key area of focus is on improving compliance with the peripheral line care bundle 2 serious incidents were investigated through a root cause analysis and appropriate actions initiated Our infection rate for orthopaedic surgical site infections for the last four reported quarters was 1.4%. This is above the national average of 0.7%. An audit to look back at all infections since 2010 is being initiated. ***Overall summary – consider are you happy with the situation you are describing and why? Or if not, why not?** Overall there are robust controls in place to monitor and manage the prevention and control of infection. Assurance of these controls is through a comprehensive process of monitoring and surveillance which identifies any compliance issues. A copy of full report is available on request from Vida Djelic, Board Governance Manager.
DECISION/ ACTION	For information.

1.0 Introduction

1.1 This paper summarises the measures taken to protect patients and staff against infection, and provides assurance to the Board in relation to the Trust's compliance with the statutory requirements of the Health Act 2008 and CQC Quality Standards:

- Mandatory surveillance reporting and progress against targets
- Cleaning and decontamination
- Hand hygiene
- Antibiotic prescribing
- Education and training
- Body fluid exposure
- The Infection Prevention and Control Team Annual Programme

2.0 Background

2.1. The IPCT aims to ensure there are processes in place to manage risks associated with infection prevention and control through statutory surveillance; the maintenance of Level 2 NHSLA Risk Management Standards, and compliance with the 10 Care Quality Commission (CQC) criteria for infection control.

2.2. The IPCT implements an annual programme and policies, makes clinical decisions about the prevention and control of infection, and advises staff on the management of infection and the reduction of infection risks.

2.3. The team meets this role through the following functions;

- Identification and control of outbreaks
- Education of hospital staff
- Monitoring of hospital hygiene
- Production and review of policies
- An annual programme of surveillance
- Reporting on key incidents, actions, surveillance and audit results.
- Liaison with clinical teams on development of standards, audit and research.

3.0 Compliance with Statutory Requirements

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

3.1.1 **Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia:** The DH MRSA Target for 2012-2013 was two hospital acquired cases. The Trust had one case which was hospital acquired (in ITU in November 2012);

therefore the Trust did not incur any penalties. The DH has set a zero tolerance target for MRSA bacteraemias in 2013-14. (See section 7.1 in the annual report for further information).

3.1.2 **Clostridium difficile:** The target set by the Department of Health for 2011-2012 was 31 hospital-acquired (HCAI) cases. At the end of the financial year 2012/13 we had 15 toxin positive cases of Clostridium difficile. We are required to report cases which are both PCR gene positive and toxin positive and undertake Root Cause Analysis (RCA) on each HCAI gene/toxin positive case to support the identification of practice that can be improved and share learning. The target for 2013-14 is no more than 13 HCAI toxin positive Clostridium difficile cases. (See section 7.2 in the annual report for further information).

3.1.3 **Orthopaedic Surgical Site Infections (OSSI):** It is a mandatory requirement to collate data in at least one category of orthopedic surgery for at least one quarter per year using national criteria set by the Health Protection Agency (HPA). At Chelsea and Westminster Hospital NHS Foundation Trust all patients undergoing total hip replacements are monitored for OSSI. Between April 2012 and March 2013, there were 213 elective operations that met the HPA category for hip replacement carried out. There were 3 wound infections reported within this period; 1 superficial and 2 deep wound infections. Our infection rate (at the time of writing this report) for the last four reported quarters was 1.4%. This is above the national average of 0.7% (calculated over the last 5 years). Data was also collected from April 2012- to March 2013 inclusive of all repair of neck of femurs. A total of 120 procedures were reported to the HPA for this period of which only 1 deep wound infection has been reported to date. This puts us slightly above the national average of 0.7% for the last 5 years. (See section 7.3 in the annual report for further information).

Mr Charlie Gibbons (CB), Orthopaedic Consultant Surgeon, has conducted an audit to look back at all infections that have occurred since continuous surveillance began in 2010. At the time of writing the annual report a letter had been drafted on behalf of the orthopaedic consultants, to the Chief Nurse and the Chief Operating Officer requesting orthopaedic patients to be ring-fenced, i.e. placed separately from general surgical patients, in line with BOA best practice guidelines.

3.1.4 **Glycopeptide Resistant Enterococci (GRE):** GRE bacteraemias are subject to mandatory surveillance but no target. Vancomycin Resistant Enterococci (VRE) are the most frequently occurring GRE bacteraemias and are reported to the DH as part of the mandatory surveillance scheme. Between April 2012 and March 2013 we had 1 VRE bacteraemia.

3.1.5. **Methicillin Sensitive Staphylococcus Aureus (MSSA):** The DH requires mandatory surveillance of MSSA bacteraemias. We had 19 HCAI and 23 CAI MSSA bacteraemias in 2012-13. The PCT included a target of 18 HAI MSSA bacteraemias as part of our contract in 2012-13. This was the first MSSA target we have had. This will reduce to a target of no more than 15 HCAI cases in 2013-14. (See section 7.5 in the annual report for further information).

3.1.6. Since June 2011 the DH has introduced mandatory surveillance of E.coli Bacteraemia. There are no targets associated with this. We have had 75 blood culture positive cases in 2012-13. 11 were likely to have been HCAI. In

2013/14, the internal target agreed with our commissioners is no more than 11 'likely to be HCAI' cases.

3.1.7 NHS Trusts have not been required to report rates of resistant Gram-negative organisms to DH. However, the Infection Control team closely monitor local incidence. In 2012/13, the majority of the Trust's resistant Gram negative organisms have been Extended-Spectrum Beta-Lactamases (ESBLs). This correlates with a national trend reported by the HPA.

3.1.8. **Serious Incidents (SI's):** In 2012-13 there were 2 SI's. One was an MRSA bacteraemia in ICU, the root cause of which was considered to be multiple visiting clinicians; the other was two Clostridium difficile cases that occurred in the same bay and same week on Rainsford Mowlem ward. The investigation demonstrated that the cases were unrelated. There were also 8 clusters of infection of which three were diarrhoea with no causative organism identified, 11 infectious disease exposures of which seven were Chickenpox, 1 outbreak of Acinetobacter Baumannii in the Burns Unit

3.2 **Antibiotic and Proton Pump Inhibitor (PPI) Prescribing:** C&W pharmacy department have worked with Trust medical colleagues and primary care colleagues to address the inappropriate overuse of PPIs at C&W. Since proactive interventions have been introduced, the Trust has realised a 30% reduction in PPI usage in 2012/13 compared with 2009/10 with the trend continuing to decrease.

The Trust can demonstrate strong adherence to antibiotic guidelines through regular audits of antibiotic prescribing, with in-patient prescribing consistently remaining above 90% compliant to guidelines / specialist microbiology advice. Funding has also been secured to support the development of a smartphone app to aid user access to the antibiotic guidelines.

3.3 **NHS Litigation Authority (NHSLA) Risk Management Standards:** The Trust achieved the Level 2 NHSLA Risk Management Standards for Infection Prevention and Control and Hygiene in December 2011. The Trust has remained at Level 2 in 2012-13 and an assessment for Level 3 is scheduled for 13/14.

3.4 **MRSA Screening**: MRSA screening of elective and emergency patients has continued in 2012/13. The target is to screen 95% of both elective and emergency admissions. Elective admissions must be screened up to three months prior to admission, emergencies within 24 hours of admission. In 2012-13, the average percentage screened was 91.48% for electives and 98% for emergencies. There has been a steady improvement in both categories and it is a small number of patients (up to 10 per month) that have prevented us from achieving our target of 100%.

3.5 **Decontamination:** A National decontamination programme has been implemented in the Trust and all invasive medical devices (surgical instruments and flexible endoscopes) are decontaminated in the Trust's centralised Sterile Services Department and Endoscope Decontamination Unit. Both units successfully passed an annual audit by the Notified Body in July 2012 and are compliant with the requirements of the Medical Devices Directive 93/42EEC and ISO EN 13485,ISO 9001.

3.6 **Standards of Cleaning:** In 2012, 1451 cleanliness audits were conducted across all risk categories with 96% of these audits being jointly conducted

with a Trust member of staff maintaining the 3% improvement achieved from previous year. The average cleaning score for 2012/2013 was 98.96%, which is an improvement of 0.18% compared to last year.

3.7 **Water Assurance:** The Trust extended its programme of Legionella control to include testing and control of Pseudomonas aeruginosa in augmented care areas (ITU, NICU, Burns). This was a mandatory change required by Health Protection England. Water temperature and quality monitoring by Norland's has continued with 31230 tests being completed, through the use of the ZetaSafe system. The overall ratio for required temperatures being achieved was 97% and performance increased to 98% in March 2013.

3.8 **Hand Hygiene:** The target for completion of audits is 100% whilst for compliance it is 95%. The average hand hygiene compliance has increased over the last year from 94% (average compliance 2011/12) to 94.5% (2012/13). 96.26% of hand hygiene audits were completed compared to 93.63% the year before. Action plans are completed if compliance is below target and progress reported to the Divisional Boards. This is monitored in the monthly Infection Prevention and Control Committee.

3.9 **Saving Lives Care Bundles:** A target of 90% was set for each of the Saving Lives care bundles. The average Trust compliance for both Adult and Paediatric Peripheral lines (PVC) and Central lines (CVC) compliance (respectively) for the year April 2012-March 2013 can be seen below:

Adults:

- PVC: 79% compared to 78% in 2011-12
- CVC: 94% compared to 87% in 2011-12
- Urinary catheters: 91% compared to 92% in 2011-12

Paediatrics:

- PVC: 49% in 2012/13
- CVC: 89% in 2012/13

3.10 **Education and Training:** Education has continued to be a priority in 2012/13. Sixty four% of all current staff have completed either their mandatory update or induction against a Trust target of 80%. The Target increases to 85% for 2013-4, and thereafter it will be 95%. The Infection Prevention and Control Team provide training for staff across the organisation including mandatory training for all staff, mandatory updates for clinical staff and the provision of a wide range of additional education and training as required.

3.11 **Body Fluid Exposure (BFE):** There were that there were 133 body fluid exposures between Jan and Dec 2012, 106 were Percutaneous and 27 Mucocutaneous. Doctors are the staff group with the highest percutaneous injury rates and nurses have the highest mucotaneous injuries.

4.0 Infection Control Team Activity

4.1 **Infection Control Link Professionals:** The ICLP system commenced in July 2005, being developed by the Infection Prevention and Control Team as a local initiative based on National Audit Office (2000) recommendations. 42 ICLPs were trained in the Trust in 2012-13. To date 288 ICLPs have completed the training and 176 are still active in the Trust.

4.2 **Flu Response:** The IPCT supported the flu response through processes established in previous seasons. Staff Vaccination began in October with 1862 staff vaccinated in 2012/13.

4.3 **Auditing Activity**: The IPCT has facilitated auditing of hand hygiene, Saving Lives Care Bundles (both described above), daily hygiene code checks and matrons weekly audit. All are recorded on the Synbiotix system. Audits of antibiotic prescribing in inpatient and outpatients have also taken place.

4.4 **2012/13 Infection Control Team Annual Programme:** The Trust Infection Prevention and Control Team under the leadership of the DIPC and Chief Nurse have overseen the Annual Programme of work during 2012/13. Key objectives were to reduce hospital-acquired infection rates, to further reduce the risk of infection through improving key aspects of clinical care, to improve staff engagement and public awareness by further developing staff training and patient information.

4.5 **2013/14 Infection Control Team Annual Programme:** During 2013/14, the IPCTs key objectives for the coming year include; reducing hospital acquired infections, the prevention and early detection /treatment of blood stream infections and the prevention of orthopaedic surgical site infections. Key focuses of work will be improving compliance with 'Bare Below the Elbows', the proposal to acquire an infection control software package to improve the efficiency of the Infection Prevention and Control Team and further developing the skills and knowledge of staff, ensuring evidence based clinical guidance on IPC practices.

5.0 Summary

5.1 The Trust has made significant improvements over the year in the way in which patients and staff are protected from acquiring infections whilst in hospital, and in controlling infections when they do occur. Particular achievements have been reduction in *Clostridium difficile* cases, increased MRSA screening, increased hand hygiene compliance and increased awareness by staff and patients of key issues through a comprehensive signage programme. This included the Trust wide roll out of automated gel dispensers, signage by the lifts and escalators and on entrances to wards and speaking signs which have been fitted by the lifts and on entrances to some ward areas (activated during the day by movement sensors).

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

6.0 Decision

6.1 To note the contents of the annual report.

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.3/Oct/13
PAPER	Response to the Francis and Keogh Reports
AUTHOR	Tony Pritchard, Deputy Chief Nurse
LEAD	Elizabeth McManus, Executive Director of Nursing and Quality
PURPOSE	To provide our trust response to the Francis report recommendations and Keogh report Ambitions To provide feedback from our trust 'Listening Events'
LINK TO OBJECTIVES	• Improve patient safety and clinical effectiveness • Improve the patient experience • Deliver excellence in teaching and research • Ensure financial and environmental sustainability
RISK ISSUES	No
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	Following the publication of the Francis Report, all Chairs and Chief Executives were asked to ensure their organisations considered the report in full, considered whether it accepted the 290 recommendations and to

	undertake a listening exercise with its staff. The outcome of this must be presented to a public board meeting. A subsequent report by Professor Sir Bruce Keogh KBE was published in July 2013. This looked at the quality of the care and treatment provided by 14 trusts identified as having higher than average death rates in the previous two years, and set out 8 Ambitions. This paper presents the feedback from our listening exercises held within the trust. Our responses to the relevant recommendations contained within the Francis Report along with the Ambitions identified within the Keogh report are presented within an action plan.
DECISION/ ACTION	For approval.

Response to Francis and Keogh Reports

1.0 Introduction

1.1. Following the publication of the Francis Report, all Chairs and Chief Executives were asked to ensure their organisations considered the report in full, considered whether it accepted the 290 recommendations and to undertake a listening exercise with its staff. The outcome of this must be presented to a public board meeting.

1.2. A subsequent review into the quality of care and treatment provided by 14 hospital trusts in England was commissioned by David Cameron and undertaken by Professor Sir Bruce Keogh KBE.

1.3. This paper presents the feedback from our listening exercises held within the trust. Our responses to the relevant recommendations contained within the Francis Report along with the Ambitions identified within the Keogh report are presented within an action plan.

2.0 Background

2.1 An initial independent inquiry was undertaken into the failings of care at Mid Staffordshire NHS Foundation Trust which occurred between 2005 and 2009. This, along with a series of recommendations was published in 2010. Andrew Lansley then requested a further enquiry which was led by Robert Francis. This investigated the failings at Mid Staffordshire and considered the lessons for the wider NHS. The report containing 290 recommendations was published on the 6th February 2013.

2.2. A subsequent report by Professor Sir Bruce Keogh KBE was published in July 2013. This looked at the quality of the care and treatment provided by 14 trusts identified as having higher than average death rates in the previous two years. Though there were pockets of excellent practice in all 14 of the trusts, there was also significant scope for improvement.

3.0 Francis Report Recommendations

3.1. The Francis report made a total of 290 recommendations, and the essential aims were to;

- Foster a common culture shared by all in the service of putting patients first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern.
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients - individuals and organisations properly accountable for what they do and to ensure that the public is protected from those not fit to provide a service.
- Provide a proper degree of accountability for senior managers and leaders to protect the interests of patients.

- Enhance the recruitment, education, training and support of all the key contributors to healthcare, in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything we do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

4.0 Keogh Report Ambitions

The Keogh report identifies the following 8 Ambitions;

- Progress towards reducing avoidable deaths in hospitals
- Boards and leadership of provider and commissioning organisations to confidently and competently use data and other intelligence for quality improvement. Along with patients and public, have rapid access to accurate, insightful and easy to use data about quality at service line level.
- Patients, carers and members of the public being treated as vital and equal partners in the design and assessment of their local NHS. Confidence that feedback is listened to and makes impact on care.
- Patients and clinician confidence in the Care Quality Commission quality assessments as active participants in inspections.
- No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.
- Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.
- Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.
- All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

5.0 Our response to Francis Recommendations and Keogh Ambitions

5.1 Recommendations detailed within the Francis report have been reviewed by the clinical governance team to identify those that are relevant to Chelsea and Westminster Hospital. Following this, the executive leads have discussed the list in order to agree where there remain actions for us to take forward.

5.2 The 8 Ambitions detailed within the Keogh report have been reviewed in detail through our Quality Committee.

5.3 An action plan providing a response to relevant Francis recommendations and Keogh ambitions is provided in appendix 1.

6.0 Our listening exercise

6.1 Our approach:

6.1.1 Following the publication of the Francis report, The Trust arranged listening events from April through to June to listen to our frontline staff. The listening events were run by the Executive Directors initially and then by other managers in the organisation. Governors were invited to attend these events.

6.1.2 A total of 20 listening events were run. 18 of these were open to any staff and were attended by a cross section of clinical, administrative and managerial staff, whilst 2 focussed specifically on the engagement of support workers.

6.1.3 The purpose of these events was to provide staff with an overview of key recommendations from the Francis report, and to discuss the following questions:

- How do we always ensure we put the patients first, how can we improve?
- How do we support our staff to speak out, how can we improve?
- Is there anything else we should be doing?

6.1.4 Feedback from these discussions with staff was captured by the facilitator for each event. Detailed feedback is provided against each theme from the Francis recommendations in appendix 2, whilst the following provides an overview of the themes and responses.

7.0 Key themes and responses from listening events

The following provides a summary of the key themes from listening events which are aligned to the themes of the Francis recommendations

7.1 Putting the patient first

- Ensure that we listen to, inform, engage and respect our patients, and develop services around their needs
- Ensure that we have patient representatives who reflect the needs of all service users, engaging patients in service developments and seeking engagement from our stakeholders
- Develop a comprehensive range of ways in which we seek feedback from patients and families including surveys, patient stories and senior visits, and link this into learning and improvement.

7.2 A common culture

- Continue to embed our trust values, relate these to individuals and teams, and build into our processes of recruitment, education, training and development.
- Focus on ways of challenging and managing inappropriate attitude and behaviour of staff, and those who don't demonstrate the trust values.
- Develop a range of approaches towards positive recognition of staff, recognising and rewarding those who live the values and are positive role models

7.3 Standards of service

- Set clear expectations about clinical and non-clinical standards at induction, ensure that processes are clear to all our staff and that training of staff in monitored
- Ensure that safety is maintained and that all staff know what is expected of them
- Ensure that we work in a consistent way with the same standards for everyone

7.4 Complaints handling

- Ensure that patients and families are clear about how they can raise a concern or make a complaint, and that they receive a timely and appropriate response to these
- Develop ways in which patients and families can discuss concerns with staff informally
- Provide ways to demonstrate learning and actions taken as a result of feedback from patients and families

7.5 Performance Management & Information

- Identify metrics to monitor the effectiveness of service developments and provide assurance against the impact of key cost improvement programmes
- Develop clear metrics of quality, safety and patient experience as a component of the trust and divisional performance dashboards in order to understand areas of success and concern
- Ensure a robust audit process as an approach to quality assurance.
- Use a range of approaches to assessing the quality of the service. Empirical data along with direct observation and feedback from patients, families and staff
- Ensure that staff have access to key information on performance

7.6 Openness, transparency and candour

- Ensure that all staff know who they can speak to and make sure they receive appropriate feedback about any suggestions or concerns that they raise
- Facilitate the opportunity for staff to speak freely in a supportive impartial environment
- Ensure that we listen to staff feedback and concern and enable staff to make appropriate decisions

7.7 Nursing

- Invest in training and development of staff in their customer service skills, their understanding of the importance of patient experience, caring and compassion..
- Focus on the recruitment and retention of permanent nursing staff, ensure adequate staffing levels and reduce the dependence on temporary staff
- Develop partnerships with carers to promote consistency and continuity in care for patients
- Ensure that we focus on patients fundamental needs such as nutrition and hygiene

7.8 Leadership

- Value everyone's contribution and the of shared responsibility of all staff in the care of the patient
- Ensure that clinical and non-clinical managers have the skills and knowledge to lead and manage effectively

- Focus on the development of the Ward manager supervisory role to support effective communication, coordination and leadership in the clinical setting

8.0 Patient Experience Summit

8.1 In addition to our listening events, we ran a Patient Experience Summit on June 12th. 140 staff, governors and stakeholders attended this event.

8.2 A key focus was the development of 'Always Events' which were identified through discussion of the same 3 questions used in our listening events. These were subsequently presented in a sequence of publications on the trust Daily notice board and are detailed in appendix 2.

9.0 Next Steps

9.1 Our listening events and review of the Francis and Keogh reports have identified many areas of action for us to consider. The Trusts next step is to pull together a plan as to how we take the outcome of both of these forward. It is essential that we build on the engagement and enthusiasm of our staff whilst also ensuring we appropriately respond to the recommendations of these reports.

9.2 This work will be aligned to the development of a comprehensive Quality Strategy for the trust and our future Customer Service Strategy which will be taken forward by our Director of Nursing and Quality

10. Summary

This paper has presented a background to the Francis Report Keogh Reviews. The paper has detailed the trust response to the relevant recommendations within the Francis Report along with the Ambitions defined within the Keogh Review, whilst presenting feedback from our listening exercises held with staff in the trust.

Appendix 1

Trust Response to Francis Recommendations and Keogh Ambitions

Putting the patient first				
Report Author	**Response**	**Action**	**Lead / Committee**	**Completion / Review Date**
Francis Recommendation 4 Clarity of values and principles.	The trust supports the recommendation that the overriding value should be to ensure that our patients take priority. Embedding of our own Trust values is underway including featuring in adverts, job descriptions, person specifications and induction information and each department is looking at their practice compared to our values	We will continue to embed the trust values with individuals and teams and integrate recruitment, training, and appraisal processes. This work will be overseen by the Patient and Staff Experience Committee	SY / LM	Ongoing
Fundamental standards of behaviour				
Report Author	**Response**	**Action**	**Lead / Committee**	**Completion / Review Date**
Francis recommendation 11 Standards of behaviour	The Trust supports this recommendation. We actively engage staff in the development of standard procedures. We have a comprehensive programme of mandatory training for clinical and non clinical staff, and monitor compliance with this mandatory training requirement via the Assurance Committee	We will continue to monitor compliance with mandatory training of clinical and non clinical staff through the Trust Assurance Committee. We will monitor compliance with protocols/guidelines via clinical audit and this will be monitored through the Quality Committee. Work is on-going with respect to clinical audit planning and we need to ensure that this is explicit	LM / ZP Quality Committee Quality Committee	Ongoing Ongoing 01 14

Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis recommendation 75 Enhancement of role of Governors Council of Governors and Board should consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest.	The trust supports this recommendation	We will await Monitor and the Care Quality Commission guidance for governors and further consider the role of Governors through Joint Board and Governor away-days	FH	04/14
Francis recommendation 76 Enhancement of role of Governors Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large .	The trust supports this recommendation. The Membership Sub Committee develops an annual strategy for membership recruitment and engagement 3 Membership mailings per year and annual members meeting. Meet a Governor sessions Medicine for Members events Performance information published in the "Transparency" section of the Trust's website, and annual Quality Report. Monthly e-mail newsletter for Public and Patient Constituency members . . Council of Governors campaign to confirm C&W as a major hospital under the review of North West London services i.	Through our membership recruitment and engagement strategy, we will identify ways to ensure a representative membership and develop further opportunities for engagement with members and the wider public.	FH	04/14

Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 89 Information sharing Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	This process is followed through the Serious Incident Escalation process. All SUIs involving death or serious injury are considered by the Executive Team, at which point notification to relevant external agencies, such as the HSE, Coroner's Office, NHS London, Care Quality Commission etc. may be confirmed. The HSE requires notification of only deaths to workers and non-workers, with the exception of suicides, if they arise from a work-related accident, including an act of physical violence to a worker.	Add to policy - The policy already stipulates a requirement to report RIDDOR (Reporting Injuries/Diseases & Dangerous Occurrences Regulations 2005) to the Health & Safety Executive (HSE) within the specified timeframe This will be strengthened by adding a prompt to consider notification to relevant external agency to the current SUI escalation template. We will implement the key recommendations from the Caldicott 2 review	CM ZP	01 14 04 14
Effective complaints handling				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 109 Readily accessible and easily understood Methods of registering a comment or complaint	We support this recommendation We have a range of approaches for patients and families to register a comment or complaint	Complete the current review of complaints and PALS structures and roles. Ensure every ward and outpatient area has details of how to raise a concern, including senior staff who will be available	EM EM	01 14 01 14
Francis Recommendation 110 Lowering Barriers	Await outcome of complaints process National review. We accept the importance of	Review complaints and PALS policies following recommendations of national review of complaints process.	EM	01 14

Actual or intended litigation should not be a barrier to the processing or investigation of a complaint	focussing on narrative and not just numbers Unless litigation has commenced we tend to investigate even when litigation is intended or explicitly stated			
Francis Recommendation 111 Promote desire to receive and learn from comments and complaints; **Keogh Ambition 3** Real-time patient feedback and comment as normal part of customer service in addition to the Friends and Family Test	We support this recommendation. We actively promote our complaints and PALS service to patients and families, and we publish themes and learning from complaints on an annual basis We also seek feedback through Hospedia real-time surveys and periodic postal surveys whilst participating in the national patient survey programme.	Implement the Care Connect service Roll out of Friends and Family Test to Maternity, outpatients and children's areas. Develop divisional Patient Advisor roles Implement Hospedia surveys in outpatient areas Collate themes from senior team clinical visits Present patient stories at trust board meetings.	EM	01 14
Francis Recommendation 112 Patient feedback suggesting cause for concern should be investigated and responded to as a formal complaint.	This recommendation would be dependent on the national review of complaints Currently concerns are not managed in the same way as formal complaints, but if investigation is required, subject to consent to investigate, this is then referred to the complaints team and managed within the complaints process.	Await outcome of National review of complaints	EM	01 14
Francis Recommendation 113 Complaints handling. Recommendations and standards of Patients Association's review into complaints implemented in the NHS.	There are 9 recommendations which inform the Hart/Clwyd review of complaint handling.	Review complaints and PALS policies following recommendations of national review of complaints process.	EM	01 14

Francis Recommendation 115 Investigations Arms-length independent investigation initiated for some categories of complaints	In the serious untoward incident process, a Lead Investigator is appointed with a degree of independence. No current reciprocal arrangements with other Trusts for independent investigation. Where we are unable to resolve issues locally, we arrange for an external review and share the outcome of this with the complainant	Review complaints and PALS policies following recommendations of national review of complaints process.	EM	01 14
Francis Recommendation 117 Support for complainants through Independent Complaints Advocacy Services.	Await recommendations of National review This would have cost implication	Review complaints and PALS policies following recommendations of national review of complaints process.	EM	01 14
Francis Recommendation 118 Learning and information from complaints Trust's response to care related complaints published on website.	This is not current practice, however, a request for this could be included in final the response letter to the complainant. A summary of all clinical complaints is currently included in quarterly reports. Due to data protection requirements individual detail is not currently included in public reports of complaints	Trust Governor could be link with the complainant after the response to help in telling the story and also providing reassurance that the actions described will be undertaken	EM	01 14
Francis Recommendation 119 Overview and scrutiny committees and Local Healthwatch access to detailed complaints information,	The trust supports this recommendation; however, anonymity and confidentiality of the complainant would need to be a primary considerations. Local Healthwatch has access to complaints information through reports	Meet with committees to agree format of this information and ensure consistent information provided by all Trusts.	DR	04 14

	to the Council of Governors and Quality Sub Committee			
Francis Recommendation 120 Commissioner access to real-time complaints information and outcome	NHS Choices Care Connect provides real–time access to concerns raised through this system and the trust response to these is published.	Continue implementation of the Care Connect system and await response from commissioners to this recommendation	DR	01 14
Performance management and strategic oversight				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 142 Clear lines of responsibility supported by good information flows Unambiguous lines of referral and performance information flows,.	The trust supports this recommendation. The trust has a good overall set of arrangements that have continually improved over recent years. The trust is refreshing its performance framework to ensure improved board level reporting.	Complete the implementation of the updated performance framework	DR	01 14
Francis Recommendation 143 Clear metrics on quality Relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified **Keogh Ambition 2** Develop expertise to use data to drive tangible improvements .	The performance report has clear quality metrics which we keep under review as we continue to evolve our approach to quality improvement	Quarterly review of quality and experience metrics and progression on improvement in priority areas Reconvene “Clinical Information Committee	ZP	Quarterly
Keogh Ambition 2	Quality metrics are currently reviewed	Develop the trust quality strategy and	EM	04 14

Board executives and non-executives collective responsibility for quality within organisation and service lines.	at each Trust Board meeting	associated metrics		
Keogh Ambition 4. Boards to consider how to apply aspects of revised CQC review methodology to their own organisations to help improved quality.		Establish links with the Keogh review team and identify how to replicate this methodology within the organisation, for example by establishing Mini Keogh Reviews internally	Assurance committee	04 14
Keogh Ambition 5. Release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including Royal Colleges.		Complete a 'stock take' of the current external contribution and opportunities to develop this further	EM / ZP	04/14
Openness, transparency and candour				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 174 Candour about harm Where death or serious harm has been or may have been caused to a patient by an act or omission, the patient or representative should be informed of the incident and circumstances and be offered appropriate support.	The Trust actively supports open communication between organisations, teams, staff and patients and/ or carers and relatives. Detailed within the 'Being Open' Policy. Identification of an individual to communicate with those affected by an incident is detailed within the serious incident escalation template, Investigation Report and considered by the panel which meets to review the incident.	This is already routine custom and practice, and very clearly outlined within the Being Open and also the Incident Reporting and Investigation Procedure.	Risk management committee	04 14
Nursing				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**

Francis Recommendation 185 Focus on culture of caring Nurse training, education and professional development on delivering compassionate care in addition to the theory. Selection of recruits with appropriate values, attitudes and behaviours along with technical skills Leadership which reinforces compassionate care; Support and incentivisation which values nurses and the work they do:	The Trust supports the recommendation, but suggest that this should also apply to other professions such as midwifery The trust values are integrated into trust recruitment and induction process. We would be keen to work with Health Education England and education providers to integrate values into the pre registration recruitment process and training curricular We have invested in leadership development for our Band 7 clinical leaders and for those at band 6. Through quarterly 'Delivering Excellence' reviews, the Chief Nurse meets with all nursing leads to review the effective provision of care and treatment in respective services. Senior visits to clinical areas provide a further mechanism for monitoring the deliver of care along with the satisfaction of patients, families and staff We recognise, acknowledge and reward good practice through Governors Quality Awards, the annual Star Awards, the criteria for these being linked to the trust values	Work with Health Education England and education providers to integrate values into the pre registration recruitment process, training curricular and assessment processes	Education Strategy Committee	04 14
Francis Recommendation 191 Recruitment for values and commitment	The trust supports this recommendation and any commissioning / regulatory	Questionnaires are being considered for use in the pre shortlisting process and we will continue to implement values based	SY	04 14

At recruitment, assess values, attitudes and behaviours qualified or unqualified nursing staff, , towards well-being of patients Requirement to do so by commissioning and regulatory requirements.	requirement to do so for both nurses and support workers. We would comment however that unqualified staff are not nurses. This recommendation should be considered in relation to other clinical professions including midwives, therapists and medical staff. The trust has taken steps to embed the trust values within the recruitment process for nursing, midwifery, support workers and medical staff.	interviewing		
Francis Recommendation 194 As part of a Mandatory annual performance appraisal, Nurses demonstrate an up-to-date knowledge of nursing practice and implementation, Documented evidence of recognised training and wider learning. Demonstrate commitment, compassion and caring for patients, evidenced by patient and family feedback Portfolio and appraisal available to the NMC Appraisal & portfolio signed by nurse and appraiser	We support this recommendation. • A personal development plan is integrated to the trust appraisal document and completion of mandatory training is reviewed in the annual appraisal process. The appraisal form is signed by the appraisee and manager on completion. • All mandatory training for nursing staff is captured with the trust reporting system, and compliance is reported to managers on a monthly basis. • Overall compliance with mandatory training requirements is monitored through the trust Assurance Committee. Compliance with the completion of annual	We will await any further guidance from the NMC on any proposed changes to the revalidation process for nursing. We will continue to develop a consistent approach to the 360 degree appraisal process We will continue to monitor compliance with mandatory training requirements and compliance with completion of annual appraisals	EM SY Assurance committee	04 14 04 14 Ongoing

	appraisals is also captured centrally, and reported to managers monthly. • Appraisal form revised to include appraisal against values.			
Francis Recommendation 195 Nurse leadership Ward nurse managers should operate in a supervisory capacity.	The trust supports this recommendation, seeing the ward sister / charge nurse is pivotal to continuity, communication and coordination of care within the ward. Our ward Sisters and charge nurses commonly provide 0.8wte provision to the clinical establishment, and 0.2wte to their management and leadership responsibilities.	We have developed an outline proposal and business case to pilot the supervisory ward sister / charge nurse role in a number of wards, and have developed metrics to evaluate a potential pilot.	EM	04 14
Keogh Ambition 6. Directors of Nursing to use evidence based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.	The trust supports this recommendation. We have developed an application which uses the AUKUH acuity and dependency toolkit to monitor staffing in relation to A&D on a daily basis Midwifery have completed as skill mix review and 'Birthrate Plus' is monitored locally and regionally. Staffing ratios for paediatrics and neonatology are reported on a weekly sitrep	Implement the acuity and dependency toolkit across adult inpatient areas. Review nursing establishments across clinical areas and establish a method of reporting this to the board and publicly publishing information on a six monthly basis	EM EM	01 14 04 14
Francis Recommendation 199 Key nurses	We support the recommendation to allocate key nurses to patient groups on a shift by shift basis, and this is our	Continue to develop approaches to strengthening communication between the multi professional team around the care	SNMC	04 14

Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient.	current practice. Nurses would aim to be present for interaction between the patient and doctor, however, this is challenging when there are multiple rounds occurring concurrently within a ward area. To strengthen MDT communication, we have introduced 'board rounds' where the MDT update on the discharge plans for patients. We also utilise weekly MDT meetings for patient reviews within specialties Many of our clinical nurse specialists act as case managers for patients within specialties both within and out of hospital .	and treatment of the patient		
Staff Engagement				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Keogh Ambition 7. All NHS organisations to consider innovative ways of engaging staff Directors of Nursing to consider how to harness loyalty and innovation of student nurses to become ambassadors for their hospital and for promoting innovative nursing practice. Junior doctors to routinely participate in trusts' mortality and morbidity review meetings.	The trust agrees that the relationship between students and organisation can have a positive impact on practice, placements, culture and recruitment & retention. With respect to participation in M&M meetings, the Trust needs to ensure that multidisciplinary M&Ms are established in all areas.	Work with local educational providers to develop early relationship with undergraduate/pre-registration nurses & midwives. Consider appropriate forum for students and practice placement facilitators to enable learning and facilitate a loyal and respectful relationship. Undertake a gap analysis across all specialties, in order to identify and address deficiencies in this area. All specialty leads	EM ZP	04 14 01 14

		will be asked the following: 1. Is there an established M&M meeting within your specialty? 2. Is your specialty M&M multidisciplinary and attended by junior doctors? 3. Frequency of your M&M meeting, i.e. is it weekly, monthly, quarterly etc. 4. How do you select your cases for discussion at the M&M meetings? Responses will be collated and considered at the Quality Committee, and action plan agreed.		
Patient and Public Engagement				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Keogh Ambition 3 Relationship with local Healthwatch to engage with patients and support their journey to ensure more comprehensive participation and involvement from patients, carers and the public Harness the leadership potential of patients and members of the public Patient and public engagement central to those who plan, run and regulate hospitals	Local Healthwatch currently attend the Council of Governors and Governors Quality Sub Committee, and are actively engaged in the development of our annual quality account. Healthwatch conduct audits of dignity and nutrition within the trust and there is a representative on our trust carers forum Patient representatives are members of our PLACE committee and are responsible for the undertaking of our annual PLACE audits. Patient representatives and Patient Governors are represented on a	Ensure Healthwatch representation on key committees and working groups Engage patient representatives in shaping service developments and in key quality improvement projects	SN SN	04 14 04 14

	number of taskforces and working groups			
Caring for the elderly				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 236 Identification of who is responsible for the patient Identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	The Trust supports this recommendation, where it is thought to be clinically appropriate	A stocktake of current practice will occur in the Trust and areas where the allocation of a lead clinician seems appropriate (rather than allocation to team care), this will be considered through the Quality Committee and other multidisciplinary clinical groups.	ZP	04 14
Francis Recommendation 237 Effective teamwork between disciplines to provide care for elderly patients	The trust supports this recommendation and team working is included as a feature within our training in leadership and management	Continue to work with partner agencies to improve the overall patient pathway for older people	ZP / EM	01/14
Francis Recommendation 238 Communication with and about patients Regular interaction and engagement between nurses and patients through ward rounds: Communication with relative by email s. Review practice of providing summary discharge letters followed up with substantive ones Information about older patient's condition, progress, care and discharge plans	We support these recommendations. We have implemented routine 'Comfort rounds' across our inpatient areas, and many areas have implemented ward round handovers between staff, which include the patient. Enhanced day room facilities for patients and relatives have been included in refurbishment plans for wards. We offer email communication with relatives should this be their preferred method. Our current standard is for discharge	Continue to monitor and evaluate the effectiveness of comfort rounds Continue with implementation of bed side care plans Continue with implementation of carers strategy Ensure day room facilities for patients and families are incorporated into remaining plans for refurbishment and new builds. Continue to monitor performance against target for provision of discharge letters and for completeness of these.	EM EM EM	01 14 01 14 01 14

available and shared with the patient and appropriate others	letters to be provided to the patient and GP within 24 hours of discharge. Compliance with this is monitored through our trust key performance indicators. We have begun to implement bed side care plans for patients, so that they and their family are aware of this plan and are included in it. We have developed a carers strategy and best practice guidance for working in partnership with carers			
Francis Recommendation 239 Continuing responsibility for care It should never be acceptable for patients to be discharged in the middle of the night, or at any time without assurance that a patient will receive care on arrival at planned destination. Discharge areas to be properly staffed and provide continued care to the patient.	The Trust supports this recommendation, but recognise that some patients may choose to take their own discharge against medical advice which may be out of hours, and without sufficient resources to meet their continuing care needs. The trust discharge policy sets out clear guidance for the management of out of hours discharges. We have a discharge team who support the discharge process for more complex patients We have introduced an electronic discharge assessment, discharge e-communication notes and a discharge checklist. We have introduced cards for patients on discharge with details of who to contact if needed.	Continue to implement and evaluate the use of the discharge assessment, communication notes and checklist Look at the potential for risk scoring discharges, to identify those at higher risk Monitor the provision of discharge cards for patients	HA	01 14

	Our discharge lounge is sufficiently staffed, and some patient may wait in ward day rooms which are a part of our staffed wards			
Francis Recommendation 240 Hygiene. All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	The trust supports this recommendation. We have clear signage in all public and clinical areas of the hospital, and 'voice box' prompts at strategic locations We reiterate the key messages about hand hygiene at our team briefings and monitor hand hygiene on a monthly basis, reporting this to the infection control committee. Any non compliance is escalated to our infection control team.	Continue to reiterate required standards and practice in relation to hand hygiene and audit compliance. Continue to enforce our Bare Below the Elbows policy	EM	01 14
Francis Recommendation 241 Provision of food and drink The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	The trust support this recommendation, but believe that it should relate to all patients who may compromised in their fluid and nutritional status. We complete nutritional screening for patients within 24 hours of admission and then weekly. We have protected mealtimes in our inpatient areas and use a red and blue tray scheme and electronic status boards to identify individual patients who require assistance We have a volunteers mealtime support service in place	Continue to monitor compliance with weekly nutritional screening of patients Identify how we can better support patients at breakfast and evening meal times	EM	04 / 14

Francis Recommendation 242 Medicines administration In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or deputy. Checks to ensure all patients have received prescribed medication, including when moved from one ward to another or on return to ward after treatment.	We support this recommendation. We recognise that our current practice can be strengthened as we have dual paper and electronic recording of administration and that we can strengthen our handover between carers and on transfer of the patient	Introduce a 'missed dose' report into each handover of staff within ward areas and monitor this as a key performance indicator Include medication review in handover prompts for patient transfer	EM	01/14
Francis Recommendation 243 Recording of routine observations Recording of routine observations should be done automatically when possible and results immediately accessible to all staff electronically so that progress can be monitored and interpreted. A system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded. **Keogh Ambition 1** Progress towards reducing avoidable deaths in our hospitals, Rapidly embed the use of an early warning system Have clinically appropriate escalation procedures for deteriorating, high-risk patients - in particular at weekends and out of hours	The Trust supports this approach . The trust has replaced the 'CHEWSS' early warning system with the National EWS. Early Warning Systems are in place of paediatric and maternity services A Hospital at Night service is in place to provide appropriate management out of hours	We would aspire to observations being collected automatically and displayed electronically and our IM & T strategy broadly supports this aspiration. Develop guidance for handover of observations between carers as component of transfer policy The use of NEWs, PEWS and MEWS will be continuously audited and monitored through the Performance dashboard and the clinical audit programme, reporting to the Board, Executive and Assurance Committee. Establish NEWS within the burns service following validation Embed the use of SBAR and escalation processes	EM / ZP	04 /14

Information				
Report Author	**Response**	**Action**	**Lead**	**Completion / Review Date**
Francis Recommendation 244 Common information practices, shared data and electronic records Shared information databases of performance information for monitoring purposes. Principles of EPR systems; User friendly, real time and retrospective access for patients to read their records, and a facility to enter comments. Copy of records in a form useable by the patient and access to summary care record Prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information Alert when actions which might be expected have not occurred, or inaccuracies entered. Collecting of anonomysed performance management and audit information automatically Designed in partnership with patient groups to meet needs of patients, professional, managerial and regulatory requirements. Able to meet changing needs and local	The current electronic patient record incorporates alerts and flags Alerts and pop-up's are used in the EPR to indicate non completed actions (e.g. assessments), and reporting facilities reporting non completed actions such as missed doses. The trust Electronic Document Management system is being implemented and a public governor is a member of the project board. The trust has implemented Clikview business intelligence software and the Synbiotix application for clinical audit date.	Continue the implementation of the Electronic Document Management system. Develop the patient portal	DR	01 14

requirements over and above nationally required minimum standards.				
Francis Recommendation 255 Using patient feedback Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made	The Trust supports this recommendation. Web based real-time survey data from the Hospedia system is available to nursing leads. This information informs 'You said / we did boards in wards and departments. The Friends and Family test results are circulated to clinical leads each month and are published on our trust web site	Develop 'you said / We did' displays on the trust web site and in public areas to display trust wide themes from feedback and related actions.	EM	1/14
Francis Recommendation 256 Follow up of patients post discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	We support this recommendation and currently have a variety of post discharge follow up initiatives in place	Further develop post discharge telephone follow up to capture wider numbers of patients	EM	01 14
Francis Recommendation 262 Enhancing the use, analysis and dissemination of healthcare information Develop and maintain systems which provide: Real-time information on performance of against patient safety and minimum quality standards; Real-time information of the performance	Through the implementation of our performance framework, we are giving electronic access to the latest information across the balanced scorecard and indicators. We are clarifying how this should be reviewed by each lead in the organisation to secure continuous quality improvement	Build on good practice through implementing the performance framework The recording and reporting of 'real time patient safety incidents' will be facilitated through the roll-out of an on-line incident reporting system.	DR CM	01 14 04 14

of consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. Reflect Information Centre best practice for information management and recommendations of specialist organisations such as the medical Royal Colleges. Information should be published / made available to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.				

Appendix 2.

Feedback from Listening Events and Patient Summit Always Events

Themes from recommendations	Feedback from Listening Exercises	Always Events
1. Putting the patient first *Patients must be the first priority in all the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights.* *The NHS Constitution should be the first reference point for all NHS patients and staff and should set out values, rights, obligations and expectations of patients.* *Consider integrating patients through representatives into Trust structures*	• Ensure the Trust Values are incorporated into care provision and provide training on this such as 'Walk in their shoes' and shadowing' • Clinical services should be provided around the needs of patients and not around inflexible staffing practices • Provide patients with details of our services so that they have clear and realistic expectations, but enable flexibility if they need it' • More patient representatives who reflect the needs of all service users – not just the more vocal ones. • Use voluntary organizations to access some of the other groups of users • Involve patients in service changes using patient focus groups. Reasons for any suggestions not being implemented should be documented. • Discharge summaries and GP letter should always be addressed to the patient	• Always meet and greet people when they first walk onto the ward • Always Listen carefully and attentively • Always treat patients individually as different patients will require different approaches • 'Always approach every sitaution with the attitude of 'I am a potential patient' • 'Always ensure a patient is given a full explanation of what to expect throughout their visit' • 'Always explain treatments to patients. Why are they going to Xray? What will happen?' • 'Always keep patients updated during their stay including waiting times' • 'Always avoid patients waiting an unnecessarily long time for things by pre-empting problems and planning ahead' • 'Always check the understanding of the patient about their plan of care before leaving the bedside at each ward round' • 'Always ensure flexibility of a service to meet individual needs of service users including telephone consultations and out of hours drop in's' • 'Always put the patient first by making them feel welcome when first entering the hospital and having the knowledge to guide them to the right appointment or place'

		• 'Always listen to patients and respect their informed decision'
2. Common culture *Commitment to common set of values and accessible basic care and treatment standards and also:* • *Openness, transparency and candour* • *Strong leadership in all professions* • *Support for leadership roles* • *Level playing field for accountability* • *Information accessible and used allowing comparison of performance by individuals, services and organisation*	• 'Focus on trust values and ways to embed them • Build on these to develop a Trust code of conduct for all the staff in the organization which works across professional boundaries • New managers to be taught people management skills' • 'Develop assessment of staff values and skills as part of the recruitment process • Develop guidance on how to measure staff against the values' • Individuals could document value statements at induction which is returned to them 3 months later. • Develop a culture in which staff challenge one another around attitude and behaviours. • Identify ways to capture staff behaviours and feed back to them as part of their development • Staff who don't demonstrate the trust values need to be challenged and actively managed as they set a poor example to others • Use positive recognition for staff such as the Star awards, employee and team of the month to recognize and reward those who live the values • Peer supervision set up in every department	• 'Always add to the sense of community in the Trust' • 'Always celebrate success and reward good work' • 'Always acknowledge people with a smile' • 'Always give feedback to staff on how they are doing'
3. Standards of service *Fundamental basic standards of care need to be applied by all those who work and serve in healthcare.* *Behaviours at all levels need to be in accordance with at least these standards.*	• Empower clinicians and nurses to make appropriate decisions about direct care, even if this breaches a target or measure • All our academic skills should be focused on the underpinning fundamentals of patient care. • Work in a consistent way with the same standards for everyone • Set expectations for clinical standards of care at induction and ensure that processes are clear to	• 'Always encourage new staff to put forward new ideas from their experience and other Trusts'

	all staff. • Ensure that safety is maintained. all staff should know what is expected of them including that they should speak up and report problems	
4. Complaints handling *Recommendations from Patients Association's peer review into complaints at the Mid Staffs should be reviewed and implemented.* *Making a complaint should be easy and any concern made by a patient should be treated as a complaint unless the patient's permission is refused.* *A senior clinician and nurse should be obliged to be involved in responding to complaints to facilitate a speedy resolution, wherever possible.* *Complaints relating to possible breaches of basic standards and serious complaints should be accessible to the CQC, relevant commissioners,* *health scrutiny committees, Communities and* *Local HealthWatch. Learning from complaints must be effectively identified, disseminated and made known to the complainant and the public, subject to suitable*	• Ensure that patients and families are clear about who they can discuss concerns with and how to raise a complaint • Ensure a timely response to concerns and complaints • Provide feedback about learning and any changes from complaints and concerns to patients and staff • PALS could contact clinical areas immediately to respond to patient and family worries/ concerns • Consider development of a live electronic customer service feedback service • Develop ways for patients and families to discuss concerns informally with staff	
5. Performance Management & Information *Through Quality Accounts, full and accurate information about a Providers compliance or noncompliance with standards should be published and available on Trust website.*	• Identify metrics to be measured in high impact cost improvement programmes / restructures and monitor any impact on the quality & safety of the service • Identify quality metrics as a component of service developments to measure success of	

Quality Accounts should contain information in a common form to enable comparisons to be made between organisations. *Quality Accounts should contain observations of commissioners and overview and scrutiny committees.* *Information must be made available about the performance and outcomes of a service to enable patients to make treatment choices and have a proper understanding of the outcomes for them.* *Providers should publish real time information on performance of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction, and on the performance of each team and their services against the fundamental standards.* *Real-time information must be provided to commissioners, regulators and the public should include statistics of outcomes, and safety-related information from investigations, complaints and incidents.* *Every provider organisation should have a designated board member as a chief information officer.*	these • Develop clear metrics of quality as a component of the trust and divisional performance dashboards in order to understand areas of success and concern • Ensure a robust audit process as an approach to quality assurance. • Use a range of approaches to assessing the quality of the service. Empirical data along with observation and feedback from senior visits to clinical areas and patient feedback on their experience. • Develop electronic incident reporting to improve recording, tracking and monitoring of incidents • Give staff feedback on clinical incidents, complaints, issues so that they can participate in the solutions and any changes. • Develop easier access for patients to provide feedback and comments on services • Introduce suggestion boxes in wards and departments and include comments / changes into you said / we did boards. • Ensure that patients and families are aware of access to advocacy service and are assisted to access these when needed.	
6. Openness, transparency and candour *The NHS Constitution should include clear obligations to comply with the following*	• Have an independent person to liaise with staff who is not involved any particular ward/dept to get a fresh perspective' • 'Graffiti board for staff managed by a neutral	• 'Always be able to approach managers with ideas and problems' • 'Always ensure that staff are easily identifiable, both clinical and non-clinical'

principles: ***Openness**: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;* ***Transparency**: allowing true information about performance and outcomes to be shared with staff, patients and the public;* ***Candour**: ensuring patients harmed are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.* *Quality Accounts should be accompanied by a declaration by all directors certifying the accounts to be true and Providers should have their quality accounts independently audited*	body' • 'Make sure all staff know who they can speak to and make sure they receive appropriate feedback about any suggestions or concerns that they raise • Introduce a hotline for staff with concerns • Develop ways to listen to staff feedback and concern and encourage staff making comments to take ownership so that action can be taken. • Retain an open culture by inviting new ideas and feedback from new staff at 3 months' • 'Ensure organized forums for team discussions and for any issues to be raised' • 'Facilitate the opportunity for staff to speak freely in a supportive environment – clinical supervision, ward meetings'	• Always have a dedicated person to speak to about your concerns and take it forward with a plan'
7. Nursing *Increased focus on a culture of compassion and caring in nurse recruitment, training and education.* *The knowledge and skills framework should be reviewed with a view to giving explicit recognition to nurses 'commitment to patient care and the priority* *Ward nurse managers should work in a supervisory capacity and are not office bound. They should be involved and aware of the plans and care for their patients.*	• Ensure we keep putting ourselves in the patients shoes • Communication and attitude of staff. More time and investment is needed to train staff in customer service skills and understand the importance of patient experience. • Reinforce the need for Nurses to be attentive and responsive to patients and families – Responding to queries & call-bells in a timely way despite other pressures. • Benefits of working as a HCA for a year pre studying as a nurse • Need to recruit and retain permanent nurses to reduce the dependence on agency nurses. • Agency staff have variable skills and knowledge.	• 'Always doing comfort rounds- creating opportunity for patient communication' • Always Make sure we take the time to listen

There should be a responsible officer for nursing in each trust, and they should be accountable to the NMC.	They cannot fulfil the remit of permanent staff or support continuity of care. • Agency nurses need to be given quicker access to IT and given other responsibilities so they can contribute more to team and therefore patient care. • We can improve by thinking about how we deliver patient care – proving continuity like giving nurses a team of patients for a period of time to build up a rapport with them • More help needed for patients who need help with eating meals • Shared responsibility with Drs. AHP's, etc. • All staff – not just nurses and doctors taking responsibility for basic aspects of care and making sure patients have call bell, can reach drink etc. when leaving bed side • 'Value everyone's contribution and importance to overall care of the patient' • Shared responsibility with Drs. AHP's, etc. • Work in a consistent way with the same standards for everyone • All staff – not just nurses and doctors taking responsibility for basic aspects of care and making sure patients have call bell, can reach drink etc. when leaving bed side	
8. Leadership *The common culture and values of the NHS must be applied at all levels of the organisation, particularly to leaders.* *A common code of ethics, standards and conduct for* *senior board-level healthcare leaders and managers should* *be produced and should be consistent with the common* *culture (Fit and Proper Persons* *Test). The principles appearing in those*	• Focus on developing the Ward manager supervisory role to support changes in care plans and train new staff. • Coordinator on the wards to allow appropriate allocation of work dependent on need' • The right patients cared for in the right area by the right teams ensures patients are cared for by the staff with the correct skill set – i.e. reduce the number of outliers on the wards. This would help teams work together and get to know each	• 'Always ask if you can help and really mean it' • 'Always ensure adequate cover to prevent clinics or services being cancelled' • Always value everyone's contribution and importance to the overall care of the patient'

ethics and standards should apply to all staff, and it is the responsibility of employers to ensure that they are honoured.	other and allow for open communication	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.5/Oct/13
PAPER	Shaping a Healthier Future (SaHF) Programme Initiation Document, May 2013*
AUTHOR	NHS Northwest London
LEAD	David Radbourne, Chief Operating Officer
PURPOSE	This document sets out NHS Northwest London programme management proposals to deliver the option decided in the SaHF Decision Making Business Case (DMBC). The programme consists of numerous projects, one of which the trust is currently working to deliver: a Business Case to establish how Chelsea and Westminster will respond to the changes in the local health economy under SaHF.
LINK TO OBJECTIVES	[xxx]
RISK ISSUES	Any risks associated with SaHF itself will be analysed in Chelsea and Westminster's Business Case. This Northwest London document in itself does not generate any new risks for the trust.
FINANCIAL ISSUES	SaHF will impact on the finances of Chelsea and Westminster. These issues will be considered in the trust's Business Case.
OTHER ISSUES	N/A
LEGAL REVIEW REQUIRED?	No

EXECUTIVE SUMMARY	The Programme Initiation Document (PID) is focused on the operation of SaHF from February 2013. It updates the PIDs that were developed to support the earlier stages of the programme and reflects the decisions that have been made and refinements to the approach going forward. The PID focuses on the provider transformation that is part of Shaping a healthier future and the enabling projects and work that is required to successfully support those changes. Note that since this document was published, SaHF timelines have been pushed back – the suite of SaHF Business Cases will now be reviewed by NW London in February 2014. Due to the length of the Shaping a Healthier Future (SaHF) Programme Initiation Document, the full document can be obtained on request from Vida Delic, Board Governance Manager.
DECISION/ ACTION	The Board is asked to note the plans set out in the document. The Board will review the high-level findings of the Chelsea and Westminster Business case work in November, and a full draft of the document in January 2014.

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.6/Oct/13
PAPER	Monitor In-Year Financial and Governance Combined Return for Q2 2013/14
AUTHOR	Carol McLaughlin, Financial Controller
LEAD	Rakesh Patel, Director of Finance
PURPOSE	Compliance with Monitor's Compliance Framework 2013-14
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
RISK ISSUES	The Trust is submitting a 'Green' Governance Risk Rating having met all of its clinical targets in Q2. The Trust has triggered 1 financial risk indicator per the Monitor template, as follows: Debtors > 90 days old are greater than 5% of total debtors. This is explained in more detail in the commentary below.
FINANCIAL ISSUES	The Trust has achieved a year-to-date Financial Risk Rating of 3 for Q2 of 2013/14, which is in line with plan. However YTD EBITDA is £1.5m behind plan (6.7% YTD actual compared to plan of 7.8%). The Trust has implemented a detailed recovery plan that was initiated at the end of Q1. The recovery plan is two months into implementation and the Trust has achieved the target run rate for these two months, whilst ensuring that there is no detrimental impact on quality. The main reason for the Trust being behind plan is slippage in delivery of Cost Improvement Plans (CIPS). The Trust is £2.5m behind on its CIP plan and action is under way for additional CIP and recovery schemes to bring this back into line in the remaining two quarters, as outlined above. Monitor's new Risk Assessment Framework has been published and is due to come into effect from 1st October 2013. The Trust has been monitoring performance against the new COSR (Continuity of Services) rating alongside the FRR and the rating at Q2 was a 3 against a plan of 4, due to

	the impact of the reduced surplus on the capital servicing capacity ratio.
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	None
EXECUTIVE SUMMARY	**<u>Governance Declaration</u>** The Board is asked to authorise a GREEN declaration with respect to its governance risk rating having met all of the targets for Quarter 2 2013/14. There was a CQC visit during September and we are awaiting the feedback report, although no issues have been raised at this point. *(NB: there is an error in the Monitor Plan figures, stating that the MRSA target for the year is 0, when it in fact should read 6. Thus the Trust is within the target and has stated the MRSA objective as achieved).* In the second quarter of 2013/14, there were elections to fill vacant posts on the Council of Governors. There was a change in the composition of the Board of Directors, with the appointment of a Director of Nursing and Quality. (See Appendix 1 for a full breakdown of all these changes). **<u>Finance</u>** The Trust recorded a Financial Risk Rating of 3 YTD at Quarter 2 compared to a plan of 3. The EBITDA % metric is in line with the planned 3 at Q2 but the actual performance is 6.7% rather than the planned 7.8%. The EBITDA % of plan achieved is a 4 against a planned 5, and the I&E Surplus Margin rating is a 2 against a planned 3. Net Return after Financing and Liquidity are both in line with plan at a rating of 3 and 4 respectively. The COSR rating at Q2 is a 3 against a planned 4, the underperformance against plan being due to the impact of the reduced surplus on the capital servicing capacity ratio. The YTD financial performance for the Trust at Quarter 2 is summarised in the table below:

	Plan YTD	Act YTD	Var YTD
	£m	£m	£m
Operating Revenue	172.5	177.1	4.6
Employee Expenses	(89.4)	(92.0)	(2.6)
Other Operating Expenses	(75.3)	(78.6)	(3.3)
Non-Operating Income	0.1	0.1	0.0
Non-Operating Expenses	(5.6)	(5.7)	(0.1)
Surplus/(Deficit)	2.3	0.8	(1.4)
Net Surplus %	1.3%	0.5%	-0.9%
Net Surplus rating	3	2	(1.0)
Total Operating Revenue for EBITDA	171.5	176.1	4.6
Total Operating Expenses for EBITDA	(158.2)	(164.3)	(6.0)
EBITDA	13.3	11.8	(1.5)
EBITDA Margin %	7.8%	6.7%	-1.04%
EBITDA Margin rating	3	3	0.0
Capex (Cash Spend)	(3.8)	(3.5)	0.3
Net Cash Inflow / (outflow)	(5.1)	(24.6)	(19.5)
Period end cash	36.5	17.0	(19.5)
CIP	7.4	4.8	(2.5)
Financial Risk Rating	3	3	0

NB: There are a number of items excluded from both revenue and expenses that are not included in the EBITDA calculation.

As at the end of Quarter 2 the Trust reported a surplus of £0.8m against a plan of £2.3m with an EBITDA of £11.8m (6.7%) against a plan of £13.3m (7.8%).

The YTD Q2 performance of a £6.5m actual surplus (from operations) vs a £7.8m planned surplus (from operations) has been largely driven by under-achievement of Trust CIP plans (£2.5m) and under-performance on Private Income (£0.5m). These are offset by over-performance in NHS Clinical Revenue, although it should be noted a high level of excluded drugs income in relation to HIV ARV drugs is included here; there are also pressures within Clinical supplies and Consultancy.

The achieved Q2 CIPs for the Trust are in the table below. This was against a Q2 plan of £3.8m and thus under-achievement of £0.5m, representing an improvement on Q1 performance. .

Monitor Return Category	Q2 Actual
Revenue Generation	1.144
Pay Expense savings CIP recurrent	1.361
Drugs Expense savings CIP recurrent	0.065
Clinical Supplies savings CIP recurrent	0.377
Non-Clinical Supplies savings CIP recurrent	0.386
	3.334

Statement of Comprehensive Income

NHS Clinical Revenue

NHS Clinical revenue was £2.9m ahead of plan in Quarter 2. Overall planned admitted patient care activity was on plan in the quarter, with a £0.6m over-performance in Day Case income offset by a £0.6m under-performance in Elective activity, due to the higher transfer of activity from inpatient to day case settings than planned. The main over-performing specialities in the day case setting were paediatric dentistry to address waiting list pressures and endoscopy, with the under-performance in elective mainly driven by Dermatology due to the closure of the phototherapy unit in September for installation of a new phototherapy machine, which is forecast to recover during the rest of the year and Bariatric Surgery due to a change in commissioning criteria in 2013/14.

Non-elective income was £0.4m ahead of plan in the quarter, which comprised of with lower levels of emergency and obstetrics inpatient activity than planned resulting in under-performance on activity, but an offsetting benefit due to improvements against locally agreed commissioner productivity and efficiency metrics aimed at reducing emergency admissions and length of stay.

The Trust reported a £1.2m favourable variance against plan for outpatient activity in the 2nd quarter, mainly due to the rephasing of a local commissioner metric to reduce the number of internally generated referrals which now has a start date of 1st October. There was also an over-performance against plan for GUM and Gynaecology outpatient activity, continuing the trend from the first quarter. A&E and UCC activity remained on plan in the quarter.

Other NHS income reported a £1.3m favourable variance in Quarter 2, which was primarily driven by higher levels of excluded drugs and devices usage in the quarter compared to plan (£1.2m), which is offset by expenditure. Overall critical care activity is £0.1m behind plan in the quarter, due to an under-performance in paediatric HDU, which is partly offset by an over-performance in adult and neonatal critical care. The Trust has forecast planned levels of CQUIN income for the year to date in line with internal assessment, until the first two quarters' achievement is agreed with commissioners.

Other Non-Mandatory/Non protected revenue

Other Non-Mandatory/Non-Protected income under-performed by £0.2m in Q2, mainly due to amenity bed under-utilisation.

Income from non-NHS sources (formally Private Patient Income Cap)

From October 1st 2012 the revised definition for the private patient cap obliges foundation trusts to ensure that the income received from providing goods and services for the NHS (their principal purpose) is greater than income from other sources. At the end of Q2 the Trust generated £6.2m of private patient income and thus currently there is no risk to breaching the revised cap definition. This level of income represents under-performance against plan (£0.5m) relating entirely to Q1. Q2 performance has been aided by high Private Maternity activity and upturns in both ACU (price and activity driven) and Overseas income (price and activity driven).

Other Operating Income

Research & Development Income and Education & Training Income were ahead of plan in Q2 (and now also YTD), with the main contributing factor being additional SIFT income in relation to an increase in student numbers. The other main variance to outline was the result of the reclassification of salary recharges from net to gross accounting (moving from reducing down of pay expenditure, to gross income), this has accounted for c£1.2m of movement increasing pay expenditure, but also increasing income. In addition there were some un-planned additional income streams in respect of invoicing for C&W incurred consultancy for West Middlesex acquisition due diligence work.

Operating Expenditure

Operating Expenditure within EBITDA was £4.7m higher than plan during Quarter 2. The key variances are as follows:

Employee Benefits (£2.0m over-spent): The majority of the over-spend is due to the reclassification in the accounting for recharged staff costs; moving from the netting off of staff expenditure for salary recharges invoiced to other organisations, to the grossing-up of staff costs, with the invoicing coded to operating income (this was backdated to the start of the year, accounting for £1.2m). There is also CIP slippage in the quarter, although a reduced amount compared to Q1.

Drugs Costs (£1.4m over-spent): HIV ARV excluded drugs are the main driver for the overspend position (as per Q1), due to continued growth in HIV newly diagnosed patients; these costs are however fully offset by income. There was also a catch up on expenditure from prior periods for FP10 usage of drugs.

Clinical Supplies (£0.9m overspend): The overspend position is mainly the result of general MSSE usage, alongside activity over-performance,

combined with CIP slippage on some procurement led initiatives. Within this Pathology costs have increased, with the main specialties (HIV & Sexual Health) that drive these costs seeing increased activity.

Other Raw Materials & Consumables (breakeven): The main drivers within this expenditure category were minor over-spends against plan, offset by benefits in 2012/13 legal fee provisions/accruals released in 2013/14.

Other Operating Expenditure (£0.4m over-spent): This over-spend is largely driven by an increase in Consultancy usage, although this is partially offset by income in relation to due diligence work for the acquisition of West Middlesex. In addition there are benefits from 2012/13 bad debt provision releases, with some further increase for provisions in relation to 2013/14 commissioner metrics.

CIP (£0.5m below target): The Trust set a CIP target for 2013/14 of £16.9m and has achieved £3.3m in Q2 against a plan of £3.8m; the year to date position is delivery of £4.8m at the end of Q2, against a plan of £7.4m. The table below shows the Q2 and year-to date position.

CIP as Per Monitor Template	Q2			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Revenue Generation	0.960	1.144	0.185	1.845	1.535	(0.310)
Pay Expense savings CIP recurrent	1.097	1.361	0.264	2.110	1.852	(0.258)
Drugs Expense savings CIP recurrent	0.063	0.065	0.002	0.122	0.130	0.009
Clinical Supplies savings CIP recurrent	0.447	0.377	(0.069)	0.859	0.552	(0.307)
Non-Clinical Supplies savings CIP recurrent	1.261	0.386	(0.876)	2.425	0.743	(1.682)
Sub-Total	**3.828**	**3.334**	**(0.494)**	**7.360**	**4.811**	**(2.549)**

Due to the continuation of CIP under-performance being the main driver of the year to date adverse position against plan, the trust-wide CIP recovery plan process outlined in Q1 is now well under way. The executive is meeting regularly with each Division/Directorate to review and report progress on the achievement of recovery schemes and CIP plans. The outcomes of the recovery schemes and the plans for the rest of year have been set as control targets for each Division to be monitored against, with the trajectory of delivery of these schemes planned to ramp up in Q3 and Q4.

Statement of Financial Position

Property, Plant and Equipment

Capital spend at Q2 is reported at £3.8m against the planned capex of £4.2m. This variance from plan is 10% in the quarter and 4.5% year to date, which is within tolerance of Monitor's capex financial indicator.

Capital spend in Q2 is shown below in the capex table by Monitor categories. The Trust has incurred capital spend of £0.7m against plan of £0.3m on maintenance expenditure. This is due to an early start on a number of small schemes to refurbish, and also to carry out flooring replacement, bathroom and hand basin upgrade and decorating

programme in the various areas within the Trust.

The expenditure incurred on other property plant and equipment category is behind the plan by 14%. The schemes in progress are the Adult Burns, the Midwifery Led Unit and the Dean Street Express development. These schemes are in the programme to complete in Q3 and Q4.

Capital spend on both information technology and purchase of intangible assets is 4% behind plan. IT expenditure has been mainly on LastWord Development and Electronic Document Management (EDM).

The planned equipment replacement programme is in place and the YTD spend on Plant and Equipment is £2.1m against planned capex of £2.6m, 18% behind plan.

Property Plant and Equipment including Intangibles Capex at Q2

Monitor Scheme Categories	Q2 Budget £'m	Q2 Actual £'m	Q2 Var £m	Q2 Var %
Property - New land, buildings or dwellings	0.025	0.000	0.025	100.0%
Property - Maintenance expenditure	0.241	0.696	(0.455)	(188.5%)
Plant and equipment - Information Technology	0.572	0.613	(0.041)	(7.2%)
Plant and equipment - Other equipment	1.228	0.634	0.594	48.4%
Property, plant and equipment - Other expenditure	1.880	1.604	0.277	14.7%
Purchase of Intangible Assets	0.290	0.214	0.076	26.3%
Grand Total	**4.236**	**3.761**	**0.476**	**11.2%**

Receivables and Other Current Assets

Receivables and other current assets (£41.5m excluding cash) are £19m above plan as at 30th September 2013. The key variance against plan is in NHS trade receivables, which are £17.7m higher than plan. The factors causing this variance are the following:

- The change in commissioning of GUM activity from PCTs to Local Authorities – this has meant that activity that would previously have been paid for as part of the monthly SLA block payments is now being invoiced retrospectively, thus affecting cash flow. In addition there have been set up issues with identifying the correct level to direct invoices to within the LA organisational structure, which have meant that LAs have been slow to pay for activity for months 1-4 that has already been billed. The value of GUM activity for the full year is approximately £19m, and outstanding GUM debt accounts for approx. £7m of the total NHS debt as at Q2, therefore the Trust is dedicating significant resource within the finance team to pursuing payment and resolving any outstanding issues around invoicing.

- The change in the NHS commissioning landscape from 1st April

	2013 has also caused delays in payment for monthly SLA invoices, since some CCGs have been part-paying monthly invoices on the basis that contracts have not yet been signed. At the time of writing 98% by value of contracts have been agreed, therefore the Trust believes there should be no reason for invoices not to be paid and is pursuing outstanding payments vigorously. The Trust has triggered Monitor's financial risk indicator relating to debtors >90 days old being higher than 5% of total debtors (the actual position being 14.6%). Of the balance >90 days old, £0.88m relates to Welsh and Scottish Health Boards and is fully provided for and approx. £2.4m (43%) is NHS debt relating to part payment of invoices by CCGs across Q 1 and 2. This is expected to be collected by the end of Q3. The remainder is mainly Overseas and other General Trading debt which is also between 80-100% provided for. **Trade and Other Payables – Current** The total of trade and other payables, accruals and other current liabilities is £36m at the end of Quarter 2, which is £1m below plan. This is mainly due to capital payables and accruals being slightly below plan. **Cash Flow** The cash balance at the end of Quarter 2 is £17m, which is £19.4m below plan. The main reason for cash being below plan is the adverse position on NHS debtors explained above, together with the I&E deficit position (£1.4m adverse) and cash outflow on settlement of capital creditors (£2.5m adverse variance). The cash position is being monitored closely to ensure that the issues affecting collection of NHS debt are resolved as soon as possible. **<u>Finance Declaration</u>** The Trust has achieved a Financial Risk Rating of 3 YTD at the end of Quarter 2 of 2013/14 compared to a plan of 3. The Trust has triggered one financial risk indicator in Quarter 2 as described above.
DECISION/ ACTION	The Board is asked to; • Approve submission of the in-year financial reporting return Quarter 2 2013/14 to Monitor. • Approve the commentary for submission to Monitor. • Approve the declaration that the Trust will continue to maintain a **Continuity of Service Rating** of at least 3 over the next 12 months.

	• Approve the In Year Governance Statement (attached).

Appendix 1

In the second quarter of 2013/14:

I. ELECTIONS

There were elections to fill posts on the Council of Governors.

II. BOARD OF DIRECTORS

There have been changes in the composition of the Board of Directors.

Elizabeth McManus has been appointed as the Executive Director of Nursing and Quality (09/09/13).

Role	Date of change	Full Name	Telephone	Email address	Job Title (if different to 'role')
Director of Nursing and Quality	09/09/2013	Elizabeth McManus	02033156721	elizabeth.mcmanus@chelwest.nhs.uk	

III. COUNCIL OF GOVERNORS

a. Retirements and Resignations

i. Elected

Status of vacancies filled at election in July 2013.

Category	Constituency	Status at 30 September	First Name	Last Name	Start Date of Office	Telephone	E-mail
Patient		Filled	Chris	Birch	04/07/13	02077363104	chris@chrisbirch.me.uk
Patient		Filled	Charles	Steel	04/07/13	07771867369	crasteel@hotmail.co.uk

Public	Hammersmith and Fulham Area 1	Filled	Samantha	Culhane	04/07/13	02076037601	sam@culhane.co.uk
	Kensington and Chelsea 1	Filled	Capt Edward	Coolen	04/07/13	02072290159	EDWARDCOOLEN@aol.com
Staff	Management	Filled	Dominic	Clarke	04/07/13	07876193000	Dominic.clarke@chelwest.nhs.uk

Constituency	Date of Election	Number of candidates nominated in each constituency	Number of votes cast in each constituency	Number of eligible voters	Turnout (%)
Patient	04/07/13	2	655	5,914	11.1%
Public: Hammersmith & Fulham 1	04/07/13	1	0	693	0%
Public: Kensington and Chelsea 1	04/07/13	1	45	529	8.5%
Staff: Management	04/07/13	1	15	145	10.3%
OVERALL TURNOUT			**715**	**7281**	**10%**

A vacancy was created following the resignation of Alan Cleary, patient governor (30.07.13).
The Council of Governors unanimously agreed at its September meeting that Andrew Lomas, the next highest polling candidate at July election, fills the vacant patient seat (19/09/13).

Category	Constituency	Status at 30 September	First Name	Last Name	Start Date of Office	Telephone	E-mail
Patient		Filled	Andrew	Lomas	19/09/13	[redacted]	[redacted]

ii. Stakeholders

There were no changes.

b. Appointments (stakeholder)

There were no changes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.7/Oct/13
PAPER	Register of Seals Report Q2*
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Fleur Hansen, Interim Director of Corporate Affairs and Company Secretary
PURPOSE	To keep the Board informed of the use of seal.
LINK TO OBJECTIVES	NA
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	There were no documents to which the seal was affixed during the period under review.
DECISION/ ACTION	The Board is asked to note the paper.

Register of Seals Report Q2

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

12.2 Sealing of Documents

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

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

During the period 1 July 2013 through 30 September 2013, there were no documents to which the seal was affixed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.8/Oct/13
PAPER	Risk Report Q2
AUTHOR	Cathy Mooney, Director of Quality Assurance Fleur Hansen, Interim Director of Corporate Affairs and Company Secretary
LEAD	Elizabeth McManus, Executive Director of Nursing and Quality
PURPOSE	To update the Board on risks arising from the previous year's Board Assurance Framework and Board papers up to quarter 2.
LINK TO OBJECTIVES	Links to strategic objectives
RISK ISSUES	Included in paper
FINANCIAL ISSUES	Included in paper
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The mapping exercise of the Trust's strategic objectives is to be completed and will be presented in detail to the Board along with the Board Assurance Framework at the next meeting. The Board will be aware of the revised presentation of the objectives which was discussed at the Board of Directors / Council of Governors Away Day on 17th October and should note that this be used as the framework for the mapping exercise.

	The Board is asked to note that the Risk Report is being presented to provide the Board with assurance that these risks are being managed. Strategic risks will continue to be identified and actively managed through the Board and the sub-committee processes and will be highlighted to the Board as necessary.
DECISION/ ACTION	For information and noting the risk update.

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RISK REPORT QUARTER 2 September 2013 UPDATE

The risks below are those that are rated orange or above, identified from Board reports and previous Board Assurance Frameworks. Risks not on this report have been mitigated or superseded by subsequent reports

Risks from board reports Q4 12/13 and Q2 13/14

Updates from Q3 12/13 are in italics and bold

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
July 13	Papers to Board 2.1/Jul/13 Finance report (Public)	Risk of Trust not delivering financial plan. **Risk Rating: Impact 4 – Loss of between £1 and £4m).** Likelihood 3 – Possible Total Rating **Orange**	**Control totals have been set for each Division and corporate department. Fortnightly financial recovery meetings monitor progress against divisional plans. Additional controls over temporary staffing, discretionary non-pay and minimising contractual penalties have been agreed with oversight from named Executive.**	**Orange (reduced from red)** 880
Apr 2013	Papers to Board 13/14 PRIVATE	**Trust Budget and Business Plan 2013/14** 1. Transfer of £19m of sexual health services to local authority commissioning brings a risk of reduced margin. 2. Potential risk of £.1.1m to the financial plan if sexual health services are not funded at the 2013-14 non-mandatory tariff.	This risk is in relation to local authority commissioning of sexual health services. The value of the risk has reduced to £0.5m from £1.1m. The risk is graded orange. Action plan: 1) TB has written to David Nicholson to escalate concerns and explore alternative models of commissioning. **2) The Trust is continuing to engage with commissioners and has proposed alternative quality based incentive schemes to CQUINs,** The Trust has billed local authorities for months 1 and 4, most of which has not yet been paid and is being actively pursued for resolution.	Orange 862
Mar 2013	Papers to Board 12/13	**Trust Budget and Business Plan 2013/14** 1. Transfer of £19m of sexual health services to local	1) Sexual health commissioning is covered is covered in the above risk.	Orange 881

		authority commissioning brings a risk of reduced margin. 2. CIP delivery is high risk with £2.4m recurrent gap carried forward from 12/13 and only 66% of 13/14 target identified at time of report. 3.**Cash risk with potential impact on ratings on all commissioning contracts for April and May due to delay in contract agreement.** 4. Treatment of the Cheyne lease on buy back of Doughty House may deteriorate the risk rating if our treatment is not accepted.	**2) CIP delivery- at the end of September £3.1m CIPs were not delivered. Mitigating schemes as part the financial recovery have been identified to bridge this gap. (see above|)** **3) Cash risk- this risk is graded Orange (881). At the time of writing there is £11.8m of months 1-6 income billed to CCGs and NHSE was outstanding. The is continuing to engage with commissioners to have the debt paid.** 4) This risk on accounting treatment of lease buy back is graded yellow; dependent on concluding transaction and completing treatment and agreeing it with auditors and potentially Monitor.	
Feb 2013	Papers to Board 12/13	**Finance and Capital Plans for SAHF Reconfiguration** 1. The 'Do minimum' build, which forms the basis of the NPV evaluation for the capital requirement is not the preferred design solution though it is technically feasible. The Executive Directors have assurance from the NWL Programme sponsor that we will not be held to deliver this solution and there will be a fair risk share on any capital spend above the 'Do Minimum'. (cf Paragraph 13). 2. The outline timetable is too ambitious and the phasing of the Chelsea and Westminster build vis a vis the St Mary's build need to be more aligned. (cf Paragraph 14) 3. Alternative options for the local hospitals have been considered and are preferred in principle but these involve builds up to 6 times the level of the Do Minimum Capital Investment and would require a	This risk is subject to the SaHF business case being developed during 2013/14.	Orange 863

		cumulative additional efficiency of 5% by 17/18 to maintain the target 1% net surplus position. The affordability to the whole reconfiguration plan therefore depends on the outcome of the next phase of OBCs and FBCs to be worked up by individual trusts. (cf Paragraph 20 – 23)		

Orange and red risks from risk register relating to previous BAF and from papers to the Board in 12/13

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
Apr 12	Papers to Board 12/13	**Inpatient Survey 2011** Reputational risk due to poor results on the inpatient survey. Also demonstrates potentially poor care.	The patient and staff experience committee is now established. A patient experience lead has been appointed to take forward key objectives within the patient and staff experience action plan. Real time and quarterly patient surveys are now in place to allow closed monitoring and action planning to address areas of poor performance Trust values and linked behaviours have been developed and have been launched. Values have been sent to all staff and teams and departments have identified behaviours Values have been included in the quality planning process, incorporated into appraisals and wok in on-going to incorporate into other HR processes such as recruitment. **Remains orange until next survey results**	Orange 783
April 11-June 11	Papers to Board 11/12	SUI Report – **gynaecology death** Risk of not having timely consultant reviews. Audit showed performance could improve.	The incident review actions were: To introduce a system (amend the rotas) to ensure that patients admitted to gynaecology as an emergency are seen by a consultant at the earliest opportunity. Ideally this should be within 12 hours and should not be longer than 24 hours. Documentation of the first consultant review should be clearly indicated in the clinical records and be subject to 6-monthly audit, or until assurance is provided to the Divisional Board that this is in place. **Update on Consultant Attendance Emergency**	Orange 715

			The last formal audit was July 2012 where 91% of women admitted were seen within 24 hours and 62% were seen within 12hrs with continuing improvement from previous years (78% and 48% respectively for 2011. There has not been a repeat formal audit since July 2012 . There is directorate priority to meet new pan London commissioning standards for Consultant review of emergency admissions within 12 hours. Currently day time Emergency Consultant cover is provided by consultants from a rota where sessions are either providing care in an SPA or from other clinical sessions. However since July 2012 3 dedicated day time emergency gynaecology sessions have been resourced from new appointment and locum consultant sessions. These sessions are highly regarded with improvement in teaching, quality of care and responsive proactive consultant input from a consultant with dedicated session for emergency gynaecology. Simultaneously the Directorate have put forward a business case for 168 hours consultant cover for labour ward which includes provision of two consultant posts which mirror each other but who will also provide resident on call. Their duties will include responsibility for weekday consultant emergency care from leading an emergency assessment/admissions, review of inpatient admissions and performing or supervising emergency gynaecology e operating in the daytime. Even in the event that the 168 hours consultant cover for labour is phased, the two emergency gynaecology consultant roles will be in the first wave of phased resident consultant expansion, **Summary** There has been a year on year improvement of consultant attendance of emergency gynaecology inpatients. There has been in year strengthening of the provision of the emergency gynaecology consultant cover during the day with additional dedicated daytime sessions which allow proper triaging, management of emergency admissions in hours. There are firm plans to provide robust dedicated care by the appointment of two	

			emergency gynaecology consultants as part of the 168 hours Labour ward business case. A repeat audit is due. **The lead is off sick and a date for this cannot be confirmed currently.**	
Mar 12	Papers to Board 11/12 Performance Report	**Never events**	Schedule for review of controls and assurances in place for all never events. Retained swab – actions been discussed at Quality Committee and Assurance Committee. Assurance Committee requested monthly update on Never Events **Confirmed remains orange**	Orange 787
12/13	BAF	**Develop and embed our values** Lack of engagement by staff means that there is no change to behaviour and therefore no impact on patient experience	Values have been sent to all staff and teams and departments have identified behaviours Values have been included in the quality planning process, incorporated into appraisals and work in on-going to incorporate into other HR processes Patient Experience Committee -define expected outcomes, measure and review. - establish a model of engagement - highlight good and bad practice Patient experience summit – 130 staff and stakeholders attended – developed a series of always events based on values and good practice. Have also developed 'you said we did boards' across wards and depts. which identify feedback from patients and families and are linked to our values **Risk remains orange**	Orange 801
12/13	BAF	**Drive efficiency through service line reviews** Lack of engagement from services for service line reviews and lack of follow through on implementation leading to no change	**SRL and more detailed EBITDA information has now been issued to divisions and discussed at wider Executive.**	Orange 803
10/11	BAF	**Staff failure to recognise deteriorating patient.**	Actions for this covers two areas, early warning systems supported by documentation and a communication tool SBAR. NEWS is being rolled out. MEWS – recent audit showed a greater than 75% compliance rate. SBAR – SBAR is an integral part of the NEWS role out. SBAR is currently taught on all resuscitation courses which include induction and updates.	Orange 594

			Update: audit results presented to the Quality Committee show that the NEWS observation charts were scoring at 87% Completeness of observations was also very high with 93.5% of all observations recorded using all elements of the NEWS but that evidence of escalation was poor. A detailed action plan is in place	
11/12	BAF	**Staff not trained or competent which affects quality of care.**	Training provision; selection process; appraisals. Mandatory training reports to managers and Trust Executive and Assurance Committee meetings every quarter. Appraisal rates are now over 80% and feedback is that they are well structured. Mandatory training is still falling short of requirements. **No change**	Orange 663
11/12	BAF	**Agency staff - not familiar with the area and level of competency unclear - can, therefore, affect quality of care to patients.**	Recruitment policies aiming to minimise agency staff. Bank office only books via LPP approved agencies. Induction training procedures to reduce risk. Vacancy and sickness management reduces likelihood of needing agency staff. Regular monitoring of agency use. We know from a recent audit that local induction is not occurring for agency staff and therefore they remain a risky group. A senior nurse has been appointed to support training and recruitment of bank and agency staff. **In July a working group was established to focus on more effective use of agency staff and reducing numbers. Plans are in place to review our ward staffing establishment to increase our complement of bank staff and to further develop out flexible pool of bank nurses.**	Orange 664

Risks downgraded since last report (Q3 2012-13)

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
11/12	BAF	**Failure to retain CLAHRC collaborative.**	CLAHRC Board need to get programme grants in. Develop and maintain partnership working within the CLAHRC. Ensure CLAHRC projects align with BSC research. Actively working with CEO and others in area including AHSN. **Funding approved**	Yellow 678
12/13		**IT/telephony** - significant investment and substantial CIP Risk is timeliness and delivery Not all identified partners will join. Clarifying that partners requirements are aligned	Long term programme director is now in place. The business case for the Fulham Road shared services IT project was approved at the June FIC.	Yellow 802

		Concern re our IT resilience to be able to support Implementation Chief Technical Officer is key and need to identify Complexity re economics of scale Issues about partners' IT Directors	**Risk now considered yellow by Chief Operating Officer**	

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.9/Oct/13
PAPER	Health and Safety Policy 2013-14
AUTHOR	Cathy Mooney, Director of Quality Assurance Kevin Ray, Health & Safety Consultant
LEAD	Elizabeth McManus, Executive Director of Nursing and Quality
PURPOSE	To request the Board to approve the policy for 2013-14
LINK TO OBJECTIVES	Links to trust objective for safety
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The attached is a yearly review. Changes are mainly to titles and reporting committees to reflect current practice. The health and safety objectives are part of the Risk Strategy and Policy and will be approved at the next meeting.
DECISION/ ACTION	For approval.

HEALTH AND SAFETY POLICY

START DATE:	October 2013	**NEXT REVIEW:**	October 2014
COMMITTEE APPROVAL:	Trust Board	**CHAIR'S SIGNATURE:**	
	DATE: October 2013		
	ENDORSED BY: Health, Safety & Fire Committee	**DATE:** July 2013	
DISTRIBUTION:	Trustwide		
LOCATION:	Intranet: Trustwide Policies and Procedures		
RELATED DOCUMENTS:	Trust Risk Management Strategy and Policy, Trust Incident Reporting Policy, Risk Management Strategy, Trust Fire Policy, Moving & Handling Policy, Infection Control Policy, Security Policy, First Aid Policy, Control of Contactors Policy, Smoke Free Policy, COSHH Policy, Stress Policy, Management and Prevention of Body Fluid Exposure Policies, Slips Trips & Falls Policy, Violence and Aggression Policy, Lone Working Policy, Display Screen Equipment Policy, Waste Policy, Latex Policy and New & Expectant Mothers Policy		
AUTHOR / FURTHER INFORMATION:	Cathy Mooney, Director of Quality Assurance Kevin Ray, Health & Safety Consultant		
STAKEHOLDERS INVOLVED:	Health & Safety Committee members		

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
February 2005	1	Health & Safety Consultant	Review
February 2007	2	Health & Safety Consultant	Review
August 2008	3	Health & Safety Consultant	Review
November 2009	4	Health & Safety Consultant	Review
January 2010	5	Health & Safety Consultant	Review
February 2011	6	Health & Safety Consultant	Organisational change
August 2012	7	Health & Safety Consultant	Organisational changes reflecting Divisional structure. RIDDOR changes for reporting absence of more than 7 days.
July 2013	8	Health & Safety Consultant	Yearly review
DATE EXPIRED:		**February 2015**	

Contents

1. Policy Statement

The Chief Executive and Board of the Chelsea and Westminster Hospital NHS Foundation Trust are committed to providing and maintaining, so far as reasonably practicable, a safe and healthy environment for all employees, contractors, patients, visitors and those who may be affected by work related activities. The Trust regards the promotion and progressive improvement of health, safety and welfare at work as a mutual objective for management and employees at all levels. The Trust recognises that the only effective approach to the prevention of injury and loss is the systematic identification and control of risk through the Trust's risk assessment process, the adoption of best practice in health and safety management and the allocation of necessary resources.

The Health and Safety Policy is intended to confirm the management arrangements which are designed to ensure the health and safety of anyone who could be adversely affected by the activities of the Trust. In recognition of the obligations imposed under the Health and Safety at Work Act, the following policy has been prepared. The policy will be reviewed annually or when legislation, codes of practice and official guidance dictate.

The executive responsibility for the management of health and safety for the Trust has been delegated by the Chief Executive to the Director of Nursing and Quality, with advice and support from the Trust's Health and Safety Consultants, Occupational Health Services Manager, Infection Control, Risk Managers, Fire Consultant and the Director of Estates & Facilities. However, the Trust regards the promotion of health, safety and welfare at work as a mutual objective for management and employees at all levels.

To maintain and promote the implementation of this policy and enable employees to function efficiently with regard to health and safety; information, instruction, training and supervision will be provided in accordance with identified needs.

The Trust has a Health, Safety & Fire Committee which comprises management, staff representatives and site partners to ensure good and effective communication.

Whilst overall responsibility to provide and maintain safe and healthy working conditions, equipment and systems of work rests at the highest level of management, every individual has a responsibility to prevent personal injury and damage to property and to protect everyone from foreseeable work hazards, including the public insofar as they come into contact with Trust premises and services.

2. Introduction

The Trust will manage health and safety using the process of risk management which includes the identification of hazards, assessment of risks and introduction of control measures. To ensure this the Trust will:

- Adopt a systematic approach to safety. This includes following any standards published by the Health & Safety Executive, NHS or Department of Health which identify priorities and set objectives whereby risks are eliminated or minimised by the correct selection and design of facilities, equipment and processes;

- Provide and maintain safe and healthy working conditions, adequate welfare facilities, safe means of access and egress and take account of all statutory requirements;

- Provide information, operational policies and procedures, training, instruction and supervision to enable employees to perform their work safely and efficiently;

- Make available all necessary safety devices and protective equipment and provide instruction in their use;

- Maintain a constant and continuing interest in health, safety and welfare matters by consulting and involving employees or their representatives;

- Liaise with other employers upon its sites insofar as the activities of these employers affect the health, safety and welfare of the Trust's staff, students visitors and patients; and where the activities of the Trust may affect the activities of the other employers;

- Carry out a risk assessment when planning new developments, systems of work and when purchasing new equipment;

- Keep and maintain accurate records of accidents, incidents and injuries;

- Evaluate the application of Trust Health & Safety related policies and procedures.

3. Organisation and Responsibilities

Boards and Committees

3.1 The Trust Board

In the context of effective corporate governance, management of health and safety risks is a key issue for the Board, who have a collective role in providing committed leadership in the continuous improvement of health and safety performance. The Board will ensure that their actions and decisions always reinforce this commitment, and that they will review the effectiveness of the health and safety management system and performance, at least annually via the Assurance Committee which is a sub committee of the Board.

The Board has a specific responsibility under the Health and Safety at Work etc Act, to prepare a General Policy statement and all staff are expected to comply with this policy, as outlined in the statement.

The Board has a monitoring, review and policy setting role in health and safety.

3.2 Assurance Committee

This is a sub committee of the Board and its aim is to seek assurance on systems, processes and outcomes relating to quality (patient safety, effectiveness and patient experience), staff satisfaction and safety and the environment, and assuring compliance with the Care Quality Commission Standards. It is responsible for assuring the Board that there are effective systems in place for health and safety. It receives a monthly report on health and safety and provides a monthly report on all areas considered to the Board.

3.3 Risk Management Committee

The Risk Management Committee is responsible for ensuring that proactive, progressive and continuous improvement in the Trust's approach to risk management is achieved. This includes overseeing the development and maintenance of a risk register and associated risk management processes.

3.4 Health, Safety & Fire Committee

The Health, Safety & Fire Committee is responsible for ensuring the development and implementation of a Health & Safety Policy and safety management systems for dealing with safety risk issues, and for encouraging and fostering greater awareness of safety risk management throughout the Trust at all levels. The Health, Safety & Fire Committee will receive regular reports from the safety sub-groups, Radiation Safety Committee, Medical Gas Committee, Sustainability Committee (waste and environment) and Fire Action Group.

Health and safety issues are also addressed within clinical areas under the auspices of the Trust's Quality Committee arrangements and these include clinical risk management and control of infection.

Individual Post Holders

3.5 The Role of the Chief Executive

The Chief Executive has prime overall responsibility for Health and Safety. The duty to implement Health and Safety Regulations has been delegated to the Chief Nurse. The Chief Executive will ensure:

- Appropriate management arrangements exist for the Trust to comply with the requirements of health and safety legislation in maintaining and implementing this policy;
- That so far as is reasonably practicable adequate resources will be provided to meet the requirements;
- All managers identified within this policy understand and discharge their specific health and safety responsibilities.

3.6 The Role of the Director of Nursing and Quality

The Director of Nursing and Quality will:

- Chair the Health, Safety & Fire Committee
- Ensure that the Health & Safety policy is reviewed annually or earlier as appropriate;
- Promote a healthy, safe environment by effective communication and coordination on matters of health and safety;
- Ensure that health and safety is given a sufficiently high profile to maintain a culture which encourages effective health and safety management;
- Support the Chief Executive in relation to corporate health and safety responsibilities.
- Ensure that staff have access to fire safety advice as part of their induction and to a range of health and safety related training as required to undertake their roles.

3.7 The Role of the Director of Quality Assurance

The Director of Quality Assurance reports to the Director of Nursing and Quality on health and safety and is responsible for implementing the Health and Safety Policy through the Health and Safety Consultants and Divisional teams.

3.8 Health and Safety Consultants

Health and safety consultants provide advice on general Health and Safety, support Trust management and monitor and advise on safety performance. The Health and Safety Consultants have a co-ordinating role in relation to general safety issues including delivering health and safety training, review of risk assessments including COSHH and audit of the Trust's arrangements for managing health and safety.

The duties and responsibilities are:

- on a day-to-day basis to assist the Trust in ensuring, as far as is possible, that activities comply with the necessary legislation and to advise the management

on safety matters, to ensure that the Trust's procedures for caring for the health, safety and welfare of its staff and students are of the highest standard and that the health, safety and welfare of the general public is not adversely affected by the Trust's activities;

- to act as the Fire Safety Advisor as required by the NHS Firecode to support the Fire Safety Manager;

- to act as the secretary of the Health, Safety & Fire Committee and follow up any recommendations made;

- to provide on behalf of the Fire Safety Manager training and instruction of staff and students in respect of safety and fire prevention, and to keep them conscious of the problems of safety, and of their responsibility for the safety of those with whom they work;

- to carry out health & safety audits of each department at appropriate intervals and provide a report to department managers and safety committees;

- to obtain, where appropriate, expert external advice to ensure that the safety procedures in operation are of the highest necessary standard;

- to act directly as advisor to managers and members of staff on safety matters and, where necessary, to obtain expert advice on their behalf;

- to liaise on behalf of the Trust with the enforcing authorities on all safety & fire issues.

- to flag significant concerns and non-compliance

The Safety Consultants can be contacted by telephone on 58656 or by email at **Safety.officer@chelwest.nhs.uk**

3.8 The Role of the Trust Executive Directors

The Trust Executive Directors will be accountable to the Chief Executive for ensuring safe and healthy working conditions. Executive Directors will provide appropriate support to managers within their Divisions to meet their responsibilities for health and safety.

3.9 The Role of Divisional Medical Directors and Divisional Operational Directors

Divisional Medical Directors and Divisional Directors of Operations will implement this policy within their Divisions by operating a safety culture and ensuring adequate communication, training and assessment and monitoring of risks. In particular, this will include:

- Ensuring sufficient suitable staff are identified within their Division to carry out the roles of Safety Coordinator, COSHH Assessors, Fire Marshall and Radiation Protection Supervisors, as appropriate. The Safety Consultant maintains the list of nominated individuals who have attended the relevant training sessions.

- Ensuring that annual health and safety objectives are defined with key indicators and success criteria established to monitor performance within their Division.

- Ensuring that Trust health and safety key performance indicators are met and plans developed in the Division to address shortfalls.

- Ensuring that annual budget reviews identify adequate resources and facilities to enable achievement of these objectives.

- Ensuring that mandatory training identified in the Trust training needs analysis is undertaken in the Division.

- Obtaining commitment from their managers to the health and safety risk management system and encouraging them to foster health and safety consciousness, including developing local health and safety policies and procedures within the overall General Statement of Policy published by the Trust.

- Developing, maintaining and reviewing annual Comprehensive Risk Reviews as set out in the Trust's Risk Management Policy, which reflect local risks and other issues.

- Ensuring that all incidents, whether injury is sustained or not, are reported and fully investigated, that immediate and underlying causes are identified and recorded, and that appropriate remedial action and lessons are learned and longer-term objectives relating to health and safety are introduced.

- Ensuring that reports from the HSE and other similar sources relating to their Division receive prompt attention and appropriate action.

3.10 The Role of Managers and Supervisors

- To undertake a health and safety audit once a year, ideally in consultation with the local health and safety representative, prioritising risks identified and developing risk treatment plans to eliminate or minimise exposure. Where risks cannot be eliminated, developing written safe systems of work and ensuring that staff are aware of them through training and supervision. Maintaining a local Risk Register to record assessment outcomes.

- Nominate a Safety Coordinator and sufficient Fire Marshalls for each ward/department. To support the Coordinator/Marshall and ensure they are trained.

- Identify potential occupational health and safety hazards involved in their operations and the precautions to be taken and record those precautions.

- Identify actual and potential hazards at work and ensure either their removal, where possible, or that risk is minimised.

- Produce and update appropriate local Health and Safety Policies, procedures and assessments. Ensuring that these are available to all requiring them.

- Ensure that all relevant policies, procedures and assessments are brought to the attention of, and made available to, staff under their control, and that appropriate warning notices and all instructions are prominently displayed.

- Ensure that staff comply with mandatory health and safety training identified in the Trust training needs analysis.

- Ensure that local induction, and refresher training on health and safety issues is provided, covering policies/procedures, safe systems of work and safe operation of equipment.

- Ensure that all staff are made aware of Trust and Departmental safety policies and procedures, hazards and any other safety information, which they require in order to perform their duties safely.

- Ensure that all appropriate health and safety equipment, protective clothing etc is always available, properly maintained and used.

- Ensure that all supervisors understand instructions regarding health and safety, monitoring staff compliance.

- Investigate and record all accidents/dangerous incidents within their area of control and ensure that any remedial action is implemented as soon as possible reporting to their Director/General Manager as appropriate.

- Ensure that equipment used in the department is safe and adequate for the purpose for which it is intended.

- Ensure that faulty equipment, plant or buildings are reported promptly for repair and adequate steps are taken to put the relevant unit or area out of use in the interim should this be considered necessary.

- in conjunction with the Occupational Health Department, to maintain where appropriate departmental First Aid arrangements to the required standard;

3.11 The Role of the Human Resources and Training and Development Departments

- To ensure all job descriptions define the post holders' responsibilities in relation to health and safety

- To ensure that health and safety training is accommodated within the Trust's training programme

- To ensure that the philosophy of accident and ill health reduction by good management and working techniques is promoted throughout the Trust

- To maintain a computerised database of staff who have received mandatory training throughout the Trust – to include induction; statutory training and ad hoc health and safety courses provided by the Trust.

- To provide reports for managers on compliance against the mandatory standards described in the Trust training needs analysis.

3.12 The Role of the Safety Coordinators

Safety Coordinators are appointed by Ward or Department Managers. Safety Coordinators assist the Manager to meet their health and safety responsibilities.

The duties are:

- to understand and apply the Trust's Health and Safety Policy, its guidelines and procedures, as well as the Departmental Health and Safety Policy;

- to liaise with the Manager and Safety Consultant and other health & safety representatives, including representing their Department at the Health, Safety & Fire Committee as required;

- to inform and liaise with the manager to identify training needs, organise training where appropriate, and maintain training records within the department;

- to maintain the local Safety Manual, and other related policies;

- to review at regular intervals all local Health and Safety Policies and operational procedures and advise the Manager when changes are necessary;

- to monitor plant, equipment, processes, working practices, procedures and standards of housekeeping to ensure that they are safe;

- to assist the manager in the preparation of risk assessments;

- to distribute Health and Safety information and draw to the attention of staff particular areas of relevance to work procedures;

- to carry out local safety inspections and maintain records;

- to monitor the selection, use, maintenance and replacement of personal protective equipment (PPE);

- to refer promptly to the manager and the Health and Safety Consultant, any health and safety problems which cannot be resolved locally on a timescale appropriate to the risk;

- to ensure that staff, agency and visiting workers within their areas are familiar with accident procedures, fire precautions and first aid arrangements.

3.13 The Role of Safety Representatives

Safety Representatives may be appointed by recognised Trade Unions and Professional Organisations in accordance with the Safety Representatives and Safety Committees Regulations as modified by the Management of Health and Safety at Work Regulations and the Health and Safety (Consultation with Employees) Regulations.

Their role and functions under the Regulations are recognised by the Trust and they will be afforded the necessary time off with pay to attend any necessary courses and meetings as laid down in the Trust's Time Off for Trade Union Duties/Activities Policy.

A list of currently recognised Trade Unions is maintained and updated as necessary by the Director of Human Resources.

3.14 The Role of Every Member of Staff

All employees have a duty to themselves, colleagues, and to any person who might be affected by their actions, to work in a safe manner. In particular this will include:

- taking reasonable care for the health and safety of themselves and any other person who may be affected by their acts or omissions;

- Cooperating with managerial and supervisory staff to ensure that all relevant statutory regulations, policies and procedures are followed.

- Attending as directed, health and safety training sessions designed to further the cause of health and safety, and increase individual awareness;

- Ensuring that where required, safety equipment/devices are used as directed and appropriate protective clothing is worn.

- Reporting to their manager/supervisor all faults, hazards, unsafe practices, accidents, adverse incidents, dangerous occurrences and near misses whether injury is sustained or not;

- Ensuring that any ill health or medical condition, which may affect their ability to work safely, is reported immediately to their line manager and /or the Occupational Health Department;

- Reporting to their manager any incident of somebody intentionally interfering with, or misusing any equipment or material provided to ensure a healthy and safe environment.

3.15 Contractors

All contractors engaged by the Trust (or their nominated contractors e.g. Norland Managed Services and ISS Mediclean) have a responsibility, as specified in all contract documents to carry out their work in a safe manner in respect of their own staff, sub-contractors, Trust staff and premises, patients and member of the pubic. The Trust policy Controlling Contractors provides further detail.

The Trust will ensure so far as is reasonably practicable, employment of competent contractors who are able to demonstrate that they have in place management systems for safely undertaking work for which they have been employed.

3.16 Specialist Advisors

These are employees working within, or managing a department with the Trust and who have designated responsibilities for advising on and ensuring the implementation of Health and Safety measures. Managers within the Trust should refer to these advisors on matters relevant to their speciality, and for assisting in investigating adverse incidents and near misses, and identify solutions to prevent reoccurrence. These are listed below:

3.16.1 Occupational Health Department

The Occupational Health Service, in conjunction with managers, is responsible for promoting and helping to maintain a high standard of good health at work for all staff of the Trust. This encompasses both mental and physical health and well-being. The Occupational Health department is responsible for:

- Work Health Assessments and evaluating any implications for fitness;

- the provision of, or arrangement for, treatment of employees becoming ill or who are injured at work.

- the assessment of the needs of health surveillance programmes and provision of relevant health information on jobs or processes to protect employees health;

- advising management regarding the fitness of individuals and the suitability of working practices;

- the provision of advice on rehabilitation and help with resettlement into appropriate work;

- the provision of advice and care to employees after accidents at work and to provide a monthly report to the Health& Safety Committee to monitor risks to health from accidents;

- the investigation of outbreaks of acute ill-health affecting employees and implementing appropriate control measures and to liaise with Infection Control as appropriate;

- to liaise with others, e.g. Safety Consultants, Infection Control and the Health Safety & Fire Committee, to formulate policy and examine working practices;

- developing health promotion practices to help employees meet and address their health needs and assist employers' responsibilities;

- the implementation of relevant health care programmes, such as an immunisation service;

- the provision of a secondary counselling role and liaison with the Trust Counselling Service.

The Occupational Health Service is provided by the Royal Marsden NHS Trust under contract to Chelsea & Westminster Hospital NHS Trust. The contract is managed by the Director of Human Resources.

3.16.2 Infection Control Team

The Infection Control Team is responsible for undertaking surveillance of infection for the prevention and management of outbreaks and report to the Trust's Infection Control Committee. It will provide education in all relevant aspects of infection control and prepare policies for and give advice on infection control issues.

The Infection Control Team will keep up to date with all new developments and procedures relating to infection control, disseminating this information to all appropriate sectors of the Trust.

In addition to this advisory and monitoring role, in the event of a major infection outbreak, the Consultant Microbiologist and Infection Control Nurses have executive authority, and all managers will ensure compliance with the procedures and advice provided.

3.16.3 Risk Managers

Risk Managers are part of the Clinical Governance Support Team and will work closely with nominated Risk Leads within Directorates and Departments to implement the Risk Management Strategy and policy for the Trust. In particular, the Risk Managers will:

- Support the risk management process to promote incident reporting

- Work with the Health & Safety Consultant, Occupational Health and others to provide a holistic risk management approach

- Forge links with all risk and governance activities
- Provide advice and support

3.16.4 Manual Handling Advisor

The Trust has appointed Manual Handling Advisors to advise on manual handling issues. The main duties and responsibilities are:

- To implement, audit, review and develop the Moving & Handling Policy;
- To assist managers undertake ergonomic workplace assessments;
- To advise the Trust on appropriate handling equipment to complement safe handling practice;
- To develop appropriate codes of practice for safe handling;
- To develop appropriate training programmes and deliver those programmes to Trust employees.

3.16.5 The Radiation Protection Advisor

The Chelsea and Westminster Hospital NHS Foundation Trust has appointed Radiation Protection Advisors to provide a Radiation Protection Advice service. The role is to provide advice on all matters relating to radiation protection and radiation safety. The role includes review of working practices, advice on environmental requirements and on monitoring; liaison with enforcement bodies and ensuring maintenance of records of all acquisitions and disposals of radioactive substances.

The duties and responsibilities are:

- to assist and consult with the Divisional Medical Directors and managers in drawing up local rules for radiation work, and to ensure that these are updated as necessary in order to be always relevant to the work performed;
- to assist the Trust to comply with relevant legislation and enforcing bodies, e.g. Environment Agency, Health & Safety Executive.
- to ensure that local rules are available to all relevant staff and are applied effectively;
- to instruct individual staff on specific equipment, procedures etc;
- to report to the appropriate manager all incidents, hazards, potential problems with the radiation work, and on any new training requirements;
- to ensure that monitored staff have access to the results of routine dose monitoring;
- to liaise as necessary with the radiation protection service and other safety specialists;
- to review staff doses and investigate radiation incidents;
- to provide radiation expertise with respect to the Ionising Radiations (Medical Exposure) Regulations;

- to attend safety and radiation protection committee meetings.

3.16.6 The Radiation Protection Supervisor

Radiation Protection Supervisors are appointed by managers for defined areas. The duties and responsibilities are defined in the Local Rules and include the following:

- to assist the Divisional Medical Directors, managers and the Radiation Protection Advisor in drawing up local rules for radiation work, and to ensure that these are updated as necessary in order to be always relevant to the work performed;

- to ensure that local rules are available to all relevant staff and are applied effectively;

- to instruct individual staff on specific equipment, procedures etc;

- to report to the appropriate manager all incidents, hazards, potential problems with the radiation work, and on any new training requirements;

- to ensure that monitored staff have access to the results of routine dose monitoring;

- to liaise as necessary with the radiation protection service and other safety specialists;

- in conjunction with the Divisional Medical Director or appropriate manager, to consult with the Radiation Protection Advisor on any proposals which will change existing radiation practices, or which will introduce new procedures.

3.16.7 Clinical Engineering Department

The Clinical Engineering Department is responsible for overseeing from a health and safety viewpoint, the selection and subsequent maintenance of medical equipment. In addition they receive, distribute and coordinate responses to Medical Device Agency (MDA) Safety Notices;

3.16.8 Estates and Facilities Directorate

The Estates and Facilities Directorate is responsible for:

- Ensuring that the estate plant and non-medical equipment is maintained in a safe condition by arranging regular maintenance and inspection schedules.

- Ensuring compliance and record keeping in line with Statutory Instruments, including Health Technical Memoranda, Health Building Notes, Approved Codes of Practice and other mandatory standards, as well as the Electricity at Work Regulations, Provision and Use of Work Equipment Regulations and lifting operations and Lifting Equipment Regulations.

- Ensuring that all contractors employed on Trust sites demonstrate compliance with the Health and Safety at Work Act and associated regulations and are aware of the Trust's Health and Safety Policies and Procedures.

- Ensuring that written records are kept of the communication of health and safety requirements to contractors.

- Ensuring that a "Permit to Work" system is operated where risks to an individual or to the organisation have been identified (e.g. hot work, entry into confined spaces and work involving medical gases);

- Responsible for nominating a competent CDM Co-ordinator for certain projects as required in the Construction (Design and Management) Regulations (CDM).

3.16.9 Security Manager

The Security Manager is responsible for the day-to-day management of the Security Service and for recommending strategies for security risk management across the Trust. This will include monitoring the effectiveness of security and crime prevention measures, identifying and participating in relevant security and personal safety training and awareness sessions and for advising all levels of staff on appropriate security and crime prevention measures.

3.16.10 Health & Safety Organisation Structure

Attached at Appendix 1 is a flowchart describing the organisation arrangements for health and safety management within the Trust.

4. Health & Safety Arrangements

4.1 Policies, Procedures and Codes of Practice

All Policies, procedures and codes of practice approved by the Trust Executive Quality Committee, Risk Management Committee, the Health, Safety & Fire Committee, the Radiation Safety Committee, the Sustainability Committee and Control of Infection Committee are accessible at locations throughout the Trust's premises. This information is also made available on the Trust intranet as each policy or procedure is reviewed.

Managers shall ensure that each member of staff is made aware of and understands those documents that apply to them.

4.2 Identifying Hazards, and Assessing, Controlling & Monitoring Risks

Each area of the Trust is inspected at regular intervals by the Safety Co-ordinator to identify hazards in the workplace. The hazards that cannot be immediately eliminated are subjected to risk assessment.

Assessments are carried out by the Safety Co-ordinator or other competent person. Assessments are recorded in a retrievable format and are produced in consultation with persons directly affected.

Risk assessments are reviewed by the Safety Consultants as part of a rolling programme of safety inspections. Reports are presented to the Safety Committee for consideration and follow up where required.

Safety audits are carried out on a 5-year programme. Executive summaries are presented to the Safety Committee for consideration and follow up where required. Follow up inspections are carried out to monitor progress in implementation of recommendations and reported back to the Safety Committee.

4.3 Accident, Incident and Hazard Reporting

All accidents, incidents, hazards, near misses and violent occurrences, which occur on Trust premises, are to be reported on the Trust accident/incident report forms.

Accident/incident report forms are available from Heads of Department/Safety Co-ordinators or the Safety Consultant. It is the responsibility of the Manager in whose area the accident occurred to ensure that an adequate report is made and followed up where appropriate. The Policy for Incident Reporting must be followed at all times.

Accidents/Incidents & serious untoward events involving clinical risk are reviewed under the auspices of the Trust's Clinical Governance arrangements.

The Safety Consultants review health & safety reports to determine the severity and the remedial actions taken to prevent the accident occurring again. Accidents that fall under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) are reported by the Safety Consultant on behalf of the Trust. Expectations of RIDDOR are set out in section 4.4 below.

4.4 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) – Reporting Guidance

Accidents and diseases that arise out of or in connection with work must be reported to the Health & Safety Executive (HSE). The HSE has laid down criteria for these types of accidents etc and some of these are given below.

Staff or Visitor Major Injuries/Death
Managers must notify the Trust's Safety Office **IMMEDIATELY** during office hours and the Clinical Site Manager out hours if there is an accident connected with work **and**:

- A member of staff, or a self-employed person, e.g. contractors, working on our premises dies or suffers a major injury (including as a result of physical violence); **or**
- A member of the public dies **or**
- A member of the public (including patients) sustains a major injury.

Major injuries include:

- Fracture (except to fingers, thumbs or toes), amputation, dislocation (of shoulder, hip, knee or spine), loss of sight (temporary or permanent), chemical or hot metal burn to the eye, electric shock or any other injury leading to unconsciousness or requiring resuscitation, or any injury requiring admittance to hospital for more than 24 hours.

Accidents That Result in Inability to Work Over 7 Days

- Any accident or incident which leads to a member of staff being **unavailable for work for more than seven days.**

An over-7-day injury is one which is not "major" but results in the injured person being away from work OR unable to do their full range of their normal duties for more than seven days (including non-work days).

It is this category where it is important that managers inform the Safety Office within 48 hours when they become aware that a member of staff is going to be off work or has been for more than seven days. Examples of this may include injuries as a result of a slip or fall, manual handling, physical or verbal assault etc.

It is recognised that managers may not always know how long a staff member is going to be away immediately following an accident. However, the person must be asked if they were unable to perform normal duties for more than 7 days as soon as they return to work.

Diseases
Advice must be sought from Occupational Health as soon as possible if a member of staff becomes ill at work or as a result of work.
Reportable diseases include (non-exclusive list):

- Some skin diseases such as : occupational dermatitis.
- Occupational asthma or respiratory sensitisation.
- Infections such as: leptospirosis; hepatitis; tuberculosis; anthrax; legionellosis and tetanus.
- Other conditions such as: occupational cancer; certain musculoskeletal disorders including work related upper limb disorder (RSI); hand-arm vibration syndrome.

Dangerous Occurrences

Dangerous occurrences are specified events which may not result in a reportable injury, but have the potential to do significant harm.

Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment e.g. hoist failure.
- The accidental release of a biological agent likely to cause severe human illness (a hazard group 3 or 4 pathogen) e.g. needlestick injury known to contain pathogen 3 or 4 material – Hep B, HIV.
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

Should any of the above occur the Safety Office should be contacted **IMMEDIATELY** on extension 58656.

4.5 Training and Information

Training is an indispensable ingredient of an effective health and safety system and it is essential that all grades and disciplines of staff are trained to perform their job effectively and safely.

All managers will identify the health and safety training needs of their staff as part of the personal development planning process. All staff identified as Safety Coordinators, COSHH Assessors, Fire Marshalls and Safety Representatives will attend health and safety training specific to their needs.

General health and safety awareness will be included in the Trust Induction Programme, reinforced with more specific training as part of Department induction. Additional training will be provided when staff are exposed to new or increased risks because of a change in responsibilities or place of work. Refresher training will be provided as appropriate and in line with the Trust Policy for Statutory & Mandatory Training.

Managers will ensure the maintenance of training attendance records and that inadequate attendance is rectified.

4.6 First Aid

The Trust maintains suitable numbers of first aid personnel to deal with minor accidents and emergencies at the workplace. These personnel have sufficient training and qualifications in accordance with statutory requirements. Members of staff should familiarise themselves with who is their nearest first aider. Further information is contained in the Trust First Aid Policy.

4.7 Emergency Procedures

The Chief Executive will ensure that arrangements are in place for the development of robust plans to deal with all situations which may present serious and imminent danger to the health and safety of people. These include for example:

- Major incident and Internal Disaster Plans
- Fire Evacuation Plans
- Estates continuity plans for loss of utilities and services

- Bomb theatres
- Radiation and chemical release

Managers will ensure that all staff within their area are familiar with these arrangements and have received suitable training. Managers will also ensure that other people who are in their area are informed of an emergency and of the arrangements in place to handle it.

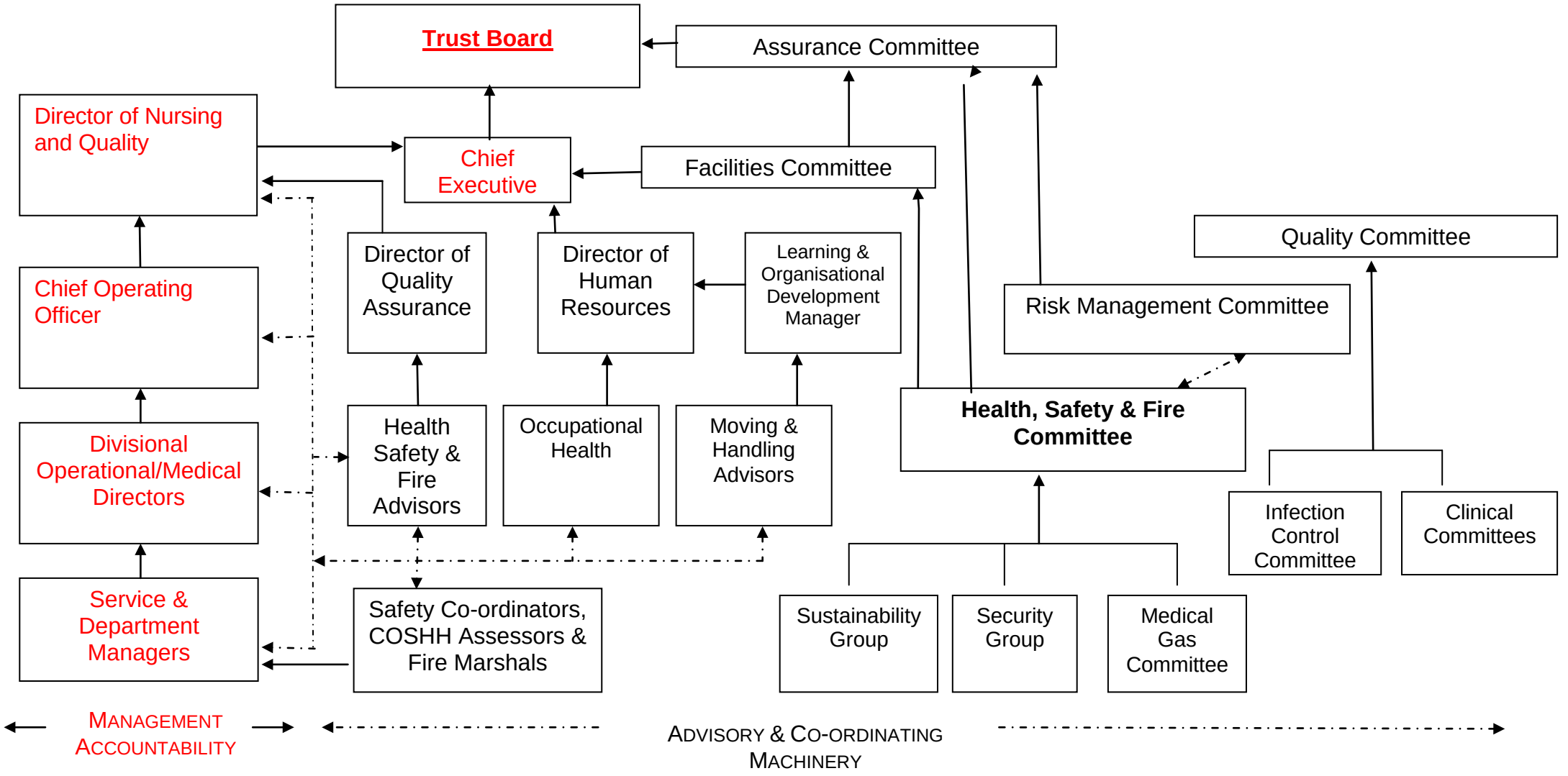
4.8 Monitoring This Policy

The Director of Nursing and Quality will ensure that the Health, Safety & Fire Committee review this policy on an annual basis. The effectiveness of the policy and arrangements are monitored by the Health, Safety & Fire Committee by reviewing the following:

- Mandatory Health & Safety training compliance
- Incidents graded yellow and above
- Relevant risk assessments graded orange and above
- Body fluid exposure trends and patterns
- Violence and aggression trends and patterns
- Waste non-conformity
- Health & safety performance feedback from Divisions.
- Trust Health & Safety Key Performance Indicators

Any changes made by the Trust Executive and/or Trust Board which have an impact on the arrangements set out in this policy will be brought to the attention of the Health, Safety & Fire Committee and amendments proposed to the policy, as necessary.

APPENDIX 1: SAFETY MANAGEMENT STRUCTURE



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.10/Oct/13
PAPER	GMC Responsible Officer Appointment
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Fleur Hansen, Interim Director of Corporate Affairs and Company Secretary
PURPOSE	To formally endorse and approve the appointment position of Responsible Officer for the Trust in place of Dr Mike Anderson.
LINK TO OBJECTIVES	NA
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	
DECISION/ ACTION	The Board is asked to approve the appointment of Zoe Penn as the GMC Responsible Officer in line with The Medical Profession (Responsible Officers) Regulations 2010.

GMC Responsible Officer

1.0 Introduction

From 1st January 2011 all NHS Trusts and other designated bodies are legally required to have appointed a Responsible Officer in order to implement the requirements for Revalidation and Strengthened Medical Appraisal.

2.0 Background

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to provide extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Licensed doctors have to revalidate every five years by having regular appraisals, which include the completion of a 360 appraisal tool, feedback from patients and self-assessment.

The process of revalidation commenced on 3 December 2012 – the General Medical Council (GMC) expects that the majority of licensed doctors in the UK will be revalidated for the first time by March 2016.

The Responsible Officer is a senior doctor within the organisation with local responsibility for overseeing the process and making recommendations to the GMC on a doctor's revalidation.

The three core components of revalidation are to improve patient safety, effectiveness of care and patient experience.

2.1 Responsibilities of the Responsible Officer:

From 1st January 2011 all NHS Trusts and other designated bodies are legally required to have appointed a Responsible Officer, whose duties will be:

- To provide the mechanism to facilitate the revalidation of doctors
- To make recommendations to the GMC about the fitness to practise of doctors employed by the Trust
- To maintain secure records of doctors' fitness to practise evaluations, including appraisals and any other investigations or assessments
- To ensure that the doctors employed by the Trust take part in annual appraisals
- To establish and implement procedures to investigate concerns about a doctor's fitness to practise raised by patients or staff of the trust or arising from another source, in line with Maintaining High Professional Standards in the NHS Where appropriate, to refer concerns about a doctor to the General Medical Council
- Where a doctor employed by the Trust is subject to conditions imposed by or undertakings agreed with the GMC, to monitor compliance with those conditions
- To liaise with the relevant Deanery on issues concerning the revalidation of doctors in training
- To ensure there is an integrated system for monitoring doctors' performance, recognising good practice and encouraging and supporting development and learning that is closely linked with the Trust's clinical governance structures and processes
- To ensure that effective systems, processes and training for doctors' appraisal are in place

- To ensure appropriate action is taken to work with doctors to remedy identified areas of weakness in doctors' performance
- To ensure doctors have qualifications and experience appropriate to the work to be performed and that appropriate references are obtained and checked
- To ensure doctors' performance and conduct is monitored
- To ensure that appropriate timely action is taken when concerns about doctors' performance or conduct are identified, including reporting matters to the Deanery when appropriate.

2.2 Requirements of the Post holder:

- The Responsible Officer must be a doctor in the consultant grade and:
- The person must at the time of appointment, have been a medical practitioner throughout the previous 5 years and for this purpose 'medical practitioner' means a person who is fully registered under the Act
- The Responsible Officer must continue to be a doctor in order to remain as a Responsible Officer

3.0 Action/Decision

The Board is asked to approve the appointment of Zoe Penn as the GMC Responsible Officer in line with The Medical Profession (Responsible Officers) Regulations 2010.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	3.11/Oct/13
PAPER	Donor Recognition
AUTHOR	Mark Norbury, Chief Executive, Chelsea and Westminster Health Charity
LEAD	Tony Bell, Chief Executive
PURPOSE	To notify the Board of criteria for recognition of donors for the Chelsea and Westminster Health Charity.
LINK TO OBJECTIVES	This does not link to any specific Trust corporate objective but the financial and reputational support through donors through the Charity is of clear importance to the Trust.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper details how the Charity intends to recognise its donors and is for the Board's information. A key point of note is the levels of funding for naming opportunities which will apply to physical areas, research funds and academic posts. A process of due diligence is undertaken by the Charity to assess the integrity of any prospective donations and to determine if there are any conflicts of interest. The executive team will work with the Charity on further naming opportunities.
DECISION/ ACTION	For information.

DONOR RECOGNITION

Levels of Support

Chelsea and Westminster Health Charity is fortunate to have an increasing number of generous supporters giving £5,000+ p.a. over three years or more. We are now looking to recognise these supporters and propose three levels of major giving:

Giving level (cumulative)	Name of Circle
£75,000+	Patrons/Founding Donors
£30,000+	Gold Partners
£15,000+	Silver Partners

Donor cultivation and communication

We want to recognise donors' support in a meaningful way. We want them to be deeply engaged with our work and to feel inspired to seek support for the charity from others.

All major donors would be recognised in charity communications. Patrons would be recognised on letterhead. We would also create a donor board in the hospital, thanking major donors for their generosity. We would of course offer anonymity for those who prefer.

There are a number of other ways we will keep donors informed and involved.

Newsletter
We will send a quarterly e-newsletter to all donors (major or not). This will give donors a chance to hear about the impact of their support, our progress on fundraising, and any news or events that may be relevant.

Donor reception
We will hold an annual donor reception with our Trustees, the Chairman and CEO of the hospital, key clinicians and our major donors. This will most likely be in a key supporter's home or distinctive private club/venue.

Impact Report
This will be a more in depth annual report on key research findings, the insights these offer clinicians and patients, our impact on patients and milestones reached.

Event Invitations
As we build up our donor support and engage more interesting and influential individuals, we are likely to have a series of intimate and fun dinners – we would look to invite major donors to one or two of these each year. These would be by

invitation only. In addition there would be ticketed events which will form a core part of our fundraising and communications effort.

Appeal Board participation

Where there is a compelling rationale for a specific initiative, the charity may form a group of Patrons/Founding Donors who would meet quarterly. The term would be three years unless otherwise agreed with the Chair and Chief Executive. The remit would be to:

- Support the strategic development of the initiative
- Ensure our fundraising success through making connections happen, engaging key people and championing our plans
- Provide feedback and guidance on the initiative's impact / progress

The ambition and intent of the Appeal Board is to focus key supporters/volunteers on realising the vision of a specific initiative.

Donor recognition

Here is a summary of the various ways in which major donors will be recognised and we will communicate with you:

Giving level (cumulative)	Name of Circle	News Letter	Events	Donor reception	Project report	Clinician dinner	Advisory Board participation
£75,000+	**Patrons/ Founding Donors**	√	√	√	√	√	√
£30,000+	**Gold Partners**	√	√	√	√	√	
£15,000+	**Silver Partners**	√	√	√	√		

Naming opportunities

The following naming opportunities will be available for specific levels of funding:

<u>Current Funds</u>

- Fellowship: £50,000 p.a. over three years
- Research fund: £250,000 - 750,000 over three years (approximate)
- Atriums (areas etc.): £250,000 – 750,000
- Ward: £1 million (precedent of Ron Johnson Ward)
- Chair: £1 million (over five years)
- Centre: £2 million (approximate – over five years)

<u>Endowed Funds</u>

- Chair: £3 million
- Clinical Centre: £5 million
- Research Institute: £10 million
- Wing: £10 million+

Each of these would still need to be approved on a case by case basis by trustees and the hospital's Chair and Chief Executive.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 October 2013 (PUBLIC)

AGENDA ITEM NO.	4.1/Oct/13
PAPER	Audit Committee minutes – 10 July 2013
AUTHOR	Lorraine Bewes, Chief Financial Officer
LEAD	Sir John Baker, Non-executive Director
PURPOSE	The purpose of this report is to share minutes with the Board.
LINK TO OBJECTIVES	Ensure financial and environmental sustainability
RISK ISSUES	None noted
FINANCIAL ISSUES	None noted
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines a record of proceedings of the meeting of the Audit Committee held on 10 July 2013.
DECISION/ ACTION	For information.

CONFIDENTIAL

Date…….. **Signed……..**

Audit Committee, 10th July 2013
Minutes

Present:

Non-Executive Directors: Sir John Baker (JB) Chairman
Sir Geoff Mulcahy (GM), Non-Executive Director

In Attendance: Tony Bell (TB), Chief Executive
Lorraine Bewes (LB), CFO
David Radbourne (DR), COO
Rakesh Patel (RP), Director of Finance
Cathy Mooney (CM), Director of Governance and Corporate Affairs
Carol McLaughlin (CMl), Acting Deputy Director of Finance
Helena Moss (HM)
Neil Hewitson (NH), KPMG
Neil Thomas (NT), KPMG
Alex Gallow (AG), KPMG (observing)
Simon Spires (SS), Parkhill
Veran Patel (VP), Parkhill
Ben Sheriff (BS), Deloitte

1. GENERAL BUSINESS

1.1 Apologies for Absence

Heather Bygrave (HB), Deloitte and Tony Bell (TB), Chief Executive

1.2 Declarations of Interest

None

1.3 Minutes of the Previous Meetings held 10th July 2013

On page 3, third paragraph, JB asked for an explanation of the following sentence: "The agreement of balances was pretty clean". In response to JB, BS advised that compared with other Trusts we have had fewer issues with respect to the agreement of balances.

Apart from the above amendments, the minutes were agreed as a true and accurate record.

1.4 Schedule of Actions

- 2.4 Report of those charged with governance of the financial statements for the year ended 31st March 2013

CM advised that she had sent the comments flagged by Deloitte on the content of the annual report to Layla Hawkins – Head of Communication and Fleur Hansen – General Manager to note for next year.

BS advised that he had compared differential income growth against fourteen Trusts and the findings were as follows:

- 2% growth compared with 0.6% for the Chelsea and Westminster Foundation Trust;
- Non-elective income declined by 0.4% compared with growth in benchmarked trusts;
- Larger decline in elective income at C&W compared with the benchmark;
- However the Trust CQUIN was better than other Trusts

The Audit Committee noted these findings.

2. COUNTER FRAUD PRO-ACTIVE WORK

2.1 Counter Fraud Intelligence Briefing

VP presented the report to the Committee. In response to GM, VP advised that patient fraud relates to overseas payments.

VP informed the Committee that the role of NHS Protect had changed from April 2013 and as a result it was not mandated as Commissioners were now responsible for everything being in place.

GM queried the value of NHS Protect.Iit was noted that public bodies have a duty to record fraud when found.

The Counter Fraud Intelligence Briefing was noted by the Committee.

2.2 Counter Fraud Annual Report 2012/13

The report was taken as read and noted by the Committee.

2.3 Counter Fraud Progress Report 1st April 2013 – 3rd July 2013

SS raised concerns related to PAA5751 – Alleged Duplicate Timesheets investigation. He stated that a cross-match between shift data on the subjects timesheets against the MAPS rostering system could not be relied upon as wholly accurate due to the failure by many staff to update MAPS. He added that attempts to use data from other systems such as “Last Word” were also found to be unacceptable because a large number of staff use a generic login to access this system. This concern had been noted by the Head of Information Governance.

CM advised that staff using a generic login was also of concern clinically and she would investigate this issue.

Action: CM to investigate using generic login by large number of staff and report back to the Committee.

JB commented that the bank timesheets fraud was still a significant problem which needed to be resolved and queried our attitude to staff who do not check and miss the duplicates.

CMl informed the Committee that the Trust would be moving from a paper system of timesheets to an electronic one to improve fraud proofing.

In response to JB, LB advised that the Trust was investigating the possibility of passing authorisation of the timesheets to matrons to minimize this issue.

Action: SS to review possibility of including shift and timesheet authorisation to matron accountability.

JB suggested that a report to assure that our timesheets process is working should be presented at the next Committee meeting.

Action: RP to commission a report to assure on the timesheet approval process

In response to LB, SS advised that the total value of all duplicate timesheets was around £35k.

SS advised that a presentation would be given to the Finance department in July 2013 in relation to all aspects of known fraud within NHS Finance and this would include key "Do's and Don'ts" for each area.

The Committee was advised that the Veriscan Document Verification System Protocol had now been approved by all parties but the scanner was still not installed.

Action: SS to escalate to HR Director and Finance Director issue with scanner still not being installed.

The Counter Fraud Progress Report 1st April 2013 – 3rd July 2013 was noted by the Committee.

2.4 Fraud Risk Assessment

VP advised that this report included the Top 10 identified fraud risks together with the proposed action plan and the agreed actions for the LCFS were proposed for incorporation within the 2013/14 LCFS Workplan.

The Committee was informed that Parkhill had used the 5 x 5 matrix and engaged senior managers while preparing the report. The Committee suggested the graph on page 2 could be omitted.

GM asked how we think outside the box. JB suggested that staff responsible for procurement transactions should be rotated so the same people were not dealing with the same suppliers in order to prevent the opportunity for fraud as well as to ensure that senior management are also in touch with suppliers.

Action: LB to investigate if organised rotation of staff responsible for procurement transactions can be implemented at the Trust.

The Fraud Risk Assessment was noted by the Committee.

2.5 Counter Fraud Work plan 1st July 2013 – 31st March 2014

The Committee was informed that the work plan detailed the proposed counter fraud work for the period 1st July 2013 – 31st March 2014 following completion of the Fraud Risk assessment (FRA).
VP advised that the training sessions on the Bribery Act and examples of corrupt behaviour and their consequences had been already presented to the procurement team. He added that following the completion of the FRA, the staff bank timesheets/payroll and outsourced contracts had been highlighted as areas which required a proactive exercise.

RP advised that the Trust Counter Fraud work plan included more days than the West Middlesex plan but had a similar approach.

GM asked if we looked at senior individuals' ability to commit fraud e.g. revenue fraud and the ability to divert income and not charge for services.

Action: KPMG and Parkhill to look at senior individuals' ability to commit fraud revenue e.g. the ability to divert income and not charge for services and present their findings at the next Committee meeting.

JB suggested that next years' Internal Audit plan should include a procurement review.

Action: KPMG to include procurement review in 14/15 plan

The Counter Fraud Work plan was signed off by the Committee.

3. INTERNAL AUDIT

3.1 Progress Report and Technical Update

The Committee was informed that the internal audit progress report summarised the work performed to date since the May 2013 Audit Committee, and work to be performed in advance of the next Committee meeting.

The report was noted by the Committee.

3.2 Recommendation Tracker

NH advised that this report was an assurance for the Committee that KPMG was on track with completing all recommendations.

CM asked if there was another way of monitoring recommendations as the current system whereby the executive monitor closed recommendations only (on the basis that the Audit Committee only considered open recommendations) was confusing. In practice the executive receive a recommendation with no context.

JB suggested that the Executive Team should monitor all recommendations and report on progress to the Audit Committee. The role of Internal Audit would be to provide assurance through continuing its annual follow up of recommendations and any recurrent reviews as part of their annual review. Internal Audit would review the management arrangements for tracking recommendations implementation to provide the Audit Committee with assurance that the arrangements are fit for purpose.

Action: DR to lead on implementing the new system relating to the Executive Team involvement in completing the outstanding recommendations.

The recommendation tracker was noted by the Committee.

3.3 Assisted conception unit report

The Committee was advised that the internal audit review had raised four high priority recommendations as well as four medium and four low priority recommendations. It was noted that all recommendations have been accepted by management.

NH advised that the internal audit review provided limited assurance that the Trust's arrangements within ACU were robust and appropriate.

LB advised that all high priority recommendations had been now completed and the only ones outstanding were recommendations 9 – Storage invoicing and consent process and 10 – Private patient invoice payment process on page 8 with the revised due date of August 2013. She stated that the previous billing system was not fit for purpose which had now been addressed through implementation of the Compucare system. She added that the management structure had also been changed to resolve existing issues.

The Assisted Conception Unit report was noted as a helpful report by the Committee.

3.4 Board Governance Report

NH advised that the internal audit review has raised five low priority recommendations and three of them had been accepted by management already. The remaining two were awaiting a response from

the Chairman.

The Committee was informed that it was very difficult to carry out this type of review as the role of the Board and relationship between the Board and Governors was not defined. It was noted that the Board should consider its diversity as part of its development agenda.

The Board Governance Report was noted by the Committee.

4. EXTERNAL AUDIT

4.1 Sector Developments

BS advised that this report identified five sector developments which were as follows:

- 2012/13 Foundation Trust Performance
- Care Quality Committee consultation – in response to JB, CM advised that the Trust would respond to this consultation but it would not be presented to the Trust Board
- Monitor consultation on the 2013/14 Annual Reporting Manual
- Monitor briefing note on merger control rules and pathology reconfigurations – In response to JB, BS advised that the Office of Fair Trading requirements set out a number of considerations. JB stated that the Board would like to see a briefing on the Monitor rules and guidelines. DR agreed to circulate relevant guidance on competition.

Action: DR to circulate to the Board relevant guidance on competition.

- National Audit Office report on Confidentiality Clauses and Special Severance Payments

The Sector Development report was noted by the Committee.

5. GOVERNANCE & RISK MANAGEMENT

5.1 Risk Management Strategy

CM highlighted the main amendments in the Risk Management Strategy to the Committee.

The Committee agreed that the following changes should be incorporated in this policy:

- An update showing difference between CFO and DoF
- Trust Executive to be taken out of the organisational structure The split between executive and assurance to be included in the organisational structure

The Risk Management Strategy was approved by the Committee and will be ratified by the Board.

6. ITEMS FOR APPROVAL/INFORMATION

6.1 Losses and Special Payments including write offs

CMl advised that there was a total of £50.913 for losses and special payments for the period 01/05/13 to 30/06/13 of which £34.655 related to debts written off and £16.258 related to special payments.

JB asked what “Debt Collectors closed account - all means exhausted” as a reason for write off meant. CMl replied that this meant that the staff member had already left the Trust and payroll couldn’t track his/her actual address.

The Committee agreed that the staff overpayments related to account no 73244 of £6722. 70 and account no 65487 of £3961.56 should be investigated further instead of written off.

Action: CMl to investigate further staff overpayments related to account nos 73244 and 65487

BS advised that the rules of special payments might change this year as they are under revision. He stated that he would update the Committee once the changes were implemented.

6.2 Waivers of Tenders and Quotations

6.3 Forward Audit Committee Plan

6.4 Q4 2012/2013 Monitoring Feedback

All noted

7. DATE OF THE NEXT MEETING

24th October 2013 1-3pm Main Hospital Boardroom