Chelsea & Westminster Hospital NHS Foundation Trust
Council of Governors

Mansfield Room, 4th Floor, St Stephen's Centre, Chelsea and Westminster Hospital

18 May 2017 16:00 - 18 May 2017 18:00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
18 May 2017, 16.00 – 18.00
Mansfield Room, Chelsea and Westminster Hospital, St Stephen's Centre,
4th Floor, 369 Fulham Rd, London SW10 9NH

Agenda

	1.0	**STATUTORY/MANDATORY BUSINESS**			
16.00	1.1	Council of Governors Quality Awards	Verbal	Presentation	Chairman
16.15	1.2	Welcome & Apologies for Absence	Verbal		Chairman
16.18	1.3	Declarations of Interest	Verbal		Chairman
16.20	1.4	Minutes of Previous Meeting held on 16 March 2017 & Action Log	Report	For Approval	Chairman
16.25	1.5	Quality			
	1.5.1	Draft Quality Report and Governor Commentary	Report	For Information / Approval	Pippa Nightingale
	1.5.2	People & OD Committee Report	Report	For Information	Liz Shanahan
	1.5.3	Draft Month 12 Financial Position	Pres.	For Information	Chief Financial Officer
	1.5.4	Finance & Investment Committee Report	Report	For Information	Jeremy Jensen
	1.5.5	Independent review findings	Report	For Information	Medical Director
17.00	1.6	Media Policy and Social Media Guide	Report	For Discussion / For Information	Director of Communications
	2.0	**PAPERS FOR INFORMATION**			
17.15	2.1	*Chairman's Report	Verbal	For Information	Chairman
17.20	2.2	*Chief Executive Officer's Report	Report	For Information	Chief Executive Officer
17.25	2.3	*Integrated Performance Report	Report	For Information	Chief Operating Officer
17.30	2.4	*Governors' Questions	Report	For Information	Chief Executive Officer
17.35	2.5	*Quality Sub-Committee Report: 28 April 2017, including Terms of Reference	Report	For Information	Chair of Quality Sub-Committee
17.40	2.6	*Membership Sub-Committee Report: 20 April 2017, including Terms of Reference and Open Day 20 May 2017 – update (Verbal)	Report	For Information	Chair of Membership Sub-Committee

	3.0	**OTHER BUSINESS**			
17.45	3.1	Questions from public	Verbal		Chairman
17.55	3.2	Any other business			
18.00	3.3	Date of next meeting – 27 July 2017, Room A, West Middlesex			

Minutes of the Council of Governors
Held 16 March 2017 at West Middlesex Hospital

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Julia Anderson	Appointed Governor	(JA)
	Juliet Bauer	Patient Governor	(JB)
	Tom Church	Patient Governor	(TC)
	Nigel Davies	Public Governor	(ND)
	Angela Henderson	Public Governor	(AH)
	Anna Hodson-Pressinger	Patient Governor	(AHP)
	Elaine Hutton	Public Governor	(EHA)
	Kush Kanodia	Patient Governor	(KK)
	Paul Kitchener	Public Governor	(PK)
	Susan Maxwell	Patient Governor	(SM)
	Lynne McEvoy	Staff Governor	(LMc)
	Wendy Micklewright	Public Governor	(WM)
	Guy Pascoe	Public Governor	(GP)
	Tom Pollak	Public Governor	(TP)
	Sonia Samuels	Public Governor	(SS)
	Matthew Shotliff	Staff Governor	(MS)
	Laura Waering	Public Governor	(LW)
In Attendance:	Karl Munslow-Ong	Deputy Chief Executive	(KMO)
	Pippa Nightingale	Director of Midwifery	(PN)
	Zoe Penn	Medical Director	(ZP)
	Virginia Massaro	Deputy Director of Finance	(VM)
	Donald Neame	Director of Communications	(DN)
	Nick Gash	Non-Executive Director	(NG)
	Eliza Hermann	Non-Executive Director	(EH)
	Dr Andrew Jones	Non-Executive Director	(AJ)
	Jeremy Loyd	Non-Executive Director	(JL)
Apologies:	Nowell Anderson	Public Governor	(NA)
	Ian Bryant	Staff Governor	(IB)
	Simon Dyer	Patient Governor	(SD)
	Cllr Catherine Faulks	Appointed Governor	(CF)
	Paul Harrington	Public Governor	(PH)
	Andreea Petre-Goncalves	Patient Governor	(APG)
	David Phillips	Patient Governor	(DP)
	Chisha McDonald	Staff Governor	(CMD)
	Philip Owen	Public Governor	(PO)
	Lesley Watts	Chief Executive	(LW)
	Dr Zoe Penn	Medical Director	(ZP)
	Pippa Nightingale	Director of Midwifery	(PN)
	Sandra Easton	Acting Chief Financial Officer	(SE)
	Robert Hodgkiss	Director of Operations	(RH)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Keith Loveridge	Director of Human Resources	(KL)
	Martin Lupton	Imperial College	(ML)
	Chris Cheney	CEO, CW+	(CC)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Liz Shanahan	Non-Executive Director	(LS)

1. 1	**Welcome, apologies for absence and declarations of interest**
a.	The Chairman noted that the meeting was held in the new format as recommended by the Governors at the October 2016 Council of Governors Away Day. The key changes suggested were: engaging with the Non-Executive Directors and having the sufficient time to look at key strategic priorities with a Non-Executive Director responsible for that area presenting. The key items should also appear high up on the agenda. The Chairman welcomed comments on both the format and the content of the meeting and asked the governors to feedback their views to Susan Maxwell. **Action: All Governors to feedback their views on both the format and the content of the meeting to Susan Maxwell, Lead Governor.**
b.	He added that the format of the Lead Governor having an informal pre-meeting with governors provides an opportunity for the Chairman to have an informal meeting with the Non-Executive Directors at the same time.
c.	The Chairman reminded all that the Council of Governors also agreed at the Away Day that there is no need for all Executive Directors to attend all Council of Governors meeting.
d.	On the point of use of acronyms in papers the Chairman said that it has been noted that this should improve in future with less acronyms appearing in papers.
1.2	**Declarations of Interest**
a.	None.
1.3	**Minutes of Previous Meeting held on 8 December 2016 & Action Log, including Governors' expenses and Re-admissions**
a.	Minutes of the previous meeting were accepted as a true and accurate record of the meeting.
b.	In relation to action 1.h KMO noted that the performance dashboard was provided with the papers. The dashboard provided an overview of improvements made in administrative areas, in specific Did Not Attend (DNAs) and how the Trust is aiming to improve.
c.	In response to a question from SM (the question raised on behalf of Simon Dyer who was unable to attend) relating to Kobler Clinic appointments, KMO replied that Kobler, including few other administrative areas were not included in the dashboard provided. However, he confirmed that most of administrative areas were included in the dashboard.
d.	In congratulating KMO and the Executive Team for the improvements made in such an important area of appointments boking, AH asked about clinical appointments letter turn around. KMO replied that this is also an area of the focus and that the aim is to get letters out within 7 days.
e.	The Chairman concluded the subject by saying that it will come back to Governors in future under the overall heading of quality.
f.	In relation to the action 8.f Governors' expenses, KMO said that an initial review of the practice at other Foundation Trusts was conducted and noted that the Trust is in line with other trusts in relation of expenses it covers for its governors.
g.	EHA asked if the Trust would consider covering childcare expenses so to enable diversity and inclusion. The Chairman said that from the review conducted two foundation trust cover childcare. The governors recognised that there may be some inequalities in there however it would like to have representation on the Council of Governors. He suggested that this could be discussed with the Lead Governor at one of Lead Governor and Governors pre-meetings in future. **Action: All**

h.	The Council of Governors agreed that in light of the wider financial challenges that the NHS face, the Trust continue with the current arrangements for expenses but continue to consider exceptional issues on a case-by-case basis.
i.	The Chairman confirmed that governors requiring clarification in relation to expenses should initially seek clarification from Lead Governor and VD.
j.	In relation to the action 9.a KMO said that 6% of patients, who are initially admitted to the hospital and subsequently discharged, get readmitted within a month.
1.4	**Quality**
1.4.1	**Quality Committee Report to Council of Governors**
a.	EH noted that following on a decision of the Council of Governors to receive a presentation from a Non-Executive Director, as the Chair of the Quality Committee (a sub-committee of the Board), she has produced her first report and was looking forward to receiving feedback as to whether it meets Governors' needs.
b.	In presenting the report she highlighted the two key elements of quality – what is working well and what is not working well. • Working well: reduction in pressure ulcers and the Trust is looking at sustaining good level • The Committee is seeking that learning is shared and embedded
c.	Continous improvement required: communication between nurses, doctors and patients, learning, sharing and embedding good practice.
d.	In response to a question from AH which hospitals perform well in areas where CWFT need improvements EH said that from reading board papers of a foundation trust which is rated by CQC as having an outstanding performance, they put together quality initiatives very well and in a very simple and readable form.
e.	AHP joined the meeting.
f.	In response to a question from LW how the particular Trust manages it, EH said she was unsure and she was hoping that the communication expertise from newly appointed Director of Communications, Donald Neame could help with this.
g.	WM queried how the Transformation Plans (STP) fit into the role of the Quality Committee. EH replied that the Quality Committee is not the primary forum for monitoring progress in this area. The Chairman noted that the Board at its Strategy meetings consider wider system impact on the NHS.
h.	In response to a question from PK in relation to sustainability of improvements stated earlier, EH said that it potentially aligns to a number of behaviours and the focus is on nurse recruitment and retention. It is difficult to get tangible evidence that an issue has been permanently resolved. The Chairman added that in order to ascertain Non-Executive Directors assurance on issue there will be organised quality visits by Non-Executive Director to particular areas. This initiative will support the Nursing and the Executive Team with their work on quality.
i.	LM noted that it would be important to observe other staff groups, not just nurses. EH agreed and said that she will take it on board.
j.	In response to a question from ND relating to approach Board takes in relation to variation in care in certain areas, EH said that both the Quality Committee and the Board receive performance reports and they review and scrutinise data provided. The Committee also regularly receive updates on ward

	accreditation programme and Serious Incidents Reports. There is a huge wealth of data that reports provide and the Trust is trying its best to learn to interrogate right questions.
k.	SM congratulated EH on providing such an excellent report and for presenting to the Governors.
1.4.2	**Priority Progress Report 2016/17 and Proposed Quality Priorities for 2017/18**
a.	In presenting the paper PN noted that the report provided had been considered by the Trust Executive, Quality Committee and the Council of Governors Quality Sub-Committee.
b.	ND noted that an extensive discussion took place at the COG Quality Sub-Committee and added that the WHO checklist was recommended as a governor chosen indicator.
c.	The Council of Governors expressed that they are content with the chosen seven quality priorities; they also agreed the WHO checklist to be the governor chosen indicator.
1.5	**Tender for the Provision of External Audit**
a.	VM introduced the paper by saying that a tender process had been undertaken for the provision of external audit. The market response to the tender was unexpected, with 6 bids received, however only one bid meets the full specification and offers the required value for money.
b.	VM noted that a presentation from Deloitte to enable clarification of the bid and confirmation of value for money will be held on 23 March to members of the Audit Committee. A governor representative will be put forward by the Lead Governor to join the external auditor appointing panel.
c.	The Council of Governors confirmed that they were content with the proposed appointment of Deloitte as Trust's external auditor.
1.6	**Final Operational Plan 2017-19**
a.	VM noted that the final Trust Operational Plan for 2017-19 which was submitted to NHS Improvement was provided in the meeting pack. The operational plan sets out the Trust's objectives for the two year period in terms of performance, activity, finance, workforce and alignment with wider plans for the local health economy.
b.	ND expressed his support for the Trust's approach not to accept the NHS Improvement control total. Governors expressed their support for the Trust's approach.
c.	A governor brought up the recent media story about Richmond CCGs stopping commissioning IVF treatment. KMO said that the Trust has been discussing commissioning arrangements with various CCGs.
2.1	**Ward Accreditation Programme**
a.	PN introduced the paper, which presented the results of the first round of ward accreditation assessments of all inpatient wards undertaken on both sites.
b.	The process was welcomed by both staff and patients; some quality improvement themes, which had arisen from the process, were noted. In addition, main areas for improvement were also noted.
c.	In response to a question from SM in relation to whether pressure ulcers decline can be sustained by staff, PN said that regular reassessments will be undertaken and if necessary a prompt action to improve will be taken.

d.	In response to a question from KK regarding sharing best practice rather than encouraging competition between wards, PN said that inevitably there is an element of competition there; an experienced matron was appointed to help with delivering quality improvement. ZP said that the accreditation process has been a huge achievement. NG said that the Quality Committee recognise the level of expertise required and this will be underpinned by Non-Executive Directors quality visits.
e.	The Council of Governors noted that a quarterly update on ward accreditation programme is provided to the Quality Committee.
3.1	***Chairman's Report**
a.	The Chairman noted that the report provided with the papers is taken as read.
b.	He highlighted the following points: • The recent visit of the Chair of trustees of Mulberry Centre • Jacqueline Totterdell was announced as Chief Executive of St George's University Hospitals NHS Foundation Trust • Welcome to the recently appointed Director of Communications, Don Neame • He has undertaken the Chief Executive's performance review; in addition the Non-Executive Directors performance review will be undertaken in summer.
c.	The Chairman added that he has commissioned review on how Board and Council of Governors communicate with media and asked Don Neame to bring a media communications policy to the May Council of Governors; the policy should include both internal and external communications. **Action: Bring a media communications policy to the May Council of Governors meeting.**
d.	The Chairman noted that the strategic priorities for the 2017/18 were discussed by the Board in February and the final priorities are due to come back to the Board for sign off; an update on priorities will be provided to the next Council of Governors meeting under the Chair's report.
e.	LMc expressed her satisfaction with learning that the strategic objectives have been set up in relation to improving recruitment and retention. She noted her concern regarding achieving flexible working hours for nursing staff. PN said that flexible working is offered in order to provide staff with a better work life balance.
f.	WM asked if 12-hour shift is convenience for staff or patients/public. PN said that it is staff's choice that some benefits include continuity of care for patients, reduced handover with no midday handover. ND linked to it by saying that some work done on this subject indicate that there is no evidence either way; some studies show added benefit and recognised that inadequate rest breaks can impact on patient safety.
g.	In response to a question from EH, PN confirmed that nursing staff were consulted on their choice in relation to working shifts.
h.	In response to AHP comment about staff working long shifts, PN said that the majority of hospital nursing staff chose to work 12-hour shifts. ND added that there might be some useful learning that can be taken from other sectors i.e policy in relation to working long shifts.
i.	The Chairman concluded the item by saying that Trust's two important priorities are delivering high quality care and workforce strategy; some more information on these two subjects will come to governors in due course.
3.2	***Chief Executive Officer's Report**

a.	KMO presented the report and highlighted the following points: • The Trust continues to implement the estates plans on both sites. • The Trust achieved an immunisation rate of 70% which is one of the highest in London; this helped minimise flu outbreak in the country and helps protect our patient. • The communications team greater efforts to engage with staff in a way that suits their needs.
b.	In response to a question from PK regarding the 62 day cancer target, KMO said that the variation in achievement detailed in the CEO report is driven by changes in referral protocol and the change in the national guidance; the referral rates have increased and it impacts on the Trust's ability to cope with the demand. Currently, a lot of work is going on in the Trust to ensure the demand is met and the adequate capacity provided.
c.	WM expressed the interest in hearing more about PFI arrangements at West Middlesex hospital site. The Chairman suggested that this is addressed as part of finance session for governors to be organised in April. **Action: SE to address specific queries from WM in relation to PFI arrangements at West Middlesex hospital site as part of finance session for governors.**
d.	DN announced that the Chelsea and Westminster Hospital Open Day will be held on 20 May. Some more information about the day will be communicated to governors via email.
e.	DN also announced that the West Middlesex Hospital Open Day will be held on 16 September.
3.3	***Governance - Committees of the Board**
a.	The Chairman noted that the paper provided, which was discussed and agreed with both the Lead Governor and the Board, detailed the revised governance process relating to Board committees reporting to the Council of Governors and in turn providing assurances to governors that it operates effectively.
b.	SM confirmed that she is content with the approach of Non-Executive Directors providing in future a summary of the deliberations of their committee and attending the Council of Governors to deliver their paper and take any questions governors may have.
c.	In response to a question from TP, KMO confirmed that the Trust is in the process of recruiting the substantive Company Secretary. Meanwhile, Harbens Kaur, Head of Legal Services, will act as Company Secretary.
3.4	***Integrated Performance Report**
a.	KMO noted that the highlights from the performance report were provided in the Chief Executive's report and questions were invited from governors.
b.	In response to a question from TP relating to the recently published suggestion for paramedics to treat patients in ambulance cars rather than taking to hospital, ZP responded that NHS England asked the Trust to explore working together with London Ambulance Service.
3.5	***Governors' Questions**
a.	The Council of Governors noted the paper provided.
b.	The Chairman said that the governor David Philips asked by email whether it would be possible to provide governors with shorter meeting papers pack. The Chairman's view was that the meeting papers are already short and it needs to be ensured that papers provided to governors contain the right level

	of detail for them to be able to discharge their duties appropriately. Lead Governor SM supported Chairman's view.
c.	The Chairman concluded the item by saying that any recommendation relating to reducing the meeting papers size should be considered carefully before being put forward.
3.6	***Quality Sub-Committee Report: 23 February 2017**
a.	ND highlighted key points discussed at the February sub-committee meeting; these included: • Variation in catheter associated urinary tract infection between CW and WM sites. • Quality priorities for 2017/18, including a governor chosen quality priority were discussed and agreed. • Demo of patient experience dashboard. • The schedule for spring round of quality awards was received. • Aligning the sub-committee dates to the Patient Experience Group in order to enable timely reporting from the Group.
b.	The Chairman confirmed that since the Chair of the Board Quality Committee will be presenting twice a year to the Council of Governors there will be no need to separately present the same assurance report to the Quality Sub-Committee.
3.7	***Membership Sub-Committee Report: 9 February 2017**
a.	PO noted few important action points arose from the February sub-committee meeting.
b.	PO updated the Council of Governors that the Trust is in the process of recruiting Membership Manager and conveyed his thanks to the Trust staff involved in this process.
4.1	**Questions from public**
a.	None.
4.2	**Any other business**
a.	None.
4.3	**Date of next meeting – 18 May 2017, 16.00-18.00, Boardroom, Chelsea & Westminster**

The meeting closed at 16.55.

Council of Governors– 16 March 2017 Action Log

Minute number	Agreed Action	Current Status	Lead
1.1.a	Action: All Governors to feedback their views on both the format and the content of the meeting to Susan Maxwell, Lead Governor.	Ongoing.	**All**
1.3.g	Action: Any expenses related issues to be discussed with the Lead Governor at a future Lead Governor and Governors pre-meeting.	Ongoing.	**All/SM**
3.1.c	Action: Bring a media communications policy to the May Council of Governors meeting.	This is on current agenda.	**DN**
3.2.c	Action: SE to address specific queries from WM in relation to PFI arrangements at West Middlesex hospital site as part of finance session for governors.	Complete.	**SE**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM O.	1.5.1/May/17
REPORT NAME	Quality Report 2016/17 – Draft
AUTHOR	Shân Jones, Director of Quality Improvement
LEAD	Pippa Nightingale – Chief Nurse
PURPOSE	The Quality Report forms part of the overall Annual Report, and is a record of achievement for last year and to set our aspirations for next year. Quality Report is an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.
SUMMARY OF REPORT	The paper provides an overview of progress against 2016/17 quality priorities and an outline of the plans for 2017/18 in addition to the requirements as laid out in NHS Improvement's 'Detailed requirements for quality reports for foundation trusts 2016/17'. To date comments have been received from the Quality Committee, Council of Governors and CCG. Formatting and further proof reading will be required once report is complete. The Council of Governors Commentary on Quality Report, p.58-59, is enclosed for ratification at the 18 May meeting.
KEY RISKS ASSOCIATED	Publication of an annual quality report is a mandatory requirement for all NHS Foundation Trusts.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	This report provides an overview of the quality agenda for 2016/17
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Quality Report is enclosed for information. The Council of Governors Commentary, p.58-59, is enclosed for ratification.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Quality Report

2016/17

09/05/2017

Part 1

Statement on quality from the Chief Executive

Introduction

The aim of the Quality Report is to review the quality of the care and services that we provide at Chelsea and Westminster Hospital NHS Foundation Trust (the 'Trust'). This document complies with the Trust's statutory duty under the Health Act 2009 and is a formal record of the steps we have taken over the past year and will be taking over the coming year to ensure we maintain a strong focus on improving quality across the board.

Welcome by the Chief Executive

I'm pleased to introduce our second Quality Report since the merger of our two hospitals in September 2015. Last year we started developing a truly integrated organisation and there's been a lot of hard work by everyone in the Trust to develop a culture of continuous improvement. All this hard work will help us deliver the very best care and experience for patients. We are already seeing real improvements to the provision of care, the quality of services and staff experience.

Our key achievements since we became one organisation include:

- Developing new clinical services, for instance: Surgical Assessment Units at both hospitals; a state of the art sexual health clinic (10 Hammersmith Broadway); a dedicated gynaecology inpatient ward at Chelsea and Westminster; and a new Cardiac Catheter Lab at the West Middlesex so that patients don't have to travel as far for diagnosis and treatment
- The redevelopment of key hospital areas to provide patients with better care and experience including A&E departments at both hospitals and medical inpatient wards at the West Middlesex
- Being shortlisted by the national Friends and Family Test awards for improvements in food service on a surgical ward. The Friends and Family Test indicates whether patients feel they are getting a high standard of care and have a good experience while in hospital.
- Many of our dedicated staff being recognised for their hard work and excellence in regional and national awards
- Being ranked as one of the top 30 employers for working families in the UK by leading work-life balance charity Working Families — the only NHS organisation in this year's top 30 list
- A significant reduction in hospital acquired pressure ulcers (see priority 1)
- A reduction in the number of unexpected admissions to neonatal unit (see priority 4)

But we are not stopping there. Because of the embedded improvement methodology, we will be able to invest in more improvements to patient experience and new models of care listening to our staff and patients. Great progress has been made in developing a single electronic patient record system in partnership with our colleagues at Imperial College Healthcare. As both organisations will share one digital platform we be able to access patient records seamlessly across both organisations so that doctors and nurses are able to access relevant information about their treatment irrespective of where it was received. This will improve coordination of patient care and make it more efficient.

In 2017/18 we will also make significant and essential investments in services for some of our most critically ill patients. Working with our charity CW+ we will expand and redevelop our adult and neonatal intensive care facilities at Chelsea and Westminster – allowing us to care for 650 more critically ill adults and children a year, and we will redevelop facilities for children's services at the

West Middlesex. We will be fundraising to support these vital developments during summer 2017; if you would like to support these improvements please visit www.cwplus.org.uk. In addition to this CW+ are supporting the Trust to lead a pilot project to use a new web based tool to compile quality information during the ward accreditation process.

Working with the Friends Charity we have refurbished 3 Butterfly Rooms to support dying patients and their families, 3 more will be refurbished in 2017/18.

I would like to take this opportunity to thank all of our 6,000 staff who have shown they are proud to care for their patients and colleagues. I know that they will continue to go 'above and beyond' for the patients and communities we serve and I look forward to being able to showcase more excellent practice over the coming year.

Core services

Our core services include:

- Full emergency department (A&E) services for medical emergencies, major and minor accidents and trauma on both sites. The departments are supported by separate on site Urgent Care Centres (UCC) and have a comprehensive Ambulatory Emergency Care.
- Emergency assessment and treatment services including critical care and a Surgical Assessment Unit at the West Middlesex Hospital. The Trust is a designated trauma unit and stroke unit.
- Acute and elective surgery and medical treatments such as day and inpatient surgery and endoscopy, outpatients, services for older people, acute stroke care and cancer services.
- Comprehensive maternity services including consultant led care, midwifery led natural birth centre, community midwifery support, antenatal care, postnatal care and home births. There is also a neonatal specialist intensive care unit (Chelsea and Westminster Hospital), special care baby unit (West Middlesex Hospital) and specialist fetal medicine service. We also have a private maternity service.
- Children's services including emergency assessment, 24/7 Paediatric Assessment Unit, inpatient and outpatient care.
- HIV and Sexual Health Services.
- Diagnostic services including pathology and imaging services. In 2016/17 a cardiac catheterisation laboratory was opened on the West Middlesex site.
- A wide range of therapy services including physiotherapy and occupational therapy.
- Education, training and research.
- Corporate and support services.

Clinical services are also provided in the community and we have a range of visiting specialist clinicians from tertiary centres that provide care locally for our patients. For a number of highly specialised services, patients may have to travel to other trusts.

Key facts and figures for the past three years

	Chelsea and Westminster NHS Foundation Trust. 2016/17	Chelsea and Westminster NHS Foundation Trust. 2015/16	West Middlesex University Hospital. 2015/16	Chelsea and Westminster NHS Foundation Trust. 2014/15	West Middlesex University Hospital. 2014/15
Outpatient attendances	767330	475477	267753	475872	253313
Total A&E attendances	282157	121214	63324	117114	58537
Total urgent care centre attendances	87683	-	83716	82798	
Inpatient admissions	136837	73927	61189	76326	41520
Babies delivered	10682	5389	5115	5148	4596
Patients operated on in our theatres	33683	23284	10233	23525	10528
X-rays, scans and procedures carried out by clinical imaging	391609	174403	174073	175917	
Number of staff, including our partners ISS and Norrland	(5538 C&W + 369 ISS/Norland and Byes)	3911 (3515 C&W + 396 ISS and Norrland	2340 (2007 WMUH + 333 ISS/Byes)	3738 (3338 C&W +400 ISS and Norrland)	2294 (1,985 WMUH + 308 ISS/Byes)

Our vision and values

Chelsea and Westminster Foundation Trust's vision and ambition is "to deliver excellent experience and outcomes for our patients". "We are already among the highest performing Trusts in the NHS and we will seek to build on this''.
The Board have set the Strategic Priorities for 2017/18 to:

- Deliver high quality patient centred care
- Be the employer of choice
- Deliver better care at lower cost
- Improve communication within and outside our organisation
- Deliver our key strategic programmes

Our PROUD Values were launched in December 2016, they underpin the new performance and development review system and the quality board work on wards and departments. They are a bringing together of the two sets of values from Chelsea and Westminster and West Middlesex prior to the merger. They were developed in consultation and engagement with staff, governors, directors and non-exec directors.

- **P**utting patients first
- **R**esponsive to, and supportive of, patients and staff
- **O**pen, welcoming and honest
- **U**nfailingly kind, treating everyone with respect, compassion and dignity
- **D**etermined to develop our skills and continuously improve the quality of our care

Quality Strategy and Plan 2015 to 2018

The Quality Strategy and Plan (QSP) launched in 2015/16 set out a three-year journey for how we will work to continuously improve the quality of the services provided by Chelsea and Westminster Hospital NHS Foundation Trust. This strategy and plan was rolled out over both hospitals during 2016/17.

The QSP was developed against a backdrop of the local and national context including the recommendations of the Care Quality Commission review of both hospitals in 2015.

We have considered quality based on the four components of Experience, Safety, Effectiveness and Access (recognising that this represents an expanded definition of Quality that includes Access). For each component we have set ambitions and supporting priorities, taking into account our current

performance. Delivering excellence in experience of care will be an overarching ambition for us over the next few years, supported by our ambitions across Safety, Effectiveness and Access.

We will continue to deliver our ambitions for Quality through the tranches of 'special projects' focusing on priority areas that have been identified through engagement to date on the development of the QSP. The projects will continue to focus on Frailty, Admitted Surgical Care, Sepsis and Maternity. The Quality Priorities that were identified for Chelsea and Westminster for 2016/17 link to these overarching plans and will continue to do so in 2017/18.

Part 2

Our priorities -

Priorities for improvement 2016/17

This section of the report reviews how we performed in 2016/17 in relation to the priorities set in our Quality Report 2015/16. Each of the priorities will have an outline of what we set out achieve, what we did during the year to improve our patient care, the results we achieved and what we will do going forward in 2017/18.

Chelsea and Westminster NHS Foundation Trust set the following priorities for 2016/17:

Patient safety
Priority 1: Reduction of hospital acquired pressure ulcers
Priority 2: Embedding of the WHO surgical checklist
Priority 3: Early identification of the deteriorating patient

Clinical effectiveness
Priority 4: Reduce avoidable admissions of term babies to the NICU

Patient experience
Priority 5: Friends and Family Test—inpatient responses
These priorities were rolled over from 2015/16.

How did we do in 2016/17?

Patient safety

Priority 1: Reduction of hospital acquired pressure ulcers
What did we set out to achieve during 2016/17?
The plan for 2016/17 was to continue to report on the prevalence of hospital acquired pressure ulcers across the Trust. A 15% target reduction for hospital acquired pressure ulcers reported as serious incidents was agreed.

What did we do during the year to improve patient care?
The pressure ulcer group continued through 2016/17 with the aim of overseeing on going improvements in the prevention and management of hospital acquired pressure damage.

The tissue viability team have led a number of key projects and service improvements to support the overall pressure ulcer strategy. These have included significant multi-professional training & education, 'Stop the Pressure', Under Pressure and Lift off, 3 focused engagement projects. In addition the team has focused on enhancing their clinical visibility and promoting an 'at the bedside' approach with a strong inspirational leadership ethos.

A systematic approach to root cause analysis was introduced across both hospital sites. This has resulted in a clearer understanding of the causal factors, senior oversight of the incidents and the introduction of a number of focused pieces of work developed from shared learning.

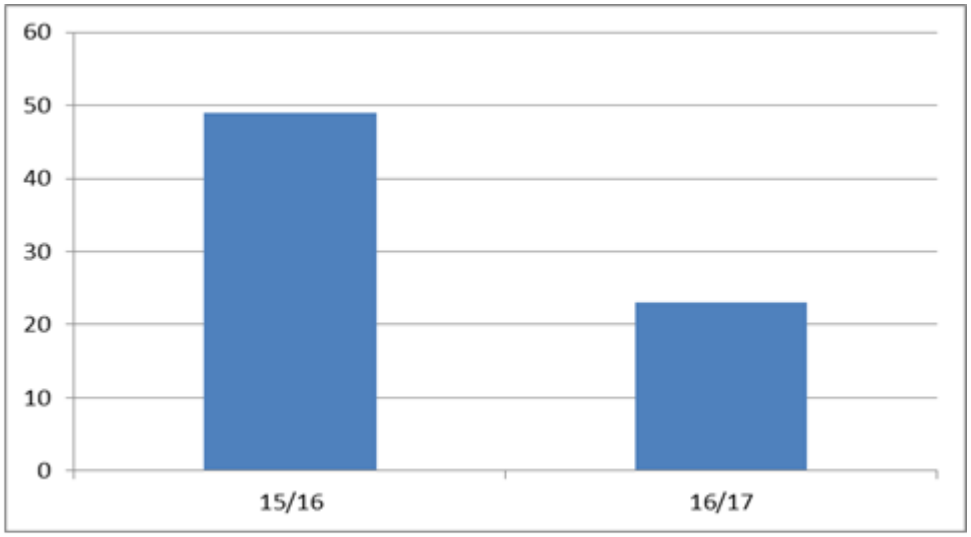
Using the learning from the root cause analysis the strategy with the clinical teams has been simplified into 3 key messages.

- Systematic and systemic assessment of all pressure areas on admission or when the patient's condition changes. Understand the additional impact of comorbidities particularly, liver / alcohol related conditions, peripheral vascular disease and hypoxic effects on skin breakdown.
- Take early prevention strategies with 2-4 hourly repositioning and utilise pressure relieving equipment including specialist beds and off -loading boots. Take an 'every contact counts' approach to involve all clinical teams, not just nursing. This maximises assessment and visibility of patients at risk.
- Escalate noncompliance or vulnerable and high risk patients to the senior nurse and TVN for specialist advice and intervention.

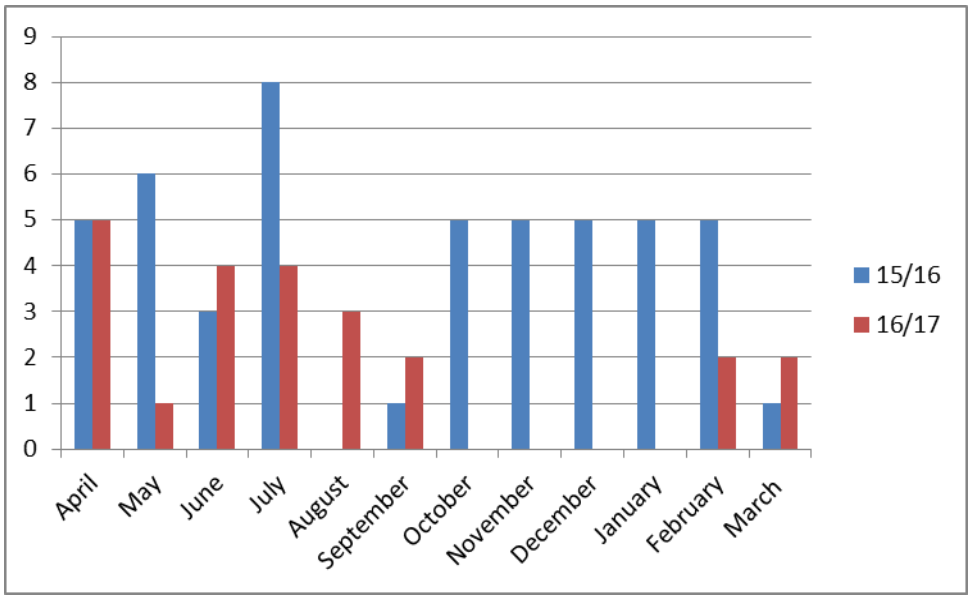
What results did we achieve?

The target reduction set for 2016/17 was to reduce hospital acquired pressure ulcers reported as serious incidents by 15%. Graphs 1 and 2 demonstrate that this has been substantially exceeded. The year-end position for 2016/17 is a significant reduction of 53%.

Graph 1 – Total Pressure Ulcers reported as serious incidents 2015/16 v 2016/17



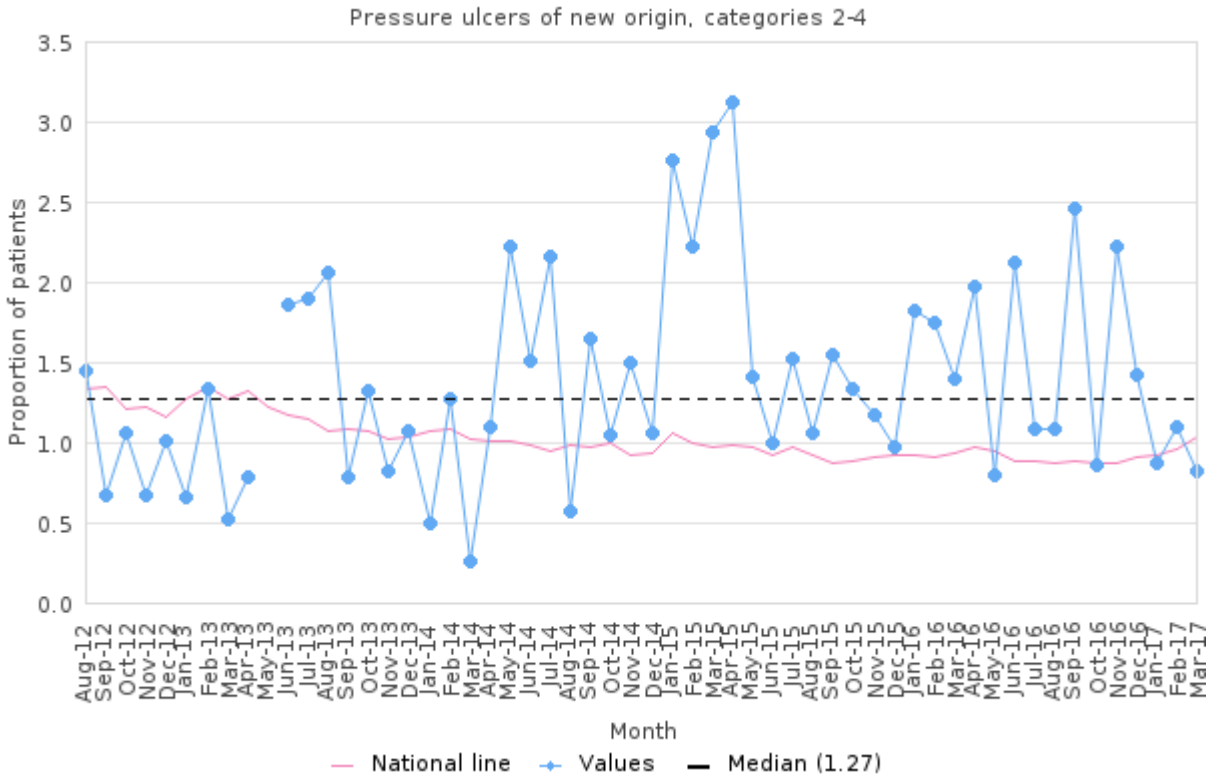
Graph 2 – Pressure Ulcers reported as serious incidents by month 2015/16 v 2016/17



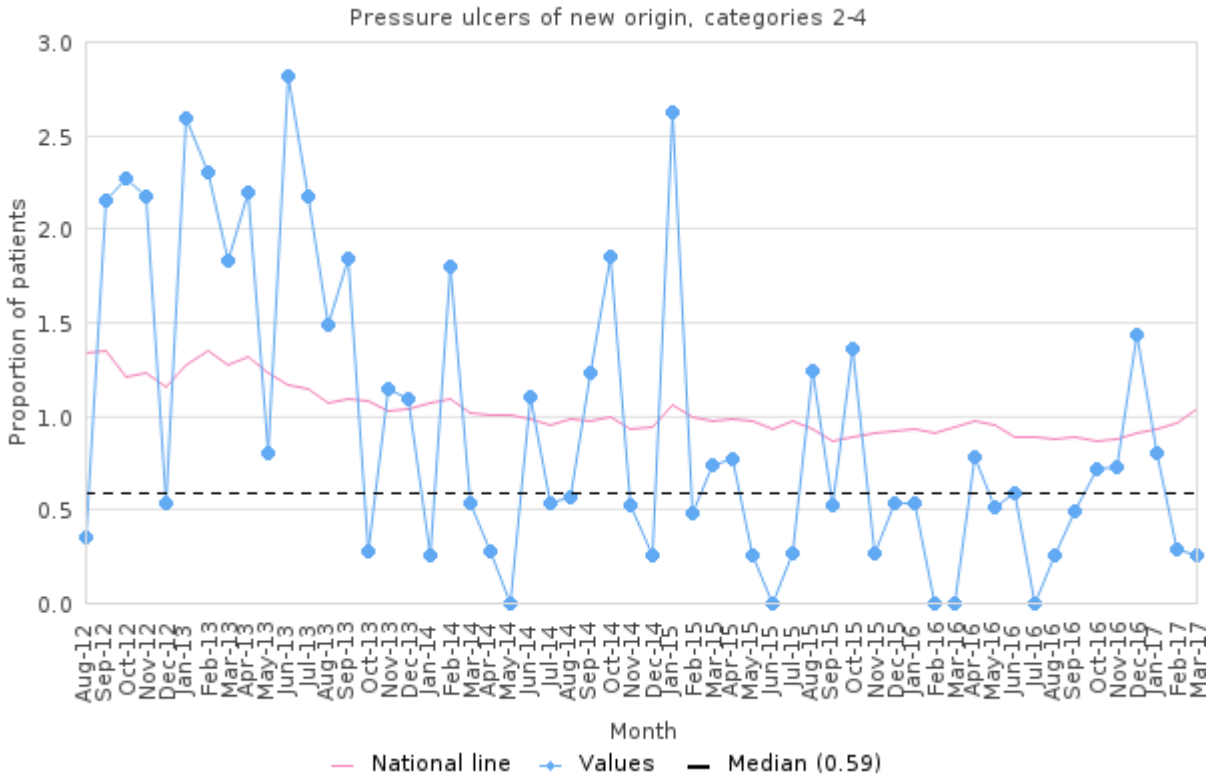
We have successfully achieved the reporting of all grades of pressure ulcers by using our internal electronic incident reporting tool, Datix which provides a live dashboard approach to reporting data.

In addition to this there is a monthly point prevalence audit using the national 'Safety Thermometer Tool' that measure harm. Using the safety thermometer data the graphs below show the national position for hospital acquired pressure ulcers is just below 1% of patients have a hospital acquired pressure ulcer. Chelsea and Westminster Hospital site has a median of 1.27%; this is an improvement from last year where the median was 1.33%. The West Middlesex site has a median of 0.59% which is below the national median of 0.99%. The actual numbers of pressure ulcers (Grade 2, 3 and 4) are reported on the Trust's incident reporting system and are displayed in the section of the report reviewing local quality performance indicators in Part 3 of this report.

Graph 3 - Safety Thermometer Prevalence Data September 2012 – March 2017 (C&W)



Graph 4 - Safety Thermometer Prevalence Data September 2012 – March 2017 (WM)



What are we going to do going forward?
Although pressure ulcers are not a designated quality priority for 2017/18 the improvement work will continue and all grades 2, 3 & 4 will be monitored via the incident reporting system. All actions implemented this year will continue with progress being monitored via the Pressure Ulcer Group to the Patient Safety Group. We will continue to report progress in next year's Quality Report as a local quality indicator.

In addition to this we will continue to record pressure ulcers using the 'National Patient Safety Thermometer'. The safety thermometer data collection provides a 'temperature check' on harm. It provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers.

Priority 2: Embedding of the World Health Organisation (WHO) surgical safety checklist

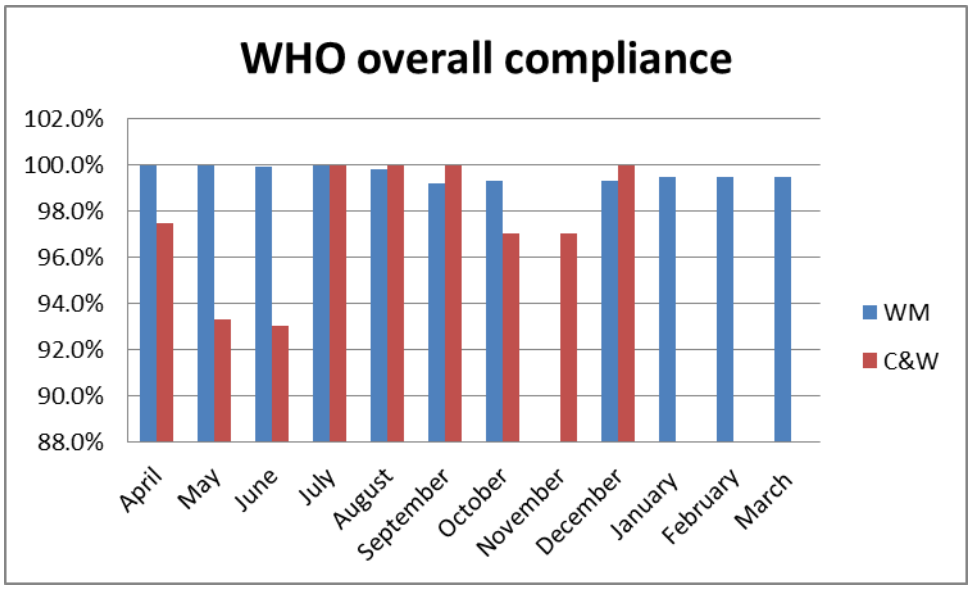
What did we set out to achieve during 2016/17?
To fully embed use of the WHO checklist across the organisation, reflecting feedback from the CQC's review of the services we provide and building on existing progress.
What did we do during the year to improve patient care?

- The WHO checklist was not completely aligned on both sites due to the differences in the process of getting the patients to theatres. This approach was agreed by the Service Director for Surgery, however the 3 core steps on the checklist – 'the sign in' the 'time out 'and the 'sign out' are present on both checklists so the headline criteria of the WHO are met.
- A new audit methodology has been developed and agreed through the Patient Safety Group.
- The two sites now use the same audit tool on survey monkey (started on the 6th February 2017) using a rolling speciality 6 week audit timetable. Graphs 5 and 6 indicate performance since the implementation of the new audit tool.
- West Middlesex is now auditing the Team Brief (before the start of each theatre list) where previously this was not captured through the old audit tool.

What results did we achieve?

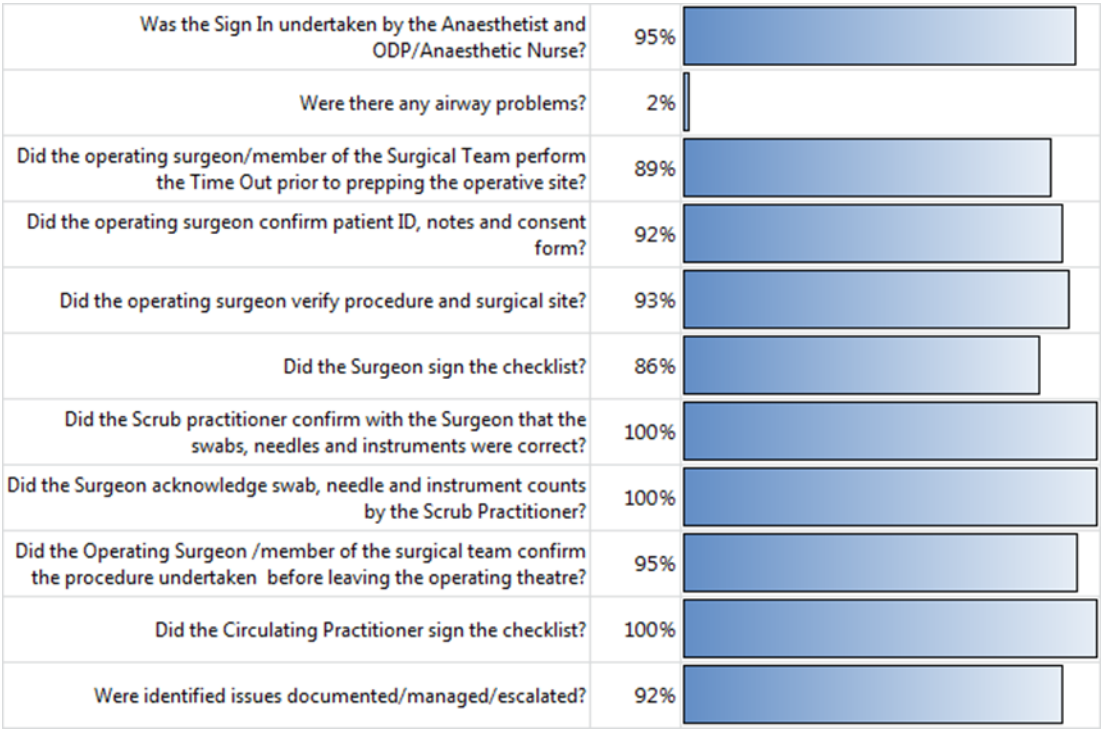
Graph 5 below demonstrates that the overall WHO compliance ranges from between 92% and 100%. The November data for WM is unfortunately unavailable. In January the data collection methodology was changed hence no data for January to March for C&W.

Graph 5: WHO Overall Compliance

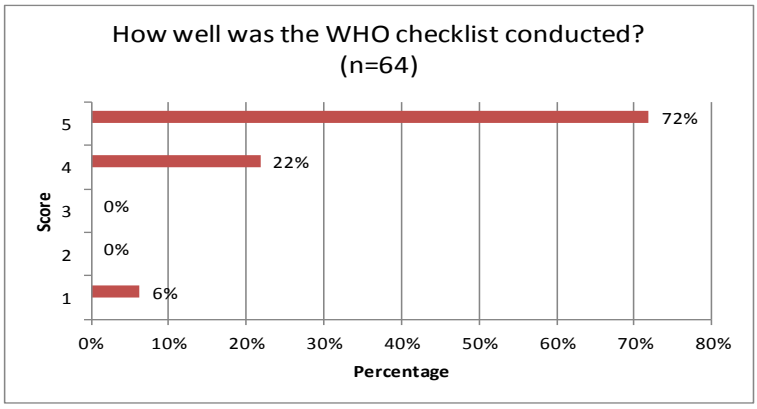


In January 2017 the audit methodology changed; graph 6 shows a snap shot of the Cross-site WHO audit report for the four week period 13 February 2017 to 10 March 2017 (n=79). This methodology will allow consistent reporting during 2017/18.

Graph 6 - Compliance table for main questions with percentages and data bars



Graph 7 - Distribution of responses to the rating question



What are we going to do going forward?
The WHO check list remains a priority for 2017/18. Further information is provided in the next section on quality priorities 2017/18.

Priority 3: Early identification of the deteriorating patient

What did we set out to achieve during 2016/17?
To rapidly identify potentially unwell and/or septic patients and institute prompt treatment, in order to reduce mortality and morbidity.

What did we do during the year to improve patient care?
The Sepsis Management guidance was agreed:

The steering group looked at the current best evidence and the decision was made to follow the NICE guidelines (NG51, Sepsis: recognition, diagnosis and early management). The guideline helps us to identify early moderate and low risk sepsis, especially helpful in the hospitalised patient cohort.

Protocols were updated:

Adult Emergency Department: C&W site has introduced use of stickers for screening and has updated the protocol; WMUH site has continued the established screening programme.

Adult Inpatient: Screening & Management protocol has been agreed, screening at C&W site will be facilitated by the use of Think Vitals software (Think Vitals is a tool used to records patient observations), WMUH site will be a paper based collection.

Paediatric ED & Inpatient: Screening & Management Protocol has been completed

Training & Engagement:

Training is crucial to the delivery of 2017/18 quality priorities so during 2016/17 the following was achieved:

- A training plan has been drafted with the Learning &Development team and will deliver teaching on IV Cannulation & taking blood cultures to nurses.
- ED professional development nurse, Band 7 nurse & Medical Education fellow will help deliver this training

Engagement of staff has been instrumental through 2016/17.

- Departmental level training in ED for medical and nursing staff
- Grand Round Presentation at CW site on sepsis and inpatient screening and management tool
- Meeting with medical consultants at the WMUH site at the medical directorate meeting and explained the protocols

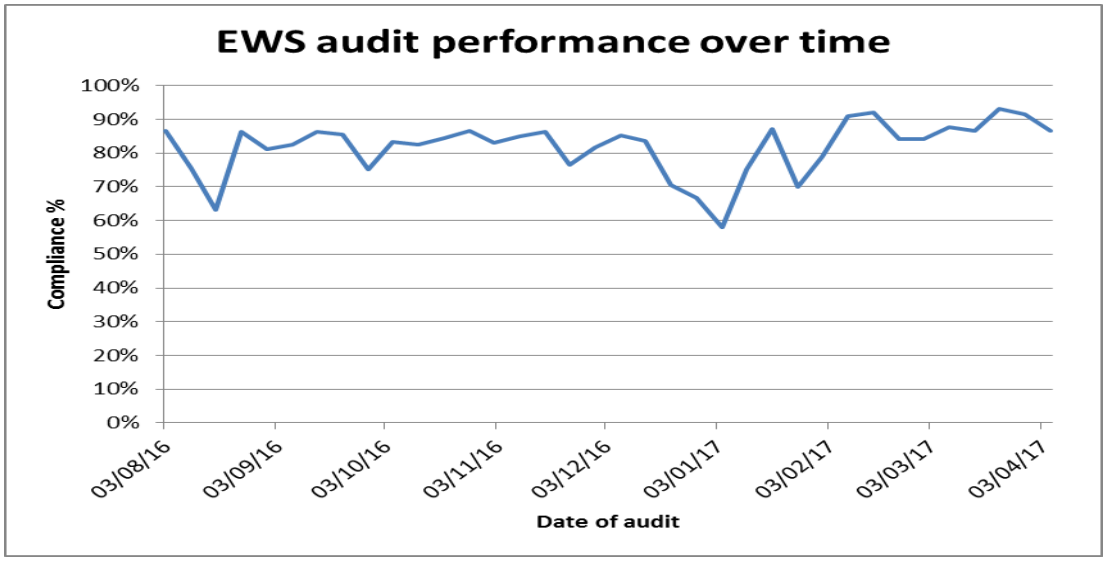
In addition:

- First Line antibiotic agreed for adults & paediatrics
- Think Vitals implemented on all Adult Inpatient wards at CW site, there is an alternative solution in place on the WM site
- Audit of early warning score compliance was introduced. Graph 8 shows compliance with the Early Warning Score audit across both sites since August 2016 when the audit was introduced.

What results did we achieve?

Graph 8 below shows the compliance with the Early Warning Score Audit across the two sites.

Graph 8 - Compliance with the Early Warning Score Audit



What are we going to do going forward?
Sepsis remains a priority for 2017/18. Further information is provided in the next section on quality priorities 2017/18.

Clinical effectiveness

Priority 4: Reduce avoidable admissions of term babies to the Neonatal Intensive Care Unit

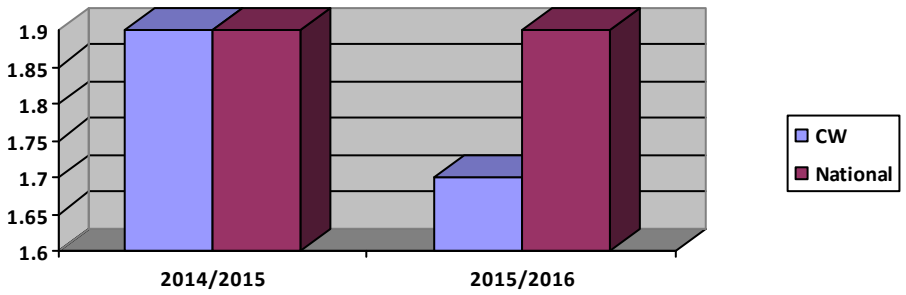
What did we set out to achieve during 2016/17?
To deliver a 20% reduction in the number of term babies admitted unexpectedly to the neonatal intensive care unit (NICU).

What did we do during the year to improve patient care?

- Agreed to use the Growth Assessment Protocol (GAP) to identify at risk babies.
- Implemented a training package for fetal heart rate monitoring in labour, in coherence with NICE guidelines and the International Federation of Gynaecology and Obstetrics (FiGO) classification system.
- survey monkey audit tool to assess staff knowledge gaps relating to hypoglycaemia and hypothermia, and we aim to complete a random audit of practice on 2 days a week for 1 month to assess current practice.

What results did we achieve?
The data from the National Neonatal research database demonstrates that in 2014/2015 C&W had an unexpected admission to the neonatal unit rate the same as the national average. The rates in 2015/2016 have reduced to a rate of 1.7 admissions per 10000 births compared to the national average of 1.9 admissions per 1000 births (see Graph 8). The reduction in this rate has resulted in the NHSLA making a 1% reduction which totals £70k reduction in the insurance premium for maternity.

Graph 9 - Unexpected admission to the neonatal unit (C&W v National)



What are we going to do going forward?

- Create a skills development programme around hypothermia and hypoglycaemia.
- Monthly audit of compliance to measure if babies receive antibiotics in a timely manner.

Patient experience

Priority 5: Friends and Family Test—inpatient responses

What did we set out to achieve during 2016/17?

To use the Friends and Family Test (FFT) as a key measure for our continued ambition to provide excellent experience of care in everything we do. This measure was chosen by our governors in 2014/15 and remains a priority for improvement.

What did we do during the year to improve patient care?

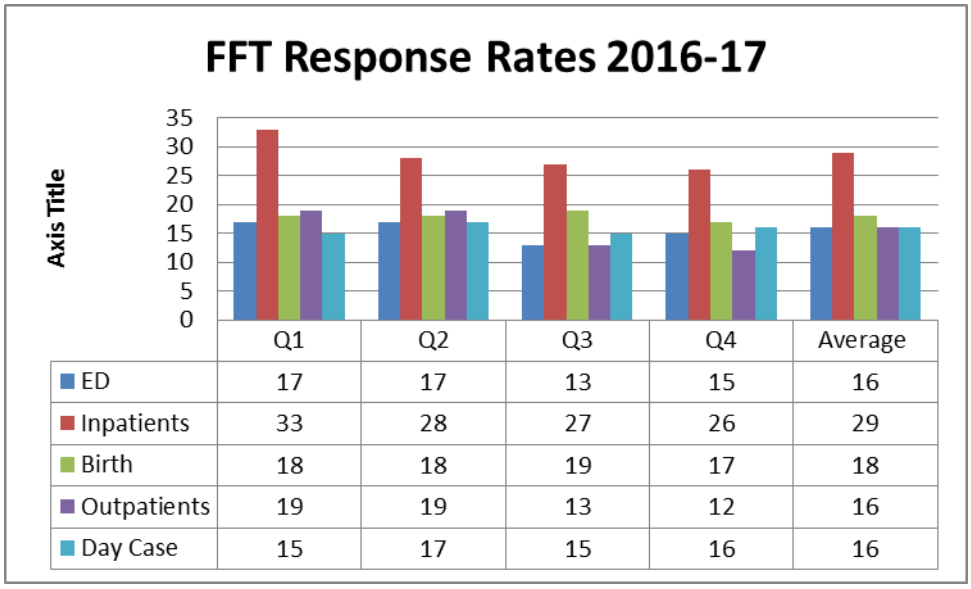
Engagement was strengthened with the Divisions, through both the monthly Patient Experience Group meetings, and the monthly Divisional Quality meetings. FFT data is combined within the Quality Report and shared with all key staff outside of the meetings, with key best practice/concerns or trends highlighted with the local Senior Nurse. Feedback from staff has informed a new FFT strategy for 2017/18 which will further strengthen and promote FFT.

What did results did we achieve?

The trust target of 90% recommendation rate was achieved within the Maternity services and Day Case. The In-patients wards vary individually with the recommendation rate, some high achieving areas rate 90-100% however collectively they reach just under the target. This is due to specific wards which have complex challenges which reflect in lower patient experience.

The trust did not achieve the targets of >30% overall Response Rate (Table 1). This highlights the need for a different approach to survey methods. A deep dive analysis has identified why this has not been achieved and targets for 2017/18 have been set to reflect this. Graph 9 the data shows we do not meet the internal target of >30% response rate.

Graph 10: FFT Response Rates Q1-3 2017/17

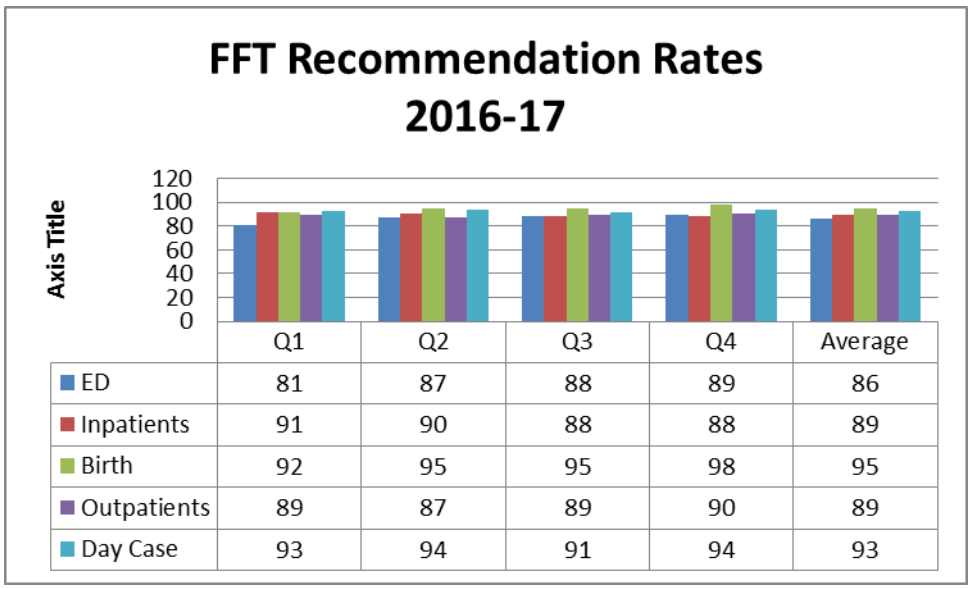


	Q1	Q2	Q3	Q4	Average
ED	17	17	13	15	16
Inpatients	33	28	27	26	29
Birth	18	18	19	17	18
Outpatients	19	19	13	12	16
Day Case	15	17	15	16	16

Graph 11 demonstrates that Maternity and Day Case reaches well above the target of 90%. The ED department decreased at the height of the winter pressures but also in the midst of building renovations for both sites. However, the preliminary data for Q4 does show ED reaches over 90% at the Chelsea site for Q4, which may coincide with the complete of the build work and a calmer environment, which should reflect at the West Mid site in due time.

There are specific In-Patients wards that do reach 90-100% satisfaction but specific areas with lower scores bring down the average to <90%.

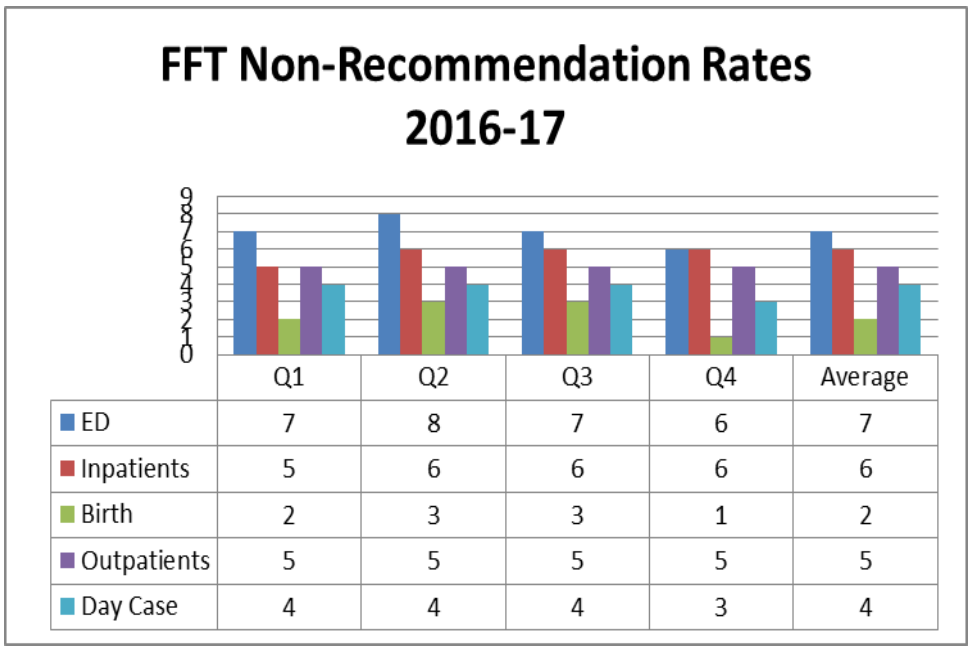
Graph 11 FFT Recommendation Rates



	Q1	Q2	Q3	Q4	Average
ED	81	87	88	89	86
Inpatients	91	90	88	88	89
Birth	92	95	95	98	95
Outpatients	89	87	89	90	89
Day Case	93	94	91	94	93

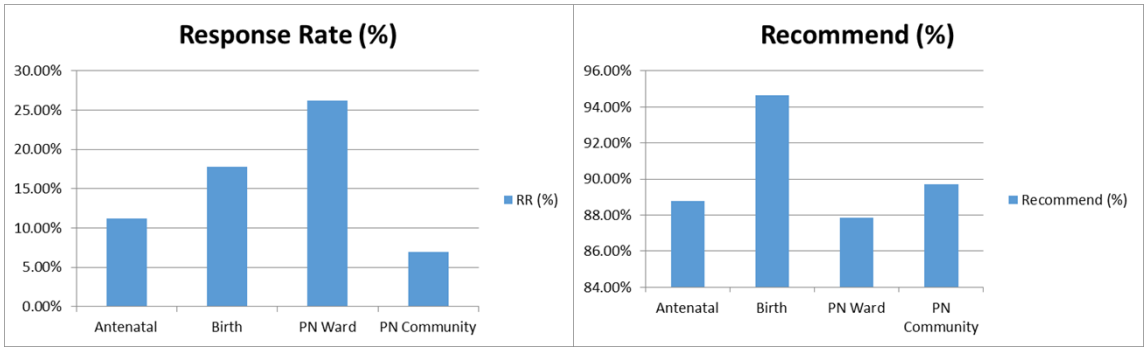
Graph 12 shows that all areas reach the target of <10% Non-Recommendation rate.

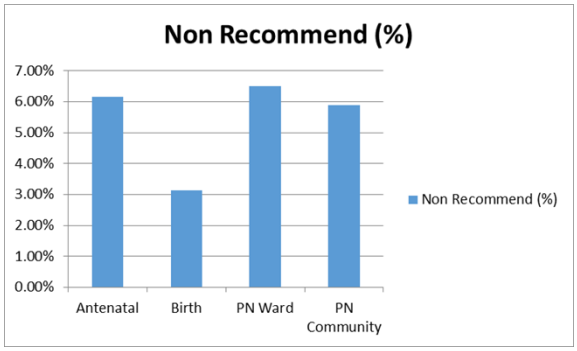
Graph 12 FFT Q1-3 Non-Recommendation Rates



	Q1	Q2	Q3	Q4	Average
ED	7	8	7	6	7
Inpatients	5	6	6	6	6
Birth	2	3	3	1	2
Outpatients	5	5	5	5	5
Day Case	4	4	4	3	4

The FFT for maternity services is aligned to touch points, pre natal, birth and post natal. The following three graphs show the position for the year across all four touch points. The low response rate demonstrates the challenges that exist with capturing feedback from women. However the recommendation rates are above 88% for all four areas.





What are we going to do going forward?
FFT remains a priority for 2017/18. Further information is provided in the next section on quality priorities 2017/18.

Priorities for improvement 2017/18

This section of the report sets out the Trust's quality improvement priorities for 2017/18. The plan for 2017/18 is to continue to link the quality priorities to the Quality Strategy and Plan 2015/18 and in each case, as we did last year, we have aligned the priority to one of the three Quality domains (Patient Safety, Clinical Effectiveness and Patient Experience). However, we recognise that in reality each priority is likely to impact on multiple domains—in particular patient experience which we are focusing on as an overarching objective of our Quality Strategy.

In 2017/18 priorities were, as in previous years, identified through engagement across a number of areas which have endorsed the chosen priorities:

- Engagement and feedback from our Council of Governors' Quality Sub Committee that includes external stakeholders (for example commissioners and Healthwatch)
- Engagement and feedback from our Board's Quality Committee
- The development of the Quality Strategy and Plan for 2015 to 2018
- Incident reporting and feedback from complaints

Our ambition for 2017/18 is to continue a supportive process with all these projects aimed at ensuring teams continue to develop transferrable and sustainable knowledge and skills in order to

carry on the journeys of improvement within the organisation and across wider healthcare. These are critical skills for the future and for working with patients and colleagues across the sectors.

Quality consists of three areas which are crucial to the delivery of high quality services:

- Patient safety—how safe the care provided is
- Clinical effectiveness—how well the care provided works
- Patient experience—how patients experience the care they receive

We have set the following priorities for 2017/18 which have been agreed with the Council of Governors. Details of each of these priorities, including the actions planned and how we will monitor our progress throughout the year, are presented below. A quarterly report will be provided to the relevant subgroup i.e. Clinical Effectiveness Group, Patient Safety Group or Patient Experience Group, and subsequently to the Quality Committee.
The quality priorities for 2017/18 are outlined below:

Patient Safety
Priority 1 - Reduction in falls (Frailty)

What have we set out to achieve during 2017/18?
To see a reduction in all falls, reduction in falls with moderate and severe harm, reduction in externally reported falls - targets for 2017/2018:

- 25% reduction in externally reportable fall incidents (Apr 2016 to date =4)
- 40% reduction in falls resulting in moderate harm (Apr 2016 to date =11)
- 20% reduction in falls resulting in no harm low harm (Apr 2016 to date =881)

What will we do during the year to improve patient care?

- Every patient to have a falls assessment and action plan on admission
- Staff to attend prevention training
- Correct staffing levels, recruitment and retention
- Falls prevention group to continue
- All Falls with moderate or severe harm to be reviewed by the Falls Standing Panel using root cause analysis methodology
- Investment in equipment/hoist for post falls management
- Policies will be aligned across both sites

How will we measure our success?

- Falls dashboard will be reviewed monthly by the falls group
- Falls prevention to be reported to Divisional Quality meetings
- Analysis of themes will take place quarterly using the DATIX incident reporting system
- A quarterly report on progress will be provided to the patient safety group

Priority 2 - Antibiotic administration in Sepsis (Sepsis)

What have we set out to achieve during 2017/18?
All recognised sepsis patients to have antibiotics administered within an hour of prescribing.

What will we do during the year to improve patient care?
Senior nurses and midwives in all clinical areas to receive training by end of May 2017 on:

- Sepsis recognition
- Taking blood cultures
- Administering antibiotics from the PGD

- Antibiotics to be administered to septic patients within one hour of sepsis diagnosis in accident & emergency [Target >90% by year end]
- Antibiotics to be administered to septic patients within one hour of sepsis diagnosis for in-patient wards [Baseline data for 2015/16 = 35%; Target >60% by year end]
- All antibiotics started for suspected sepsis should have a documented review within the medical notes by an appropriate staff member within 24-72 hours detailing initial response to therapy and future plan of therapy [Target >90% by year end]

How will we measure our success?

- Retrospective audit of medical notes
- Feedback of performance monthly by Sepsis team
- 100% of senior nurses and midwives in all clinical areas will be competent in taking blood cultures
- A quarterly report on progress will be provided to the clinical effectiveness group

Priority 3 - National Early Warning Score (Sepsis)

What have we set out to achieve during 2017/18?

All inpatients to have clinical observations taken and recorded as per clinical policy and charted on a EWS chart.

What will we do during the year to improve patient care?

- All staff will be trained on EWS clinical observations, recording and escalation on induction
- Observation charts will be standardised across the two sites and in all clinical areas
- Completing actions and audit cycles from the monthly EWS audits

How will we measure our success?

- 95% of all patients will have observations taken as per clinical guideline and recorded on the EWS chart; audit will be undertaken monthly in each clinical area.
- A quarterly report on progress will be provided to the clinical effectiveness group

Priority 4 - National Safety Standards for Invasive Procedures (NatSSIPs) (Admitted Surgical Care)

What have we set out to achieve during 2017/18?

WHO safety check list to be completed on all patients having surgery, with the effective process preventing never events.

What will we do during the year to improve patient care?

- All theatre staff to undertake human factors simulation training on theatre safety
- Continuous learning from monthly WHO checklist audit cycles
- Specialty specific WHO checklists / LocSipps to be developed for all invasive procedures

How will we measure our success?-

- 100% compliance in Who checklist clinical audits
- Human factor training compliance
- Improve audit results across both sites reporting through all 3 divisional governance boards.
- Decrease in Datix incidents relating to safer surgery incidents.
- Achieve local reporting of audits in all specialties and departments including those outside theatre settings.
- A quarterly report on progress will be provided to the patient safety group

Clinical Effectiveness

Priority 5 - Reduction in still births (Maternity)

What have we set out to achieve during 2017/18?
Achieve a still birth rate which is lower than the national average

What will we do during the year to improve patient care?

- Implementation of the Growth Assessment Protocol (GAP) to identify at risk babies on both sites
- Named midwife for all women
- Implementation of K2 intrapartum central CTG display
- Standardised CTG assessment for all staff annually

How will we measure our success?

- Named midwife compliance reported on the maternity dashboard monthly compliance >90%
- Training data on CTG assessment- compliance >90%
- National stillbirth rates
- A quarterly report on progress will be provided to the clinical effectiveness group

Patient Experience

Priority 6 - Focus on complaints and demonstrate learning from complaints

What have we set out to achieve during 2017/18?
Achieve a 1% reduction in informal complaints and 90% of all complaints responded to within 25 days, with all complainants receiving acknowledgement of a complaint within 48 hours. Actions and learning from complaints to be inputted onto Datix following the risk process.

What will we do during the year to improve patient care?
Complaints team phoning and sending acknowledgements letters within 48 hours

- Weekly complaints meeting with divisions to track compliant progress on Datix
- Monitoring of a complaints dashboard in the patient experience committee
- Effective management of the complaint process
- The four key themes from complaints will be cascaded in the Big 4 safety message to enhance learning from complaints
    - Communication
    - Not involved in decisions about care
    - Admin and clerical concerns i.e. letters not being received
    - Not satisfied with the outcome if care.

How will we measure our success?

- Number and % of complaints
- Compliance data on response to complaint
- Compliance data on acknowledgement of complaints
- A quarterly report on progress will be provided to the patient experience group

Priority 7 - FFT improvements in recommend scores

What have we set out to achieve during 2017/18?

All clinical areas to have a recommend score of over 90%

What will we do during the year to improve patient care?

- Individual ward accountability for improvement action plans
- Evidence clinical areas reviewing trends in complaints and addressing these actions
- Improved communication to patients
- New method for data collection to include tablets in all ward areas in addition to the existing methodologies of texting and paper based collections.

How will we measure our success?

- FFT scores visible on ward quality boards
- A quarterly report on progress will be provided to the patient experience group

Review of services

During 2016/17 the Chelsea and Westminster Hospital NHS Foundation Trust provided and or sub-contracted 87 relevant health services.
The Chelsea and Westminster Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.
The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by the Chelsea and Westminster Hospital NHS Foundation Trust for 2016/17.

Participation in clinical audit

During 2016/17, 30 national clinical audits and 10 national confidential enquiries covered relevant health services that the Chelsea and Westminster Hospital NHS Foundation Trust provide. During that period Chelsea and Westminster Hospital NHS Foundation Trust participated in 93% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS Foundation Trust was eligible and participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1: National Clinical Audit Project Participation

National Clinical Audit Title	Trust eligible	Trust participated	% Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	Ongoing
Adult Asthma	Yes	Yes	100
Adult Cardiac Surgery	No	Not eligible	.
Asthma (paediatric and adult) care in emergency departments	Yes	Yes	100
Bowel Cancer (NBOCAP)	Yes	Yes	Ongoing
Cardiac Rhythm Management (CRM)	Yes	Yes	Ongoing
Case Mix Programme (CMP)	Yes	Yes	100
Chronic Kidney Disease in primary care	No	Not eligible	.
Congenital Heart Disease (CHD)	No	Not eligible	.
Consultant Sign-off (Emergency Departments)	Yes	Yes	100
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	No	Not eligible	.
Diabetes (Paediatric) (NPDA)	Yes	Yes	100
Elective Surgery (National PROMs Programme)	Yes	Yes	100
Endocrine and Thyroid National Audit	No	Not eligible	.
Falls and Fragility Fractures Audit programme (FFFAP)	Yes	Yes	Ongoing
Head and Neck Cancer Audit	Yes	Yes	Ongoing
Inflammatory Bowel Disease (IBD) programme	Yes	Yes	50
Learning Disability Mortality Review Programme (LeDeR)	No	Not eligible	.
Major Trauma Audit	Yes	Yes	Ongoing

National Clinical Audit Title	Trust eligible	Trust participated	% Submitted
National Audit of Dementia	Yes	Yes	100
National Audit of Pulmonary Hypertension	No	Not eligible	.
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	Yes	Ongoing
National Comparative Audit of Blood Transfusion programme	Yes	Yes	100
National Diabetes Audit - Adults	Yes	Yes	Ongoing
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100
National Heart Failure Audit	Yes	Yes	Ongoing
National Joint Registry (NJR)	Yes	No	-
National Lung Cancer Audit (NLCA)	Yes	Yes	100
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100
National Ophthalmology Audit	Yes	No	-
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	No	Not eligible	.
Nephrectomy audit	No	Not eligible	.
Neurosurgical National Audit Programme	No	Not eligible	.
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Ongoing
Paediatric Intensive Care (PICANet)	No	Not eligible	.
Paediatric Pneumonia	Yes	Yes	Ongoing
Percutaneous Nephrolithotomy (PCNL)	No	Not eligible	.
Prescribing Observatory for Mental Health (POMH-UK)	No	Not eligible	.
Radical Prostatectomy Audit	No	Not eligible	.
Renal Replacement Therapy (Renal Registry)	No	Not eligible	.
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	Ongoing
Severe Sepsis and Septic Shock - care in emergency departments	Yes	Yes	100
Specialist rehabilitation for patients with complex needs following major surgery	No	Not eligible	.
Stress Urinary Incontinence Audit	No	Not eligible	.
UK Cystic Fibrosis Registry	No	Not eligible	.

Table 2: Confidential Enquiries Project Participation

Confidential Enquiry Project Title	Trust eligible	Trust participated	Trust submission
Young People's Mental Health	Yes	Yes	Ongoing
Acute Pancreatitis	Yes	Yes	-
Cancer in Children, Teens and Young Adults	Yes	Yes	Ongoing
Chronic Neurodisability	Yes	Yes	Ongoing
Acute Heart Failure	Yes	Yes	Ongoing

Confidential Enquiry Project Title	Trust eligible	Trust participated	Trust submission
Non-invasive ventilation	Yes	Yes	Ongoing
Perioperative diabetes	Yes	Yes	Ongoing
Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	Ongoing
Suicide by children and young people in England(CYP)	No	Not eligible	-
Suicide, Homicide & Sudden Unexplained Death	No	Not eligible	-
The management and risk of patients with personality disorder prior to suicide and homicide	No	Not eligible	-
Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	Yes	Yes	Ongoing
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	Ongoing
Perinatal Mortality Surveillance	Yes	Yes	Ongoing
Confidential enquiry into serious maternal morbidity	Yes	Yes	Ongoing
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	Yes	Yes	Ongoing
Maternal mortality surveillance	Yes	Yes	Ongoing

National Clinical Audit projects reviewed by the Trust

The reports of 29 national clinical audits on each site were reviewed by the provider in 2016/17 and Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

1. Review the remaining national clinical audits relating to 2016/17 to identify and collate actions to be taken to improve the quality of healthcare provided.
2. Publish the findings of all reviews in August 2017 in the Trust's Clinical Audit Annual Report 2016/17.

Table 3 provides a summary of some of the actions we intend to take to improve the quality, safety and clinical effectiveness arising from participation in national clinical audit. It is not intended to be the action plans. The actions are on-going and are monitored via clinical effectiveness group.

Table 3 – National Clinical Audit Summary

National clinical audit	Dept Leading Review	Summary & agreed actions arising from National Clinical Audits
National Diabetes Audit (adults)	Diabetes Service	The Trust National Diabetes audit report were reviewed by the Diabetes Service and following improvement were made: • An increase inpatient staff and consultant's time for inpatients, with consideration of a seven day services. • The implementation of an improved screening assessment and identification for patients requiring a diabetes review and foot check.
National Emergency	General Surgery	The Trust participated in the National Emergency Laparotomy Audit (NELA) Clinical Audit.

National clinical audit	Dept Leading	Summary & agreed actions arising from National Clinical Audits
Laparotomy Audit		• Both sites performed well in the indicators for patient arrival in theatre within a timescale appropriate for urgency and admission to critical care following surgery. • Both sites are below national average against many criteria, actions are being taken to improve overall performance.
National Oesophago-Gastric Cancer Audit (NOGCA)	Cancer Services	The National Oesophago-Gastric Cancer Audit (NOGCA) was reviewed by the Trust Multidisciplinary teams. • There is clear organisational protocols are in place to ensure all cancer cases are discussed at Multidisciplinary Team Meeting (MDT). • The MDTs monitor management of High Grade Dysplasia (HGD), and ensure there is access to endoscopic treatment of Barrett's HGD.
National Joint Registry	Ortho services	The Trust participated in the National Joint Registry (NJR) audit, the organisation were audited against nine indicators. • The Trust scored above the NJR's benchmark for cases submitted with NHS number (98%). • However, patient consent confirmation was below the NJR's benchmark at 82% against the NJR benchmark of 95%. Actions are being taken to increase performance.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Respiratory Services	The Trust is compliant with 13 out of 17 recommendations, two of the recommendations were partial compliant. While one of the recommendation was not compliant and one recommendation was not applicable to the Trust. • Improvement made as a result of this audit is to provide NIV or high flow oxygen training for all nursing staff on the respiratory ward.
Inflammatory Bowel Disease (IBD) programme	Gastro Services	The Trust has performed above average and is compliant with 5 out of 6 recommendations from this audit. Best practices identified are: • Infliximab biosimilars is used as the first line anti-TNFα for appropriate patients with active IBD. • All patients are screened prior to treatment with biological therapies. A proforma pre-initiating biologics has been designed and in use for 2years. • Weaning regime in place, most children off steroids by the time infliximab are commenced.
Neonatal Intensive and Special Care (NNAP)	Neonatal Services	The Trust performed above national average for most of the audit criteria. The Neonatal unit scored higher than the national average for level of vigilance in preventing admission hypothermia (95%, national average 93%) and maintaining correct temperature 36-37.5 degrees in the unit (83%, national average 75%). The rate of antenatal steroid administration was above national average (86%, national average 84%).
National Audit of Cardiac Rhythm Management Devices	Cardiology	The Trust registered a total of 33 new pace makers implanted with National Institute for Cardiovascular Outcomes Research (NICOR). While a total five were register as replacement implanted pacemakers. One new implantable Cardioverter defibrillator (ICD) was registered and one as replaced. • Physiological pacing for Sick Sinus Syndrome was above

National clinical audit	Dept Leading	Summary & agreed actions arising from National Clinical Audits
		national average at 100% (national average 89.4%). • 15 out of 17 recommendations from this audit were met, while one recommendation is in its planning stage. This is due to the catheter lab service being new at the WestMid site. • A plan is in place to review the service in six months to ascertain activity compliance to the British Heart Rhythm Society (BHRS) guidelines and NICE Technology Appraisal Guidance. • Recommendations applicable to the validation of data submitted to NICOR were also met as data are captured electronic database at time of implant. Validation is completed by the consultant cardiologist prior to submission to NICOR.

Local Clinical Audit projects reviewed by the Trust

The reports of 35 of 93 local clinical audits were reviewed by the provider in 2016/17 and Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the on-going actions taken to improve the safety and effectiveness of our services.

Table 4 – Local Clinical Audit Summary

Local Clinical Audits	Summary & agreed actions arising from Local Clinical Audits
Audit of referrals to anaesthetic antenatal clinic.	Retrospective audit of the compliance to the guidance for the Anaesthetic Antenatal Clinic (ANC) referrals. 60% (205) of referrals were compliant with the referral guidance. 40% (134) of the referrals were deemed to be inappropriate. The agreed action was to review the current guidance and to raise awareness of the correct referral criteria were completed.
ECG documentation Audit.	A re-audit of the documentation of ECGs to meet the guidelines published by the Society for Cardiology Sciences and Technology. The re-audit revealed there had been no significant improvement and only 8% of the audited ECGs had a sticker attached. A recommendation for further education of nursing and medical staff working on the Acute Assessment Unit.
Appropriate antibiotic prescribing in Lower respiratory tract infections (LRTIs).	An audit to assess the appropriateness of the prescribing of antibiotics for lower respiratory tract infections (LRTIs). The results revealed 30% of patients admitted with LRTI had antibiotics according to trust protocol. Actions agreed were to liaise with microbiology team to develop hospital infective exacerbation of asthma guideline.
Audit of compliance with NICE Quality Standard 33, Statement 7, specifically that 'People with rheumatoid arthritis have a	Audit to assess compliance with the NICE recommendations relating to assessing control and pain management in people with rheumatoid arthritis. The audit results show that care plans and provision of

Local Clinical Audits	Summary & agreed actions arising from Local Clinical Audits
comprehensive annual review that is coordinated by the Rheumatology Department'.	educational activities/self-management were >90% compliant with the standard.
An Audit of the Quality of Bowel Care Amongst Elderly Patients following Emergency Surgery for Hip Fracture.	The audit result has led to a departmental intervention, of placing coloured labels on all hip fracture pathway booklets, to prompt early laxative prescription. The findings also resulted in the introductions of a sustained teaching programme led by the anaesthetic team and the implementation of routine training on the use of peripheral nerve blocks for staff working in A&E, Orthopaedics and Ortho-geriatrics departments.
An Audit of the Appropriate Escalation of High NEWS on a Medical Ward.	The audit was carried out to assess compliance to the National Early Warning Score (NEWS). To enable the efficient identification and response to patients who present with or develop acute illness. • The findings of this audit shows some improvement is required and has resulted in on-going NEWS training for nurses and doctors via the Trust mandatory e-learning module.
An audit of the appropriateness and safety of oral anticoagulation therapy newly initiated for non-valvular atrial fibrillation for adult patients.	The cohort study was carried out to highlight that clinicians were prescribing DOAC agents over warfarin therapy for patients with non-valvular atrial fibrillation (nvAF). • Overall the audit results show that there was good adherence for documentation of patients received counselling on the anticoagulation agent to alert them of side effects and adverse events that require urgent medical attention. • Some criteria for this audit require further improvement to ensure the appropriateness of anticoagulation therapy given to patients. • Further education is required for medical and pharmacy staff to ensure patients is offered verbal and written information on anticoagulation agent.
Perioperative Management and Outcomes of People with Diabetes Mellitus (DM) & Impaired Glucose Tolerance (IGT) Referred for Bariatric Surgery.	Audit was carried out to compare the management of T2DM in the peri and post-operative periods following bariatric surgery with the local and national guidelines and to identify non-compliance of these standards. • The findings of this audit were overall positive and as a result there is increase awareness and prescribing of postoperative metformin therapy to patients after Bariatric Surgery. • An abstract of this audit was also submitted as a poster to a national conference to increase awareness further.
WMUH Acute Medical Unit Clinical Quality Indicators Audit (Re-Audit).	Society of Acute Medicine (SAM) published four Clinical Quality Indicators for Acute Medical Units (AMUs) in 2011, defining the gold standard for the delivery of acute medical care.

Local Clinical Audits	Summary & agreed actions arising from Local Clinical Audits
	There were overall improvement with compliance Further audit and strategy increase completion of discharge summaries for patients who die in hospital. The results were disseminated to AMU Consultants and other relevant clinical leads (AMU matron, A&E matron). An abstract for a poster will be presented at the SAM spring conference in 2017 to share the experience of rota change on the performance of the AMU.
Appropriate recognition, assessment and management of pain in the Emergency Department.	Audit carried out in the Emergency Department against the Royal Colleges of Emergency Medicine Guidelines (RCEM) 2014 for pain management. Pain scoring in line with the RCEM standards was not fully compliant in the Emergency Department at both triage assessments and doctor assessment. However, as a result of this audit a new pain pathway for patients was introduced in the Emergency department.
Audit on the management of epididymo-orchitis in a London-based level 3 sexual health clinic	This audit demonstrated that patients attending clinic were treated in concordance with national guidelines and the vast majority showed a good clinical response. However, lack of routine urine sampling for microscopy/culture was evident. Although a urine dipstick was performed in most cases, guidelines do stipulate that this only serves as a useful adjunct. As a result of this audit the department intends to obtain a midstream specimen of urine for culture in all cases of epididymo-orchitis. The findings of this audit has been published in the International Journal of STD & AIDS (Feb 2017).
Post exposure prophylaxis after sexual exposure (PEPSE) – are we following BASHH guidelines?	This audit identified key areas where the trust is not compliant against NHS guidelines on PEPSE prescription. One change that has been implemented in Genito Urinary Medicine(GUM) clinic is the use of proformas which captures key guideline recommendation. The audit identified key loop holes where some of the data was missing or held on an alternative database – Adastra. This system is used when patients are seen in the Urgent Care Centre rather than in Majors or Resus of ED. The ED department plans to work with the HIV Pharmacy Team to identify a pathway that would be beneficial and useful for both departments.

Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 3947.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting 262 research studies in 2016/17 in A&E, Anaesthesia, Critical Care, Diabetes, ENT, Maternity, Ophthalmology, Surgery, Metabolic and Endocrine, Sexual Health, Genetics, Neurology, Neonatology, Infection, Urology, Cancer, Gastroenterology, Paediatric, Haematology, Respiratory, Cardiology, Rheumatology, Dermatology and Stroke during 2016/17. The improvement in patient health outcomes demonstrates the Trust's commitment to clinical research which leads to better treatments for patients.

123 Trust staff participated in research as Principal Investigators for research studies approved by a Research Ethics Committee at the Trust during 2016/17.

In the last three years, 1544 publications have resulted from our involvement in research and audits, which shows our commitment to transparency and our desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques.

Commissioning for quality and innovation (CQUIN) payment framework

Every year Chelsea & Westminster Hospital NHS Foundation Trust agree a number of quality indicators with its commissioners. The indicators cover areas of patient safety, patient experience and clinical effectiveness.

A proportion of Chelsea & Westminster Hospital NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Chelsea & Westminster Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period will be available electronically on the Trust's website.

The tables on the following pages detail the payment received by the Trust for the achievement against each of the indicators for 2016/17 and sets out the goals for 2017/19. Q4 milestones are yet to be signed off by commissioners and therefore the numbers in the table are based on the Trust's forecasts.

Table 5 – Nationally agreed CQUIN indicators

Nationally Agreed CQUIN Indicators					
Description of CQUIN	**Quality Priorities**	**Forecast Achievement (%)**	**Forecast Achievement (£000)**	**Total Value allocated to each CQUIN (£000)**	**Comments**
Provision of Staff Wellbeing Initiatives	Patient safety, clinical effectiveness and patient experience	63%	£477	£763	Q1-3 achieved in full, risk on Q4 milestones.
Promotion of Healthy Eating to staff, patients and visitors	Patient safety, clinical effectiveness and patient experience	60%	£458	£763	Q1-3 achieved in full, risk on Q4 milestones.
Staff Influenza Vaccination	Patient safety, clinical effectiveness and patient experience	100%	£763	£763	Forecast to be achieved in full
Sepsis (screening & antibiotic administration & Review) - Emergency Department	Patient safety, clinical effectiveness and patient experience	80%	£305	£382	Partial compliance against target for sepsis screening
Sepsis (screening & antibiotic administration & Review) - Inpatients	Patient safety, clinical effectiveness and patient experience	80%	£305	£382	Partial compliance against target for sepsis screening
Anti-microbial Resistance - reduction in antibiotic usage	Patient safety, clinical effectiveness and patient experience	50%	£191	£382	Forecast partial compliance against target for reduction in antibiotic usage
Anti-microbial Resistance - empiric review of prescribing	Patient safety, clinical effectiveness and patient experience	88%	£334	£382	Q1-3 achieved in full, risk on Q4 milestones.
Implementation of Clinical Utilisation Review systems	Patient safety, clinical effectiveness and patient experience	0%	£0	£286	Non-achievement, as the Trust has chosen not to pursue this CQUIN scheme
Enhanced Supportive Care for Care Patients	Patient safety, clinical effectiveness and patient experience	100%	£143	£143	Forecast to be achieved in full
Chemotherapy Dose Banding	Patient safety, clinical effectiveness and patient experience	100%	£143	£143	Forecast to be achieved in full

Table 6 – Regionally agreed CQUIN indicators

Regionally Agreed CQUIN Indicators					
Description of CQUIN	**Quality Priorities**	**Forecast Achievement (%)**	**Forecast Achievement (£000)**	**Total Value allocated to each CQUIN (£000)**	**Comments**
NW London IT & IG Strategy & Governance	Patient safety, clinical effectiveness and patient experience	100%	£191	£191	Forecast to be achieved in full
Sharing of Integrated Care Plans	Patient safety, clinical effectiveness and patient experience	100%	£382	£382	Forecast to be achieved in full
Improve Communication method for GP follow ups to Trust Clinical Services	Patient safety, clinical effectiveness and patient experience	93%	£1,765	£1,908	Q1-3 achieved in full, risk on Q4 milestones.
Electronic Clinical Correspondence	Patient safety, clinical effectiveness and patient experience	88%	£334	£382	Q1-3 achieved in full, risk on Q4 milestones.
NW London Data Quality	Patient safety, clinical effectiveness and patient experience	100%	£191	£191	Forecast to be achieved in full
Dental Schemes - recording of data, participation in referral management & participation in networks	Patient safety, clinical effectiveness and patient experience	100%	£110	£110	Forecast to be achieved in full

Table 7 – Locally agreed CQUIN indicators

Locally Agreed CQUIN Indicators					
Description of CQUIN	**Quality Priorities**	**Forecast Achievement (%)**	**Forecast Achievement (£000)**	**Total Value allocated to each CQUIN (£000)**	**Comments**
Blueteq Implementation for High Cost Drugs Approvals	Patient safety, clinical effectiveness and patient experience	93%	£672	£763	Q1-3 achieved in full, risk on Q4 milestones, due to tougher year-end target.
Richmond OBC Engagement	Clinical effectiveness and patient experience	100%	£100	£100	Forecast to be achieved in full
Timely Discharge Communication with Wandsworth CAHS	Patient safety, clinical effectiveness and patient experience	100%	£287	£287	Forecast to be achieved in full
Developing Telemedicine	Patient safety, clinical effectiveness and patient experience	100%	£206	£206	Forecast to be achieved in full
ARV Switch for HIV patients	Clinical effectiveness	100%	£326	£326	Forecast to be achieved in full
Reducing Ventilator Associated Pneumonia	Patient safety, clinical effectiveness and patient experience	100%	£40	£40	Forecast to be achieved in full
Total Forecast Achievement		**83.3%**	**£7,723**	**£9,274**	
Total achieved by CWFT for 2015/16 was 93.9%, £2.2m out of a maximum of £2.3m. In 2015/16 CQUIN only applied to West Middlesex, but in 2016/17 it applies to both sites.					

For 2017-19 12 CQUINS have been agreed; 7 National and 5 for Specialised Commissioning

Table 8 – Agreed CQUIN indicators 2017-19

National	Description
Improving staff health and wellbeing	To Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.
Improving services for people with mental health needs who present to A&E	Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.
Offering Advice and guidance	Improvement in access for GPs to consultant advice prior to referring patients in to secondary care.
NHS e-Referrals (2017/18 scheme only)	All providers to publish all of their services and make all first outpatient appointment slots available on e-referral service by 31st March 2018.
Supporting safe & proactive discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.
Preventing ill health by risky behaviours (2018/19 scheme only)	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.
Specialised Commissioning	**Description**
Enhanced Supportive Care	The scheme seeks to ensure patients with advanced cancer are, where appropriate, referred to a Supportive Care Team, to secure better outcomes and avoidance of inappropriate aggressive treatments.
Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy	A national incentive to standardise the doses of SACT in all units across England in order to increase safety, to increase efficiency and to support the parity of care across all NHS providers of SACT in England. A set of dose-banding principles and dosage tables have been developed by a small team of Pharmacists supported by the Medicines Optimisation CRG.
Optimising Palliative Chemotherapy Decision Making	Provision of optimal care for by employing SACT to review the full effect of treatment for patients with advanced cancer, starting or continuing chemotherapy by ensuring direct consultation with peers and the shared decision with the patient.
Hospital Medicines Optimisation	Improvement in productivity and performance in related medicines, by unifying hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine best practice and effective remedial interventions.
Neonatal Community Outreach	Ensure that neo-natal units are running at safe levels by improving utilisation of intensive care and high dependency capacity, through early discharge and community support, with an impact on patient flows and improvement in service provision.

Registration with the Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care in England. They register, and therefore license, providers of care services if they meet essential standards of quality and safety. They monitor licensed organisations on a regular basis to ensure that they continue to meet these standards.

Chelsea and Westminster Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'fully registered'. Chelsea and Westminster Hospital NHS Foundation Trust has 'no conditions' on registration. The CQC has not taken enforcement action against Chelsea and Westminster Hospital NHS Foundation Trust during 2016/17. To find out more about the CQC visit www.cqc.org.uk.

Chelsea and Westminster Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2016/17.

Secondary Uses Service information (SUS)

- Chelsea and Westminster Hospital NHS Foundation Trust submitted 1,641,574 records during April 2016 to March 2017 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. We are not able to get best/worst figures for NHS Number completeness and GMC Practice Code completeness. We have the national mean, which is the most important reference point.

Valid NHS Number

	2015/16		2016/17	National Performance		
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
A&E	96.4%	89.7%	91.6%	DNP	DNP	96.7%
Outpatients	100.0%	91.1%	94.0%	DNP	DNP	99.5%
Admitted patient care.	97.8%	95.4%	97.0%	DNP	DNP	99.3%

General Medical Practice Code

	2015/16		2016/17	National Performance		
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
A&E	99.9%	99.7%	99.8%	DNP	DNP	99.0%
Outpatients	100.0%	99.3%	99.9%	DNP	DNP	99.8%
Admitted patient care.	99.9%	99.8%	99.9%	DNP	DNP	99.9%

Information Governance Toolkit attainment levels

Information governance concerns the way in which organisations process information about patients and staff, and apply the necessary safeguards to ensure that its use is appropriate and secure.

The Information Governance Toolkit is an online assessment system that enables NHS organisations and their partnering bodies to measure how well they are complying with Department of Health standards on the correct and secure handling of data, and how well they are protecting data from unauthorised access, loss, and damage. The attainment level assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes. The Toolkit sets out specific criteria that enables performance to be assessed based on submitted evidence, resulting in a score between 0 and 3 for each of the 45 requirements for Acute Trusts. If anything less than level 2 in all 45 requirements is achieved, the overall score for the whole IG Toolkit is recorded as "not satisfactory".

Chelsea and Westminster Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2016/2017 was 66% and was graded green. For more information about the Information Governance Toolkit please visit Information Governance Toolkit.

Clinical coding error rate

The Chelsea and Westminster Hospital site was not subject to the Payment by Results clinical coding audit during 2016/17.
The West Middlesex University Hospital site was not subject to the Payment by Results clinical coding audit during 2016/17.

Data Quality

Chelsea and Westminster Hospital NHS Foundation Trust has/will be taking the following action to improve data quality:

- Manual data validation is undertaken by the Information Team based on reviews of information entered into the patient administration system and investigation of data underlying reported performance.
- Validation of patient pathways is undertaken by the performance team at C&W and the validation team at WMUH.
- Where issues are identified they will be investigated and corrected, however a formal mechanism for investigating the cause of recurring issues and determining corrective actions will be established.
- Known data quality issues should be logged by the performance team and for recurring issues a root cause analysis should be completed to understand the cause. A corrective action plan will be developed to support the relevant service to improve the quality of data input and reported.

- The Information and Data Quality policy will be reviewed to ensure it is current and appropriate for the whole Trust.
- A minimum frequency for completing refresher training on data entry into the patient administration systems will be established.
- Draft terms of reference have been developed for a Data Quality Improvement Group (DQIG) to provide focused review of data quality policies, strategies and reviews.
- The DQIG should report to the Executive Board to enable prompt escalation of emerging issues to the Board where required. The Chief Operating Officer, as the responsible Executive for data quality, should be an attendee of the DQIG to enable issues to be raised at the Executive Board.

Reporting against core indicators

The following data outlines the Trust performance on a selected core set of Indicators. Comparative data shown is sourced from the Health and Social Care Information Centre (HSCIC) where available.

Where the data is not available from the HSCIC then other sources, as indicated have been used. Where data has not been published this is indicated as DNP.

The West Middlesex University Hospital information shown for the 2015/16 period is from April 2015 until August 2015. The Chelsea and Westminster Hospital NHS Foundation Trust information shown is five months of CWFT only April to August 2015 and seven months of CWFT and WM site combined (September 2015 to March 2016).

Core indicators

Summary hospital level mortality indicator (SHMI)

	2015/16		2016/17	National Performance
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	National Average
Summary hospital level mortality indicator ("SHMI")	Data not published	0.86(better than expected)	0.85 (better than expected)	1

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has consistently maintained good performance with regards to mortality against national indicators.

The Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by:

- Mortality surveillance assurance is provided through detailed analysis of information from HES, SHMI, Dr Fosters and the internal mortality reviews
- A dedicated mortality review module has been developed within the Datix Safety

Learning system; the module provides a single repository for all in-hospital deaths and provides a platform for the recording and analysis of consultant led case reviews
- Trends requiring further investigation or trust response are documented within the Mortality Management Plan

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level

	2015/16 West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	2016/17 Chelsea and Westminster NHS Foundation Trust.	National Performance Worst	Best	Mean
Percentage of patient deaths with palliative care coded	29.90%	34.60%	31.50%	56.30%	3.90%	30.10%

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The on-going increase in recorded palliative care activity compared to the previous years is noted. This is reassuring and compares well with the national pattern of specialist palliative care service delivery

The Chelsea and Westminster Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Training and support for all staff involved in palliative care
- Roll out of the Gold Standards Framework (GSF)
- Implementation of 'Co-ordinate my Care'
- Implementation of the 'Compassionate Care Agreement' (personalised care plan)
- Extending a seven day face to face specialist palliative care nursing service to the WM site
- Appointment of medical and nursing staff, including two end of life care specialist nurses, a new consultant in palliative medicine at WM and a consultant post advertised for CW site

Patient Related Outcome Measures (PROMS).

Patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. PROMS data can be used to inform changes in service delivery. The scores reported are adjusted health gain as per national definition. The national performance is taken from the most recent nationally published data which is for the period April 2015 to September 2015, these national scores have not been published nationally for this period at the time of writing the report. For 2015/16 there are insufficient responses from C&W and WM to enable national reporting and no data is available locally.

Readmission rate (28 days) – 0-15 Age

There are no longer published national statistics on Readmissions within 28 days, so we have no national comparators to include.

	2015/16 West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	2016/17 Chelsea and Westminster NHS Foundation Trust.
Readmission (28 days) (0-15) (P00902)	4.9%	4.3%	1.7%

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The readmission rate on both sites has remained at a relatively low level. The indicators are reviewed as part of standard governance procedures in place within the Trust and any anomalies investigated.

The Chelsea and Westminster Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Both hospital sites now have senior paediatric medical cover in line with the RCPCH guidelines from 08.00 – 22.00 7 days a week, aiding in both the assessment of children presenting for treatment and those who are deemed fit for discharge.
- A Paediatric Assessment Unit was introduced at the WMUH site in 2015/16 and this has ahd a positive impact on the readmission rate during 2O16/17.
- On both sites there are rapid access clinics which enable on-going care to be accessed quickly, without an inpatient admission.

Readmission rate (28 days) – 16+ Age

There are no longer published national statistics on Readmissions within 28 days, so we have no national comparators to include.

	2015/16 West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	2016/17 Chelsea and Westminster NHS Foundation Trust.
Readmission (28 days) (16+) (P00902)	10.3%	6.3%	6.1%

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The indicators are reviewed as part of the bed productivity meeting within the Trust and any anomalies investigated.

The Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by focusing on:

Care of the Elderly

- Reviewing quality of discharge summaries to GPs. Establish access to System1 for OAST (Older Adult Support Team) clinic to enable sharing of notes with GPs
- Hounslow/Richmond Frail Elderly Workstream – Red Bag scheme, Care navigators in A&E, care coordinators, locality based MDTs and clinics
- Establish and expand model of one stop shop/hot clinics for care of the elderly to offer comprehensive, multi-disciplinary assessment and care provision with access to rapid diagnostic, therapies input, community and social care pathways

Discharge planning

- Review discharge planning and processes. Focus on more comprehensive discharge planning, started on admission, to reduce the risks of readmission
- Roll out of Red to Green days will identify reasons why discharge planning has not been effective and expected dates of discharge are not met, or frequently changed. Red to Green days is an approach that has been developed nationally to identify and tackle any delays which lead to a patient being in hospital for longer than they should be.
- Involvement in NWL/WLA integrated discharge project to support MDT discharge planning

Development of Ambulatory Care services

- Proposals to expand and standardise the AEC offer across both sites, looking at reducing both short term admissions and reducing LOS through offering AEC follow up for inpatients to enable discharge through developing pathways from ED, AAU and step up from GP/Community would support reducing readmissions

Responsiveness to personal needs

	2015/16		2016/17	National Performance		
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
Response to personal Needs. (P01779)	DNP	65.95	DNP	DNP	DNP	DNP

The patient survey results for 2016/17 are not due for publication until June 2017 so cannot yet be published in this report. Despite this there are a number of actions underway to improve survey results across the board.

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator forms part of the national patient safety survey and is reviewed alongside the friends and family test, complaints and incidents and not in isolation.

The Chelsea and Westminster Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Patient experience is a priority for the organisation; the previous year 2015/16 generated an action plan which was shared amongst key staff to take forwards. The 2016/17 Inpatient survey has shown some improvements from the previous year yet highlights room for improvements regarding care and treatment, which fits with 'Response to Personal Needs'
- An In-Patient Action Plan 2017/18 has been developed with staff which will be continuously monitored alongside the Friends and Family Test
- The patient experience group reviews the survey results along with other key metrics. Divisional leads are responsible for taking forward actions within their areas.
- Divisional patient experience metrics are in place however there is emphasis on staff engagement, to share good practice but also improve on the negative themes from results

Staff recommending trust

	2015/16		2016/17	National Performance
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	
Staff recommending Trust	**54%**	**82%**	**73%**	**70%**

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The indicators are reviewed as part of workforce reporting within the Trust and any anomalies investigated

Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:

- We will be holding open conversations with our staff over the next few weeks to discuss the results and action planning. Once this has been formulated, we will share with the Executive Board and the rest of the trust. We anticipate this to be at the beginning of June.

Venous Thromboembolism Assessment

	2015/16		2016/17	National Performance		
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
Percentage of admitted patients risk assessed for VTE	94.3%[18]	96.1%	89.9%	72.14%	100%	95.5%

Please note national performance is based on Q1-Q3

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The national target (≥95%) of adult patients with completed VTE risk assessments on admission to hospital was not achieved 2016-17. There is a difference in performance across the two sites, WMUH site did not achieve ≥95% but C&W did. The methodology for reporting differs on both sites making it difficult to capture on WM site.
- There is monitoring of VTE risk assessment completion rates with circulation of performance reports to clinicians to address and target areas to improve performance.

Chelsea and Westminster Hospital NHS Foundation Trust has taken the following actions to improve performance and quality of its services by:

C&W site:

- Weekly and monthly monitoring of VTE risk assessment performance, with circulation of reports to divisions, and support to those departments not meeting target.
- Audits on whether patients at-risk of VTE are prescribed appropriate pharmacological and mechanical thromboprophylaxis, unless contraindicated, performed on a quarterly basis by pharmacy staff.
- Audits on whether patients receive verbal and/or written information on VTE prevention, aware of the signs and symptoms of VTE and when to seek urgent medical attention.
- Patients who develop a hospital associated VTE event, defined as a VTE event occurring during or within 90 days of hospital admission, are investigated (root cause analysis) to identify VTE prevention measures and the contributory factors leading to VTE event, with implementation of an action plan to prevent future recurrence, and dissemination of learning to teams/department.

WMUH site:

- Changes are being implemented to the RealTime electronic VTE risk assessment to include assessment of a cohort group of patients e.g. day cases at low risk of VTE, changes to the VTE risk assessment fields, and inclusion of management guidance to assist the clinician with decision-making for the prescribing of appropriate thromboprophylaxis.
- Changes are being implemented for VTE risk assessment performance reports with introduction of weekly and monthly reports to feedback to divisions and departments, and identification of patients without a VTE risk assessment by ward, speciality and Consultant to target education.
- VTE risk assessment status to be displayed on ward whiteboards, with introduction on priority wards

- Audits on the prescribing of appropriate anti-coagulant therapy introduced and performed on a quarterly basis by pharmacy staff.
- The root cause analysis investigation has changed to identify patients with a hospital associated VTE event via radiology alert report and Datix incidents. Clinicians are requested to complete root cause analysis investigation to identify VTE prevention measures and the contributory factors, with identification of any changes to practice, and dissemination of learning to teams/department.

VTE agenda for both sites:

- Joint Thrombosis and Thromboprophylaxis Group introduced, with terms of reference and representation for divisions across both sites.
- Anticoagulation and VTE guidelines are in the process of being reviewed and updated for both sites. Published joint guidelines available on the intranet. Introduction of anticoagulation pocket guides at WMUH site.
- VTE patient information leaflets are in the process of being updated and available for both sites.
- VTE education provided to medical, nursing and pharmacy staff.
- VTE mandatory training will be standardised for junior medical staff across both sites.
- VTE ward rounds on medicine, surgical and obstetric wards to be re-established at C&W site and introduced at WMUH site.
- Standardising VTE pathways across both sites e.g. introducing a VTE management pathway for patients in lower limb immobilisation at WMUH site, extending thromboprophylaxis for hip fracture surgical patients at WMUH site
- Anticoagulation incidents are reviewed for both sites with education provided to departments and any changes to practice to prevent future recurrence

C – Difficile occurrence

The nationally published data on C difficile is in terms of absolute number, not in terms of per 100k bed days, and so we have no national comparators to include.

	2015/16		2016/17
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.
C. difficile occurrence per 100k bed days. (P01792)	6.72	5.02	4.2

Chelsea and Westminster Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The numbers of cases of C. difficile and the rate per 100,000 bed days has fallen year on year between 2007/08 and 2016/17

The Chelsea and Westminster Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Harmonising the Trust policy on the management of diarrhoea across both hospital sites
- Restricted antibiotic policy and prudent antibiotic prescribing.

- Enhanced daily cleaning and annual deep cleans of clinical areas
- Patients to be isolated in a side room within 2 hours of onset of diarrhoeal symptoms (WMUH site. C&W state ASAP)
- Staff to adhere to strict hand washing with soap and water, rather than the use of hygienic hand rubs, when attending cases of diarrhoea.
- Availability of hand wipes for patients prior to meals along with educating patients, carers and visitors to wash their hands; and in the case of visitors not to visit their relatives if they have symptoms of diarrhoea and vomiting.
- On-going training of staff and auditing of practice as set out in the Department of Health High Impact interventions.
- Root cause analysis of each case by senior medical and nursing staff caring for the patient, and development of an action plan to address lessons learnt which will be monitored at the quality and risk meetings.
- The outcome of the RCA will be reviewed by the Infection Prevention and Control Committee.
- The use of *Clostridium difficile* packs to aid early medical review and reduce the number of inappropriate specimens sent (C&W site only)

Number of patient safety incidents that resulted in severe harm or death

The data for this indicator is taken from the National Reporting and Learning System (NRLS).
The figures for lowest and highest scoring hospitals enable comparison with other acute non-specialist NHS Trusts and demonstrate the wide range of incident reporting across the NHS acute sector.

Number and rate of patient safety incidents		**CWFT**	**Lowest scoring hospital**	**Highest scoring hospital**
Oct 15-Mar 16	Number	3866	1499	11998
	Rate per 1000 bed days	26.82	14.77	40.89
Apr 16-Sept 16	Number	3793	1485	13485
	Rate per 1000 bed days	26.98	21.15	41.19

Number and % of patient safety incidents that result in severe harm or death		**CWFT**	**Highest scoring hospital**	**Lowest scoring hospital**
Oct 15-Mar 16	Number	21	26	20
	%	0.5	1.7	0.2
Apr 16-Sept 16	Number	13	1	18
	%	0.34	0.02	0.56

Chelsea and Westminster Hospital NHS Foundation Trust considers this data is as described for the following reasons:

- All staff at Chelsea and Westminster NHS Foundation Trust are reminded through a number of different channels (for example, induction) that all incidents must be reported on the local incident management system, Datix. To support this, the Trust employs a Datix Administrator who, together with the rest of the Quality and Clinical Governance team, provides training and is available for drop-in sessions and one-to-one support for staff.
- The Divisional Quality Boards include incident reporting as a standing item on their agenda as part of the on-going work to continually improve reporting rates.
- All incidents reported on Datix are reviewed by the Quality and Clinical Governance team prior to upload to the NRLS. As part of this validation process, if necessary the incident lead is contacted for further information to ensure that not only have actions been put in place to ensure safety, but that the details have been correctly recorded and the system updated to provide an accurate reflection of patient safety incidents across the Trust.

Chelsea and Westminster Hospital NHS Foundation Trust has taken/will be taking the following actions to improve this rate and so the quality of its services by:

- Continuing to focus our priorities on improving patient safety, in 2016 the Trust implemented a new and improved version of DatixWeb. This was not merely the latest available upgrade, it was customized in-house resulting in a bespoke patient safety reporting and learning system rolled out across all hospital sites.
- Patient safety incidents continue to be reviewed on a daily basis by the Quality and Clinical Governance team who escalate or take appropriate action when necessary.
- Serious incidents are investigated and the findings used to inform learning and quality improvement.
- Root cause analysis training introduced from May 2017 in line with national standards
- Investigation reports continue to be reviewed at both local level through morbidity and mortality meetings or quality and risk meetings and also at Board level via the monthly serious incident report.

Part 3 - Other information

Performance indicators

During 2016/17 we met the majority of the key standards that the Government and our commissioners—the NHS organisations that buy services from us on behalf of our patients—set for us, and only narrowly missed others. Doing well against these standards demonstrates that we are providing our patients with the best possible care. Below is a summary of some of our key performance for 2016/17. However, this should be read in conjunction with the main narrative of the annual report for a better understanding of the context of these performance measures. (*You can find details of our current performance, updated on a monthly basis, on our website at chelwest.nhs.uk.)*

NHS Improvement Risk Assurance Framework

The table below summarises the performance indicators for the Trust.

	Target 2016/17 Combined C&W and WM	Performance 2016/17 - combined year end position
Incidents of Clostridium difficile	16	14
All cancers: 31-day wait from diagnosis to first treatment	96%	99%
All cancers: 31-day wait for second or subsequent treatment: surgery	94%	100%
All cancers: 31-day wait for second or subsequent treatment: anti-cancer drug treatments	98%	100%
All cancers: 62-day (urgent GP referral to treatment) wait for first treatment	85%	87%
Cancer: two week wait from referral to date first seen comprising all cancers	93%	92%
Referral to treatment waiting times <18 weeks - Incompletes[19]	>92%	92%
A&E : Total time in A&E <=4hrs	95%	92%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		

Local Quality Indicators.

The local quality indicators are the same as last year. This provides us with an opportunity to review the key indicators that are important to us and the quality of patient care that our patient's receive. The indicators chosen are important not just to Chelsea and Westminster but to North West London as a whole. In determining the indicators we have focused on where we can embed and sustain improvements and share learning from the wider NHS. Falls and pressure ulcers are linked to the Trust's 'Quality Strategy and Plans for 2015 to 2018'. Having the same local quality indicators allows us to compare performance year on year.

Patient Safety

Pressure Ulcers

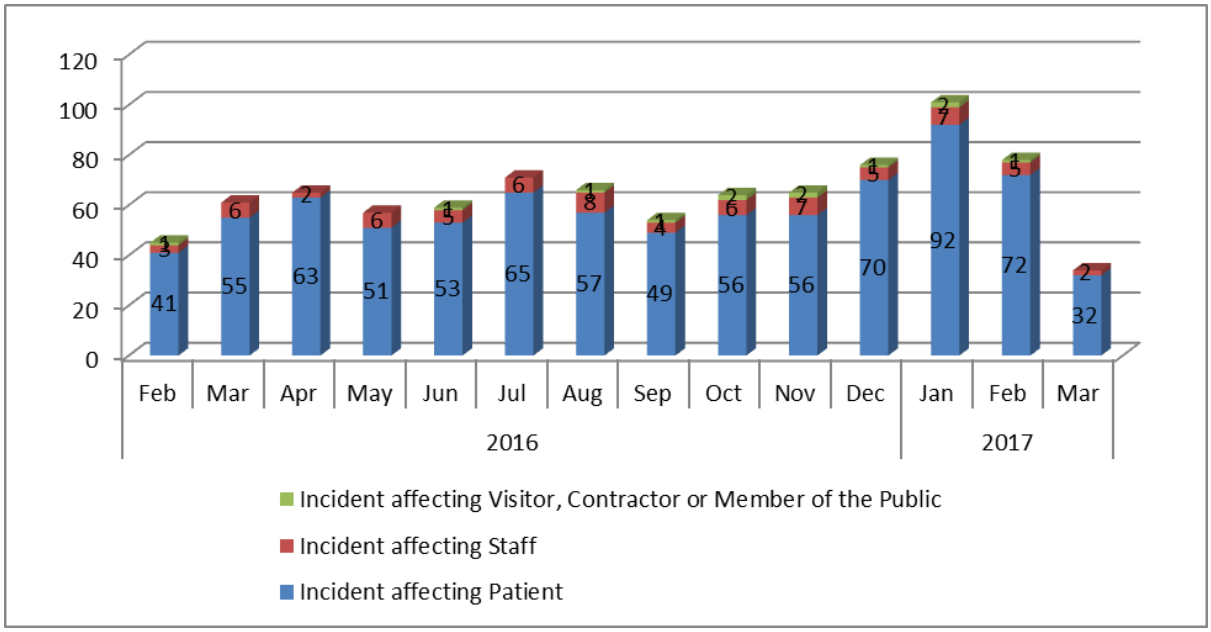
Prevention of hospital acquired pressure ulcers is crucial to the prevention of harm agenda. An update on pressure ulcers and the actions for 2016/17 was provided in the Our Priorites Section of this report. The table below provides an overview of the number of incidents reported on the Trust's incident reporting system on both sites during 2016/17 comparing to the previous year's data. This data shows that in addition to the decrease in the volume of grade 3 and 4 pressure ulcers documented earlier in this report, there has been a 24% reduction in grade 2 hospital acquired pressure ulcers. The focus in 2017/18 will be to continue to ensure timely accurate reporting. The Trust continues to be engaged in work across North West London on the prevention and reduction of pressure ulcers across hospital and community.

	2015/16 West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	2016/17 Chelsea and Westminster NHS Foundation Trust.
Grade 3 and 4 reported as Serious Incidents	**23**	**26**	**21**
Pressure ulcers (grade 2,3, & 4)	**199**	**205**	**291**
Pressure ulcers (grade 2,3, & 4 including community acquired)	**1072**	**792**	**1770**

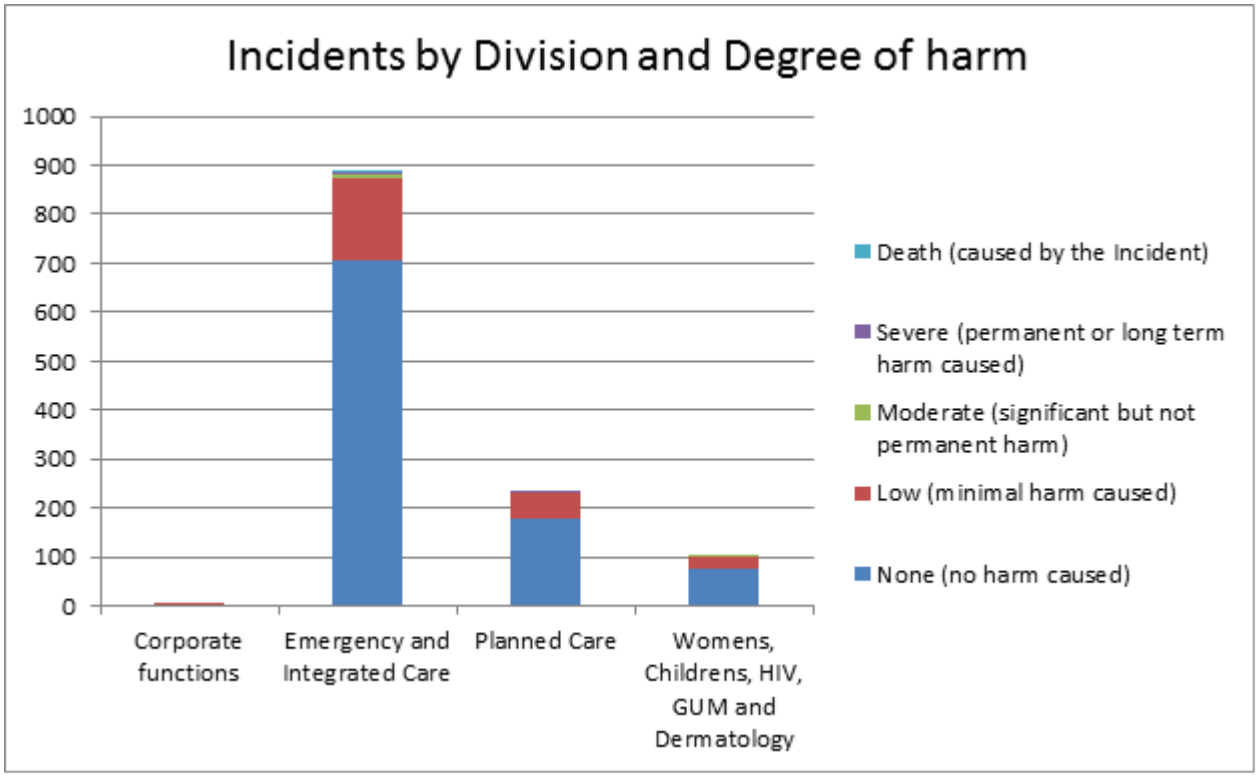
Falls

Falls are another indicator covered by the prevention of harm agenda. The prevention of avoidable falls remains a high priority for the Trust. Graphs 12 & 13 provide an overview of the falls reported on the Trust's incident reporting system. The Trust is showing a below national average for falls with harm, however there are too many preventable falls occurring. Graphs 14 & 15 which are taken from the safety thermometer data show the national median is 1.78, the median at C&W is 1.42 and WM is 1.6 both below the national position. Falls are a quality priority for 2017/18, the focus on falls prevention will continue and there will be agreed metrics to monitor progress. The work on falls prevention is reported quarterly to the Patient Safety Group and to the three Divisional Quality and Governance Meetings. Details of the objectives and plans for 2017/18 are detailed in the Quality Priority 2017/18 Section of this report.

Graph 13 Total Falls: Chelsea and Westminster



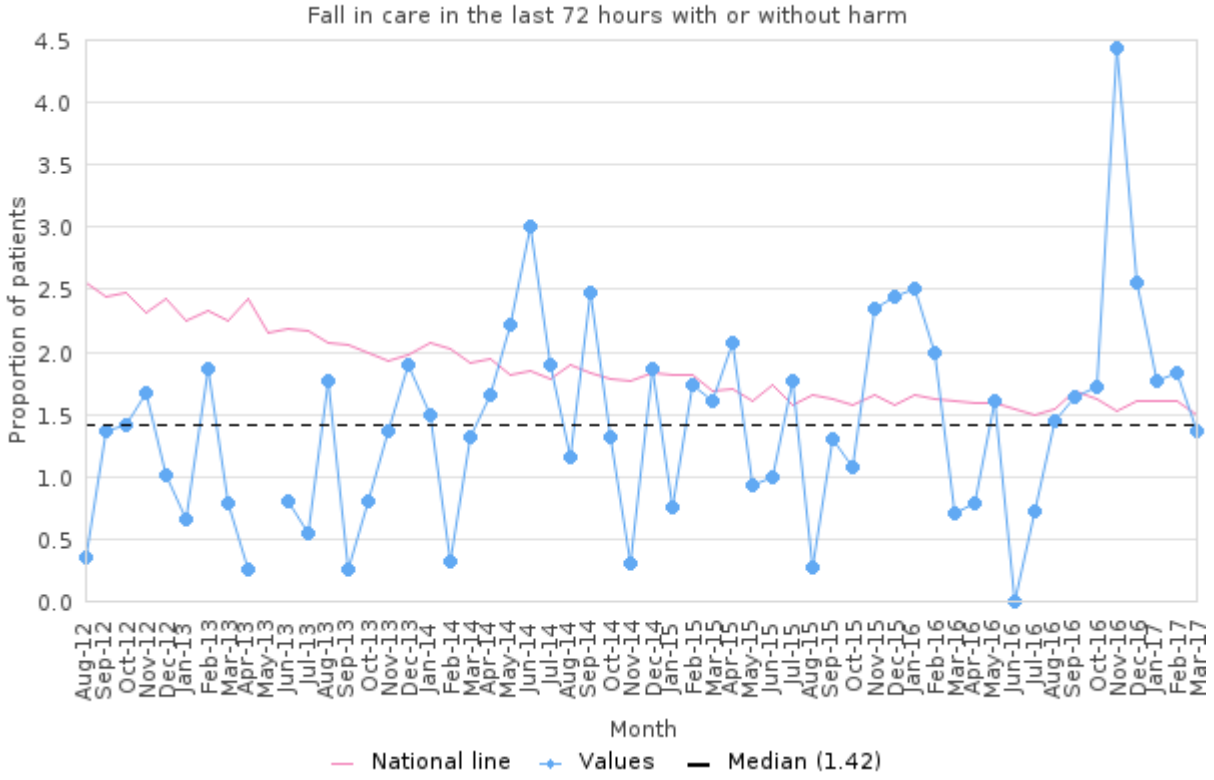
Graph 14 Degree of harm by division



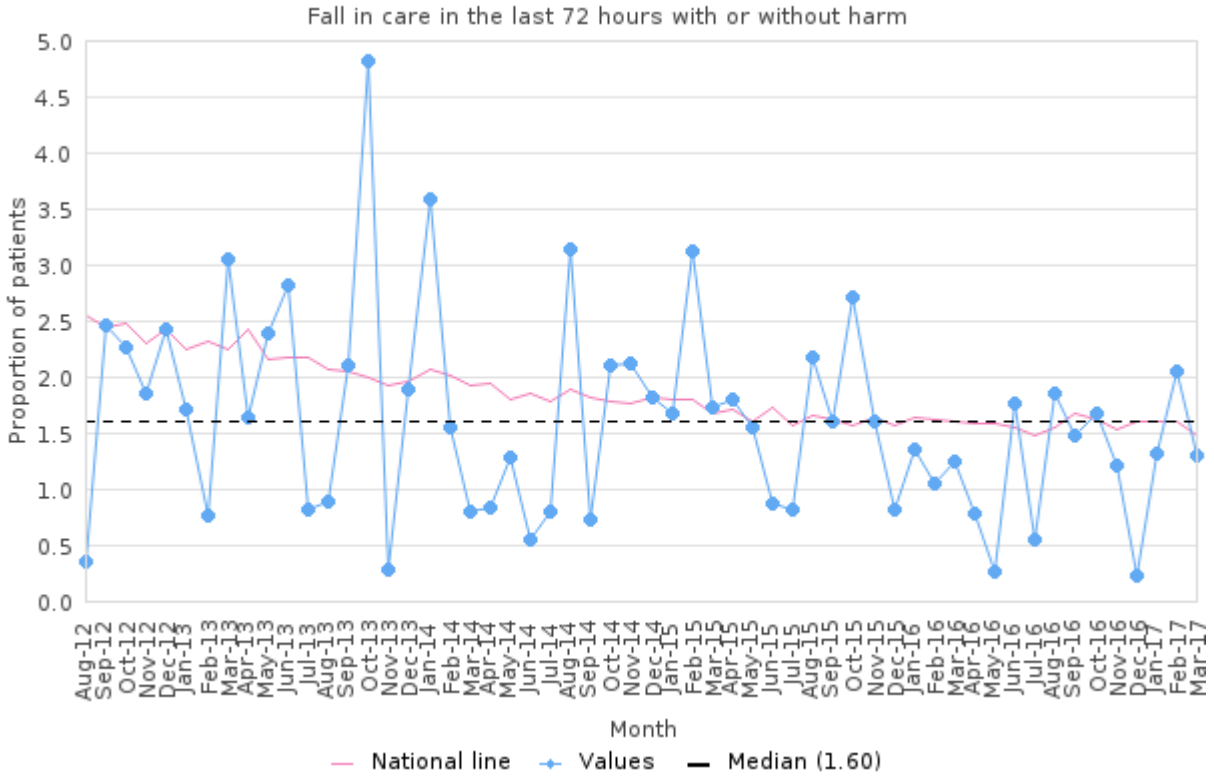
Key actions completed for 2016/17

- Assistant Director of Nursing appointed as Trust Lead for Falls Prevention.
- Joint Falls Steering Group established with an action plan
- Updating agreed training cross site
- Key metrics for 2017/18 agreed

Graph 15 Safety Thermometer Total Falls C&W



Graph 16 Safety Thermometer Total Falls WM



Patient Safety and Patient Experience

The trust is currently waiting for the National patient experience data to be published

	2015/16		2016/17	National Perfomance		
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
A&E/UCC Patient stay in A&E less than 4 hours Type1.	**90.40%**	**95.40%**	**89.46%**			
A&E/UCC Patient stay in A&E less than 4 hours Type 3.	**99.10%**	**N/A**	**N/A**			

Performance against the A&E 95% standard has been particularly challenging during the year, most notably during Q3 & Q4 across both sites. The non-elective demand facing the NHS has been the subject of much National media scrutiny and whilst the aggregate yearly performance for Chelsea & Westminster only met 92.4%, this is in no way reflective of the efforts of our staff. Demand has increased by c.10% compared to 2015/16 and Chelsea & Westminster remains in the upper quartile in terms of overall performance.

Clinical Effectiveness and Patient Experience

	2015/16		2016/17	National Performance		
	West Middlesex	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.	Worst	Best	Mean
18 Week RTT	**N/A**	**92.10%**	**92.00%**	**67.56%**	**100.00%**	**92.09%**
Cancer 2 week waits	**93.80%**	**95.30%**	**92.00%**	**75.00%**	**100.00%**	**95.42%**
Cancer 31 day diagnosis to treatment.	**99.50%**	**99.70%**	**99.00%**	**66.67%**	**100.00%**	**95.95%**
Cancer 62 days referral to treatment	**90.00%**	**87.10%**	**87.00%**	**0.00%**	**100.00%**	**79.05%**

To note the national performance data is based on February data as year-end is not yet published.

RTT performance over the year has been difficult, in the context of both increased referrals and non-elective demand. December was a particularly difficult month for the NHS as a whole and Trusts were asked to prioritise non-elective demand above elective demand, hence the standard in that month being only 90.7%. The Trust has made significant inroads in dealing with its longest waiting patients.

Whilst our performance in relation to the 62-day cancer GP referrals to first treatment standard has been excellent during the year, our compliance with the 2 week wait standard has been particularly challenging with a number of months where the required 93% has been missed. Both of our sites have experienced significant growth in demand from Primary Care with increased referrals compared to 2015/16. Colorectal services on the Chelsea site have been the single biggest challenged speciality during the year.

Patient Experience

	2015/16		2016/17
	West Middlesex University Hospital.	Chelsea and Westminster NHS Foundation Trust.	Chelsea and Westminster NHS Foundation Trust.
Complaints responded to within 25 working days	60.8%	62.8%	29.1%
Maternity Friends and Family Test (Post Natal response rate)	13.0%	28.7%	20.5%
Safeguarding Adults Training	91.80%	96%	87.30%
Safeguarding Children's Training	83.10%	92.60%	90.80%

During 2016/17 there has been a significant reduction in the number of complaints responded to within 25 working days. The following actions will be or have been put in place to improve the response times.

- Restructure of the complaints team including roles and responsibilities
- Patient Experience Module on Datix to be implemented. This allows visibility of process and timescales.
- Weekly meetings between complaints and divisions
- Number of outstanding complaints reviewed at senior operational groups

The FFT for maternity services is aligned to touch points, pre natal, birth and post natal. During 2015/16 there was an increase in the response rates for the post natal services on the C&W hospital site but a reduction at WMUH. Response rates for postnatal services continue to be a challenge as 42% of women that are delivered at C&W do not have their postnatal care provided by C&W. The low response rate is reflective of this. For 2017/18 the aim is to increase the response rates and to analyse the percentage recommended with the aim of reaching above 90% of women recommending the service.

Safeguarding training remains a key quality indicator for the Trust. There have been some challenges during 2016/17 which have resulted in the 90% target for safeguarding adults not being met at 87.3%. Safeguarding children was just above the 90% target at 90.8%. During the year there has been a review of the content of both adult and children's training in line with the national guidance and following an in-depth look at safeguarding a robust action plan is in place to help facilitate improvements in training compliance. The Trust continues to work closely with the Designated Professionals.

Other Quality Improvement Indicators

NHS England has requested additional consideration for 2015/16 reporting and NHS foundation trusts are requested to incorporate the information below for 2015/16.

Duty of Candour – How we are implementing 'Duty of Candour'

The 'Duty of Candour' is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
'Duty of Candour' aims to help patients receive accurate, truthful information from health providers.

This section of the report shows how the Trust is implementing the 'Duty of Candour'.

Duty of Candour ensures that we are open and transparent with our patients, their families or carers. We will inform, explain and apologise should something go wrong with the care and treatment we provide that results in significant harm.

Policy

Last year we reported that a policy had been developed and was being implemented. This has now been in place for nearly a year and been downloaded more than 200 times since publication. We plan to review our processes in the upcoming year to ensure they are fit for purpose.

Training and education for staff

The programme of training and education is on-going and is now also included as a regular slot within the management module for junior doctors. Members of the governance department are always available to provide training or updates on request and there are regular sessions within the Trust governance half-days.

The intranet site continues to be developed in line with staff feedback.

Documentation

- Checklist of completed actions (to be signed and dated)
- Documentation of the initial (verbal) notification and apology following the incident

These forms are not only available on the intranet but have also been developed within the Trust's Electronic Document Management system as 'e-forms'. This means they can be readily scanned and transferred in to the patient's notes.

Monitoring compliance

Compliance with the steps required to ensure our duty of candour is delivered is monitored within a specially developed section of the Trust's reporting and learning system. This is then reported within the monthly divisional quality reports which are discussed at the divisional Quality Boards and scrutinised at the Trust Patient Safety Group.

Patient safety improvement plan as part of the Sign Up To Safety campaign

What is Sign up to Safety

Sign up to Safety is a national campaign to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The aim is to deliver harm free care for every patient, every time, everywhere. Sign up to Safety champions' openness and honesty, and supports everyone to improve the safety of patients. The overall goal is to reduce avoidable patient harm by 50% and save 6,000 lives over 3 years.

As separate organisations West Middlesex University Hospital and Chelsea and Westminster Hospital NHS Foundation Trust had each signed up to participate in this campaign. Now as one organisation we are working to combine and refresh our strategy.

What are our pledges?

1. **Putting Safety First** – commit to reduce avoidable harm by half and make public our locally developed goals and plans.

   We will

a) Focus on preventable harm – Pressure ulcers, falls with harm (including environmental reviews and a focus on the link with dementia), the deteriorating patient (including the roll out of electronic NEWS – Think Vitals)

b) Continue to focus on infection control – environment (PLACE), visibility of hand hygiene being undertaken, utilisation of Sepsis 6 bundles, catheter related UTI's.

2. **Continually Learning** – make our organisation more resilient to risks by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.

   We will

   a) **Educate our staff and patients to improve all aspects of safety**
   b) **Focus on performance at ward and speciality level –** ensuring visibility of safety data to staff and patients in a standardised format using quality boards**.**
   c) **Ensure a formal plan of regular ward visits from Board Members and Governors,** including feedback to individual areas as well as the Board**.**
   d) **Ensure systematic analysis of all patient feedback mechanisms –** Complaints, Compliments, FFT, Picker surveys.
   e) **Provide a patient feedback session at each Board –** to offer patients, families and staff the opportunity to directly feed back to the Board their own experiences.

3. **Being Honest –** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

   We will

   a) **Provide regular opportunities for staff and patients to share their views**, and feedback on actions taken following these.
   b) **Ensure root cause analysis investigations are carried out where serious incidents occur, or themes emerge**, and share these with patients and carers, as well as with external stakeholders, in a timely manner.
   c) **Provide patients and families with the opportunity to meet with clinical staff and senior managers following complaints or incidents** to share understanding and learning.
   d) **Continue to foster an open and transparent cu**lture throughout the organisation.
   e) **Report to key stakeholders and internal committees/ Board** to promote thorough surveillance and scrutiny of patient safety and quality performance.
   f) **Continue to encourage staff to raise any concerns** regarding safety and quality within our organisation.

4. **Collaborating**. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

   We will

   a) **Work with patients and carers through our Patient Experience Group, as well as our Learning Disability Steering Group and Transition Group,** to ensure we are designing models of care which meet the needs of our patient group.
   b) **Utilise our transformation programme to provide effective, patient centred pathways** which continuously improve safety and quality**.**

5. **Being supportive.** Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress

We will

a) **Improve our feedback to staff individually and as groups,** following incidents, through the use of Datix online reporting system, and Clinical Governance Half Days, promoting shared learning from incidents.
b) **Through our Quality strategy continue to promote improvements** in quality and safety of care for patients.
c) **Continuously monitor the quality of care,** and challenge poor performance**.**
d) **Promote and encourage innovations in health care provision,** including the use of new technology.

How are we progressing?

We have now combined our strategies as above and are dividing the goals between the Divisions. Whilst each will have a Trust wide focus they will be led by the Division to which they most closely align. Within the Division a lead will be identified.

There will be a steering group, to involve patient representatives, which brings the strands together.

As a result of the two plans coming together progress with historical actions relating to 'Sign up to Safety' has not been as effective as we would have liked.

Future plans

A combined re- launch is being planned to engage staff and public in promoting safety and understanding what safety means to patients and families, which may be different to the meaning to staff. A priority is involving patients in promoting their own safety and questioning our practices.

The priorities have been developed in line with the Quality Plans, and need to be incorporated in this work.

Staff Survey Results

KF26 - percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months = 27%

KF21 - percentage believing that trust provides equal opportunities for career progression or promotion = 80%

The following measures are being put in place to address these indicators in the staff survey:

- We will be holding open conversations with our staff over the next few weeks to discuss the results and action planning. Once this has been formulated, we will share with the Executive Board and the rest of the trust. We anticipate this to be at the beginning of June.

CQC Ratings

Both hospital sites were independently assessed against the Care Quality Commission's Fundamental Standards during 2014/15 with a rating of 'requires improvement'. Action plans that addressed the themes that were identified were completed on both Trust sites.

The Trust has developed a systematic approach to monitoring of compliance with standards as set by the Care Quality Commission. One part of this work has been demonstrated by Senior Nurses and

Midwives working clinically with different multidisciplinary stakeholders in taking forward a weekly quality review or 'quality round'.

Quality Rounds

This process has been developed over the past two years and is an established and scheduled programme. The process has been established as a regular mandatory quality round to ensure:

- Professional leaders stay connected to the reality of delivering care
- Nurses and midwives are able to assure themselves and the organisation with regard to standards of care
- Senior staff are able receive direct feedback from patients on the care they receive
- Nurses and Midwives are able to use the sessions as an opportunity to refresh their clinical knowledge to support their professional development and the Nursing and Midwifery Council's Revalidation requirements to re-register
- Staff feel they are supported by their senior professional leaders being available and regularly visible

Ward Accreditation

Over the past year, a new system of ward and clinical area accreditation was launched. The system is a quality assurance and improvement process with the aim to oversee and assure the quality standards being met in all clinical areas. When a clinical area has been subject to the accreditation process it is then rated from 'white' to 'gold' in a similar manner to the CQC's grading system of regulation. The grading runs from gold being the highest rating noting excellent/outstanding practice, to silver, bronze and white to be the lowest grading.

The process aims to identify good practice in the clinical areas and for areas that need to make improvement, to facilitate support and guidance for these to meet the standards expected. The accreditation tool uses a template in line with the Care Quality Commission's (CQC's) Key Lines of Enquiry.

Key leads in the nursing, midwifery and multidisciplinary healthcare staff have completed a dedicated briefing to join the accreditation teams. The accreditation programme forms part of the Trust's on-going quality portfolio reviewing the quality of services offered to patients and relatives, stakeholders and the support to staff in the Trust's clinical areas.

The ward accreditation process was completed for all ward areas and some specialist areas on both sites by March 2017. All remaining relevant specialist clinical areas will be subject to the accreditation process. The process will be repeated at least yearly in every area on the programme.

Other work themes

Towards the end of the year a business case was awarded to the Trust by the Trust's official Charity CW+. This award permits the Trust to lead a pilot project to use a new web based tool to compile quality information during the ward accreditation process. This will support the substantial degree of data that is collected during accreditation and provide a more precise scoring system. This will mean Chelsea and Westminster NHS Foundation Trust will be one of only a handful of Trusts in the UK who will use this new innovation; aimed to release time spent on accreditation administration by healthcare professionals.

Other work to meet the requirements of the CQC has included a focus on enhancing patient documentation which has become a major work stream in the Corporate Nursing Division. Also through every department there has been an additional work programme to harmonise policies and procedures from the two organisations into one set of documents.

Chelsea and Westminster Hospital NHS Foundation Trust Board recognise its responsibility to have robust governance and oversight in place to ensure compliance with requirements of regulatory and professional bodies. Another area of work, the Trust Compliance Group is delegated to monitor compliance via a compliance matrix. The Compliance Group seek assurance in respect of any other specific compliance areas that fall outside of the generic testing used within the Ward Accreditation programme, in addition to Peer Review preparation and to include area or profession specific external visits and accreditations.

Over the past year there has been a programme of work to establish a direction for on-going quality improvement with the CQC's standards at the forefront of its direction. This has included completing action plans and merging a process for quality improvement into a sustainable programme for both hospital sites.

There remain a small number of outstanding actions on both sites resulting from CQC's 2014 inspections. Work is in progress for all of this small number of themes. These are highlighted in Table 9.

Table 9. Final outstanding actions following the previous 2014 CQC reports

Site	Issue	Update	RED/AMBER /GREEN rating
Chelsea and Westminster site	Patients with mental health issues spending long periods in the Emergency Department (ED), unable to access appropriate provision.	Following building work in both EDs there is more appropriate space available for these patients. There has been increased Child and Adolescent Mental Health Service (CAMHS) and psychiatric liaison support to review patients. Engagement with NHS England and West London Mental Health Trust/ Central North West London to improve provision of appropriate mental health beds.	
Chelsea and Westminster site	Patients are not always transferred from the Intensive Care Unit (ICU) to a ward within 4 hours of being medically fit. Patients on occasions are being transferred between the hours of 22.00 – 07.00 which is not the optimum time for patient transfer in terms of best practice.	The ICU leads continue to audit these incidents, and to highlight early in the day patients who are suitable for step-down to the ward area.	
West Middlesex	The hospital not meeting the national target of providing 'face to	Increased number of nurses and medical staff within the palliative care team has	

site	face' specialist palliative care services 09.00-17.00, 7 days a week.	been increased.	
West Middlesex site (relevant to both sites)	Provision of information in other languages to be accessible.	Using nationally available leaflets where possible. A number of leaflets are now available in 'Easy Read' format.	

Aside of the work undertaken in the Trust during the year, key Trust representatives have worked closely with the Trust's CQC's relationship manager to ensure key work is identified and taken forward to maintain firm working relationships by the Trust with the CQC.

Additional Quality Highlights

Council of Governors Quality Awards

During the year a number of Quality Awards were presented by The Council of Governors. The five highlighted below are an example of the awards presented.

Laser Clinic at 10 Hammersmith Broadway - HPV infection can cause harmless (but cosmetically significant) skin growths or warts, but also pre-cancerous changes in infected skin. The Laser Clinic at 10HB meets an unmet need and offers an holistic and patient-centred approach, treating all refractory warts and suitable ano-genital pre-malignant conditions in one clinic. Given the paucity of this type of service, regionally it also presents the opportunity to develop a referral clinic for patients from further afield.

The ICU Team - The ICU Airway Group team was set up following a critical incident involving a young ICU patient with a difficult airway. Issues were identified which the Team worked hard to remedy. Vulnerable patients now have an Airways alert at the head of their bed; an Airways alert handover was initiated; there is improved simulation training for difficult airways; there are new Airways trolleys throughout the Trust, and difficult airways patients are flagged on care plans. This project has enabled the staff to learn as a team in a supportive environment, improving confidence, competency and team-working skills.

Oliver Lynch, IV Line Practitioner - The Nurse-Led Vascular Access Service appointed a dedicated IV Line Practitioner enabling an improvement of choice of lines, skilled placement of lines and a programme of education for ward staff on optimisation of ongoing care. Oliver Lynch has driven the project and delivered the service. With the implementation of this project - "Right patient, Right line, Right time" – there is also potential to generate income through training of nurses from other acute Trusts and District nurses.

10 Hammersmith Broadway Re-location Team -Rachael Jones (Lead clinician of 10HB) and her team, working closely with the design and build team, successfully re-located the former West London Centre for Sexual Health (WLCSH) to 10 Hammersmith Broadway. The work involved was intense and all parties, patients especially, were consulted at all times in order to make the move successful and in order to provide a much higher level of service.

Kathryn Mangold and her Team - Kathryn Mangold (Lead Nurse for Learning Disability and Transition) and her team, consisting of carers of patients with learning disabilities and the Trust

Facilities team, worked tirelessly with the Changing Places Consortium to provide a Changing Places (CP)P toilet on the ground floor at Chelsea and Westminster hospital, Fulham Road. This is the first Changing Places facility within an NHS hospital in London. The parent carers worked with the architect, the building contractors, the lead nurse and the Estates and Facilities team to design the facility, including art work and lighting; they also advised them on the latest suitable equipment to install.

Additional Quality Improvement highlights

Clinical Innovation and Improvement Fellowship

Initiatives to improve quality frequently involve frontline staff, including junior doctors. However, hospital trusts do not always harness the knowledge and skills of this cohort.

Chelsea and Westminster NHS Foundation Trust has undergone significant recent changes, merging with West Middlesex University Hospital. The Trust is transforming and integrating following this, whilst continuing to strive for excellence in patient care. It was recognised that engaging junior doctors would be vital to this strategy

After an initial successful pilot with a single fellow, five junior doctors were employed by the Trust in August 2016 as Clinical Innovation and Improvement Fellows. These unique roles allow the Fellows to bring their clinical knowledge into the managerial arena and to develop their understanding of the inner workings of a hospital.

Three of the fellows are closely aligned to specific services, each working within one of the divisions, whilst the remaining two are aligned to the prestigious Darzi leadership programme and focus on issues spanning the Trust and community.

Currently, the Fellows are working on a wide range of improvement projects, including the development of a service to better care for the frail elderly patient group and the implementation of a new electronic patient record system. Fellows provide clinical advice to managerial staff and work with front line clinicians. They continue their clinical commitment and have a day a week working in a clinical setting, ensuring they are able to better understand the problems of clinicians, patients and managers in their areas. The fellowship is also part of the development of a wider Trust commitment to quality improvement and staff engagement, with particular focus on junior doctors.

A selection of their individual projects includes:

Red to Green

Red to Green is an approach that has been developed nationally in order to identify and tackle any delays which lead to a patient being in hospital for longer than they should be. Experience from other trusts that have used this tool have shown that it can improve patient care by tackling delays and also help staff caring for patients by solving the problems that they know lead to unnecessary delays and are often a source of huge frustration.

This approach began at the trust as a pilot on David Erskine and is now being rolled out across the trust. There has been a huge amount of clinical engagement in the project and feedback has been broadly positive with staff identifying how important it is to our patients. Whilst the approach is being rolled out we are seeing a change in how delays are identified and a new focused effort to ensure that patients receive the highest quality care in the shortest amount of time that clinically they need to be in hospital.

Choosing Wisely

The Choosing Wisely Campaign is a global initiative aiming to open up a dialogue between patients and clinicians about the best tests and treatments relating to their personal values and goals. Having these discussions can help us to avoid tests, treatments and procedures that are at best, ineffective

and, at worst, harmful. Aaminah Haq leads on the project to implement the Choosing Wisely principles throughout the Trust, by engaging doctors and patients in behavioural change. To date, an impressively detailed level of data around ordering behaviours has been analysed, patient directed campaigns have started and Choosing Wisely champions have been identified throughout the Trust. These champions are working on their individual projects on ways to stop overuse of tests, empower patients and develop doctor education. It is hoped that this project will improve patient experience and allow us to care for more patients with the same resources. Although this project is in its infancy, the national branch of the campaign, led by the Academy of Medical Royal Colleges, has highlighted how proactive the Trust has been in its early adoption of these principles.

FlexiStaff+

Locum and agency staffing is a significant patient safety issue for the trust as well as a huge financial pressure, as it is for trusts up and down the country. Last year a new approach was sought to ensure that locum and agency spend was decreased whilst providing optimum levels of medical staff to provide the highest quality of care for patients. This involved a new and innovative staff bank – FlexiStaff+ - which launched at the West Middlesex site in November 2016 and is due for launch at the Chelsea and Westminster site in spring 2017. Already FlexiStaff+ has filled over 10,000+hours of shifts at West Middlesex, providing significant cost savings to the trust whilst filling shifts with doctors approved through FlexiStaff+ and evaluated to ensure high quality of care

All of the projects undertaken by the fellows have excellence in quality of care at their core. Over the next few months of the fellowship the fellows will continue to work on a wide range of projects and look forward to showing the impact that they have had for their patients.

End of Life Care

The Trust continues to be engaged in a comprehensive plan led by the End of Life Care Steering Group to implement and deliver care, treatment and support for people moving towards the end of their life and their family/friends. This includes;

- training and support for all staff
- roll out of the Gold Standards Framework (GSF)
- implementation of 'Co-ordinate my Care'
- implementation of the 'Compassionate Care Agreement' (personalised care plan)
- extending a seven day face to face specialist palliative care nursing service to the WM site from July 2017
- Appointed additional medical and nursing staff, including two end of life care specialist nurses, a new consultant in palliative medicine at WM and a consultant post advertised for CW site.

The Trust continues with the development programme to become one of the first London Teaching hospitals to become a GSF accredited hospital, a kite mark for excellence in end of life care. The aim of the programme is to support clinical and non-clinical staff to deliver excellent end of life care, twenty four hours a day, seven days a week in line with the EoLC strategy.

In phase one 4 wards began the training process and will apply for accreditation in September 2017. The second phase of training began in June 2016 and a further 8 wards are undergoing training. Phase three will begin later this year and include all other clinical areas in the Trust. The plan continues for all clinical areas/wards to be fully accredited with the GSF standard of care within the next two years.

Working with the Friends Charity we have refurbished the Butterfly Room on David Erskine ward and completed two new Butterfly Rooms on Nell Gwynne and Edgar Horne wards, a further 3 rooms across both sites of the Trust will be completed by April 2017. Each Butterfly Room is designed to better support dying patients and their families. The refurbishment involves an upgrade in the clinical environment, coloured art panels for ceiling and windows and recliner chairs converting to single beds for relatives. Visitors from other Trusts have come to see and review the Butterfly Room concept.

Mortality Review

A quality initiative was established in October 2016 to provide a standardised process for the identification, review and response to all in-hospital deaths. This initiative aimed to provide increased opportunities to learn from mortality, drive service improvement and offer assurance to our patients and their families that the causes and contributory factors of all deaths are understood and acted upon.

Following a death the patient's clinical team meet to share and agree the reasons for the outcome and to consider if care could or should have been managed differently; the outcome of this review is recorded within a dedicated mortality review module to support wider trust learning.
If issues in the way care was provided are identified corrective action is supported by both a Divisional Mortality Review Group (chaired by the Divisional Medical Director or deputy) and the trust wide Mortality Surveillance Group (chaired by the Trust Mortality Lead).

Through systematic review of mortality the Trust continues to develop our safety learning culture.

Annex 1
Council of Governors

Governors' statement

Governors' comments on Quality Report

The governors have read the Quality Report with great interest and we are always amazed at the amount of commitment shown by staff in working toward continual improvement of the quality of care.

We governors fully endorsed ***the Reduction of Hospital Acquired pressure ulcers*** as a continued priority during 2016/17. It was noted that a cross-site approach to root cause analysis resulted in clear steps being put in place, which proved extremely helpful in dramatically reducing the occurrences of hospital acquired pressure ulcers.

The governors fully approved the choice of the ***Friends and Family Test*** as a Priority yet again, since there is still scope for improvement in the number of patients completing these tests. The FFT is a key measurement of patient satisfaction with the quality of care provided, so the fact that we are continually just under the target continues to disappoint.

The governors are pleased to see the ongoing commitment of our Research and Development department in their continued recruitment of patients to participate in clinical research, approved by a research ethics committee. This demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques, which go a long way to improving the quality of care.

The Ward Accreditation scheme introduced this year has proved very successful, with wards competing with each other to attain high status. The governors were delighted to learn that this system is a process of assuring that quality standards are being met and sustained in all clinical areas. We were also pleased to learn that with the help of our official hospital charity CW+ a new web-based tool was introduced as a pilot project to compile quality information. The accreditation work, utilising this work tool, while improving quality of care on the wards, is also gathering essential data which the CQC will require during their inspection.

The governors would also like to thank the Friends Charity for their support in refurbishing the Butterfly Room on David Erskine ward and for completing new Butterfly Rooms on Nell Gwynne and Edgar Horne wards. Their commitment to a further three rooms across both sites of the Trust is much appreciated.

With a keen eye to the continued quality of care provided to our patients, the governors continue to take an interest in the training and education of the trust staff. It was good to note that this is now included as a regular slot within the management module for junior doctors.

Good to see, too, that after an initial successful pilot with a single fellow, five junior doctors were employed by the Trust as Clinical Innovation and Improvement fellows. We governors shall follow their progress with great interest.

The governors continue to provide Quality Awards for innovations which improve the patient experience, or which improve the working procedures or environment of the hospital staff,

particularly where an idea which saves money can be rolled out cross-site. We are continually impressed by the standard of the applications we receive.

There continue to be disappointing complaints about the appointment system, especially where hospital letters are concerned. The governors will keep an eye on the number of complaints and look forward to the promised improvements this coming year.

We were disappointed, too, to see from the Staff Survey results that 27% stated they experienced harassment, bullying or abuse from other staff. This percentage is worrying and the governors will keep an eye on what plans are put into action to combat this situation.

The governors have been pleased to see that both the trust senior leadership and front line managers have continued to strive to achieve integration across the two main sites (in Chelsea and at the West Middlesex hospital). We have seen joint work taking place to improve both the patient experience and the feedback to staff in Team Briefings showing appreciation of their help with work on integration.

The governors would like to thank the staff of both sites for the hard work and dedication that goes into making us one of the top Trusts. We governors are aware that it is only through your continual efforts that we achieve high ratings in many areas. We want staff throughout the Trust to know how appreciated you are. Thank you all.

Susan Maxwell
21st April 2017

CWHHE Clinical Commissioning Group (CCG) –
Meeting held May 2nd all comments included will turn final comments around in a week

Healthwatch

Royal Borough of Kensington and Chelsea Adult Social Care and Health Scrutiny Committee – Details included in e mail

Royal Borough of Richmond Adult Social Care and Health Scrutiny Committee – Details included in e mail

needs to be sent to Hounslow OSC as well

Annex 2

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2016 to [the date of this statement]
    - papers relating to quality reported to the board over the period April 2016 to [the date of this statement]
    - feedback from commissioners dated XX/XX/20XX
    - feedback from governors dated 21/04/2017
    - feedback from local Healthwatch organisations dated XX/XX/20XX
    - feedback from Overview and Scrutiny Committee dated XX/XX/20XX
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
    - the [latest] national patient survey: February 2017
    - the [latest] national staff survey XX/XX/2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated XX/XX/20XX
    - CQC inspection report dated XX/XX/20XX

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the board

.....Date.....Chairman
.....Date.....Chief Executive

Annex 3

Independent auditors' limited assurance report to the directors of the Trust on the Quality Report

To be added in
Deloitte LLP
Chartered Accountants
St Albans
Date ??

Epilogue

About the Trust website

The maintenance and integrity of The Trust's website is the responsibility of the directors. The work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Your comments are welcome

We hope that you have found our Quality Report interesting and easy to read. We would like to hear what you thought of it, so please let us have your comments by using the contact details below. Please also let us know if you would like to get involved in helping us to decide our priorities for improving quality.

Would you like to stay in touch with the hospital by becoming a member and receiving our hospital newsletter, 'Going Beyond'. If so, please contact us—your details will not be shared with anyone else.

Write to:
Head of Communications
Chelsea and Westminster Hospital NHS Foundation Trust
369 Fulham Road
London
SW10 9NH
Email: communications@chelwest.nhs.uk

People and Organisational Development Committee, Chairpersons report to Council of Governors, May 2017

As the governors are now familiar with, this will be the first of what will be a bi-annual report to the Council of governors. It is intended to give you an overview of the activity and effectiveness of the People and Organisational Development committee. This report covers the 2016\2017 year.

About the Committee Chairman

I am from Kerry, which is in southwest Ireland, but I have lived in London now longer than I have lived in Ireland. I have almost always worked in healthcare and life sciences. Initially, for a major pharmaceutical company, subsequently for a number of communication consultancies, and eventually, I started my own company, Santé Communications, which became one of the worlds leading healthcare communication companies. My company covered corporate, financial, brand & medical communications, as well as employee engagement.

I sold the business to a management consultancy and exited in 2014. I am now an investor & advisor to pharmaceutical, biotech and start-up/scale up health corporations and I am a director of some of those. I was also chair of the Irish International Business Network, the largest and most highly valued global network of senior Irish business leaders and entrepreneurs around the club for the last two years.

I was appointed a non-executive director of Chelsea and Westminster FT in July 2014.

Committee Background and Terms of Reference

The committee was first established in March 2015. Until that point, all people related issues were addressed at the main board. It was clear to all board members that our people, probably our most valuable asset, needed greater scrutiny and assurance, and that a subcommittee of the main board was the most appropriate way to achieve that. It was thus agreed that we would establish the People and Organisational Development Committee.

Because it is a relatively new committee, the terms of reference have been through a number of iterations, including some re-vision following the merger with West Middlesex University Hospital, which we acknowledge as being both an opportunity, as well as a challenge on the People side, that is likely to take some time to fully resolve. In addition, we have spent some time thinking about how we focus on the pivotal issues around our people that impact on the organization to ensure we focus on those.

The committee terms of reference can be summarised via its key aims.

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

The Committee in particular looks at the following areas:

- People strategy and planning (including recruitment and retention)
- Leadership development and talent management
- Education, skills and capability (clinical and non-clinical, statutory and mandatory)
- Performance, reward and recognition
- Culture, values and engagement

Given the remit of the Committee, there are a number of groups that report into the committee, some of which are only recently formed, are namely:

- The Workforce Development Committee, Chaired by Keith Loveridge, HR Director
- The Education Strategy Board, which is chaired by Zoe Ball, Medical Director
- The Nursing Recruitment and Retention Group, which ongoing forwards will be chaired by Pippa Nightingale, Chief Nurse.

Committee Membership and Attendance

As a new committee, the membership has evolved and some of the individuals have changed due to promotions, interim positions, secondments etc.

Membership
Chair, Liz Shanahan, Non Executive Director
Jeremy Lloyd/ Nick Gash, Non Executive Director*
Martin Lupton, Ex-Officio member of the Trust Board, Imperial College representative
Lesley Watts, Chief Executive**
Zoe Penn, Medical Director
Peta Hayward/Keith Loveridge, Director of HR***
Karl Munslow-Ong/Rob Hodgkiss, Chief Operating Officer**
Libby McManus, Chief Nurse/Lucy Flanagan, Director of Nursing WMUH/Pippa Nightingale, Director of Midwifery / Vanessa Sloane, Director of Nursing***
Christine Caitlin, Assistant Director of Learning and Organisational Development
Tina Benson, Hospital Director WMUH
Mark Titcomb, Hospital Director CW
Adrian Kerr/John Kitching/Natasha Elvidge, Associate Director of HR ***
Don Neame, Interim Director of Communications

*Jeremy Lloyd stepped down as a member of the committee when he took his position as chair of the audit committee and Nick Gash replaced him.

** From July 2016, the CEO became a full committee member and the COO stepped down.

*** Changes in individuals but not in the function

Because of all the changes, it is not really appropriate to address attendance, but we would envisage being able to address this at the next Report.

Our people have been identified as one of our two most important priorities by the main board, so the focus of attention on this group is quite significant. Committee participation and contribution has been very good, and we have regularly invited additional individuals to present to us. As Chair, my approach is evolving as the Committee matures.

The approach/key items addressed by the committee.

Following our November 2016 meeting, we agreed that the committee would have three strategic sessions each year and three deep dive sessions each year.

At every meeting, we review Key Performance Indicators, which give us a detailed insight into our workforce parameters. It has taken a little time for the data to be robust and reliable, primarily because of the merger of two different systems between the two hospitals. We now have staff profile data which covers key areas such as vacancy rates, turnover, sickness, temporary staffing usage, core training, staff career development and staff performance and development.

There are a number of key issues, which need to be addressed by the Committee at least once a year, and in 2016/2017 the committee reviewed:

- The staff survey
- Medical staff annual appraisal and revalidation
- Nurse revalidation
- Statutory and mandatory training compliance
- Equality and diversity annual report
- Health and well-being
- The new performance and development review process

The key areas that the committee has reviewed in 2016/2017 are:

- A number of sessions on staff experience at CW covering, attraction strategy, recruitment process; retention strategies; exit interviews, nurse recruitment & retention.
- Detailed reviews of how the organisation is aiming to reduce its reliance on agency staff, including a review of the the bank process for nurses and Flexistaff, an initiative for bank & locum doctors piloted in West Middlesex University Hospital and now being rolled out at Chelsea.
- Our Leadership and Organisational Development program
- People related issues associated with the Integration and Transformation program
- The New Ways of Working, which included culture, values and engagement
- The impact of the junior doctor contract on the organisation, both in terms of the strike disruption as well as the implementation of the contract itself
- A deep dive on how the organisation engages with its doctors, particularly junior doctors
- Deep dive on the E rostering system for nurses
- Review on future nursing workforce including the Capital Nurse Project and Nurse Associates
- The impact of the apprenticeship targets and levy on the organization
- A deep dive on the Health Education England multi professional review of clinical education in 2016 and its recommendations
- Our first strategic session was on engagement with our people, learning from leaders outside of the NHS. An external speaker showcased best practice, followed by examples of how our engagement and values have been adopted by one particular team.

Committee Forward Plan

Our strategy meetings are addressing:

- Future workforce
- Behavioural change
- A review of novel IT solutions that can help with our most challenging people issues.

We are reviewing/undertaking deep dives on:

- Medical and other Education
- Temporary staff – bank and agency
- Workforce KPIs following the Audit by our internal auditors
- Detailed overview of how we have improved our employee experience and our retention & recruitment.

Conclusions - What's Working Well, What Needs Improvement

A Committee evaluation process was conducted in June 2016 and the overall evaluation was favourable. The Committee is evolving, the membership is evolving and there are some key issues we are addressing. Some of the challenges are not unique – many of our fellow London organisations have similar challenges. For a variety of reasons, some plans are only just coming into place. We anticipate significant improvements over the next 12-18 months on our key KPIs, which the People & organisational Committee will scrutinise appropriately.

This is a brief overview of the work of the People & Organisational Committee, and I look forward to answering any questions at the upcoming meeting of the Council of Governors.

Liz Shanahan
9th May 2017

Finance and Investment Committee (FIC) - Chairman's Report to Council of Governors, 18 May 2017

This purpose of this report is to provide governors with information about the activities and effectiveness of the Finance and Investment Committee (FIC). This report covers the committee's meetings during the period from April 2016 to March 2017.

About the Committee Chairman

Jeremy was appointed an NED of the Trust in July 2014 and was asked to chair the Finance and Investment Committee (FIC). He was made Vice Chairman and Senior Non-Executive Director when Sir John Baker stepped down on 31 October 2015.

He is an experienced financial and managerial trouble shooter with a track record of success in rescuing and turning around large complex organisations with multiple stakeholder groups.

He has been on the board of a number of companies over the last ten years, and chaired all the main committees primarily focussed on turnaround in a range of industries (Hotels, Technology, Steel, Healthcare, Property, Telecoms, News)

He was with Reuters between 1987 and 2002 in the Middle East, Far East and Sub Saharan Africa as a Finance and General Manager. He was with Cable and Wireless as CFO of Cable and Wireless worldwide in the period to 2007.

In 2011 he organised the rescue of the care home group Southern Cross and the turnaround of the retirement house builder McCarthy and Stone playing various roles including Chief Restructuring Officer, Chairman and CEO.

Committee Background and Terms of Reference

The aim of the FIC is to bring the finances of the hospital under scrutiny on behalf of the main board.

There are three objectives:

1) Oversight of Financial Planning and Performance
    a. Review budgets, annual and medium term targets
    b. Maintain an oversight as to the robustness of the Trusts income streams and contractual safeguards
2) Investment Policy
    a. Approve and keep under review the Trusts investment and treasury policy and ensure compliance by reviewing the Trusts' balance sheet and cash flows.
3) Other

a. Review proposals for major business cases prior to submission to the board (>£1m in budget >£200k out of budget)
b. Commercial and Private Patient growth strategy and business cases
c. All Capital Expenditure and business cases >£1m

Committee Membership and Attendance (April 2016-March 2017)

The Committee meets 10 times each year i.e. monthly except for August and December.

Membership	# meetings attended / expected
Chair, Jeremy Jensen, Non-Executive Director	10/ 10
Eliza Herman , Non-Executive Director	9/ 10
Nilkunj Dhodia, Non-Executive Director	8/ 10
Lesley Watts, Chief Executive	9/ 10
Sandra Easton, Chief Financial Officer	10/ 10
Karl Munslow-Ong, Deputy Chief Executive	8/ 10
Rob Hodgkiss, Chief Operating Officer	7/ 10

Committee proceedings are lively and robust with participation from all members. The committee moves through its large agenda at pace.

Significant Items Covered Since March 2016

At every meeting, the committee reviews:

- Monthly financial results
- Cost Improvement Programme (CIP) status
- Business cases as they arise
- Deep dive into an aspects of performance
- Capital expenditure forecast and plan (In detail at least twice yearly)
- Annual budget and plan preparation
- Forward diary of the committee's agenda

In the past Year the committee has reviewed the following major items:

- Deep Dives
    - Accident and Emergency (A&E) review
    - Theatre productivity
    - Bed productivity
    - Procurement
    - Temporary staff
    - Estates
    - Clinical administration
- Business Cases
    - Overseas recruitment
    - Neonatal Intensive Care Unit (NICU) & Intensive Care Unit (ITU)
    - Electronic Patient Record (EPR)
    - Shaping a Healthy Future (Sahf)
    - On-Line sexual health tender
    - Genitourinary medicine (GUM) Tender
    - Cardiac Catheter Laboratory (Cath Lab) business case
    - Contract Negotiations Update (2017-19)
    - Soft facilities management tender
    - Hammersmith sexual health Post Investment Review
- Other
    - Borrowing capacity
    - Cash forecasting
    - North West London (NWL) Sustainability and Transformation Plan (STP) Feasibility
    - Research and Development Expenditure
    - Service Line Reporting and review (main hospital departments)
    - Private Finance Initiative (PFI) performance review
    - Reference costs assurance
    - Carter programme status (Benchmarked productivity comparisons)

Conclusions - What's Working Well, What Needs Improvement

A Committee evaluation process was conducted in June 2016 by both the committee members and the main board, and the overall evaluation was very positive. The Committee was viewed as being effective in carrying out its aim of providing review and assurance over the finances of the Trust.

The impact of FIC is felt beyond the committee as teams are often asked to attend and present on their given area. FIC members often visit the parts of the hospital affected before the business case is presented. This interaction with the hospital and it staff is working well.

The committee is currently reviewing its own performance, one of the challenges is how to support the management team in achieving the 2017/18 CIP programme which has increased clinical focus in areas where we have struggled to improve productivity and reduce costs in the past.

The other main financial challenge faced by the Trust (and by most Trusts) is the increasing growth in Non-Elective Services (caused by ageing population, overstretched primary care and reductions in the provision of social care) which costs the Trust £18m more every year than it receives in income.

The cost improvement programme (CIPS) helps to plug the gap created by the increasing growth of Non Elective work and the annual national efficiency requirement which is passed to Hospitals through a real terms reduction in tariff.

Whilst the CIPs are challenging and the non-elective burden continues the Trust does have a medium term plan to ensure that it books are balanced over the coming few years (LTFM – Long Term Financial Model). Its Cash balances and working capital are currently robust compared to others in the sector and the FIC continues to work with and provide challenge to the executive team as we face into the issues of the NHS

Jeremy Jensen
19 April 2017

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM O.	1.5.5/May/17
REPORT NAME	Review into the quality of care and treatment and clinical governance processes provided in relation to three gastroenterology cases between 2012 and 2015.
AUTHOR	Vivia Richards, Head of Quality and Clinical Governance Zoe Penn, Medical Director
LEAD	Zoe Penn, Medical Director
PURPOSE	To provide the Council of Governors and the Chief Executive's Cabinet with a report of the findings of an independent review into 3 cases (one complaint/incident and two incidents), related to the gastroenterology services at Chelsea and Westminster Hospital. This review was prompted by concerns raised by a former staff governor member. The initial question in November 2016 was to specify the numbers of case reviews considered at speciality morbidity and mortality meetings which were thought to be CESDI Grade 0 to 3, at both hospital sites in 2016 and 2015. The questions was considered to be unanswerable without disproportionate resource put to it, because of the large number of patients and the fact that the proceeds from morbidity and mortality meetings were held locally at that time. Further enquiry of the staff governor revealed a general concern about 3 specific cases and the quality of care received by the patients and the quality of the management of the ensuing complaint or incident. As a consequence an external review of the clinical management of these 3 cases was commissioned from an external expert, who was also asked to consider the integrity and robustness of the clinical governance process.
SUMMARY OF REPORT	The report presents the findings and conclusions of an independent external review into the clinical management of 3 patient cases, associated incidents and complaints with their respective investigations, which took place in 2012 and 2015 at Chelsea and Westminster Hospital. Case 1: Appropriate clinical management. Resolution of the complaint was slow and resolution with the patient has not yet been achieved. Delay in recording this complaint as an incident. Case 2: Appropriate clinical management. No governance concerns identified. Case 3: Appropriate clinical management, but no prior agreement in the multidisciplinary team meeting prior to treatment. There were a number of overarching clinical governance recommendations for optimal clinical governance process. 1. To procure an electronic risk management system – COMPLETED April 2016 2. To convene a regular standing panel for review of serious incidents –

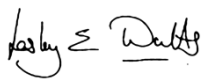
	COMPLETED 2015 3. To appoint a Clinical Director for Patient Safety – COMPLETED April 2017. 4. To review of the functioning of the multidisciplinary morbidity and mortality reviews to ensure that there is robust challenge to clinical decision making going forward and this will be undertaken by the Clinical Director for Patient Safety by July 2017.
KEY RISKS ASSOCIATED	Failure to provide excellent patient care
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Learning from experience means analysing and evaluating actual or perceived adverse events to make improvements and where possible prevent errors reoccurring. This process is critical to the delivery of safe and effective services. We can learn from investigation of individual incidents, staff or patient feedback and complaints. This approach is underpinned by the Trusts' commitment to working within a just and open culture in which staff and patients are encouraged to report any errors or incidents and raise concerns in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Council of Governors is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	1.6/May/17
REPORT NAME	Media Policy and Social Media Guide
AUTHOR	Donald Neame, Director of Communications
LEAD	Donald Neame, Director of Communications
PURPOSE	To share the two key Communications Department documents with Governors.
SUMMARY OF REPORT	As enclosed. It should be noted that section 8 of the Media Policy particularly applies to Governors.
KEY RISKS ASSOCIATED	The policies aim to reduce reputational risk for the Trust
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Adherence to the policies and guidance will promote the quality of our services and encourage continual improvement
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	All.
DECISION/ ACTION	For discussion/information.

MEDIA POLICY

START DATE:	Feb 2016	**EXPIRY DATE:**	Feb 2018
COMMITTEE APPROVAL:	Executive Board **DATE:** 10 Feb 2016	**CHAIR'S SIGNATURE:** 	
	ENDORSED BY: Communications Team	**DATE:** 10 February 2016	
DISTRIBUTION:	Trustwide, Board of Directors, Council of Governors, contracted staff, affiliated charities		
LOCATION:	Trustwide Policies & Procedures section of intranet		
RELATED DOCUMENTS:	• Web Communications Policy • Social Networking Policy • Communications Policy and Toolkit • Information Governance policies (including Freedom of Information) • Major Incident Plan		
AUTHOR / FURTHER INFORMATION:	Layla Hawkins, Head of Communications		
STAKEHOLDERS INVOLVED:	Communications Departments at both sites Executive Board		

FRONT LINE STAFF APPROVAL (NAME AND DESIGNATION)			
DOCUMENT REVIEW HISTORY: None			
Date	**Version**	**Responsibility**	**Comments**
NEXT REVIEW	Jan 2018		

1. SCOPE

This Media Policy sets out the Trust's processes for handling media enquiries, both in and out of hours, and what staff should do when they are contacted by the media in their capacity as a Trust employee, as an expert in their field (for example, in a particular medical or surgical specialty) or as a representative of another body (for example, a professional organisation, a trade union or a charity). It also sets out the Trust's process for foundation trust governors speaking to the media in their capacity as governors.

The Media Policy does not include the use of social media (for example, Facebook, Twitter etc) which is covered by the Trust's Web Communications Policy.

The handling and coordinating of media during a major incident is managed by the Communications Department and the approach is detailed in the Major Incident Plan.

It is the responsibility of all staff, volunteers, contractors working on hospital premises, foundation trust governors and Non-Executive Directors to adhere to this Media Policy.

2. INTRODUCTION

As a Trust, we engage with the media in an open and responsive fashion—we undertake media activity proactively to generate positive publicity and we respond reactively to legitimate media enquiries, often within tight deadlines.

The Communications Department takes a lead in generating positive media coverage and handling any potential negative media coverage in order to raise the profile of the Trust and enhance our reputation among patients, our local community, staff and other key stakeholders.

This activity includes issuing press releases and statements, facilitating TV documentaries, organising VIP visits, official openings of new facilities and other events that may attract media interest such as annual hospital Open Days, and maintaining good relationships with a wide range of journalists and media outlets.

The media is an important communication channel between the Trust and our key audiences including foundation trust members, patients, the public, GPs, existing staff and people potentially interested in working at Chelsea and Westminster.

Positive media coverage enables the Trust not only to maintain its reputation and high profile but also to market its service to the key audiences identified above. Negative media coverage damages our reputation and our potential to market our services.

At all times the Trust's media relations work is undertaken in a way that safeguards the confidentiality of our patients and protects our staff. This is managed solely by the Communications Department who support the following sites:

- Chelsea and Westminster Hospital
- West Middlesex University Hospital
- St Stephen's Centre
- West London Centre for Sexual Health at Charing Cross Hospital (and subsequently 10 Hammersmith Broadway)
- 56 Dean Street and Dean Street Express
- Other Trust-run off-site facilities

Staff are encouraged to get in touch with the Communications Department if they have stories that they think may be of interest to the media or if they believe an issue will lead to negative media coverage.

3. DEFINITIONS

The definition of media relates to all publications, broadcast channels, radio and online/social media. The definition of a Very Important Person (VIP) in respect of this policy relates to people with a high public/media profile who are either visiting or being cared for at the Trust.

4. STAKEHOLDERS

The following departments and staff groups that have been consulted with and involved in the production of this policy include:

- Communications Departments at both sites
- Executive Board

5. DUTIES

The Chief Executive has executive responsibility for the media management function, and is responsible for supporting the enforcement of this policy and to challenge staff and stakeholders who fail to adhere to its contents.

The Communications Department is responsible for all direct liaison with the media, ensuring Executive Director level approval of any press releases or responses, and for communicating this policy to relevant staff and stakeholders.

The Board of Directors, staff and governors are required to adhere to the requirements of this policy in full.

Affiliated charities are also expected to adhere to this policy when any media activity or VIP visits are likely to have an impact on the Trust.

6. CORE ELEMENTS

6.1 ROLES AND RESPONSIBILITIES

The Communications Department has overall responsibility for all media enquiries, filming and photography requests in the Trust.

All media and filming enquiries should be dealt with in the first instance by the Communications Department or by the public relations agency retained by the Trust to handle media interest out of hours—see below for information about what to do if a journalist contacts you directly and at the end of this policy for the Communications Department's contact details.

All significant reactive press statements, proactive press releases and filming requests are approved by the Chief Executive or another member of the Executive Department as appropriate.

The Communications Department provides the Trust's press office service between 9am and 5pm, Monday to Friday. The Communications Department liaises with all internal and external stakeholders as appropriate to each media request.

Jonathan Street PR are contracted to provide an out-of-hours press office service from 5pm to 9am, Monday to Friday, and at weekends and on Bank Holidays—an on-call press officer is available via pager 24/7.

In addition, the Trust's contract enables us to use Jonathan Street PR services if we require extra media relations support at any time.

6.2 MONITORING MEDIA COVERAGE

The Trust's Communications Department informs both the Trust Board and Council of Governors of media activity and coverage—especially potentially negative coverage of which it would be helpful for Directors and governors to be aware in advance of publication.

In addition, Directors and Governors will be updated verbally by the Chief Executive on media issues at Board and Council of Governors meetings as required.

7. YOUR RESPONSIBILITY AS A TRUST EMPLOYEE

All Trust employees should be aware of the Trust's Media Policy and adhere to it.

No member of staff should speak to the media in their capacity as a Trust employee without first informing and discussing with the Communications Department (9am–5pm, Mon–Fri) or the on-call press officer from Jonathan Street PR (out-of-hours).

No filming or photography should be set up or take place in the Trust without approval by the Communications Department.

If you receive a call from a journalist, or from someone who you suspect is a journalist, you should refer them to the Communications Department.

Many media requests can be an opportunity to showcase the work of clinical departments and the Communications Department is happy to facilitate all such requests.

If the media have approached you because they are interested in your work or research, want to interview you or have asked you to comment on a media story, please contact the Communications Department.

8. COMMENTING AS AN INDIVIDUAL, ON BEHALF OF ANOTHER ORGANISATION, AS A FOUNDATION TRUST GOVERNOR OR AS A NON-EXECUTIVE DIRECTOR

You may be approached by the media in a different capacity—for example, as a representative of a professional organisation or a trade union or as an expert in a particular specialty.

You may wish to speak or write to the media in a personal capacity.

Staff intending to speak to the media as either an individual or on behalf of another organisation should contact the Communications Department before doing so.

If you speak to the media in a capacity other than as a Trust employee it is your responsibility to make this clear to the journalist in question.

In addition, foundation trust governors and Non-Executive Directors intending to speak to the media in their capacity as a governor or Non-Executive Director should contact the Communications Department before doing so.

9. CONDITION CHECKS

Hospitals are often asked by the media for condition checks on patients who may have been in a road traffic accident (RTA), fire or another incident, or who may have a high public profile that means they are of interest to the media.

No personal details about an individual patient will be disclosed without the permission of the patient or his/her family or partner (next of kin).

If you are contacted by the media for a condition check on a patient you should refer them to the Communications Department. Do not give any information yourself.

10. MEDIA ACCESS TO THE TRUST

Any member of the media wishing to come onto Trust property must seek permission from the Communications Department.

Similarly, any member of staff wishing to invite a member of the media into a Trust department, ward or clinic on a hospital site or elsewhere must discuss the matter in advance with the Communications Department.

No member of staff at any level in the organisation should give or agree to give a media interview without first consulting the Communications Department.

No filming or photography should take place on the Trust premises without prior permission from the Communications Department—security staff will remove any film crews or photographers who are on the premises without the correct permissions.

11. VIP VISITS AND OTHER TRUST EVENTS

Any proposed VIP visit to the Trust should be discussed in the first instance with the Chief Executive and subsequently with the Chairman—they can be contacted via the Business Manager to the Chief Executive on 020 3315 6711.

Any formal invitation to a VIP to visit the Trust, for any reason, must be issued by the Chairman on behalf of the Trust.

Planning for a VIP visit can be complex and time-consuming. The preparations for such visits are managed by the Communications Department on behalf of the Chief Executive and Chairman, with support from senior staff at Jonathan Street PR who have more than 20 years' experience in this area. VIPs are always accompanied when visiting areas of the hospital.

Staff or foundation trust governors planning to organise external Trust events, especially those that may attract media interest, should contact the Communications Department as a first step.

12. VIP PATIENTS

The Communications Department need to be made aware of any VIP patients being cared for by the Trust because they may be the subject of media interest.

VIPs have the same rights of patient confidentiality as any other individual and that right is always respected unless they choose to 'go public'. As such, no information about VIPs is disclosed—the need for the Communications Department to be informed is to ensure that they can monitor the location, thereby helping to protect confidentiality.

The Communications Department will work with VIP patients and any PR advisers/publicists or family members on media handling.

13. PUBLICATION OF ACADEMIC PAPERS

If a member of staff has an academic paper accepted for publication by a journal, they are encouraged to inform the Communications Department if there is likely to be any media interest. It should be noted that some journals will notify the media about papers of particular interest or even issue press releases about their findings.

14. PHOTOGRAPHY AND FILMING

No filming or photography should take place on Trust premises without prior permission from the Communications Department—security staff will remove any film crews or photographers who are on the premises without the correct permissions. In all cases, a member of the Communications Department will need to accompany media when on hospital property and must have suitable notice in order to fulfil this requirement. Filming is not permitted out of hours unless in exceptional circumstances and with the approval of the Chief Executive.

Any patient being filmed or photographed will be asked to sign a written consent form—a copy should be retained by the ward or department where the filming or photography is taking place and a copy sent to the Communications Department. The consent form is enclosed in this policy as Appendix 1.

Consent forms are also required for any photography or filming undertaken by the Communications Department for use in Trust publications or on the Trust website.

The Trust is often asked if film, TV crews or still photographers can use the hospital for location shooting for a range of purposes including stock library footage, TV drama and light entertainment, feature films, and commercial advertisements. All such requests should be referred to the Communications Department.

Most of these requests are declined because such projects can be time consuming and disruptive to the normal working of the Trust, without obvious benefits to the organisation's reputation, although there are occasional exceptions and requests may be considered. Fees for commercial filming of this nature are negotiated on a case-by-case basis. Part of the fee will be provided to the department whose location is accommodating the filming and part of the fee will be provided to the Communications Department as they will have to coordinate and observe all the filming that takes place on site.

The Trust prioritises filming for news and feature items that directly relate to the Trust or long term TV documentaries that will have a demonstrable benefit to delivering the ambitions set out in the Clinical Services Strategy.

The Trust does not generally give permission for photographers to take stock library footage because these images can be used to illustrate negative health stories that have nothing to do with the Trust and can have a negative impact on our reputation.

15. TV DOCUMENTARIES

The Trust is often approached by independent TV production companies to be involved in documentaries. All such requests should be referred to the Communications Department.

Requests are considered on a case-by-case basis, usually only if the documentary has been commissioned for broadcast by a channel—in other words, we will usually only consider a proposal if we know the programme is going to be made.

Other criteria for proceeding include whether the documentary subject matter is aligned to the ambitions set out in the Clinical Services Strategy, whether the staff in the service are willing to support it, and the amount of disruption that it's likely to cause. The reputation of the independent TV production company is also a key factor.

If the decision is taken to proceed, a written contract will be drawn up for agreement by the Communications Department and the production company—this always includes the Trust's right to a pre-broadcast viewing for factual accuracy with a member of the Communications Department and appropriate senior clinical and managerial staff.

16. INQUESTS

Staff are obliged to provide evidence in person at inquests upon request by a coroner. Should an inquest provoke media attention, staff providing evidence are advised to leave once evidence has been given without talking to anybody outside court, instead referring journalists to the Communications Department.

17. DISSEMINATION

This policy will be disseminated via the Trust intranet. Regular media training for relevant staff is part of the Major Incident training programme.

18. MONITORING IMPLEMENTATION AND EFFECTIVENESS OF THE POLICY

In addition to the annual communications survey where staff awareness of communications policies is monitored, the Communications Department will alert the Chief Executive to any relevant staff or stakeholders who fail to adhere to the standards set out in this policy.

19. CONTACT INFORMATION

All media enquiries, requests for interviews or requests to film on Trust premises should be referred to:

Communications Department (Mon–Fri, 9am–5pm)

Chelsea and Westminster Hospital, St Stephen's Centre, West London Centre for Sexual Health, 56 Dean Street, Dean Street Express
Layla Hawkins (Head of Communications & Marketing)
T: 020 3315 6828 (x56828)
E: layla.hawkins@chelwest.nhs.uk

West Middlesex University Hospital
Richard Elliot (Senior Communications Manager)
T: 020 8321 6342
E: richard.elliot@chelwest.nhs.uk

For all out-of-hours enquiries across all sites, Jonathan Street Public Relations (Mon–Fri, 5pm–9am, at weekends and on Bank Holidays)
On-call press officer
24-hour pager: 07659 125 409

20. EQUALITY IMPACT ASSESSMENT

Describe the aims of the parts of the policy causing concern. n/a

Describe how the policy has a significant impact on the equality group(s) mentioned above. n/a

Does this amount to an adverse impact or unlawful discrimination? No

Describe what actions you will implement to eliminate any adverse impact (recommendations should be SMART—specific, measurable, achievable, realistic and timely). n/a

Describe stakeholder involvement and consultation in the Equality Analysis Assessment to assist with eliminating any adverse impact. n/a

Monitoring: Describe how the actions put into place to eliminate or reduce any unjustified negative impact will be monitored, including timeframes and accountability. n/a

PHOTOGRAPHY/VIDEO CONSENT FORM

I have agreed to be photographed/filmed and/or agreed for my child to be photographed/filmed. I give Chelsea and Westminster Hospital NHS Foundation Trust permission to use the photograph(s)/video or any part thereof, in which I/my child appear on the clear understanding that the photographs will only be used in an appropriate context and to support the work of the Trust.

Name of person being photographed/filmed (please print): _____

_____

If a child give date of birth: _____

Parent/guardian's name (print): _____

Signature: _____

Address: _____

_____

_____

_____

For official use:

Date: _____ Photographer/videographer: _____

Location: _____

Staff in photograph: _____

_____

_____

_____

Please return form to:
Communications Department, LGF, Chelsea and Westminster Hospital

YOUR GUIDE TO USING SOCIAL MEDIA

YOUR RESPONSIBILITIES ON SOCIAL MEDIA
USING FACEBOOK
USING TWITTER
USING INSTAGRAM

Communications Department
May 2017

YOUR RESPONSIBILITIES ON SOCIAL MEDIA

GUIDELINES FOR STAFF, NON-EXECUTIVE DIRECTORS AND GOVERNORS

INTRODUCTION

This guide sets out your responsibilities when using social media as part of your role at Chelsea and Westminster Hospital NHS Foundation Trust. We want to encourage you to spread the great comments and thanks we get via social media, but we also know that inappropriate use of social media can damage the reputation of the Trust and the individuals involved.

Our priority is the safety and wellbeing of our patients, their families and our staff. Be considerate of sensitive situations that may attract media attention for the safety of our patients and yourself. If in doubt, check with the Communications Department at communications@chelwest.nhs.uk.

WHAT IS SOCIAL MEDIA?

Social media is a range of computer-based technologies that enable the creation and sharing of information, ideas, interests and other forms of expression via virtual communities and networks.

The main social media channels are Facebook, Twitter and Instagram. Other popular channels include LinkedIn, Pinterest, Google+, Reddit, Snapchat, Tumblr, Twitter, WhatsApp and YouTube.

OUR AIM

We use social media to:

- Share news about our staff and patients
- Share our own health promotion messages and campaigns
- Share job opportunities
- Share good patient feedback and thanks
- We respond to complaints or poor reviews we respond and encourage people to contact PALS

OUR FOLLOWERS

Our followers are made up of a range of organisations, professionals, patients and staff (past and present). We have approximately 14,600 followers across our Twitter accounts; 2,100 across Facebook and just over 200 on Instagram.

OUR MAIN CHANNELS

Twitter

- www.twitter.com/chelwestft
- www.twitter.com/westmidhospital

Facebook

- www.facebook.com/chelwest
- www.facebook.com/westmidhospital

Instagram

- www.instagram.com/chelwestft

DOs

- If you decide to use social media for work-related purposes and you choose to display your job title/ association with the Trust we require you to add a disclaimer—*Views/opinions are my own*—to ensure that if you interact (and we hope you do) in a personal capacity, this is not seen as Trust policy or views.

- Be careful about the amount of personal information you post online. Most social media channels allow you to hide key information but if your name and photo are online, then journalists (and our patients) can contact you. Think about the aim of your online profile (for example, personal or work-related) and apply the right security settings and preferences to limit your audience appropriately.

- Take time to read the Trust policies, including the Media Policy, Web Communications Policy and Toolkit and the Use of Social Networking Policy. These are available on the intranet.

- Be aware of your personal responsibility for what you say on social media, and for any comments others may post on your profile.

- If someone tweets or posts to you and is upset about their experience at the hospital please consider carefully whether to respond. In some cases, it may be best not to reply to avoid "trolling". You may want to encourage them to contact PALS in the first instance, if appropriate. If comments are aggressive or inappropriate, such as targeted harassment, you can report this to Twitter/Facebook and we ask that you escalate this to the Communications Team.

- Keep your password safe.

- When registering with a website, understand what you are signing up to. Read the terms and conditions carefully.

DON'Ts

- Don't make negative comments about the Trust, patients or colleagues on a social network site.

- Don't identify any patients, or post information that may lead to the identification of a patient, without their consent. This would breach the Data Protection Act and/or your professional Code of Practice, and may have serious consequences. Retweeting or liking patient tweets or posts is fine, as the patient has chosen to put their identity in the public domain and is therefore deemed to have given consent.

- Don't say anything online that you wouldn't say publicly or wish others to hear—journalists can, and do, take things out of context.

- Don't post any information relating to the hospital operations or visitors during an incident. For instance, the media may not know we are receiving patients. Communications will be very considered on the external messages sent out. We may not wish to attract media attention or unwittingly confirm details.

- Don't upload photographs of patients or Trust staff taken in the workplace or wearing their uniform without their consent (consent should be written or witnessed in the case of patients—please contact the Communications Department for further details).

- Don't post sexually explicit, racially offensive, homophobic or other discriminatory remarks.

USING FACEBOOK

INTRODUCTION

Facebook is a social media and social networking service which can be used on mobile devices (smartphones/tablets) or computers and enables users to post text, images, video and audio publicly, to groups of people (such as friends and followers) or to individuals.

NEW USER REGISTRATION

- Smartphone and tablet users can download the Facebook app from your device's app store—App Store for iOS devices (iPhone/iPad), Google Play for Android devices or Microsoft Store for Windows devices. If you are using your computer to access Facebook, visit www.facebook.com.

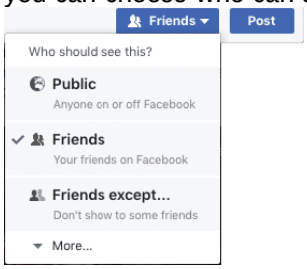
- Choose "Sign up" and follow the instructions to set up your account.

- Once you have registered your account we advise you to visit *Settings* and review your *Privacy*, *Timeline and tagging,* and *Public posts*. Most users set these so that only their added friends can see posts, interests and information. However, if you post on a public page such as www.facebook.com/chelwest, that post will be visible publicly to all Facebook users.

NEWSFEED, CREATING A POST, SEARCHES AND FOLLOWING

- Your **Newsfeed** includes your posts and the posts of your friends and organisations you like and are following.

- Your profile page has a **Create a Post** box for you to "*Post something...*" to your friends. There is no limit on characters and you can upload as many images, videos, graphics etc as you like. When posting you can choose who can see your post:



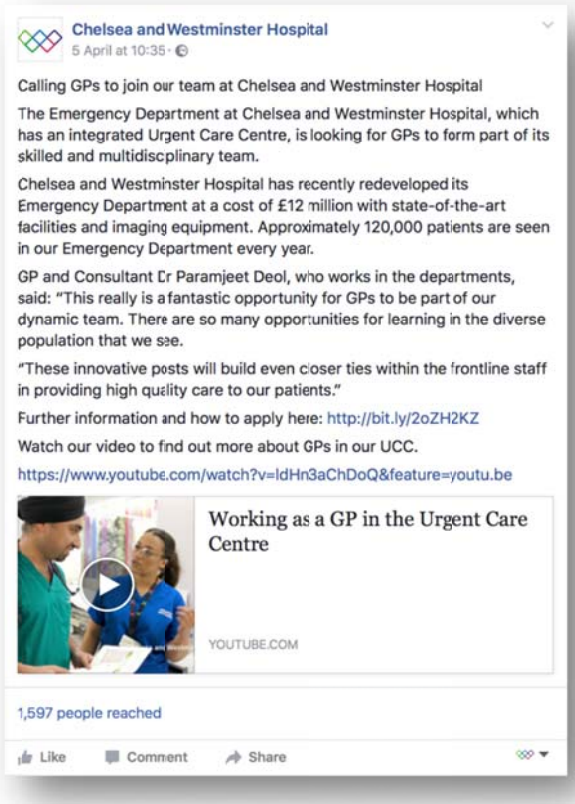
- You can also add photographs to albums (again, check your privacy settings).

- You can use the **Search Facebook** field to look for organisations, friends, colleagues or things which interest you. For example, search *Chelwest* and *WestMidHospital*—our official Facebook accounts are easily identifiable by our logo, so why not like and follow us?

    - Other profiles for our hospitals do exist as they have been created automatically based on location when visitors check-in. We do monitor these however we are unable to interact officially. Some departments such as Therapies, Chelsea Children's Hospital and Kensington Wing have their own pages. There are also social or community groups looked after by staff members or patients—these are not maintained by the Trust but you may wish to engage with them such as Chelsea and Westminster Hospital Friends http://www.facebook.com/groups/1744040345914167/

- You will see options on the organisation's profile page to **Like** and **Follow**. If you select *Follow,* posts will appear in your newsfeed but the Trust will not be aware that you can see our posts. We encourage you to *Like* our organisations so that we know you are following us!

INTERACTING WITH POSTS



Like

- Liking a post is different to liking an organisation. You are acknowledging a post and not automatically following the organisation. You can like a post by selecting **Like** underneath the post. If you select and hold **Like**, a range of reactions will pop up, which you can chose to express how you feel about the post.

Comment

- Select **Comment** or click in the text box below the post to write a comment. You may want to **tag** someone in your comment e.g. "Dr XYZ excellent work today!" If Dr XYZ is your friend on Facebook then Facebook will prompt you to tag her/him as you type his/her name and s/he will be alerted.

Share

- You can share a post onto your own personal profile page which will then show up in your friends' newsfeeds—just select **Share** underneath the post. We encourage you to **share** our posts so that more people can see the good work that we do in our Trust.

Hashtags

- **Hashtags** are recognised and searchable on Facebook if you want to use them. Try searching for #PROUDtoCare. You can include hashtags in both comments and posts—a hashtag will become a link which, when selected, brings up all posts on Facebook which contain this hashtag.

FURTHER INFORMATION

Need advice or help? See www.facebook.com/help or contact Katie Allen on 020 3315 6829.

YOUR GUIDE TO USING TWITTER

INTRODUCTION

Twitter is a news and social networking service which enables users to post and interact with messages limited to 140 characters. It can be used on mobile devices (smartphones/tablets) or computers.

NEW USER REGISTRATION

- Smartphone and tablet users can download the Twitter app from your device's app store—App Store for iOS devices (iPhone/iPad), Google Play for Android devices or Microsoft Store for Windows devices. If you are using your computer to access Twitter, visit www.twitter.com.
- Choose "Sign up" and follow the instructions to set up your account.
- Your Twitter username (known as your **handle**) is your unique identifier on Twitter and can be up to 15 characters—for example, ChelwestFT. Your username will also form the web address (URL) for your Twitter feed, in this case www.twitter.com/ChelwestFT.

TIMELINE AND FOLLOWING PEOPLE

- Your **timeline** (or feed) includes your tweets and those of the people and organisations you are following.
- When you register a new account, Twitter will suggest popular feeds to **follow**. You can also use the search field to look for organisations, friends and colleagues—just type in the name of someone you wish to follow.
- So that people's tweets appear on your timeline, go to their timeline and select the "Follow" button:

- On your mobile device, if you would like to receive notifications when someone you follow writes a new tweet, go to their timeline and select the notifications icon:

- You will start with no followers but as you tweet and follow others, engaging in conversation, this number will increase. Your followers are your audience who can read your tweets and may like, comment or share them by retweeting.

Who to follow

To get you started, we suggest following:

- @ChelwestFT
- @WestMidHospital
- @LesleyWattsCEO
- @donchelwest
- @jrbeckett162
- @penn_zoe
- @chelwestlearn
- @chelwestrecruit
- @NHSEnglandLDN
- @NHSEngland
- @RDH1974

MAKING YOUR VIEWS KNOWN

Tweeting

- A **tweet** is simply a post that is publicly visible. Twitter limits you to 140 characters. You can add up to 4 images or up to 30 seconds of video. Get started by selecting the Tweet icon:

Mentions (and replying to a tweet)

- You can engage with, or bring something to, a user's attention, by mentioning someone in a tweet
- An easy way to **mention** is to select the reply icon ( ) under one of their tweets
- You can also select the Tweet icon while on their feed, or type '@' and their username when composing a tweet
- Remember—this is not a private conversation and mentions can be seen by users who are following you and the user you're mentioning. For example, if you write "@ChelwestFT @WestMidHospital I am on Twitter!", the Trust's Communications Team will be alerted, and so will everyone else who follows us.
- If you would like to have a private conversation with someone, from their Twitter feed choose the direct message icon:

  If you do not see this icon, either the user has direct messaging disabled, or they have set their account to only accept direct messages from people they follow.

Liking

- You can let someone know you **like** or appreciate their tweet by selecting the heart icon ( ) under one of their tweets. They will be able to see that you've liked their tweet.

Hashtags

- A **hashtag** is used during a Twitter conversation to make it easier for other users to find all content related to a given topic or story. You can include them in your tweets or search for them. To create a hashtag, type '#' followed by the appropriate text. For example, if you type #PROUDtoCare, this becomes a link which, when selected, brings up all tweets on Twitter which contain this hashtag.

Retweeting

- A **retweet** shares (or forwards) someone else's message to your Twitter feed. @ChelwestFT will often retweet positive patient feedback and stories as well as staff news and comments. We would like you to retweet our stories so that all your (hopefully different) followers can see the good news. To retweet, select the retweet icon ( ) under the tweet.

FURTHER INFORMATION

Need advice or help? See www.twitter.com/help or you can contact Katie Allen on 020 3315 6829.

YOUR GUIDE TO USING INSTAGRAM

INTRODUCTION

Instagram is a mobile photo sharing service which is designed for use on a smartphone (it is possible to install on a tablet but the user interface simply scales up to fill the screen). While it is only possible to post photos using a mobile device, viewing, liking and commenting on photos can be done on any device, including computers, using a web browser.

NEW USER REGISTRATION

- Smartphone users can download the Instagram app from your device's app store—App Store for iOS devices (iPhone), Google Play for Android devices or Microsoft Store for Windows devices.
- Choose "Sign up" and follow the instructions to set up your account—you also have the option to sign up using your Facebook account.
- Instagram accounts are public by default, but you may choose to create a private account. Private accounts can only be viewed by users whom you approve. On your profile page, choose the settings icon (⚙) and switch on "Private Account". Note that this only affects new followers going forward, as your existing followers will not be affected.
- An easy way to monitor who likes or comments on your images, or when someone mentions you, is to set up notifications. Click on the settings icon (⚙) on your profile page and select "Push Notification Settings", then choose the options you'd like.

POSTING A PHOTO OR VIDEO

- Select the plus icon (⊕) at the bottom centre of your screen. On the first screen, you can either take a picture or video then and there, or choose a picture or video from your phone's photo library. Alternatively, you can also select the camera icon in the top left of the home screen or swipe right.
- When taking a photo with Instagram it will be cropped to a square. When posting a photo from your photo library, you can move around the photo to best position it within a square. However, it is also possible to post horizontally (landscape) or vertically (portrait) oriented photos by pinching the image—but this will leave white bands on either side of the image.
- The second screen allows you to edit your chosen and cropped photo to correct the colour and lighting, or apply a filter.
- The third screen enables you to add a caption or comment, and you can refer to the hospital (or another account) by typing '@' and the username, for example @chelwestft which will alert the Communications Team.
- You can also include a hashtag, for example #chelseaandwestminsterhospital or #westmiddlesexhospital.
- You also have the option to include the location information which makes the photo appear on a map—be aware that this is publicly viewable for standard accounts, and viewable by your followers for private accounts.

SEARCHING AND FOLLOWING

- You can use the search icon (🔍) in the navigation panel at the bottom of your screen to look for organisations, friends, colleagues. To follow us, search *Chelwestft* (we have one account for both sites) and then select 'Follow'.
- When a user posts an image or video on an account you follow, this will appear on your home screen.
- You can also search by hashtag and place. If you want to see what patients and staff are posting you can search under places or the most commonly used hashtags, which are #chelseaandwestminsterhospital and #westmiddlesexhospital.

INTERACTING WITH POSTS

Liking

- If you select a photo or video you will notice 4 icons underneath. Selecting the heart icon (♡) will show you **like** the post.

Commenting

- Selecting the speech bubble icon (💬) will allow you to **comment** on the post. You can also view comments posted to the photo/video and like and comment on these too. You can include hashtags in your comments which will become a link which, when selected, brings up all photos on Instagram which contain this hashtag

Sharing

- Selecting the paper airplane icon (✈) will allow you to send a link to the post to someone you follow.

Saving

- The bookmark icon (🔖) enables you to save the photo to your own collection, which only you can see.

FURTHER INFORMATION

Need advice or help? Visit help.instagram.com or you can contact Katie Allen on 020 3315 6829.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	2.2/May/17
REPORT NAME	Chief Executive's Report
AUTHOR	Lesley Watts, Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Governors are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Chief Executive's Report

March 2017

1.0 Major Incident

The C&W site declared a major incident on 23 March in response to the tragic events in Westminster. All our staff worked incredibly hard to ensure we provided patients and their families with the very best care possible. I would also like to take the opportunity to thank the other agencies, in particular the police and ambulance services who responded magnificently to what was a difficult, and at times chaotic incident.

Prime Minister Theresa May visited the hospital the following day to meet some of the victims and to personally thank key members of our staff who delivered such compassionate and timely care on the day. I'm sure the Board would wish to convey their thanks to clinical and corporate teams who worked tirelessly throughout, and demonstrated both the expertise and values of the organisation that make us so very proud to be part of a National Health Service.

As with all major incidents there are lessons to learn from our response and we have had a number of very helpful debriefing sessions with staff across the Trust.

2.0 Performance

The month of March was another busy and challenging month for the organisation in the delivery of our performance metrics. Whilst neither of our sites delivered against the 95% A&E standard, we saw a 2% improved performance from the previous month and ended the year at 92.3%, which was amongst the best performing Trusts in the country. We were successful in our appeal to NHSI for the full payment of Sustainability and Transformation Funds (STF) owing to our unprecedented and unplanned levels of demand.

We did not deliver in March against the required 92% RTT standard with a reported position of 90.6% in Month and an end of year position of 91.8%. The Board will be aware of the recently introduced large scale restructuring of the administration function on the CW site and, unfortunately this has had an impact on the way patients are booked in line with the Trust Access Policy, due to a high number of new staff in post. A full recovery plan is in place and the teams are working hard to rectify our position and ensure compliance as quickly as possible. Despite the months decline in RTT performance there were no reported patients waiting over 52 weeks to be treated and this is expected to continue. The procedural and administrative shortfalls also resulted in the in-month failure (96.88%) to deliver the 6ww diagnostic standard. This was the first failure to achieve the standard since August 2016 and was not due to lack of capacity. Investigation and subsequent audit has revealed that incorrect booking protocols were followed after a change of staff in March. Despite the in-month position, the Trust delivered 99.01% for the end of year position against the 99% standard.

All of the Cancer standards were achieved in March including 2 week wait performance, which has been a particular challenge on the Chelsea site for some months given the significant increase in demand.

Overall though, despite the challenges noted above especially in relation to non-elective demand and recent administrative changes, the performance for the year 2016-2017, when benchmarked externally, continues to place our Trust as one of the best performing and I offer my thanks and congratulations to the teams involved.

3.0 Care Quality Programme

This month we have focused on engaging with staff and partners about our Care Quality Programme in order to continuously improve the quality of care and experience we provide to our patients. Every ward and clinical department now has a senior management lead assigned to them in order to build direct engagement between senior management and front line staff and continuously improve our services. We will shortly be rolling out the new PROUD to care boards in all clinical areas. These will show daily monitoring of key aspects of care e.g. falls instances; ward accreditation; quality indicators, staffing names and numbers and patient feedback. We will also be publishing a handbook for staff about the programme, with a particular focus on preparing for a Care Quality Commission inspection.

4.0 Communications and Engagement

The monthly team briefings we hold at Chelsea and Westminster Hospital, West Middlesex University Hospital and Harbour Yard have focused on embedding new initiatives and learning lessons. Topics have included red to green days (which looks at anything that could be changed to help get patients home quicker); ward accreditation, CW+, the care quality programme, emergency preparedness, resilience and response. The latest Team Brief follows this report.

I have started providing a fortnightly email to all staff to talk about our key strategic and operational priorities, share outstanding examples of work I have seen whilst visiting clinical and corporate areas, as well as some of the fantastic feedback we have received from patients and families via social media. Staff have commented to me that they welcome this additional form of communication and we will continue to work hard to provide the right channels for communication and engagement that ensure staff feel supported and heard.

We have issued media releases on a range of topics including: the investments we've made to gynaecology facilities at C&W; encouraging women to complete the 2017 maternity survey; our recognition as an apprenticeship training provider; our selection as a Global Digital Exemplar with Imperial College Healthcare; our recruitment drive for GPs to join our Urgent Care team at C&W; and an innovative screening project developed at WMUH which has improved the detection of abnormal heartbeats by turning smartphones into heart monitors via a secure app. We are participating in a number of broadcast programmes including a BBC3 documentary about Lesbian, Gay, Bisexual and Transgender (LGBT) and mental health; the popular children's show Operation Ouch where we will showcase the role of male midwives; and we are supporting our mental health colleagues on a documentary about the care of people with eating disorders.

Later this month I am looking forward to meeting the HIV team in Harlow who joined the Trust on 1 April. The eagerly awaited C&W Open Day is on Saturday 20 May and I hope to see many of you there.

5.0 Elections and Purdah

Following the announcement of the General Election on 8th June we have had confirmed the following election milestones

- 22 April Purdah commences (see below)
- 3 May Parliament dissolves
- 11 May All Parliamentary Prospective Candidates confirmed
- 22 May Deadline for voter registration
- Mid-May Manifestos expected to be published
- 8 June Election day
- 9 June Election results announced (if a government is formed immediately, purdah will be lifted)

It is important to note that we are now in a period Purdah and we have reminded staff of our responsibilities in the run up to the election.

6.0 Finance

The year-end accounts have been drafted and the final accounts will be approved by the Board on 25th May. A huge thanks to the finance team for submitting our draft accounts on time despite Easter. Draft full year figures are consistent with our forecast position and means that the Trust has been eligible to receive some incentive based Sustainability and Transformation Funds that other Trusts have failed to achieve in recognition of our financial delivery.

In 2016/17 we delivered an impressive 96% of our Cost Improvement Programme (CIP) which is a great achievement. This level of delivery means we have been able to submit a capital plan for next year which will see investment in our IT infrastructure, our wards and our medical equipment. If we had not delivered our CIP's we would have finished the year in deficit and would not have cash in the bank to spend on the capital programme.

However, whilst we have achieved our 2016/17 surplus plan, this was after we received significant sums of non-recurrent funding from the Department of Health and NHS Improvement. This means we have 2 years to deliver our CIPs at the level required to get us back into financial balance. We will be back in sustainable balance when we stop spending more money than we receive for the work we undertake. At the moment we spend £2m a month more than we receive from our commissioners so there is much hard work to still do.

7.0 North West London Pathology

1st April was the official 'go-live' date for North West London Pathology which is collaboration between our Trust, Imperial College Healthcare Trust and Hillingdon Hospital Foundation Trust. This is a major milestone in the development of pathology services in North West London, bringing together the skills and expertise of pathology staff from the three Trusts to build a modern, integrated service that will drive innovation and enhance the quality of services for clinicians and patients across North West London and beyond.

A huge amount of work has recently been undertaken in transferring staff to the new venture and putting in place a senior management team and Board, including the recent appointment of a new Chair. The next 12 months will be incredibly busy as we look to embed the new structures and implement a single pathology IT platform as part of the new venture. I will continue to keep you updated on progress throughout the year.

8.0 RM Partners

RM Partners is the Cancer Alliance across north west and south west London and covers a population of 3.9 million people. It is hosted by The Royal Marsden NHS Foundation Trust and comprise of all NHS acute trusts in west London, as well as representatives from our two STPs and the Specialised Commissioning. It collaborates across the health economy with our clinical commissioning groups, community services, hospices, and third sector and voluntary organisations.

Through critical review of the wider system data and understanding the priorities of both STPs, we have collectively agreed to focus our resources and attention on the lung, prostate, colorectal and Upper GI pathways. The data shows that by improving these pathways – and giving our population parity of access to the most innovative technologies – we will make the biggest impact on diagnosing cancer earlier and reduce variation in performance across tumour groups.

To deliver on the vanguard objectives the programme has set an ambitious programme of work to the end the March 2018 when the funding ceases. This can be grouped under three overarching themes:

- **Transforming the clinical model of delivery** through the use of early diagnostics and pathway redesign to reduce variation, as well as medicines optimisation and improving access to palliative and end of life care. We will develop and roll out best practice, evidence based pathways for our key tumour groups.

- **Implementing enabling infrastructure**, by exploring the option of single budgets and lead provider models, establishing shared accountability mechanisms, and looking at models to strengthen and streamline commissioning across the system, as well as introducing cancer specific patient feedback.
- **Changing the system architecture**, such as the use of replicable dashboards, outcomes measurement and shared reporting will help to reduce inequitable variations in care across geographical areas. We will also explore and develop new workforce models to make our pathways sustainable.

Our senior team are actively engaged in the alliance to ensure we appropriately represent the interests of the trust and ensure we support progress in the key objectives set out. I will continue to provide regular updates on this important programme of work.

9.0 Partnership Board Meeting with Imperial College Healthcare Trust

We held a very constructive meeting with our ICHT colleagues in April as part of our now established governance arrangements between the two trusts. We discussed a number of our existing work programmes including our shared Electronic Patient Record (EPR) and Global Digital Excellence projects and reflected on an incredibly successful EPR launch event for the Trust which was very well supported by ICHT colleagues.

We noted good progress with the North West London Pathology venture and the significance of standing up the shadow board arrangements from 1st April. We discussed, at length, the STP arrangements and noted both the progress of number of programmes of work but also the requirement for the system to be better focused on a smaller number of priorities.

Finally we received a progress update on the West London Genomic Medical Centre and an overview of potential future work programmes that the two trusts were currently considering. We will meet again in early July.

Lesley Watts
Chief Executive Officer
May 2017

Team briefing

April 2017

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

Tell us why you are #PROUDtocare on Facebook or Tweet @ChelwestFT or @WestMidHospital

HERE AND NOW

CW+ PROUD Award winners
The first of our CW+ PROUD award winners have been announced. Each month, the divisions will recognise an individual or a team that has exceeded expectations and gone the extra mile in carrying out their work. If you would like to nominate a team or individual please see the intranet for details. Well done to all our winners and thanks to our charity CW+ for kindly sponsoring these awards.

Planned Care: ENT and Audiology
For their professional, proactive team approach during an IT upgrade; working evenings and weekends to book patient appointments, review them in clinic and ensure the data was uploaded on the audiology system.

Emergency and integrated care: Rainsford Mowlem ward
For remaining optimistic and positive, striving to deliver the best care they can for patients under increased pressures. The resilience and hard work of this small team, on a new ward, is commended, and in particular the ward manager Haroun Kamara.

Women, neonatal, children and young people, HIV/GUM and dermatology: Assisted Conception Unit (ACU)
For dealing with exceptionally high levels of activity in February. While under these pressures Dr Paula Almeida, Dr Julian Norman-Taylor, Sarah Campbell and Magda Krolak joined together to ensure that a time sensitive procedure was performed that exceeded patient expectation.

Corporate: Lauren Healy, Medical Workforce Co-ordinator
Since Lauren has taken up her post as Medical Workforce Advisor her contribution to the new model of operation is outstanding; her responses are timely, courteous, and thorough and she always explains her reasons for actions clearly and manages expectations well.

Performance update – February 2017
This month we were again compliant with the Referral to Treatment (RTT) target so well done to all who have contributed to this achievement. WMUH remain complaint with work streams in place to further improve the position. CW site, whilst not reaching 92%, shows improvement in month with significant progress in both the medical and surgical adult surgical specialities. There are no patients waiting over 52 weeks to be treated on either site for the sixth successive month, which is fantastic for patient care and experience, so thank you.

We continue to meet the cancer 62 day target from GP referral to treatment, but remain challenged by the two week wait referral to first appointment target. We have seen a significant increase in urgent cancer referrals to both our hospitals over the last year and teams continue to ensure they are responsive, with additional capacity to meet this demand. We are working with local GPs to ensure that this referral pathway is used appropriately.

Westminster incident Wednesday 22 March
Thank you to all our staff who helped us provide timely care under extremely challenging circumstances last month following the tragic events in Westminster. Two debriefs have already taken place and there will be a Board report on lessons learned. Please can all departments review their local cascade systems and staffing, it is essential that your contact list is ready at all times. If you feel you are not prepared for a major incident, please contact Catherine Sands to arrange training (including prevent) and ensure that you read our Emergency Preparedness plans on the intranet.

Financial update – February 2017
Our year to date adjusted surplus position is ahead of internal plan by £0.93m. However pay costs are overspent, predominantly due to medical pay. This overspend has been offset by underspends in non-pay and revenue in excess of plan. We planned to achieve 91.67% of our savings target by the end of February and only achieved 85.33%. We are now forecasting that our year-end target figure of £21.6m will not be achieved by £0.9m. This is disappointing and we must get a firmer grip on our finances now for the upcoming year which is set to be more challenging, but achievable. We must make sure that everyone takes responsibility for achieving efficiencies.

The Care Quality Programme
The Care Quality Programme has been established to create a continuous programme of quality improvement for our patients, with staff in all departments involved. The programme has a Steering Group and work streams to focus on meeting relevant clinical standards and to address estates issues. A Reference Group is at the centre of this work. If you have an interest in quality improvement and would like to be part of the Reference Group please email cqp@chelwest.nhs.uk. Look out for the Daily Notice Board and the intranet which will provide more information.

Emergency and Integrated Care division
It has been a busy month for the division with a particular focus on improving our quality and governance processes, while also ensuring we have sustainable activity and financial plans for the next year. Everyone can help play their part by making sure their own mandatory training is up to date, actively helping with Red/Green days on the wards, and doing everything we possibly can to discharge patients in the morning and not late in the day (2B412). As we head into spring we should no longer require the use of the escalation ward at CW (which has been brilliantly supported by the Nell Gwynne ward manager and team) and this will allow us to temporarily decant part of the Acute Assessment Unit for floor refurbishment. At WMUH, planning is underway to bring the Cardiac Cath Lab to full capacity as the remaining staff joiners begin shortly, and work continues to ensure our vital junior doctor workforce is

supported and integrated during rotations and time within the hospital.

Women's and Children's division
The division has had an exciting month with a huge amount of excellent work going on. It is always difficult to pick out specific highlights but the Paediatric Assessment Unit was shortlisted for a HSJ Award, whilst 56 Dean Street was shortlisted for a BMJ Award. Best of luck to both teams. The Assisted Conception Unit has had an extremely busy month and the Fetal Medicine service goes from strength to strength. Last month saw the opening of the Elizabeth Suite and new Annie Zunz ward at CW and good feedback for the cross-site colposcopy service. We have more exciting estates developments planned, and welcome the HIV service in Harlow to our division this month. This is just a small snapshot of all of the good work going on across the division - thank you and please keep it up! Our divisional priorities, in line with the Trust, remain quality, our staff and efficiency.

Planned care division
The division welcomes Bruno Botelho as Divisional Director of Operations, starting on 24 April. A new emergency surgeon has started at the CW site which will help us see our emergency patients in a timely way. As we start the new financial year it is vital that we maintain our RTT performance, even when we are getting more referrals, doing this as much as possible in normal working hours by filling the operating lists and reducing our 'did not attend' rates, which sit at about 12%.

2016 Staff Survey results
The National NHS Staff Survey results are now available from www.nhsstaffsurveyresults.com. In the next few weeks we will be holding lunchtime sessions to discuss the results and action planning – all staff are invited and encouraged to attend:

CW site:
- 19 Apr, 12.15pm – 1pm, UMO Seminar Room, LGF (near the Gleeson Lecture Theatre)
- 5 May, 12.15pm – 1pm, UMO Seminar Room, LGF (near the Gleeson Lecture Theatre)

WMUH site:
- 25 Apr, 12.15pm – 1pm, Room B Trust Management offices 2nd Floor
- 9 May, 12.15pm – 1pm, Room A Trust Management offices 2nd Floor

IN THE FUTURE

Gas works affecting roads around CW
National Grid will be replacing gas mains from Gunter Grove, along Fulham Road, past the hospital, to the junction with Beaufort Street. The work is scheduled to take place from May to September 2017.

Work will start outside the St Stephen's Centre on 2 May and the existing crossing will be removed and replaced with temporary lights. Please use the crossing opposite Boots instead. Bus stops will be suspended during this period to ease congestion.

Due to the scale of the project and to ensure everyone's safety the westbound lane of Fulham Road between Beaufort Street and Gunter Grove will be closed from July - September.

It is likely there will be disruption in the area so it will be important to allow more time for your journeys. If you have any queries please contact Catherine Sands.

Cerner EPR update: building the virtual hospitals
On our first day using the Cerner EPR system, patients will start arriving for their outpatient clinic appointments. Staff will want to find those patients on Cerner in the right appointment slots on the right day and to have access to information about their medical history. All this is fundamental to safe patient care and the same applies to wards, day case areas, theatres and A&E.

To make it happen, over the coming months we have to create on Cerner a digital replica of our hospitals including buildings, wards, clinics and staff. These virtual hospitals have to match both our physical hospitals and what is on our current CaMIS and LastWord systems. Patient information and future appointments that are copied from our current systems into the Cerner EPR will then go into the right places.

Staff will be involved in making sure that the virtual hospital is correct for their areas. For simple definitions of virtual hospital and other terms associated with the Cerner EPR, check the glossary on the electronic patient record site on the intranet

Commissioning for Quality and Innovation (CQUINs)
A proportion of our income is allocated to delivery of CQUIN schemes, which are designed to improve quality of care and increase innovation. The Trust has done incredibly well at delivering the CQUIN schemes in 2016/17, with 90% achievement forecast for the year, so well done and thanks to all that have been involved with these schemes. For 2017/18 there are a number of new CQUIN schemes, including improving staff health and wellbeing, offering advice and guidance to GPs and improving availability of outpatient services through NHS E-Referrals. Operational leads have been identified for each scheme, but some of these schemes will need support and input across all divisions. For more information on these schemes, please contact Paul Harniess, Head of Contracts.

CW Open Day
We are gearing up to welcome visitors to our 11th annual open day on Saturday 20 May from 11am-3pm. This year the theme is our Critical Care Campaign to support the redevelopment of our Neonatal Intensive Care Unit (NICU) and Intensive Care Unit (ICU). We will give everyone an interesting insight into our work, show how proud we are to care, as well as encourage people to support and/or join the Trust.

There will be all the usual fun, including behind-the-scenes tours, careers talks, health checks, music and entertainment for all ages. If you would like more information about the day or would like to have a stand please contact Katie Allen.

May 2017 team briefing dates

- Tuesday 2 May, 12-1pm, CW Medicinema
- Wednesday 3 May, 1-2pm, WMUH Meeting Room A
- Friday 5 May 9-10am, HY G2 office

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	2.3/May/17
REPORT NAME	Integrated Performance Report – March 2017
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for March 2017 for both Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for March 2017. **Regulatory performance** – The A&E Waiting Time figure for March (92.0%) continued the upward trajectory for the Trust from January (86.6%) to February (90.4%). There was a 7% increase in WMUH from January to March. However the January performance resulted in a Q4 figure of 89.7% and a full year performance of 92.3%. March RTT reported trust position is below the national expected target of 92%. This position is adverse to the improving compliant trend over the past 3 quarters of the 16/17 financial year. WM as a site reported continued compliance with the decline on the CW site. The number of patients waiting over 18 weeks increased across the majority of specialties despite good activity levels on the site. Operationally a large scale review of the administration function on the CW site has had an impact on the way patients are booked in line with the Trust Access Policy, due to a high number of new staff in post. The focus across all teams is to book capacity in the appropriate way ensuring patients who are now waiting over 18 weeks are booked first. Despite the months decline in RTT performance the trust reported no patients waiting over 52 weeks to be treated and this is expected to continue. Several factors combined together to result in the March failure (96.88%) to deliver the 6ww diagnostic standard. This was the first failure to achieve the standard since August 2016 and resulted from procedural and administrative shortfalls, not from any lack of capacity. Investigation and subsequent audit has revealed that incorrect booking protocols were followed after a change of staff in March, which led to delays adding patients to the waiting list. This was then compounded by a sub-optimal process for 6ww monitoring, which stemmed from an incorrect escalation process being followed. An audit undertaken on 21 April identified these issues and rectifying action was then taken. At the time of writing this report, an on-going analysis of the position is continuing and this will include an assessment of any clinical impact. An immediate action plan has been developed with staff implemented to regain the delivery of the standard and

	ensure immediate grip is recaptured ; this will achieve an improved, but non-compliant position for April, with the full recovery of the standard due in May 2017. All cancer indicators were passed in March on unvalidated March data. However 2WW Urgent Cancer failed for Q4 at 91.6%. All other cancer indicators passed Q4 with unvalidated March data. There was one reported CDiff infection in March at WMUH. This represents a Trust annual figure of 14 is which is below the threshold of 16 for the full year. Both sites have achieved all other regulatory performance indicators. **Safety and Patient Experience**: Incident reporting rates on both sites increased again in March and aggregate Trust performance has now reached the target level. **Access** There were 160 breaches in March resulting in a 96.88% diagnostic waiting time performance in March. The Q4 performance was 98.5%. The full year performance achieved target with 99.01%.
KEY RISKS ASSOCIATED:	There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times, and cancer 62 days waits.
FINANCIAL IMPLICATIONS	The Trust finance figures are draft and subject to external audit and therefore cannot be published.
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure financial and environmental sustainability
DECISION/ ACTION	For information.

TRUST PERFORMANCE & QUALITY REPORT

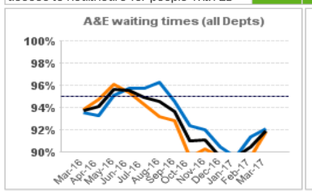
March 2017

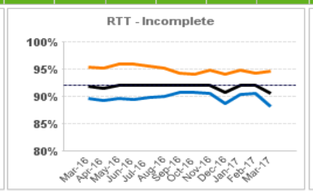
March 2017
Performance Dashboard

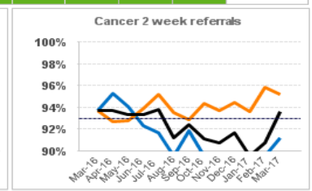
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

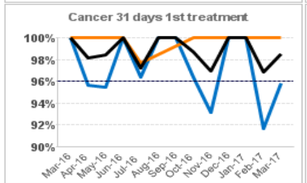
Regulatory Compliance

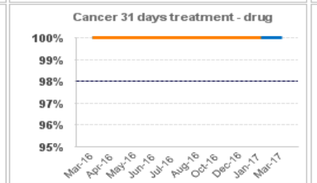
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	88.8	91.4	92.1	84.7	89.6	91.8	86.6	90.4	92.0	89.7	92.3	
RTT - Incomplete (Target: >92%)	90.4	90.6	88.2	94.9	94.3	94.6	92.0	92.0	90.6	91.5	91.8	
Cancer 2 week urgent referrals (Target: >93%)	84.4	84.1	91.3	93.7	95.8	95.2	89.8	90.8	93.6	91.6	92.1	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	92.5	100	94.5	92.5	100	94.5	95.3	94.5	
Cancer 31 days first treatment (Target: >96%)	100	91.7	95.8	100	100	100	100	96.8	98.5	98.5	98.6	
Cancer 31 days treatment - Drug (Target: >98%)	100	n/a	100	100	n/a	n/a	100	n/a	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	100	n/a	100	100	100	100	100	100	100	100	99.0	
Cancer 62 days GP ref to treatment (Target: >85%)	75.7	79.4	82.1	94.1	92.6	94.9	86.4	87.5	90.8	88.2	86.9	
Cancer 62 days NHS screening (Target: >90%)	n/a	n/a	n/a	100	100	100	100.0	100.0	100.0	100.0	94.1	
Clostridium difficile infections (Targets: CWf: 7; WM: 9; Combined: 16)	0	0	0	3	1	1	3	1	1	5	14	
Self-certification against compliance for access to healthcare for people with LD	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	

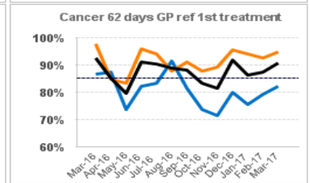






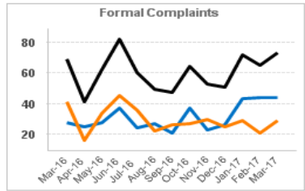


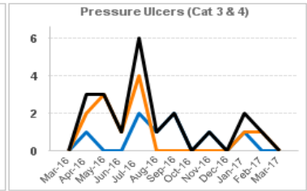


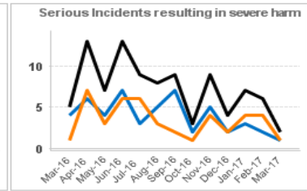


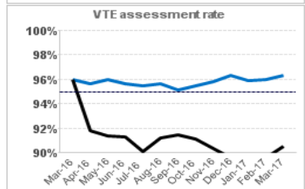
Quality

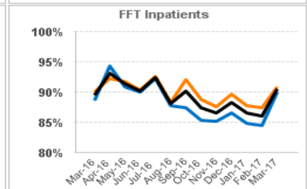
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	95.7	96.3	96.0	91.0	96.0	98.4	94.1	96.2	96.7	95.7	95.7	
Pressure Ulcers (Cat 3 & 4)	1	0	0	1	1	0	2	1	0	3	20	
VTE assessment % (Target: >=95%)	95.9	96.0	96.3	70.8	80.1	82.7	84.7	88.4	90.5	87.9	89.9	
Formal complaints number received	43	44	44	29	21	29	72	65	73	210	719	
Formal complaints responded to <25days	9	17	9	8	4	6	17	21	15	53	209	
Serious Incidents	3	2	1	4	4	1	7	6	2	15	90	
Never Events (Target: 0)	0	0	0	0	0	0	0	0	0	0	1	
FFT - Inpatients recommend % (Target: >90%)	84.8	84.4	89.9	87.8	87.5	90.9	86.5	86.1	90.5	88.0	89.5	
FFT - A&E recommend % (Target: >90%)	91.0	90.5	89.0	78.6	82.9	83.4	88.9	89.4	88.1	88.7	87.9	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	2	

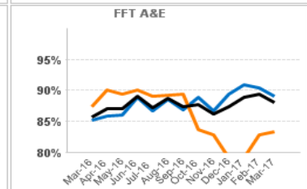






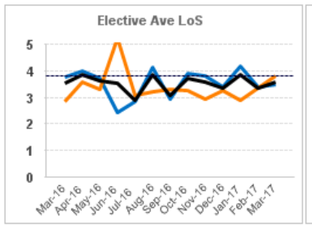


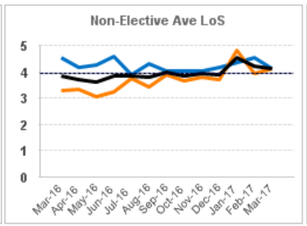


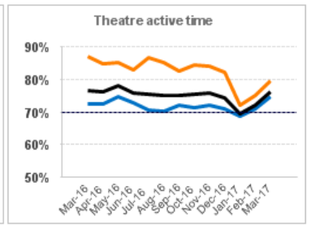


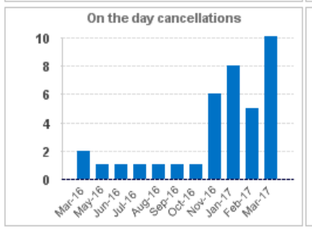
Efficiency

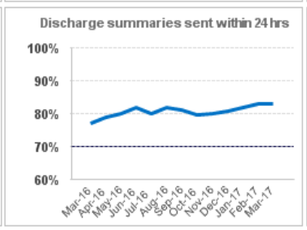
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	4.2	3.4	3.5	2.9	3.3	3.8	3.9	3.4	3.6	3.6	3.5	
Non-Elective average LoS (Target: <3.95)	4.3	4.5	4.1	4.8	3.9	4.1	4.6	4.2	4.1	4.3	3.9	
Theatre active time (Target: >70%)	68.5	70.8	74.6	72.0	75.1	79.6	69.6	72.2	76.1	72.8	75.0	
Discharge summaries sent within 24 hours (Target: >70%)	81.8	83.0	82.9	dev	dev	dev	81.8	83.0	82.9	82.5	81.0	
Outpatient DNA rates (Target: <11.1%)	11.5	10.6	10.8	9.4	9.0	9.7	10.7	10.0	10.4	10.4	11.1	
On the day cancelled operations not re-booked within 28 days (Target: 0)	8	5	15	0	0	0	8	5	15	28	40	

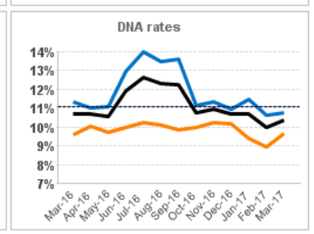






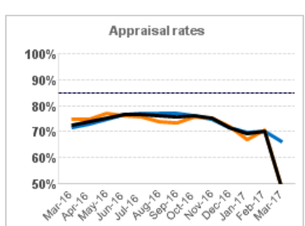


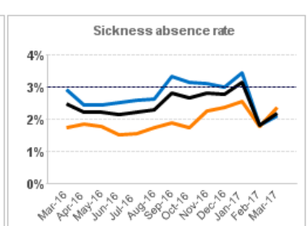


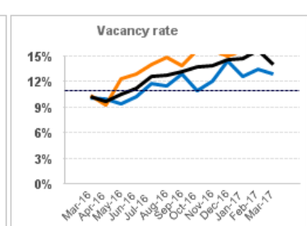


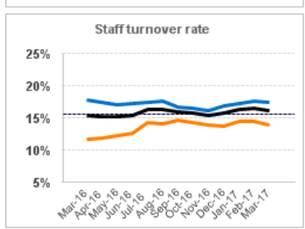
Workforce

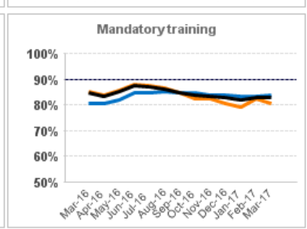
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Jan-17	Feb-17	Mar-17	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	69.9	70.0	65.9	67.1	70.5	2.3	69.1	70.2	4.2	9.3	26.4	
Sickness absence rate (Target: <3%)	3.46	1.83	2.11	2.57	1.78	2.36	3.16	1.81	2.19	2.41	2.45	
Vacancy rates (Target: CW<12%; WM<10%)	12.7	13.5	12.9	18.7	18.5	16.0	14.8	15.2	14.0	14.0	14.0	
Turnover rate (Target: CW<18%; WM<11.5%)	17.1	17.6	17.4	14.5	14.4	13.8	16.2	16.5	16.2	16.2	16.2	
Mandatory training (Target: >90%)	83.4	83.3	83.9	79.0	82.3	80.4	81.9	83.0	82.7	82.5	83.8	
Bank and Agency spend (£ks)	£2,546	£2,827	£3,488	£2,291	£2,184	£1,997	£4,836	£5,011	£5,486	£15,333	£54,190	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	9.4	11.8	11.9	16.0	13.8	7.4	12.0	12.5	9.8	11.4	10.2	

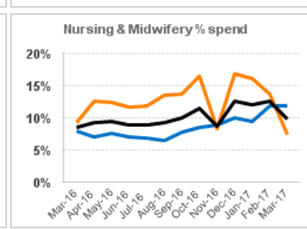












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NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	88.8%	91.4%	92.1%	93.1%	84.7%	89.6%	91.8%	91.6%	86.6%	90.4%	92.0%	89.7%	92.3%		!
RTT	18 weeks RTT - Admitted (Target: >90%)	69.1%	75.6%	75.5%	73.5%	82.0%	83.8%	80.9%	85.3%	75.7%	80.5%	78.6%	78.3%	80.0%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	91.9%	93.9%	93.6%	93.0%	93.1%	93.0%	93.4%	93.8%	92.3%	93.6%	93.5%	93.1%	93.3%		!
	18 weeks RTT - Incomplete (Target: >92%)	90.4%	90.6%	88.2%	89.8%	94.9%	94.3%	94.6%	94.9%	92.0%	92.0%	90.6%	91.5%	91.8%		!
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month in this report)	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	84.4%	84.1%	91.3%	89.4%	93.7%	95.8%	95.2%	94.0%	89.8%	90.8%	93.6%	91.6%	92.1%		!
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	92.5%	100%	94.5%	94.5%	92.5%	100%	94.5%	95.3%	94.5%		-
	31 days diagnosis to first treatment (Target: >96%)	100%	91.7%	95.8%	96.9%	100%	100%	100%	99.8%	100%	96.8%	98.5%	98.5%	98.6%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	n/a	100%	100%	100%	n/a	n/a	100%	100%	n/a	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	n/a	100%	94.7%	100%	100%	100%	100%	100%	100%	100%	100%	99.0%		-
	31 days subsequent cancer treatment - Radiotherapy (Target: >94%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-
	62 days GP referral to first treatment (Target: >85%)	75.7%	79.4%	82.1%	79.1%	94.1%	92.6%	94.9%	90.9%	86.4%	87.5%	90.8%	88.2%	86.9%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	100%	100%	100%	94.1%	100%	100%	100%	100%	94.1%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	0	0	0	1	3	1	1	13	3	1	1	5	14		!
Learning difficulties Access & Governance	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-
	Governance Rating	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-

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

Trust commentary

A&E 4 hour waiting time
Both hospitals showed a sizeable improvement in performance from the previous month, but this remained insufficient to achieve the 95% target. Overall performance was 92.0% (CW site 92.1%, WM site 91.8%) which was within 1.0% of the corresponding M11 for the previous year despite the overall growth in attendances. As described last month, the early indications are that the key actions to recover performance are beginning to have increasing effect and that further progress on schemes to reduce length of stay on both sites:(eg: Red/Green roll out, continuation of Frailty pathways, and opening of a Gynaecology unit on Chelsea site from 6 March 2017) – are helping this process. However, further immediate impetus is required for 2017/18 performance if the agreed trajectory is to be met, and this work will comprise: 1) a dedicated improvement action plan to address the consistency of performance, primarily at WM site due to underperformance in April so far, and 2) accelerating the acute frailty work stream across both sites that will have significant benefit to ED 4hr performance.

18 weeks RTT – Incomplete
March RTT reported trust position is below the national expected target of 92%. This position is adverse to the improving compliant trend over the past 3 quarters of the 16/17 financial year. WM as a site reported continued compliance with the decline on the CW site. The number of patients waiting over 18 weeks increased across the majority of specialties despite good activity levels on the site. Operationally a large scale review of the administration function on the CW site has had an impact on the way patients are booked in line with the Trust Access Policy, due to a high number of new staff in post. The focus across all teams is to book capacity in the appropriate way ensuring patients who are now waiting over 18 weeks are booked first. Despite the months decline in RTT performance the trust reported no patients waiting over 52 weeks to be treated and this is expected to continue.

Cancer - 2 Weeks from referral to first appointment all urgent referrals
Chelsea site continues to be challenged to meet the 2ww target, particularly colorectal. However there has been some significant improvement following the creation of additional nurse led capacity, meaning the trust is now in a passing position overall.

2 weeks from referral to first appointment all Breast symptomatic referral
The trust meets this target at 95.4% with 10 breaches of the target. 7 were patient cancellations and 3 related to clinic capacity

Cancer - 62 days GP referral to first treatment
The trust is in an overall passing potion for March against the 62day target with a total of 39 patients treated and 4.5 breaches of the target. Please see the Tumour by Site dashboard for a further breakdown.

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	1	0	1	1	3	0	1	1	2	4		-
	Hand hygiene compliance (Target: >90%)	95.7%	96.3%	96.0%	95.4%	91.0%	96.0%	98.4%	96.2%	94.1%	96.2%	96.7%	95.7%	95.7%		-
Incidents	Number of serious incidents	3	2	1	47	4	4	1	43	7	6	2	15	90		-
	Incident reporting rate per 100 admissions (Target: >8.5)	7.0	8.2	6.5	7.0	10.0	9.8	9.8	8.5	8.2	8.9	7.9	8.3	7.7		!
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.02	0.00	0.03	0.03	0.09	0.04	0.00	0.03	0.05	0.02	0.02	0.03	0.03		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	258.04	614.62	343.36	422.57	155.47	277.89	271.53	279.22	208.44	458.07	308.51	319.17	355.27		!
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	12.8%	15.5%	9.8%	12.0%	22.7%	6.1%	15.8%	7.3%	16.4%	12.8%	12.4%	13.5%	10.3%		-
	Never Events (Target: 0)	0	0	0	1	0	0	0	0	0	0	0	0	1		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	95.6%	98.8%	95.3%	95.8%	96.0%	95.0%	95.8%	94.6%	95.8%	96.2%	95.6%	95.9%	95.1%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	1	0	0	8	1	1	0	12	2	1	0	3	20		-
	NEWS compliance %	93.1%	93.9%	95.6%	92.4%	97.3%	98.1%	96.0%	95.3%	94.4%	94.9%	95.7%	95.1%	93.3%		-
	Safeguarding adults - number of referrals	29	17	27	240	20	24	34	257	49	41	61	151	497		-
	Safeguarding children - number of referrals	33	23	31	286	85	83	132	994	118	106	163	387	1280		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4		-
	Number of hospital deaths - Adult	50	37	32	382	100	75	63	827	150	112	95	357	1209		-
	Number of hospital deaths - Paediatric	0	1	1	9	0	0	0	0	0	1	1	2	9		-
	Number of hospital deaths - Neonatal	2	1	1	14	1	0	0	7	3	1	1	5	21		-
	Number of deaths in A&E - Adult	0	3	2	14	18	1	5	70	18	4	7	29	84		-
	Number of deaths in A&E - Paediatric	0	0	0	1	0	0	1	3	0	0	1	1	4		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	0	0	0	0	0	0	0	0		-

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

Trust commentary

Number of serious incidents

There was a significant decrease in the number of SIs reported in March 2017 (2) compared to February 2017 (6). This is mainly attributed to no falls or pressure ulcers being reported in March.

2 Serious Incidents were reported during March 2017; both of which are referred to within the Serious Incident Report, and relate to an unexpected admission to the Neonatal Intensive Care Unit, and one self-inflicted harm incident.

Incident reporting rate per 100 admissions

The incident reporting rate on the WMUH site is encouragingly increasing; however the reporting rate on the CWH site has dipped. Work is underway to understand the reporting patterns and to increase reporting from areas with low levels of reporting.

Trust commentary continued

Rate of patient safety incidents resulting in severe harm or death

On incident leading to severe harm linked to a reported delay in discharge. We await clinical validation, following which the degree of harm may be adjusted.

Medication-related safety incidents

Combined Trust performance is in line with the target, however slightly higher on the WMUH site.

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

Combined reporting rates improved for Quarter 4. The Trust average for 2016-2017 of 352/100,000 FCE bed days is better than the Trust target and the latest benchmarks published on the Carter dashboard; National Median 286 and Peer Median 279 (March 2016 data).

Medication-related (reported) safety incidents % with harm

Chelsea Site showed a reduction in the % of medication incidents with-harm in Quarter 4 (due to an increase in the number of no-harm incidents reported) while West Middlesex Site showed a worsening trend. All of the incidents with harm were categorised as low-harm. The average Trust % of medication related safety incidents with-harm for 2016-2017 of 10.3% is better than the Trust target but worse than the latest Carter National Benchmark data (9.7%) and that of the Peer Median (8.2% - March 2016 data). The Medication Safety Group continues to monitor and act upon incident trends, to promote reporting of no - harm and near - miss incidents and work to improve safety culture.

Incidence of newly acquired category 3 & 4 pressure ulcers

No hospital acquired grade3 or 4 pressure ulcers in March 2017. There has been a significant reduction in pressure ulcers for 2016/17 – 57%.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	84.8%	84.4%	89.9%	88.4%	87.8%	87.5%	90.9%	90.3%	86.5%	86.1%	90.5%	88.0%	89.5%		!
	FFT: Inpatient not recommend % (Target: <10%)	8.6%	6.2%	4.3%	6.0%	6.7%	6.8%	4.4%	4.6%	7.5%	6.5%	4.3%	6.0%	5.1%		-
	FFT: Inpatient response rate (Target: >30%)	31.4%	32.9%	33.3%	33.9%	21.6%	23.7%	31.2%	26.8%	25.1%	27.2%	32.0%	28.2%	29.2%		-
	FFT: A&E recommend % (Target: >90%)	91.0%	90.5%	89.0%	88.2%	78.6%	82.9%	83.4%	86.5%	88.9%	89.4%	88.1%	88.7%	87.9%		!
	FFT: A&E not recommend % (Target: <10%)	5.0%	5.8%	5.5%	6.8%	13.0%	8.4%	9.4%	8.2%	6.4%	6.1%	6.1%	6.2%	7.1%		-
	FFT: A&E response rate (Target: >30%)	14.5%	14.4%	14.9%	14.2%	14.1%	13.6%	14.7%	18.2%	14.5%	14.3%	14.9%	14.5%	14.9%		!
	FFT: Maternity recommend % (Target: >90%)	93.8%	88.2%	93.4%	90.8%	100.0%	96.3%	98.2%	93.7%	95.0%	89.6%	94.3%	93.0%	91.4%		-
	FFT: Maternity not recommend % (Target: <10%)	4.1%	7.1%	3.9%	5.5%	0.0%	1.9%	0.0%	3.7%	3.3%	6.1%	3.2%	4.2%	5.1%		-
	FFT: Maternity response rate (Target: >30%)	19.7%	22.0%	20.2%	21.6%	16.7%	14.8%	14.2%	17.1%	19.0%	20.3%	18.8%	19.3%	20.5%		!
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Complaints	Complaints formal: Number of complaints received	43	44	44	379	29	21	29	340	72	65	73	210	719		-
	Complaints formal: Number responded to < 25 days	9	17	9	116	8	4	6	93	17	21	15	53	209		-
	Complaints (informal) through PALS	113	104	140	1170	57	23	60	408	170	127	200	497	1578		-
	Complaints sent through to the Ombudsman	0	0	0	0	1	1	2	14	1	1	2	4	14		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	2	10	0	0	2	2	10		-

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Trust commentary

There was a local initiative to achieve a >90% recommend rate and 30% response rate in inpatients and it is reassuring that this was met in March. Maternity in both sites also achieve over the 90% recommend rates but need improvement on response rates. Kiosks in both ED will be in place in May to help increase the response rate.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <3.7)	4.19	3.37	3.47	3.52	2.90	3.34	3.80	3.53	3.86	3.36	3.56	3.60	3.52		-
	Average length of stay - non-elective (Target: <3.9)	4.33	4.53	4.13	4.20	4.79	3.93	4.10	3.70	4.56	4.22	4.12	4.29	3.94		!
	Emergency care pathway - average LoS (Target: <4.5)	5.25	5.24	5.05	5.11	5.98	4.81	4.90	4.57	5.64	4.99	4.97	5.19	4.80		!
	Emergency care pathway - discharges	216	199	230	2495	249	266	292	3354	466	466	522	1455	5850		-
	Emergency re-admissions within 30 days of discharge (Target: <2.8%)	3.43%	4.26%	3.70%	3.41%	8.84%	8.97%	7.71%	8.31%	5.51%	6.23%	5.32%	5.66%	5.46%		!
	Non-elective long-stayers	476	475	454	5305	580	523	575	6909	1056	998	1029	3083	12214		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	84.6%	87.5%	84.3%	83.3%	86.3%	86.2%	88.3%	83.9%	85.3%	87.0%	85.8%	86.0%	83.5%		-
	Operations canc on the day for non-clinical reasons: actuals	17	10	23	97	9	17	3	85	26	27	26	79	182		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.60%	0.39%	0.72%	0.29%	0.85%	1.44%	0.22%	0.57%	0.67%	0.72%	0.57%	0.65%	0.38%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	8	5	15	40	0	0	0	0	8	5	15	28	40		!
	Theatre active time (C&W Target: >70%; WM Target: >78%)	68.5%	70.8%	74.6%	71.8%	72.0%	75.1%	79.6%	82.0%	69.6%	72.2%	76.1%	72.8%	75.0%		-
	Theatre booking conversion rates (Target: >80%)	84.7%	85.4%	83.1%	86.8%	43.9%	50.5%	49.3%	51.5%	71.8%	73.9%	72.8%	72.8%	75.2%		!
Outpatients	First to follow-up ratio (Target: <1.5)	1.63	1.57	1.55	1.67	1.33	1.25	1.22	1.33	1.40	1.33	1.31	1.35	1.45		!
	Average wait to first outpatient attendance (Target: <6 wks)	7.9	8.1	7.8	7.6	6.7	6.3	6.3	6.5	7.3	7.2	7.1	7.2	7.1		!
	DNA rate: first appointment	13.3%	12.2%	12.4%	13.2%	10.8%	9.7%	10.0%	11.4%	12.1%	11.0%	11.3%	11.4%	12.4%		-
	DNA rate: follow-up appointment	10.9%	10.1%	10.2%	11.4%	8.4%	8.4%	9.5%	8.8%	10.1%	9.6%	10.0%	9.9%	10.6%		-

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Trust commentary

Elective average Length of Stay
The increase in LoS at West Middlesex includes 6 medical patients admitted under elective medicine with a total of 240 bed days. The elective LoS is 2.6 days if the above are excluded which is below target. Work in progress to ensure medical patients is recorded under the right admission method on CAMIS.

Non-Elective average Length of Stay
A slight improvement on CW site and a largely steady figure for WM site resulting in an overall modest improvement. Linked to both A&E improvement trajectory and the Acute Frailty work, a further improvement work stream is underway via the 2017/18 length of stay and NEL schemes which aim to deliver significant reductions in LOS and lower readmissions to both hospitals; the major focus being a significantly enhanced service for the frail elderly patients These and Emergency care pathway LOS data are being tracked by the NWL system-wide A&E Delivery Board and at a more local level by the new Acute Frailty strategy group.

Emergency re-admissions within 30 days (Adult & Paediatric)
This has moved downwards on both sites but with a significant differential between both hospitals with this the focus of the on-going Emergency Care divisional improvement work stream through April 2017. Detailed data to support the Frailty agenda shows that there is a significant dividend in terms of readmission arte reductions when the frailty improvement pilots are developed in a more wide scale manner during 2017.

Non-Elective LoS - long stayers
This metric has been subject to a deep dive in support of the LOS and acute frailty work. One initiative in place is provision of an enhanced discharge team. This is being supported via additional CCG funding for immediate roll out which will allow an expanded team of discharge coordinators to support the wards from mid-2017.

Theatre Active Time - % of staffed time
The West Middlesex site has seen improved theatre utilisation as a result of reduced number of elective cancellations and maximising of existing lists.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	86.5%	88.7%	78.5%	89.9%	90.7%	90.0%	86.5%	91.3%	88.6%	89.4%	83.2%	87.2%	90.7%		!
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)				88.0%	85.7%	76.2%	65.0%	73.8%	85.7%	76.2%	65.0%	75.8%	80.0%		!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	94.0%	89.7%	100.0%	100.0%	96.2%	96.4%		-
VTE	VTE: Hospital-acquired (Target: tbc)					3	0	0	10	3	0	0	3	10		-
	VTE risk assessment (Target: >95%)	95.9%	96.0%	96.3%	95.8%	70.8%	80.1%	77.1%	82.1%	84.7%	88.4%	87.5%	86.9%	89.6%		!
TB	TB: Number of active cases identified and notified	5	5	3	31	4	13	8	102	9	18	11	38	133		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

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Trust commentary

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

At the West Middlesex site 6 patients did not have the surgery within 36 hours was due to there being no theatre space. Work in progress to review trauma / elective list utilisation to identify a means of managing unmet trauma demand within funded capacity

Dementia screening remains non compliant this is a focus of quality rounds in May to train staff to improve compliance

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	0	0	0	19	0	0	0	0	0	0	0	0	19		-
	Diagnostic waiting times <6 weeks: % (Target: >99%)	99.06%	99.38%	95.83%	99.08%	99.08%	99.43%	98.08%	98.96%	99.07%	99.40%	96.88%	98.51%	99.01%		-
	Diagnostic waiting times >6 weeks: breach actuals	20	19	114	262	30	17	46	384	50	36	160	246	646		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	7.1%	7.3%	7.6%	7.4%	8.8%	7.8%	8.2%	8.4%	7.7%	7.5%	7.8%	7.7%	7.8%		!
	A&E time to treatment - Median (Target: <60')	01:12	01:06	01:12	01:10	00:41	00:33	00:27	00:41	01:04	00:57	01:00	01:00	01:02		!
	London Ambulance Service - patient handover 30' breaches	84	27	16	434	218	124	54	1110	302	151	70	523	1544		-
	London Ambulance Service - patient handover 60' breaches	14	2	1	28	1	0	1	3	15	2	2	19	31		!
Choose and Book (available to Feb-17 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	1778	1485	1232	2076	0	0	0	1	1778	1485	1232	1495	2076		-
	Choose and book: capacity issue rate (ASI)				27.4%				35.0%					31.1%		-
	Choose and book: system issue rate															-

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Trust commentary

RTT Incompletes – 52 week waiters at month end

Despite the months decline in RTT performance at the Chelsea site as described in the NHSI Dashboard commentary, the Trust reported no patients waiting over 52 weeks to be treated and this is expected to continue.

Diagnostic wait times >6weeks

Several factors combined together to result in the March failure (96.88%) to deliver the 6ww diagnostic standard. This was the first failure to achieve the standard since August 2016 and resulted from procedural and administrative shortfalls, not from any lack of capacity. Investigation and subsequent audit has revealed that incorrect booking protocols were followed after a change of staff in March, which led to delays adding patients to the waiting list. This was then compounded by a sub-optimal process for 6ww monitoring, which stemmed from an incorrect escalation process being followed. An audit undertaken on 21 April identified these issues and rectifying action was then taken. At the time of writing this report, an on-going analysis of the position is continuing and this will include an assessment of any clinical impact. An immediate action plan has been developed with staff implemented to regain the delivery of the standard and ensure immediate grip is recaptured ; this will achieve an improved, but non-compliant position for April, with the full recovery of the standard due in May 2017.

A&E Unplanned Re-attendances

There has been little substantial change to this metric with the overall figure remaining stable. Given the continuing pressure on both sites, keeping re attendances steady reflects the on-going care and focus on avoiding readmissions within both hospitals.

A&E LAS 60 min handover breaches

CW site improved and WM has one 60 min breach albeit this may improve further with outstanding validation. In light of A&E improvements, LOS delivery programme and the enhanced bed escalation areas (that should be available at both hospitals for next winter) it is intended to reduce ambulance delays and cut hospital fines by c£150k for 2017/18.

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Birth indicators	Total number of NHS births	478	491	459	5635	366	373	405	5064	844	864	864	2572	10699		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	34.6%	33.5%	40.3%	33.9%	25.9%	25.5%	24.5%	26.6%	30.8%	30.1%	32.9%	31.2%	30.4%		!
	Midwife to birth ratio (Target: 1:30)	1:30	1:30	1:30	1:30	1:32.7	1:32.7	1:32.7	1:32.7	1:31.3	1:31.3	1:31.3	1:31.3	1:31.3		!
	Maternity 1:1 care in established labour (Target: >95%)	97.6%	98.3%	94.9%	96.8%	94.9%	95.8%	95.3%	94.3%	96.3%	96.7%	95.2%	96.0%	95.4%		-
Safety	Admissions of full-term babies to NICU	15	22	21	223	n/a	n/a	n/a	n/a	15	22	21	58	223		-

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Trust commentary

Total number of NHS births

The cross site plan was once again achieved for the month. The Trust also achieved the 2016/2017 full year plan.

Total caesarean section rate

Ongoing work continues to address the caesarean section rate at the Chelsea site

Midwife to birth ratio - births per WTE

Midwife to birth ratios are being reviewed for 2017-18 which should see a rate of 1 to 30 achieved on both sites

Maternity 1:1 care in established labour

The rate dropped in March on the Chelsea site due staffing levels. Recruitment has been commenced to reflect increased activity

Workforce Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	12.7%	13.5%	12.9%	12.9%	18.7%	18.5%	16.0%	16.0%	14.8%	15.2%	14.0%	14.0%	14.0%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	17.1%	17.6%	17.4%	17.4%	14.5%	14.4%	13.8%	13.8%	16.2%	16.5%	16.2%	16.2%	16.2%		!
	Sickness absence (Target: <3%)	3.5%	1.8%	2.1%	2.7%	2.6%	1.8%	2.4%	1.9%	3.2%	1.8%	2.2%	2.4%	2.5%		-
	Bank and Agency spend (£ks)	£2,546	£2,827	£3,488	£30,786	£2,291	£2,184	£1,997	£23,404	£4,836	£5,011	£5,486	£15,333	£54,190		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	9.4%	11.8%	11.9%	8.6%	16.0%	13.8%	7.4%	12.8%	12.0%	12.5%	9.8%	11.4%	10.2%		-
Appraisal rates	% of appraisals completed - medical staff (Target: >85%)	80.5%	81.9%	79.1%	82.8%	92.0%	88.5%	89.5%	89.4%	85.4%	84.6%	83.5%	84.5%	85.6%		!
	% of appraisals completed - non-medical staff (Target: >85%)	68.7%	68.7%	64.4%	72.6%	61.9%	67.0%	65.8%	70.3%	66.8%	68.2%	64.8%	66.6%	71.9%		!
Training	Mandatory training compliance (Target: >90%)	83.4%	83.3%	83.9%	83.9%	79.0%	82.3%	80.4%	83.7%	81.9%	83.0%	82.7%	82.5%	83.8%		!
	Health and Safety training (Target: >90%)	83.1%	83.4%	85.0%	85.3%	80.9%	83.4%	80.9%	82.6%	82.3%	83.4%	83.6%	83.1%	84.3%		!
	Safeguarding training - adults (Target: 90%)	87.8%	87.8%	89.2%	88.6%	81.5%	84.3%	80.8%	84.8%	85.7%	86.6%	86.3%	86.2%	87.3%		!
	Safeguarding training - children (Target: 90%)	90.6%	90.0%	91.1%	90.1%	87.8%	89.1%	88.3%	92.1%	89.6%	89.7%	90.2%	89.8%	90.8%		!

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	With a joint payroll operating from mid Mar-17, Bank & Agency spend has been split pro-rata by Site from a Trust total position for March based on Months 1-11			

Trust commentary

Staff in Post

In March the Trust employed 5080 whole time equivalent (WTE) people on substantive contracts, 25 more than last month.

Turnover

The Trust's voluntary turnover rate was 16.18%, which is 0.3% lower than last month. Voluntary turnover is 17.4% at Chelsea and 13.8% at West Middlesex.

Vacancies

Our general vacancy rate for March was 14%, down by 1.3% since February. We have embarked on a piece of work to cleanse our workforce data which involves removing inactive vacancies. This work will be completed by June. Our average time to recruit is just under 12 weeks, down from 17 weeks in the September 2016. Work is currently underway to streamline our occupational health assessment process which will result in further reductions in our time to recruit.

Core training (statutory and mandatory training) compliance

The Trust reports core training compliance based on the 10 Core Skills Training Framework (CSTF) topics to provide a consistent comparison with other London trusts. Our compliance rate stands at 84% against its target of 90%.

Appraisals

The appraisal rate for non-medical staff was 64.8% in March, a 3.4% reduction on last month. The appraisal rate for medical staff was 83.5%, 1.5% less than last month and below our 85% target. A new approach to performance and development reviews will be adopted in FY17/18 which will increase both quality and uptake.

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	Jan-17	Feb-17	Mar-17	2016-2017	YTD breaches	Jan-17	Feb-17	Mar-17	2016-2017	YTD breaches	Jan-17	Feb-17	Mar-17	2016-2017 Q4	2016-2017	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Brain	n/a	n/a	n/a	n/a		n/a	n/a	n/a	100%	0	n/a	n/a	n/a	n/a	100%	0		-
	Breast	n/a	n/a	n/a	n/a		100%	88.9%	100%	97.0%	2.5	100%	88.9%	100%	96.0%	97.0%	2.5		-
	Colorectal / Lower GI	66.7%	25.0%	100%	75.0%	6	100%	85.7%	100%	91.8%	3	81.8%	63.6%	100%	82.9%	85.1%	9		-
	Gynaecological	100%	0.0%	100%	66.7%	4.5	100%	100%	100%	94.0%	1.5	100%	66.7%	100%	93.3%	84.4%	6		-
	Haematological	100%	100%	n/a	81.3%	1.5	100%	100%	100%	90.9%	2	100%	100%	100%	100%	88.3%	3.5		-
	Head and neck	n/a	n/a	n/a	0.0%	1	0.0%	0.0%	100%	60.0%	5	0.0%	0.0%	100%	40.0%	55.6%	6		-
	Lung	100%	100%	n/a	98.1%	0.5	n/a	n/a	100%	96.0%	0.5	100%	100%	100%	100%	97.4%	1		-
	Sarcoma	n/a	n/a	n/a	100%	0	n/a	n/a	n/a	0.0%	0.5	n/a	n/a	n/a	n/a	66.7%	0.5		-
	Skin	100%	100%	83.3%	91.8%	3	100%	100%	71.4%	94.0%	3	100%	100%	76.9%	93.6%	93.1%	6		-
	Upper gastrointestinal	100%	100%	100%	89.3%	1.5	100%	100%	50.0%	93.1%	1	100%	100%	80.0%	93.8%	91.2%	2.5		-
	Urological	22.2%	57.1%	71.4%	61.6%	19	87.5%	87.5%	100%	83.9%	14	64.0%	78.3%	88.2%	78.0%	75.8%	33		!
	Urological (Testicular)	100%	n/a	n/a	100%	0	n/a	n/a	n/a	100%	0	100%	n/a	n/a	100%	100%	0		-
	Site not stated	n/a	50.0%	n/a	40.0%	1.5	100%	n/a	0.0%	83.3%	1	100%	50.0%	0.0%	60.0%	70.6%	2.5		-

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

Trust commentary

Breakdown of 62 day Cancer referrals by tumour site is as follows:

Chelsea Site

Skin 0.5 avoidable breach - delayed treatment due to plastics capacity and complex procedure
Urology 0.5 unavoidable breach - patient choice to delay initial appointment and then patient delayed surgery date
0.5 avoidable breach - delays to discussion at MDT and clinic capacity
1.0 avoidable breach - issues with clinic capacity and capacity for surgical procedure

West Middlesex Site

Upper GI 0.5 unavoidable breach - complex pathway requiring multiple discussions at MDT and other provider prior to treatment
Skin 1.0 avoidable breach - capacity issue in Plastic Surgery due to consultant on sick leave
0.5 avoidable breach - shared with Chelsea

CQUIN Dashboard

March 2017

National CQUINs

			Forecast			
No.	**Description of goal**	**Responsible Executive (role)**	**Q1**	**Q2**	**Q3**	**Q4**
N1.1	Provision of Staff Wellbeing Initiatives	Director of HR & OD	G	n/a	n/a	G
N1.2	Promotion of Healthy Eating to staff, patients and visitors	Deputy Chief Executive	G	n/a	n/a	G
N1.3	Staff Influenza Vaccination	Director of HR & OD	n/a	n/a	G	G
N2.1	Sepsis (screening)	Medical Director	A	A	A	A
N2.2	Sepsis (antibiotic administration and review)	Medical Director	A	A	A	A
N5.1	Anti-microbial Resistance - reduction in antibiotic usage	Medical Director	n/a	n/a	n/a	A
N3.2	Anti-microbial Resistance - empiric review of prescribing	Medical Director	G	G	G	A
GE1	Implementation of Clinical Utilisation Review systems	Chief Operating Officer	R	R	R	R
CA1	Enhanced Supportive Care for Care Patients	Chief Operating Officer	G	G	G	G
CA2	Chemotherapy Dose Banding	Chief Operating Officer	G	G	G	G

Regional CQUINs

			Forecast			
No.	**Description of goal**	**Responsible Executive (role)**	**Q1**	**Q2**	**Q3**	**Q4**
R1.1	NW London IT & IG Strategy & Governance	Chief Information Officer	G	G	G	G
R2.2	Sharing of Integrated Care Plans	Chief Information Officer	G	G	G	G
R2.4	Improve Communication method for GP follow-ups to Trust Clinical Services	Chief Information Officer	n/a	G	n/a	G
R3.2	Electronic Clinical Correspondence	Chief Information Officer	G	G	G	G
R3.4	NW London Data Quality	Chief Information Officer	G	G	G	G

Local CQUINs

			Forecast			
No.	**Description of goal**	**Responsible Executive (role)**	**Q1**	**Q2**	**Q3**	**Q4**
L1.1	Blueteq Implementation for High Cost Drugs Approvals	Chief Operating Officer	n/a	n/a	G	G
L1.2	Engagement with Richmond Outcome Based Commissioning Project	Deputy Chief Executive	G	G	n/a	n/a
L1.3	Timely Discharge Communication with Wandsworth CAHS	Chief Operating Officer	G	G	G	G
L1.4	Developing Telemedicine	Chief Information Officer	G	G	G	G
L1.5	ARV Switch for HIV patients	Chief Operating Officer	G	G	G	G
L1.6	Reducing Ventilator Associated Pneumonia	Chief Operating Officer	G	G	G	G

Commentary

A total of £7.8m of income is available in 2016/17 through 21 separate CQUIN schemes negotiated with the Trust's Commissioners. Senior Responsible Officers have been established for each of the 21 projects, and operational leads identified who will supported with performance monitoring information to support successful delivery.

NWL CCGs have now ratified the Q3 16/17 position at 98%. NHS England have confirmed achievement of Q1-3, with the exception of the CUR CQUIN, which gives an overall forecast achievement of 75% for the year to date for NHSE schemes. This combined with the Q1-3 position for NWL CCGs represents an overall achievement of 89.1% for Q1-3 for the Trust.

Evidence for the Q4 milestones is due to be submitted to both CCG and NHSE commissioners by the end of April and therefore the final 2016/17 position will not be confirmed until later in Q1 2017/18.

The Trust is currently forecasting an overall 2016/17 achievement of 83.3%, which includes some risks to the continued achievement of some schemes due to tougher milestones in the last quarter and continued parital achievement for the sepsis and reduction in antibiotic usage schemes.

National CQUINs

The majority of projects met their Q3 milestones, with the exception of partial achievement forecast for the Sepsis CQUIN project.

Regional & Local CQUINs

The Trust achieved 100% compliance against Q3 milestones, with e-consult for Cardiology, Paediatrics and Acute Medicine at WMUH site going live in November.

2017/18

The Trust has agreed 11 CQUIN schemes (6 national, 5 local) for 2017/18 with NHS England and CCGs and is working with internal and external stakeholders to agree the CQUIN detail and milestones by the end of April. Senior Responsible Officers and operational leads have been established for all schemes and they are working towards the Q1 milestones.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CQC Action Plan Dashboard

Chelsea and Westminster NHS Foundation Trust

Area	Total	Green (Fully complete)	Amber	Red
Trust-wide actions: Risk / Governance	17	17	-	-
Trust-wide actions: Learning disability	4	4	-	-
Trust-wide actions: Learning and development	14	14	-	-
Trust-wide actions: Medicines management	5	5		-
Trust-wide actions: End of life care	26	26		-
Emergency and Integrated Care	33	32		1
Planned Care	55	54	1	-
Women & Children, HIV & GUM	35	35	-	-
Total	189	187	1	1
December position for comparison	189	185	3	1

Chelsea and Westminster commentary

The outstanding action relates to caring for mental health patients in an appropriate place; we are working with NHSE and partners. to address this

ICU transfers overnight remain an issue due to capacity issues within ICU, a new build is planned to address capacity.

Across both sites, the Trust has now now moved to planninng for the next CQC inspection

West Middlesex University Hospital

Area	Total	Complete	Green	Amber	Red
Must Have Should Do's	33	30	3	0	0
Children's & Young Peoples	32	32	0	0	0
Corporate	2	2	0	0	0
Critical Care	27	27	0	0	0
ED- Urgent & Emergency Services	17	16	0	1	0
End of Life Care	32	10	20	2	0
Maternity & Gynae	22	22	0	0	0
Medical Care (inc Older People)	19	18	0	1	0
Surgery	26	26	0	0	0
Theatres	15	15	0	0	0
OPD & Diagnostic Imaging	14	14	0	0	0
Total	239	212	23	4	0
December position for comparison	239	212	21	6	0

West Middlesex Commentary

Following successful recruitment into the end of life and palliative care team 2 actions have moved from amber to green

1 action will soon be closed with the reconfiguration/ rebuild of the Emergency Department and 1 outstanding for medical care relates to the community infrastructure and other health partners supporting earlier discharge.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	2.4/May/17
REPORT NAME	*Governors' Questions
AUTHOR	Various
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To note.
SUMMARY OF REPORT	**1. The question raised by Governor Tom Pollak:** Would it be possible for the items to be discussed in the private part of Board meetings to be listed on the agenda paper below the public session items? **Response from Lesley Watts, Chief Executive Officer:** We acknowledge the Board's responsibility to be transparent and have therefore significantly increased the number of items we take in public board session. In parallel we have also reviewed the approach of other Trusts regarding the publication of their private board agenda and have found very few examples of this practice in the NHS. Having considered this matter carefully, we have decided to not publish our private board agenda. Items are only discussed in private if they are either highly confidential or of a commercially sensitive nature. We would therefore potentially be compromising our position should this be made public, even in summarised form. **2. The question raised by Governor Lynne McEvoy:** Last year I met with Keith Loveridge and Thomas Lafferty regarding the staff governor role and how best the trust could facilitate them. This issue had previously been raised at Board meeting. I am not sure if any other staff governors had similar meetings. As yet I have had no feedback from that meeting. **Response from Keith Loveridge, Director of HR & OD:** We have met with staff governors and as a result letters had been sent out to the line manager of all elected staff governors to ensure their role as governor is being supported in order to discharge their role.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.

QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	2.5/May/17
REPORT NAME	*Draft Minutes of the Council of Governors Quality Sub-Committee meeting held on 28 April 2017, including Terms of Reference
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Nigel Davies, Chairman
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Quality Sub-Committee meetings held on 28 April 2017. The Quality Sub-Committee Terms of Reference, which were reviewed and updated by the sub-committee at its meeting on 28 April, are appended for ratification by the Council of Governors.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	The draft minutes are enclosed for information. The Terms of Reference are enclosed for ratification.

Minutes of a meeting of the Council of Governors Quality Sub-Committee
Held at 10am on 28 April 2017
Boardroom, Chelsea and Westminster

Attendees	Nigel Davies	Chair (Public Governor – Ealing)	ND
	Susan Maxwell	Patient Governor	SM
	Simon Dyer	Patient Governor	SD
In attendance	Shan Jones	Director of Quality Improvement	SJ
	Sian Nelson	Patient Experience Team	SN
	Vida Djelic	Board Governance Manager	VD
Apologies	Anna Hodson-Pressinger	Patient Governor	AHP
	Laura Wareing	Public Governor – London Borough of Hounslow	LW
	Paul Harrington	Public Governor – London Borough of Richmond	PH
	Lynne McEvoy	Staff Governor – Nursing and Midwifery	LM
	Chisha McDonald	Staff Governor – Allied Health Professionals, Scientific and Technical	CMD
	Sonia Samuels	Public Governor – City of Westminster	SS
	Guy Pascoe	Public Governor – London Borough of Hammersmith and Fulham	GP
	Sonia Richardson	Patient Representative on the West London CCG	SR

1.	**Welcome and Apologies**	
a.	The Chair welcomed members to the meeting.	
b.	Apologies received were noted.	
2.	**Minutes of previous meeting held on 23 February 2017**	
a.	Minutes of the previous meeting were accepted as a true and accurate record of the meeting.	
2.1	**Matters Arising**	
a.	The sub-committee reviewed the action log and noted that most of actions were complete.	
b.	In relation to the action 4.b SJ noted that the Quality Committee reporting template was provided for information.	
c.	In relation to the action 6.g SN noted that a proposal to involve governors in helping with FFT will be actioned once the training programme has been established. It was clarified that governors would collate responses from outpatients, Emergency Department and discharge lounge as opposed to inpatients.	
3.	**Nomination/election of sub-committee Deputy Chair**	

a.	The sub-committee noted that in accordance with the governance process it should elect a Deputy Chair. SM proposed Simon Dyer for the post of the Deputy Chair. All members agreed to elect Simon Dyer as the Deputy Chair of the sub-committee.	
b.	As way of promoting good corporate governance and in line with the Membership & Engagement Sub-Committee the appointment of the Deputy Chair is added to the sub-committee Terms of Reference at para 4.2.	
4.	**Governor's Patient Story**	
4.1	**Governor feedback on patient contacts**	
a.	SD provided his experience of finding difficult to get though the hospital phlebotomy in Kobler Day Clinic in order to make a phlebotomy appointment via a phone call. Two issues arose from here; one being the telephone system and the second availability of appointments in phlebotomy. **Action: VD to invite Lee Watson/Chris Hill to update the sub-committee on phlebotomy.**	
b.	It was recognised that experience of making a hospital appointment impacts on overall patient experience of hospital services.	
c.	SM reported on a recent positive experience of dermatology appointment booking. Two weeks prior to the appointment she received a call to confirm the appointment and then a day before the appointment another call followed up to remind her of the appointment. She complimented the department and hoped that confirmation calls help with reducing number of non-attendances.	
5.	**Quality Sub-Committee Terms of Reference**	
a.	ND noted that a slightly revised Terms of Reference were provided with the papers.	
b.	It was noted that SM reviewed and contributed towards the updated Terms of Reference. It was further suggested to insert at 3.7 'such as COG Quality Awards' after 'initiatives'. Add 'and recognise as well as' after word 'staff'. Remove 'Board' from para 3.9.	
c.	Replace 'identify' with 'review' at para 3.1 and remove 'in line with national local initiatives' since this is specific to the Quality Report.	
d.	Remove from the in attendance list at 4.3 the following: Assistant Director of Nursing, Membership and Engagement Manager, Equality and Diversity Manager and Head of Clinical Governance.	
e.	It was noted that the revised Terms of Reference will be submitted to the May Council of Governors meeting for approval alongside the draft minutes. **Action: VD to update the Terms of Reference and to add to the May Council of Governors meeting for approval alongside the draft minutes.**	
6.	**Quality**	
6.1	**Governors' Commentary for the Quality Report**	
a.	It was noted that SM produced a draft Governors' comments on Quality Report on behalf	

	of the Council of Governors and presented it to the Sub-Committee. The commentary acknowledges what has gone well in the previous year and recognises that there is a room for improvement. ND added that he was pleased that there is a joint working developed between the two hospitals to ensure consistency.	
b.	ND noted that he will provide SM with a line for the commentary to include the acquisition of West Middlesex Hospital. The final draft commentary will be taken to 18 May Council of Governors meeting for approval. **Action: ND to provide SM with the additional wording for the commentary relating to the acquisition of West Middlesex Hospital.**	
6.2	**Update on significant items from Board Quality Committee held 25 April 2017**	
a.	SJ updated the sub-committee on feedback she has received from the Quality Committee on the draft Quality Report and noted that it will be written in a story style as opposed to providing data with little or no narrative, as suggested by the Chair of the Committee. She confirmed that the content of the report remained the same.	
b.	SJ noted that the Quality Committee received an update on the Care Quality Programme led by Melanie van Limborgh, Assistant Director of Nursing. SJ highlighted some good quality initiatives taking place as part of preparation process, including staff engagement.	
c.	In response to a question from ND, SJ said that the inspection is likely to take place in the summer.	
d.	The Quality Committee also received assurance around the fire safety programme which aims to deliver best practice against the regulatory requirements, including regular reviews of fire risk assessments, fire training for staff and fire safety improvement works.	
e.	Quality programme is managed within each of three hospital's divisions and Nathan Askew, Divisional Director of Nursing, presented the Women, Neonatal, Children, HIV/GUM, Dermatology and Private Patients quality and safety plan. The report provided useful insight into how the division is addressing its quality priorities and service improvement.	
7.	**Questions or clarification arising from Patient Experience Report***	
a.	SN noted that a summary dashboard of divisional performance provided in the meeting pack.	
b.	In response to a question from SM relating to FFT rate of 118%, SN said that there were two submissions in one month and it affected the overall monthly submissions.	
c.	SJ noted that some further work was required in relation to data consistency and accuracy of the divisional quality report and more divisional involvement is required.	
8.	**Questions or clarification arising from Integrated Performance Report***	
a.	The sub-committee note that the Trust's performance for February 2017 and were pleased that the A&E performance improved. However, the 2WW Urgent Cancer target was of a concern. SJ said that the commentary provided lower down in the report detailed plans for improvement.	

9.	**Forward Plan**	
a.	The sub-committee reviewed the forward plan and the following points arose: • Invite Marie Courtney to provide an update on quality of food and choice of menu. **Action: VD** • ND to review and update the forward plan including the outstanding matters list. **Action: ND**	
10.	**Any other business**	
a.	It was noted that a mock-up of Intensive Care Unit was taking place in the Atrium (opposite the Hospital Boardroom).	
11.	**Date of next meeting** – 23 June 2017, 10.00-12.00, Room A, West Middlesex site	

The meeting closed at 11.45.

Post Meeting Notes:

Quality Awards Spring Winners

The Quality Awards Judging Panel met immediately after the Quality Sub-Committee meeting. The candidates listed below were selected to receive awards.

Emily Ward – Reviewing medication in older patients (individual prize)
Cara Taylor – Children's Bravery Box (individual prize)
Darren Brown – HIV and Physiotherapy (individual prize)
Dr Bobby Mann & his Project Team – Adult Asthma Care Bundle (team prize)

The two applications receiving "Highly Commended" certificates only are:
Dr Sheba Azam and her Support Team - Digital Transformation in Neurophysiology Reporting
Dr. Marcela Vizcaychipi and Dr. Linsey Christie - ITU Clinical Research Team

The awards will be presented by the Chairman to the winners at the 18 May Council of Governors meeting.

Council of Governors Quality Sub-Committee
Terms of Reference
DRAFT – proposed amendments shown in red

1.0 Authority

1.1 The Council of Governors Quality Sub-Committee is constituted as a Sub- Committee of the Council of Governors under Standing Orders 5.1 and 5.2 of Annex 7 to the Trust Constitution.

1. 2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

2.0 Aim

This sub-committee is to monitor and enquire into all aspects of the quality of services provided in the Trust's hospitals, providing key stakeholder input into the development and implementation of the Trust's quality programme, including safety, effectiveness and patient experience.

3.0 Role

3.1 To ~~identify~~ review priorities for quality improvement ~~in line with national and local initiatives~~

3. 2 To contribute to the structure and content of the Quality Account, within the required framework, to ensure it is clearly and well-presented and can be understood by all stakeholders, including developing agreed metrics.

3.3 To advise on communication of the Quality Account, and quality initiatives including meeting the needs of a range of patients.

3.4 To identify ways in which stakeholders can be involved in the quality programme e.g. safety walkabouts, advising on leaflets.

3.5 To champion the patient's experience and encourage and advise on patient involvement.

3.6 To identify areas where there is particular added value from stakeholders.

3.7 By the inducement of a Council of Governors' Quality Award, to encourage staff to enhance the quality of care through initiatives, projects, and/or new working methods, which bring about improvements to the patient and staff experience.

3.8 To obtain the lay perspective on assurance of quality.

3.9 To link in to work of the Quality Committee and receive a bi-annual update from the Quality Committee.

4.0 Membership of the Sub-Committee

4.1 The Sub-Committee shall comprise both elected and appointed governors, with representatives from CCGs and Healthwatch in attendance.

4.2 A Chair and Deputy Chair will be appointed by and from the governor members of the sub-committee

4.3 The following Trust staff shall be members of the Sub-Committee:

a) The Chief Nurse and/or the Medical director

b) The Director of Quality Improvement

c) ~~The Director of Governance and Corporate Affairs~~Company Secretary

In attendance:

- ~~Assistant Director of Nursing~~
- ~~Membership and Engagement Manager~~
- ~~Equality and Diversity Manager~~
- ~~Head of Clinical Governance~~
- Board Governance Manager
- Other Trust staff maybe be invited to attend

5.0 Quorum

5.1 A quorum shall comprise at least one of the ~~Director of Governance and Corporate Affairs~~Company Secretary, Chief Nurse or Medical Director (or their nominated deputy) and three Governors.

6.0 Frequency of Meetings

6.1 The Sub-Committee shall meet ~~bi-monthly~~ quarterly and report to the Council of Governors after each meeting. Members of the sub-committee will be invited to participate in other trust 'task and finish' groups relating to quality issues as appropriate.

7.0 Administration of the Meeting

7.1 This will be undertaken by the Board Governance Manager.

8.0 Review

8.1 The terms of reference of the sub-committee shall be reviewed by the Council of Governors at least annually.

Revised by the Quality Sub-Committee on 28 November 2017

Council of Governors Meeting, 18 May 2017

AGENDA ITEM NO.	2.6/May/17
REPORT NAME	*Draft Minutes of the Council of Governors Membership Sub-Committee meeting held on 20 April 2017, including Terms of Reference
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Phillip Owen, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Membership Sub-Committee meeting held on 20 April 2017. The Quality Sub-Committee Terms of Reference, which were reviewed and updated by the sub-committee at its meeting on 20 April, are appended for ratification by the Council of Governors.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	The draft minutes are enclosed for information. The Terms of Reference are enclosed for ratification.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of a meeting of the Council of Governors Membership & Engagement Sub-Committee
Held at 10.00 on 20 April 2017
Room A, West Middlesex

Attendees	Philip Owen	Chair	PO
	David Phillips	Patient Governor	DP
	Nowell Anderson	Public Governor – Hounslow	NA
	Kush Kanodia	Patient Governor	KK
	Tom Pollak	Public Governor – Wandsworth	TP
In attendance	Don Neame	Director of Communications	DN
	Michael Hill	Strategy Analyst	MH
	Vida Djelic	Board Governance Manager	VD
Apologies / Absence	Paul Harrington	Public Governor – Richmond	PH
	Anna Hodson-Pressinger	Patient Governor	AHP
	Sonia Samuels	Public Governor – Westminster	SS
	Ian Bryant	Staff Governor	IB
	Susan Maxwell	Lead Governor	SM
	Matthew Shotliff	Staff Governor	MS

1.	**Welcome and Apologies**	
a.	The Chairman welcomed the members to the meeting.	
b.	Apologies were received from Anna Hodson-Pressinger, Paul Harrington and Matthew Shotliff.	
2.	**Minutes of the previous meeting held on**	
a.	Minutes of the previous meeting were accepted as a true and accurate record of the meeting.	
3.	**Matters Arising**	
a.	The sub-committee reviewed the list of actions and the following points were noted: • TP did not receive any updates from the sub-committee members relating to public events on health related matters taking place in their relevant public areas. PO added that other ways of finding out about health related events held in the local boroughs will be explored in order to promote membership of CW via these meetings. • PO confirmed to the sub-committee his plans to run another membership survey considering that the outcomes of last year's survey were very valuable to the Trust and the sub-committee.	

	• PO confirmed that he and Don Neame will be working jointly on advertising benefits of becoming a member. • PO noted that from his experience holding a meet a governor session in local borough libraries works well and reported that so far he has recruited approx. 27 new members and received interest from public members about joining as volunteers. • TP to find out dates of Clinical Commissioning Groups annual meetings and to share with the sub-committee. **Action: TP** • VD noted that Matthew Shotliff, Staff Governor, and she will be organising the next Your Health seminar. A topic and speaker are to be identified. She was hoping to be in the position to distribute the May seminar details to members on email by the end of the following week. KK suggested getting a speaker from organisations other than just the hospital that are of interest to members. VD said that all events are organised in coordination with the Chair of the sub-committee and that topics for future seminars were identified by members during the membership survey. She added that all sub-committee members should provide her with a list of external speakers for future health seminars planning. **Action: ALL** • In relation to the budget for 2017/18 VD said that the Finance Manager confirmed the figure of £58k.	
4.	**Terms of Reference**	
a. b.	The Terms of Reference were reviewed and approved by the sub-committee. It was noted that the Terms of Reference will be appended to the minutes and submitted to the 18 May Council of Governors for ratification.	
5.	**Chairman's remarks**	
a. b. c. d.	PO reported that he has recently attended neighbouring residents' association meeting and as a result managed to sign up seven new members. KK felt that people who attend association meetings are regularly engaged in these meetings and therefore more likely to sign up. He suggested that benefits of being a member of the Trust can go in their magazine which is distributed to local residents. PO noted that the total membership numbers in the West Middlesex public areas could improve and a though will be given to that effect. PO reported on his recent with the Interim Director of Communications and he was pleased that some improvements have already taken place in the communication area. He added that communication department will continue to facilitate advertising of membership events on screens. The sub-committee noted the progress with recruiting for the post of Membership	

	Officer and discussed the requirements for the post-holder. TP noted that it would be beneficial if the post-holder had knowledge of West Middlesex public areas and that the person works across the two Trust's major sites.	
6.	**Membership Report**	
a.	The sub-committee reviewed the report provided by MES and the following points were raised: • The report implied that there was no movement in staff numbers and that the numbers were updated once in 2016/17. VD to check with MES the frequency of updating staff numbers. **Action: VD** • % of area index chart on p.8 of the report indicated that the Royal Borough of Kensington and Chelsea had the lowest %. **Action: VD to query this with MES.**	
7.	**Membership Engagement & Communications Calendar of Events, including Open Day 20 May 2017**	
a.	The sub-committee noted the draft calendar of events and acknowledged that dates of for some events were due to be firmed up.	
8.	**Guest Speakers**	
8.1	**GP Surgeries and Membership**	
a.	Michael Hill, Strategy Analyst, gave a presentation on where our members live and where GPs who refer patients to us are located and where there are gaps in GPs not referring patients to us.	
b.	Michel clarified that the membership included only patients and did not include any staff members.	
c.	The presentation demonstrated that there was a high referral rate by GPs to the Trust; this included both CW and WM sites. In response to a question from PO how we define high level referral MH said that it is defined by referral vs patient list size.	
d.	DP said that the sub-committee is interested in MH helping out with the marketing the Trust's membership. MH confirmed that he could assist with providing details of some GP surgeries which governors can visit and publicise their membership brochure.	
e.	MH concluded that the membership covers most of the areas from which GPs refer to the Trust.	
f.	In response to KK's question if it would be possible to look at emergency care patients to see how this compares against population density, MH said that it was possible and that he can provide that information at the next sub-committee meeting. **Action: MH**	
g.	DP thanked MH for providing a very helpful presentation thus reassuring governors that GPs refer to the Trust and so that governors could see where the patient membership comes from.	
8.2	**Communications update**	

a.	Don Neame, Director of Communications, provided an overview of communications department work. The main focus currently is on external communications and on the quality improvement programme. We are in the process of developing patient leaflets and ward boards. The department is also working on updating the website, maintaining good relationship with media, etc. The team is progressing with organising the 20 May Open Day at CW site. The Open Day event at West Middlesex site will be held on 16 September. Both events present a good opportunity for recruitment of members and publicity of the Trust. He recognised the Council of Governors contribution with sponsoring the event.	
b.	In light of West Middlesex Open Day DN proposed to the sub-committee that the next year Open Day takes place earlier in the year ie. May or June. The Sub-Committee agreed.	
c.	VD said that Susan Maxwell indicated that so far only two governors volunteered to assist with the governor stand. She would like some more governor volunteers to help with the stand. **Action: ALL**	
d.	In response to a question from KK, DN said that he would look into the possibility of including a pager on becoming a member of the Trust in the leaflet. **Action: DN to consider and to get back to the sub-committee.**	
e.	In response to a question from TP if the leaflet will be produced in other languages, DN said that since the leaflet is in the process of development that would be considered at a later stage.	
f.	Other communication team's activities included: • Development of Social Media Guide and the positive engagement with the social media • Focus on internal communication and staff engagement • Production of Going Beyond magazine • Working on streamlining TV messages	
g.	In response to a question from PO if DN could assist with the production of E-News publication for members, DN said that since he was not previously involved in governor / membership publications however, he would be happy to discuss the content and to share any publications already available from the communications team with the corporate affairs. **Action: DN/VD to discuss.**	
9.	**Funding report**	
a.	The funding report was noted.	
10.	**Feedback from members**	
a.	DP informed the sub-committee of an event to acknowledge the CW+ and the Chelsea Arts Club will be held on 3 May at 19.00 in Medicinema and encouraged the members to attend.	

b.	NA reported on feedback received from patients in relation to some patients not being aware where to feedback their experience; there was also a useful suggestion to have inpatient wards visiting times list available. DN responded that the patient experience should be directed to PALS and that a list of wards and visiting times is available on the hospital's website.	
11.	**Any other business**	
a.	None.	
12.	**Date of next meeting** – 22 June 2017, 10.00-12.00 (Hospital Boardroom, Chelsea and Westminster)	

The meeting closed at 12.10.

Council of Governors Membership & Engagement Sub-Committee

Terms of Reference

1.0 Authority

1.1 The Council of Governors Membership & Engagement Sub-Committee is constituted as a sub-committee of the Council of Governors. The purpose of the sub-committee is to assist the Council of Governors to implement and develop the Trust's Membership Recruitment, Engagement and Communications Strategy and to facilitate communication between the Trust's members and the Council of Governors.

1.2 Its terms of reference shall be as set out below and shall not be amended, revoked or replaced except by a resolution passed at a general meeting of the Council of Governors.

2.0 Role

2.1 The Council of Governors Membership & Engagement Sub-Committee shall be responsible for advice and support on:

a) the production of material to recruit new members for the Trust and to engage members in the work of the Trust;
b) the content of the material on the hospital's website and publicity materials for use across the hospital sites and within the community;
c) the use of the Council of Governors budget for the implementation and development of the Trust's Membership Recruitment, Engagement and Communications Strategy, membership engagement and communication calendar of events and membership recruitment calendar of events;
d) ensuring that publicity material is written in plain English, free of jargon and unexplained acronyms.

2.2 The Council of Governors shall not delegate any of its powers to the sub-committee and the sub-committee shall not exercise any of the powers of the Council of Governors.

3.0 Membership of the sub-committee

3.1 The sub-committee shall comprise 9 elected Governors from the public, patient and staff constituencies who are concerned with the implementation and development of the Trust's Membership Recruitment, Engagement and Communications Strategy.

3.2 The following members of the Trust's staff are eligible to attend:

a) ~~Director of Corporate Affairs~~ The Company Secretary
b) ~~The Deputy Director of Corporate Affairs~~The Deputy Company Secretary
c) ~~The Head of Communications and Marketing~~
~~c)~~d) The Membership Officer
~~d)~~e)The Equality & Diversity Manager (as required)

e)f) The Board Governance Manager

~~h~~g) In addition, the committee may invite other people to attend including those from an external organisation

4.0 Quorum

4.1 A quorum shall comprise:

(1) 3 Governors

(2) 2 trust staff: one of either ~~Director of Corporate Affairs or Deputy Director of Corporate Affairs~~ Company Secretary, or Board Governance Manager and Membership Officer.

5.0 Frequency of meetings

5.1 The committee shall meet quarterly and report regularly to the Council of Governors.

6.0 Attendance requirements

6.1 The committee members are expected to attend two thirds of the meetings in a year.

7.0 Planning and administration of meetings

7.1 The committee shall elect from its membership, a Governor to serve as Chairman to serve for term agreed by the Committee. The Chairman will be eligible for re-election after the term has expired.

7.2 The committee shall elect from its membership, a Governor to serve as a Deputy Chairman who will be appointed at the same time as the Chairman.

7.3 The ~~Deputy Director of Corporate Affairs~~ Board Governance Manager will support the planning of the Sub-Committee.

7.4 The Board Governance Manager will act as secretary to the Sub-Committee.

7.5 The Membership Engagement & Communications and Recruitment Plans will be agreed by the Sub-Committee and ratified by the Council of Governors.

8.0 Review

8.1 The terms of reference of the Sub-Committee shall be reviewed by the Council of Governors annually.

Revised by the Membership & Engagement Sub-Committee on 20 April 2017