Chelsea & Westminster Hospital NHS Foundation Trust
Council of Governors

Boardroom, Chelsea and Westminster Hospital

17 May 2018 15:00 - 17 May 2018 17:00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS
17 May 2018, 15.00 – 17.00
Boardroom, Chelsea and Westminster Hospital

Agenda

14.00 – 14.30		**Lead Governor and COG Informal Meeting PRIVATE (attended by the Lead Governor and Governors only)**			
14.30 – 14.55		**Chairman's Appraisal PRIVATE (attended by the Senior Independent Director, Lead Governor and Governors only)**			
	1.0	**STATUTORY/MANDATORY BUSINESS**			
15.00	1.1	Welcome and apologies for absence	Verbal		Chairman
15.03	1.2	Declarations of interest	Verbal		Chairman
15.05	1.3	Minutes of previous meeting held on 15 February 2018 and Action Log, including	Report Report	For Approval / For Information	Chairman
	1.3.1	Car Parking review	Report	For Information	Deputy Chief Executive
15.10	1.4	QUALITY			
	1.4.1	Care Quality Commission (CQC) report	Report	For Information	Eliza Hermann
	1.4.2	Draft Quality Report 2017-18	Report	For Information	Eliza Hermann
	1.4.3	Draft Governor Commentary on the Quality Report 2017-18	Report	For Approval	Lead Governor
15.40	1.5	FINANCE 1.5.1 Finance & Investment Committee Report to Council of Governors 1.5.2 Draft Month 12 Financial Position 1.5.3 Annual Plan submission to NHSI	 Report Report Report	 For Information For Information For Information	 Jeremy Jensen Chief Financial Officer Chief Financial Officer
15.55	1.6	North West London landscape	Pres.	For Information	Deputy Chief Executive
	2.0	**PAPERS FOR INFORMATION**			
16.15	2.1	*Chairman's Report	Report	For Information	Chairman
16.20	2.2	*Chief Executive Officer's Report	Report	For Information	Chief Executive Officer

16.25	2.3	*Performance and Quality Report, including 2.3.1 Workforce Performance Report	Report Report	For Information For Information	Chief Executive Officer /Chief Financial Officer
16.30	2.4	*Governors' questions	Report	For Information	Chief Executive Officer
16.35	2.5	Quality Sub-Committee Report February and April 2018, including • Terms of Reference • Governors quality improvement award	Report/ Verbal	For Information / For Approval	Lead Governor
16.40	2.6	Membership Sub-Committee Report February and April 2018, including • Terms of Reference	Report	For Information / For Approval	Chair of Membership Sub-Committee
	3.0	**OTHER BUSINESS**			
16.45	3.1	Questions from the public	Verbal		Chairman
16.55	3.2	Any other business	Verbal		Chairman
17.00	3.3	Date of next meeting – 26 July 2018, 15.00-17.00, Room A, West Middlesex site			

*Items that have been starred will not be discussed, however, questions may be asked.

17.00 – 18.00	**NED/COG Informal Meeting PRIVATE (attended by NEDs, Lead Governor and Governors only)**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of the Council of Governors Meeting
Held on 15 February 2018 at 16.00 in Boardroom, Chelsea and Westminster

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Julia Anderson	Appointed Governor	(JA)
	Nowell Anderson	Public Governor	(NA)
	Richard Ballerand	Public Governor	(RB)
	Juliet Bauer	Patient Governor	(JB)
	Nigel Davies	Public Governor	(ND)
	Simon Dyer	Lead Governor/Patient Governor	(SD)
	Anna Hodson-Pressinger	Patient Governor	(AHP)
	Kush Kanodia	Patient Governor	(KK)
	Paul Kitchener	Public Governor	(PK)
	Martin Lewis	Public Governor	(ML)
	Johanna Mayerhofer	Public Governor	(JM)
	Guy Pascoe	Public Governor	(GP)
	Andrea Petre-Goncalves	Patient Governor	(APG)
	David Phillips	Patient Governor	(DP)
	Tom Pollak	Public Governor	(TP)
	Chisha McDonald	Staff Governor	(CMD)
	Mark Nelson	Staff Governor	(MN)
	Fiona O'Farrell	Public Governor	(FOF)
	Matthew Shotliff	Staff Governor	(MS)
In Attendance:	Lesley Watts	Chief Executive	(LW)
	Sandra Easton	Chief Finance Officer	(SE)
	Robert Hodgkiss	Chief Operating Officer	(RH)
	Paul Goodrich (in part)	Managing Director Private Care	(PG)
	Nick Gash	Non-Executive Director	(NG)
	Eliza Hermann	Non-Executive Director	(EH)
	Steve Gill	Non-Executive Director	(SG
	Jeremy Jensen	Non-Executive Director	(JJ)
	Liz Shanahan	Non-Executive Director	(LS)
	Gary Sims	Non-Executive Director	(GS)
	Renuka Jeyarajah-Dent	NExT Director	RJD
	Julie Myers	Company Secretary	(JM)
Apologies:	Ian Bryant	Staff Governor	(IB)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Tom Church	Patient Governor	(TC)
	Cllr Catherine Faulks	Appointed Governor	(CF)
	Jodiene Gringam	Staff Governor	(JG)
	Angela Henderson	Public Governor	(AH)
	Elaine Hutton	Public Governor	(EHA)
	Lynne McEvoy	Staff Governor	(LMc)
	Sonia Samuels	Public Governor	(SS)
	Laura Wareing	Public Governor	(LWa)
	Andrew Jones	Non-Executive Director	(AJ)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Karl Munslow-Ong	Deputy Chief Executive	(KMO)
	Pippa Nightingale	Chief Nurse	(PN)
	Zoe Penn	Medical Director	(ZP)

1.0	**STATUTORY/MANDATORY BUSINESS**
1.1	**Welcome (including to newly elected governors) and apologies for absence**
	The Chairman welcomed new governors and those attending the meeting for the first time. EH introduced Renuka Jeyarajah-Dent (RJD) to the meeting and explained that the Trust was participating in the NExT Director scheme run by NHS Improvement (NHSI). The scheme matched aspiring NHS Foundation Trust (FTs) non-executive directors with a Trust, with the ultimate aim of increasing female and BAME appointments to FTs. RJD would be with the Trust until September 2018. Whilst she would attend Board meetings, she was not appointed to the Board and would be non-voting. Apologises for absence had been received from Governors Councillor Catherine Faulks, Angela Henderson, Lynne McEvoy, Christopher Digby-Bell, Sonia Samuels, Elaine Hutton and Ian Bryant. The following Board members also sent apologies: Andrew Jones and Nilkunj Dodhia and Karl Munslow-Ong, Pippa Nightingale and Zoe Penn.
1.2	**New Governors introduction**
	Introductions were made by new governors Johanna Mayerhoff, Fiona O'Farrell and Professor Mark Nelson. Martin Lewis, a previous lead governor and now a returning governor, also introduced himself. All were welcomed by the Chairman.
1.3	**Declarations of Interest**
	There were none.
1.4	**Minutes of previous meeting held on 30 November 2017 and action log**
	Minutes The minutes of the meeting held on 30 November 2017 were approved subject to the attendance list being corrected: - to record that Steve Gill was present - to correct the spelling of Tom Pollak's (Pollak not Pollock) **Action log** LW noted that a review of car parking was conducted across both sites. This was ongoing and included an exercise to benchmark the Trusts parking against charges. The emerging results suggested that the Trusts parking charges were lower than those of others. This matter will return to the Council once the review had concluded. With regard to drop-off arrangements, LW advised that the Trust was speaking to the Council to request a limited drop-off time. She acknowledged that the current arrangements at the Chelsea site were difficult and that parking wardens were on duty 24 hours each day. **Action: Outcome of car parking review to be reported to a future Council meeting.**
1.5	**Quality**
1.5.1	**'Where we are with our staff': People and Organisation Development (POD) Committee report to Council of Governors**
	LW informed Council informed that Keith Loveridge, Director of People and Organisation Development had decided to leave the Trust. In his absence, people and organisation development matters were being led in the interim by Sandra Easton (Chief Finance Officer) and Pippa Nightingale (Chief Nurse). The Board would discuss the longer-term arrangements for executive leadership of this function in due

course.

POD Committee report

LS introduced herself, as the outgoing Chair of POD, and SG, as the incoming POD Chair, to the meeting. The Council was reminded that the Committee was relatively new but LS reported that membership was now stable and the right spread of sub-committees had been established. Initially, the Committee was concerned that the data it received on people was not sufficiently robust but LS was pleased to report that it was now much better. The data provided reassurance that plans that had been put in place to address identified people issues were now starting to deliver results, although the position was not perfect and more work was still required.

One area that was seeing results was in statutory and mandatory training. The programmes had been refreshed and were now online. Positive feedback had been received and completion rates were increasing. New starters were able to complete the training before they commenced work, saving valuable time.

The Committee would be reviewing the progress of other initiatives, such as the programme to attract and retain staff, at future meetings. LS reported that considerable work was underway to ensure different parts of the organisation worked together to resolve problems.

SG extended his thanks to LS and NG for their work in establishing and driving the Committee. He noted that people are the most important asset any organisation has. It was important to look at recruitment, retention and development to make sure that the pipeline for talent was in place. He reported that there was work underway by PA Consulting to look at a number of processes and procedures to help to identify improvements and enable a plan to be put in place so that performance in relation to people can be measured effectively and reported to both Board and the Council.

During discussion of the POD report, the following points were made:

- MN suggested that graphs included in the POD paper risked giving a misleading picture of performance. In particular, as regards training, the improvement was not significant. He asked how this situation would be improved. LW advised that the Trust has now stated that there will be no study leave and no increments awarded to anyone who has not completed their mandatory training. She noted that most people do complete their training and the preference would obviously be for people to complete it willingly, as the vast majority do. NG reinforced that POD were looking to make sure that new starters completed their training before they started work with the Trust. THH noted that the Board had recently received a helpful presentation from NHSI regarding the presentation and use of data and that this was being considered across the Trust.
- PK asked for clarification of the second graph. LS and SE explained that the graph showed how a new approach in A&E at West Middlesex site had resulted in a significant reduction in the use of agency staff for vacant shifts and a welcome increase in the number of shifts being covered by the Trust's own bank staff. This brought not only cost benefits but benefits from consistency in that the staff were known to the Trust.
- ML asked whether time from appointment to start date is reducing. SE confirmed that it is, as Disclosure and Barring Service (DBS) checks are now much quicker. The Trust was also now more proactive in chasing references, but this relied on third parties. She noted that the average time between offer and start date had reduced by six weeks.
- ML asked about new forms of practice such as assistant nurse roles. LS confirmed that POD had reviewed these developments and they remained on the forward agenda.
- SD reported that he has observed some anomalies whilst completing the online training. LW asked that he feedback to the learning and development team.
- GP commented that Governors were concerned that there had been such a change in Non-Executive membership of the Committee. He asked how this could be avoided in the future and if there had been adequate handover. THH advised that the Board had taken a considered look at the skills and experience of the NEDS and the requirements of all of the Committees. The changes reflected the skills and experience of new NEDs and the need to ensure that

	Committees were refreshed. There had been a three month handover to ensure continuity. EH noted that, as Chair of Quality Committee, she already had considerable familiarity with a number of the people issues considered by POD. SG noted also that, whilst LS and NG would not be on the Committee, they did remain as NEDs on the Board. NG observed also that he retained his Freedom to Speak UP remit and so would continue to liaise with the Committee as required. - In response to a question from CM, LW confirmed that the number of increments withheld until mandatory training was completed would be checked. **Action: SE to confirm number of staff who had increments withheld until mandatory training completed**. On behalf of the Board and the Council, THH thanked LS and NG for their hard work in establishing POD.
1.5.2	**Private patients briefing**
	RH introduced PG, Managing Director of Patient Care to give an overview of the Trust's developing thinking as regards its private patient strategy. PG spoke to the paper presented and noted that private patient work generates circa £20million of profit, equating to around 150 nurses, and is a major source of non-NHS income to the Trust. The four main areas in which the Trust generates private patient income are: Kensington Wing (private maternity); assisted conception; private paediatrics; and Chelsea Wing (general). PG noted that the market for private healthcare in London was dynamic, and increasing at a rate of 5 – 7% per annum as a result of it being a destination of choice for international patients and the increasing number of self-paying patients. There have also been a number of changes in the private medical insurance market. PG indicated that the Trust is considering both its short-term and long-term strategies. In the short-term it is primarily about how to maximise existing assets (32 beds). Longer term the Trust may be looking at, for instance, collaboration with others. In response to a question from DP, PG confirmed that the Trust's private patient work would not detract from the Trust's NHS work including in terms of both beds and consultants. There was an argument to suggest it would improve the NHS position as all profits would be reinvested. With regard to space, PG noted that the Trust does not operate currently at full capacity eg evenings and weekends and does not utilise fully all of its assets. In the longer-term, the Trust may need to look at collaboration with other providers. KK suggested that it would be helpful to clarify potential for income generation and to look at comparator Trusts. Ideally, a target income for the end of a three-year period should be identified, growth trends analysed and utilisation rates studied. PG and LW confirmed that this work was in train but that it was important to recognise that there were commercial sensitivities attached to it. As plans developed, they would be brought back to the Council. JJ and RH confirmed that thinking was being scrutinised at executive level and by Finance and Investment Committee (FIC). In response to a question from ND regarding the enthusiasm for the strategy from the consultant body, LW noted that it was important to meet the needs of loyal staff's legitimate NHS and private patient expectations. MN asked about plans for developing a strategy for West Middlesex and, also, how decisions about where income was invested would be made. PG advised that a strategy was being developed for WM but that it would be different to C&W. C&W was a mature operation whereas WM was, in effect a start-up, without any of the basics in place. LW advised that any decisions on investment would be made by the Board in line with strategic priorities, not by individual consultants.

	PK asked whether there were any concerns about access to facilities, noting that, in the past, he was aware of consultants choosing to work elsewhere because of this. PG emphasised that the clinical needs of patients, whether private or NHS, would always take priority. There were no dedicated facilities for private patients and this meant that it was different to a dedicated private facility. A private patient in this Trust would have a dedicated bed, but not dedicated facilities: these would need to be shared. TP asked about the WM estates strategy, where he believed there was capacity to expand. PG agreed and noted that it was clearly important to develop a private patient offering at WM but estates matters took time to resolve. In the meantime, there were some basics to address, such as ensuring private medical insurers recognised West Middlesex. In response to a question from SHP, LW confirmed that the same nursing strategy was in place across all areas of the hospital but that there were some particular skills mixes in place on the private wards. THH thanked Council for a constructive discussion and confirmed that Council was content with the direction of travel for the Trust's private patient strategy, including the cross-subsidisation of NHS activity by non-NHS activity, and expansion in a measured way to create income in order to preserve NHS services. The overriding principle would be that private patient activity would never be to the detriment of NHS patients. The subject would return to Council as plans developed.
1.6	**Council of Governors sub-committee membership**
	SD introduced the paper presented to the Council and confirmed that the subject had been discussed informally at the Governors pre-meeting. It remained the case that there was still likely to be a vacancy on the Membership and Engagement sub-committee. The Chairman expressed his surprise that the Membership and Engagement sub-committee did not have the requisite number of members, bearing in mind the important role that Governors play in representing the interest of Members. This should be one of the Council's key sub-committees. In response, JB suggested that to answer this question, it would be important for the Trust to understand why members had stood down from the sub-committee, in particular, to understand whether the sub-committee had been given tasks but no tools. TP observed that timings of meetings could also usefully be reviewed. Council agreed the following changes to sub-committee membership: - Agenda sub-committee – MN and JA to join - Nomination sub-committee – DP and SS to join - Quality sub-committee – no change - Membership and engagement sub-committee – RB to join, one vacancy remains. DP confirmed as Chairman Council discussed the following: - The need to ensure sub-committee membership was reviewed annually - Whether the Nominations sub-committee should have a role in identifying governors with good skills for specific sub-committees - Whether all governors should be a member of a sub-committee - Whether attendance at sub-committees could be by telephone. THH confirmed that he would reflect with SD and JM on AHP's question as to whether it was appropriate for non-members to attend sub-committees and MN's question as to why sub-committees had differing membership requirements.
2.1	***Chairman's Report**
	THH reported on a number of his recent and forthcoming meetings including: - Meeting the new Chair and CEO of NHSI

	- Forthcoming meeting with Care Quality Commission (CQC) Chairman - Meeting with new Minister of State for Health – who had singled the Trust out as an exemplar - Meeting with Chair Imperial College Healthcare NHS Trust - Forthcoming meeting to be scheduled with Members of the Royal Marsden NHS Foundation Trust - Meeting with Dean of Westminster Abbey, who had agreed to hold a service to celebrate the 300th Anniversary of the hospital - Recent dinner hosted by Chairman of CW+ to celebrate 25 years of the Chelsea and Westminster Hospital Council noted the potential for membership engagement arising from the number of important anniversaries taking place in 2018. KK suggested that a link might usefully be made with Chelsea Football Club (CFC). **Action: KK to alert Chris Chaney, CW+, to CFC contact.**
2.2	***Chief Executive Officer's Report**
	LW presented her report, focusing on the following points: - The CQC inspection had taken place in December and January, and NHSI had also conducted their review of use of resources. The draft CQC report is due in early March for factual accuracy checking and the final report is expected to emerge in late March/early April 2018. LW noted how hard the staff had worked to demonstrate to the CQC how much they care and how committed they are to patients. The inspection had taken place during one of the busiest times of the year and overall performance had been fantastic. It was these excellent levels of performance that had been an important contributing factor to the congratulatory letter received from the Secretary of State. It is important that staff know their hard work does not go unnoticed. - The conclusion of the HSE investigation. - The work underway to ensure the Trust has good communication and engagement, including referencing the quarterly newsletter and the CEO staff briefing. - The considerable amount of work underway to implement the Cerner EPR system. AHP thanked LW for her report and offered a vote of thanks on behalf of all of the Governors for the most outstanding performance. THH advised Council that he had asked JM to investigate how best to maximise the contribution of the Governors. JM noted that Governors are an essential part of the Trust's governance and have a responsibility to hold the non-executives to account and represent the views of the membership. It was important to identify a range of ways Governors could learn more about the Trust, and engage with the membership, especially for those who may not want to join sub-committees. She would be looking at arrangements in other Trusts and building on the work undertaken by NG in 2017, as well as working closely with SD, with the aspiration that the Trust is an exemplar of best practice. THH confirmed that he was committed to this work, which would also involve the Director of Communications. Governor involvement, and communication back to Council, would be coordinated through the Lead Governor.
2.3	***Performance & Quality Report, including**
	RH introduced the November performance report and updated Council on performance delivered over December and through to January. Throughout the period, the Trust had continued to deliver well against targets for Referral To Treatment (RTT), A&E and cancer. For A&E, in January, the Trust's performance was the 5th highest in the country. For cancer, performance was the 3rd highest nationally and performance was improving. On RTT, there had been some historic difficulties with the Trust's processes, which meant it had been hard to reach the target, but recent changes had seen the Trust

	reach the national target and backlogs were now the lowest they had ever been. RH noted that it was also important to see these levels in performance in the context of an increase in non-elective demand of more than 8% compared to this time last year. The teams had been working incredibly hard.
2.3.1	**Patient Services Team update**
	RH also reported on the new Patient Services Team structure. He advised that the team had chosen their new name themselves as they felt it represented clearly their purpose. A number of apprenticeships had been offered in the team and complaints have halved since June 2017. He reported that there was still some work to do, but through regular monitoring of key performance indicators (KPIs) it is clear that performance is going in the right direction. In response to a question from AHP, RH said that the three main reasons for the decline in complaints were likely to be: the introduction of a single telephone number for each specialism; reducing vacancies and increasing staff numbers; and a much greater focus on being slicker. AHP commended the performance of the team.
2.3.2	**Workforce Performance Report**
	Council noted this report.
2.4	***Governors' Questions**
	THH thanked Council for engaging in the new process for ensuring that Governors received as robust as possible an answer to their questions. The ability to see questions in advance, and answers, should ensure that real focus could be given to them. In discussion: - Question 3: TP observed that the question had not been answered in full.SE responded to the outstanding elements, noting that the Trust has seen an increase in nursing staffing, with more bank nurses and less agency nurses being utilised. The Trust spends £19m on agency staff across all areas. JJ reminded Governors that this was in the context of a payroll of circa £300m. He confirmed that, whilst the position was improving, the Trust's current spend on agency staff was just above the NHSI cap of £18m. SE advised that if the Trust continues on its current trajectory, it should expect to spend 20% less on agency staff next year. NG commented that Quality Committee had scrutinised quality aspects attached to agency nursing and had seen no evidence of any greater concern. There was a good common standard in place. - Question 4: PK asked whether the flu jab had had an impact on rates of sickness absence. LW confirmed that the flu jab does not give recipients flu and that there was no evidence of people taking time off sick as a consequence of receiving the jab. She reiterated firmly the benefits of all staff having the jab. PK said he had hoped to hear that receiving the jab had reduced sickness absence from flu. MN wondered if it were possible to correlate sickness rates of those who had had the jab with those who had not. LW advised that the Trust was exploring whether or not to make having the flu jab mandatory, as was the case currently for some other vaccinations. - Question 14: RB observed that a good answer had been provided, but noted that national research had shown that many clinicians were using such systems in breach of NHS policies. LW noted that clinicians ere members of eg WhatsApp groups and that activity was monitored to ensure it was in compliance with that permitted, where it was possible to do so. THH noted that the Board had been alerted to the forthcoming changes in legislation and the potential for increased levels of fine in these areas. The Audit and Risk Committee was alert to risks attached to data protection. - Question 11: DP thanked SE for the reply and asked if the information could be provided on a regular basis. **Action: Quarter-by-quarter payroll figures for medical/nursing/other groups to be appended to the quarterly performance report.**

	- Question 13: SD queried why the advice was to raise the matter with the local authority when this was a national issue. LW advised that the matter had been raised consistently by the Trust on a national basis but that any pressure that Governors could bring to bear on local authorities would also be helpful. - Question 15: KK reported that Governors had agreed that, whenever Governor representation was required for a meeting, Governors should self-select attendees. LW confirmed that this position was understood. She apologised if the process described in response to question 15 had led to any disharmony or upset. AHP noted the important role played by Governors in representing members. THH confirmed that the Governors had made their position very clear. MN and TP commented that the position reached by Governors was wider than simply in relation to CQC. In future, if numbers need to be limited for any meeting or consultation, Governors should meet or discuss in advance what should be raised by those who are selected by Governors to attend. This was acknowledged by THH, who confirmed that he would invite all Governors to attend a forthcoming meeting with the Dean of Westminster Abbey when he visits the hospital in the next few months.
2.5	***Quality Sub-Committee Report: 9 February 2018**
	This item was deferred in the absence of minutes.
2.6	***Membership Sub-Committee Report: 8 February 2018**
	This item was deferred in the absence of minutes.
3.1	**Questions from public**
	There were none.
3.2	**Any other business**
	Council agreed that 'any other business' would remain an agenda item to allow for discussion of urgent business. KK raised the importance of email etiquette. Discussion included the need to respond to emails in a timely fashion and to avoid the use of 'blind copying'. THH suggested that this may be an area that warranted further review. THH confirmed that he had met Philip Owen recently and had thanked him for his contribution and his offer of continued engagement. DP informed Council that a Health Matters seminar on stroke would be held on 21 February at the WM site. A Governor was requested to Chair the session. TP and CM indicated that they may be available and would confirm via VD or JM. THH reminded Governors that it would be helpful if any communication for the Chairman or CEO could also be copied to both JM and VD so that responses could be coordinated. THH closed the meeting and advised that JM would provide an introduction to her background at the next meeting.
3.3	**Date of next meeting – 17 May 2018**

The meeting closed at 18.15pm

Council of Governors – 15 February 2018 Action Log

Meeting	Minute number	Agreed Action	Current Status	Lead
Feb 2018	1.4	Outcome of car parking review to be reported to a future Council meeting.	This is on current agenda.	**KMO**
	1.5.1	SE to confirm number of staff who had increments withheld until mandatory training completed.	7 staff had increments withheld.	**SE**
	2.1	KK to alert Chris Chaney, CW+, to CFC contact.	This has been discussed with a contact at Chelsea FC and unfortunately they were not interested in the sponsorship opportunity with the hospital for our anniversary event next year.	**KK**
	2.4	Quarter-by-quarter payroll figures for medical/nursing/other groups to be appended to the quarterly performance report.	This will be provided on a quarterly basis. Month 12 will be provided after audit.	**SE**

Car parking briefing paper

The car parks at Chelsea and West Middlesex sites have been reviewed to assess how best to utilise the assets in the delivery of timely care to patients. A number of quality initiatives have been agreed by the Trust Board.

Summary

1. Staff parking

A proposed increase in tariffs for staff will apply at both sites subject to agreement with the Trust's Partnership Board. Despite the increase, both sites remain lower-cost than car parking alternatives in both boroughs, as well as at other hospitals.

Key messages:
- Small increase in cost is reflective of improved, safer car parking facilities.
- The small increase is also in line with rising costs and inflation across the board – as experienced by many of our colleagues who use public transport, who have experienced increases of up to 2.5% over two years. Car parking tariffs have not increased since 2016.
- Income generated will go directly to improving patient care, which is our top priority and benefits our patients as well as our valued staff.

2. Blue Badge parking (Chelsea site)

Blue Badge spaces are available at both sites. Currently, those at Chelsea are free for Blue Badge holders, but from 1 June, a tariff will apply (capped at £3/day). At West Mid, and many other hospitals, full tariffs apply for badge holders.

Key messages (Chelsea):
- We remain committed to providing car parking facilities for Blue Badge holders to ensure we offer accessible parking.
- We are introducing a small, capped tariff for Blue Badge holders utilising our Blue Badge car parking spaces on Chelsea site in 2018/19. This is at a significantly reduced rate from standard tariffs, and other nearby parking options. Financial support is available for those who need it, as it is now.
- Income generated will go directly to improving patient care, which is our top priority.
- We are also looking at options to increase the number of Blue Badge spaces at Chelsea.

3. Public parking (West Mid site)

Effective 1 July, improved car parking facilities will open at West Mid. This will coincide with a tariff increase for visitors.

Key messages (West Mid):
- We are offering improved, safer car parking facilities for our patients and visitors, including 46 new car spaces.
- To reflect the improved facilities and inflation, there will be a modest increase in tariffs, which have been carefully benchmarked with other local parking charges and neighbouring outer London hospital sites.
- Income generated will go directly to improving patient care, which is our top priority.

- Furthermore, we are committed to ensuring there is car parking available for our valued patients, visitors and staff. The modest increase will help make sure the car park is used primarily by those accessing the hospital, rather than those taking advantage of low-cost car parking.

(Night-time public tariffs at Chelsea will increase slightly, however daily public rates were will remain the same as they were increased in 2017).

Tariffs

Staff parking

Chelsea and Westminster Hospital – staff parking		
Staff group/car parking type	**Current tariff (monthly)**	**New tariff (monthly)**
Band 6 and above	£130/pm	**£135/pm**
Band 5 and under	£90/pm	**£95/pm**
Nights & weekends	£30/pm	**£35/pm**
One Day Per Week Permit	£30/pm	**£35/pm**

West Middlesex University Hospital – staff parking		
Staff salary group	**Current tariff (monthly ongoing permit)**	**New tariff (monthly)**
Up to £ 12,999	£10/pm	**£12/pm**
£ 13,000 - £ 19,999	£12/pm	**£14/pm**
£ 20,000 - £ 29,999	£23/pm	**£25/pm**
£ 30,000 - £ 59,999	£29/pm	**£32/pm**
£ 60,000 - £ 79,999	£42/pm	**£45/pm**
£ 80,000 and above	£50/pm	**£55/pm**

Public parking (including Blue Badge parking)

Chelsea and Westminster Hospital - public		
Type: 8am–6pm (Sun–Fri)	**Current tariff (These were increased in 2017)**	**New tariff**
Up to 1 hour	£3	£3 (no change)
1-2hrs	£7	£7 (no change)
2-3hrs	£9	£9 (no change)
3-4hrs	£12	£12 (no change)
4-5hrs	£15	£15 (no change)
5-6hrs	£18	£18 (no change)
6-7hrs	£21	£21 (no change)
7-8hrs	£24	£24 (no change)
8-9hrs	£26	£26 (no change)
9-10hrs	£28	£28 (no change)
10-24hrs	£40	£40 (no change)
6pm–8am (off peak)	**£2/hr**	**£3/hr**

Type: 8am–6pm (Saturdays)	Current tariff (These were increased in 2017)	New tariff
Up to 1 hour	£3	£3 (no change)
1-2hrs	£7	£7 (no change)
2-3hrs	£10	£9 (no change)
3-4hrs	£13	£12 (no change)
4-5hrs	£16	£15 (no change)
5-6hrs	£20	£18 (no change)
6-7hrs	£20	£21 (no change)
7-8hrs	£24	£24 (no change)
8-9hrs	£26	£26 (no change)
9-10hrs	£28	£28 (no change)
10-24hrs	£40	£40 (no change)
6pm–8am (off peak)	**£2/hr**	**£3/hr**
Blue Badge holders	**£0**	**£3 for entire length of stay**

West Middlesex University Hospital – public		
Type: daily	**Current tariff**	**New tariff**
Up to 1 hour	£1.40	**£2.00**
1-2hrs	£2.50	**£3.50**
2-3hrs	£3.40	**£5.00**
3-4hrs	£4.30	**£6.00**
4-5hrs	£5.20	**£7.00**
5-8hrs	£6.10	**£7.00**
8-12hrs	£6.80	**£9.00**
12-24hrs	£7.50	**£12.50**
Blue Badge holders	**Same as above**	**Same as above**

Exceptions

- Free for motorcycles and bicycles.
- A range of discretionary exemptions and concessions apply for certain groups, including some of our most unwell patients and/or families.

FAQs

1. Staff parking

What will staff be charged?

Staff choosing to park on site will be charged a maximum of £5 more per month. Tariffs will continue to be staggered and reflect income, as they do now. Night-time rates will continue to be offered at a lower rate than the daytime tariffs.

What about staff on night shifts who rely on driving?

Night-time rates will continue to be offered at a lower rate than the daytime tariffs.

Our intention that there will be no night-time charge for on-call staff remains.

What benefit will this be to the Trust?

For both sites, this is expected to amount to a combined annual revenue increase of about £27,000.

Our car parking continues to be charged at a lower rate than many other hospitals and community centres.

2. Blue Badge parking

What will Blue Badge holders be charged?

At Chelsea, Blue Badge holders will be charged a standard £3.00 charge for their entire length of stay for parking at the hospital.

What benefit will this be to the Trust?

It will generate a potential increase in annual revenue of around £58,500.

Is it appropriate to charge Blue Badge holders?

Blue Badges are in place to ensure parking is accessible, not free of charge. Blue Badge holders are required to pay for parking at West Mid, a range of other local hospitals, and at various locations in the community. Our tariff is significantly lower than many alternative car parking options.

Our responsibility is to ensure there is parking available for Blue Badge holders, and that our parking is accessible. Ability to park is our duty – but ability to pay is a separate issue, assessed in a different way.

Making this approach more consistent for all of our visitors improves equality of access. We offer financial support for those who need it irrespective of if they hold a Blue Badge or not.

Anyone who can't afford to pay can reclaim the costs very simply.

3. Public parking (West Mid)

What improvements are being made?

Increased capacity: *46 new parking spaces, with additional tarmacked spaces and converted grass areas, and an additional 10 new electric charging points. This will improve ongoing queuing issues and reduce the number of complaints. The entrance barriers will also be moved to an ideal location to enable a more effective traffic flow.*

Streamlined access: *improved signage and road marking, a new automated number plate system (ANPR), and new pay machines with a contactless option. This will allow our patients, staff and visitors more payment options, with improved secure technology.*

Improved security: *enhanced cameras to make the car park safer and reduce crime. The cameras will also allow us to review trends and monitor when the car park attendant or security team will be required to assist in locating empty spaces and keeping the car park at maximum capacity.*

What will visitors be charged?

There will be a small increase to the current visitor tariff at West Mid. This has been benchmarked and is in line with the costs of parking at Hillingdon and Kingston hospitals

It's important to note that many of our patients and visitors are given free (or significantly reduced) car parking depending on their circumstances. This includes some of our most unwell patients and/or families.

What benefit will this be to the Trust?

It is expected to equate to an additional income of approximately £567,000 in 2018/19, which will help fund front line services.

Communications activity

Communications and engagement will include:

- Direct communication with affected stakeholders as appropriate
- FAQs for key stakeholders
- Briefing for key stakeholders
- Update to external website and intranet (internal comms)
- Poster/s in car park area
- Flyer for affected users
- Reactive media/complaint responses

Messages and channels will be tailored to suit each specific stakeholder group, with issues and risk management front of mind.

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	1.4.1/May/18
REPORT NAME	Care Quality Commission (CQC) Report
AUTHOR	Attached is a summary provided by Serena Stirling, Quality Improvement Manager, and the 97 page CQC inspection report itself.
LEAD	Eliza Hermann, Non Executive Director and Chair of Board Quality Committee
PURPOSE	To provide the Council of Governors with an opportunity to discuss the outcomes of the Trust's recent CQC inspection.
SUMMARY OF REPORT	CWFT's overall "Good" rating from the CQC is a significant achievement and testimony to the hard work and commitment to patients of our 6000 staff members. The Council of Governors should be reassured regarding the quality and safety of our services by this result. The "Good" outcome has been further reinforced by our principal regulator, NHS Improvement, moving CWFT to their "segment one" reflecting their view that the Trust should have maximum autonomy. NHSI says the move to segment one "shows that the Trust is providing high quality services to its population, using its resources well, is playing an important collaborative role in the STP and is highly rated by both the patients who use its services and the people who work for it." Of course there is opportunity for further improvement. In the near term the Quality Committee's oversight will be particularly focussed on - • the completion and embeddedness of the 57 "should do" items identified by the CQC; • broader themes for example those pertaining to patient experience (especially responding to and learning from complaints); • the programme of activity to prepare for the CQC's pending unannounced inspections of Critical Care, Maternity, Diagnostic Imaging and HIV/Sexual Health Services; and • management's efforts to bring more coherence to all of the Trust's improvement efforts including care quality, efficiency and productivity. The Quality Committee continues to believe the biggest risks to CWFT's care quality are those relating to the workforce. In particular, achieving a significant reduction in voluntary staff turnover should result in reduced time, effort and costs of recruitment and induction, reduced utilisation of temporary staff, improved training compliance, and improved staff satisfaction, all of which should flow through to improved care quality.

KEY RISKS ASSOCIATED	Negative impact on patients, as well as negative regulatory, financial and reputational impact and stakeholder loss of confidence if service quality was to deteriorate rather than improve.
FINANCIAL IMPLICATIONS	As above
QUALITY IMPLICATIONS	As above
EQUALITY & DIVERSITY IMPLICATIONS	As above
LINK TO OBJECTIVES	Providing high quality patient centred care is CWFT's number one priority.
DECISION/ ACTION	For discussion.

Care Quality Commission (CQC) Report

Background

In 2017/18 the Trust underwent the first comprehensive CQC inspection since integration to assess the quality of care being delivered to patients. This occurred in December 2017 (onsite inspection) and January 2018 (Well-Led and Use of Resources inspections).

This regulator asks five key questions of all organisations: Is it Safe; Is it Effective; Is it Caring; Is it Responsive; and Is it Well-Led.

The services which were inspected on both hospital sites are as follows: Urgent and Emergency Care; Medicine (including older people's care); Surgery; Services for Children and Young People; End of Life Care; and Outpatients.

Outcome

Both the Chelsea and West Middlesex sites improved their ratings from 'Requires improvement' to 'Good'; and the Trust improved the overall rating from 'Requires Improvement' to 'Good'. The Trust is also rated as 'Outstanding' for Use of Resources.

Urgent and Emergency Care, Services for Children and Young People, and therefore the Chelsea site overall, is rated as 'Outstanding' for the Caring domain.

Themes of positive feedback include:

- The trust had learned from previous inspections;
- Delivery of a successful integration;
- Maintained financial surplus as well as achieving all major targets;
- Staff are proud to work for the organisation;
- Culture of openness and honesty;
- The trust engages with the wider health and care economy;
- Examples of innovation and research;
- Continued determination to improve; and
- Patients and carers all gave positive feedback about the care they received.

The CQC identified 57 'Should Do' actions for the organisation, however, did not believe that any of the identified issues constituted a breach in organisational compliance with the Health and Social Care Act 2008.

Themes for further improvement include:

- Workforce (Recruitment and retention, management and support of temporary staff, appraisals, mandatory and statutory training compliance)
- Patient Experience (Complaints and Friends and Family Test - response times and learning from patient feedback)
- Medicines Management (Fridge temperature monitoring, ambient room temperatures, safe storage of medicines)
- Clinical documentation
- Clinical audit

Areas of outstanding practice which were identified include:

- 'On medical wards at West Middlesex Hospital, the Kew ward team had developed an innovative mouth care project following feedback from patients and relatives and a review of patient outcomes. This had resulted in a reduction in cases of acquired pneumonia as a result of poor mouth care.'

- ‘End of life care had a high profile throughout the Hospitals on both sites. There was a focus on improving the experience for patients nearing the end of life and there appeared to be a widespread commitment to achieving this.’
- ‘On medical wards at Chelsea and Westminster Hospital the work on Nell Gwynne and David Erskine ward in relation to elderly patients including those living with dementia was outstanding. Staff engaged patients in a wide range of activities and were passionate about the needs of these patients.’

Next steps

The Care Quality Programme has developed a ‘CQC Quality Improvement Plan’ to monitor and track the Trust’s progress addressing the 57 ‘Should Do’ actions. This will support the Trust's continuous quality improvement journey and subsequent ongoing regulatory compliance.

The CQC inspection regime is now a continuous cycle of monitoring and regulating. Providers should expect some interaction with CQC inspections on an annual basis.

The CQC will return to the Trust 2018/19 to inspect those services not included in this latest inspection, those being: Critical Care; Maternity; Diagnostic Imaging; and HIV/Sexual Health. These services will be inspected on an unannounced basis, which is anticipated in Q1/Q2 2017/18.

Preparations have commenced and include:

- Service self-assessment against CQC core standards
- Completion of historic actions from 2014/15 CQC inspection
- Ward/Department Accreditations
- Senior Partner Programme visits
- Senior Nursing and Midwifery Rounds
- Out of Hours unannounced reviews

This work stream will continue to be monitored and reported through the embedded governance structure via Executive Management Board and Quality Committee.

Chelsea and Westminster Hospital NHS Foundation Trust

Inspection report

369 Fulham Road
London
SW10 9NH
Tel: 02087468000
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Date of inspection visit: 5 Dec 2017 to 24 Jan 2018
Date of publication: xxxx> 2017

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Chelsea and Westminster NHS Foundation Trust operates acute Hospital services from two main Hospital sites:

- Chelsea and Westminster Hospital
- West Middlesex Hospital

Chelsea and Westminster Hospital NHS Foundation Trust is a large provider of acute and specialist services that services a population of over 1,000,000 in North West London, the south east and further afield. The trust operates at two acute sites: Chelsea and Westminster Hospital and West Middlesex Hospital. The trust has completed its first full year as an enlarged organisation following the merger with West Middlesex Hospital. The trust has never been inspected as this larger trust as both Hospitals previous inspection took place prior to the merger.

The trust has 1007 beds including;

- 166 children's beds/cots,
- 131 maternity beds,
- 35 critical care and burns unit beds and
- 675 acute adult beds.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good 

What this trust does

The trust runs services at Chelsea and Westminster Hospital and West Middlesex Hospital.

It provides urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, children's and young people services, end of life care and outpatients services at both Hospitals. The trust has 1007 beds. It provides outpatient and other ambulatory care in 12 further locations. We inspected both Hospitals.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Summary of findings

Between 5 and 7 December 2017 we inspected six out of eight core services provided by this trust at its two sites. We carried out further unannounced visits for a 10 day period following the core service inspection.

We inspected urgent and emergency care because we rated the service at both sites as requires improvement during our last inspections.

We inspected medical care at both sites because one site had previously been rated as requires improvement and we received information giving us concerns about the safety and quality of these services.

We inspected surgery because we rated the service at both sites as requires improvement during our last inspections.

We inspected end of life care because we rated the service at both sites as requires improvement during our last inspections.

We inspected children's and young people services because we rated the service at both sites as requires improvement during our last inspections.

We inspected outpatients because we rated the service at both sites as requires improvement during our last inspections.

We did not inspect critical care and maternity because the information we reviewed about the services indicated no change in the safety and quality of these services. These services were also rated as good at our last inspections.

From 22 to 24 January 2018 we conducted a trust wide well led inspection as part of our scheduled inspection programme.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed: Is this organisation well-led?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Our rating of the trust improved. We rated it as good because:

- We rated safe effective, caring, responsive and well-led as good. We rated both Hospitals – Chelsea and Westminster and West Middlesex as good.
- We found that the trust had learned from our previous inspections at the two sites and had put in place improvements in the domains that had been rated previously as requires improvement.
- We rated well-led at the trust level as good. The trust had successfully merged the two former trusts and this merger had been undertaken sensitively to ensure cohesion acknowledging and adopting the best practice from both. At the same time the trust maintained financial surplus as well as achieving all major targets such as the national access standards for A&E 4 hour waits, most Referral to Treatment (RTT) and Cancer.
- Staff were proud to work for the organisation and engaged with managers and senior leaders. The trust had consulted with staff and patients at both sites in developing its PROUD set of values.
- The trust leadership team was stable and, with a clear example from the chief executive, were highly visible at both sites and took part in a regular programme of ward and departmental visits. The trust board and senior leaders had offices at both sites, and trust board meetings rotated between the sites.

Summary of findings

- We noted the openness and honesty displayed by the trust at all levels, not seeking to hide areas where development and improvement were still needed but acknowledging them and making clear remedial plans.
- Having established a clear base of good performance the trust was engaging with the wider health and social care economy of North West London.
- There were clear examples of innovation and research across services and in individual cases. We found a genuine no blame, learning culture and a continued determination to improve.
- Patients and carers all gave positive feedback about the care they received. They said they were involved in decisions about their care and that staff considered their emotional well-being, not just their physical condition.

Are services safe?

Our rating of safe improved. We rated it as good because:

- The trust managed patient safety incidents well. Incident reporting was embedded into the culture of the services and there was evidence of learning from incidents.
- The trust used safety monitoring results well. There were ward accreditation schemes to monitor quality and safety performance in each inpatient ward. The results were used to identify areas of good practice and areas for improvement.
- The trust controlled infection risk well. We observed consistent standards of hand hygiene and infection control measures amongst clinical and ward-based staff.
- The trust had suitable premises and equipment and looked after them well. Staff had ready access to medical, IT and personal protective equipment to carry out their duties. Equipment was checked in date. The trust had recently refurbished, extended and improved the urgent and emergency departments (ED) at both locations to a high standard.
- Overall, staff used effective and embedded medicines management processes.
- Staff kept appropriate records of patients' care and treatment. We found an overall improvement in patient risk assessments and accessibility of care plans in comparison to the previous inspections.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The trust provided mandatory training in key skills to all staff. Mandatory training completion rates varied across the trust. In response to this the trust launched a new learning platform in October 2017 which allowed staff to access training from home and before they start employment with the trust. The trust aimed to reach the 90% standard by end of March 2018 and as of February 2018 achieved an 87% completion rate against the 90% target by the end of March.
- The trust had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Vacancy rates were a challenge to the trust in common with most London NHS trusts. Skills were maintained by supplementing regular agency staff from approved agencies as well as initiatives to give extensive support to nursing staff recruited from overseas and a recognition of promoting flexible working to attract and retain staff.
- The trust planned for emergencies and staff understood their roles if one should happen. The most recent real life example of this was treating people involved in the Grenfell fire disaster in June 2017.

Summary of findings

Are services effective?

Our rating of effective improved. We rated it as good because:

- The trust provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- The trust monitored the effectiveness of care and treatment through participation in national and local audits, research and national, regional and local innovation projects and used the findings to improve them.
- The trust made sure staff were competent for their roles through access to training, support from practice development staff and mentoring and appraisal. The trust implemented a new PDR system in April 2017 which identified staff who wanted to progress and also linked the appraisal process to the trust values and strategic aims. The trust aimed to complete 90% of PDRs by March 2018. As of February 2018, 89.6% of all staff had a new appraisal completed.
- We found evidence of good team working at all levels of the trust from the board downwards. There were examples of good divisional, ward and multi-disciplinary team working to enhance patient care.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Staff had access to trust policies and treatment protocols via the trust intranet.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The trust's mortality and morbidity were below the national average following work undertaken to scrutinise and learn from every death and not just unexpected deaths.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- All managers and staff treated patients with compassion, dignity and respect.
- All patients and carers said staff did everything they could to support them and were attentive to their needs. Staff displayed the trust ethos of being unfailingly kind.
- Staff involved patients in decisions about their care and treatment. Staff considered all aspects of a patient's wellbeing, including the emotional, psychological and social.
- There was good support from the trust chaplaincy and religious support services.
- Staff reflected the trust values of putting the patient first.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

- The trust engaged closely with commissioners and other external bodies to make sure it planned and delivered services according to the needs of the populations it served.
- The trust was achieving the national access standards for A&E 4 hour waits, most Referral to Treatment (RTT) and Cancer. For example the trust was ranked first in the country for 62 day cancer waits in October 2017 and third in November 2017.
- Between June 2016 and July 2017 the trust reported no mixed sex accommodation breaches.
- People could access the service when they needed it.

Summary of findings

- The trust took account of patients' individual needs.
- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The trust was reviewing its local response target of 25 days which it was not achieving. It was taking steps to improve its response performance and response rates were now at 78% of target.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The trust had recognised different cultures at its two sites and had maintained while combining the best from both sites in terms of practice and in forming its PROUD values.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. There was a distinct emphasis on learning from mistakes in a no blame culture.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The governance structure drawing together the two sites was maturing if not yet completely mature.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients from diverse backgrounds and patient groups, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust was committed to improving services by an extensive programme of research and innovation, holding annual innovation awards for the best innovations. It had trialled a consultant led Learning from Excellence programme in ED which it was intending next to roll out to Anaesthetics.

However the trust had further opportunities for improvement:

- The trust recognised the need to improve its staff retention rate from 77.2% (October 2017), to the London median (79.9%) and beyond to the national median (85.5%). The trust was engaged in the NHS Improvement Retention Support programme, and understood the need to invest in training and career development opportunities. The latest monthly Trust Gross Turnover rates (December 2017) demonstrated a 2% improvement in 6 months. The trust had developed a workforce strategy plan with some innovative workforce models to underpin this improvement.
- The outpatients DNA rate of 10% was in the 4th (worst) quartile of performance nationally, although comparable or better in respect of London NHS trusts. The national median was 7.47% (Q1 2017/18). The trust had plans to reduce DNA rates to this level and save 30,000 outpatient appointments, using improved planning, standardisation of processes and technological solutions.
- The trust stated that it needed to increase its medical job planning completion rate from 85% to 100% and ensure that each medical Programmed Activity (PA) is electronically rostered.

Summary of findings

- The above Use of Resources summary is taken directly from the Chelsea and Westminster Hospital NHS Foundation Trust Use of Resources Assessment Report published by NHS Improvement on 13 February 2018 following their assessment visit on 18 January 2018.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, Hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in caring in both Urgent and Emergency Care (ED) and in Services for Children and Young People at Chelsea and Westminster Hospital. In both services caring was rated as outstanding. In our previous inspection we had found outstanding practice in the HIV and Sexual Health service which we did not re-inspect on this occasion.

Areas for improvement

We found areas for improvement in 58 things where the trust should make improvements. We did not think that the 58 identified items constituted a breach of Health and Social Care Act 2008 regulations.

For more information, see the Areas of improvement section of this report.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections and engagement meetings with the trust.

Outstanding practice

We found outstanding practice for caring in urgent and emergency care and services for children

and young people at Chelsea and Westminster Hospital.

- In both services we witnessed all clinical staff interacting with patients and their family members and carers in in a caring, polite and friendly manner. There was very good rapport between nurses and patients.
- In both services patients, families and carers were positive about the care across the service and we observed compassionate and courteous interactions between staff and patients. Patients said staff went the extra mile to meet their needs.
- In both services staff were highly motivated to offer care that promoted people's dignity. Observations of care showed staff maintained patient privacy and dignity at all times and was embedded within the culture of the service.
- In both services staff explained what they were doing at all times and allowed patient and relatives opportunities to ask questions. Staff were committed to working in partnership with patients and relatives.
- In ED staff provided emotional support to patients and relatives and could signpost them to services within the organisation as well as external organisations for additional support.
- There were appropriate and sensitive processes for end of life care for neonates and children and young people.

Summary of findings

- The service for children and young people had a broad programme of emotional support services for children and young people and their families and carers. This included a variety of therapeutic support services.
- Doctors, nurses and therapists worked in partnership with parents and families. Staff in children and young people's services demonstrated a patient-centred approach which encouraged family members to take an active role in their child's healthcare.
- The Hospital school at Chelsea and Westminster Hospital was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the Hospital.
- On medical wards at Chelsea and Westminster Hospital the work on Nell Gwynne and David Erskine ward in relation to elderly patients including those living with dementia was outstanding. Staff engaged patients in a wide range of activities and were passionate about the needs of these patients.
- We saw staff on the Burns Unit used evidence based practice to improve outcomes for patients. Staff showed outstanding contribution to new ways of wound healing and acted as leaders within their speciality and now share their practice with other NHS providers.
- End of life care had a high profile throughout the Hospitals on both sites. There was a focus on improving the experience for patients nearing the end of life and there appeared to be a widespread commitment to achieving this.
- On medical wards at West Middlesex Hospital, the Kew ward team had developed an innovative mouth care project following feedback from patients and relatives and a review of patient outcomes. This involved identifying more effective equipment for mouth care and more consistent care pathways. The team aimed to implement a trust-wide policy as a result of this work, which had resulted in a reduction in cases of acquired pneumonia as a result of poor mouth care.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In Urgent and emergency services:

- Services needed to ensure fridge and room temperature checks were completed daily and if temperatures exceeding the maximum temperature this was reported to facilities and pharmacy in a timely way.
- The service should ensure that consultant cover continues to increase to provide 16 hours per day consultant cover as per Royal College of Emergency Medicine guidelines.
- The West Middlesex emergency department should ensure that all patient records are completed fully, including risk assessments for capacity and dementia.
- West Middlesex Hospital should review the arrangements for supervision of the clinical decision unit.
- West Middlesex clinical staff should have access to a wider range of standardised pathways to ensure patients received consistent, evidence-based treatment.

Summary of findings

- Staff should make more use of national and local audits to monitor care and treatment and bring about improvement at West Middlesex Hospital.
- The Emergency Department at West Middlesex should provide more information to patients to help them lead healthier lives.

In Medical care:

- Have a clear policy on the opening and closing of escalation areas at Chelsea and Westminster Hospital.
- Review medical cover at night in order to address continuing staff shortages at night at Chelsea and Westminster Hospital.
- Ensure that agency staff has access to patient records.
- Ensure that staff assess patients for the risk of malnutrition on admission.
- Ensure that staff reassess patients for the use of the red tray system at Chelsea and Westminster Hospital as per trust policy.
- Medicines are managed and stored safely in all medical areas
- West Middlesex Hospital should ensure senior staff comply with trust policy on agency nurses, including positive ID verification and inductions.
- West Middlesex Hospital should ensure all staff adhere to the Control of Substances Hazardous to Health Regulations 2002.
- West Middlesex Hospital should improve oversight of storage areas used for chemicals and cleaning equipment.

In Surgery:

- West Middlesex Hospital should improve the quality of their risk register and include all risks mentioned in the report.
- West Middlesex Hospital should improve the utilisation rate in theatres.
- West Middlesex Hospital should improve its response rate for complaints and adhere to their own policy of responding to complaints within 25 days.
- West Middlesex Hospital should improve the response rate of the FFT.
- West Middlesex Hospital should conduct starvation audits to access how many patients were starved for the recommended number of hours and to assess whether or not the Hospital stuck to its own protocol.
- The Hospitals should continue its implementation of one electronic patient record.
- Chelsea and Westminster Hospital should ensure action is taken when fridge temperatures are outside the recommended temperatures.
- Chelsea and Westminster Hospital should continue to review its policies and guidelines.
- Chelsea and Westminster Hospital should work towards reducing its RTT rates.
- Chelsea and Westminster Hospital should work towards improving appraisal rates.

In Children and young people's services:

- Ensure all staff in the service complete required mandatory training to improve compliance with the trust's target for completion.

Summary of findings

- Review training and processes for ensuring that nurse managers in all paediatric clinical areas understand their responsibilities for safely managing controlled drugs, for example ensuring that the key to the controlled drug cupboard remains with the nurse in charge, or authorised delegate, at all times.
- Take further steps to ensure that safe staff levels are maintained for all shifts across children and young people services at Chelsea and Westminster Hospital.
- Redevelop the trust intranet search function to ensure staff can find and access policies, guidelines and other information in a timely way.
- Take steps to improve nursing involvement and leadership in clinical research activities.
- Review consent training and processes to ensure all clinicians understand their responsibilities for obtaining and recording consent in patient records.
- Take steps to improve the training, development and engagement of healthcare assistants and nursery nurses.
- Clarify the intended purpose and admission criteria for the paediatric high dependency unit.
- Ensure plans for the relocation of the paediatric ambulatory care unit at Chelsea and Westminster Hospital to a more suitable space are enacted in a timely way.
- Review paediatric theatre usage to improve efficiency and utilisation rates at Chelsea and Westminster Hospital.
- Take steps to reduce discharge delays, such as medication and patient transport delays.
- Take steps to reduce complaint response times to improve compliance with the trust's complaints policy.
- Ensure all staff with leadership and management responsibilities have sufficient protected time, training and support to discharge their responsibilities.
- Take steps to improve Wi-Fi network access in all areas of the children and young people services at Chelsea and Westminster Hospital to ensure staff can access the trust network.
- Ensure agency staff have access to electronic patient information.
- Address children and young people having timely access to speech and language therapy at West Middlesex.
- Ensure that data recording in the national neonatal audit programme (NNAP) improves at West Middlesex.
- Ensure the service meets all the NICE quality standards (QS) for epilepsy at West Middlesex.
- Ensure staff receive timely appraisals and meet the trust's target rates for completion.
- The fracture clinic at West Middlesex should have appropriate waiting and treatment areas for children.
- Clarify the funding and level of high dependency care on special care baby unit at West Middlesex.
- Ensure all staff at West Middlesex feel engaged in service planning, research and service reconfiguration.

In End of life care:

- The trust should ensure there is improved consistency in the completion of DNACPRs.
- The trust should ensure that information technology is compatible with working practices.
- Chelsea and Westminster should ensure that compassionate care agreements are consistently completed.
- Chelsea and Westminster Hospital should ensure that staff training for the London End of Life care register 'Co-ordinate my Care' continues in order to maximise its use.

Summary of findings

In Outpatients:

- West Middlesex Hospital should ensure that staff meet the trust's target for staff completing mandatory training.
- West Middlesex Hospital should ensure that incidents are investigated and there is learning from incidents across the department.
- The service should ensure staff meets the trust's target for appraisal rates.
- West Middlesex Hospital should ensure they are monitoring waiting time for patients.
- The trust should ensure the OPD risk register is reflective of risks within the OPD department.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a clear vision and strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust chief executive, board members, non-executive directors and other senior managers were highly visible at all locations of the trust. They engaged fully with staff, patients and carers and were able to communicate and receive constant feedback on the services provided by the trust and it's staff.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The trust had recognised different cultures at its two sites and had maintained while combining the best from both sites in terms of practice and in forming its PROUD values.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. There was a distinct emphasis on learning from mistakes in a no blame culture.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The governance structure drawing together the two sites was maturing if not yet completely mature.
- The trust leadership was open and honest and fully aware of areas that were still in need of improvement. They demonstrated that they had active plans in place to tackle those areas.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients from diverse backgrounds and patient groups, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Summary of findings

- The trust was committed to improving services by an extensive programme of research and innovation, holding annual innovation awards for the best innovations.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Mar 2018	Good ↑ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chelsea and Westminster Hospital	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
West Middlesex Hospital	Requires improvement ➔➔ Mar 2018	Good ↑ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Overall trust	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Chelsea and Westminster Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Good Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Surgery	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Critical care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Maternity	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Services for children and young people	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
End of life care	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
Diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
HIV and Sexual Health Services	Good Jul 2014	Not rated	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014
Overall*	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for West Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Requires improvement Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Requires improvement ↓ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Surgery	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Critical care	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Maternity	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Services for children and young people	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
End of life care	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
Diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall*	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Chelsea and Westminster Hospital

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Key facts and figures

Chelsea and Westminster Hospital NHS Foundation Trust is a large provider of acute and specialist services that services a population of over 1,000,000 in North West London, the south east and further afield. The trust operates at two acute sites: Chelsea and Westminster Hospital and West Middlesex Hospital. The trust have completed their full financial year as an enlarged organisation following the merger with West Middlesex Hospital. The trust has never been inspected as this larger trust as both Hospitals previous inspection took place prior to the merger.

The trust has 1007 beds including 166 children's beds/cots, 131 maternity beds, 35 critical care and burns unit beds and 675 acute adult beds. In the year April 16 to March 17 the trust had 369,840 emergency attendances, 136,837 inpatient spells and 767,330 outpatient attendances. All core services are provided from both acute Hospital sites.

The trust provides services to a number of local boroughs including services to Kensington and Chelsea, Westminster, Hammersmith and Fulham, Hounslow, Ealing, Richmond and Wandsworth. Specialist services for patients from London, the South East and beyond, including paediatric and neonatal surgery, the extensive HIV and sexual health service, and a regional burns unit for London.

Chelsea and Westminster Hospital provide the following services:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services
- HIV and sexual health services

Summary of services at Chelsea and Westminster Hospital

Good ↑

Summary of findings

Our rating of services improved. We rated it them as good because:

- We rated caring at Chelsea and Westminster Hospital as outstanding. We rated safe, effective, responsive, and well-led as good.
- All the departments we inspected had improved from requires improvement to good.
- The Hospital environment was clean. Equipment was clean and maintained.
- There were effective infection prevention and control measures in place.
- Patient records included risk assessments and care plans were complete.
- Good medicines management processes were embedded in practice.
- Staff followed treatment protocols and national guidelines
- Staff showed patients dignity, respect, care and emotional support and were helpful to patients and public in corridors.
- Care was planned to meet patients' needs.
- The Hospital met national access standards for A&E 4 hour waits, most Referral to Treatment (RTT) and Cancer.
- Divisional leadership which was across both sites was effective.
- Staff were proud to work for the Hospital and were supported.

Urgent and emergency services

Good ↑

Key facts and figures

The emergency department at Chelsea and Westminster Hospital provides care for the local population 24 hours a day, seven days a week.

Between April 2016 and March 2017, the Hospital had 282,115 attendances, an average of 773 patients a day. From April 2016 to March 2017, 15.8% of attendees were admitted to Hospital, which was lower than the national average of 21.6%.

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 17 years. Attendances of children under 17 in the last 12 months was 55469 which was 28% of attendances

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a triage nurse (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). Patients were streamed from triage to the most appropriate areas.

The department has different areas where patients are treated depending on their needs, including an urgent care centre (UCC), resuscitation area, majors area, and an emergency observation unit (EOU). A separate paediatric emergency department with its own waiting area and bays was within the department.

The department was a trauma unit but more severely injured patients go to the nearest major trauma centre in London if their condition allows them to travel directly. Otherwise, they would be stabilised at Chelsea and Westminster, where staff follow a protocol to decide which injuries they could treat or would have to transfer.

We visited the ED over three days during our announced inspection. We looked at all areas of the department and we observed care and treatment. We looked at 26 sets of patient records. We spoke with 59 members of staff, including nurses, doctors, allied health professionals, managers and support staff. We also spoke with 18 patients and seven relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The department had undergone a £12 million refurbishment since the last inspection. The environment was clean and spacious and supported a positive patient experience. Patients waited in appropriate areas and were seen in individual bays for assessments and treatment. There was no additional capacity in the department to accommodate increased attendances.
- Staff monitored patients who were at risk of deteriorating appropriately. Early warning scores were in use in both adult and paediatric areas.
- There were good protocols in place for the recognition and management of sepsis. The department had adopted a traffic light system for sepsis screening and patients were escalated according to risk.
- The department had increased their standard grade four or above doctor provision since the last inspection. The middle grade doctor rota was sufficiently covered so there was no use of locum doctors.

Urgent and emergency services

- There was consistent recording of information within the patient records reviewed. This included good completion of risk assessments and pain scores. The recording of pain assessments had improved since the last inspection.
- Manager supported staff and provided new staff with an individual induction plan to make sure the skills they brought to the team were recognised along with any training needs.
- Staff were professional and care for patients in a caring and compassionate manner. Feedback from patients and relatives was positive.
- The department had good performance against the four-hour wait time for admission, treatment or discharge between October 2016 and October 2017.
- When staff decided to admit a patient, the number waiting between four and 12 hours for a Hospital bed was generally below the England average between December 2016 and November 2017.
- There was a positive culture within the department and staff generally felt supported by managers.

However:

- Consultant cover did not meet the recommended 16 hours per day cover recommend for A&E departments by the Royal College of Emergency Medicine (RCEM). Consultant provision was on the services' risk register. However, the existing consultants were providing cover out of their existing consultant resources to ensure the service remained safe.
- There were still some delays in patients being triaged. Patients were not always triaged in line with the recommended 15 minute triage target. However, during the inspection all patents we reviewed were triaged within 15 minutes.
- Staff had difficulty accessing approved mental health professionals (AMHPs) out of hours to conduct mental health act assessments. This created delays and increased waiting times to discharge or transfer to other services for patients with mental health concerns in the emergency department.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- We found staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff. Staff now reported incidents on an online incident reporting system which had improved since the last inspection.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.
- Since the last inspection the department had increased their standard grade four or above doctor provision. The middle grade doctor rota was sufficiently covered so there was no use of locum doctors.
- Since the last inspection the trust had introduced the use of early warning scores. This ensured staff were effectively able to check patients for risk of deterioration. We saw that patients at risk were suitable escalated and managed. Patients at a high risk of sepsis were reviewed and treated within recommended time frames.
- The emergency department had undergone a refurbishment since the last inspection which improved patients access to appropriate waiting areas and cubicles for assessment.
- The department had enough nursing staff with the right skill mix to care for patients.

Urgent and emergency services

- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children.
- Staff recorded patient care consistently. There was good completion of nursing assessments.
- The department was clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- The designated cubicle for patients attending with a mental health crisis met the Royal College of Psychiatrist's guidelines.
- Staff followed the trust policy to check the resuscitation and difficult airways trolley every day.
- Medicines were stored securely and staff followed appropriate procedures for controlled drugs.
- The department had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed. The Hospital had responded well to four major incidents in London over the past 12 months.

However:

- Patients did not always get face-to-face assessments within the recommended time of 15 minutes. However, during the inspection all patients we reviewed were seen within the 15 minute target.
- The number of whole time equivalent consultants had increased since the last inspection. The service was still not staffed sufficient to meet the 16 hour per day consultant presence target. However, the existing consultants were providing cover out of their existing consultant resources to ensure the service remained safe.
- Controlled stationery was not stored securely and no tracking system was in place. In the Urgent Care Centre FP10SS prescriptions were available but NHS Protect guidance was not being followed in regards to the security of these prescriptions. However, since the inspection the trust had updated their policy regarding storage of these prescriptions.

Is the service effective?

Good

We rated it as good because:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- Staff regularly reviewed patients pain levels and recorded pain scores.
- From September 2016 to August 2017, the trust's unplanned re-attendance rate to accident and emergency within seven days was equal to or better than the national standard of 5% and also consistently better than the England average.
- New staff received a package of support including a mentor, induction, and list of competencies, which was flexible according to their previous experience and training.
- We saw examples of good multidisciplinary working. Doctors, nurses and other healthcare professionals supported each other to provide care.

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The Hospitals performance in the Royal College of Emergency Medicine (RCEM) vital signs in children audit was in the lower quartile for three standards.
- Not all staff had received their annual appraisal. However, there was a rolling programme in place for appraisals to meet the 90% trust target by the end of the year.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Patients, families and carers were positive about the care across the service and we observed compassionate and courteous interactions between staff and patients. Patients said staff went the extra mile to meet their needs.
- We saw patients were respected and valued as individuals and empowered within their care both physically and emotionally. There was a strong person centred culture.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Staff were highly motivated to offer care that promoted people's dignity. Observations of care showed staff maintained patient privacy and dignity at all times and was embedded within the culture of the service. The department refurbishment had prevented patients' dignity being compromised due to the environment as we previously found.
- Staff explained what they were doing at all times and allowed patient and relatives opportunities to ask questions. Staff were committed to working in partnership with patients and relatives. The staff worked jointly with patients and relatives to overcome obstacles to care. For example, we saw one patient had difficulties communicating their needs and staff worked with the patient to find out their preferences.
- Staff provided emotional support to patients and relatives and could signpost them to services within the organisation as well as external organisations for additional support.

Is the service responsive?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

- The department's performance for Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival was good. Between October 2016 and October 2017, the trust met the 95% target on for six months out of 12.
- Between December 2016 and November 2017, the percentage of patients who waited between four and 12 hours from decision to admit varied between 2% and 17%. This was generally below the England average.

Urgent and emergency services

- There were no patients at Chelsea and Westminster emergency department who waited more than 12 hours from decision to admit until being admitted
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.
- The refurbishment within the emergency department had catered for patient needs to improve experience. For example, music was available to be played in paediatrics and resuscitation and the department was colour coded so patients could find their way around easier.
- Due to the refurbishment there were no issues with overcrowding and there was more space in both the adult and paediatric waiting areas.
- We saw all patients were waiting in appropriate areas in the department which had improved since the last inspection.

However:

- The percentage of patients who left before being seen was higher than the England average. The median length of total time spent in the department was also consistently higher than the England average.
- There were sometimes delays for patients requiring specialist mental health beds. This was on the department's risk register as this was a national challenge. The trust was continuously engaging with mental health services to try improve this

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The service had a clear vision and strategy that all staff understood and put into practice.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff and managers were clear about the challenges the department faced. They explain the risks to the department and the plans to deal with them.
- The emergency department had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.

Outstanding practice

- The department had introduced a new protocol for the identification, treatment and management of sepsis. Patients were risk assessed and rated on a traffic light scale to identify whether they were low, moderate or high risks of sepsis. Patients were then treated accordingly.

- To improve flow within the department the emergency department and acute assessment unit (AAU) had developed strong joint working protocols. The lengthy referral process had been removed and AAU doctors regularly reviewed patients in the emergency department to assess them for ward beds.

Areas for improvement

Action the trust SHOULD take to improve:

- Services should ensure fridge and room temperature checks are completed daily and if temperatures exceeding the maximum temperature this is reported to facilities and pharmacy in a timely way.
- The service should continue to increase consultant cover to provide 16 hours per day consultant cover and meet the Royal College of Emergency Medicine recommendations.

Medical care (including older people's care)

Good ↑

Key facts and figures

Chelsea and Westminster Hospital is part of Chelsea and Westminster Hospital NHS Foundation Trust. It is one of the two Hospitals making up this trust. The other Hospital is West Middlesex University Hospital. The two Hospitals merged in 2015.

The Hospital receives and treats patients from across the United Kingdom and overseas. Medical care services at this Hospital are provided under the emergency and integrated care division and the women, neonatal, children and young people HIV/GUM and dermatology division. Services include neurology, haematology, endocrinology, gastroenterology, cardiology, elderly care, rheumatology, oncology, and general medicine. We also included the endoscopy unit in our inspection.

During our inspection, we visited the acute assessment unit, ambulatory emergency care unit, David Erskine ward (respiratory), Edgar Horne ward (care of the elderly, haematology, and endocrinology), Nell Gwynne ward (neurology and stroke),Rainsford Mowlem ward (general medicine and care of the elderly), Ron Johnson ward (HIV and oncology), Chelsea Wing (all specialities for private inpatients), the diagnostic centre (cardiology, neurophysiology, and respiratory), the medical day unit (Edith Smith), the discharge lounge, and the endoscopy unit.

We last inspected Chelsea and Westminster Hospital in 2014 and rated medical care as requires improvement overall. This reflected a rating of requires improvement for safe and well led and a rating of good for effective, caring, and responsive. Following our inspection in 2014, we told the trust they must do the following:

- Ensure learning from incidents is shared.
- Ensure that risks identified on the risk register have appropriate actions to mitigate them, with timely reviews and updates.
- Ensure that all medicines are stored safely and securely and are in date and fit for use.
- Ensure that nurse staffing levels for level two patients in AAU met the core standards set out by the Faculty of Intensive Care Medicine.
- Ensure that agency staff have access to patient records.
- Protect patients against the risk of unsafe equipment. This was in relation to the cardiac arrest call bell system on the AAU, which was faulty and not linked to the nurses' station at the time of the inspection.

Summary of this service

Our rating of this service improved. We rated it it as good because:

- The Hospital made improvements in most of the areas above that we told them they must improve following the inspection in 2014.
- There had been a review of staffing requirements for level two patients in AAU, the call bell system had been refurbished, there was evidence of sharing of learning from incidents, and there was regular review of the risk register with appropriate mitigating actions being indicated.
- Overall, medicines were managed and stored appropriately across medical wards.

Medical care (including older people's care)

- Staff demonstrated knowledge of safeguarding processes and were able to effectively escalate safeguarding concerns.
- The senior divisional team used a ward accreditation scheme to monitor quality and safety performance in each inpatient ward. The results were used to identify areas of good practice and areas for improvement.
- Although staff vacancies remained a challenge for the service, ward managers and senior nurses actively addressed recruitment and retention using various initiatives.
- The work of the Hospital at night team mitigated the risk related to low junior doctor cover on medical wards at night.
- Staff provided care and treatment in line with national guidance and good practice. The service monitored the effectiveness of care and treatment through continuous local and national audits.
- Staff competencies were monitored by practice development nurses (PDNs) working within medical services who we found to be passionate and keen to improve the service.
- There was effective multidisciplinary team (MDT) working, which was embedded into practice in all the areas we inspected.
- Staff were knowledgeable about and demonstrated a good awareness of consent, mental capacity and the Mental Capacity Act (2005). This was evidenced in our conversations and from looking at patient records.
- Staff treated patients and their relatives with kindness, compassion, respect and dignity.
- Between September 2016 and August 2017, five of eight medical specialties performed better than the national average for referral to treatment within 18 weeks.
- There was a clear vision and strategy for the service and senior staff understood their responsibilities in carrying out the strategy.
- There had been an improvement in relation to staff engagement by senior teams. In 2014, we told the Hospital staff engagement needed to improve.
- Leadership and governance processes had been simplified and were clearly structured and this encouraged effective governance from board level to ward level.
- Risks identified on the risk register had appropriate actions to mitigate them and had been reviewed regularly. This meant the service had taken action in response to our 2014 recommendations.
- There had also been an improvement in relation to service leading being aware of the risk faced by staff and patients on the wards.

However:

- Similar to the findings in 2014, not all agency staff had access to the electronic patient records.
- Due to staff shortages, ambulatory emergency care (AEC) staff were not always able to follow up patients requiring urgent investigation or ongoing support following discharge from AAU.
- There was variable completion of mandatory training. For medical staff, the trust target of 90% was met in one out of eight training modules. For nursing staff the target was met in four out of nine modules.
- There was poor overall compliance with annual staff appraisals with only 64% of staff having been appraised from August 2016 to July 2017.
- From July 2016 to June 2017, the average length of stay for both medical elective and medical non-elective patients at Chelsea and Westminster Hospital was higher than the England average.

Medical care (including older people's care)

- From August 2016 to August 2017, the Hospital had 91 complaints which took an average of 49 days to investigate and close. This was not in line with their complaints policy, which states complaints should be closed within 25 working days. Eighteen complaints remained open at the time of the trust's submission.
- Between September 2016 and August 2017 three of eight medical specialties performed worse than the national average for referral to treatment within 18 weeks.
- On some medical areas, staff said they did not feel they were part of the service, for example the diagnostic centre.
- Although the working culture was generally positive, some individuals said they did not feel supported by colleagues or senior staff on the wards.

Our findings reflect improvements in most of the areas we told the Hospital they must improve following the inspection in 2014. Although we found instances where staff had not managed or stored medicines safely or in line with the trust policy, overall there was appropriate medicines management across the medical service. Although we found that not all agency staff had access to electronic patient records, overall, our findings in relation to the safe domain were positive.

During our inspection, we spoke with 76 members of staff including health care assistants, doctors, nurses, allied health professionals and ancillary staff. Staff represented a range of roles and grades across all specialties and medical departments. We also spoke with the directorate leadership team, 34 patients and 15 relatives. We reviewed 23 electronic patient records, multiple paper records including bedside patient notes, 23 electronic prescription charts and various pieces of equipment. We also reviewed evidence sent to us before and after the inspection including minutes of meetings and audit results.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service had improved in relation to sharing learning from incidents. We found a culture which encouraged the sharing of learning from incidents.
- Staff were knowledgeable about safeguarding and demonstrated an awareness of the trust's safeguarding processes.
- Overall, staff managed and stored medicines safely and securely on the medical wards and areas.
- Although there were fewer consultants and junior doctors than expected, the Hospital at night team supported wards to provide medical cover when needed and this helped staff provide safer care at night.
- The service had improved in relation to staffing levels for level two patients in AAU. There was increased staffing provision in comparison to the staffing arrangements at the time of our 2014 inspection.
- Although there remained challenges in recruiting and retaining staff evidenced by high nurse vacancies on some of the medical wards, ward teams had implemented strategies to reduce vacancies and increase retention.
- We observed consistent standards of hand hygiene and infection control measures amongst clinical and ward-based staff.
- The service had improved the accessibility of care plans. In the 23 patient records we checked, staff had completed patient risk assessments in all 23 records which we accessed easily.

However:

- Similar to 2014, not all agency staff had access to the electronic patient records.

- There was variable completion of mandatory training. For medical staff, the trust target of 90% was met in one out of eight training modules. For nursing staff the target was met in four out of nine modules.
- The results of national early warning scores (NEWS) audits were variable across medical wards with some wards achieving 0% compliance. However, on inspection we found that staff appropriately calculated and recorded NEWS in the patient records we looked at.
- Due to staff shortages, ambulatory emergency care (AEC) staff were not always able to follow up patients requiring urgent investigation or ongoing support following discharge from AAU.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment in line with national guidance and best practice standards.
- The service monitored the effectiveness of care and treatment by participating in national and local audits and used the findings to drive improvements.
- Staff were knowledgeable about and demonstrated a good awareness of consent, mental capacity and the Mental Capacity Act (2005). This was evidenced in our conversations and from looking at patient records.
- The endoscopy unit had achieved Joint Advisory Group (JAG) accreditation in recognition of achievements in patient-centred care according to the measurements of the global rating scale.
- The Hospital achieved a grading of B in the quarterly Sentinel Stroke National Audit Programme (SSNAP). This was based on a scale of A-E, where A is best and E is the worst.
- Staff of all grades and responsibilities had access to a range of teaching, learning and development opportunities delivered by specialist teams.
- There was an effective multidisciplinary team (MDT) working environment within medical services with the involvement of external partners (such as mental health service providers) to support patients' health and wellbeing.

However:

- Eight out of nine staff groups did not meet the trust's standard of 100% annual appraisal completion.
- Dieticians' audits showed that staff did not always assess patients for the risk of malnutrition on admission. Staff did not always reassess patients' nutritional needs after one week per trust policy. However, during the inspection we checked patient records for nutritional needs assessments on admission and found that staff had completed these assessments in all the records we looked at.
- For the heart failure audit, Chelsea and Westminster Hospital's results were worse than the England average in terms of the percentage of inpatients and cardiologist input.
- For the heart failure audit, Chelsea and Westminster Hospital's results were worse than the England and Wales average for seven of the nine standards relating to discharge.

Medical care (including older people's care)

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion.
- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed positive, polite, friendly and professional interactions between staff and patients and family members.
- We spoke with 34 patients during the inspection and overall patients spoke positively about staff.
- Staff treated patients with dignity and respect and this was evident in our interviews with patients and relatives.
- The service provided counselling and support services to patients and their carers/relatives via the MacMillan support centre located within the Hospital.
- Staff routinely included patients in care planning and delivery, including in medicines management.

However:

- In our conversations with patients, there were a few negative comments made. For example, one patient said they did not feel staff communicated with them enough to involve them in their care.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Staff demonstrated an awareness of the needs of local population and developed services accordingly. This included establishing a ten bedded frailty section on Rainsford Mowlem, opening a twelve bedded escalation unit on Nell Gwynne ward, and developing nurse specialist roles such as the establishment of the learning disability specialist nurse role.
- The service provided rapid access to clinics such as the Ambulatory Emergency Care (AEC) unit, a diagnostic centre and a medical day unit. This helped address the increased demand on the service.
- Medical wards delivered the national Gold Standards Framework for patients at the end of their life. The framework aims to improve quality of care for all people nearing the end of life.
- The service took into account the needs of various people, for example patients living with dementia and patients with learning disability.
- Between September 2016 and August 2017 referral to treatment rates for admitted pathways were similar to or better than the England average.

However:

- From July 2016 to June 2017, the average length of stay for both medical elective and medical non-elective patients was higher than the England average.

- Not all senior staff were clear about the policy or arrangements for the opening and closing of the escalation area on Nell Gwynne.
- From August 2016 to August 2017, the Hospital had 91 complaints which took an average of 49 days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 25 working days. Eighteen complaints remained open at the time of the trust's submission.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- There was a clear vision and strategy for the trust and for medical services. Senior staff on the medical wards demonstrated knowledge of this vision and understood their responsibility in relation to the strategy to achieve this vision.
- Following the inspection in 2014, the trust had simplified the governance structures by using the triumvirate model of leadership. This encouraged effective governance from board level to ward level.
- Staff spoke positively about the leadership of the service including the visibility of senior leadership. Staff also spoke positively about the culture of the service describing it as a place they were proud to work in.
- Although challenges remained in relation to recruiting and retaining staff, senior leaders used various initiatives in order to recruit and retain staff.
- There had been an improvement in relation to staff engagement which we found lacking in the previous inspection. We found multiple examples of senior staff engaging staff and patients in order to obtain their views on improving the service.
- There were a wide range of initiatives to encourage learning, continuous improvement and innovation, for example the ward accreditation scheme.
- There had been an improvement in relation to the management and review of the risk registers for the service. Risks in the divisional risk registers were reviewed regularly and mitigating actions were indicated.
- In the previous inspection, we found that divisional leads were not aware of the risks faced by staff and their patients on the wards. There had been an improvement in relation to this and we found that divisional leads were aware of risks at the ward level.

However:

- Some medical teams did not feel part of the overall service, for example the diagnostic centre.
- Although the working culture was generally positive, some individuals said they did not feel supported by colleagues or by senior staff on the wards.

Outstanding practice

- The work on Nell Gwynne and David Erskine ward in relation to elderly patients including those living with dementia was outstanding. Staff engaged patients in a wide range of activities and were passionate about the needs of these patients.

Medical care (including older people's care)

- Inpatient wards and clinical departments participated in a ward accreditation scheme to assess performance in relation to safety and quality indicators set by the trust. The trust used this system to establish and monitor ward performance against our key lines of enquiry and to identify areas of good practice and for improvement.
- On David Erskine ward, a nurse had created and implemented a 'drinking wheel', which was a tool to encourage patients to drink more and keep hydrated. This was an example of innovation by staff.
- Medical wards participated in the 'fab change' week and on other wards 'fab change month'.Fab week/month encouraged staff to make a pledge to help improve aspects of healthcare within their own service or wider.

Areas for improvement

Action the trust SHOULD take to improve:

- Have a clear policy on the opening and closing of escalation areas.
- Review medical cover at night in order to address continuing staff shortages at night.
- Ensure that agency staff has access to patient records.
- Ensure that staff assess patients for the risk of malnutrition on admission.
- Ensure that staff reassess patients for the use of the red tray system as per trust policy.
- Ensure that medicines are managed and stored safely in all medical areas.

Surgery

Good ↑

Key facts and figures

The trust had 27,803 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 8,045 (29%), 14,876 (54%) were day cases, and the remaining 4,882 (18%) were elective.

The surgery department at Chelsea and Westminster Hospital provides elective (planned) and non-elective (emergency) surgery services in a range of specialities, including general surgery, trauma and orthopaedic, urology and plastic surgery. The Hospital provides care to people across the breadth of the United Kingdom. The vast majority of their patient activity originates from Greater London, particularly the W and SW postcodes. A private ward also provided care for patients.

The department has four surgical wards, a pre-assessment clinic, a surgical admissions lounge, a Treatment Centre with 7 theatres that supports day case surgery.

Summary of this service

Our rating of this service improved. We rated it it as good because:

- The overall completion rate for mandatory training for nursing staff at the Hospital had improved since the last inspection from 72% to 87%. Work was ongoing to raise this to the trust target of 90%. Electronic (E) learning was used for the majority of mandatory training.
- Staff in the operating theatres and Treatment Centre followed the World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery, and monitored this to make sure this was completed accurately.
- Observations and a review of documents confirmed a minimum of four hourly national early warning scores (NEWS) were carried out and recorded recording for all patients.
- Vacancy rates for nursing staff had improved. The Hospital reported an overall vacancy rate among nursing staff in surgery of 7% from August 2016 to July 2017. This was an improvement from the last inspection where the vacancy rate was 15%.
- Junior surgical doctors reported no current gaps in the on-call rota and they said that they were supported well by their senior colleagues.
- We saw improvements which showed that medicines were being stored securely. We also saw that tamper evident seals were in use for emergency medicines to ensure that they were readily available when needed and fit for use.
- Patients and staff now had access to safety thermometer information, as it was presented on the patient safety and staffing boards in each ward.
- The Practice Development Nurse (PDN) was heavily involved and engaged in developing new staff, and was particularly keen to impart high standards of documentation and care delivery. We saw that newly qualified staff were well supported by this process.
- Multi-disciplinary (MDT) working was evident, such as collaboration between occupational therapists, physiotherapists and pharmacists. Staff working in Decontamination Services showed outstanding MDT working with the surgical teams.

Surgery

- We observed patients were looked after in a caring and professional manner. Most patients that we spoke with during this inspection were very complimentary about the level of care they had received.
- Psychological support was provided to patients where needed. For example the Burns Unit had five psychologists who were able to provide support to patients who had experienced a burns injury. This service also included their relatives.
- Patients scheduled for surgery had all been through pre-assessment and assessed by the anaesthetists to be fit for surgery.
- From July 2016 to June 2017 the average length of stay for all elective patients at Chelsea and Westminster Hospital was 3.1 days, which is better than the England average of 3.3 days.
- There were quiet facilities in the Hospital, which patients, relatives and staff could use in their personal time and space for reflection.
- Staff at ward level were able to corroborate senior management's accounts of being regularly present and involved at ward level and we were told by a senior manager that the Chief Operating Officer was very visible both on and off the rota for working clinically.
- There were no individual strategies for each of the surgical specialities. However, we saw that the strategy for the surgical division was broadly linked to the trust's three corporate strategies.
- There were ongoing plans to increase private patient working within the NHS framework, with a potential increase in the operating capacity.
- There was a transparent and open culture where staff escalated concerns, reported incidents and sought support from peers and seniors.

However,

- Access to mandatory training for nursing staff varied across wards and clinical areas with some staff having dedicated time to complete training whilst others having to undertake their training in their own time.
- We looked at a total of 11 patient records. There were a number of different ways in which staff were recording medical data at the time of our inspection. This had the potential to cause confusion, given the combination of written notes and online notes.
- We found issues with the monitoring of fridge and room temperature readings where medicines were being stored. Staff took minimum, current and maximum temperature readings each day however, we did not find evidence of action taken by staff when temperatures were found to be outside of the recommended range.
- The service did not meet national standards for care and treatment in key areas, such as length of Hospital stay and perioperative assessments.
- There remained some overlap in understanding of differences between mental capacity and mental health and this was mainly amongst junior nurses, though they were clearly aware of when and how to escalate to senior nurses.
- The service had not achieved its referral to treatment (RTT) target for general surgery, oral surgery, trauma and orthopaedics and urology. However, it was meeting the target for: ENT, ophthalmology, plastic surgery and cardiothoracic surgery.
- From August 2016 to August 2017 there were 160 complaints about surgery. The trust took an average of 57 working days to investigate and close complaints. This was not in line with the trust's complaints policy, which states complaints should be completed within 25 working days. As of August 2017, there were 22 complaints still open and yet to be completed.

Surgery

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The overall completion rate of mandatory training for nursing staff at the Hospital was 87%. This was an improvement from the last inspection where only 72% of staff were compliant.
- We saw improvements in how theatre staff followed the World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery, and monitored this to make sure they continued to do it accurately.
- The PLACE survey for March 2017 scored 96.32% for the condition, appearance and maintenance of the patient environment at the Hospital.
- We saw evidence of nurses undertaking a minimum of four hourly national early warning scores (NEWS) recording for all patients.
- Chelsea and Westminster Hospital reported an overall vacancy rate among nursing staff in surgery of 7% from August 2016 to July 2017. This was an improvement from the last inspection where the vacancy rate was 15%.
- Junior surgical doctors reported no current gaps in on-call rota and that they were supported well by their senior colleagues.
- We saw improvements which showed that medicines were being stored securely. We also saw that tamper evident seals were in use for emergency medicines to ensure that they were readily available when needed and fit for use.
- Patients and staff now had access to safety thermometer information, as it was presented on the patient safety and staffing boards in each ward.

However

- Storage space was limited in theatres for equipment and as a result, equipment was temporarily being stored in an old paediatric recovery room.
- We looked at a total of 11 patient records. There were a number of different ways in which staff were recording medical data at the time of our inspection. This had the potential to cause confusion, given the combination of written notes and online notes.
- We found issues with the monitoring of fridge and room temperature readings where medicines were being stored. Staff took minimum, current and maximum temperature readings each day however, we did not find evidence of action taken by staff when temperatures were found to be outside of the recommended range.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- There were regular audits of resuscitation responses to cardiac arrests, notes reviews within 24 hours, and looking at the patients' preceding care to highlight if there was anything that could be avoided within 7 days of a cardiac arrest call.

Surgery

- In the PLACE survey for March 2017, the Hospital scored 94.92% for food and hydration.
- We saw evidence that newly qualified staff were well supported by practice development nurses (PDNs) who were very enthusiastic and passionate about the development of junior nurses.
- Multi-disciplinary (MDT) working was evident, such as collaboration between occupational therapists, physiotherapists and pharmacists. Staff working in the Decontamination Services Department showed outstanding MDT working with the surgical teams.

However:

- The service did not meet national standards for care and treatment in key areas, such as length of Hospital stay and perioperative assessments.
- There remained some overlap in understanding of differences between mental capacity and mental health and this was mainly amongst junior nurses, though they were clearly aware of when and how to escalate to senior nurses.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- We saw staff treating patients with compassion, dignity and respect.
- Most patients that we spoke with during this inspection were very complimentary about the level of care they had received.
- We saw that doctors and nurses gave emotional support to patients as and when it was needed.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- Patients scheduled for surgery had all been through pre-assessment and assessed by the anaesthetists to be fit for surgery.
- From July 2016 to June 2017 the average length of stay for all elective patients at Chelsea and Westminster Hospital was 3.1 days, which was better than the England average of 3.3 days.
- There were quiet facilities in the Hospital, which patients, relatives and staff could use in their personal time and space for reflection.
- Between 1 August 2016 and the 31 July 2017, there were no mixed sex breaches on any of the surgical wards.
- There was a Hospital chaplaincy service, which provided spiritual, pastoral and religious care to all patients, carers and to staff. This care was inclusive to ensure that everyone who wished to receive spiritual care and support did.

However

- The service had not achieved its referral to treatment (RTT) target for general surgery, oral surgery, trauma and orthopaedics and urology.

Surgery

- From August 2016 to August 2017 there were 160 complaints about surgery. The trust took an average of 57 working days to investigate and close complaints. This was not in line with the trust's complaints policy.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Staff at ward level were able to corroborate senior management's accounts of being regularly present and involved at ward level and we were told by a senior manager that the Chief Operating Officer was very visible both on and off the rota for working clinically.
- There were no individual strategies for each of the surgical specialities. However, we saw that the strategy for the surgical division was broadly linked to the trust's three corporate strategies.
- There were ongoing plans to increase private patient working within the NHS framework, with a potential increase in the operating capacity.
- There was a transparent and open culture where staff escalated concerns, reported incidents and sought support from peers and seniors.
- The Practice Development Nurse (PDN) was heavily involved and engaged in developing new staff, and was particularly keen to impart high standards of documentation and care delivery.

However:

- A surgeon told us of a lack of image intensifying equipment for hand surgery, which was raised on the risk register. We saw no evidence of this having been added to the risk register.

Outstanding practice

- Outstanding practice was found in the Burns Unit where medical staff have trained and empowered nursing staff to become leaders in the management of wound healing in patients suffering major burns. New techniques in wound care such as wound debridement and skin replacement therapy has resulted in the development of an advanced training course and the sharing of evidence based practice to other NHS care providers.
- Multidisciplinary working with staff in the Decontamination Services Department which has resulted in purchasing new equipment which will support the reduction of any potential cross contamination: teaching sessions for operating theatre staff when new equipment has been purchased: induction sessions for new staff in the Decontamination Services Department so staff can appreciate the importance of handling and maintaining new equipment which overall demonstrates the value and importance staff have for this department.

Areas for improvement

Action the trust SHOULD take to improve:

- The service must ensure action is taken when fridge temperatures are outside the recommended temperatures.
- The service must review and act upon the PROM data to ensure outcomes are improved for patients
- The service must improve its response rate for complaints and adhere to their own policy of responding to complaints within 25 days.

Services for children and young people

Good ↑

Key facts and figures

Chelsea and Westminster Hospital NHS Foundation trust is one of London's largest providers of children and young people services. The trust cares for more than 80,000 children and young people each year. The main aim of the service is to 'provide all children and young people with safe, effective and reliable care, ensuring that their stay in Hospital is as short as possible'.

Chelsea and Westminster Hospital is a tertiary Hospital which provides a wide range of general and specialist services to children and young people predominately from Central and West London. 96% of patients were from Greater London, but many patients from South East England were referred to the Hospital for investigation and treatment. In the 12 months before our inspection there were 8,535 inpatient spells at the Hospital, of which approximately 50% were emergency spells, 15% day case and 35% were elective.

Chelsea and Westminster Hospital was the lead centre for specialist paediatric and neonatal surgery in northwest London, meaning that it carries out the most complex surgeries on babies and children. The Hospital provided numerous specialities for children including: emergency medicine, anaesthetics, allergies, audiology, oncology, dermatology, diabetes, cardiology, general medicine, orthopaedics, outpatients, therapies, ophthalmology, plastic surgery, endocrinology, otolaryngology, paediatric urology, foetal/prenatal medicine, psychology and dentistry.

We visited the children and young people services over three days during our announced inspection. We looked at all neonatal and paediatric clinical areas including all inpatient wards, Children's Outpatients Unit and paediatric theatres. We observed care and treatment and we looked at a sample of nine patient records. We spoke with approximately 60 members of staff, including nurses, doctors, allied health professionals, managers and support staff. We also spoke with 20 patients and their relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service improved. We rated it it as good because:

- There was a good overall safety performance in the service and a culture of learning to ensure safety improvements. Staff were encouraged to report incidents and received timely feedback. There was evidence of learning from incidents, which was shared in a number of ways.
- Clinical staffing was mostly well managed and there were processes in place to ensure safe staffing levels based on patient acuity. Their service had 24 hour consultant cover.
- There were effective processes in place to assess and escalate deteriorating patients.
- There was good compliance with infection prevention and control processes. Equipment was checked regularly and medicines were stored appropriately.
- Staff had a good understanding of safeguarding and were aware of their responsibilities. The service had good multi-agency partnerships to share relevant safeguarding information.
- Patient records were completed to a good standard.
- Staff provided care and treatment in line with national guidance and good practice. The service monitored the effectiveness of care and treatment through continuous local and national audits.

Services for children and young people

- There were effective processes to ensure that patients' nutritional and pain management needs were met.
- The trust had good performance in local and national patient outcome and performance audits. For example the Hospital NICU had the lowest perinatal mortality rate in the UK and the Hospital demonstrated the highest rates of breastfeeding at the time of discharge.
- Staff were supported to develop and there was a culture of learning and teaching within the service.
- There was effective multidisciplinary team (MDT) working both internally and externally to support patients' health and wellbeing.
- There was a clear research ethos within children and young people services.
- There was a comprehensive range of information and support available for patients and their families and carers. Staff helped patients manage their own health.
- Staff understood their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff worked in partnership with parents and families. They demonstrated a patient-centred approach which encouraged family members to take an active role in their child's healthcare. All staff interacted with patients and their relatives and carers in in a caring, polite and friendly manner. All of the people we spoke with were very happy with their care and treatment.
- Staff spent time with children to help make their experience more comfortable, relaxed and home-like. They supported them after discharge with teaching and community support.
- The service had a broad programme of emotional support services for children and young people and their families and carers. This included a variety of therapeutic support services. There were appropriate and sensitive processes for end of life care.
- Young people were supported by a dedicated youth worker, who was trained in counselling and talking therapies. There was a dedicated play therapy team which incorporated play into clinical interventions and therapies.
- The Hospital delivered a broad range of services for children and young people, including a number of highly specialist paediatric services. There was timely access to services and good overall compliance of 95% for referral to treatment times. Flow within the service from admission, through theatres, wards and discharge was mostly managed effectively.
- There was very comprehensive provision to meet the individual needs of children and young people, including vulnerable patients and those with specific needs. There were efforts across the Hospital to make the environment more child-friendly and welcoming for young people.
- The Hospital school was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the Hospital.
- There was an established and stable leadership team in the CYP service. Staff told us senior leaders were visible, approachable and supportive. There was an inclusive and constructive culture within the services. We found highly dedicated staff who were very positive, knowledgeable and passionate about caring for children and young people.
- The service used appropriate governance, risk management and quality measures to improve patient care, safety and outcomes. Senior staff understood their local challenges and demonstrated a desire to improve CYP services for the benefit of patients.
- There was a clearly defined clinical strategy for the service up to 2020.

Services for children and young people

- The service engaged with young people and parents and carers in the design of services. The trust had established a Hospital Youth Forum. There were examples of service co-design, for example parental involvement in the redevelopment of the NICU.
- There was a very strong record of innovation in the Hospital's children and young people services and the trust was internationally recognised as an innovator and leader in paediatrics and neonatology research.

However:

- During our inspection we found isolated instances where trust policies were not adhered to, for example in the safe management of controlled drugs and consent recording, and mandatory training completion.
- There remained some challenges with clinical staffing vacancies, for example nurse staffing in the neonatal unit and on the paediatric burns unit. Managers were aware of these challenges and there were interim measures in place to ensure safety.
- Some trust computer systems did not always work as effectively as they should, which impacted staff efficiency, for example the policy database and online learning platform. There was limited Wi-Fi network access in some areas of the Hospital.
- Some staff felt the trust could do more to support them, for example staff with leadership and management responsibilities and healthcare assistants.
- Some clinical areas were suboptimal, for example the paediatric high dependency unit (HDU) was not always used for its intended purpose and the paediatric ambulatory care unit did not provide a high quality experience for patients.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- In the previous inspection we found incident reporting needed to improve and lessons needed to be shared more effectively. In this inspection we found this had improved. There was a good overall safety performance in the service and a culture of learning to ensure safety improvements. Staff were encouraged to report incidents and they received timely feedback.
- Since the previous inspection the service had introduced a nursing acuity tool to monitor safe staffing and skill mix on the wards.
- In the previous inspection we noted some challenges with infection prevention and control. In this inspection we found wards and clinical areas were visibly clean and staff complied with current infection prevention and control guidelines.
- There were appropriate systems for staff to monitor and escalate deteriorating patients. The service used a paediatric early warning score system, which incorporated a sepsis identification tool.
- Staff had a good understanding of safeguarding and were aware of their responsibilities. The service had good multi-agency partnerships to share relevant safeguarding information.
- Equipment was checked regularly and medicines were stored appropriately.
- Patient documentation across the service was completed to a good standard.

However:

Services for children and young people

- Completion for some mandatory training modules, particularly for medical staff was slightly below trust targets. Managers were aware of this and plans were in place to address it.
- During our inspection we found one instance where the key to a controlled drugs cupboard was left in the cupboard in error and not kept with the nurse in charge. This was rectified immediately when we raised it at the time.
- There remained some challenges with clinical staffing vacancies, for example nurse staffing in the neonatal unit and on the paediatric burns unit. Managers were aware of these challenges and there were interim measures in place to ensure safety.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- In the previous inspection we found clinical practice guidelines needed to be updated and monitored to ensure compliance with national standards. During this inspection we found care was delivered in line with referenced national clinical guidance and good practice.
- Service leaders monitored the effectiveness of care and treatment through continuous local and national audits. There were regular reviews of service performance and outcome data to ensure provision was meeting the needs of children and young people, including benchmarking activities and peer review with other NHS Hospital trusts, for which it compared favourably.
- There were very effective processes to ensure patients' pain relief needs were met. There were appropriate processes to ensure that patients' nutritional needs were met.
- The Hospital NICU had the lowest perinatal mortality rate in the UK. The Hospital also demonstrated the highest rates of breastfeeding at the time of discharge.
- There was good completion of staff appraisals and there were appropriate supervision and reflection processes in place.
- Doctors in training, students and newly qualified nurses reported a supportive and encouraging learning environment with good supervision, access to senior staff and good teaching and learning opportunities.
- Nurses told us there the trust was supportive of their progression and there were opportunities to develop their careers.
- There was an effective multidisciplinary team (MDT) working environment within children and young people services and with external partners to support patients' health and wellbeing.
- There was 24 hour on site consultant cover across children and young people services, including in the Hospital NICU.
- The trust had invested in the recruitment of a public health consultant doctor to help address key public health outcomes in the local area.
- There was a comprehensive range of information and support available for patients and their families and carers. Staff helped patients manage their own health.
- Staff were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

- The service was actively involved in clinical research and there was a clear research ethos at the Hospital. However research in the service was mostly medically led. There were some examples of therapies research leadership and involvement, for example in art and music therapy, but the Hospital's nursing research profile was limited.

However:

- The trust intranet search function was not always effective and this sometimes impacted on the time it took to find relevant policies and guidelines. Senior managers were aware of this and there were plans in place to redevelop it.
- We found isolated evidence that consent processes in paediatric surgery did not always follow best practice.
- Some of the healthcare assistants we spoke with felt that the trust could invest more in their development.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- In the previous inspection we found staff were caring and child-centred. On this inspection we found that staff attitude and Hospital processes to embed care had improved further.
- There was very good rapport between staff and patients. All staff interacted with patients and their relatives and carers in in a caring, polite and friendly way.
- All of the people we spoke with during the inspection were very happy with their care and treatment.
- Staff spent time with children to help make their experience more comfortable, relaxed and home-like, for example by spending time to make Christmas decorations together.
- NHS Friends and Family Test (FFT) results were consistently very good across children and young people service areas.
- There were appropriate and sensitive processes for end of life care for neonates and children and young people. Tailored training was provided to staff to help them support the emotional needs of end of life care patients and their families.
- The service had a broad programme of emotional support services for children and young people and their families and carers. This included a variety of therapeutic support services.
- Young people were supported by a dedicated youth worker, who was trained in counselling and talking therapies.
- There was a dedicated play therapy team which worked very closely with doctors, nurses and therapists to incorporate play into clinical interventions and therapies.
- The service signposted patients and their families to local support groups to help them build links with others facing similar challenges.
- Staff worked in partnership with children, parents and families. Staff demonstrated a child-centred approach which encouraged family members to take an active role in their child's healthcare.
- Staff spoke with young people in an age appropriate way so they understood their treatment and had opportunities to ask questions.
- Clinical nurse specialists provided tailored teaching and support to a wide spectrum of families with home management across a range of subjects.

- Nurses on Mercury ward had produced a 'bravery box' which contained stickers and certificates for children to provide assurance and encouragement during clinical interventions.
- Staff in the NICU provided families discharging from the NICU with a parcel of consumables and information leaflets to support them when they returned home.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The Hospital delivered a broad range of services for children and young people, including a number of highly specialist paediatric services.
- There was timely access to children and young people services and there was a good overall compliance of 95% for referral to treatment times.
- In the previous inspection we found that out-of-hours support for patients needing mental health support needed to improve. In this inspection we found very comprehensive provision to meet the individual needs of children and young people, including vulnerable patients and those with specific needs.
- The Hospital had introduced a learning disability 'passport' system, which was incorporated in patient records to help inform decision making and meet the needs of the individual.
- There were efforts across the Hospital to make the environment more child-friendly and welcoming for young people.
- The Hospital school was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the Hospital.
- There were appropriate translation and advocacy services to support patients with English as an additional language.
- The Hospital provided a wide variety of child friendly food and snacks and there were specific menus for children and young people. The menus included options for specific cultures and needs.
- The Hospital play team provided a very comprehensive programme of play support to children aged 0-11 across all paediatric clinical areas.
- The flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively and children and young people were transferred from the theatre recovery area to the ward without unnecessary delays.
- The Children's Outpatient Unit was very flexible with appointment times to suit the needs of children and their families.

However:

- The paediatric high dependency unit (HDU) was not always used for its intended purpose and HDU admission criteria were not always followed, which resulted in some patients being admitted to the ward who did not require HDU level care, or those with unclear dependencies.
- The present location of the paediatric ambulatory care unit on Saturn ward was suboptimal and could impact on the patient experience. Senior leaders were aware of this and there were advanced plans to relocate it to a more suitable space.

- There were some instances of discharge delays while waiting for medications or patient transport.
- The service took an average of 35 days to investigate and close complaints which was not in line with the trust complaints policy.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- In the previous inspection we found that the service needed to develop a clear strategy. In this inspection we found there was a clearly defined clinical strategy which detailed the vision for the service up to 2020.
- In the previous inspection we found that governance structures did not provide adequate assurance around quality, safety and risk. In this inspection we found the service used appropriate governance, risk management and quality measures to improve patient care, safety and outcomes.
- In the previous inspection staff told us the leadership team was not visible or fully supportive. In this inspection staff told us senior leaders of the service were visible, approachable and supportive.
- In the previous inspection we found staff engagement needed to improve. We also found some isolated concerns around bullying. In this inspection we found an inclusive and constructive working culture within the service. We found highly dedicated staff who were very positive, knowledgeable and passionate about their work and passionate about caring for children and young people.
- There was an established and stable leadership team in the CYP service and there was clear representation of children and young people services at trust board level.
- Senior staff understood their local challenges and demonstrated a desire to improve CYP services for the benefit of patients. Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented.
- The service engaged with young people and parents and carers in the design of services. The trust had established a Hospital Youth Forum
- There were examples of service co-design, for example parental involvement in the redevelopment of the NICU.
- There was a very strong record of innovation in the Hospital's children and young people services and the trust was internationally recognised as an innovator and leader in paediatrics and neonatology research.

However:

- Consultant doctors had allocated time for leadership and management responsibilities but some found it frequently challenging to manage both sets of responsibilities. Some nurse managers also told us their allocated time for management responsibilities was not protected. There were instances of limited ward management capacity.
- Access to leadership and management training was not universal and in some areas of the service, band 6-7 nurses felt that the trust could support them with more development opportunities to be better leaders.
- Information was well managed within the service. However we found that the Children's Outpatients area was located in a Wi-Fi network 'dead spot' within the Hospital, which meant staff could not access the trust network on mobile devices.

Services for children and young people

Outstanding practice

- The comprehensive range of emotional support services for children and young people and their families and carers, including comprehensive therapeutic support services ensured that support was available when they needed it. All staff working in children and young people services demonstrated a commitment to ensuring patients and their families were fully supported during and after their treatment at the Hospital.
- The Hospital's approach to engaging and supporting young people demonstrated a genuine desire to involve young people in decision making and co-design of services that met their needs. The dedicated youth worker had the skills and resources to provide support to all young people, including vulnerable patients.
- The Hospital play therapy team provided a very comprehensive programme of play support to children aged 0-11 across all paediatric clinical areas. They worked very closely with doctors, nurses and therapists to incorporate play into clinical interventions and therapies.
- The Hospital school was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the Hospital.
- The inclusive and constructive culture within the services meant that staff working across the service demonstrated a positive, caring and passionate attitude towards the children and young people they cared for. All of the staff we spoke with demonstrated a desire to improve services for the benefit of their patients.

Areas for improvement

Action the provider SHOULD take to improve:

- Ensure all staff in the service complete required mandatory training to improve compliance with the trust's target for completion.
- Review training and processes for ensuring that nurse managers in all paediatric clinical areas understand their responsibilities for safely managing controlled drugs, for example ensuring the key to controlled drugs cupboards remains with the nurse in charge at all times.
- Take further steps to ensure that safe staff levels are maintained for all shifts across children and young people services.
- Redevelop the trust intranet search function to ensure staff can find and access policies, guidelines and other information in a timely way.
- Take steps to improve nursing involvement and leadership in clinical research activities.
- Review consent training and processes to ensure all clinicians understand their responsibilities for obtaining and recording consent in patient records.
- Take steps to improve the training, development and engagement of healthcare assistants and nursery nurses.
- Clarify the intended purpose and admission criteria for the paediatric high dependency unit.
- Ensure plans for the relocation of the paediatric ambulatory care unit to a more suitable space are enacted in a timely way.
- Take steps to reduce discharge delays, such as medication and patient transport delays.
- Take steps to reduce complaint response times to improve compliance with the trust's complaints policy.

Services for children and young people

- Ensure all staff with leadership and management responsibilities have sufficient protected time, training and support to discharge their responsibilities.
- Take steps to improve Wi-Fi network access in all areas of the children and young people services to ensure staff can access the trust network.

End of life care

Good ↑

Key facts and figures

The Chelsea and Westminster NHS Foundation Trust provides end of life care across both Chelsea and Westminster Hospital and West Middlesex University Hospital sites. End of life care encompasses all care given to patients who are approaching the end of their life. It may be given on any ward or within any service in the trust. It includes aspects of essential nursing care, specialist palliative care and, after death, bereavement support and mortuary services.

End of life care sits within Emergency and Integrated medicine directorate. The divisional leadership team included a director of operations, medical director, director of nursing and a human resources business partner. The medical director chairs the End of Life steering group across both acute Hospital sites.

There were 1,300 deaths between July 2016 and June 2017 of which 450 were at Chelsea and Westminster Hospital. The latest local audit dated December 2016 showed that around 64% of patients who died at the Hospital were seen by the Specialist Palliative Care Team.

The SPCT included a palliative care consultant (who was also the clinical lead for both acute Hospital sites) and five clinical nurse specialists. It was very clear that whilst this team was site based, they wished to be considered as one palliative care service across the two acute Hospital sites. For the purpose of this inspection, we requested that data was separated out for the two Hospital sites in order to accurately reflect the provision of service in the individual Hospitals in our reports.

The Specialist Palliative Care Team (SPCT) at Chelsea and Westminster has delivered a seven day week service since July 2015 and has a catchment area which takes in three London boroughs.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Security measures had been improved in the mortuary since the last inspection in July 2014. Closed circuit television had been installed, free access was restricted to certain groups of staff and there was a signing in book to be completed.
- Medical staffing had increased since the time of the last inspection.
- In July 2014, we found there was not an effective system to identify patients who should have access to palliative care. During this inspection, staff told us they had training from the SPCT which meant they were more confident and better able to identify patients in their last year of life.
- End of life care was embedded in practice throughout the Hospital. The specialist palliative care team provided training in a variety of forums and reinforced the message that end of life care was everybody's responsibility.
- There was early recognition of when a patient was in their last days or hours of life, at which point a compassionate care agreement would be completed and if they had complex symptoms, be escalated to the specialist palliative care team. This was an individualised care plan based on the five priorities of care of the dying patient. It was agreed with the patient and/or their next of kin. It supported staff to provide good quality of care for people who are dying. Each care plan was led and regularly reviewed by a named consultant and named nurse, supported by the specialist palliative care teams as required.

End of life care

- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders we viewed were completed properly and reflected the information included in the patient's mental capacity assessment.
- There was adherence to national clinical guidelines and a culture of evidence based practice. There were local audits carried out which informed and improved practice.
- 22 wards were working towards Gold Standard Framework accreditation. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It enables frontline staff to provide a gold standard of care for people nearing the end of their life.
- There was a comprehensive programme of training across the trust in relation to end of life care. This was delivered by members of the specialist palliative care team and included 'pop up' training on wards in areas of weakness identified in local audits.
- There was strong evidence of good multidisciplinary working. This was in keeping with the message as put forward by the SPCT which was that 'end of life care was everybody's responsibility'. Training sessions were planned for clinical and non-clinical staff. Governance meetings were attended by a range of staff from different specialisms.
- The chaplaincy team was an integrated part of the overall delivery of care to the dying patient.
- Patients and their relatives told us they were fully included in discussions around their plan of care.
- There were established governance systems in place which identified risk and monitored quality against national standards. Local audit outcomes informed actions as required to continuously improve end of life care standards.
- There was good representation of end of life care at trust board level which was a public demonstration of the importance the trust place in good end of life care.
- Staff had a clear vision for the direction in which the service should go and told us the leadership team was approachable and supportive.

However:

- The current information technology system did not fully support all aspects of record keeping. It did not allow for certain data to be collected and could not support coordinated care plans between the Hospital and GP.
- A recent audit of DNACPR records showed there were certain areas which fell below the 100% target for certain standards.
- There was inconsistency in how compassionate care agreements were completed.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- At the time of the last CQC inspection in July 2014, consultant provision was 0.35 whole time equivalent (WTE) and was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations; or the National Council for Palliative Care. During this inspection we found this had been increased to 0.95 WTE.
- Security measures in the mortuary had improved since the time of the last CQC inspection in July 2014. Closed circuit television had been installed and access to the mortuary was restricted to certain staff groups.

End of life care

- Nursing and medical staff demonstrated a greater recognition of the deteriorating patient and proactively initiated a Compassionate Care Agreement
- The specialist palliative care team (SPCT) was 100% compliant with mandatory training.
- Good infection prevention and control practices were evident.
- The service followed appropriate processes for the prescription, administration, recording and storage of medicines. Patients received the right medication at the right dose at the right time.
- The use of risk assessments and associated documentation had improved since our last inspection. An early warning system (EWS) was used by staff to identify if escalation of care was required. This was used to identify patients who were deteriorating and may require specialist team involvement if their symptoms were complex.
- The specialist end of life services had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was increased consultant cover since the time of our last inspection.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However:

- The current information technology system did not support staff to do their work efficiently. There were different IT systems on which patient information was stored. This made it time consuming to access each part of a patient's record.
- There was inconsistency in how compassionate care agreements were completed. This was evident in areas which included preferred place of death and recording the spiritual and emotional needs of the patient.
- The London End of Life care register, Co-ordinate my Care (CMC) was not yet fully operational. CMC allows healthcare professionals to electronically record patient's wishes and ensure that their personalised urgent care plan is available 24/7 to all those who care for them.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- At the time of the last CQC inspection in July 2014, there was no on-site seven day access to the specialist palliative care team. Since then, an increase in staffing levels meant there was an on-site seven-day service to patients since 2015.
- We saw evidence of the use of national clinical guidelines and a culture of evidence based practice. There were local audits carried out to inform and improve practice.
- 22 wards were working towards the Gold Standards Framework (GSF). This is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis.
- The trust compassionate care agreement was ratified for use across both sites at the End of life steering group following assessment and review. It was implemented in its current form in April 2017 and replaced all previous plans of care.

End of life care

- Staff considered adequate pain relief for end of life care patients to be a priority and demonstrated an awareness of symptom control and the use of anticipatory medication.
- A wide variety of training took place across the trust in relation to end of life care. This included 'pop up' teaching on wards by members of the SPCT where audits had identified areas of weakness in knowledge of processes and procedures.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and allied healthcare professionals supported each other to provide good care. There was evidence of good working relationships with external agencies.
- The chaplaincy team worked closely with the SPCT and attended a range of multidisciplinary meetings including the end of life steering group, which helped them to maintain a high profile as a service across the Hospital.
- The SPCT had introduced a seven day service since the last inspection. This was staffed by clinical nurse specialists between 08:00 and 16:00 on a Saturday and Sunday. Clinical support was available from a local hospice.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005.
- We reviewed a number of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and found them all to be correctly completed and accurately reflected the information included in the patient's mental capacity assessment.
- Weekly multidisciplinary meetings included all professionals involved in the patient's care. The patient's plan of care was discussed and whether the patient may be in their last weeks or days of life.

However:

- A recent audit of DNACPR showed there were certain areas which fell below the 100% target for all standards. For example, results showed that 63% were reviewed by a consultant within 48 hours; 39% showed a discussion took place with next of kin where patient had capacity and 71% showed discussion took place with next of kin where patient lacked capacity.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. We saw several examples of staff from all disciplines being supportive and kind to patients and their relatives. We saw members of staff other than clinical or nursing staff actively directing patients and relatives to where they needed to be.
- Feedback from patients and their carers found that staff treated patients with dignity and respect, explained what was happening and were caring towards the relatives of patients.
- Patients and their relatives felt included in their plan of care. Staff involved patients and those close to them in decisions about their care and treatment.
- The chaplaincy team offered support to patients of all faiths and none. They were available to patients 24 hours a day.
- Mortuary staff and bereavement office staff considered ways in which to make it as easy as possible for relatives to view the deceased's body and to acquire death certificates.

End of life care

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- During the last CQC inspection in 2014, staff told us end of life care was not generally seen to be a whole Hospital responsibility. During this inspection, we found that there was widespread embedded practice which took into account the needs of the patient at the end of their life.
- We found at the last inspection there was no routine audit of the specialist palliative care team's response times. This was now being audited and showed there was 96% compliance with patients seen within the four hour standard.
- The trust introduced a compassionate care agreement in April 2017. In October 2017, the mortality surveillance group added a review of patients' end of life care information to the monthly agenda as part of the national drive to review every death.
- It was identified during the last inspection that not all patients had a care plan which specified their wishes regarding end of life care; a recent audit of compassionate care agreements showed there was100% with documentation of ceilings of treatment.
- The specialist palliative care team (SPCT) audit of time to first contact from referral for specialist palliative care across showed results which in most cases were better than national standards.
- The SPCT treated all palliative care patients and not just those with a cancer.
- Weekly multidisciplinary meetings included all professionals involved in the patient's care. The patient's plan of care was discussed and whether the patient may be in their last weeks or days of life.
- The trust had a total of five butterfly rooms across all wards. These were individual side rooms reserved for patients identified as having days or hours to live. These enabled family members to spend time with the dying person.
- The lead nurse for patients with a learning disability developed an easy read guide to end of life care in collaboration with the SPCT. This was designed to help patients with a learning difficulty understand the process they were likely to undergo during their care.
- There were two places of prayer in the Hospital; the chapel and the tent which was a multi faith area. Both provided places of worship, quiet time and prayer for people of all faiths and none. The tent had separate ablution areas for men and for women to wash themselves before prayer.
- All members of the SPCT were able to arrange fast track discharges. Discharge took on average three days from the time the decision to discharge was made.
- The service took account of patients' individual needs. All staff had training in equality and diversity and there was guidance was available on to support staff with providing care in accordance with peoples' religious and cultural preferences.
- There had been no formal complaints relating to end of life care in the 12 months before our inspection. However, there were processes in place that demonstrated the service treated concerns and complaints seriously. Lessons learned from the results of investigations and local resolution meetings were shared with all staff across the trust.

However:

End of life care

- Fast track discharges were occasionally delayed due to the timely provision of Hospital beds in the community to a patient's home.
- A recent audit of compassionate care agreements identified 83% compliance with documentation of those patients able to express their preferred place of death and 80% compliance where the spiritual and emotional needs of the patient were documented.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- There were robust governance systems in place for identifying risk and monitoring quality against national standards. Local audits informed actions required to continuously improve the end of life care standards.
- End of life care was well represented at trust board level which was reflected throughout the Hospital. The end of life steering committee membership was chaired by a medical director and comprised of clinical and non-clinical staff from both acute Hospital sites.
- All staff spoken with were positive about the divisional leadership team and the local SPCT. They told us their biggest strengths were their passion for good service delivery, their transparency and visibility.
- Staff told us they felt listened to, their opinions were valued and they got recognition for their work.
- There was general consensus amongst managers and staff about what the departmental top risks were. These included meeting the demands of an ever-increasing rise in patient numbers and ensuring there was an adequate number of appropriately trained staff.
- The trust had managers at all levels with the right skills and abilities to run a service which provided high-quality sustainable care.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust end of life care policy was reviewed in May 2017 and set out the roles and responsibilities of all those involved in treating and supporting patients at the end of their life.
- There was a clear vision for the direction in which the service should go. This was developed with consultation and involvement from staff, patients, and key groups from the local community.

However:

- The current information technology system did not fully support staff to perform their duties efficiently.

Outstanding practice

- End of life care had a high profile throughout the Hospital. There was a focus on improving the experience for patients nearing the end of life and there appeared to be a widespread commitment to achieving this.
- There was an innovative approach to how clinical and non-clinical staff were trained in all aspects of end of life care; in particular the use of high fidelity simulation scenarios modelled on a patient's journey at the end of life.

End of life care

- Butterfly rooms were developed which are rooms reserved for patients identified as having days or hours to live. They included all the necessary equipment and facilities patients and their families needed to remain close to one another until death.

Areas for improvement

Action the trust SHOULD take to improve:

- Improve consistency in the completion of DNACPRs.
- Ensure that information technology is compatible with working practices.
- Ensure that compassionate care agreements are consistently completed.
- Ensure that staff training for the London End of Life care register 'Co-ordinate my Care' continues in order to maximise its use.

Outpatients

Good

Key facts and figures

The outpatient department (OPD) at Chelsea and Westminster Hospital is part of the Planned Care Division of Chelsea and Westminster NHS Foundation Trust.

The department was open 9am to 5pm Monday to Friday with some clinics offering appointments at evenings and weekends.

Chelsea and Westminster OPD delivered 609,633 outpatient appointments from July 2016 to June 2017.

The OPD ran clinics in cardiothoracic surgery, general medicine, gynaecology, medicine and care of the elderly, oral surgery, cardiology, plastic surgery, ear nose and throat (ENT), dermatology, trauma & orthopaedics, thoracic medicine, gastroenterology, neurology and urology.

We visited all areas of the OPD across three floors of the Hospital, based predominantly out of four clinic areas on the lower ground floor and we also visited clinical records and phlebotomy.

We spoke with patients who used the service and their families and observed how patients were cared for by staff. We reviewed care or treatment records of people who used services. We also spoke with staff including doctors, nurses, health care assistants, other health professionals, receptionists, porters and clerical staff. We interviewed the matron, consultant clinical lead and access managers for the service.

In addition, we reviewed national data and performance information about the trust and read a range of policies, procedures and other documents relating to the operation of the OPD as well as data and information provided to us directly by the trust.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We rated it as good because:

- The department had improved how they managed incidents; there were clear processes in place for reporting and investigating incidents.
- Staff had a good awareness of safeguarding and knew how to protect patients from abuse. Staff understood how to escalate safeguarding concerns and report incidents. Learning was shared effectively about safeguarding.
- There was protection and support in place for women and children who had undergone female genital mutilation (FGM) or were considered to be at risk.
- There were clear infection control procedures and an infection prevention and control lead. Staff were aware of their responsibilities around preventing infection.
- There were clear protocols and procedures in place for assessing and responding to patients who became unwell in the department.
- The department was visibly clean and there were cleaning schedules in use which were fully completed.

Outpatients

- Medicines were managed safely and the Hospital audited their compliance with medicines procedures. Patients received the right medications at the right time.
- Staff had a good understanding of mental capacity, deprivation of liberty safeguards and consent.
- Patients we spoke with were universally positive about the care and treatment they received in the department.
- The department met patients' needs through a wide range of services; there were plans in place to improve patient access to the service.
- Staff we spoke with were positive about the support they received from their managers and colleagues and there was good multidisciplinary team working.
- There was a positive working culture in the department, staff we observed were friendly and helpful and proud to work at the Hospital.
- We observed staff treating patients with kindness and compassion and there was emotional support in place.

However:

- Managers in the department felt that incidents were underreported by staff. Incidents were not reported promptly and we were not assured that learning was shared.
- There was limited auditing of the performance of the department.
- Failure to mitigate staffing shortages in ophthalmology had resulted in poor patient outcomes for patients undergoing injections for wet macular degeneration.
- The department was not compliant with all referral to treatment targets across the reporting period.
- There was limited evidence that people's views and experiences were gathered and used to shape improvements to the department.

Is the service safe?

Good

We rated it as good because:

- The service had improved how it managed patient safety incidents. Staff recognised incidents and could explain how they would report them. Staff apologised to patients when things went wrong and gave them honest information and support.
- Almost all staff we spoke with were able to accurately describe the duty of candour and give examples where it would be applied.
- The service controlled the risk of infection and staff followed infection control protocols.
- The department was visibly clean and cleaning checklists were in place and used regularly.
- There were sharps bins in place where sharps would be used and we saw that sharps were managed in line with health and safety regulations.
- The department prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Outpatients

- The department had improved management of patient records. They were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and there were clear procedures in place to support staff to do this.
- The condition of the environment had improved since the last inspection. Previously there had been marks and dents on the floor and walls, we saw that the floor and walls were now clean and recently refurbished.
- Staff could explain how they assessed patient risk and responded to deteriorating patients. There was information displayed in reception areas for alerting staff to deteriorating patients. There were fully stocked resuscitation trolleys available for staff to use in the event of patients becoming unwell.
- Staff were aware of their roles and responsibilities in the event of a major incident.
- Medicines were stored in secure rooms and cupboards and prescriptions were audited against the trust medicines policy and found to be compliant.

However:

- Mandatory training attendance remained below the trust target, and attendance was low at fire safety training.
- Few meetings had minutes taken so we were unable to ascertain whether incidents were discussed and learning shared at meetings. Managers told us they were not assured that staff were reporting incidents consistently.
- The incident log showed that there was an average of 22 days between incidents occurring and being reported in the three months prior to inspection.
- There was some out of date single use equipment stored in the department. We were told by staff that these would not have been used and would be disposed of.
- There was poor mobile phone signal on the lower ground floor where most of the department was situated. This had resulted in situations where doctors were not contactable; this was mitigated with the use of bleeps which had a better signal.

Is the service effective?

Not sufficient evidence to rate

We do not rate this domain:

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff were able to access pain relief and there was a good multidisciplinary service provided to patients in the pain clinic and in women's health. There were a range of nurse led specialist clinics.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Patient records showed that consent was gained from patients prior to procedures or treatment. Staff told us they had access to guidance on gaining consent.
- There was a low staff appraisal rate, only 38% of staff had received an appraisal between August 2016 and July 2017.

Outpatients

- Clinical auditing was left to individual specialties so there was limited monitoring of the effectiveness of care and treatment in the department and this information was not consistently used to improve patient outcomes.

Is the service caring?

Good

We rated it as good because:

- Staff cared for patients with compassion. Our observations of interactions in the department and feedback from patients confirmed that staff treated them with kindness and compassion.
- Patients told us that they were treated with dignity and respect and that staff were friendly and helpful.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients were provided with information leaflets and they told us that staff took care to ensure they understood their treatment and that their questions were answered.
- Staff provided emotional support to patients to minimise their distress. Staff we spoke with understood the need to reduce patient distress.

Is the service responsive?

Good

We rated it as good because:

- The service took account of patients' needs and provided a wide range of services to meet the needs of the local population. Information about services was readily available to support patients and their relatives.
- The outpatient department was fully accessible to patients with reduced mobility. There was support for bariatric patients, those living with dementia and with a learning disability. Signs in the department were clear and there was adequate space for patients to wait.
- The ability of patients to have private conversations with receptionists had improved since the last inspection.
- One stop clinics were available so that patients could have all of their tests done on the same day. Some clinics offered weekend and out of hours appointments.
- Communication with patients had improved since the last inspection. Patients we spoke with felt they were able to speak to someone about their appointments although managers of the service still wanted this to improve and were introducing a dashboard to measure customer service metrics.

However:

- Though there was improvement in recent months across all referral targets, data provided by the trust showed that the department did not meet the 18 weeks referral treatment target in each of the months between June and November 2017 at an average of 89.93% against the national target of 92%.
- There was evidence of poor outcomes for patients with wet macular degeneration due to understaffing in the ophthalmology department which resulted in limited patient access.

Outpatients

- Across the reporting period the trust did not meet the 93% standard for patients receiving an appointment within two weeks of an urgent referral or the 85% standard of 62 days to treatment, though there was improvement at the time of inspection.
- The service did not routinely monitor waiting times for patients in clinics and so were unable to identify patterns and areas of concern to improve the service.

Is the service well-led?

Requires improvement

We rated it as requires improvement because:

- The department did not meet national standards for referral to treatment across the reporting period, although performance had recently improved.
- There was not a consistent view among staff of the risks in the department or what was on the risk register. Incidents were not reliably reported and so were not used to identify risks.
- Although there were plans to audit key performance indicators for the department, at the time of inspection these were not in place which meant that managers could not identify adverse patterns and use data to improve the department.
- The trust was not compliant with the Accessible Information Standard.

However:

- Managers of the service had the right competencies to lead the service and had an understanding of the challenges facing the department and how they planned to address them.
- Most staff were positive about the skills, knowledge and experience of their immediate managers. They felt supported by their managers and the trust and had an understanding of the strategy and priorities of the service.
- There was a positive, supportive working culture in the department. Staff and managers were supportive of each other and worked well together. We saw good multidisciplinary team working in clinics and there was a productive, helpful culture among staff of different disciplines and levels of seniority.

West Middlesex Hospital

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Key facts and figures

Chelsea and Westminster Hospital NHS Foundation Trust is a large provider of acute and specialist services that services a population of over 1,000,000 in North West London, the south east and further afield. The trust operates at two acute sites: Chelsea and Westminster Hospital and West Middlesex Hospital. The trust have completed their full financial year as an enlarged organisation following the merger with West Middlesex Hospital. The trust has never been inspected as this larger trust as both Hospitals previous inspection took place prior to the merger.

The trust has 1007 beds including 166 children's beds/cots, 131 maternity beds, 35 critical care and burns unit beds and 675 acute adult beds. In the year April 16 to March 17 the trust had 369,840 emergency attendances, 136,837 inpatient spells and 767,330 outpatient attendances. All core services are provided from both acute Hospital sites.

The trust provides services to a number of local boroughs including services to Kensington and Chelsea, Westminster, Hammersmith and Fulham, Hounslow, Ealing, Richmond and Wandsworth. Specialist services for patients from London, the South East and beyond, including paediatric and neonatal surgery, the extensive HIV and sexual health service, and a regional burns unit for London.

West Middlesex Hospital provides the following services:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Outpatients and diagnostic imaging
- Critical care
- End of life care
- Children and young people's services

Summary of services at West Middlesex Hospital

Good ↑

Summary of findings

Our rating of services improved. We rated it them as good because:

- All core services previously rated as requires improvement improved to good. All core services were now good overall, except urgent and emergency care which was rated as required improvement. The domain of safe remained at requires improvement.
- The Hospital ED had been refurbished including the provision of a full children's ED , and new waiting area which had previously not been separate from the ED for adults. There were also new rooms for mental health patients
- The Hospital environment was clean. Equipment was clean and maintained.
- There were effective infection prevention and control measures in place.
- Patient records included risk assessments and care plans and were complete.
- Good medicines management processes were embedded in practice. There were measures in place to equalise pharmacy arrangements between the two sites.
- Staff followed treatment protocols and national guidelines.
- Staff showed patients dignity, respect, care and emotional support and were helpful to patients and public in corridors.
- Care was planned to meet patients' needs.
- The Hospital met national access standards for A&E 4 hour waits, most Referral to Treatment (RTT) and Cancer.
- Divisional leadership which was across both sites was effective.
- Staff were proud to work for the Hospital and were supported.
- Strong efforts had been made to ensure the merger ran smoothly and to adopt best practice from West Middlesex and to fully engage West Middlesex staff in the formulation of the trust's PROUD values as well as ensuring senior trust leaders had offices there, were visible and conducted trust board meetings there on rotation with the Chelsea site.

Urgent and emergency services

Good ↑

Key facts and figures

The emergency department (ED) at West Middlesex University Hospital is open 24 hours a day, seven days a week. It sees over 6,000 patients a month with serious and life threatening emergencies. Patients with less serious emergencies are seen by the urgent care centre (UCC). The UCCC service is not commissioned by the trust. It is commissioned a CGG commissioned service managed by a third party provider. The UCC was not part of the inspection.

The department includes a paediatric emergency department dealing with emergency attendances for young people up to age 16. It is trust policy that 16 year olds who do not have complex needs or conditions, attend the adult emergency department.

Patients present to the department either by walking into the reception area or arrive by ambulance through a dedicated ambulance only entrance. Reception staff book in patients inside the ambulance entrance, and in the UCC reception which receives both UCC and ED patients. A few ambulance patients each day are treated in the UCC because their conditions do not meet ED criteria.

Patients walking into the department register first with the co-located urgent care centre (UCC) and the streaming nurse reviews them. If the nurse assesses the patient as more appropriate for treatment in the ED, the patient the registers with the emergency department receptionist, at the next window, and awaits triage. Triage is the process of determining the priority of treatment based on the severity of the patients' condition, and is carried out by a nurse within ED in one of two triage rooms.

The department has different areas for treating patients depending on their needs. A resuscitation area has four bays, (one bay is designated for use with children). This area has full facilities for resuscitating critically unwell patients, for example a patient with a serious injury. There are 28 majors' cubicles and rooms, a six bed observation unit and a clinical decision unit (CDU) for seated patients awaiting test results.

A separate paediatric ED has its own waiting area and 9 bays, including one bay that staff can use for a child stepping down from the resuscitation area. About a third of ED attendances are children.

We visited the ED over three days during our announced inspection. We looked at 17 sets of patient records. We spoke with about 30 members of staff including doctors, nurses, managers, allied health professionals, support staff and ambulance crews. We spoke with 12 patients and 14 relatives who were in the department at the time of the inspection. We reviewed and used information provided by the trust in making our decisions about the service.

We last inspected this service in November 2014. The report was published April 2015. The Hospital was run by a different trust at that time.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The Hospital had undergone refurbishment since the last inspection to improve the environment for staff and for patients, including providing a children's ED with a children's waiting area with audio and visual separation from the main waiting area. Our previous concerns about the privacy of patients during registration and streaming had been overcome in the new design.

Urgent and emergency services

- There had been clear improvements in flow through the department into the Hospital. This had reduced ambulance handover times and increased the percentage of patients being seen, treated, discharged or admitted within four hours.
- The number of nurses had been increased since the previous inspection and appeared sufficient for the level of activity.
- We saw effective team working across the department and with other areas in the Hospital.
- At the last inspection we had noted that learning from incidents and issues was limited. There had been improvements in recording and learning from incidents. An electronic incident recording system had been introduced. Staff told us that they discussed incidents in team meetings, at handover and had feedback in emails.
- There were reliable systems and training to protect people from abuse. Staff were knowledgeable about safeguarding, although numbers of staff with up to date training in high-level child safeguarding needed to increase.
- Junior doctors were positive about the support and teaching they received from senior clinicians. Longer serving nurses reported improvements in training opportunities.
- Staff cared for patients with compassion and professionalism and we received mainly positive feedback from patients and their friends and relatives.
- Leaders and senior managers were visible to staff.
- The service had a clear vision and strategy that all staff understood and put into practice.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff and managers were clear about the challenges the department faced and had plans to deal with them.

However, although many of the concerns identified at the last inspection had been rectified:

- Consultant cover did not meet the recommended 16 hours per day cover recommend for A&E departments by the Royal College of Emergency Medicine (RCEM). Consultant provision was on the service's risk register.
- Not all patient records and risk assessments were fully completed, including assessment of capacity and dementia , although risk assessments of patients with mental health problems had improved.
- There were few standardised pathways to ensure consistent, evidence based care and treatment.
- We found inconsistent recording of information within patient records. We saw no capacity assessments or assessments of dementia for elderly adults. There was little information for patients about the emergency department and its processes or information to support patients to help them lead healthier lives.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The department had improved accommodation through refurbishment of both the reception and waiting areas, the opening of a separate children's ED with a waiting area screened from adults, and more majors beds in the adult ED.

- At the last inspection the accommodation for mental health patients did not meet expected standards. On this inspection, the new designated rooms for patients attending with a mental health crisis were appropriate. There was reduced risk that mental health patients could harm themselves whilst in the department. There was also a designated mental health room for children and adolescents.
- The department had increased nurse staffing since the last inspection and there were enough nursing staff with the right skills.
- At the last inspection early warning score tools were not being used in ED. Early warning scores were now used in ED to alert staff to patient deterioration and their use was audited.
- Our review of incident report investigations showed staff were aware of their responsibility to report incidents, and learning from incidents was shared with staff members.
- At the last inspection there had been insufficient nurses on duty to meet the guidelines of the Nursing Baseline Emergency Staffing tool (BEST). Nursing numbers had improved since the last inspection with the addition of 2 nurses a shift, which meant that ED nursing cover was more assured and there was less reliance on agency staff.
- There were reliable systems and training to protect people from abuse. Staff were knowledgeable about safeguarding, although numbers of staff with up to date training in high-level child safeguarding needed to increase.
- Dedicated security staff and dedicated porters were based within the ED.
- The department strongly supported both nurses and doctors training and development through nurse educators and dedicated teaching time.
- Medicines were stored securely and staff followed appropriate procedures for controlled drugs.
- The department had up to date plans for dealing with major incidents and staff understood their roles.

However

- The number of whole time equivalent consultants had increased since the last inspection. However, the service was still not staffed sufficiently to meet the 16 hour per day consultant presence target as we had noted at the last inspection. Recruitment was continuing and the existing consultants were providing cover out of existing resources in an effort to ensure the service remained safe.
- There was a shortage of middle grade doctors within the department, although the trust had invested in one additional middle grade a shift, and 98% of shifts were filled by hospital staff rather than locums.
- Patient records showed inconsistent recording in some areas. Not all checklists to assess risk of falls had been completed and we saw no capacity assessments or assessments of dementia, and few risk assessments of falls or venous thromboembolism (VTE) in the notes we reviewed. The trust subsequently told us that VTE assessments were in the electronic record.
- Staff did not document episodes of restraint as incidents in line with trust policy.

Is the service effective?

Requires improvement  ➔➔

Our rating of effective stayed the same. We rated it as requires improvement because:

- There were few standardised clinical pathways used in ED to assist clinicians to manage patients with specific presenting conditions, and ensure that evidence based practice was followed.

Urgent and emergency services

- The performance of the department was worse than the national average in a number of Royal College of Emergency Medicine audits: the consultant sign off audit (2016/17), vital signs in children 2015/16 and procedural sedation in adults (2016/7). Audits to bring about improvement in patient treatment outcomes were not given sufficient priority.
- Some data was collected manually which made data analysis difficult and potentially unreliable.
- There was little evidence of health promotion activity.

However:

- Policies and protocols we reviewed were up to date and well-presented.
- At the last inspection we had concerns about the arrangements for providing people with food and drink. We saw that refreshments were provided to patients in ED and those accompanying them if they had lengthy waits.
- At the last inspection we had concerns that staff were not using pain scoring tools to measure the efficacy of analgesia. On this inspection we saw staff asking patients about pain and that pain scoring tools were available, but not always completed.
- Multidisciplinary working was well-embedded in the department and we saw effective working to support care and discharge of patients.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff in the ED provided compassionate care to patients and their families. Patients reported that staff were patient and reassuring.
- Patients were treated with dignity and respect by all staff and the majority were very positive about the experience.
- Patient privacy had improved since the last inspection both in the waiting area and the observation area by redesign of facilities. However we had also commented on the difficulty of maintaining privacy and dignity in the small resuscitation area when this was full. The situation had not changed as it was constrained by the space available until planned refurbishment took place.
- All patients we spoke with spoke positively about the care they received. Patients told us they felt informed about their treatment and were involved in decisions about their care.
- Staff made sensitive provision for relatives in cases of bereavement.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good because:

- At the last inspection we found patient flow poor and waiting times above the national average. On this inspection, we found patient flow and significantly improved and the trust was among the top performers against this high profile standard. The department was slightly below the standard to see, treat and discharge 95% patients within four hours but was maintaining strong performance against the England average.

- Hospital-wide activity on admission avoidance and reducing length of staff had improved the experience for patients.
- The Hospital recorded informal and formal complaints and sought to improve patient experience as a result.
- The service planned services to meet the needs of local people and worked with commissioners, external providers and local authorities.

However:

- There was little information for patients in the waiting room or the inside department itself about what to expect in ED. The information board for majors patients was not visible to most patients in the department.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Since the last inspection the Hospital had merged with another trust. There was experienced, committed, caring and strong leadership. The trust leaders understood the challenges ED faced at West Middlesex.
- The service had a clear vision and strategy that all staff understood and put into practice.
- There was a clear and holistic strategy for improvement in patient flow. We saw evidence of systematic progress on the many different areas of Hospital and community activity that affected patient flow through ED.
- At the last inspection we found that not all risks were included in the risk register. On this inspection we found risks were identified and managed appropriately. We saw that risks were reviewed regularly and there was momentum behind the process for addressing them
- In the last inspection we found morale in ED was low and there were tensions among staff. We found on this inspection that managers promoted an open and positive culture. Staff felt respected and valued. There was effective team working and recognition of success and excellence.

However:

- There was limited provision for patients living with dementia.
- Friends and family test scores were lower than expected. The Hospital was not capitalising on the willingness of patients and families to provide feedback on the service
- Inherited paper-based systems from the previous trust limited the analysis of clinical data to understand performance and bring about improvement. However we were aware that plans for a new electronic system were well-advanced.

Outstanding practice

- There were several examples of digital innovation. A flexi staff mobile phone app had streamlined the process of filling medical shifts and was reported to work effectively so 98% of shifts were covered. Senior staff could sign off doctors' hours electronically. This had reduced the need use locums by filling shifts more easily within the Hospital. A digital device about to come into use was a smartphone lens attachment that turned a smartphone into a mini ophthalmoscope for retinal imaging.

Urgent and emergency services

Areas for improvement

Action the trust SHOULD take to improve:

- Ensure that all patient records are completed fully, including risk assessments for capacity and dementia.
- Review the arrangements for supervision of the clinical decision unit.
- Make sure clinical staff should have access to a wider range of standardised treatment pathways to ensure patients received consistent, evidence-based treatment.
- Provide more information to patients to help them lead healthier lives.

Medical care (including older people's care)

Good ➔➔

Key facts and figures

The trust acquired West Middlesex Hospital in 2015/16 and this report reflects our first inspection since the completion of the merger process.

Medical care services are provided under the emergency and integrated care division and include 11 specialties: gastroenterology, endocrinology, cardiology, elderly care, neurology, rheumatology, thoracic medicine, dermatology, diabetes, nephrology and general medicine. We also included the endoscopy unit in our inspection of the medical care core service.

We last inspected West Middlesex University Hospital in September 2015. At that inspection we rated medical care as good overall. This reflected a rating of good for safe, caring, responsive and well-led and requires improvement for effective.

We told the trust they must:

- Review the processes for management of policies and procedures so that staff had up to date access.
- Ensure staff fully completed do not attempt resuscitation (DNACPR) forms.
- Address the lack of acute oncology services.
- Improve the provision of palliative care services.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The Hospital had made progress in all of the four areas listed above that we told them they must improve.
- Medical services performed consistently well in the national patient-led assessment of the care environment (PLACE). In the previous 12 months, the service performed better than national and trust averages in all categories.
- The senior divisional team used a ward accreditation scheme to monitor quality and safety performance in each inpatient ward. The results were used to identify areas of good practice and areas for improvement.
- Safeguarding processes were embedded into clinical and administrative practice and we saw effective escalation of safeguarding concerns.
- Ward managers and senior nurses were empowered to address nurse vacancies and improve retention with local initiatives. We saw this was effective in a number of wards and clinical areas.
- Vacancy rates and turnover rates of doctors were generally low, with consultant vacancies covered by locum staff from within the trust.
- Staff used effective, embedded medicines management processes and implemented learning and improvements when mistakes happened.
- Staff learnt from incidents and implemented changes to practice and policy as a result.
- There was consistent evidence staff used national and international best practice guidance and benchmarks in the delivery of care, audits and research.

Medical care (including older people's care)

- From June 2016 to May 2017, patients had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Specialist teams had developed targeted training programmes to ensure staff had access to professional development and continued to advance their clinical competencies. Education programmes were also offered as a result of learning from incidents and complaints.
- Multidisciplinary care was embedded into practice in all areas and a wide range of specialists coordinated care and treatment pathways.
- The trust did not provide data on Mental Capacity Act (2005) training at site level, however we saw evidence of good practice in line with national guidance.
- We observed consistent compassion and kindness from staff in all roles and significant effort to involve patients and their relatives in care planning and decision-making.
- Staff were empowered to plan, pilot and implement services to meet the changing needs of the local population. All such projects were demonstrably focused on improving patient outcomes and reducing long-term morbidities.
- The Gold Standards Framework was embedded into end of life care and staff delivered this in a person-centred way on each ward.
- Staff worked to meet individual patient needs when they were at increased risk, such as those at risk of falls. This was demonstrative of an overall patient-centred approach to care planning and treatment.
- Between September 2016 and August 2017 five of eight medical specialties performed better than the national average for referral to treatment within 18 weeks.
- Leadership and governance processes were clearly structured and contributed to effective and stable ward teams in most areas.
- Senior staff and ward teams placed value on engagement and this contributed to improvements in ward environments and work processes.

However:

- There was variable compliance with the early warning scores system, which staff used to identify, monitor and escalate patients whose conditions were deteriorating. We saw limited evidence of sustained improvement as a result of audits and overall compliance was 92%, which did not meet the trust standard of 95%.
- Senior ward staff did not always follow trust safety policies in relation to agency nurses.
- Cleaning and housekeeping staff did not always ensure the safe storage of chemicals or hazardous substances in relation to national guidance.
- Although audit results demonstrated consistently good standards of infection control practice and hand hygiene, there were localised exceptions to this.
- There was variable completion of mandatory training and no clinical staff group in this division met the trust target for all training.
- Patients in general medicine had a much higher than expected risk of readmission for elective admissions, with rates for respiratory medicine also higher.
- Overall performance in national inpatient audits was variable and the Hospital did not meet minimum standards by significant margins (over 10% difference) in the national audit of inpatient falls or the lung cancer audit.

Medical care (including older people's care)

- There was poor overall compliance with annual staff appraisals.
- Although medical services performed better than trust and national averages in response rates for the NHS Friends and Family Test (FFT), recommendation rates were highly variable with little consistency in meeting the 90% target.
- From July 2016 to June 2017 the average length of stay for medical elective patients was 10.3 days, which was higher than the national average of 4.2 days. The average length of stay for all individual specialities at the Hospital was also higher.
- The Hospital achieved level C performance rating in the quarterly Sentinel Stroke National Audit programme.

Our findings reflect broad improvements in all of the areas we told the trust to take action on in 2015. However, our rating for safe has gone down. This reflects deterioration in standards relating to infection control and environmental management, poor compliance with basic life support training requirements and inconsistent use of some clinical risk assessments. We also found numerous examples of outstanding practice to improve person-centred care and staff engagement.

We spoke with 53 members of staff, seven patients and three relatives. Staff represented a range of roles and grades across all specialties and medical departments. We looked at 34 patient records and the overview of patient status for over 150 people. We reviewed over 100 additional pieces of evidence, including the minutes of meetings and audits. During our inspection we spent time on the acute medical unit, the acute assessment unit, the coronary care unit, the endoscopy unit and on every medical inpatient ward except for Crane ward, which was closed due to a norovirus outbreak.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Staff did not always manage chemicals or dangerous substances in line with the Control of Substances Hazardous to Health Regulation 2002. This included in safe storage with restricted access.
- We did not see that senior ward staff always followed trust procedures to ensure agency nurses were appropriately checked or inducted.
- Between July 2017 and August 2017 medical inpatient wards and endoscopy scored an average of 92% compliance in weekly national early warning score audits.
- Nursing and medical staff did not meet the trust target for basic life support, with only 80% of eligible staff holding up to date training.
- The infection control team found inconsistent practice in relation to the treatment and prevention of *Clostridium difficile* in two cases in 2016/17.
- There were significant inconsistencies and gaps in the completion of venous thromboembolism (VTE) risk assessments and prophylaxis provision and limited evidence that initiatives to improve this had been effective.
- The results of early warning scores (EWS) audits indicated wide variances in performance between clinical areas, including instances of 0% compliance including where wards had not submitted data. We found inconsistent practice in relation to EWS during our inspection.
- Senior staff used a patient acuity tool to establish the safe number of nurses needed for each shift. However staff in some areas told us this was often insufficient and they felt patient safety could be compromised as a result.

Medical care (including older people's care)

- Staffing skill mix amongst the medical team was not similar to national averages and there were fewer consultants and more junior doctors than expected. However vacancy rates were low and the medical team demonstrated stability through low turnover rates.

However:

- We observed consistent standards of hand hygiene and infection control measures amongst clinical and ward-based staff although non-clinical or contracted staff did not always follow this.
- Staff managed safety in the clinical environment through the use of daily bedside checklists and adherence to national policies and accreditation, such as the Joint Advisory Group (JAG) in the endoscopy unit.
- Although nurse vacancy rates were reported as up to 29% in some areas, there was evidence ward teams had implemented strategies to reduce this and to improve retention. This had resulted in nurse vacancy rates as low as 2% in areas such as Lampton ward.
- The antimicrobial stewardship group had improved and standardised medicine practices in the Hospital and across trust sites. This included increasing pharmacy and microbiology presence on ward rounds, which we saw in practice.
- Medicines management systems were embedded in practice and staff used them consistently. There was evidence of learning from medicines errors and the pharmacy team were proactive in increasing their scope of service.
- Staff demonstrated how they improved practice and safety standards as a result of learning from incidents, including as a result of a more structured morbidity and mortality review process.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff used national and international best practice guidance and benchmarks to ensure care, treatment, new projects and pathways were evidence-based. This was embedded in daily clinical practice and in the audit programme.
- The Hospital senior team ensured resources for health promotion interventions and information were available. We saw this resulted in a range of information provided by health promotion organisations and campaigns in public areas of the Hospital and in wards.
- The endoscopy unit had achieved Joint Advisory Group (JAG) accreditation in recognition of achievements in patient-centred care according to the measurements of the global rating scale.
- The Hospital performed similarly to or better than national minimum standards in the national diabetes inpatient audit, the myocardial ischaemia national audit project and in three out of nine measures from the national audits for lung cancer and inpatient falls.
- We saw effective use of the national Saving Lives programme and high impact intervention care plans as a strategy to improve patient outcomes.
- Staff of all grades and responsibilities had access to a range of teaching, learning and development opportunities delivered by specialist teams. This included pharmacy, therapists and the antimicrobial stewardship team.
- There was extensive evidence of proactive, well-coordinated multidisciplinary working with support from trust and community-based teams readily available.

Medical care (including older people's care)

- Although there were gaps in seven-day working in some teams, individual teams were piloting increased capacity in the acute medical unit and therapies teams.
- Clinical areas contained a range of health promotion material appropriate to the needs of patients cared for. This complemented a wider proactive approach to health promotion from the Hospital that focused on the health needs of the local population.
- Staff demonstrated a good awareness of consent, mental capacity and the Mental Capacity Act (2005). This was evidenced in our conversations and from looking at patient records.

However:

- Dietician audits indicated there was a need for improved effectiveness in the use of the malnutrition universal scoring tool (MUST).
- We saw nursing staff did not consistently use recording tools for nutrition and hydration.
- Performance in national audits for lung cancer and inpatient falls was variable and the Hospital performed worse than minimum standards in six out of nine measures. There was evidence of a deterioration of standards in some areas. For example, between 2015 and 2016 the proportion of patients seen by a cancer nurse specialist as part of the national lung cancer audit decreased by 10% to 73%. This was worse than the minimum standard of 90%.
- Seven out of eight staff groups did not meet the trust's standard of 90% annual appraisal completion. Amongst doctors and nurses, 62% had an up to date appraisal.
- Neurology services were limited and staff described delays in patients being seen by this team. However the trust told us after the inspection that a new consultant neurologist had been appointed.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good because:

- The Hospital performed better than the national and trust averages in response rate for the NHS Friends and Family Test (FFT).
- The AMU, Lampton ward, Marble Hill 1 ward and the CCU scored above the trust average in FFT recommendation scores between September 2016 and August 2017.
- We saw substantial evidence staff worked to build a positive and natural rapport with patients and relatives. This included clinical and non-clinical staff as well as bank and agency staff.
- All staff we observed and spoke with could demonstrate how they involved patients in their care. This included through joint care planning, multidisciplinary meetings and improved communication frameworks.
- The Hospital had placed significant focus on improving communication during the discharge process and a dedicated discharge coordination team worked with ward clerks and administrators to provide a more streamlined, transparent process.
- Staff routinely included patients in care planning and delivery, including in medicines management.
- Carers were openly welcomed in the Hospital and ward teams provided additional services and support to them.

However:

Medical care (including older people's care)

- Between September 2016 and August 2017 medical wards had an average FFT recommendation rate of 82%. This was below the trust target of 90% and represented a wide range of individual ward scores, with seven individual wards or departments averaging below 90%. In addition none of the wards achieved a consistent track record of recommendation scores of 90% or above during this period.
- Relatives provided variable feedback on the attentiveness of staff. Ward-based teams we spoke with described significant challenges in establishing positive communication with relatives and feedback from both groups was demonstrative of this.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The average length of stay for medical non-elective patients was better than the national average, at six days compared to 6.6 days.
- The acute medical unit (AMU) team had considerable focus on improving services and care pathways to meet individual needs. This included targeted care and treatment from the acute frailty team and a new hourly nurse-led ward round system.
- Medical wards were demonstrably committed to delivering the national Gold Standards Framework for patients at the end of their life. This included applying national standards and adapting them to the individual needs of each patient, including planning for known complications of each medical specialty. This complemented a drive to improve overall palliative care in the Hospital.
- A range of facilities were available for relatives to improve the quality of the time they spent visiting the Hospital and two medical units had received awards from the trust in recognition of improvements they had made.
- Staff on inpatient wards worked with the trust's charitable foundation to improve the activities and social opportunities available to patients on inpatient wards. This contributed to improved wellbeing and mental health, which can positively influence physical recovery.
- A dedicated discharge coordination team worked across medical specialties to liaise with social care services and facilitate timelier, structured discharges. This was reflective of a broader focus on improving discharge processes, including daily input from the senior divisional team and a 'discharge to assess' programme led by the therapies team.
- Between September 2016 and August 2017, referral to treatment rates for admitted pathways were similar to or better than the England average

However:

- The average length of stay for elective medical patients was 6.1 days longer than the national average and the average length of stay for individual medical specialties was also higher.
- Between August 2016 and August 2017 the Hospital took an average of 59 days to investigate and close complaints. This was not in line with the 25 day standard indicated by the complaints policy.

Medical care (including older people's care)

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Staff spoke positively of the leadership structure in each ward and clinical area and the triumvirate model meant leadership teams were balanced by experience and skill mix.
- A senior divisional manager and an executive board member were assigned to each ward to help build relationships with teams. This resulted in improved working conditions for staff and better outcomes for patients awaiting discharge or referral.
- Seven of eight medical wards were awarded bronze status or higher in the ward accreditation scheme in November 2017, including Crane ward and Osterley 2 ward, both of which achieved gold status.
- Initiatives to stabilise staff turnover and sickness and to improve development opportunities for staff were key priorities for the divisional team and we saw a track record of action to achieve goals.
- The majority of staff we spoke with said they felt morale was high and that they enjoyed working in the Hospital. We observed non-clinical staff were routinely welcoming and helpful to visitors, including contracted cleaning staff and security staff.
- A risk management committee maintained oversight of key clinical and divisional risks and met regularly with senior teams to establish improvement plans.
- There was evidence of an embedded culture of engagement between staff and patients that helped to contribute to engaging ward environments, which was acknowledged in ward accreditation assessments.
- There were a wide range of initiatives to engage staff in providing feedback and contributing to development. The trust recognised such work and achievements through award schemes, which staff told us helped motivate them. Each ward or departmental team displayed their own vision and work ethos as well as what they were proudest of. This contributed to a cohesive team culture focused on continuous quality improvement.

However:

- Although the working culture was generally positive, some individuals said they had been pressured to work when unwell.
- Information management processes did not always ensure patient confidentiality was maintained.

Outstanding practice

- The Kew ward team had developed an innovative mouth care project following feedback from patients and relatives and a review of patient outcomes. This involved identifying more effective equipment for mouth care and more consistent care pathways. The team aimed to implement a trust-wide policy as a result of this work, which had resulted in a reduction in cases of acquired pneumonia as a result of poor mouth care.
- Physiotherapists, occupational therapists and community liaison nurses provided an acute frailty team (AFT) that provided intensive therapy to patients over the age of 75. This service was provided to patients admitted to the AMU whose medical needs meant they were likely to be discharged within 72 hours. The AFT ensured patients with social and mobility needs received rapid care that reduced the need for an inpatient ward admission and meant patients were discharged safely to community teams.

- Inpatient wards and clinical departments participated in a ward accreditation scheme to assess performance in related to safety and quality indicators set by the trust. The trust used this system to establish and monitor ward performance against our key lines of enquiry and to identify areas of good practice and for improvement. Seven of eight medical wards were awarded bronze status or higher in the ward accreditation scheme in November 2017, including Crane ward and Osterley 2 ward, both of which achieved gold status. Each ward team had access to a 'perfect ward app' that enabled them to model and test ideas for improvement to project how it could improve their ward accreditation performance.
- The Kew ward team had established a 'positive box' engagement programme that enabled the senior team to use comments from patients, staff, relatives and other visitors to reward good care and drive improvements. In addition in November 2017 the ward facilitated a 'fab change week' event that encouraged staff to make a pledge towards their work. The ward team displayed these on a colourful public display and examples of pledges included, "To appreciate the work of colleagues," "I will encourage the independence of patients" and "To sit and talk to a patient to keep them calm."

Areas for improvement

Action the trust SHOULD take to improve:

- Ensure senior staff comply with trust policy on agency nurses, including positive ID verification and inductions.
- Ensure all staff adhere to the Control of Substances Hazardous to Health Regulations 2002.
- Improve oversight of storage areas used for chemicals and cleaning equipment.

Surgery

Good ↑

Key facts and figures

The trust had 27,803 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 8,045 (29%), 14,876 (54%) were day cases, and the remaining 4,882 (18%) were elective.

We visited the theatre department, three wards, the pre-assessment unit and the day surgery unit

during our announced inspection and we observed care and treatment. We looked at 34 sets of patient records. We spoke with over 50 members of staff, including nurses of all bands, doctors, allied health professionals, pharmacists, managers, executive staff and admin staff. We had an Expert by Experience on our team who spoke with 10 patients. Experts by Experience are people who have experience of using or caring for someone who uses health and/or social care services.

We also used information provided by the organisation and information we requested following our inspection.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The trust had improved on their own performance in completing mandatory training for nursing staff.
- The trust had improved on the number of hand hygiene audits performed and displayed these results on the "proud to care boards" outside their wards.
- Medication was stored correctly.
- The Hospital had improved their training in safeguarding from 45% compliance to 96% compliance in nursing staff.
- There were improvements in theatre utilisation since the time of the last CQC inspection.
- There was evidence of good multidisciplinary working across the surgical services.
- The most recent figures for average length of stay for surgical elective patients were better than the England average.
- ENT, ophthalmology, plastic surgery and cardiothoracic surgery were above England average for referral to treatment times.
- Discharge rates had improved slightly, with the introduction of a '2 b4 12' initiative. This scheme encouraged the discharge of two patients before midday from each ward.
- Patients had spoken to their surgeon and knew who had performed their surgery.
- In 2016/207 only 3% of cancelled operations were not treated within 28 days.
- Staff reported a positive culture within the Hospital and staff were happy to work for this trust.

However:

- Some fridge temperatures that were out of range were not acted upon.
- Only 50% of patients had pre-operative assessments prior to surgery. The trust had taken action to remedy this.

Surgery

- Referral-to-treatment time (RTT) performance remained below the England average for urology, trauma and orthopaedics, oral surgery and general surgery.
- Storage space was still limited in theatres.
- There was still a low response rate to Family and Friends Tests (FFT).
- Risk registers did not include the risks we found on inspection.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The trust training target was not met for any applicable modules for medical staff.
- Similarly to the last inspection, we saw equipment stored in the corridors due to a lack of storage space.
- The surgical wards contained outliers and senior nurses informed us that a mixture of specialities caused difficulties with inexperienced nurses.
- Theatres did not operate on emergency cases on a Monday morning; this was preserved for paediatric surgeries.
- We saw that the Hospital had a low staff retention rate, therefore wards often relied on agency staff which sometimes added pressure to other nurses on that ward.
- Fridge temperatures were recorded but no action was taken if the temperature was out of range.
- There was some inconsistency in staff following the world health organisation five steps to safer surgery. While we observed satisfactory practice in general surgery, during our inspection, we observed an ultrasound guided liver biopsy in the radiology unit. The WHO checklist was not completed correctly, although boxes were ticked. For example, the patient ID was not verified against the patient's wristband.

However:

- The overall completion rate for safeguarding training modules by nursing staff at the Hospital was 96% and met trust targets. This was an improvement from the last inspection.
- Similarly to the last inspection all staff we spoke with understood safeguarding vulnerable adults and children and knew how to report such matters.
- We observed effective hygiene and cleanliness across the theatres and wards.
- Staff knew how to identify and escalate risks, which affected patient safety, using the national early warning scores.
- Patient records had good documentation and all entries were signed and dated.
- Controlled drugs were securely stored.
- Nurses had adequate training for administering medications.
- Staff we spoke with knew how to report incidents, which were discussed at regular team meetings. Duty of candour was embedded in the reporting of incidents.

Surgery

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- ▪ Policies and protocols were available on the Hospital's intranet, which were in line with national guidelines and regulations and staff knew how to access these.
- ▪ Staff used a malnutrition universal screening tool (MUST) to identify patients who were malnourished or at risk of malnutrition.
- ▪ Staff used a recognised tool based on a numeric rating scale to assess patients' pain and the effectiveness of pain relief.
- ▪ General surgery patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- ▪ During our last inspection we found that there was emergency cross cover of doctors outside their normal hours of practice, however there was now appointed emergency surgical cover.
- ▪ Patient records demonstrated input from allied health professional including physiotherapy, dieticians, occupational therapists, pharmacists as well as nursing and medical teams.
- ▪ The wards had a senior house officer and a registrar available at night. Haematology services were available over the weekend and wards also had access to an anaesthetist that was on call over the weekend.
- ▪ The Hospital did not meet its own target of discharging two patients before midday but the discharge rate had improved since the last inspection.
- ▪ We saw four different smoking cessation leaflets on the ward for patients to promote healthy living.
- ▪ Consent forms were clearly documented and patients were informed of the risks of their procedures.
- ▪ The trust reported that, as of November 2017, Mental Capacity Act and Deprivation of Liberty training had been completed by 86% of staff within surgery.
- ▪ Staff in pre-assessment always informed the surgical wards if a patient had learning difficulties or dementia. We saw adequate tools in the resource folder to aid patients with learning difficulties.

However:

- There were no starvation audits for elective patients. We spoke to one patient who had been starving since 4am, for a scan at 2pm that was then cancelled.
- From June 2016 to May 2017, all patients had a slightly higher than expected risk of readmission for elective admissions when compared to the England average.
- For hip and knee replacements, performance was worse than the England averages.
- Only 50% of patients had pre-operative assessments prior to surgery. The trust had remedied this by admitting all patients via the acute medical unit, which was consultant, led 24 hours per day seven days per week.
- Competencies for full time nurses on the surgical wards were newly introduced to the Hospital and it was not yet confirmed how often these competencies would be re-checked.

Surgery

- The Hospital had an overall appraisal completion rate of 64% from August 2016 to July 2017. This was lower than the average appraisal completion rate from the last inspection, which was reported at 78%.
- We saw old do not attempt cardiopulmonary resuscitation (DNACPR) forms filed in some patient notes. New forms were required to be completed for each in-patient episode.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Patients we spoke to during our inspection were happy with their care. We spoke to patients on the wards who told us that the nurses provided fantastic care and were very friendly.
- Staff in pre-assessment organised a visit to the ward for a patient that was extremely anxious.
- There was a bereavement service information leaflet available for family and friends for when a patient passed away.
- There was a multi-faith chaplaincy service available in the Hospital which provided a multi-faith service for patients and their families.
- We spoke to patients on the ward who told us that they were offered counselling after their surgery.
- During the previous inspection, we found that patients did not know who performed their surgery and had little contact with their surgeon. Patients we spoke to on the ward, during this inspection had good contact with their surgeon and spoke positively about their surgeon.

However:

- We did, however, observe an inadvertent comment made by a radiographer to a patient, which in turn made the patient very upset.
- The Friends and Family Test (FFT) response rate for surgery at Chelsea and Westminster Hospital NHS Foundation Trust was 23%, which was worse than the England average of 29% from September 2016 to August 2017.

Is the service responsive?

Good ➔

Our rating of responsive improved. We rated it as good because:

- Over the last 12 months, 60% of patients with a fractured neck of femur were taken to theatre within 36 hours. This was an improvement since the last inspection, where we found that only 30% of procedures had met recommended timescales.
- From July 2016 to June 2017 the average length of stay for all elective patients at West Middlesex University Hospital was 2.7 days, which is lower compared to the England average of 3.3 days.
- The average length of stay for all non-elective patients at West Middlesex University Hospital was 4.4 days, which is lower compared to the England average of 5.1 days.

Surgery

- The pre-assessment clinic was led by a consultant anaesthetist, we saw that the consultant was very proactive and organised prescriptions for patients requiring medication for blood clots. We saw that the clinic had a computer tablet for teaching patients to self-administer injections.
- We saw that patients had access to patient information that was displayed in the wards entrance. This included a chaplaincy service, Alzheimer's society, end of life and bereavement support, Macmillan cancer support information and infection control information.
- There were services in place to optimise patient iron levels prior to surgery to reduce the needs of a blood transfusion post-surgery.
- Day surgery would utilise the space on the ward by allowing suitable patients to recover on a comfortable chair rather than a bed.
- Staff we spoke with told us that theatre lists would often start with patients that had no clinical concerns for surgery, and this would ensure that theatres ran on time.
- ENT, ophthalmology, plastic surgery and cardiothoracic surgery were above the England average for referral to treatment times.
- In 2016/207 only 3% of cancellations were not treated within 28 days.
- The wards were managed to ensure single sex compliance by managing patient flow.

However:

- The day surgery unit was often opened at night for additional patients, when there was no space on the surgical wards. Staff told us that this was not ideal for patients as the ward was not suitable for overnight stay patients.
- Theatre utilisation was recorded as 73% for day patients. This was a 2% decrease from the last inspection which recorded as 75% utilisation in October 2014. Utilisation for elective surgery was recorded at 78% in both inspections.
- Urology, trauma and orthopaedics, oral surgery and general surgery were below England average for referral to treatment times.
- The department had 76 complaints which took an average of 51 days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 25 working days.
- The trust had stopped using butterflies as a representative symbol for dementia and had started using butterflies for end of life patients but this information had not filtered down to all staff. Many staff we spoke with said that butterflies were an association with dementia.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- The chief executive officer (CEO) and the chief nurse were very visible within the Hospital.
- Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons, who were visible and approachable.
- Staff we spoke with told us that they felt there was a lot more focus in the values since the merger, and that the values were visible throughout the Hospital.

Surgery

- Staff reported that the pre-assessment unit was better staffed now and that they felt supported.
- We found, for the most part, an inclusive and constructive working culture within the surgery service.
- Staff we spoke with felt that the Hospital was a good place to work. We met many staff members that had been working at this Hospital for over 20 years, and lots of staff knew each other.
- Some staff groups said that the merger had resulted in an upgrade of the equipment for example the anaesthetic machines, given there was more finances available for capital expenditure.
- Staff reported that everybody helped each other and were friendly.
- Syon Two ward was nominated for the best ward for students. We also observed that Syon One ward was a finalist for a nursing times ward award for student placement of the year, for excellence in mentoring and supporting practice learning.
- Staff reported that they felt empowered and encouraged to challenge poor practice and behaviour.
- Staff were given the choice to transfer wards which was an active response by the Hospital in order to retain staff.
- Staff members working over the Christmas period were offered transport and accommodation. We saw that this was displayed in the staff room of Syon Two ward.
- The Hospital had been preparing for an update in their computer management system. The Hospital had organised a team of 'super uses' for their new electronic management system, which would be primarily the senior staff group. This meant that these staff members would be highly trained in the use of this system and would be dotted around the Hospital for support to other staff groups.

However:

- Some of the administration staff we spoke with felt that if was difficult to build a rapport with the executive team. Their last interaction with the CEO was during the Christmas period in 2016.
- It was evident from the change in the use of butterflies within the Hospital that information took a while to be cascaded down from the executive level.
- Overall there was mixed feelings about the merger amongst staff in the surgery division. Some staff groups felt that since the merger there had been a loss in identity at West Middlesex Hospital.
- During the inspection we found that there were many more risks that needed to be added to the risk register, in order for the trust to be aware of these risks and provide mitigating actions.

Areas for improvement

Action the trust SHOULD take to improve:

- Improve the quality of their risk register and include all risks mentioned in the report.
- Improve the utilisation rate in theatres.
- Increase its response rate for complaints and adhere to their own policy of responding to complaints within 25 days.
- Improve the response rate of the FFT.
- Conduct starvation audits to access how many patients were starved for the recommended number of hours and to assess whether or not the Hospital stuck to its own protocol.

Surgery

- Improve the on-call urologist, pharmacy cover, physiotherapists and occupational therapists availability over the weekend.

Services for children and young people

Good

Key facts and figures

West Middlesex University Hospital is an acute Hospital in , West , operated by . It is a of and a designated (Imperial College Academic Health Sciences Partnership).

West Middlesex University Hospital serves patients in the London Boroughs of , and .

As of 1 September 2015, West Middlesex University Hospital became part of .

Chelsea and Westminster NHS Foundation Trust have a dedicated Children's Centre on the third floor of the East Wing at West Middlesex University Hospital. This includes: , a 24 bed inpatient unit but funding for 20 beds (overnight stay) with a dedicated area for teenagers; , an eight bed unit for day cases (no overnight stays); clinics.

The is based on the first floor of the maternity unit. The provides 16 cots, including two for short term intensive care which are stabilization cots.

West Middlesex University Hospital has 50 beds are located within three wards

- Starlight ward: 24 beds
- Sunshine ward: eight beds
- Special care baby unit: 18 beds

The trust had 14,856 spells from July 2016 to June 2017.

Emergency spells accounted for 61% (8,992 spells) of the total spells, 29% (4,321 spells) were day case spells, and the remaining 10% (1,543 spells) were elective.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Overall safety performance in the service had improved and there was a culture of learning to ensure safety improvements. Staff were encouraged to report incidents and received timely feedback. There was evidence of learning from incidents, which was shared across children and young people's services.
- Clinical staffing was mostly well managed and there were processes in place to ensure safe staffing levels. There service had 24 hour consultant cover.
- There were effective processes in place to assess and escalate deteriorating patients.
- Overall compliance with infection prevention and control processes had improved. Equipment was checked regularly and medicines were stored appropriately.
- Staff had a good understanding of safeguarding. Staff were aware of their responsibilities in relation to safeguarding children.
- Patient records were completed to a good standard.
- Staff provided care and treatment in line with national guidance and good practice. The service monitored the effectiveness of care and treatment through continuous local and national audits.

Services for children and young people

- There were effective processes in place to ensure that patients' nutritional and pain management needs were met.
- Overall, the trust had good performance in local and national patient outcome and performance audits. However, there were issues with data recording in the national neonatal audit programme (NNAP).
- Staff were supported to develop and there was a culture of learning and teaching within the service.
- MDT working had improved. There was effective multidisciplinary team (MDT) working both internally and externally, including SCBU, to support patients' health and wellbeing.
- The trust had invested in the recruitment of a public health consultant doctor to help address key public health outcomes in the local area.
- There was a range of information and support available for children, young people, families and carers.
- Staff understood their responsibilities for gaining children's, young people's and families consent.
- Doctors, nurses and therapists worked in partnership with parents and families. Staff in children and young people's services demonstrated a patient-centred approach which encouraged family members to take an active role in their child's healthcare.
- Staff were aware of the need to provide emotional support services for children and young people and their families and carers. This included a variety of therapeutic support services. There were appropriate and sensitive processes for end of life care for neonates and children and young people.
- There was timely access to children and young people services and there was a good overall compliance of 95% for referral to treatment times.
- There was provision to meet the individual needs of children and young people using services at the Hospital, including vulnerable patients and those with specific needs.
- There was an established and stable leadership team in children and young people's services. Staff told us senior leaders of the service were visible, approachable and supportive, and said the culture in children and young people's services was nurturing.
- The department used appropriate governance, risk management and quality measures to improve patient care, safety and outcomes. Staff awareness of the risk register had improved.
- There was a clearly defined clinical strategy for children and young people services which detailed the vision for the service up to 2020.
- The service engaged with young people and parents and carers in the design of services. The trust had established a Hospital youth forum to engage young people in service planning.

However:

- All staff were not achieving the trust's 90% mandatory training target in December 2017.
- Some agency staff did not have access to electronic patient information.
- There remained some challenges with nursing staffing vacancies, for example, nurse staffing in Starlight Ward. There was a long-term plan in place to recruit staff and staff were working flexibly across the Chelsea and Westminster Hospital and West Middlesex University Hospital.
- Staff could not access speech and language therapy in a timely way as the speech and language service was not based on the West Middlesex University Hospital site.
- The fracture clinic did not have dedicated children's plastering area.

Services for children and young people

- Complaints were not always investigated in accordance with the trust's complaints policy.
- Senior staff with leadership and management responsibilities did not always have sufficient protected time and support to discharge their responsibilities.
- Some staff did not feel fully engaged and involved in the merger of West Middlesex University Hospital with Chelsea and Westminster Hospital.
- Staff told us the merger with Chelsea and Westminster Hospital had taken precedence since 2015 and this had an impact on the ability of children and young people's services' opportunities for research and innovation.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- Overall safety performance in the service had improved and there was a culture of learning to ensure safety improvements were embedded.
- Staff were encouraged to report incidents via an electronic incident reporting system and they received timely feedback. Incident investigators received training in root cause analysis (RCA). There was evidence of learning from incidents, which were shared across children and young people's services.
- A nursing acuity tool was used to monitor safe staffing and skill mix on the wards. The neonatal unit used British Association of Perinatal Medicine (BAPM) guidelines to ensure staffing was safe on the ward.
- The department used a paediatric early warning score (PEWS) system to identify and escalate deteriorating patients. A sepsis tool was also incorporated within the paediatric early warning score chart to help staff identify and escalate a patient when sepsis was detected.
- Overall, infection prevention and control processes had improved since our previous inspection. The wards and clinical areas were visibly clean and staff were aware of and adhered to current infection prevention and control guidelines.
- Staff had a good understanding of safeguarding for both adults and children. Staff were aware of their responsibilities in relation to safeguarding children. The service worked with other agencies to share relevant safeguarding information.
- Equipment was checked regularly and medicines were stored appropriately.
- The special care baby unit (SCBU) had seen improvements. There was a newly refurbished extension to the unit. This offered a modern and clean environment for both staff and babies.
- The documentation we reviewed across the special care baby unit (SCBU) and children's and young people's wards was completed to a good standard.

However:

- In December 2017, with the exception of managers and SCBU, children and young people's staff were not achieving the trust's 90% mandatory training target in December 2017.

Services for children and young people

- There remained some challenges with nursing staffing vacancies, for example nurse staffing in Starlight Ward. There was a long-term plan in place to recruit staff, including incentive schemes to attract staff, overseas recruitment, increased senior presence on the ward daily, and staff from SCBU working flexibly across both SCBU and Starlight ward.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff provided care and treatment in line with national guidance and good practice. Care pathways for children and young people services were delivered in line with reference to national guidelines.
- The trust contributed to relevant local and national patient outcome and performance audits, including benchmarking activities. However, there were a number of audits that were exceeding their completion dates.
- Service leaders monitored the effectiveness of care and treatment through continuous local and national audits for both paediatrics and neonates. There had been improvements in feeding back on the results of audits to SCBU staff. There were regularly reviews of service outcome data to ensure provision was meeting the needs of children and young people.
- There were appropriate processes in place to ensure that babies, children and young people's nutritional needs were met.
- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed across neonates and children and young people services.
- Nurses told us there the trust was supportive of their progression and there were opportunities to develop their careers.
- There was an effective multidisciplinary team (MDT) working environment within children and young people services, including special care baby unit (SCBU), and with external partners to support patients' health and wellbeing.
- Children and young people's services offered a full complement of inpatient services seven days a week.
- There was a range of information and support available for patients and their families and carers. Staff helped patients manage their own health.
- Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA), Gillick competence and Fraser guidelines.

However:

- The children and young people's risk register identified that gaps had been identified in the national neonatal audit programme (NNAP) data recording. However, this was identified on the services risk register and managers were taking action to address it.
- The service were not meeting all the quality standards (QS) for epilepsy. However, there was an action plan in place to address shortfalls.
- Staff could not access speech and language therapy (SLT) in a timely way as the SLT service was not based on the West Middlesex University Hospital site.

Services for children and young people

- Staff appraisal rates were below the trust's target. However, this was due to a reconfiguration of staff professional development reviews (PDR). Plans were in place to ensure all staff had received an appraisal by 31 December 2017.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- We saw staff interacting with patients and their family members and carers in in a caring and compassionate way.
- All the children, young people, parents and carers we spoke with during the inspection were positive with the care and treatment provided by children and young people's services.
- Staff spent time with children to help make their experience more comfortable, relaxed and home-like. For example, a parent told us staff at the special care baby unit (SCBU) played with their baby and we saw a 10 year old child who could not sleep spending time being entertained by nurses on Starlight Ward.
- There were appropriate and sensitive processes for end of life care for neonates and children and young people.
- We observed staff providing emotional support to children, young people and their families. Staff were aware of the emotional aspects of care for children and young people living with long term conditions and provided specialist support where this was needed.
- Staff were aware of local counselling services and how to refer children, young people and their families in need of therapeutic support to the counselling services.

However:

- Senior staff told us some staff could become task focused if the service was very busy and had to be reminded about providing emotional support at these times.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- There was a two year plan in place from 2016 for children and young people's services and this involved cross-site policies and procedures and protocols being produced as well as cross-site working for staff.
- The service used an escalation policy to plan and monitor services in advance. For example, there were twice weekly paediatric breach meetings which looked at demand and capacity and issues leading to waiting time breaches in A&E
- The service pre-planned the expected number of attendances by using a 'predictor' tool which looked at attendances over the previous six weeks and predicted the likely demand on the service in any given week.
- The specialist children's emergency care department which was based in A&E and provided care for around 34,000 children every year, treating a range of cases from minor injuries to major medical problems, surgical emergencies and trauma. In the 12 months to December 2017, 98% of children were seen within four hours of arriving in A&E.

Services for children and young people

- Children and young people's services had a winter action plan in place. This detailed actions the service would take to meet increased demand in the winter months. This included the use of an escalation tool to assess the capacity of the service to meet increased demands.
- There were regular weekly 'breach meetings' at which breaches in four hour waiting times in A&E were reviewed by the service manager. We saw that all breaches of waiting times were reviewed and an action log was in place.
- There was timely access to children and young people services and there was a good overall compliance of 95% for referral to treatment times, with the exception of dermatology (89%).
- There was provision to meet the individual needs of children and young people using services at the Hospital, including vulnerable patients and those with specific needs.
- Children and young people had access to interpreters where children, young people, and families did not have English as a first language.
- The Hospital provided a wide variety of child friendly food and snacks and there were specific menus for children and young people. The menus included options for specific cultures, tastes and specific needs.
- Mothers with babies on the SCBU could stay on the ward. Mothers staying on the ward were provided with meals during their stay.
- Staff had access to the learning disabilities team lead nurse. Starlight Ward had a folder with 'easy read' card to enable communication with children, young people, and families with a learning disability.
- The flow within children and young people services from admission, through theatres, wards and discharge was mostly managed effectively and children and young people were transferred from the theatre recovery area to the ward without unnecessary delays.

However:

- Staff said the service did not have funding for a high dependency unit (HDU Staff told us SCBU was functioning as level 1; but, met the criteria for level 2 in terms of baby resuscitations.). But, the service had submitted a business case for HDU funding.
- The risk register recorded that the fracture clinic did not have dedicated children's plastering area. In response children would be seen first in the day. But, this was not always effective and further work needed to be done including risk assessments.
- From August 2016 to August 2017 the trust took an average of 40 days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be completed within 25 days.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- There was an established and stable leadership team in children and young people's services. Staff at special care baby unit (SCBU) told us leadership had improved and leaders were approachable.
- The service used appropriate governance, risk management and quality measures to improve patient care, safety and outcomes.

Services for children and young people

- There was a clearly defined clinical strategy for children and young people services which detailed the vision for the service up to 2020.
- Staff we met during the inspection were open and friendly and told us the culture in children and young people's services was nurturing. Staff in SCBU told us the culture and levels of staff motivation had improved as a result of a new SCBU extension opening.
- Children and young people's governance structure was clearly defined from ward to board. The service held regular planned governance meetings. There were forums and meetings for staff to monitor quality, and review performance information.'
- Senior leaders and managers of the service had a good understanding of risks to the service and these were appropriately documented. The risk register was reviewed at divisional quality board meetings, where risk scores on the register were discussed and agreed. Risks on the risk register were regularly reviewed and updated.
- Children and young people's services engaged with young people, parents and carers in the design of services. The trust had an established Hospital Youth Forum to engage young people who used services.
- The trust provided a number of communications in the form of regular newsletters that provided staff with news, achievements, and changes across the trust, as well as and policy updates.

However:

- The clinical lead was the lead for paediatric services. They were also the named doctor for safeguarding and the college tutor. Staff told us the clinical lead was very competent, visible and supportive. However, some medical staff told us decision making could be slow due to the clinical lead's workload.
- The matron was working regular clinical shifts on Starlight Ward due to staffing pressures, and this had an impact on their ability to complete managerial tasks. However, senior managers had taken responsibility for some of the matron's managerial tasks to facilitate the matron working clinically.
- Some medical staff in the consultant body felt that managers did not give weight to their views. Some staff felt that the trust did not understand the culture at West Middlesex University Hospital. But, managers said there was recognition from the board and senior management team that the trust needed to acknowledge and preserve the positive differences in the culture of West Middlesex University Hospital and that of the trust's Chelsea and Westminster Hospital.
- Senior managers told us there had been a number of focus groups to engage staff with the merger. However, some staff told us the merger had not been smooth and they felt there had been a 'top down' approach to the merger with Chelsea and Westminster Hospital and staff had not felt fully involved.
- Staff told us the merger with Chelsea and Westminster Hospital had taken precedence since 2015 and this had an impact on the ability of children and young people's services opportunities for research and innovation.

Areas for improvement

Action the provider SHOULD take to improve:

- Ensure all staff in the service complete required mandatory training to improve compliance with the trust's target for completion.
- Ensure agency staff have access to electronic patient information.
- Take further steps to ensure that safe staff levels are maintained for all shifts across children and young people services.

Services for children and young people

- Address children and young people having timely access to speech and language therapy (SLT).
- Ensure that data recording in the national neonatal audit programme (NNAP) improves.
- Ensure the service meets all the NICE quality standards (QS) for epilepsy.
- Ensure staff receive timely appraisals and meet the trust's target rates for completion.
- The fracture clinic should have appropriate waiting and treatment areas for children.
- Clarify the funding and level of high dependency care on special care baby unit (SCBU).
- Take steps to reduce complaint response times to improve compliance with the trust's complaints policy.
- Ensure all staff with leadership and management responsibilities have sufficient protected time, training and support to discharge their responsibilities.
- Ensure all staff feel engaged in service planning, research and service reconfiguration.

End of life care

Good ↑

Key facts and figures

The Chelsea and Westminster NHS Foundation Trust provides end of life care across two sites. These include Chelsea and Westminster Hospital and West Middlesex University Hospital. End of life care (EoLC) encompasses all care given to patients who are approaching the end of their life. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services following death.

EoLC sits within the Emergency and Integrated Care Divisional Management Team. The divisional leadership team included a director of operations, medical director, director of nursing and a human resources business partner. The trust's medical director chairs the EoLC steering group across both acute Hospital sites.

A palliative care lead consultant and clinical lead nurse lead the specialist palliative care team (SPCT) across the two acute Hospital sites. On the West Middlesex Hospital site the team included two palliative care consultants, three clinical nurse specialists, two associate nurse specialists and an occupational therapist. It was clear that whilst this team was site based, they wished to be considered as one palliative care service across the two acute Hospital sites. For the purpose of this inspection, we requested that data was separated for the two Hospital sites in order to accurately reflect the provision of service in the individual Hospitals in our reports.

The trust reported 778 deaths at West Middlesex Hospital between December 2016 and November 2017. The SPCT received 308 new referrals between January 2017 and July 2017. Of these, 121 were discharged home, 53 were discharged to care homes, nine to hospices and 119 died in Hospital.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Following our inspection in 2014, there had been improvements to End of Life Care (EoLC). The trust had implemented a clear strategy for end of life care and the service was now represented at the trust board level. End of life care was fully embedded throughout the trust and had a high profile in the trust.
- The trust had addressed areas of concern from the last CQC inspection. Investment in EoLC meant there were now sufficient numbers of staff to provide safe care. Staff were appropriately qualified to provide care and treatment based on national guidance.
- Staff knew how to report incidents and there were effective systems in place to safeguard vulnerable adults. Managers investigated incidents and shared lessons learned.
- Patient feedback was mostly positive. Staff treated patients with compassion, dignity and respect. Patients and their relatives were involved in their care.
- Services were developed to meet the needs of patients. Staff arranged rapid discharge in line with patients' preferences. Staff had access to translators when needed giving patients the opportunity to make decisions about their care, and day-to-day tasks. Patients had individualised care plans tailored to their needs.
- Patients and relatives had access to the Hospital's chaplaincy, which was open to people of all faiths and none. The bereavement and mortuary services took into account people's religious and cultural needs and were flexible around people's needs.

End of life care

- There was good local leadership in place. Staff felt valued, were supported in their role and had opportunities for learning and development. Staff were positive about working in EoLC.
- The service had implemented a number of innovative practices to improve patient care. These included improvements made to the fast track discharge process as well as comprehensive training program across the trust.

However:

- We found inconsistencies in the way "do not attempt cardiopulmonary resuscitation" (DNA CPR) records were completed. A recent audit of DNACPR records showed there were certain areas which fell below the 100% target for certain standards.
- The current information technology system did not fully support all aspects of record keeping. It did not allow for certain data to be collected and could not support coordinated care plans between the Hospital and GP.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Nursing and medical staffing had improved since our last inspection. A new team of palliative care specialists had been recruited which supported safe care at the trust. There were link nurses on wards to support safe care.
- Medicines were stored safely and securely. Anticipatory medicines (or medicines prescribed in anticipation of managing symptoms) were prescribed and administered appropriately.
- There were systems in place to protect patients from harm and there was a good incident reporting culture. There were effective arrangements in place for safeguarding vulnerable adults. Learning from incident investigations were disseminated to staff.
- The environment was visibly clean and supported safe care. A closed circuit television was installed in the mortuary to safeguard people's bodies.

However:

- The current information technology system did not fully support all aspects of record keeping.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Since our last inspection, an action plan had been implemented to address low scoring areas of national audits. The service monitored patient outcomes and used it to improve patient care. The specialist palliative care team now provided a seven day service and patients were empowered to manage their own health.
- Policies and procedures were developed in line with national guidance and best practice. Guidelines were easily accessible on the trust intranet page and staff were able to demonstrate ease of access.
- There were local audits carried out to inform and improve practice. Results of recent audits showed patient outcomes had improved since our last inspection.

End of life care

- Patients were cared for by appropriately qualified nursing staff. New staff had received induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from the specialist palliative care team and consultants.
- Staff managed pain relief effectively and nutritional and hydration needs were closely monitored.
- Wards across the trust were working towards the Gold Standards Framework (GSF) accreditation. This is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis.

However:

- We found inconsistencies in the way “do not attempt cardiopulmonary resuscitation” (DNA CPR) records were completed. A recent audit of DNACPR records showed there were certain areas which fell below the 100% target for certain standards.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good because:

- Feedback from patients and their relatives were mostly positive, an improvement since the last inspection.
- Staff provided a caring, kind and compassionate service, which involved patients in their care. We saw examples of staff being supportive and kind to patients and their relatives.
- Observations of care showed staff maintained patients’ privacy and dignity, and patients and their families were involved in their care.
- The chaplaincy team offered emotional support to patients of all faith and none. Families could also access the bereavement team for support and follow up.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Increased investment in the specialist palliative care team (SPCT) meant the service was better equipped to meet the needs of the local population. The SPCT provided a system of rapid discharge and had worked to improve the process for end of life care patients.
- Where possible patients approaching the end of their life were cared for in side rooms.
- Staff had access to translators when needed giving patients the opportunity to make decisions about their care, and day-to-day tasks.
- Visitors to the trust had access to a variety of information leaflets pertaining to end of life care. This included an easy to read guide designed for people with learning difficulties.

However:

End of life care

- We found no evidence of psychological and spiritual needs assessment in the records we reviewed. Results from a recent compassionate care agreement audit showed that spiritual and emotional needs of the patient and next of kin were documented in only 35% of cases.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- The trust had implemented a formal trust strategy for end of life care since our last inspection. The leadership team had a clear vision and staff were able to verbalise future plans.
- We saw good local leadership on the unit and staff reflected this in their conversations with us. Staff said the culture was open and honest and they could raise concerns with senior staff.
- The trust engaged both internal and external stakeholders through meetings, publications and surveys.
- There was a robust governance structure in place. The management team had oversight of the risks within the service and mitigating plans were in place.
- The service was involved in a number of innovative practices and had recently won the governors' quality award for improving the fast track discharge process.

Outstanding practice

- Following on from the last inspection in 2014, the trust had implemented systems to improve patient care. The trust employed a new team of palliative care specialist and instituted seven day working which meant the service was now able to meet the needs of patients. Local audits were carried out to improve practice and the service now had a clear strategy for EoLC.
- In autumn 2017, the SPCT team received the council of governors' quality award for improving the fast track discharge process.
- There was an innovative approach to how clinical and non clinical staff were trained in all aspects of end of life care; in particular, the use of simulated scenarios modelled on a patient's journey at the end of life.
- The trust participated in several quality initiatives including the Commissioning for Quality and Innovation (CQUIN) for enhanced supportive care 2016 - 2017. The CQUIN was based on early intervention of care for cancer patients. The trust achieved 100% of targets in the first year in terms of how quickly patients were seen, readmissions, patient satisfaction, time from diagnosis to SPCT involvement and relationship with the referring team.

Areas for improvement

Action the trust SHOULD take to improve:

- Ensure there is improved consistency in the completion of DNACPRs.
- Ensure that information technology systems are updated to support all aspects of record keeping.

Outpatients

Good

Key facts and figures

The outpatients department (OPD) at the West Middlesex University Hospital is part of the Planned Care Division of Chelsea and Westminster Hospital NHS Foundation Trust.

The OPD was open Monday to Friday 8.30am to 4.30pm with some clinics offering appointments on a Saturday and in the evening until 9.00pm.

The OPD runs clinics in cardiothoracic surgery, general medicine, gynaecology, medicine and care of the elderly, oral surgery, cardiology, plastic surgery, ear nose and throat (ENT), dermatology, trauma and orthopaedics, thoracic medicine, gastroenterology, neurology, and urology.

We visited a range of clinics in OPD areas 2, 3, 4, 5, 6, and 8. We met with people who use services and carers, who shared their views and experiences of the OPD service. We spoke with 18 patients who used the services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

In addition, we reviewed national data and performance information about the trust and read a range of policies, procedures and other documents relating to the operation of the OPD.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We rated it it as good because:

- Staff understood how to protect patients from abuse and were aware of their roles and responsibilities for escalating safeguarding concerns. Staff had training on how to recognise and report abuse.
- Records were held securely with in lockable note trolleys which had a keypad. Records used by reception staff were kept out of sight to ensure patient's confidentiality was maintained. We observed nursing checking records in separate rooms in clinical rooms out of sight of patients.
- The OPD looked visibly clean. Cleaning schedules and daily checklists were completed and in place in the OPD departments. Checklists from November 2017 were held and where available. This had improved since the last inspection.
- Medicines were stored in locked cupboards and treatment rooms. The trust audited prescriptions against with the trust medicines policy in July 2017. The audit included OPD prescriptions and assessed compliance with 20 standards which covered various aspects of the Medicines policy. Of these, 18 (90%) scored 80% compliance or greater.
- The OPD was part of the planned care division which had an audit programme. For the year April 2017 to March 2018 six audits which had been registered. This demonstrates the Hospital was engaged in auditing the effectiveness of the care they provided.
- Staff were able access appropriate pain relief for patients within outpatient's clinics. Patient's pain was assessed and monitored. Staff in outpatients could give patients paracetamol if they experienced pain, but if patients needed other analgesia these would be prescribed by a medical practitioner.

Outpatients

- There were systems in place to obtain consent from patients before carrying out most procedures or providing treatment, which we saw evidenced in patients' notes. Records reviewed showed evidence that consent was gained for care and treatment. Staff told us they had access to guidance for obtaining consent from a patient with a learning disability.
- Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic patients. Patients we spoke with were positive about the staff that provided their care and treatment. They told us they had confidence in the staff they saw and the advice they received.
- Patients told us they were given written information on their aftercare and leaflets on a healthy lifestyle.
- Patients told us staff helped them to understand their care and treatment, and that medical staff took time to ensure they answered their questions. Several patients told us they the doctors explained their conditions and treatment options, and answered there questions.
- The OPD took account of people's needs. The OPD offered a range of services for patients, this included audiology, ENT, dermatology, breast surgery, podiatry, respiratory, trial without catheter and fracture clinics.
- West Middlesex Hospital was meeting its cancer referral targets between September 2016 and September 2017. The operational target of 93% for patients to be seen within 2 weeks of an urgent referral from a GP had been met (93%). The operational target of 85% for patients for patients receiving their first treatment within 62 days of an urgent GP referral had been exceeded (91%). This was higher than the England average.
- Outpatient clinics were clearly signed and colour coded on the floor to OPD areas so that people could find their way to respective clinics. The hospital also used volunteers to guide patients to the right departments however volunteers were only on site one day of the inspection.
- There was a clear management structure across the Planned Care Division which operated across both Hospital sites, the West Middlesex University Hospital and Chelsea and Westminster Hospital. Staff were positive about the skills, knowledge and experience of their immediate managers. They felt supported by their managers and the trust.
- Staff described good team and peer support; they felt they worked well as a team. We saw multidisciplinary working which involved patients, relatives, and nursing staff working together to achieve good outcomes for patients. Most patients acknowledged a positive and caring ethos and were happy with the care they received.

Is the service safe?

Good

We rated it as good because:

- Staff understood how to protect patients from abuse and were aware of their roles and responsibilities for escalating safeguarding concerns. Staff had training on how to recognise and report abuse.
- Records were held securely with in lockable note trolleys which had a keypad. Records used by reception staff were kept out of sight to ensure patients' confidentiality was maintained. We observed nursing checking records in separate rooms in clinical rooms out of sight of patients.
- The OPD looked visibly clean. Cleaning schedules and daily checklists were completed and in place in the OPD departments. Checklists from November 2017 were held. This had improved since the last inspection.

- Medicines were stored in locked cupboards and treatment rooms. The trust audited prescriptions against with the trust medicines policy in July 2017. The audit included OPD prescriptions and assessed compliance with 20 standards which covered various aspects of the Medicines policy. Of these, 18 (90%) scored 80% compliance or greater.

However:

- Mandatory training in key skills for staff within the OPD was below the trust targets in six of the nine core areas. The trust set a target of 90% for the completion of all mandatory training with the exception of information governance which had a target completion rate of 95%. The overall completion rate was 82%. The lowest completion rates were for the conflict resolution module 65%, patient handling 70% and basic life support 70% as at August 2017.

Is the service effective?

Not sufficient evidence to rate

We rated it as good because:

- The OPD was part of the planned care division which had an audit programme. For the year April 2017 to March 2018 six audits which had been registered. This demonstrates the Hospital was engaged in auditing the effectiveness of the care they provided.
- Staff were able access appropriate pain relief for patients within outpatients clinics. Patients' pain was assessed and monitored. Staff in outpatients could give patients paracetamol if they experienced pain, but if patients needed other analgesia these would be prescribed by a medical practitioner.
- There were systems in place to obtain consent from patients before carrying out most procedures or providing treatment, which we saw evidenced in patients' notes. Records reviewed showed evidence that consent was gained for care and treatment. Staff told us they had access to guidance for obtaining consent from a patient with a learning disability.

However:

- The OPD did not meet the trusts targets for staff appraisals. Annual appraisals for staff were below the trust target of 100%. The trust reported 68% of nursing staff had received an appraisal during the 12 month period from August 2016 to July 2017.

Is the service caring?

Good

We rated it as good because:

- Staff provided treatment and care in a kind and compassionate way and treated people with respect. Staff were seen to be very considerate and empathetic patients. Patients we spoke with were positive about the staff that provided their care and treatment. They told us they had confidence in the staff they saw and the advice they received.
- Patients told us they were given written information on their aftercare and leaflets on a healthy lifestyle.
- Patients told us staff helped them to understand their care and treatment, and that medical staff took time to ensure they answered their questions. Several patients told us the doctors explained their conditions and treatment options and answered there questions.

Outpatients

Is the service responsive?

Good

We rated it as good because:

- The OPD took account of people's needs. The OPD offered a range of services for patients, this included audiology, ENT, dermatology, breast surgery, podiatry, respiratory, trial without catheter and fracture clinics.
- West Middlesex Hospital was meeting its cancer referral targets between September 2016 and September 2017. The operational target of 93% for patients to be seen within 2 weeks of an urgent referral from a GP had been met (93%). The operational target of 85% for patients for patients receiving their first treatment within 62 days of an urgent GP referral had been exceeded (91%). This was higher than the England average
- Outpatient clinics were clearly signed and colour coded on the floor to OPD areas so that people could find their way to respective clinics. The hospital also used volunteers to guide patients to the right departments however volunteers were only on site one day of the inspection.

However

- The OPD pharmacy was open hours Monday to Friday from 9.10am until 5.30pm. There was no Saturday or evening opening when the OPD was open.

Is the service well-led?

Requires improvement

We rated it as requires improvement because:

- The OPD risk register did not reflect our findings. The backlog of incidents waiting investigation had not been identified on the risk register. There were two risks identified, a third risk seen on documentation related to paediatric patients being seen in the OPD due to lack of space within the paediatric OPD was no longer on the risk register.
- Incidents were not being investigated within the timescales set out in the trusts incident reporting management and investigation policy. The OPD had eight incidents waiting to be investigated which meant there was no learning from them. Two of the incidents related to medicines, one of the incidents had been reported in June 2017 and the other in September 2017.
- Senior managers could not be assured that OPD staff were learning from incidents across the trust. A review of OPD meeting minutes, staff meetings showed incidents were not discussed.
- The trust did not monitor waiting times for patients, and this was one of the main concerns raised by patients that we spoke with during the inspection. Patients told us that their waits had varied from 15 minutes to an hour.

However

- There was a clear management structure across the Planned Care Division which operated across both Hospital sites, the West Middlesex University Hospital and Chelsea and Westminster Hospital. Staff were positive about the skills, knowledge and experience of their immediate managers. They felt supported by their managers and the trust.

Outpatients

Areas for improvement

Action the trust SHOULD take to improve:

- Ensure that staff meet the trust's target for staff completing mandatory training.
- Ensure that incidents are investigated in line with the trust's incidents' reporting management and investigation policy and there is learning from incidents across the trust.
- Ensure staff meet the trust's target for appraisal rates.
- Monitor waiting time for patients.
- Have a OPD risk register is reflective of risks within the OPD department.

Our inspection team

Nicola Wise, Head of Inspection North London and Robert Throw, Inspection Manager led the inspection. An executive reviewer, Carolyn Mills, supported our inspection of well-led for the trust overall.

The team included 22 inspectors, seven executive reviewers, 30 specialist advisers, and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	1.4.2 /May/18
REPORT NAME	Draft Annual Quality Report 2017-18
AUTHOR	Attached is the near-final draft of CWFT's Annual Quality Report for 2017-18, provided by Shân Jones, Director of Quality Improvement.
LEAD	Eliza Hermann, Non Executive Director and Chair of Board Quality Committee
PURPOSE	To provide the Council of Governors with an opportunity to discuss the Trust's Annual Quality Report for 2017-18.
SUMMARY OF REPORT	CWFT's Annual Quality Report is a review of the quality of the care and services provided by the Trust and meets the Trust's statutory reporting requirements. The Quality Committee has reviewed two drafts of the report with the exception of certain sections which, at the time of writing this covering sheet, have yet to be received. Overall, the Committee is pleased with the Trust's progress in improving care quality, as recognised by both the Care Quality Commission and NHS Improvement. As documented in the Quality Report, improvement is evident in many specific areas including, for example - • a further reduction in 2017-2018 in the Trust's already low patient mortality rate (SHMI), and the robust process of mortality reviews and learning from deaths; • sustained reductions in hospital acquired pressure ulcers; • performance above target in all cancer related metrics; • extended provision of seven day services in a number of clinical areas; • sustained reductions in hospital acquired infections e.g. C Diff; • still births below the national average; and • full or partial achievement of most of the CQUIN (Commissioning for Quality and Innovation) targets set by Commissioners. The Committee has not been satisfied with progress in some areas. Some of these are now 2018-19 Quality Priorities, others will receive Committee oversight via our regular Committee reviews and deep-dives. A few of these areas are - • falls, for which the Trust still experiences a higher rate than the national average; • complaints management, including the need to improve both timeliness of responses and ensuring there is organisation wide learning from complaints; • venous thromboembolism risk assessments, for which the Trust is below the national target (however, the Trust has retained its "VTE Exemplar Centre" status for the robustness of its VTE prevention measures); • implementation and embeddedness of the Trust's 'Responsible Consultant and

	Named Nurse' policy; and • although the Trust has had a year on year reduction in Serious Incidents, there has been an increase in Never Events (fortunately all with little or no harm to the patient) for which the Committee has commissioned a deep dive to better understand root causes and gain assurance that follow on learnings and changes in practice are embedded. The Quality Committee's role of oversight, assurance and scrutiny means we take in a great deal of information from different sources. The CQC inspection report and the Trust's own Quality Report are two such sources but others include monthly performance metrics, reports and meeting minutes from the four quality sub groups (Patient Safety, Clinical Effectiveness, Patient Experience, and Health Safety and Environmental Risk) and their respective sub groups, quarterly mortality surveillance reports, ward accreditation results, Getting It Right First Time (GIRFT) review findings, complaints, incidents, various patient survey results (including Family and Friends Test results) and other patient feedback, Commissioner or other external reviews, and clinical audit findings. I understand the Governors' Quality sub-committee is interested in the Quality Committee's involvement in reviewing clinical audits. One of the Committee's sub groups, the Clinical Effectiveness Group (CEG) which is Chaired by the Deputy Medical Director Roger Chinn, coordinates and oversees the Trust's clinical audit participation and results. The CEG reports 2 - 3 times each year to the Quality Committee, and always includes in these reports any significant findings. The CEG also reports plans for future clinical audits; most recently the Committee discussed this in March. We welcomed the enthusiasm of clinicians in undertaking clinical audits as these audits are an important vehicle for learning, but we questioned the realism of what was at that time a very large number of possible clinical audits being proposed for 2018-19 by the three Divisions. The CEG's next report is due in early June.
KEY RISKS ASSOCIATED	Negative impact on patients, as well as negative regulatory, financial and reputational impact and stakeholder loss of confidence if service quality was to deteriorate rather than improve.
FINANCIAL IMPLICATIONS	As above
QUALITY IMPLICATIONS	As above
EQUALITY & DIVERSITY IMPLICATIONS	As above
LINK TO OBJECTIVES	Providing high quality patient centred care is CWFT's number one priority.
DECISION/ ACTION	For discussion

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QUALITY REPORT

2017/18

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QUALITY REPORT

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

Being finalised

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 (AEC) services.
- Emergency assessment and treatment services including critical care and a Surgical Assessment Unit (SAU) at West Middlesex University 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, a midwifery-led natural birth centre, community midwifery support, antenatal care, postnatal care and home births. There is also a specialist neonatal intensive care unit (Chelsea and Westminster Hospital), special care baby unit (West Middlesex University Hospital) and specialist fetal medicine service. We also have a private maternity service.
- Children's services including emergency assessment, 24/7 Paediatric Assessment Unit (PAU), and 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

	2017/18	2016/17	2015/16
Outpatient attendances	776,287	767,330	743,230
Total A&E attendances	306,048	282,157	187,538
Total urgent care centre attendances	98,933	87,683	83,716
Inpatient admissions	141,476	136,837	135,116
Babies delivered	10,644	10,682	10,504
Patients operated on in our theatres	36,140	33,683	33,517
X-rays, scans and procedures carried out by clinical imaging	468,154	391,609	348,476
Number of staff including our partners (C&W + ISS and Norrland)	5,879+722	5,981+369	5,745+729

Our vision and values

Chelsea and Westminster Foundation Trust's vision and ambition is to deliver excellent care 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 following Strategic Objectives for 2018/19 which are to:

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

Our PROUD Values underpin our performance and development review system and the quality board work on wards and departments. They were developed in consultation and engagement with staff, governors, directors and non-executive 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 2015–18

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 (CQC) review of both hospitals in 2015.

We have considered quality based on the four components:

- Patient and staff experience
- Patient safety
- Clinical effectiveness
- Patient access and operational performance

Under these components, we have set ambitions and supporting priorities as well as governance structures to manage each agenda these all feed into an overarching Quality Committee.

We will continue to deliver our ambitions for quality through the tranches of focused 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 2017/18 link to these overarching plans.

Declaration

It is important to note, as in previous years, that there are a number of inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.

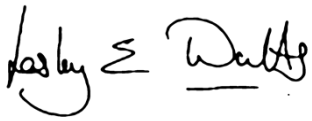
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.

- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

Notwithstanding these inherent limitations, to the best of my knowledge the information in this report is accurate.



Lesley Watts
Chief Executive Officer

Date:

Part 2: Our priorities

Priorities for improvement 2017/18

This section of the report reviews how we performed in 2017/18 in relation to the priorities set in our Quality Report 2016/17. 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 2018/19.

Chelsea and Westminster Hospital NHS Foundation Trust set the following priorities for 2017/18:

Patient safety

- **Priority 1:** Reduction in falls (Frailty Quality Plan)
- **Priority 2:** Antibiotic administration in sepsis (Sepsis Plan)
- **Priority 3:** National Early Warning Score (NEWS) (Sepsis Plan)
- **Priority 4:** National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)

Clinical effectiveness

- **Priority 5:** Reduction in stillbirths (Maternity Plan)

Patient experience

- **Priority 6:** Focus on complaints and demonstrate learning from complaints
- **Priority 7:** FFT improvements with new FFT provider

How we did in 2017/18

During 2017/18 a quarterly progress report for all seven priorities was provided to the Quality Committee, the dashboard below was used to give an overarching view of progress.

Quality priorities dashboard Quarter 4 2017/2018

Patient Safety

QP n°	Description of goal	Responsible executive (role)	Forecast			
			Q1	Q2	Q3	Q4
1	Reduction in falls (Frailty Quality Plan)	Director of Nursing				
2	Antibiotic administration in sepsis (Sepsis Plan)	Medical Director				
3	National Early Warning Score (NEWS) (Sepsis Plan)	Medical Director				
4	National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)	Divisional Medical Director				

Clinical Effectiveness

QP n°	Description of goal	Responsible executive (role)	Forecast			
			Q1	Q2	Q3	Q4
5	Reduction in stillbirths (Maternity Plan)	Director of Midwifery				

Patient Experience

QP n°	Description of goal	Responsible executive (role)	Forecast			
			Q1	Q2	Q3	Q4
6	Focus on complaints and demonstrate learning from complaints	Director of Midwifery				
7	FFT improvements with new FFT provider	Director of Midwifery				

The projects rated as amber have been as a result of ongoing work that will continue as business as usual.

Patient safety

Priority 1: Reduction in falls (Frailty)

What 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 2017/18:

- 25% reduction in externally reportable fall incidents
- 40% reduction in falls resulting in moderate harm
- 20% reduction in falls resulting in no or low harm

What we did during the year to improve patient care
- Trustwide launch of new falls risk assessment and care plan
- Launch week held for falls prevention and awareness 19 Mar 2018 with Trustwide and external communications support
- Falls strategy was revised and is being monitored through Falls Steering Group
- Started equipment audit with a view to application for funding to support meeting equipment needs by end Q4
- Clinical fellow working with West London Clinical Commissioning Group and Triborough Public Health to map community falls services, monitor long term outcomes and improve integration of falls prevention across sector

What we achieved

There has been a 38% reduction in falls with severe harm and an overall reduction in falls per 100 bed days, however falls resulting in moderate, low or no harm have increased slightly. This may be due to increased reporting.

Falls metrics	Q1	Q2	Q3	Q4	Total
Externally reported Serious Incident (Severe Harm)					
2016/17	4	2	2	5	13
2017/18	0	1	4	3	8
% change	-100%	-50%	+ 100%	-40%	-38%
Moderate harm					
2016/17	6	5	3	2	16
2017/18	2	4	6	4	16
% change	-66.7	-20.0	100.0	100.0	0
No harm/low harm					
2016/17	286	266	299	362	1213
2017/18	284	293	328	326	1231
% change	-0.7	10.2	9.7	-9.9	+1.5%
Falls per 1,000 bed days					
2016/17					3.7
2017/18					3.6

What we plan to do going forward
Falls will continue to be a quality priority—see section on priorities for improvement 2018/19 on p17.

Priority 2: Antibiotic administration in Sepsis (Sepsis)

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

What we did during the year to improve patient care
- Agreement of Trustwide Sepsis Clinical Guideline and screening tool for adult inpatient wards and emergency departments
- Implementation of new guideline and screening tool across both sites
- Training programme to be rolled out from Apr/May 2018
- Agreement for 0.5 WTE Band 7 Sepsis Nurse to support audits and improvement cross site. This has been increased to a request for 1.0 WTE for 2018/19
- Audits show improvements in screening and treatment
- Engagement with Cerner development to understand sepsis flags and algorithm—and how it will fit with new clinical guidelines and screening
- Cross site sepsis working group meeting monthly with good representation

What was achieved

Target	Baseline Q4 2016/17	Q1	Q2	Q3	Q4
>90% Observations recorded on EWS Chart [CQUIN 2a: Timely identification of sepsis in emergency departments and acute inpatient settings]	ED – 61% (Inpatients - CW 100% (WM not collected)	70.2% (ED and Inpatient – WM inpatient not collected)	54.5% (ED and Inpatient – WM inpatient not collected)	56.3% (Target >90%) (ED and Inpatient – WM inpatient not collected)	Target >90% Achieved 56%

Target	Baseline Q4 2016/17	Q1	Q2	Q3	Q4
> 90% Antibiotics administered by year end (ED and Inpatients) [CQUIN 2b. Timely treatment of sepsis in emergency departments and acute inpatient settings]	92.9% (ED) 90.3% (Inpatients)	56.8% (117 eligible patients)	56.7% (213 eligible patients)	63.55% (Target >90%) 213 eligible patients	85.44% Target >90%
>90% Antibiotics started for sepsis will have documented review within 24-72 hours by year end [CQUIN 2c. Review of Antimicrobial Prescribing for Sepsis within 24-72hours]	Data not collected	93% (Target >25%) - Evidence of review of antimicrobials documented in 28 of 30 reviewed patients	93% (Target >50%)	Target >75%	93% Target >90%
Training Metrics to be developed following agreement of Clinical Guideline and training programme					tbc

What we plan to do going forward
The management of sepsis will be managed as business as usual and reported going forward as a local quality indicator.

Priority 3: National Early Warning Score (Sepsis)

What we set out to achieve during 2017/18
All inpatients will have clinical observations taken, recorded and scored as per clinical policy and charted on an early warning score (EWS) chart.

This is linked to Priority 2: Antibiotic administration in Sepsis (Sepsis) and reported above.

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

What we set out to achieve during 2017/18
WHO safety check list to be completed on all patients having surgery to prevent never events

What we did during the year to improve patient care
- Quality priorities bi-weekly meeting embedded leads—Theatre, Anaesthetics, Surgery and Radiology in attendance
- New WHO standardised safety checklist now in use in planned care division await further roll out in Women's and EIC
- New online WHO audit collection tool set up to improve data collection and analysis
- Drafting of 32 LoCSIPPs completed—under consultation with surgeons for final sign off
- National Safety Standards for Invasive Procedures intranet webpage under development with Communications team
- Video of how to use WHO safety Checklist and LoCSIPPs under development with Communications team

What results were achieved?
The following indicators were chosen as they are a measure of safety within areas where invasive procedures are being undertaken:

- Supportive teamworking is enhanced by the use of simulation and the use of the WHO checklist. With this in mind, low vacancy levels are a key indicator of staff who feel supported.
- Reporting of incidents is an indication of a positive safety culture.
- This measure allows a review of cancellations related to the use of the WHO checklist
- Recording the number of LocSSIPS allows the clinical team to monitor the number being written and left to write.

KPI	Base-line	Q1			Q2			Q3			Q4		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. WHO Compliance	See following tables												
2. Vacancy Levels (variance) – Trust (12%)		11.89%	8.21%	8.21%	10.43%	10.48%	12.78%	10.48%	11.58%	12.10%	13.32%	12.4%	11.6%
3. Total incidents reported on Datix (theatres)		40	50	61	25	28	33	44	50	38	32	19	23
4. Datix Reporting – Serious Incidents (Internal & External) (Theatres)		0%	4.00%	1.64%	4%	7%	3.03%	2.27%	0%	0%	0%	5%	0%
5. On the day cancelled operations (non-clinical) as % total of elective admissions (Trustwide)	<0.80%	0.78%	0.78%	0.49%	0.35%	0.55%	0.81%	0.42%	0.47%	0.36%	0.39%	0.44%	0.77%
6. Total Number of LocSSIPs completed									4	8	20	61	79

WHO compliance C&W

Chelsea and Westminster Hospital				
Month	Sign in	Time out	Sign out	Overall Compliance (Sign In/Time Out/Sign Out)
April	97.2%	97.2%	99.0%	97.8%
May	99%	98%	97%	98%
June	100%	80%	99%	93%
July	93%	99%	100%	98%
August	91%	100%	99%	99%
September	92%	100%	100%	99%
October	100%	100%	100%	100%
November	100%	95%	100%	98.4%
December	94%	98%	98%	97%
January/18	92%	97%	97%	95%
February/18	89%	95%	94%	93%
March/18	95%	94%	93%	94%

WHO Compliance WM

West Middlesex	Documentation Checks (Sign-In/Time In/Sign Out)		Overall Compliance (Sign In/Time Out/Sign Out
Month	Yes	No	
April	9898	64	99.35%
May	12391	291	97.65%
June	11500	179	98.44%
July	11770	11	99.90%
August	11305	0	100.00%
September	11741	6	99.9%
October	13292	19	99.9%
November	14113	133	99.1%
December	11769	131	98.9%
January	10658	273	97.4%
February	11469	74	99.4%
March	11415	94	99.2%

What we plan to do going forward

The continued implementation and audit of NaTSIPS/LoCSIPS will continue as a quality priority—see section on priorities for improvement 2018/19 on p17.

Clinical effectiveness

Priority 5: Reduction in still births (Maternity)

What we set out to achieve during 2017/18

Achieve a still birth rate which is lower than the national average.

What we did during the year to improve patient care

- Implementation of the Growth Assessment Protocol at WMUH
- Implementation of K2 central fetal monitoring and documentation system at WMUH
- Training data on CTG assessment—compliance >90%
- Implementation of cross site intrapartum fetal monitoring guidance incorporating NICE 2017 guidance
-

What results were achieved?

- 94% compliance with training on CTG assessment was achieved
- Cross site intrapartum fetal monitoring guidance is in final draft

The table below shows the number of stillbirths per 1,000 births > 24 weeks gestation by site compared to the national average. The Trust is below the 1.14 below the national average at year end.

Period	CW site	WM site	National average	Trust	RAG rating against local target
Quarter 1	3.77	6.31	4.2	4.90	
Quarter 2	1.78	3.93	4.2	2.70	
Quarter 3	1.82	3.9	4.2	2.75	
Quarter 4	2.57	0.88	4.2	1.86	
Total for year	2.47	3.84	4.2	3.06	Target < 3.3

RAG rating		
<4 per 1,000 births	4–4.2 per 1,000 births	>4.2 per 1,000 births

What we plan to do going forward
This will become business as usual and reported at divisional level.

Patient experience

Priority 6: Focus on complaints and demonstrate learning from complaints

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

What we did during the year to improve patient care
- Central complaints team phoning and sending acknowledgement letters within 48 hours from first working day received
- Weekly complaints meeting with divisions to track compliant progress on Datix
- Monitoring of a complaints dashboard in the patient experience committee, and for oversight and scrutiny at divisional board
- Review and implement a new complaints policy in line with national recommendation
- CEO reviews and signs all complaints letters personally

The table below demonstrates the total numbers and percentage resonded to within 25 days.

Formal Complaints														
2017-18		Q1			Q2			Q3			Q4			Total
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Corp		0	0	3	1	0	1	6	4	4	4	4	2	**29**
%		0	0	33	100	0	100	15	75	75	100	0	0	
EIC		11	15	17	13	25	19	33	27	16	25	22	21	**244**
%		36	40	12	38	28	42	59	48	56	60	55	14	
PC		17	13	18	16	18	23	28	34	17	27	31	27	**269**
%		17	15	16	25	38	35	46	18	35	44	58	30	
WCHGDPP		16	15	21	11	21	20	15	19	13	26	23	35	**235**
%		43	40	48	72	62	35	53	37	38	54	30	11	
Total		**44**	**43**	**59**	**41**	**64**	**63**	**82**	**84**	**50**	**82**	**80**	**85**	**777**
Ack <2 days		43	42	48	36	61	60	78	76	41	78	79	69	711
%		98	98	81	88	95	95	95	90	82	95	99	81	92
Res <25 days		14	14	16	17	23	15	43	29	23	44	37	15	290
%		32	33	27	41	36	24	52	35	46	54	46	18	37

000

Consistent improvement in the acknowledgement by the complaints team in 2 working days achieved. There is more focus required on the response rate in all divisions.

What are we going to do going forward?
Complaints will continue as a quality priority for 2018/19 the section on priorities for improvement 2018/19 on p17.

Priority 7: Friends and Family Test (FFT) improvements in recommend scores

What we set out to achieve during 2017/18
All clinical areas to have a recommend score of over 90%.

What we did during the year to improve patient care
- Individual ward accountability for improvement action plans
- New method for data collection includes tablets in all ward areas in addition to the existing methodologies of texting and paper-based collections.
- 'You said, we did' boards visible on all wards
- Behaviour insights study undertaken to identify additional methods of improving outcomes
- Development of PREMS (Patient Reported Experience) for use across the organisation

The results we achieved

Friends and Family Test														
2017-18	Target	Q1			Q2			Q3			Q4			Average
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
FFT Response Rate														
Inpatients	30	31	36	32	33	32	32	32	33	36	33			**33**
ED		15	19	19	16	15	16	16	16	16	15			**16**
Birth		18	24	22	22	19	16	16	18	16	NA			**19**
Day Case		14	19	15	16	17	16	16	16	16	18			**16**
Outpatients		13	13	13	13	13	13	11	10	10	12			**12**
Paediatrics		12	12	12	11	12	14	15	13	13	13			**13**
GUM		23	28	27	24	22	24	16	22	21	18			**23**
FFT Recomends														
Inpatients	90	90	90	90	92	90	90	90	90	90	90			**90**
ED		88	83	83	84	83	82	**89**	87	88	90			**86**
Birth		97	95	97	96	98	96	93	91	97	NA			**96**
Day Case		93	92	95	93	93	95	93	93	91	90			**93**
Outpatients		90	89	90	89	91	90	90	90	90	91			**90**
Paediatrics		92	90	90	90	92	92	91	91	91	92			**91**
GUM		95	96	95	97	96	95	95	95	97	96			**96**

Achievement in all areas of the 90% recommendation score. The response rate has achieved the target of 30% in inpatient areas, though work is needed to improve this in other areas.

What we are going to do going forward
There is a review of FFT underway. This will become business as usual and will be reported as a local quality indictor going forward.

Priorities for improvement 2018/19

This section of the report sets out the Trust's quality improvement priorities for 2018/19. The plan for 2018/19 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 2018/19 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 2015–2018
- Divisional review of incident reporting and feedback from complaints

Our ambition for 2018/19 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 continue to be critical skills for the future and for working with patients and colleagues across the sectors.

Quality consists of four 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
- Patient access and operational performance—how easily patients can access services, and how long they wait

We have set the following priorities for 2018/19 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—ie Clinical Effectiveness Group, Patient Safety Group or Patient Experience Group and, subsequently, to the Quality Committee.

The quality priorities for 2018/19 are outlined below:

Patient Safety

Priority 1: Reduction in falls

What we aim to achieve during 2018/19

- Target to reduce falls by 30% to be consistent with national best practice—2.62 falls per 1,000 bed days based on Q3 2017/18

What we will do during the year to improve patient care

- Falls steering group will meet monthly to review project progress
- New Trust falls strategy launches Mar 2018
- Ongoing community pathway work with public health and RBKC

How we will measure our success

- Number of falls per 1,000 bed days

Priority 2: National Safety Standards for Invasive Procedures (NatSSIPs) (Admitted Surgical Care)

What we aim to achieve during 2018/19
- 90% reduction in serious incidents relating to invasive procedures
- To implement a robust audit cycle

What we will do during the year to improve patient care
- Standardisation of the WHO safety check list Trustwide
- The WHO safety check list will be completed on all patients having surgery, with the effective process preventing never events
- All invasive procedures to have a Local Safety Standards for Invasive Procedures (LocSSIPs) developed
- Implementation and embedding of LocSSIPs in practice

How we will measure our success
- Number of serious incidents relating to invasive procedures
- Compliance with local audit plan

Priority 3: NHS Resolution 10-point safety plan

What we aim to achieve during 2018/19
Trust is meeting 10 safety actions set out by Clinical Negligence Scheme for Trusts (CNST) to improve patient safety for all those using our maternity services.

What we will do during the year to improve patient care
The ten points in the safety plan are:

- Use of the National Perinatal Mortality Review Tool to review perinatal deaths
- Use of the Maternity Services Data Set to the required standard
- Transitional care facilities in place and operational to support the implementation of avoiding term admissions into neonatal units (ATAIN programme)
- Effective system of medical workforce planning
- Effective system of midwifery workforce planning
- Compliance with all elements of the Saving Babies' Lives (SBL) care bundle
- Demonstrate that there is an effective use of the Maternity Voices Partnership Forum, (a forum which encourages patient engagement) and that the services acts on feedback received
- 90% of staff have attended an 'in-house' multiprofessional maternity emergencies training
- Local safety champions (obstetric and midwifery) meet bi-monthly with Trust-level safety champions via the patient safety group to escalate local identified issues
- 100% of qualifying 2017/18 incidents are reported under the NHS Resolution's Early Notification Scheme

How we will measure our success
- Conduct baseline audit of the 10-point plan during Apr 2018 and report quarterly thereafter
- Report to Trust Board Jun 2018

Clinical Effectiveness

Priority 4: Reduction in *E.coli* infections

What have we set out to achieve during 2018/19
The Trust aims to reduce infection caused by *E.coli* by 50% by 2021. This is in line with a national ambition to reduce healthcare associated gram-negative bloodstream infections (healthcare associated GNBSIs) by 50% by Mar 2021, with the initial focus on infections caused by *E.coli*.

What we will do during the year to improve patient care
- Monthly reporting to Public Health England of bloodstream infections caused by *E.coli*, *Pseudomonas aeruginosa* and *Klebsiella species.*

- Monthly review of reported infections by the Infection Prevention and Control Group.

- Review Trust data to understand risk groups and factors which could be modified, for example:
    - urinary tract infections (UTI)
    - catheter related UTIs
    - skin or soft tissue, including ulcers or cellulitis
    - intravascular access associated
    - surgical interventions

- Review Trust data on PHE Fingertips portal to benchmark against similar organisations.

- Patients treated for gram-negative sepsis will be prescribed an antimicrobial by responsible medical team in line with local guidelines / microbiology advice Patients treated for gram-negative sepsis will have antimicrobial treatment reviewed by responsible medical team within 48–72 hours to optimise therapy How we will measure our success

1% reduction from baseline of 14.9%

Patient Experience

Priority 5: Complaints management

What have we set out to achieve during 2018/19
- Complaints acknowledgement within 48 hours
- Complaints response within 25 working days
- Individual complaints action assurance
- System of learning from complaints

What we will do during the year to improve patient care
- A new complaints policy and structure will support the divisional teams more robustly in the delivery of the Trust-agreed targets and will be in place by end of May 2018
- The policy will contain an internal escalation process for non-compliance of complaints response
- Patients will receive a timely and appropriate response
- Ensuring learning from complaints will help to improve the overall patient experience

How we will measure our success
Baseline position is to be agreed in Apr 2018 so that improvement and progress can be tracked quarterly.

- 90% of complaints will be acknowledged within 2 working days
- 90% of complaints will be responded to within 25 working days
- Action trackers to be in place for all actions arising from complaints responses, monitored through divisional quality board
- Development of a Trustwide system which demonstrates learning from complaints

Review of services

During 2017/18 the Trust provided and or sub-contracted 87 relevant health services. The 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 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

Participation in clinical audit

During 2017/18, 41 national clinical audits and 13national confidential enquiries covered relevant health services that the Trust provides. During that period the Trust participated in 90.2% 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 the Trust was eligible for and participated in, and for which data collection was completed during 2017/18, 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
Adult Cardiac Surgery	No	Not eligible	N/A
BAUS Urology Audit: Female Stress Urinary Incontinence Audit	Yes	No	N/A
BAUS Urology Audit: Radical Prostatectomy Audit	No	Not eligible	N/A
BAUS Urology Audit: Cystectomy	No	Not eligible	N/A
BAUS Urology Audit: Nephrectomy audit	No	Not eligible	N/A
BAUS Urology Audit: Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	Ongoing
BAUS Urology Audit: Urethroplasty Audit	No	Not eligible	N/A
Cardiac Rhythm Management (CRM)	Yes	Yes	Ongoing
Case Mix Programme (CMP)	Yes	Yes	Ongoing
Elective Surgery (National PROMs Programme)	Yes	Yes	Ongoing
Endocrine and Thyroid National Audit	No	Not eligible	N/A
Falls and Fragility Fractures Audit programme (FFFAP): Fracture Liaison Service Database	No	Not eligible	N/A
Falls and Fragility Fractures Audit programme (FFFAP): Inpatient Falls	Yes	Yes	100%

National clinical audit title	Trust eligible	Trust participated	% Submitted
Falls and Fragility Fractures Audit programme (FFFAP): National Hip Fracture Database	Yes	Yes	Ongoing
Fractured Neck of Femur (care in emergency departments)	Yes	Yes	100%
Head and Neck Cancer Audit	No	Not eligible	N/A
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	Yes	No	N/A
Major Trauma Audit	Yes	Yes	Ongoing
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Ongoing
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	Ongoing
National Audit of Dementia (in General Hospitals): Dementia care in general hospitals	Yes	Yes	100%
National Audit of Intermediate Care (NAIC)	No	Not eligible	N/A
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	TBC
National Audit of Pulmonary Hypertension	No	Not eligible	N/A
National Bariatric Surgery Registry (NBSR)	Yes	Yes	TBC
National Bowel Cancer Audit (NBOCA)	Yes	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme: Pulmonary rehabilitation	No	Not eligible	N/A
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme: Secondary Care	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme: Primary Care (Wales)	No	Not eligible	N/A
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	No	N/A
National Clinical Audit of Psychosis: Core audit	No	Not eligible	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI): Specialist rehabilitation level 1 and 2	No	Not eligible	N/A
National Comparative Audit of Blood Transfusion programme: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	Yes	100%
National Comparative Audit of Blood Transfusion programme: 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	Yes	100%
National Congenital Heart Disease (CHD): Paediatric, Adult	No	Not eligible	N/A
National Diabetes Audit – Adults: National Diabetes Foot Care Audit	Yes	Yes	Ongoing
National Diabetes Audit – Adults: National Diabetes Inpatient Audit (NaDia) -reporting data on services in England and Wales	Yes	Yes	100%
National Diabetes Audit – Adults: National Core Diabetes Audit	Yes	Yes	100%
National Diabetes Audit – Adults: National Pregnancy in Diabetes Audit	Yes	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Ongoing

National clinical audit title	Trust eligible	Trust participated	% Submitted
National Heart Failure Audit	Yes	Yes	100%
National Joint Registry (NJR)	Yes	Yes	85%
National Lung Cancer Audit (NLCA)	Yes	Yes	Ongoing
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Ongoing
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Ongoing
National Ophthalmology Audit: Adult Cataract surgery	Yes	No	N/A
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Ongoing
National Prostate Cancer Audit	Yes	Yes	Ongoing
National Vascular Registry	Yes	Yes	Yes
Neurosurgical National Audit Programme	No	Not eligible	N/A
Paediatric Intensive Care Audit Network (PICANet)	No	Not eligible	N/A
Pain in Children (care in emergency departments)	Yes	Yes	100%
Prescribing Observatory for Mental Health (POMH-UK): Use of depot/LA antipsychotics for relapse prevention	No	Not eligible	N/A
Prescribing Observatory for Mental Health (POMH-UK): Prescribing for bipolar disorder (use of sodium valproate)	No	Not eligible	N/A
Prescribing Observatory for Mental Health (POMH-UK): Rapid tranquilisation	No	Not eligible	N/A
Prescribing Observatory for Mental Health (POMH-UK): Prescribing high-dose and combined antipsychotics on adult psychiatric wards	No	Not eligible	N/A
Procedural Sedation in Adults (care in emergency departments)	Yes	Yes	CW 72% WM: 0 cases submitted
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Ongoing
UK Parkinson's Audit: (incorporating Occupational Therapy: Speech and Language Therapy, Physiotherapy Elderly care and neurology)	Yes	Yes	100%

Table 2: Confidential Enquiries Project Participation

Confidential Enquiry Project Title	Trust eligible	Trust participated	Trust submission
Child Health Clinical Outcome Review Programme (NCEPOD): Chronic Neurodisability	Yes	Yes	1
Child Health Clinical Outcome Review Programme (NCEPOD): Young People's Mental Health	Yes	Yes	3
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Mortality Surveillance	Yes	Yes	Ongoing

Confidential Enquiry Project Title	Trust eligible	Trust participated	Trust submission
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Perinatal Confidential Enquiry	Yes	Yes	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK): Confidential Enquiry into Maternal Deaths and Morbidity	Yes	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Acute Heart Failure	YES	YES	8
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Pulmonary embolism	YES	YES	Ongoing
Medical and Surgical Clinical Outcome Review Programme: Cancer in Children, Teens and Young Adults .	YES	YES	Ongoing
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Perioperative diabetes	YES	YES	Ongoing
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Mental health in general hospitals	Yes	Yes	6
Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Non-invasive ventilation	Yes	Yes	2
Mental Health Outcome Review Programme (NCISH)	No	Not eligible but the Trust reviews NCISH recommendations	

National clinical audit projects reviewed by the Trust

The reports of 36 national clinical audits on each site were reviewed by the provider in 2017/18. Chelsea and Westminster Hospital NHS Foundation Trust intends to take actions to improve the quality of healthcare provided and review the remaining national clinical audits relating to 2017/18 to identify and collate actions to be taken to improve the quality of healthcare provided.

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

Table 3

National clinical audit	Department leading review	Summary and agreed actions arising from National Clinical Audits
Diabetes (Paediatric) (NPDA)	Paediatrics Diabetes Service	The national report for the audit of Paediatrics Diabetes was reviewed by the Paediatrics Diabetes Team and the Trust Clinical Effectiveness Group. Most of the recommendations are already in place. An action plan is in place to improve: • coding of diabetes related admissions • develop a structured education for paediatric self-management during inter-current illness and episodes of hypoglycaemia for this patient group.

National clinical audit	Department leading review	Summary and agreed actions arising from National Clinical Audits
National Emergency Laparotomy Audit	General Surgery	The Trust participated in the National Emergency Laparotomy Audit (NELA). Both sites performed above national average for most indicators, this is a key achievement when compared to previous audit results. However, the Trust needs to improve on case ascertainment in line with national average and reporting of CT scan before surgery by a consultant radiologist. These were the lowest scoring indicators.
National Oesophago-Gastric Cancer Audit (NOGCA)	Cancer Services	The National Oesophago-Gastric Cancer Audit (NOGCA) was reviewed by the Trust Multidisciplinary teams. The overall results for key data are in line with national average.
Falls and Fragility Fractures Audit programme (FFFAP)	Falls Steering Group	The National Falls Report was reviewed by the Trust Falls Steering Group. Most of the national recommendations were met. The following improvements were made to meet those recommendation that were partially met: • Falls risk assessment tool (FRAT) has been updated in line with NICE Guidelines. • New falls care plan to include continence management, regular spot checks audits to assess whether mobility aids and call bell are within the patient's reach and visual impairment.
National Audit of Dementia	Dementia Team	The Trust performance has been mixed across both sites. WMUH site scored above national average for most of the audit criteria including clinical assessment for delirium (90%, national average 85%). CWH scored below average for most of the clinical criteria including clinical assessment for delirium (39%, national average 85%). The Trust intends to take the following actions to meet the national recommendations: • Review the system in place to ensure that all staff in the ward or care area are aware of the person's dementia or condition. • Develop training and knowledge framework or strategy that identifies necessary skill for working with and caring for people with dementia • Review the care pathways for people with dementia and delirium to include falls, fractured hips, UTIs, chest infections and stroke.
Sentinel Stroke National Audit programme (SSNAP)	Stroke Service	The Trust performance for the National Stroke Audit was reviewed by the Stroke Service. The Trust is partially compliant with six out of eight applicable recommendations. An action plan to achieve the following compliance is in place: • Review discharges to ensure patients with stroke are offered a structured health and social care review at 6 months and annually as per NICE Quality Standards and National Stroke Strategy. • Review staffing and recruit for a stroke specialist psychologist and stroke physician.
Bowel Cancer (NBOCAP)	Cancer Services	The National Bowel Cancer report was reviewed by the Cancer Services. The overall results for key data are in line with national average.

National clinical audit	Department leading review	Summary and agreed actions arising from National Clinical Audits
National Heart Failure Audit (NICOR)	Cardiology	A total of 514 patient data was submitted for both sites, the audit results are mostly above or in line with national average. Achievement for patients admitted with heart failure receiving an echocardiogram is above the national average. (99%- CWH and 96%-WMUH). A lower than national average score for WMUH for an input from a heart failure specialist, (62%, national average 79%). Both sites scored below national average for referral to cardiac rehabilitation and to heart failure nurse follow up. An action plan is in place to ensure: • Referral for cardiac rehabilitation, and an appointment to see a member of the Heart Failure team within 2 weeks, is made before the patient leaves hospital. • An introduction of a new heart failure discharge clinic on both sites. • Staffing review for specialist care including recruitment of a heart failure cardiologist and nurse.
National Diabetes Transition Audit Report	Diabetes Service	The Trust National Diabetes audit report was reviewed by the Diabetes Service and the Trust Clinical Effectiveness Group. The National audit was carried out to measure the care of young people with diabetes during the transition from paediatric diabetes services to adult diabetes services. The report covers young people with Type 1 diabetes. The least variation in care process was found where transition occurred between the age of 16 and 19 years. There is a decrease in the achievement of targets post-transition compared to pre-transition for blood pressure and serum cholesterol, along with checking for early evidence of kidney damage. The Trust has met most of the recommendations from this audit and an action plan is in place to meet those that are partially compliant.
Asthma (paediatric and adult) care in emergency departments		The Trust is compliant with 2/5 recommendations, the results was presented to clinical staff at the Trustwide clinical Governance half day meeting. The Trust has an action plan for the following service improvement as a result of the audit recommendation: • Create a patient leaflet to include inhaler type/technique/steroids and follow up. • Create proforma to improve documentation and act as an aide memoir for assessment. • Schedule weekly NEWS audit continues to demonstrate excellent compliance with vital sign recording
Myocardial Ischaemia National Audit Project (MINAP)		The trust is fully compliant with 9/10 of the national audit recommendations. An action plan is in place to ensure that patients have access to timely angiography within 72 hours of admission to hospital.

Local clinical audit projects reviewed by the Trust

The reports of a random selection of 12 of 315 local clinical audits were reviewed by the provider in 2017/18. 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 ongoing actions taken to improve the safety and effectiveness of our services.

Table 4: Local clinical audit summary

Local Clinical Audits	Summary and agreed actions arising from local clinical audits
Evaluating the completion and documentation of both a postural blood pressure reading and a Glasgow-Blatchford score in patients with a suspected Upper GI Bleed (UGIB) presenting to West Middlesex Hospital Accident & Emergency.	The audit revealed that 5% of cases attending Accident and emergency for UGIB had a documented Glasgow-Blatchford score and were referred to general medicine with a significant UGIB. A significant proportion of patients who were discharged did not have a Glasgow-Blatchford score documented. A postural Blood Pressure was not routinely documented as a standard component of the clinical assessment for a patient with a suspected UGIB. A recommendation to ensure that full documentation for postural blood pressure and glasgow-blatchford score should be completed for all patients presenting to the Emergency Department with UGIB.
Audit of implant-based breast reconstructions in breast cancer patients at West Middlesex University Hospital	Sixty-six patients underwent immediate implant-based breast reconstruction. The age ranged from 34 to 73 years. • 52 (78.8%) patients had unilateral • 4 (21.8%) had bilateral reconstructions • 18 (27.3%) patients received neo adjuvant chemotherapy and 22 (33.3%) patients had adjuvant chemotherapy. • 29 (44%) patients had adjuvant radiotherapy. Prophylactic antibiotics were administered in all patients during induction, but accurate antibiotic usage data in the post-operative period was unavailable. Complications were noted in 24 (36.4%) patients, infection / cellulitis – 12 (50%), seroma – 10 (42%), wound breakdown – 2 (8%). The implants could not be salvaged in 13 patients (19.7%) of whom 2 were bilateral. There has been a total of 15 implant losses (18.75%) which is significantly higher than the BAPRAS guidelines of 5% at 3 months. The recommendations from this audit is to introduce a protocol for patient selection, antibiotic usage and a post-operative treatment.
Management of allergic reactions in paediatric oncology patients receiving blood products and chemotherapy	A total of 31 paediatric shared care oncology notes were audited. The results revealed that only 12 patients received chemotherapy, blood products, immunoglobulins and albumin. 6(50%) of these patients had allergies reactions recorded. One patient had anaphylaxis order set pre-prescribed. Recommendations from this audit includes ensuring: • anaphylaxis order sets should be prescribed for all paediatric oncology patients receiving blood products and chemotherapy • introduce an additional tick box at the bottom of the chemotherapy proforma • educate doctors in the department • check compliance by re-auditing
An audit of Adult Total Parenteral Nutrition (TPN) use at Chelsea and Westminster Hospital site	The audit revealed a decrease in inappropriate TPN prescriptions and the number of patients on TPN for 5 days or less. The introduction of a gastroenterology consultant on the TPN ward round has improved TPN prescription, by rationalising indications for TPN use, and the phasing out of the out of hours TPN initiation.
Audit of Presentations of neutropenic sepsis	The audit revealed that 40% of patient presented with fever met the criteria for neutropenic sepsis with most attending the Emergency Department out of hours. Assessment and Risk stratification were not completed for all patients meeting the criteria at 0 hour and 48 hours. 70% of the case received IV antibiotics within 1-2 hours as per guideline. Recommendations from this audit is to raise awareness of assessing patients that meets the neutropenic sepsis at 0 and 48 hours and to ensure all relevant patients received IV antibiotics within 1-2 hours. The introduction of a newly designed proforma to ensure adherence to the guidelines is now in place and a re-audit is planned to assess compliance.

Local Clinical Audits	Summary and agreed actions arising from local clinical audits
Sedation & MRI Audit	A retrospective audit of 23 paediatrics notes who underwent MRI. The audit revealed that 66% had no documented clinical examination/history or medication history recorded. 78% had no physical examination recorded. 15% had no fasting documentation 25% had no record of consent. 100% had allergies recorded. 45% had no documentation of O2 saturations during MRI. The outcome of this audit has resulted in the introduction of a Paediatrics Sedation Guideline. Awareness raised with all clinical staff regarding the documentation of all clinical assessments and monitoring after a sedated MRI.
Audit of Tuberculosis (TB) screening process in children	Seventy-seven cases were audited, a total 64 patients were referred due to TB contact and the remainder for pulmonary contact. 4 patients had not received the Bacillus Calmette–Guérin (BCG) vaccine. The overall screening process was in line with NICE guidelines and patients were seen in a timely manner. The recommendation is for a re-audit after local TB policy is reviewed and updated to reflect the changes in the latest updates of the NICE TB Guidelines.
Audit of Induction of Labour (IOL)	The number of inductions for a three months audit period was 27.6% Birth outcome data: SVB 46.5%, Kiwi/Vent 13.5%, Forceps 11% and EMCS 29%. The audit revealed that the community midwives are almost consistently documenting their discussion regarding IOL and the appropriate Indications for IOL most of the time. Inductions were performed at recommended gestations. Recommendations includes the review of antenatal pathway for IOL. To improve documentation of discussion in patient notes by all healthcare professionals and review and update the IOL guidelines including booking process.
An audit of the process of consent in chronic groin pain after inguinal hernia repair	The outcome of this audit resulted in the implementation of leaflets explaining the risks of procedure during the consent process. An education session on chronic groin pain was held for clinical staff and to raise awareness of documenting the management of post-operative pain after inguinal hernia repair. Re-audit of notes to re assess implementation and effect.
Improving length of stay for elective total hip replacement patients	Following implementation of the action plan from the previous audit. A period of re-audit was undertaken to include all elective total hip replacement patients listed for a period of 4 months. Key improvements were noted in the mean length of stay (reduce from 4.6 to 3.8) and number of patients stay less than 3 days rose from 42.6% to 65.2%. A recommendation to maintain the improvements and to consider updating the Trust's enhanced recovery programme.
An Audit Investigating the Completion of 'Do Not Attempt Cardio-Pulmonary Resuscitation'(DNACPR) Orders at West Middlesex University Hospital	The audit of DNACPR forms was carried out across several wards. The majority were completed appropriately, documenting patient and family involvement. This included decisions to withdraw or cancel DNACPRs. The incomplete forms were mainly due to the patient's consultant not countersigning the form in a timely manner and mental capacity assessments not fully documented. The audit results were disseminated to all clinical staff to raise awareness of the importance of fully completing all sections of the form and a re-audit is planned.
Audit of Outcomes for Bilateral Tubal Ligation (BTL)	Forty-four sets of patient notes were audited, the audit revealed that some patients were not being sufficiently counselled regarding other options, failure rate of BTL and given sufficient time to make decision. The audit highlighted some inconsistencies in consent process and not all risks quoted in line with guidance. Recommendations are to develop a local guideline to include patient information leaflet. A re-audit is planned after implementation of local guideline to assess compliance.

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

6,595 patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 were recruited during that period to participate in research approved by a research ethics committee.

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 staying abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

The Trust was involved in conducting 290 research studies in 2017/18 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. The improvement in patient health outcomes demonstrates the Trust's commitment to clinical research which leads to better treatments for patients.

120 Trust staff members participated in research as principal investigators for research studies approved by a research ethics committee at the Trust during 2017/18.

In the last three years, 1,082 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.

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

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

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

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 CQC and its current registration status is 'fully registered'. The Trust has 'no conditions' on registration. The CQC has not taken enforcement action against the Trust during 2017/18. To find out more about the CQC visit www.cqc.org.uk.

The Trust has not participated in any special reviews or investigations by the CQC during 2017/18.

Secondary Uses Service (SUS) information

The Trust submitted 1,426,879 records during Apr 2017–Mar 2018 to the SUS 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

	2017/18	2016/17	National Performance		
	Chelsea and Westminster Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust	Worst	Best	Mean
A&E	97.4%	91.6%	DNP	DNP	96.7%
Outpatients	97.2%	94.0%	DNP	DNP	99.5%
Admitted patient care	96.8%	97.0%	DNP	DNP	99.3%

General medical practice code

	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	National Performance		
			Worst	Best	Mean
A&E	97.1%	99.8%	DNP	DNP	99.0%
Outpatients	99.9%	99.9%	DNP	DNP	99.8%
Admitted patient care	99.4%	99.9%	DNP	DNP	99.9%

Information governance toolkit attainment levels

Information governance concerns the way organisations process or handle information. It covers information relating to patients and staff as well as corporate information and helps ensure the information is handled appropriately and securely.

The information governance toolkit is an online self-assessment tool 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 across six main areas (see table below). The toolkit sets out specific criteria that enable 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. Level 2 for all 45 requirements needs to be achieved to get to 'satisfactory' status.

The Trust information governance assessment report overall score for 2017/18 was 71% and was graded green (satisfactory). Last year's assessment for the toolkit was changed to satisfactory with improvement plan following audit. For more information about the information governance toolkit please visit www.igt.hscic.gov.uk.

IG Toolkit v14.1 Assessment scores 2017/18

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade
Information Governance Management	0	0	3	2	5	80%	Satisfactory
Confidentiality and Data Protection Assurance	0	0	9	0	9	66%	Satisfactory
Information Security Assurance	0	0	15	0	15	66%	Satisfactory
Clinical Information Assurance	0	0	4	1	5	73%	Satisfactory
Secondary Use Assurance	0	0	5	3	8	79%	Satisfactory
Corporate Information Assurance	0	0	3	0	3	66%	Satisfactory
Version 14.1 (2017-2018) - Overall	0	0	39	6	45	71%	Satisfactory

Clinical coding error rate

The Chelsea and Westminster Hospital site was not subject to the payment by results clinical coding audit during 2017/18.

The West Middlesex University Hospital site was not subject to the payment by results clinical coding audit during 2017/18.

Data quality

The Trust has been/will be taking the following action to improve data quality:

- External audits from KPMG, NHSI and Deloitte. Key themes and actions from these audits are fed in to the data quality steering group for ongoing monitoring and oversight and form a key part of the 2018/19 work plan.
- Validation or RTT data is undertaken by the performance team at C&W and the RTT validation team at WMUH.
- The EPR programme has funded full investigation in to the WMUH data as part of the data migration work stream. This has uncovered issues that are being fed in to the project governance and will form part of the data quality work plan for 2018/19.

- Establishment of a data quality team is underway with the Deputy CEO as the executive lead.

- Data quality steering group will be reviewing and republishing the data quality policy.

- A data quality dashboard has been procured to monitor and enforce correct system usage at both sites. Where retraining is required, this will be highlighted to the relevant line manager. This is especially key for the EPR go-lives.

- Known data quality issues should be logged by the performance team/data quality 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. Data quality issues that are chronic will be tackled by ad-hoc temporary staff as to not impact operational activities.

Learning from deaths

During 2017/18 1,329 patients died at the Trust. This comprised the following number of deaths in each quarter of that reporting period:

- 289 in Q1
- 294 in Q2
- 352 in Q3
- 395 in Q4

By 12 Apr 2018, 777 case record reviews and 16 investigations have been carried out in relation to the 1,329 deaths.

In 16 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 236 in Q1
- 219 in Q2
- 201 in Q3
- 121 in Q4

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0% for Q1
- 0 representing 0% for Q2
- 0 representing 0% for Q3
- 0 representing 0% for Q4

These numbers have been estimated following case record review (777 cases) and root cause analysis (16 investigations). The impact of problems in care provision is graded using the classification system initially developed within the Confidential Enquiry into Stillbirth and Deaths in Infancy (CESDI).

CESDI outcome grading system:

- **Grade 0:** Unavoidable death, no suboptimal care
- **Grade 1:** Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **Grade 2:** Suboptimal care, but different care *might* have affected the outcome (possibly avoidable death)
- **Grade 3:** Suboptimal care, different care *would reasonably be expected* to have affected the outcome (probable avoidable death)

No deaths within this reporting period were categorised as CESDI grade 3.

Excellent clinical care is provided to the majority of patients who die at Chelsea and Westminster Hospital NHS Foundation Trust, however areas for improvement are identified via the case record review process. Key themes for improvement identified via this route include:

- The recognition, escalation and response to deteriorating patients
- The establishment of and ongoing communication with patients and their families regarding ceilings of care
- The timely transportation of patients between Trust sites and other organisations

Where case record review or investigation identified potential areas for improvement individual actions plans are developed to support monitor change delivery. Learning from case record review is scrutinised by the organisations Mortality Surveillance Group (MSG). During this reporting period the MSG has initiated the following organisation wide actions to support learning and improve outcomes:

- Triangulated learning from mortality review and incident investigation
- Examined timeframes (days/hours) where provision of care has been concluded to be less than optimal for dying patients—information used to support review of service provision
- Expanded provision of specialist palliative care services
- Expanded provision of clinical site management and senior house officers
- Revised handover arrangement
- Introduced safety huddles within maternity
- Developed guidance to support transfer between the special care baby unit and paediatric ward
- Reviewed and relaunched the Early Warning Score Policy
- Initiated multiple channels of communication to cascade learning from deaths to all staff

The following actions are proposed to be undertaken within 2017/18:

- Thematic review of cases involving the availability of interventional radiology
- Thematic review of hospital transfers and audit of the organisations transfer policy

The impact of the case record review process and the associated improvement actions can be assessed using the Hospital Standardised Mortality Ratio (HSMR). On 6 Apr 2017 the relative risk of mortality at the Trust between Jan 2017 and Dec 2017 was 79.1 (74.7–83.6) which is below the expected range—this is below the expected range. 10 consecutive months of low relative risk, where the upper confidence limit fell below the

national benchmark, have been experienced between Mar 2017 and Dec 2017. This represents a step change improvement in the relative risk of mortality within the Trust.

290 case record reviews and 9 investigations completed after 1 Apr 2017 which related to deaths which took place before the start of the reporting period.

1 case review/investigation outlined in section 27.7 (representing 0.08% of total deaths in 2016/17) was judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated following case record review (290 deaths occurring in 2016/17 but care record reviews completed within 2017/18) and root cases analysis (9 deaths occurring in 2016/17 but root cause analysis investigation completed within 2017/18).

3 deaths representing 0.24% of the patient deaths (during the previous reporting period) are judged to be more likely than not to have been due to problems in the care provided to the patient.

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 'data not published' (DNP).

West Middlesex University Hospital information shown for the 2015/16 period is from Apr–Aug 2015. The Trust information shown is five months of Chelsea and Westminster Hospital only (Apr–Aug 2015) and seven months of Chelsea and Westminster and West Middlesex hospitals combined (Sep 2015–Mar 2016).

Core indicators

Summary hospital level mortality indicator (SHMI)

	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust	National Performance		
			Worst	Best	Mean
Summary hospital level mortality indicator ("SHMI")	0.8 (better than expected)	0.8 (better than expected)			

(SHMI period Jul 2016–Jun 2017)

The Trust considers that this data is as described for the following reasons:

- The Trust maintains good performance with regards to mortality and has seen a sustained steady improvement in the key national indicators which compares performance with peers—HSMR and SHMI.

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

- Mortality surveillance and assurance is provided through scrutiny and analysis of information both from internal mortality reviews and SIs and from external data and potential alerts from HES, NHS Digital, SHMI and Dr Foster.

- A dedicated bespoke mortality review module has been developed within the Datix Safety System and feeds information to clinical teams to prompt specialty mortality reviews and learning.

- Learning system—the module supports and provides a single repository for all in-patient deaths providing a platform for the recording and analysis of consultant led-reviews, and any adverse findings trigger further action plans/learning and more in-depth reviews if required.

- Trends or themes identified at the Mortality Surveillance Group are listed for further investigation or review within the Trust Mortality Management Plan.

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

	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust	National Performance		
			Worst	Best	Mean
Percentage of patient deaths with palliative care coded	31.5%	32.0%			

The Trust considers that this data is as described for the following reasons:

- The ongoing 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 Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Better established palliative care teams on both sites
- Recording palliative care team contact in the health record.

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 Apr 2016 to Sep 2017, national scores

have not been published nationally for this period at the time of writing the report. For 2017/18 there are insufficient responses from C&W and WMUH 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.

	2016/17	2017/18	National Performance		
	Chelsea and Westminster Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust	Worst	Best	Mean
Readmission (28 days) (0-15) (P00902)	1.7%	2.3%	-	-	-

The Trust considers that this data is as described for the following reasons:

- The readmission rate on both sites, although showing a slight increase for 2017/18, 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 Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Both hospital sites have senior paediatric medical cover in line with the RCPCH guidelines from 8am–10pm, 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 (PAU) model was introduced at the WMUH site in 2015/16 and this had a positive impact on the readmission rate during 2016/17. The pathway has since been further refined and the introduction of Paediatric Consultants in Emergency Medicine to the ED Department has also had a significant positive impact on the acute pathway.
- On both sites there are protected rapid access slots in outpatients which enable ongoing 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.

	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust	National Performance		
			Worst	Best	Mean
Readmission (28 days) (16+) (P00902)	6.1%	7.2%	-	-	-

The 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 and actions identified to address them

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

Readmissions audit

- An audit was undertaken looking at sample of patient cases where a readmission had occurred within 30 days. The findings showed that about 40% of the sample were readmitted with a different medical reason and were seemingly unavoidable. Around 10% were already known to social services and this has prompted further consideration of how we can improve pathways with social services and community partners for this cohort of patients—for example, the Red Bag scheme for care home residents. There was also a cohort of patients, around 10–15% of the audit, where the readmission related to a transfer or care, or where the patient returned to an acute observation area. This has prompted discussions with commissioners about how these attendances and transfers are recorded.

Patient flow and discharge initiatives

There are a number of initiatives which have been coordinated via the Bed Productivity programme board which have aimed to improve readmission rates:

- **Red to Green days:** The initiative is now fully rolled out across our main downstream wards (medical and surgical). It provides daily identification of issues causing delays to care delivery and discharge, allowing action to be taken by the ward MDT or to be escalated for support.

- **Ambulatory Care:** For 2018/19 there will be a continued focus on enhancing the ambulatory care services.

- **7-day therapies:** Following successful pilots, 7-day therapies provision for medical rehabilitation teams has commenced on both sites. This enables timelier therapies intervention and discharges across a 7-day period, enabling earlier discharges and reducing the time to be seen by the therapies team.

- **Home First:** A discharge to assess pathway aim to discharge patients when medically fit allowing for therapies and social care/reablement assessments to take place in the patient's home. The benefits are seen to be reducing length of stay, and also reducing the care needs once assessed in the patient's own environment which it is hoped would impact on readmission rates.

- **Expansion of the discharge team:** This includes the introduction of a B4 discharge assistant role assigned to wards to support discharge planning and ensure timely discharges.

Responsiveness to personal needs (Table needs updating)

	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

Commented [JS(1]: Table to be updated
2017/18
Trust 66%
National
Worst 66%
Best 96%
average 71%

The patient survey results for 2016/17 were published in February 2018. There are a number of actions underway to improve survey results across the board.

The 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 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 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 Inpatient Action Plan 2018/19 is in development with staff which will be continuously monitored alongside the Friends and Family Test, and will incorporate any recommendations from the CQC report.
- The patient experience group reviews the survey results along with other key metrics. Divisional leads are responsible for taking forward actions within their areas and reporting back to the Trust Patient Experience Group.
- Divisional patient experience metrics are in place and there is emphasis on staff engagement, to share good practice but also improve on the negative themes from results.

Staff recommending our Trust

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

Commented [JS(2]: This is in the text but table to be updated.
2017/18 Trust = 78% against a national performance of 71%

The 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.

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

- As a result of the findings of the 2016 staff survey the Trust implemented a two-year staff experience action plan which was devised in conjunction with staff who were invited to a series of focus groups. This plan is broken down into eight areas of focus, with a number of specific actions within each of these.

- In 2017 we have seen an increase in staff response to the questions relating to staff recommending the organisation as a place to work or receive treatment. For these questions there has been an increase of 5% meaning that 69% of staff would now recommend the Trust as a place to work (against a national average of 61%), and 78% of staff would recommend the Trust as a place to be treated (against a national average of 71%).

Venous thromboembolism assessment

	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust	National Performance		
			Worst	Best	Mean
Percentage of admitted patients risk assessed for VTE	93.0%	86.1%			

The 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 at both hospital sites for 2017/18, however audit demonstrates that patients are receiving appropriate prophylaxis.

- At WMUH, VTE risk assessment performance is unlikely to improve due to current IT infrastructure which does not support VTE risk assessment processes

- There is monitoring of VTE risk assessment completion rates with circulation of performance reports to divisions to address and target areas to improve performance

- Audits on whether patients at-risk of VTE are prescribed appropriate pharmacological and mechanical thromboprophylaxis (if indicated), unless contraindicated, are performed on a quarterly basis by pharmacy staff. Over 90% of patients at risk of VTE are prescribed appropriate thromboprophylaxis. Feedback on appropriate pharmacological and mechanical thromboprophylaxis is disseminated to divisions/clinical leads.

The Trust has taken the following additional 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

WMUH site
- The VTE steering group explored changes to the VTE risk assessment on RealTime with a full review and options appraisal, however deemed not feasible as resources were allocated to Cerner project

- VTE risk assessment performance is unlikely to improve until Cerner implementation as the current IT infrastructure does not support VTE risk assessment processes

- Collaboration with the information team to introduce VTE risk assessment performance reports (by division and ward) to feedback on completion rates in a timely manner for divisions to address performance

- Introduction of a pathway for hospital associated VTE events (identification and reporting) and root cause analysis investigation via radiology alerts and Datix system. Learning from VTE/anticoagulation incidents and hospital associated VTE events is shared among staff/departments.

VTE effectiveness at both sites
- The Thrombosis and Thromboprophylaxis Group is delivering the local VTE prevention programme across both sites

- The Trust passed the revalidation process and retained ‘VTE Exemplar Centre’ status by the NHS VTE Exemplar Centre Network, via NHS England, for its delivery of the local VTE prevention programme at both hospital sites. There are 28 VTE Exemplar Centres in England and Wales, of which the Trust is one of four London trusts with ‘VTE Exemplar Centre’ status. As part of the VTE Exemplar Network, the Trust has been recognised for the provision of quality VTE prevention measures, working with the patient safety collaboratives to drive improvement, and contribution to the national VTE prevention programme working to reduce avoidable harm and improve outcomes for patients.

- Harmonisation of cross site anticoagulation/VTE guidelines (more than 20 clinical guidelines) including bespoke anticoagulation pocket guides covering VTE prevention and treatment

- Introduction, harmonisation and standardisation of VTE pathways in clinical settings
- Delivery of a local strategy to manage the global shortage of Clexane® (low molecular weight heparin) affecting adult patients who require VTE prevention or treatment
- Anticoagulation incidents are reviewed for both sites with education provided to departments and any changes to practice to prevent future recurrence
- Ongoing VTE awareness and education provided to medical, nursing/midwifery and pharmacy staff
- Ongoing developments to standardise VTE mandatory training for junior medical staff across both sites
- VTE training standardised for nursing/midwifery and pharmacy staff across both sites
- VTE audits performed to assess clinical practice with feedback to relevant stakeholders/departments, with improvement action plans in place
- Haematology/pharmacy staff continue to work across both sites to standardise VTE services, and deliver the VTE agenda via Thrombosis and Thromboprophylaxis Group

C.difficile occurrence

The nationally published data on *C.difficile* is in terms of absolute number, not in terms of per 100,000 bed days, and so we have no national comparators to include.

	2016/17	2017/18	National Performance		
	Chelsea and Westminster Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust	Worst	Best	Mean
C.difficile occurrence per 100k bed days. (P01792)	4.2	1.2			

The Trust considers that this data is as described for the following reasons:

- The numbers of cases of *C.difficile* infection (CDI) and the rate per 100,000 bed days has fallen year-on-year between 2007/08 and 2017/18.

The Trust has taken the following actions to improve this indicator, and the quality of its services, by:

- Harmonising the Trust policy on the management of diarrhoea across both hospital sites
- Proactive antimicrobial stewardship programme
- Patients to be isolated in a side room within 2 hours of onset of diarrhoeal symptoms with enhanced daily cleaning

- Staff to adhere to strict hand washing with soap and water, rather than the use of alcohol hand rub, when attending cases of diarrhoea

- Availability of handwipes 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

- Ongoing training of staff and auditing of practice as set out in the Department of Health high impact interventions

- A root cause analysis (RCA) of each case is undertaken by senior medical and nursing staff caring for the patient, and development of an action plan to address lessons learned which are monitored at the quality and risk meetings

- The outcome of RCAs are reviewed by the Infection Prevention and Control Group

- The use of *C.difficile* packs at both sites to aid early medical review and reduce the number of inappropriate specimens sent

NHS Improvement has set the CDI case objective for 2018/19 as **15**, and the CDI rate objective for 2018/19 of **4.9**, compared with an annual objective of 16 cases in 2017/18.

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		C&WFT	Lowest scoring hospital	Highest scoring hospital
Oct 16–Mar 17	Number	4,507	1,301	14,506
	Rate per 1000 bed days	29.18	23.13	68.97
Apr 17–Sept 17	Number	4,361	1,133	15,228
	Rate per 1000 bed days	29.16	23.47	111.69

Number and % of patient safety incidents that result in severe harm or death		C&WFT	Highest scoring hospital	Lowest scoring hospital
Oct 16–Mar 17	Number	19	92	1
	%	0.42	1.1	0.02
Apr 17–Sept 17	Number	7	121	0
	%	0.16	1.97	0

The Trust considers this data is as described for the following reasons:

- All staff at the Trust are reminded through a number of different channels (for example, induction, safety meetings) that all incidents must be reported on the local incident management system, Datix

- All incidents reported on Datix are investigated by the clinical team and then quality checked and reviewed by the Quality and Clinical Governance department prior to upload to the NRLS

- All patient safety incidents are uploaded to NRLS within the required timeframe

The Trust has taken/will be taking the following actions to improve this rate and so the quality of its services by:

- Efforts to embed the Datix incident reporting system throughout the organisation continue with an ongoing programme of training and awareness raising. Clinical governance present at meetings—this includes senior nursing and midwifery quality rounds, team briefings, divisional away days and quality boards

- Patient safety incidents continue to be reviewed on a daily basis by the Quality and Clinical Governance department who escalate or take appropriate action when necessary

- Serious incidents are investigated and the findings used to inform learning and quality improvement

- Investigation reports continue to be reviewed at both local level through morbidity and mortality meetings or quality meetings and also at Board level via the monthly serious incident report which is also disseminated widely throughout the organisation

- The divisional quality boards include incident reporting as a standing item on the agenda as part of the ongoing work to continually improve reporting rates

- A quarterly incident report summarises incident investigations, pulls out themes and learning and also identifies any trends in incidents. This report is disseminated throughout the organisation

Part 3: Other information

Performance indicators

During 2017/18, the Trust has performed very well against the key regulatory and contractual performance metrics, including quality and workforce KPIs. The start of the financial year was challenging in the delivery of all three regulatory standards but during the year compliance has shown continuous improvement. Of particular note is the Trust's continued strong performance in delivering A&E, RTT and Cancer access standards, despite unprecedented demand during Q3 and Q4. Below is a summary of some of our key performance indicators for 2017/18. 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 www.chelwest.nhs.uk.

NHS Improvement risk assurance framework

The table below summarises the performance indicators for the Trust.

	Target 2017/18 Combined C&W and WM	Performance 2017/18— combined year end position
Incidents of Clostridium difficile	16	4
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%	89%
Cancer: two week wait from referral to date first seen comprising all cancers	93%	94%
Referral to treatment waiting times <18 weeks - Incompletes[19]	>92%	92%
A&E : Total time in A&E <=4hrs	95%	94%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes	Yes

Seven Day Services

The Trust is implementing the priority clinical standards for seven day hospitals by focusing on delivering best value for patients and the system.

The Trust has complied with the national requirements to audit Seven Day Services. We have seen a large improvement in the patients in downstream wards receiving appropriate review, and we have consistently performed well on:

- Initial review and ongoing review in high dependency areas.
- Acute medicine consultants provide twice daily ward rounds

- Working closely with our colleagues across North West London, we tested new models of care with a focus on delivering better flow and the four national priority clinical standards for Seven Day Service
- The Trust has acted as an exemplar across North West London and, as part of the seven day services programme we have been engaging in pilot studies in:

Frailty
- Dedicated unit for frail patients
- Specialist frailty team for patients at risk of functional deterioration

Therapy
- Additional therapy resource at weekends to reduce functional deterioration, improve patient outcomes and minimise delays in treatment and thereby discharge
- Evidence generated from pilots was subsequently used to inform implementation

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 patients 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. In addition, falls and complaints have been reported as a quality priority. 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

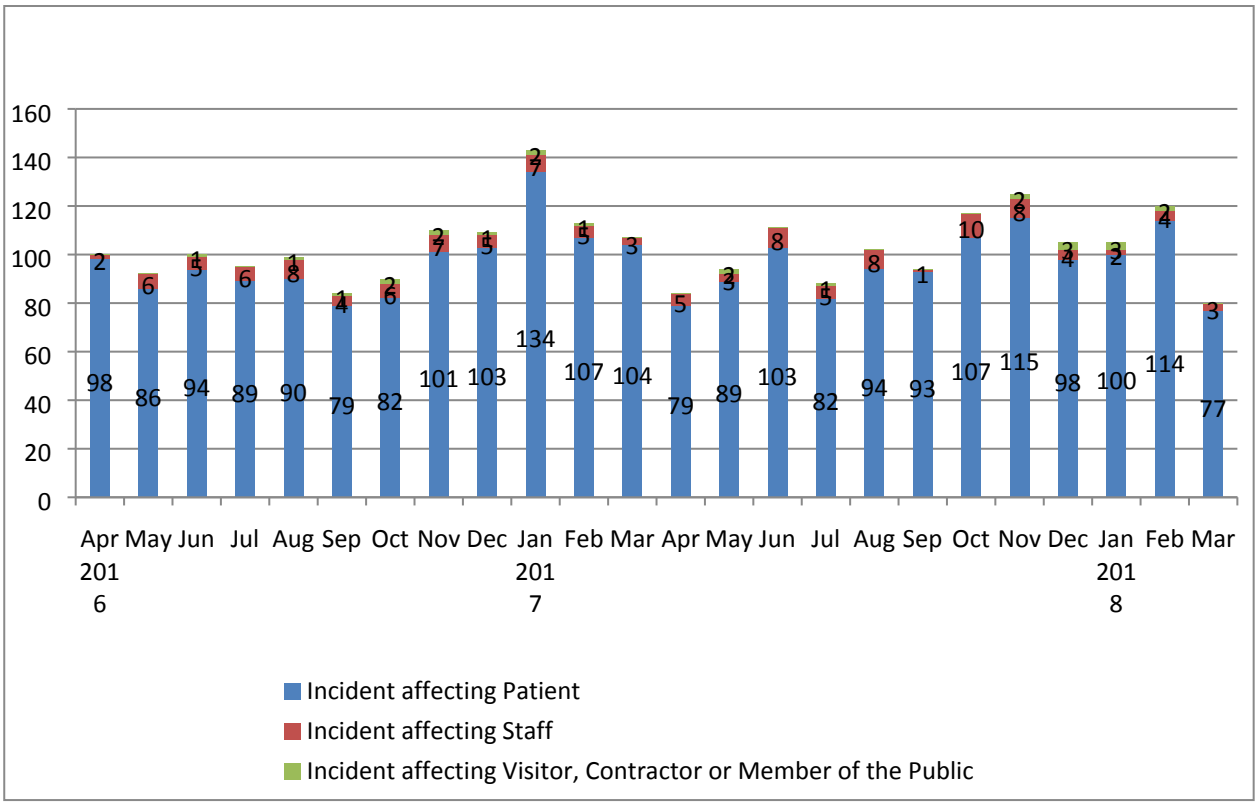
Prevention of hospital acquired pressure ulcers is crucial to the prevention of harm agenda and has remained a focus for the Trust in 2017/18. The table below provides an overview of the number of incidents reported on the Trust's incident reporting system on both sites during 2017/18 compared to the previous two year's data. This data shows that there has been sustained improvement with a further decrease in the volume of grade 3 and 4 pressure ulcers reported in 2017/18. There has been a further 20% reduction in grade 2 hospital acquired pressure ulcers. The focus in 2018/19 will be to continue to ensure timely accurate reporting. The Trust continues to be engaged in work with NHS Improvement on the prevention and reduction of pressure ulcers across hospital and community.

	2015/16 West Middlesex University Hospital NHS Trust	2015/16 Chelsea and Westminster Hospital NHS Foundation Trust	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust
Grade 3 & 4 reported as Serious incidents	23	26	21	13
Pressure ulcers (grade 2,3 & 4	199	205	291	229
Pressure ulcers (grade 2,3 & 4 including community acquired)	1072	792	1770	1160

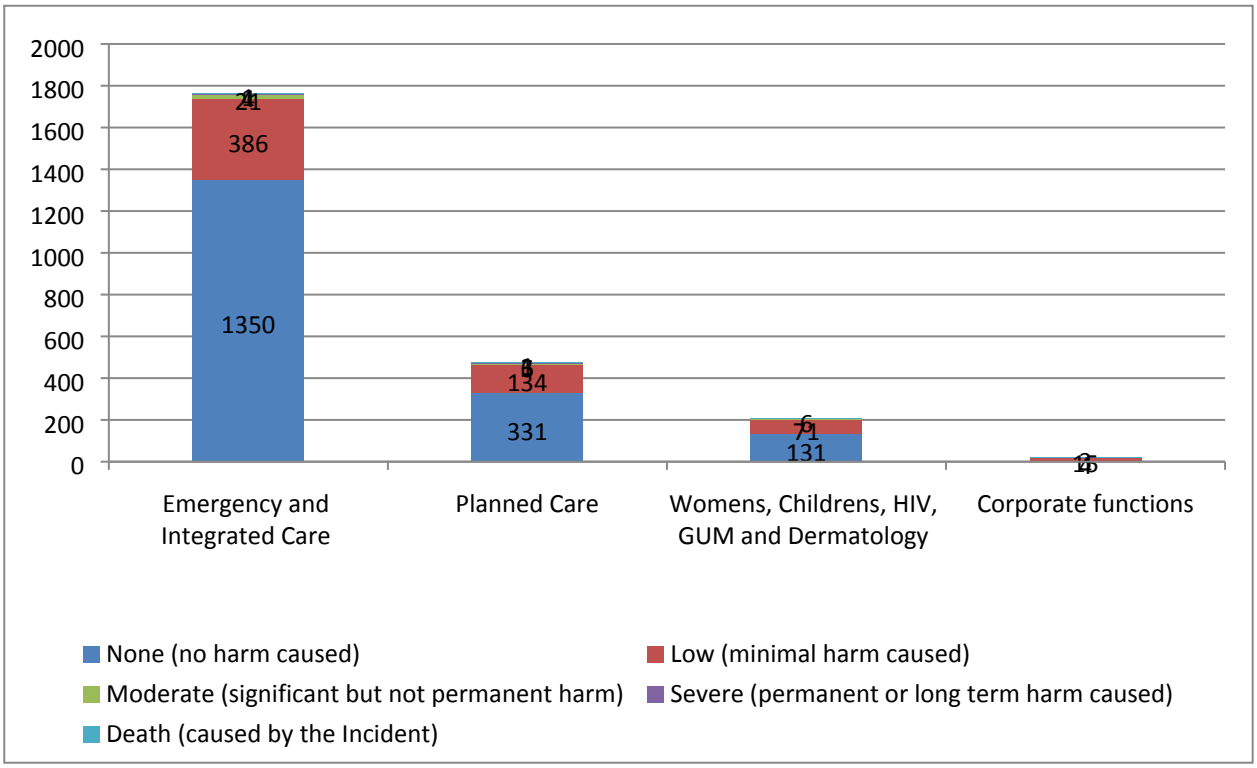
Falls

Falls are another indicator covered by the prevention of harm agenda and as such were a quality priority for 2017/18 and will continue to be for 2018/19. Progress on agreed metrics is reported under the section on quality priorities. The prevention of avoidable falls remains a high priority for the Trust. Graphs 1 and 2 provide an overview of the falls reported on the Trust's incident reporting system. The Trust continues to have a below national average for falls with harm, however there are too many preventable falls occurring. Graph 3, which is taken from the safety thermometer data, shows the national median is 1.68, the median at the Trust is 1.37 below the national position. 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 2018/19 are detailed in the Quality Priority Section of this report.

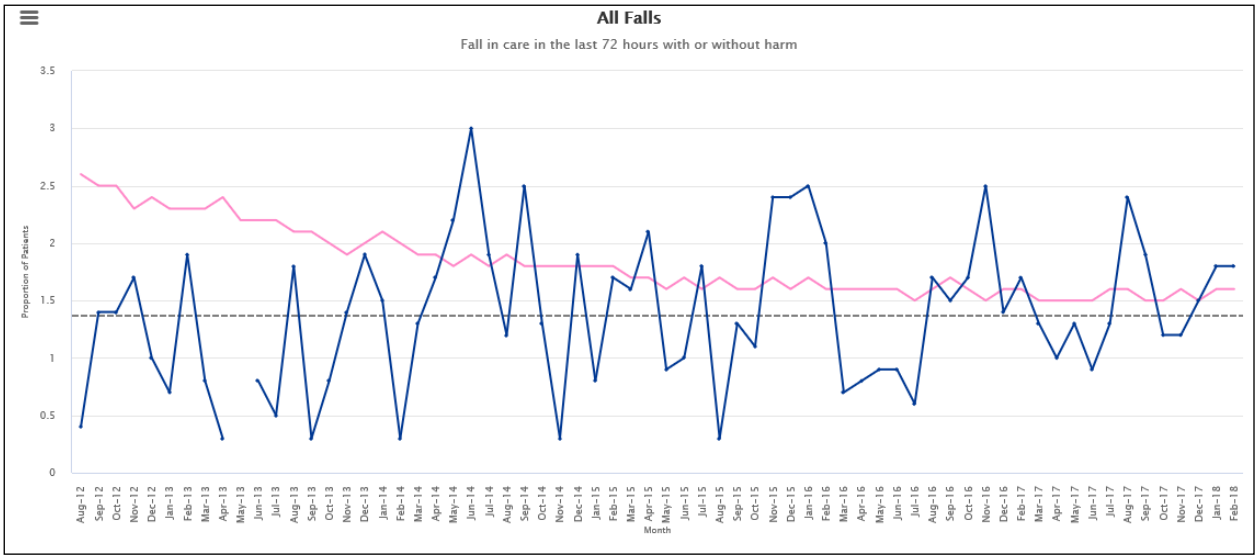
Graph 1: Total falls at the Trust



Graph 2: Degree of harm by division 2016–18



Graph 3: Safety thermometer, total falls at the Trust



Clinical effectiveness and patient experience

A&E performance

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 and Westminster only met 94.3%, this is in no way reflective of

the efforts of our staff. Demand has increased by about 9.4% compared to 2016/17 and the Trust is in the upper decile nationally in terms of overall performance.

	2016/17	2017/18	National Performance		
	Chelsea and Westminster Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust	Worst	Best	Mean
A&E/UCC Patient stay in A&E less than 4 hours all types	92.4%	94%			88.4

RTT

Throughout 2017/18, the RTT performance has been increasing and from Nov 2017, the aggregate performance has been compliant with the national 92% standard. Q4 represented the best performance since the merger of the two sites in Sep 2015 which is significant given the challenges the organisation faced with non-elective demand. During 2017/18, there were no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue into 2018/19.

Our performance in relation to the 62-day cancer GP referrals to first treatment standard has been excellent during the year, with two months being the number one performing Trust in the UK (Nov 2017 and Jan 2018). Our compliance with the 2-week wait standard has also been excellent. Both of our sites have experienced significant growth in demand with increased referrals compared to 2016/17 yet the organisation has responded well to deliver timely care for our patients.

	2016/17	2017/18	National Performance		
	Chelsea and Westminster Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust	Worst	Best	Mean (Q3 YTD)
18 Week RTT	91.8%	91.5%			89.5%
Cancer 2 wee waits	92.0%	93.8%			94.2%
Cancer 31 days diagnosis to treatment	99.0%	99.1%			97.6%
Cancer 62 days referral to treatment	87.1%	89.4%			82.1%

Patient experience

The final inpatient CQC patient survey is not included in this report as it is not finally published until June 2017; the Trust has the initial high-level data which it has used in this report.

Complaints and safeguarding training

Complaints and FFT have been reported on in the Quality Priority section.

Safeguarding training remains a key quality indicator for the Trust. Despite challenges of high turnover and IT issues which led to difficulties in accessing online training, Adult

Safeguarding Level 1 has achieved 90% compliance, Children's Safeguarding Training Level 1 is currently at 88% but was at 90% for most of the last quarter. Both adult and children's training content is reviewed at least annually to ensure it is relevant, up-to-date and in line with national and pan-London guidance. We are awaiting the publication of the final collegiate document for adult safeguarding. Following a deep dive into both adults and children's safeguarding in Q3 2016/17 we have continued to work through our action plan with our CCG partners and designated professionals. Our policy and training incorporate domestic abuse, CSE and MSE as well as PREVENT.

	2016/17 Chelsea and Westminster Hospital NHS Foundation Trust	2017/18 Chelsea and Westminster Hospital NHS Foundation Trust
Complaints responded to within 25 working days	32.0%	38.4%
Maternity Friends and Family Test (Post Natal response rate)	20.5%	18.7%
Safeguarding adults training	87.3%	90%
Safeguarding children's training	90.8%	88%

Other quality improvement indicators

Care Quality Programme

The Care Quality Programme (CQP) commenced as a Trust work stream in February 2017 and established a structure for continuous quality improvement in the Trust. Part of the programme was to ensure the Trust was prepared for the Care Quality Commission (CQC) inspection in 2017 and early 2018 using and embedded programme.

The programme is governed by a:

- Core team which determines the direction of the project, reporting to the Quality Committee and led by the Chief Nurse
- A steering group that includes, directors, managers and clinical leads who provide oversight and leadership to the introduction of the CQP programme
- A reference group leading local initiatives supporting the operational objectives of the project in clinical areas

From Jan 2018 the CQP is continuing to lead quality improvement to maintain a dynamic quality programme to enhance patient care and staff experience in the Trust. The objectives of this programme are in line with the Trust's strategic and quality priorities.

Ward and department accreditation

The Trust started a process of peer review led by the Chief Nurse using an assessment tool similar to the CQC framework. From summer 2016 to Dec 2017 the Trust undertook the first accreditation cycle and a new system of peer reviews in 66 clinical areas. The grading awarded is now displayed on the quality board in each clinical area. The final results for the first year of accreditation were:

Gold	2 areas
Silver	31 areas
Bronze	28 areas
White	1 area

A further 4 areas had been reviewed with a similar peer review process aligned with the accreditation scheme and these graded in a different mode.

The gradings ranged from white to gold as outlined in the table below:

Gold	Achieving highest standards with embedded evidence in data
Silver	Achieving minimum standards and above with evidence in improvement data
Bronze	Achieving minimum standards with some improvement work underway
White	Not achieving minimum standards and no evidence of active improvement work

Any actions requiring quality improvement during the accreditation visit are documented into the accreditation report to inform the work programmes of clinical teams. The actions are documented by priority in relation to staff and patient safety.

Over the next year further clinical areas have been added to the accreditation programme. The tool and process have been reviewed by staff members and has been updated to align closely with the CQC's framework for inspection.

Care Quality Commission (CQC) ratings

Prior to the integration in Sep 2015, the Chelsea and Westminster and West Middlesex sites were inspected separately by the CQC and both awarded gradings of 'Requires Improvement'. The sites both achieved 'Good' in the 'Caring' domain. HIV and Sexual Health Services at the Chelsea and Westminster site achieved an overall CQC rating of 'Outstanding'.

As part of the CQP, a workstream was developed to prepare the Trust for the first comprehensive CQC inspection since integration. This included inviting external partners from other hospitals, regulators, non-executive directors and governors to join our own hospital staff teams in reviewing the quality of care across the Trust.

These peer review visits used an assessment tool aligned to the CQCs fundamental standards of care. During 2017 and 2018, 4 cycles of these peer reviews were held across the Trust and the outcomes embedded in current live workstreams. As part of inspection preparations, the Trust has also engaged with NHS Improvement (NHSI) on key workstreams to address national challenges—for example, workforce, emergency care and planned care.

The CQP also launched a CQP Partner Link Programme to support staff engagement and provide staff with regular opportunities to talk to senior leaders of the Trust.

Every department in the Trust has been assigned a senior leader who visits the clinical teams on a regular basis.

Senior Nurses, Midwives and Allied Health professionals have also continued to meet weekly together to audit different areas of quality known as 'Quality Rounds'. These offer staff educational sessions from subject matter experts in addition to protected time to review practice in clinical areas.

Topics addressed during 2017/18 include quality for pressure ulcers, falls, monitoring deteriorating patients, safeguarding, medicines management, incident management and education and development issues.

The CQC completed a comprehensive inspection of the 'safe, effective, caring, responsive and well-led' domains across key services during Dec 2017 and a well-led inspection of senior leadership in the Trust in Jan 2018. This also included a review by NHSI inspection of the Trust Use of Resources. The Trust has been rated as 'Outstanding' for Use of Resources.

The specialties inspected at this time were, Urgent and Emergency services, medical care including older peoples care, surgery, services for children and young people, end of life care, neonatal, outpatients and diagnostic imaging.

The overall rating provided at the end of the inspections was that the CQC's ratings of the services in the Trust rose from 'Requires Improvement' to 'Good.'

The final report was published on 10 Apr 2018 and the following ratings awarded from the CQC 2017/18 inspections can be seen in the following tables:

Overall results for Chelsea and Westminster Hospital NHS Foundation Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chelsea and Westminster Hospital	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
West Middlesex Hospital	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Overall trust	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

Ratings for Chelsea and Westminster Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Good Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Surgery	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Critical care	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Maternity	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Jul 2014
Services for children and young people	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
End of life care	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
Diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
HIV and Sexual Health Services	Good Jul 2014	Not rated	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014
Overall*	Good ↑ Mar 2018	Good ↑ Mar 2018	Outstanding ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

Ratings for West Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Mar 2018	Requires improvement Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Medical care (including older people's care)	Requires improvement ↓ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018
Surgery	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Critical care	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Maternity	Requires improvement Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015	Good Nov 2015
Services for children and young people	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
End of life care	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
Diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall*	Requires improvement →← Mar 2018	Good ↑ Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018

Improvements in Medicines Management

Medicines Optimisation vs. Medicines Management

Medicines Optimisation differs from *Medicines Management* in that it focuses on outcomes for patients rather than processes and systems, putting the patient at the centre of all we do. However, underpinning systems for *Medicines Management* are required to make medicines use as safe as possible. The Trust has approved a *Medicines Optimisation Strategy* for 2017-2020 which provides assurance to the Trust Board that the principles of *Medicines Optimisation* are embedded within the Trust, not just within the policies and procedures relating to *Medicines Management* but in the ethos of how we deliver the best possible care to our patients, according to the Trust PROUD values.

The four guiding principles of *Medicines Optimisation* are:

- ***Principle 1*** – Aim to understand the patient's experience
- ***Principle 2***- Evidence based choice of medicines
- ***Principle 3*** – Ensure medicines use is a safe as possible *(Medicines Management)*
- ***Principle 4 –*** Make medicines optimisation part of routine practice.

Principle 3 – Ensure medicines use is a safe as possible *(Medicines Management)*

Aspiration	Implementation
• To provide patients and /or their carers with the information they need to take their medicines safely and so that they understand when to seek further advice about side effects of medicines.	• Clinical Pharmacists and Medicines Management Technicians counsel patents on how to take their medicines safely, with special attention on high risk medicines such as anticoagulants, antimicrobials, antiretrovirals or immune suppressants that require specialist monitoring. • Trust Medicines Helpline
• To effect the safe transfer of care	• Pharmacists work with medical teams to ensure that there is communication to GPs and Community Pharmacists about medication changes
• To provide Board assurance that all medicines related duties and responsibilities (Medicines Management requirements) are embedded within the Trust policies and procedures and are discharged	• Trust Medicines Policy Audit; • Trust Controlled Drug Accountable Officer Monitoring; • Medication Safety Officer role; • Medicines Optimisation training at induction and update for staff who handle medicines; • Trust Medicines Safety Group - review medication related incidents to identify trends and prevent reoccurrence; • Trust Homecare Medicines Group monitors the safety of Homecare medicines via Key Performance Indicators (KPIs)

Examples of measurement & monitoring:

- Trust Medicines Policy Audit 2017;
- Senior Nurse and Midwifery Quality Round - Safe Storage of Medicines Audits.

Trust Medicines Policy Audit 2017

Every two years an audit is undertaken to assess compliance with Medicines Policy standards for the safe and effective use of medicines. This is essential to demonstrate that the standards for Medicines Management are being maintained in practice. The 2017 audit was undertaken during July/August 2017 at the Chelsea and Westminster Hospital and West Middlesex University Hospital Sites.

Chelsea and Westminster Hospital Site

Overall, the results show that there is very good compliance with the Trust Medicines Policy for the majority of standards that were assessed in this audit.

- Of the 21/22 standards where it was possible to undertake an assessment of compliance, 90% (n=19) scored 90% or greater compliance. 76% (n=16) scored 100% compliance.
- Of the 20 standards where variance in compliance from the 2015 audit could be assessed, the compliance for 85% (n=17) either improved or remained static. Where the compliance remained static, 82% (n=9) of these standards continued to have 100% compliance.

Compliance to one of the prescribing standards relating to units being written in full decreased (e.g. write “puffs” for inhalers, “drops” for eye drops and “tablets” where the oral dose is routinely

prescribed in number of tablets e.g. senna) compared to the 2015 audit. This standard scored 100% when compliance was determined using electronic medication charts only. The result was lower when the score for paper charts was incorporated in the overall results, demonstrating a very high level of compliance when electronic prescribing is in operation.

West Middlesex University Hospital Site

Overall, the results show that there is good compliance with most of the aspects of the Trust Medicines Policy for the majority of standards that were assessed in this audit.

- Of the 21/22 standards, where it was possible to undertake an assessment of compliance, 90% (n=19) scored 80% or greater compliance. 43% (n=9) scored 100% compliance.
- It was not possible to assess the improvement in compliance compared to 2015 for any of the standards, as this was the first time compliance to the chosen set of 22 audit standards was assessed across the West Middlesex University Hospital Site.

Results from this audit were collated using paper medication charts. The scores for compliance with the prescribing standards were lower in comparison to the Chelsea and Westminster Hospital Site, demonstrating the positive impact that electronic prescribing has on prescribing accuracy and ensuring it is in line with policy.

Cross-site

One standard relating to documentation of indication and target INR for warfarin prescriptions scored less than 80% compliance.

Additional quality highlights

Council of Governors Quality Awards

During the year a number of Quality Awards were presented by our Council of Governors. The seven highlighted below are examples of the awards presented.

Dr Rashmi Kaushal and the Team

The award was received for the team's outstanding work on a new, online endocrine referrals system, which has resulted in much improved, and quicker patient referrals and reviews.

Dr Dominika Dabrowska—individual award

The award was received for adapting and introducing the 'Gentle' Caesarean Section Protocol to the Trust.

Specialist Palliative Care Team

The award was received for greatly improving the fast-track discharge process of patients at the end of life.

Cara Taylor—individual award

The award was received for the successful introduction of a Bravery Box on Neptune paediatric ward, which will now be rolled out to all paediatric areas in the Trust.

Emily Ward—individual award

The award was received for her pilot work in engaging stakeholders in referrals for the reviewing of medication in older people. We now identify older patients for review who need further intervention once back home in the community.

Darren Brown—individual award

The award was received for creating and leading a specialised physiotherapy supervised group rehabilitation intervention for people living with HIV, providing an individualised exercise and HIV-specific educational 'self-management programme'. Darren invented and developed a HIV-specific app called BeYou+ to support self-management strategies of people living with HIV, using a goal oriented rehabilitative framework. This app was released on Android and iOS devices in 2016.

Dr Bobby Mann and his Adult Care Bundle Implementation Team

The award was received for the development and ongoing implementation of an adult asthma care bundle. Clinical leaders (medical and nursing) of UCC, A&E, AMU and respiratory ward are working together to improve care for a vulnerable patient group:

- Patient information material is now available to all services and used where appropriate
- Continuous audit has shown that where the bundle is used, more patients get more of the recommended interventions

Additional quality improvement highlights

End of life care

This has been an incredibly active year for the Trust in terms of palliative and end life care:

- We have welcomed new medical and nursing staff to the palliative care teams on both sites. We now have EOL facilitators on both sites
- The seven day specialist palliative care service at Fulham Road was extended to West Middlesex site
- We have achieved 100% of our targets in a national Quality Improvement project (CQUIN project) to provide earlier palliative care to more patients with advanced cancer, which retained £142,000 for the Trust
- We have benchmarked our EOL services against national standards
- The Trust Medical Director now chairs the EOL steering group
- We have started a survey of all bereaved relatives on both sites
- We have delivered EOL training at induction and updates in simulation training with actors and pop-up training on the wards
- We have implemented individualised care plans for dying patients on both sites and audited their use

- We have reviewed the rapid discharge process for patient at the EOL and reduced the time by 30%, a quality improvement project that was awarded a Council of Governors Quality Award
- We have put forward two wards for accreditation in the nationally recognised Gold Standards Framework programme
- Working with the Friends charity we have completed two new butterfly rooms on Nell Gwynne and Edgar Horne wards, with a further three rooms across both sites of the Trust funded—each butterfly room is designed to provide an enhanced environment for dying patients and their families

Mouth care on Kew Ward

This project was commended as being outstanding practice in the CQC report. The Kew Ward team have developed an innovative mouth care project following feedback from patients and relatives and a review of patient outcomes.

The aim of the project was to develop a Trustwide oral care protocol and policy, to improve standards of care for all patients who are nil by mouth or who require assistance with maintaining oral hygiene.

The benefits are that every patient will have a mouth care assessment and oral care plan, improved patient experience, improved nutrition and reduction in antibiotics usage. Improved end of life care and reduction in hospital acquired pneumonia.

Since implementation of new mouth care practice within Kew Ward, there has been higher compliance rates with oral hygiene and care has significantly improved, increased patient comfort, positive feedback from patients and a reduction in the number of hospital acquired pneumonia.

Clinical innovation and improvement

Initiatives to improve quality frequently involve frontline staff, including junior doctors.

The Trust, as part of the improvement and transformation programme, has engaged junior doctors by the continuation of the roles of Clinical Innovation and Improvement Fellows introduced in 2016/17.

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.

In addition to supporting the quality priority improvement projects the fellows are working on additional wide range of improvement projects:

- **PredictED is a** ‘Model for ED demand’ at WMUH site including expected admissions, breaches and diagnosis. This can then link to staffing and availability of ambulatory pathways.

- **Healthcare at Home** is a project which aims to improve clinical oversight for ambulatory patients and to maximise the use of the most appropriate ambulatory pathway.

- **Big Bites and Pearly Whites** is a children's oral health initiative which aims to raise awareness and improve the oral health of children attending CW and to reduce the number of hospital admissions for dental caries by 2020.

- **Postnatal Pathways—Presumed Sepsis** is a project relating to clinically well neonates with presumed sepsis, the aim being to align practice with NICE guidance and as a result reducing length of stay.

- **DC Summary and Clinical Coding Support** is a project which aims to provide accurate, complete, timely coded clinical information to support coding teams. Discharge summaries will be provided for all patients being discharged from the postnatal ward.

- **MRSA Targeted Rescreening** is a project which aims to implement new guidance relating to MRSA targeted rescreening:
    - All patients continue to have universal screens on admission
    - MRSA screen valid for 12 months
    - Repeat screening only mandatory for high risk patients (as per DoH guidance) within 12 months (surgical, renal and ICU patients)

Annex 1: Council of Governors statement

Governors' comments on the Quality Report

Annex 2: CWHHE Clinical Commissioning Group (CCG) statement

Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2017/18: Commissioners' Statement

(after draft circulated)

Annex 3: Healthwatch Central West London statement

Healthwatch Central West London Statement on Chelsea and Westminster Hospital NHS Foundation Trust's Quality Report 2017/18

(after draft circulated)

Annex 4: Royal Borough of Kensington and Chelsea Adult Social Care and Health Scrutiny Committee statement

(after draft circulated)

Annex 5: Statement of Directors' Responsibilities for the Quality Report – to be confirmed

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 2017/18 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 2017 to May 2018
- papers relating to quality reported to the board over the period April 2017 to May 2018
- feedback from commissioners dated ??
- feedback from governors dated ??
- feedback from local Healthwatch organisations dated ??
- feedback from Overview and Scrutiny Committee dated ??
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated ??
- the latest national patient survey dated ??
- the latest national staff survey dated ??
- the Head of Internal Audit's annual opinion of the Trust's control environment dated ??
- CQC inspection reports dated ??

- 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

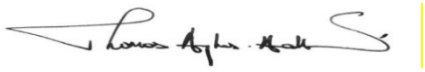
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- 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.

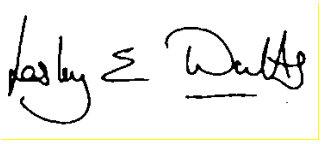
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board:



Sir Thomas Hughes-Hallett
Chairman

?? May 2018



Lesley Watts
Chief Executive Officer

?? May 2018

Annex 6: Independent Auditor's Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Quality Report

(once complete)

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

E: communications@chelwest.nhs.uk

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	1.4.3/May/18
REPORT NAME	Draft Governor's Commentary on the Quality Report 2017-18
AUTHOR	Simon Dyer, Lead Governor
LEAD	Simon Dyer, Lead Governor
PURPOSE	As part of preparing the Quality Report governors and other stakeholders are required to provide formal commentary for inclusion in the final Quality Report.
SUMMARY OF REPORT	A draft Governor's Commentary, which relates to the contents of a draft Quality Report, was prepared by the Lead Governor Simon Dyer and supported by the governors from the Quality Sub-Committee. The Trust's draft Quality Report was discussed at the April Quality Sub-Committee meeting and the latest draft Quality Report is included in the 17 May Council of Governors meeting pack. The Governor's Commentary is attached for endorsement by the full Council of Governors.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	
DECISION/ ACTION	The Council of Governors is asked to endorse the Commentary.

Annex 1: Council of Governors statement

Governors' comments on the Quality Report

The Governors have read the Trust Quality Report 2017/18 with great interest. We remain impressed by the continued commitment of the Trust's Staff in working towards the continued improvement to the Quality of Care across the Trust.

The Governors have endorsed the **reduction in falls as the** as the Priority 1 for 2017/18. It was noted that the Trustwide launch of new falls risk assessment and care plan and the revision of the Falls Strategy and its monitoring through the Falls Steering Group has seen a decrease in Externally reported falls, but there is much work to be done to reduce those of moderate harm and welcome the maintenance of this quality priority in 2018/19. We will watch with interest the launch of the new Trust Falls Strategy and note the aim to reduce falls by 30% to be consistent with national best practice.

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, with only Inpatients being the only area where the response rate has achieved the 30% target. 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 response rate target continues to disappoint. Although, it is noted that achievement in all areas is around or above the 90% recommendation score. Governors will be keen to see if the review of FFT, which is underway, and the move to business as usual will improve response rates.

The Governors are pleased to see the ongoing steady recruitment of patients to participate in clinical research, approved by a research ethics committee. Together with the numbers of Trust Staff Members participating in research as PI, and the numbers of publications resulting from the research, this demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. This provides patients with access to novel and ground-breaking therapies, which goes a long way to improving the quality of care.

The Care Quality Programme (CQP) introduced to establish a structure for continuous quality improvement and to ensure the Trust was prepared for the Care Quality Commission (CQP) Inspection stood the Trust in good stead for that Inspection. The Ward Accreditation scheme introduced in the Summer of 2016 also proved a very successful preparation for the CQC Inspection. The Governors were delighted to learn that this system will continue and will be extended to cover up to 70 different areas of the Trust business and will be assisted by suitably trained Governors.

The Governors commend all the hard work carried out across the Trust under the Care Quality Programme, which has resulted in the overall rating provided at the end of the CQC Inspections moving up from "Requires Improvement" to "Good", and welcome the rating of "Outstanding" for Use of Resources.

The Governors would also like to thank the Friends Charity for their support in 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.

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 and these are highlighted in the Quality Report.

There continue to be disappointing complaints about the appointment system, especially where hospital letters are concerned. The Governors are continuing to keep an eye on the number of complaints and look forward to the promised improvements this coming year as the Administration Programme is rolled out.

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.

Simon Dyer
Lead Governor
1st April 2018

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	1.5.1/May/18
REPORT NAME	Finance and Investment Committee Report to Council of Governors
AUTHOR	Jeremy Jensen, Non-Executive Director and Chair of Finance and Investment Committee
LEAD	Jeremy Jensen, Non-Executive Director and Chair of Finance and Investment Committee
PURPOSE	To provide governors with information about the activities and effectiveness of the Finance and Investment Committee (FIC).
SUMMARY OF REPORT	This paper updates the Council of Governors on the Committee's business transacted during the period May 2017 to April 2018.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	Deliver financial sustainability
DECISION/ ACTION	For noting.

Finance and Investment Committee (FIC) - Chairman's Report to Council of Governors, 17 May 2018

The 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 May 2017 to Apr 2018.

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 (May 2017-Apr 2018)

The Committee met 10 times

Membership	# meetings attended/expected
Chair, Jeremy Jensen, Non-Executive Director	9/10
Eliza Herman, Non-Executive Director	7/7
Nilkunj Dodhia, Non-Executive Director	10/10
Nick Gash, Non-Executive Director	4/4
Liz Shanahan, Non-Executive Director	1/1
Lesley Watts, Chief Executive	7/10
Sandra Easton, Chief Financial Officer	10/10
Karl Munslow-Ong, Deputy Chief Executive	10/10
Rob Hodgkiss, Chief Operating Officer	8/10

Committee proceedings are lively and robust with participation from all members. The committee moves through its large agenda at pace, the attendance record is over 90%.

Significant Items Covered Since May 2017

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
    - Non- Elective review
    - Theatre productivity
    - Bed productivity
    - Procurement
    - Temporary staff
    - Estates
    - Clinical administration improvement programme
    - Private Patients
    - Clinical Negligence Scheme for Trusts (CNST) review
    - Ophthalmology review
    - Paediatric Specialist Review
    - Beds and length of stay review
- Business Cases
    - Sutton Sexual Health relocation feasibility
    - Modular Maternity Building – lease vs purchase decision
    - Network upgrade
    - ICU/NICU project progress update
    - Catheter Lab – post investment review
    - E tender for Sexual Health
    - Hard Facilities management – Chelsea site
- Other
    - Electronic Patient Record (EPR) – Gateway Reviews
    - Borrowing capacity and benchmark
    - Cash forecasting
    - Business assurance framework
    - Corporate cost benchmarking
    - Use of resources assessment
    - Reference costs assurance
    - Carter programme status (Benchmarked productivity comparisons)
    - EPR Gateway Process and EY assurance reports
    - Business reviews of three main divisions (Women's, Planned, Emergency)

Conclusions - What's Working Well, What Needs Improvement

A Committee evaluation process was conducted in June 2017 by the committee members and the overall evaluation was positive but with suggestions to try and reduce the number of meetings. In 2018 there will be 8 physical meetings and one telephone meeting.

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 its staff is working well.

A new area in 2018 has been the review of the Electronic Patient Record implementation at West Middlesex site, including the Gateway Reviews conducted by Ernst and Young. The project went live over the weekend May 5/6.

One of the challenges facing the committee is how to support the management team in achieving the 2018/19 CIP programme which has increased clinical focus in areas where the Trust has struggled to improve productivity and reduce costs in the past.

Another big 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.

Overall the Trust continues to have an underlying deficit, which given that its cost reference index is one of the lowest in the country, implies that services continue to be priced at unsustainable levels for the given level of services provided.

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.

In 2018 the Trust's Use of Resources was rated as Outstanding by its financial regulator, NHSI.

Jeremy Jensen
4 May 2018

2017/18
Financial Performance

Sandra Easton

Chief Financial Officer

Chelsea and Westminster Hospital NHS Foundation Trust

Annual Financial Statements 2017/18

Statement of Comprehensive Income

	2017/18 £000s	2016/17 £000s
Operating income from patient care activities	556,312	517,492
Other operating income	101,605	107,476
Total operating income from continuing operations	**657,917**	**624,968**
Operating expenses	-604,895	-595,361
Operating surplus/(deficit) from continuing operations	**53,022**	**29,607**
Net finance costs	-14,836	-13,840
Other Gains/(losses)	13	-807
Share of profit of associates/joint arrangements	229	357
Gains/ (losses) arising from transfers by absorption	-	-
Surplus for the year from continuing operations	**38,428**	**15,317**
Adjust for Exceptional Items		
Other comprehensive income		
Asset impairment/revaluation	12,833	5,608
Gains/(losses) of disposal of non-current assets	-	-807
2016/17 STF funding received in 2017/18	268	-
Donated asset adjustment	-293	312
Total	**12,808**	**5,113**
Surplus/(Deficit) adjusted for exceptional items	**25,620**	**10,204**

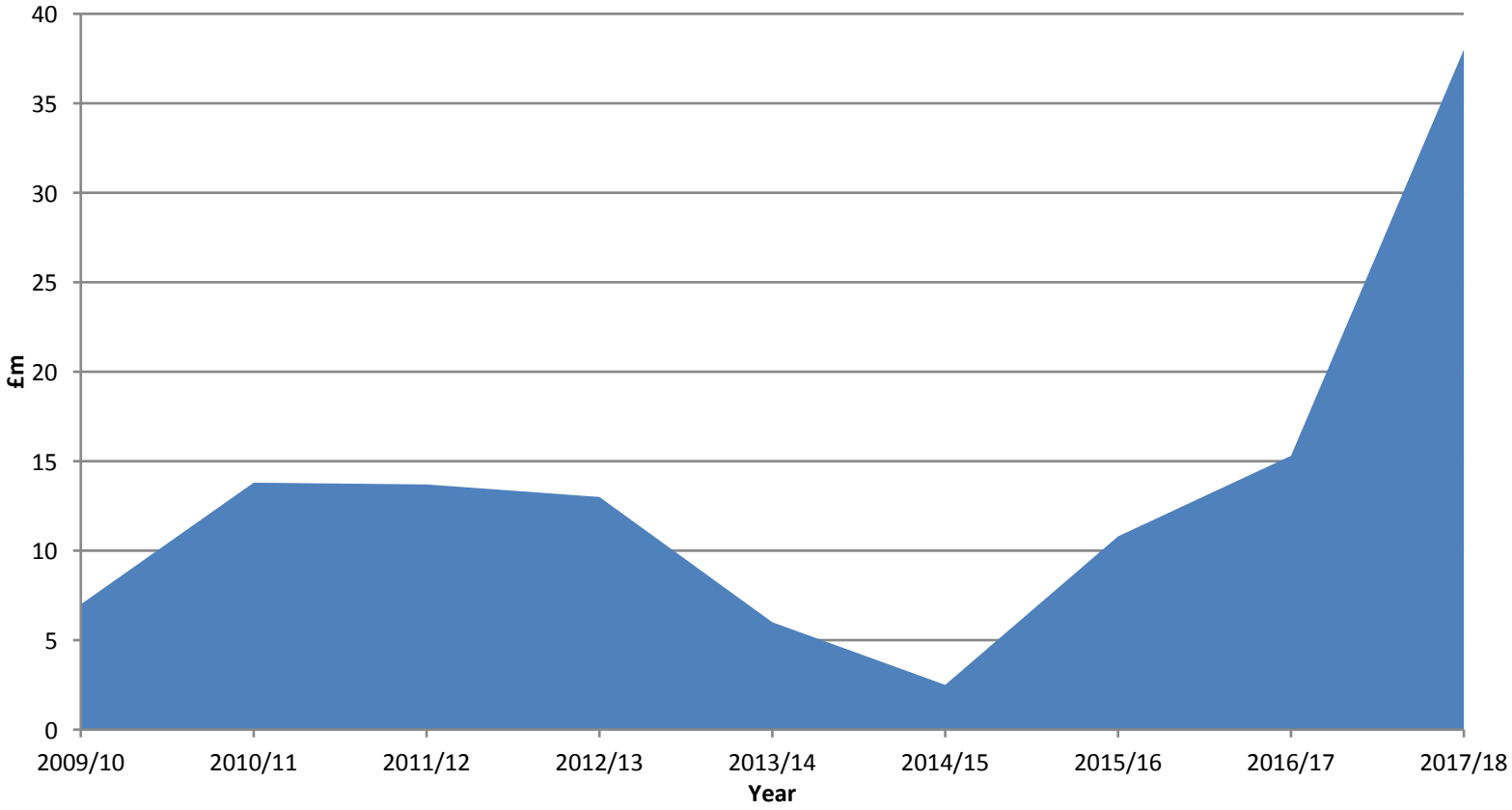
Exceptional Items in 2018/19

- Our property portfolio was revalued which resulted in a benefit of £12.8m
- We received our allocated £14.1m STF funding
- In addition we received additional incentive STF totalling £13.6m (including £0.3m 2016/17 post accounts reallocation)
- We delivered CIP's of £25.9m

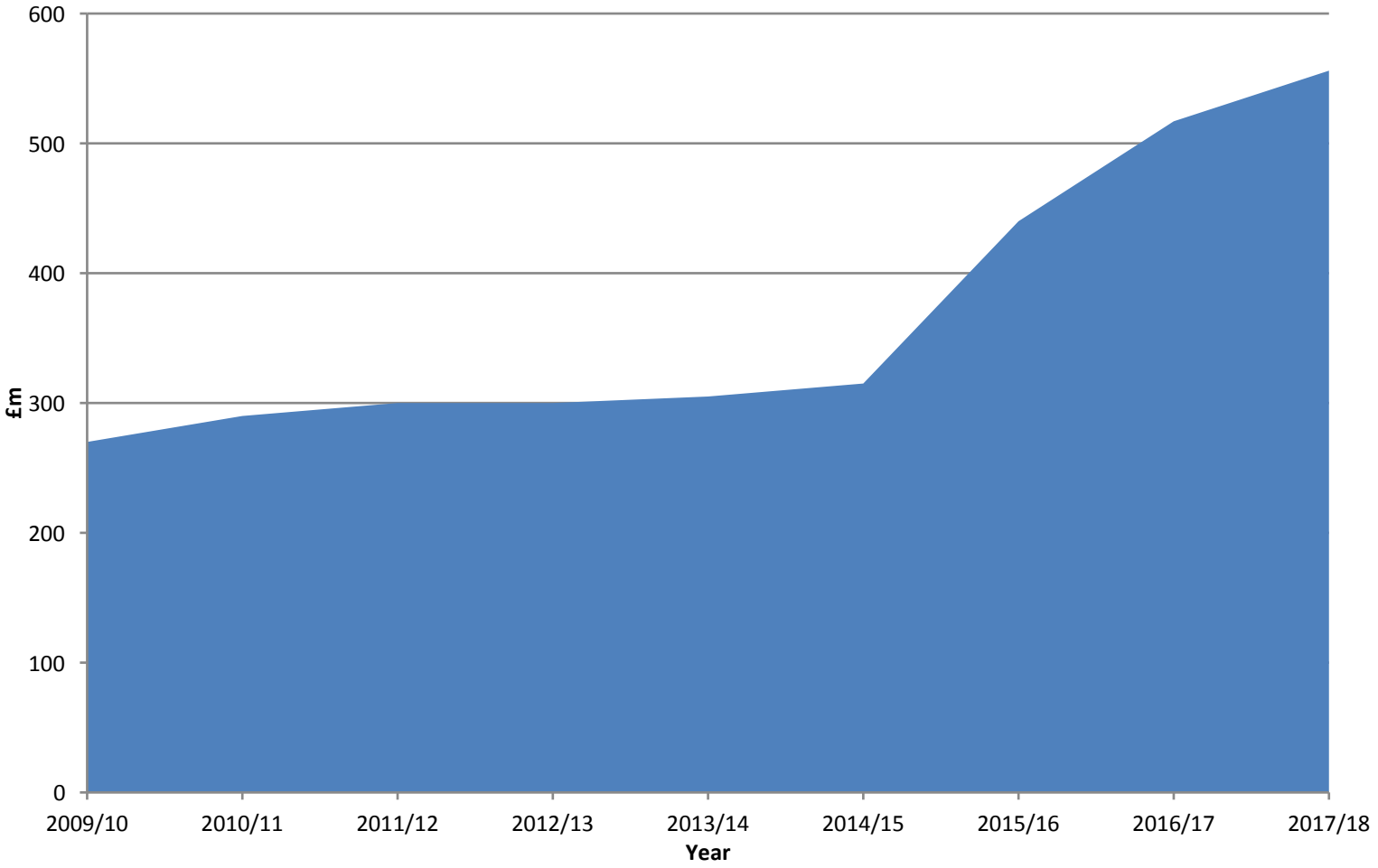
Our underlying adjusted position for 2017/18 without exceptional and other non recurrent income and expenditure was a deficit of £19.4m

Income & Expenditure Trend

Surplus 2009/10 – 2017/18

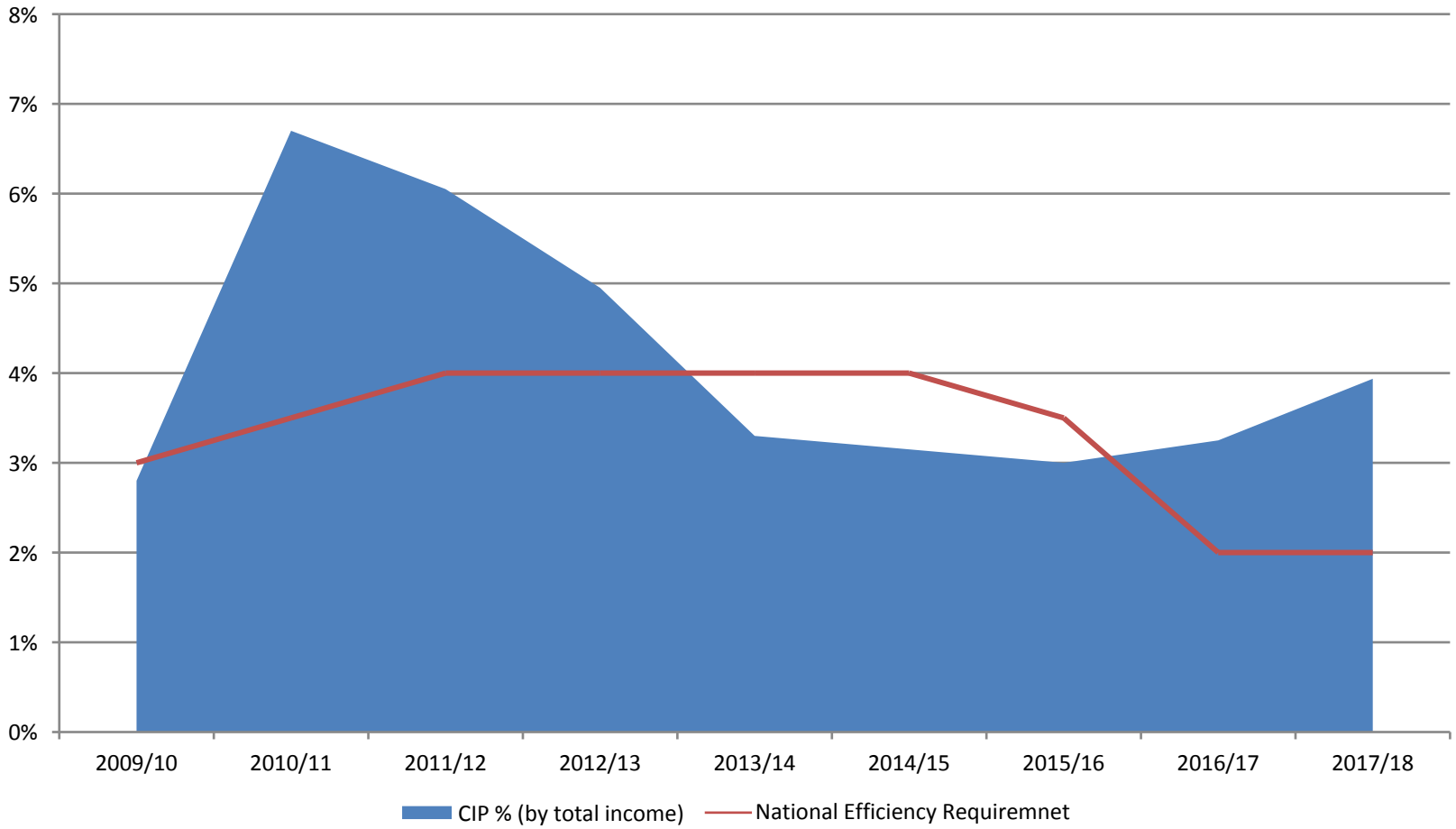


Clinical Income 2009/10 – 2017/18



Cost Improvement Programme (CIP)

CIP 2009/10 – 2017/18



Capital Programme

- In 2017/18 we invested £37.9m in capital

- *Key items were*
  - *Start of NICU/ICU project (£2.2m)*
  - *Electronic Patient Record (£16.5m)*
  - *Updating medical equipment (£5.4m)*
  - *Fire Safety (£5.5m)*

Looking Ahead

- 2018/19 plan is for a surplus of £22.7m
- Use of Resources Rating: 1
- CIP requirement £25.1m
- Capital programme £51.9m

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	1.5.3/May/18
REPORT NAME	Annual Plan 2018/19
AUTHOR	Virginia Massaro, Deputy Director of Finance
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	To approve the 2018/19 operational and financial plan.
SUMMARY OF REPORT	• The draft operational plan was submitted to NHSI on 8th March and the final operational plan was submitted to NHSI on 30th April. • The Trust has accepted the control total of £14.8m, with an overall £22.7m surplus • The capital plan for 2018/19 is £51.9m. • The commissioner contracts for 2018/19 have been signed and include 6 months' block funding for West Middlesex to mitigate any income impact due to the Cerner implementation.
KEY RISKS ASSOCIATED:	• Commissioner affordability • Loss of STF funding if the control total or A&E target is not met • Delivery of CIP target • Impact of the phase 1 EPR roll out on income reporting at WM site, which has been partly mitigated by the agreement of block commissioner funding for 6 months at the WM site. • Potential removal of Shaping a Healthier Future transitional funding for A&E on the CW site
FINANCIAL IMPLICATIONS	See above
QUALITY IMPLICATIONS	None noted
EQUALITY & DIVERSITY IMPLICATIONS	None noted
LINK TO OBJECTIVES	• Excel in providing high quality clinical services • Deliver financial sustainability
DECISION/ ACTION	The Council of Governors is asked to note the 2018/19 operational plan as submitted to NHS Improvement on 30th April 2018.

2018/19 Annual Plan

1. Summary

- The final operational plan was submitted to NHSI on 30th April.
- The Trust has accepted the control total of £14.8m, with an overall £22.7m surplus
- The final capital plan for 2018/19 is £51.9m.
- The commissioner contracts for 2018/19 have been signed and include 6 months' block funding for West Middlesex to mitigate any income impact due to the Cerner implementation.

2. Business Planning 2018/19

2.1. 2018/19 Operational Plan

The final operational plan, finance, workforce, activity and triangulation returns were all submitted to NHS Improvement on 30th April. The Trust has accepted the control total of £14.8m. The draft operational plan is included in **appendix 1**.

2.2. Overview of Financial Plan 2018/19

The Trust submitted a draft plan of a £22.7m surplus in 2018/19, with a plan on a control total basis of £14.8m (in line with the revised control total issued by NHS Improvement).

A summary of the key financial indicators in 2017/18 forecast outturn and 2018/19 plan is in table 1 below.

Table 1 – Summary 2018/19 financial plan compared to 2017/18 Outturn

	2017/18 Draft Accounts	2018/19 Plan
	£m	£m
Operating Revenue	657.9	669.9
Employee Expenses	-345.8	-354.8
Other Operating Expenses	-259.1	-275.8
Non-Operating Income & Expenditure	-14.6	-16.6
Surplus/(Deficit)	**38.4**	**22.7**
Net Surplus %	5.8%	3.4%
Remove capital donations/grants/ Impairment	-12.8	-7.9
Surplus/(deficit) on a Control Total Basis	**25.6**	**14.8**
EBITDA	57.0	49.5
EBITDA Margin %	**8.7%**	**7.5%**
Use of Resources Rating	1	1
Closing Cash Balance	52.6	50.5

2.3. Capital Plan

The capital expenditure plan is £51.9m in 2018/19, which includes £4m of deferred schemes from 2017/18.

2.4. Risks

There are a number of financial risks to the draft plan for 2018/19, including:

- Commissioner affordability
- Loss of STF funding if the revised control total or A&E performance is not met
- Delivery of CIP target
- Impact of the phase 1 EPR roll out on income reporting at the WM site
- Potential removal of Shaping a Healthier Future transitional funding for A&E on the CW site
- Cost pressures/ investments identified by Divisions exceed planned levels

3. 2018/19 Contracting Update

The Trust has agreed refreshed activity and finance plans and signed contract variations with CCGs and NHS England to reflect 2017/18 forecast outturn and expected changes to growth, service developments and commissioner demand management schemes. The Trust has agreed 6 months block funding with both CCGs and NHS England for the West Middlesex site from April to September 2018 to cover any potential reporting and income risks arising from the Cerner implementation.

4. Decision/ Action Required

The Council of Governors is asked to note the 2018/19 operational plan as submitted to NHS Improvement on 30th April 2018.

Appendix 1 – Final Operational Plan – as submitted to NHS Improvement on 30th April 2018

2017-2019 Operating Plan – 2018/19 Refresh
Chelsea and Westminster Hospital NHS Foundation Trust

1. Strategic Priorities

At the beginning of 2017/18, the Trust Board agreed 3 high-level strategic priorities. In conjunction with the Trust values, these priorities set the strategic framework for the work we do as an organisation. They are:

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

The Board Assurance Framework breaks these priorities down into individual objectives and associated key performance indicators, through which delivery of these priorities are tracked by the Board.

2. Quality Priorities

2.1. Summary of Quality Priorities

As in previous years the quality priorities for 2018/19 are linked to the Quality Strategy and Plan 2015-18. For 2018/19 priorities were 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
- Divisional review of incident reporting and feedback from complaints

The 5 priorities for 18/19 are outlined below. For each a specific objective, proposed actions and measurements for success have been identified.

2.1.1. Priority 1: Reduction in falls

What we aim to achieve during 2018/19

- Target to reduce falls by 30% to be consistent with national best practice - 2.62 per 1000 bed days based on Q3 17/18

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

- Falls steering group will meet monthly to review project progress
- New Trust falls strategy launches March 2018
- On-going community pathway work with public health and The Royal Borough of Kensington and Chelsea

How will we measure our success?

- Number of falls per 1000 bed days

2.1.2. Priority 2: National Safety Standards for Invasive Procedures (NatSSIPs) (Admitted Surgical Care)

What we aim to achieve during 2018/19

- 90% reduction in serious incidents relating to invasive procedures
- To implement a robust audit cycle

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

- Standardisation of the WHO safety check list Trust wide
- The WHO safety check list will be completed on all patients having surgery, with the effective process preventing never events.
- All invasive procedures to have a Local Safety Standards for Invasive Procedures (LocSSIPs) developed
- Implementation and embedding of LocSSIPs in practice

How will we measure our success?

- Number of Serious Incidents relating to invasive procedures
- Compliance with local audit plan

2.1.3. Priority 3: NHS Resolution 10 point safety plan

What we aim to achieve during 2018/19

Trust is meeting 10 safety actions set out by Clinical Negligence Scheme for Trusts to improve patient safety for all those using our Maternity Services.

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

The ten points in the safety plan are:

1. Use of the National Perinatal Mortality Review Tool to review perinatal deaths.
2. Use of the Maternity Services Data Set to the required standard.
3. Transitional care facilities in place and operational to support the implementation of avoiding term admissions into neonatal units (ATAIN Programme).
4. Effective system of medical workforce planning.
5. Effective system of midwifery workforce planning.
6. Compliance with all elements of the Saving Babies Lives (SBL) care bundle.
7. Demonstrate that there is an effective use of the Maternity Voices Partnership Forum, (a forum which encourages patient engagement) and that the services acts on feedback received.
8. 90% of staff have attended an 'in –house' multi-professional maternity emergencies training.
9. Local Safety champions (obstetric and midwifery) meet bi-monthly with Trust level safety champions via the patient safety group to escalate local identified issues.
10. 100% of qualifying 2017/18 incidents are reported under the NHS Resolution's Early Notification scheme.

How we will measure our success?

Conduct baseline audit of the 10 point plan during April and report quarterly thereafter. Report to Trust Board June 2018.

2.1.4. Priority 4: Reduction in E coli infections

What have we set out to achieve during 2018/19

CWFT aims to reduce infection caused by *E.coli* by 50% by 2021. This is in line with a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021, with the initial focus on infections caused by *E.coli*.

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

- Monthly reporting to Public Health England of bloodstream infections caused by *E.coli*, *Pseudomonas aeruginosa* and *Klebsiella* spp.
- Monthly review of reported infections by the Infection Prevention & Control Group.
- Review Trust data to understand risk groups and factors which could be modified, for example:
- urinary tract infections (UTI),
- catheter related UTIs
- skin or soft tissue, including ulcers or cellulitis
- intravascular access associated
- surgical interventions
- Review Trust data on PHE Fingertips portal to benchmark against similar organisations.
- Patients treated for Gram negative sepsis will be prescribed an antimicrobial by responsible medical team in line with local guidelines / microbiology advice
- Patients treated for Gram negative sepsis will have antimicrobial treatment reviewed by responsible medical team within 48-72hours to optimise therapy

How will we measure our success?

Conduct baseline audit in April 2018 and then audit quarterly thereafter to measure progress.

2.1.5. Priority 5: Complaints Management

What have we set out to achieve during 2018/19

- Complaints Acknowledgement within 48 Hours
- Complaints Response within 25 working days
- Individual complaints action assurance
- System of learning from complaints

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

- A new complaints policy and structure will support the Divisional teams more robustly in the delivery of the Trust agreed targets (what is the date?).
- The policy will contain an internal escalation process for non-compliance of complaints response
- Patients will receive a timely and appropriate response
- Ensuring learning from complaints will help to improve the overall patient experience

How will we measure our success?

Baseline position is to be agreed in April so that improvement and progress can be tracked quarterly.

- 90% of complaints will be acknowledged within 2 working days.
- 90% of complaints will be responded to within 25 working days

- Action trackers to be in place for all actions arising from complaints responses, monitored through divisional quality board
- Development of a Trust wide system which demonstrates learning from complaints

3. Workforce

As part of our ambition to be the employer of choice in the local NHS, the Trust continues to focus on increasing the proportion of posts filled by permanent staff and to reduce the proportion of staff that leave the organisation each year. The past 12 months have seen improvements in both vacancy rates and staff turnover that the Trust aim to improve on further in the coming year.

4. Operational Performance

In line with the conditions around the Provider Sustainability Fund, we will aim to maintain and improve our performance against the 4 hour A&E standard. Given our strong performance in 2017/18, this means that the Trust will aim to meet the national standard of admitting or discharging 95% of patients within 4 hours.

The Trust will continue to deliver the referral-to-treatment standard of 92% of patients at any given time waiting less than 18 weeks. Whilst we are currently meeting this standard as an organisation, we have recovery trajectories in place for key services that are not yet achieving 92% at a specialty level. Over the past 12 months no patient has waited longer than 52 weeks from referral to treatment, and the Trust aims to maintain this record.

The Trust will aim to continue to deliver on the cancer waiting time standards, all of which are currently being met.

5. Activity

The activity plan for 18/19 comprises of a year on year growth of 2.8% for elective inpatients, 0.6% for outpatient attendances, 4.3% for A&E attendances and 3.1% for non-elective inpatients, net of commissioner QIPP schemes. The activity numbers have been agreed and triangulated with commissioners as part of the signed contract variations for 2018/19.

There may be a risk to the delivery of key performance standards should growth exceed these levels, or if key improvement schemes in the community do not reduce the demand on hospital services to the extent that is planned.

Activity plans have been built up through discussions with individual services to reflect expected demand and available capacity and aligned to performance trajectories, income assumptions, workforce requirements and associated expenditure plans.

5.1. Summary of Activity by POD

The activity numbers by POD and comparison with the 2017/18 outturn are included in table 1 below. The planned reduction in outpatient attendances and non-elective activity is driven by the commissioner QIPP assumptions exceeding growth assumptions.

Table 1 – 2018/19 Summary Activity by POD & Comparison to 2017/18 Forecast Outturn

	2017/18 Forecast Outturn	Growth	Commissioner QIPP	2018/19 Plan	% Year on Year Change
	000	*000*	*000*	*000*	*%*
Outpatient Attendances	**616.0**	11.8	-8.2	**619.6**	**0.6%**
Elective Inpatients	**49.1**	1.5	-0.1	**50.5**	**2.8%**
Non-Elective Inpatients	**62.3**	4.6	-2.7	**64.2**	**3.1%**
A&E Attendances	**206.4**	11.3	-2.3	**215.4**	**4.3%**

6. Finance

6.1. Financial planning

The Trust's 2018/19 financial plan has been updated from the original 2 year plan to reflect the forecast outturn for 2017/18, and any changes in assumptions for 2018/19, primarily due to the changes in the planning guidance.

The Trust has accepted the adjusted control total of £14.8m surplus in 2018/19, and therefore has planned for sustainability and transformation funding (STF) of £19.9m.

There are a number of significant risks to the Trust delivery of the control total:

- Commissioner affordability – the plan is dependent on actual activity remaining in line with our planning assumptions and therefore appropriate payment in line with agreed contract mechanisms. There is also a risk around overall affordability within the North West London sector as per the sector's STP plans and current gap to the sector control total.
- Loss of STF funding if the revised control total or A&E performance is not met
- Delivery of CIP target
- Impact of the phase 1 EPR roll out on income reporting at the West Middlesex site, which has been mitigated for the first 6 months of 2018/19 through a block funding agreement for the site.
- Potential removal of Shaping a Healthier Future transitional funding for A&E on the CW site and CCG Winter Resilience funding

6.2. Financial Plan

The Trust's financial plan for 2018/19 is built up from the Trust's long term planning model and updated following revised planning guidance and Trust priorities on quality and other investments, activity assumptions and service developments.

The Trust is planning an overall £22.7m surplus, with an adjusted surplus (on a control basis) of £14.8m. The planned Use of Resources rating is 1 and the closing cash balance is £50.5m. This will generate an EBITDA of £49.5m (7.5%) from total operating income of £669.9m.

Table 2 – 2018/19 Summary Financial Plan & Comparison to 2017/18 Outturn (as per Draft Accounts)

	2017/18 Forecast Outturn	2018/19 Plan
	£m	£m
Operating Revenue	637.1	650.0
Employee Expenses	-343.3	-349.8
Other Operating Expenses	-253.5	-261.1
Non-Operating Income & Expenditure	-14.8	-16.3
Surplus/(Deficit)	**25.5**	**22.7**
Net Surplus %	4.0%	3.5%
Remove capital donations/grants/ Impairment	-12.8	-7.9
Surplus/(deficit) on a Control Total Basis	**12.7**	**14.8**
EBITDA	44.4	48.9
EBITDA Margin %	**7.0%**	**7.6%**
Use of Resources Rating	1	1
Closing Cash Balance	52.0	59.8

6.3. Financial forecasts and modelling

The table below shows the bridge from the original 2018/19 surplus in the 2 year plan to the final 2018/19 surplus and control total.

Table 3 – 2018/19 Financial Plan & Bridge from Original 2018/19 Plan

	Overall Surplus/ (Deficit) £m	Surplus/ (Deficit) on a control total basis £m
Original 2018/19 Plan (as per 2 year plan)	**15.95**	**12.61**
Adjustments:		
Increase in CNST costs	-4.93	-4.93
Other cost pressures	-7.22	-7.59
Income tariff uplift	4.19	4.19
Activity/ contract/ QIPP assumption updates	3.36	3.36
Increase in STF allocation	5.74	5.74
CQUIN risk reserve	1.40	1.40
Donated income for NICU/ITU project	4.24	0.00
Revised 2018/19 Plan (Final)	**22.73**	**14.78**

6.4. Contracting

The Trust has refreshed activity and income baselines with its main commissioners, North West London CCGs and NHS England and CCG associates for 2018/19 to reflect forecast outturn and revised growth and commissioner QIPP levels. The contract risk share agreements across the North West London sector will continue into 2018/19. All other contracts, including the NHS England specialised commissioning contract, continue on a cost and volume basis.

Six months block funding at 2017/18 outturn has been agreed with both CCGs and NHS England for the West Middlesex site from April to September 2018. This was agreed to cover the period immediately post the EPR implementation to mitigate any income risk arising from the new system.

6.5. Efficiency Plans

The Trust's CIP programme for 2018/19 remains a challenging target of £25.1m, which is c.6% of addressable spend. The key themes and overall programme is in line with the original 2 year plan.

6.6. Capital planning

The capital plan for 2018/19 is £51.9m, with the breakdown by asset category, funding source and movement from the original 2018/19 plan in the table below. The capital programme funded other than by donations has been increased from the draft plan submission to include:

- £8m forecast expenditure deferred from 2017/18
- £1.9m relating to the Global Digital Exemplar (GDE) scheme for which PDC funding was awarded for three years commencing in 2017/18
- £10.9m for a business case to purchase modular buildings currently being leased

The loan and transaction PDC funding sources are all agreed and in place following the acquisition of WMUH NHS Trust, though the Trust is awaiting confirmation of the PDC re-phasing from the Department of Health. External donated income of £8.4m from the Trust's charity CW+ has been included to fund capital developments relating to the NICU and ITU capital scheme and represents 50% of forecast cumulative expenditure to 31st March 2019.

Table 4– 2018/19 Capital Programme by Asset Category and comparison to original 2 year plan

Contingency	Original Plan 2018/19 £'000	Proposed 2018/19 £'000
Information Technology	11,460	12,594
IT - Cerner Estates Works	0	350
Estates	12,915	23,220
Estates Contingency	0	1,185
Medical Equipment	1,407	3,000
Non-Medical Equipment	150	150
Contingency	1,000	540
Modular Maternity Building*	0	10,844
Total	**26,932**	**51,883**
Funded:		
Donations (NICU/ITU)	4,161	8,400
Loans (NICU/ITU)	0	1,244
Transaction PDC (IT & Estates)	4,742	11,685
GDE PDC	0	1,868
Internal Depreciation**	18,029	17,842
Cash (assuming maternity building is bought outright)*	0	10,844
Total	**26,932**	**51,883**
Required excluding donations	**22,771**	**43,483**

** Subject to Trust Board approval of business case and funding source*
*** Includes deferred funding from 17/18.*

7. Sustainability and Transformation Partnerships

The past year has seen the Trust take an active role in leading work as part of the North West London Sustainability and Transformation Partnership. The Trust Chief Executive Chairs the Provider Board and a range of clinical and operational colleagues are leading or actively participating in work to improve the quality and sustainability of services for patients across the STP.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Local Provider Landscape

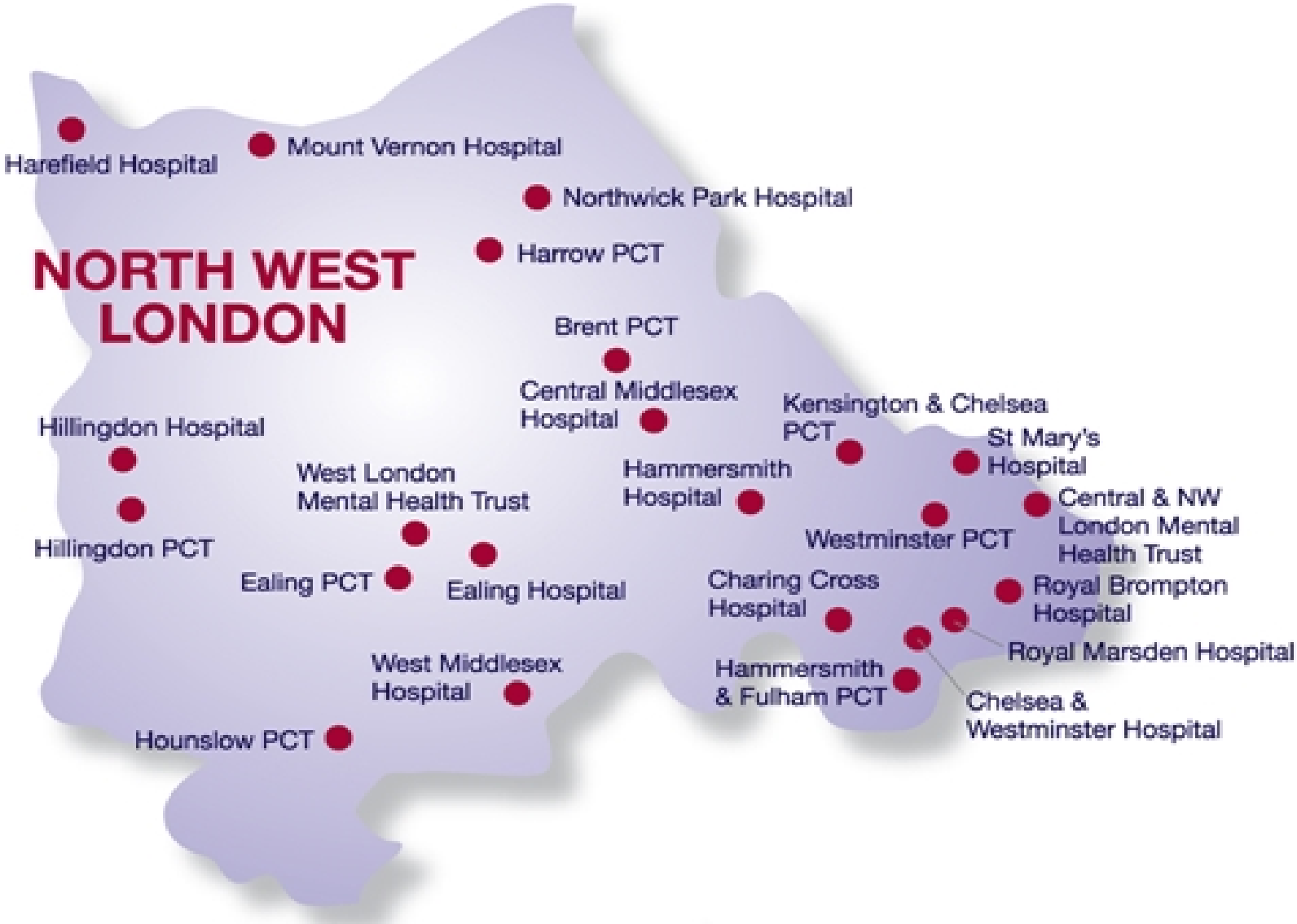
Council of Governors Meeting – May 2018

Provider Landscape

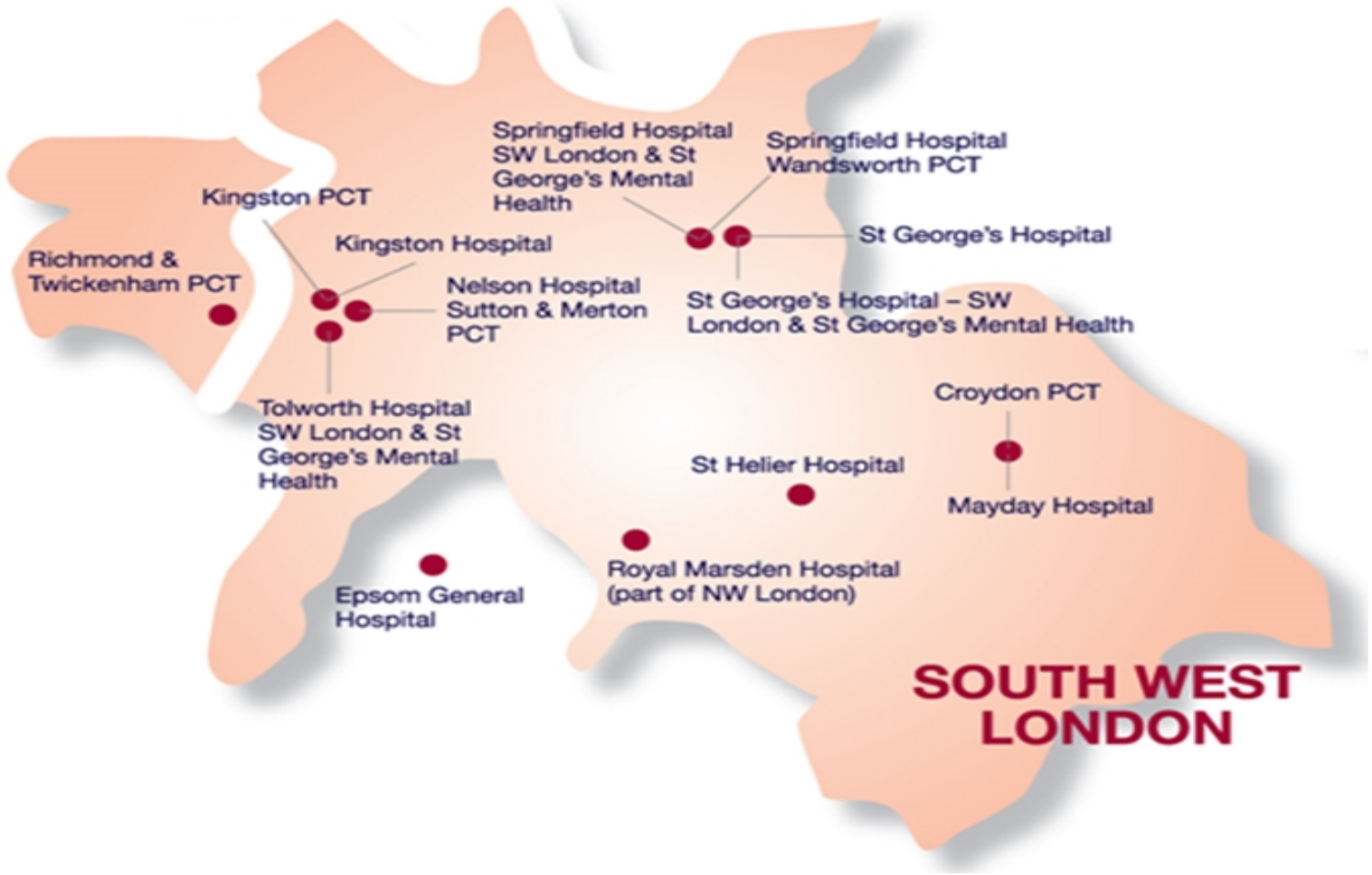
This deck provides an overview of the NWL and SWL provider landscape and includes:

- Map of NWL and SWL to indicate location and population served
- Summary snapshot overview on size & scale; turnover; performance
- Detailed indicators on quality and efficiency and performance against national ratings
- By provider schedule of current and future joint initiatives

Local Landscape: Map



Local Landscape: Map



Summary Provider Analysis (West Mid)

Org.	Services	Turnover	Staff	Profit/Loss	(Trust) Acute KPIs†
West Middlesex University Hospital	Acute hospital services	£181m (clinical income)	1,767 staff		A&E 4 hour: **94.0%** Cancer 62 days: **95.2%** RTT 18 weeks: **94.5%**
London Borough of Hounslow	Adult social care Health and well being Children's and family services	£64.7m (2016/17 Adult Social Care)	n/a	£3.3m overspend on Children's, Adult's & Housing Services.	n/a
Richmond upon Thames London Borough Council	Adult Social Care	£80.7m (Adult social care 2016/17)	-	£2.3m overspend on Children's Service. £980k underspend in Adult Social Services.	n/a
Hounslow & Richmond Community Health Care	Community services for adults and children Walk-in Centre Urgent Care Centre	£67.6m	1,167 staff	£1.6m surplus* (Plan: £1.4m surplus)	n/a
Kingston Hospital NHS FT	Acute hospital services	£254.3m	3,200 staff	£3.3m deficit* (Plan: £2.5m deficit)	A&E 4 hour: **85.3%** Cancer 62 days: **89.4%** RTT 18 weeks: **94.3%**
West London Mental Health Trust	Community and inpatient mental health services	£249.6m (after dividend)	3,325 staff	£0.4m surplus* (Plan: £0.3m surplus)	n/a
London North West Healthcare NHS Trust	Acute hospital and community services	£681.1m	7,958 FTE	£45.8m deficit* (Plan: £42.5m deficit)	A&E 4 hour: **84.7%** Cancer 62 days: **85.7%** RTT 18 weeks: **82.3%**

*Actual YTD (Q3)

† A&E 4 hour (Q4)
Cancer 62 days: (Q3)
RTT 18 weeks: (Feb 18)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Summary Provider Analysis (CW)

Org.	Services	Turnover	Staff	Profit/Loss	(Trust) Acute KPIs†
Chelsea & Westminster Hospital	Acute & specialist hospital services	£434m	3,413 staff	£25.6m surplus* Whole Trust	A&E 4 hour: **94.6%** Cancer 62 days: **92.5%** RTT 18 weeks: **91.8%**
RBKC Council	Adult Social Care Children's Services Public Health Services	£221.2m (£77m on adult social care + £122m on children services + £22m on public health)	n/a	£1.4m underspend on Adult Social Care. £4m overspend on Children's Services.	n/a
Hammersmith & Fulham Council	Adult Social Care Children's Services Public Health Services	£256m 2016/17 (£87m on Adult Social Care + £152m on Children's Services + £21m on Public Health)	n/a	£1.9m overspend on Adult Social Care. £780k overspend on Children's Services.	n/a
Westminster City Council	Adult Services Children, Young People and Families Sexual Health Services	£292m 2015/16 (£150m Adults and Public Health + £142m Children and Young People)	n/a		n/a
Royal Brompton	Specialist hospital services	£393m	3,345 staff	£24m deficit* (Plan: £28.5m deficit)	n/a
Royal Marsden	Specialist hospital services	£397m	3,615 staff	£9.7m surplus* (Plan: £3.1m surplus)	n/a
ICHT	Specialist & acute hospital services	£1,084m	10,973 staff	£13.7m deficit* (Plan: £11.3m deficit)	A&E 4 hour: **83.6%** Cancer 62 days: **87.9%** RTT 18 weeks: **82.8%**
Central and NW London Mental Health Trust	Community and inpatient mental health services	£474m	6,550 staff	£1.2m deficit* (Plan: £1.3m deficit)	n/a
Central London Community Healthcare	Community services	£207m	4,100 staff	£3.2m surplus* (Plan: £3.2m surplus) (Actual: YTD Q3)	n/a

† A&E 4 hour (Q4)
Cancer 62 days: (Q3)
RTT 18 weeks: (Feb 18)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Provider Analysis: Key Quality & Efficiency Ratings

Org.	CQC Rating	Reference Cost Rating
CWFT	Good	92
ICHT	Requires Improvement	101
Royal Brompton	Requires Improvement	118
Royal Marsden	Good	110
Kingston	Requires Improvement	89
London North West	Requires Improvement	103
West London Mental Health	Requires Improvement	93
Central and NW London Mental Health Trust	Good	113
Central London Community Healthcare	Good	91
Hounslow & Richmond Community Trust	Requires Improvement	91

Source:

1) Current CQC rating 2014-2018:

2) RCI: based on 2016/17 NHSI published index

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Work Programmes: ICHT

- Joint EPR
- NWL Pathology
- Tertiary paediatrics
- HIV inpatients
- H&F accountable care
- Tertiary referral centre for several specialties including cancer and surgery
- Series of clinical/service agreements

Work Programmes: Royal Brompton

- MoU for Paediatric Services
- Development of joint Paediatric HDU service
- FRC partnership (soft services – ISS recently contracted for 5 years)
- MDTs in designated sub speciality areas

Work Programmes: Royal Marsden

- FRC partnership (soft services – ISS recently contracted for 5 years)
- Sphere (Joint venture for IT services)
- RM Partners (National Cancer vanguard programme)

Work Programmes: CNWL

Current Initiatives

- System partner for RKBC/West London CCG integrated care model for <65's, *My Care My Way*
- Current provider of community and mental health services based around CW site

Work Programmes: HRCH

Current Initiatives

- Richmond Outcomes Based Contract
- Joint review to explore pop health and integrated care in the borough of Hounslow
- *Response at a Time of Crisis*; implementing the NWL model of care for Frailty patients (builds on previous Urgent Care Board collaborations)

Work Programmes: CLCH

Current Initiatives

- Long standing partnership models and joint contracts to provide Sexual Health services
- Partnership Agreement for H&F Integrated Care
- System partner for RKBC/West London CCG integrated care model for <65's, *My Care My Way*

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.1/May/18
REPORT NAME	Chairman's Report
AUTHOR	Sir Thomas Hughes-Hallett, Chairman
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide an update to the Council of Governors 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	This paper is submitted for the Governor's information.

Chairman's Report
May 2018

1.0 Governor update

I continue to host informal lunch sessions with Governors, including in late April, at West Middlesex Hospital. As always, these provide an opportunity to discuss matters of mutual interest in an informal and frank way. I was also pleased to hold an induction session for some of our new Governors which also provided a useful opportunity for discussion. I am also aware that those Governors who were able to attend, appreciated the separate in-depth briefing session on Trust finances.

2.0 Care Quality Commission (CQC) inspection report and NHSI use of resources

The report is on the agenda for discussion today. I want to place on my record my personal thanks to everyone who contributed to delivering such positive outcomes for our patients, staff and the public at large.

3.0 Strategy planning

The Board held a strategic discussion on 12 April 2018. This provided an early opportunity to consider the Care Quality Commission report which had been issued just two days prior to the meeting. The Board also reviewed its strategic priorities and its annual plan, and discussed ideas for the main topics that we will choose to discuss in June at the Board's away day.

4.0 Electronic patient record (EPR) system implementation

I hope Governors will join me in congratulating the executive team on the implementation of the Electronic Patient Record (EPR) system, at West Middlesex hospital. The work involved in preparing for this major system change has been considerable and we are confident it will deliver significant benefits for patients and staff. Go live took place on 4 May and, at the time of drafting, has happened in line with plans.

5.0 PROUD working group

I undertook to report to Governors on the work of the Proud (Health and Wellbeing) Action Group. The Group was formed in September 2017 as part of the actions outlined in the Trust's two year Staff Experience Improvement plan. It meets on a monthly basis and is established as a sub-committee of the People and Organisational Development committee. I initially chaired the Group, although this has now changed to being jointly chaired by Sandra Easton, Chief Financial Officer and Pippa Nightingale, Chief Nurse.

The aim of the Group is to drive the overall health and wellbeing agenda and support the development of a Trust strategy for promoting the health and wellbeing of those working in the Trust, focusing on areas such as mental health and wellbeing, physical health and wellbeing, smoking cessation, alcohol consumption awareness and healthy eating. The Group is also responsible for considering key external quality benchmarks for health and wellbeing and agreeing the use of these in the Trust.

In order to achieve its aims the membership of the group is wide ranging and includes representation from medical , nursing and therapy staff, HR, Occupational Health, management , admin and clerical staff , volunteers, staff side representatives and CW+.

The group has agreed that the Trust will seek accreditation under the London Healthy Workplace Charter and a gap analysis was conducted during the meeting in January to identify key areas of focus in order to the Trusts application to be approved. An action plan was developed in response to this analysis and these actions are currently being worked through with the aim that our application will be submitted by October 2018.

At each meeting there is also the opportunity for group members to identify 'quick wins' to improve staff health and wellbeing and ideas so far have been to improve storage facilities for staff to leave their belongings, increasing the number of exercise and leisure groups offered in the Trust and publicising the current staff benefits offering in a more systematic way.

A key focus so far for the group has been on mental health and wellbeing and in particular how to reduce the stigma surrounding this. As a result of discussions initially held at this group a full programme of activities has been developed to recognise Mental Health Awareness Week which runs from the 14th to the 20th May.

The group is currently exploring the importance of hydration for our staff and volunteers with the view to launching a hydration drive across the Trust as well as exploring how the use of external volunteers form the private sector could help to improve the working lives of our staff.

6.0 Report from the March and May Closed Boards

Items discussed at the March closed session included a) the way in which the new North West London Pathology partnership is developing, including the interaction with its IT systems and the Trusts and b) the costs attached to clinical negligence claims brought against the Trust.

Items discussed at the May closed session included a) a business case for an estates matter at West Middlesex b) cyber security and c) the car parking review as tabled at this Council meeting.

7.0 Update on Board Committees

Further to the resignation of Gary Sims, we have rearranged some responsibilities around Board Committees. The new arrangements are as follows:

- **Audit and Risk Committee** will be chaired by Nick Gash, supported by Liz Shanahan and Nilkunj Dodhia.
- **People and Organisational Development Committee** will be chaired by Steve Gill, supported by Eliza Hermann and Martin Lupton.
- **Finance and Investment Committee** will be chaired by Jeremy Jensen, supported by Nilkunj Dodhia and Liz Shanahan.
- **(no change) Quality Committee** will be chaired by Eliza Hermann, supported by Nick Gash and Dr Andrew Jones.

In addition, we are working on establishing a new group to lead on oversight of the Trust's digital strategy and risks associated with it. This is such an important area. This group will comprise Nilkunj Dodhia and Steve Gill, supported by Kevin Jarrold our Chief Information Officer.

Non-Executive portfolios continue to be:

- Estates, led by Dr Andrew Jones;
- Marketing and Communications, led by Liz Shanahan;
- Strategy, to include succession planning, led by Jeremy Jensen, supported by Steve Gill, Dr Andrew Jones, Liz Shanahan and Nick Gash;
- Health and Wellbeing, myself;

- Raising Concerns, Nick Gash; and
- for the Charity, CW+, Nick Gash.

8.0 External engagements

Since the last Council meeting I have:

- Attended the NHSI's Chair's Advisory Panel
- Had a private meeting with the Chair of NHSI, Baroness Dido Harding
- With the CEO, met Sir Richard Sykes, Chairman of Imperial College Healthcare NHS Trust to continue building our relationship with Imperial College
- Met Charles Alexander, Chairman of the Royal Marsden NHS Foundation Trust to identify new areas of collaboration
- Met Peter Wyman, Chairman of the Care Quality Commission
- With the CEO, met our equivalents at Guy's and St Thomas' NHS Foundation Trust
- Held discussions re: North West London STP Transformation Board with the Chairs' Group
- Met Lord Prior, Chairman of University College Hospitals London NHS Foundation Trust
- Met Dominic Dodd, Chair of the Royal Free London NHS Foundation Trust

9.0 Volunteering

I have now spent two days as a 'Bleep volunteer' at Chelsea and Westminster Hospital. Working with two other volunteers, our key role was to get prescribed drugs swiftly to the wards from pharmacy. Our professional pharmacy team are convinced the 'Bleep' service gets people home earlier, freeing up beds we need urgently for other patients. Meanwhile our nurses can focus on the jobs they were trained to do. The wards welcomed us, as did ICU, and we were told that as a result of our speedy delivery a gentleman would get back to his home in the north-west of England before darkness fell. One lady was so thrilled by getting her drugs so quickly that she signed up on the spot to become a Bleep. Finally, and most significantly, we were bleeped from Reception to support a very anxious patient. We spent time with this patient, talking to them and calming them. I am absolutely sure that the appointment would not have been kept if we had not gone with him and introduced him to the clinician the patient was seeing in clinic.

I also discussed with our nursing team on one ward how they could have freed up an urgently needed bed occupied by a patient who wanted to go home but was unable to as no member of his family was going to be there to receive him until late evening – one of HelpForce's strategic objectives is to complete a companion service which would have taken this patient home and sat with him until the return of their family member.

I would strongly encourage any Governor who is interested in volunteering to get engaged. It does provide tremendous benefit to the hospitals.

Sir Thomas Hughes-Hallett
Chairman

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.2/May/18
REPORT NAME	Chief Executive's Report
AUTHOR	Karl Munslow Ong, Deputy Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Council of Governors 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

May 2017

1.0 Care Quality Commission and Use of Resources Assessment

I'm delighted to report that we have been rated 'Good' overall across both hospitals and in all the 5 main CQC domains - safe, effective, caring, responsive and well-led. This gives the Trust a 'Good' rating overall. We've also been awarded an 'Outstanding' rating for 'use of resources' by an NHS Improvement inspection which was completed during the same period as the CQC assessment.

It's a fantastic result and is a tribute to the hard work and dedication of our staff to deliver the highest quality care to our patients both today and into the future.

It's a proud moment to be the first NHS hospital foundation trust to gain 'Good' across all categories under the CQC's new framework and outstanding from NHSI. Looking back over the past year we've performed incredibly well, consistently delivering on our national access standards and ranking in the top ten best performing trusts in the country. I know the organisation is very committed to continuing our improvement journey and providing the very highest quality of care both today and into the future.

In light of the recent regulatory assessments we have also had the very positive news that NHSI have moved us in to Segment 1 in line with their Single Oversight Framework (SOF). This means that the Trust is recognised as one of the highest performing providers and is afforded maximum autonomy with no support needs identified and will have only very light touch regulation.

2.0 Performance

During 2017/18, the Trust has performed very well against the key regulatory and contractual performance metrics, including quality and workforce KPIs. The start of the financial year was challenging in the delivery of all 3 regulatory standards but during the year compliance has shown continuous improvement. Of particular note is the Trust's continued strong performance in delivering A&E, RTT and Cancer access standards, despite unprecedented demand during Q3 and Q4.

Throughout 2017/18, the RTT performance has been increasing and from November 2017, the aggregate performance has been compliant with the National 92% standard. Quarter 4 represented the best performance since the merger of the two sites in September 2015 which is significant given the challenges the organisation faced with non-elective demand. During 2017/18, there were no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue into 2018/19.

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 and Westminster only met 94.3%, this is in no way reflective of the efforts of our staff. Demand has increased by c.9.4% compared to 2016/17 and Chelsea and Westminster in is the upper decile nationally in terms of overall performance.

Our performance in relation to the 62-day cancer GP referrals to first treatment standard has been excellent during the year, with 2 months being the Number 1 performing Trust in the UK (November 2017 and January 2018). Our compliance with the 2 week wait standard has also been excellent. Both of our sites have experienced significant growth in demand with increased referrals compared to 2016/17 yet the organisation has responded well to deliver timely care for our patients.

3.0 Quality Priorities

In 2017/18 we set ourselves 7 quality priorities linked to patient safety, clinical effectiveness or patient experience:

Patient safety
Priority 1: Reduction in falls (Frailty Quality Plan)
Priority 2: Antibiotic administration in sepsis (Sepsis Plan)
Priority 3: National Early Warning Score (NEWS) (Sepsis Plan)
Priority 4: National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)

Clinical effectiveness
Priority 5: Reduction in stillbirths (Maternity Plan)

Patient experience
Priority 6: Focus on complaints and demonstrate learning from complaints
Priority 7: FFT improvements with new FFT provider

Significant progress has been made with all 7. Some of the highlights are: There has been a 38% reduction on falls with severe harm; the implementation of the sepsis plan is showing improvements in screening; and treatment of patients and our still birth rate is lower than the national average. 3 of the priorities have been rolled over to 2018/19 and others are now being managed as part of 'business as usual'.

4.0 Staff Achievements and Awards

Celebrating long service
This month we announced that the Trust is introducing long service awards, which will be sponsored by our charity CW+. These awards aim to show our sincere appreciation for our staff and their loyalty to our hospitals, clinics and the NHS as a whole.

The first round of awards will be given in May, coinciding with Chelsea and Westminster Hospital's 25th anniversary. Members of staff with 25 years or more of service will receive a badge, certificate and a special Trust notebook. Awards for 10, 15 and 20 years will be given out via the Divisions throughout the rest of the year. These awards will celebrate our staff and support our engagement efforts.

Our latest CW+ PROUD award winners:
February 2018:

- Rachel Sharkey, Emergency and Integrated Care
- Jupiter Ward, Women's and Children's
- Avril Blenman and Aine Lennon, Planned Care
- Vida Djelic and Barbara Kasprzyzk, Corporate

External recognition:

56 Dean Street was recognised in the well-renowned Boyz Awards:

- It was named as the 'Best sexual health organisation or clinic' for the fourth year running
- Leigh Chislett, Clinic Manager at 56 Dean Street, was awarded for his 'Outstanding Contribution' for his services to people with HIV, longstanding leadership and commitment to sexual health.

Music Therapists, Grace Watts and Claire Flower, received a Jessica Kingsley Publishers Poster Prize for 'Music While You Wait', which is a music therapy and maternity project across the antenatal clinic, and the antenatal and post labour wards.

5.0 Communications and Engagement

CQC result summary

Our social media comms including several videos and photos reached nearly 100,000 social media users. One video alone being seen by 15,000 people within the first 24 hours. It was the best ever engagement seen on our social media channels, generating several hundred new followers on the results day.

Ongoing activity
Our monthly all staff briefings at the start of April were well-attended, covering improvement initiatives in theatres, our charity's innovation programmes, and a new core training compliance system, Qlikview. Our new podcasts of each briefing, which were introduced this year, have been very well-received by staff, increasing exposure and engagement. The latest all staff briefing is attached to my report.

We issued press releases on CQC, getting coverage in the Evening Standard, the staff survey and the introduction of 'bleep volunteers'. In March, we were pleased to host Jeremy Hunt, Secretary of State for Health, who toured our busy CWH A&E and spoke to staff about important safety initiatives across the NHS.

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

- Our HOME initiative linking to the national #endPJparalysis challenge, featuring Theo, a West Mid patient, and his road to recovery. NHS England have picked up his story and asked to use this in their promotional material.
- We continue to promote and support CernerEPR ahead of its go-live on May 4, rolling out a series of countdown videos in the final 10 days.

- Highlighted the work of our Paediatrics team at West Mid, ahead of their open day to aid in nursing recruitment.

We are continuing to update the Trust's website, key recent changes include:

- Featuring our new CQC 'PROUD' result video on the homepage of our website
- Launching an innovative new tool for staff to report excellence – initially covering A&E/UCC/AAU at Chelsea and A&E at West Mid
- Creating a new video library, to showcase some of the Trust's key videos
- Fresh information on our medicine services including A&E, Haematology, Rheumatology
- Various updates made to wards and departments list, including visiting times and location/contact information updated
- Added eReferral information, tailored for patients, public and GPs and health professionals
- Updated information on our sexual health clinics
- Updated prescription charges information

Update on the Comms Strategy (KPIs and more detail in appendix)

Over last 6 months, the Comms team have delivered:

- Five regular newsletters instead of one
- Podcasts of Staff Team Brief
- Video content on all channels
- Increased staff engagement via social media, with 4,000 more followers across all channels in last 6 months, a 20% increase
- Increased number of positive media stories, eg London Standard CQC result, Use of Robots in Orthopaedic surgery, new EPR systems in the Digital press.
- Higher number of visitors to our webpages, often viewing new videos or directed to our website via social media content (making a better user journey)
- Going Beyond 50% more pages and content
- More prominent and consistent branding
- Announcement of new long service awards

We continue to lift our communications and engagement activity, with a focus on brand identity and consistency.

6.0 General Data Protection Regulation Preparations

As I have previously reported to Trust Board, on 25th May new legislation will be coming into effect to safeguard the use of an individual person's data. The new legislation seeks to protect the fundamental rights and freedoms through the processing of personal data and safeguarding the secure transfer of data within and across organisational boundaries. There are also significant financial consequences for organisations that get this wrong. There will be a wider definition of personal data which includes anything that discloses identity and is unique to the individual.

As a large healthcare provider we have access to a large amount of personal data of staff and patients and we are very clear about our responsibilities to kept this secure and accessible only to those who professionally need it. The new legislation will bring about a number of changes in the

way we process the personal information of our staff, patients and the public as well as giving people more control over how their personal data is used. A significant amount of work has been completed in preparation for GDPR. As with other NHS organisations, we will not yet been able to state full compliance with all standards, particularly as some of the legislation is still be clarified. We do however have a plan that addresses the gaps in compliance and that has been reviewed by the Information Commissioners Office and will be monitored on an ongoing basis by the Audit and Risk Committee.

7.0 Strategic Partnerships Update

Strategy Development

The Board Strategy Working Group has made its outline recommendations which were discussed at the March Board Strategy meeting. It was agreed that the Executive Team would develop an options appraisal with more detailed supporting analysis, using the *matrix* methodology employed by the Board in 2014 when the Acquisition Business Case was adopted. This will ultimately support the wider strategy development discussions at the Board away day in June.

North West London Sustainability & Transformation Partnership

The STP continues, broadly, on its twin track process:

1. A series of detailed service/system improvement initiatives where NWL providers are coming together to focus on closing current gaps on quality and financial performance. The guiding principles of consolidation/scale and standardisation are being applied to clinical and clinical support areas. Work programmes include the Outpatient Transformation Programme and North West London Radiology Network
2. The 5 Delivery Areas which are more population and prevention based and where the Trust is engaged in a smaller number of transformational programmes remain focussed on long term conditions and population health priorities such as Diabetes, Mental Health and Older Adults. This continues to be supported by supporting programmes such as the Care Information Exchange, Business Principles and Workforce Development.

Paediatric Services

NHSE (London) have set out their proposed approach to engaging stakeholders following the consultation on Children's Congenital Heart Disease. Broadly there are two areas where the Trust is engaged:

1. NHSE (London) have indicated that they believe there are still a number of viable options which should be explored as alternatives to the Royal Brompton and Harefield(RBH) preferred model of co-location with St Thomas'. These options are to be developed and tested in parallel with the larger RBH preferred case
2. The work led by the Trust in developing Paediatric Surgical Services is seen as a leadership model for network development. Discussions are focusing on Critical Care and Surgery and NHSE (London) are keen to explore the potential scale of a North Thames leadership

model based on the work we have undertaken to date.

Integrated Care Partnerships

The Strategic Partnerships Board (SPB) continues to monitor these strategic work programmes. These programmes currently remain proportionate to the wider priorities of the Trust and small scale/evaluatory in nature but do provide opportunities for early engagement and learning. At this stage they are borough based CCG sponsored initiatives rather than STP wide:

1. Hammersmith & Fulham ICP. Partnership Agreement in place with H&F GP's, ICHT, CLCH and WLMHT. Working assumption from H&F CCG is that an Outcomes Framework and alliance contract will be in place from Q2 of this year. This will not transfer resources from current contracts but will set out incentives. Three likely programmes:
   a) Establishment of multidisciplinary team (MDT) model in Child Health of 1 per network (3 across H&F)
   b) Adult Care project likely to review re-admissions in long term conditions
   c) Older Adults to support Frailty and End of Life
2. My Care; My Way (West London over 65s hub): Proposed alliance contract (CW value between 60-200k). This would support MDT working in south hub and would target consultant and other workforce support to ambulatory care. Builds on existing Older Adult Support Team (OAST) and possible initiatives in 18/19 include hosting of post A&E 'hot clinics'; post discharge OP activity.
3. Hounslow STP Implementation: This is focussing on review of urgent care pathways and the development of the Emergency Care Portal on WMUH site. CCG support for development of WMUH Estate and (first phase) ambulatory care is being managed through this programme.
   Dialogue with CCG and NHSE on primary care models was curtailed over CQC inspection period and wider winter focus but is being re-initiated
4. Kingston & Richmond Care Transformation Board: the alignment of the 2 CCGs and creation of a sub SWL STP footprint. This is effectively replacing the Richmond OBC as a change programme but remains at very early stages while the proposed model of care is developed. End of Life indicated as an early priority area.

Imperial College Healthcare NHS Trust

We continue to make good progress with a number of our clinical service workstreams. We have now formalised our joint paediatric surgical arrangements with the shared appointment of two new paediatric surgical consultant posts. We have also looked to integrate our two service governance structures including the appointment of a single Clinical Service Director.

Work has begun on exploring areas of collaboration in paediatric critical care. Three areas have been chosen; patient pathway alignment, clinical governance and management and education and training.

Imperial College Health Partners have over the last few months been supporting our two HIV services to identify areas of closer collaboration with a specific focus on inpatient care. A proposal will be brought to our Exec to Exec meeting in mid May with the intention to then engage

commissioners, STP colleagues, and other stakeholders in any proposed services changes to support improvements to care and patient experience.

Northwest London Pathology

NWL Pathology went live with their new Laboratory Information Management System (LIMS) on 7th and 8th April. During the weekend activity took place to switch over from the old IT laboratory system to the new SunQuest LIMS product on the Imperial and Chelsea & Westminster sites. This is the first 'go live' of the LIMS project that started back in September 2016 and constitutes a significant milestone for NWLP and its transformation plans. The new LIMS covers many elements of service including Blood Sciences, Infection and Immunity, Cellular Pathology and specialist services.

As with any new system we have experienced some ongoing issues that are being dealt with in conjunction with North West London Pathology team although these are now largely resolved.

There are further 'go lives' that are required to complete this work that will take place over the next few months. These include roll out at the West Middlesex site which we chose to delay in light of the Cerner roll out plan at the beginning of May.

8.0 Implementation of the Cerner Electronic Patient Record – Phase 1

We are now on track to take Phase 1 of the Cerner Electronic Patient Record live over the early May Bank Holiday. This will involve replacing the Patient Administration System and implementing new functionality for the emergency department and theatres at the West Middlesex Hospital. This is the first step on our journey towards having a single electronic patient record across the whole trust. Phase 2 is schedule for next year and will see the replacement of the LastWord system on the Chelsea site.

We have been tracking progress through a series of Gateway reviews and the outcome of the final one of these for Phase 1 is scheduled for review by the EPR and Digital Transformation Board on Friday 4th May. Subject to the outcome of the review our expectation then is that we will initiate the process of taking the existing West Middlesex Patient Administration System down so that the data migration process can complete. A very detailed plan has been developed for managing the cut over to the Cerner system and continuing to deliver care throughout this transition phase. The new system should be live across the whole of the West Middlesex site by start of business on Tuesday 8th May. We have a very detailed plan for 'at the elbow' support from our team of floorwalkers as users get familiar with the new system.

A high proportion of staff have now completed their training and the communication campaign for staff, patients and stakeholders has really ramped up.

9.0 External Inspections

Appended to this report is a list of external inspections over the coming few months.

10.0 Finance

The financial position is £25.6m adjusted surplus on a control total basis, which includes £27.4m of Sustainability and Transformation Funding (STF). The Trust has over-delivered against the control total for 2017/18 and the appeal for the A&E quarter 4 STF was upheld. It should be noted that the numbers are draft and subject to External Audit.

Lesley Watts
Chief Executive Officer
May 2017

Appendix

Timetable of External Inspections, Visits and Accreditations 2018

Month	Specific Date	Reviewing Authority	Where Will the Inspection Take Place?	Aspects of Compliance to be Tested	Executive Lead	Lead Director	Operational Lead	Reporting Group	Group overseeing compliance	Info/ Timetable
May	14th May All Day Soft Services Visit 09:00am – 15:30pm	All Day Visit 09:00am – 15:30pm	CW	Covering meal Service - Cleaning Standards and Fabric						
	24th of May	United Kingdom Accreditation Service (UKAS)	Audiology, WM	Physiological Services accreditation (IQIPS)	Mr Peter Dawson	Faizal Mohomed-Hossen	Karlien Van Staden Deputy Head of Audiology/ Gillian Ross, Head of Audiology 020 8321 5681	Planned Care Division Board	Trust Compliance Group	Timetable
June		Society for Endocrinology	CW/WM	? Specific Endocrinology standards	Zoe Penn	Dilys Lai	Daniel Morganstein	EMIC Division Board	Trust Compliance Group	Attach here
	6th of June	North West London Trauma Network (St. Mary's Hospital)	A&E CW	Trauma Network Guidelines	Miss Zoe Penn	Dilys Lai	Dr Peta Longstaff	EMIC Division Board	Trust Compliance Group	

Inspections to be confirmed

CQC- 2018/19 - Critical Care; Maternity; Diagnostic Imaging; and HIV/Sexual Health

All staff briefing

April 2018

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

How will Cerner EPR change what you do?

What is going to change for you when we go live with Cerner EPR from May 4th? The way to find out is to attend your Cerner EPR training. As we get into the final weeks, places on training are becoming more scarce. So don't waste yours!

You are not expected to be an expert after your training. There will be support after go-live from floorwalkers and champions and the ICT service desk and we have a collection of quick reference guides to show how to complete tasks on Cerner.

Do you know who your champion is? Do you know where to find the quick reference guides?
Each day in daily noticeboard we are publishing a tip for a particular role. For example, for clinicians in outpatients setting up favourites for the procedures and follow-up appointments you routinely order is a real time saver. You'll see these tips in posters, flyers and screensavers.

Care Quality Programme (CQP)

The Care Quality Commission (CQC) draft report has been reviewed by the Trust, from here our final report and grading is expected imminently. Once this is published, the news will be available to Trust staff - and on the Trust website for the public to see the rating and report on the Trust's services.

Current work continues to enhance quality and standards of care and meeting the CQC core standards. This will help the Trust work to the next unannounced inspections on our services that were not inspected in December and January. The CQP team have commenced a series of updates and briefings for staff. Further information is available on the intranet page, http://connect/departments-and-mini-sites/cqp/ or via cqp@chelwest.nhs.uk. The updated staff information handbook 'Contributing to a successful Care Quality Commission inspection' is available from the Communications Offices on both main sites, or the CQP Lower Ground floor on the Chelsea site.

It is a good time to reflect on the positive changes to improving quality, safety and performance over the last 12 months, and ensure they continue! Inspectors can arrive to inspect any of our services at any time, but more importantly, we will be continuing our quality journey because it is the right thing to do for our patients and ourselves.

Financial Performance

The 2017/18 financial year is coming to a close and our February year to date adjusted financial position is £1.36m ahead of plan. As in previous months, pay costs continue to be over plan with the year to date overspend increasing to £12.56m. Pay overspends are offset by underspends in non-pay. The year to date underlying financial position, after adjusting for non-recurrent income, is a deficit of £21.51m.
We have achieved 81.5% of our 2017/18 savings target of £25.9m.

Anniversaries in 2018

We will be celebrating four special anniversaries this year:

- 25th anniversary of Chelsea and Westminster Hospital—13 May
- 70th anniversary of the NHS—5 July
  On this date we will be holding open days at both hospital sites
- 30th anniversary of the Kobler Centre—13 September
- 15 anniversary of West Middlesex University Hospital—17 November

Plans are now well underway but we would love to hear from you, if you have any great historical photos or stories to share, please email communications@chelwest.nhs.uk

Staffing

Nursing Recruitment

The first couple of months of the year has been pretty busy for nursing recruitment at the Trust. We have offered a total of 78 nursing posts so far this year, travelling up to Manchester and Birmingham to attend the RCN jobs fairs, attending university open days at Kingston and Kings College and holding on site and Skype interviews.

The capital nurse programme is proving very popular for both graduates thinking of moving to London and for graduates completing their nursing degree/post graduate diploma in London. We are showcasing our innovative work with recruitment and retention with the rest of London at the Capital Nurse Expo last month.

Internal transfer continues to be available to Band 5s and Band 2s to broaden depth of experience and do remember to book into the weekly career clinics held on Tuesdays at Midday if you would like some careers advice. Contact Julie.Pie@chelwest.nhs.uk

If you are keen to increase your experience in carrying out interviews we have regular on site recruitment days for Band 2s and Band 5s and will also be attending RCN fairs in London and Glasgow in the coming month so please contact Cariosa.Murray@chelwest.nhs.uk if you are interested.

We take care to ensure that our new starters settle in and feel part of our team especially for those coming from overseas who have left family and friends behind for the first time. On 13 April we are repeating our successful new starters cinema event at the CW+ MediCinema where they will get to see the latest movie screening and spend time getting to know each other. Please contact Cariosa.Murray@chelwest.nhs.uk for more details.

Core (mandatory and statutory) training

Although we have made good progress with core training compliance this has declined recently and all staff are reminded of the importance of making sure they are up to date. We are rolling-out access for all compliance records on a revamped QlikView reporting platform (and removing Wired). Please see the intranet to access this.

Staff can complete the Core Training e-learning modules online at the Learning.Chelwest website learning.chelwest.nhs.uk—which is available from both within and outside the Trust, across a variety of devices. We will be adding additional topics in the coming months. The Cerner team are developing some refresher eLearning modules which will also be available via Learning.Chelwest shortly.

Latest CW+ PROUD award winners

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

- **Planned Care:** Avril Blenman, Technician in Decontamination Services, and Aine Lennon, Ward Manager - Lord Wigram Ward
- **Emergency and Integrated Care:** Rachel Sharkey, Acute Oncology Clinical Nurse Specialist
- **Women and Children:** Jupiter Ward
- **Corporate:** Vida Djelic, Board Governance Manager, and Barbara Kasprzyzk, ISS Hostess on AAU

Visit the intranet to nominate a team or individual.

May *All Staff Briefing* dates:

- Thu 10 May, 10:00 – 11:00, HY
- Thu 10 May, 13:00–14:00 — CWH Gleeson lecture theatre
- Due to Cerner EPR Go Live there will be no WMUH session in May

Communications Strategy Update

Gill Holmes
April 2018

proud to care

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Comms Strategy Timeline

Year 1 (2018)
Focus & Grip

- **Focus and centralise:**
  - Media and external requests
  - Staff engagement
- **Grip and Planning**
  - Divisional and priority area comms plans in place by end January
  - Website content & updates
  - Staff recruitment and retention campaign
  - Improvement/Innovation
  - Press activity
- **Consistent brand identity**
  - 'World Class'
  - 'Hospital of Choice'
  - 'Outstanding Specialist care'

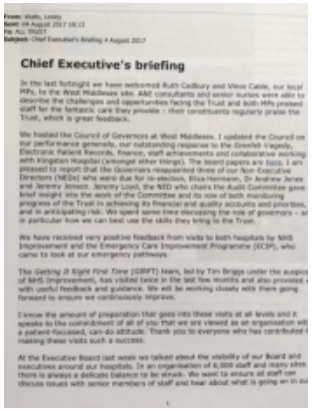
Year 2 (2019)
Strengthen & Promote

- **Strengthen :**
  - Staff engagement initiatives eg educational videos; newsletters, group events
  - Quality and reach of 'Going Beyond'
  - Improvement and innovation comms and coverage
  - External relationships and partnerships
  - Website
- **Promote**
  - Brand
  - Staff
  - Specialist services
  - Improvement, Innovation, Research

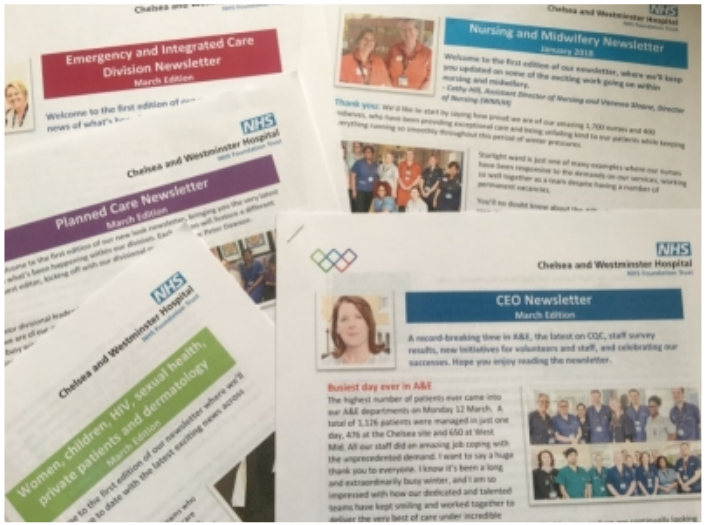
Year 3 (2020)
Grow & become 'Outstanding'

- **Grow**
  - Staff opportunities
  - Press coverage
  - Brand awareness
  - Innovation/Improvement
  - Income initiatives
- **'Outstanding'**
  - Support delivery of 'Outstanding' services and staffing
  - Successful integrated internal and external website
  - Delivery of high performing KPIs

October 2017


Chief Executive's briefing

End March 2018



1 CEO briefing every 2-3 weeks
No video content
No consistent branding or social media promotion

- **5 Newsletters instead of 1**
- **Podcasts of Staff Team Brief**
- **Video content on all channels**
- **Increased staff engagement via social media**
- **Going Beyond 50% more pages and content**
- **More prominent and consistent branding**

Monitoring Performance: KPIs

KPI	C&W Trust	C&W (NHS 17 survey)	Target end 2018	Benchmark
NHS staff survey: % completing survey (2016)	40%	**32%**	45%	43% (Nationally)
NHS staff survey: % reporting good comms btw senior mgrs and staff	34%	**41%**	40%	33% (other Acute Trusts)
Items of positive media coverage	n/a	**10-12 (last 5 months)**	24 pa	Two per month
Staff engagement % opening all staff emails (use of comms tool 'Poppulo')	n/a	Launch in May	50%	40-50%
Website: number of sessions (added 12 new videos)	100k per month	**10% increase last 3 months**	120k per month	120-150k p/m

KPI	C&W (Oct 17)	C&W (March 18)	Target end 2018	West Mid (Oct 17)	WMUH (March 18)	Target end 2018	Benchmark (other London Trusts)
Twitter: Number of followers	8,200	**9,300**	10,000	7,800	**8,600**	9,000	17,000
Facebook: Number of followers	1,800	**2,100**	2,200	1,020	**1,200**	1,300	4,000
Linkedin **Instagram**	3,800 100	**5,000** **500**	5,000 500	n/a	n/a	n/a	8-10,000

Comms Strategy 6 Month Progress

Year 1 (2018)
Focus & Grip

- **Focus and centralise:**
  - Media and external requests
  - Staff engagement
- **Grip and Planning**
  - Divisional and priority area comms plans in place by end January
  - Website content & updates
  - Staff recruitment and retention campaign
  - Improvement/Innovation
  - Press activity
- **Consistent brand identity**
  - 'World Class'
  - 'Hospital of Choice'
  - 'Outstanding Specialist care'

- **FOCUS AND GRIP:**
  - **Divisional newsletters in place alongside CEO Newsletter**
  - **Nursing and Midwives newsletter to focus on retention/recruitment**
  - **Poppulo staff engagement tool to be launched in May**
- **KPIs show increased social media engagement**
  - **4,000 total extra followers**
  - **UP 20% in 6 months**
- **High quality videos available and being shared across all channels**
- **Website being updated**
- **Pick up in positive media articles**
- **Consistent brand look/style developed**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.3/May/18
REPORT NAME	Integrated Performance Report – March 2018
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for March 2018 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for March 2018. **Regulatory performance** – The A&E Waiting Time figure was not met for March with 94.0%. The figure, however, compares favourably with a 2% increase on that reported for the same month in 2017, with a 12% increase in attendances. National figures show that Chelsea and Westminster ranked 7th of the 137 reporting Trusts. The RTT incomplete target was achieved in March for the Trust, with performance of 93.0% and both of our sites in a complaint position. This represents the fifth consecutive month the national standard was reached and represents the best performance since the merger of the two sites in September 2015. There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue. All reportable Cancer Indicators met the target in March which helped deliver a strong Q4 position in the delivery of the of 62 Day standard. There was one reported CDiff infection in March. However, the Trust remained within its target for this indicator for the full year. **Access** Issues in Urology at the Chelsea Site plus Cardiology and Endoscopy at West Middlesex continue to be addressed. These issues saw the Trust's performance against the Diagnostic Wait metric slip to 98.17%
KEY RISKS ASSOCIATED:	There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer 31 and 62 day waits remains a high priority. The Trust will continue to focus on the Diagnostic Waiting time issues in the weeks to come.

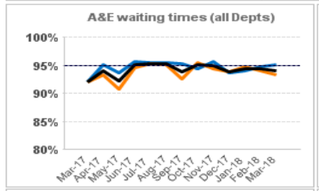
FINANCIAL IMPLICATIONS	To be confirmed
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Improve patient safety and clinical effectiveness • Improve the patient experience • Ensure financial and environmental sustainability
DECISION/ ACTION	To note.

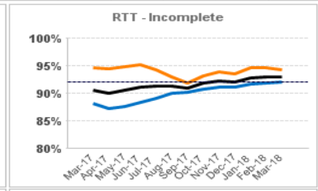
TRUST PERFORMANCE & QUALITY REPORT

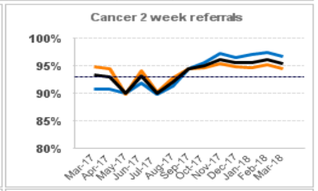
March 2018

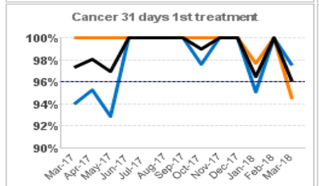
Regulatory Compliance

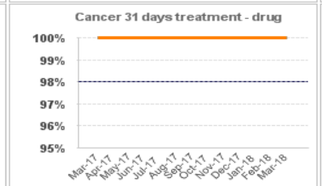
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	94.0	94.7	95.0	94.8	94.1	93.3	94.4	94.4	94.0	94.3	94.3	
RTT - Incomplete (Target: >92%)	91.6	91.8	92.1	94.6	94.5	94.3	92.9	93.0	93.0	92.9	91.7	
Cancer 2 week urgent referrals (Target: >93%)	97.0	97.4	96.7	94.6	95.2	94.5	95.5	96.1	95.4	95.7	93.9	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	93.5	94.6	96.1	93.5	94.6	96.1	95.1	93.8	
Cancer 31 days first treatment (Target: >96%)	95.1	100	97.5	97.7	100	94.4	96.5	100	96.1	97.5	98.9	
Cancer 31 days treatment - Drug (Target: >98%)	100	100	100	100	100	100	100	100	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	100	100	100	100	100	100	100	100	100	100	100.0	
Cancer 62 days GP ref to treatment (Target: >85%)	91.5	97.0	94.3	95.5	92.3	80.0	93.8	93.7	86.7	91.4	88.8	
Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16)	0	1	1	0	1	0	0	2	1	3	12	
Average Emergency PreOp LoS	0.60	0.59	0.88	1.27	1.08	1.38	0.91	0.82	1.10	0.94	0.96	
Average Elective PreOp LoS	0.19	0.16	0.12	0.50	0.03	0.13	0.27	0.12	0.13	0.17	0.19	

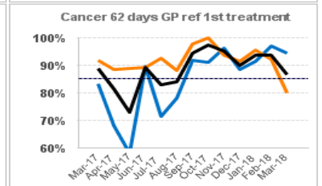






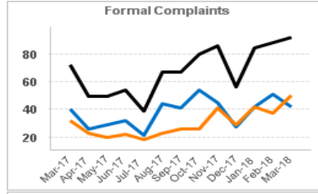


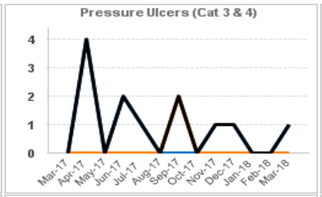


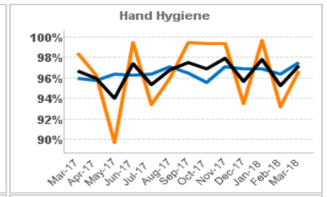


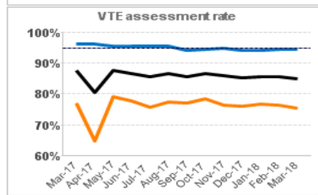
Quality

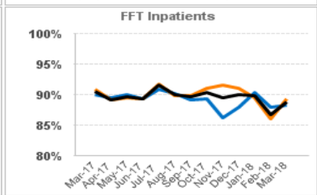
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	96.8	96.4	97.5	99.7	93.2	96.7	97.8	95.2	97.2	96.8	96.5	
Pressure Ulcers (Cat 3 & 4)	0	0	1	0	0	0	0	0	1	1	12	
VTE assessment % (Target: >=95%)	94.2	94.7	94.6	76.9	76.5	75.4	85.7	85.6	84.8	85.4	85.6	
Formal complaints number received	42	51	42	42	37	50	84	88	92	264	811	
Formal complaints responded to <25days	28	30	21	19	13	17	47	43	38	128	347	
Serious Incidents	2	5	3	6	2	4	8	7	7	22	83	
Never Events (Target: 0)	0	0	1	0	1	0	0	1	1	2	6	
FFT - Inpatients recommend % (Target: >90%)	90.4	87.9	88.2	89.4	86.0	89.3	89.8	86.7	88.9	88.5	89.6	
FFT - A&E recommend % (Target: >90%)	91.1	90.7	89.4	89.1	84.7	82.3	90.8	89.8	88.3	89.5	87.1	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	0	

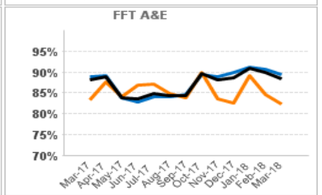






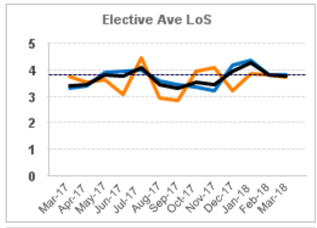


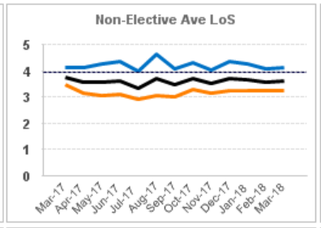


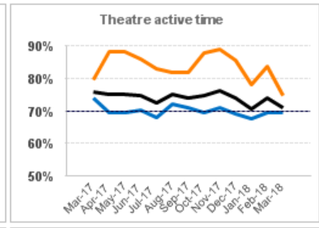


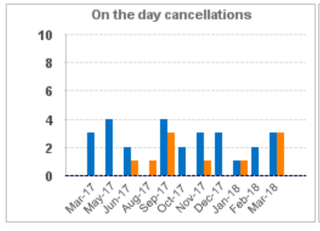
Efficiency

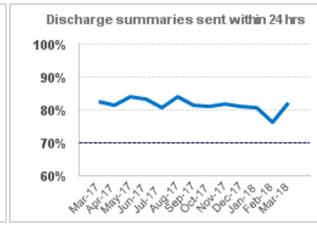
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	4.4	3.8	3.8	3.9	3.8	3.7	4.3	3.8	3.8	3.9	3.7	
Non-Elective average LoS (Target: <3.95)	4.3	4.1	4.1	3.2	3.2	3.2	3.7	3.6	3.6	3.6	3.6	
Theatre active time (Target: >70%)	67.6	69.5	69.3	77.9	83.7	74.8	70.6	73.8	70.9	71.7	73.9	
Discharge summaries sent within 24 hours (Target: >70%)	80.8	76.5	82.1	dev	dev	dev	80.8	76.5	82.1	79.8	81.6	
Outpatient DNA rates (Target: <11.1%)	10.4	10.2	10.8	9.9	10.4	10.6	10.2	10.3	10.7	10.4	11.1	
On the day cancelled operations not re-booked within 28 days (Target: 0)	1	2	3	1	0	3	2	2	6	10	34	

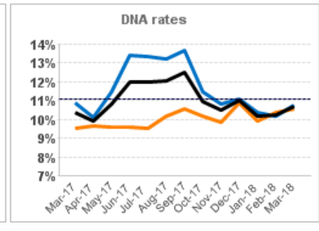






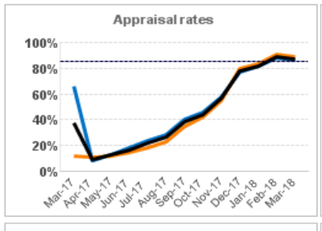


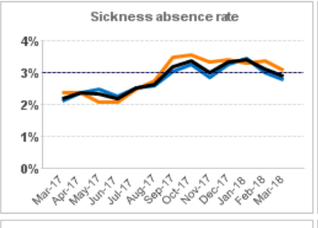


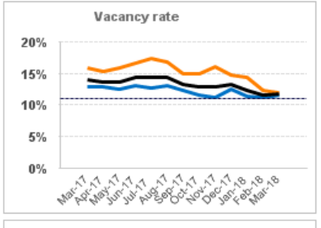


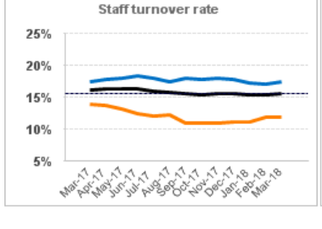
Workforce

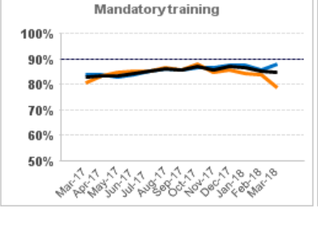
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Jan-18	Feb-18	Mar-18	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	81.2	87.7	86.4	83.1	90.7	88.7	81.9	88.7	87.2	85.9	47.1	
Sickness absence rate (Target: <3%)	3.44	2.98	2.78	3.28	3.36	3.08	3.39	3.11	2.89	3.13	2.86	
Vacancy rates (Target: CW<12%; WM<10%)	11.3	11.2	11.5	14.5	12.3	12.0	12.4	11.6	11.7	11.7	11.7	
Turnover rate (Target: CW<18%; WM<11.5%)	17.3	17.1	17.4	11.1	11.8	11.8	15.3	15.3	15.5	15.5	15.5	
Mandatory training (Target: >90%)	87.6	85.7	88.1	84.4	84.0	78.7	86.5	85.1	84.6	85.4	85.4	
Bank and Agency spend (£ks)	£2,702	£2,703	£2,963	£2,518	£2,451	£2,964	£5,220	£5,154	£5,926	£16,301	£59,825	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	8.6	9.2	9.0	13.1	10.1	12.6	10.4	9.5	10.4	10.1	9.5	

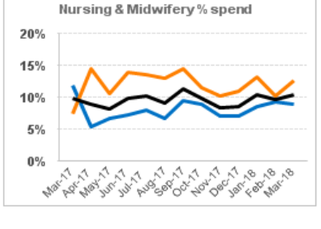












NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	94.0%	94.7%	95.0%	94.8%	94.8%	94.1%	93.3%	94.0%	94.4%	94.4%	94.0%	94.3%	94.3%		!
RTT	18 weeks RTT - Admitted (Target: >90%)	72.7%	69.0%	72.3%	69.2%	89.1%	87.4%	87.7%	86.1%	81.8%	79.6%	81.8%	81.1%	78.7%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	93.5%	93.8%	95.0%	93.0%	90.2%	91.9%	91.7%	90.8%	92.2%	93.1%	93.6%	92.9%	92.2%		!
	18 weeks RTT - Incomplete (Target: >92%)	91.6%	91.8%	92.1%	90.1%	94.6%	94.5%	94.3%	93.9%	92.9%	93.0%	93.0%	92.9%	91.7%		-
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-18) in this report)	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	97.0%	97.4%	96.7%	94.1%	94.6%	95.2%	94.5%	93.8%	95.5%	96.1%	95.4%	95.7%	93.9%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	93.5%	94.6%	96.1%	93.8%	93.5%	94.6%	96.1%	95.1%	93.8%		-
	31 days diagnosis to first treatment (Target: >96%)	95.1%	100%	97.5%	98.3%	97.7%	100%	94.4%	99.4%	96.5%	100%	96.1%	97.5%	98.9%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Radiotherapy (Target: >94%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-
	62 days GP referral to first treatment (Target: >85%)	91.5%	97.0%	94.3%	84.6%	95.5%	92.3%	80.0%	91.7%	93.8%	93.7%	86.7%	91.4%	88.8%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	50.0%	100%	100%	88.9%	50.0%	100%	100%	88.9%	88.9%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	0	1	1	2	0	1	0	10	0	2	1	3	12		-
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 Hours waiting time

The Trust did not achieve the 95% standard but significantly improved the position from March last year by a 2% increase, despite a 12% rise in attendances. Nationally this placed CWFT 7/133 Trusts and top in London for the month. To improve further, the plan is to use the LOS/Bed productivity work stream to continue current schemes and provide an enhanced ambulatory offering on both sites ahead of winter 2018/19.

18 Weeks RTT – Incomplete

Trust wide compliance was achieved for March at 93.0% with both sites individually achieving compliance. This was the first time since July 2015 that both sites have achieved this.

18 weeks or RTT awareness sessions have continued at the West Middlesex site with clinical training to support build awareness pre Cerner launch. This will improve data quality and aid clinical input post Cerner go-live.

Cancer Indicators

The Trust once again met the national target for all cancer indicators in March (unvalidated position) – although there was pressure on the 62 day standard at West Middlesex.

The breakdown of performance against this metric by tumour site can be found on page 12 of this document

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	1	0	0	3	1	0	0	1	3		-
	Hand hygiene compliance (Target: >90%)	96.8%	96.4%	97.5%	96.6%	99.7%	93.2%	96.7%	96.4%	97.8%	95.2%	97.2%	96.8%	96.5%		-
Incidents	Number of serious incidents	2	5	3	43	6	2	4	40	8	7	7	22	83		-
	Incident reporting rate per 100 admissions (Target: >8.5)	7.6	7.2	7.8	7.6	9.2	9.2	9.7	9.3	8.4	8.1	8.7	8.4	8.4		!
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.05	0.03	0.05	0.02	0.05	0.02	0.07	0.02	0.05	0.03	0.06	0.05	0.02		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	430.26	521.48	469.20	502.33	260.38	264.86	246.43	286.49	349.20	397.11	363.03	368.32	399.67		!
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	9.0%	13.4%	7.2%	10.9%	5.4%	6.3%	18.2%	12.9%	7.7%	11.1%	10.8%	9.8%	11.6%		-
	Never Events (Target: 0)	0	0	1	4	0	1	0	2	0	1	1	2	6		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	95.4%	95.5%	95.6%	96.0%	93.6%	96.5%	92.0%	93.0%	94.3%	96.2%	92.9%	94.6%	94.1%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	1	10	0	0	0	2	0	0	1	1	12		-
	NEWS compliance %	96.6%	97.2%	98.4%	97.1%	98.2%	99.2%	98.0%	97.0%	97.3%	98.1%	98.2%	97.8%	97.1%		-
	Safeguarding adults - number of referrals	18	31	19	241	8	5	4	219	26	36	23	85	460		-
	Safeguarding children - number of referrals	52	7	15	321	77	73	54	1100	129	80	69	278	1421		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7		-
	Number of hospital deaths - Adult	45	29	40	425	85	69	72	731	130	98	112	340	1156		-
	Number of hospital deaths - Paediatric	2	0	2	11	0	0	0	2	2	0	2	4	13		-
	Number of hospital deaths - Neonatal	2	1	2	17	0	0	0	11	2	1	2	5	28		-
	Number of deaths in A&E - Adult	1	2	3	30	8	10	10	81	9	12	13	34	111		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	0	2	0	0	0	0	2		-
	Number of deaths in A&E - Neonatal	0	0	0	0	1	0	0	2	1	0	0	1	2		-

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

Seven Serious Incidents were reported in March 2018; three at the Chelsea site with a further four at West Middlesex

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

Incident reporting rate per 100 admissions

Of the 1041 patient safety incidents reported, 503 relate to incidents occurring on the Chelsea site, 525 at West Middlesex,13 in Community clinics.

Trust commentary continued

Rate of patient safety incidents resulting in severe harm or death

Two incidents causing severe harm were reported in March 2018. One is categorised as a Patient fall land the other is categorised as Failure to rescue. Both incidents reported on the CWH site.

Three incidents causing death were reported in March 2018. One incident was reported on the Chelsea site and categorised as Failure to rescue. The other two incidents were reported at West Middlesex and were categorised as: Airway (Aspiration) and Venous thromboembolism (VTE) incidents.

Comprehensive investigations are currently underway relating to these incidents. Degrees of harm are yet to be confirmed.

Medication-related safety incidents

Of the 127 medication related safety incidents reported, 83 relate to incidents occurring on the CWH site and 44 on WMUH site.

WMUH site medication related safety incident reporting is improving. The pharmacy team are working with teams

Never Events

The one ‘Never Event’ reported in March 2018 was a retained vaginal swab post-delivery.

A comprehensive investigation is currently underway relating to this incident.

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

The Trust has achieved an overall reporting rate of NRLS reportable medication-related incidents of 355/100,000 FCE bed days in March 2018.

This is higher than the Trust target of 280/100,000. There were 459 and 239 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively.

There has been a decrease in reporting of medication incidents this month compared to recent months; reporting at WM site is lower than the Trust target

Medication-related (reported) safety incidents % with harm

The Trust had 11% medication-related safety incidents with harm in March 2018. This figure is similar to the previous month and is above the Carter dashboard National Benchmark (10.3%). The year to date figure is 11.6%.

Overall there were 10 incidents that caused low harm; 4 occurred at CW site and 6 at WM site. The low harm incidents mainly involved disconnected furosemide infusion, sedative effect of medication post bronchoscopy procedure, omission of opioid analgesia administration, administration of medication (codeine, penicillin) with a known documented allergy, incorrect administration dose of IV metronidazole, lack of monitoring of amikacin levels prior to prescribing, and incorrect prescribing of levothyroxine.

The Medication Safety Group continues to monitor trends and aim to improve learning from medication related incidents.

Incidence of newly acquired category 3 & 4 pressure ulcers

Preventing Hospital Acquired Pressure Ulcers remain high priority for both sites.

There was 1 grade 3 pressure ulcer reported on the CWH site. This is currently being validated as a potential serious incident

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	90.4%	87.9%	88.2%	89.1%	89.4%	86.0%	89.3%	89.8%	89.8%	86.7%	88.9%	88.5%	89.6%		!
	FFT: Inpatient not recommend % (Target: <10%)	4.3%	6.7%	5.1%	5.3%	4.2%	5.0%	3.7%	4.3%	4.2%	5.6%	4.3%	4.7%	4.7%		-
	FFT: Inpatient response rate (Target: >30%)	38.6%	36.8%	31.6%	35.3%	32.4%	36.2%	27.4%	32.8%	34.6%	36.4%	28.9%	33.1%	33.7%		-
	FFT: A&E recommend % (Target: >90%)	91.1%	90.7%	89.4%	87.5%	89.1%	84.7%	82.3%	85.5%	90.8%	89.8%	88.3%	89.5%	87.1%		!
	FFT: A&E not recommend % (Target: <10%)	5.1%	5.3%	5.9%	5.8%	5.3%	7.3%	8.1%	8.4%	5.1%	5.6%	6.2%	5.7%	6.2%		-
	FFT: A&E response rate (Target: >30%)	16.3%	18.7%	18.1%	17.4%	9.9%	12.6%	12.9%	12.2%	14.9%	17.5%	17.0%	16.4%	16.3%		!
	FFT: Maternity recommend % (Target: >90%)	92.0%	91.8%	88.1%	91.4%	93.1%	92.5%	90.0%	94.1%	92.3%	92.0%	88.6%	90.7%	92.1%		-
	FFT: Maternity not recommend % (Target: <10%)	6.7%	5.7%	7.3%	5.5%	5.2%	7.5%	7.1%	4.3%	6.3%	6.1%	7.3%	6.6%	5.2%		-
	FFT: Maternity response rate (Target: >30%)	14.8%	17.5%	22.0%	19.7%	14.5%	15.1%	19.1%	16.7%	14.7%	16.8%	21.2%	17.6%	18.9%		!
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	42	51	43	455	42	37	51	359	84	88	94	266	814		-
	Complaints formal: Number responded to < 25 days	28	30	20	230	19	13	14	113	47	43	34	124	343		-
	Complaints (informal) through PALS	136	129	133	1202	171	178	112	1194	307	307	245	859	2396		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	1	0	0	0	0	1		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	0	3	0	0	0	0	3		-

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

Inpatient Indicators

The recommend rate, having seen a slight decline in February, saw the Trust moving back towards the target in March.

Accident and Emergency Indicators

The decline in recommend rates at West Middlesex seen in February continued into March. This has led the Trust as a whole to fail to reach the target. Though not meeting the target the response rate continues to improve with the West Middlesex site in line with the national average and the Chelsea site above the national average

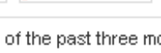
Maternity Indicators

The Maternity services fail to meet the target for response rate though this is in line with the national average

Complaints (formal) responded to within 25 working days

The Trust continue to struggle to meet the 25 day target. The new structure and process for formal complaints will be in place for the 30th April 2018

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <3.7)	4.37	3.82	3.81	3.75	3.86	3.79	3.69	3.60	4.26	3.81	3.78	3.94	3.72		!
	Average length of stay - non-elective (Target: <3.9)	4.26	4.07	4.13	4.21	3.24	3.22	3.24	3.14	3.67	3.57	3.62	3.62	3.59		!
	Emergency care pathway - average LoS (Target: <4.5)	5.15	4.70	4.94	5.02	3.67	3.89	3.82	3.76	4.22	4.19	4.23	4.21	4.23		!
	Emergency care pathway - discharges	227	196	218	2494	386	336	377	4278	613	533	595	1742	6772		-
	Emergency re-admissions within 30 days of discharge (Target: <2.8%)	3.79%	3.79%	3.61%	3.59%	10.35%	10.27%	9.41%	9.85%	6.87%	6.83%	6.36%	6.68%	6.52%		!
	Non-elective long-stayers	470	404	498	5319	383	392	380	4690	853	796	878	2527	10009		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	83.1%	80.7%	81.4%	82.8%	91.7%	87.0%	83.1%	87.3%	86.1%	83.1%	82.1%	83.7%	84.5%		!
	Operations canc on the day for non-clinical reasons: actuals	12	13	16	165	5	5	17	70	17	18	33	68	235		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.40%	0.46%	0.55%	0.48%	0.42%	0.41%	1.23%	0.47%	0.40%	0.44%	0.77%	0.54%	0.48%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	1	2	3	24	1	0	3	10	2	2	6	10	34		!
	Theatre active time (C&W Target: >70%; WM Target: >78%)	67.6%	69.5%	69.3%	69.7%	77.9%	83.7%	74.8%	84.0%	70.6%	73.8%	70.9%	71.7%	73.9%		!
	Theatre booking conversion rates (Target: >80%)	84.3%	85.9%	85.5%	85.0%	69.9%	71.4%	68.6%	72.8%	78.7%	80.0%	78.2%	78.9%	80.3%		!
Outpatients	First to follow-up ratio (Target: <1.5)	1.48	1.51	1.50	1.58	1.32	1.27	1.30	1.26	1.36	1.33	1.35	1.35	1.34		-
	Average wait to first outpatient attendance (Target: <6 wks)	7.5	7.2	6.7	7.5	7.1	6.8	6.7	8.6	7.3	7.0	6.7	7.0	8.0		!
	DNA rate: first appointment	11.3%	11.5%	11.6%	13.2%	10.6%	10.4%	10.8%	10.6%	11.0%	11.0%	11.2%	11.1%	12.0%		-
	DNA rate: follow-up appointment	10.0%	9.7%	10.5%	11.1%	9.5%	10.3%	10.4%	9.7%	9.8%	9.9%	10.4%	10.0%	10.7%		-

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

Elective length of stay

Elective LOS on the CW site remained at 3.8 days against a target of 3.7 days. Driving this period there were 2 patients under Urology and General Surgery who on discharge had remained as inpatients for over 100 days after their elective procedure due to the requirement for post-operative critical care requirements and planned extended recovery.

Non-Elective and Emergency Care length of stay

NEL LOS has suffered a frustrating dip at Chelsea site in March while continuing to improve (and be below target) at West Middlesex. This may reflect the concentrated work at West Middlesex to address this through a number of schemes: (improving discharge, focussed work on Top 20 longest stayers, better OOH engagement for delayed transfers), while suggesting the programme may not have delivered to the same extent at Chelsea. If this indication continues for more than 1 month, then more radical action may be required at CW site, but the data may be being skewed by 2 very long stay patients at Chelsea.

Overall, the current model hospital and other peer data, suggest the Trust benchmarks very well (top quartile) when compared with peer group hospitals for NEL LOS and further details are provided within the FIC/ Board paper on NEL growth. Improving this further (especially at the Chelsea site) remains an absolute focus for the BEDS/LOS work stream and will be closely monitored as we progress out of winter and into May 2018

Average wait to first outpatient appointment

Work on access has continued throughout the year and has lead not only to the increase in the reportable 18 week wait for treatment percentage but also a fall in the average wait for first attendance. Both sites ended the financial year with wait times well below the average for the year as a whole

Clinical Effectiveness Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site Jan-18	Feb-18	Mar-18	2017-2018	West Middlesex University Hospital Site Jan-18	Feb-18	Mar-18	2017-2018	Combined Trust Performance Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trust data 13 months Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	93.5%	93.3%	90.8%	89.7%	93.6%	92.6%	92.6%	94.6%	93.5%	92.9%	91.8%	92.8%	92.3%		-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	81.8%	80.0%	84.0%	91.8%	81.8%	94.1%	81.5%	84.9%	81.8%	86.5%	82.7%	83.6%	88.5%		!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	99.2%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	94.2%	94.6%	94.6%	95.0%	76.9%	76.5%	75.4%	76.1%	85.7%	85.6%	84.8%	85.4%	85.6%		!
TB Care	TB: Number of active cases identified and notified	2	4	0	42	4	5	8	68	6	9	8	23	110		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

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

Trust commentary

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

West Middlesex sustained over 80% performance despite an increase of 10 fractures in the month due to cold weather.

The Chelsea site also saw an increase in fractures – 25% more than in February. There were 4 breaches of the 36 hour standard – all of which were in Theatre within 40 hours. Three were delays waiting reversal of drugs; one is noted as 'other'

VTE Hospital-acquired

C&W site: Backlog due to clinical commitments/no dedicated resources. Radiology reports are manually screened to identify positive VTE events. Retrospective data analysis required to identify hospital associated VTE events for root cause analysis investigation.

WMUH site: Ambulatory Emergency Care have introduced a thrombosis pathway, and includes the identification and reporting of hospital associated VTE events on Datix.
Data information team agreed to develop a programme to identify hospital associated VTE events via radiology reports linked to admission episode *(resources required to complete work)*

VTE Risk assessments completed

C&W site: Performance has declined. Performance has been disseminated to divisions to highlight amongst clinical teams and areas not meeting ≥ 95% target. Weekly and monthly VTE performance reports continue to be circulated to all divisions. Divisional Medical Directors are due to highlight at divisional meetings.

WMUH site: Target not achieved due to current IT infrastructure. RealTime VTE whiteboard developed to highlight patients with outstanding VTE risk assessments. Information team continuing to work to incorporate cohorting arrangements (low risk patients/procedures excluded from VTE risk assessment) and new performance reports (work in progress) to feedback to divisions in a timely and accurate manner. A gap analysis is planned to compare current service provision and (RealTime/Lastword) and Cerner.

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Diagnostic waiting times <6 weeks: % (Target: >99%)	97.56%	98.82%	98.95%	97.86%	98.62%	97.91%	97.60%	96.96%	98.12%	98.34%	98.17%	98.21%	97.32%		!
	Diagnostic waiting times >6 weeks: breach actuals	72	35	33	690	46	70	104	1449	118	105	137	360	2139		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	8.3%	8.5%	8.4%	8.2%	7.9%	7.9%	8.3%	8.3%	8.2%	8.3%	8.4%	8.3%	8.2%		!
	A&E time to treatment - Median (Target: <60')	01:05	01:04	01:08	01:04	00:39	00:48	00:51	00:42	00:58	01:01	01:05	01:01	00:58		!
	London Ambulance Service - patient handover 30' breaches	30	29	29	284	63	73	53	498	93	102	82	277	782		-
	London Ambulance Service - patient handover 60' breaches	1	0	1	2	0	0	0	0	1	0	1	2	2		-
Choose and Book (available to Jan-18 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	2172	2145	1567	1455	0	0	0	0	2172	2145	1567	1959	1455		-
	Choose and book: capacity issue rate (ASI)				48.6%									48.6%		-
	Choose and book: system issue rate															-

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

Trust commentary

RTT Incomplete 52 week waiters at month end

The Trust ended the financial year with no patients waiting greater than 52 weeks for treatment.

Diagnostic waiting times

Diagnostics remains challenging for the Trust. March ended with an increase in the number of patients breaching the 6 week standard. This was marked at the West Middlesex site.

24 of the breaches at the Chelsea site were for Cystoscopy, the reasons for which are being addressed. Echocardiography had 45 breaches at West Middlesex; with Colonoscopy, Cystoscopy and Gastroscopy contributing a further 87. Radiology remains compliant on both sites with only 5 breaches in March.

Diagnostics remains of the highest priority for the Trust with ongoing work to address capacity issues

A&E unplanned re-attendances

The Trust continues to work with its Commissioners in addressing this metric. There has been little movement in the percentages in the last 12 months so identifying individual patients and patterns is of the highest priority

A&E Time to Treatment – median

March saw the highest daily average of attendances on both sites across 2017/2018. This lead to an increase in the time taken to begin treatment, but the Trust overall fir the year was able to post a median time of 58 minutes thereby delivering against the one hour standard

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
Birth indicators	Total number of NHS births	505	399	458	5663	419	361	383	5006	924	760	841	2525	10669		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	34.9%	37.0%	36.6%	34.0%	29.4%	28.6%	29.6%	27.1%	32.4%	33.0%	33.5%	32.9%	30.8%		!
	Midwife to birth ratio (Target: 1:30)	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30		-
	Maternity 1:1 care in established labour (Target: >95%)	96.9%	99.3%	95.4%	98.0%	98.5%	97.1%	98.4%	96.7%	97.7%	98.2%	96.8%	97.5%	97.3%		-
Safety	Admissions of full-term babies to NICU	21	13	22	251	n/a	n/a	n/a	n/a	21	13	22	56	251		-

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

Trust commentary

Total number of NHS births

The Maternity target is based on mothers who deliver rather than the number of babies born shown in the table above. The Chelsea target for mothers for the full year was 5664; with 5542 mothers delivering children – a shortfall of 122.

There was a similar shortfall against plan at West Middlesex.

In total 10464 mothers gave birth to 10669 children across the Trust in 2017/2018

Total C-Section rate

Caesarean section rates slightly decreased at the Chelsea site. However, each of the last three months saw a rate higher than that for the year as a whole. The Service is continually looking at ways to decrease the rates

West Middlesex site showed an increased section rate in March, but was within its target rate for the year

Midwife to birth ratio - births per WTE

The midwife to birth ratio is consistent throughout the year and across site at 1:30

Maternity 1:1 care in established labour

Both sites were compliant for with 1:1 in established labour

Workforce Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	11.3%	11.2%	11.5%	11.5%	14.5%	12.3%	12.0%	12.0%	12.4%	11.6%	11.7%	11.7%	11.7%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	17.3%	17.1%	17.4%	17.4%	11.1%	11.8%	11.8%	11.8%	15.3%	15.3%	15.5%	15.5%	15.5%		-
	Sickness absence (Target: <3%)	3.4%	3.0%	2.8%	2.8%	3.3%	3.4%	3.1%	2.9%	3.4%	3.1%	2.9%	3.1%	2.9%		-
	Bank and Agency spend (£ks)	£2,702	£2,703	£2,963	£30,177	£2,518	£2,451	£2,964	£29,648	£5,220	£5,154	£5,926	£16,301	£59,825		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	8.6%	9.2%	9.0%	7.8%	13.1%	10.1%	12.6%	12.3%	10.4%	9.5%	10.4%	10.1%	9.5%		-
Appraisal rates	% of Performance & Development Reviews completed - medical staff (Target: >85%)	78.7%	76.3%	70.6%	79.3%	87.6%	89.2%	90.1%	86.1%	82.1%	81.3%	77.9%	80.4%	82.0%		!
	% of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%)	81.5%	89.0%	88.4%	88.4%	82.5%	90.9%	88.5%	88.5%	81.8%	89.6%	88.4%	88.4%	88.4%		-
Training	Mandatory training compliance (Target: >90%)	87.6%	85.7%	88.1%	85.8%	84.4%	84.0%	78.7%	84.6%	86.5%	85.1%	84.6%	85.4%	85.4%		!
	Health and Safety training (Target: >90%)	95.2%	93.7%	95.4%	89.4%	88.0%	88.0%	87.7%	86.9%	92.8%	91.7%	92.6%	92.4%	88.5%		!
	Safeguarding training - adults (Target: 90%)	91.6%	90.6%	91.5%	90.3%	88.1%	88.1%	87.6%	87.2%	90.4%	89.7%	90.1%	90.1%	89.2%		!
	Safeguarding training - children (Target: 90%)	88.7%	88.5%	90.1%	88.6%	87.1%	87.9%	85.5%	88.4%	88.2%	88.3%	88.4%	88.3%	88.5%		!

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

Trust commentary

Staff in Post

In March we employed 5405 whole time equivalent (WTE) people on substantive contracts, 3 WTE less than last month. Taking into account bank and agency workers our WTE workforce was 6536 WTE.

Turnover

Our voluntary turnover rate was 15.5%, 0.2% higher than last month. Voluntary turnover is 17.4% at Chelsea and 11.8% at West Middlesex.

Vacancies

Our general vacancy rate for March was 11.7%, which is 0.1% higher than February. The vacancy rate is 12.3% at West Middlesex and 11.2% at Chelsea.

Sickness Absence

Sickness absence in the month of March was 2.9%, 0.2% lower than February.

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 85% against our target of 90%.

Performance and Development Reviews

From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to have had a PDR by the end of December. The PDR rate decreased by 1.2% in March and now stands at 88.41%.

The rolling annual appraisal rate for medical staff was 77.9%, 3.4% lower than last month.

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	Jan-18	Feb-18	Mar-18	2017-2018	YTD breaches	Jan-18	Feb-18	Mar-18	2017-2018	YTD breaches	Jan-18	Feb-18	Mar-18	2017-2018 Q4	2017-2018	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Brain	n/a	n/a	n/a	100%		n/a	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a	100%	0		-
	Breast	n/a	n/a	n/a	n/a	0.5	100%	100%	90.9%	99.5%	0.5	100%	100%	90.9%	98.0%	99.0%	1		-
	Colorectal / Lower GI	100%	100%	n/a	89.2%	3.5	85.7%	80.0%	57.1%	74.4%	11	89.5%	88.9%	57.1%	78.6%	80.8%	14.5		-
	Gynaecological	100%	100%	75.0%	92.0%	1	100%	n/a	0.0%	88.1%	2.5	100%	100%	50.0%	72.7%	89.6%	3.5		-
	Haematological	100%	n/a	100%	100%	0	100%	100%	100%	91.8%	2	100%	100%	100%	100%	94.0%	2		-
	Head and neck	n/a	n/a	n/a	100%	0	100%	100%	66.7%	82.6%	2	100%	100%	66.7%	83.3%	86.2%	2		-
	Lung	100%	0.0%	n/a	77.3%	2.5	100%	100%	100%	96.7%	0.5	100%	66.7%	100%	90.0%	88.5%	3		-
	Sarcoma	n/a	n/a	n/a	100%	0	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	100%	0		-
	Skin	100%	100%	100%	96.2%	3.5	83.3%	100%	100%	93.8%	2.5	95.0%	100%	100%	98.3%	95.4%	6		-
	Upper gastrointestinal	n/a	100%	50.0%	81.3%	3	n/a	100%	50.0%	88.2%	1	n/a	100%	50.0%	77.8%	83.7%	4		-
	Urological	78.9%	100%	94.7%	66.2%	25	100%	82.8%	94.1%	91.1%	9	91.1%	87.5%	94.4%	90.9%	80.6%	34		-
	Urological (Testicular)	n/a	n/a	n/a	100%	0	n/a	100%	n/a	100%	0	n/a	100%	n/a	100%	100%	0		-
	Site not stated	100%	100%	100%	84.6%	1	n/a	100%	100%	100%	0	100%	100%	100%	100%	92.6%	1		-

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

For the 62 day GP Cancer referrals to first treatment pathway the Trust has an unvalidated position of 86.73% for March

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

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

Breast: WMUH: 0.5 of a breach of 5.5 patients treated

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

Head & Neck: WMUH: 0.5 of a breach of 1.5 patients treated

Colorectal / Lower GI: WMUH: 3 breaches of 7 patients treated

Upper Gastrointestinal: C&W: 0.5 of a breach of 1 patient treated
WMUH: 0.5 of a breach of 1 patient treated

Urological: C&W: 0.5 of a breach of 9.5 patients treated
WMUH: 0.5 of a breach of 8.5 patients treated

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

QUALITY PRIORITIES DASHBOARD

Quarter 4 2017/2018

Patient Safety

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Forecast Q2	Forecast Q3	Forecast Q4	4th Quarter Commentary
1	Reduction in falls (Frailty Quality Plan)	Director of Nursing					The status is rated as green as the year end position for 2017/18 has continued to show a reduction in falls requiring external reporting compared to 2016/7. Falls as a priority is being continued in 2018/19.
2	Antibiotic administration in Sepsis (Sepsis Plan)	Medical Director					Q4 data is not yet available
3	National Early Warning Score (Sepsis Plan)	Medical Director					Q4 data is not yet available
4	National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)	Divisional Medical Director					The division has continued to make significant progress in Q4.

Clinical Effectiveness

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Forecast Q2	Forecast Q3	Forecast Q4	4th Quarter Commentary
5	Reduction in still births (Maternity Plan)	Director of Midwifery					C&W continues to remain below the national still birth rate.

Patient Experience

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Forecast Q2	Forecast Q3	Forecast Q4	4th Quarter Commentary
1	Focus on complaints and demonstrate learning from complaints	Director of Midwifery					Complaints turnaround remains a concern however significant progress has been made in reducing the number of overdue complaints. We continue to aspire to the stretched target of 90%. .
2	FFT improvements with new FFT provider	Director of Midwifery					Response rates remain low with only inpatient areas achieving the >30%. Recommendation rates are above the 90% in all areas apart from ED which is currently at 84% year to date.

Nursing Metrics Dashboard

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	96.7%	82.0%	92.9%	87.5%	9.3	3.3	12.6	7 – 17.5
Annie Zunz	100.1%	78.7%	97.1%	97.3%	5.1	2.0	7.2	6.5 - 8
Apollo	96.8%	100.0%	92.3%	87.1%	16.7	3.3	20.0	
Jupiter	173.6%	48.1%	167.9%	-	12.7	1.1	13.8	8.5 – 13.5
Mercury	80.7%	83.7%	82.8%	25.8%	6.7	0.7	7.4	8.5 – 13.5
Neptune	98.3%	57.2%	97.6%	0.0%	8.1	0.5	8.6	8.5 – 13.5
NICU	95.7%	-	100.0%	-	12.8	0.0	12.8	
AAU	105.9%	70.5%	99.9%	97.5%	9.4	2.0	11.3	7 - 9
Nell Gwynn	169.2%	127.9%	249.5%	206.2%	5.3	4.2	9.4	6 – 8
David Erskine	100.1%	83.8%	111.8%	98.9%	3.3	2.7	6.0	6 – 7.5
Edgar Horne	95.4%	87.9%	96.8%	96.8%	3.0	3.1	6.1	6 – 7.5
Lord Wigram	94.3%	92.4%	97.8%	105.4%	3.4	2.5	6.0	6.5 – 7.5
St Mary Abbots	90.5%	95.7%	93.5%	98.7%	3.6	2.5	6.1	6 – 7.5
David Evans	85.5%	81.5%	95.3%	104.1%	5.0	2.3	7.3	6 – 7.5
Chelsea Wing	91.1%	96.2%	100.0%	96.8%	10.3	6.1	16.4	
Burns Unit	94.3%	98.4%	100.0%	100.0%	9.0	4.5	13.5	
Ron Johnson	110.8%	113.3%	124.9%	119.3%	5.4	2.9	8.2	6 – 7.5
ICU	98.6%	-	98.6%	-	30.0	0.0	30.0	17.5 - 25
Rainsford Mowlem	88.2%	94.0%	126.0%	100.8%	3.5	2.8	6.3	6 - 8

West Middlesex University Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	95.3%	71.3%	100.5%	91.4%	10.2	2.1	12.3	7 – 17.5
Lampton	100.0%	141.8%	98.9%	101.6%	2.8	2.6	5.4	6 – 7.5
Richmond	98.2%	122.8%	73.3%	103.3%	5.3	3.8	9.2	6 – 7.5
Syon 1	89.8%	150.3%	101.6%	165.6%	3.3	2.8	6.1	6 – 7.5
Syon 2	95.5%	187.7%	115.5%	231.5%	3.6	4.3	7.9	6 – 7.5
Starlight	95.4%	38.7%	112.5%	57.5%	9.1	0.6	9.6	8.5 – 13.5
Kew	94.3%	88.9%	144.0%	148.4%	4.1	3.4	7.5	6 - 8
Crane	107.0%	138.3%	95.7%	162.9%	3.0	3.7	6.7	6 – 7.5
Osterley 1	114.0%	149.1%	122.8%	220.8%	3.2	4.3	7.6	6 – 7.5
Osterley 2	102.5%	129.0%	111.3%	232.4%	3.8	3.9	7.7	6 – 7.5
MAU	93.7%	104.8%	92.3%	99.8%	5.9	3.5	9.4	7 - 9
CCU	99.3%	105.8%	99.8%	-	5.2	0.8	6.0	6.5 - 10
Special Care Baby Unit	94.9%		95.8%		7.7	0.0	7.7	
Marble Hill 1	91.2%	97.7%	106.5%	101.4%	3.3	2.2	5.6	6 - 8
Marble Hill 2	102.4%	109.4%	104.3%	121.0%	3.3	3.1	6.4	5.5 - 7
ITU	95.8%	0.0%	92.6%	-	29.0	0.0	29.0	17.5 - 25

Summary for March 2018

Nell Gwynne is showing high fill rates to cover the escalation beds and to care for patients tracheostomies.

Patient on Rainsford Molem and Ron Johnson requiring RMN contributing to increased fill rates for qualified nurses. High number of paediatrics on Jupiter requiring RMNs.

CHPPD is showing an overly generous amount on Richmond due to bed census data being counted at midnight and therefore not accounting for day surgery activity. Lower fill rates on RNs on nights due to staff being shared with escalation ward.

Low fill rates for HCAs for paediatric wards due to skills mix review and need for compliance with ratio of 1RN:4 patients. Additional HCAs booked to care for confused patients at risk of falls on Kew, Crane, Osterley 1, Syon1 &2. High acuity on Osterley 1&2 due to patients on NIV an d chemotherapy. RMN usage on Osterley 1 for a sectioned patient.

CQUIN Dashboard

March 2018

National CQUINs

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

NHS England CQUINs

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

2017/18 CQUIN Performance

The Trust has agreed 12 CQUIN schemes (6 national schemes for CCGs, 6 NHS England schemes) for 2017/18.

Quarter 1 & 2 Performance

The quarter 1 & 2 performance has been signed off by NHSE and CCGs at 100% for NHSE schemes and 92% for Q1 and 86% for Q2 for CCG schemes. Partial achievement was reported for the Sepsis, improving services for people with mental health needs who present to A&E, NHS e-Referrals and supporting proactive and safe discharge CQUIN schemes in quarter 2, which was in line with forecast achievement. Quarter 3 reports have been submitted and the commissioner outcome is expected to be known in April 2018.

National Schemes

There is a continued risk to delivery of the a number of schemes, including Sepsis screening and review scheme, in line with the year to date delivery, and the Trust is forecasting partial achievement. However the associated financial risk is partly mitigated by a local payment agreement with NWL CCGs.

NHS England Schemes

The schemes are all on track for the year to date. There is a risk regarding the specification for the neonatal community outreach scheme, which is being jointly developed between commissioners and providers, to ensure that an agreed quality improvement scheme is in place across all organisations in the neonatal network.

2018/19 CQUINs

Planning guidance has now been issued for 2018/19 and there are some changes identified for national schemes, including:
- Removal of the Supporting Safe & Proactive Discharge schemes for 2018/19, with the values of the other schemes increasing to compensate. This is a temporary measure for next year only.
- Minor adjustments to a few other schemes, including the Improvement of health and wellbeing of NHS staff and Sepsis and Anti-microbial resistance schemes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the Workforce Development Committee

Month 12 – March 2018

Workforce Performance Report Apr ‘17 - Mar ‘18

Performance Summary

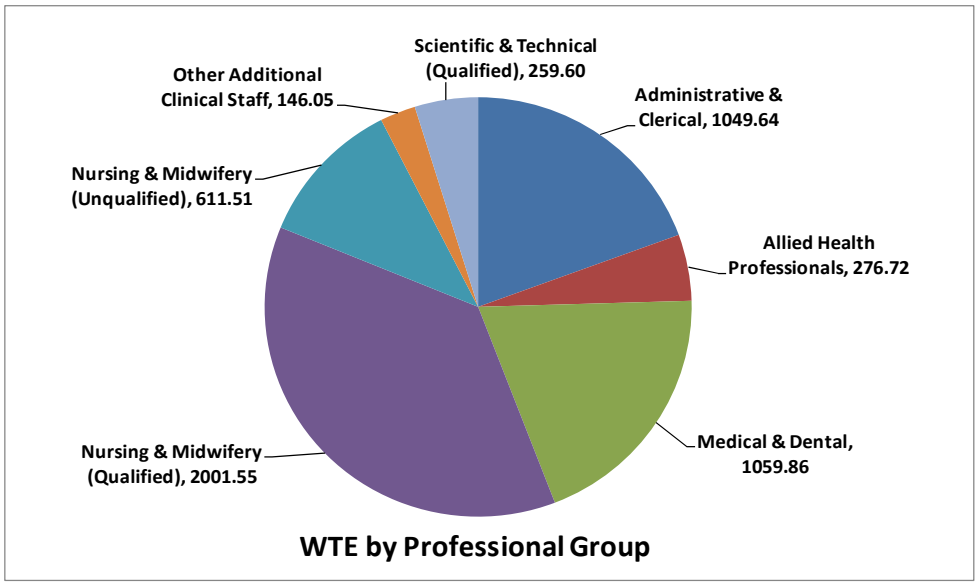
Summary of overall performance is set out below

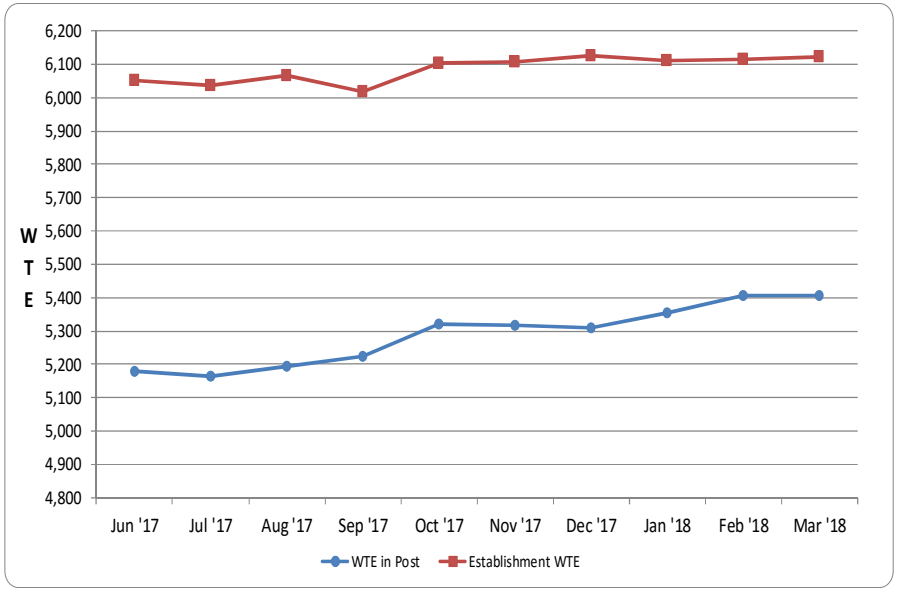
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	Target	Change
5	Vacancy	Vacancy rate has increased by 0.1%	14.0%	11.6%	11.7%	10.0%	↗
6	Turnover	Turnover has increased by 0.1%	21.5%	19.4%	19.5%		↗
7	Voluntary Turnover	Voluntary turnover has increased by 0.2%	16.2%	15.3%	15.5%	13.0%	↗
10	Sickness	Sickness has decreased by 0.2%	2.2%	3.1%	2.9%	3.3%	↘
15	Temporary Staffing Usage (FTE)	Temporary Staffing % usage has increased by 1.5% this month		15.8%	17.3%		↗
17	Core Training	Core Training compliance has decreased by 0.5%	83.9%	85.1%	84.6%	90.0%	↘
18	Staff PDR	The percentage of staff who have had a PDR since 1st April '17 has decreased by 1.2%	64.8%	89.6%	88.4%	90.0%	↘

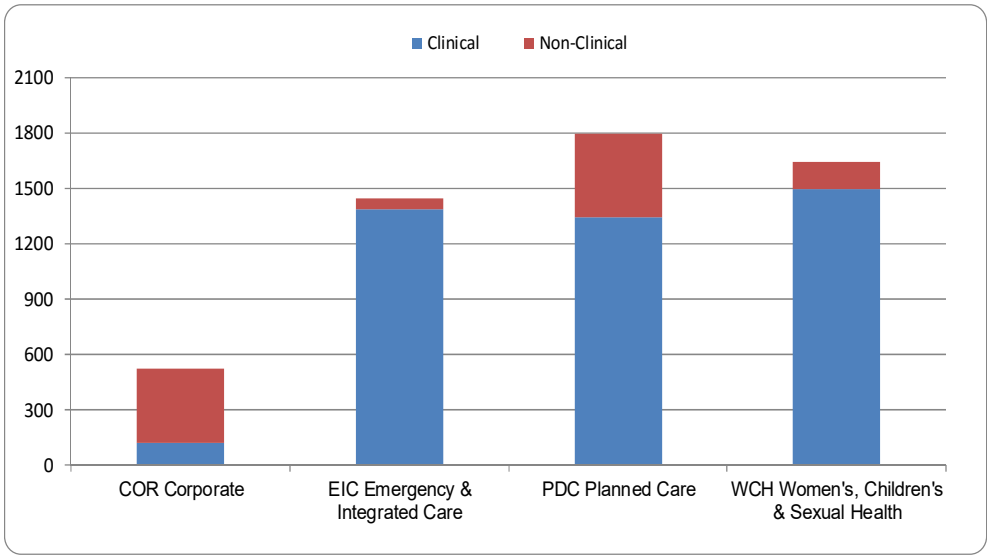
In addition to the information in this report, the trust monitors its workforce data by protected characteristics as defined by the Equality Act. To view the most recent annual workforce equality report please click this link http://connect/departments-and-mini-sites/equality-diversity/

Current Staffing Profile

The data below displays the current staffing profile of the Trust







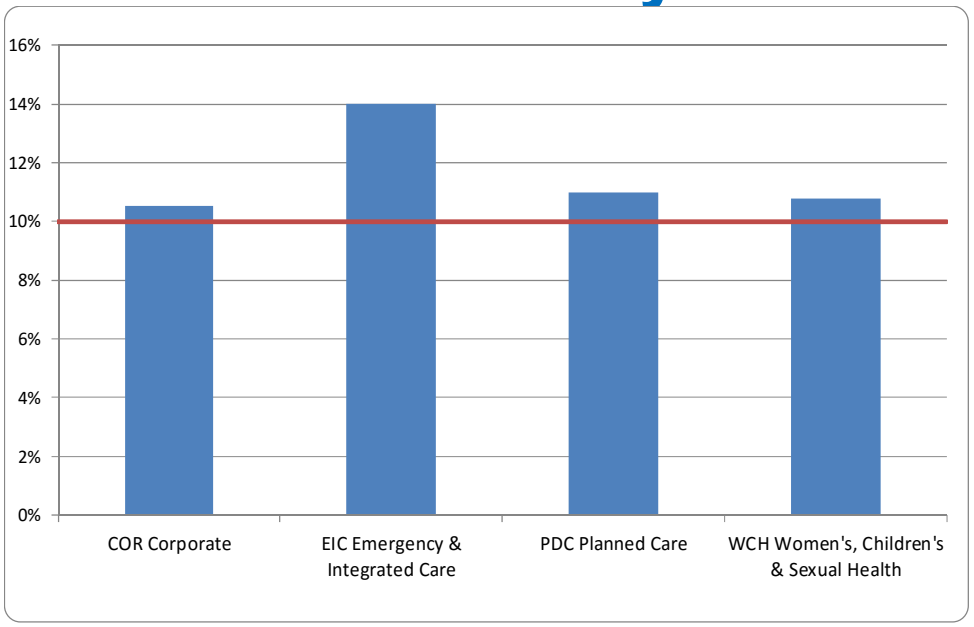
COMMENTARY

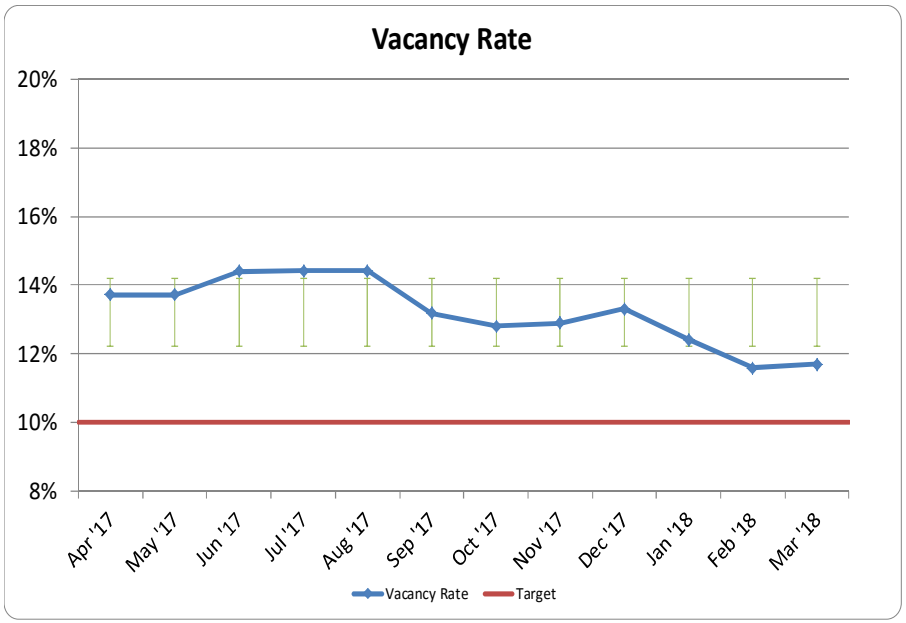
The Trust currently employs 5876 people working a whole time equivalent of 5405 which is 3 WTE less than February. The largest increase in March was in Qualified Nursing (16 WTE), whilst Admin & Clerical staff reduced by 12 WTE.

Since April '17 staff numbers have increased by 279 WTE with the highest increase being in the EIC Division (138 WTE). The professional group with the highest increase has been Qualified Nursing & Midwifery (94 WTE).

In March there were 1867 WTE staff assigned to the West Middlesex site and 3538 WTE to Chelsea.

Section 1: Vacancy Rates





Vacancies by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	11.8%	9.7%	9.9%	10.5%	↗
EIC Emergency & Integrated Care	16.1%	15.0%	14.0%	14.0%	↔
PDC Planned Care	12.8%	12.0%	10.6%	11.0%	↗
WCH Women's, Children's & Sexual Health	11.7%	11.4%	11.0%	10.8%	↘
Whole Trust	**13.3%**	**12.4%**	**11.6%**	**11.7%**	↗
West Mid Site	**14.9%**	**14.5%**	**12.3%**	**12.0%**	↘
Chelsea Site	**12.5%**	**11.3%**	**11.2%**	**11.5%**	↗

Vacancies by Professional Group	Dec '17	Jan '18	Feb '18	Mar '18	Trend
Administrative & Clerical	12.3%	10.7%	10.8%	11.5%	↗
Allied Health Professionals	14.1%	12.2%	10.0%	10.8%	↗
Medical & Dental	9.5%	9.4%	9.3%	10.1%	↗
Nursing & Midwifery (Qualified)	15.6%	15.4%	13.5%	12.8%	↘
Nursing & Midwifery (Unqualified)	18.0%	14.1%	13.5%	14.0%	↗
Other Additional Clinical Staff	3.2%	6.4%	8.3%	7.5%	↘
Scientific & Technical (Qualified)	7.7%	7.3%	7.5%	7.8%	↗
Total	**13.3%**	**12.4%**	**11.6%**	**11.7%**	↗

Service	Establishment WTE	Staff in Post WTE	Vacancy Rate %	Trend
WM T&O	32.4	19.7	39.1%	↗
WM Paediatric Starlight Unit	59.2	36.8	37.8%	↗
CW Cardiology	22.3	14.6	34.5%	↘
WM Radiology	57.7	38.7	32.9%	↗
CW Ron Johnson	31.1	21.4	31.2%	↗

COMMENTARY

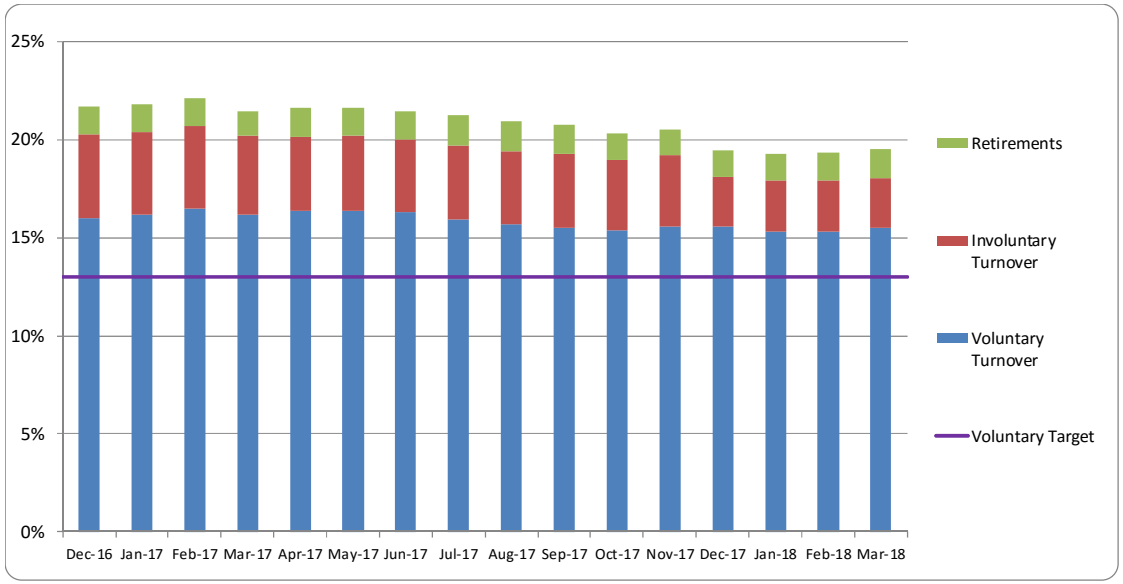
The vacancy rate has increased by 0.1% in March corresponding with an small decrease in staff in post.

The vacancy rate currently is highest in the Nursing & Midwifery (Unqualified) professional group at 14% and in the Emergency & Integrated Care Division also at 14.0%.

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

Section 2a: Gross Turnover

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



COMMENTARY

The total trust turnover rate has increased slightly by 0.1% to 19.5% this month. In the last 12 months there have been 996 leavers. In December a decrease of 1% can be seen due to the leavers from a TUPE of Scientific staff moving into the previous rolling year calculation.

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

	Gross Turnover				
Division	**Dec '17**	**Jan '18**	**Feb '18**	**Mar '18**	**Trend**
COR Corporate	21.2%	21.5%	21.0%	23.3%	↗
EIC Emergency & Integrated Care	19.7%	19.5%	19.6%	20.0%	↗
PDC Planned Care	18.5%	17.8%	18.0%	17.8%	↘
WCH Women's, Children's & Sexual Health	19.8%	19.9%	20.0%	19.7%	↘
Whole Trust	**19.5%**	**19.3%**	**19.4%**	**19.5%**	↗

	Gross Turnover				
Professional Group	**Dec '17**	**Jan '18**	**Feb '18**	**Mar '18**	**Trend**
Administrative & Clerical	18.8%	18.4%	18.2%	19.9%	↗
Allied Health Professionals	24.3%	22.2%	21.6%	20.9%	↘
Medical & Dental	13.9%	14.7%	15.7%	14.6%	↘
Nursing & Midwifery (Qualified)	19.7%	19.7%	19.8%	19.3%	↘
Nursing & Midwifery (Unqualified)	22.5%	21.5%	21.1%	21.8%	↗
Other Additional Clinical Staff	25.0%	24.5%	25.7%	25.5%	↘
Scientific & Technical (Qualified)	17.2%	17.3%	18.2%	19.1%	↗
Whole Trust	**19.5%**	**19.3%**	**19.4%**	**19.5%**	↗

Section 2b: Voluntary Turnover

	Voluntary Turnover						Other Turnover Mar 2018	
Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend	Leavers HC	In-voluntary	Retirement
COR Corporate	17.5%	17.0%	16.4%	18.0%	↗	94	4.0%	1.3%
EIC Emergency & Integrated Care	17.0%	16.9%	16.8%	17.2%	↗	221	1.9%	0.9%
PDC Planned Care	13.7%	13.2%	13.4%	13.3%	↘	228	3.0%	1.6%
WCH Women's, Children's & Sexual Health	15.8%	15.7%	15.7%	15.7%	↔	258	2.1%	1.8%
Whole Trust	**15.6%**	**15.3%**	**15.3%**	**15.5%**	↗	**801**	**2.5%**	**1.5%**
West Mid Site	**11.0%**	**11.1%**	**11.8%**	**11.8%**	↘	**206**		
Chelsea Site	**17.7%**	**17.3%**	**17.1%**	**17.4%**	↗	**581**		

	Voluntary Turnover						Other Turnover Mar 2018	
Professional Group	Dec '17	Jan '18	Feb '18	Mar '18	Trend	Leavers HC	In-voluntary	Retirement
Administrative & Clerical	14.5%	14.3%	14.3%	15.7%	↗	169	2.9%	1.4%
Allied Health Professionals	22.3%	20.2%	19.9%	18.9%	↘	58	1.6%	0.3%
Medical & Dental	4.6%	5.1%	5.9%	5.7%	↘	33	7.6%	1.4%
Nursing & Midwifery (Qualified)	17.6%	17.6%	17.5%	17.1%	↘	363	0.7%	1.6%
Nursing & Midwifery (Unqualified)	18.9%	17.8%	17.2%	18.0%	↗	114	2.1%	1.7%
Other Additional Clinical Staff	13.8%	13.8%	14.7%	14.6%	↘	24	7.3%	3.6%
Scientific & Technical (Qualified)	13.5%	12.6%	13.2%	14.1%	↗	40	4.2%	0.7%
Whole Trust	**15.6%**	**15.3%**	**15.3%**	**15.5%**	↗	**801**	**2.5%**	**1.5%**

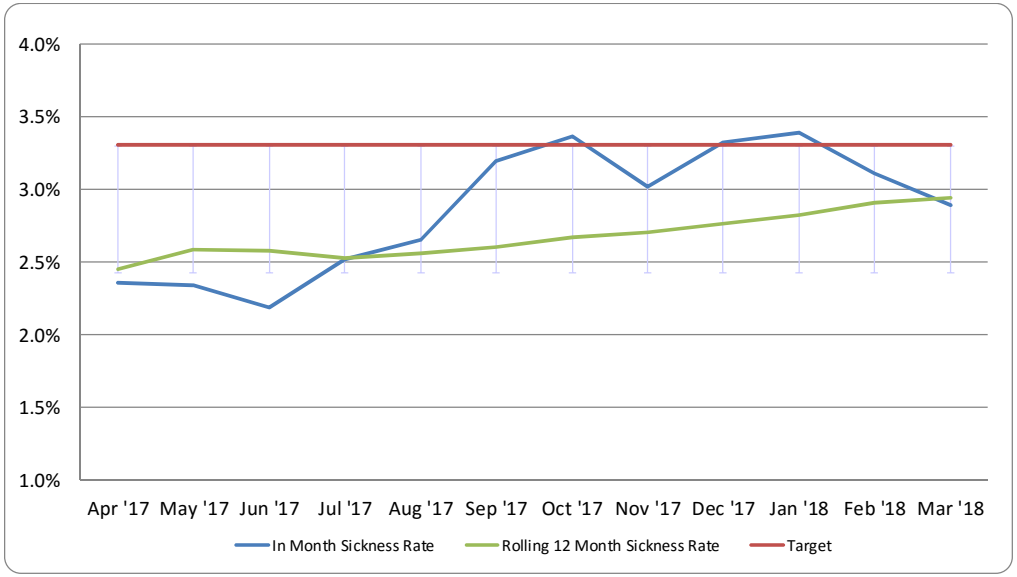
Service	Average Staff in Post HC	Leavers HC	Voluntary Turnover Rate
CW Ron Johnson	23	11	48.9%
CW Mercury Ward	29	10	35.1%
CW Acute Medicine	62	21	33.9%
CW Outpatients	21	7	33.3%
CW John Hunter Clinic	53	17	32.4%

COMMENTARY

Voluntary Turnover has increased by 0.2% this month. Chelsea Site has a voluntary turnover rate consistently about 5 % higher than West Mid. The 5 services with more than 20 staff with the highest voluntary turnover rates are shown in the bottom table. Divisional HR Business Partners are working within divisions to tackle any issues within these areas. The Trust is also taking part in the NHSi Retention Support Program to help reduce turnover.

Section 3: Sickness

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



COMMENTARY

The monthly sickness absence rate is at 2.9% in March which is a decrease of 0.3% on the previous month. The rolling 12 month sickness percentage at the Trust is seen to be increasing as data collection has improved. A new system was implemented in August 2017.

The Planned Care Division had the highest sickness rate in March at 3.3%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 4.8%.

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

Sickness by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	2.54%	2.88%	2.58%	2.82%	↗
EIC Emergency & Integrated Care	2.50%	2.77%	2.81%	2.46%	↘
PDC Planned Care	3.61%	3.37%	3.15%	3.29%	↗
WCH Women's, Children's & Sexual Health	3.96%	4.10%	3.51%	2.84%	↘
Whole Trust In Month %	**3.32%**	**3.38%**	**3.11%**	**2.89%**	↘
Whole Trust Annual Rolling %	**2.76%**	**2.82%**	**2.90%**	**2.94%**	↗
Long Term Sickness Rate %	**1.75%**	**1.75%**	**1.60%**	**1.49%**	↘
Short Term Sickness Rate %	**1.57%**	**1.63%**	**1.51%**	**1.40%**	↘

Sickness by Professional Group (In Month)	Dec '17	Jan '18	Feb '18	Mar '18	Trend
Administrative & Clerical	3.99%	3.74%	3.42%	3.67%	↗
Allied Health Professionals	1.93%	2.19%	2.07%	1.83%	↘
Medical & Dental	0.63%	0.69%	0.73%	0.59%	↘
Nursing & Midwifery (Qualified)	3.80%	4.16%	3.66%	3.20%	↘
Nursing & Midwifery (Unqualified)	6.27%	5.73%	5.24%	4.81%	↘
Other Additional Clinical Staff	2.98%	4.06%	4.36%	1.53%	↘
Scientific & Technical (Qualified)	2.87%	2.51%	2.87%	4.07%	↗
Whole Trust In Month %	**3.32%**	**3.38%**	**3.11%**	**2.89%**	↘
Chelsea Site %	**3.26%**	**3.44%**	**2.98%**	**2.78%**	↘
West Mid Site %	**3.43%**	**3.28%**	**3.36%**	**3.08%**	↘

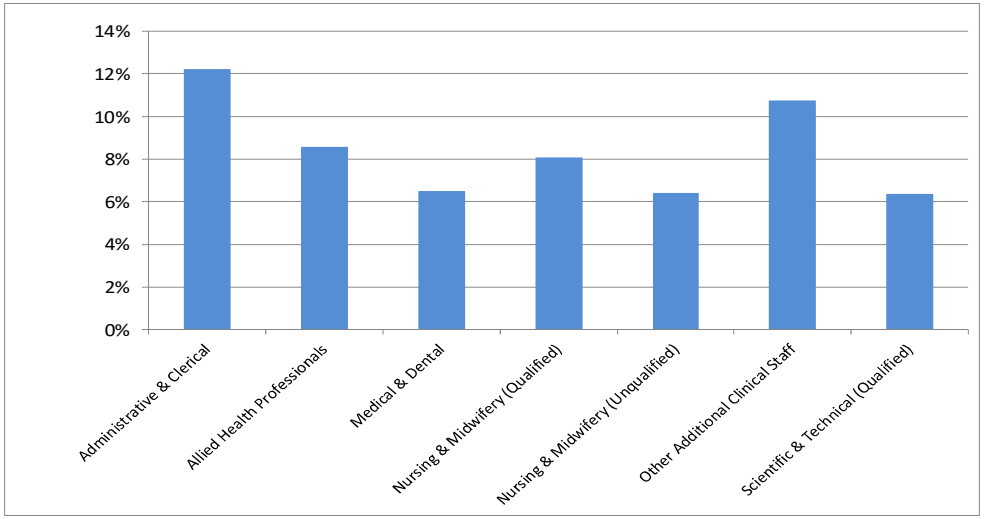
Service	Staff in Post WTE	Sickness WTE Days Lost	WTE Days Available	Sickness %
CW Edgar Horne Ward	40.01	184.24	1195.41	15.4%
WM Syon 2 Pay	33.73	125.12	972.73	12.9%
CW Dermatology	28.79	66.00	881.57	7.5%
WM Pharmacy	49.88	111.59	1544.05	7.2%
CW David Erskine Ward	26.61	61.00	853.01	7.2%

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	30.01%
S25 Gastrointestinal problems	18.52%
S12 Other musculoskeletal problems	8.32%
S10 Anxiety/stress/depression/other psychiatric illnesses	8.09%
S16 Headache / migraine	7.62%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	22.14%
S13 Cold, Cough, Flu - Influenza	12.44%
S25 Gastrointestinal problems	11.36%
S12 Other musculoskeletal problems	11.21%
S28 Injury, fracture	8.67%

Section 4: Staff Career Development

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



COMMENTARY

In March, 36 staff were promoted, there were 89 new starters to the Trust (excluding Doctors in Training). In addition, 67 employees were acting up to a higher grade.

Over the last year 8.6% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Division.

Admin & Clerical currently have the highest promotion rate at 12.2% followed by the Other Additional Clinical Staff group at 10.7%.

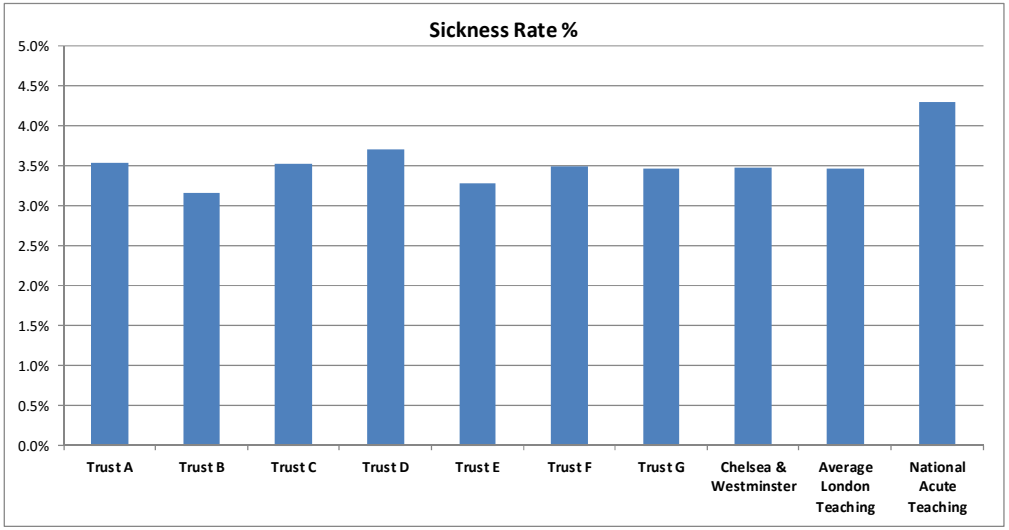
	Monthly No. of Promotions				
Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	9	10	6	3	↘
EIC Emergency & Integrated Care	6	13	9	6	↘
PDC Planned Care	16	14	7	13	↗
WCH Women's, Children's & Sexual Health	17	16	10	14	↗
Whole Trust Promotions	**48**	**53**	**32**	**36**	↗
New Starters (Excludes Doctors in Training)	**52**	**116**	**92**	**89**	↘

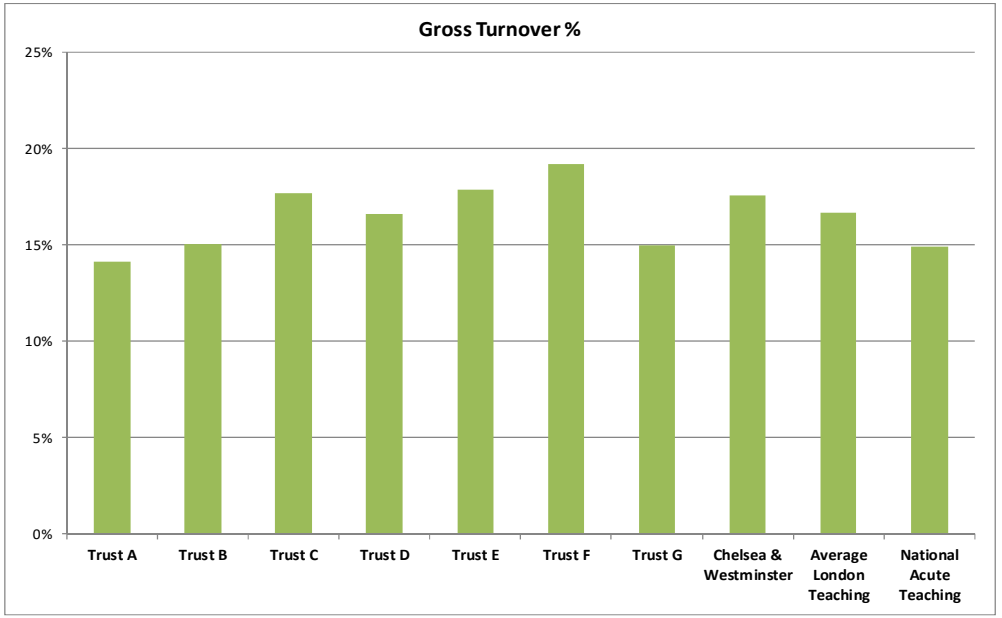
Division	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up	BME % Overall Division	BME % Promoted
COR Corporate	417	51	12.2%	6	43.8%	41.2%
EIC Emergency & Integrated Care	1001	99	9.9%	21	44.7%	41.4%
PDC Planned Care	1417	94	6.6%	19	48.2%	41.5%
WCH Women's, Children's & Sexual Health	1346	114	8.5%	21	34.2%	18.4%
Whole Trust	**4181**	**358**	**8.6%**	**67**	**42.5%**	**34.1%**
New Starters (Excludes Doctors in Training)		**1184**				

	No. of Promotions				
Professional Group	Dec '17	Jan '18	Feb '18	Mar '18	Trend
Administrative & Clerical	15	18	10	10	↔
Allied Health Professionals	1	5	2	4	↗
Medical & Dental	1	0	0	2	↗
Nursing & Midwifery (Qualified)	20	23	19	16	↘
Nursing & Midwifery (Unqualified)	0	3	0	1	↗
Other Additional Clinical Staff	9	4	0	0	↔
Scientific & Technical (Qualified)	2	0	1	3	↗
Whole Trust	**48**	**53**	**32**	**36**	↗

Professional Group	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up	BME % of Prof Group	BME % Promoted
Administrative & Clerical	876	107	12.2%	21	44.0%	41.1%
Allied Health Professionals	233	20	8.6%	11	18.0%	20.0%
Medical & Dental	494	32	6.5%	1	36.2%	12.5%
Nursing & Midwifery (Qualified)	1736	140	8.1%	27	42.0%	29.3%
Nursing & Midwifery (Unqualified)	485	31	6.4%	0	60.4%	58.1%
Other Additional Clinical Staff	121	13	10.7%	7	48.8%	23.1%
Scientific & Technical (Qualified)	236	15	6.4%	0	46.5%	53.3%
Whole Trust	**4181**	**358**	**8.6%**	**67**	**42.5%**	**34.1%**

Section 5: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from Dec '17 which is the most recent available on iView. Compared to other Acute teaching trusts in London, Chelwest had a rate just above the average at 3.47%. In the top graph, Trusts A-G are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in December.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). Chelwest currently has higher than average turnover (12 months to end January). Stability is lower than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 1.5% lower than Chelwest.

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

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	14.14%	85.32%	3.54%
Trust B	14.94%	84.66%	3.16%
Trust C	16.09%	83.54%	3.52%
Trust D	17.72%	82.23%	3.70%
Trust E	17.99%	82.25%	3.27%
Trust F	20.21%	80.00%	3.49%
Trust G	15.26%	84.48%	3.46%
Chelsea & Westminster	16.57%	82.85%	3.47%
Average London Teaching	16.62%	83.17%	3.45%
National Acute Teaching	14.96%	85.14%	4.29%

Section 6: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	88.1	88.1	89.1	88.1	↘
EIC Emergency & Integrated Care	1022.0	1020.3	1024.3	1024.3	↔
PDC Planned Care	712.2	712.4	711.9	712.0	↗
WCH Women's, Children's & Sexual Health	1183.9	1183.9	1181.7	1182.4	↗
Total	**3006.1**	**3004.7**	**3007.0**	**3006.7**	↘

Nursing Staff in Post WTE

Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	81.2	87.2	86.0	85.0	↘
EIC Emergency & Integrated Care	812.9	825.2	848.2	852.2	↗
PDC Planned Care	618.2	628.3	645.7	651.6	↗
WCH Women's, Children's & Sexual Health	1008.3	1011.4	1021.2	1024.2	↗
Total	**2520.6**	**2552.1**	**2601.0**	**2613.1**	↗

Nursing Vacancy Rate

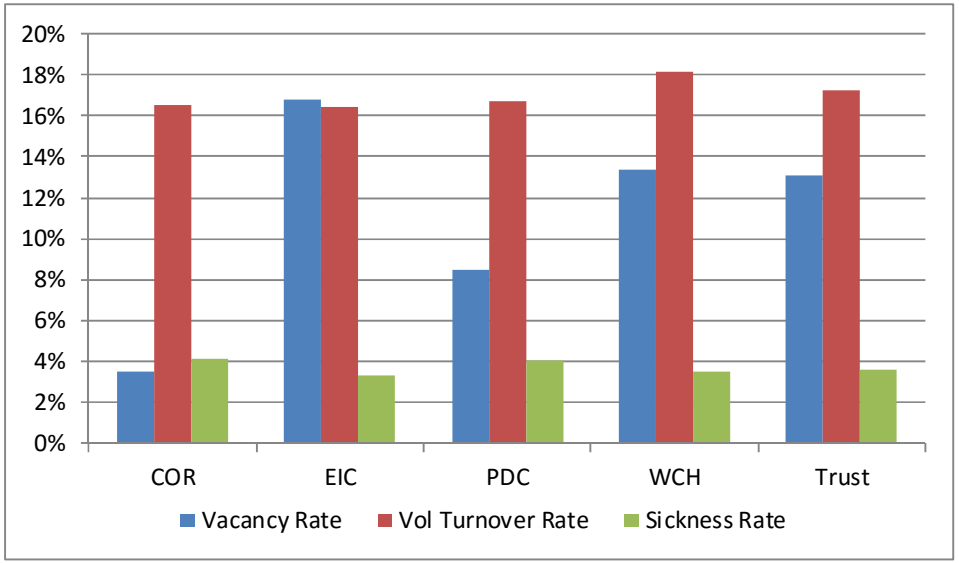
Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	7.8%	1.0%	3.5%	3.5%	↘
EIC Emergency & Integrated Care	20.5%	19.1%	17.2%	16.8%	↘
PDC Planned Care	13.2%	11.8%	9.3%	8.5%	↘
WCH Women's, Children's & Sexual Health	14.8%	14.6%	13.6%	13.4%	↘
Total	**16.2%**	**15.1%**	**13.5%**	**13.1%**	↘

Nursing Sickness Rates

Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	4.2%	6.8%	3.7%	4.2%	↗
EIC Emergency & Integrated Care	3.3%	4.1%	3.7%	3.3%	↘
PDC Planned Care	4.1%	3.6%	4.0%	4.0%	↗
WCH Women's, Children's & Sexual Health	5.4%	5.3%	4.4%	3.5%	↘
Total	**4.4%**	**4.5%**	**4.0%**	**3.6%**	↘

Nursing Voluntary Turnover

Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	19.48%	18.60%	18.17%	16.52%	↘
EIC Emergency & Integrated Care	16.71%	16.94%	15.97%	16.44%	↗
PDC Planned Care	17.60%	16.87%	17.21%	16.72%	↘
WCH Women's, Children's & Sexual Health	18.81%	18.38%	18.35%	18.18%	↘
Total	**17.9%**	**17.6%**	**17.3%**	**17.2%**	↘
West Mid Site	**11.6%**	**11.4%**	**12.5%**	**12.5%**	↔
Chelsea Site	**21.6%**	**21.2%**	**20.3%**	**20.1%**	↘



COMMENTARY

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

The nursing workforce has increased by 12 WTE in March and the combined vacancy rate has gone down across all Divisions.

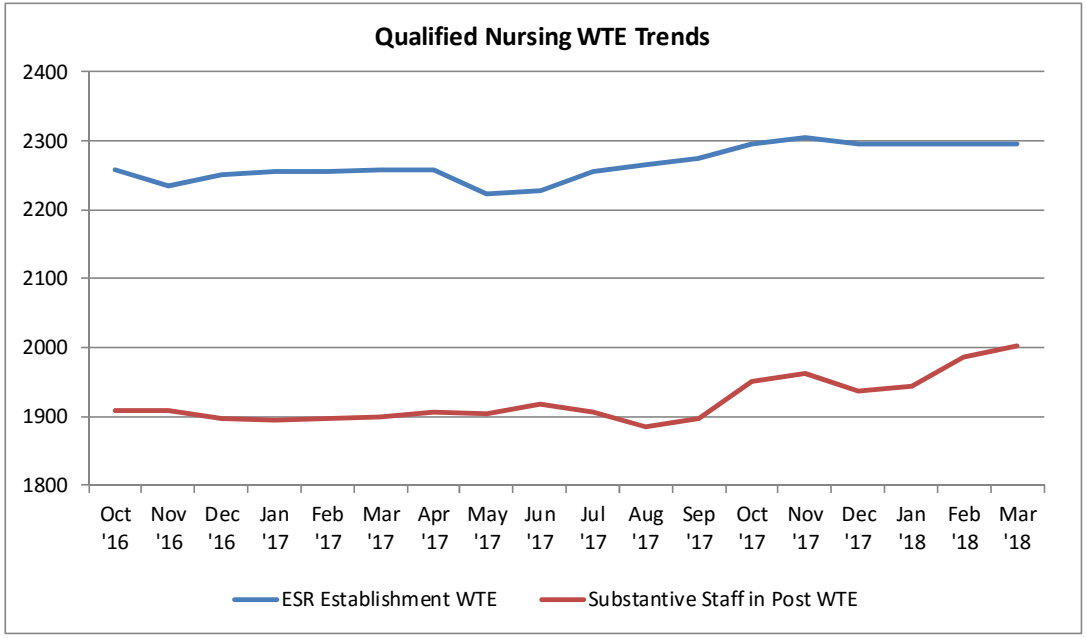
Voluntary Turnover is much higher at the Chelsea site compared to West Mid.

Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

Measure	Mar '17	Apr '17	May '17	Jun '17	Jul '17	Aug '17	Sep '17	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18
ESR Establishment WTE	2257.5	2258.6	2223.7	2227.0	2255.0	2266.1	2273.5	2294.4	2304.3	2294.4	2296.2	2295.6	2296.0		
Substantive Staff in Post WTE	1900.4	1907.3	1904.0	1918.1	1905.6	1884.5	1897.4	1950.5	1962.2	1937.1	1943.3	1985.3	2001.5		
Contractual Vacancies WTE	357.1	351.2	319.7	309.0	349.4	381.6	376.1	343.8	342.1	357.4	353.0	310.3	294.4		
Vacancy Rate %	15.82%	15.55%	14.38%	13.87%	15.49%	16.84%	16.54%	14.99%	14.85%	15.58%	15.37%	13.52%	12.82%		
Actual/Planned Leavers Per Month*	28	41	36	29	31	44	31	45	28	34	28	27	23	32	32
Actual/Planned New Starters**	33	58	32	38	19	19	39	73	25	20	34	53	42	64	64
Pipeline: Agreed Start Dates														31	7
Pipeline: WTE No Agreed Start Date														200 - with no agreed start date	

* Based on Gross Turnover of 20%

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



COMMENTARY

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

March saw more starters than leavers which has resulted in a 0.7% reduction in the vacancy rate. There are 200 nurses in the pipeline without a start date, 69 of which are from overseas.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the nursing and midwifery vacancy rate down to 10% by May 2018.

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

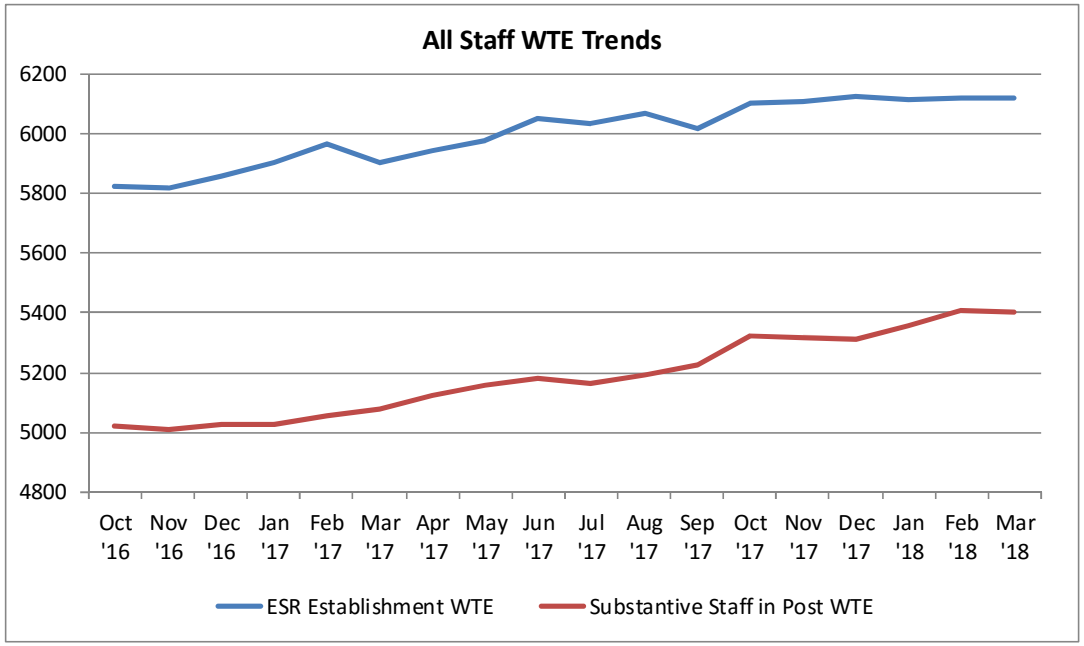
Section 8: All Staff Recruitment Pipeline

Measure	Mar '17	Apr '17	May '17	Jun '17	Jul '17	Aug '17	Sep '17	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18
ESR Establishment WTE[1]	5905.0	5940.6	5975.5	6051.6	6035.3	6067.5	6016.5	6103.3	6106.3	6124.5	6112.7	6116.2	6120.7		
Substantive Staff in Post WTE	5080.2	5125.6	5156.2	5180.3	5165.7	5193.0	5223.4	5321.8	5318.3	5309.9	5354.6	5407.7	5404.9		
Contractual Vacancies WTE	824.8	814.9	819.2	871.3	869.5	874.5	793.1	781.5	788.0	814.6	758.1	708.5	715.7		
Vacancy Rate %	13.97%	13.72%	13.71%	14.40%	14.41%	14.41%	13.18%	12.80%	12.90%	13.30%	12.40%	11.58%	11.69%		
Actual/Planned Leavers Per Month[2]	67	90	95	63	96	280	128	146	92	89	71	103	96	89	89
Actual/Planned New Starters[3]	127	151	130	86	94	252	179	210	94	62	124	129	114	137	121
Pipeline: Agreed Start Dates														60	13
Pipeline: WTE No Agreed Start Date														412 - with no agreed start date	

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

[2] Based on Gross Turnover of 20%

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



COMMENTARY

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

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the vacancy rate down to 10% by May 2018.

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

Section 9: Agency Spend

COR Corporate

Corporate	Dec '17	Jan '18	Feb '18	Mar '18	YTD
Actual Spend	£90,839	£90,825	£143,845	£204,960	£1,907,207
Target Spend	£222,190	£222,190	£210,631	£210,150	£2,895,700
Variance	-£131,351	-£131,365	-£66,786	-£5,190	-£988,493
Variance %	-59.1%	-59.1%	-31.7%	-2.5%	-34.1%

EIC Emergency & Integrated Care

Emergency & Integrated Care	Dec '17	Jan '18	Feb '18	Mar '18	YTD
Actual Spend	£646,947	£640,862	£588,256	£770,487	£8,257,832
Target Spend	£537,198	£537,198	£509,252	£508,087	£7,001,045
Variance	£109,749	£103,664	£79,004	£262,400	£1,256,787
Variance %	20.4%	19.3%	15.5%	51.6%	18.0%

PDC Planned Care

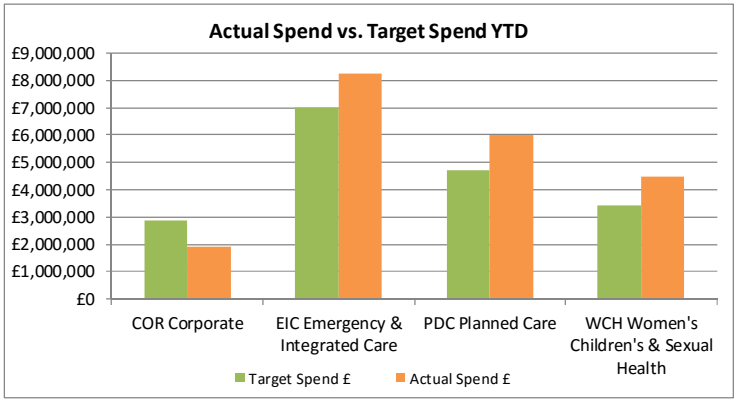
Planned Care	Dec '17	Jan '18	Feb '18	Mar '18	YTD
Actual Spend	£492,285	£550,771	£484,656	£637,825	£6,013,351
Target Spend	£361,345	£361,345	£342,547	£341,763	£4,709,233
Variance	£130,940	£189,426	£142,109	£296,062	£1,304,118
Variance %	36.2%	52.4%	41.5%	86.6%	27.7%

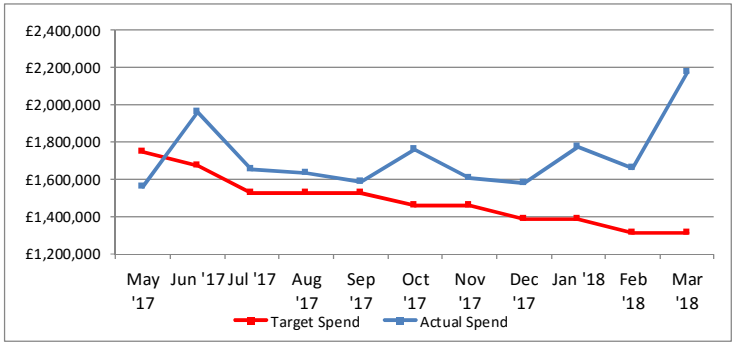
WCH Women's, Children's & Sexual Health

Women's, Children's & Sexual Health	Dec '17	Jan '18	Feb '18	Mar '18	YTD
Actual Spend	£345,443	£491,362	£444,066	£558,385	£4,486,640
Target Spend	£263,266	£263,266	£249,570	£248,999	£3,431,017
Variance	£82,177	£228,096	£194,496	£309,386	£1,055,623
Variance %	31.2%	86.6%	77.9%	124.3%	30.8%

Clinical Divisions and Corporate Areas

Trust	Dec '17	Jan '18	Feb '18	Mar '18	YTD
Actual Spend	£1,575,514	£1,773,820	£1,660,823	£2,171,657	£20,665,030
Target Spend	£1,383,999	£1,383,999	£1,312,000	£1,308,999	£18,036,995
Variance	£191,515	£389,821	£348,823	£862,658	£2,628,035
Variance %	13.8%	28.2%	26.6%	65.9%	14.6%





COMMENTARY

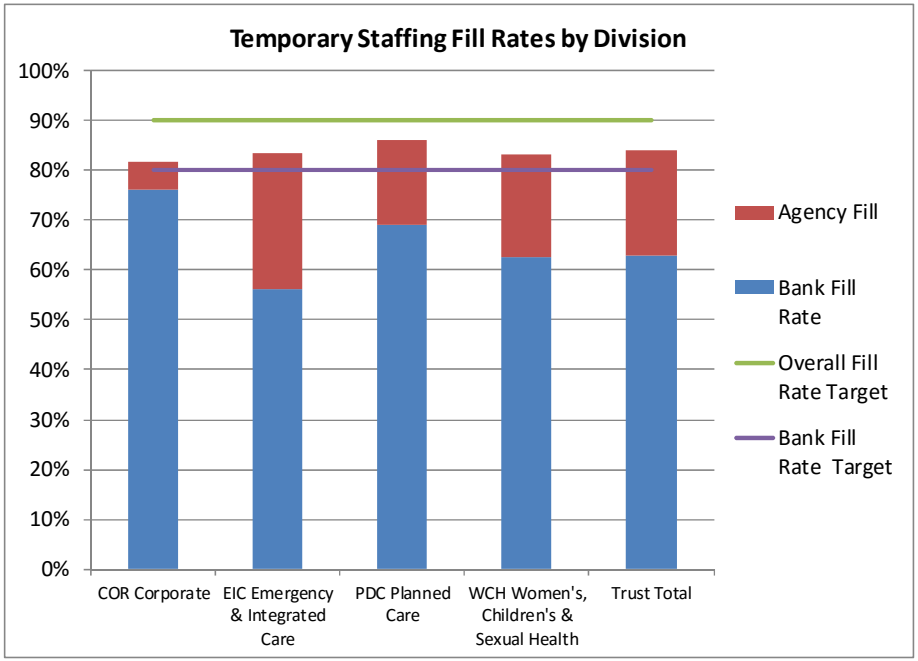
These figures show the Trust agency spend by Division compared to the spend ceilings which have been set for 17/18.

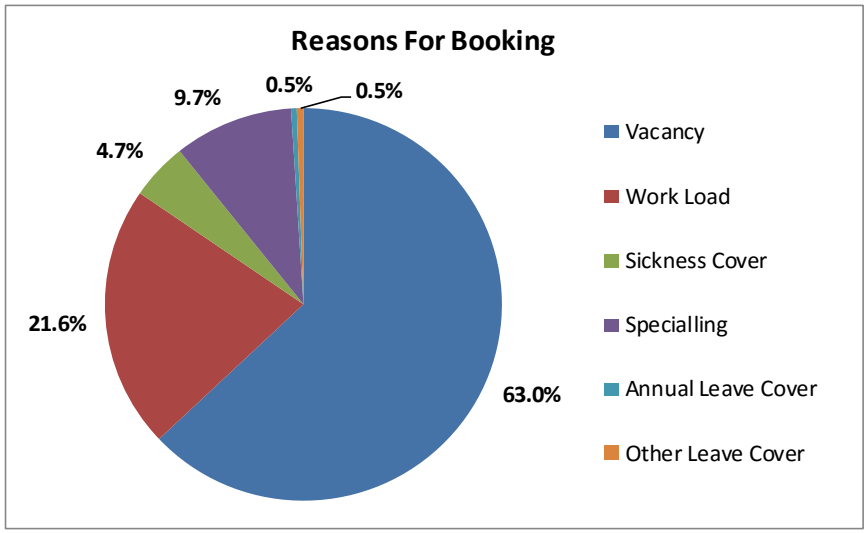
In Month 12, the Women's Children's & Sexual Health Division spent 124.3% more than the target for the month.

Overall, the only Division below it's annual target is Corporate, by 34.1%.

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

Section 10: Temporary Staff Fill Rates





COMMENTARY

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

The Overall Fill Rate was 84.1% this month which is a 0.9% decrease since February. The Bank Fill Rate was reported at 62.9% which is 0.8% lower than the previous month. The number of shifts requested in March was almost 2500 more than in February. The Planned Care Division is currently meeting the demand for temporary staff most effectively.

The Bank to Agency ratio for filled shifts was 75:25. The Trust target is 80:20.

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

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

Overall Fill Rate % by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	82.8%	72.6%	79.9%	81.7%	↗
EIC Emergency & Integrated Care	86.2%	83.8%	85.0%	83.5%	↘
PDC Planned Care	85.6%	80.7%	87.4%	86.1%	↘
WCH Women's, Children's & Sexual Health	77.5%	81.4%	83.2%	83.1%	↘
Whole Trust	**83.4%**	**81.5%**	**85.0%**	**84.1%**	↘

Bank Fill Rate % by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	79.5%	69.9%	76.0%	76.2%	↗
EIC Emergency & Integrated Care	54.6%	55.5%	57.3%	56.2%	↘
PDC Planned Care	70.5%	64.3%	70.6%	69.0%	↘
WCH Women's, Children's & Sexual Health	58.9%	62.9%	61.8%	62.7%	↗
Whole Trust	**61.6%**	**61.2%**	**63.7%**	**62.9%**	↘

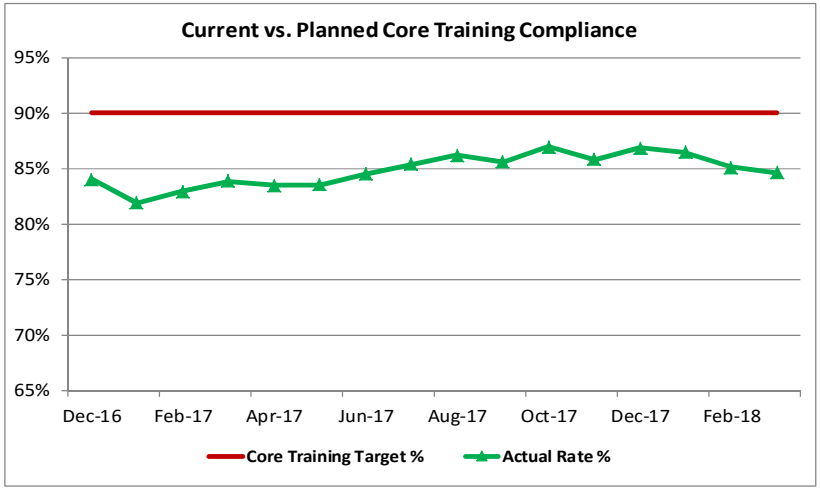
Section 11: Core Training

Core Training Topic	Feb '18	Mar '18	Trend
Basic Life Support	81.0	81.0	↔
Conflict Resolution	82.0	84.0	↗
Equality, Diversity and Human Rights	86.0	87.0	↗
Fire	86.0	84.0	↘
Health & Safety	92.0	93.0	↗
Inanimate Loads (M&H L1)	85.0	83.0	↘
Infection Control (Hand Hyg)	87.0	90.0	↗
Information Governance	78.0	82.0	↗
Patient Handling (M&H L2)	80.0	67.0	↘
Safeguarding Adults Level 1	90.0	90.0	↔
Safeguarding Children Level 1	88.0	88.0	↔
Safeguarding Children Level 2	81.0	73.0	↘
Safeguarding Children Level 3	83.0	84.0	↗

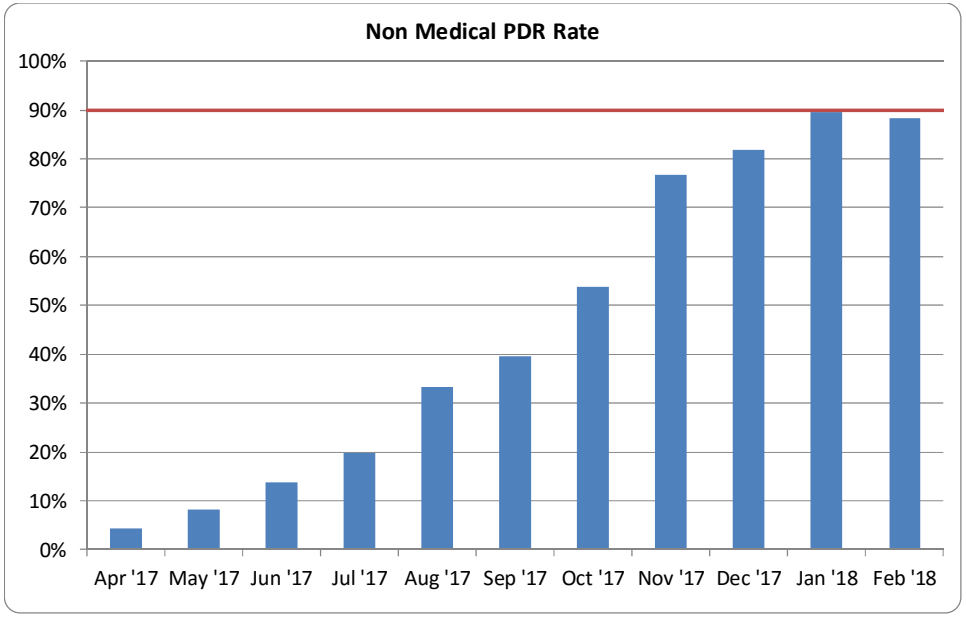
Core Training Compliance % by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	87.0%	88.0%	86.0%	91.0%	↗
EIC Emergency & Integrated Care	86.0%	85.0%	85.0%	82.0%	↘
PDC Planned Care	87.0%	86.0%	84.0%	84.0%	↔
WCH Women's Children's & Sexual Health	87.0%	86.0%	84.0%	86.0%	↗
Whole Trust	**87.0%**	**86.0%**	**85.0%**	**85.0%**	↔

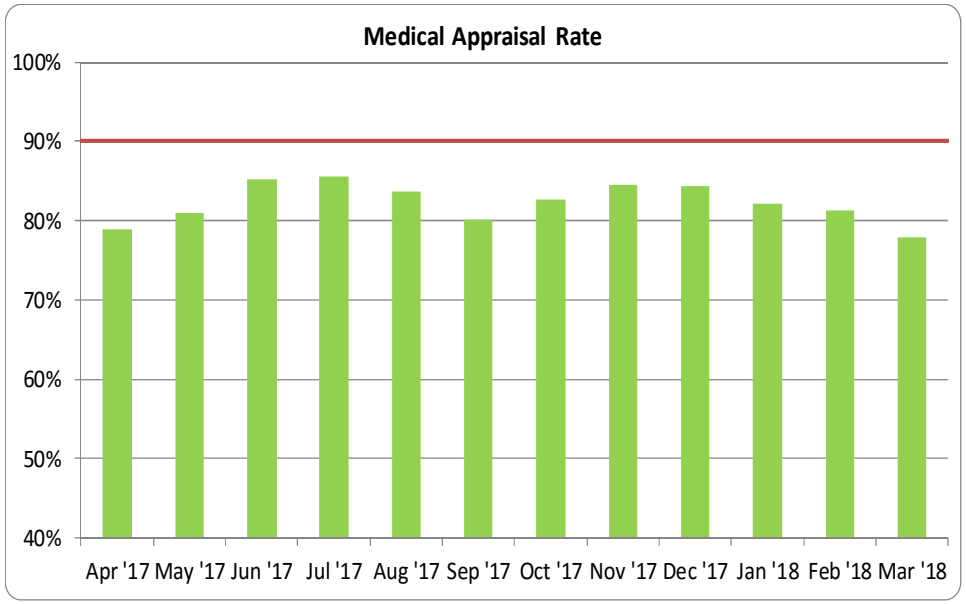
COMMENTARY

The overall Trust position is static, although there are noticeable improvements across a number of subjects. The fall in compliance for Patient Handling is as a result of consolidating the requirements for WM-based staff and bringing this into line with the Trust standard of 2-year refresher (as opposed to a "one-off" requirement which was set for all Moving & Handling at WM). A rationalisation of requirements for all the Safeguarding levels was undertaken and has impacted the Safeguarding Children Level 2 compliance; it is anticipated this will recover in the coming few months as staff awareness is raised via the new QlikView reporting platform.
A significant improvement for Information Governance has been achieved following a number of awareness-raising approaches by the IG and L&D teams. Smaller, but equally important progress has been made in other subjects.



Section 12: Performance & Development Reviews





PDRs From April '17

Division	Band Group	%	Division	Band Group	%
COR	Band 2-6	85.5%	PDC	Band 2-6	87.5%
	Band 7-8b	94.8%		Band 7-8b	96.8%
	Band 8c +	97.9%		Band 8c +	100.0%
Corporate		**90.3%**	**PDC Planned Care**		**88.9%**
EIC	Band 2-6	87.1%	WCH	Band 2-6	84.5%
	Band 7-8b	95.4%		Band 7-8b	95.1%
	Band 8c +	100.0%		Band 8c +	85.7%
EIC Emergency & Integrated Care		**89.0%**	**WCH Women's, Children's & SH**		**86.6%**
Band Totals			**Band 2-6**	**Band 7-8b**	**Band 8c +**
			86.30%	95.5%	96.4%
Trust Total			**88.4%**		

Medical Appraisals

Medical Appraisals by Division	Dec '17	Jan '18	Feb '18	Mar '18	Trend
COR Corporate	-	-	-	-	-
EIC Emergency & Integrated Care	88.6%	88.4%	84.1%	89.4%	↗
PDC Planned Care	83.3%	76.5%	77.3%	72.1%	↘
WCH Women's, Children's & Sexual Health	82.7%	83.4%	83.4%	76.7%	↘
Whole Trust	**84.4%**	**82.1%**	**81.3%**	**77.9%**	↘

Non-Medical Commentary

From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to have had a PDR by the end of December. The PDR rate decreased by 1.2% in March and now stands at 88.4%.

Medical Commentary

The appraisal rate for medical staff was 77.9%, 3.4% lower than last month.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.4/May/18
REPORT NAME	*Governors' Questions
AUTHOR	Various
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To note.
SUMMARY OF REPORT	**1. The question raised by Governor Prof Mark Nelson:** During the cold snap people were smoking close to the revolving doors and the smoke was coming inside but the staff did nothing I know Charring Cross has no smoking outside their doors but clearly not directly on street. **Response from Karl Munlsow-Ong, Deputy Chief Executive:** There are very visible signs at the front of the hospital that state it is a no smoking area. We do however recognise that we need to remain constantly vigilant to this issue and front desk staff in particular have been reminded that they should challenge individuals who are not adhering to the arrangements in place. **2. The question raised by Governor David Phillips:** It is possible that local institutions such as the South Kensington museums, Albert Hall and Cadogan Hall would be happy to offer free or discounted entrance to all categories of Trust membership. This could be a useful way to further engagement between hospital, membership and communities. If offers were made via the Trust for onward dissemination to its members, would this conform to the requirements of the Data Protection Act? **Response from Julie Myers, Company Secretary:** The Trust is only allowed to use personal data for the reasons for which it was collected. Using personal data to send out information about discounts being offered by third parties is unlikely to fall within the agreed basis for processing and to do so would risk exposing the Trust to risk of breaching the Data Protection Act. Under the soon to be implemented GDPR, there will be much more emphasis on gaining explicit consent for specific processing. Were the Trust to negotiate any such Member benefits, information could be provided on publicly available material, such as the Trust website or in other non-personalised Trust communication material.

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

Appendix 1

Staff Type	2017 Quarter 1 £'000	2017 Quarter 2 £'000	2017 Quarter 3 £'000	2017 Quarter 4 £'000	2018 Quarter 1 £'000	2018 Quarter 2 £'000	2018 Quarter 3 £'000
Medical	26,687	27,909	27,988	28,929	28,079	29,168	30,108
Nursing including HCA	33,301	32,554	33,139	34,981	34,991	35,268	35,948
Other staffing	21,941	21,309	21,556	22,355	21,256	21,502	21,821
Grand Total	**81,929**	**81,772**	**82,683**	**86,264**	**84,325**	**85,937**	**87,877**

Please note these figures are as per the accounts and have not been normalised to account for pay awards or new services.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.5/May/18
REPORT NAME	Minutes of the Council of Governors Quality Sub-Committee meeting held in February and April 2018
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Simon Dyer, Lead Governor
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 9 February and 20 April 2018
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Minutes of a meeting of the Council of Governors Quality Sub-Committee
Held at 10am on 9 February 2018
Boardroom, Chelsea and Westminster Hospital

Attendees	Simon Dyer	Lead Governor (Patient Governor)	SD
	Nowell Anderson	Public Governor	NA
	Anna Hodson-Pressinger	Patient Governor	AHP
	Chisha McDonald	Staff Governor – Allied Health Professionals, Scientific and Technical	CMD
	Guy Pascoe	Public Governor – London Borough of Hammersmith and Fulham	GP
	Sonia Richardson	Patient Representative on the West London CCG	SR
In attendance	Julie Myers	Company Secretary	JM
	Vida Djelic (Minutes)	Board Governance Manager	VD
	Shan Jones	Director of Quality Improvement	SJ
	Anna Letchworth (in part)	General Manager Patient Access	AL
Apologies	Nigel Davies	Chair (Public Governor – Ealing)	ND
	Kush Kanodia	Patient Governor	KK
	Lynne McEvoy	Staff Governor – Nursing and Midwifery	LM
	Sonia Samuels	Public Governor – City of Westminster	SS
	Laura Wareing	Public Governor – London Borough of Hounslow	LW

1.	**Welcome and Apologies**	
	SD welcomed members to the meeting. Apologies that had been received were noted as above.	
2.	**Minutes of previous meeting held on 16 November 2018**	
	Minutes of the previous meeting were accepted as a true and accurate record of the meeting.	
3.	**Matters Arising**	
	The sub-committee reviewed the action log and noted that most of actions were complete. The following updates were received: Regarding action 5 re time delay on the day of appointment – VD said that Pippa Nightingale confirmed that she has met with the patient and received his constructive feedback; all the actions which we agreed have been completed. In relation to the action 5 re availability of patient record on the day of the appointment, Tina Benson, Hospital Director WM/Deputy Chief Operating Officer has been invited to attend the next sub-committee meeting to provide an update.	
4.	**Quality Priorities for 2018/19**	

	SJ outlined the process for agreeing the Trust's quality priorities and shared an early indication of priorities for 2018/19. By way of background she explained that the Trust is required to agree priorities for its Quality Accounts under the domains of safety, clinical effectiveness and patient experience. She added that proposals for quality priorities are developed by the three divisions and quarterly updates against progress are provided to the Quality Committee from each division. The divisions considered their proposals for quality priorities at a recent away day and these are in the process of being finalised. She noted that as part of the Quality Account, there will need to be a Governors' chosen quality indicator. This will need to be agreed by the full Council of Governors. SJ agreed to share the list of Trust proposed quality priorities once it had been agreed with the Executive Management Board in early March. Following a discussion the sub-committee indicated that they would wish to recommend to the Council of Governors prevention of grade/level 2 Pressure Ulcers as their quality indicator. It was noted that the governors will be asked to select their quality indicator via e-governance in due course. **Action: Alert the Council of Governors at its 15 February meeting of the sub-committee's recommendation and that they will be asked via e-governance to agree their quality indicator.**	**JM**
5.	**Quarter 3 2017/18 Incident Summary Report**	
	SJ explained that the incidents reporting through the Patient Safety Group commenced this year following the introduction of Datix (incidents and risk management software) in February 2016. She stated that the Trust has a relatively low level of incidents reporting. Work is required to provide assistance and help improve reporting in areas where there is potential underreporting. SJ noted, however, that the Trust has one of the lowest mortality rates in the country and that may be one of reasons for low level of incidents reporting. In response to a question from GP, SJ said that 20% of serious incidents come from 20 areas of the hospital (compared against circa 100 hospital areas). The sub-committee acknowledged the importance of incidents reporting and steps taken to prompt staff to report. It further acknowledged that an automated feedback mechanism with the outcome of investigation is shared with the relevant staff for learning. It was noted that due to some information being redacted from the report, for the reason of preserving confidentiality, care needed to be taken to ensure the report was clear enough to enable learning from the SI outcome. **Action: SJ to ensure that future reports include clear SI outcome/learning.**	**SJ**
6.	**Appointment system update**	
	By way of background SD noted that the sub-committee, via feedback from patient	

	contacts, heard of a number of issues on the subject of appointment system. The issues included: letters arriving after date of appointment, appointment telephones unanswered / busy phones (not being able to get through) and date/time of original appointment changed with no advance notice given to patient (via letter or phone). AL provided a brief overview of the administrative system, part of which is the appointment system. She highlighted the steps taken to improve Clinical Administration organisational structure i.e. call wait times and letter backlogs. AL noted that there are two major hospital sites and both use different appointment system. In response to CMD's query as to whether the Trust is looking into other systems, AL said that a number of system providers had been considered and the preferred option seemed to be to go with the system used by West Middlesex hospital. This was not yet confirmed. In response to a question from GP, AL confirmed that the hospital was likely to adopt a managed mail system across both sites. Additionally, from September 2018, all GP referrals to the Trust were required to be done electronically, as part of a national initiative. AL noted that complaints linked to appointment system had been considered and it seems that over the summer time there were lot of complaints. Subsequently, the staff vacancy rates were reduced and the leadership structure was established. In response to question from SR in relation to admin staff morale, AL said that there are development and education opportunities as well as training available to those staff. There are quarterly listening events which offer the opportunity to staff to raise any issues with the senior management team. In response to a question from NA, AL noted that the key area of focus is complaints on Chelsea and Westminster site; it is predominantly based on communication issues. SJ added that the Divisional Director for Planned Care has set communication as one of planned care quality priorities with customer satisfaction and complaints being the theme across all directorates within the Planned Care Division. AL further stated that the Netcall system the Trust is opting for will have a call monitoring option for quality and assurance purposes. SR asked if further update on the system can be provided at a future meeting. **Action: Further update on the appointments system to be provided at a future meeting.**	**AL/VD**
7.	***Questions or clarification on Quality Issues arising from Integrated Performance Report**	
	SD invited questions on quality issues arising from the report. CMD commented on the Workforce Dashboard where most of performance metrics appeared to be red. This will be raised at the 15 February Council of Governors meeting. In response to a question relating to cancer performance indicators, SJ confirmed that following on improving internal governance processes in this area the Trust has been	

	preforming well in this area. In response to a question from CMD, SJ confirmed that the winter flu season has not affected cancer performance. In response to a question from NA, SJ said that she is charged with managing clinical governance and that there are four staff members who directly report to her; she further said that she works closely with the Medical Director, Deputy Medical Director and the Chief Nurse.	
8.	**COG Quality Awards Spring Schedule**	
	The sub-committee discussed the schedule for the next round of Quality Awards, which recognise and reward initiatives from an individual or team who have made an improvement to the quality of care given to patients, or whose initiative has greatly enhanced the working methods of Trust staff, and noted that there was a suggestion from Chief Nurse Pippa Nightingale, who is the Trust lead for Staff Awards, to align the timing of the presentation of Governors Quality Awards with Staff Awards . The sub-committee recognised that there is a distinct difference between Governors and Staff Awards. Most of governors on the sub-committee agreed that the profile of awards is raised if they are presented to staff winners at an annual event. However, AHP felt that the full Council of Governors should be present when awards are presented. This gives them the opportunity to hear from staff who deliver excellent quality of patient care and she also felt it provides an opportunity for governors to meet staff. She also felt it important for the governors to have the opportunity to get to know staff. It was agreed that SD and Pippa Nightingale will discuss detail around Governors Quality Awards and SD will bring back the revised time table to the April sub-committee. **Action: SD and Pippa Nightingale to discuss detail around Governors Quality Awards and SD to bring back the revised timetable to the April sub-committee.**	**SD/PN**
9.	**Governor feedback on patient contacts**	
	The Lead Governor reported that he has not recently had any complaints arising from his interaction with patients and the public. NA reported on a number of small issues that sometimes get raised by hospital visitors on West Middlesex site. He added that occasionally he receives a complaint about a shortage of car parking places which sometimes cause patients being late for appointment. AHP reported on her own experience with parking on West Middlesex site when attending a meeting. SD noted that Governor Laura Wareing (due to be unable to attend the meeting in person) forwarded to him her patient experience of the hospital when visiting dermatology department. The Lead Governor suggested that Laura's feedback is shared with the sub-committee and that VD should contact LW to obtain her consent.	

	Action: VD to contact Laura Wareing to obtain her consent for circulating her feedback on patient experience to the sub-committee members.	**VD**
10.	**Forward Plan**	
	The sub-committee reviewed the forward plan and noted that the Quality Awards timetable will be scheduled for the April. SD reported that he has recently been involved in Ward Accreditation which involves assessing all aspects of patient care and staff satisfaction, speaking to patients and staff, estates reviews and clinical documentation reviews. It involves a team of around 5 people clinical and non-clinical undertaking the assessment that takes half a day. He added that Melanie van Limborgh, Assistant Director of Nursing who leads on accreditations will attend the next meeting to provide an overview of the Ward Accreditation and governor involvement. SJ highlighted that feedback from Ward Accreditation is shared with wards, clinical services and reported though the Clinical Effectiveness Group and the Quality Committee.	
11.	**Any other business**	
	AHP said that it has been reported through national news that NHS organisations have been struggling with winter pressure and she was wondering how Chelsea and Westminster Hospital has been copying with a rise in the number of people visiting A&E Department and being admitted during the winter season. SJ said that the hospital has been copying very well with the winter pressure.	
12.	**Date of next meeting–20 April 2018, Boardroom, Chelsea and Westminster** (To note the venue change due to all meeting rooms on West Middlesex site being booked between 15 April and 13 May for EPR).	

The meeting closed at 12.00.

DRAFT Minutes of a meeting of the Council of Governors Quality Sub-Committee
Held at 10am on 20 April 2018
Boardroom, Chelsea and Westminster Hospital

Attendees	Simon Dyer	Lead Governor (Patient Governor)	SD
	Nowell Anderson	Public Governor	NA
	Anna Hodson-Pressinger	Patient Governor	AHP
	Kush Kanodia	Patient Governor	KK
	Guy Pascoe	Public Governor – London Borough of Hammersmith and Fulham	GP
	Laura Wareing	Public Governor – London Borough of Hounslow	LW
In attendance	Julie Myers	Company Secretary	JM
	Nathan Askew	Director of Nursing	NA
	Shan Jones	Director of Quality Improvement	SJ
	Melanie van Limborgh (in part)	Assist Director of Nursing	MvL
	Priscilla Gyewu	Membership Officer	PG
	Vida Djelic (Minutes)	Board Governance Manager	VD
Apologies	Nigel Davies	Chair (Public Governor – Ealing)	ND
	Lynne McEvoy	Staff Governor – Nursing and Midwifery	LM
	Sonia Samuels	Public Governor – City of Westminster	SS
	Chisha McDonald	Staff Governor – Allied Health Professionals, Scientific and Technical	CMD
	Sonia Richardson	Patient Representative on the West London CCG	SR

1.	**Welcome and Apologies**	
	SD welcomed members to the meeting. Apologies that had been received were noted as above.	
2.	**Minutes of previous meeting held on 9 February 2018**	
	Minutes of the previous meeting were accepted as a true and accurate record of the meeting.	
3.	**Matters Arising**	
	The sub-committee noted that all actions were completed and the following updates were received: Action 4 – The sub-committee received an early indication on the Trust's long-list of quality indicators for 2018/19 under consideration at its February meeting and it was advised that the Trust would be finalising a short-list in due course. As outcome of this discussion the sub-committee initially felt that reduction in pressure ulcers should be their priority. It was subsequently decided that this no longer required to be a quality priority and was removed from the Trust's quality priorities list. The sub-committee had supported the priority 1 Reduction in falls as their preferred quality indicator and recommend it to the Council of Governors for ratification. This	

	priority had been identified as such an important area to get right, minimising length of stay in hospital, supporting fragile patients, particularly in light of the ageing population. It was noted that the Council of Governors via e-governance approved the Reduction in falls to be their preferred quality indicator. NA clarified that pressure ulcers will continue to be monitored through divisional quality; He reflected on the excellent progress being made in this area. In response to a question from KK if the sub-committee could have a paper on best practice for prevention of falls, NA said that the Trust Falls Working Group is in operation and he will ask an appropriate lead to talk to the sub-committee at its next meeting. **Action: NA to invite Lizzie Wallman to the June sub-committee.** SD further asked if there could be a governor representative on the Falls Working Group. NA replied that this will be confirmed in due course. **Action: NA to check and confirm if there could be a governor representative on the Falls Working Group.** Action 5 – the sub-committee confirmed that they do not need to be sighted on Serious incidents and that the quarterly incident summary report would be sufficient to them. Action 8 – SD reminded the sub-committee of the discussion held at its February meeting around the proposal for governor's quality awards to change the timing of presentation of the awards such that they were awarded at the same time as the Trust Staff Awards. The awards will be made once a year, however, the same number of awards in total and the criteria and process for shortlisting winners will remain as it was. The awards will also continue to be clearly branded as the Governor's Quality Awards and be presented by representatives from the Governors at the annual event. The sub-committee further discussed and agreed that the profile of Governor's quality awards would be raised if they were presented to staff winners at the Trust Staff Awards annual event. **Action: SD and Pippa Nightingale to discuss detail around Governor's Quality Awards and SD to bring back the revised timetable to the June sub-committee.**	**NA** **NA** **SD/PN**
4.	**Terms of Reference review**	
	The sub-committee noted that the Terms of Reference were presented for good housekeeping. SJ noted that her job title has been recently changed to Director of Quality Governance and that this needed to be updated on the terms of reference. **Action: VD to update SJ's job title on the Terms of Reference.** The sub-committee approved the revised terms of reference.	**VD**
5.	**Ward Accreditation programme**	
	Melanie van Limborgh introduced herself to the sub-committee and presented the work undertaken in respect of ward accreditation.	

In introducing the background to this, MvL noted that 66 areas were accredited by a peer review process during the first accreditation cycle summer 2016 to December 2017. Subsequently a grading was awarded for each area, an action plan put in place after the visit for improvement as required and the final grading displayed on the ward quality board. MvL noted that hospital wards are expected to have a quality board as detailed on slide 5.

MvL also noted that the ward accreditation process, as part of Care Quality Programme, was recognised as positive in the 2017/18 CQC inspection. The ward accreditation links to the five CQC key domains i.e safe, effective, caring, responsive and well led with the largest part being the domain of safe. A copy of document used for the ward accreditation assessment was tabled.

She further added that the ward accreditation takes place over a day with the assessment tool looking at 8 sections. The usual size of the team would be 5 people; this depends on the area that is looked at as well as how busy it is on the day of assessment.

In response to a question from KK, MvL said that the assessors are required to have knowledge and experience and are carefully chosen.

The gradings ranged from white to gold as outlined on slide 10.

In response to a question from GP, MvL said that 'White grading' means that ward has not achieved minimum standards and no evidence of active improvement work or failure of mandatory safety areas. We are there to support and move forward that area and the assessment is repeated in two weeks' time.

In response to a question from JM, MvL said that as part of CQC preparations outside of standard working hours house an announced assessment was arranged. However, most of assessments are conducted during the standard working hours.

GP commented on his mother's hospital experience which was very different when visiting in the night. NA linked to it by saying that the level of patient support is different during night and the assessment aims to assess quality during the standard working hours.

In response to a question from LW, NA said that nurse vacancy has been reduced to 17% and also the use of agency nurse has been reduced.

In response to a question from AHP, MvL said that a patient representative has not been involved in the assessment process and this will be looked into as well as how the process can be further developed.

In response to a question from KK what has changed in relation to quality improvements, learning and any action points, MvL said that the action plan will be considered and these will be picked up by different departments. She added that CQC inspection of areas which were graded good in the 2014 inspection will be re-inspected in due course. This will be continuous process and will become business as usual.

In highlighting slide 14 MvL said that the feedback form is completed on the day of the assessment to highlight flags i.e red, amber and green. The report and grading are

	prepared within 24 hours and the Lead Assessor updates the ward. The CQP team compile the document and sends it to the Ward/Department Manager/Divisional Managers 2 to 3 weeks following on the assessment. In response to a question from KK what reference points are used for reviewing the Trust culture, MvL said that it comprises many aspects of ward working some of which include the guidance document provided for the assessment, link with multidisciplinary teams, handover, communication and many other elements. MvL concluded her presentation by saying that the assessment takes place every month and invited governors who wish to be involved in the process to contact her and the Lead Governor who is already involved in the process.	
6.	**Draft Quality Report**	
	SJ thanked governors for confirming their quality indictor. She highlighted that all quality indicators are RAG rated and how pleased she was with the progress on quality priorities. Following on feedback from the Quality Committee (a board committee) in March 2018 the committee approved the five priorities in principle, subject to streamlining of the metrics. In response to a question from KK relating to decreased number of A&E attendances NA said that where appropriate patients are seeing by a GP in UCC but not A&E. In response to GP's query relating to an increased number in X-rays, scans and procedures carried out by clinical imaging, NA said that this is likely to have been caused by the Trust having stopped outsourcing some services. SJ added that the quality highlight section of the report include Council of Governors Quality Awards. She further added that the Governor's Commentary on the draft Duality Report will be agreed with the Council of Governors in due course and it will be included in the final Quality Report. **Action: SJ to email the latest version of the Quality Report to the Lead Governor.** **Action: The Lead Governor to prepare Governor's Commentary and to circulate to the sub-committee for support/agreement.** In response to a question from GP regarding clinical audit summaries p.28 - Sedation and MRI Audit, SJ said that this is example of improvement made following the clinical audit with a new Paediatrics Sedation Guideline being introduced. She added where relevant action plans are developed. GP said he was interested in learning whether the Quality Committee noticed the same problem. SJ highlighted that other quality improvement indicators section include CCQ rating, Care Quality programme and ward & department accreditation.	**SJ** **SD**
7.	**Patient Experience Report**	
	NA noted that the formal consultation to amend the team structure is now complete and the team are in the process or redesigning the procedures of complaints management in line with the new structure. Vacant posts have been advertised including the newly	

	formed complaints manager role. All posts have now been recruited to and we are awaiting successful applicants into post over the next weeks. The Trust has participated in four national surveys which focus on the Emergency Department, adult inpatients, maternity services and children and young people's services. He highlighted the maternity survey response rate being the highest nationally; however the ED survey response rate was below the average national response rate and the department is about to develop an action plan which will then be monitored through their divisional quality board. The Trusts services for children and young people have potential to improve services to be better performing than the national average. A comprehensive plan will be developed to address some of the areas identified as most in need of improvement and this plan will be presented to the Patient and Public Engagement and Experience Committee.	
8.	**Integrated Performance Report – for information**	
	This report was noted.	
9.	**Governors quality improvement award**	
	This item was discussed earlier in the meeting under matters arising and action log.	
10.	**Governor's patient story and feedback on patient contacts**	
	LW reported on her patient experience of the hospital as an outpatient. She expressed her concerns over delays with the biopsy results being communicated to her. Upon querying the delays she was advised that at the time the department was understaffed. SD queried if this was a general theme or it was an unfortunate isolated case. NA advised that this feedback be logged with PALS to look into and for the department concerned to be aware of feedback. He confirmed that there is a system in place for communicating results to patients and that to his knowledge there are no indications that this is a persistent issue. LW confirmed that she will log a complaint with PALS. She also confirmed that she will ask her mother to log her own complaint in relation to a fall she suffered and communication issues between hospital departments that arose. SD noted that LW's experience relates to the Trust's ongoing efforts with administrative improvements and noted that the next update on the improvements is due at the November meeting. GP said that Governor Sonia Samuels noticed that the PALS form has recently changed in relation to how it is structured and it included Chief Executive's contact details. LW also reported on an issue with availability of wheelchairs in orthopedic department. NA said that he will look into it as he was confident that there should be a range of wheelchairs available to patients in orthopedic department. He added that hospital volunteers spend a considerable time collecting wheelchairs and distributing to relevant departments. **Action: NA to look into issue of wheelchair availability in orthopedic department.**	**NA**

11.	**Forward Plan**	
	The forward plan was noted.	
12.	**Any other business**	
	None.	
13.	**Date of next meeting – 29 June 2018, 10.00-12.00, Boardroom, Chelsea and Westminster Hospital**	

The meeting closed at 12.00.

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.5/May/18
REPORT NAME	COG Quality Sub-Committee Terms of Reference
AUTHOR	Julie Myers, Company Secretary
LEAD	Simon Dyer, Lead Governor
PURPOSE	To maintain good governance.
SUMMARY OF REPORT	The Quality Sub-Committee Terms of Reference were updated and reviewed by the sub-committee at its April meeting, scheduled as a rolling programme of annual review. The changes include: • Job titles of Trust's staff updated • Attendance requirements added • Minor grammar improvements The sub-committee proposes the attached terms of reference.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	All
DECISION/ ACTION	For approval.

Council of Governors' Quality Sub-Committee
Terms of Reference

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 4 and 5 of Annex7 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

2.1 The aim of 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 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 To encourage the quality of staff performance through the Quality Awards scheme.

3.8 To obtain the lay perspective on assurance of quality.

3.9 To link in to work of the Board's 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 The following Trust staff shall be members of the Sub-Committee:

a) The Chief Nurse

b) The Medical Director

c) The Director of Quality Governance

d) The Company Secretary

In attendance:

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

5.0 Quorum

5.1 A quorum shall comprise at least one of the Company Secretary, Medical Director or Chief Nurse and three Governors.

6.0 Frequency of Meetings

6.1 The Sub-Committee shall meet bi-monthly and report to the Council of Governors after each meeting.

7.0 Attendance requirements

7.1 Sub-Committee members are expected to attend two thirds of the meetings in a year.

8.0 Administration of the Meeting

8.1 This will be undertaken by the Board Governance Manager.

9.0 Review

9.1 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 19 April 2017
Approved by the Council of Governors at 18 May 2017
Revised by the Quality Sub-Committee on 20 April 2018

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.6/May/18
REPORT NAME	Minutes of the Council of Governors Membership & Engagement Sub-Committee meeting held in February and April 2018
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	David Phillips, 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 & Engagement Sub-Committee meeting held on 8 February and 19 April 2018.
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

Notes of a meeting between members of the Council of Governors Membership & Engagement Sub-Committee
Held at 10.00am on 8 February 2018 in Room A, West Middlesex Hospital

Attendees	David Phillips	Deputy Chair	DP
	Nowell Anderson	Public Governor – Hounslow	NA
In attendance	Gillian Holmes (in part)	Director of Communications	GH
	Jaudan Izzo (in part)	GP Liaison Manager	JI
	Julie Myers	Company Secretary	JM
	Priscilla Gyewu	Membership Officer	PG
	Vida Djelic	Board Governance Manager	VD
Apologies /absence	Matthew Shotliff	Staff Governor	MS
	Ian Bryant	Staff Governor	IB
	Anna Hodson-Pressinger	Patient Governor	AHP
	Simon Dyer	Lead Governor	SD
	Elaine Hutton	Public Governor	EH
	Tom Pollak	Public Governor	TP

1.	**New Chair Election**	
	It was noted that the meeting was not quorate but would proceed informally. VD stated that only one nomination was received from Governor David Phillips for the position of the Chair of the sub-committee. In the absence of the quorum this item will be dealt with via e-governance. **Action: Circulate an email to the sub-committee to ratify the nomination for the Chair position via e-governance.** VD noted that once the Chair position has been ratified, the Deputy Chair should be elected at the next meeting.	**VD**
2.	**Welcome & Apologies**	
	The Deputy Chair noted that more governors should be encouraged to join the sub-committee and the emphasis made to the current members on the meeting attendance with the support from the Lead Governor. The Deputy Chair welcomed Jaudan Izzo to the meeting. Apologies for absence were noted as above.	
3.	**Minutes of previous meeting held on 9 November 2017**	
	Minutes of the previous meeting were noted.	

4.	**Matters Arising & Action Log**	
	The sub-committee reviewed a list of actions and the updates were noted.	
	4.1.1 Engagement with CCGs & Patient Participation Groups JI confirmed that he has established communication with local CCGs and that communication about the Council of Governors and the Trust membership can be included in the relevant practices' bulletins. In relation to better engagement with local CCGs, JI confirmed that governors can attend Patient Participation Group meetings. To that end, he said he would forward a list of Practices and Practice Managers to VD to forward to the sub-committee. **Action: JI to forward a list of Practices and Practice Managers to VD to forward to the sub-committee.** The sub-committee welcomed the opportunity for communication and engagement with local practices. PG noted that she would welcome an early distribution of upcoming 'Your Health' Seminars via Ealing GP practices and Richmond upon Thames practices. To that end, she said that she would forward the advert to JI. **Action: PG to forward the advert to JI for inclusion in the relevant practices' bulletins (soft and hard copy).** It was also noted that in addition to promoting 'Your Health' seminars the following should be publicised: - Become a member of the Foundation Trust (leaflet) - Council of Governors meetings - Annual Members' Meeting JI noted that based on the referral numbers from the Wandsworth geographic area the Council of Governors should concentrate its efforts on engaging with members from Battersea area. In response to a question from the Deputy Chair if as his part of engaging with CCGs they are asked of any particular services required by patients that we may not have. JI said that the Communications Team are working on promoting hospital services and its delivery of the world class care. He added that in near future referrals will be done via e-referrals with a choice of hospital and clinic appointments. The Deputy Chair emphasised the importance of increasing membership numbers in the Hounslow public area and articulating messages to that effect. The Deputy Chair also emphasised the need for engaging with members from the Chelsea and Westminster area and in particular staff, promoting greater understanding of being a member amongst the current members and benefits. Having more governors on the sub-committee would help it generate some ideas. VD noted that the Trust initially started recruiting members from the Hounslow public area when it acquired the West Middlesex Hospital in September 2015 and that the membership	**JI/VD** **PG**

	in this area is expected to grow. JI confirmed that he will assist with distributing communication the sub-committee think appropriate to go to GP practices in Hounslow. The Deputy Chair of the sub-committee thanked JI for a very helpful insight into GP practices and for attending the meeting.	
	4.1.2 Meet a Governor sessions The Deputy Chair noted that members of Chelsea and Westminster Hospital NHS Foundation Trust have the opportunity to meet their elected representative on the Council of governors as independent representatives of the Trust at regular 'Meet a Governor' sessions held at both main hospital sites. These sessions are held on a weekly basis and help governors generate views on the operation and services provided by the hospital. The aim is that feedback provided to the governors is then used to raise issues directly with the senior team in order to address any issues. The Deputy Chair said that at the Council of Governors meeting on 15 February he plans to encourage more governors to do these sessions. VD added that when encouraging governors to undertake meet a governor session, they should be reminded of their statutory responsibility to represent the interests of members of foundation trusts and the public. It was felt that establishing guidance for governors on how to manage Meet a Governor sessions and process feedback collated from these sessions would be helpful. **Action: PG to prepare guidance for governors on how to manage Meet a Governor sessions and process feedback collated from Meet a Governor.** **Action: PG to maintain the Meet a Governor timetable.**	**PG** **PG**
	4.1.3 Your Health seminars PG introduced the item by saying that these are educational seminars led by clinicians on specific medical topics, held on a monthly basis and at alternate sites. PG highlighted the upcoming Health seminar on the subject of Stroke which will be held on 21 February on West Middlesex site. She added that other events are planned for the year and some are subject to confirmation. The Deputy Chair highlighted that seminar are very informative, however member attendance need improving. This was raised with the Director of Communications and a suggestion was put forward to advertise widely to the public. PG confirmed that a seminar flyer has been passed to communications team to advertise. PG noted that a governor volunteer is required for each seminar to host it i.e introduce the presenter and close the seminar. She added that she will need a governor volunteer to host the 21 February seminar and any volunteers were welcome.	

5.	**Membership Report**	
	VD noted that PG and she were trained on MES database and that the report presented was produced by PG. She added that staff numbers were subject to checking with MES and Human Resources. The sub-committee noted the following points: - There would be merit in being clear about why the Trust has members and why it was important for potential members to join. This might encourage greater membership. - Reach out to carers, parents with children, Trust volunteers and young people to join the membership - Produce an annual membership report for the next meeting **Action: PG and VD to work on the above action points.** NA queried that some members who he had recruited claim that they have not heard from the Trust. **Action: PG and NA to take this outside the meeting.**	**PG/VD** **PG**
6.	**Communications update**	
	GH attended for this item. GH noted that the communications team is in the process of preparing the next edition of Going Beyond quarterly publication and introduced the Governor/Membership section. Some points of accuracy were noted regarding meet a governor dates; the page content was also noted. **Action: PG to provide the communication team with the most up to date dates of meet a governor sessions and any other updates as required for Governor/Members page.** In response to a question from DP regarding if communications gathers all news for the publication, GH said that any interesting stories can be gathered by governors and provided to the communications team; she added that Governor news web page can be developed. In response to a question from NA, GH replied that circa 3,000 copies of the publication will be produced and will be widely distributed. GH encouraged governors to be alive to the newsworthy-ness of any event they attended, to take photos and to think about why others might be interested. This would help add the Communications team to communicate news about Governors.	**PG**
7.	**Membership Engagement & Communications Calendar of Events**	
	PG noted that a comprehensive membership engagement and communications calendar of events has been provided. It detailed key events of interest to members and the public. The item was discussed earlier in the meeting and the paper was noted.	
8.	**Feedback from members**	

	None noted.	
9.	**Council of Governors funding report**	
	In response to a question from NA, JM confirmed that the budget setting process has commenced and the outcome will be shared with the Council of Governors in due course. This item and the report were noted.	
10.	**Any other business**	
a.	None.	
11.	**Date of next meeting – 19 April 2018, 10.00-12.00, Boardroom, Chelsea and Westminster**	

The meeting closed at 12.00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

DRAFT Minutes of a meeting between members of the Council of Governors Membership & Engagement Sub-Committee
Held at 10.00am on 19 April 2018 in Boardroom, Chelsea and Westminster Hospital

Attendees	David Phillips	Chair	DP
	Nowell Anderson	Public Governor	NA
	Ian Bryant	Staff Governor	IB
	Anna Hodson-Pressinger	Patient Governor	AHP
	Tom Pollak	Public Governor	TP
	Matthew Shotliff	Staff Governor	MS
In attendance	Katie Allen (from item 6)	Senior Communications Officer	KA
	Julie Myers	Company Secretary	JM
	Priscilla Gyewu	Membership Officer	PG
	Vida Djelic	Board Governance Manager	VD
Apologies /Absence	Simon Dyer	Lead Governor	SD
	Richard Ballerand	Public Governor	RB
	Elaine Hutton	Public Governor	EH

1.	**Welcome & Apologies**	
	The Chair welcomed all to the meeting. Apologies for absence were noted as above. The Chair proposed that future sub-committee meetings start at 10.30am in order to allow members sufficient time to arrive. The sub-committee agreed. **Action: VD to update the meeting calendar and to circulate the updated calendar to the sub-committee.**	**VD**
2.	**Election of Deputy Chair**	
	The Chair stated that as per the Terms of Reference, the sub-committee should elect a Deputy Chair who will deputise in an unlikely event if Chair not available. The sub-committee discussed some potential candidates for the position of Deputy Chair. It concluded that due to low governor attendance it was unable to appoint the substantive deputy chair. It was agreed that the deputy will be elected at the next meeting. **Action: VD to add election of Deputy Chair item to the June agenda.**	**VD**
3.	**Minutes of previous meeting held on 8 February 2018**	
	Minutes of the previous meeting were approved as a true and accurate record.	

4.	**Matters Arising & Action Log**	
	The sub-committee reviewed a list of actions and the updates were noted. Action 3.1 Engagement with CCGs & Patient Participation Groups - VD said that some material about promoting the Trust membership, including membership application forms have been sent to the Chair of Patient Participation Group network in Hounslow via Jaudan Izzo. The Chair noted how useful the sub-committee find Jaudan Izzo attending the sub-committee and asked that he is invited to future meetings. **Action: VD to invite Jaudan Izzo to future meetings.**	**VD**
5.	**Terms of Reference review**	
	The sub-committee reviewed the terms of reference and noted that the attendance requirements did not suit the number of meetings. It was agreed that the sub-committee members will be expected to attend 3 out of 5 meetings in a year. **Action: VD to update the sub-committee terms of reference.** In relation to sub-committee attendance it was agreed that DP/SD/JM will discuss individual member attendance outside the meeting. **Action: DP/SD/JM to discuss individual member attendance outside the meeting.** The sub-committee approved the Terms of Reference.	**VD** **DP/SD/ JM**
6.	**COG Membership Strategy review**	
	The sub-committee discussed at length the two year strategy and plan and the following points were highlighted: • No agreement is required from the full Council of Governors should the sub-committee wish to ask one of its members to take an activity • Any GP outreach work should target GP practices which refer patients to the Trust • Target people who come to the hospital to sign up to the membership • Confirmed that it is a statutory requirement that the Foundation Trust has members and that the Council of Governors role is to represent the interests of the Foundation Trust members • The sub-committee to monitor implementation of the membership strategy and plan which is designed to reach out to both members and the wider community so people may decide to become a member of the Trust • Bringing GP practices with up to date information about hospital services might help the Trust gain some new members and Jaudan Izzo can assist with publishing communication to CCGs • The difficulties with involving hospital staff in distributing membership forms, noting the costs attached to hard copy distribution • IB to explore the possibility of adding text to the effect of joining the membership to a reminder text messaging about patient appointment **Action: IB to explore the possibility of adding text to the effect of joining the membership to a reminder text messaging about patient appointment**	**IB**

	• It was agreed that the sub-committee needed to understand what activities the Trust already has in place in relation to promoting membership before considering any new activities. **Action: JM to discuss with the Director of Communications.** • Governors could attend Healthwatch meetings; to that end the Chair asked AHP to consider attending her local Healthwatch meeting and to feedback to sub-committee. **Staff engagement** The Chair noted that generally a small proportion of Trust members vote in Council of Governors election and a consideration needs to be given as to how to engage members in specific activities and in particular how to engage staff members. MS commented it was more important that staff understand that as employees they are members of the Trust unless they decide to opt out on joining the employment or during their employment. He suggested that this needs to be made clear to staff and could be addressed at corporate induction; other suggestions included setting up a stand and running a meet a governor session during lunch time so that staff can meet their elected representatives; all staff team brief etc. JM added that it needs to be checked with HR what information regarding membership of the Trust is included in the starter pack and how staff can opt out. **Action: VD to contact HR.** The sub-committee agreed that it needed to think about what it wanted to achieve by greater Governor/staff engagement to avoid any confusion with the Trust's employer/employee relationship with its staff. **Action: PG to check if TP is registered member of the FT on MES database.** PG said that currently the awareness and promotion of benefits of Membership happens though a variety of communications channels. These include: • The Trust website • Going Beyond magazine • Open Days and Christmas events • Annual Members' Meeting • Meet a Governor sessions In response to a question from NA, PG said that a link to the Going Beyond magazine will be emailed to the Trust members. She recognised that there is a considerable number of members who have not got their email address registered with the Trust and added that a consideration will be given as to how to gain more email addressed in order to enable an ease communication with members. JM emphasised that the membership is fundamental component of the FT and as such part of the democratic process; members are involved in the work of the Trust via electing Governors who in turn appoint Non-Executive Directors amongst other duties. AHP felt that it was important that as many governors as possible are involved in the current activities which provide them with the opportunity to meet the membership. The Chair said that he will discuss it with the Lead Governor outside the meeting.	**JM** **VD** **PG**

	Action: DP and SD to discuss governor involvement in engaging with members.	**DP/SD**
7.	**Membership Report**	
	PG noted that there has been an increase by 80 members between January and April 2018. It was suggested that a membership application form should be made available at health seminars. She congratulated NA on actively recruiting members during regular meet a governor sessions. In response to a question from TP, VD said that the meaning of 'PR' will be checked with MES. TP expressed his disappointment with number of members in the public constituency City of Westminster and noted that it would be interesting to see how hospital income relates to number of members. The Chair asked the sub-committee to email any questions to VD and PG in advance of meeting in future so that they can prepare a response. **Action: PG to seek explanation from MES on the meaning of PR.** **Action: Sub-Committee members to email any questions to VD and PG in advance of every meeting in future.**	**PG** **ALL**
8.	**Membership Engagement & Communications Calendar of Events**	
	PG presented the calendar of events and noted that the April Sexual Health seminar has been deferred to 16 May due to all meeting rooms on West Middlesex site being booked for Cerner EPR. In response to a suggestion from a number of governors, the seminar will be held at the Sexual Health Centre, 10 Hammersmith Broadway. In response to a question from the Chair, JM said that seminars are open to all Trust members and the general public. These are advertised by email to members, on the Trust's website and across the hospital sites. KA added that social media can be utilised for the purpose of a wider public advertising. To that end, communications team would require more content on the subject, making it sound more interesting and appealing to a wider audience. PG has been asked to develop a short story for advertising on social media and to forward to the communication team. In response to a question from AHP, PG confirmed that posters advertising the seminar are displayed across the hospital sites. It was recognised that it would be useful to survey those members who attend seminars to find out what they think of seminars, why they came, what they gain and what topics they would like to hear on in future. A consideration should also be given to whether the timing is most suitable for people to attend. It was agreed that the communication team could work best with corporate affairs by providing as much notice as possible and developing a clear communications plan for any event well in advance.	

	Action: PG to obtain more information on the content of the seminar from Dr Rayment and to develop a short story appealing to the wider audience. **Action: PG to consider what the most exciting lines about the event were to assist KA in publishing on social media.** **Action: PG/KA to discuss advertising the event on social media outside the meeting.** Two governors on the sub-committee expressed their doubt whether they receive regular invites to health seminars. PG said that an email invite is sent from MES on behalf of Chelsea and Westminster Hospital. **Action: PG to check if AHP and TP are registered and receive regular emailing from MES.**	**PG** **PG** **PG/KA** **PG**
	8.1.1 Communications update KA said she was representing the communication team and highlighted the following upcoming events: • 25th Chelsea site anniversary to be held on 13 May • Official 25th Chelsea site anniversary celebration and launch of CW+ Long Service Award to be held on 14 May • NHS 70th anniversary and Open Day at Chelsea and West Middlesex sites to be held on 5 July • 30th anniversary of Kobler Centre to be held on 13 September In response to a question from the Chair, KA said that she will check whether governors will be invited to the 25th anniversary celebration. **Action: KA to check whether governors will be invited to the 25th anniversary celebration.** In response to a question from TP, KA said that the NHS 70th anniversary will be held in the afternoon on 5 July and will include hospital Open Day event; KA said that it will be a smaller scale event as it is held on a working day and it is planned to be a historical memorable event. She added that governors will be kept updated on organising the event.	**KA**
9.	**Your Health' seminars – update**	
	This item was discussed earlier in the meeting.	
10.	**Meet a Governor Schedule** The Committee discussed whether having tea, coffee and biscuits on hand during a 'Meet the Governors' sessions would help the conversation flow. VD noted the updated 'Meet a Governor' schedule and advised that any changes to the current schedule should be forwarded to PG. The Chair noted that only few governors undertake a regular session and encouraged other members to be involved.	

	The sub-committee also noted that the guidance note for 'Meet a Governor' Sessions has been provided to assist governors with running these sessions. Along with a governor name plate the guidance note should be provided to governors holding these sessions. **Action: PG to provide a governor name plate and the guidance note to governors holding 'Meet a Governor' Sessions.**	**PG**
11.	**Feedback from members** The Chair reflected on a patient he met via meet a governor session who experienced the lengthy discharge process.	
12.	**Council of Governors funding report – for information** VD noted that the paper detailing a list of projects planned 2017/18 including estimated spend has been provided for information. In response to a question from TP, JM replied that the 2018/19 budget will be confirmed in due course. The sub-committee noted the paper.	
13.	**Any other business** NA noted that there is an interesting event taking place the following week – 'security awareness week'.	
14.	**Date of next meeting** – 28 June, 10.00-12.00 (Room A, West Middlesex)	

The meeting closed at 12.05

Council of Governors Meeting, 17 May 2018

AGENDA ITEM NO.	2.6/May/18
REPORT NAME	COG Membership and Engagement Sub-Committee Terms of Reference
AUTHOR	Julie Myers, Company Secretary
LEAD	David Philips, Chair
PURPOSE	To maintain good governance.
SUMMARY OF REPORT	The Membership and Engagement Sub-Committee Terms of Reference were updated and reviewed by the sub-committee at its April meeting, scheduled as a rolling programme of annual review. The changes include: • The Deputy Company Secretary removed from the membership of the sub-committee (redundant post) • Attendance requirements changed from two thirds to three out of five meetings • Minor grammar improvements The sub-committee proposes the attached terms of reference.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	All
DECISION/ ACTION	For approval.

Council of Governors' Membership and Engagement Sub-Committee

Terms of Reference

1.0 Authority

1.1 The Council of Governors' Membership and 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 and Engagement Sub-Committee shall be responsible for providing 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) The Company Secretary
b)
c) The Director of Communications or suitable deputy
d) The Membership Officer
e) The Equality and Diversity Manager (as required)

f) The Board Governance Manager
g) In addition, the sub-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 Company Secretary, or Board Governance Manager and Membership Officer.

5.0 Frequency of meetings

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

6.0 Attendance requirements

6.1 The sub-committee members are expected to attend three out of five meetings in a year.

7.0 Planning and administration of meetings

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

7.2 The sub-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 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 and 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 and Engagement Sub-Committee on 20 April 2017
Approved by the Council of Governors at 18 May 2017
Revised by the Membership and Engagement Sub-Committee on 19 April 2018