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

2 November 2017 11:00 - 2 November 2017 13:30

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Location: Boardroom, Chelsea and Westminster Hospital
Date: Thursday, 2 November 2017
Time: 11.00 – 13.30

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome & Apologies for Absence Apologies received from Zoe Penn.	Verbal	Chairman
11.03	1.2	Declarations of Interest	Verbal	Chairman
11.05	1.3	Minutes of the Previous Meeting held on 7 September 2017	Report	Chairman
11.07	1.4	Matters Arising & Board Action Log	Report	Chairman
11.10	1.5	Chairman's Report	Report	Chairman
11.15	1.6	Chief Executive's Report, including 1.6.1 Hammersmith & Fulham Integrated Care Partnership: Approval of Partnership Agreement	Report Report	Chief Executive Chief Executive
	2.0	**QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE**		
11.20	2.1	Patient Experience Story	Verbal	Chief Nurse
11.35	2.2	Our approach to improvement culture	Report	Chief Nurse / Deputy Medical Director
11.50	2.3	IMPACT Study	Pres.	Chief Operating Officer / David Asboe
12.05	2.4	Serious Incidents Report	Report	Chief Nurse
12.15	2.5	Integrated Performance & Quality Report, including 2.5.1 Winter Preparedness 2.5.2 Workforce Performance Report - Month 6	Report Report Report	Chief Operating Officer Chief Operating Officer Director of HR & OD
12.25	2.6	Mortality Surveillance Q2 Report	Report	Deputy Medical Director
	3.0	**STRATEGY**		
12.30	3.1	Volunteering Strategy Implementation Update	Report	Chief Operating Officer

12.40	3.2	EPR Programme Update	Report	Chief Information Officer
	4.0	**GOVERNANCE AND RISK**		
12.50	4.1	Board Assurance Framework	Report	Deputy Chief Executive
13.05	4.2	Business planning 2018/19	Report	Chief Financial Officer
	5.0	**ITEMS FOR INFORMATION**		
13.15	5.1	Questions from Members of the Public	Verbal	Chairman
13.25	5.2	Any Other Business	Verbal	Chairman
13.30	5.3	Date of Next Meeting – 11 January 2018		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of the Board of Directors (Public Session)
Held at 11.00 on 7 September 2017, Room A, West Middlesex

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Jeremy Jensen	Deputy Chairman	(JJ)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Sandra Easton	Director of Finance	(SE)
	Nick Gash	Non-Executive Director	(NG)
	Eliza Hermann	Non-Executive Director	(EH)
	Rob Hodgkiss	Chief Operating Officer	(RH)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Andrew Jones	Non-Executive Director	(AJ)
	Keith Loveridge	Director of Human Resources	(KL)
	Jeremy Loyd	Non-Executive Director	(JL)
	Karl Munslow-Ong	Deputy Chief Executive	(KMO)
	Pippa Nightingale	Acting Chief Nurse	(PN)
	Zoe Penn	Medical Director	(ZP)
	Liz Shanahan	Non-Executive Director	(LS)
	Lesley Watts	Chief Executive	(LW)
In Attendance:	Sarah Ellington	Interim Board Secretary	(SEL)
	Donald Neame	Director of Communications	(DN)
Apologies:	Martin Lupton	Ex-officio member, Imperial College Representative	(ML)
	Roger Chinn	Deputy Medical Director	(RC)
	Chris Chaney	CEO, CW+	(CC)

1.0	**GENERAL BUSINESS**
1.1 a.	**Welcome and Apologies for Absence** Apologies received from Martin Lupton, Roger Chinn and Chris Chaney.
1.2 a.	**Declarations of Interest** THH declared that a member of staff had approached him on investment of funds of CW+ into SuperCarers, on which THH had refused to comment and notified the Chief Executive of the request and that THH was, and had declared that he was, a founder and current passive shareholder in SuperCarers.
1.3	**Minutes of the Previous Meeting held on 6 July 2017**

a.	Minutes of the previous meeting were approved as a true and accurate record of the meeting as re issued and including resolution of issues raised with KMO, THH and SME since 1 September 2017. No further issues were notified. There was a request that minutes be circulated to the board sooner after meetings in future. Action: KMO/LW/SEL to agree turnaround times for Board minutes
1.4 a.	**Matters Arising** Completed actions marked green in the action log (p15) were noted and no questions were raised. RH addressed 2.4.a. (yellow) from the Board meeting of July 2017. The rise in Non-elective demand was reported in the Integrated Performance Report to Board in July 2017. Since then, discussions with NHSI had led to agreement to a retrospective bid to be made for Winter preparedness. The Trust would also benefit from a bid with Royal Marsden Partners and for A & E capital investment at the West Middlesex site. On RTT targets, if further investment is required it will be through the Finance and Investment Committee. JJ asked what the position was irrespective of grants. LW said this year Winter Preparedness required provider Chief Executive authority and would not all be green for RAG rating. Planning was in place with investments made independently of successful grants. PN addressed 2.6.a. (yellow) from the Board meeting of July 2017, on streamlining of the Risk Assurance Framework (RAF). This was noted to go to Audit and Risk Committee in October. No questions were raised. ACTION: VD to remove yellow and green items from action log once Audit and Risk Committee had reviewed the RAF in October
1.5 a.	**Chairman's Report** THH presented the Chairman's report (p17), which was noted. He added that since the report: • THH met with Steve Russell, Executive Regional Managing Director (London). The Trust had a good reputation as leading initiatives, LW's transparency was highly regarded and the Trust was encouraged to consider becoming an Accountable Care Organisation ("ACO"). • THH met with Niall Dixon, Chief Executive of NHS Confederation. There was an increasing spotlight on the costs of clinical negligence claims and divergence between costs in different NHS Trusts, which appeared significant. This was relevant to the financial contribution the Trust had to make to NHS Resolution (formerly the NHS Litigation Authority). EH confirmed the Quality Committee had queried this in July. AJ requested more data and it was on the Committee agenda for September. • THH spoke to NHS Digital. KJ and Kathy Lanceley were highly praised. THH had been greatly assisted by briefings provided by Board members. A bilateral secondment had been suggested to THH and he asked LW to take this forward ACTION: LW/ZP/KJ to liaise with NHS Digital and consider the possible opportunity of bilateral secondments In addition, THH said Chairman's breakfast events were working well. Executives were encouraged to support junior staff attendance. THH hoped to develop some dissemination of actions from issues raised with the Communications team.

1.6	**Chief Executive's Report, including:** • Sustainable Transformation Plans update • EPR Programme Update
a.	LW paid tribute to Annette Funai, RIP, who had been a very well regarded member of staff and had shown great commitment to the Trust for a very long time. NG and PN in particular echoed those sentiments. LW presented the Chief Executive's report (P21), which was noted. She highlighted: • 1.0: The Board had impressed her in its teamwork and commitment whilst gathering the data which CQC required as part of their forthcoming assessment process. • 2.0: The achievement of A & E waiting targets had shown a high level of commitment from the whole Trust • 2.0: On Referral to Treatment Times (RTT) no patients had a wait of more than 52 weeks. • The CEO briefing was attached as an example. As this was between the Chief Executive and staff it would not go to each public board, but would be shared with NEDs each fortnight. 7.0: Fire Update JJ asked for an update on testing of cladding. KMO confirmed that the compliance certificate for cladding on the main building at the West Middlesex site was available. This had not been available at Board meeting in July. The placement was also confirmed as directly onto concrete, without a ventilation gap and our fire officers had therefore deemed us to be at low risk. Whilst the independent test certificates provide the Trust with assurance all cladding products remain suitable for use; the Trust continues to pursue further independent assurance to ensure the cladding on the Main Hospital remains compliant. Due to pressures on independent testing centres in the UK, enquiries were on-going abroad. JJ and AJ confirmed actions were appropriate. AJ, KMO and David Butcher (Property Director) had spent the morning as part of the property working group reviewing wider fire prevention for the Trust including detection systems, compartmentation and general procedures. This had included a walk around and evaluation at the WM site including cladding, compartment review, new electrical distribution and new combined heat and power units. A similar walk around the CW site took place last month focusing on detection system renewal, compartments/ fire door scheme and sprinkler system. 11.0: Electronic Patient Record (EPR) Programme Following a query by JJ, it was agreed the independent assessor, Ernst and Young, would report to the Board twice yearly, but in any event at the next Gateway. ACTION: VD: Add to Board Forward Plan • PN commended the Patient Information Booklet produced by DN. • LW Highlighted the Open Day at West Middlesex site on 16 September, Annual Members Meeting on 28 September and Staff Awards on 18 October. • THH asked for further volunteers for membership recruitment to contact Dominic Conlin
2.0	**QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE**

2.1	**Patient Experience Story**
a.	Natalie Carter, Midwife Consultant introduced Heidi, a new mother whose first delivery had been elsewhere and had been difficult (Heidi felt through poor staff communication and poor pain management) and led to her requesting an elective caesarean for this most recent delivery at West Middlesex Hospital. In fact, alternative birth plans were agreed. Heidi praised the dedication of staff, such as texting contact details for Natalie as promised; prompt face to face meetings; developing an agreed birth plan, which was respected; and commented that as a patient she felt the love of staff. The importance of birth plans, the strong impact of birth experience on mothers and the learning opportunities of hearing when things go right were all commented on. Heidi had written to Natalie Carter, which had been shared with the team. The Board congratulated Heidi on the birth and thanked her sincerely for taking the time to speak to them.
2.2	**Serious Incidents Report**
a.	PN presented the Serious Incident Report (P47), which was noted. She highlighted: • Data was more robust and allowed for prompt intervention • There was a continued focus on hospital acquired pressure ulcers (HAPU), which were lower than the same time last year and last month and there was continued working with NHSI • Overdue actions from Serious Incidents had reduced to 12 JJ asked about themes of temporary staff and deteriorating patients against priorities. PN noted there was a lot of work on-going with HR on temporary staff; the trends had led to quality priorities; work on recognising deteriorating patients, including work on dementia and frailty was continuing, including communications with community providers. EH noted the progress made with no new HAPU at grade 3 or 4, no falls related harm incidents and good learning. EH asked about Duty of Candour; 12 outstanding actions. PN said these had been closed off and related to a failure to record the conversations with families that had in actuality occurred on a timely basis. LW noted there was on-going work for London as a whole around temporary staff, end of life care, sepsis and deteriorating patients, as well as frail patient flows, of which the Trust was part. JJ asked about training for temporary staff. PN confirmed contracts with agencies confirm completion of core training. There is an issue to resolve on higher training from the Trust, whilst avoiding duplication of this.
2.3	**Integrated Performance Report, including:** **2.3.1 Winter preparedness** **2.3.2 NHSI/ ICIP review Emergency Department** **2.3.3 Workforce performance report**
a.	RH presented the Integrated Performance Report (p59), which was noted. A Quality Priorities Dashboard would be presented to Quality Committee in September. NG asked about Venous Thromboembolism (VTEs) risk assessments being RAG rated red. In the discussion, ZP said the biggest issue was reporting due to a lack of appropriate IT systems on the West Middlesex site. There was an issue about completing screening too. This would only ultimately be resolved with the introduction of Cerner. Oversight was through quarterly random audits, which

	were shared with NHSI and CQC. LW noted action was needed to avoid the risk of harm and plans were for whiteboards to be installed in situ, and drill down to individual consultants. PN noted no elevated level of serious incidents for VTE. EH noted the lowering of the safety thermometer. RH and PN responded. There had been some decrease in RTT compliance at West Middlesex, but the primary issue was an IT issue on reporting which had now been resolved. SE presented the Finance dashboard (p75), which was noted. There was a discussion around delivery of the Cost Improvement Programme (CIPs). The Trust would endeavour to make budget and deliver CIPs. JJ as Chair of FIC confirmed that the Trust was on track to make budget. The Chair reinforced the importance of only agreeing budgets that we can deliver rather than yielding to pressure from regulatory authorities to agree to an unattainable budget KL presented the Workforce performance report (p79) which was noted. There was a discussion around completion of core training. Technical issues on 'e learning' were in the process of being resolved and the Trust would move to internet based training in November 2017 (LS). LW was not convinced all training had been captured and staff had been asked to respond if training was not recorded, with foreshadowing of disciplinary action where training had not been completed. EH highlighted the retention rates and need for pipeline recruitment, also referencing overseas recruitment. PN and SE confirmed overseas recruitment was in process, combined with post business case evaluation of success which will be reviewed at the next FIC meeting on 28th September. The chair of the People & OD committee will be in attendance at that meeting. JL asked about 'PDR'. KL confirmed this is the re-launched (April 2017) appraisal system (Personal Development Record). ND raised promotions (p87) against controversy on the national NHS pay freeze. KL confirmed the promotion data was a Trust innovation, and there was no national benchmarking. NG noted that equality data sits below the report and asked that this be referenced ACTION: KL to add reference to equality data to Workforce Performance Report
2.4 a.	**Learning from Deaths Implementation** ZP presented the paper (p77) which was noted. Going forward, the Board would receive quarterly reports, supported by Dr Iain Beveridge, Associate Medical Director WM**.** ZP found this was a valuable tool which enabled the Trust to note themes and trends and intervene and had provided valuable insights on deteriorating patients. THH and EH commended the paper, which built upon the deep dives undertaken already. JJ asked about mortality on the West Middlesex site. ZP noted that although matrices were included to standardise for demographics and medical conditions, the standardisation is not perfect. However the overall trust HSMI placed the organisation in the top decile of performers.
3.0	**STRATEGY**
3.1 a.	**Key Measurables for 2017/18 key trust priorities, including Board Assurance Framework** KMO presented the paper (p135), which was noted. He highlighted that the format had been reviewed by Audit and Risk Committee in July and benchmarking appeared at p140. THH commended the paper, which the Board would develop further.

3.2	**Shaping a Healthier Future and Sustainability and Transformation Partnership**
a.	KMO presented the paper (p144) which was noted. There was discussion around the resources needed and the Trust's own financial and performance requirements. It was noted that the modelling would be completed within the next two weeks. The Board recognised the importance of the project and that the estate in NW London was in urgent need of reparation. It recognised its duty to the patients of NW London, as well as its statutory and constitutional duties as the Board of this NHS Foundation Trust and supported the paper in this context. NG asked what land disposals were proposed. SE clarified that some primary care assets were to be disposed of alongside other NHS facilities.
4.0	**GOVERNANCE AND RISK**
4.1	**Key Risks: Medical Workforce**
a.	ZP presented the paper (p151), which was noted. It was highlighted that there are significant difficulties in developing an effective medical workforce strategy as doctors are in training between 15-20 years (medical school through to consultant). There was a discussion around junior doctors and projects including improvement of the fellowship programme, the 'Hospital at Night' initiative, the Independent Guardian for junior doctors, health and well-being strategy, apprenticeship schemes to consultant status and learning mentors for longer. There was support for maintaining more control and closer links with junior doctors and the paper was commended.
4.2	**Raising Concerns Report**
a.	KL presented the report (p171), which was noted. There was a request for more detail for Board level Assurance. The learning opportunities from whistle blowing were highlighted, and the need to track outcomes, ensuring that whistleblowing incidents were not withdrawn without good reason. It was noted that further detail would reflect Trust openness. There was a discussion around which committee should review and it was agreed People and Organisational Development (POD) should continue to oversee the process and data. Individual incidents would also be reviewed by relevant Board Committees ACTION: Note for Board Committee terms of reference review 2018/19 VD Review in light of Board comments on detail KL
4.3	**Board Committees Terms of Reference**
a.	The terms of reference for Quality Committee (QC), Finance and Investment Committee (FIC), Audit and Risk Committee (ARC) and People and Organisational Development Committee (POD) had been approved by e governance. POD terms of reference had been amended to provide for quorum as below: "**7. Quorum** 7.1 The People and Organisational Development Committee will be deemed quorate to the extent that the following members are present:

	• Two Non-Executive Directors (one of whom may be the Chair of the Committee) • Two Executive Directors or suitable deputies • Either the Director of HR or Deputy Director of HR " Noted and agreed. ACTION: VD to send final terms of reference to Board
5.0	**ITEMS FOR INFORMATION**
5.1 a.	**Questions from members of the public** Barbara Benedek, Carer, Hounslow, praised the patient experience presentation and asked what initiatives were in place to help patients be mobile and out of bed, particularly the elderly and those with learning difficulties. THH replied that Rachael Allsop as Head of Volunteering had a particular focus to develop strategy on mobility of the elderly patient. LW noted the Trust saw this as important as Ms Benedek and was working with both patient groups. EH asked for an update on volunteer strategy. It was noted this would be on the POD agenda in November. ACTION: VD Update on volunteers to be at November Board
5.2 a.	**Any Other Business** Nothing raised.
5.3	**Date of Next Meeting – 2 November 2017**

Trust Board Public – 7 September 2017 Action Log

Meeting	Minute Number	Action	Current Status	Lead
Sep 2017	**1.3.a**	Minutes Action: KMO/LW/SEL to agree turnaround times for Board minutes.	It has been agreed that minutes will be with the Chair for sing off within a week. Complete.	**KMO/LW/SEL**
	1.4.a	Matters arising ACTION: VD to remove yellow and green items from action log once Audit and Risk Committee had reviewed the RAF in October.	Complete.	**VD**
	1.5.a	Chairman's Report ACTION: LW/ZP/KJ to liaise with NHS Digital and consider the possible opportunity of bilateral secondments.	KJ in discussion with NHS Digital about ongoing relationship.	**LW/ZP/KJ**
	1.6.a	Electronic Patient Record (EPR) Programme ACTION: VD to add to Board Forward Plan.	This is on the forward plan.	**VD**
	2.3.a	Workforce performance report ACTION: KL to add reference to equality data to Workforce Performance Report.	Verbal update.	**KL**
	4.2.a	Raising Concerns Report ACTION: VD to note for Board Committee terms of reference review 2018/19. KL to review in light of Board comments on detail.	This is on the forward plan for Board committees in 2018.	**VD/KL**
	4.3.a	Board Committees Terms of Reference ACTION: VD to send final terms of reference to Board.	Complete.	**VD**
	5.1.a	Questions from members of the public ACTION: Update on volunteers to be at November Board.	This is on current agenda.	**VD**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	1.5/Nov/17
REPORT NAME	Chairman's Report
AUTHOR	Sir Thomas Hughes-Hallett, Chairman
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chairman's Report
November 2017

1.0 Jeremy Loyd Retirement

We are all indebted to Jeremy, who now retires as Non-executive Director (NED) in line with guidance on restricting the length of office of NEDs. Jeremy has been a NED of the Trust since 2011, long before my own appointment. With good humour and great talent, Jeremy has steered the Trust through a time of great change. In particular, he has chaired the Audit & Risk Committee, an arduous but rewarding task during the integration of West Middlesex University Hospital; worked closely on the restructuring of CW+ as a Trustee of CW+ and he has been a passionate advocate of patient rights throughout his tenure. We all wish Jeremy well in his future ventures.

2.0 NED Recruitment

The Board required a replacement NED to maintain the majority of Non-executive to Executive Board roles. In fact the Council of Governors committee which interviewed a field of exceptional candidates was so impressed with Steve Gill and Gary Sims that they recommended appointment of both, which the Council of Governors has approved. Steve trained as an accountant and moved into the IT sector, focussing on change management, including the merger between Hewlett Packard (HP) and Compaq. He then became HP's CEO in Korea and China. His NED appointments also include a focus on education.

Gary Sims also trained as an accountant, working in the financial sector. He has led a number of operational, delivery-focused, projects, implementing changes to financial practice, information governance, and complaints. He chairs the Audit & Risk Committees for the Discovery Schools Academy Trust (DSAT), the national Parent Teacher Association and the Parole Board. Gary will become the Chair of the Audit & Risk Committee on Jeremy's retirement.

3.0 Susan Maxwell

Susan is retiring as Lead Governor and as a Governor. She has been an invaluable source of support to myself as Chairman and, I know, to the Council of Governors. Susan has always been unfailingly generous with her time and her good sense and I thank her most sincerely for her contribution.

4.0 Lead governor elections

The process for Lead Governor elections was approved at the Council of Governors meeting of 28 September and a new Lead Governor will be elected at the Council of Governor meeting of 30 November 2017.

5.0 Governor elections

Vacancies have arisen for five public representatives (City of Westminster – 2 seats; London Borough of Hammersmith and Fulham Area – 1 seat; London Borough of Wandsworth – 1 seat; and Kensington and Chelsea – 1 seat) and 2 staff representatives (Support, Administrative and Clerical Class – 1 seat; and Allied Health Professionals, Scientific and Technical Class – 1 seat). The election process has been published and we will know the results by 27 November.

6.0 Governor Away Day

We are looking forward to a thought provoking day on 20 November 2017 at Cadogan Hall and are delighted both that Governor Philip Owen has secured this venue free of charge and that Professor Chris Ham, CBE, CEO of the King's Fund, is due to join us.

7.0 Annual Members Meeting

At the end of September we held the Annual Members Meeting. We have around 17,000 members who support this Trust and this is their opportunity to hear about Trust progress, let us know their views, and hold us to account. Around 50 people came along to the Rumbles restaurant at West Middlesex. The members I spoke to were impressed with the progress we have all made together and enjoyed the presentations from Dr Anne Davies on the Paediatric Assessment Unit and Dr Roger Chinn and Dr Sadia Khan on quality and innovation. We were delighted to welcome Seema Malhotra, our local MP for Feltham and Heston. She was very engaged with the challenges we face and we look forward to working with her on a range of issues.
I was grateful to a number of patients and families of patients for raising issues. This takes courage in a public meeting. Some of the issues needed a more detailed response outside of the meeting and I invited those people to provide their details so we can take this forward.

8.0 Integrated Governance & Risk Review (IG &RR)

I am delighted that the Board has approved the scope and timetable for this, which we plan to have available early next year. The current operating environment has seen increasing risk to healthcare providers in parallel with increasing demand on our services, staff and funding. In these circumstances, our governance arrangements must be particularly robust, transparent, display total clarity of responsibility, have appropriate accountability and be subject to Board oversight. We also need to confirm our process of governance is sufficiently resourced by people at the right level of seniority, who have the right experience and skill.

9.0 NW London Chairs meeting

The four hospital trust chairs for North West London have agreed to increase the frequency of our collaborative meetings – we will now meet quarterly. We are determined to ensure that we support as a group our CEO's to influence the successful implementation of our Strategic Transformation Programme. We have some shared concerns about how decisive the STP is able to be at present.

10. Health and Wellbeing group

Lesley Watts has asked me to chair our new Health and Wellbeing group which is tasked with improving the happiness of our staff and volunteers and reducing the stress that they experience. It is an entirely action based group which will report to our staff and volunteers after each session. I am working closely with our Director of People and Director of Communications on this. Obviously we will feed in the the People Committee.

11. Board to Board Trust and CW+ meeting

Recently the Board of Trustees of CW+ and the Board of the hospital Trust held their first annual meeting together. The purpose of the meeting was to reflect on our relationship, our agreed joint priorities, and to allow the CEO's of both organisations to brief us on current developments. We celebrated the significant progress on all fronts during the last 12 months and also the recent particular success of our capital appeal supporting the expansion of NICU and ICU. As a hospital, we are fortunate indeed to be supported by such an effective and well-run charity.

12. Volunteering

We are discussing volunteering at the Board meeting. I am pleased to report that HelpForce of which we are one of the five pilot sites has now been funded by Big Lottery with impact and insight work being led by the Kings Fund and, in principal, economic evaluation being supported by Pro Bono Economics.

Sir Thomas Hughes-Hallett
Chairman

November 2017

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017 **PUBLIC SESSION**

AGENDA ITEM NO.	1.6/Nov/17
REPORT NAME	Chief Executive's Report
AUTHOR	Karl Munslow Ong, Deputy Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chief Executive's Report

September 2017

1.0 Care Quality Programme

We have been informed of our planned comprehensive Care Quality Commission (CQC) dates which are the 5-7th of December with a 10 day period following the 7th to undertake unannounced inspections. The well led inspection will then be on the 22nd -24th of January 2018. We are continuing with our preparations and briefings to ensure all staff are prepared.

NHS Digital has recently published the hospital mortality rates for England 2016/17. This showed that out of 135 trusts, we were one of only 17 that had a lower than expected number of deaths. Mortality statistics are one of our key indicators in ensuring we are delivering high quality safe care to our patients so we are delighted that we continue to be one of the best performing trusts nationally.

I am very pleased to announce that our Ward Accreditation has been completed in all our clinical areas on both main sites and all off-site facilities. The results were 1 gold (congratulations Neptune Ward); 33 silver; 29 bronze; and just 2 white which overall is a very good set of results. I know some wards have been disappointed about their ratings, but overall the message is very positive and our performance benchmarks well with other Trusts. It is also very evident across our wards that there is a strong desire to continuously improve. A new round of accreditation will be starting soon, so I look forward to seeing wards and departments progressing up the levels.

2.0 Performance

On 15 September we again initiated our major incident plan as we responded to a terrorist incident at Parsons Green. We received 14 casualties and all our staff worked incredibly hard to ensure all casualties received excellent care. Once again we worked incredibly closely with our other emergency service partners and I would like to extend my thanks to all those involved.

We have been informed that the General Medical Council have closed the continuous monitoring of Obstetrics on our Chelsea site as the action plan has been completed and no further concerns have been raised.

As the Board will be aware, in early 2016 the Care Quality Commission as part of its review of maternity indicators alerted the Trust to higher than expected rates of puerperal sepsis and/or other puerperal infections within 42 days of delivery on two separate occasions. The CQC wanted to be certain that the high rates in this area had been recognised, explanations explored and appropriate actions taken by the trust in a timely manner to ensure the future safety of patients. The on-going review process can often take some time but I am pleased to confirm that the CQC are fully satisfied that there is no risk to patients and we are no longer under active monitoring.

September was another busy month with the organisation achieving 93.8% for A&E. The Chelsea site delivered 95.2% and West Middlesex 92.6%. This is against a 9% increase in attendances compared to the same period 2016/2017 and we remain one of the best performing London Trusts for this standard. Our Q2 overall position was 94.8% which meant we secured the full amount of Sustainability and Transformation

Funding for that quarter. I am pleased to say our Cancer Standards for 2WW and 62 days were delivered with very impressive results given the increased numbers of patients treated. Our RTT position is now the main focus for us as this was not achieved in September for the Trust with a performance of 90.93%. We have seen deterioration in RTT performance across a number of specialities on the West Middlesex site in particular which has affected both the Trust and aggregate positions. A comprehensive speciality-based recovery plan has been developed and submitted to NHS England which is monitored through the weekly elective access meetings. We need to work hard to ensure we get back to a complaint position as soon as possible and I am aware the operational and clinical teams are working hard to make this happen for our patients.

3.0 Winter Planning

As we enter in to the winter period it is incredibly important that we take all steps available to minimise the risk of flu to our patients, staff and visitors. Vaccination is the most effective way of minimising the risk of catching flu and we are strongly encouraging all of our staff to take this up. We will continue to update Board and our regulators on progress with the flu vaccination programme.

From October we have expanded our Acute Frailty Pathway on the West Mid site through the introduction of a 12-bedded Frailty Unit on Crane Ward. The Unit builds on the work of the Acute Frail Elderly Team who work in the Acute Medical Unit to identify frail patients and undertake a Comprehensive Geriatric Assessment (CGA) to develop care plans. Patients who need to remain in hospital but who are likely to return home within seven days will be cared for on the Frailty Unit providing continuity of care from the AMU team and with dedicated consultant cover for the 12 beds. Through the development of a clinical management plan, combined with provision of intensive rehabilitation, the Unit aims to reduce the length of stay for these patients by an average of 2 days. The Unit will focus on improving patient's physical and psychosocial function by encouraging mobility and activity on the ward so that patients are sat out, dressed and mobile. Improvements to the ward environment for patients with dementia are also planned. A formal launch of the Unit will be scheduled for later in the year.

The Trust is expecting increased Emergency activity from October 2017 through to March 2018 and the Quality Committee received the system-wide winter resilience plan last month, and then the CWFT specific winter resilience plan, this month. The teams have prioritised the top 15 actions which operationally, we believe will have the greatest impact to help the flow of patients through our hospitals. The delivery of the actions will be monitored through the bed productivity programme and reported through the A&E Delivery Board which I chair.

4.0 Staff Achievements

I am delighted that our Trust has been awarded a special ***Kate Granger Awards*** for compassionate care. The recognition was made for 'providing exceptionally high standards of compassionate care following the major incidents in London'. Congratulations to everyone, even though we all wish that the events had never happened. Professor Oliver Shanley, London Chief Nurse presented the award and expressed his gratitude, saying that staff are "completely inspiring and compassionate".

<u>Staff awards</u>

We celebrated our amazing staff and their achievements at the annual staff awards ceremony on 18 Oct. The event, sponsored by CW+ and other generous contributors enables us to recognise the wide range of

talent we have in our organisation and is a chance for staff to reflect on their fantastic achievements. This year we had almost 600 nominations from patients and staff. The winners and photos can be found at www.chelwest.nhs.uk/about-us/awards/staff-awards/staff-awards

Nurse of the Year: Robert Breen and Nerissa Vardeio
Midwife of the Year: Anne O'Sullivan
Doctor of the Year: Dr Sarkhell Radha
Clinical Support Worker of the Year: Gregory Olumekor
Allied Health Professional of the Year: Caroline Benson
Pharmacist/Healthcare Scientist of the Year: Anand Vadgama
Corporate employee/Administrator of the Year: Jason Tatlock
Support Service employee of the Year: Nadia Yolova
Team of the Year: Elizabeth Suite
Volunteer of the Year: Barry Dew
Inspiring Leadership Award: Shalee Lasam
Lifetime Achievement Award: Liz Barnshaw
Quality Improvement Award: Hellen Hood
CW+ Proud to Care Award: Melany-Jane Knight
CW+ Special Award: Dr Sadia Khan
Chief Executive's Special Awards: Crane Ward; David Erskine Ward and a posthumous award for Annette Funai.

CW+ Proud Staff Award Winners

August: Sarkhell Radha (senior registrar, trauma and orthopaedics); Marisa Rodriguez (clinical site manager); Early Pregnancy Unit Nurses: Anthoula Kanari (domestic services).

September: Kiran Chhokar (senior pharmacist); Tom Rafferty and Joe Donnelly from the Strategy Team; and the Tuberculosis team at West Middlesex; Matt Clegg, Healthcare Assistant on Neptune Ward.

Regional and national industry awards

Sheena Patel has been honoured by the VTE (venous thromboembolism) Exemplar Centres for her exemplary contribution to VTE prevention. The award was made by Professor Sir Bruce Keogh (NHS Medical Director), Professor Roopen Arya (Director for the National VTE Exemplar Centres) and Dr Shelley Dolan (Chief Nurse at King's College Hospital).

The finance team have been shortlisted for the Innovation Award in the national Healthcare Financial Management Association (HfMA) awards for their work on the sexual health e services tender.

5.0 Workforce

Our voluntary turnover rate was 15.5%, 0.2% lower than last month. Voluntary turnover, which stood at 16.4% in April 2017, has dropped every month since. Voluntary turnover is 18.0% at Chelsea and 10.9% at West Middlesex.

Our general vacancy rate for September was 13.2%, which is 1.2% lower than August.

In September 41 staff were promoted. In addition, 58 employees were acting up to a higher grade. Over the last year 8.0% of current staff have been promoted to a higher grade.

6.0 Leadership Away Day

We held our leadership away day on 13th September with over 100 attendees from all different parts of our organisation. The morning focused around our three priorities of:

- high-quality patient-centred care
- being the employer of choice
- delivering better care at a lower cost

Dr Cathryn Brock (Consultant Oncologist) as part of the Acute Diagnostic Oncology Clinic demonstrated how the team has brought positive change to vulnerable people's lives; Chisha McDonald (Deputy Chief Pharmacist) spoke about how the pharmacy team are addressing the challenges of high turnover; And Dr Chrystalla Macedo (Consultant Dermatologist) presented work on how the team has reduced costs and increased income – making a difference of over £1.7 million a year to the bottom line. There was a very strong theme of team working through the presentations and they all generated a great amount of debate and interaction.

The afternoon was about getting to know Cerner, our Electronic Patient Record system. We heard from Cerner staff, trusts that had implemented Cerner, and from our own staff who have been through similar implementations in other organisations. The lessons I took away were:

- Preparation is key. We cannot get too many people involved. This will affect every member of staff in a multitude of different way.
- Implementation will not go perfectly. The culture of the organisation is paramount to get through the challenges safely, respectfully and professionally.
- The prize will be worth it – true 21st century healthcare that will benefit all our patients and staff.

7.0 West Middlesex Open Day

We held the West Mid open day on 16th September which followed the Chelsea site open day earlier in the year. Once again it was a great day of teamwork, team spirit and a celebration of all that is great in our hospitals. We launched the fundraising programme to support improvements on starlight and sunshine wards and the hospital and were delighted to welcome many local friends including the Council Leader, local MPs and many people from our community. As always a huge thank you should go to our staff that put in a great amount work to make this a very special day.

8.0 Communications and Engagement

We had a packed agenda at our monthly team briefing sessions with staff presenting on the organisation's response to the staff survey; ambitions around Quality Improvement (QI) and a fascinating demonstration of this by Sunita Sharma and how she has been working with colleagues to improve postnatal care; how the audiology team managed to carry on providing a great service whilst compromised by IT issues; and discharge planning. Like all trusts, getting better at discharging people when they are ready is essential both for patients and for efficient use of resources. So it was great to hear about 10 different schemes that are progressing well and safely reducing lengths of stay. The latest team briefing is attached to my report.

We have again been punching above our weight at national events including the UK Health Show where Zoe Penn and Chris Chaney gave presentations. We held our own annual Research, Audit & Service Improvement (RASI) event which was a fantastic opportunity to showcase and celebrate the great work

done at our Trust, exchange knowledge and learn how to start a project and access the available resources and support. The research we do at the Trust is really driving improvement in all areas of care, and it is everyone's business. Research-active hospitals achieve better patient outcomes.

We have developed:

- a new recruitment pack (which can also be found on our website) www.chelwest.nhs.uk/about-us/working-here
- a Trust leaflet http://www.chelwest.nhs.uk/about-us, in particular for Governors to use when representing us at local community events
- an adult inpatient booklet for the Chelsea site http://www.chelwest.nhs.uk/your-visit/information-for-patients (to mirror the recently published West Middlesex version)
- and a map of the Chelsea site to help visitors easily locate where they are going.

9.0 Getting it Right First Time

The Paediatric Surgery service was reviewed by the Getting It Right First Time (GIRFT) national team on 28th September. The GIRFT programme supports the NHS in delivering productivity and efficiency improvements and sits alongside the Carter report and Model hospital work. Its purpose is to identify areas of unwanted variation in clinical practice and enable specialties to pinpoint where improvement work should be focused.

The feedback from the visit overall was very positive – the data evidences a high quality service with good performance. The report received from the team in particular notes good practice in terms of overall good outcomes; elective financial performance and procurement costs.
The team identified some potential areas for improvement which are grouped into 5 key points:

1. Fragmentation of specialist paediatric services in the sector was identified, with a recommendation to have a clear strategic vision of future services. This is currently being considered through the discussions with ICHT and the Royal Brompton collaboration. We are also currently awaiting the outcome of the NHS England specialist paediatric surgery review which will support strategic planning of the service
2. A small amount of variation in clinical practice was identified with a recommendation to produce policies to support consistency e.g. umbilical hernias and circumcisions and internal audits are already underway to examine this in more detail.
3. Opportunities to move certain procedures i.e. hypospadias and pyeloplasty from inpatient to day case
4. The length of stay is generally very good, but there is the potential to improve this further, with neonatal surgery mentioned. Additional specialist nursing workforce was recommended to support this and also noted to be low, relative to the size and complexity of services.

The next steps are for the Paediatric surgery team to provide a response to GIRFT report, and will develop a local action plan to progress the recommendations.

We have GIRFT visits planned for both General Surgery and Urology before the end of the calendar year so I will report back on these at our next Board meeting in January.

10.0 The wider NHS system

It has been a busy few months across the wider NHS as the whole system puts in place its plans for this winter. I have attended several regional and national meetings with other providers, commissioners, NHS

England and NHS Improvement to discuss winter planning as well as progress with the wider Sustainability and Transformation Plans (STPs). It is clear that the system right across the country is under severe strain but there remains a strong desire to ensure we deliver the best possible care for patients as we put in place plans to cope with the demands of winter.

Several things are also happening more locally in North West London; We are still awaiting information on progress with the Shaping a Healthier Future (SaHF) Outline Business Case. We have not been given any definitive timescales for a decision but we hope to have a progress update over the next month or two. In addition, local Clinical Commissioning Groups (CCGs) are currently considering their future management arrangements and are consulting on whether the 8 CCGs should more closely align their governance and decision making.

The Strategic Partnership Board (SPB) continues to monitor our strategic work programmes including activities as part of the Sustainability and Transformation Partnerships (STPs) and the Trust's agreed strategic priorities for 2017/18. The SPB received updates on:

- The Board Strategy Working Group and how we should reflect existing and future partnerships and relationships. A refreshed Clinical Services Strategy will be coming back to Trust Board in early 2018
- Estate development and the relationship with the wider *Shaping a Healthier Future* programme.
- Hammersmith & Fulham ACP: where, following analysis by the communications workstream and public feedback, the programme is being rebadged as an Integrated Care Partnership. As set out in the July CEO Board Report, the current proposal is to sign a formal Partnership Agreement as an enabling step for possible contract award (see below)

<u>Hammersmith and Fulham Integrated Care Partnership Agreement</u>

I attended a CEO seminar, facilitated by the Kings Fund, for the Hammersmith & Fulham Integrated Care Partnership. There is an existing Memorandum of Understanding (MoU) between partners. We agreed that our immediate focus for the rest of this year and into 2018/19 would be on urgent care flows and reducing re-admissions to hospital.

As part of our preparatory work the Integrated Care Partnership is proposing to sign a Partnership Agreement. The Partnership Agreement has been co-designed by the Company Secretaries of the provider partners, with legal input from Capsticks, and is recommended for approval by the Strategic Partnership Board. In summary;

1) The Hammersmith & Fulham Health and Care Partnership consists of:
    - Hammersmith & Fulham GP Federation (all 29 GP practices in the borough)
    - Imperial College Healthcare NHS Trust
    - Chelsea & Westminster Hospital NHS Foundation Trust
    - West London Mental Health NHS Trust
    - Central London Community Healthcare NHS Trust
    - Lay representatives

2) The registered population is c200,000 and H&F is our 4th biggest contract at c£40m (behind NHSE, Hounslow and West London) and therefore is important enough to us to be involved in these new arrangements rather than risk being on the outside of possible capitated budget arrangements

3) The Partnership Agreement is in line with emerging 'system management' arrangements as incentivised by changes to Single Operating Framework. It uses STP type metrics to rate performance which are also recognised by both NHSI and CQC as part of their assessment framework.

A specific paper for Board approval is appended to my CEO report.

11.0 External Reviews

A list of forthcoming external reviews is appended to this report (Appendix 1).

12.0 Perfect Day

We have continued with our monthly Perfect Day programmes. I thoroughly enjoyed our September Perfect Day which saw me working in A&E at West Mid. I spent much of my time portering, seeing both examples of great care and the challenges we face with rising demand. In October I focused on the discharge element of the patient pathway. I worked with the discharge team looking at how we are managing the process around delayed transfers of care (DTOCs). It is clear that there are elements of good work taking place with our mental health and community partners but there is clearly still room for considerable improvement to ensure we get patients in to the most appropriate care setting.

13.0 Finance

In September, month 6 of the financial year, we achieved a small surplus of £0.02m against our monthly plan. However, the over spend on pay has increased by £0.93m from £4.33m last month to £5.26m at the end of September but this was not reflected in a corresponding increase in activity. The over spend is offset by underspends in non-pay as in previous months. The year to date underlying financial position is a deficit of £13.2m so we need to continue our efforts to control pay costs and treat the planned number of patients.

We have achieved 33.7% of or 2017/18 savings target of £25.9m against planned year to date achievement of 40.0%. We need to continue to work hard in the remainder of the year to improve CIP delivery and achieve our target.

Lesley Watts
Chief Executive Officer
November 2017

APPENDIX 1 - External Reviews

November 2017	7th November	Visit from Simon Stevens – CEO NHSE	WM						
	9th November 2017 10:00am-1:00pm	NHSE NWL Network Lead	Chelsea & Westminster Hospital Site	EPRR ANNUAL ASSURANCE AUDIT VISIT	Rob Hodgkiss	Mark Titcomb/ Tina Benson	Catherine Sands	EPRR Working Group	EPRR Strategic Group
	14th of November	EL(97)52 Audit of Pharmacy Technical Services by	Pharmacy Technical Services, Chelsea Site	Good Manufacturing Practice (GMP) Standards	Zoe Penn	Bruno Botelho	Deirdre Linnard	Planned Care Divisional Board	Compliance Group
	15th +16th November	UNICEF Baby Friendly Initiative	Maternity & NICU	BFI standards	Lesley Watts	Simon Mehigan	Gillian Meldrum	Maternity Experience Meeting	MSM
	28th of November	GIRFT	General Surgery	GIRFT dataset	Zoe Penn	Bruno Botelho	Faizal Mohomed-Hossen/Musa Barkeji	Planned Care Divisional Board	Compliance Group
	29th of November 2017	Human Tissue Authority Mock Audit by NHS Blood and Transplant	Burns Unit , CW Site	HTA Standards Four broad categories; consent, governance and quality systems, premises, facilities and equipment and disposal.	Zoe Penn	Karen Bonner	Jane-Marie Hamill	PCD Divisional Board	Compliance Group
December 2017	18th December 9 - 11.30	GIRFT	Urology	GIRFT dataset	Zoe Penn	Bruno Botelho	Faizal Mohomed-Hossen	Planned Care Divisional Board	Compliance Group

Team briefing

October 2017

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

Latest CW+ PROUD award winners

- Planned Care – Sarkhell Radha (senior registrar, trauma and orthopaedics), for demonstrating exceptional care for patients, ensuring they received clear communication and are comforted and reassured.
- Emergency and Integrated Care – Marisa Rodriguez (clinical site manager). For her commitment to providing excellent, safe, caring services out-of-hours.
- Women and Children – Early Pregnancy Unit Nurses. Described in their nomination as being a compassionate, caring, efficient, and organised team providing excellent service to patients and colleagues.
- Corporate – Anthoula Kanari (domestic services) for being a fantastic domestic who always ensures that the ward is clean and tidy from the start to the end of her shift, regularly going the extra mile.

Visit the intranet to nominate a team or individual.

Performance and winter plans

We have achieved our A&E 95% 4 hour target for the last three months. It is key to the delivery of patient care that we continue with this excellent performance.

The Trust is working with commissioners and the voluntary sector on system-wide plans (including funding), to support delivery of timely care and discharge. This will allow us to continue some of the schemes we had last year and some we have just started, such as discharge co-ordinators and Red and Green Days being visible on electronic whiteboards.

We are expecting a busy winter and supporting these initiatives will help maintain patient flow through our hospitals, so we can deliver excellent care.

Financial update

In August we achieved our monthly plan. However, overspend in pay costs continues to increase from £4.14m to £4.33m in August. As in previous months, this is offset by underspends in non-pay. However, as in month four, activity was lower than expected despite the increased pay costs. The year-to-date underlying financial position is a deficit of £11.01m so we need to continue our efforts to control pay costs and treat the planned number of patients. We have achieved 29.12% of our 2017/18 savings target of £25.9m (we had planned 36.48% at this point in the year). We must continue to work hard in the remaining seven months to improve CIP delivery and achieve our target.

Divisional updates

Emergency and Integrated Care

Another busy month; the Division welcomed new staff in many areas, especially in an expanded hospital discharge and flow team. All new starters should try and go to the monthly 'welcome breakfast' on each site; these are increasingly well attended and are valuable for making our new staff feel part of the team.

A few months ago, NHS Improvement visited both hospitals to review our emergency pathways. Overall their feedback was very positive, with the areas requiring some more focus now being included in an improvement plan. We are also continuing winter preparations so please think about your own, departmental and ward preparations as well.

Women's and Children's

The Division had a successful month of recruitment, with new starters in all areas, so welcome to all, including those beginning nursing or medical rotations this month! Paul Goodrich has joined as Managing Director for Private Patients with the aim to increase the money brought into the Trust, which can be used to support our NHS services.

There is significant service improvement going on, including in maternity at CW (notable given the large number of births recently). The paediatric surgery team have had a very successful external visit. Our sexual health services continue to provide high quality care as the commissioners make significant changes to clinics; and a new e-service involving C&W goes live shortly. Finally, congratulations to the paediatric diabetes team on the WM site who go from strength to strength and have won a number of accolades for improvements made and the high quality of patient care.

Planned Care

We held our first 'Divisional Welcome Event' for new staff at CW. These are an opportunity to celebrate the PROUD awards and to hear from all staff about work taking place in the clinical and non-clinical areas and to share feedback and get to know each other. More sessions are being arranged.

Governor elections

We are looking for new staff governors. There are two vacancies in 'contractors' and 'medical and dental'. Download the form at www.chelwest.nhs.uk/elections or contact vida.djelic@chelwest.nhs.uk

Cerner Electronic Patient Record update

Over 500 staff and patients attended Cerner EPR events in September and 97% of staff rated their experience useful or very useful. Mabel's Story showed how Cerner EPR supports staff in delivering every step in a patient's care. Countdown to Cerner helped divisional leadership teams to start detailed planning. The WMUH Open Day and the Trust Annual Members' Meeting gave us the opportunity to talk to members, patients and staff about the benefits of shared electronic records. The next steps include providing tailored familiarisation sessions for specific staff groups.

Information Commissioners Office (ICO) visit

The ICO visit showed that whilst we have strengths (e.g. an emphasis on training, and some of our systems); there is plenty of work to do. We will be developing an action plan, but in the meantime, please ensure you follow sensible information governance practice e.g. Make sure you are up to date with your IG training; wear your identity badges; don't talk about patients in public places; always lock your computer screen when not at your desk; lock away patient data; and never let people tailgate you into secure areas.

Non-executive directors (NEDs)

Jeremy Loyd will shortly be leaving us after many years' service. In his place we will be welcoming Gary Sims (who will be the new Chair of our Audit Committee) and Steve Gill, both of whom are outstanding individuals with experience in the voluntary, statutory and private sectors.

Care Quality Programme Update
The CQP programme is supporting the preparation for the upcoming CQC inspection. The Trust has sent its pre-inspection information to the CQC (now an annual requirement). The CQP team have arranged briefing sessions for all staff regarding the CQC visits and these will be held later this month – see Daily Noticeboard for details.

If you need further information about the CQC visit, see the staff handbook on the Trust's CQP intranet page, *Contributing to a successful CQC inspection September 2017*. Our CQP team can be reached: cqp@chelwest.nhs.uk

Mandatory and statutory training

Division	Compliance
Corporate	**87%**
Emergency and Integrated Care	**90%**
Planned Care Division	**85%**
Women, Neonatal, CYP, HIV/GUM etc	**86%**
Overall compliance	**88%**

All staff should check they are up to date with their training and managers must ensure that their staff have this in hand. Use Qlickview or Wired which are in the ELearning Apps section of the intranet. Most mandatory and statutory training can be completed using the eLearning website www.e-lfh.org.uk/home/. Face to face sessions, where needed, can be booked: learning@chelwest.nhs.uk

Nursing recruitment update
This autumn we have 40 new nurses commencing the Capital Nurse Rotation Programme across our two sites. This has been a really successful venture in association with Health Education England offering staff a preceptorship, mentorship and leadership course during the 18 month programmes with ward placements in surgery, medicine or paediatrics. On 13 Oct our latest Filipino nursing recruits join us and begin to gain their registration. We continue to recruit nurses from overseas. In August the team offered 48 staff nurse posts in Dubai. This month we are recruiting in the Philippines for CW and next month in Dubai for WM.

If you are a Band 2 HCA or a Band 5 Nurse/Midwife keen to experience nursing in a new speciality, our *Internal Transfer Policy* means you can transfer jobs without having to go through a formal interview.

If you introduce a nurse to work within the Trust, who hasn't been a student with us, you could earn yourself £1,000. Contact aibhin.burke@chelwest.nhs.uk for details.

The Trust is working closely with NHSI to improve the retention of our nurses and midwives. Surveys and focus groups are being carried out on both sites to generate ideas. Please send ideas to cathy.hill@chelwest.nhs.uk

Staff uniform and dress code policy
This policy sets out the dress code requirements for all Trust. Please familiarise yourself with these, including: staff should never travel to or from work wearing uniform on public transport. Staff who travel to work in their own vehicle may wear their uniform if it is fully covered at all times. Scrubs may only be worn in designated area and staff are required to change out of these before leaving the hospital or when moving between areas. Download here.

Staff Survey 2017
This year's survey has been launched and all staff in post on 1 Sept will receive a questionnaire. This will be via work email or a paper copy will be given out. Please complete the survey as soon as possible. Your feedback is very important as its helps us understand how you are feeling about work in the Trust so we build on what is working well and what we may be able to do better. If you manage an area where paper copies are being used, please hand them out without delay and encourage staff to fill them in. If you don't get a survey, contact: nicole.porter-garthford@chelwest.nhs.uk

You Said, We Did
As a result of feedback from the 2016 survey an action plan has led to improvements including: improving staff security; work to promote dignity and respect and equality and diversity in the workplace; and initiatives to improve staff health and wellbeing.

Flu vaccination
Flu season is upon us and it is important that you protect yourself, your patients and your family by ensuring you have the flu vaccine. For full details of drop in sessions and other ways that you can get your vaccination please keep an eye on the Daily Noticeboard. Alternatively you can contact the Occupational Health and Wellbeing department for details: (WMUH on ex 5044 and CWH on ex 58830).

Leadership Away Day
Our Leadership Away Day was both inspiring and thought provoking. There were presentations on our three priorities:
- high-quality patient-centred care
- being the employer of choice
- delivering better care at a lower cost

These showed how different teams have been helping achieve success. You can view them on the intranet.

Leaders went away with a clear message to lead with vision and be visible. If any managers have not seen the CQP fortnightly messages, please make sure you read them, live them, and disseminate them. They are on the intranet.

Our improvement culture
We are implementing a structured approach to improvement to deliver our strategic priorities. We expect improvement to become part of everyone's job with staff *enthused, enabled and empowered*. Our Trust-wide approach will see: an education and training programme to provide all staff with knowledge and skill in improvement science (building on existing leadership programmes and devising new training for every level) and:
- A faculty of experienced improvement practitioners to support training and coaching and collective learning
- A resource centre with access to knowledge, improvement tools and expert support
- Access to a project tracking tool

There are many improvement projects in place or underway including a clinical fellows programme; improved divisional capability; a tool developed to prioritise projects and:
- Experienced improvement practitioners identified
- Added improvement methodology to leaders' programmes

For more details contact: hugh.rogers@chelwest.nhs.uk

WMUH Open Day
The WMUH open day proved to be even more popular and enjoyable than previously for staff and our local community. More than £1,000 was raised for our CW+ paediatric appeal, eight nurses received job offers with six more invited back for interviews, and 71 people signed up to be Foundation Trust members.

November 2017 team briefing dates
Monday 6th, 9-10am, G2 offices, Harbour Yard
Monday 6th, 12-1pm, CW+ Medicinema, CWH
Tuesday 7th, 12-1pm, Meeting Room A, WMUH

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	1.6.1/Nov/17
REPORT NAME	Hammersmith & Fulham Integrated Care Partnership: Approval of Partnership Agreement
AUTHOR	Dominic Conlin, Director of Strategy
LEAD	Lesley Watts, Chief Executive
PURPOSE	For Approval
SUMMARY OF REPORT	There is an existing Memorandum of Understanding (MoU) between partners in Hammersmith & Fulham. The Integrated Care Partnership is seeking to sign a Partnership Agreement. The Partnership Agreement has been co-designed by the Company Secretaries of the provider partners, with legal input from Capsticks and recommended for approval by the Trust Strategic Partnership Board. The corporate governance proposal will see the introduction of 'committees in common', whereby the Integrated Care Partnership Board will become a formal committee of each partner's sovereign Board. This paper is the Partnership Agreement and corporate governance proposal for review by the Trust Board. The Board is asked to sign the Partnership Agreement and approve the introduction of 'committees in common'. The most relevant risk to the long-term governance of the H&F Integrated Care Partnership programme is summarised below: The CEO Cabinet and Strategic Partnership Board considered the proposal and have approved it, subject to Board approval. The key factors identified by the Executive were: • Introducing the ACP Programme Board as a 'committee in common' and accountable to each constituent member reflects emerging national practice as established by Vanguards. For CWFT the governance route would be through the Strategic Partnership Board and then to Executive Management Board and Trust Board; this echoes the Imperial College Healthcare Trust governance

	arrangements • The proposal is a key enabling step to any contract award and the development of an alliance contract • The proposal would ***not be legally binding*** so represents a positive but lower risk first step in a transition towards a more formal joint venture or new entity in the future • In the context of our own governance and regulatory duties it would align with the Well Led domain and the key measures within the revised Single Operating Framework. This would be considered as demonstrable evidence that the Trust are linked in with key external stakeholders and are able to reflect and account on relevant local health economy issues.
KEY RISKS ASSOCIATED	Potential risks include: • Failure of partners to agree contract terms between themselves or with commissioners • Bandwidth: Significant internal portfolio of work with potentially limited additional time for other strategic programmes Key Mitigations include: • Formal Partnership Agreement between providers as a first step towards an alliance contract • Prioritisation of OD work to engender trust between partners; participation in accelerated support programme offered by Imperial College Health Partners (ICHP together with commissioners • Using learning from pioneer and vanguard sites (e.g. Cambridge & Peterborough contract collapse).
FINANCIAL IMPLICATIONS	None Long term implications include the approx. £40m of contract income attributable to Hammersmith & Fulham CCG and level of risk in event of Accountable Care contracting system. Developing the work programme and establishing Partnership Agreement is a key mitigation to being outside of any developing arrangements.
QUALITY IMPLICATIONS	As above – bandwidth/focus on current Care Quality Programme
EQUALITY & DIVERSITY IMPLICATIONS	N/A

LINK TO OBJECTIVES	All
DECISION/ ACTION	The Board is asked to: 1. Approve the proposed Partnership Agreement

Dated 2017

Partnership Agreement

Hammersmith & Fulham Integrated Care Partnership

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Clause heading and number Page number

THIS PARTNERSHIP AGREEMENT is made the ..... day of 2017

BETWEEN: The Parties listed in Schedule 2 (Parties)

INTRODUCTION:

(A) The Parties will work in common in accordance with this Partnership Agreement to decide the specific arrangements for the provision by the Parties of the Integrated Care Partnership and what each Party shall do to ensure the delivery of the desired Integrated Care Partnership Outcomes; once agreed this will be documented in an Integrated Services Schedule.

(B) The Parties recognise that over the term of this Partnership Agreement there may be changes in the way that individual Parties provide the Integrated Care Partnership Services and how responsibilities are allocated between them. This Partnership Agreement aims to foster integration of the Integrated Care Partnership Services delivery via a committee in common structure.

(C) The aim of this Partnership Agreement is to facilitate that the development of the Integrated Care Partnership Services by the Parties to be delivered in a seamless and patient focussed manner.

(D) The Parties acknowledge that each Commissioning Contract will detail the payments due from any CCG to the Parties individually.

(E) In consideration of the above, the Parties have agreed to enter into this Partnership Agreement to set out how they will work together to facilitate the integrated provision of the Integrated Care Partnership Services in order to deliver its outcomes.

1. DEFINITIONS AND INTERPRETATION

1.1 The provisions of this Partnership Agreement shall be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2. PRE COMPLETION

2.1 Each Party acknowledges and confirms that as at the date of this Partnership Agreement it has obtained all necessary authorisations to enter into this Partnership Agreement.

2.2 The Parties have agreed the terms of reference of:

2.2.1 the Integrated Care Partnership Board, acting as a committee in common for all parties, as set out in Part 1 of Schedule 4 (Integrated Care Partnership Board – Terms of Reference) (the "**Integrated Care Partnership Board TORs**"); and

2.2.2 the Integrated Care Partnership Management Group, as set out in Part 2 of Schedule 4, (Integrated Care Partnership Management Group– Terms of Reference) (the "**Integrated Care Partnership Management Group TORs**").

2.3 The Parties will agree the format of an Integrated Services Schedule – this will be added to the Partnership Agreement when completed and approved by the Integrated Care Partnership Board.

3. PRINCIPLES

Partnership Principles

3.1 The Parties acknowledge and confirm that this Partnership Agreement is not intended to create binding obligations compelling any Party to act otherwise than as such Party determines in its sole discretion.

3.2 Subject to Clause 3.1, the Parties agree to work together at all times in accordance with the Partnership Principles to collectively achieve the Integrated Care Partnership Outcomes.

3.3 The Parties acknowledge and confirm that:

3.3.1 each Party shall be solely responsible for delivering its obligations strictly in accordance with its own Commissioning Contracts;

3.3.2 each Party shall be responsible for delivering such obligations as are identified as being its responsibility in the Integrated Services Schedule (once confirmed by the Integrated Care Partnership Board); and

3.3.3 nothing in this Partnership Agreement shall be interpreted as an assumption by any Party of obligations or liabilities arising under the other Parties' Commissioning Contracts, the Integrated Services Schedule or otherwise (unless expressly agreed to the contrary in writing).

3.4 The Parties also recognise that engagement and consultation duties, relating to any changes in clinical services, rest largely with the commissioners who will lead on such changes.

Commissioning Principles

3.5 Whilst acknowledging (i) the sovereign nature of each Party; (ii) the application of competition law (as relevant); and (iii) any applicable procurement obligations, the Parties consider that patient benefits and national policy stemming from the Five Year Forward View and the GP Forward View will be optimised by commissioning services from the Integrated Care Partnership where possible..

3.6 In due course (and forming part of the usual contracting round in the NHS), the Parties intend that the relevant CCGs will hold contracts with the Parties which will contain the Integrated Care Partnership Outcomes that are to be achieved collectively by the Parties.

3.7 The Parties will seek to agree that Commissioning Contracts relevant to Clause 3.6 above:

3.7.1 are agreed in a manner consistent with this Partnership Agreement; and

3.7.2 recognise the collective interdependencies with respect to the performance or non-performance of the Integrated Care Partnership Outcomes.

3.8 The Parties acknowledge that each Commissioning Contract details the payments due directly from any CCG to the Parties individually.

3.9 In order to discharge its payment obligations under each of the Commissioning Contracts, the relevant CCG shall be responsible for making payments to each of the Parties in accordance with the relevant Commissioning Contract.

4. INTEGRATED CARE PARTNERSHIP GOVERNANCE

Integrated Care Partnership Board

4.1 The Parties have established the Integrated Care Partnership Board, which acts as a committee in common of the Parties. The common governance arrangements for the committee in common are outlined in Schedule 6. Where any decision is outwith the delegated authority of the Integrated Care Partnership Board, each of the Party's board or governing body (as applicable) will be required to approve such decision, and report this to the Integrated Care Partnership Board prior to implementation. For the avoidance of doubt, nothing in this Partnership Agreement shall create a joint committee of the Parties.

4.2 The Parties have each agreed that the Integrated Care Partnership Board TORs shall apply in respect of the Integrated Care Partnership Board.

Integrated Care Partnership Management Group

4.3 The Parties have established the Integrated Care Partnership Management Group.

4.4 The Integrated Care Partnership Management Group TORs shall apply in respect of the Integrated Care Partnership Management Group although each Party acknowledges and confirms that such Integrated Care Partnership Management Group TORs are not intended to be contractually enforceable between the Parties but rather to indicate intended behaviours and processes of the Parties.

Admitting new members to the Integrated Care Partnership

4.5 Where a Party or Parties wish to admit a new member to be a provider under this Partnership Agreement, such a proposal shall be considered at the next Integrated Care Partnership Board meeting.

4.6 The relevant Party or Parties that wish to admit a new member shall serve a written notice on the Integrated Care Partnership Board setting out the details of:

4.6.1 the proposed new member (where known);

4.6.2 reasons and rationale for the proposed admission of a new member; and

4.6.3 the likely impact on the Integrated Care Partnership.

4.7 Following receipt of the notice referred to in Clause 4.6, the Integrated Care Partnership Board shall then consider the proposal and decide what actions (if any) need to be taken, in terms of varying this Partnership Agreement, for example.

5. INTEGRATED PROVISION OF THE SERVICES

5.1 All Parties intend for the services which fall within the remit of the Integrated Care Partnership to be provided in an integrated and patient-centred way by the Parties.

5.2 Subject to the provisions of each relevant Commissioning Contract, the Parties shall determine between themselves how they shall collaborate to achieve the Integrated Care Partnership Outcomes, and shall record the manner of their collaboration in the Integrated Services Schedule (once approved).

5.3 In accordance with Clause 11, the Integrated Services Schedule (once approved) may be varied by signed written agreement of the Parties and the Parties agree to work on the basis that the latest agreed Integrated Services Schedule (once approved) indicates how the Parties intend to work collectively.

6. GOVERNANCE

6.1 The Parties are individual organisations and each has their own individual corporate and clinical governance arrangements. The Parties shall comply with their own policies and procedures in the provision of the Integrated Care Partnership Services.

6.2 Nothing in this Partnership Agreement shall absolve any of the Parties from their obligations under each Commissioning Contract.

6.3 Without prejudice to the generality of Clause 6.2, where there are any Patient Safety Incidents or Information Governance Breaches relating to the Integrated Care Partnership Services, the Parties shall ensure that they each comply with their Commissioning Contract(s) and work collectively and share all relevant information to that Patient Safety Incident or Information Governance Breach (or other similar issue) for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

7. TRANSPARENCY AND INFORMATION SHARING

Transparency

7.1 The Parties shall seek to operate in an open and transparent manner with each other for the purposes of this Partnership Agreement, save for ensuring compliance with competition law requirements.

7.2 The Parties will provide to each other all information that is reasonably required in order to achieve the Integrated Care Partnership Outcomes and to design and implement changes to the ways in which the Integrated Care Partnership Services are delivered (and from where the Integrated Care Partnership Services are delivered).

7.3 The Parties have obligations to comply with competition laws and each acknowledges that it will comply with those obligations. The Parties will therefore ensure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

7.4 The Parties shall ensure that the Integrated Care Partnership Board establishes appropriate ethical walls between and within the Parties so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Parties who need to see it for the purposes of this Partnership Agreement and for no other purpose whatsoever.

Patient information sharing

7.5 The Parties acknowledge their respective obligations arising under the 1998 Act and under the common law duty of confidentiality and shall assist each other as necessary to enable each other to comply with these obligations.

7.6 Each Party shall procure that certain patient data for which it is Data Controller shall be made available to other Parties in accordance with the information sharing arrangements set out in Schedule 5 (Information Sharing Arrangements).

7.7 Each Party shall ensure that it does not share any patient identifiable data under this Partnership Agreement otherwise than in accordance with the arrangements set out in Schedule 5 (Information Sharing Arrangement).

7.8 Each Party agrees and understands that it retains responsibility for data for which it is Data Controller.

8. INTELLECTUAL PROPERTY RIGHTS

Pre-existing IPR

8.1 Nothing in this Partnership Agreement or any activity undertaken that is contemplated by this Partnership Agreement shall affect the ownership by any Party of any Intellectual Property Rights held immediately prior to this Partnership Agreement coming into effect ("**Pre–existing IPR**").

8.2 Each Party (the "**Granting Party**") shall grant to the other Party a revocable, royalty free, non-exclusive licence to use its Pre-Existing IPR for as long as the Granting Party remains a Party under this Partnership Agreement solely to the extent that this is necessary for the carrying out of the obligations in this Partnership Agreement and for the collective delivery of the Integrated Care Partnership Outcomes and the Integrated Care Partnership by the other Parties.

IPR created in the course of the integrated working

8.3 Subject to Clause 8.2, any Intellectual Property Rights created individually by a Party or jointly by more than one of the Parties in the course of the activities contemplated by this Partnership Agreement during the term of this Partnership Agreement ("**Shared Intellectual Property Rights**") shall be jointly owned by the Parties (as at the date of creation of the relevant Intellectual Property Rights) unless otherwise agreed by the Integrated Care Partnership Board.

8.4 The Parties shall:

8.4.1 subject to Clause 8.4.3, not enter into any licence or other contract exploiting or disposing of the Shared Intellectual Property Rights without the agreement of all of the Parties;

8.4.2 share any receipts produced by such exploitation with the Parties from time to time in the same proportions as may be agreed by the Parties; and

8.4.3 grant to each of the Parties at the time of creation of the relevant Shared Intellectual Property Rights a non-exclusive, perpetual, non-terminable, royalty free, licence to use the Shared Intellectual Property Rights for the purposes of providing NHS services.

9. CONFIDENTIALITY AND ANNOUNCEMENTS

Confidentiality

9.1 Each Party agrees:

9.1.1 to use a disclosing Party's Confidential Information only in connection with the receiving Party's performance of this Partnership Agreement, particularly in relation to commercially sensitive information;

9.1.2 not to disclose a disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party;

9.1.3 to maintain the confidentiality of a disclosing Party's Confidential Information; and

9.1.4 to return it immediately on receipt of written demand from the disclosing Party.

9.2 The obligations in Clause 9.1 will not apply to any Confidential Information which:

9.2.1 the receiving Party is required to disclose to comply with law, or is required to disclose by any court or other authority of competent jurisdiction or any governmental or other regulatory authority;

9.2.2 is in or comes into the public domain other than by breach of this Partnership Agreement;

9.2.3 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

9.2.4 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

9.3 The Parties acknowledge that the some of the Parties are subject to the provisions of the Freedom of Information Act 2000 ("**FOIA**") and will facilitate such Parties' compliance with their information disclosure requirements and FOIA in connection with this Partnership Agreement.

Announcements

9.4 No Party shall make any public announcement about the matters set out in this Partnership Agreement without the written agreement (which will be accepted by email correspondence) of all of the Parties.

Branding

9.5 As soon as reasonably practicable after the date of this Partnership Agreement, the Parties shall agree on the branding to be used by the Integrated Care Partnership, as set out in Schedule 4.

Indemnity Arrangements

9.6 Each Party agrees to ensure that it shall, at all times, have in place adequate Indemnity Arrangements (as defined in the NHS England standard contract General Conditions) for the purposes of its own service delivery that it is providing at any relevant time, and shall provide details of the same to the other Parties upon reasonable written request.

10. EXIT PLAN

10.1 The Parties shall produce and maintain an exit plan ("**Exit Plan**") setting out:

10.1.1 the likely impact on the Integrated Care Partnership should a Party's involvement in this Partnership Agreement be terminated;

10.1.2 the steps that the remaining Parties shall take in respect of any equipment, IT systems or premises that has been jointly used by the Parties for the purposes of providing the Integrated Care Partnership;

10.1.3 the steps that the remaining Parties must take to mitigate any detrimental impact upon patients receiving the Integrated Care Partnership Services

should a Party's involvement in this Partnership Agreement be terminated, including transitional governance arrangements; and

10.1.4 the steps that the Parties must take in relation to the following matters:

(a) any third party contracts entered into by the Parties specifically in connection with the Integrated Care Partnership; and

(b) staff employed or engaged by the Parties strictly in connection with the Integrated Care Partnership.

10.2 The Exit Plan shall be reviewed periodically by the Integrated Care Partnership Board and any changes must be agreed by the Parties.

10.3 Upon the termination of a Party's involvement in this Partnership Agreement, such Party and each remaining Party shall comply with their respective obligations under the Exit Plan.

11. VARIATION

11.1 A variation to this Partnership Agreement shall only be effective if it is in writing and signed by all of the Parties.

SCHEDULE 1 **- Definitions and Interpretation**

1.1 In this Partnership Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

1998 Act	means the Data Protection Act 1998;
Integrated Care Partnership	means the collective of the Parties;
Integrated Care Partnership Board	the Hammersmith and Fulham Health and Care Partnership (HFHCP) Integrated Care Partnership Board established in accordance with the provisions of Clause xx (Integrated Care Partnership Governance) and subject to the Integrated Care Partnership Board TORs;
Integrated Care Partnership Board TORs	has the meaning set out in Clause 2.2.1;
Integrated Care Partnership Management Group	means the Integrated Care Partnership Management Group established in accordance with the provisions of Schedule 7 (Integrated Care Partnership Governance) and subject to the Integrated Care Partnership Management Group TORs;
Integrated Care Partnership Outcomes	the outcomes specified in each of the specifications of the contracts;
Integrated Care Partnership Services	the services described in the Commissioning Contracts and referenced as the Integrated Care Partnership services as well as the services detailed in the Integrated Services Schedule (once agreed) as amended from time to time;
Commissioning Contract	means a contract for the provision of services entered into by a Party with a NHS Clinical Commissioning Group Party;
Competition Sensitive Information	means such information (not being in the public domain, generic or sufficiently aggregated) that, if shared between some or all of the Parties might constitute a breach of an of the Parties' competition law obligations;
Confidential Information	means all information which is confidential or otherwise not publically available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Partnership Agreement;
Data Controller	has the meaning set out in the 1998 Act;
Exit Plan	has the meaning set out in Clause 10;
Integrated Services Schedule	a schedule developed by the Parties setting out the specific arrangements between them as to which Party provides which aspect of the Integrated Care Partnership Services which is incorporated, as amended from time to time, into this Partnership Agreement once agreed.

Intellectual Property Rights	inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Month	means a calendar month and "Monthly" shall be interpreted accordingly;
Party	has the meaning set out in Schedule 2 (Parties);
Patient Safety Incident	has the meaning set out in the NHS Standard Contract as amended from time to time;
Partnership Agreement	means this agreement including its Schedules;
Partnership Principles	means the principles set out in Schedule 4 (Partnership Principles);
Party and **Parties**	has the meaning set out in Schedule 2 (Parties);

1.2 A reference to any Party shall include that Party's successors and permitted assigns.

1.3 A reference to a statute or statutory provision is a reference to it as amended, extended or re-enacted from time to time.

1.4 A reference to a statute or statutory provision shall include all subordinate legislation made from time to time under that statute or statutory provision.

1.5 References to Clauses and Schedules are to the Clauses and Schedules of this Partnership Agreement.

1.6 Any words following the terms **including**, **include**, **in particular**, **for example** or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase or term preceding those terms.

SCHEDULE 2 **- Parties**

#	Party	Signed for and on behalf of the Party
1	**Chelsea and Westminster Hospital NHS Foundation Trust**	
2	**Central London Community Healthcare NHS Trust**	
3	**H&F GP Federation**	
4	**Imperial College Healthcare NHS Trust**	
5	**West London Mental Health NHS Trust**	

Parties 1 to 5 are collectively "**the Parties**".

SCHEDULE 3 (1) – Integrated Care Partnership Board Terms of Reference

HAMMERSMITH & FULHAM HEALTH & CARE PARTNERS

Integrated Care Partnership BOARD

TERMS OF REFERENCE

Role

The role of the Integrated Care Partnership Board is to ensure the engagement, alignment and shared decision making of all participant organisations in the Integrated Care Partnership and to oversee the programme of work to deliver the Integrated Care Partnership, as set out in the Memorandum of Understanding ("**MOU**") in place between Imperial College Healthcare NHS Trust ("**ICHT**"), Chelsea & Westminster Hospitals NHS Foundation Trust ("**C&W**"),the Hammersmith & Fulham GP Federation ("**HFGPFED**") and West London Mental Health NHS Trust ("**WLMHT**") signed on 28 June 2016 and which Central London Community Healthcare NHS Trust did not sign at the time but which it wishes to implement in accordance with the terms of this Partnership Agreement.

1. Membership

1.1. The Integrated Care Partnership Board will be made up of sovereign board committees or executives delegated from each Party - membership of which is to consist of Chief Executive, one senior clinical lead and one Programme Director:

1.2. The Integrated Care Partnership Board may request attendance of other officers from partner organisations and/or other individuals to attend all or any part of its meetings as the agenda requires.

1.3. Two lay members will be standing attendees of the Integrated Care Partnership Board to ensure a patient-centric approach is adopted by the Integrated Care Partnership and to hold providers to account for their commitment to co-design but shall have no voting rights.

1.4. The Clinical Chair of the HFGPFED will act as chair for administrative and meeting management purposes at Board meetings and shall nominate a Chief Executive colleague of one of the Parties to deputise in his absence.

2. Secretary

2.1. ICHT's Integrated Care Programme Director will coordinate the overall common administrative arrangement for the Integrated Care Partnership Board. Member organisations will rotate administration and minuting of the meetings.

3. Quorum

3.1. Given the Integrated Care Partnership Board's status as a committee in common, no formal quorum is necessary for the transaction of business. However, to ensure appropriate engagement and validity of decision making each member organisation is intended to be represented. The quorum of each member's individual committee will be decided by that organisation.

4. Frequency of meetings and attendance requirements

4.1. The Integrated Care Partnership Board will meet monthly;

4.2. Members should aim to attend all scheduled meetings.

5. Duties

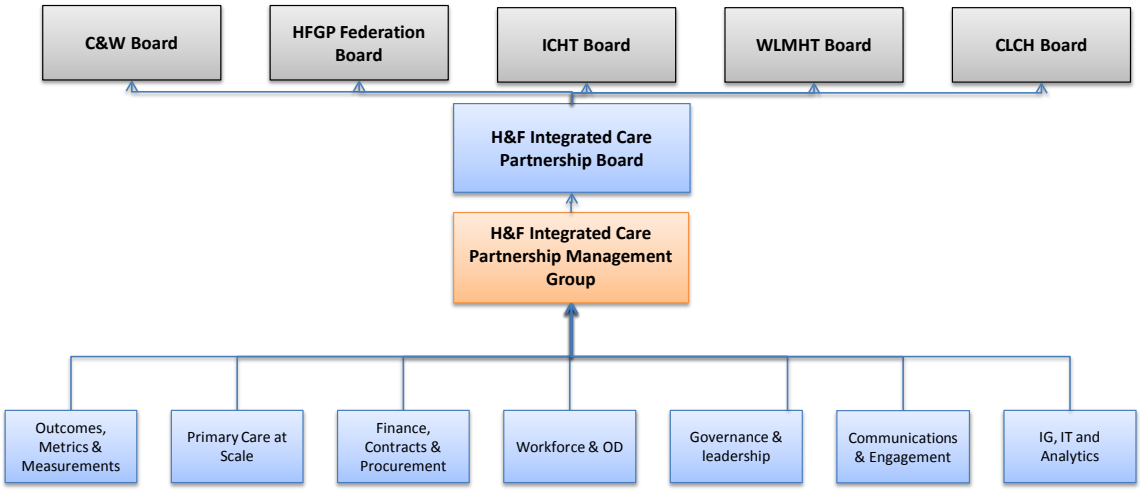
Whilst fully acknowledging (i) the committee in common structure, (ii) that the Integrated Care Partnership Board is not a joint contractual decision making forum; (iii) the sovereignty and ultimate accountability of each Party; and (iv) each Party's obligations in relation to competition and procurement law, the Integrated Care Partnership Board is intended to carry out the following duties for the Parties:

5.1. obtain assurance that high quality care is being delivered across Integrated Care Partnership Services;
5.2. scrutinise and approve proposals from the Management Group (described in the governance structure below) for wider dissemination and/or cascading through member organisations;
5.3. make decisions about joint investments;
5.4. obtain assurance that robust governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all member organisations;
5.5. agree key messages to be communicated to shared stakeholders e.g. commissioners, other providers, staff, the public, local politicians;
5.6. consider how the Integrated Care Partnership responds to any relevant tender processes for service in Hammersmith and Fulham, and beyond;
5.7. share member organisations' key strategic intentions that may impact on Integrated Care Partnership development or delivery of other initiatives relating to the Whole Systems/Integrated Care agenda;
5.8. facilitate appropriate sharing of data between member organisations;
5.9. provide a forum for broader strategic discussion; and
5.10. enable onward referral of appropriate issues to partner organisations' relevant committees (including the operational and management committees) for further review or action.

6. Reporting responsibilities

6.1. The Integrated Care Partnership Board will report into the Board of each of the partner organisations, and provide reports to relevant executive committees as appropriate.
6.2. It will receive reports from the Management Group, focusing on technical and enabling aspects and co-design of care pathways.

Proposed Programme Governance Structure



Key deliverables:
- Financial analysis tool and indicative scenario based risks & opportunities
- Draft Partnership Agreement
- A detailed work plan for progressing the ACP against all areas of competency framework

Resource:
- **Key support:** Programme Manager
- **Specialist knowledge:** BAU within corporate directorates
- **Identified resource gap:** Support for financial work stream

Key deliverables:
- Key opportunities for quality and efficiency improvement identified
- Work plan for integrated pathway development

Resource:
- **Key support:** Programme Manager
- **Specialist knowledge:** Clinical & operational leads
- **Identified resource gap:** Flexible back-fill resource for clinical input

7. Monitoring and Review:

7.1. Terms of reference approved October 2016

7.2. Reviewed and amended September 2017

SCHEDULE 3 (2) – Integrated Care Partnership Management Group Terms of Reference

HAMMERSMITH AND FULHAM HEALTH & CARE PARTNERSHIP

Integrated Care Partnership MANAGEMENT GROUP

TERMS OF REFERENCE

Role

The role of the Integrated Care Partnership Management Group is to oversee the development of technical capabilities within the Integrated Care Partnership that will enable the delivery of the new care models designed within the new care model steering groups. This will require working in a matrix structure working with the clinical model driving the operating model. This will include capabilities in:

- Governance (both clinical and corporate)
- Technology and information governance
- People and culture
- Finance & contracts
- Outcomes and metrics
- Communications and engagement

1. Membership

1.1. The Integrated Care Partnership Management Group will be made up of Directors or Deputies from each Party with expertise in technical work areas stated above and also a citizen representative.

1.2. The Integrated Care Partnership Management Group may request other officers from local provider organisations and/or other individuals to attend all or any part of its meetings as the agenda requires.

1.3. The Chief Executive from the Hammersmith & Fulham GP Federation ("**HFGPFED**") will chair Integrated Care Partnership Management Group meetings and the agenda will be set by programme leads across the partnership.

2. Secretary

2.1. The jointly appointed Integrated Care Partnership Programme Manager will act as the secretary to the Integrated Care Partnership Management Group.

3. Quorum

3.1. The quorum necessary for the transaction of business shall be one Director level member from each Party.

4. Frequency of meetings and attendance requirements

4.1. The Integrated Care Partnership Management Group will meet every month.

4.2. Members should aim to attend all scheduled meetings but where this is not possible are asked to nominate an appropriate deputy.

5. Objectives

5.1. The Integrated Care Partnership Management Group will adopt the principles of co-design laid out in the MOU between Imperial College Healthcare NHS Trust ("**ICHT**"), Chelsea & Westminster Hospitals NHS Foundation Trust ("**C&W**"), West London Mental Health NHS Trust ("**WLMHT**"), and HFGPFED. Objectives will be reviewed in real time as commissioning intentions are communicated to providers. Current objectives of the Integrated Care Partnership Management Group are to:

5.1.1. Ensure commitment to working together for the improvement of health and wellbeing for the population of Hammersmith and Fulham, including embedded engagement with service users and the voluntary sector, and to extracting maximum value from public spend on health;

5.1.2. Drive cultural change towards the management of population health and wellbeing;

5.1.3. Ensure open and regular communication, early raising of risks and issues and a shared commitment to their resolution wherever possible;

5.1.4. Ensure transparent sharing of data, where this does not represent a commercial conflict.

5.2. The Integrated Care Partnership Management Group has been delegated the following objectives from the Integrated Care Partnership Board:

5.2.1. To direct and oversee the work of the care model project groups and technical enabler working groups to ensure joined up matrix working;

5.2.2. To provide advice to the Integrated Care Partnership Board as requested, for example in terms of options appraisals to support their decision making;

5.2.3. To ensure that processes put in place enable the partnership to operate effectively;

5.2.4. To ensure organisational readiness for the transition to accountable care in North West London, which could include use of capitated budgets, alliance or joint venture arrangements and outcomes based contracting;

5.2.5. To undertake analysis and identify opportunities to realise benefits from partnership working;

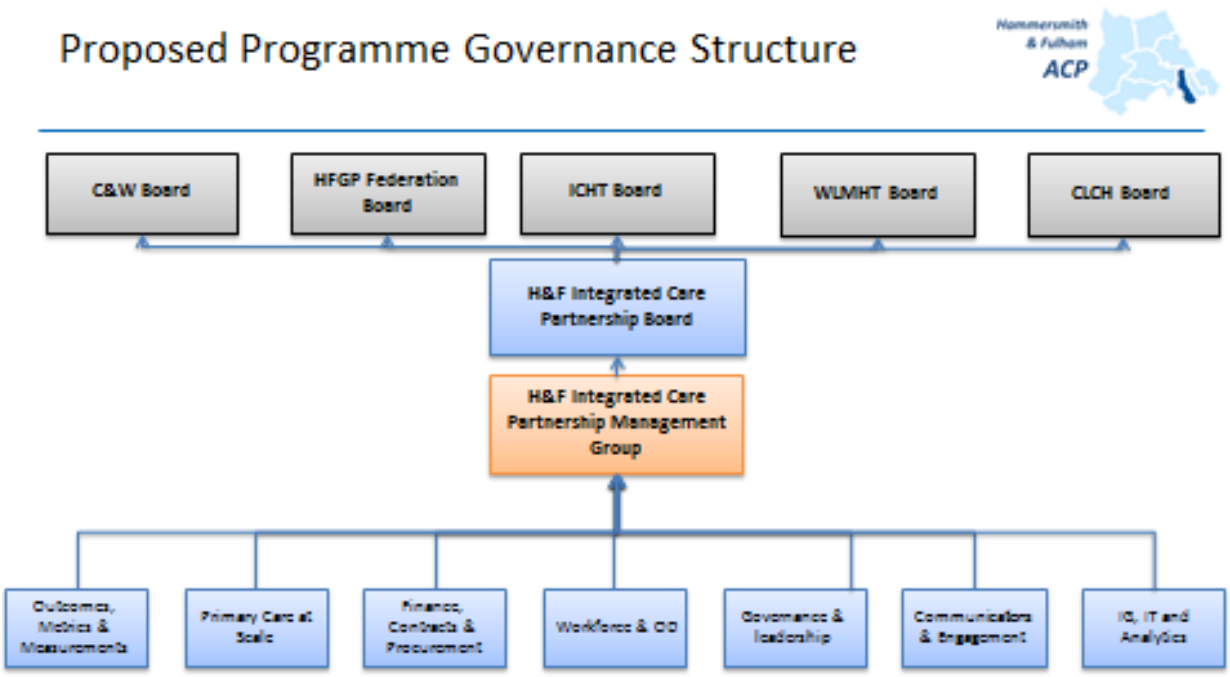
5.2.6. To ensure that appropriate financial and risk management controls are in place to manage services under the remit of the partnership and to manage project work within the partnership;

5.2.7. To support compilation and assess business cases for the partnership, reporting into the Integrated Care Partnership Board for a final decision; and

5.2.8. To protect the duty of confidentiality and commercial sensitivity for sovereign bodies & patients.

6. Reporting responsibilities

6.1. The Integrated Care Partnership Management Group will report into the Integrated Care Partnership Board. It will receive reports from task and finish groups which it will use to deliver specific piece of work as required to meet the objectives of the group.



7 Monitoring and Review:

7.1 Terms of reference – initial approval: March 2017

7.2 Reviewed, and amended: July 2017

SCHEDULE 4 - Partnership Principles

[The Partners agree to adopt the following principles (the "**Partnership Principles**"):

A core group of health and care organisations working in Hammersmith and Fulham have come together to work in partnership with local patients and residents to develop a radically better way of providing care.

There is a growing consensus that we need to change from being reactive and crisis-driven to being proactive, health and well-being focused. Patients need to feel that their care is joined-up, consistent and high quality, regardless of the provider.

- Our care will be integrated and seamless with the whole of health and care system **working as one partnership organisation** across a population
- Savings will be **reinvested** in services where they are most needed
- Focus on **preventing a more serious intervention later and hospital admission**
- **Pooled budgets** and **shared benefits/risks** is a fundamental change and ensures everyone is working together
- **The partnership is driven by the needs of patients and local people** – not commissioners or providers
- **We will make care simpler**

To be practical and flexible, **we want to start small** (43,000 population across three merged GP practices) and open up to whole borough, and potentially beyond

Branding

Until such a time that a definitive name and logo has been approved, the Integrated Care Partnership will use the NHS logo followed by a list of all partners.

SCHEDULE 5 - Information Sharing Arrangements

All Parties are signed up to the NWL Information Sharing Protocol (see Appendix 1 to this Schedule). For the initial Integrated Care Partnership Services, each Party will use its own systems for reporting operational activity. Initially, staff requiring access to these systems will have contracts with the respective Parties. The GP Federation does not have access to patient identifiable information.

The NWL Care Information Exchange (CIE) pilot will confirm the information sharing requirements for the strategic solution and it is envisaged that the GP Federation (EMIS Web) ISA will form the basis for this development.

Parties have SIRO and Caldicott Guardians and the Parties will address incidents together, but carry their own risks. Each Party will be responsible for reporting incidents, as appropriate, through the IG Toolkit incident reporting tool and will keep other Parties informed of on-going investigations and outcomes.

The Partner Organisations recognise that where Personal Confidential Data is shared because it is necessary for Direct Care, the patient's consent may usually be implied, providing a legal basis for such sharing as set out in the North West London Information Sharing Protocol.

Appendix 1 to Schedule 5

NWL Information Sharing Protocol

NORTH WEST LONDON

INFORMATION SHARING PROTOCOL

(F) The purpose of this Protocol is to facilitate the secure sharing of information amongst key public sector, private and voluntary organisations in North West London Clinical Commissioning Groups to support the provision of effective and efficient health and social care services to the populations of the local area.

(G) This Protocol sets out general principles, standards and governance agreed between the identified Partner Organisations to provide a secure framework for the sharing of information between the Partner Organisations within which they can all operate.

(H) By signing this document, each Partner Organisation undertakes to implement and adhere to the principles, standards and governance set out in this Protocol, reassuring the other Partner Organisations that patient information will be used and managed only in agreed and appropriate ways.

(I) This Protocol will be underpinned by service specific Information Sharing Agreements between the Partner Organisations that are designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems.

(J) This Protocol will be extended to include other organisations working in partnership to deliver services in North West London. Organisations that enter an approved specific Information Sharing Agreement will automatically become a Partner Organisation and a signatory to this Protocol.

12. PARTIES TO THIS PROTOCOL

We the undersigned agree that each organisation that we represent will adopt and adhere to the principles, standards and governance set out in this Protocol, and are prepared to sign Information Sharing Agreements for the sharing of specific information for specific purposes, using specific systems:

(Please see next page and the list of Partner Organisations in Appendix 2)

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Responsible Manager	

Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	

Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

This page must be completed by the Caldicott Guardian:

Organisation Name	
Address	
Contact Details	

Organisation Name	
Address	
Contact Details	
Authorised Signatory- Caldicott Guardian for	

Each of the above listed organisations shall be a **Partner** and together they shall be the **Partner Organisations**.

13. OVERARCHING PRINCIPLES

13.1 The Partner Organisations recognise that many services cannot be effectively delivered without the exchange of Personal Confidential Data across key public sector, private and voluntary organisations. This Protocol sets out the principles by which the Partner Organisations agree to exchange information, in a manner which is compliant with their legal responsibilities. The Partner Organisations will ensure the accurate, timely, secure and confidential sharing of information where such information sharing is essential for the provision of health and social care to the local population in North West London.

13.2 Each Partner Organisation is responsible for ensuring that robust technical and organisational measures and information governance arrangements are in place to protect the security and integrity of information to ensure a trusted sharing environment.

13.3 Information shared pursuant to this Protocol may not be shared with any other organisation not a signatory to this Protocol without the prior consent of the relevant Partner Organisation and/or patient/client.

13.4 The Partner Organisations recognise that there must be a legal basis for any sharing of Personal Confidential Data.

13.5 The Partner Organisations recognise that where Personal Confidential Data is shared because it is necessary for Direct Care, the patient's consent may usually be implied, providing a legal basis for such sharing.

13.6 The specific purpose for use and sharing information will be defined in the Information Sharing Agreements, however the following principles should form the basis of such Information Sharing Agreements relevant to its type:

13.6.1 Provided any disclosure is in accordance with this Protocol, Partner Organisations should share Personal Confidential Data when it is needed for the safe and effective care of an individual.

13.6.2 Where Personal Confidential Data is shared for Indirect Care, consent may not be implied. The Partner Organisations agree to anonymise such data before sharing where possible. Any Personal Confidential Data should only be shared for Indirect Care if:

(a) the Data Subject has given consent;

(b) the data sharing is required by law;

(c) the recipient has approval to receive it under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (otherwise known as Section 251 support).

13.7 The Partner Organisations agree to respect an individual's right to object to the sharing of Personal Confidential Data about them.

14. KEY LEGISLATION AND GUIDANCE

14.1 The Partner Organisations are subject to a variety of legal obligations, and statutory and other guidance in relation to the sharing and disclosure of information, including (without limitation):

14.1.1 Data Protection Act 1998

14.1.2 Human Rights Act 1998

14.1.3 Common Law Duty of Confidence

14.1.4 Caldicott Principles

14.1.5 ICO Data Sharing Code of Practice

14.1.6 Confidentiality: NHS Code of Practice

14.1.7 HSCIC: A guide to confidentiality in health and social care

14.1.8 NHS England Information Governance and Risk Stratification: Advice and Options for CCGs and GPs

14.1.9 Department of Health: Information Security: NHS Code of Practice

This is not an exhaustive list and other legislation applies in specific circumstances.

14.2 Each Partner Organisation must have documented policies and procedures to ensure compliance with the national requirements for data protection, information security and confidentiality and committed to ensuring that any information is shared in accordance with its legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

As part of each Information Sharing Agreement each Partner Organisation shall specify how it meets its legal obligations and the legal basis under which information can be shared.

15. INFORMATION GOVERNANCE REQUIREMENTS

15.1 Subject to clause 15.3, each Partner Organisation is required to comply with the then current NHS Information Governance Toolkit as appropriate to its organisation type and adhere to robust information governance management and accountability arrangements, including effective security event reporting and management.

15.2 Subject to clause 15.3, each Partner Organisation must comply with the IGT assessment, reporting and audit requirements relevant to its organisation type. Each Partner Organisation will provide evidence of compliance to the Governing Group or the other Partner Organisations on written request.

15.3 Any Partner Organisation which is a non-NHS organisation and unable to comply with the IGT must obtain prior written approval from the Governing Group to adopt an alternative, but equivalent standard to the IGT for NHS organisations. For the avoidance of doubt, the Governing Group reserves the right to reject/amend any proposed standard at its sole discretion.

15.4 Each Partner Organisation must ensure and maintain its registration with the Information Commissioner under the Data Protection Act 1998.

15.5 In the event of a Security Incident, the responsible Partner Organisation should immediately inform the Governing Group and all other affected Partner Organisations (usually the disclosing Partner Organisation(s)) with as many details as known at that time and regularly update the relevant Partner Organisations and Governing Group thereafter, including any subsequent investigation report or remedial actions. Any affected Partner Organisation will then pass on the information in accordance with incident reporting procedures within their own organisation if appropriate.

15.6 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group

immediately. The Governing Group will undertake an urgent review and has the discretion to authorise derogation from or amendment to the requirements of this clause, on such terms as the Governing Group considers to be appropriate, as long as the derogation or amendment is lawful.

16. PERSONAL CONFIDENTIAL DATA: COMMUNICATION AND CONSENT

Communication

16.1 Each Partner Organisation must:

16.1.1 Effectively inform patients about the ways the information they have provided may be used, who it may be shared with, what will be shared and for what purpose;

16.1.2 effectively inform patients that they have the right to opt out of sharing their information or select/restrict which elements of their information may or may not be shared and that any consent can be changed in the future;

16.1.3 effectively inform patients of the implications for the provision of care or treatment, such as the potential risks involved if their full record is not made available to health professionals involved in their Direct Care; and

16.1.4 ensure fair processing notices are always in place.

16.2 Any Partner Organisation which does not have the ability to mark part of a record as private, must notify the Governing Group and inform the patient that they must decide whether all or none of their record should be shared.

16.3 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

16.4 Each Partner Organisation should employ a variety of channels to communicate with its patients regarding information sharing, such as information leaflets, posters, at the point of care, during the patient registration process or when referring into other services.

Consent

16.5 Patient consent must be obtained in line with NHS guidance then in force. Consent can be Explicit Consent or Implied Consent. Each Partner Organisation recognises that different consent arrangements are needed in respect of sharing information for Direct Care and Indirect Care purposes.

16.6 Obtaining Explicit Consent for information sharing is best practice and ideally should be obtained when the patient first accesses the service.

16.7 Partner Organisations must make arrangements for the systematic obtaining of consent.

16.8 Consent must be informed. Each Partner Organisation must ensure that the patient has the capacity to give consent and if not, follow the relevant guidance to obtain the appropriate consent.

16.9 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also

allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

16.10 Each Partner Organisation will, as a matter of good practice, seek fresh consent if there are significant changes in the circumstances of the individual or the work being undertaken with them.

16.11 Each Partner Organisation must ensure that where required, consent is recorded and a full audit trail retained of who obtained consent.

16.12 Partner Organisations have authority to seek consent only on behalf of their own organisation.

17. DECIDING WHETHER TO SHARE PERSONAL CONFIDENTIAL DATA

17.1 Partner Organisations will follow the decision tree at Appendix 4, adapted from the guidance given by the HSCIC in its *Guide to confidentiality in health and social care*.

17.2 Information relating to a deceased person is not subject to the Data Protection Act 1998, however careful consideration should be given and further advice sought before any such information is released. Duties of confidence still apply.

17.3 If a Partner Organisation decides not to disclose some or all of the Personal Confidential Data, the requesting Partner Organisation must be informed why in so far is as permitted by law. For example, if the Partner Organisation is relying on an exemption or on the inability to obtain consent from the patient.

18. SYSTEM SUPPLIER STANDARDS

18.1 Each system operated by any Partner Organisation for sharing clinical information should have NHS Interoperability Toolkit accreditation, thus assuring its system specifications and standards meet the agreed interoperability standards for the NHS. Partner Organisations that operate such systems will provide evidence of compliance to the Governing Group or other Partner Organisations on written request.

18.2 Any proposed non-compliance must be explained, documented and agreed in advance by the Governing Group.

18.3 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group immediately. The Governing Group will undertake a review and may in its discretion authorise derogation from the above requirements subject to such conditions as it deems appropriate.

18.4 All partner organisations' systems under this Protocol must have user authentication mechanisms to ensure that all instances of access are auditable against an individual, including the following information:

18.4.1 Job role and name of staff member accessing the system;

18.4.2 Organisation name;

18.4.3 What actions were performed; and

18.4.4 The date and time the information was viewed.

18.5 The systems and technical measures used by each Partner Organisation for the sharing of Direct Care and Indirect Care must be specified in any Information Sharing Agreement.

19. KEY CONTACTS

19.1 Each Partner Organisation will nominate a person as a key contact to deal with queries and requests for information under this Protocol. This person shall also represent the Partner Organisation in the Governing Group. It is advisable that such appointed contact shall usually be the Partner's Caldicott Guardian or data protection officer or equivalent.

19.2 A Partner Organisation may change its appointed contact at any time on written notice to all Partner Organisations.

19.3 The key contact for each Partner Organisation will ensure dissemination of this Protocol in line with each Partner Organisation's internal arrangements for the distribution of policies, procedures and guidelines and monitor the implementation and compliance of this Protocol within their own Partner Organisation.

20. GOVERNING GROUP

20.1 The purpose of the Governing Group is to oversee, support and maintain the secure sharing of information under this Protocol.

20.2 Each Partner Organisation will have a representative on the Governing Group which in accordance with clause 19 will be each Partner Organisation's key contact under this Protocol.

20.3 Patient representation on the Governing Group will be nominated by Partner Organisations

20.4 The Governing Group will meet at least annually.

20.5 The Governing Group shall have the following powers and responsibilities:

20.5.1 to approve ISAs and additional Partner Organisations to this agreement;

20.5.2 to administer membership of this Protocol

20.5.3 to determine whether a Partner Organisation should cease to be a party to this Protocol for a specific period of time or permanently for non-compliance;

20.5.4 to determine whether a Partner Organisation may derogate from or amend any requirement under this Protocol;

20.5.5 to maintain an information conduit between the Partner Organisations;

20.5.6 to maintain a channel of liaison with pan-London personal information sharing initiatives and relevant NHS and local authority national initiatives;

20.5.7 to investigate breaches of the Protocol and require Partner Organisations to take remedial actions;

20.5.8 to monitor each Partner Organisation's compliance with this Protocol or any ISA The Governing Group may request evidence of compliance with this Protocol on written request to any Partner Organisation;

20.5.9 to approve common patient communication materials; and

20.5.10 to develop, review and maintain the Protocol to ensure that it reflects any legal and statutory obligations and any other related best practice guidance in relation to information governance.

20.6 The Governance Group may regulate its own procedure subject to the provisions of this Information Sharing Protocol.

20.7 It is noted that there may be specific information sharing protocols already in place between some Partner Organisations, which must be taken into consideration.

20.8 In accordance with clause 19, any Partner Organisation wishing to amend the details of its representative must notify, in writing, the Governing Group, providing details of the newly appointed representative as soon as is practicably possible.

21. DATA RETENTION STANDARDS

21.1 Each Partner Organisation must have a written policy for the retention and disposal of information in accordance with NHS Best Practice guidance.

21.2 No Partner Organisation should retain information for longer than is necessary to achieve the objectives for which the information was obtained.

22. ASSURANCE

22.1 Each Partner Organisation must, so far as possible, ensure the accuracy of the information (correct, complete and up-to-date) which it is sharing under this Protocol and must have in place appropriate systems to update any information if subsequently discovered to be inaccurate.

22.2 If a Partner Organisation is aware of a material inaccuracy or omission in information that it shares under an Information Sharing Agreement, the Partner Organisation must inform the recipient of that inaccuracy or omission.

22.3 Where possible, the NHS number must be used as the unique patient identifier and systems used by the Partner Organisations should connect to the Connecting for Health Personal Demographic Service to ensure the NHS numbers are accurate and demographic data synchronised.

23. STAFF

23.1 Each Partner Organisation is responsible for ensuring that access to shared information is documented and restricted to those staff who have a legitimate and appropriately approved reason to access it and those staff who are properly trained to discharge any relevant obligations in accordance with this Protocol.

23.2 Each Partner Organisation shall provide staff with training on the principles and legal requirements for information sharing and the appropriate tools to enable them to comply with the obligations under this Protocol.

23.3 Each Partner Organisation shall ensure that shared information can only be accessed via username and password.

23.4 Each Partner Organisation shall make it a condition of employment that all employees, agents or contractors will abide by the rules and policies of that Partner Organisation in relation to information governance. This condition should be written into employment and other contracts and each Partner Organisation shall make staff aware that any failure to comply with the requirements outlined in this Protocol is likely to be subject to disciplinary action.

24. SUBJECT ACCESS AND COMPLAINTS

24.1 Each Partner Organisation is responsible for putting into place effective procedures to address complaints about data sharing and subject access requests relating directly

to this Protocol. Information about these procedures should be made available to patients.

24.2 Each Partner Organisation must have a designated Data Protection Officer or Information Governance Manager who is responsible for subject access requests and complaints.

24.3 Subject access requests from third parties for data available to organisations under this Protocol are to be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

24.4 Any complaints about data sharing relating directly to this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

25. FREEDOM OF INFORMATION

25.1 The Partner Organisations recognise that public bodies are subject to the requirements of the Freedom of Information Act 2000 ("**FOIA**") and the Environmental Information Regulations ("**EIR**"). Any such requests relating to information governed by this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

25.2 The Partner Organisations shall notify the Governing Group of any such request and assist and co-operate with the Governing Group to enable compliance with any obligations under the FOIA and the EIR.

26. AUDIT

26.1 Each Partner Organisation accepts responsibility for independently or jointly auditing its own compliance with this Protocol and any Information Sharing Agreements in which it is involved on a regular basis (at least annually).

26.2 Each Partner Organisation is required to keep and maintain records of all requests for information sharing received and track the flow of Personal Confidential Data.

26.3 This Protocol will be formally reviewed annually by the Governing Group, unless in the Governing Body's opinion new or revised legislation or national guidance necessitates an earlier review.

26.4 Following each review the Governing Group will confirm whether this Protocol remains fit for purpose, or whether to recommend amendments to the Partner Organisations.

APPENDIX 4 - GLOSSARY

In this Protocol unless the context otherwise requires the following words and expressions shall have the following meanings:

"Anonymised Data"	means data in a form where the identity of the individual cannot be recognised i.e. when: • Reference to any data item that could lead to an individual being identified has been removed; • The data cannot be combined with any data sources held by a Partner with access to it to produce personal identifiable data;
"Data Controller"	A company, organisation or person who decides what data is collected, the purposes for which it is used and how that data is handled;
"Direct Care"	means clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals (all activities that directly contribute to the diagnosis, care and treatment of an individual);
"Explicit Consent"	means articulated patient agreement which gives a clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear, and in relation to data sharing, the consent covers the specific details of processing; the data to be processed; and the purpose for processing;
"Implied Consent"	means patient agreement that has been signalled by behaviour of an informed patient;
"Indirect Care"	means activities that contribute to the overall provision of services to a population as a whole or a group of patients with a particular condition, but which fall outside the scope of direct care. It covers health services management, preventative medicine, and medical research;
"Information Sharing Agreement(s)"	means the agreement to be entered into between Partner Organisations prior to sharing information that is designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems and based on the attached template in Appendix 3;
"NHS Information Governance Toolkit" "IGT"	means the set of information governance requirements produced by the Department of Health and now hosted by the Health and Social Care Information Centre. It is a tool with which health and social care organisations can assess their compliance with current legislation and national guidance;
"Partner" **"Partner Organisations"**	means the organisation(s) party to this Protocol, or automatically added as a signatory to this Protocol by way of entering an approved specific Information Sharing Agreement;
"Personal	means personal information about identified or identifiable

Confidential Data"	individuals, which should be kept private or secret. For the purposes of this Protocol 'personal' includes the definition of 'Personal Data', but it is adapted to include dead as well as living people. 'Confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'Sensitive Personal Data' as defined in this Protocol;
"Personal Data"	has the meaning given to it in the Data Protection Act 1998, namely: data which relate to a living individual who can be identified: (a) from those data; or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the Data Controller, and includes any expression of opinion about the individual and any indication of the intentions of the Data Controller or any other person in respect of the individual. Typical examples of this type of data could include a Name, Address, Full Postcode, Date-of-Birth, Email Address, and Telephone Number or a photograph or CCTV image. A unique number such as an employee number or NHS number could be considered as personal data if the organisation holds the identifying data relating to the unique identifier;
"Security Incident"	means an actual, suspected or threatened unauthorised exposure, access, disclosure, use, communication, deletion, revision, encryption, reproduction or transmission of any component of Personal Data and/or Sensitive Personal Data or unauthorised access or attempted access to any Personal Data and/or Sensitive Personal Data;
"Sensitive Personal Data"	means Personal Data consisting of information as to - (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings,

APPENDIX 5 - RESPONSIBILITIES OF PARTNER ORGANISATIONS

Partner Organisation	Responsibility
Federation of Brent, Harrow and Hillingdon CCGs	Governing Group (Informatics Sub-Committee)
NHS Brent Clinical Commissioning Group	Host of Protocol
NHS Harrow Clinical Commissioning Group	Host of Protocol
NHS Hillingdon Clinical Commissioning Group	Host of Protocol

The following pages set out the Partner Organisations for each borough.

Hillingdon Partner Organisations:

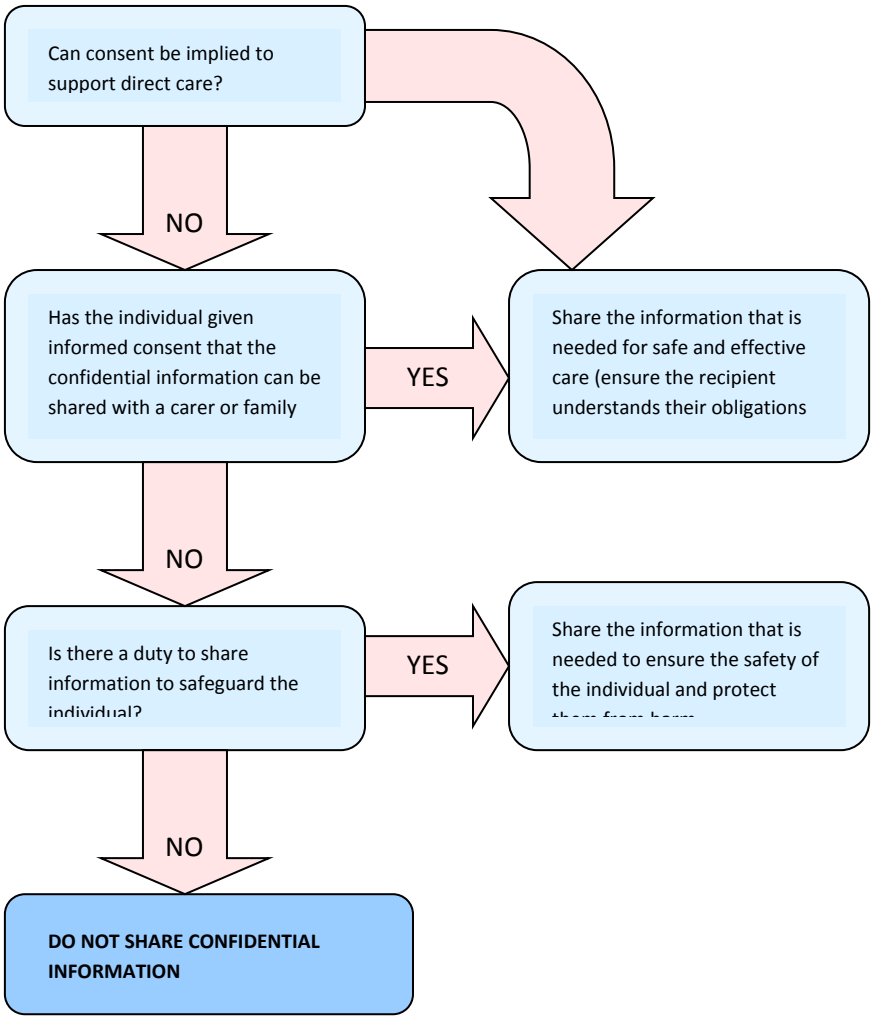
Partner Organisation	Responsibility
GP Practices within NHS Hillingdon CCG	Primary Healthcare provision – direct care
Hillingdon Hospitals NHS Foundation Trust	Secondary Healthcare provision – direct care
Central and North West London NHS Foundation Trust	Community and mental healthcare provision – direct care
London Borough of Hillingdon	Social Services – direct care Telecare services – direct care
Greenbrook Healthcare Ltd – Urgent Care Centre at Hillingdon Hospital	Urgent care services – direct care
Harmoni Ltd – Out of Hours and 111 services	OOH and 111 services – direct care
Imperial College Healthcare NHS Trust – including West London Breast Screening	Secondary Healthcare provision – direct care and screening services
North West London Hospitals NHS Trust (Northwick Park Hospital) – colorectal screening, cervical cytology screening	Secondary Healthcare provision – direct care and screening services
Ealing Hospital NHS Trust	Secondary Healthcare provision – direct care
Royal Brompton and Harefield NHS Foundation Trust (Harefield Hospital)	Secondary Healthcare provision – direct care
West Hertfordshire Hospitals NHS Trust (Watford General Hospital)	Secondary Healthcare provision – direct care
Heatherwood and Wexham Park Hospital NHS Foundation Trust	Secondary Healthcare provision – direct care
West Middlesex University Hospital NHS Trust	Secondary Healthcare provision – direct care
London Ambulance Service	Emergency care services – direct care
North West London Commissioning Support Unit	Clinical Quality and Patient Safety – clinical audit and/or investigation; recording, monitoring and analysing serious incidents; supporting the CCG in its statutory responsibilities for clinical quality and patient safety in all elements of the

	commissioning cycle
Age UK - Hillingdon	Support services as per agreed care pathways – direct care
Royal Marsden – Host of the Co-ordinate My Care (CMC) Programme	Host of shared electronic healthcare record created with patient consent
Healthcare Gateway Ltd - Medical Interoperability Gateway	Host of Information Technology solution that enables the sharing of electronic patient records

APPENDIX 3 - Information Sharing Agreement Template

[see separate document]

APPENDIX 4 - Deciding whether to share Patient Confidential Information



Appendix 2 to Schedule 5

GP Federation (EMIS Web) ISA

To be provided

SCHEDULE 6 - Governance Arrangements for Committees in Common

The Parties agree to establish an Integrated Care Partnership Board to implement the Integrated Care Partnership. The Integrated Care Partnership Board will not operate as a statutory committee or a committee with delegated decision making. The Integrated Care Partnership Board will be comprised of a committee of three representatives from each Party.

As at the date of entering into this Partnership Agreement, the Parties' representatives on the Integrated Care Partnership Board are as follows:

Chief Executive, one senior clinical lead and one Programme Director from each partner, as well as two lay members who will be standing attendees of the Integrated Care Partnership Board to ensure a patient-centric approach is adopted by the Integrated Care Partnership and to hold providers to account for their commitment to co-design but shall have no voting rights.

In addition, the Integrated Care Partnership Board may invite such persons as it thinks fit to attend the Integrated Care Partnership Board meetings from time to time.

The Integrated Care Partnership Board shall send monthly progress updates to the Parties.

The Integrated Care Partnership Board shall not have any authority to make binding decisions on behalf of the Parties.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL
Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.2/Nov/17
REPORT NAME	Our approach to Improvement Culture
AUTHOR	Pippa Nightingale Chief Nurse Dr Roger Chinn, Deputy Medical Director
LEAD	Pippa Nightingale, Chief Nurse Dr Roger Chinn, Deputy Medical Director
PURPOSE	This paper updates the Board on progress with the development of an improvement culture in the Trust and outlines the next steps.
SUMMARY OF REPORT	This report relates to the need for the Trust to embrace an improvement culture and to adopt an agreed methodology for projects and programmes, whether they be quality, service or financial improvements. **Context:** In 2014, both CW and WMUH Trusts were rated 'Requires Improvement' prior to merger. The enlarged merged Trust set out on a subsequent 3 year journey to deliver an approach to improvement. In Year 1 (2015/16) there was a process of standardisation of structures, governance processes and values. In Year 2, (2016/17) following consolidation of Year 1, implementation of the processes was used to apply focus and grip upon quality. In Year 3, (2017/18) Sustainability of the first 2 years activity now has to be achieved to support the development of a continuous improvement culture **Vision:** That, as part of an improvement culture, continuous improvement becomes part of everyone's job. Staff are enthused, enabled and empowered to improve their services. **Method:** A trust-wide approach to improvement: • A tiered education and training programme provides all staff with a proportionate level of knowledge and skill in improvement science, developing existing leadership programmes and devising new ones. • Application of evidence based improvement tools centred on the Method for improvement. • Setting up a resource centre – virtual and physical – to provide access to knowledge, improvement tools and expert support.
KEY RISKS ASSOCIATED	Delivery of the Quality Strategy and Maintenance of Quality Standards Performance related to Elective and non-elective demand Cost Improvement Plan Workforce development

FINANCIAL IMPLICATIONS	Financial implications of above
QUALITY IMPLICATIONS	Improvement methodology will affect the delivery of a sustainable impact upon the Quality Strategy
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Board is asked to note and comment upon the progress to date.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Our Improvement Culture

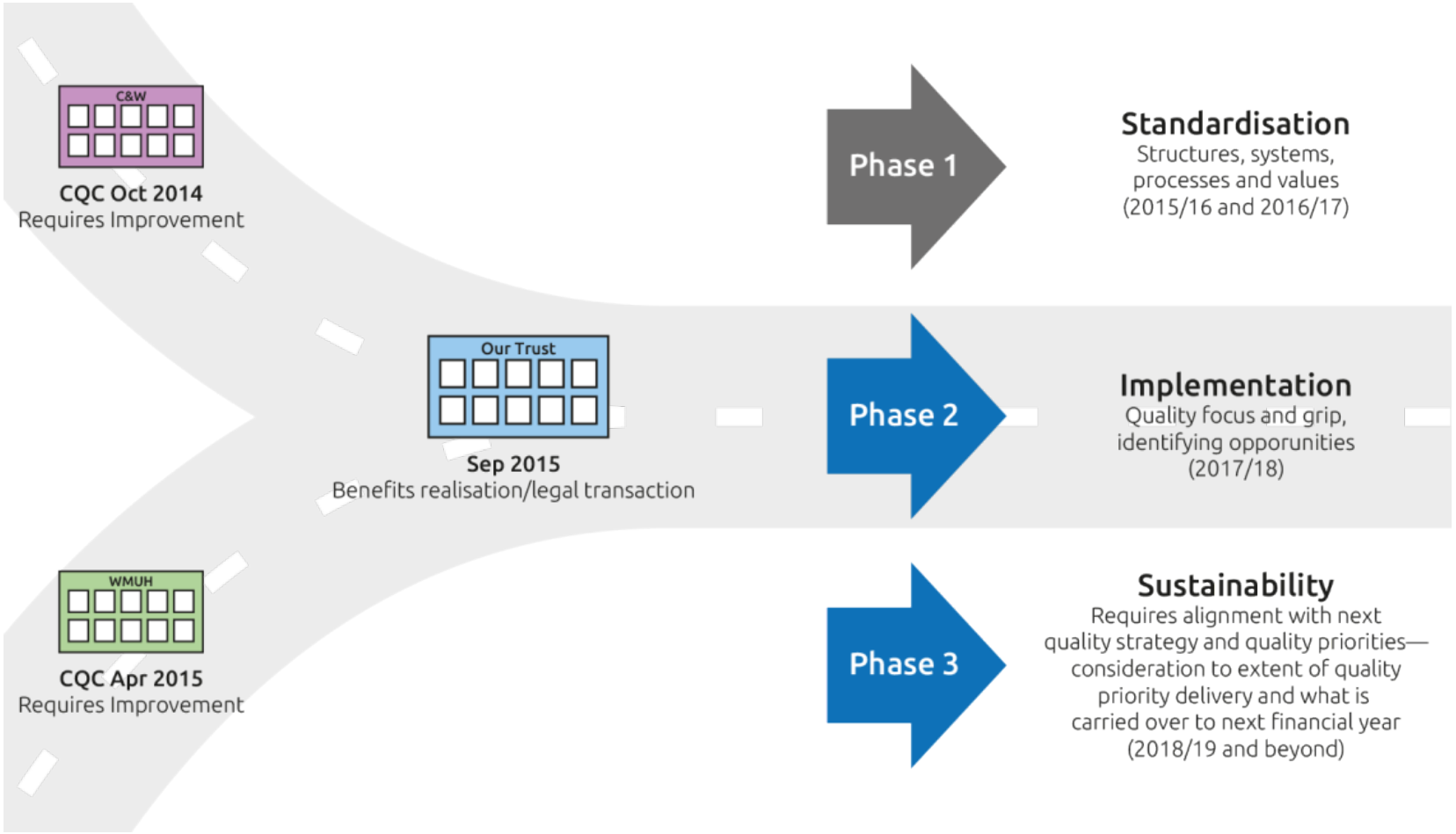
The Journey So Far

Pippa Nightingale Chief Nurse / Roger Chinn Deputy Medical Director

November 2017

proud to care

Improvement Journey



Phase One – Standardisation

- Unified governance structure
- Implementation of Datix across sites
- Alignment of cross site governance and quality teams
- Standardisation and integration of clinical guidelines, pathways and practices
- Launch of Trust values, clinical strategy and Trust objectives
- Development of whole Trust quality dashboard

Phase Two – Implementation
Continuous Quality Programme (CQP)

Core **Values**
PROUD

Quality deep dives
Assurance on quality at ward and speciality level

Mock **peer review** inspections

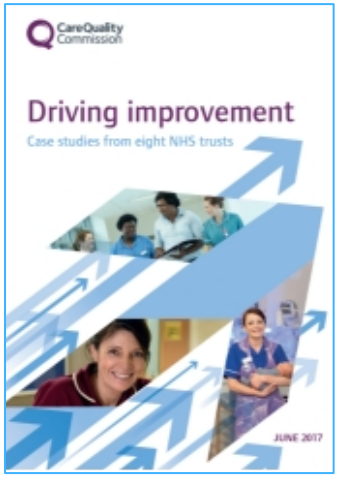
Ward accreditation & Perfect Ward
All 63 assessments undertaken with continued improvement process

Weekly senior nursing and Midwifery **quality rounds**

Perfect day all leadership roles have patient or staff contact to have first hand visibility of the clinical areas and patient care

Executive leads
for all clinical areas

Partnership Quality Improvement work with NHSI



Improvement as a Tool for Change

Prof Mike Richards, Chief Inspector of Hospitals
Driving Improvement: Case studies from 8 NHS Trusts
June 2017

"One of the first steps on an improvement journey starts with changing the culture of the organisation"

	Trust	From	To
+ 2 level ratings	University Hospitals of Morecambe Bay NHS Foundation Trust	Special measures	Good
	East Lancashire Hospitals NHS Trust	Special measures	Good
	Cambridge University Hospitals NHS Foundation Trust	Inadequate	Good
	Wexham Park Hospital	Inadequate	Good
	University Hospitals Bristol NHS Foundation Trust	Requires improvement	Outstanding
+ 1 level rating	Barking, Havering and Redbridge University Hospitals NHS Foundation Trust	Special measures	Requires improvement
	Leeds Teaching Hospital NHS Foundation Trust	Requires improvement	Good
	Mid Essex Hospital Services NHS Trust	Requires improvement	Good

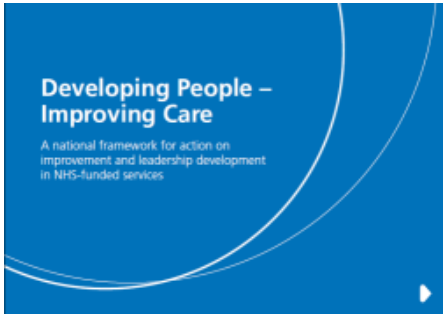
"Some trusts changed the leadership team to help drive improvement.

For others, it was about empowering existing staff to take leading roles in effecting organisational change.

Trusts that *unleashed the potential of their staff* now see improved patient outcomes and higher staff morale"

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

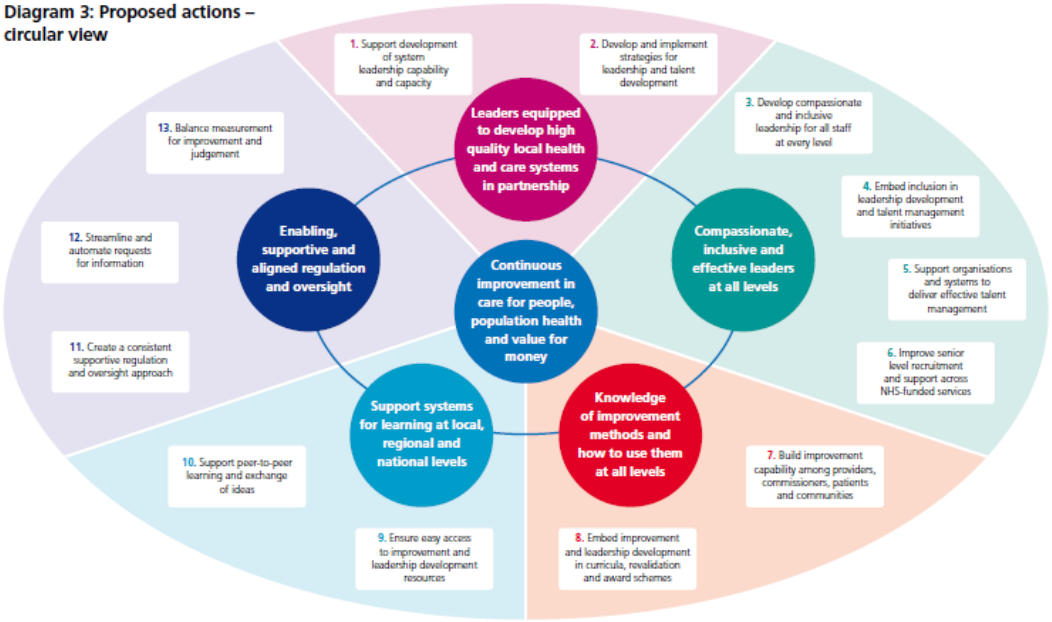
NHS Improvement Leadership Framework
Developing people - Improving Care June 2017



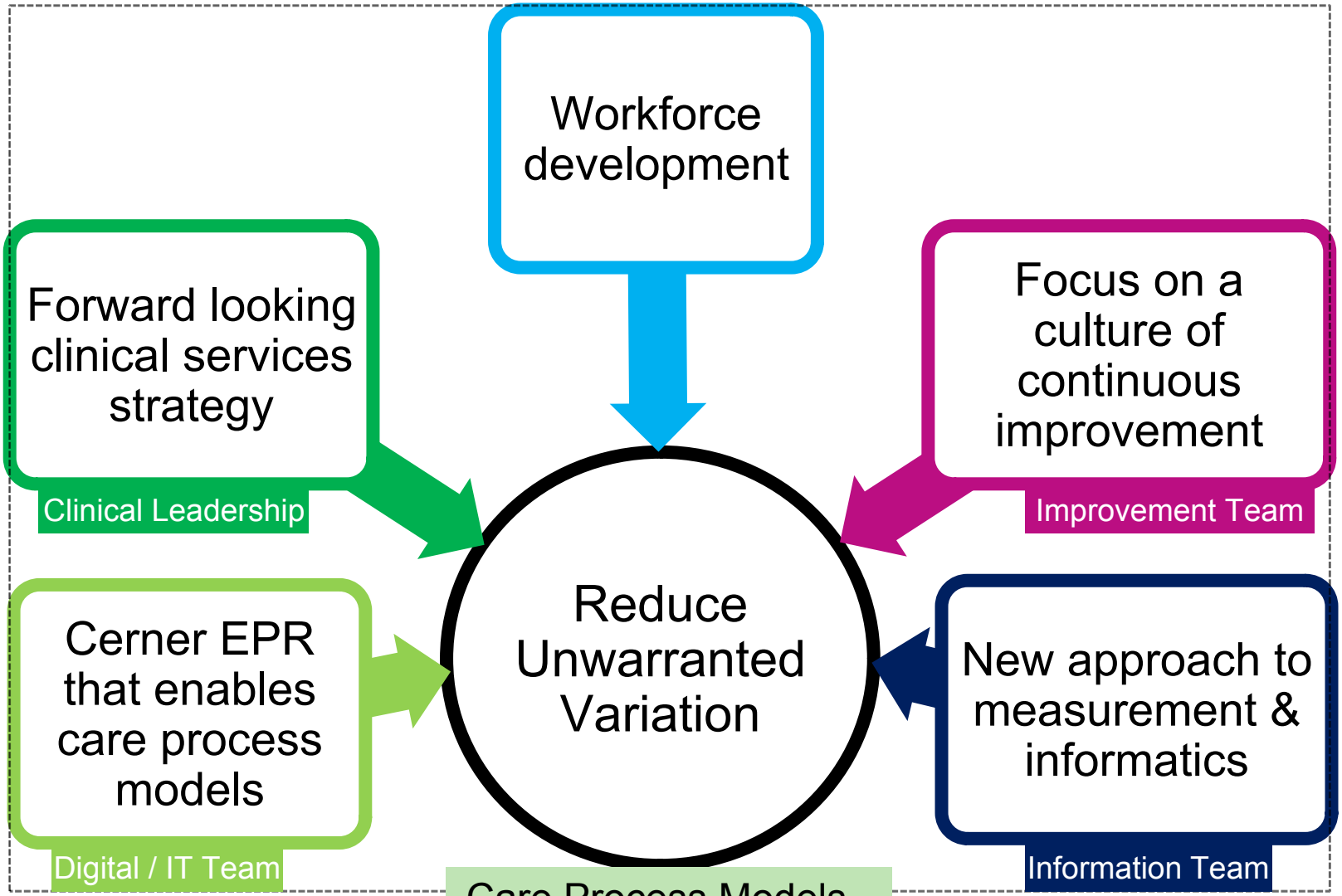
The five conditions

- Leaders equipped to develop high quality local health and care systems in partnership
- Compassionate, inclusive and effective leaders at all levels
- Knowledge of improvement methods and how to use them at all levels
- Support systems for learning at local, regional and national levels
- Enabling, supportive and aligned regulation and oversight

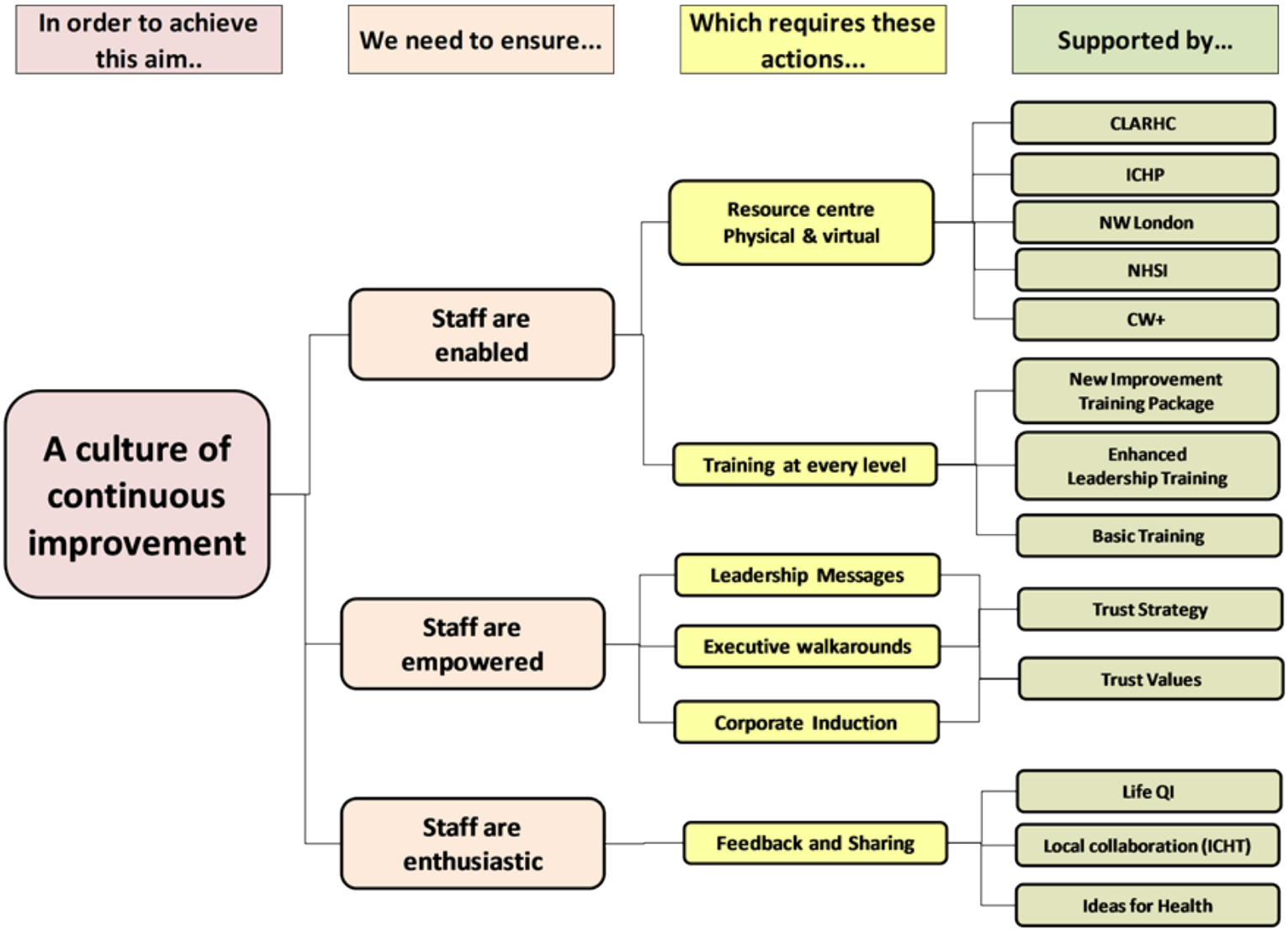
Diagram 3: Proposed actions – circular view



Chelsea and Westminster Transformation Strategy
A Culture of Continuous Improvement



Phase Three – A Culture of Continuous Improvement



Our Values

proud to care

P: Putting patients first

R: Responsive to, and supportive of, patients and staff

O: Open, welcoming and honest

U: Unfailingly kind, treating everyone with respect, compassion and dignity

D: Determined to develop our skills and continuously improve the quality of care

I want to improve how we care for patients

I know how to do it and where to get help

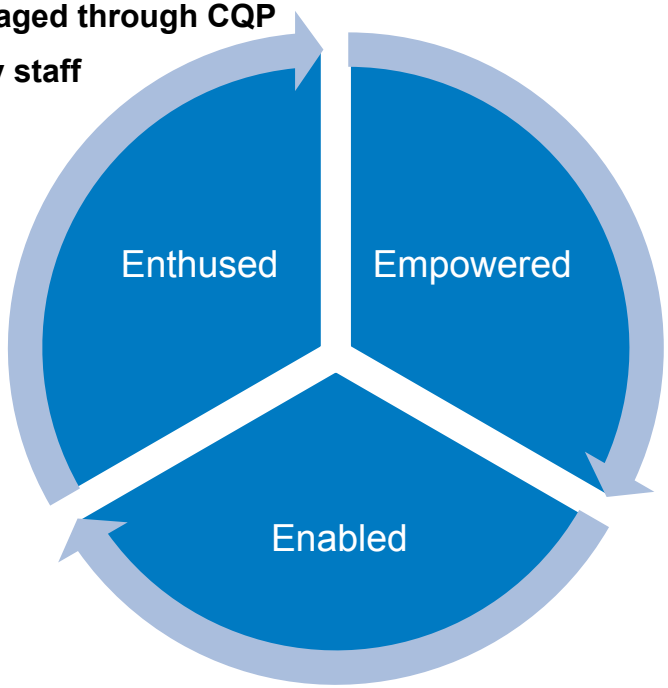
We all speak with pride about our service

We put patient experience at the heart of our changes

I learn how I can improve the care I give

What We've Achieved To Date

- Clinical Innovation and Improvement fellows
- Experienced improvement practitioners identified (CLAHRC, Q)
- Many improvement champions engaged through CQP
- Service improvement and efficiency staff devolved to divisions
- Divisional Data analyst
- Divisional Clinical Information Officers
- Working with ICHT on reducing unwarranted variation



- Bespoke Appropriateness Tool developed
- Life QI (provided through licence by ICHP)
- QI4U online training (provided through licence by CLARHC)
- Horizon scanning of existing electronic tools (e.g. Driver diagrams, PDSA planning tools, SPC)
- Ideas for Change App
- NHSI Emergency flow tool

- Improvement training included in all leadership programmes
- Emerging leaders syllabus adapted to include QI methodology
- Training material for each tier in development
- QI4U online self learning modules available now
- Training for CEO team and Exec Management Board

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Progress

10 lessons for NHS leaders	
Make quality improvement a leadership priority for boards	☑☑
Share responsibility for quality improvement with leaders at all levels	☑☑☑
Don't look for magic bullets or quick fixes	☑☑☑
Develop the skills and capabilities for improvement	☑☑
Have a consistent and coherent approach to quality improvement	☑☑
Use data effectively	☑
Focus on relationships and culture	☑☑☑
Enable and support frontline staff to engage in quality improvement	☑☑
Involve patients, service users and carers	☑
Work as a system	☑☑

Next Steps

- Integration of the quality compliance and improvement teams
- Developing faculty of staff across the Trust with expertise for mentoring / coaching and delivery of training
- Delivery of training to ensure we have rapid coverage where most needed
- Development of the Improvement Space (Physical & Virtual)
- Collation, co-ordination and recording of improvement projects

Summary - A Culture of Continuous Improvement

- Improvement of the patient's journey is **everyone's job**
- All staff are **enthused, enabled and empowered** to do improvement work on a day-to-day basis
- There is **an agreed methodology** for quality improvement across the organisation and various ways through which staff can learn this methodology, tailored to their particular level of need
- The organisation is committed to providing support for all staff in **knowledge, skills and tools** for improvement
- The organisation has **better visibility** of improvement work underway across the Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.4/Nov/17
REPORT NAME	Serious Incident Report
AUTHOR	Shân Jones, Director of Quality Improvement
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	The purpose of this report is to provide the Trust Board with assurance that serious incidents are being reported and investigated in a timely manner and that lessons learned are shared.
SUMMARY OF REPORT	This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2015. Comparable data is included for both sites.
KEY RISKS ASSOCIATED	• The issue of lack of mental health capacity is highlighted in this paper • Progress has been made in two divisions on closure of action plans
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	• There are two incidents in this report where no care or service delivery problems were identified.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Trust Board is asked to note and discuss the content of the report.

SERIOUS INCIDENTS REPORT
Trust Board – 2nd November 2017

1.0 Introduction

This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2017. For ease of reference, and because the information relates to the two acute hospital sites, the graphs have been split to be site specific. Reporting of serious incidents follows the guidance provided by the framework for SI and Never Events reporting that came into force from April 1st 2015. All incidents are reviewed daily by the Quality and Clinical Governance Team, across both acute and community sites, to ensure possible SIs are identified, discussed, escalated and reported as required. In addition as part of the mortality review process any deaths that have a CESDI grade of 1 or above are considered and reviewed as potential serious incidents.

2.0 Never Events

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

There have been 2 'Never Events' reported to date. One 'Never Event' was reported in June 2017 (Wrong route administration of medication), oral medication was administered via an intravenous route. The patient suffered no harm. This incident occurred in the Intensive Care Unit at the Chelsea and Westminster (C&W) site. Immediate action arising from this incident included ensuring all Trust in-patient wards and departments that care and manage patients with a nasogastric tube have purple EnFIT syringes in stock.

The second 'Never Event' was not originally reported as a 'Never Event', however, following a discussion with the Commissioners, the transfusion incident reported in June 2017 (Steis ref. 2017/14670) which involved a patent unintentionally being given a transfusion of platelets which was considered to be an ABO-incompatible blood component has been reclassified as a Never Event'. The patient suffered no harm. This incident occurred on the Acute Assessment Unit at the West Middlesex Hospital site. Immediate action arising from this incident included extra training provided for MAU/AAU including temporary staff re: 'safe blood transfusion sampling', with inclusion of no distraction during blood sampling.

The Trust Quality Improvement Programme has had a focus on 'Never Events'. This is intended to raise awareness of these incident categories, which are serious and typically preventable.

During 2016/17 the C&W site reported 1 never event, an incorrect tooth extraction.

3.0 SIs submitted to CWHHE and reported on STEIS

Table 1 outlines the SI investigations that have been completed and submitted to the CWHHE Collaborative (Commissioners) in September 2017. There were 7 reports submitted across the 2 sites. A précis of the incidents can be found in Section 7.

Table 1

STEIS No.	Date of incident	Incident Type (STEIS Category)	External Deadline	Date SI report submitted	Site
2017/15985	08/06/2017	Pressure ulcer meeting SI criteria	18/09/2017	18/09/2017	CW
2017/15653	16/06/2017	Maternity/Obstetric incident meeting SI criteria:	14/09/2017	15/09/2017	CW
2017/15766	20/06/2017	Treatment delay meeting SI criteria	14/09/2017	14/09/2017	CW
2017/15993	21/06/2017	Diagnostic incident including delay meeting SI	18/09/2017	18/09/2017	CW
2017/16333	24/06/2017	Maternity/Obstetric incident meeting SI criteria	21/09/2017	13/09/2017	WM
2017/16462	27/06/2017	Sub-optimal care of the deteriorating patient	22/09/2017	22/09/2017	WM
2017/17079	01/03/2017	Sub-optimal care of the deteriorating patient	29/09/2017	29/09/2017	WM

Table 2 shows the number of incidents reported on StEIS (Strategic Executive Information System), across the Trust, in September 2017.

Table 2

Details of incidents reported	WM	C&W	Total
Diagnostic incident including delay meeting SI criteria (including		1	1
Maternity/Obstetric incident meeting SI criteria: mother and baby	1		1
Surgical/invasive procedure incident meeting SI criteria		1	1
Grand Total	**1**	**2**	**3**

Charts 1 and 2 show the number of incidents, by category reported on each site during this financial year 2017/18.

Chart 1 Incidents reported at WM YTD 2017/18 = 17

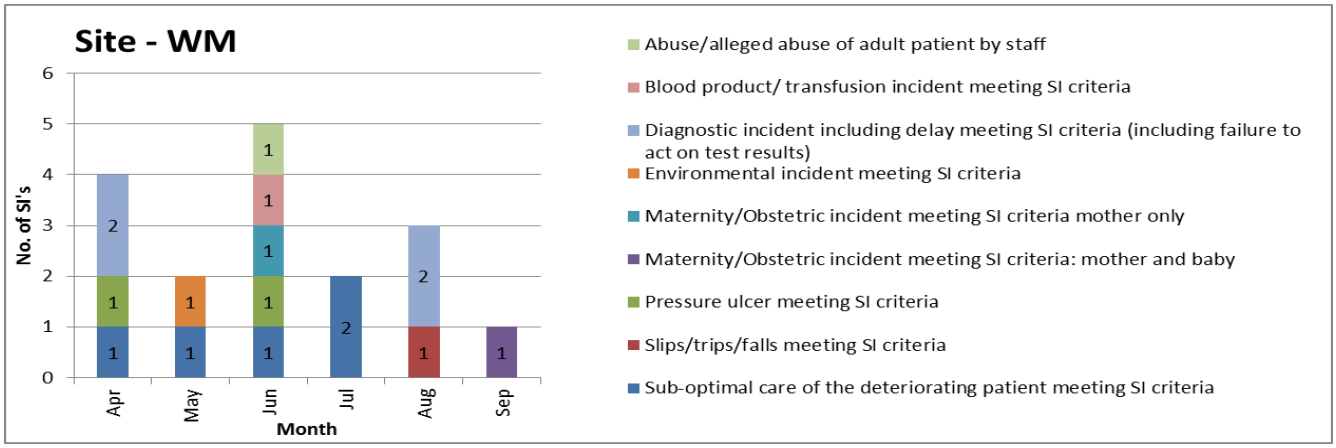
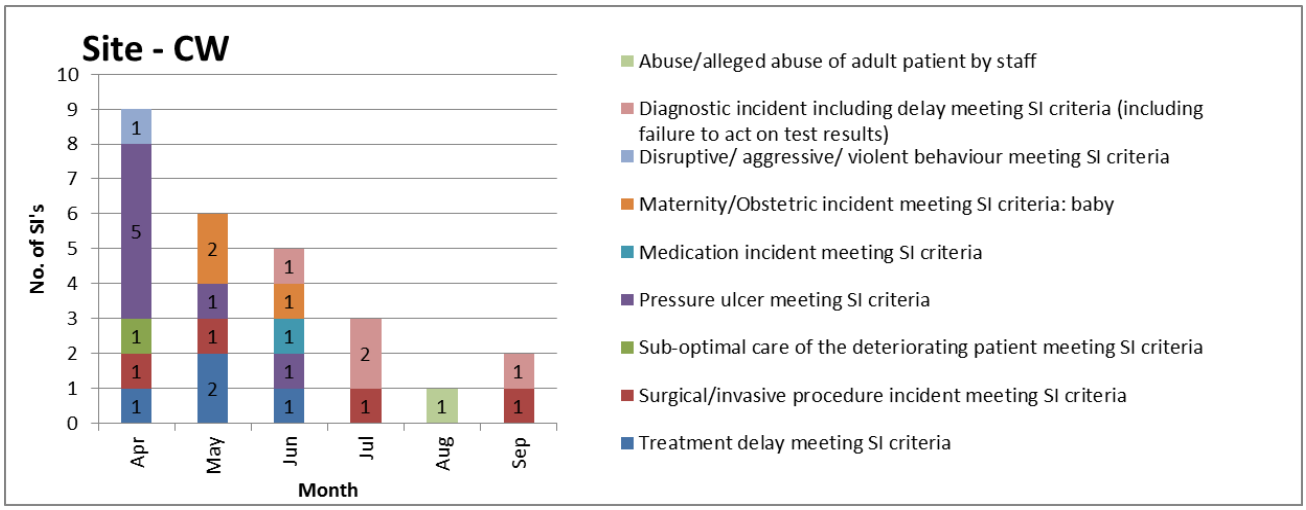


Chart 2 Incidents reported at C&W YTD 2017/18=26



There was a slight decrease in the number of SIs reported in September 2017 (3) compared to August 2017 (4).

During September the trust reported one diagnostic incident meeting SI criteria. This is the fourth consecutive month the Trust has reported against this category. Year to date the Trust has reported 8 diagnostic incidents meeting SI criteria. The incidents have occurred between December 2016 and August 2017. With the exception of two incidents, the incidents have occurred in different locations around the Trust. The Chelsea site has reported 4 incidents and the West Middlesex site has reported 4. The Clinical Director for Patient Safety is currently undertaking a review of diagnostic delays.

Charts 3 and 4 show the comparative reporting, across the 2 sites, for 2015/16, 2016/17 and 2017/18.
The total number of incidents reported on each site year to date is 17 at WM and 26 at C&W. For both sites this is a reduction in the number reported compared to the same period last year.

Chart 3 Incidents reported 2015/16, 2016/17 & 2017/18 – WM

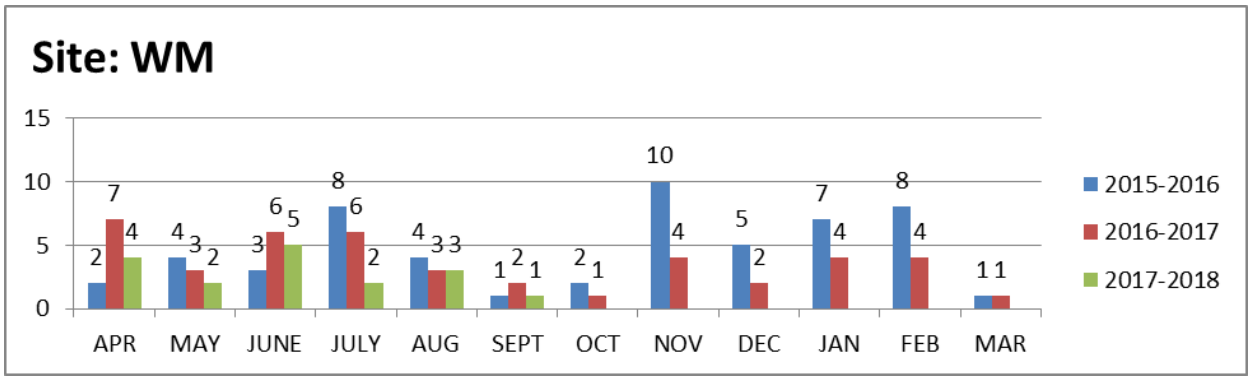
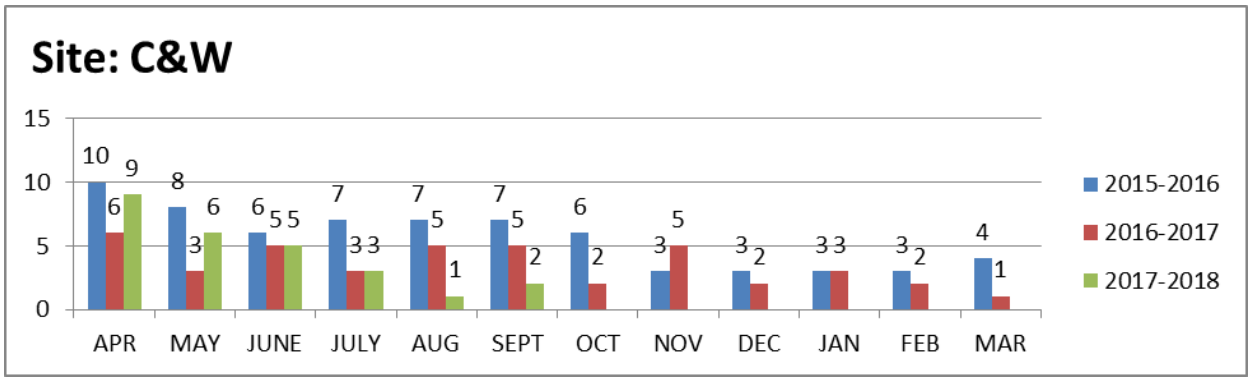


Chart 4 Incidents reported 2015/16, 2016/17 & 2017/18 – C&W



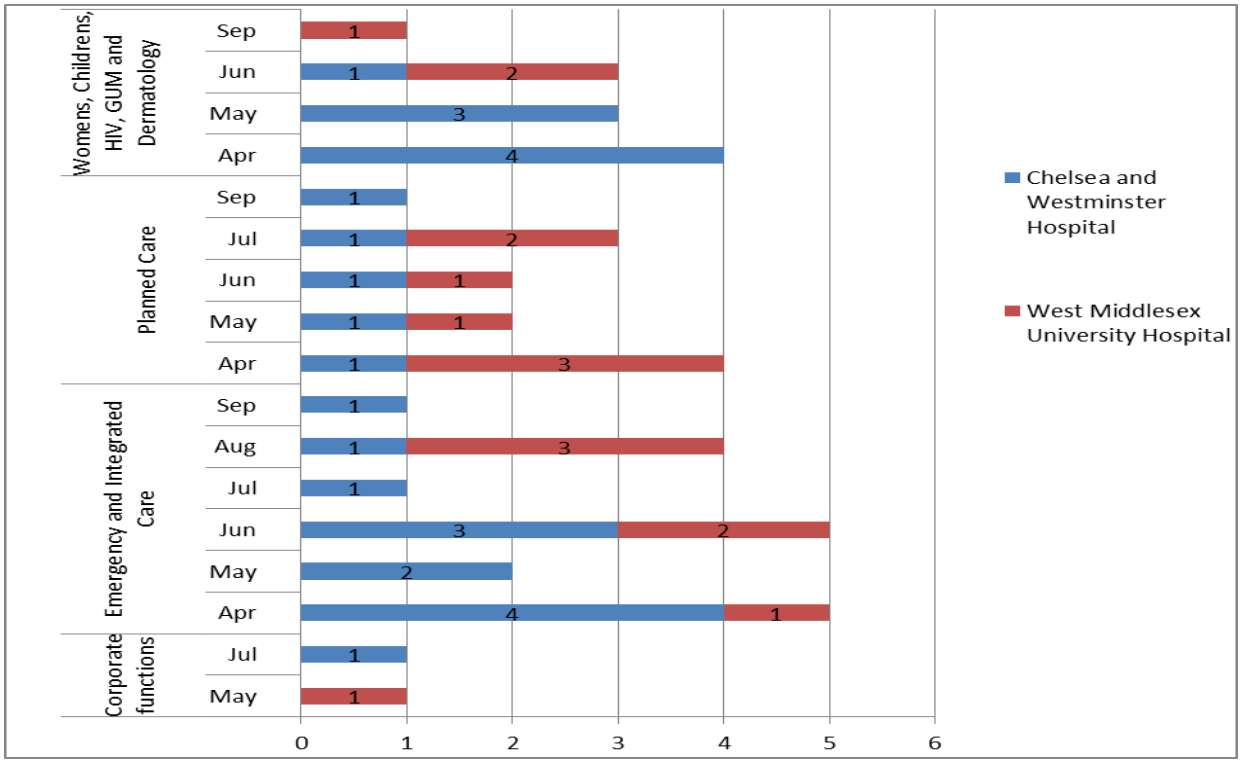
3.1 SIs by Clinical Division and Ward

Chart 5 displays the number of SIs reported by each division, split by site, since 1st April 2017. The number of incidents reported by each division is very similar.

Since April 1st 2017, the Emergency and Integrated Care Division have reported 18 SIs (C&W 12, WM 6). The Women's, Children's, HIV, GUM and Dermatology Division have reported 11 SIs (C&W 8, WM 3) and the Planed Care Division have reported 12 SIs (C&W 5, WM 7).

In addition there have been two reported by the corporate division; a power failure affecting the WM site only and IT system failure whereby discharge summaries were not sent. This affected the CW site.

Chart 5



Charts 6 & 7 display the total number of SIs reported by each ward/department. All themes are reviewed at divisional governance meetings.

As the year progresses we will, as in previous years, be able to identify trends in reporting. Rainsford Mowlem Ward at CWH is showing a higher number of reported SIs. The divisional management team are aware and have plans in place to address concerns on this ward with support from the Quality Governance Manager.

Chart 6 – CW 2017/2018

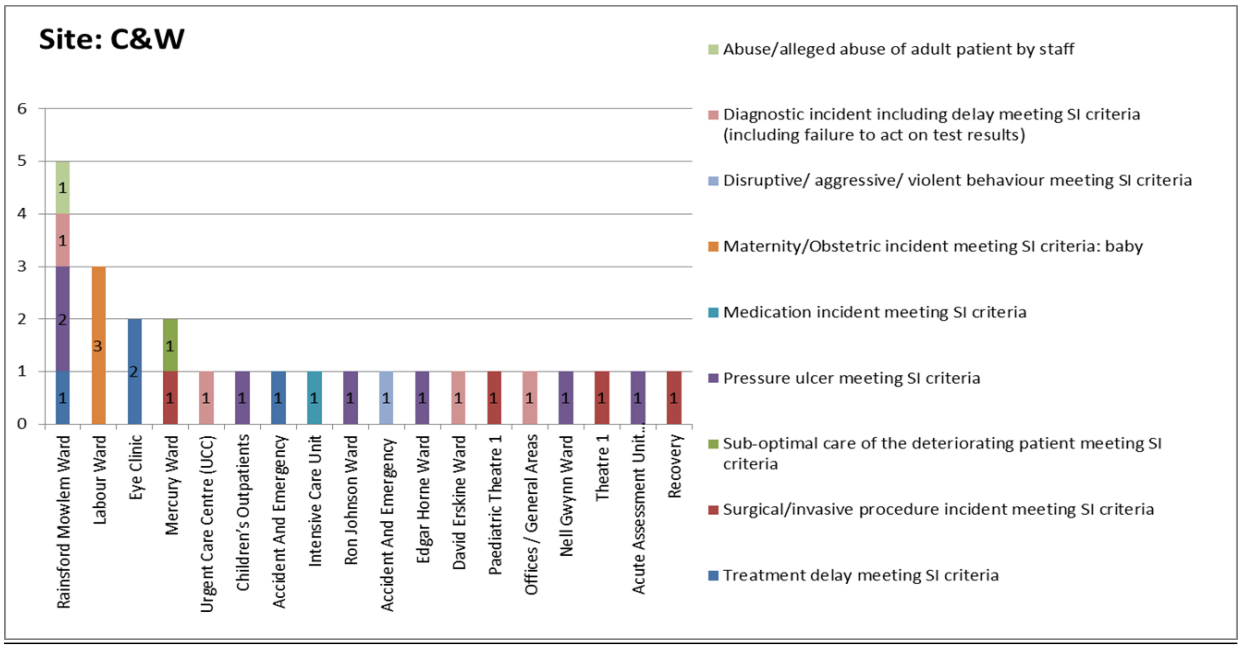
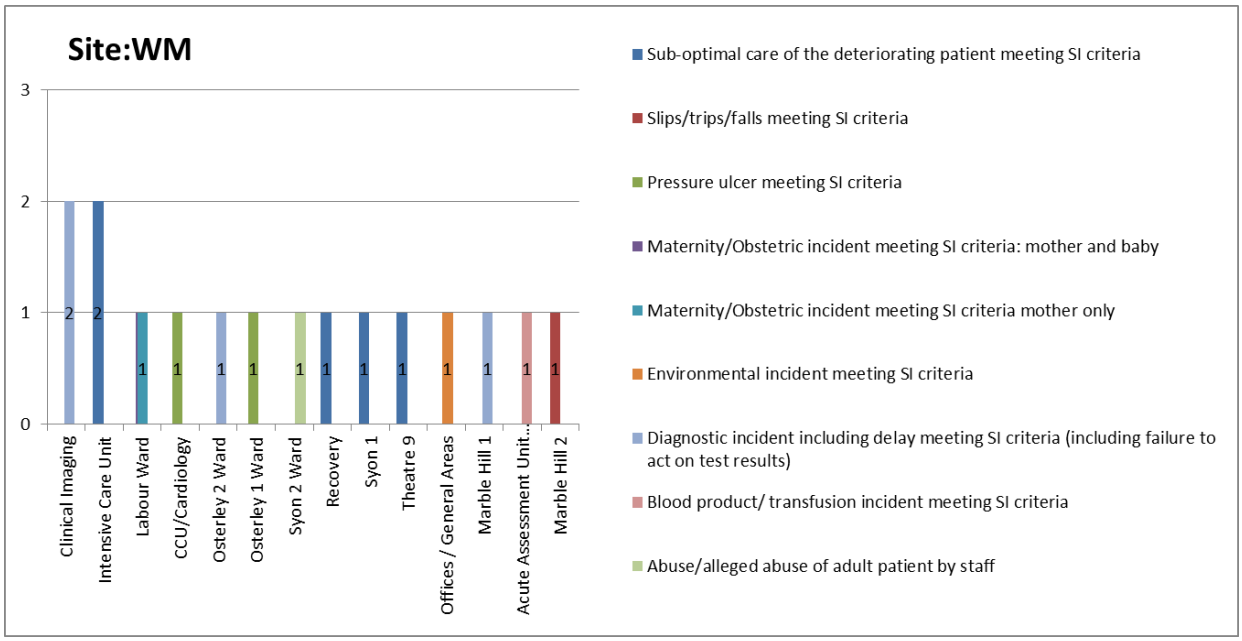


Chart 7 - WM 2017/2018

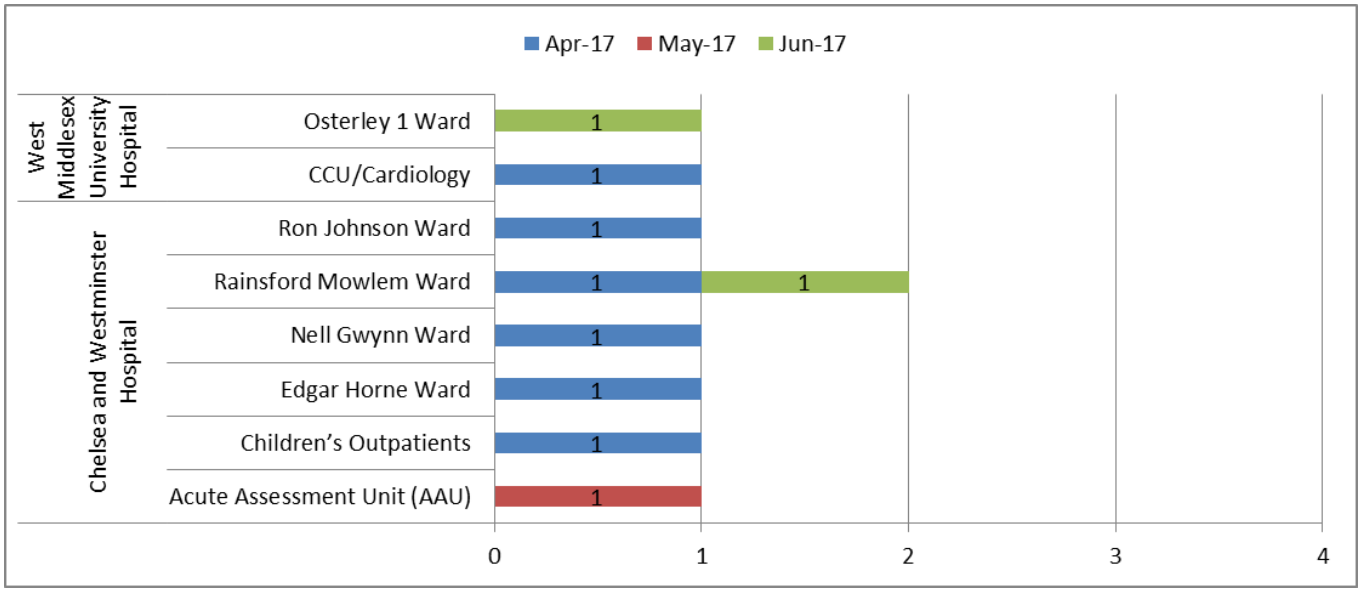


3.2 Hospital Acquired Pressure Ulcers

Hospital Acquired Pressure Ulcers (HAPUs) remain high profile for both C&W and WM sites. The following graphs reflect the volume and areas where pressure ulcers classified as serious incidents are being reported. No one ward is showing a trend higher than another, on either site. The reduction in HAPU remains a priority for both sites and is being monitored by the Trust Wide Pressure Ulcer working group. The YTD position is 9 compared to 19 for the same period last year.

There were 0 reported hospital acquired pressure ulcers meeting SI criteria during July, August & September 2017.

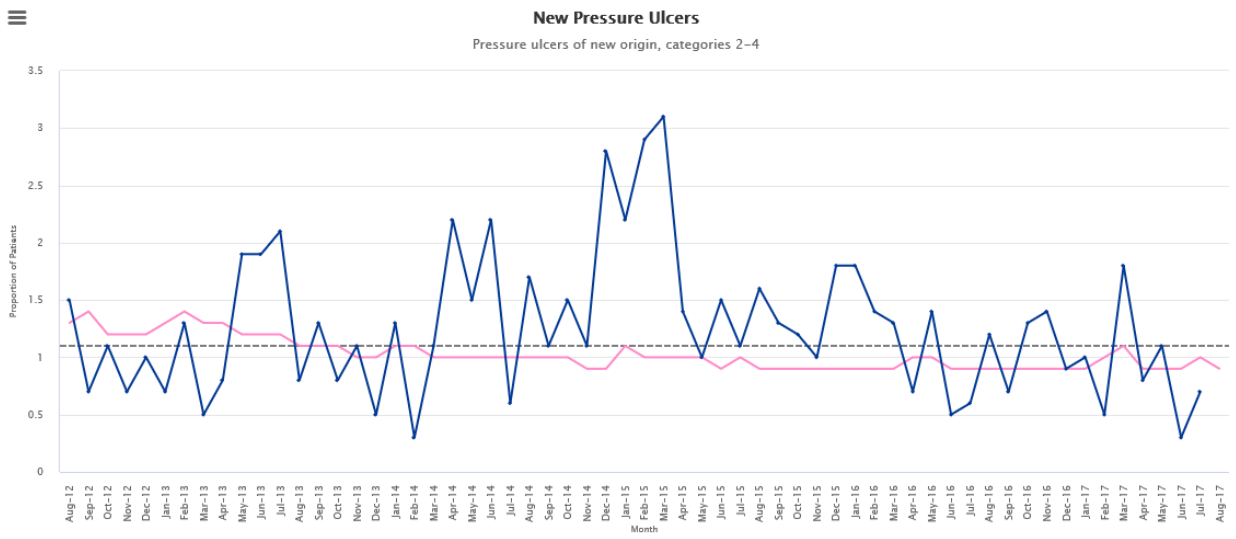
Chart 8 – Pressure Ulcers reported (Apr 2017–March 2018) YTD total = 9



3.2.1 Safety Thermometer Data

The national safety thermometer data provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers. The nationally reported data appears now to be for Chelsea and Westminster Hospital NHS Foundation Trust as the combined organisation and is showing a favourable position below the national average. National data is published up to July 17.

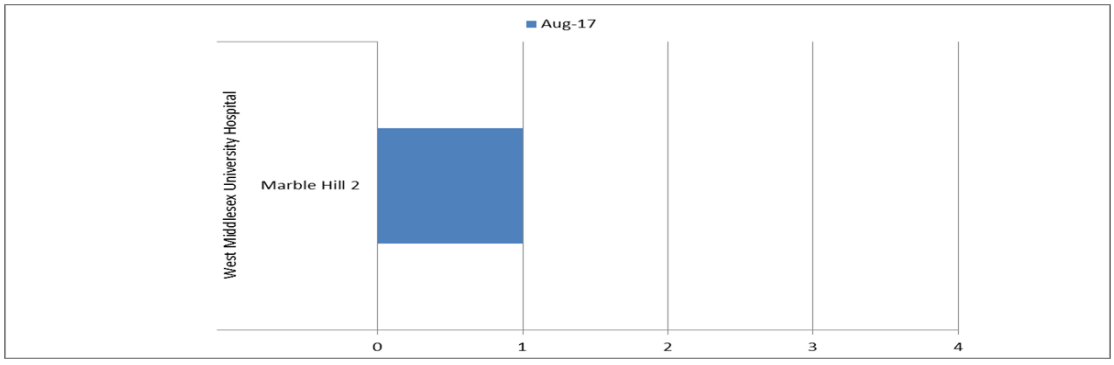
Graph 1 C&W comparison with national average



3.3 Patient Falls

Inpatient Falls are a quality priority for 2017/18 and will therefore be a focus for both C&W and WM sites during 2017/18.

Chart 9



Since the 1st of April 2017, the Trust has reported one patient fall meeting the serious incident criteria. This was reported during August 2017.

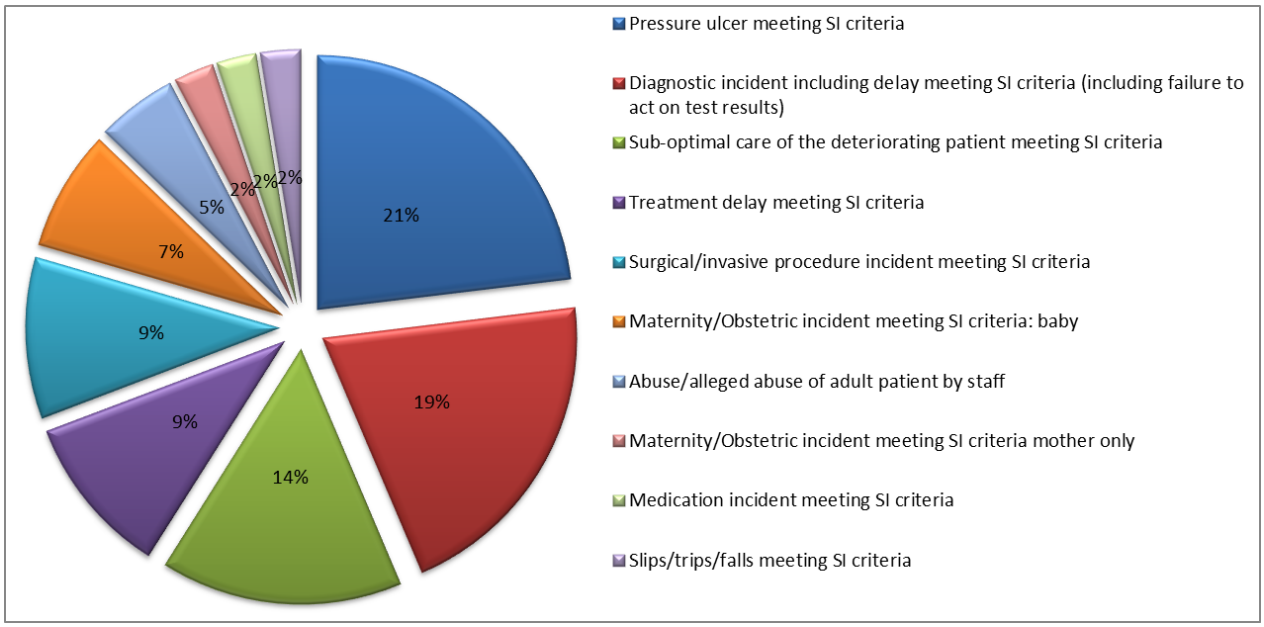
3.4 Top 10 reported SI categories

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

Year to date pressure ulcers continue to be the most commonly reported incident despite the significant reduction from last year. Diagnostic incidents including delay are the second most reported serious

incident (8). Sub-optimal care of the deteriorating patient is the third most reported incidents with 6 incidents reported.

Chart 10 – Top 10 reported serious incidents (April 2017 – March 2018)



3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (18).

Table 3

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2017/13090	30/04/2017	CORP	*Environmental incident meeting SI criteria	WM	15/08/2017
2017/16909	16/05/2017	PC	Surgical/invasive procedure incident meeting SI criteria	CW	28/09/2017
2017/17614	26/05/2017	CORP	Diagnostic incident including delay meeting SI criteria	CW	06/10/2017
2017/17668	28/04/2017	EIC	Diagnostic incident including delay meeting SI criteria	CW	06/10/2017
2017/18989	24/07/2017	PC	Sub-optimal care of the deteriorating patient meeting SI	WM	23/10/2017
2017/20178	12/07/2017	EIC	Diagnostic incident including delay meeting SI criteria	WM	06/11/2017
2017/20069	08/08/2017	EIC	Abuse/alleged abuse of adult patient by staff	CW	03/11/2017
2017/20918	13/08/2017	EIC	Diagnostic incident including delay meeting SI criteria	WM	14/11/2017
2017/21438	24/08/2017	EIC	Slips/trips/falls meeting SI criteria	WM	20/11/2017
2017/21856	29/08/2017	W&C,HG	Maternity/Obstetric incident meeting SI criteria: mother	WM	24/11/2017
2017/22077	05/12/2016	EIC	Diagnostic incident including delay meeting SI criteria	CW	28/11/2017
2017/23484	20/09/2017	PC	Surgical/invasive procedure incident meeting SI criteria	CW	14/12/2017

*The report for the Environmental incident was submitted in October.

4.0 SI Action Plans

All action plans are recorded on DATIX on submission of the SI investigation reports to CWHHE. This increases visibility of the volume of actions due. The Quality and Clinical Governance team work with the Divisions to highlight the deadlines and in obtaining evidence for closure.
As is evident from table 4 there are a number of overdue actions across the Divisions. There are 41 actions overdue at the time of writing this report. This is a decrease on last month when there were 49. Women's, Children's, HIV, GUM and Dermatology Division has 5 outstanding actions, Emergency and Integrated Care Division have 13 and the Planned Care Division has 23 outstanding actions.

Table 4 - SI Actions

	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Total
EIC	3	0	0	0	3	0	0	2	1	1	1	1	0	1	12	9	2	1	**37**
PC	0	2	3	0	0	1	0	1	1	0	0	0	5	10	12	22	8	0	**65**
W&C,HGD	0	0	0	0	0	0	0	0	0	0	0	2	2	1	8	4	2	1	**20**
Total	**3**	**2**	**3**	**0**	**3**	**1**	**0**	**3**	**2**	**1**	**1**	**3**	**7**	**12**	**32**	**35**	**12**	**2**	**122**

Table 4.1 highlights the type of actions that are overdue. Divisions are encouraged to note realistic time scales for completing actions included within SI action plans. Divisions have been asked to focus on providing evidence to enable closure of the actions so an updated position can be provided to the Quality Committee. Evidence of duty of candour adherence remains the largest type of action overdue. A Duty of Candour task and finish group has been re-launched to address the poor compliance.

Table 4.1 – Type of actions overdue

Action type	EIC	PC	W&C,HGD	Total
Duty of Candour - Patient/NOK notification	9	4		13
Share learning	1	6	4	11
Other action type	1	6		7
Create/amend/review - Policy/Procedure/Protocol		3		3
Create/amend/review - proforma or information sheet	1	1		2
Audit		2		2
Personal reflection/Supervised practice			1	1
One-off training		1		1
Overhaul existing equipment	1			1
Grand Total	**13**	**23**	**5**	**41**

5.0 Analysis of categories

Table 5 shows the total number of Serious Incidents for 2015/2016, 2016/2017 and the current position for 2017/18. Tables 6, 7 and 8 provide a breakdown of incident categories the Trust has reported against.

Since April 2017 the total number of reported serious incidents is 40 which is slightly less compared to the same reporting period last year and significantly less compared to 2015/2016. (2105/16 = 59, 2016/17 = 47). The reduction in reported pressure ulcers is a significant factor in lower number reported.

Table 5 – Total Incidents

Year	Site	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2015-2016	**WM**	2	4	3	8	4	1	2	10	5	7	8	1	**55**
	CW	10	8	6	7	7	7	6	3	3	3	3	4	**67**
		12	**12**	**9**	**15**	**11**	**8**	**8**	**13**	**8**	**10**	**11**	**5**	**122**
2016-2017	**WM**	7	3	6	6	3	2	1	4	2	4	4	1	**43**
	CW	6	3	5	3	5	5	2	5	2	3	2	1	**42**
		13	**6**	**11**	**9**	**8**	**7**	**3**	**9**	**4**	**7**	**6**	**2**	**85**
2017-2018	**WM**	4	2	5	2	3	1							**17**
	CW	9	6	5	3	1	2							**26**
		13	**8**	**10**	**5**	**4**	**3**							**43**

Table 6 - Categories 2015/16

Incident details	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Pressure ulcer meeting SI criteria	5	6	3	8		1	5	5	5	5	5	1	49
Slips/trips/falls				1	2	4		1		2	2	1	13
Maternity/Obstetric incident: baby only		2		1	3	1		2	1			1	11
Treatment delay		1			1		2	1			1	1	7
Maternity/Obstetric incident: mother only						1		1		1	2	1	6
Sub-optimal care of the deteriorating patient				1	2			1		2			6
Communicable disease and infection issue	5												5
Diagnostic incident (including failure to act on test results)				2	1			1			1		5
Abuse/alleged abuse by adult patient by staff			2	1									3
Medication incident				1	1				1				3
Accident e.g. collision/scald (not slip/trip/fall)							1	1					2
Confidential information leak/information			1			1							2
Safeguarding vulnerable adults	1	1											2
Surgical/invasive procedure			1		1								2
Ambulance delay	1												1
HAI/infection control incident			1										1
Other		1											1
Radiation incident (including exposure when scanning)			1										1
VTE meeting SI criteria									1				1
Ward/unit closure		1											1
Grand Total	12	12	9	15	11	8	8	13	8	10	11	5	122

Table 7 - Categories 2016/17

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

Table 8 - Categories 2017/18

Incident details	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Pressure ulcer meeting SI criteria	6	1	2										9
Diagnostic incident including delay meeting SI criteria	2		1	2	2	1							8
Sub-optimal care of the deteriorating patient meeting SI criteria	2	1	1	2									6
Surgical/invasive procedure incident meeting SI criteria	1	1		1		1							4
Treatment delay meeting SI criteria	1	2	1										4
Maternity/Obstetric incident meeting SI criteria: baby		2	1										3
Abuse/alleged abuse of adult patient by staff			1		1								2
Blood product/ transfusion incident meeting SI criteria			1										1
Environmental incident meeting SI criteria		1											1
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1												1
Maternity/Obstetric incident meeting SI criteria: mother and baby						1							1
Maternity/Obstetric incident meeting SI criteria mother only			1										1
Medication incident meeting SI criteria			1										1
Slips/trips/falls meeting SI criteria					1								1
Grand Total	13	8	10	5	4	3	0	0	0	0	0	0	43

The quality and clinical governance team continues to scrutinise all reported incidents to ensure that SI reporting is not compromised. There are some incidents that are being reported retrospectively as a result of the mortality review process.

6.0 Serious Incidents De-escalations

The figures within the report do not include the SIs that were reported but have since been de-escalated by the Commissioners. Table 9 shows the number of incidents reported this year that have since been de-escalated (1) and the number of SIs the Trust has requested to be de-escalated (0).

Table 9 De-escalation requests

De-escalation Status	STEIS No.	Date reported	Incident Type (STEIS Category)	Date SI report submitted	Site
De-escalation confirmed	2017/3419	03/02/2017	Pressure ulcer meeting SI criteria	03/05/2017	CW

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.5/Nov/17
REPORT NAME	Integrated Performance & Quality Report – September 2017
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for September 2017 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 September 2017. **Regulatory performance** – The A&E Waiting Time figure for September was 93.7%. The Chelsea Site maintained the 95% target but there were significant pressures at West Middlesex with a 9% increase in attendances against the same period 2016/2017 which lowered the overall performance. Q2 overall was 94.8% which secured the full release of STF linked to A&E. The RTT incomplete target was not achieved in September for the Trust with a performance of 90.93%. The Trust has seen significant deterioration in RTT performance across a number of specialities on the West Middlesex site which has affected both the Trust and aggregate positions. A comprehensive speciality-based recovery plan has been developed and submitted to NHS England which is monitored through our weekly elective access meetings. We are confident that we will recover RTT compliance at the West Middlesex site by November 2017 and on an aggregate Trust level by end January 2018. There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue. Performance for 31 day first and subsequent Cancer Treatments remained at 100% for September. The target for Breast Symptomatic was also achieved. Previous challenges around 2 week referral to first appointment and 62 day GP referral to first treatment were addressed in September with both metrics surpassing the target. There were three reported CDiff infections in September at West Middlesex. **Access** After previous issues with this metric, Trust achieved the 99% target for the six week Diagnostic Waiting Time for the second consecutive month.

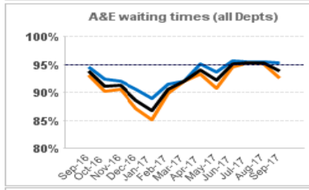
KEY RISKS ASSOCIATED:	There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer 62 days waits remains a high priority.
FINANCIAL IMPLICATIONS	To be confirmed
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure financial and environmental sustainability
DECISION/ ACTION	The Board is asked to note the performance for September 2017 and to note that whilst a number of indicators were not delivered in the month, the overall YTD compliance remains good.

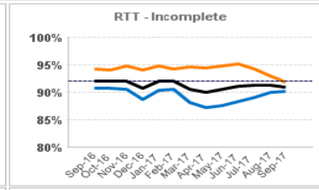
TRUST PERFORMANCE & QUALITY REPORT

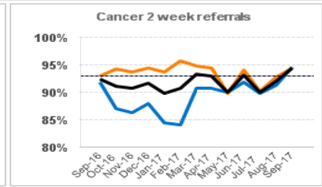
September 2017

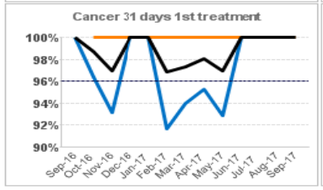
Regulatory Compliance

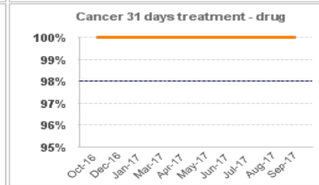
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.4	95.5	95.2	95.2	95.1	92.6	95.3	95.3	93.7	94.8	94.3	
RTT - Incomplete (Target: >92%)	89.1	90.0	90.3	94.2	93.0	91.8	91.2	91.3	90.9	91.1	90.8	
Cancer 2 week urgent referrals (Target: >93%)	89.8	91.3	94.6	90.3	92.7	94.5	90.1	92.1	94.5	92.2	92.1	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	91.5	93.1	97.7	91.5	93.1	97.7	94.5	92.6	
Cancer 31 days first treatment (Target: >96%)	100	100	100	100	100	100	100	100	100	100	99.3	
Cancer 31 days treatment - Drug (Target: >98%)	n/a	100	100	100	n/a	100	100	100	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	n/a	100	100	100	100	100	100	100	100	100	100.0	
Cancer 62 days GP ref to treatment (Target: >85%)	71.4	78.3	89.8	92.5	88.3	98.0	82.9	84.0	93.6	86.7	84.1	
Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16)	0	0	0	0	1	3	0	1	3	4	8	
Average Emergency PreOp LoS	0.49	0.49	0.62	1.13	1.12	1.60	0.83	0.81	1.11	0.91	0.94	
Average Elective PreOp LoS	0.26	0.11	0.22	0.09	0.08	0.27	0.21	0.10	0.23	0.18	0.17	

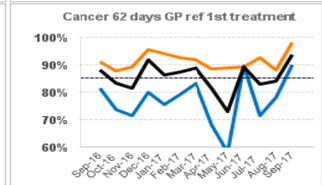






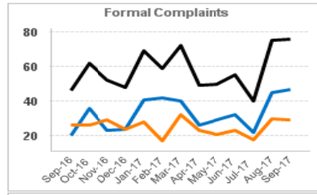


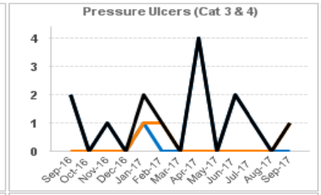


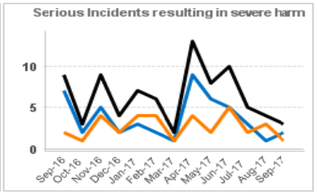


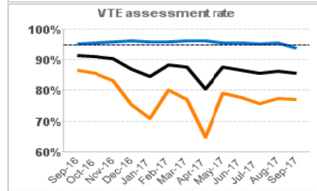
Quality

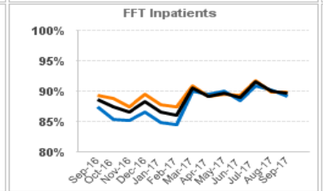
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	96.4	97.1	96.5	93.4	96.0	99.5	95.3	96.7	97.5	96.5	96.2	
Pressure Ulcers (Cat 3 & 4)	1	0	0	0	0	1	1	0	1	2	8	
VTE assessment % (Target: >=95%)	95.4	95.6	94.0	75.8	77.4	77.1	85.5	86.5	85.8	85.9	85.5	
Formal complaints number received	22	45	47	18	30	29	40	75	76	191	345	
Formal complaints responded to <25days	10	23	16	4	5	7	14	28	23	65	114	
Serious Incidents	3	1	2	2	3	1	5	4	3	12	43	
Never Events (Target: 0)	0	0	0	0	0	0	0	0	0	0	2	
FFT - Inpatients recommend % (Target: >90%)	90.9	90.2	89.1	91.8	89.8	89.9	91.5	90.0	89.6	90.3	89.8	
FFT - A&E recommend % (Target: >90%)	84.1	83.0	84.6	87.2	84.9	83.8	84.7	83.5	84.4	84.2	84.8	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	0	

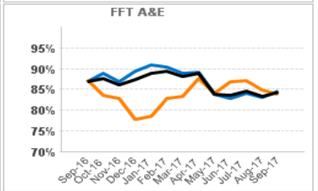






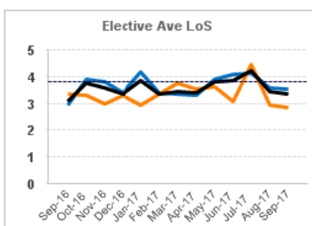


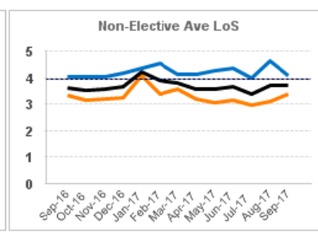


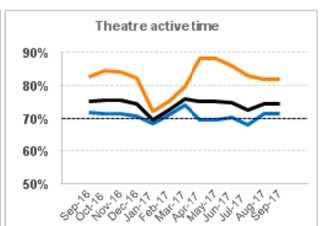


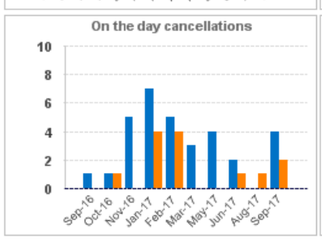
Efficiency

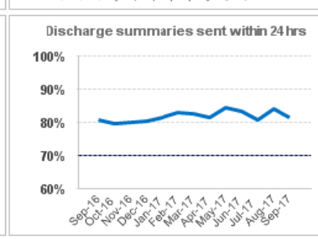
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	4.1	3.6	3.5	4.5	3.0	2.9	4.2	3.4	3.4	3.7	3.7	
Non-Elective average LoS (Target: <3.95)	4.0	4.6	4.1	2.9	3.1	3.4	3.4	3.7	3.7	3.6	3.6	
Theatre active time (Target: >70%)	67.9	71.3	71.2	82.8	81.9	81.6	72.3	74.4	74.2	73.6	74.3	
Discharge summaries sent within 24 hours (Target: >70%)	80.6	84.2	81.6	dev	dev	dev	80.6	84.2	81.6	82.2	82.7	
Outpatient DNA rates (Target: <11.1%)	13.4	13.2	13.7	9.6	10.2	10.6	12.0	12.1	12.6	12.2	11.6	
On the day cancelled operations not re-booked within 28 days (Target: 0)	0	0	4	0	1	2	0	1	6	7	14	

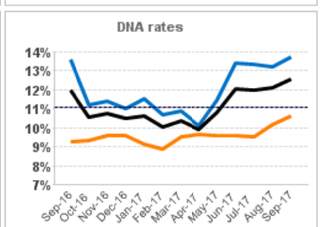






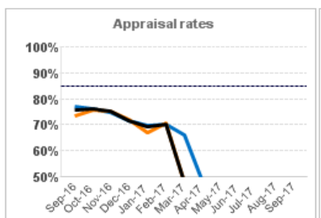


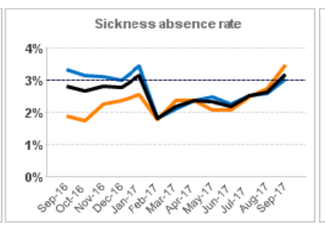


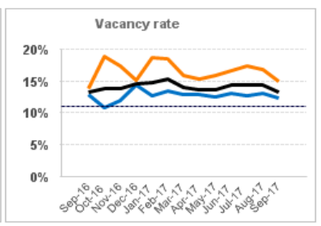


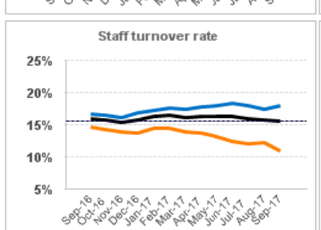
Workforce

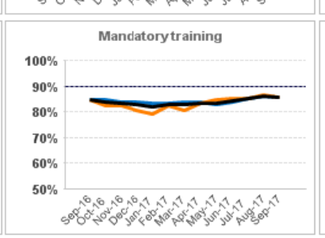
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Jul-17	Aug-17	Sep-17	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	23.5	28.8	40.4	18.6	22.8	34.6	21.8	26.8	38.4	29.0	21.0	
Sickness absence rate (Target: <3%)	2.52	2.60	3.05	2.49	2.75	3.47	2.51	2.65	3.19	2.78	2.54	
Vacancy rates (Target: CW<12%; WM<10%)	12.8	13.1	12.3	17.4	16.8	14.9	14.4	14.4	13.2	13.2	13.2	
Turnover rate (Target: CW<18%; WM<11.5%)	18.0	17.5	18.0	12.1	12.3	10.9	15.9	15.7	15.5	15.5	15.5	
Mandatory training (Target: >90%)	85.4	86.1	85.5	85.2	86.5	85.7	85.4	86.2	85.6	85.7	84.8	
Bank and Agency spend (£ks)	£2,486	£2,624	£2,209	£2,544	£2,417	£2,548	£5,030	£5,040	£4,757	£14,828	£29,038	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	8.0	6.7	9.5	13.6	12.9	14.5	10.1	9.1	11.4	10.2	9.6	

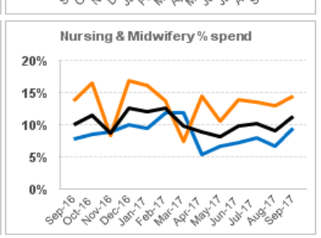












NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.4%	95.5%	95.2%	95.1%	95.2%	95.1%	92.6%	93.6%	95.3%	95.3%	93.7%	94.8%	94.3%		-
RTT	18 weeks RTT - Admitted (Target: >90%)	59.8%	69.1%	69.6%	65.2%	87.7%	84.2%	84.4%	84.5%	75.1%	76.9%	77.7%	76.6%	75.9%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	91.7%	93.1%	92.1%	92.6%	92.0%	91.6%	91.1%	92.3%	91.8%	92.5%	91.7%	92.0%	92.5%		!
	18 weeks RTT - Incomplete (Target: >92%)	89.1%	90.0%	90.3%	88.7%	94.2%	93.0%	91.8%	93.9%	91.2%	91.3%	90.9%	91.1%	90.8%		!
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Sep-17) in this report)	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	89.8%	91.3%	94.6%	91.5%	90.3%	92.7%	94.5%	92.6%	90.1%	92.1%	94.5%	92.2%	92.1%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	91.5%	93.1%	97.7%	92.6%	91.5%	93.1%	97.7%	94.5%	92.6%		-
	31 days diagnosis to first treatment (Target: >96%)	100%	100%	100%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	99.3%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	100%	100%	100%	100%	n/a	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	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%)	71.4%	78.3%	89.8%	75.1%	92.5%	88.3%	98.0%	90.9%	82.9%	84.0%	93.6%	86.7%	84.1%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	90.0%	100%	100%	93.8%	90.0%	100%	100%	95.0%	93.8%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	0	0	0	0	0	1	3	8	0	1	3	4	8		-
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

A&E waiting times

The Chelsea site maintained the 95% target in September making us one of the only sites in London to meet this target. The west Middlesex site had some very difficult days and ended the month at 92.6%. Whilst this performance did not meet target, this also compared favourably across London. Various new initiatives continue to be rolled out with the aim of improving flow further

18 weeks RTT – Incomplete Pathways

The RTT Incomplete Target was not achieved in September for the Trust with a performance of 90.93%. The Chelsea Site maintained its month on month improvement, however significant deterioration across a number of specialities at the West Middlesex site resulted in a drop in aggregate performance. A comprehensive speciality-based recovery plan has been developed and submitted to NHS England which is monitored through our weekly elective access meetings. We are confident that we will recover RTT compliance at the West Middlesex site by November 2017 and on an aggregate Trust level by end January 2018, assuming the Elective programme isn't adversely impacted by non-elective bed pressures.

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

After continued focus across the Divisions the Trust is in a com pliant position for 2WW referrals.

2 weeks from referral to first appointment all Breast symptomatic referral

The Trust continues to achieve the Breast Symptomatic 2WW referral target.

Cancer - 62 days GP referral to first treatment

The Trust has achieved the 62 day target. Unvalidated position at 55 treatments and 3.5 breaches – 93.6%, putting the Trust into an overall compliant position for Q2 at 86.7%.

C-Difficile

There were 3 reportable C-Diff cases in September on the West Middlesex site. All have had thorough case reviews. Issues with sample collection have been highlighted and revised protocols for sample collection have been implemented by the IC team

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	0	2	2	0	0	2	2	2		-
	Hand hygiene compliance (Target: >90%)	96.4%	97.1%	96.5%	96.4%	93.4%	96.0%	99.5%	95.7%	95.3%	96.7%	97.5%	96.5%	96.2%		-
Incidents	Number of serious incidents	3	1	2	26	2	3	1	17	5	4	3	12	43		-
	Incident reporting rate per 100 admissions (Target: >8.5)	7.6	7.7	7.3	7.5	8.9	8.6	9.6	9.5	8.2	8.1	8.3	8.2	8.4		!
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.00	0.00	0.03	0.02	0.00	0.02	0.00	0.03	0.00	0.01	0.02	0.01	0.02		-
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	686.17	401.34	490.81	494.08	318.09	327.39	329.25	272.50	510.98	368.08	414.15	430.26	390.17		-
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	8.4%	3.3%	16.9%	10.2%	10.0%	25.0%	2.3%	15.5%	8.9%	12.0%	11.4%	10.6%	11.9%		-
	Never Events (Target: 0)	0	0	0	1	0	0	0	1	0	0	0	0	2		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	96.4%	97.3%	95.2%	95.6%	85.3%	95.6%	87.9%	92.0%	89.9%	96.3%	90.7%	92.2%	93.4%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	1	0	0	7	0	0	1	1	1	0	1	2	8		-
	NEWS compliance %	96.3%	97.0%	96.5%	96.7%	96.2%	97.4%	98.8%	96.7%	96.3%	97.1%	97.2%	96.9%	96.7%		-
	Safeguarding adults - number of referrals	16	26	24	120	27	31	32	163	43	57	56	156	283		-
	Safeguarding children - number of referrals	22	25	21	152	107	83	106	654	129	108	127	364	806		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4	86.4		-
	Number of hospital deaths - Adult	41	30	28	191	39	62	53	313	80	92	81	253	504		-
	Number of hospital deaths - Paediatric	1	1	1	5	0	0	0	1	1	1	1	3	6		-
	Number of hospital deaths - Neonatal	2	0	1	8	1	2	0	8	3	2	1	6	16		-
	Number of deaths in A&E - Adult	5	1	1	12	7	6	4	30	12	7	5	24	42		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	1	2	0	0	1	1	2		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	0	0	1	0	0	0	0	1		-

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

MRSA

The West Middlesex site had 2 reported MRSA bacteraemias in September. Both of these have had a full root cause analysis which identified clinical issues with the collection of samples. The Infection Control team have implemented and are in the process of embedding, the sample collection protocol as in use of the Chelsea site.

Number of serious incidents

3 Serious Incidents were reported in September 2017; 2 at CWH and 1 at WMUH. 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 958 patient safety incidents reported, 439 relate to incidents occurring on the CWH site, 498 on WMUH site, 21 in Community clinics.

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 415/100,000 FCE bed days in September. This is considerably higher than the Trust target of 280/100,000. There were 491 and 338 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively. Reporting rates at CW site have reduced in September compared to July 2017.

Medication-related (reported) safety incidents % with harm

The Trust had 12% medication-related safety incidents with harm in September. This figure is similar to the previous month so continues to be above the latest Carter dashboard National Benchmark (9.7%). The year to date figure is 11.9%. Overall, there were 13 incidents resulting in low harm, 1 at WM and 12 at CW site. These mainly involved inappropriate prescribing, administration and dispensing of anti-infective therapies, therapeutic drug level monitoring and medication dose omissions.

The Medication Safety Group aim to promote the timely investigation and learning from medication-related incidents resulting in harm. The group are working to improve reporting of no-harm and near-miss incidents so trends and themes of potential risks can be identified, addressed and subsequently reduced.

Incidence of newly acquired category 3 & 4 pressure ulcers

Preventing Hospital Acquired Pressure Ulcers remain high priority for both Chelsea and Westminster and West Middlesex Sites. There were no newly acquired pressure ulcers categorised as 3 or 4 reported during September 2017. However, one is showing in the table above at West Middlesex, occurring in September which has been reported in October

NEWS Compliance

Early warning scores continue to be audited weekly. We are now seeing 100% participation in audits & compliance is improving in the majority of areas. Training & support is given to areas not improving, escalation is a particular area of focus.

Safeguarding Adults – number of referrals

The number of referrals from both sites is broadly at a consistent level when compared to previous reports. Domestic abuse referrals remain a significant proportion of referrals on both sites

Safety Thermometer

There has been a decline in the reported compliance for the WM site, which is currently under investigation and will be reported to Quality Committee once complete.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	90.9%	90.2%	89.1%	89.7%	91.8%	89.8%	89.9%	89.9%	91.5%	90.0%	89.6%	90.3%	89.8%		-
	FFT: Inpatient not recommend % (Target: <10%)	4.6%	5.3%	5.2%	5.5%	2.7%	4.2%	4.0%	4.7%	3.3%	4.6%	4.4%	4.1%	5.0%		-
	FFT: Inpatient response rate (Target: >30%)	37.7%	37.1%	38.3%	34.7%	33.2%	31.0%	31.6%	32.7%	34.6%	33.1%	33.8%	33.8%	33.4%		-
	FFT: A&E recommend % (Target: >90%)	84.1%	83.0%	84.6%	84.6%	87.2%	84.9%	83.8%	85.8%	84.7%	83.5%	84.4%	84.2%	84.8%		!
	FFT: A&E not recommend % (Target: <10%)	5.2%	5.5%	6.1%	5.8%	7.3%	10.3%	8.5%	8.3%	5.6%	6.7%	6.5%	6.2%	6.3%		-
	FFT: A&E response rate (Target: >30%)	16.3%	15.6%	17.0%	17.3%	13.2%	12.3%	11.7%	13.1%	15.6%	14.6%	15.8%	15.4%	16.3%		!
	FFT: Maternity recommend % (Target: >90%)	90.3%	94.9%	93.3%	92.3%	94.3%	100.0%	95.5%	95.9%	91.4%	96.1%	93.8%	93.6%	93.2%		-
	FFT: Maternity not recommend % (Target: <10%)	5.0%	3.8%	4.8%	5.3%	5.7%	0.0%	1.5%	2.3%	5.2%	2.9%	4.0%	4.1%	4.7%		-
	FFT: Maternity response rate (Target: >30%)	19.4%	22.6%	18.6%	21.0%	21.2%	16.6%	15.8%	18.2%	19.8%	20.9%	17.8%	19.5%	20.2%		!
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	22	45	47	201	18	30	29	144	40	75	76	191	345		-
	Complaints formal: Number responded to < 25 days	10	23	7	71	4	5	6	33	14	28	13	55	104		-
	Complaints (informal) through PALS	93	110	78	574	71	69	45	354	164	179	123	466	928		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	1	1	0	0	1	1	1		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	1	1	0	3	1	1	0	2	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

Friends and Family Test - Inpatient recommend %

The Inpatients recommendation rate across the Trust is below the target by 0.4%. This is largely due to the low response rate, and whilst we are delivering above 30% at aggregate level, there are a number of wards where a change in the data collection methods are required in order to improve their response rates

Friends and Family Test - A&E recommend %

The recommend rate improved from the previous month however remains below the 90%. Detailed work in underway with both ED teams, led by the Chief Nurse, to understand why the monthly FFT scores are not consistent with the Nationally reported Patient experience Survey which places both sites in a positive benchmarked position.

Friends and Family Test - Maternity response rate

Maternity recommended rate consistently delivers >90% which is consistent with the national Maternity Patient Experience Survey findings. Work is on-going to improve response rates

Complaints

There were no complaints in September upheld by the Ombudsmen. The Director of Nursing (Chelsea site) is leading a QI project to improve our complaint response rates.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <3.7)	4.13	3.59	3.53	3.77	4.46	2.96	2.85	3.44	4.22	3.44	3.36	3.67	3.68		-
	Average length of stay - non-elective (Target: <3.9)	4.00	4.63	4.08	4.24	2.94	3.09	3.39	3.14	3.38	3.72	3.70	3.60	3.60		!
	Emergency care pathway - average LoS (Target: <4.5)	4.68	5.08	5.00	5.15	3.48	3.42	4.11	3.74	3.91	4.02	4.44	4.12	4.26		!
	Emergency care pathway - discharges	199	207	200	1239	359	365	330	2083	558	572	530	1661	3322		-
	Emergency re-admissions within 30 days of discharge (Target: <2.8%)	3.43%	3.06%	3.26%	3.40%	9.91%	10.25%	9.04%	9.92%	6.46%	6.40%	5.86%	6.25%	6.39%		!
	Non-elective long-stayers	404	410	448	2493	539	535	492	3295	943	945	940	2828	5788		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	83.6%	84.7%	84.4%	84.0%	89.8%	90.1%	81.8%	88.1%	86.3%	86.7%	83.4%	85.5%	85.6%		!
	Operations canc on the day for non-clinical reasons: actuals	33	11	20	128	1	3	10	32	34	14	30	78	160		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	1.15%	0.38%	0.74%	0.75%	0.08%	0.26%	0.89%	0.44%	0.83%	0.34%	0.78%	0.65%	0.66%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	4	10	0	1	1	3	0	1	5	6	13		-
	Theatre active time (C&VV Target: >70%; WM Target: >78%)	67.9%	71.3%	71.2%	69.9%	82.8%	81.9%	81.6%	84.8%	72.3%	74.4%	74.2%	73.6%	74.3%		-
	Theatre booking conversion rates (Target: >80%)	85.1%	85.3%	84.9%	84.9%	73.5%	74.7%	73.5%	74.1%	80.7%	81.4%	80.6%	80.9%	80.8%		!
Outpatients	First to follow-up ratio (Target: <1.5)	1.63	1.57	1.55	1.57	1.22	1.23	1.23	1.24	1.32	1.31	1.31	1.31	1.32		!
	Average wait to first outpatient attendance (Target: <6 wks)	7.7	7.3	7.9	7.7	10.1	9.5	10.0	9.6	9.0	8.4	9.0	8.8	8.6		!
	DNA rate: first appointment	15.1%	15.9%	15.7%	14.4%	10.1%	10.6%	11.2%	10.4%	12.7%	13.3%	13.5%	13.2%	12.4%		-
	DNA rate: follow-up appointment	12.7%	12.3%	13.0%	12.0%	9.1%	9.9%	10.2%	9.5%	11.6%	11.5%	12.1%	11.8%	11.2%		-

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

Elective average LoS

Elective length of stay has improved across the Trust in September and this is largely driven by a significant reduction in the elective LoS across medicine.
The average pre-operative LoS for elective care is within expected limits in September across the Trust.

Non-Elective and Emergency Care LoS

Modest improvement at Chelsea site for NEL LOS, but a corresponding shifts at WM site. Monthly figures are subject to volatility and can be skewed by one or two very long stay patients leaving which adversely affects LOS in month. Work to address the overall NEL LOS is focused work streams covering 'home first', discharge coordinators, R/G, 2b412 and out of borough long stay patients – all of which will see benefit between now and December. The emergency care pathway shows a small increase in September but this should reverse as ECIST action plan delivers in Oct/Nov and Dec

Procedures carried out as Daycases - basket of 25 procedures

Performance remains consistent at Chelsea site, but there has been a decline in month at the WM site due to a loss of 7 lists for Clinical Governance ½ day morning and an increase in complex cancer cases in colorectal.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	77.2%	79.6%	79.2%	84.5%	96.5%	95.7%	93.5%	94.6%	88.5%	88.7%	87.0%	88.1%	90.1%		!
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	100.0%	100.0%	95.5%	97.1%	100.0%	100.0%	58.8%	85.1%	100.0%	100.0%	79.5%	91.6%	91.6%		-
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	99.0%	100.0%	97.1%	100.0%	98.9%	99.4%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	95.4%	95.6%	94.0%	95.3%	75.8%	77.4%	77.1%	75.5%	85.5%	86.5%	85.8%	85.9%	85.5%		!
TB Care	TB: Number of active cases identified and notified	1	6	4	21	11	4	3	32	12	10	7	29	53		-
	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 within 36hrs

At the West Middlesex site, 11 patients did not meet the 36h target in September 2017. 7 were delayed due to theatre availability, 3 due to being medical unfit and 1 patient where further clinical input was required to establish diagnosis. Work is in progress to ensure sufficient capacity is in place to ensure patients are treated across a 7 day a week period.

At the Chelsea Site, one patient from a cohort of 22 medically fit patients was not in Surgery within the 36 hour target. This was due to an administrative delay which is being investigated

VTE Hospital-acquired

C&W site: Radiology reports are manually screened to identify positive VTE events. Retrospective data analysis in progress to identify hospital associated VTE events.

WMUH site: Data information team support required to develop a programme to identify hospital associated VTE events via radiology reports and relate to admission episode to allow reporting on Datix for root cause analysis investigation (on hold due to other pressing priorities by information team). The Datix process is to be refined to improve reporting, investigation and feedback (awaiting meeting with Datix team).

VTE Risk assessments completed

C&W site: Target not achieved and performance highlighted to teams with low performance to address.

WMUH site: Target not achieved due to current IT infrastructure. There is ongoing collaboration with divisions to encourage staff to complete assessments on admission. There are proposed plans to improve reporting on completion rates via RealTime/e-whiteboard (pending approval by PAS Implementation Group).

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	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%)	97.26%	98.42%	99.38%	97.10%	99.57%	99.66%	99.52%	99.31%	98.67%	99.12%	99.47%	99.12%	98.43%		-
	Diagnostic waiting times >6 weeks: breach actuals	57	44	17	436	14	12	20	157	71	56	37	164	593		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	7.6%	8.5%	8.1%	8.0%	7.8%	8.8%	8.5%	8.4%	7.7%	8.6%	8.2%	8.1%	8.1%		!
	A&E time to treatment - Median (Target: <60')	00:56	00:56	01:04	01:01	00:40	00:34	00:42	00:39	00:52	00:51	00:59	00:53	00:56		-
	London Ambulance Service - patient handover 30' breaches	22	16	17	136	11	26	32	228	33	42	49	124	364		-
	London Ambulance Service - patient handover 60' breaches	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Choose and Book (available to Jul-17 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	1237	1342	1095	1181	0	0	0	0	1237	1342	1095	1228	1181		-
	Choose and book: capacity issue rate (ASI)	45.1%			50.5%					45.1%			45.1%	50.5%		-
	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 Waits

There continues to be no patient waiting >52 weeks across the Trust

Diagnostic 6 week standard

The Trust achieved the 99% standard for the 2nd consecutive month with both sites delivering >99%.

London Ambulance Handovers

The Trust continues to perform exceptionally well with LAS handovers with the Chelsea site being the 2nd best performer in London and West Middlesex being 3rd. There continue to be no 60 minute handover breaches on either site.

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Birth indicators	Total number of NHS births	471	456	536	2862	420	440	430	2577	891	896	966	2753	5439		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	32.5%	32.5%	33.4%	32.2%	20.7%	23.4%	26.5%	25.4%	26.8%	28.0%	30.3%	28.4%	28.9%		!
	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%)	100.8%	99.7%	96.9%	98.3%	96.4%	95.1%	97.0%	96.7%	98.6%	97.4%	96.9%	97.6%	97.5%		-
Safety	Admissions of full-term babies to NICU	19	17	28	119	n/a	n/a	n/a	n/a	19	17	28	64	119		-

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

The maternity unit had an extremely busy month especially at the Chelsea site where the team delivered 536 babies. The team worked extremely well to ensure that the level of service was maintained despite such high delivery numbers

The C-section rates at both sites remain fairly static with the Chelsea site remaining above the target of 29%. The Trust continues to monitor this performance but doesn't have concerns about the current rate

The Midwife to Birth ratio remains at a 1:30 ratio on both sites, continuing our commitment to ensure staffing levels are comparable at both sites.

The team continued to deliver a high level of 1:1 care in established labour despite the busy month. This was a combination of good resource utilisation by the team and an increased spend on Bank and Agency staffing to ensure we maintained our ratios.

Workforce Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	12.8%	13.1%	12.3%	12.3%	17.4%	16.8%	14.9%	14.9%	14.4%	14.4%	13.2%	13.2%	13.2%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	18.0%	17.5%	18.0%	18.0%	12.1%	12.3%	10.9%	10.9%	15.9%	15.7%	15.5%	15.5%	15.5%		!
	Sickness absence (Target: <3%)	2.5%	2.6%	3.0%	2.5%	2.5%	2.7%	3.5%	2.5%	2.5%	2.6%	3.2%	2.8%	2.5%		-
	Bank and Agency spend (£ks)	£2,486	£2,624	£2,209	£14,400	£2,544	£2,417	£2,548	£14,638	£5,030	£5,040	£4,757	£14,828	£29,038		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	8.0%	6.7%	9.5%	7.3%	13.6%	12.9%	14.5%	13.3%	10.1%	9.1%	11.4%	10.2%	9.6%		-
Appraisal rates	% of Performance & Development Reviews completed - medical staff (Target: >85%)	85.6%	84.6%	80.7%	80.5%	85.5%	82.2%	79.2%	83.7%	85.6%	83.7%	80.1%	83.1%	81.8%		-
	% of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%)	16.4%	22.4%	35.7%	15.4%	8.8%	14.7%	28.8%	9.8%	13.8%	19.8%	33.3%	22.3%	13.4%		-
Training	Mandatory training compliance (Target: >90%)	85.4%	86.1%	85.5%	84.6%	85.2%	86.5%	85.7%	85.1%	85.4%	86.2%	85.6%	85.7%	84.8%		!
	Health and Safety training (Target: >90%)	85.3%	86.2%	85.6%	84.0%	85.0%	87.6%	87.2%	85.8%	85.2%	86.7%	86.2%	86.0%	84.6%		!
	Safeguarding training - adults (Target: 90%)	89.9%	90.6%	89.7%	89.4%	85.6%	87.4%	86.9%	86.2%	88.4%	89.5%	88.7%	88.8%	88.3%		!
	Safeguarding training - children (Target: 90%)	88.6%	89.1%	88.2%	88.4%	88.8%	89.7%	88.9%	88.8%	88.7%	89.3%	88.4%	88.8%	88.6%		!

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

Workforce Commentary September 2017 figures

Staff in Post

In September we employed 5223 whole time equivalent (WTE) people on substantive contracts, 31 more than last month. Taking into account bank and agency workers our WTE workforce was 6292.

Turnover

Our voluntary turnover rate was 15.5%, 0.2% lower than last month. Voluntary turnover is 18.0% at Chelsea and 10.9% at West Middlesex.

Vacancies

Our general vacancy rate for September was 13.2%, which is 1.2% lower than August. The vacancy rate is 14.9% at West Middlesex and 12.3% at Chelsea. Work to reconcile ESR to the financial ledger is now reaching completion with divisions being asked to sign off each service area.

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 85.6% against our target of 90%. In November the trust will introduce a new electronic platform which will improve both user access and our ability to capture records of completion.

Performance and Development Reviews

From 1 April 2017 everyone is required to have their PDR in a set period, starting first with the most senior staff. At the end of September the PDR rate for staff in band 8c-9 roles was 99% and for band 7-8b was79%. 90% of all staff in band 2-6 roles should have had their PDR by December.

The rolling annual appraisal rate for medical staff was 80.1%, 3.5% less 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	Jul-17	Aug-17	Sep-17	2017-2018	YTD breaches	Jul-17	Aug-17	Sep-17	2017-2018	YTD breaches	Jul-17	Aug-17	Sep-17	2017-2018 Q2	2017-2018	YTD breaches	Trend charts
62 day Cancer referrals by site of tumour	Brain	n/a	n/a	100%	100%		n/a	100%	n/a	100%	0	n/a	100%	100%	100%	100%	0	-
	Breast	n/a	n/a	n/a	n/a	0.5	100%	100%	100%	100%	0	100%	100%	100%	100%	98.9%	0.5	-
	Colorectal / Lower GI	90.0%	100%	85.7%	84.8%	2.5	57.1%	0.0%	85.7%	61.3%	6	76.5%	63.6%	85.7%	76.2%	73.4%	8.5	-
	Gynaecological	75.0%	100%	n/a	92.9%	0.5	100%	100%	100%	100%	0	90.0%	100%	100%	95.8%	97.3%	0.5	-
	Haematological	n/a	100%	100%	100%	0	100%	66.7%	n/a	87.5%	1.5	100%	71.4%	100%	90.0%	89.7%	1.5	-
	Head and neck	n/a	n/a	n/a	100%	0	50.0%	100%	100%	75.0%	1	50.0%	100%	100%	80.0%	83.3%	1	-
	Lung	100%	n/a	100%	73.3%	2	80.0%	100%	100%	95.2%	0.5	85.7%	100%	100%	94.1%	86.1%	2.5	-
	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	87.5%	88.9%	100%	94.0%	2.5	100%	100%	n/a	93.6%	1.5	90.9%	93.3%	100%	95.4%	93.8%	4	-
	Upper gastrointestinal	60.0%	75.0%	100%	75.0%	2	n/a	100%	n/a	100%	0	60.0%	87.5%	100%	80.0%	86.2%	2	-
	Urological	47.4%	50.0%	64.3%	43.8%	20.5	100%	94.1%	100%	86.1%	5	67.7%	72.7%	82.1%	73.9%	64.8%	25.5	!
	Urological (Testicular)	n/a	100%	n/a	100%	0	n/a	n/a	n/a	100%	0	n/a	100%	n/a	100%	100%	0	-
	Site not stated	n/a	n/a	n/a	0.0%	1	100%	100%	n/a	100%	0	100%	100%	n/a	100%	66.7%	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

All tumour sites, with the exception of Urology achieved the standard for September. Urology, whilst not compliant with the 85% standard, achieved the best performance all year with the recovery plans in place clearly delivering the required actions.

QUALITY PRIORITIES DASHBOARD

Quarter 2 2017/2018

Patient Safety

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Q2	Q3	Q4	1st Quarter Commentary
1	Reduction in falls (Frailty Quality Plan)	Director of Nursing					There has been an improvement in the falls with harm in Q1 compared to Q1 last year. There has only been a slight reduction in falls with low or no harm, however this could be due to raised awareness and as such an increase in reporting.
2	Antibiotic administration in Sepsis (Sepsis Plan)	Medical Director					56.8% achievement against CQUIN measures in Q1.
3	National Early Warning Score (Sepsis Plan)	Medical Director					70.2% achievement against CQUIN measures in Q1
4	National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)	Divisional Medical Director					Further work is required to report on the WHO checklist compliance across the organisation. In addition to this work is required to identify quantify the number of LoCSIPS required in each speciality and the implementation.

Clinical Effectiveness

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Q2	Q3	Q4	1st 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	Q2	Q3	Q4	1st 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 one area achieving the >30%. Recommendation rates are above the 90% in all areas apart from ED which is at 85%.

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	91.1%	72.0%	94.4%	81.9%	8.6	2.6	11.2	7 – 17.5
Annie Zunz	95.6%	82.3%	106.7%	86.7%	5.9	2.1	8.0	6.5 - 8
Apollo	82.1%	81.4%	84.8%	100.0%	17.1	3.7	20.8	
Jupiter	96.3%	41.2%	97.1%	16.7%	10.7	1.1	11.9	8.5 – 13.5
Mercury	91.5%	52.5%	90.2%	13.3%	6.8	0.8	7.5	8.5 – 13.5
Neptune	89.2%	56.7%	88.2%	6.7%	7.7	0.7	8.4	8.5 – 13.5
NICU	91.4%	-	94.3%	-	12.0	0.0	12.0	
AAU	109.5%	75.4%	108.4%	135.2%	11.3	2.7	13.9	7 - 9
Nell Gwynn	123.4%	90.2%	173.1%	125.6%	5.2	3.8	9.1	6 – 8
David Erskine	121.0%	97.1%	133.3%	93.3%	4.0	2.8	6.8	6 – 7.5
Edgar Horne	114.8%	97.4%	122.2%	96.7%	3.8	3.3	7.1	6 – 7.5
Lord Wigram	105.9%	109.1%	98.9%	122.2%	3.7	3.1	6.8	6.5 – 7.5
St Mary Abbots	119.1%	95.7%	146.6%	188.2%	4.4	2.9	7.3	6 – 7.5
David Evans	74.7%	66.6%	92.8%	108.5%	6.1	2.8	8.9	6 – 7.5
Chelsea Wing	100.8%	59.7%	100.0%	159.9%	7.0	4.3	11.4	
Burns Unit	95.3%	87.5%	96.2%	169.7%	13.3	4.5	17.8	
Ron Johnson	112.1%	126.1%	114.4%	123.3%	5.4	3.2	8.5	6 – 7.5
ICU	100.4%	-	100.0%	-	27.4	0.0	27.4	17.5 - 25
Rainsford Mowlem	84.2%	82.3%	103.3%	92.4%	3.6	2.8	6.4	6 - 8

West Middlesex University Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	90.9%	73.1%	97.1%	94.3%	5.9	1.6	7.5	7 – 17.5
Lampton	100.0%	109.1%	100.0%	113.1%	2.8	2.2	5.1	6 – 7.5
Richmond	93.0%	99.0%	72.8%	65.0%	5.7	3.2	8.9	6 – 7.5
Syon 1	95.4%	117.8%	100.2%	103.4%	3.8	1.8	5.6	6 – 7.5
Syon 2	101.1%	152.3%	98.9%	170.0%	3.3	3.2	6.5	6 – 7.5
Starlight	91.6%	98.8%	101.1%	70.0%	7.3	1.0	8.3	8.5 – 13.5
Kew	79.2%	114.8%	100.0%	208.3%	3.0	4.3	7.3	6 - 8
Crane	76.9%	104.3%	95.6%	193.3%	2.9	3.9	6.9	6 – 7.5
Osterley 1	104.2%	133.2%	96.7%	171.7%	2.7	3.6	6.3	6 – 7.5
Osterley 2	96.4%	121.6%	104.1%	161.7%	4.1	3.7	7.8	6 – 7.5
MAU	92.8%	90.5%	92.2%	90.2%	4.9	2.5	7.5	42985.0
CCU	97.7%	110.6%	100.8%	-	5.4	0.9	6.2	6.5 - 10
Special Care Baby Unit	101.5%	-	100.8%	-	7.4	0.0	7.4	
Marble Hill 1	108.3%	92.2%	101.0%	138.3%	3.4	2.3	5.7	6 - 8
Marble Hill 2	98.4%	129.0%	102.2%	168.3%	2.9	3.5	6.5	5.5 - 7
ITU	101.0%	0.0%	95.6%	-	26.7	0.0	26.7	17.5 - 25

Summary for September 2017

High fill rates on SMA due to the new staffing model for SAU. David Evans showing low fill rates as staffing levels were reduced when elective lists were not fully booked. Due to workload and staff feedback extra HCA used on nights on AAU. David Erskine showing high fill rates due to high RMN usage. Nell Gwynn showing high fill rates to care for patient with a tracheostomy in a side room and additional shifts for Kobler escalation were booked via Nell Gwynne. Low fill rates on the paediatric wards Neptune and Mercury as 12 Paediatric beds were closed for the majority of the month due to low activity.

CHPPD is showing an overly generous amount on Richmond due to bed census data being counted at midnight and therefore not accounting for day surgery activity. Additional HCAs booked to care for confused patients at risk of falls on Kew, Crane, Osterley 1, Marble Hill 2 and Syon 2. High acuity due to increased numbers of patients with NIV on Osterley 2. Extra HCA booked for a patient with mental health needs on Marble Hill 1.

CQUIN Dashboard

September 2017

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. Most of these schemes are 2 year schemes across the 2017-19 contracts; with the exception of NHS e-referrals, which is a 2017/18 only scheme. Senior Responsible Officers and operational leads have been established for all schemes.

Quarter 1 Performance

The quarter 1 reports were submitted at the end of July and the Trust's performance has been verbally confirmed at 100% for NHS England CQUIN schemes and 92% for CCG schemes, subject to final ratification. The only scheme that did not achieve 100% in quarter 1 was the Sepsis CQUIN scheme, which reported partial achievement in line with forecast. Quarter 2 submissions are due at the end of October.

National Schemes

The first two schemes are an extension from the 2016/17 schemes on improving the health and wellbeing of staff, patients and visitors and reducing the impact of serious infections. There is a continued risk to delivery of the Sepsis and anti-microbial resistance scheme, in line with 2016/17 and Q1 delivery, and the Trust is forecasting partial achievement.

There are risks around some of the schemes, particularly where delivery is required to be undertaken jointly with other organisations, such as improving services for people with Mental Health needs presenting at A&E, and with some of the systems and process changes required, for example implementing and improving compliance with NHS e-Referrals and implementation of the Emergency Care Data Set.

Discussions are being held at a North West London Sector level regarding standardising GP advice and guidance systems and developing a roll-out programme across all acute providers.

NHS England Schemes

Three of the schemes are expanded schemes from 2016/17, including the enhanced supportive care, chemotherapy dose banding and dental CQUIN and therefore already have a firm base for extension in 2017/18. There is a potential 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.

The risk to the dose banding scheme due to recent disruption to the Aria electronic prescribing system for chemotherapy has now been resolved.

Final Version

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance Dashboard

Month 6 2017/2018

Integrated Position

Financial Position (£000's)

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	309,357	312,554	3,197
Expenditure	(293,013)	(296,166)	(3,153)
Adjusted EBITDA	16,344	16,388	44
Adjusted EBITDA %	5.283%	5.243%	-0.04%
Interest/Other	(2,628)	(2,592)	36
Depreciation	(8,650)	(8,398)	252
PDC Dividends	(4,750)	(4,750)	0
Other	0	0	0
Trust Deficit	**317**	**649**	**332**

Comments

The Trust is reporting a YTD surplus of £649k which is £332k favourable against the internal plan.

Income is favourable by £3,197k YTD predominantly against NHS clinical income. Activity has deteriorated in M6 however there was a non-recurrent benefit from prior year income following final settlement with commissioners

Pay is adverse by £5,260k year to date, The Trust continues to use bank and agency staff to cover vacancies. Temporary staffing is also used to cover sickness, pressure shifts and additional activity, including unfunded beds in escalation areas on both sites which remain open at month 6.
Under achievement against CIP targets has also contributed to this variance.

Non-pay is £2,107k favourable YTD. Included in this position is an adverse variance against clinical supplies which is mainly activity driven.
The Trust forecast outturn is a surplus of £7.16m which is adverse against plan submitted to NHSI by £4.77m. This is predominantly as a result of slippage on the NICU/ITU capital scheme as the element of planned expenditure to be funded from donations has been deferred to 2018/19. As donations are excluded from the calculation of outturn against control total, the Trust is forecasting a favourable variance of £0.19m against yearend control total. The forecast UORR rating is "1" in line with plan.

Risk rating (year to date)

Use of Resource Rating (UOR)	M03 (Before Override)	M03 (After Override)
Use of Resource Rating	2	2

Comments

Under the Use of Resources Rating (UORR) a "1" is the highest score and a "4" the lowest. The overall score is a simple average of the individual scores however, if any individual score is a "4", an override is applied under which the best score achievable is a "3".

From July NHSI changed the calculation of the Capital Service cover rating adjusting income for capital donations and grants. NHSI adjusted plan for this change

At the end of September, the Trust is performing in line with plan for all areas of measurement except against its agency rating, where YTD expenditure was £10.14m against a ceiling of £9.74m, an adverse variance of £0.40m. As the Trust did not score a "4" in any of its risk ratings, the override does not apply and the Trust scores a UORR rating of "2" in line with plan.

Cost Improvement Programme (CIPs)

Theme	In Month			Year to Date		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Service Developments/Business Cases	35	0	(35)	209	0	(209)
Targeted Specialities	564	487	(77)	3,310	2,833	(477)
Residual % Based Savings	1,110	698	(412)	7,040	5,895	(1,145)
Unidentified	321	0	(321)	918	0	(918)
Trust Total	2,030	1,186	(844)	11,478	8,728	(2,750)

Comments RAG rating

The Trust has achieved YTD CIPs of £8.73m against an internal target of £11.48m, an adverse variance of £2.75m.

The Trust has found it challenging maximising CIP plans within target speciality areas in relation to Care of the Elderly, Paediatrics, Obstetrics & Gynaecology and General Surgery. However new schemes totalling £4.17m have been added to mitigate any risk of underachievement.

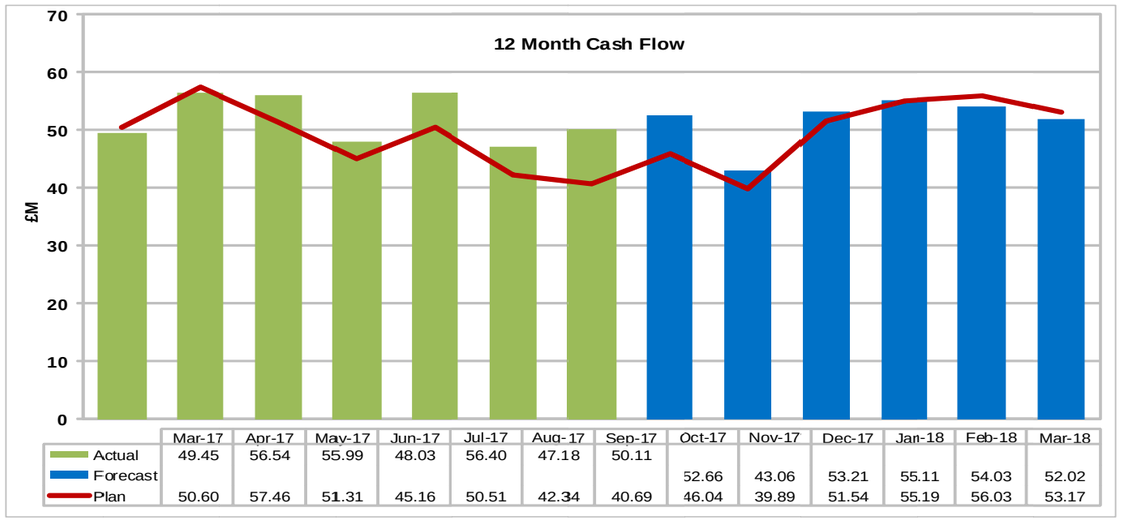
Through new schemes identified the Trust aims to close the gap on unidentified schemes and achieve the target plan of £25.9m.

Cash Flow

Comments RAG rating

The cash balance at the end of month 6 is £50.11m which is £9.42m more than plan of £40.69m. The main drivers of this increase are receipt of £0.27m of additional STF relating to the 2016/17 post accounts reallocation, reduction in opening cash figure compared to plan of £(1.15m), decrease in capital expenditure on a cash basis of £1.42m, cash generated through movements in working capital compared to plan of £14.6m, decrease in PDC drawdown compared to plan £(3m), decrease in loan drawdown compared to plan £(3.2m) and decrease in PDC paid compared to plan £0.67m

The Trust is forecasting to end the year with a cash balance of £52.02m, an adverse variance to plan of £1.15m representing the difference between the closing cash balance at 31st March 2017 and that assumed as the



	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
Actual	49.45	56.54	55.99	48.03	56.40	47.18	50.11						
Forecast								52.66	43.06	53.21	55.11	54.03	52.02
Plan	50.60	57.46	51.31	45.16	50.51	42.34	40.69	46.04	39.89	51.54	55.19	56.03	53.17

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.5.1/Nov/17
REPORT NAME	Winter preparedness - Update
AUTHOR	James Beckett, Divisional Director of Ops, WCHGD Mark Titcomb, Divisional Director of Ops, EMIC Bruno Botelho, Divisional Director of Ops, PC Tina Benson, Hospital Director, WMUH Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To provide visibility to the Quality Committee of priority actions being undertaken for Winter 2017/18
SUMMARY OF REPORT	The Trust is expecting increased Emergency activity from October 2017 through to March 2018. The Quality Committee received the system-wide Winter resilience plan last month, following submission to NHSI via the A&E Delivery Board. Within the CWFT specific winter resilience plan there are 97 actions which will help support delivery of the emergency targets through winter. The attached paper contains the top 15 priority actions which operationally, we believe will have the greatest impact. The delivery of the actions will be monitored through the bed productivity programme and reported through the respective A&E Operational Group. Divisional-specific actions will be monitored via divisional meetings.
KEY RISKS ASSOCIATED	• Activity demand exceeding available capacity • Staffing challenges • Patient & Staff Experience
FINANCIAL IMPLICATIONS	30% of the total STF funding is predicated on the delivery of the A&E 4hr 95% standard by March 2018.
QUALITY IMPLICATIONS	As identified above and within the paper

EQUALITY & DIVERSITY IMPLICATIONS	None identified
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Deliver financial sustainability
DECISION/ ACTION	For the Quality Committee to note and comment on the update.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Winter Planning

1. Purpose.

The purpose of this paper is to describe the high priority actions which will support the delivery of safe and effective care on the Emergency pathway over winter 2017/18.

2. Background.

The Trusts performance during 2017/18 shows an improving trend overall compared with recent years, however the achievement of the 4 hour unscheduled care target (95%) remains challenging.

Winter is historically the most challenging time in terms of performance; it is our expectation that we will continue to strive to deliver against all targets expected of us including the A&E 4 hour target of 95%.

This challenge is set against a context of increasing patient activity and demand, capacity short-falls, increasing number of delayed discharges, poor patient flow, and the knock on impact on elective cancellations, alongside well-rehearsed staffing challenges; all challenges that are not localised to our trust. That said, there is a significant amount of work in admission avoidance in both planned care and EMIC, changes to discharge teams and processes as well as improved close relationships with our community colleagues.

3. Workforce and Staffing

Medical workforce challenges remain within a number of specialties within Planned Care and EMIC. Difficulties in filling vacancies within both the trained and training grade workforces require gaps to be covered by short term staffing measures and the utilisation of external capacity.

Within nursing there has been a move to reduce the establishment gap through filling more posts on a substantive basis and reducing reliance on supplementary staffing. There has also been a continued investment made within the clinical workforce, site management and discharge management to help sustain and enhance capacity.

4. Key Risks

Patient Safety

Evidence suggests that the longer patients wait in the emergency department the greater risk there is to morbidity and mortality. Also boarding (patients remaining in the Accident and Emergency and cared for in the department whilst waiting for a suitable inpatient bed to become available) is likely to increase length of stay, detract from overall patient experience and risk breakdown in communications because of the number of hand offs/transfers involved.

Delayed Discharge

Delayed Discharges result in poor experience and greater risk for the patients concerned and prevents others accessing appropriate care settings for treatment in a timely way. Despite investment, the issue of delayed discharge has remained a key pressure and is likely to increase during the winter period, especially with differing levels of intermediate and community care across the 8 CCG's in the STP footprint.

In addition processes and systems are different for each Trust site causing significant delays to discharge.

Elective Capacity

There is a risk to Elective Care if a harsh winter results in increased numbers of medical and trauma orthopaedic patients. Increased admissions currently compromise patient flow and lead to boarding of patients and delayed discharge. In extreme circumstances this may lead to the cancellation of elective cases, especially at West Middlesex Hospital where the only physical escalation space is day surgery.

In mitigation to this risk the Surgical assessment units on both sites have been re-launched so that the pull of the surgical patients from A&E can happen. There is further work to do to reduce the elective LoS to ensure the flow out of SAU is maintained and close working relationships with site teams cross site are being developed.

Infection Control

The West Middlesex site has already seen one significant, contained, outbreak - this saw over 20 people affected on one ward. Recommendations have been made during this outbreak around improved signage and communication which will be carried forward into this winter.

Winter 2016/17 flu activity rates in England were among the lowest seen in recent years – only rising above the baseline threshold for approximately 6

weeks. The Trust has an Occupational Health Influenza Plan which sets out the target and process for immunising front line health care workers and staff who do not fall into this category.

Finance

There are a number of key risks which will present a major challenge to achieving financial balance and delivering against the relevant performance targets. These include:

- Opening of incremental beds over and above the levels agreed in the Winter Plan
- There are two wards (Rainsford Mowlem and Marble Hill 1) that are open and supported with non-recurring funding. Given that there is no recurring funding source this represents a risk to the organisation.
- STF funding is based on both streaming targets and delivery of 95%
- Use of premium rate staffing solutions such as agency/bank, overtime, to support core vacancies and to provide bridging support to workforce investment plans.

5. Priority Actions.

Area	Action	Site	Lead	Action due date	RAG	Update	Evidence/Information
EMIC	Deliver ECIST action plan	Both	Mark Titcomb	Various			
	Creation of a Clinical Decisions Unit	WM	Mark Titcomb	5th October 2017		Works complete	
	Reviewing junior doctors rota to improve substantive out of hours cover	Both	Mark Titcomb	30th November 2017			
	Explore ICRS in reach to A&E/AAU	WM	Tina Benson	1st December 2017		HRCH and CWFT working on a plan to present to commissioners	
	Support Home First model with early identification of suitable patients. Band 7 or above regular review of all patients with stay of over 14 days. Senior therapy presence in ED to ensure early therapy intervention	Both	Mark Titcomb/ Tina Benson	Throughout winter period			
	Weekly Top 20 long stay meeting – hospital site specific. To monitor internal and external delivery of discharge	Both	Mark Titcomb/ Tina Benson	2nd October 2017		Started at WM& CW	
	HomeFirst pathway to be promoted, increasing the numbers of patients utilising this according to plan	Both	Mark Titcomb	1st November 2017		Work with community partners capacity to deliver increased numbers	

PLANNED CARE	Reduce length of stay for #NOF patients post op	Both	Bruno Botelho	1st December 2017			
	Reviewing CePOD Trauma provision to support a discharge home to return approach	WM	Bruno Botelho	1st November 2017			
	Work with therapies and NWL MSK to improve LOS of long stay joint patients	CW	Bruno Botelho	1st November 2017			
	Implementation of the hand e-referral system	CW	Bruno Botelho	Sep-17			
	Review out of hours capacity for Imaging	Both	Bruno Botelho	31st October 2017		Urgent and emergency capacity over OOH periods is satisfactory	
WCHGD	Significant improvement in recruitment of junior medical staff to populate both acute rotas	Both	James Beckett	31st October 2017			
	Additional reg in PED	WM	James Beckett	31st October 2017		Shifts currently being covered	
	Increase starlight establishment to 20 (with B&A flex to 24)	WM	James Beckett	31st October 2017		Recruitment challenges currently, division looking at options to encourage recruitment. New band 7 appointed.	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.5.2/Nov/17
REPORT NAME	Workforce Performance Report - Month 6 - 2017/18
AUTHOR	Keith Loveridge. Director of human resources and organisational development
LEAD	Keith Loveridge. Director of human resources and organisational development
PURPOSE	The workforce performance report highlights current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	**Staff in Post** In September we employed 5223 whole time equivalent (WTE) people on substantive contracts, 31 more than last month. Taking into account bank and agency workers our WTE workforce was 6292. **Turnover** Our voluntary turnover rate was 15.5%, 0.2% lower than last month. Voluntary turnover, which stood at 16.4% in April 2017, has dropped every month since. Voluntary turnover is 18.0% at Chelsea and 10.9% at West Middlesex. **Vacancies** Our general vacancy rate for September was 13.2%, which is 1.2% lower than August. The vacancy rate is 14.9% at West Middlesex and 12.3% at Chelsea. Our professional group with the highest vacancy rate is qualified nurses and midwives at 16.5%. Taking into account leavers and starters the Trust made a net gain of nine qualified nurses and midwives in September. **Sickness Absence** Sickness absence increased to 3.2%, up from 2.6% last month. **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 85.6% against our target of 90%. A new electronic system that will improve both staff access to our electronic core learning modules and our ability to capture and report core training completion will be implemented in November. **Staff Career Development** In September 41 staff were promoted. In addition, 58 employees were acting up to a higher grade. Over the last year 8.0% of current staff have been promoted to a higher grade. **Performance and Development Reviews** From 1 April 2017 everyone is required to have their PDR in a set period, starting with the most senior staff. 80% of people in bands 7-8a roles had received their PDRS by September 2017, compared to our 90% target. At least 90% of people in band 2-6 roles should have

	had a PDR by the end of December 2017. The PDR compliance rate for all non-medical staff since April 2017 increased by 14% in September and now stands at 33.3% The rolling annual appraisal rate for medical staff was 80.1%.
KEY RISKS ASSOCIATED	The need to reduce vacancy and retention rates.
FINANCIAL IMPLICATIONS	Costs associated with high vacancy and retention rates and high reliance on agency workers.
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability.
EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and develop integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For noting

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the Workforce Development Committee

Month 6 - September 2017

Workforce Performance Report Oct ‘16 - Sep ‘17

Performance Summary

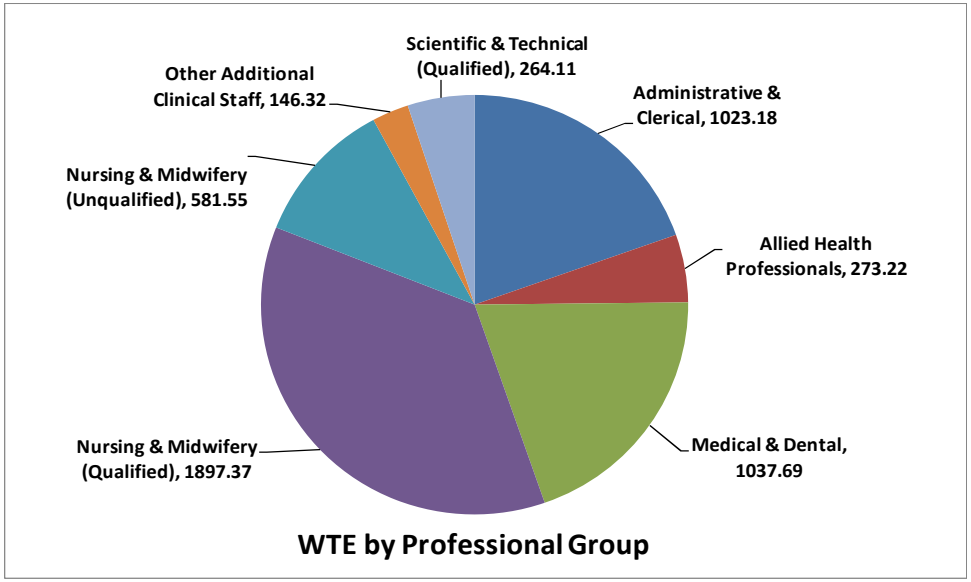
Summary of overall performance is set out below

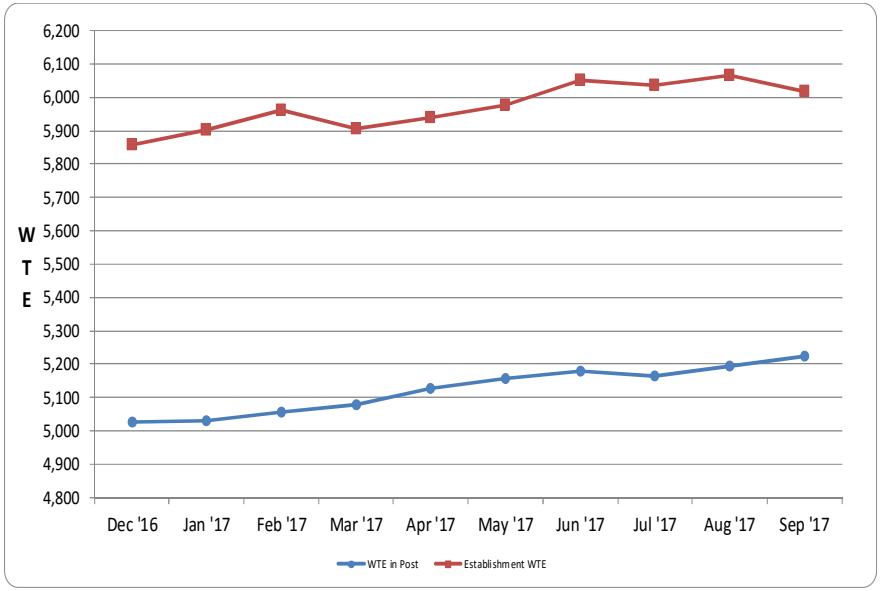
Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	Target	Change
5	Vacancy	Vacancy rate has decreased by 1.2%	13.2%	14.4%	13.2%	10.0%	↘
6	Turnover	Turnover has decreased by 0.2%		20.9%	20.7%		↘
7	Voluntary Turnover	Voluntary turnover has decreased by 0.2%	15.9%	15.7%	15.5%	13.0%	↘
10	Sickness	Sickness has increased by 0.5%	2.8%	2.7%	3.2%	3.3%	↗
15	Temporary Staffing Usage (FTE)	Temporary Staffing % usage has decreased by 0.5% this month		17.5%	17.0%		↘
17	Core Training	Core Training compliance has decreased by 0.6%	87.0%	86.2%	85.6%	90.0%	↘
18	Staff PDR	The percentage of staff who have had a PDR since 1st April has increased by 13.5%	74.9%	19.8%	33.3%	90.0%	↗

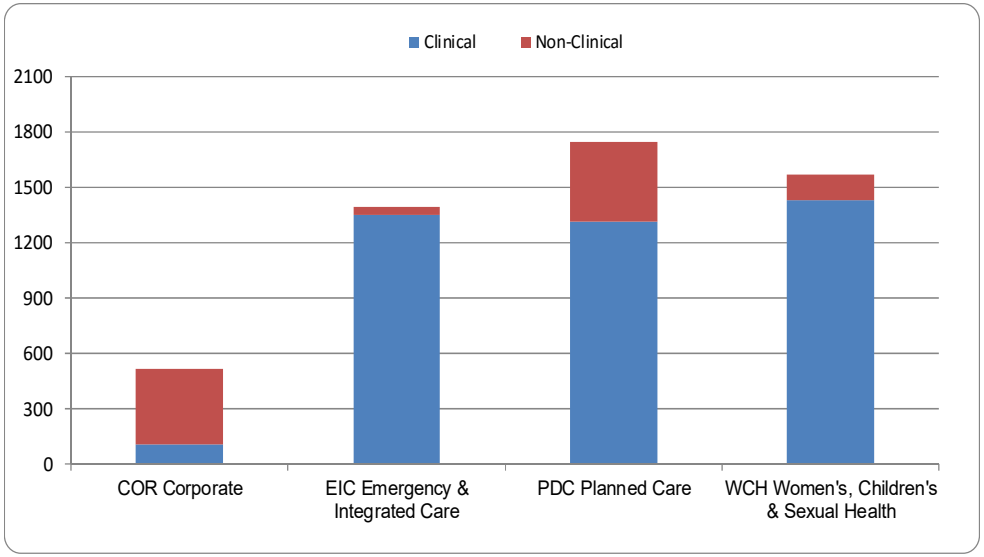
In addition to the information in this report, the trust monitors its workforce data by protected characteristics as defined by the Equality Act. To view the most recent annual workforce equality report please click this link http://connect/departments-and-mini-sites/equality-diversity/

Current Staffing Profile

The data below displays the current staffing profile of the Trust







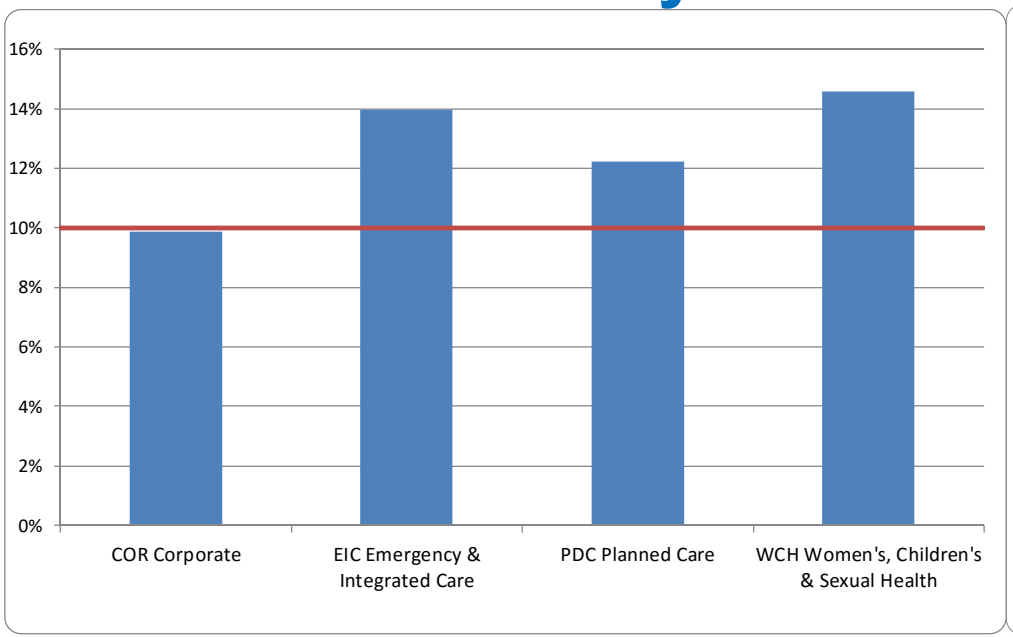
COMMENTARY

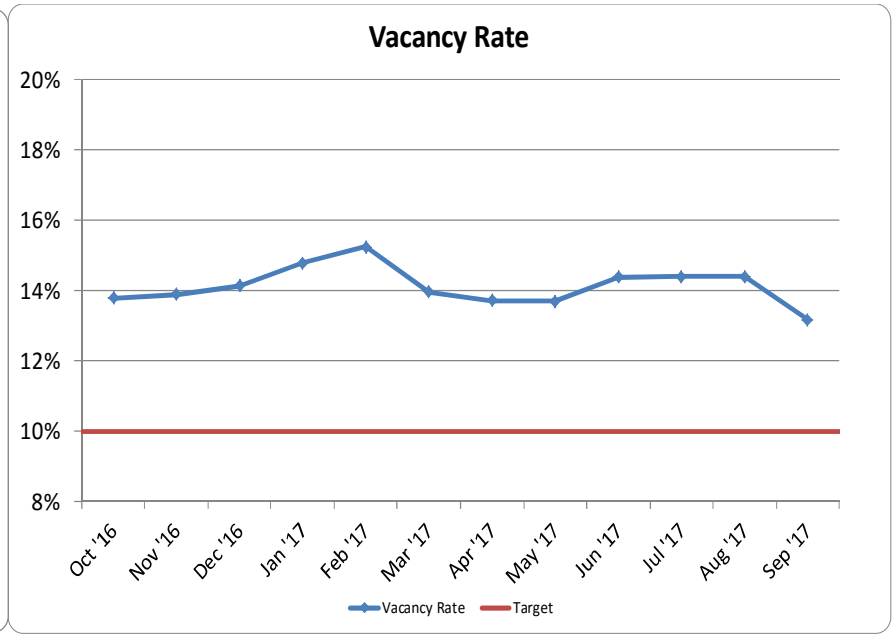
The Trust currently employs 5715 people working a whole time equivalent of 5223 which is 31 WTE more than August.

There were 1777 WTE staff assigned to the West Middlesex site and 3447 WTE to Chelsea.

The largest professional group at the Trust is Qualified Nursing & Midwifery employing 1897 WTE.

Section 1: Vacancy Rates





Vacancies by Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	17.7%	11.4%	11.2%	9.9%	↘
EIC Emergency & Integrated Care	18.4%	19.3%	16.6%	14.0%	↘
PDC Planned Care	11.0%	10.8%	13.6%	12.2%	↘
WCH Women's, Children's & Sexual Health	13.2%	14.6%	14.3%	14.6%	↗
Whole Trust	**14.4%**	**14.4%**	**14.4%**	**13.2%**	↘
West Mid Site	**16.7%**	**17.4%**	**16.8%**	**14.9%**	↘
Chelsea Site	**13.2%**	**12.8%**	**13.1%**	**12.3%**	↘

Vacancies by Professional Group	Jun '17	Jul '17	Aug '17	Sep '17	Trend
Administrative & Clerical	16.3%	10.2%	16.0%	11.8%	↘
Allied Health Professionals	16.4%	19.1%	11.9%	10.8%	↘
Medical & Dental	9.4%	14.2%	11.0%	8.8%	↘
Nursing & Midwifery (Qualified)	13.9%	15.5%	16.8%	16.5%	↘
Nursing & Midwifery (Unqualified)	20.0%	17.6%	16.1%	16.0%	↘
Other Additional Clinical Staff	20.5%	16.1%	10.9%	7.5%	↘
Scientific & Technical (Qualified)	9.6%	8.9%	2.4%	8.1%	↗
Total	**14.4%**	**14.4%**	**14.4%**	**13.2%**	↘

COMMENTARY

The vacancy rate has decreased by 1.2% in September.

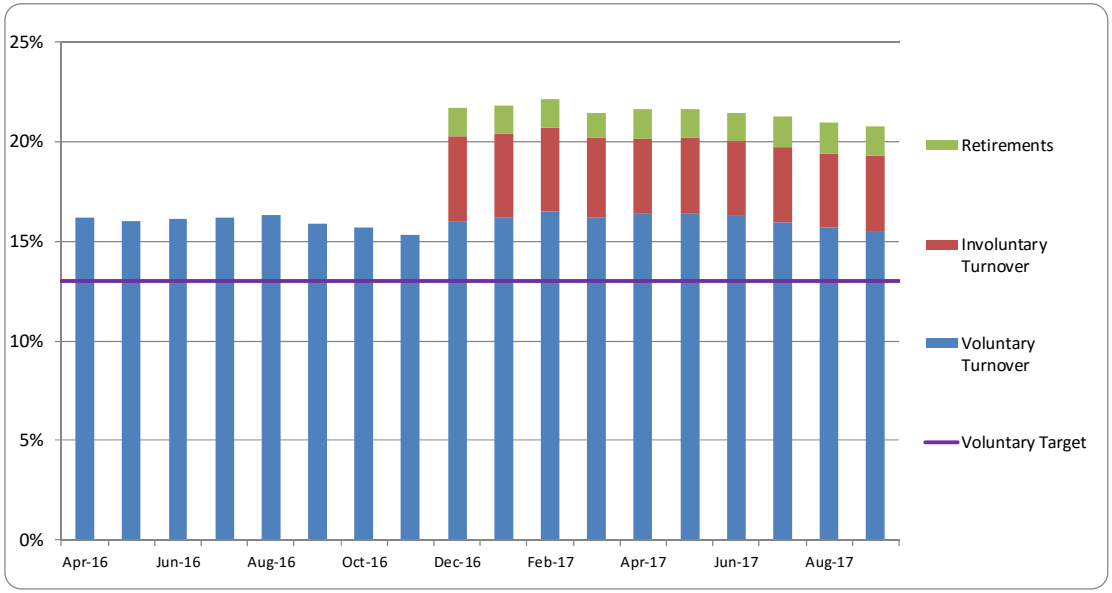
Work to reconcile ESR to the ledger is nearing completion with Divisions now in the process of signing off their ESR Establishments as final adjustments are made.

The vacancy rate is currently highest in Qualified Nursing & Midwifery professional group at 16.5%.

The Women's, Children's & Sexual Health Division has the highest vacancy rate at 14.6%.

Section 2a: Gross Turnover

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



COMMENTARY

The total trust turnover rate has decreased by 0.2% to 20.7% this month. In the last 12 months there have been 1047 leavers.

The Trust has received initial data from the responses to the new exit surveys, this information will enable more focused work on retention.

	Gross Turnover				
Division	**Jun '17**	**Jul '17**	**Aug '17**	**Sep '17**	**Trend**
COR Corporate	24.3%	24.4%	23.5%	23.4%	↘
EIC Emergency & Integrated Care	22.2%	21.7%	20.3%	19.8%	↘
PDC Planned Care	22.0%	21.5%	21.9%	21.7%	↘
WCH Women's, Children's & Sexual Health	19.4%	19.7%	19.7%	19.8%	↗
Whole Trust	**21.4%**	**21.2%**	**20.9%**	**20.7%**	↘

	Gross Turnover				
Professional Group	**Jun '17**	**Jul '17**	**Aug '17**	**Sep '17**	**Trend**
Administrative & Clerical	22.0%	21.8%	21.5%	20.9%	↘
Allied Health Professionals	18.2%	18.8%	20.1%	21.0%	↗
Medical & Dental	16.3%	16.2%	14.3%	14.3%	↔
Nursing & Midwifery (Qualified)	20.2%	20.0%	20.3%	20.4%	↗
Nursing & Midwifery (Unqualified)	28.3%	21.8%	20.2%	19.6%	↘
Other Additional Clinical Staff	15.1%	27.4%	26.4%	27.7%	↗
Scientific & Technical (Qualified)	38.1%	35.3%	34.9%	33.7%	↘
Whole Trust	**21.4%**	**21.2%**	**20.9%**	**20.7%**	↘

Section 2b: Voluntary Turnover

	Voluntary Turnover						Other Turnover Sep 2017	
Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend	Leavers HC	In-voluntary	Retirement
COR Corporate	19.9%	20.4%	19.6%	19.0%	↘	94	3.2%	1.2%
EIC Emergency & Integrated Care	18.9%	18.3%	17.6%	16.9%	↘	214	2.3%	0.6%
PDC Planned Care	14.0%	13.4%	13.7%	13.5%	↘	223	6.3%	1.9%
WCH Women's, Children's & Sexual Health	15.4%	15.3%	15.1%	15.5%	↗	253	2.5%	1.7%
Whole Trust	**16.3%**	**16.0%**	**15.7%**	**15.5%**	↘	**784**	**3.8%**	**1.4%**
West Mid Site	**12.5%**	**12.1%**	**12.3%**	**10.9%**	↘	**190**		
Chelsea Site	**18.3%**	**18.0%**	**17.5%**	**18.0%**	↗	**594**		

	Voluntary Turnover						Other Turnover Sep 2017	
Professional Group	Jun '17	Jul '17	Aug '17	Sep '17	Trend	Leavers HC	In-voluntary	Retirement
Administrative & Clerical	16.0%	15.9%	15.5%	15.0%	↘	155	4.1%	1.8%
Allied Health Professionals	15.9%	16.6%	18.2%	19.0%	↗	59	1.9%	0.0%
Medical & Dental	5.7%	5.3%	4.1%	4.2%	↗	24	8.4%	1.7%
Nursing & Midwifery (Qualified)	17.9%	17.6%	18.0%	17.9%	↘	371	0.9%	1.6%
Nursing & Midwifery (Unqualified)	24.9%	18.7%	17.2%	16.9%	↘	102	1.8%	0.8%
Other Additional Clinical Staff	10.7%	19.9%	18.9%	18.9%	↔	30	7.5%	1.3%
Scientific & Technical (Qualified)	19.0%	16.3%	15.0%	14.5%	↘	43	17.9%	1.3%
Whole Trust	**16.3%**	**16.0%**	**15.7%**	**15.5%**	↘	**784**	**3.8%**	**1.4%**

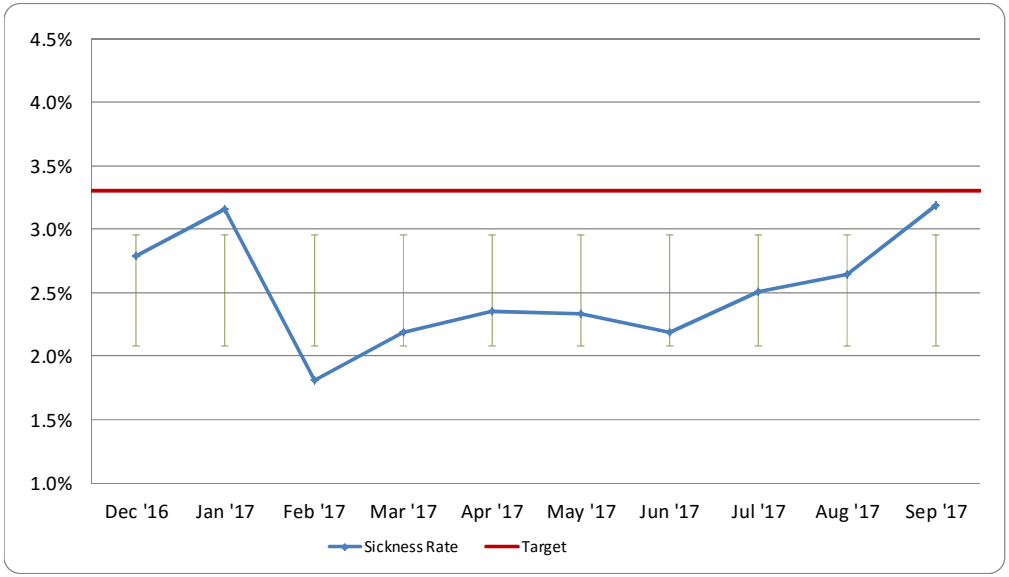
Service	Average Staff in Post HC	Leavers HC	Voluntary Turnover Rate
John Hunter Clinic - CW	42	18	43.4%
Oncology - CW	21	9	42.9%
Paediatric Starlight Unit - WM	44	17	38.6%
Osterley 1 - WM	29	10	34.5%
Acute Assessment Unit - CW	71	23	32.4%

COMMENTARY

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.

Section 3: Sickness

The chart below shows performance over the last 10 months, the tables by Division and Staff Group are below.



COMMENTARY

The monthly sickness absence rate is at 3.2% in September which is an increase of 0.5% on the previous month.

A new process for collecting sickness data for staff not on HealthRoster has been implemented. As the new process becomes embedded the sickness rate is expected to increase further as accuracy improves.

The table below lists the services with the highest sickness absence percentage during September 2017. 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	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	1.0%	1.7%	2.2%	2.7%	
EIC Emergency & Integrated Care	2.0%	2.2%	2.0%	2.6%	
PDC Planned Care	2.6%	2.7%	2.8%	3.4%	
WCH Women's, Children's & Sexual Health	2.3%	2.8%	3.2%	3.5%	
Whole Trust Monthly %	**2.2%**	**2.5%**	**2.6%**	**3.2%**	
Whole Trust Annual Rolling %	**2.6%**	**2.5%**	**2.6%**		

Sickness by Professional Group	Jun '17	Jul '17	Aug '17	Sep '17	Trend
Administrative & Clerical	2.2%	3.0%	3.6%	3.9%	
Allied Health Professionals	3.2%	1.6%	1.7%	1.8%	
Medical & Dental	0.5%	0.4%	0.5%	0.7%	
Nursing & Midwifery (Qualified)	2.4%	3.0%	2.7%	3.5%	
Nursing & Midwifery (Unqualified)	3.7%	4.2%	4.8%	5.4%	
Other Additional Clinical Staff	2.1%	1.6%	3.2%	3.6%	
Scientific & Technical (Qualified)	2.7%	2.8%	2.8%	3.8%	
Total	**2.2%**	**2.5%**	**2.6%**	**3.2%**	

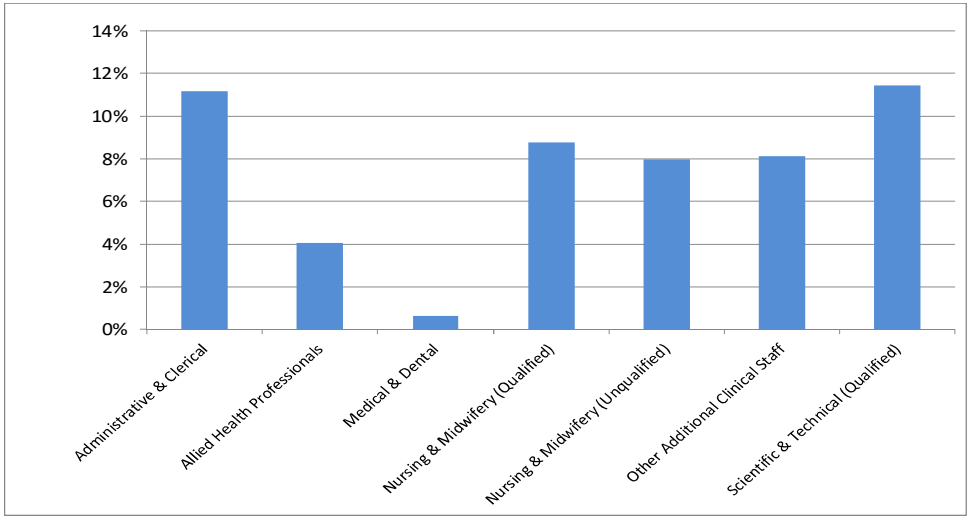
Service	Staff in Post WTE	Sickness WTE Days Lost	Sickness %
John Hunter Clinic - CW	36.89	151.60	13.3%
Syon 2 - WM	26.73	107.60	13.2%
Saint Mary Abbots - CW	26.11	62.07	8.5%
Nell Gwynne - CW	34.15	83.56	8.5%
Pharmacy - CW	97.48	191.73	6.5%

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S13 Cold, Cough, Flu - Influenza	28.76%
S25 Gastrointestinal problems	18.12%
S12 Other musculoskeletal problems	7.88%
S10 Anxiety/stress/depression/other psychiatric illnesses	7.47%
S16 Headache / migraine	6.24%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	16.26%
S12 Other musculoskeletal problems	11.78%
S25 Gastrointestinal problems	11.17%
S13 Cold, Cough, Flu - Influenza	11.05%
S26 Genitourinary & gynaecological disorders	7.25%

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 September 41 staff were promoted, there were 121 new starters to the Trust (excluding Doctors in Training). In addition, 58 employees were acting up to a higher grade.

Over the last year 8.0% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Directorates.

The Scientific & Technical staff group have the highest promotion rate at 11.5% followed by at Admin & Clerical 11.2%.

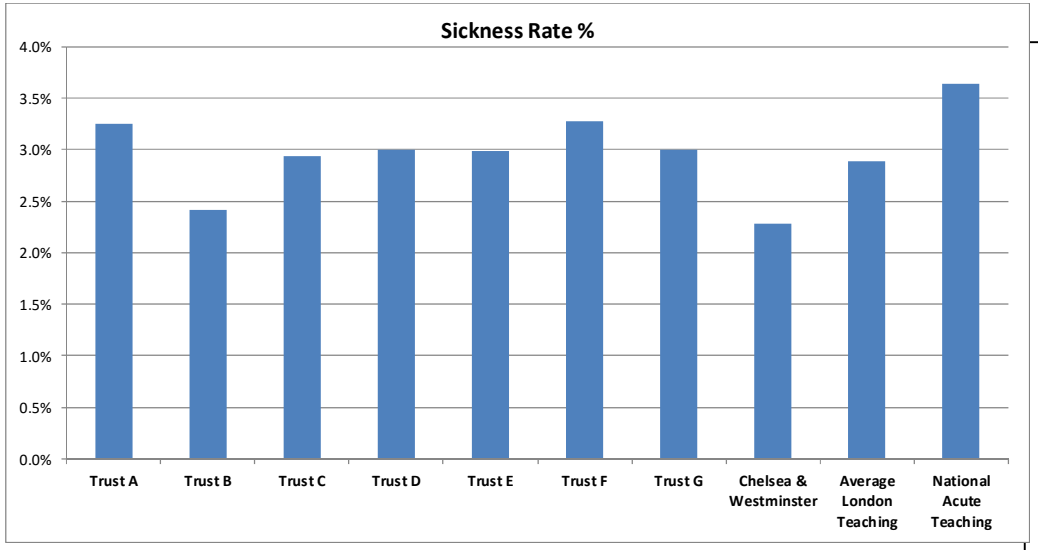
	Monthly No. of Promotions				
Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	10	7	0	6	↗
EIC Emergency & Integrated Care	9	13	6	10	↗
PDC Planned Care	9	10	15	12	↘
WCH Women's, Children's & Sexual Health	18	14	11	13	↗
Whole Trust Promotions	**46**	**44**	**32**	**41**	↗
New Starters (Excludes Doctors in Training)	**81**	**98**	**72**	**121**	↗

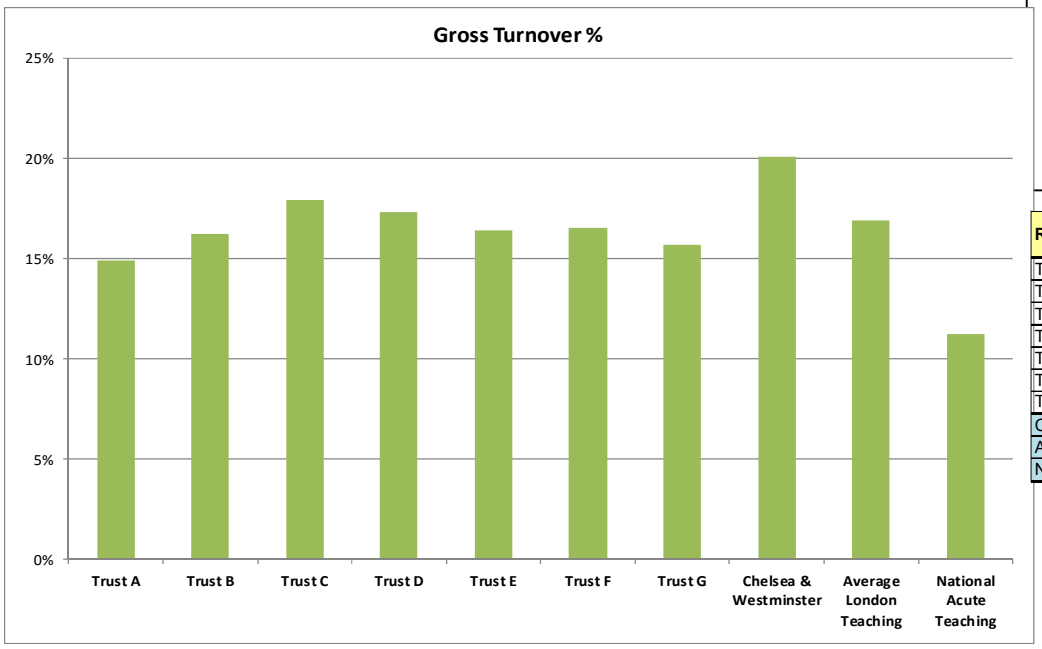
Division	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up
COR Corporate	377	34	9.0%	7
EIC Emergency & Integrated Care	985	89	9.0%	16
PDC Planned Care	1351	95	7.0%	21
WCH Women's, Children's & Sexual Health	1309	104	7.9%	14
Whole Trust	**4022**	**322**	**8.0%**	**58**
New Starters (Excludes Doctors in Training)		**1145**		

	No. of Promotions				
Professional Group	Jun '17	Jul '17	Aug '17	Sep '17	Trend
Administrative & Clerical	21	13	10	11	↗
Allied Health Professionals	1	1	2	0	↘
Medical & Dental	1	0	3	3	↔
Nursing & Midwifery (Qualified)	15	21	10	14	↗
Nursing & Midwifery (Unqualified)	6	6	4	8	↗
Other Additional Clinical Staff	1	2	1	1	↔
Scientific & Technical (Qualified)	1	1	2	4	↗
Whole Trust	**46**	**44**	**32**	**41**	↗

Professional Group	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up
Administrative & Clerical	798	89	11.2%	21
Allied Health Professionals	246	10	4.1%	12
Medical & Dental	487	3	0.6%	1
Nursing & Midwifery (Qualified)	1677	147	8.8%	18
Nursing & Midwifery (Unqualified)	476	38	8.0%	0
Other Additional Clinical Staff	111	9	8.1%	1
Scientific & Technical (Qualified)	227	26	11.5%	5
Whole Trust	**4022**	**322**	**8.0%**	**58**

Section 5: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from Jun'17 which is the most recent available on iView. Compared to other Acute teaching trusts in London, Chelwest had a rate lower than average at 2.3%. 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 June.

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 the highest turnover in the group (12 months to end July). 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 9% 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	14.89%	84.60%	3.25%
Trust B	16.22%	83.35%	2.41%
Trust C	17.90%	81.82%	2.94%
Trust D	17.29%	82.64%	3.00%
Trust E	16.42%	83.48%	2.98%
Trust F	16.54%	83.21%	3.28%
Trust G	15.70%	84.05%	3.00%
Chelsea & Westminster	20.06%	79.70%	2.28%
Average London Teaching	16.88%	82.86%	2.89%
National Acute Teaching	11.26%	88.56%	3.64%

Section 6: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	104.9	80.5	86.1	84.1	↘
EIC Emergency & Integrated Care	978.3	1006.7	1003.7	1004.7	↗
PDC Planned Care	690.6	703.5	713.1	708.5	↘
WCH Women's, Children's & Sexual Health	1159.1	1160.5	1155.4	1168.8	↗
Total	**2933.0**	**2951.3**	**2958.3**	**2966.0**	↗

Nursing Staff in Post WTE

Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	71.6	73.3	75.6	75.1	↘
EIC Emergency & Integrated Care	788.5	790.7	797.2	810.6	↗
PDC Planned Care	615.1	606.1	602.2	614.0	↗
WCH Women's, Children's & Sexual Health	1007.9	1009.2	990.2	979.2	↘
Total	**2483.1**	**2479.3**	**2465.2**	**2478.9**	↗

Nursing Vacancy Rate

Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	31.8%	9.0%	12.2%	10.7%	↘
EIC Emergency & Integrated Care	19.4%	21.5%	20.6%	19.3%	↘
PDC Planned Care	10.9%	13.8%	15.5%	13.3%	↘
WCH Women's, Children's & Sexual Health	13.0%	13.0%	14.3%	16.2%	↗
Total	**15.3%**	**16.0%**	**16.7%**	**16.4%**	↘

Nursing Sickness Rates

Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	0.8%	2.2%	1.7%	2.3%	↗
EIC Emergency & Integrated Care	2.3%	2.9%	2.6%	3.7%	↗
PDC Planned Care	3.1%	3.3%	2.9%	3.9%	↗
WCH Women's, Children's & Sexual Health	2.9%	3.6%	4.0%	4.4%	↗
Total	**2.7%**	**3.3%**	**3.2%**	**4.0%**	↗

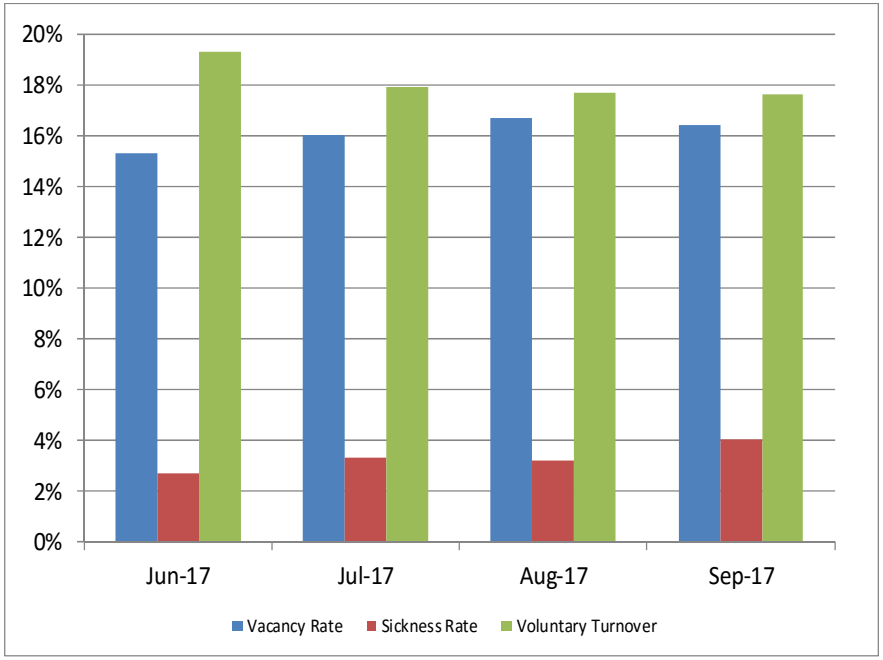
Nursing Voluntary Turnover

Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	16.27%	18.80%	17.89%	19.23%	↗
EIC Emergency & Integrated Care	22.22%	20.00%	19.09%	17.54%	↘
PDC Planned Care	17.67%	16.53%	17.26%	17.03%	↘
WCH Women's, Children's & Sexual Health	18.31%	17.09%	16.90%	17.95%	↗
Total	**19.3%**	**17.9%**	**17.7%**	**17.6%**	↘
West Mid Site				**14.7%**	↗
Chelsea Site				**23.0%**	↗

COMMENTARY

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

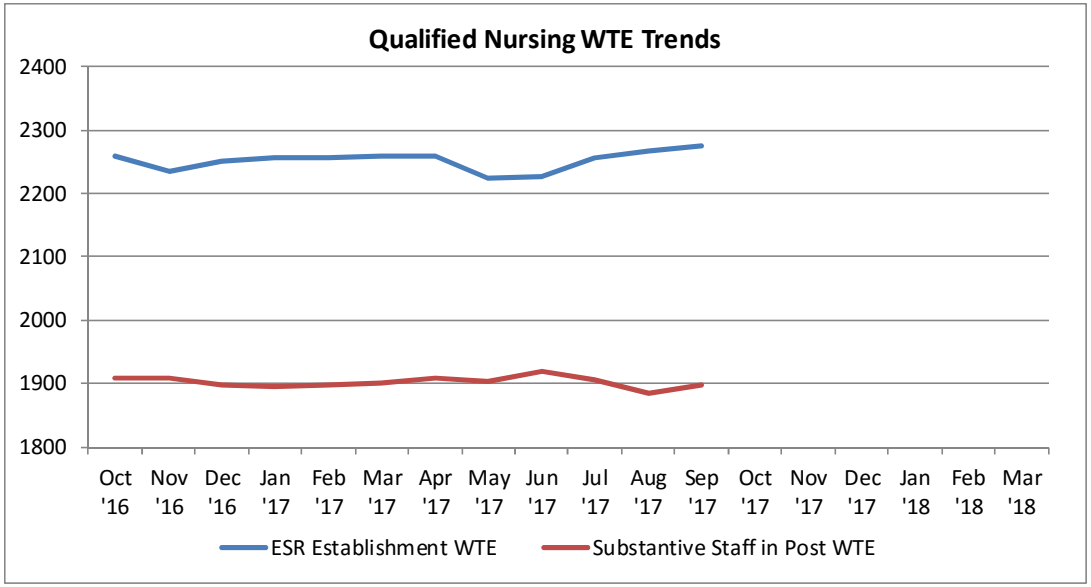
The nursing workforce has increased by 14 WTE in September.



Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

Measure	Jan '17	Feb '17	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
ESR Establishment WTE	2255.5	2256.4	2257.5	2258.6	2223.7	2227.0	2255.0	2266.1	2273.5						
Substantive Staff in Post WTE	1894.3	1896.8	1900.4	1907.3	1904.0	1918.1	1905.6	1884.5	1897.4						
Contractual Vacancies WTE	361.1	359.6	357.1	351.2	319.7	309.0	349.4	381.6	376.1						
Vacancy Rate %	16.01%	15.94%	15.82%	15.55%	14.38%	13.87%	15.49%	16.84%	16.54%						
Actual/Planned Leavers Per Month*	25	20	28	41	36	29	31	44	31	32	32	32	32	32	32
Actual/Planned New Starters**	26	23	33	58	32	38	19	19	39	57	57	57	57	57	57
Pipeline: Agreed Start Dates										47	18	4	6	2	2
Pipeline: WTE No Agreed Start Date										144 - with no agreed start date					

* Based on Gross Turnover of 20%



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.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the nursing and midwifery vacancy rate down to 10% by March 2018.

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

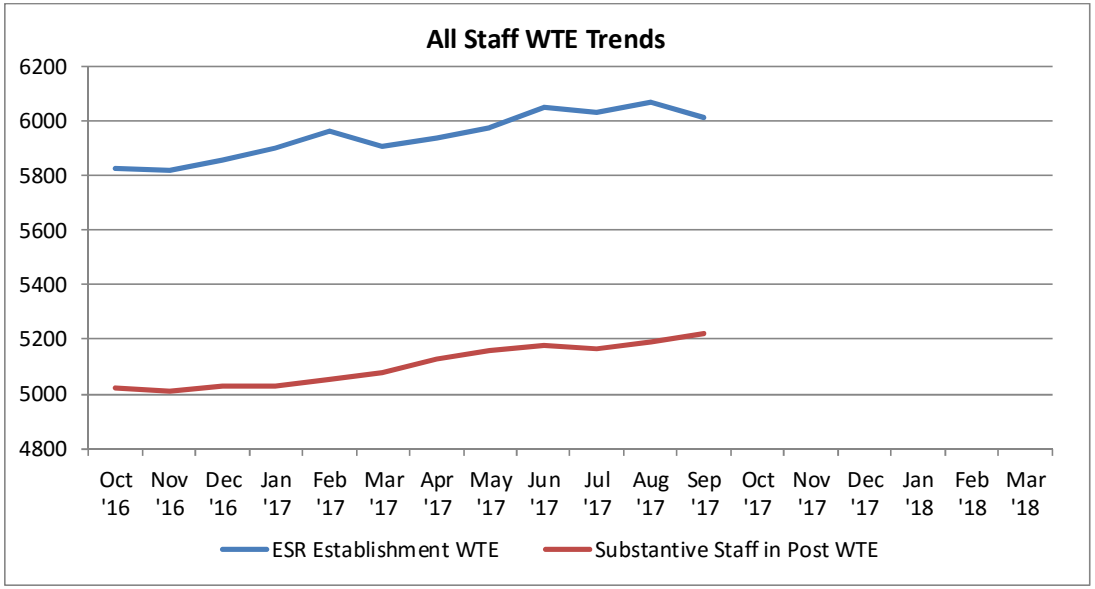
Section 8: All Staff Recruitment Pipeline

Measure	Jan '17	Feb '17	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
ESR Establishment WTE[1]	5901.5	5963.8	5905.0	5940.6	5975.5	6051.6	6035.3	6067.5	6016.5						
Substantive Staff in Post WTE	5028.8	5054.8	5080.2	5125.6	5156.2	5180.3	5165.7	5193.0	5223.4						
Contractual Vacancies WTE	872.7	909.0	824.8	814.9	819.2	871.3	869.5	874.5	793.1						
Vacancy Rate %	14.79%	15.24%	13.97%	13.72%	13.71%	14.40%	14.41%	14.41%	13.18%						
Actual/Planned Leavers Per Month[2]	76	56	67	90	95	63	96	280	128	87	87	87	87	87	87
Actual/Planned New Starters[3]	118	120	127	151	130	86	94	252	179	125	125	125	125	125	125
Pipeline: Agreed Start Dates										81	37	9	8	3	2
Pipeline: WTE No Agreed Start Date										365 - 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 March 2018



COMMENTARY

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

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the vacancy rate down to 10% by March 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	Jun '17	Jul '17	Aug '17	Sep '17	YTD
Actual Spend	£279,295	£128,916	£181,449	£175,460	£1,181,590
Target Spend	£241,308	£241,308	£241,308	£241,308	£1,447,848
Variance	£37,987	-£112,392	-£59,859	-£65,848	-£266,258
Variance %	15.7%	-46.6%	-24.8%	-27.3%	-18.4%

EIC Emergency & Integrated Care

Emergency & Integrated Care	Jun '17	Jul '17	Aug '17	Sep '17	YTD
Actual Spend	£759,878	£751,397	£715,007	£708,043	£4,323,208
Target Spend	£583,420	£583,420	£583,420	£583,420	£3,500,520
Variance	£176,458	£167,977	£131,587	£124,623	£822,688
Variance %	30.2%	28.8%	22.6%	21.4%	23.5%

PDC Planned Care

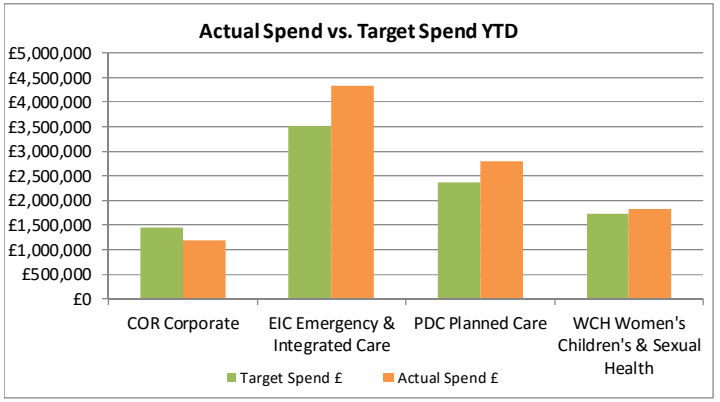
Planned Care	Jun '17	Jul '17	Aug '17	Sep '17	YTD
Actual Spend	£586,530	£398,385	£539,858	£349,986	£2,786,238
Target Spend	£392,436	£392,436	£392,436	£392,436	£2,354,616
Variance	£194,094	£5,949	£147,422	-£42,450	£431,622
Variance %	49.5%	1.5%	37.6%	-10.8%	18.3%

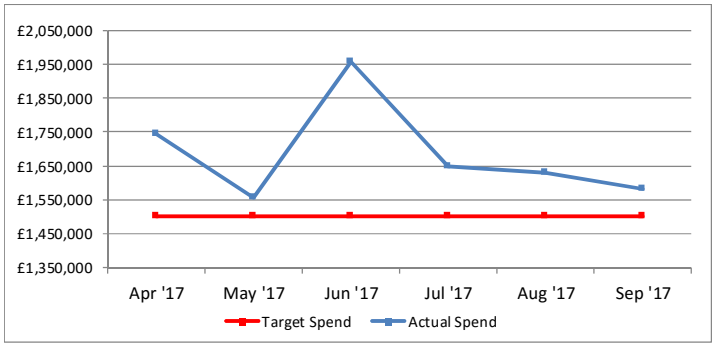
WCH Women's, Children's & Sexual Health

Women's, Children's & Sexual Health	Jun '17	Jul '17	Aug '17	Sep '17	YTD
Actual Spend	£332,285	£370,971	£194,186	£348,533	£1,828,727
Target Spend	£285,918	£285,918	£285,918	£285,918	£1,715,508
Variance	£46,367	£85,053	-£91,732	£62,615	£113,219
Variance %	16.2%	29.7%	-32.1%	21.9%	6.6%

Clinical Divisions and Corporate Areas

Trust	Jun '17	Jul '17	Aug '17	Sep '17	YTD
Actual Spend	£1,957,988	£1,649,669	£1,630,500	£1,582,022	£10,119,763
Target Spend	£1,503,082	£1,503,082	£1,503,082	£1,503,082	£9,018,492
Variance	£454,906	£146,587	£127,418	£78,940	£240,387
Variance %	30.3%	9.8%	8.5%	5.3%	12.2%





COMMENTARY

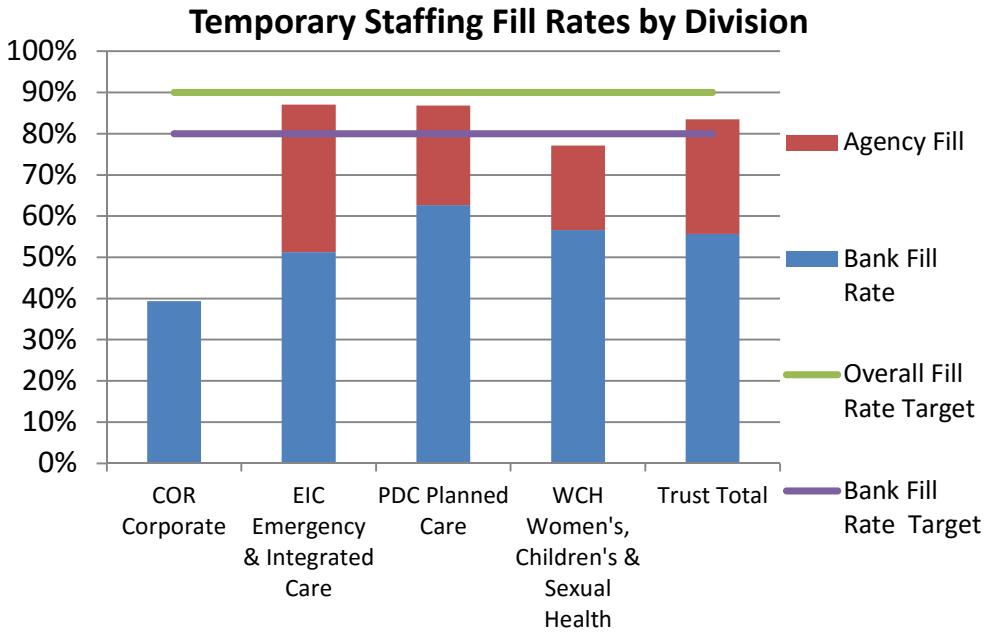
These figures show the Trust agency spend by Division compared to the spend ceilings which have been set for 17/18.

In Month 6, the Emergency & Integrated Care Division spent 21.4% more than the target for the month.

Overall, the only Division below it's YTD target is Corporate, by 18.4%.

** 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 for N&M



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.

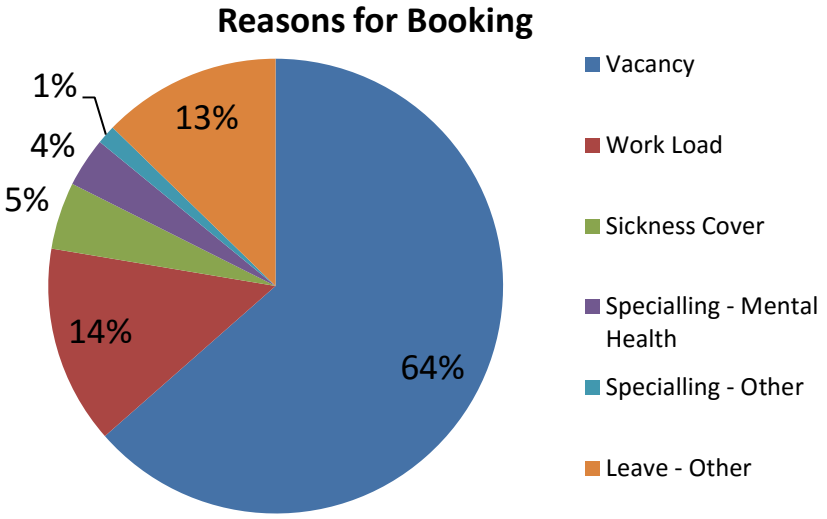
The Overall Fill Rate was 83.5% this month which 1.5% lower than August. The Bank Fill Rate was reported at 55.7% which is 3.5% lower than the previous month.

The EIC Division is currently meeting the demand for temporary staff most effectively.

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

The pie chart shows a breakdown of the reasons given for requesting bank shifts in September. 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	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	86.0%	89.3%	98.5%	39.4%	↘
EIC Emergency & Integrated Care	84.1%	87.2%	86.6%	87.1%	↗
PDC Planned Care	88.8%	88.3%	85.6%	86.8%	↗
WCH Women's, Children's & Sexual Health	85.0%	85.3%	81.6%	77.1%	↘
Whole Trust	**85.5%**	**87.0%**	**85.0%**	**83.5%**	↘

Bank Fill Rate % by Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	86.0%	89.3%	98.5%	39.4%	↘
EIC Emergency & Integrated Care	50.7%	52.8%	53.4%	51.2%	↘
PDC Planned Care	62.8%	63.4%	63.1%	62.6%	↘
WCH Women's, Children's & Sexual Health	64.9%	64.3%	62.9%	56.6%	↘
Whole Trust	**57.7%**	**58.9%**	**59.2%**	**55.7%**	↘

Section 11: Core Training

Core Training Topic	Aug '17	Sep '17	Trend
Basic Life Support	79.0	82.0	↗
Equality, Diversity and Human Rights	87.0	87.0	↔
Fire	88.0	86.0	↘
Health & Safety	87.0	86.0	↘
Inanimate Loads (M&H L1)	89.0	89.0	↔
Infection Control (Hand Hyg)	88.0	87.0	↘
Information Governance	86.0	84.0	↘
Patient Handling (M&H L2)	83.0	83.0	↔
Safeguarding Adults Level 1	89.0	89.0	↔
Safeguarding Children Level 1	89.0	88.0	↘
Safeguarding Children Level 2	81.0	81.0	↔
Safeguarding Children Level 3	86.0	84.0	↘

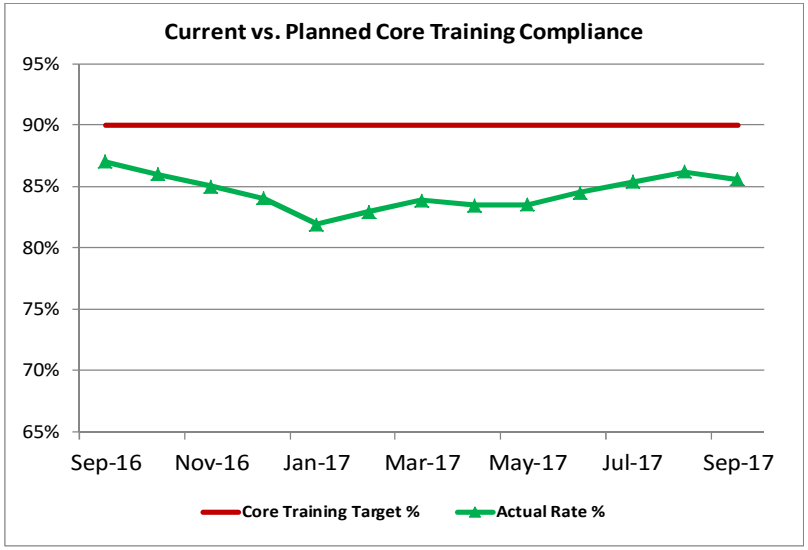
Core Training Compliance % by Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	82.0%	86.0%	88.0%	89.0%	↗
EIC Emergency & Integrated Care	85.0%	83.0%	84.0%	83.0%	↘
PDC Planned Care	85.0%	83.0%	84.0%	85.0%	↗
WCH Women's Children's & Sexual Health	84.0%	86.0%	87.0%	86.0%	↘
Whole Trust	**84.0%**	**85.0%**	**86.0%**	**86.0%**	↔

COMMENTARY

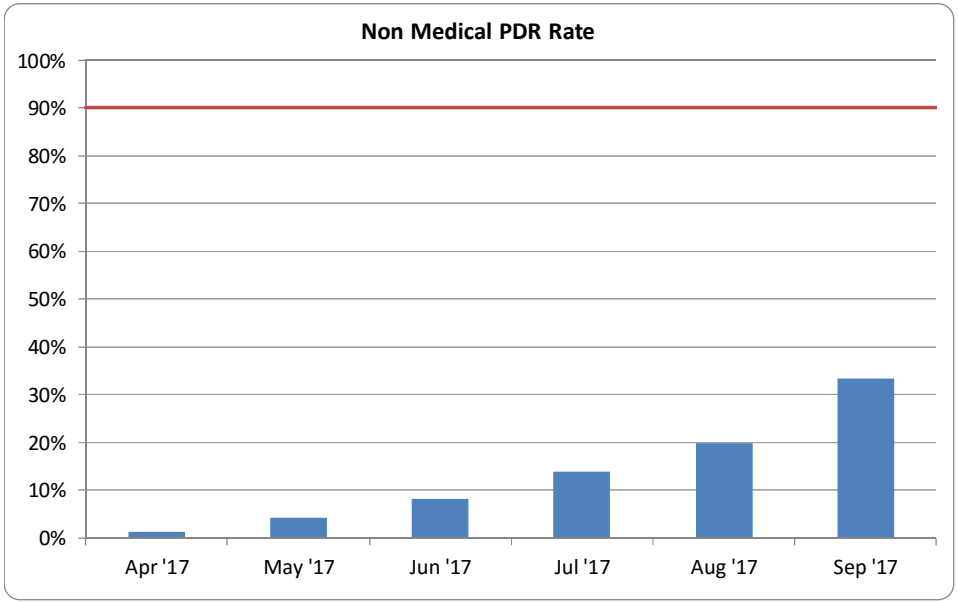
At the end of September compliance at 86% was maintained, however in some subject areas there was a dip in the compliance figures. This is where staff lose their compliance and then take time to redo the eLearning or book on to training.

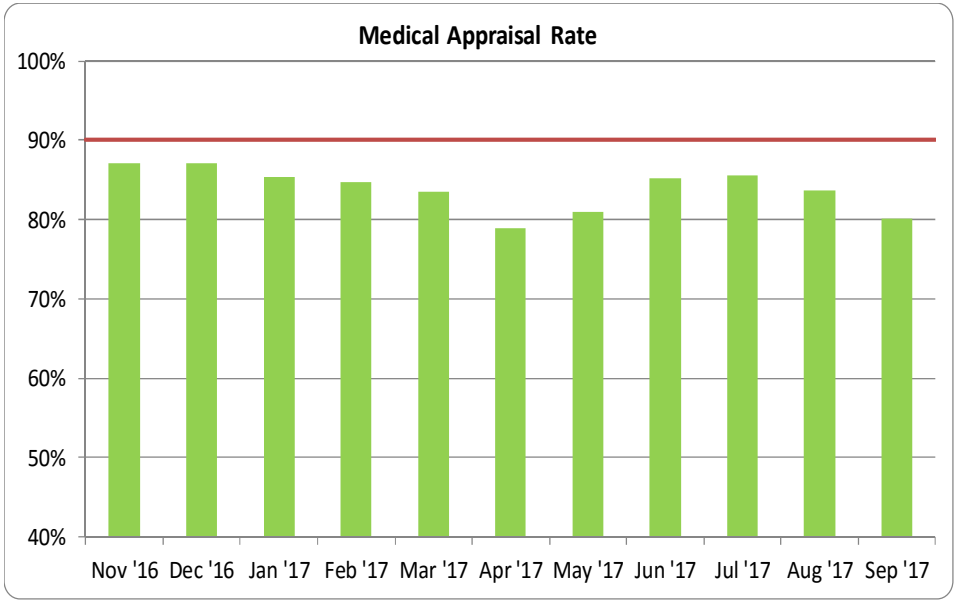
Reports are sent to managers fortnightly when staff are expired and when due to expire (in the following three months) and we are working to enable reminders on the Qlikview reports so managers are aware of when they are due to expire. All managers are asked to ensure staff undertake their refreshers before they expire.

Our new eLearning portal will go live in November, which will enable staff to access from trust and personal computers as well as tablet and mobile devices.



Section 12: Performance & Development Reviews





PDRs From April '17

Division	Band Group	%	Division	Band Group	%
COR	Band 2-6	25.4%	PDC	Band 2-6	20.3%
	Band 7-8b	75.0%		Band 7-8b	76.6%
	Band 8c +	100.0%		Band 8c +	100.0%
Corporate		**49.2%**	**PDC Planned Care**		**29.1%**
EIC	Band 2-6	23.9%	WCH	Band 2-6	15.4%
	Band 7-8b	83.5%		Band 7-8b	78.5%
	Band 8c +	83.3%		Band 8c +	100.0%
EIC Emergency & Integrated Care		**38.0%**	**WCH Women's, Children's & SH**		**28.3%**
Band Totals			**Band 2-6**	**Band 7-8b**	**Band 8c +**
			20.08%	78.8%	98.6%
Trust Total			**33.3%**		

Medical Appraisals

Medical Appraisals by Division	Jun '17	Jul '17	Aug '17	Sep '17	Trend
COR Corporate	100.0%	100.0%	-	-	-
EIC Emergency & Integrated Care	86.9%	89.8%	84.4%	80.8%	↘
PDC Planned Care	85.9%	83.8%	85.9%	80.2%	↘
WCH Women's, Children's & Sexual Health	83.3%	84.4%	81.0%	79.6%	↘
Whole Trust	**85.2%**	**85.6%**	**83.7%**	**80.1%**	↘

Non-Medical Commentary

From 1 April 2017 everyone is required to have their PDR in a set period, starting first with the most senior staff. Staff in bands 7 and above should all have had a PDR by the end of September and those in bands 2-6 are due to be completed by the end of December. The PDR compliance rate has increased by 13.5% in September.

Medical Commentary

The appraisal rate for medical staff was 80.1%, 3.6% less than last month.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	2.6/Nov/17
REPORT NAME	Learning from Deaths
AUTHOR	Alex Bolton, Safety Learning Programme Manager
LEAD	Shân Jones, Director of Quality Improvement
PURPOSE	This paper updates the Board on the process compliance and key metrics from mortality review.
SUMMARY OF REPORT	Metrics from mortality review are providing a rich source of learning; review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG). The Trust aims to review 80% of all mortality cases within 2 months of death. For cases occurring within Q1 2017/18 the Trust wide closure rate was 62%, for cases in Q2 closure rate is currently 45%. 50 cases of suboptimal care have been identified in the last 12 months (01/10/2016 and 30/09/2017) via the mortality review process. 6 cases of suboptimal care were identified in Q1 17/18, 4 cases have been identified for cases occurring within Q2. Identified sub-optimal care cases have been discussed at local specialty Morbidity and Mortality (M&M) meeting and themes have been identified at MSG. Key themes include: recognition and response to deteriorating patient; establishment and agreement of ceilings of care. Metrics are outlined in appendix B, Learning from Deaths Dashboard.
KEY RISKS ASSOCIATED	Engagement: Lack of full engagement with process of recording mortality reviews within the centralised database impacting quality of output and potential missed opportunities to learn / improve.
FINANCIAL IMPLICATIONS	Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
QUALITY IMPLICATIONS	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.

EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Deliver high quality patient centred care
DECISION/ ACTION	The Quality Committee is asked to note and comment on report

Learning from Deaths

1. Background

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

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

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

2. Relative risk

Crude mortality should not be used to compare risk between the sites; crude rates are influenced by differences in population demographics, services provided and intermediate / community care provision in the surrounding areas. The Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHMI) are used by the Mortality Surveillance Group to compare relative mortality risk.

At the Chelsea and Westminster Hospital (CW) site the overall relative risk of mortality within the 12-month period to June 2017 was 71.2 (64.8-78.2); this is below the expected range. At the West Middlesex University Hospital (WM) site the relative risk of mortality was 95 (88.8-101.6); this is within the expected national range.

3. Crude rate

Crude mortality rates are reported to the Mortality Surveillance Group to support trend recognition and resource allocation.

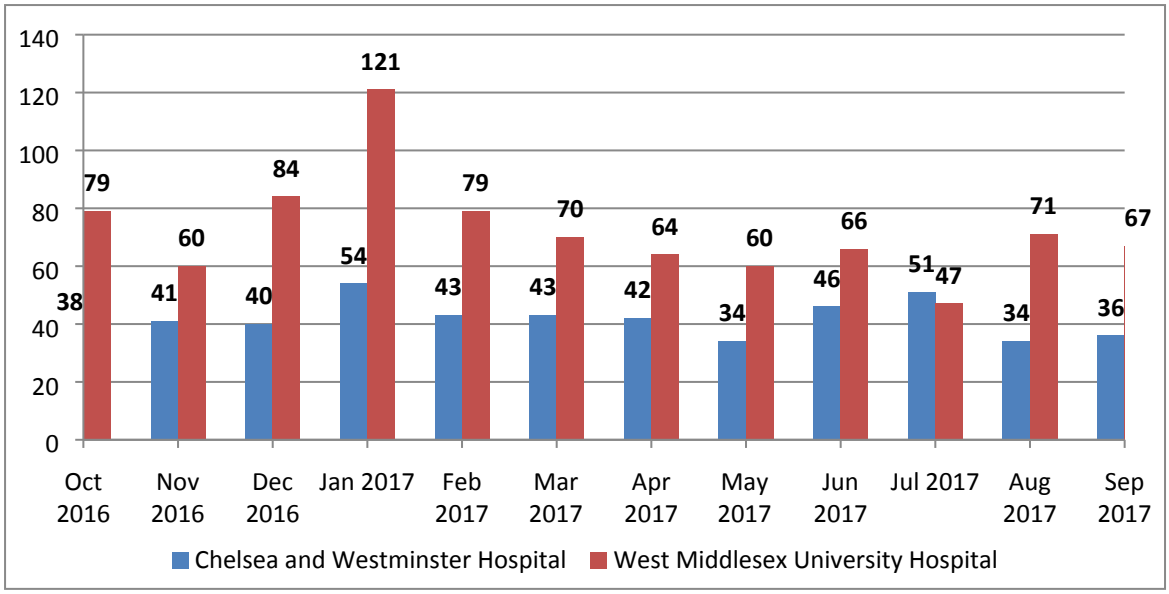


Fig 1: Mortality cases by site and month, October 2016 – September 2017

4. Review completion rates

4.1. Closure target

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

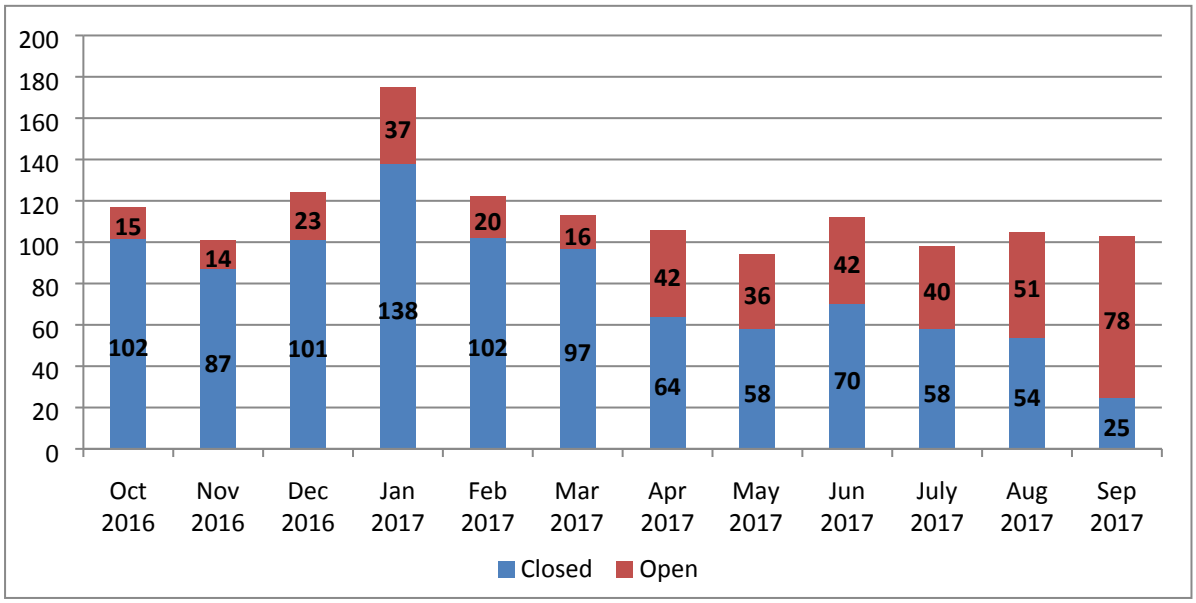


Fig 2: Open and Closed mortality cases by month, October 2016 – September 2017

1370 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period; of these 956 (70%) have been reviewed by the named consultant (or nominated colleague) and closed following M&M/MDT.

	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Total
Total	342	410	312	306	1370
open	52	73	120	169	414
closed	290	337	192	137	956
%	85%	82%	62%	45%	70%

Table 1: Cases by financial quarter, October 2016 – September 2017

Total closure rate by Division for last 12 months:

- Emergency and Integrated Care: 72%
- Planned Care: 70%
- Women's, Children's, HIV, GUM and Dermatology: 46%

Closure below target has been highlighted at the Mortality Surveillance Group, actions to improve closure rate:

- Divisional Medical Directors supporting the engagement of clinical teams
- Divisional Mortality Review groups established within PCD and EIC
- Director of patient safety review of M&M/MDT arrangements
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- WCHGD leads engaging clinical teams to fully transition from legacy mortality review recording arrangements to new process.

Sub-optimal care

Following review cases are graded using the Confidential Enquiry into Stillbirth and Deaths in Infancy scoring system:

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

Where cases are graded as CESDI 2 or 3 Serious Incident investigations are commenced.

50 cases of suboptimal care have been identified in the last 12 months (01/10/2016 and 30/09/2017) via mortality review process. Assurance that all sub-optimal care has been reviewed / identified via this route is partially limited due to sub-target closure rate.

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3
EIC	99	2	1	0
PCD	25	1	0	0
WCHGD	9	0	0	0
Total	**133**	**3**	**1**	**0**

Tab 2: Closed mortality cases by CESDI grade, Q2 2017/18

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3
EIC	149	4	0	0
PCD	28	1	1	0
WCHGD	9	0	0	0
Total	**186**	**5**	**1**	**0**

Tab 3: Closed mortality cases by CESDI grade, Q1 2017/18

Acute Medicine and anaesthetics / ITU are the key specialties identifying areas for improvement in the care provided via the mortality review process; the specialties have identified 26% and 24% of all suboptimal care cases respectively. These specialties are within the top three areas for crude mortality and receive patients with complex needs. Both specialties have regular M&Ms and are proactively seeking improvement opportunities via review.

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

Review groups seek to identify the reasons for the outcome, if the outcome could have been prevented / better managed and make recommendations for further action required. Reviews are themed to support the identification of overarching trends

The key themes across both sites link to;

- The recognition, escalation and response to deteriorating patients
- Establishing and sharing ceilings of care discussions

5. Learning / Engagement

Specialty mortality review groups (M&Ms / MDTs) are intended to provide an open learning environment where clinical teams can discuss expectations, outcomes, concerns and potential improvements with multi-disciplinary / multi-professional colleagues. These groups are steering local learning and ensuring teams are aware of all cases within their remit and the importance of mortality review.

Sub-optimal care cases and review completion rates are discussed at Divisional Mortality Review Groups currently operating within Emergency and Integrated Care and Planned Care Division. These groups are open to a broad cross section of the Division but members are intended to represent all specialties (Service Director / Leads) so key messages can be cascaded back to local groups. Divisional learning will also be supported through the inclusion of mortality metrics within the Divisional Quality Boards agenda. Women's, Children's, HIV/GUM and Dermatology Division have a range of risk / governance / M&M meetings where mortality is discussed.

Key themes and learning from the mortality review process are monitored by the Trust wide Mortality Surveillance Group; the group is attended by the Divisional Medical Directors (or nominated representative) who supports and steers delivery of the mortality review process within their areas. Key messages are cascaded from DMD through divisional management teams.

Multiple different communication channels have been used to cascade learning and engage teams in the mortality review process. A communication strategy is being developed by the Mortality Surveillance Group to bring together key learning opportunities and ensure a coordinated approach to cascade.

6. Conclusion

The outcome of mortality review is providing a rich source of learning but closure rates below 80% target are limiting assurance that sub-optimal care is being identified and responded to appropriately.

The key actions that support the work of the Mortality Surveillance Group in response to learning from deaths are outlined in appendix A.

Appendix A – Mortality management plan

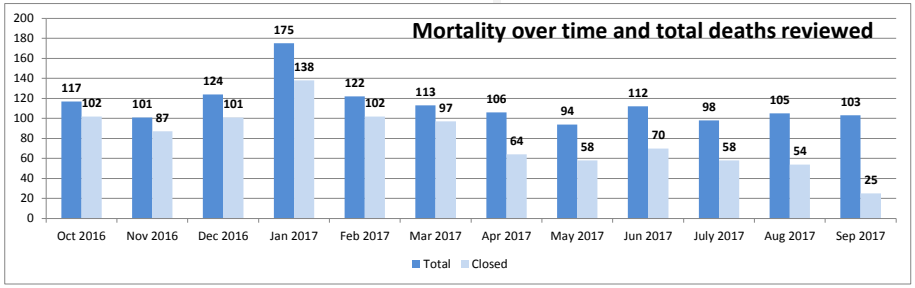
Activity	Date	Evidence	Lead	Closed
Crude mortality rates: Critically examine crude mortality rates as compared to activity, admitting diagnosis, comorbidities, patient demographics, type of admission and procedures / services provided and other metrics used within HSMR and SHMI to provide assurance that trends and risk profile is identified and understood.	**01/10/2016**	**Monthly reporting to MSG**	**Giles Rolph**	**Closed**
Dr foster data used to identify mortality alerts; process in place to undertaking clinical coding review for data validation and implement clinical review of outcomes.	**11/09/2017**	**Reports to MSG**	**Giles Rolph**	**Closed**
Review of suboptimal care by time and day as compared with staffing and activity levels	**07/08/17**	**Report to MSG**	**Alex Bolton**	**Closed**
Review and revise the Early Warning Score Policy	**31/10/17**		**Vanessa Sloane**	**Open**
Introduction of Safety Huddles in Maternity	**1/1/18**		**Nick Wales**	**Open**
Revise Hospital at Night handover	**16/10/17**	**Site specific proforma introduced. Reports to Hospital 247 Board**	**Roger Chinn**	**Closed**
Transfer guidance to be developed from SCBU to Starlight Ward	**30/11/17**		**Elizabeth Eyre**	**Open**
Palliative care provision at WestMid site increased				**Closed**
Provision of additional clinical site manager and SHO at WestMid site	**01/03/2017**	**Substantive post created August 2017**	**Dilys Lai**	**Closed**
Triangulation of mortality and incident learning	**05/07/2017**	**Paper to Patient Safety**	**Alex Bolton**	**Closed**

Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, 2017/18
Report produced: 24th October 2017

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

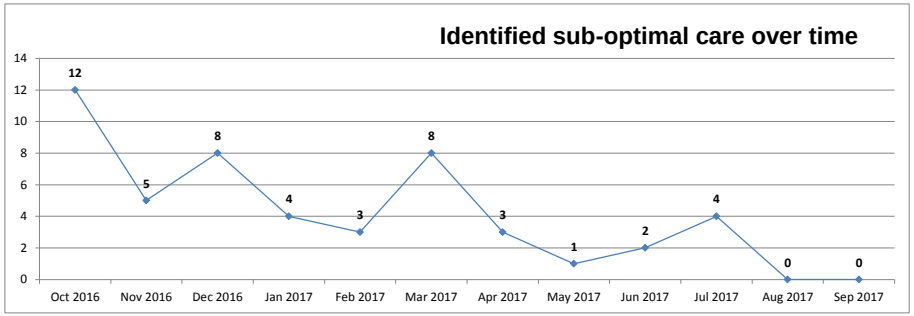
Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)
103	105	25	54	0	0
This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]
306	312	137	192	4	6
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
618	#	329	#	10	#



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

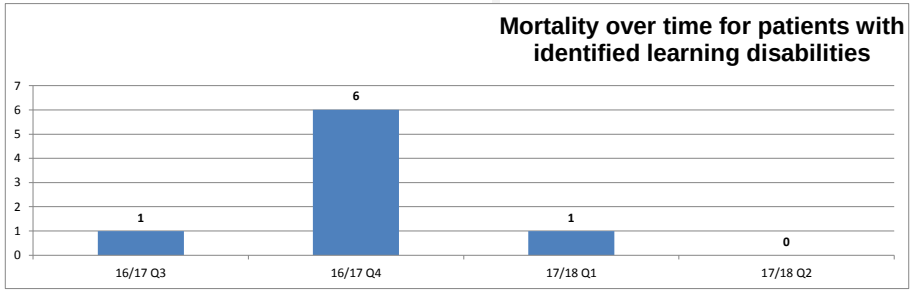
Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome		Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)	
This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)
0	0	0	0	0	0
This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]
3	5	1	1	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
8	#	2	#	0	#



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

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

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)	This Month (Sept)	Last Month (Aug)
0	0	0	0	0	0
This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]	This Quarter [Q2]	Last Quarter [Q1]
0	1	0	1	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
1	#	1	#	0	#



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	3.1/Nov/17
REPORT NAME	Volunteering Strategy Implementation Update
AUTHOR	Rachael Allsop, Head of Volunteering Services
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To provide the board with an update on the implementation of the volunteering strategy for ChelWest (following the volunteering strategy paper that was presented at May's board meeting of this year).
SUMMARY OF REPORT	This report highlights what has been achieved, current difficulties and future priorities.
KEY RISKS ASSOCIATED	Risks due to lack of implementation, resulting in suboptimal use of volunteers across the trust.
FINANCIAL IMPLICATIONS	None directly. Applications being made to charities for funding
QUALITY IMPLICATIONS	Potential to improve patient experience and increase staff satisfaction.
EQUALITY & DIVERSITY IMPLICATIONS	Volunteering process to encourage a diverse range of volunteers.
LINK TO OBJECTIVES	• high quality patient centred care • Be the employer of choice • Delivering better care at lower cost • Improved communication within and outside our organisation • Delivery of our key strategic programmes
DECISION/ ACTION	The board is asked to note the report to suggest any further improvement.

Volunteering Strategy Update

Board meeting – 2 November 2017

Rachael Allsop
Head of Volunteering Services

What has been happening over the last 6 months?

1. Strategic Development – Wide Audience Engagement
2. Improving Infrastructure – Leadership and Managerial Capacity
3. Improving Infrastructure – Facilities
4. Improving the Recruitment Process
5. Developing Volunteering Roles
6. Developing Volunteering Opportunities
7. Future Focus
8. Summary

1. Strategic Development – Wide Audience Engagement

- 15 Presentations to departments across both sites
- Engagement with ‘all charities’ – strong partnership with CW+
- Visits to 2 exemplar sites
- Developing local partnerships with
  - Imperial college
  - Chelsea FC Academy
- Developing national partnerships through HelpForce
  - Pilot site status
  - Deloitte job roles workshop
  - Health Education England (training)
  - Kings Fund (evaluation and impact assessment)
- Bid submitted to fund ‘Young Volunteers Programme’

2. Infrastructure - Leadership and Managerial Capacity

Posts now recruited to and main priorities

Head of Volunteer Services (0.5 from May 17) Rachael Allsop

- Develop volunteering
- Finalise scope of project
- Create necessary Organisation and infrastructure
- Reviewing and streamlining systems processes
- Service improvement/ re-design

Volunteer Services Project Manager (from October 17) Sherene Kiely

- Develop project plan
- Lead on implementation
- Implement engagement strategy
- Implement on-going evaluation (HelpForce model to be used)

Volunteer Services Administrator (from October 17) Alasdair Gordon-Macleod

- Processing volunteer applications and arranging interview dates
- Responding to queries from volunteers
- Managing delays to recruitment, chasing reference requests DBS applications and occupational health clearance

3. Infrastructure - Facilities

Long term

- Prime location identified within new 'Community Hubs' on both sites

Short Term

- Temporary accommodation within CW+

IT infrastructure is currently being improved

Lack of IT infrastructure has led to two main issues

1. An inadequate volunteer recruitment process
2. Lack of a purpose fit database for volunteer records

Volunteer services are working on solutions for both of these issues

4. Improving the Recruitment Process

Current Process

- Not fit for ChelWest's ambition to recruit 900 volunteers in the next three years
- 27 week average processing time
- Paper driven bureaucratic process (6 forms)
- Delays outwith the volunteering service eg. OH and DBS

TRAC Recruitment System

- - Forms are replaces by 'tick box' proformas
- Ambition to reduce processing time to 6 weeks
- Automated messages will chase outstanding documentation
- improved volunteer recruitment experience

NB: Currently 58 applicants in process (9 weeks)

5. Developing Volunteering Roles

4 broad roles have been identified in the first instance

Administrative Volunteer

Roles vary between departments but will routinely include photocopying, data entry, record keeping, telephone contact, filing etc.

Ward Helpers

Support patients through conversation, reading to them and collecting items from the shop. Engaging patients in activities and supporting staff organised activity groups

Paediatric/ Maternity Volunteers

Support young patients by offering art and craft play, activities and story-telling in clinic waiting areas and in-patient wards. Maternity volunteers assist with breast feeding and cuddling babies

Emergency Department Volunteer

Offering practical and emotional support. Tasks include providing drinks, befriending patients, conducting the Family and Friends test, tidying waiting areas and sitting with patients and/or relatives who are anxious

6. Developing Volunteering Opportunities

- Further work to engage nursing staff and therapists in role development is being undertaken
- A generic competency framework is being developed using the ChelWest “PROUD” values
- Specific role based competencies are being developed
- Induction training is being aligned with the ChelWest employee approach

7. Future Focus

November

- Infrastructure, securing a base and email inbox, landline
- Pilot the use of the TRAC system to automate recruitment
- Produce detailed project plan for the next 6 months
- Engage with the current volunteers to develop a community of interest

December

- Roll out the use of TRAC
- Role development with pilot wards to be ramped up
- Explore the use of ESR as the purpose fit database
- Redraft the volunteering policy
- Defining objectives and KPIs in line with HelpForce approach

7. Future Focus Continued

January
- Develop advertising and marketing campaign
- Migrate volunteers to the new Trust induction system
- If ESR is fit for purpose, develop it as the volunteers' database solution
- Recruit to the Young Volunteers Programme Manager post

February
- Migrate current volunteer files to database solution
- Testing new HelpForce interventions

March
- Create volunteer retention and recognition schemes to include rewards, certificate and possibly events
- Audit of volunteer satisfaction

8. Summary

- Good progress has been made in the ‘set up phase’ of the service
- Strategic development is more advanced then operational progress
- Many infrastructure issues are being resolved

The challenge now is to: -

- realise the potential generated by the new capacity;
- properly structure the work programme;
- overcome remaining infrastructure hurdles;
- accelerate recruitment, and
- fully embrace the opportunities of HelpForce pilot status.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	3.2/Nov/17
REPORT NAME	Electronic Patient Record Update
AUTHOR	Kevin Jarrold – Chief Information Officer
LEAD	Rob Hodgkiss – Chief Operating Officer Kevin Jarrold – Chief Information Officer
PURPOSE	The purpose of the paper is to update the Trust Board on progress with the Electronic Patient Record programme.
SUMMARY OF REPORT	The report provides an update on progress with the Electronic Patient Record programme. The project is on track for the West Middlesex go live in April 2018. A gateway review process has been established with E&Y providing external assurance on the progress of the programme. Gateway 1 – *Completion of Programme Set Up* was rated Green with stage gate criteria met and evaluation of Gateway 2 is now underway. The report provides an update on progress across a number of work streams and also highlights the key risks and issues.
KEY RISKS ASSOCIATED	The key risk is failure to successfully embed the EPR
FINANCIAL IMPLICATIONS	There are no additional financial implications beyond those set out in the EPR Full Business Case that the Trust Board approved.
QUALITY IMPLICATIONS	Failure to successfully embed the EPR would have significant implications for patient safety
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The Trust Board are asked to note the progress being made

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Electronic Patient Record Update

Kevin Jarrold
Chief Information Officer

2nd November 2017

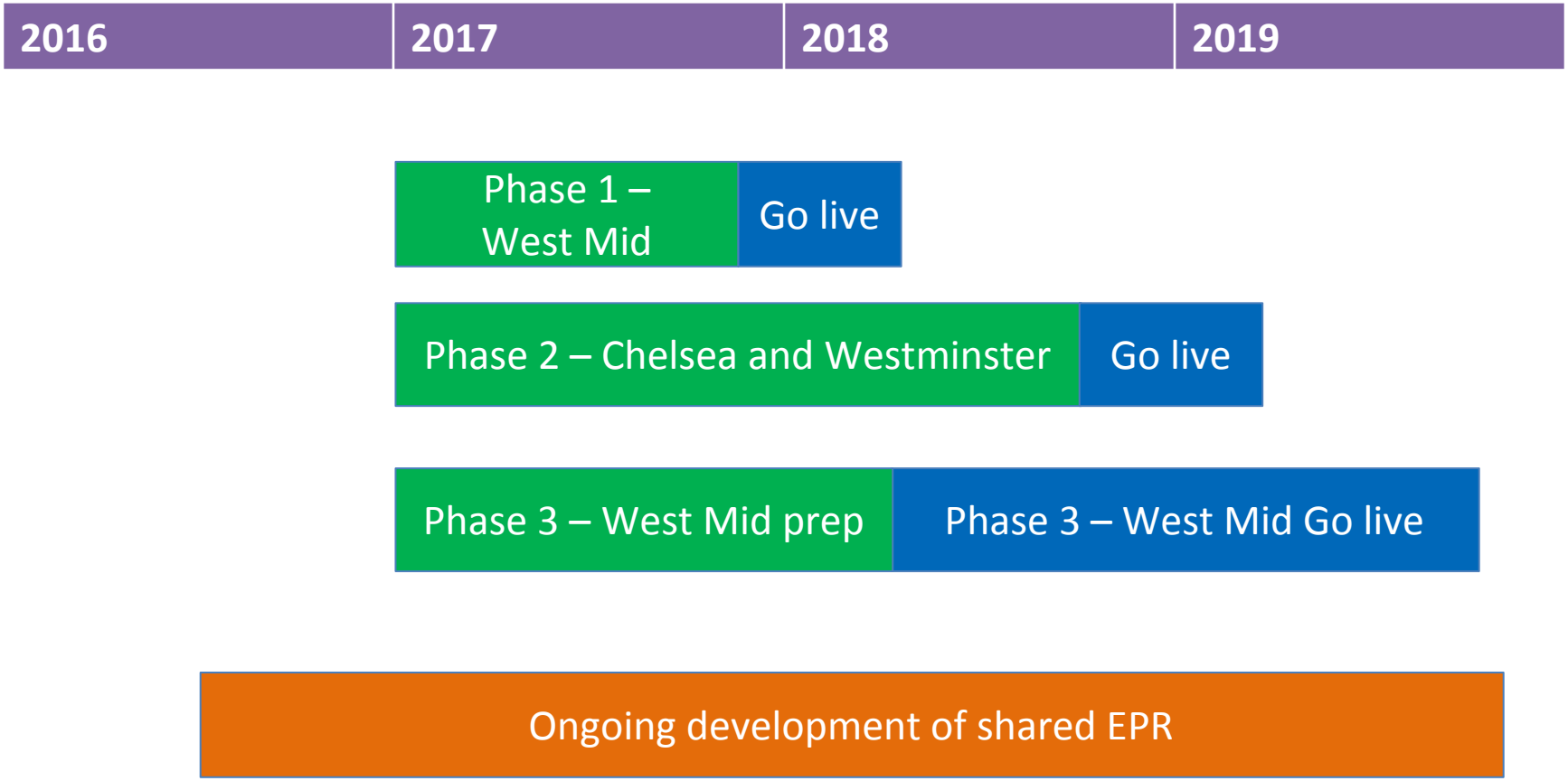
The headlines….

- The EPR Programme is on track with West Middlesex due to go live in April 2018
- The series of Gateway Reviews with E&Y providing external assurance is now underway
- Gateway 1 – *Completion of Programme Set Up* was rated Green with stage gate criteria met
- Gateway 2 – *Exit from Trial Load 1* - is currently underway with the results going to the EPR Programme Board at the end of November

Gateway Criteria Overview

- Gateway 1 – Programme Set Up Complete
- Gateway 2 – Exit First Trial Load (Nov)
- Gateway 3 – Open Booking for Training (Dec)
- Gateway 4 – Commence Training (Feb)
- Gateway 5 – Go Live (Apr)

Outline schedule



How will it be rolled out?

	Phase 1 – West Mid Spring 2018	Phase 1b – West Mid	Phase 2 – Chelwest Spring 2019	Phase 3 – West Mid Summer 2019
PAS	✔		✔	
Global PAS outpatients			✔	
Order comms	✔		✔	
ED (FirstNet)	✔		✔	
Theatres (SurgiNet)	✔		✔	
Reporting (PIEDW)	✔		✔	
Clinical documentation		✔	✔	
Prescribing (ePA)		✔	✔	
Critical care			✔	✔
Anaesthesia			✔	✔
Medical devices			✔	✔
Downtime (724 viewer)	✔		✔	

Progress Update

- The work on creating the virtual hospital within Cerner is tracking to plan
- There are positive indications coming from preliminary testing of Trial Load 1
- Smartcard uptake is better than planned at this stage
- Staff engagement in the programme is now stepping up:
  - A series of 'Countdown to Cerner' events have been arranged
  - Work on divisional implementation plans is now underway
  - A set of key performance indicators have been developed to track progress
- Some excellent collaborative work with Imperial on optimisation of the system

Risks and Issues

- Data quality in legacy systems
- Reporting
- ICT infrastructure
- NW London Pathology – Laboratory Information Management Systems
- EPR Programme team accommodation
- Clinical and operational engagement

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	4.1/Nov/17
REPORT NAME	Board Assurance Framework
AUTHOR	Alex Bolton, Safety Learning Programme Manager
LEAD	Karl Munslow-Ong, Deputy Chief Executive
PURPOSE	To update the Board on the identification, response and scrutiny of risks / barriers to the achievement of the Trust's strategic objectives.
SUMMARY OF REPORT	The well-led framework developed initially by Monitor, CQC and the Trust Development Authority requires the boards of provider organisations to ensure they have effective and comprehensive processes in place to identify, understand, monitor and address current and future risks. The Board Assurance Framework supports the Board gain a clear understanding of the principle risks or barriers faced by the organisation in the pursuit of its strategic objectives. Trust strategic objectives are aligned to an Executive Director and monitoring committee. Executive leads have considered a range of sources to identify principle barriers to the achievement of the strategic objectives; in September 2017 the committees of the Board initially assessed the level of assurance offered that controls to address the principle barriers / risks were effective. The outcome of committee scrutiny is outlined in the Board Assurance Dashboard (Appendix 1). Risks / barriers that required more detailed review by the aligned committee are being scheduled for examination at subsequent committee meetings prior to assurance rating confirmation.
KEY RISKS ASSOCIATED	Resource: Executive and Committee time to prepare and present board assurance framework impacting resource availability.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	The provision of an effective and comprehensive process to identify, understand, monitor and address current and future risks is a key component being a well-led organisation.
EQUALITY & DIVERSITY IMPLICATIONS	N/A

LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Deliver better care at lower cost
DECISION/ ACTION	The Board is asked to: • Comment on the board assurance framework development and outcomes from Committee review

Board Assurance Framework

1. Purpose

The well-led framework developed initially by Monitor, CQC and the Trust Development Authority requires the boards of provider organisations to ensure they have effective and comprehensive processes in place to identify, understand, monitor and address current and future risks.

The Board Assurance Framework supports the Board gain a clear understanding of the principle risks or barriers faced by the organisation in the pursuit of its strategic objectives.

2. Background

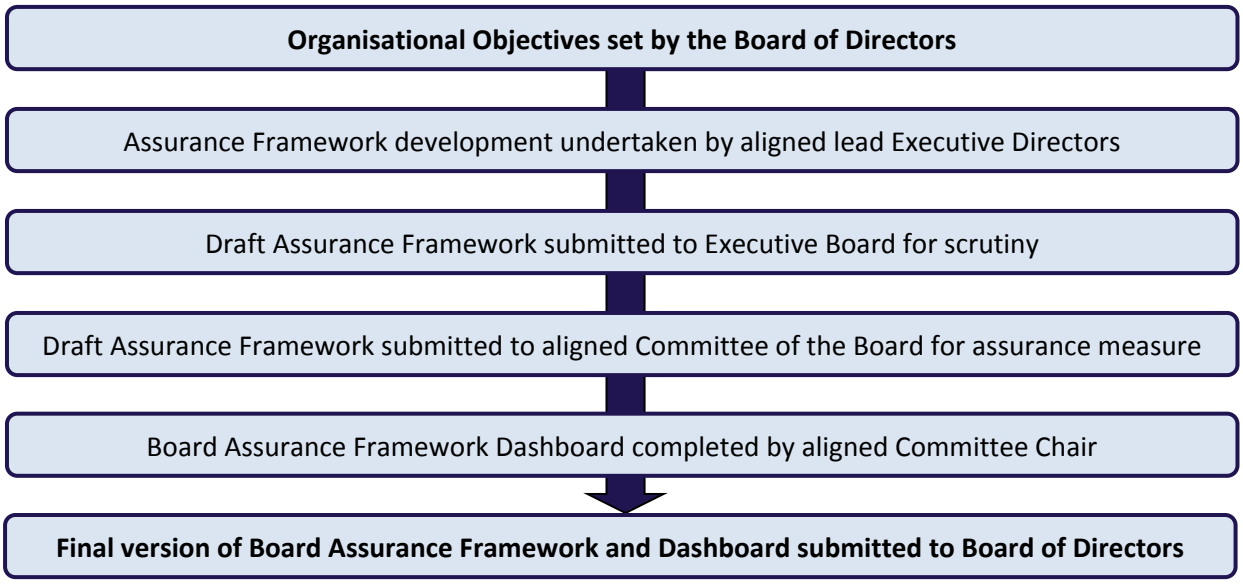
The board assurance framework is developed by aligned Executive leads and overseen / scrutinised by aligned monitoring committees. The outcome of committee review is intended to be the primary means that barriers / risks to the strategic objectives are communicated to the Board.

The Board agreed the following priorities and objectives for 2017-18.

Priority	Strategic objective	Executive Lead	Committee
1. Deliver high quality patient centred care	1a. Deliver evidence based practice in all our services	Zoe Penn Pippa Nightingale Robert Hodgkiss	Quality
	1b. Support the promotion and delivery of self-care and prevention	Zoe Penn Robert Hodgkiss	
	1c. Focus on service improvement and enhancing quality	Roger Chinn	
	1d. Proactively seek, listen, respond and learn from all the feedback we receive	Pippa Nightingale	
	1e. Work with our partners to deliver integrated, coordinated care	Karl Munslow Ong	
2. Be the employer of choice	2a. Have an engaged, responsive and flexible diverse workforce who feel valued, listened to and supported	Keith Loveridge	People and Organisational Development
	2b. Develop innovative roles and career opportunities for all our workforce	Zoe Penn Pippa Nightingale	
	2c. Improve the health, wellbeing of our workforce	Keith Loveridge	
3. Deliver better care at lower cost	3a. Drive out waste, duplication and errors.	R Hodgkiss S Easton	Finance and Investment
	3b. Be in the top 10% of NHS trust as measured by, NHSI use of resources indicator, Carter Model Hospital	Robert Hodgkiss Sandra Easton	
	3c. Deliver best value in quality and effectiveness	Robert Hodgkiss Zoe Penn	
	3d. Fully exploit digital health to support our pathways of care	Kevin Jarrold	

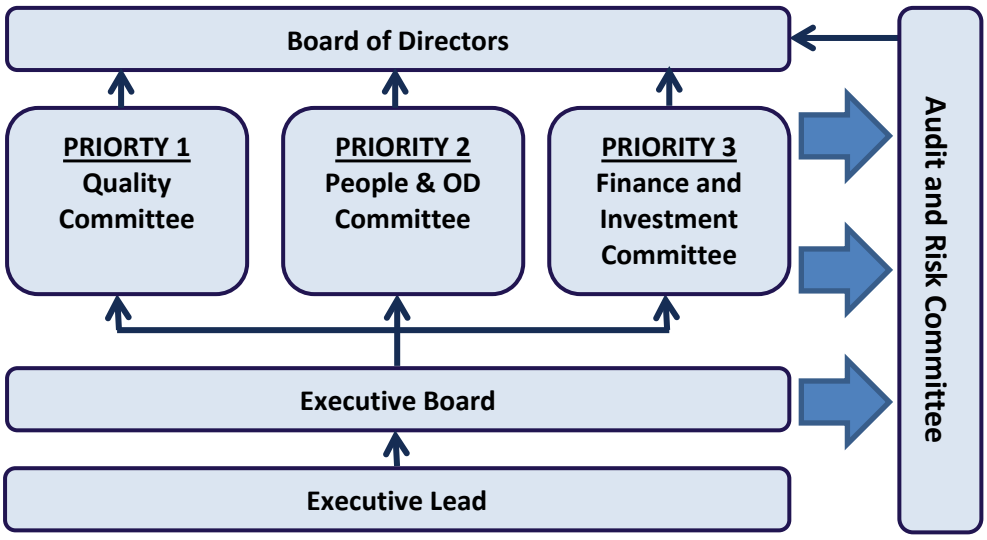
3. Development Process

The Board Assurance Framework is developed via the following route:



4. Committee structure

The framework is scrutinised via the following route:



The Audit and Risk Committee will provide assurance to the board that the development process and committee oversight are operating effectively.

The committees of the Board will assess the:

- Effectiveness of principle risk / barrier identification
- Effectiveness of controls in place
- Effectiveness of actions planned to mitigate the risk
- Effectiveness of evidence / indicators used to monitor progress
- Effectiveness of response to gaps in ability to monitor progress

The committee chair will complete the Board Assurance Framework Dashboard (appendix 1) to provide an overall assurance / RAG rating for each strategic objective.

6. Reporting to Board

The Board Assurance Framework was scrutinised by the committees of the Board in September 2017. Initial assessment and development action has been commenced; risks / barriers that require further committee scrutiny are planned for consideration at subsequent committee meetings following which assurance / RAG rating will be communicated to the Board.

Where committee chairs report limited assurance that risks are being identified and or managed effectively (RED grading) the board will be asked to undertake a detailed review of the objective. No risks are currently assessed as offering limited / RED assurance.

Partial assurance (amber rating) that principle risks are being effectively controlled has been provided for strategic objectives:

- 1a. Deliver evidence based practice in all our services
- 1c. Focus on service improvement and enhancing quality
- 1d. Proactively seek, listen, respond and learn from all the feedback we receive
- 2a. Have an engaged, responsive and flexible diverse workforce who feel valued, listened to and supported
- 2b. Develop innovative roles and career opportunities for all our workforce
- 2c. Improve the health, wellbeing of our workforce

Further committee scrutiny is required for the following strategic objectives before assurance / RAG ratings can be confirmed:

- 1b. Support the promotion and delivery of self-care and prevention
- 1e. Work with our partners to deliver integrated, coordinated care
- 3a. Drive out waste, duplication and errors.
- 3b. To be in the top 10% of NHS trust as measured by, NHSI use of resources indicator, Carter Model Hospital
- 3c. Deliver best value in quality and effectiveness
- 3d. Fully exploit digital health to support our pathways of care

Outcome from committee review is outlined within the Board Assurance Dashboard (appendix 1)

7. Next steps

The Board is asked to consider and comment on the board assurance framework development and outcomes from Committee review outlined within Appendix 1.

Appendix 1: Board Assurance Dashboard

Key:

↑ - Increase in level of assurance regarding control of principle risks since last report
↓ - Decrease in level of assurance regarding control of principle risks since last report
↔ - No change in level of assurance regarding control of principle risks since last report

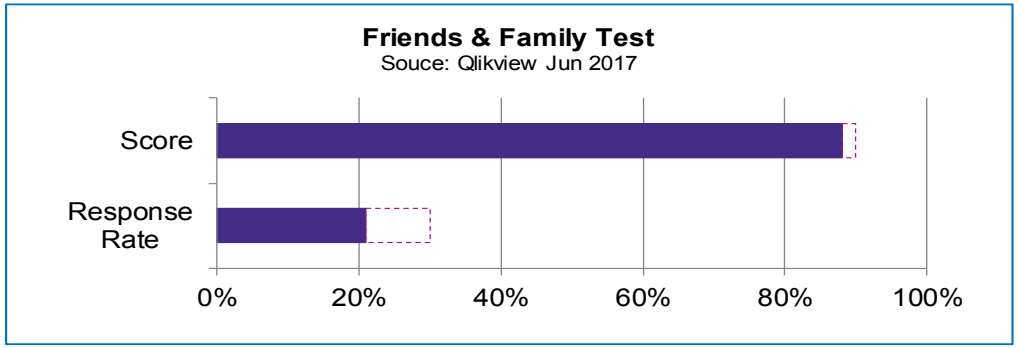
R – Red / limited assurance that principle risks are being effectively controlled
A – Amber / partial assurance that principle risks are being effectively controlled
G – Green / suitable assurance that principle risks are being effectively controlled

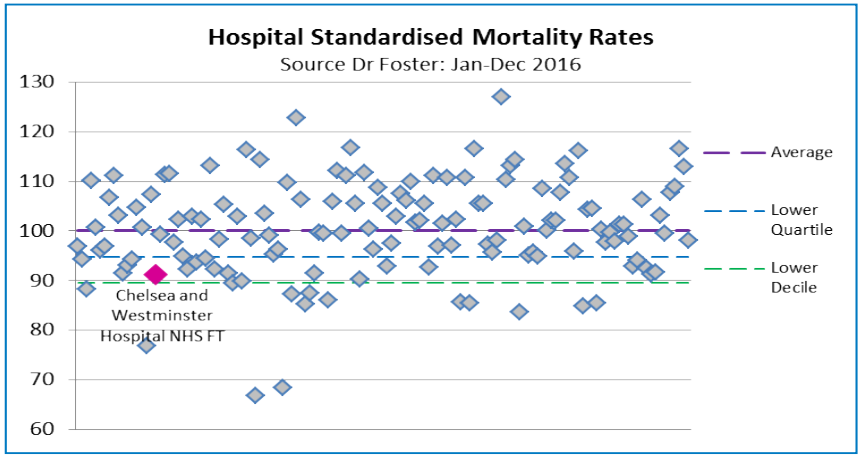
Aim	Strategic objective	Responsible Director	Oversight	Committee chair assurance comment	RAG
1. Deliver high quality patient centred care	1a. Deliver evidence based practice in all our services	Z Penn / P Nightingale / R Hodgkiss	Quality Committee	Partial assurance that risks to this objective are being appropriately controlled. Gaps in assurance relating to clinical audit programme, non-compliance with clinical guidelines and opportunities to evidence change in practice via EPR are to be presented to Quality Committee.	A
	1b. Support the promotion and delivery of self-care and prevention	R Hodgkiss / Z Penn		Risks to the achievement of this objective to be scheduled for further discussion at Quality committee prior to assessment of assurance. Ownership and of actions to be confirmed prior to this assessment.	TBC
	1c. Focus on service improvement and enhancing quality	R Chinn		Improvement work overseen by the Care Quality Programme provides mitigation to risks to this objective; the outline of the assurance offered by this programme requires inclusion within the BAF report.	A
	1d. Proactively seek, listen, respond and learn from all the feedback we receive	P Nightingale		Partial assurance currently provided; actions associated within mitigating approach, capacity and sustainability to change from feedback being addressed.	A
	1e. Work with our partners to deliver integrated, coordinated care	K Munslow Ong		Risks to the achievement of this objective require further discussion at Quality committee prior to assurance rating. Engagement with partner organisation regarding provision of home care, intermediate and hospice care to be expanded.	TBC
2. Be the employer of choice	2a. Have an engaged, responsive and flexible diverse workforce who feel valued, listened to and supported	K Loveridge	People and OD Committee	Partial assurance provided from first consideration at People and Organisational Development Committee; further development of actions and assurance gaps scheduled for November committee action.	A
	2b. Develop innovative roles and career opportunities for all our workforce	Z Penn / P Nightingale / K Loveridge			A
	2c. Improve the health, wellbeing of our workforce	K Loveridge			A

3. Deliver better care at lower cost	3a. Drive out waste, duplication and errors.	R Hodgkiss / S Easton	Finance and Investment Committee	Risks to objective initially reviewed at Finance and Investment Committee. Items scheduled to future agendas for further analysis and development prior to assurance level confirmation.	**N/A**	T B C
	3b. To be in the top 10% of NHS trust as measured by, NHSI use of resources indicator, Carter Model Hospital	R Hodgkiss / S Easton			**N/A**	T B C
	3c. Deliver best value in quality and effectiveness	R Hodgkiss / Z Penn			**N/A**	T B C
	3d. Fully exploit digital health to support our pathways of care	K Jarrold		Risks to the achievement of this objective to be scheduled for discussion at Finance and Investment Committee prior to assurance rating.	**N/A**	T B C

Strategic Priorities – Key Performance Indicators

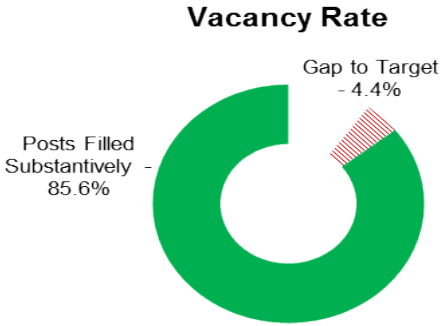
1. Deliver high-quality patient-centred care

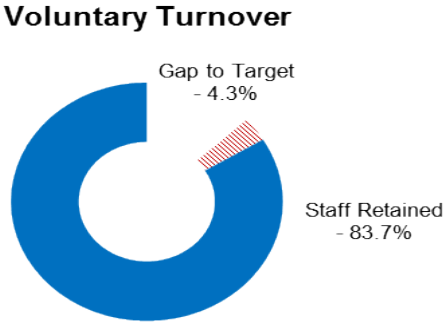




Jun 2017 (Source: NHS England)	A&E	18 weeks RTT	Cancer 62 day	Ave. Ranking
London Peer[1] Ranking	1st	4th	6th	1st

2. Be the employer of choice





3. Delivering better care at lower cost

June 2017 (Source: Model Hospital)	
Cost per Weighted Activity Unit[2]	1
NHS I Use of Resources Score – Overall[3]	3
NHS I Use of Resources Score - Delivery Against Financial Plan	1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Appendix 2a – Strategic Priorities Key Performance Indicators (Explanatory Notes)

Explanatory Notes

1. London Peer Ranking

For the purposes of comparison, a peer group has been constructed which comprises the following organisations:

- Barking, Havering And Redbridge University Hospitals NHS Trust
- Guy's And St Thomas' NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Barts Health NHS Trust
- Chelsea And Westminster Hospital NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Lewisham And Greenwich NHS Trust
- London North West Healthcare NHS Trust
- Royal Free London NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- St George's University Hospitals NHS Foundation Trust

These organisations have been selected because they fall into one or more of the following groups:

a. The Model Hospital Peer Group for CWFT (large, multi-site acute trusts)
b. The Shelford Group

London North West has also been included as an appropriate comparator although it technically sits in a different Model Hospital Peer group (large, multi-site integrated trusts) because it also provides a range of community services.

The overall ranking is calculated by taking the average ranking for each trust against each indicator and sorting the trusts from lowest (best) to highest (worst).

2. Cost per Weighted Activity

The Cost per Weighted Activity (WAU) measure provides trust with an indicative average cost per unit of activity at an HRG level, weighted by relative volume. IT forms part of the NHS Improvement Use of Resources framework and CWFT is in the highest performing segment across all providers, i.e. CWFT has one of the lowest costs per WAU of all providers.

3. NHS Improvement Use of Resources Score – Overall

NHS Improvement give all providers a ‘use of resources’ score, with one being the best possible score and 4 being the worst. The overall score is a composite indicator made up of scores against key financial metrics. The Trust has an overall score of 3, which is driven by lower scores against capital service capacity and the income and expenditure surplus/deficit rating.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 2 November 2017

PUBLIC SESSION

AGENDA ITEM NO.	4.2/Nov/17
REPORT NAME	Business planning 2018/19
AUTHOR	Virginia Massaro, Deputy Director of Finance – Financial Planning & Strategy
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	Our approach to 2018/19 business planning and high level financial plan.
SUMMARY OF REPORT	• Our 2018/19 business planning round will refresh the year 2 plan submitted to NHSI as part of the 2017/19 two year plans, which aligns to our core financial and strategic priorities. • A coordinated approach and detailed plan for business planning will be put in place, monitored by a steering group • The Trust is planning for a £16m surplus (£12.6m on a control total basis), including CIPs of £25.1m. • Next steps include updating the financial assumptions in the 2018/19 plan from bottom up activity planning, cost pressures review, service developments and analysis of inflation assumptions, as well as a review of the detailed planning guidance, working with the divisions to update the high level plan and detailed budgets.
KEY RISKS ASSOCIATED	• Delivery of the financial plan and CIPs for 2018/19. • Assumptions regarding current demand trends, changes to which (i.e. continued growth in demand) would materially affect sustainability.
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	For information and discussion only

1.0 Introduction

1.1 This paper sets out our approach to 2018/19 business planning process and the 2018/19 high-level plan.

2.0 Background

2.1 In line with 2017/18 planning guidance the Trust approved a 2 year Business plan in April 2017. NHS Improvement (NHSI) has not yet released its planning guidance for 2018/19, unofficial is that they will require a refresh of the 2018/19 plans, with no expected changes to the overall financial position. A draft Trust submission is likely to be in February 2018 and final submission in April 2018. It is also anticipated that a sector plan refresh will be required in the next few months.

3.0 Approach and timeline

3.1 A coordinated approach to business planning is proposed. Key features are:

- A plan for strategic projects and a refreshed operational plan for each division which sets out 2018/19 priorities that can be more easily communicated and monitored in year
- A robust financial work-stream that brings together all key elements (e.g. activity planning, budget setting and capital planning)
- Early CIP allocation of targets and thematic planning

3.2 The draft milestone plan for the 2018/19 planning round is set out below:

Milestone	Date
Commissioning intentions received	1st Oct 2017
Systems Plans signed off by Trust Boards	End Dec 2017
Any commissioner contract variations to be agreed	Dec 2017
Final System Plans submitted to NHSI	Early Jan 2018
Full draft 2018/19 plan submitted to NHSI	Early Feb 2018
Trust Boards to sign off Trust 2018/19 plans	End March 2018
Final Submission of 2018/19 Trust Plans	Early April 2018
Detailed divisional business plans	Dec – March 2018
Detailed 2018/19 Budgets sign-off by Divisions	Mar 2018

4.0 2018/19 financial plan

4.1 The Trust has submitted a two year financial plan for the period 2017-2019 to NHS Improvement. And there is no expectation that the high level financial plan will change as part of the refresh for 2018/19 and the plan submitted was in line with the control total of £12.9m. The CIP requirement for 2018/19 is £25.1m.

4.2 The table below shows the summary key financial indicators for the 2017/18 and 2018/19 plans

	2017/18 Plan	2018/19 Plan
	£m	£m
Operating Revenue	619.7	614.5
Employee Expenses	-323.1	-316.5
Other Operating Expenses	-251.8	-247.7
Non-Operating Income	0.1	0.1
Non-Operating Expenses	-32.9	-34.5
Surplus/(Deficit)	**11.9**	**16.0**
Net Surplus %	1.9%	2.6%
Remove capital donations/grants I&E impact	-4.9	-3.3
Surplus/(deficit) on a Control Total Basis	**7.1**	**12.6**
Total Operating Revenue for EBITDA	619.7	614.5
Total Operating Expenses for EBITDA	-574.9	-564.1
EBITDA	44.8	50.4
EBITDA Margin %	**7.2%**	**8.2%**
CIP Requirement	25.9	25.1
Use of Resources Rating	1	1
Closing Cash Balance	53.2	65.6

5.0 Budget Setting Principles

5.1 Detailed budget setting principles will be issued to Divisions and will include:

- Roll forward of recurrent 2017/18 budgets
- Adjust for specific existing and new unavoidable cost pressures and quality investments, where approved by the Executive Team
- Adjust for any service developments, only those that generate a contribution and are approved by commissioners (where associated with changes in activity levels and funding)
- CIPs allocated to divisions and service lines in line with overall CIP plan
- Activity planning based on forecast activity data, adjusting for planned service developments, commissioning intentions and demand management schemes, growth etc.
- Inflation and tariff changes, as per planning guidance

6.0 Summary and next steps

- Our 2018/19 business planning round will refresh the year 2 plan submitted to NHSI as part of the 2017/19 two year plans, which aligns to our core financial and strategic priorities.
- A coordinated approach and detailed plan for business planning will be put in place, monitored by a steering group
- Planning guidance is expected to be published by NHS Improvement in September 2017
- The Trust is planning for a £16m surplus (£12.6m on a control total basis), including CIPs of £25.1m and has accepted the NHS Improvement control total.
- Next steps include updating the financial assumptions in the 2018/19 plan from bottom up activity planning, cost pressures review, service developments and analysis of inflation assumptions, as well as a review of the detailed planning guidance, working with the divisions to update the high level plan and detailed budgets.

7.0 Decision/action required

For information and discussion only.