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

Room A, West Middlesex

7 September 2017 11:00 - 7 September 2017 13:15

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Location: Room A, West Middlesex
Date: Thursday, 7 September 2017
Time: 11.00 – 13.15

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome & Apologies for Absence Apologies received from Martin Lupton, Roger Chinn and Chris Chaney.	Verbal	Chairman
11.03	1.2	Declarations of Interest	Verbal	Chairman
11.05	1.3	Minutes of the Previous Meeting held on 6 July 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: • Sustainable Transformation Plans update • EPR Programme Update	Report	Chief Executive
	2.0	**QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE**		
11.30	2.1	Patient Experience Story	Verbal	Chief Nurse
11.40	2.2	Serious Incidents Report	Report	Chief Nurse
11.50	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	Report Verbal Verbal Report	Chief Operating Officer Chief Operating Officer Chief Operating Officer Director of HR & OD
12.05	2.4	Learning from Deaths Implementation	Report	Medical Director
	3.0	**STRATEGY**		
12.15	3.1	Key Measurables for 2017/18 key trust priorities, including Board Assurance Framework	Report	Deputy Chief Executive
12.25	3.2	Shaping a Healthier Future and Sustainability and Transformation Partnership	Report	Deputy Chief Executive

	4.0	**GOVERNANCE AND RISK**		
12.35	4.1	Key Risks: Medical Workforce	Report	Medical Director
12.45	4.2	Raising Concerns Report	Report	Director of HR & OD
12.55	4.3	Board Committees Terms of Reference	Verbal	Interim Board Secretary
	5.0	**ITEMS FOR INFORMATION**		
13.00	5.1	Questions from Members of the Public	Verbal	Chairman
13.10	5.2	Any Other Business	Verbal	Chairman
13.15	5.3	Date of Next Meeting – 2 November 2017		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of the Board of Directors (Public Session)
Held at 11.00 on 6 July 2017, Boardroom, Chelsea & Westminster

Present:	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	(JLo)
	Karl Munslow-Ong	Deputy Chief Executive	(KMO)
	Pippa Nightingale	Chief Nurse	(PN)
	Liz Shanahan	Non-Executive Director	(LS)
	Lesley Watts	Chief Executive	(LW)
In Attendance:	Roger Chinn	Deputy Medical Director	(RC)
	Chris Cheney	CEO, CW+	(CC)
	Harbens Kaur	Interim Company Secretary	(HK)
	Sarah Ellington	Interim Board Secretary	(SEL)
	Donald Neame	Interim Director of Communications	(DN)
	Dr Gerald Davies	Geriatrician	
	Dr Noam Dover (in part)		
Apologies:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Martin Lupton	Ex-officio member, Imperial College Representative	(ML)
	Zoe Penn	Medical Director	(ZP)

1.0	**GENERAL BUSINESS 11.01 start time**
1.1 a.	**Welcome and Apologies for Absence** □ JJ chaired the meeting in the Chairman's absence. □ The Chairman welcomed all to the meeting and noted the apologies received.
1.2 a.	**Declarations of Interest** □ None.
1.3	**Minutes of the Previous Meeting held on 4 May 2017**

a.	□ The minutes of the meeting held on 4th May 2017 were confirmed as a true and accurate record.
1.4	**Matters Arising & Board Action Log**
a.	□ All matters arising were noted by the Chairman. It was noted that item 2.3.a (integrated performance report, including administration improvement programme) would be discussed as part of the meeting and item 3.1.a (2016 national staff survey results) would be discussed at the September Board meeting.
1.5	**Chairman's Report**
a.	□ JJ advised that with regret the Trust had received notice that JL, would be retiring as Non-Executive Director in the autumn following seven years' service. JJ expressed his gratitude to JL on behalf of the Board for his service to the Trust. JJ advised that the Trust was recruiting a replacement NED and interviews were planned for September 2017.
1.6	**Chief Executive's Report**
a.	□ LW was sad to advise the Board of the death of Mr Nicholas Walker, Public Governor who had passed away at the Hospital in June. LW paid tribute to Nicholas Walker's excellent service to the Trust. The Chairman had written to Mr Walker's family to express condolences and acknowledge Nicholas' contribution to the Hospital.
b.	In presenting her report, the Chief Executive highlighted the following points: □ The response by the organisation as regards the major incidents that have occurred over the last few months, more specifically the Grenfell Tower tragedy, had been a true testament to the commitment of the organisation, staff, governors, NEDs and staff. The internal response had been absolutely amazing. LW emphasised how proud she was of the response by the organisation, which had been acknowledged by the Prime Minister, Secretary of State, NHSE and NHSI. □ The Trust Board remains mindful of the effect upon staff, and has ensured that staff have access to emotional and psychiatric support, to speak up at any time. There will be a further opportunity for staff to discuss the recent incidents at a forthcoming Schwartz Round (Schwartz Rounds take place on site and provide an opportunity for staff from all fields to reflect on the emotional aspects of their work). □ As well as attaching the Team Briefing to the Chief Executive's Report, I will also attach to the September Report one of my fortnightly Chief Executive Briefings to Staff. **ACTION: VD**
2.0	**QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE**
2.1	**Patient Experience Story**

a.	RH introduced and welcomed Dr Noam Dover, a Clinical Fellow to the meeting. He advised that Dr Dover had been working with junior A&E doctor Dr Matthew Hawkins on a new proposed patient referral pathway. □ Dr Dover explained with slides how the new proposal involved much closer working between acute and community services based on better understanding of the role that each service fulfills. The same patients are often referred to the intermediate care team, general practitioners and the Trust A & E services. The referral pathway shown involved the intermediate care team when test results would not justify discharging the patient home without support. Dr Dover gave an anonymous patient example of a woman in her 80s on a palliative regime for cancer who did not want an admission, but was unable to secure a GP appointment. She was referred to the intermediate care team and able to be supported to die at home on the basis that the referring clinician understood and had confidence in the intermediate care team. ▪ PN advised that better links with intermediate and community services could improve the level of patients dying where they choose – currently this only about 30%. □ EH asked whether the Trust's partners namely the Intermediate Care Team had sufficient capacity to follow this proposal. Dr Dover advised that LB Hounslow was fully committed, accepting not only A & E discharge referrals, but also preventative referrals before patients reached A & E. LB Richmond was also making referrals. □ RH praised the work, noting that Dr Dover had successfully bid for £50,000 funding for the proposal, which supported the paper on non-elective admissions. □ Governor TP enquired whether there was any funding available for patients who required access to a GP in line with the 7 day GP availability imitative, and whether this was working. □ LW advised that this was learning in action. Care packages were not always available but other aspects were working. □ The Board thanked Dr Dover for his excellent work.
2.2 a.	**Care Quality Programme Report** PN presented her report to the Board, highlighting the following points: • There had now been three external mock inspections □ The 2nd group of peer reviews took place on 19th June □ Key themes had been collected from inspected areas □ The Trust now had in place good engagement tools as regards the preparation plans □ Ward accreditations were working well, with a real desire to improve amongst all ward areas □ 'Perfect Days' in clinical and non-clinical areas had proven a great engagement tool and feedback was presented to the executive. □ Nursing Quality Rounds were picking up themes to action □ The reference to Stakeholder partnership working should also include NHS England and national guidance.

	□ Partnership work streams had enabled us to deliver work streams □ The Trust was working collaboratively as regards the common challenges such as falls prevention, safe storage of medicines etc. □ There was an Estates and Facilities work stream in place, led by the Deputy CEO, with clinical teams and estates teams working together. □ Governance work was being led by the Deputy CEO □ A preparing for an inspection booklet had been issued to staff □ The Trust had scrutinised internally and then externally. The work streams identified were integral to preparedness. The Trust was assured that it was focusing on the correct areas □ The Perfect Day ward app will be rolled out as a pilot trial this month, to take a picture of good and bad. □ LW advised that the Trust had accelerated the work that it was undertaking. She commented on the importance of articulating the excellence that had come as a result of the Improvement Programme. □ EH advised that from the Quality Committee perspective, there was much better rigour and process and accountability down the organisation. There was work to do around distilling learning. She noted however that the Trust still had work to do around outstanding Datix incidents where learning had not been disseminated. □ PN confirmed this had improved since the paper. □ AJ commented that the ward assurance programme had had a real impact. However, it would be inexcusable not to complete actions (noting especially safety and estates actions) work. There was a real need to communicate improvement. □ LW advised that the Trust agreed with the concern around complaints and incidents, which was being addressed. The estates work stream needed to complete by the end of the summer. □ JJ commented the programme had some real traction, but there was some way to go. **ACTION: PN to update next Board**
2.3 a.	**Serious Incidents Report** PN presented the Serious Incidents Report to the Board. The following matters were highlighted: □ The report covered a period of two months. □ There had been a spike in April, which were all submitted but 2 SIs had since been downgraded. □ For April and May combined there was no spike. □ JJ questioned further on pressure ulcer incidents. PN clarified that the 53% reduction achieved in 2016/17 was maintained for April and May combined, but not achieved in April alone. There may have been a slippage in completing documentation to record patient condition on admission. The Trust was looking to identify any trends on this and was to arrange supportive work with two nursing homes such as sharing tissue viability nurse resources and training

	□ PN also noted 98 incidents had been closed off after the report was written and graph 1 showed results well below the national average.
2.4 a.	**Integrated Performance Report, including Administration Improvement Programme** In presenting his report, RH outlined the following key points: □ The Trust had seen a 6.7% increase in attendance within its ED. The impact of recent major incidents was a factor. □ Despite the increase in demand, the overall Trust performance was 92.1% □ Cancer services were an area of concern in May with the team working very and anticipated improvement to performance in June. There had been a lot of work looking into this. Urology had a major issue and a new pathway had been introduced there, effective from 1 July 2017 □ There had been a significant increase in 2 week waits which were causing challenges around access performance. Discussions were ongoing with commissioners to see what can be done to manage referral increases. Diagnostic waits were non-compliant in May, we anticipated June would see an improvement. □ There had been a deterioration in RTT performance although we expected June to see an improvement. □ JJ queried what resources were needed to meet targets if the report is right and demand had seen an 8% increase. The Board needed to be fully sighted and proactive rather than reactive. **ACTION: RH to update at next Board.** □ RH advised there is a 5% inbuilt □ JL commented that there would also need over the longer term at available capacity including estate to accommodate the increased demands on service. □ RH advised there is more built capacity on the Chelsea site than on the West Middlesex site. We are in the middle of reviewing resuscitation capacity at WM. □ EH commented that this involved long term strategies and the STP working as a wider health system to manage demand. □ LW advised that the Trust was in the middle of a piece of work around demand and capacity planning; she re-assured the Board that discussions around managing demand were on-going. □ KMO advised that as regards the concern raised around capacity, the biggest constraint was actually workforce rather than space. □ JJ commented that in terms of achieving sustained performance against our access targets we would need to understand: What is stopping us achieving the targets? What would it cost to achieve the targets? What would we be paid to deliver this activity and would it cover cost?

	□ JJ advised that further detail was needed. He noted that this matter would be re-visited in September. RH provided the Board with assurance that a further update would follow. **ACTION: RH**
2.5 a.	**Review of Fire Prevention Measures** PN took the Board through the submitted paper. The following points were discussed: ▪ The programme started 6 months ago. ▪ There was a standardised policy across both sites ▪ Each clinical area has had a fire assessment in the last 12 months, owned by the ward sister ▪ Non clinical fire assessments were due by the end of July ▪ Quality Friday of 30 June 2017 looked at the fire evacuation plan for each site ▪ Fire doors were on a 12 week programme of work □ KMO provided assurance to the Board around the cladding that was being used at Netherton Grove on the Chelsea site and on the main hospital at West Middlesex. They have been verified by the manufacturers as not presenting as a fire hazard. There were some internal materials, such as prayer tent, which we had reviewed but were compliant. □ JJ asked for actual samples of Trust cladding to be removed and sent for physical fire resistance testing. **ACTION: KMO** □ LW noted that independent testing had been carried out due to lack of resources from the Fire Authority, but asked for an action to remain for the Fire Authority/ Fire Brigade to attend and inspect. □ KMO advised that he would provide a full note to the Board as regards the inspection assurances. **ACTION: KMO** □ It was noted that fire prevention assurance had also been provided to the Quality Committee before and after the Grenfell Tower tragedy. □ AJ referred to the compartment structure of the hospitals and the need for external assurance that the totality of the fire safety measures in the round met the requirements of a hospital. He advised that the Quality Committee would need to receive this assurance. He further advised of the need to also consider the sprinkler systems at both sites as well as the Hospital's smaller sites. □ PN advised that soft and hard Facilities Management had issued the Trust with an excellent report noting the Trust to be safe. There have been 9 fire drills since December, asking for a structured format to the fire drill for each department. PN concluded the discussions by summarising that:

	▪ The Trust has received good external reviews ▪ A fire drill of each compartment would be reviewed over the month of July by the Health and Safety Office. ▪ 90% compliance of fire training would be achieved by the end of July ▪ All staff are to be given fire Marshall training as part of revised training package ▪ The Trust was clear on expectations and trackers were being used by ward sisters to monitor compliance □ NG commented on the need for this compliance to become 'business as usual' going forward.
2.6 a.	**Risk Assurance Framework** □ PN took the Board through submitted paper. Two further red risks had been added to the RAF since the paper. These had since been taken off. □ RC advised one was a short delay in PACS at the WM site, now resolved with the contractor. □ SE advised that transitional arrangements on the GUM tender had been reached. The risk remained in the long run on high volume service area. □ ND enquired whether the PACS risk encountered could have been foreseen and whether there was any mitigation as regards the incident. RC advised yes, but there were unexpected delays for a number of reasons. □ KMO advised that good practice provides that the BAF be developed and will complement the RAF. This would be worked on, including committee chairs and brought back. **ACTION: KMO to present BAF to September Board** □ JJ enquired asked for the RAF to be streamlined to the top ten risks and its format made clearer and simpler. The Audit Committee could then be responsible for providing the Board with assurance around these identified risks. PN agreed this was a sensible approach. **ACTION: PN** □ JL noted the top ten should be provided, whether or not strategic
2.7 a.	**Non-Elective Demand Review** RH took the board through the prepared paper. He highlighted the following areas: ▪ 8% increase in demand equated to 53 beds, at WM site, after efficiencies ▪ There was a focus on enhancing the frailty pathway ▪ Financial impact from the growth in non-elective demand was a considerable challenge ▪ The head line figure remained around the rising numbers of A&E attendances ▪ Adult forecasts on the WM site was the main challenge going forward ▪ Levels of activity continued to be high, despite Ealing Hospital remaining open, so the growth at WM was Hounslow based. ▪ The Trust ranked 21st nationally in terms of acute A&E performance ▪ The ambulatory care results remained good at the Trust, only North Middlesex used beds more than us. ▪ Ambulatory pathways worked well across both sites ▪ Future planning working groups were on-going ▪ Visits were planned to Luton and to Dorset to understand how they met NEL admission to bed

ratio

- There was a disproportionate occupancy of over 75 year old patients at WM which needs action.

  - Dr Gary Davies advised the Board of concerns around the shortage of geriatricians; it was important that these issues were developed and discussed with the commissioners. By 2025, the Royal College of Physicians advised 45 times the number of current geriatricians were needed. Pulling across from other specialties could have no immediate effect and training numbers had not increased since 2015.

  - He stated that the department was planning to develop a Frailty Unit at the WM site with 12 beds in the first instance. This initiative was aimed at catering for the demand in elderly treatment services.

  - RH further commented on the need for the Trust to think outside of just advertising for posts, and consider other mechanisms for attracting interest into this area eg research, training and liaison with surgical care. Recent recruitment had been unsuccessful. Critical mass was needed.

  - LS enquired if other strategies, eg non-doctor led models had been considered for this area. Dr Davies advised that for the Trust's elective pathway, eg physiotherapy a larger buy-in from other specialities was required with more senior people on site being needed. At a junior level, overseas recruitment was needed.

  - AJ commented that he was pleased with the report prepared by RH. He advised that there were however three issues that needed comprehensive consideration:

1) productivity
2) capacity and
3) Trust strategy

He advised that it was important for the Board to understand where our capacity should be directed to.

  - LW advised that there is a wider conversation around the NHS in NW London and nationally about what the future of the NHS looks like. Conversations are beginning. This item would be brought back to the Board for further discussion.

  - NG enquired what conversations were taking place with commissioners. RH advised that discussions were on-going and a visit with Hounslow CCG was being arranged.

  - RH advised that Board would receive a further update in the winter as regards the healthcare system in general. The FIC would also be considering the forthcoming challenges.

  - LW concluded the discussion by advising the growth in non-elective demand was the single biggest risk to sustainable health care for both the Trust and wider STP. LW confirmed she had been appointed the provider STP lead and would provider regular updates to Board.
    ACTION: Update September Board, along with Winter preparedness RH

3.0	**WORKFORCE**
3.1	**People and Organisational Development Strategy**
a.	□ KL presented his report to the Board □ This has been taken to various parts of the Trust since April and the key actions in appendix 1 would be reviewed annually. □ The 6 strategic themes had been agreed as: 1) Attraction and on-boarding 2) Engagement, culture and leadership 3) Health and well-being 4) A great place to develop a career 5) Designing a workforce for the future and 6) Workforce productivity **ACTION: Performance report to be a standing agenda item for every Board VD/KL** □ EH advised that as recruitment and retention was a Trust priority, the Board may need more focus on this. She was frustrated at training performance. LS commented that difficulties remained as regards vacancy and activity levels in and out of the Trust. She advised that opportunities to recruit from overseas had revealed that there was no easy answer to these issues. Retention and well-being was a critical part of the strategy. □ JJ advised that he would like to hear more around what the Board could assist with in terms of wellbeing, staff engagement and relieving stress for staff. KL advised that a health and wellbeing committee was to be set up this autumn, with THH as the Chairman. □ JJ raised applicability to doctors. KL clarified that nursing and midwifery was the largest professional group. Doctors fell within 'medical and dental' on the chart. Leadership for doctors was integral to success on workforce.
4.0	**STRATEGY**
4.1	KJ provided the Board with a summary update. The following points were covered:
a.	▪ The Electronic Patient Record (EPR) Programme was progressing well ▪ It was anticipated that the Global Digital Exemplar (GDE) funding would be received by the Trust shortly □ ND enquired what the Board's views were in respect of the forthcoming Information Commissioner's Officer's (ICO) visit which was due in September 2017. □ KMO advised that the Trust were alive to the areas of vulnerability, which were set out in KJ's report. The identified areas of concern were in the process of being reviewed. In response to queries around the powers of the ICO, KMO advised that generally these included monetary and remedial orders, but not necessarily on audit/inspection.

	JL noted that IG and the remit of the ICO extended beyond the internal audit areas. □ LW advised that the visit by the ICO was a voluntary process. The Trust had been open about the issues faced in the past and had itself requested this inspection. Work should not wait for review by the Audit Committee. □ JJ enquired when Board assurance would be received as regards the EPR project work that was being carried out. KMO advised that the Audit Committee would receive the assurance in the first instance and the Board would then receive regular update reports thereafter. JJ requested that the advisor who has been commissioned to provide the required assurance presents the assurance. KMO advised that the draft audit report would be brought to the Audit Committee on 26 July 2017. **ACTION: KJ to arrange for external advisor (Ernst & Young) to attend FIC in July**
5.0	**GOVERNANCE**
5.1	**Policy approvals** CC presented his paper to the Board summarising the following key points: ▪ There was a recognised need to grow the number of supporters of the Charity; the objective of the drafted policy was to make the process easier for those who wished to offer their support ▪ The Charity's aim was to signpost expressions of interest quickly ▪ The Donor Recognition Policy would provide further clarity around the process for donating and the aims of the co-ordinated process. ▪ As there was a memorandum of understanding between the Trust and CW+, the Trust Board had to approve the policies. □ LS enquired what these policies meant for the Charity. CC advised that the process aided the need for there to be a transparent relationship which supports the activities of the Trust from a range of areas. □ CC assured the Board that the CW Policy additionally provided a tool on making decisions around raising funds and the acknowledgment of donations. Final decisions remained with the Executive Board. □ Both the policy on fundraising and the Policy on donor recognition within the hospital estate were noted and approved.
6.0	**ITEMS FOR INFORMATION**
6.1 a.	**Questions from members of the public** Two questions were raised: 1) Governor TP enquired what the Trust's plan was with regards to the STP's required saving of £1billion by 2020.

	□ LW responded by advising that the figure quoted was to be confirmed, however the Trust was working hard to put the appropriate plans in place. These plans were being brought regularly to the Board where discussions were taking place around deliverability. She further advised that all providers were required to work as a whole in order to address the bigger issues which included work streams which required practical testing. □ LW went on to advise that there were issues, however the Trust's focus was on spending as much time as possible on delivering the ask, and considering ways in which we can do better, so any gap will show itself 2) Governor A H-P enquired what the Trust was doing to address the availability of Resuscitation trolleys within the A&E department. □ LW advised that the physical space within the A&E unit was an issue not the availability of resuscitation equipment. RH advised there is a business case at WM to expand into the number of bays in the department. At Chelsea, there was plenty of A & E space. □ A H-P commented that her further question around building cladding had been responded to within the meeting.
6.2 a.	**Any Other Business** □ None.
6.3	**Date of Next Meeting – 7 September 2017**

Trust Board Public – 6 July 2017 Action Log

Meeting	Minute number	Agreed Action	Current Status	Lead
July 2017	1.6.b	Chief Executive's Report As well as attaching the Team Briefing to the Chief Executive's Report, I will also attach to the September Report one of my fortnightly Chief Executive Briefings to Staff. **ACTION: VD**	Complete.	**VD**
	22.a	Care Quality Programme JJ commented the programme had some real traction, but there was some way to go. **ACTION: PN to update next Board**	This is included in the Chief Executive's Report.	**PN**
	2.4.a	Integrated Performance Report, including Administration Improvement Programme JJ queried what resources were needed to meet targets if the report is right and demand had seen an 8% increase. The Board needed to be fully sighted and proactive rather than reactive. **ACTION: RH to update at next Board.**	Verbal update at meeting.	**RH**
		JJ advised that further detail was needed. He noted that this matter would be re-visited in September. RH provided the Board with assurance that a further update would follow. **Action: RH**	Verbal update at meeting.	**RH**

	2.5.a	Review of Fire Prevention Measures Actual samples of Trust cladding to be removed and sent for physical fire resistance testing. **ACTION: KMO**	This is included in the Chief Executive's Report.	**KMO**
		Provide a full note to the Board as regards the inspection assurances. **ACTION: KMO**	This is included in the Chief Executive's Report.	**KMO**
	2.6.a	**ACTION: KMO to present BAF to September Board.**	On current agenda.	**KMO**
		JJ enquired asked for the RAF to be streamlined to the top ten risks and its format made clearer and simpler. The Audit Committee could then be responsible for providing the Board with assurance around these identified risks. PN agreed this was a sensible approach. **ACTION: PN**	To be taken to the October Audit Committee.	**PN**
	2.7	Non-Elective Demand Review **ACTION: Update September Board on STPs, along with Winter preparedness RH**	This is on current agenda.	**RH**
	3.1	People and Organisational Development Strategy **ACTION: Performance report to be a standing agenda item for every Board VD/KL**	Complete.	**VD/KL**
	4.1	**ACTION: KJ to arrange for external advisor (Ernst & Young) to attend FIC in July.**	Complete.	**KJ**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	1.5/Sep/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
September 2017

1.0 NED Recruitment

The governors' nominations and remuneration committee is fully engaged in recruiting a successor to Jeremy Lloyd who retires later this year. After a slow start with the support of a recruitment agency we have been able to attract an exciting body of applicants. As part of this process we continue to be keen to ensure that our Board reflects the diversity of both our workforce and our patients. We hope to make a recommendation to the Council of Governors meeting at the end of September. We may wish to appoint at this stage more than one non-executive director, to support the succession planning for our non-executive body, currently being reviewed by the Chair and Vice Chair of the Board together with the Lead Governor and her colleagues. In the meantime, I am delighted to report that the Council of Governors has voted to reappoint Jeremy Jensen, Dr Andrew Jones and Eliza Hermann for a further term as NEDs, acknowledging their great contribution to the Trust.

2.0 Staff Awards

A highlight of the Trust calendar is the nominations to and voting for our annual staff awards kindly sponsored by CW+. All members of the Board are engaged in this process. It is humbling to read so many nominations that set out the extraordinary contribution made by our staff and volunteers well beyond the call of duty demonstrating innovation, commitment and adherence to our PROUD values. I look forward to the awards dinner in October and to handing over the Chairman's award for Lifetime Achievement.

3.0 Hospital Visits

I am delighted to see non-executive directors being evermore involved in visiting our staff across the Trust and hearing first hand from patients and staff alike the pride in our work but also how we continuously improve the quality of care and the experience of our staff. Jeremy Jensen recently spent a day in our operating theatres and I know emerged from his scrubs with new enthusiastic suggestions for our Chief Operating officer as to how we can become even more productive! Personally, I spent a day working on Osterley Wards 1 & 2 at the West Middlesex – again I finished the day:

A - so impressed by the quality of nursing care I witnessed.

B – recognising just how much our new volunteering strategy can contribute to spending longer periods of time in conversation with our patients

C – Recognising the challenge of engaging with junior doctors who only spend one year with us

We are currently planning for further wider engagement by the Board and by our Governors in ward accreditation and patient feedback

4.0 Events

Chairman's Breakfast:

The Chief Executive and I have now established a monthly Chairman's breakfast. This allows your Chair to meet with small groups of staff across all our sites, in all areas of the hospitals, to listen and learn from their ambitions, concerns

and frustrations. These meetings are summarised and the key points shared with the Board on an anonymised basis. For me personally and I hope for the Board they are an invaluable source of intelligence while also providing the Chair of the Board with an opportunity to be visible, to demonstrate good leadership and to communicate with the staff in a private setting.

5.0 Review of Governance and Risk

With the deputy CEO, company secretary and with input with the Chair of the Audit Committee we have now commenced a thorough review of our governance and risk procedures taking particular account of the rapidly changing external environment. While this is an action agreed by the Board it also fits well with NHSIs recent communication re developmental reviews of leadership and governance using the well-led framework. By the time of this Board meeting I will have met with Steve Russell, our lead regulator at NHSI to seek his advice on how we can conduct this review most effectively.

Sir Thomas Hughes-Hallett
Chairman

September 2017

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017 **PUBLIC**

AGENDA ITEM NO.	1.6/Sep/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 formally notified that our 'well led' Care Quality Commission (CQC) inspection will be on the 23rd and 24th of January and are in the process of completing our provider information request (pre inspection data) which will be submitted to the CQC on the 8th September. We expect our unannounced inspection to take place during the period of October to December. The new CQC inspection approach is one of a continuous inspection process and we work closely with our CQC relationship managers to ensure that we have a sustainable approach to delivering great quality care to our patients. Our internal care quality programme continues to make progress with all 64 clinical areas having had a ward/clinical accreditation during the first year. We see this determined approach driving sustainable improvements for patients, staff and our organisation. The executive leads remain linked to their clinical areas delivering improvement messages, engaging with staff and supporting continuous learning and development.

We continue to work closely with NHS Improvement (NHSI) to undertake peer review mock inspections and improvement work; they have recently undertaken a review of our emergency pathways on both sites and given positive feedback and identified helpful areas for continued improvement. We are participating in the NHSI "rapid improvement and retention programme" which supports our organisation to work in partnership with other organisations across the UK, sharing good practice, to develop effective and robust retention strategies.

The Trust quality boards are now in place in all clinical areas, and the Trust values are in place in all non-clinical areas. Additionally the patient information book has now been launched, including a recognition card that patients can award to staff members who have provided outstanding care to them.

2.0 Performance

July was another busy and challenging month for the organisation with continued increasing demand being placed on our services. Despite this, the A&E Waiting Time for the Trust in July was 95.3%; the first time for 1 year that both of our sites delivered >95% which is a fantastic achievement and a credit to all staff across both hospitals and I want to take the opportunity to acknowledge that effort.

The RTT incomplete target was not achieved in July for the Trust, but did improve again from the previous month. The CW site saw continued improvements, especially within Planned Care (the most challenged Division), but the WMUH site saw performance drop by 1% to 94% affecting the overall Trust position. I am pleased to report however, that there continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue.

Demand for 2WW cancer appointments continued in July with the number of 2WW referrals 41% higher than the same month last year. The operational and clinical teams are continuously working to provide additional capacity and the Executive team have raised the continued increases with both Royal Marsden Partners and with the Chairs and Managing Directors of the CCGs. There were no reportable C-Diff infections across either site during the month which is excellent and our Friends and Family inpatients recommended scores were >90% across both of our sites. For the first time, we also managed to achieve

100% compliance with our fractured neck of femur patients getting to theatre within the 36 hour standard which is excellent news for our patients.

Despite the demand challenges noted above, we continue to do well as a Trust and I offer my thanks and congratulations to all the teams involved.

3.0 Staff Achievements

It gives me great pleasure to report to the Board on various staff awards and achievements over the past few months.

Proud Staff Award Winners:

June
St Mary Abbots Ward (CWH); Dr Alina Grecu (CWH); Children's Surgical Team (WMUH); Alan Hardy (WMUH).

July
Jason Pyke and Melanie Davy (CWH); Lesley-Anne Marke (CWH); Dr Nneka Nwokolo (56 Dean Street); Rupinder Sarai (WMUH).

School of Medicine Teaching Excellence Awards:

1. Associate Dean Award – Dr John Platt, Consultant Lead for Care of the Elderly
2. Teaching Excellence Award – Dr Ashkan Sadighi, Consultant in Acute Medicine
3. Supporting the Student Experience Award – Mr Glen Fernandes, Undergraduate Teaching Coordinator.

Industry awards:

Patient Safety in Critical Care and Trauma Patients Award: North West London Critical Care Network (Chelsea and Westminster Hospital & West Middlesex University Hospital wins both).

Communique Awards (Industry awards founded to recognise outstanding work in healthcare communications across local, European and international markets): 56 Dean Street received the following awards
1. Innovation in Healthcare Communications
2. Excellence in Engagement through Digital Channels
3. Excellence in Content Management

4.0 Leadership Development

Board asked for an update on our succession planning and leadership development, both of which are aligned to the NHS Leadership Framework. We have delivered 5 cohorts of the emerging leaders (70 staff) aimed at Band 6 and above and junior doctors (Cohort 6 commences in September). We have also run 4 cohorts of the Established leaders (60 staff) programme, working with Healthskills aimed at Band 8A and above and Consultant staff (Cohort 5 commences in September).

The programmes seek to support staff in their development in the following areas;

- Developing your self-awareness and enhancing your impact as a leader within the organisation
- Maximise engagement from teams both locally and across boundaries

- Collectively transforming our Trust and improving patient care
- Experience of undertaking an improvement project and linked reflective learning journal

Three senior managers are currently part of the Horizons programme with Imperial healthcare Trust which covers the following;

- Increase capability as strategic leaders
- Develop the leadership behaviours to support success
- Drive exceptional performance through highly engaged people
- Create inspirational leaders who empower and engage their People

Specific programmes have also been undertaken with clinical teams to support their leadership and working together utilising the INSIGHTS tool.

5.0 Clinical training programmes

The Trust has an extensive programme of clinical training. This includes the provision of national resuscitation courses and simulation and clinical skills programmes.

In the last academic year we have run 24 National Resus courses, for 3805 people (60% trust staff and 40% external staff) utilising faculty staff to deliver training in the majority of instances.

In terms of simulation we run 13 different specific programmes and approximately 93 courses. Over the last year 985 staff have accessed simulation programmes as well as ad-hoc sessions for both Trust staff and other external candidates.

6.0 Communications and Engagement

Our monthly team briefing sessions for all staff have covered topics including the importance of our quality priorities and innovation; improvements in estates and facilities; our research programme; Electronic Patient Records; changes in clinical coding requirements and the great work that the Cardiac Catheter Lab is doing at West Middlesex and Lord Wigram ward is doing at Chelsea. This month's presentations included valuable information on our accounting systems; antimicrobial and control of infection stewardship and our ground-breaking e-services for genitourinary medicine. The latest team briefing is attached to my report. (Appendix 3) As well as sharing information with our hospital these sessions have now become a recognised opportunity for staff to both showcase their work and contribution to the delivery of our services, but also provides a developmental opportunity to prepare and present that work to mixed audiences.

I mentioned my CEO fortnightly briefing to staff at the last Board meeting and attach the latest one to this report (Appendix 4). In these briefings I aim to share some of the amazing stories I hear when I talk to patients; highlight good (and not so good) practice that I see; and provide an overview of the leadership's thinking around key issues facing the Trust.

I have welcomed the regular contact we have had with regional and national leaders and key stakeholders, enabling us to showcase our outstanding work and discuss challenges that we face in the NHS. Amongst others, Professor Oliver Shanley OBE (Regional Chief Nurse for London) and Professor Jacqui Dunkley-Bent OBE (Head of Maternity, Children and Young People at NHS England) visited to learn more about our nurse-led innovation projects. Ruth Cadbury and Vince Cable, our local MPs to the West Middlesex site visited the A&E to look at the tremendous work we do there. The *Getting it Right First Time* (GIRFT), led by Tim Briggs under the auspices of NHS Improvement, has visited twice and provided us with useful guidance.

We are also getting out and about sharing best practice (and gaining recognition) at health events such as the NHS Innovation Expo, the World Congress on Paediatric Burns, the World Confederation for Physical Therapy, and Global Digital Health; in publications such as the All-Party Parliamentary Group Inquiry Report looking at how arts and the environment add to patients' health and wellbeing; and in a range of news items on issues such as the Grenfell Tower fire, dealing with acid attacks, our Dean St services, and documentaries on birth and the wonders of the human body.

We have a busy few months ahead engaging with key stakeholder groups. The West Middlesex Hospital Open Day is on 16th September (11am – 3pm); and the Annual Members Meeting on 28th September (5pm - 6.30pm at West Middlesex). Our staff awards event is on 18th October. The event is a highlight of the year and is an opportunity to recognise the fantastic work of all our staff, not just award winners. We received almost 600 nominations, many from members of the public.

Appointments

I am delighted to report on two key senior appointments; Gill Holmes has been recruited as our new Director of Communications. Gill has extensive experience both at the BBC but also in the charity sector and joins us in October. Susan Simpson will be joining us as our new Company Secretary in November having most recently worked at Kingston Hospital in the same role.

I would also like to take this opportunity to thank Don Neames for his sterling work covering the communications brief and also the joint efforts of Harbens Kaur and Sarah Ellington who have taken responsibility for different aspects of the Company Secretary role.

7.0 Fire Update

Our fire awareness and prevention plans remain a key priority for the Trust. I have personally been undertaking a number of initiatives to ensure staff complete the necessary training, including writing to those that remain non-compliant. We have seen steady progress over recent months but still require further focused effort to get to the required standards. Staff who continue to remain non-compliant will be subject to disciplinary procedures.

We have continued to invest in our estate to ensure we have a safe environment for our patients, staff and visitors. We are underway with our investment programmes to upgrade our fire alarm system and fire doors on the Chelsea site.

In light of the wider focus on fire safety following the Grenfell tragedy, we have recently appointed an independent Fire Safety Authorising Engineer who will conduct two visits per annum to audit the Trust's premises and report on fire safety compliance. The outputs of this will be reported through to our Quality Committee.

A more detailed fire update can be found at the end of my report (Appendix 1).

8.0 Update from Strategic Partnerships Board

The Strategic Partnerships Board (SPB) continues to monitor progress against our main strategic programmes which support delivery of the Trust's vision and our Clinical Services Strategy; the Trust's agreed strategic priorities for 2017/18; and the context of national policy direction and our local Sustainability and Transformation Partnerships (STP), including various programmes of work with other

providers.

The SPB has recently received updates on:

- Joint Work Programme with Imperial College Healthcare Trust where our main progress is in corporate enablers such as the joint digital and shared EPR programme
- Joint Work Programme with Kingston Hospital FT
- Hammersmith & Fulham ACP where, as set out in July CEO Board Report, the current proposal is to sign a formal Partnership Agreement as an enabling step for possible contract award (North West London pilot for 2018-19)
- Richmond Outcome Based Contract where commissioning structures regarding a single management team across Kingston and Richmond CCG's is likely to lead to a 1 year extension to the transitional contract period (to March 2019).
- GP integration where recent good engagement with NHS England and NHS Hounslow has provided a possible model for contract compliance and a business case is being developed which would require Trust Board and NHS Hounslow Governing Body approval
- Oversight of the North West London Pathology collaboration.

I am proposing to set aside time at the Board Strategy Seminar in October to discuss this wider environment and how we consider benefits and impact on our strategic priorities.

I have also attached (appendix 5) the summary of the Board papers from the statutory bodies.

9.0 External Reviews

I am keen that the Board has sight of the various confirmed external reviews that the Trust will receive over the coming few months. Detailed within the appendix (2) of this report is the list of these reviews. Any material issues will be reported up through to the various Board committees.

10.0 NHS Improvement Consultation on revisions to Single Operating Framework and issue of revised Use of Resources Framework

The Board is asked to note expected changes to our governance arrangements and regulatory oversight. NHSI has published a number of proposed updates to the Single Oversight Framework (SOF) to be introduced in October 2017. NHSI are inviting views on these changes until 18 September.
NHSI and CQC have published the final Use of Resources (UoR) framework, following feedback from its consultation. The final framework has been informed by 7 pilots NHSI has undertaken to refine the assessment methodology. NHSI will introduce UoR assessments alongside CQC's new inspection approach from autumn 2017.

The Executive Management Board has reviewed the position and assessed impact. The changes are not considered material but do signal some changes to our reporting metrics which we are preparing to implement in Q3 in 2017/18. It is also proposed that:

1) Final impact assessment (and any response to the consultation) is coordinated through our Business Planning Group to ensure consistency with our planned Operating Plan refresh; and
2) Given the alignment between NHSI frameworks and CQC Well Led domain, that we review changes to reporting, what diagnostic (RAG rating) this shows and any proposed actions at relevant committees alongside our developing Board Assurance Framework. A more detailed review of the

changes to frameworks and proposed actions will be provided for each Committee.

The key issues are summarised below

Single Operating Framework:

There are no specific changes to the underlying framework itself— i.e. the five themes, NHSI's approach to monitoring and how support needs are identified and providers segmented will not change – although there some adjustments to individual indicators and supporting guidance.

There are no changes to finance metrics, other than no implementing the 2 new metrics in year (capital controls & cost per WAU), so no impact on financial rating is anticipated. The trajectories for A&E performance remain the same.

The development of STPs and the move in some areas towards accountable care systems and organisations increasingly means leadership across a geographic area and across organisational boundaries and suggests this will be a stronger focus of the well led framework. It is not yet clear how providers' contribution to local transformation will be measured under the SOF but it does appear that the revised SOF signals NHSI's intention to take into account system—wide leadership, as measured through the STP ratings, under its strategic change theme.

Use of Resources Framework:

The metrics are consistent with SOF so no impact is anticipated on this part of the rating (we are already reporting this each month to NHSI)

There are some additional metrics for clinical, corporate and people although still mostly financially derived. There will be a combination of absolute (our position) and relative (benchmarked) reporting

NHSI will continue to monitor a trust's finances and operational productivity — and associated support needs — between Use of Resources assessments, using the Finance Score and metrics available through the Model Hospital, alongside other relevant evidence.

11.0 Electronic Patient Record (EPR) Programme

As Part of the Trust's EPR programme the Board requested the implementation of an independent gateway review process to assess the state of readiness across a number of gates and track the delivery of the programme. In order to support this process the Trust appointed Ernst and Young (EY).

The programme has been split into three phases - Phase 1, Phase 2 and Phase 3. The focus of this gate is Phase 1 which involves the implementation of a Patient Administration System, Emergency Department, Theatres, Order Communications and Results Reporting solution for the West Middlesex University Hospital. The scope of the first gateway is to assess that the Programme set up is complete.

I am pleased to report that EY's assessment of the programme was positive and we were deemed low risk. The Finance and Investment Committee will be reviewing the report in more detail when they meet at the end of September. I'd like to thank all of the teams involved for their hard work and effort in getting us to this stage of what is a very exciting but challenging programme of work.

12.0 Finance

At the end of July, month 4, our year to date adjusted position is favourable to the internal plan by £0.32m. Pay costs remain over plan by £4.1m, offset by underspends in non-pay and revenue in excess of plan.

We had planned to achieve £7.3m of our savings target for 2017/18 of £25.9m by the end of month 4 but actually achieved £5.5m. We need to work hard to get our CIP delivery back on plan and to ensure we achieve our year-end target.

Lesley Watts
Chief Executive Officer
September 2017

APPENDIX 1

FIRE SAFETY – ESTATES UPDATE

The Trust has appointed a fire consultancy specialist to act as an independent Fire Safety Authorising Engineer. The Authorising Engineer will conduct two visits per annum to audit the Trusts premises and report on fire safety compliance. The Authorising Engineer's report will be presented to the Quality Committee biannually to identify the actions that arise from the audit. In addition, if any actions or recommendations made by the Authorising Engineer are not appropriately addressed, the Authorising Engineer will inform the Chief Executive directly.

Chelsea and Westminster Hospital

There are no internal or external cladding issues at Chelsea and Westminster Hospital.

Installation work on the new hospital fire alarm system continues with work programmed to complete in the first quarter 2018/19 financial year. In addition, a review of the fire doors throughout the hospital has now been completed.

Work to ensure ongoing compliance with fire regulations is now in progress on a number of the compartment doors to improve their resilience. A business case for the full scope of this work is being presented at the Capital Programme Board in September.

West Middlesex University Hospital Site

The Trust buildings have three different types of cladding at the West Middlesex Hospital site, none of which present a significant risk to the Trust. In addition, given the height of the buildings, the London Fire Brigade could extinguish any external fire with ease to prevent fire travel across external surfaces and into the building on which it is fitted travel.

The cladding used at the West Middlesex Hospital can be categorised as either brick facia, cedar wood stuck to concrete, or a product known as Kingspan Microrib. All of the cladding used in the construction of these buildings continues to conform to Health Building Notes (HBN's).

In addition, we have now been able to confirm that all cladding products used in the construction of the Trusts buildings are either Building Research Establishment (BRE), or British Board of Agreement (BBA), approved. Both of these organisations are government approved, and hold UKAS accreditation which is assessed against International standards.

<u>QMMU ModuleCo Units</u>

The type of cladding (Kingspan Microrib) used in the construction of the maternity units has already been independently tested by the BRE, a recognised certificated Government test base for all building related products, a certificate has been provided to the Trust.

<u>Main Hospital</u>

The Trust are now in receipt of documents from our PFI provider confirming the cladding (cedar wood stuck to concrete) has BBA test certificates confirming the safety of the cladding.

Marjory Warren Building

The brick facia cladding to the Marjory Warren Building has BBA accreditation.

Notwithstanding the above, 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 and Marjory Warren Building's remains compliant. However, the BRE has indicated a significant waiting list for this type of test, which could take up to two years to complete given we are deemed low risk. The PFI partner has therefore been instructed to obtain test certificates from an alternative European or International test facility which they are currently trying to source.

FIRE SAFETY – TRAINING AND DEPARTMENTAL PLANS

Statutory Fire General Awareness training has continued to improve and is currently 86% (C&W site) and 89% (WM site). Fire Marshal (FM) numbers have increased progressively each month and there are now 345 trained at C&W (268 at WM site) with a further 88 staff bookings on forthcoming scheduled courses at C&W and 35 at WM. Clinical Site Managers (CSM's) across both sites have also been trained as FM's to act as first responder in addition to the Security staff that are all fully trained. The Executive have made a decision that from September fire training for all staff will be to Fire Marshall Standards.

All departments across our various sites now have up to date fire risk assessments with a programme in place for ongoing review. Key focus areas as result of these updated assessments have been remedial work to some estate; increased emphasis on testing evacuation plans; and completion of routine fire drills.

All clinical areas across our sites now have an evacuation plan for their areas and we will have completed this work for non-clinical areas by the end of September. These plans form the basis of fire drills for which a schedule has been developed for all of our sites. 12 fire drills have been completed at C&W since November 2016 and 7 at WM this year. This is aligned with the required level 1 fire safety management within HTM 05-01.

APPENDIX 2

External Reviews

Month	Specific Date	Reviewing Authority	Where Will the Inspection Take Place?	Aspects of Compliance to be Tested	Executive Lead	Lead Director	Operational Lead	Reporting Group	Group overseeing compliance
September 2017	19th-21st September	Information Commissioner's Office	ICO Audit	ICO Standards and Toolkit	Kevin Jarrold/ Karl Munslow-Ong	Graham Trainor	Company Secretary	Information Governance Steering Group	Audit Committee
	20th of September	Endocrine Peer Review	Children's Services		Zoe Penn	James Beckett	Sunaina Bhatia	WCHGDPP Divisional Board	Compliance Group
	28th September 9-12 am	GIRFT	Paediatrics	GIRFT dataset	Zoe Penn	James Beckett		WCHGDPP Divisional Board	Compliance Group
October 2017	30th (October 1pm)	GIRFT	Obstetrics and Gynaecology	GIRFT dataset	Zoe Penn	Simon Mehigan		WCHGDPP Divisional Board	Compliance Group
November 2017	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
	28th of November	GIRFT	General Surgery	GIRFT dataset	Zoe Penn	Bruno Botelho	Faizal Mohomed-Hossen/Musa Barkeji	Planned Care Divisional Board	Compliance Group

Team briefing

August 2017

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

CW+ PROUD May 2017 award winners

- Planned Care - St Mary Abbots Ward. A fantastic team that always rises to a challenge, works together as a team and supports each other with learning and development. They have a unified commitment to achieving the best standard of care for our patients and representing the Trust.
- Emergency and Integrated Care – Dr Alina Grecu. For her part in responding to the Grenfell Tower fire; even though not on shift or called in Dr Grecu attended the ED department as she saw the breaking news and was on hand to receive the first affected patients. Her actions reflect her passion for the emergency service and as a real team player.
- Women and Children – Children's Surgical Team. The paediatric surgical junior doctors have risen to numerous challenges. They have strong leadership and have constantly put the PROUD values first. The patient has been at the forefront of all their decisions. Staying after contracted hours; coming in when not on duty to help; calling patients to ensure they have received information They have embodied not only the Trust's core values but have demonstrated repeatedly their commitment to good surgical practice.
- Corporate – Alan Hardy. Alan has demonstrated his dedication to Radio West Middlesex and the hospital as a volunteer for 50 years and was instrumental in setting up the service in 1967.

Visit the intranet to nominate a team or individual.

Performance

The A&E Waiting Time figure for June was achieved at 95%. Chelsea and Westminster was one of only three trusts in London to be compliant with the standard.

The RTT incomplete target was not achieved in June for the Trust with a performance of 91.2%. However, this was an improvement on the May position. The RTT recovery trajectory is based around introducing new controls and measuring administration issues at C&W on a daily basis to ensure the correct patients are booked into capacity. We are also aiming to increase capacity where possible to reduce the backlog. The trajectory indicates that compliance will be achieved by August 2017.

All cancer access indicators were passed in June except for 2 week breast symptomatic referrals and 62 days NHS screening to first treatment.

Financial update

At the end of June, month 3, our year to date adjusted position is favourable to internal plan by £0.23m. Pay costs are over plan by £3.23m; an increase of £0.84m on the previous month. As in the previous month, this is offset by underspends in non-pay and revenue in excess of plan. Our underlying financial position at the end of the first quarter was an £8.5m deficit.

We achieved 13.7% of our savings target in the first quarter when we had planned to achieve 19.8%. We need to continue to work hard to improve our CIP delivery and ensure we achieve our year-end target of £25.9m

Divisional updates

Emergency and Integrated Care

The Emergency and Integrated Care (EIC) Division has hosted several external visits and peer reviews. Most recently NHS Improvement (NHSI) has been at both hospitals reviewing our emergency pathways and you may have seen them visiting some of our wards as well. These visits take much preparation and effort, so well done to all those that took part – and so far the feedback has been very positive with just a few areas where we can improve further. Elsewhere, the Division continues to make progress with achieving better quality and governance processes, and have a continuing focus on sharing learning from incidents while also celebrating praise from many the compliments received. Some more good news: the key operational performance target (ED 4hr) is significantly improved again for July, which reflects the hard work, in both hospitals, to deliver a high quality and efficient service to our patients – so a huge thank you to everyone that has contributed. Finally, we are starting our planning for winter, so do start thinking about your own department or ward preparations and most importantly, try to enjoy some leave and rest over the summer months.

Planned Care

Planned Care will start holding a welcome breakfast for our new joiners, alternating every month between CWH and WMUH sites. This will also be an opportunity to celebrate our monthly PROUD awards as we continue to recognise the amazing work taking place in the clinical and non-clinical areas.

We would like to welcome Paul Silvester, General Manager for Theatres, Anaesthetics and Critical Care and Rachel Brough, RTT Programme Lead. Both started on 1 August and will be working closely with clinical and non-clinical teams to improve patient access and the delivery of excellent patient care.

We are aiming to re-launch the Surgical Admissions Unit (SAU) at WMUH during August. SAU at CWH has significantly improved length of stay and patient flow, and we expect these achievements will continue to be accomplished at the WMUH site.

Women's and Children's

The Division has had a busy month with the change of pathway in Paediatric ED at WMUH and Comet Short Stay Unit launched at the CWH site. Carly Knell started as the General Manager for Women's Services cross site and Maternity Support Worker Melany Knight was the well-deserved recipient of our PROUD award. Kobler Clinic is launching a new pathway for stable patients and Kobler Daycare has been renamed Gazzard Daycare in recognition of our eminent Professor. Please keep an eye out for our new starters' welcome events; the Divisional management team are keen to hear your ideas and reflections.

How will the Cerner EPR change your world?

Next month we're taking the Cerner EPR (electronic patient record) system on the road. Mabel's story will show how the system supports every step in one patient's care. Find out how you will use the Cerner EPR to care for patients like Mabel. The people who are helping design the system will

be there to show you. Experience Mabel's journey on 5 & 6 September at WMUH and 7 September at CWH.

Care Quality Programme Update
The Care Quality Programme continues its work with current focus on meeting CQC standards. The August CQP Steering Group reported firm progress on the key work themes. Thank you to all staff and leads who have been supporting work programmes for the CQP work. A more detailed briefing will be available next month. In the meantime take the chance to read the Trust CQC handbook and sure you know your part in promoting high quality care.

Mandatory and statutory training
Managers and staff are reminded to check their latest Core Training compliance status using Qlikview (CW) or Wired (WM). Please note that neither system is updated in real time so check the date last updated before raising any queries on compliance.
E-learning: due to on-going IT issues, there are contingencies in place to help staff with compliance:

- PCs in the Hub (CWH) have recently been updated and staff can now access the e-learning modules
- The same e-learning modules can be accessed directly via www.e-lfh.org.uk. On completion of the module(s) send a screen-shot of the confirmation to learnonline@chelwest.nhs.uk L&D Admin
- Paper versions are available for most modules via the intranet. (There will be a delay in updating compliance due to the volume of assessments being processed).

It is important for managers / staff to book their classroom sessions in good time, and not wait until the last minute. Use the "Due to Lapse" report that is distributed each month via the HR Business Partners, to help plan ahead.

Baby friendly
West Middlesex University Hospital has been successfully re-accredited for the UNICEF Baby Friendly Initiative (BFI), which demonstrates how our staff support mothers to breastfeed and help build a close and loving relationship with their baby. The WMUH team has worked incredibly hard over the past year, to train staff to the BFI standard for breastfeeding knowledge and skill. The CWH site is due to undergo its assessment by UNICEF in October and we will use WMUH's experience to help prepare us. We are confident we will be able to replicate their success.

School of Medicine Teaching Excellence Awards
Staff from WMUH have received three highly prestigious Teaching Excellence Awards from Imperial College London. Dr John Platt, Consultant Lead for Care of the Elderly, has been awarded the Associate Dean Award which recognises a lifetime of teaching and contribution to Imperial Medical Students. Dr Ashkan Sadighi, Consultant in Acute Medicine has made such an impact on students that despite having only been appointed as a consultant recently, has received one of eight Teaching Excellence Awards. In addition Mr Glen Fernandes, our Undergraduate Teaching Coordinator has transformed the way undergraduate tuition is provided at WMUH and has been recognised for his unstinting calm and interest in Supporting the Student Experience.

56 Dean Street wins three prestigious awards
Congratulations to teams at the sexual health and HIV centre in Soho for winning in three categories at this year's Communiqué Awards. Their digital lifestyle intervention PRIME won Innovation in Healthcare Communications; Excellence in Engagement Through Digital Channels; and Excellence in Content Management.
56 Dean Street's pivotal role in ending the AIDS epidemic in the capital has been highlighted in a recent global report by UNAIDS

Cas Shotter Weetman Doctorate
Congratulations to Cas, Lead Specialist Nurse Cardiology, who has been awarded a Doctorate (PhD) of Nursing from the University of West London, supported by CLARCH and the Ethicon Trust - RCN. The thesis focused on patient experience post angioplasty, the journey from admission to discharge, and the development of a tool for effective communication on discharge.

The Accessible Information Standard (AIS)
The AIS tells organisations how they should make sure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. We are committed to supporting our patients and service users and continue to work towards implementing this standard. More information can be found on the NHS England website and for Trust-related information, please contact Priti Bhatt, Equality and Diversity Manager by emailing priti.bhatt@chelwest.nhs.uk

Star awards nominations
Nominations for our annual staff awards are open! We want as many nominations as possible and every one we receive will be reviewed by our leadership team – each will go a long way in helping us to acknowledge the commitment and hard work of individuals and teams who work tirelessly every day to provide patients with the good care and experience they deserve. Let us know who has gone above and beyond in your department
www.chelwest.nhs.uk/about-us/awards/staff-awards/staff-awards
Nominations close at 9am on Monday 14 August with winners revealed at an evening ceremony on the 18 October.

Annual members meeting
All staff are invited to our Annual Members' Meeting on 28 September from 5.30 – 7.00pm in Rumbles restaurant (WMUH). Their will be presentations from the Chief Executive, Chief Financial Officer and Council of Governors; information about our progress and performance over the last year, and plans for 2017/18.

WMUH Open Day
We are counting down to the WMUH Open Day on 16 September. If you would like to take part please email communications.wmuh@chelwest.nhs.uk / call (72) 5035.

Waterloo and South West Upgrade – Rail Disruption
Network Rail is carrying out major improvement work at Waterloo station from 5 to 28 August. Significantly fewer South West Trains services will be running into Waterloo. This will mean lengthy queues during peak times at all major stations on the South West Trains network; station closures, and more crowded services. For more information visit www.tfl.gov.uk/waterloo-works

September 2017 team briefing dates
Mon 4 Sept, 9-10am, G2 Offices Harbour Yard
Mon 4 Sept, 11am–12pm, CW+ MediCinema CWH
Tue 5 Sept, 11am-12pm, Meeting Room A WMUH

Chief Executive's briefing

A reflective beginning

Over the past few weeks while attending many meetings with staff, patients, health partners and our senior leadership team, it became more and more apparent how crucial a part our values play in our decision making.

Our values are:

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

These values set out what we want for ourselves and our patients. We all make hundreds of decisions every day and these decisions are a reflection of our values and beliefs.

The decision taken by Oscar, HCA medical student on David Erskine ward, saved a life as he spotted a sepsis flag and escalated it. An excellent example of our valuing putting patients **first**.

We must remain committed to these values, driving the delivery of our strategy and underpinning all that we do to provide safe, high quality, compassionate care for each and every patient.

You will know that our strategic priorities are to:

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

How we deliver these priorities is outlined in our Quality Strategy and Plan (QSP) 2015/18, Clinical Services Strategy and our Operating Plan 2017/18. If you haven't already done so, I encourage you to take a look, for they outline our direction of travel to secure our future in these challenging times. In reviewing these documents, you will understand about our priorities and plans.

Our Care Quality Programme (CQP) continues to drive forward the education and changes we need to make to strengthen the way we deliver care to our patients. Safe, quality care is everyone's responsibility. We are all accountable and must never become complacent.

The simplest of mistakes can have a huge impact, whether it's not remembering to wash your hands, which is one of the most important things you can do to help prevent and control the spread of infection, to not wearing your lanyard, ID badge, which not only signifies you are part of the organisation but also that you have the authority to access the building and certain areas within it.

The latest theme in our quality improvement programme focuses on 'never events' which are serious, largely preventable patient safety incidents that should not occur... the title says it all. Last financial year we had one never event. Every day we should try to ensure another one doesn't happen in our organisation.

- Read more about never events

Great work

I see teams continuing to work hard across the Trust to ensure we meet our performance targets and although I hate to say this in August…but winter *is* coming!

We know winter brings added pressure to our services, particularly to the front end, A&E (well done to the them for achieving the waiting time performance standard for July!), and so we must be well prepared.

Our winter plan will be submitted on 7 September to NHS England and it is important that all divisions support the creation of this plan.

Targets and quality indicators often get a bad reputation. However, they give us information about how well we provide care to our patients, how we compare to other hospitals and, as important, the areas in which we have to work harder.

Targets don't have to stifle the way in which we work; we support those who rise to the challenge, offering creative ideas on how we can do things better—as shown through our joint work with the Digital Accelerator Programme and CW+ to successfully establish digital health innovation across five areas within the Trust. These are led by the Medical Directorate and Learning and Development.

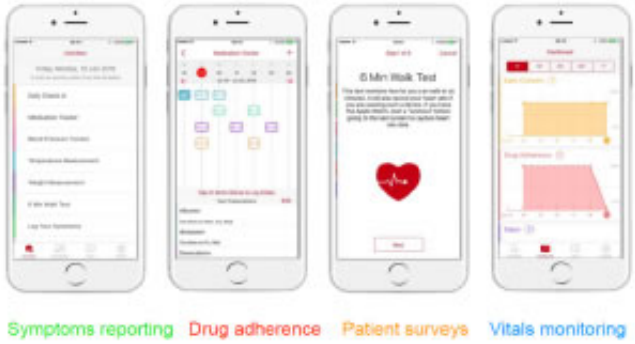
A selection of innovations were presented by our Medical Director Zoë Penn and CW+'s Lawrence Petalidis at the last Team Briefing:

- Digitising ward auditing and accreditation

- The first UK pilot for stoma patient digital health

- Physiotherapy remote guidance

- Remote monitoring of heart failure patients



- Improving postnatal ward patient experience and system efficiency

A huge 'well done' to all the teams involved. Your dedication and hard work is inspirational! Thank you.

- See Team Briefing for more information

Quality and innovation

We were delighted to welcome Professor Oliver Shanley OBE (Regional Chief Nurse for London) and Professor Jacqui Dunkley-Bent OBE (Head of Maternity, Children and Young People at NHS England) to our hospitals to learn more about our nurse-led innovation projects.

Following the three Dragon's Den-style pitches, where we saw presentations on transforming the birthing pool rooms on Labour Ward, improving oral hygiene for patients, and implementing 'safety huddles', Oliver Shanley and Jacqui Dunkley-Bent awarded first prize to Angela Chick (Kew Ward Sister) for her forward thinking oral hygiene project 'Mouth Care' which will now receive funding and support from CW+ to

implement in our hospitals. Good work, Angela!

All winners receive a £10,000 grant and a further six projects will be receiving funding in future from our charity CW+.

International recognition

LONDON

CITY CASE STUDY

The 56 Dean Street Clinic is playing a pivotal role in ending the AIDS epidemic in the capital of the United Kingdom. Located in central London, the clinic has prescribed more than one quarter of the PrEP prescriptions in England, and it diagnosed one in four of London's HIV cases in 2016 (68). New data suggest that the clinic is an important case study in how improved antiretroviral therapy outcomes, combined with PrEP uptake, can sharply reduce the risks of HIV transmission.

In recent years, the clinic has prioritized efforts to encourage repeat HIV testing among clients who show a high risk of HIV infection (e.g. those with a rectal STI) and to reduce the time between an HIV-positive diagnosis and treatment initiation. In 2010–2011, the median time between diagnosis and treatment initiation for people in the United Kingdom who seroconverted was 1.4 years. The 56 Dean Street Clinic reduced that gap to 26 days, and in 2016, it instituted new procedures and capacities that further reduced the gap to seven days after diagnosis (69).

Data from Public Health England show that the 56 Dean Street Clinic is among a small group of London clinics that have recently experienced steep reductions in HIV diagnoses among gay men and other men who have sex with men (Figure 3.22). These declines are driving an overall reduction in new HIV diagnoses among gay men and other men who have sex with men in England. This trend has been accompanied by a year-on-year increase in the median CD4 count at diagnosis, suggesting that gay men and other men who have sex with men are being diagnosed earlier (70).

Data suggest that the 56 Dean Street Clinic and other steep-fall clinics have reduced the risk of onward transmission of HIV among their clients.

Researchers developed a transmissibility ratio to measure this risk of transmission: the number of clients at risk of transmitting HIV (the estimated number of men with a viral load greater than 200 copies/mL) divided by the number of clients at risk of acquiring HIV (HIV-negative men who were diagnosed with a STI within the last year). The transmissibility ratio in steep-fall clinics in 2015 was 0.49, compared to 1.66 in other London clinics and 1.73 in clinics outside of London (70).

54

57

56 Dean Street's pivotal role in ending the AIDS epidemic in the capital has been highlighted in a recent global report by UNAIDS (United Nations AIDS)—presented at the International Aids conference in Paris.

- Read the UNAIDS report

UNICEF UK Baby Friendly reaccreditation

Maternity and SCBU on the West Mid site have successfully been reaccredited as Baby Friendly by the UNICEF UK Baby Friendly Initiative (BFI). This comes as fantastic news recognising West Mid's dedicated work over the past year to train staff to the BFI standard for breastfeeding knowledge and skill.

Kerry Person of the Year Award 2017

Our very own Non-Executive Director, Liz Shanahan has been awarded London's Kerry Person of the Year Award for her contribution to the global healthcare and pharmaceutical industry. We are PROUD to have you on our team, Liz!

North West London Critical Care Network win HSJ patient safety award

The Patient Transfer bag was designed and launched in all North West London Hospitals

in 2016 and is in use in every Emergency Department, Critical Care and High Dependency Unit to support the Transfer of critically ill and injured patients. Pictured above are Debbie van der Velden (Matron, Critical Care) and Barbara Walczynska (Clinical Audit Coordinator, ICU).

Letters of praise from patients

Nuclear medicine department at C&W
"Dr Margaret Phelan... Yesterday I attended the department for a nuclear profusion test and I wanted to let you know how superb the team was in every respect. All the staff, whatever their position, were without fail, efficient, courteous and cheerful. All the operators explained exactly what their part of the procedure was and possible effects that might be felt."

A&E, plastics and therapy departments at C&W
"I am writing to express my gratitude for the treatment which I received at the hospital, beginning with A&E when I had been knocked down by a bicyclist. My last appointment was in June at the hand therapy section. Although the department was very busy, everyone I met was very friendly and efficient.

"I had broken my wrist. The plastic surgeons (Mr McArthur's team) were excellent—explained the position and what they proposed and were most reassuring. I have to say, however, that I am most grateful for the treatment I received from Ms Zoë Thompson, the physiotherapist. She is a very caring person, who went out of her way to explain what she was doing and what to expect along the way and was very knowledgeable—a real credit to your hospital. My wrist did improve as she said despite my initial fears!

"The hospital itself is so well run and has such a good atmosphere. If I ever have to be ill or injured again, I do hope it is in your vicinity!"

Lampton, Kew and Sion 1 wards at WMUH
"I have the sad duty to write to you on the death of my dear 97 year old husband William who spent so much time in hospital between November and January. Moreover, he was admitted a number of times after that because of catheter problems not helped by his increasing dementia. He also had a couple of falls at the care home in Hounslow.

"His spells in hospital were spent in Lampton, Kew and Sion 1 wards. In all of them he received really great care, comfort and dignity from the consultants, doctors, nurses and domestic staff. This is the purpose of this letter—we would like to put this on record as testament to our appreciation and gratitude.

"We have now said goodbye at his great funeral to a devoted father, grandfather and great-grandfather. But when we needed it, we have been greatly supported by all the professionals who often worked under difficult circumstances. We do appreciate all that was done to make him comfortable and for the manner in which he was always treated with human dignity."

Defaced pictures—criminal damage

Unfortunately I sometimes need to talk about an unpleasant experience within one of our hospitals.

On 9 August from 6:24–6:44pm a man wearing a black hat, yellow jumper and grey jogging bottoms was in the Chelsea site and defaced walls and pictures in A&E and historic valuable portraits in the Trust boardroom. If you have seen this man, or have any information that may lead to his whereabouts, please contact Trevor Post.

On Instagram

46 likes

katrinasheikh I have always wanted to look after high dependency patients as an Acute Medic. Not many hospitals offer this. Chelwest let me do this ☺️. #level1reg #acutemedicine #medicine #surgery #postop #medics #surgeons #teamwork #hospital #hdu #highdependency #medreg #adrenaline #diagnosing #criticallyunwell #london #nhs #7daynhs #chelseaandwestminsterhospital #doctor #scrubs #redtrousers #suede #boatshoes #bluesuedeshoes

43 likes

niamhypoos Feeling very proud to be Birthing Partner to @mary_kay_90 Attending Antenatal Classes at #chelseaandwestminsterhospital. We are so lucky to live in a country where this level of support is provided free of charge. An amazing and fascinating workshop run by this phenomenally knowledgeable woman. A lesson taught in a calming, interesting and fun way. I'm really impressed and hope these resources will be available for everyone who could benefit from them in the future #savethenhs

I hope everyone has a good weekend.

Lesley

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

SUMMARY OF BOARD PAPERS – STATUTORY BODIES

HEALTH EDUCATION ENGLAND – 18 JULY

For more detail on any of the issues outlined in this summary, the board papers for this meeting are available here.

Expansion of medical student intakes

- The Secretary of State for Health has announced an increase of 1,500 medical school places a year from 2018/19.
- Health Education England (HEE) and other stakeholders have welcomed this expansion, as a key opportunity to expand the medical workforce to meet future needs whilst reducing the reliance on overseas doctors.
- The allocation of additional places also provides an important opportunity to address other HEE priorities: encourage wide participation among the medical workforce; boost training in under-doctored areas; provide a greater focus on those specialities where it is more difficult to recruit; encourage innovation; and consider the introduction of new medical schools.
- The introduction of these medical school places will be phased: 500 in 2018/19 and the remainder thereafter.
- Higher Education Funding Council for England (HEFCE) informed medical schools of their allocations on 31 May.
- HEE say it is safe to assume most medical schools will be keen to increase their intakes and that applications may total more than the planned additional 1,000.
- The DH's has confirmed the responses to their consultation (*Expansion of Undergraduate Medical Educations: a consultation on how to maximise the benefits from the increases in student numbers)* showed strong support for application of the following criteria: maintaining high quality of training and placements; encouraging social mobility; meeting local workforce need; supporting shortage medical specialities; and exploring new technologies and innovation.
- In order to allow providers to plan their 2019/20 recruitment based on the outcomes of this process, recommendations will need to be endorsed by the HEE board in February 2018 and communication to providers by May 2018. See Annex A for the proposed timeline.
- It has been proposed that this project will be overseen and run as a joint working group between HEFCE and HEE.

Local education and training boards' assurance 2016/17

- In May 2016, HEE's board confirmed the move from 13 Local Education and Training Boards (LETBs) to 4 LETBs to better reflect the Five year forward view delivery infrastructure.
- The *Local Education and Training Boards (LETB) Assurance Framework* requires that LETBs submit annual effectiveness reviews to demonstrate ongoing progress against four developmental domains: developing a shared vision; aligning structures, systems and processes to this shared vision; bringing their values to life; and developing an improvement-driven culture. Each LETB will be given an assurance rating by the Performance Assurance Committee considering the evidence that has been provided.

Bringing evidence to the bedside and boardroom

- The board received a presentation on the importance of and commitment of arm's length bodies to library and knowledge services, a "hidden gem" in our NHS.
- These services can play a crucial role in making sure decisions made are based on evidence. They have been referred to as a useful partner to help drive transformation in health and care outcomes.

CARE QUALITY COMMISSION – 19 JULY

For more detail on any of the issues outlined in this summary, the board papers for this meeting are available here.

Chief executive's report

- Care Quality Commission (CQC) will share their wider digital strategy in September, describing how CQC's structure, people, finances and ways of working need to change in order to deliver the digital function CQC needs over the next three years.
- Department of Health (DH) published their response to the National Data Guardian's (NDG) *Review of Data Security, Consent and Opt-Outs* and the CQC's *Safe Data, Safe Care Review.*
  - As outlined in CQC's review, CQC has amended its assessment framework and inspection approach to include assurance that appropriate internal and external validation against the new data security standards have been carried out, and will make sure that inspectors involved are appropriately trained.
  - CQC have strengthened their key lines of enquiry on information governance and will ensure providers are effectively assuring themselves and meeting the standards set out by the NDG, as part of well-led assessment.
  - CQC will also include external audit or validation results in the regulator's further assessments and work with NHS Digital to share information.
  - CQC are piloting these changes in their updated inspections of how well-led NHS organisations are at trust level, and will roll this approach out from September 2017 onwards.

Fire safety action plan 2017

- CQC's issuing of inspector fire safety guidance was brought forward and issued this month.
- CQC is also reviewing inspection reports from the past 12 months to identify the number of occasions fire safety has been raised as an inspection issue and to see how many addressed those issues.
- A CQC working group is being set up to review the organisation's registration and inspection policy and guidance across hospitals.

2017/18 Corporate Performance Report

- A project to improve report timeliness has been set up with Deputy Chief Inspectors and nominated leads across the inspection and enabling directorates.
- 68% of CQC's business plan milestones are 'on track'.
  - CQC has marked the organisation's ability to deliver information management and technology improvements as 'amber/red' (high). As outlined in May's summary, the executive team and board have agreed the priority areas for the digital programme development which is now being managed and contracts put in place.
- CQC also marked their ability to introduce their new assessment framework and approach in hospitals as 'amber/red'. Work is underway to provide assurance of system readiness, this includes: digital publication of hospital reports; the hospitals handbook has been published and the frameworks for all sectors are now in place; the next phase of regulation consultation has been published on 12 June.
- The consultation response and final assessment framework for use of resources assessments for NHS trusts will be published by NHS Improvement shortly. From October, there will be a consultation focussing on how to produce combined ratings which will be published on inspections carried out from January/February onwards.
- CQC's hospital directorate are prioritising re-inspection of services rated as inadequate prior to April 2017 which have not as yet been re-inspected so that these will all have been inspected by March 2018.
  - They will also re-inspect all services rated as requires improvement prior to April 2016 by March 2018.

- Frequency based commitments will apply to locations that are inspected from April 2017.
- Overall the trend of inspections resulting in improvement to the rating is positive and the majority of re-inspections result in an increased rating.

Local System Reviews Methodology

- Following the spring budget announcement of additional funding for adult social care, the DH approached CQC to undertake a programme of targeted reviews of local authority areas.
  - The reviews form part of a package of support measures, to identify and support local systems that are challenged, and to promote an integrated approach across adult social care and the NHS.
  - CQC have now received a formal direction from the Secretaries of State requesting that the regulator undertakes up to 20 reviews in 2017/18 under section 48 of the Health and Social Care Act 2008. CQC will make recommendations to local system leaders, advise the Secretaries of State as to how improvements may be secured, and publish a national report.
    - CQC have been informed of the first 12 sites with a further 8 to be confirmed in the coming months. The first 12 reviews will take place as follows:
    - The most up to date slide deck setting out the methodology can be found in Appendix 1 alongside the list of final draft key lines of enquiry in Appendix 2.
    - The CQC has also shared a Local System Overview Information Request form and a paper setting out a proposed approach to assessing relational working in the local system reviews, as part of the overall methodology.
    - Following each visit, CQC will produce a bespoke report for the Health and Wellbeing Board setting out the findings and making recommendations for required improvements. This will be followed by a local summit for national partners and the local area to agree the improvement offer.
    - At the end of the programme, CQC will produce a national report summarising the findings and required system improvements.

NHS ENGLAND BOARD MEETING - 21JULY

For more detail on this summary, the board papers for this meeting are available here.

Chief executive's report

- Stevens listed his visits over the last few weeks: this included the Westway centre, which he visited in light of the Grenfell tower tragedy. He paid tribute to all NHS staff and reminded the board that many lived and worked within the community. He also confirmed that he has met with the new West Midlands Mayor, Andy Street.
- Stevens was pleased by the Commonwealth Fund's assessment of the NHS. He also welcomed the annual cancer patient survey which confirmed improvement of patient experiences in cancer care.

Developing Academic Health Science Networks paper

- In March 2018 the 15 Academic Health Science Networks (AHSNs) will reach the end of their first five year cycle. There will be a developmental process for relicensing based on iterative planning and the AHSNs will submit their initial proposals.
- The board paper goes on to say "as part of the portfolio adjustments announced in June 2017, NHS England is strengthening its focus on supporting the life sciences, innovation and research."

Finance and performance report papers (month 2)

- 89.7% attainment of 4 hour A&E target in May 2017. There were 2,069,000 attendances in A&E in May. Attendances over the last twelve months are up 0.1%. 508,000 emergency admissions in May, 3% more than May 2016.
- RTT standard was met with 90.4% of patients waiting less than 18 weeks. The number of RTT patients waiting to start treatment at the end of May 2017 was just over 3.81 million
- Delayed transfers of care – 178,400, total delayed in May, of which 115,600 were in acute care. This is a small increase from May 2016, where there were 172,300 total delayed days.

Net Expenditure	Year to Date				Forecast Outturn			
	Plan	Actual	Under/(over) spend		Plan	FOT	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
CCGs	13,157.2	13,166.8	(9.6)	(0.1%)	79,924.9	79,898.7	26.2	0.0%
Direct Commissioning	3,893.2	3,890.2	3.0	0.1%	24,566.7	24,566.8	(0.1)	(0.0%)
NHSE Running & central programme costs (excl. depreciation)	193.3	163.4	29.9	15.5%	4,619.3	4,639.3	(20.0)	(0.4%)
Other including technical and ringfenced adjustments	10.7	9.1	1.6		23.0	34.0	(11.0)	
Total non-ringfenced RDEL under/(over) spend	**17,254.4**	**17,229.5**	**24.9**	**0.1%**	**109,133.9**	**109,138.8**	**(4.9)**	**(0.0%)**

- At month 2, NHSE is reporting a YTD underspend of £25m,with CCGs overspending by 0.1%, offset by underspend in direct commissioning and NHSE central budgets. The full year forecast, excluding the release of the 0.5% CCG risk reserve, shows a position broadly in line with plan.

Other

- Sustainability and transformation partnership rankings have also been released, with the 44 STPs rated "outstanding", "advanced", "making progress" or "needs most improvement".
- The board also discussed a paper on items which should not routinely be prescribed in primary care. Homeopathy and gluten free products are discussed in some detail.
- NHS England also released its annual report this week. The headlines include:
  - CCGs underspent by £154m (0.2%) in 2016/17. NHSE commissioning underspent by £296m (1.2%)
  - NHSE admin budget underspent by £439m (13.2%). The total NHSE budget underspent by £902m (0.9%)

Contact: Ginny Nash, policy officer, ginny.nash@nhsproviders.org;
Adam Wright, policy officer (finances), adam.wright@nhsproviders.org

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	2.2/Sep/17
REPORT NAME	Serious Incident Report
AUTHOR	Stacey Humphries –Quality & Clinical Governance Assurance Manger Vivia Richards – Head of Quality and Clinical Governance Harbens Kaur – Head of Legal Services
LEAD	Pippa Nightingale – Chief Nurse
PURPOSE	The purpose of this report is to provide the Quality Committee 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 investigation into the Medication-related Never Event reported in June 2017 has been completed, and the final report submitted to the CWHHE collaboration. • Rainsford Mowlem has a higher number of reported SIs than other wards.
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	• All divisions have made significant progress with closure of actions. • The number of incidents reported affecting patients has remained fairly even on both sites; a total 469 on CWH site compared to 446 on the WMUH site. • There was a significant decrease in the number of SIs reported in July 2017 (5) compared to June 2017 (10). • The YTD position relating to Hospital Acquired Pressure Ulcers is 9 compared to 14 for the same period (end July) last year.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• All divisions have made progress with closure of outstanding actions. • This report is now appearing as an agenda item at divisional quality board meetings to share Trust wide learning.
DECISION/ ACTION	The Trust Board is asked to note and discuss the content of the report.

SERIOUS INCIDENTS REPORT
Public Trust Board – 7 September 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 was one 'Never Event' reported in June 2017 (Wrong route administration of medication), oral medication was administered via an intravenous route. This incident occurred in the Intensive Care Unit at the Chelsea and Westminster (C&W) site. Immediate action arising from this incident included ensuring that all Trust in-patient wards and departments that care and manage patients with an nasogastric tube have purple EnFIT syringes in stock.

The latest theme in the Trust Quality Improvement Programme focuses 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 July 2017. There were 12 reports submitted across the 2 sites. A précis of the incidents can be found in Section 7; pages 12 to 21.

Table 1

STEIS No.	Date of incident	Incident Type (STEIS Category)	External Deadline	Date SI report submitted	Site
2017/9349	29/03/2017	Pressure ulcer meeting SI criteria	05/07/2017	05/07/2017	CW
2017/9013	01/04/2017	Disruptive/ aggressive/ violent behaviour	03/07/2017	05/07/2017	CW
2017/10179	01/04/2017	Pressure ulcer meeting SI criteria	13/07/2017	13/07/2017	CW
2017/9840	02/04/2017	Pressure ulcer meeting SI criteria	11/07/2017	11/07/2017	WM
2017/9362	03/04/2017	Surgical/invasive procedure incident meeting	05/07/2017	05/07/2017	CW
2017/9850	03/04/2017	Pressure ulcer meeting SI criteria	11/07/2017	11/07/2017	CW
2017/9399	03/04/2017	Pressure ulcer meeting SI criteria	06/07/2017	06/07/2017	CW
2017/10807	11/04/2017	Treatment delay meeting SI criteria	20/07/2017	20/07/2017	CW
2017/10989	26/04/2017	Sub-optimal care of the deteriorating patient	24/07/2017	27/07/2017	WM
2017/12036	25/04/2017	Pressure ulcer meeting SI criteria	02/08/2017	27/07/2017	CW
2017/11456	27/04/2017	Treatment delay meeting SI criteria	27/07/2017	27/07/2017	CW
2017/11467	07/12/2016	Treatment delay meeting SI criteria	27/07/2017	25/07/2017	CW

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

Table 2

Details of incidents reported	WM	C&W	Total
Diagnostic incident including delay meeting SI criteria	0	2	2
Sub-optimal care of the deteriorating patient meeting SI criteria	1	0	1
Surgical/invasive procedure incident meeting SI criteria	1	1	2
Grand Total	**2**	**3**	**5**

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 = 13

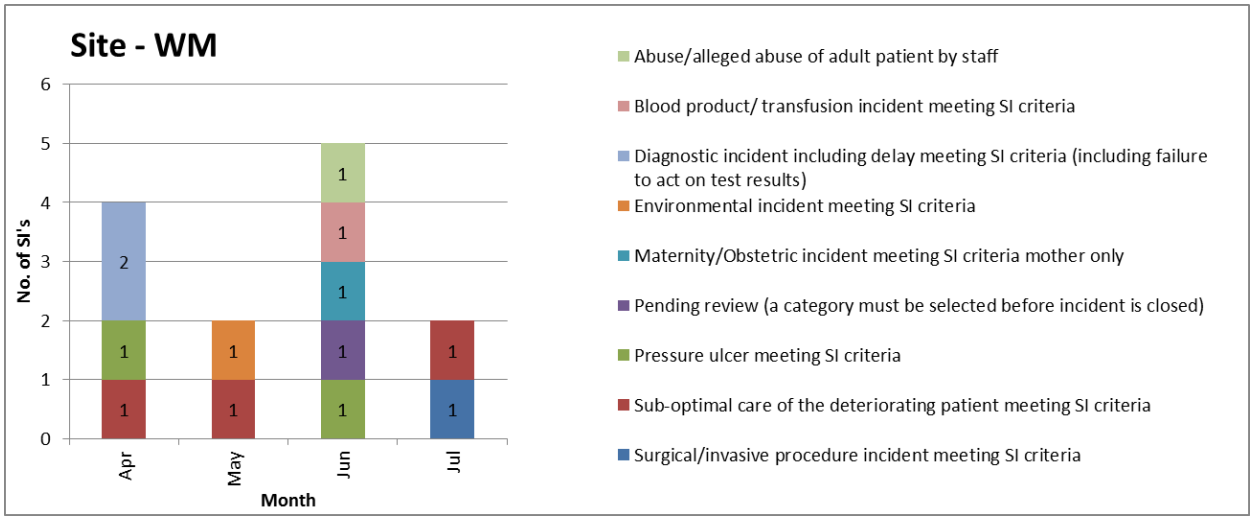
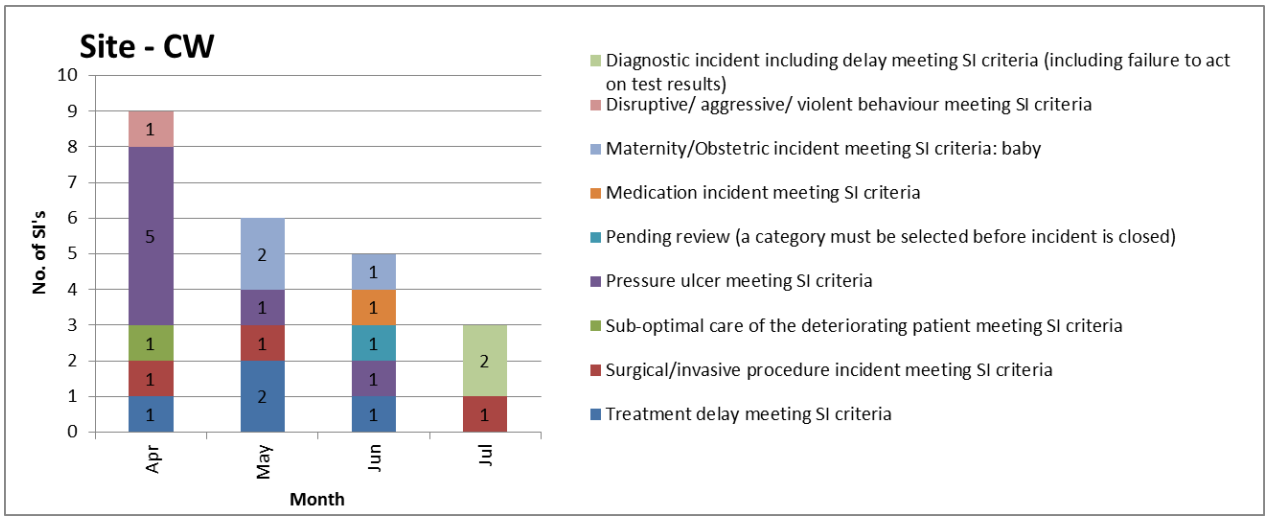


Chart 2 Incidents reported at C&W YTD 2017/18=23



There was a significant decrease in the number of SIs reported in July 2017 (5) compared to June 2017 (10). The three incidents categories reported against in July (Diagnostic incident, Sub-optimal care of the deteriorating patient and Surgical/invasive procedure) were not reported against in the previous month.

Charts 3 and 4 show the comparative reporting, across the 2 sites, for 2015/16, 2016/17 and 2016/18. The total number of incidents reported on each site year to date is 13 at WM and 23 at C&W. This is a reduction in the number reported at WM for the same period last year and an increase at C&W.

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

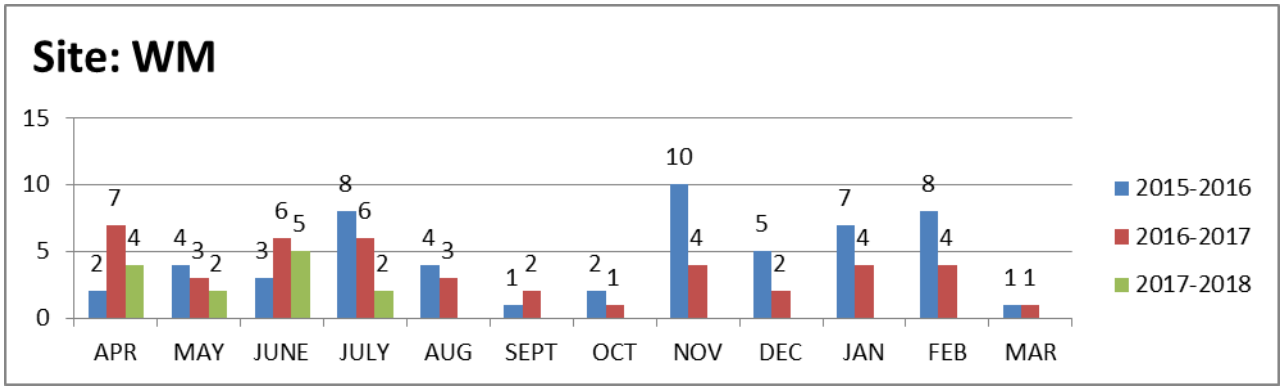
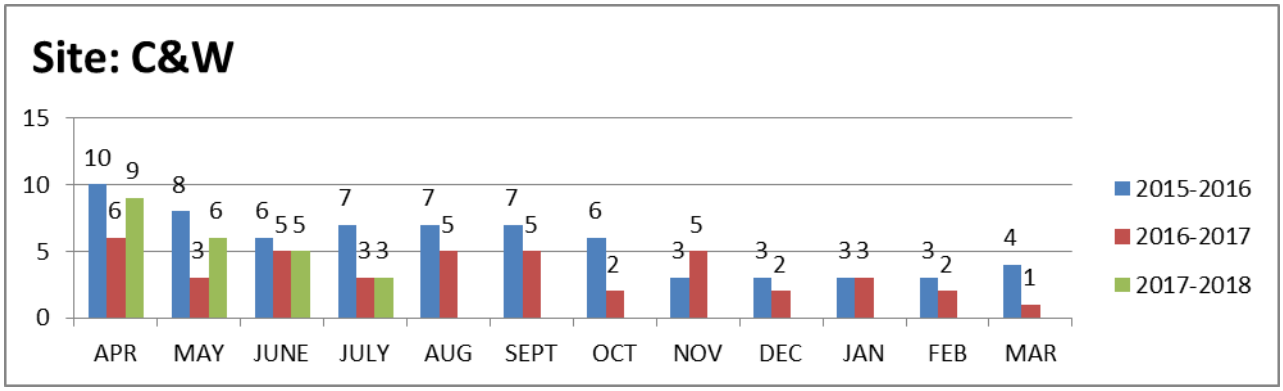


Chart 4 Incidents reported 2015/16, 2016/17 & 2017/18 – C&W



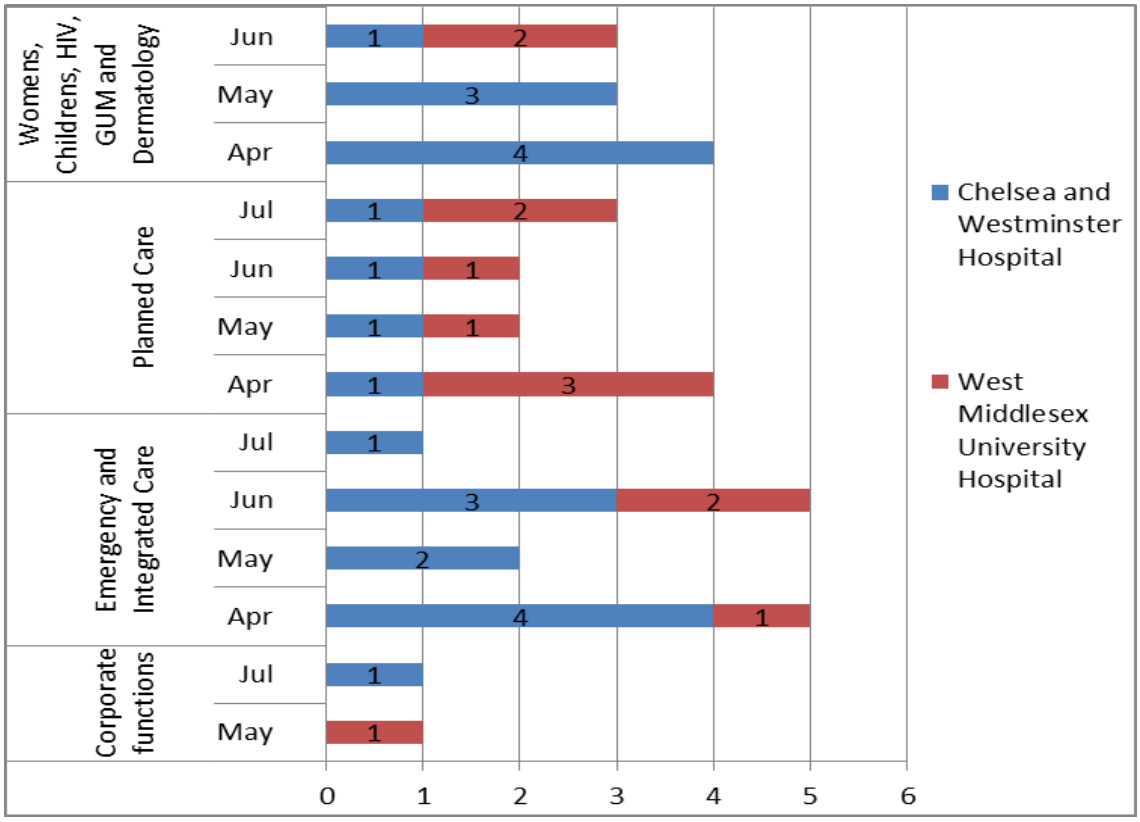
3.1 SIs by Clinical Division and Ward

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 13 SIs (C&W 10, WM 3). The Women's, Children's, HIV, GUM and Dermatology Division have reported 10 SIs (C&W 8, WM 2) and the Planed Care Division have reported 11 SIs (C&W 4, WM 7).

In addition there has been two reported by the corporate division; a power failure affecting the WM site only and IT system failure whereby discharge summaries 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 area aware and have plans in place to address concerns on this ward with support from the Quality Governance Manager.

Chart 6 - WM 2017/2018

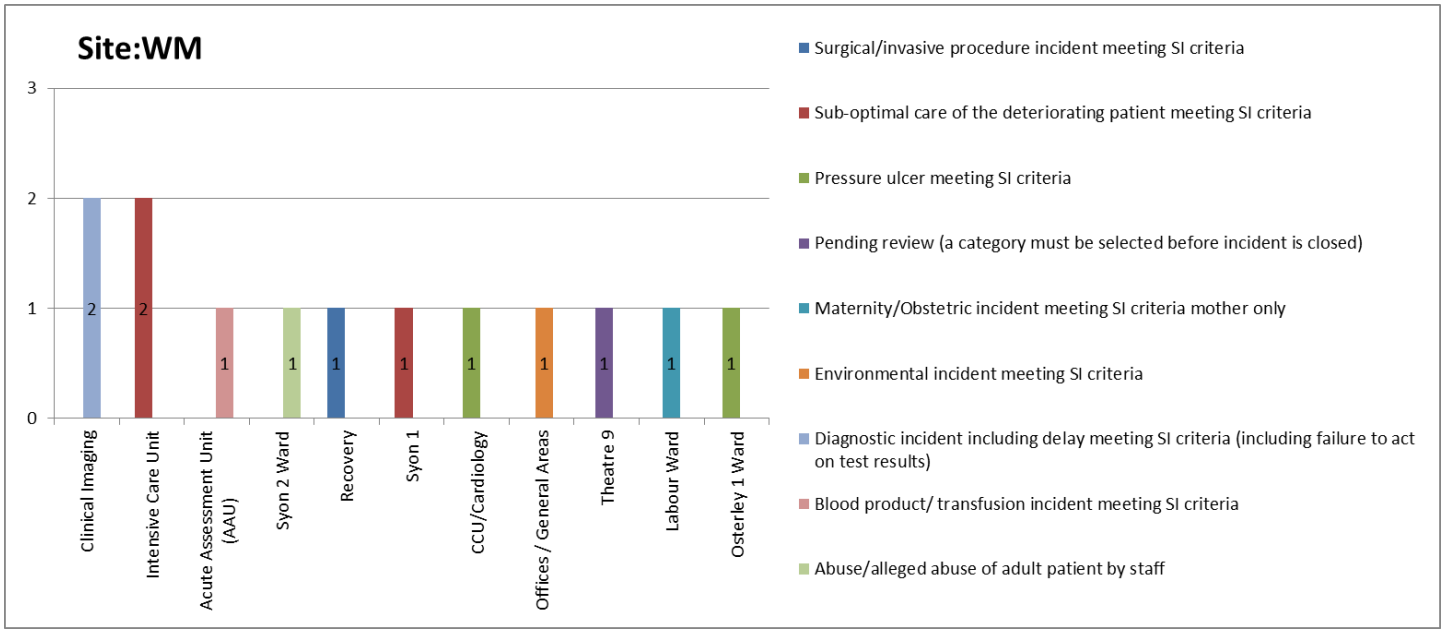
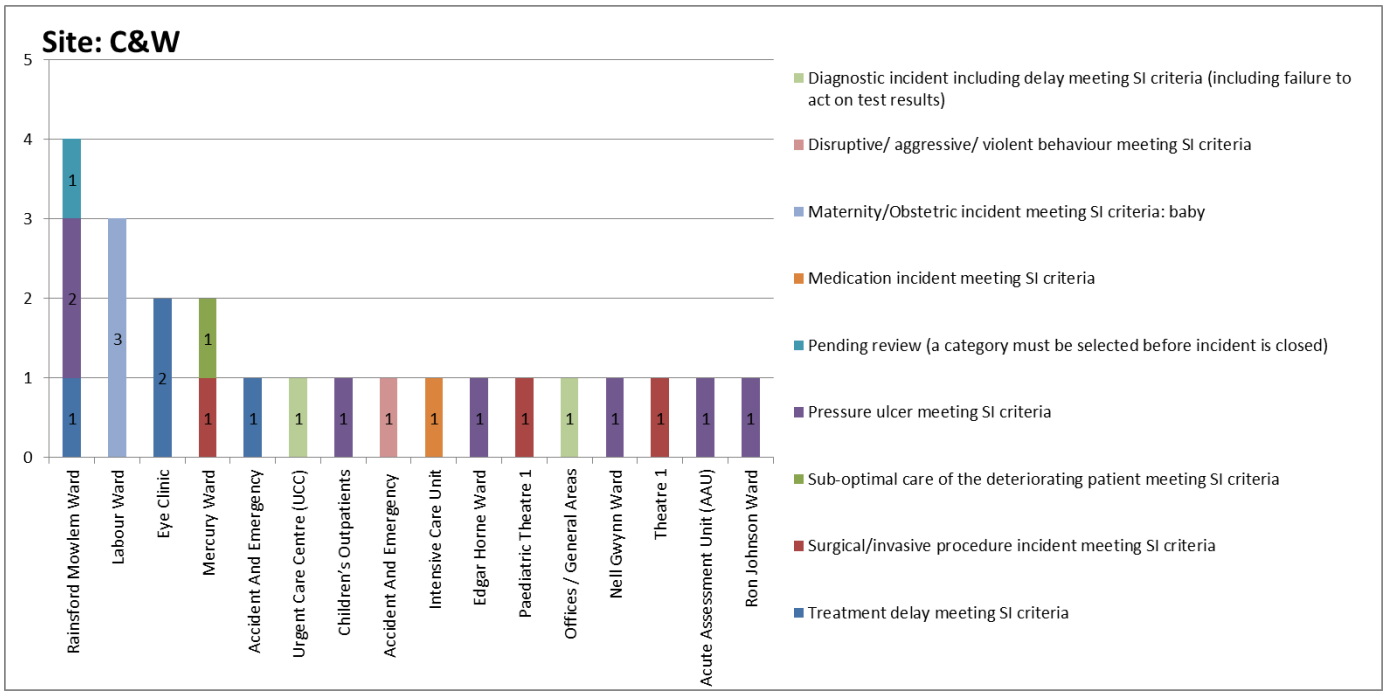


Chart 7 – C&W 2017/2018

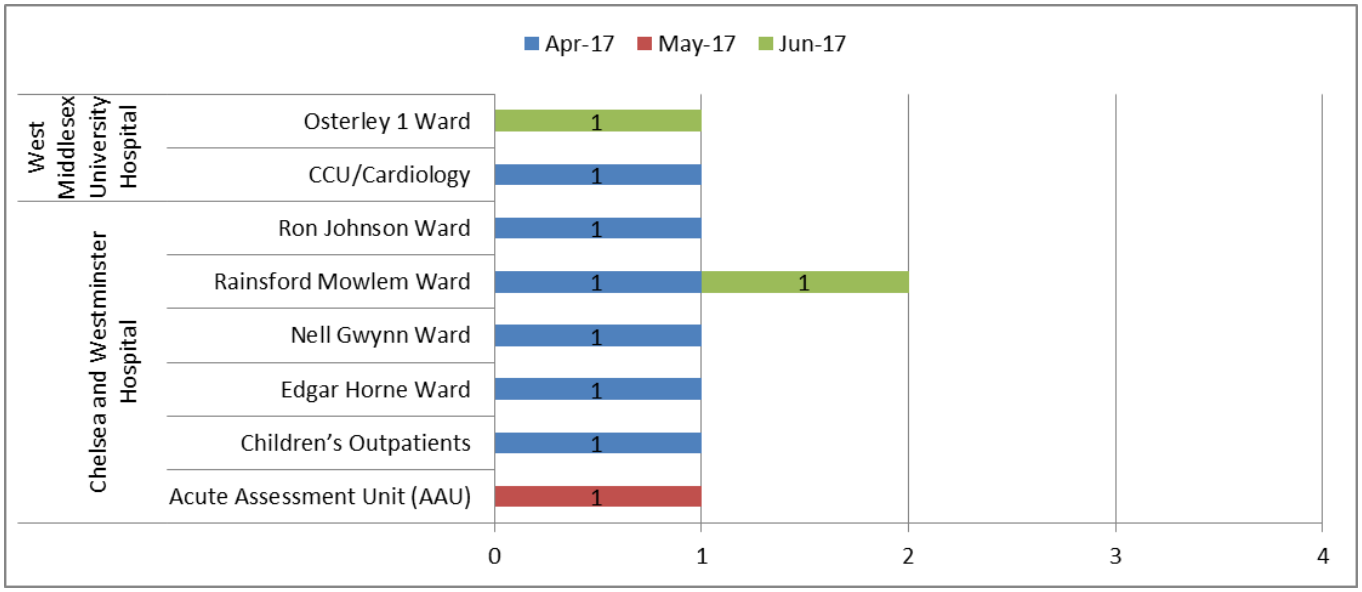


3.2 Hospital Acquired Pressure Ulcers

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 14 for the same period last year.

There were 0 reported hospital acquired pressure ulcers meeting SI criteria during July 2017.

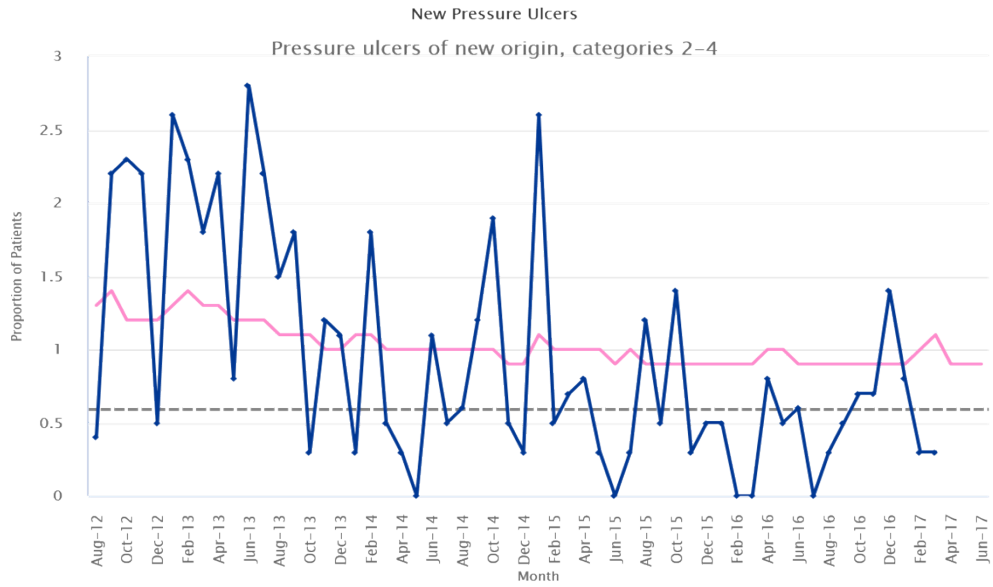
Chart 8 – Pressure Ulcers reported (Apr 2017–March 2018) YTD total = 9



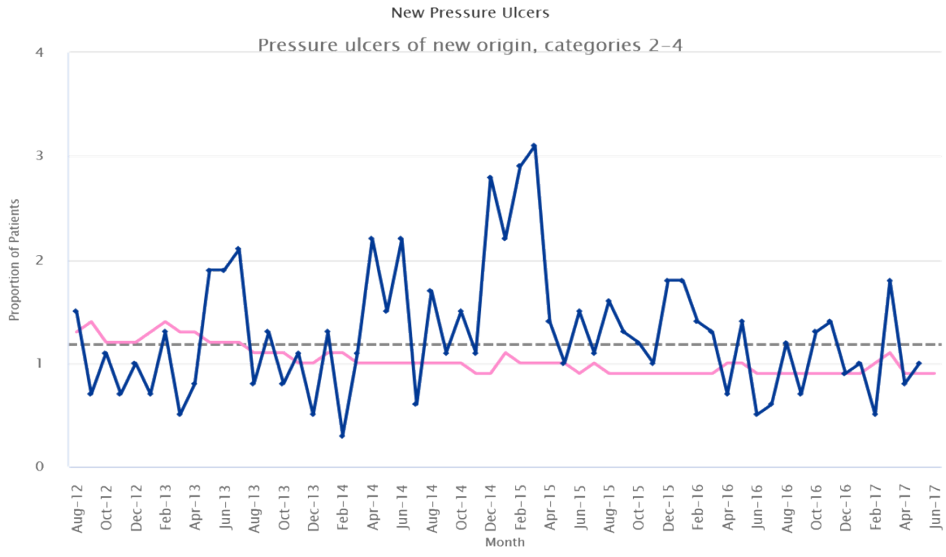
3.2.1 Safety Thermometer Data

The national safety thermometer data provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers. This is prevalence data and relates to pressure ulcers acquired whilst in hospital. The red line denotes the national position and the blue line the position for each site. This data is not currently amalgamated. The charts show that the national average is currently around 1%, WM is slightly below the national average and C&W slightly above. At the time of writing this report the data for April, May, June and July has not been published despite the Trust submitting the data. The reason for this continues to be investigated with the national team.

Graph 1 ST data WM site



Graph 2 ST data C&W site



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.

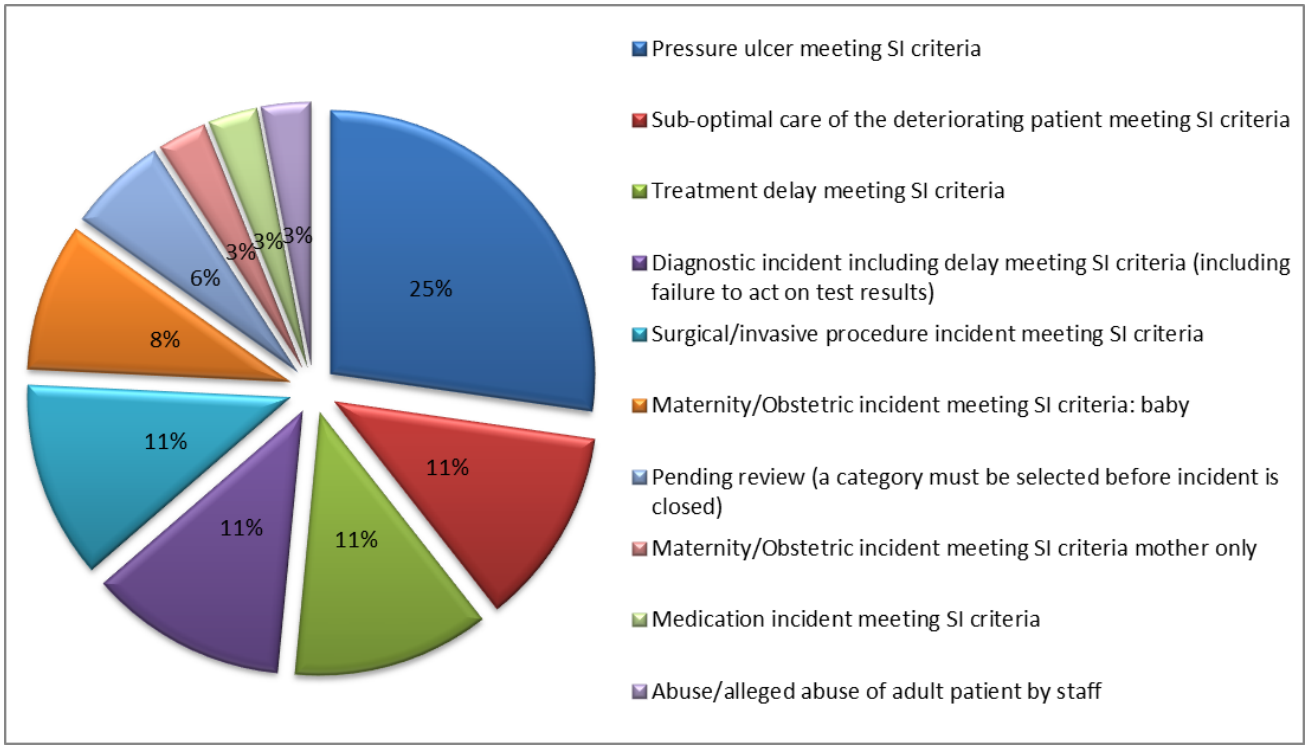
There were 0 reported patient falls meeting the serious incident criteria during July 2017.

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 thirteen of the SI categories.

Year to date pressure ulcers continue to be the most commonly reported incident despite the significant reduction last year. Treatment delay, sub-optimal care of the deteriorating patient, diagnostic incident and surgical/invasive procedure incident are jointly the second most reported incidents with 4 incidents reported against each category.

Chart 9 – Top 10 reported serious incidents (April 2017 – March2018)



3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (20).

Table 3

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2017/10997	26/04/2017	PC	Diagnostic incident including delay meeting SI criteria	WM	24/07/2017
2017/11709	29/04/2017	PC	Sub-optimal care of the deteriorating patient meeting SI	WM	31/07/2017
2017/11001	26/04/2017	PC	Diagnostic incident including delay meeting SI criteria	WM	07/08/2017
2017/12654	15/05/2017	W&C,HG	Maternity/Obstetric incident meeting SI criteria: baby	CW	09/08/2017
2017/13090	30/04/2017	CORP	Environmental incident meeting SI criteria	WM	15/08/2017
2017/14444	03/06/2017	PC	Abuse/alleged abuse of adult patient by staff	WM	31/08/2017
2017/14576	26/05/2017	EIC	Pressure ulcer meeting SI criteria	WM	01/09/2017
2017/14670	09/04/2017	EIC	Blood product/ transfusion incident meeting SI criteria	WM	01/09/2017
2017/15119	24/05/2017	PC	Medication incident meeting SI criteria (Never Event)	CW	07/09/2017
2017/15653	16/06/2017	W&C,HG	Maternity/Obstetric incident meeting SI criteria: baby	CW	14/09/2017
2017/15766	20/06/2017	EIC	Treatment delay meeting SI criteria	CW	14/09/2017

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2017/15985	08/06/2017	EIC	Pressure ulcer meeting SI criteria	CW	18/09/2017
2017/15993	21/06/2017	EIC	Pending review (a category must be selected before	CW	18/09/2017
2017/16333	24/06/2017	W&C,HG	Maternity/Obstetric incident meeting SI criteria mother	WM	21/09/2017
2017/16462	27/06/2017	W&C,HG	Pending review (a category must be selected before	WM	22/09/2017
2017/16909	16/05/2017	PC	Surgical/invasive procedure incident meeting SI criteria	CW	28/09/2017
2017/17079	01/03/2017	PC	Sub-optimal care of the deteriorating patient meeting SI	WM	29/09/2017
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	Surgical/invasive procedure incident meeting SI criteria	WM	23/10/2017

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 37 actions overdue at the time of writing this report. This is a significant decrease on last month when there were 103. Women's, Children's, HIV, GUM and Dermatology Division and Planned Care Division continue to do well with only 9 outstanding actions each. The Emergency and Integrated Care Division has made significant progress, closing 62 overdue actions in the past month with a targeted approach.

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	Total
EIC	3	1	0	0	3	0	0	3	2	1	1	5	12	7	2	1	2	**43**
PC	0	2	3	0	0	1	0	1	1	0	0	1	5	5	2	1	1	**23**
W&C,HGD	0	0	0	0	0	0	0	0	0	0	2	7	1	3	0	0	2	**15**
Total	**3**	**3**	**3**	**0**	**3**	**1**	**0**	**4**	**3**	**1**	**3**	**13**	**18**	**15**	**4**	**2**	**5**	**81**

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 sharing the learning remains the largest type of action overdue.

Table 4.1 – Type of actions overdue

Action type	EIC	PC	W&C,HGD	Total
Duty of Candour - Patient/NOK notification	9	2	1	12
Share learning	2	3	4	9
Create/amend/review - Policy/Procedure/Protocol	2	2	2	6
Create/amend/review - proforma or information sheet	1	1	1	3
Other action type	2		1	3
Set up ongoing training	2			2
Overhaul existing equipment	1			1
Audit		1		1
Grand Total	**19**	**9**	**9**	**37**

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 36 which is slightly less compared the same reporting period to last year and significantly less compared to 2015/2016. (2105/16 = 48, 2016/17 = 39).

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									**13**
	CW	9	6	5	3									**23**
		13	**8**	**10**	**5**									**36**

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					2		21
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	6	2	85

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
Treatment delay meeting SI criteria	1	2	1										4
Maternity/Obstetric incident meeting SI criteria: baby		2	1										3
Sub-optimal care of the deteriorating patient meeting SI criteria	2	1		1									4
Surgical/invasive procedure incident meeting SI criteria	1	1		2									4
*Pending review			2										2
Diagnostic incident including delay meeting SI criteria	2			2									4
Environmental incident meeting SI criteria		1											1
Abuse/alleged abuse of adult patient by staff			1										1
Blood product/ transfusion incident meeting SI criteria			1										1
Medication incident meeting SI criteria			1										1
Maternity/Obstetric incident meeting SI criteria mother			1										1
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1												1
Grand Total	13	8	10	5									36

*There are two incidents which have been categorised as “Pending review” as the incident category is yet to been confirmed. The first incident is an unexpected child death at West Middlesex Hospital. At the time of reporting there were no care and/or service delivery issues identified. The incident was reported externally as a child had died unexpectedly. The second incident, at Chelsea and Westminster Hospital, concerns an elderly patient who has a massively displaced left femur. The clinical team are unsure if the displacement was pre or post admission and the cause is currently unknown. Both Incidents’ categories will be updated accordingly following a comprehensive investigation.

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 (0) and the number of SIs the Trust has requested to be de-escalated (5). The delay in response to the de-escalation requests from 2016 has been escalated to the commissioners.

Table 9 De-escalation requests

De-escalation Status	STEIS No.	Date reported	Incident Type (STEIS Category)	Date SI report submitted	Site
Requested	2016/13086	13/05/2016	Treatment delay meeting SI criteria	27/07/2016	WM
Requested	2016/18460	08/07/2016	Sub-optimal care of the deteriorating patient meeting SI criteria	03/10/2016	CW
Requested	2016/30657	25/11/2016	Abuse/alleged abuse of adult patient by staff	28/03/2017	CW
Requested	2017/919	11/01/2017	Treatment delay meeting SI criteria	05/04/2017	WM
Requested	2017/3419	03/02/2017	Pressure ulcer meeting SI criteria	03/05/2017	CW

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	2.3/Sep/17
REPORT NAME	Integrated Performance Report – July 2017
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for July 2017 for both Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for July 2017. **Regulatory performance** – The A&E Waiting Time figure for July was 95.3%. There was a significant increase in activity at West Middlesex of 9.3% against the same period in the prior year but performance increased to 95.2% on that site, the first compliant month for 1 year. The RTT incomplete target was not achieved in July for the Trust with a performance of 91.24%, which whilst an improvement on June's reported position, it did fall short of our internal trajectory of 91.5%. The CW site saw continued improvements, especially within Planned Care (the most challenged Directorate), but the WMUH site saw performance drop by 1% to 94% affecting the overall Trust position with 2 particularly challenged specialities, Neurology and ENT, causing of the deteriorating position at WMUH. 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 July. There are challenges around 2 week referral to first appointment, Breast Symptomatic, 62 day Standard and NHS Screening Service Cancer Indicators. There were no reported CDiff infections in July at either site **Access** There were 71 breaches in July resulting in a 98.67% diagnostic waiting time. The number of breaches was significantly down from June's 109 which replicate an encouraging trend from last month's position. **Quality Priorities Dashboard**

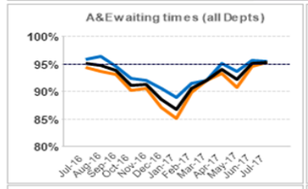
	New for this month, is the inclusion of the Quality Priorities Dashboard. This dashboard provides the Board with a template for monitoring the 7 agreed Quality Priorities as contained within the Quality Plan. Quarter 1 will be populated with the appropriate RAG rating in next Month's Integrated Board Report.
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	Income is favourable by £1.3m YTD predominantly against other income. The Trust is reporting a YTD deficit of £0.78m which is £0.32m favourable against the internal plan.
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 July 2017 and to note that whilst a number of indicators were not delivered in the month, the overall YTD compliance remained good.

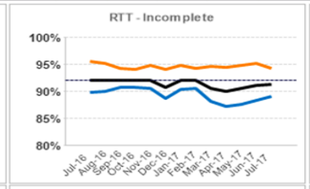
TRUST PERFORMANCE & QUALITY REPORT

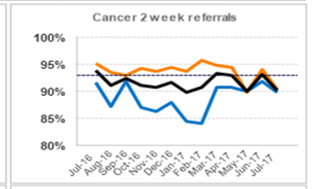
July 2017

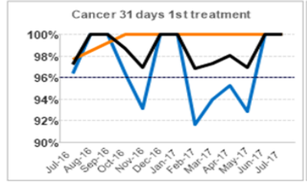
Regulatory Compliance

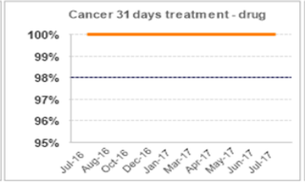
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	93.7	95.6	95.4	90.8	94.6	95.2	92.2	95.0	95.3	95.3	94.1	
RTT - Incomplete (Target: >92%)	87.6	88.3	89.1	94.8	95.2	94.2	90.5	91.2	91.2	91.2	90.7	
Cancer 2 week urgent referrals (Target: >93%)	90.1	91.8	89.8	89.9	94.1	90.3	90.0	93.1	90.1	90.1	91.5	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	90.4	91.0	91.5	90.4	91.0	91.5	91.5	90.6	
Cancer 31 days first treatment (Target: >96%)	92.9	100	100	100	100	100	96.9	100	100	100	98.9	
Cancer 31 days treatment - Drug (Target: >98%)	100	n/a	n/a	n/a	100	100	100	100	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	100	100	n/a	100	100	100	100	100	100	100	100.0	
Cancer 62 days GP ref to treatment (Target: >85%)	48.8	89.7	71.2	88.9	89.3	91.5	73.1	89.4	82.9	82.9	81.4	
Cancer 62 days NHS screening (Target: >90%)	n/a	n/a	n/a	100	83.3	80.0	100.0	83.3	80.0	80.0	86.4	
Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16)	0	0	0	3	0	0	3	0	0	0	4	
Self-certification against compliance for access to healthcare for people with LD	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	Comp	

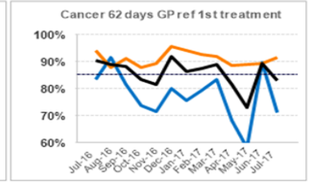






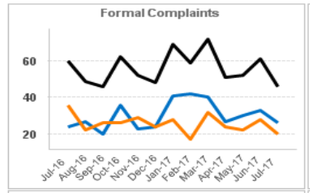


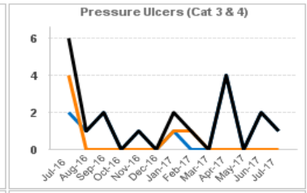


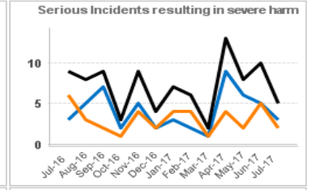


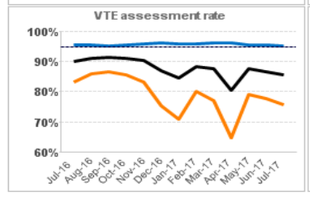
Quality

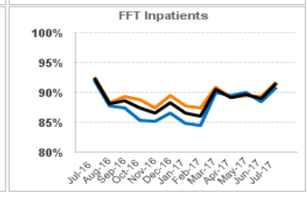
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	96.4	96.3	96.4	89.7	99.5	93.4	94.1	97.4	95.3	95.3	95.7	
Pressure Ulcers (Cat 3 & 4)	0	2	1	0	0	0	0	2	1	1	7	
VTE assessment % (Target: >=95%)	95.4	95.5	95.4	79.2	77.7	75.8	87.6	86.8	85.5	85.5	85.2	
Formal complaints number received	30	33	26	22	28	20	52	61	46	46	210	
Formal complaints responded to <25days	8	11	10	7	6	2	15	17	12	12	61	
Serious Incidents	6	5	3	2	5	2	8	10	5	5	36	
Never Events (Target: 0)	0	1	0	0	0	0	0	1	0	0	1	
FFT - Inpatients recommend % (Target: >90%)	90.0	88.4	90.9	89.6	89.4	91.8	89.7	89.0	91.5	91.5	89.9	
FFT - A&E recommend % (Target: >90%)	83.8	82.9	84.1	84.2	86.9	87.2	83.9	83.5	84.7	84.7	85.2	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	0	

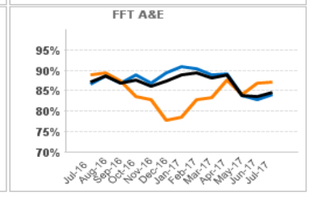






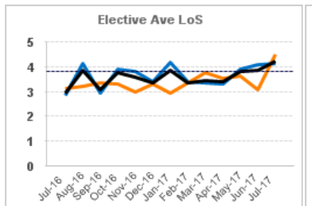


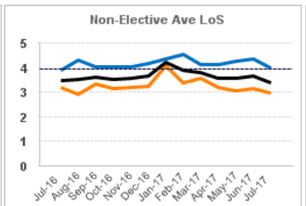


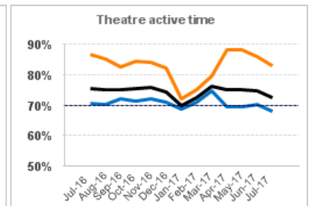


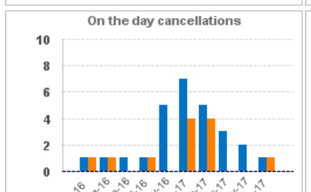
Efficiency

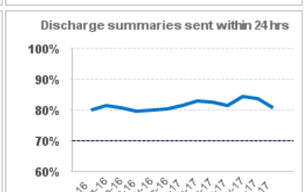
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	3.9	4.1	4.1	3.6	3.1	4.5	3.8	3.8	4.2	4.2	3.8	
Non-Elective average LoS (Target: <3.95)	4.2	4.4	4.0	3.1	3.2	2.9	3.6	3.7	3.4	3.4	3.5	
Theatre active time (Target: >70%)	69.4	70.2	67.8	88.2	86.0	82.8	75.0	74.7	72.3	72.3	74.2	
Discharge summaries sent within 24 hours (Target: >70%)	84.5	83.5	80.8	dev	dev	dev	84.5	83.5	80.8	80.8	82.7	
Outpatient DNA rates (Target: <11.1%)	11.4	13.3	13.2	9.6	9.5	9.4	10.7	11.9	11.8	11.8	11.1	
On the day cancelled operations not re-booked within 28 days (Target: 0)	2	1	0	0	1	0	2	2	0	0	4	

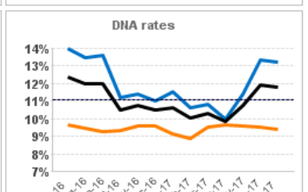






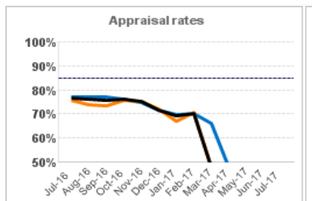


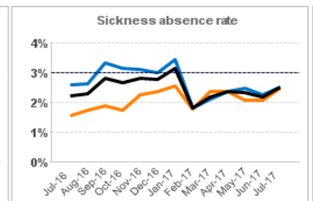


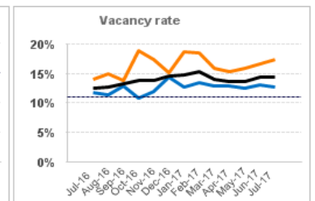


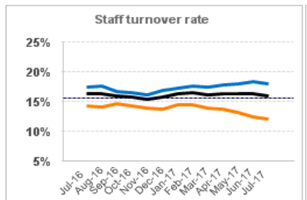
Workforce

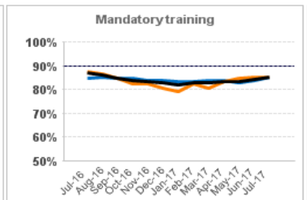
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	May-17	Jun-17	Jul-17	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	13.0	17.9	23.5	12.1	14.6	18.6	12.7	16.8	21.8	21.8	15.2	
Sickness absence rate (Target: <3%)	2.46	2.25	2.52	2.09	2.06	2.49	2.34	2.18	2.51	2.51	2.35	
Vacancy rates (Target: CW<12%; WM<10%)	12.6	13.1	12.8	15.9	16.7	17.4	13.7	14.4	14.4	14.4	14.4	
Turnover rate (Target: CW<18%; WM<11.5%)	18.0	18.3	18.0	13.2	12.4	12.1	16.3	16.3	15.9	15.9	15.9	
Mandatory training (Target: >90%)	82.9	84.0	85.4	84.6	85.4	85.2	83.5	84.5	85.4	85.4	84.2	
Bank and Agency spend (£ks)	£2,165	£2,434	£2,486	£2,347	£2,511	£2,544	£4,512	£4,945	£5,030	£5,030	£19,240	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	6.6	7.3	8.0	10.6	14.0	13.6	8.1	9.8	10.1	10.1	9.2	

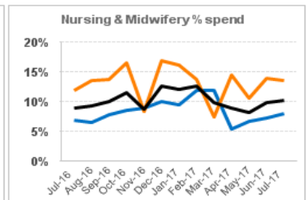












NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	93.7%	95.6%	95.4%	94.9%	90.8%	94.6%	95.2%	93.5%	92.2%	95.0%	95.3%	95.3%	94.1%		-
RTT	18 weeks RTT - Admitted (Target: >90%)	62.8%	64.7%	59.8%	63.1%	84.9%	83.7%	87.7%	84.5%	75.2%	75.4%	75.1%	75.1%	75.2%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	93.1%	93.0%	91.7%	92.6%	93.8%	92.9%	92.0%	92.8%	93.3%	93.0%	91.8%	91.8%	92.7%		!
	18 weeks RTT - Incomplete (Target: >92%)	87.6%	88.3%	89.1%	88.1%	94.8%	95.2%	94.2%	94.6%	90.5%	91.2%	91.2%	91.2%	90.7%		!
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jul-17) in this report	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	90.1%	91.8%	89.8%	90.6%	89.9%	94.1%	90.3%	92.1%	90.0%	93.1%	90.1%	90.1%	91.5%		!
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	90.4%	91.0%	91.5%	90.6%	90.4%	91.0%	91.5%	91.5%	90.6%		!
	31 days diagnosis to first treatment (Target: >96%)	92.9%	100%	100%	97.5%	100%	100%	100%	100%	96.9%	100%	100%	100%	98.9%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	n/a	n/a	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	100%	n/a	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%)	48.8%	89.7%	71.2%	68.1%	88.9%	89.3%	91.5%	89.7%	73.1%	89.4%	82.9%	82.9%	81.4%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	100%	83.3%	80.0%	86.4%	100%	83.3%	80.0%	80.0%	86.4%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	0	0	0	0	3	0	0	4	3	0	0	0	4		-
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		-

A&E Waiting Times
The Trust achieved the 95% threshold for July across both sites. The West Middlesex site achieved the target for the first time in over 12 months, despite there being a9.3% increase in activity against that of July the previous year.

Cancer - 2 Weeks from referral to first appointment all urgent referrals
The number of 2WW referrals continues to rise with referrals in July 2017 41% higher than the same month last year. The target continues to be challenged at both sites poor with high breach numbers for colorectal and urology on both sites and Skin at WM site. Straight to Test colorectal at both sites has seen an improvement in the 62day pathway however there are continued challenges with scheduling investigations within the first 2 weeks and patient's availability.

2 weeks from referral to first appointment all Breast symptomatic referral
Despite improvement, Breast symptomatic has failed to reach the standard for the 4th month with 7 breaches. An action plan has been devised by the service in conjunction with the clinical lead to improve capacity within the first 7 days and reduce the number of patient cancellations which are rebooked outside the first 2 weeks.

Cancer - 62 days GP referral to first treatment
The Trust has not met the target in July with 60 treatments and 10.5 breaches (unvalidated). The prostate pathway at Chelsea site continues to have a high number of patients' breaching with 6 patients (5 accountable breaches) commencing treatment after day 62. A revised diagnostic pathway is in place for Urology from 1st July with improved progression of pt's through the pathway with dedicated MRI and pre-booked biopsy slots.

RTT
Trust reported performance was again improved on the previous month's position although 0.3% short of the 91.5% recovery trajectory. On the CW site improvements in reducing the backlog and improving the incomplete position for planned care continued, with the total number of patients waiting to be treated having reduced by 25% since April 2017. The reported incomplete position at WM whilst compliant has seen a significant decrease in July and this has influenced the overall trust reported position due to declining compliance in Neurology and ENT. There we no patients reported to be waiting over 52 weeks for treatment, this is in line with previous submissions and expected to continue.

Clostridium difficile infections
No CDiff infections reported at either site for July. The threshold for the Year is 16 therefore the Trust is within the threshold for the four months to July

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Hand hygiene compliance (Target: >90%)	96.4%	96.3%	96.4%	96.2%	89.7%	99.5%	93.4%	94.7%	94.1%	97.4%	95.3%	95.3%	95.7%		-
Incidents	Number of serious incidents	6	5	3	23	2	5	2	13	8	10	5	5	36		-
	Incident reporting rate per 100 admissions (Target: >8.5)	6.6	7.5	7.5	7.4	9.1	9.6	8.2	9.0	7.7	8.5	7.9	7.9	8.1		!
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.01	0.05	0.00	0.03	0.02	0.06	0.02	0.05	0.02	0.05	0.01	0.01	0.03		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	504.15	486.57	684.93	515.91	179.43	276.15	306.51	240.12	351.48	388.78	503.87	503.87	384.98		-
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	3.9%	10.1%	8.4%	9.7%	16.7%	17.6%	12.8%	18.0%	7.0%	12.6%	9.7%	9.7%	12.1%		!
	Never Events (Target: 0)	0	1	0	1	0	0	0	0	0	1	0	0	1		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	98.5%	98.1%	96.4%	95.3%	95.7%	94.9%	85.3%	92.2%	96.8%	95.8%	89.9%	89.9%	93.4%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	2	1	7	0	0	0	0	0	2	1	1	7		-
	NEWS compliance %	97.4%	97.6%	96.3%	96.7%	95.8%	93.7%	96.2%	95.9%	97.0%	96.6%	96.3%	96.3%	96.5%		-
	Safeguarding adults - number of referrals	16	23	23	84	23	27	27	100	39	50	50	50	184		-
	Safeguarding children - number of referrals	24	35	22	106	98	151	107	465	122	186	129	129	571		-
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	25	35	41	133	52	50	39	198	77	85	80	80	331		-
	Number of hospital deaths - Paediatric	1	0	1	3	0	1	1	2	1	1	2	2	5		-
	Number of hospital deaths - Neonatal	1	2	2	7	0	2	1	6	1	4	3	3	13		-
	Number of deaths in A&E - Adult	1	3	5	10	4	7	7	20	5	10	12	12	30		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	1	0	1	0	1	0	0	1		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	1	0	1	0	1	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

Number of serious incidents

5 Serious Incidents reported in July 2017, compared to 10 in June. Three of the incidents relate to the Chelsea site, and two at the West Middlesex site.

These are all under investigation referred to within the Serious Incident Report prepared for the Board, reflecting each incident category.

Incident reporting rate per 100 admissions

There has been a slight increase in the number of incidents reported organisationally; however this is not in proportion with activity levels.

The Trust continues to encourage reporting, with an increased focus on the reporting of no harm/near miss incidents.

Trust commentary continued

Rate of patient safety incidents resulting in severe harm or death

1 incident led to a patient's death; this relates to an unexpected death following emergency surgery at the WMUH site.

A further two incidents led to severe harm on the CWH site (diagnosis incident, and a laboratory error leading to additional surgery). One incident relates to a surgical Site Infection, for which the Division have been contacted, however the status of the investigation and confirmation of degree of harm remains outstanding.

Never Events

No Never Events were reported in July 2017.

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

The combined Trust reporting rate for July was 500/100,000 FCE bed days, which is significantly better than the Trust target and the latest benchmark published on the Carter dashboard National Median of 286 (March 2016 data).

In month, CW site achieved 678 and WM site improved significantly to 306, both above target.

Medication-related (NRLS reported) safety incidents % with harm

The Trust % of medication related safety incidents with-harm for July was 9.8%. This is very close to the latest Carter dashboard National Benchmark (9.7%) and is a significant improvement on previous months. The year to date figure is 12.2% and improving.

There were 13 reported incidents with-harm, 8 at CW site and 5 at WM site. Two were rated as moderate-harm, one for each site. One related to inappropriate continuation of a beta blocker causing adverse effects. The other involved an incorrect but lower dose of a cytotoxic medication for one week.

There were 11 low-harm incidents. Antimicrobials and controlled drugs (CDs) continue to be the most common groups of medicines associated with incidents. The Medication Safety Group continues to monitor and act upon incident trends, to promote reporting of no - harm and near - miss incidents and work to improve safety culture. *For 2017-18, the Patient Safety Group has asked for the target for this indicator to be ≤ 9.7 % in line with the national benchmarks.*

Incidence of newly acquired category 3 & 4 pressure ulcers

1 hospital acquired grade 3/4 pressure ulcer was reported in July. However there were no avoidable factors, care or service delivery issues identified.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	90.0%	88.4%	90.9%	89.7%	89.6%	89.4%	91.8%	90.0%	89.7%	89.0%	91.5%	91.5%	89.9%		-
	FFT: Inpatient not recommend % (Target: <10%)	4.3%	8.1%	4.6%	5.6%	5.5%	6.0%	2.7%	5.0%	5.1%	6.8%	3.3%	3.3%	5.2%		-
	FFT: Inpatient response rate (Target: >30%)	35.6%	27.6%	37.7%	33.2%	37.1%	32.7%	33.2%	33.4%	36.6%	30.6%	34.6%	34.6%	33.3%		-
	FFT: A&E recommend % (Target: >90%)	83.8%	82.9%	84.1%	84.9%	84.2%	86.9%	87.2%	86.5%	83.9%	83.5%	84.7%	84.7%	85.2%		!
	FFT: A&E not recommend % (Target: <10%)	5.5%	7.3%	5.2%	5.8%	10.4%	8.6%	7.3%	8.5%	6.4%	7.5%	5.6%	5.6%	6.2%		-
	FFT: A&E response rate (Target: >30%)	19.8%	18.9%	16.3%	17.7%	14.2%	13.9%	13.2%	13.8%	18.4%	17.9%	15.6%	15.6%	16.9%		!
	FFT: Maternity recommend % (Target: >90%)	89.8%	93.5%	90.3%	91.5%	93.8%	97.3%	94.3%	95.0%	90.9%	94.5%	91.4%	91.4%	92.4%		-
	FFT: Maternity not recommend % (Target: <10%)	7.8%	5.6%	6.3%	6.1%	5.2%	1.3%	5.7%	3.7%	7.0%	4.5%	6.2%	6.2%	5.5%		-
	FFT: Maternity response rate (Target: >30%)	22.8%	23.0%	17.5%	20.7%	21.1%	19.0%	21.2%	19.2%	22.3%	21.8%	18.4%	18.4%	20.3%		!
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	31	33	28	119	22	28	21	95	53	61	49	49	214		-
	Complaints formal: Number responded to < 25 days	8	11	11	42	7	6	2	20	15	17	13	13	62		-
	Complaints (informal) through PALS	98	97	96	395	66	76	72	246	164	173	168	168	641		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	1	0	1	2	1	0	1	1	2		-

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

FFT Inpatients
Improvements seen in inpatients this month at both sites and collectively achieving above the 30% response rate and above 90% recommend rate. Electronic data collection tools also being rolled out across both sites

FFT ED
There continues to be an increase in the response rate and the recommended score on both ED's but both departments fall below the required standards. The electronic kiosks will are in place at the CW site and will be in place shortly on the WM site. The current service provider is being reviewing including the text message service, which is the main data collection tool for ED. Plans are in place to undertake a behaviour change project specifically looking at the wording and timing of text message delivery.

FFT Maternity
The recommended scores for maternity services on both sites continue to be above the target however there has been an in month decline in the response rate at both sites. Similarly to ED the main data collection method for the maternity services is through text message and will therefore be included in the behaviour changes pilot.

Same sex accommodation breaches
There have been no same sex accommodation breaches on either site.

Formal Complaints
The trust consistently holds an average of 100 open complaints only approximately 25% of which are responded to within time frame. The complaints team have worked with division to reduce the back log of overdue complaints; the trajectory for these to all be resolved will be by the middle of September. The complaints policy and process are currently being reviewed and additional support is being given to the EIC division to resolve their backlog.

PHSO Ombudsman
No new referrals to the ombudsman, 1 complaint has been upheld with 2 specific actions for the Trust.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <3.7)	3.88	4.07	4.11	3.86	3.63	3.09	4.47	3.69	3.82	3.84	4.21	4.21	3.82		!
	Average length of stay - non-elective (Target: <3.9)	4.24	4.36	4.00	4.18	3.07	3.15	2.94	3.09	3.57	3.65	3.38	3.38	3.55		!
	Emergency care pathway - average LoS (Target: <4.5)	5.51	5.29	4.68	5.20	3.75	3.75	3.48	3.74	4.45	4.31	3.91	3.91	4.28		!
	Emergency care pathway - discharges	232	200	199	832	351	350	359	1387	584	550	558	558	2220		-
	Emergency re-admissions within 30 days of discharge (Target: <2.8%)	3.19%	3.17%	3.44%	3.52%	9.76%	10.73%	10.02%	10.10%	6.15%	6.58%	6.51%	6.51%	6.54%		!
	Non-elective long-stayers	438	406	402	1632	624	541	485	2214	1062	947	887	887	3846		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	85.9%	79.7%	84.0%	83.8%	89.2%	87.6%	89.8%	89.0%	87.1%	82.9%	86.5%	86.5%	85.9%		-
	Operations canc on the day for non-clinical reasons: actuals	25	29	34	107	6	6	1	19	31	35	35	35	126		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.78%	0.94%	1.18%	0.93%	0.45%	0.50%	0.08%	0.39%	0.68%	0.82%	0.85%	0.85%	0.77%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	2	1	0	3	0	1	0	1	2	2	0	0	4		-
	Theatre active time (C&W Target: >70%; WM Target: >78%)	69.4%	70.2%	67.8%	69.2%	88.2%	86.0%	82.8%	86.2%	75.0%	74.7%	72.3%	72.3%	74.2%		-
	Theatre booking conversion rates (Target: >80%)	84.4%	84.2%	85.1%	84.8%	74.6%	76.6%	73.4%	74.1%	80.6%	81.6%	80.7%	80.7%	80.7%		!
Outpatients	First to follow-up ratio (Target: <1.5)	1.54	1.56	1.63	1.57	1.25	1.24	1.20	1.24	1.33	1.32	1.31	1.31	1.32		!
	Average wait to first outpatient attendance (Target: <6 wks)	7.7	7.8	7.8	7.7	10.9	9.9	10.1	9.5	9.3	8.9	9.0	9.0	8.6		!
	DNA rate: first appointment	13.2%	14.8%	14.8%	13.5%	9.9%	10.1%	9.9%	10.0%	11.6%	12.5%	12.4%	12.4%	11.8%		-
	DNA rate: follow-up appointment	10.8%	12.8%	12.6%	11.5%	9.4%	9.1%	9.0%	9.2%	10.4%	11.6%	11.5%	11.5%	10.8%		-

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 increased across the Trust in July. This is driven by long stay medical patients on both sites, while the surgical length of stay is maintained.

Procedures carried out as Daycases - basket of 25 procedures

Daycase rates were not achieved at Chelsea site in July but West Middlesex consistently performed. Day case rates were achieved cross site in July for Planned Care and the challenge remains in Women's and Children's services.

On the day non-clinical cancellations as a % of Elective admissions

Operations cancelled on the day for non-clinical reasons continue to be a challenge on the Chelsea site and are multifactorial. The Trust is no longer seeing changes in the administrative functions being the primary driver for cancellation.

Theatre Active Time - % of staffed time

Theatre active time continues to be an area of focus as The Trust looks to drive efficiency across both sites. There are work streams in place to improve these efficiencies surrounding Treatment Centre on the Chelsea site (day case surgery centre)

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	94.2%	81.8%	76.9%	87.1%	93.6%	97.4%	96.5%	94.7%	93.9%	90.6%	88.8%	88.8%	91.3%		-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	100.0%	100.0%	100.0%	97.2%	91.7%	82.4%	100.0%	89.5%	96.7%	92.7%	100.0%	100.0%	93.8%		-
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	95.4%	95.5%	95.4%	95.6%	79.2%	77.7%	75.8%	74.6%	87.6%	86.8%	85.5%	85.5%	85.2%		!
TB Care	TB: Number of active cases identified and notified	0	4	0	10	4	8	11	25	4	12	11	11	35		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

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Trust commentary

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

The West Middlesex Site achieved 100% for the 36 hour target for Time to Theatre in July. Of 14 patients 13 met the threshold; the one patient not doing so was due to being medically unfit. At the Chelsea Site, all 20 patients met the 36 hour time to surgery threshold.

VTE Hospital-acquired

C&W site: Radiology reports are manually screened 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. Datix process to be refined to improve reporting, investigation and feedback

VTE Risk assessments completed

C&W site: Target achieved. Clinical areas requiring improvement highlighted to teams.

WMUH site: Target not achieved due to current IT infrastructure. Patient admissions pathway from the Emergency Department revised to allow clinicians access to complete risk assessments on RealTime.

Access Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-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%)	95.96%	95.61%	97.21%	96.09%	98.96%	99.32%	99.57%	99.17%	97.81%	98.28%	98.65%	98.65%	97.96%		!
	Diagnostic waiting times >6 weeks: breach actuals	109	78	58	376	45	31	14	125	154	109	72	72	501		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	8.0%	7.9%	7.6%	7.9%	8.5%	8.4%	7.8%	8.4%	8.2%	8.1%	7.6%	7.6%	8.0%		!
	A&E time to treatment - Median (Target: <60')	01:08	00:59	00:56	01:02	00:43	00:31	00:40	00:40	01:02	00:52	00:52	00:52	00:57		-
	London Ambulance Service - patient handover 30' breaches	48	16	12	93	64	38	11	170	112	54	23	23	263		-
	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 May-17 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	998.8	1353	1237	1159	0	0	0	0	998.8	1353	1237	1237	1159		-
	Choose and book: capacity issue rate (ASI)	54.5%			56.7%					54.5%				56.7%		-
	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

Diagnostic Waiting Times

The backlog of patients waiting for Endoscopy on the CW is significantly reducing but not at a rate to make the CW site return a compliant diagnostic position, The expectation is the CW site will return a further improved position in August and enable an overall trust compliant position. WM again was compliant as a site for this metric and is expected to continue to do so,

Ambulance Breaches

Despite increasing Non-Elective demand and pressure and increasing LAS arrivals, both sites continue to perform excellently with the handover of ambulances with Chelsea being the 2nd best performing site in London and West Middlesex 3rd (out of 27 sites).

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Birth indicators	Total number of NHS births	499	437	471	1870	467	407	420	1707	966	844	891	891	3577		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	31.6%	33.7%	32.5%	31.8%	27.2%	27.3%	20.7%	25.7%	29.4%	30.6%	26.8%	26.8%	28.8%		!
	Midwife to birth ratio (Target: 1:30)	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30		-
	Maternity 1:1 care in established labour (Target: >95%)	98.8%	97.3%	100.8%	98.3%	98.1%	96.9%	96.4%	97.0%	98.4%	97.1%	98.6%	98.6%	97.7%		-
Safety	Admissions of full-term babies to NICU	21	18	19	75	n/a	n/a	n/a	n/a	21	18	19	19	75		-

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Trust commentary

Total number of NHS births

Cross site under plan for births by 22 year to date

Total C-Section rate

The Combined Trust figures are green for the first time in many months due to a substantially lower rate at West Middlesex.

Work continues around implementation of pathways in relation to maternal request for caesarean section.

Workforce Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	12.6%	13.1%	12.8%	12.8%	15.9%	16.7%	17.4%	17.4%	13.7%	14.4%	14.4%	14.4%	14.4%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	18.0%	18.3%	18.0%	18.0%	13.2%	12.4%	12.1%	12.1%	16.3%	16.3%	15.9%	15.9%	15.9%		!
	Sickness absence (Target: <3%)	2.5%	2.2%	2.5%	2.4%	2.1%	2.1%	2.5%	2.2%	2.3%	2.2%	2.5%	2.5%	2.3%		-
	Bank and Agency spend (£ks)	£2,165	£2,434	£2,486	£9,567.2	£2,347	£2,511	£2,544	£9,673.1	£4,512	£4,945	£5,030	£5,030	£19,240		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	6.6%	7.3%	8.0%	6.8%	10.6%	14.0%	13.6%	13.1%	8.1%	9.8%	10.1%	10.1%	9.2%		-
Appraisal rates	% of Performance & Development Reviews completed - medical staff (Target: >85%)	79.2%	83.6%	85.6%	79.5%	83.5%	87.6%	85.5%	85.1%	80.9%	85.2%	85.6%	85.6%	81.8%		-
	% of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%)	5.6%	10.4%	16.4%	8.5%	1.8%	4.1%	8.8%	3.8%	4.3%	8.2%	13.8%	13.8%	6.9%		-
Training	Mandatory training compliance (Target: >90%)	82.9%	84.0%	85.4%	84.0%	84.6%	85.4%	85.2%	84.6%	83.5%	84.5%	85.4%	85.4%	84.2%		!
	Health and Safety training (Target: >90%)	81.7%	82.3%	85.3%	83.0%	84.6%	85.6%	85.0%	85.0%	82.7%	83.4%	85.2%	85.2%	83.7%		!
	Safeguarding training - adults (Target: 90%)	88.5%	89.5%	89.9%	89.1%	85.3%	86.6%	85.6%	85.8%	87.4%	88.5%	88.4%	88.4%	87.9%		!
	Safeguarding training - children (Target: 90%)	87.9%	88.0%	88.6%	88.3%	88.2%	88.7%	88.8%	88.6%	88.0%	88.2%	88.7%	88.7%	88.4%		!

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Trust commentary

Workforce Commentary July 2017 figures

Staff in Post

In July we employed 5166 whole time equivalent (WTE) people on substantive contracts, 14 fewer than last month. Taking into account bank and agency workers our WTE workforce was 6212.

Turnover

Our voluntary turnover rate was 15.9%, 0.4% lower than last month. Voluntary turnover is 18% at Chelsea and 12.1% at West Middlesex.

Vacancies

Our general vacancy rate for July was 14.4%, which is the same as June. The vacancy rate is 17.4% at West Middlesex and 12.8% 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 85.4% against its target of 90%, up from 84.5% in June.

Performance and Development Reviews

On 1 April 2017 we changed our performance and development review process for non-medical staff so that everyone is required to have their performance and development review in a set period after 1 April 2017, starting with the most senior staff. More than 90% of staff in bands 8C-9 and director roles have had a performance and development review. Our focus is now on ensuring that at least 90% of band 7-8B staff have their PDR by the end of September. The rolling annual appraisal rate for non-medical staff is 60.3%. The appraisal rate for medical staff was 85.6%, 0.3% more 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	May-17	Jun-17	Jul-17	2017-2018	YTD breaches	May-17	Jun-17	Jul-17	2017-2018	YTD breaches	May-17	Jun-17	Jul-17	2017-2018 Q2	2017-2018	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Brain	n/a	100%	n/a	100%		n/a	n/a	n/a	n/a	0	n/a	100%	n/a	n/a	100%	0		-
	Breast	n/a	n/a	n/a	n/a	0.5	100%	100%	100%	100%	0	95.8%	100%	100%	100%	98.4%	0.5		-
	Colorectal / Lower GI	50.0%	100%	88.9%	77.8%	2	75.0%	50.0%	62.5%	66.7%	3.5	62.5%	66.7%	76.5%	76.5%	71.8%	5.5		!
	Gynaecological	100%	100%	75.0%	85.7%	0.5	100%	100%	100%	100%	0	100%	100%	90.0%	90.0%	95.7%	0.5		-
	Haematological	100%	n/a	n/a	100%	0	0.0%	100%	100%	93.8%	0.5	66.7%	100%	100%	100%	94.4%	0.5		-
	Head and neck	100%	n/a	n/a	100%	0	100%	n/a	50.0%	60.0%	1	100%	n/a	50.0%	50.0%	77.8%	1		-
	Lung	42.9%	n/a	100%	63.6%	2	100%	100%	80.0%	93.3%	0.5	60.0%	100%	85.7%	85.7%	80.8%	2.5		-
	Sarcoma	100%	n/a	n/a	100%	0	n/a	n/a	n/a	n/a		100%	n/a	n/a	n/a	100%	0		-
	Skin	71.4%	100%	87.5%	91.3%	2	83.3%	100%	100%	92.7%	1.5	80.0%	100%	90.9%	90.9%	92.0%	3.5		-
	Upper gastrointestinal	50.0%	100%	50.0%	71.4%	1	100%	100%	66.7%	91.7%	0.5	85.7%	100%	60.0%	60.0%	84.2%	1.5		-
	Urological	18.2%	57.1%	47.4%	34.9%	14	0.0%	77.8%	100%	78.0%	4.5	15.4%	72.0%	67.7%	67.7%	56.0%	18.5		!
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a	100%	0	100%	n/a	n/a	n/a	100%	0		-
	Site not stated	0.0%	n/a	n/a	0.0%	1	n/a	n/a	100%	100%	0	0.0%	n/a	100%	100%	60.0%	1		-

Trust commentary

Breaches by Tumour Site in July 2017

Chelsea and Westminster Site

Colorectal	0.5 unavoidable	- complex pathways with numerous diagnostic investigations
Gynaecology	0.5 unavoidable	- surgery was scheduled in trust within breach but had more extensive diseased requiring specialist input at RMH
Skin	1.0 avoidable	- unable to schedule joint Plastics/Skin surgery within date
Upper GI	0.5 unavoidable	- chemo planned to start within date but change of treatment to radiotherapy which could not then commence within breach
Urology	1.0 avoidable	- delay to biopsy (capacity)
Urology	1.0 avoidable	- delay diagnostics and theatre capacity as well as patient DNA's
Urology	1.0 avoidable	- delayed diagnostics; MRI and template biopsy
Urology	0.5 avoidable	- delay diagnostics and capacity for biopsy
Urology	1.0 avoidable	- delays to diagnostics, MRI and template biopsy
Urology	0.5 avoidable	- delays to diagnostics, MRI and biopsy

West Middlesex Site

Lower GI	0.5 unavoidable	- patient initiated delays and change of treatment modality from surgery to radiotherapy
Lower GI	1.0 unavoidable	- patient initiated delays, first OPA, DNA's diagnostic and was on holiday
Head and Neck	0.5 unavoidable	- referred to Imperial day 34 but unable to schedule long course radiotherapy within breach
Lung	0.5 unavoidable	- patient choice to delay follow up with oncologist as away on holiday
Upper GI	0.5 unavoidable	- referred to RMH day 43, complex pathway, required additional diagnostics to inform treatment plan

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	75.5%	93.9%	77.5%	87.9%	8.6	3.0	11.6	7 – 17.5
Annie Zunz	83.9%	92.1%	98.4%	90.3%	6.1	2.6	8.7	6.5 - 8
Apollo	97.4%	25.8%	96.1%	22.6%	19.0	1.0	20.0	
Jupiter	112.6%	-	101.2%	-	11.4	0.0	11.4	8.5 – 13.5
Mercury	80.2%	93.8%	70.4%	-	7.2	0.7	7.9	8.5 – 13.5
Neptune	81.1%	60.9%	82.3%	-	9.1	0.8	9.9	8.5 – 13.5
NICU	102.0%	-	91.5%	-	12.4	0.0	12.4	
AAU	118.4%	79.4%	114.8%	130.2%	13.3	3.0	16.3	7 - 9
Nell Gwynn	100.5%	90.3%	132.3%	104.2%	4.4	3.7	8.1	6 – 8
David Erskine	120.9%	91.5%	123.7%	107.9%	4.0	3.0	7.0	6 – 7.5
Edgar Horne	110.2%	97.6%	116.1%	96.0%	3.8	3.5	7.3	6 – 7.5
Lord Wigram	102.3%	120.4%	108.6%	134.4%	3.9	3.5	7.3	6.5 – 7.5
St Mary Abbots	118.3%	97.6%	130.1%	159.5%	4.4	2.9	7.3	6 – 7.5
David Evans	80.4%	58.5%	91.6%	97.9%	6.5	2.6	9.1	6 – 7.5
Chelsea Wing	115.0%	68.8%	145.4%	170.5%	9.4	5.2	14.6	
Burns Unit	100.0%	100.0%	97.4%	100.0%	15.9	3.2	19.1	
Ron Johnson	97.5%	127.4%	103.2%	139.4%	4.9	3.5	8.4	6 – 7.5
ICU	107.8%	508.1%	103.4%	-	33.1	0.7	33.8	17.5 - 25
Rainsford Mowlem	102.4%	111.0%	120.1%	123.2%	4.0	3.6	7.5	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	91.5%	68.7%	45.0%	98.7%	4.5	1.6	6.2	7 – 17.5
Lampton	102.1%	101.4%	100.0%	112.4%	2.9	2.2	5.1	6 – 7.5
Richmond	83.3%	109.5%	77.7%	51.8%	6.1	3.7	9.8	6 – 7.5
Syon 1	95.2%	152.1%	99.3%	114.3%	4.1	2.4	6.4	6 – 7.5
Syon 2	95.2%	150.4%	99.9%	170.3%	3.3	3.4	6.7	6 – 7.5
Starlight	88.0%	93.5%	99.5%	96.8%	8.8	1.4	10.2	8.5 – 13.5
Kew	73.6%	115.7%	97.8%	214.5%	3.0	4.4	7.4	6 - 8
Crane	102.1%	193.0%	107.5%	218.0%	3.4	4.6	7.9	6 – 7.5
Osterley 1	112.0%	138.0%	103.3%	171.0%	3.0	3.6	6.6	6 – 7.5
Osterley 2	96.0%	129.3%	108.9%	209.4%	3.6	3.7	7.3	6 – 7.5
MAU	92.5%	91.7%	94.4%	100.9%	5.5	3.2	8.7	7 - 9
CCU	103.5%	84.9%	105.7%	-	5.6	0.7	6.3	6.5 - 10
Special Care Baby Unit	106.9%	-	105.6%	-	7.3	0.0	7.3	15.9
Marble Hill 1	95.3%	97.7%	99.2%	98.4%	3.2	2.2	5.4	6 - 8
Marble Hill 2	100.7%	149.8%	107.5%	193.5%	3.3	4.5	7.8	5.5 - 7
ITU	92.1%	107.0%	91.0%	-	23.5	0.7	24.2	17.5 - 25

Summary for July 2017

High fill rates on SMA due to the new staffing model for SAU. High fill rates on Lord Wigram for enhanced care given to a very confused patient at high risk of falling. David Evans is showing low fill rates as staffing levels were reduced when elective lists were not fully booked. Extra HCA required at night on AAU CW due to ward being on split locations during renovation. ITU showing high fill rates due to additional staffing required for patients with mental health needs. Agitated and aggressive patient who has assaulted staff members on Chelsea wing requiring RMN/HCA special. Apollo has low fill rates for HCAs as following a skill mix review, the only HCAs used are when enhanced care is required for a patient.

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. Syon 1 &2, Osterley 1&2, Kew, Crane and Marble Hill 2 showing high fill rates for HCAs due to a high number of mobile confused patients at high risk of falls. More staff booked at night as staffing levels lower at nights. Lampton continues to show under national benchmark for CHPPD on a recurrent basis, as does Syon 2 without specials in place.

CQUIN Dashboard

July 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 and preventing Ill health caused by risky behaviours in 2018/19 only.

Senior Responsible Officers and operational leads have been established for all schemes and Quarter 1 reports were submitted at the end of July. The Trust are awaiting the feed-back and sign-off from CCGs and NHS England for Q1.

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 risk to delivery of the Sepsis and anti-microbial resistance scheme, in line with 2016/17 delivery, and the Trust is expecting partial achievement for Q1.

The other schemes are new for the Trust and 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.

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.

The Trust has proposed a delay to the modification of new systems in relation to supporting safe and proactie discharge at the WMUH site due to the new EPR implementation.

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.

There is also a short term risk to the dose banding scheme due to recent disruption to the Aria electronic prescribing system for chemotherapy as a result of the recent cyber-attack, which could jeopardise achievement of milestones. This has been discussed at the earliest opportunity with NHS England and the Trust is working with partners to resolve the systems disruption as quickly as possible.

Final Version

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance Dashboard

Month 4 2017/2018

Integrated Position

Financial Position (£000's)

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	205,324	206,635	1,311
Expenditure	(195,745)	(196,946)	(1,202)
Adjusted EBITDA	9,580	9,689	109
Adjusted EBITDA %	4.666%	4.689%	0.02%
Interest/Other	(1,752)	(1,711)	41
Depreciation	(5,767)	(5,597)	170
PDC Dividends	(3,167)	(3,168)	(1)
Other	0	0	0
Trust Deficit	**(1,107)**	**(787)**	**319**

Comments

The Trust is reporting a YTD deficit of £787k which is £319k favourable against the internal plan.

Income is favourable by £1,311k YTD predominantly against other income.

Overall clinical activity is on trend but marginally adverse against the July plan.

Pay is adverse by £4,145k 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 which remain open at month 4 and outpatient clinics not removed due to continuing demand.

Spend on specialling and RMN usage was higher than plan. Under achievement against CIP targets has also contributed to this variance.

Non-pay is £2,941 favourable year to date. Included in this position is an adverse variance against clinical supplies which is mainly activity driven.

Risk rating (year to date)

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

Comments

The Use of Resources Rating (UORR) is utilised by NHS Improvement as a measure of the Trust's financial performance.

Under this rating 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".

At the end of July, the Trust is performing in line with plan for all areas of measurement except against its agency rating, where YTD expenditure was £6.94m against a ceiling of £6.68m, an adverse variance of £0.26m. As the Trust did not score a "4" in any of its risk ratings this month then the override does not apply and the Trust scores a UORR rating of "2" in line with plan.

Cost Improvement Programme (CIPs)

Heading	In Month			Year to Date		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Service Developments/Business Cases	35	0	(35)	140	0	(140)
Targeted Specialities	731	685	(46)	2,170	1,929	(241)
Residual % Based Savings	1,381	1,234	(147)	4,976	3,553	(1,424)
Trust Total	2,147	1,919	(228)	7,286	5,482	(1,805)

Comments RAG rating

The Trust has achieved YTD CIPs of £5.48m against an internal target of £7.29m with an adverse variance of £1.81m.

Areas where the Trust has underachieved include SafeCare £0.14m, target speciality areas in relation to trauma and orthopaedics, obstetrics and gynaecology. HIV and general surgery totalling £0.35m and service line schemes for procurement £0.23m.

The Trust has identified new CIP schemes in relation to income which have provided a YTD saving of £1.2m.

Through new schemes identified the trust aims to achieve the target plan of £25.9m.

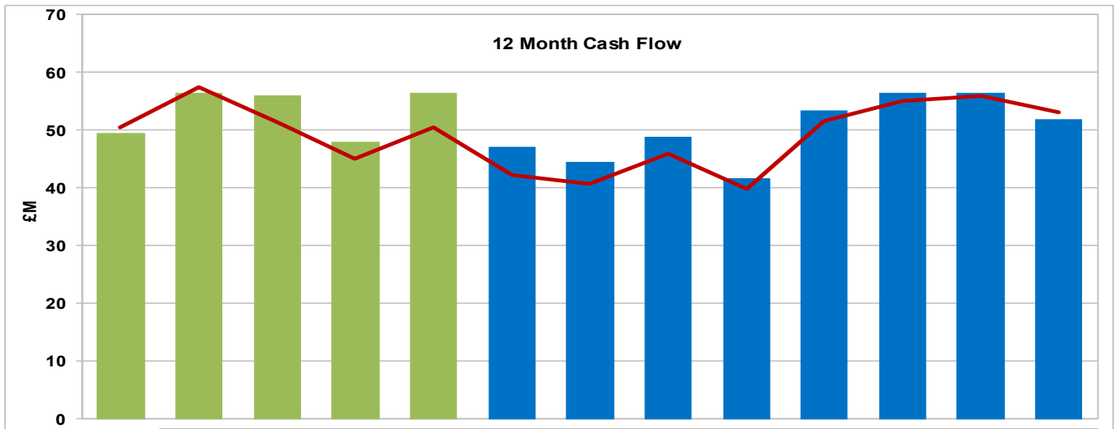
Cash Flow

Comments RAG rating

The cash balance at the end of month 4 is £56.40m which is £5.89m more than plan of £50.51m.

The main drivers of this increase are a receipt of £0.27m of additional STF relating to 2016/17 post accounts reallocation, reduction in opening cash figure compared to plan of £(1.15m), increase in capital expenditure on a cash basis of £(2.46m) and an increase in working capital compared to plan of £9.37m.

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 opening balance in the plan.



	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								
Forecast						47.23	44.58	48.93	41.78	53.43	56.58	56.53	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

QUALITY PRIORITIES DASHBOARD

Quarter 1 2017/2018

Patient Safety

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Q2	Q3	Q4	Commentary
1	Reduction in falls (Frailty Quality Plan)	Director of Nursing					This metric will track progress against preventable in hospital falls with and without harm
2	Antibiotic administration in Sepsis (Sepsis Plan)	Medical Director					This metric will track the administration of first dose of antibiotics within one hour of diagnosis of suspected sepsis
3	National Early Warning Score (Sepsis Plan)	Medical Director					This metric will track the accurate recording of patients' vital signs and the appropriate scoring and escalation of the deteriorating patient in hospital.
4	National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan)	Divisional Medical Director					This metric will track the implementation of the National theatre safety bundle in order to optimise theatre safety culture.

Clinical Effectiveness

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Q2	Q3	Q4	Commentary
5	Reduction in still births (Maternity Plan)	Director of Midwifery					This metric will track the reduction in avoidable and unavoidable still births and benchmark our position relative to the national still birth rate

Patient Experience

QP No	Description of Goal	Responsible Executive (role)	Forecast Q1	Q2	Q3	Q4	Commentary
1	Focus on complaints and demonstrate learning from complaints	Director of Midwifery					This metric will track performance against the Trust complaints process and measure and monitor the delivery of agreed action plans.
2	FFT improvements with new FFT provider	Director of Midwifery					This metric will track the response rate and recommendation rates as per the Patient Experience dashboard within the IBR

This dashboard provides the Board with a template for monitoring the 7 agreed Quality Priorities as contained within the Quality Plan. Quarter 1 will be populated with the appropriate RAG rating in next Month's Integrated Board Report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	2.3.3/Sep/17
REPORT NAME	Workforce Performance Report - Month 4 - 2017/18
AUTHOR	Keith Loveridge. Director of human resources and organisation development
LEAD	Keith Loveridge. Director of human resources and organisation development
PURPOSE	The workforce performance report highlights current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	**Workforce Commentary July 2017 figures** **Staff in Post** In July we employed 5166 whole time equivalent (WTE) people on substantive contracts. Taking into account bank and agency workers our total WTE workforce was 6212 against and establishment of 6035. The discrepancy between total workforce and establishment is due mainly to two reasons: short term changes to establishment as a result of the workforce data cleanse exercise and specialling (730 bank and agency shifts in July). More work on the gap between establishment and workforce will be carried out once the workforce data cleanse work has been completed. **Turnover** Our voluntary turnover rate was 15.9%, 0.4% lower than last month. Voluntary turnover is 18% at Chelsea and 12.1% at West Middlesex. **Vacancies** Our general vacancy rate for July was 14.4%, which is the same as June. The vacancy rate is 17.4% at West Middlesex and 12.8% at Chelsea. **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 85.4% against its target of 90%, up from 84.5% in June. **Performance and Development Reviews** On 1 April 2017 we changed our performance and development review process for non-medical staff so that everyone is required to have their performance and development review in a set period after 1 April 2017, starting with the most senior staff. More than 90% of staff in bands 8C-9 and director roles have had a performance and development review. Our focus is now on ensuring that at least 90% of band 7-8B staff have their PDR by the end of September. The rolling annual appraisal rate for non-medical staff is 60.3%. The appraisal rate for medical staff was 85.6%, 0.3% more than last month.

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 4 - July 2017

Workforce Performance Report Aug ‘16 - Jul ‘17

Performance Summary

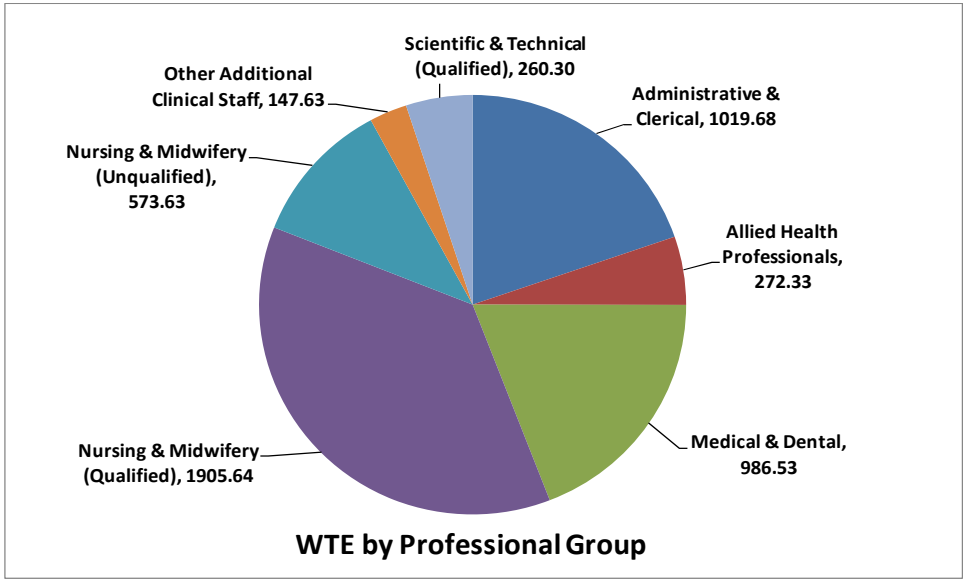
Summary of overall performance is set out below

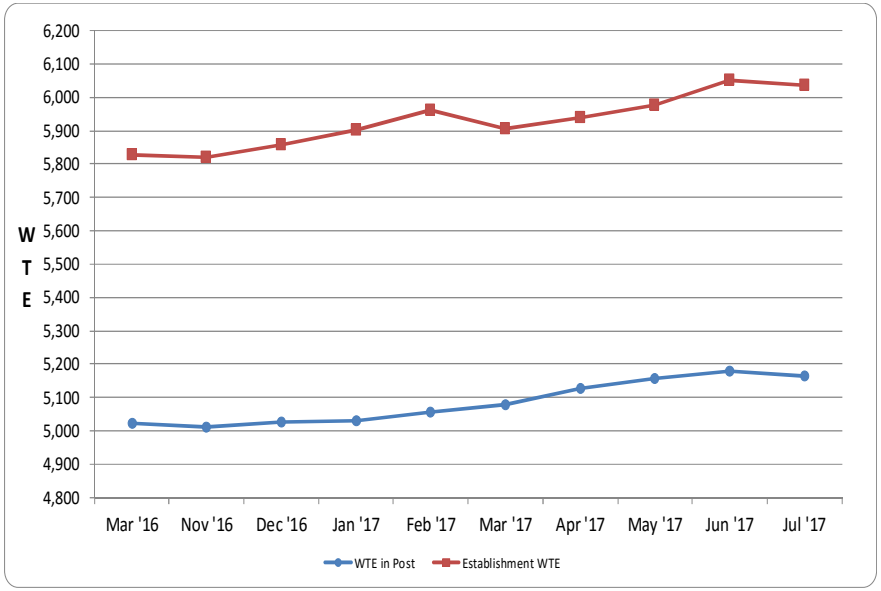
Page	Areas of Review	Key Highlights	Previous Year[1]	Previous Month	In Month	Target	Change
5	Vacancy	Vacancy rate has remained the same	12.6%	14.4%	14.4%	10.0%	↔
6	Turnover	Turnover has decreasd by 0.2%		21.4%	21.2%		↘
7	Voluntary Turnover	Voluntary turnover has decreasd by 0.3%	16.2%	16.3%	16.0%	13.0%	↘
10	Sickness	Sickness has increased by 0.3%	2.2%	2.2%	2.5%	3.3%	↗
15	Temporary Staffing Usage (FTE)	Temporary Staffing usage his decreased by 0.4% this month		17.3%	16.9%		↘
17	Core Training	Core Training compliance has increased by 0.9%	85.0%	84.5%	85.4%	90.0%	↗
18	Staff PDR	The percentage of staff who have had a PDR in the past 12 months has decreased by 0.2%	75.0%	60.5%	60.3%	90.0%	↘

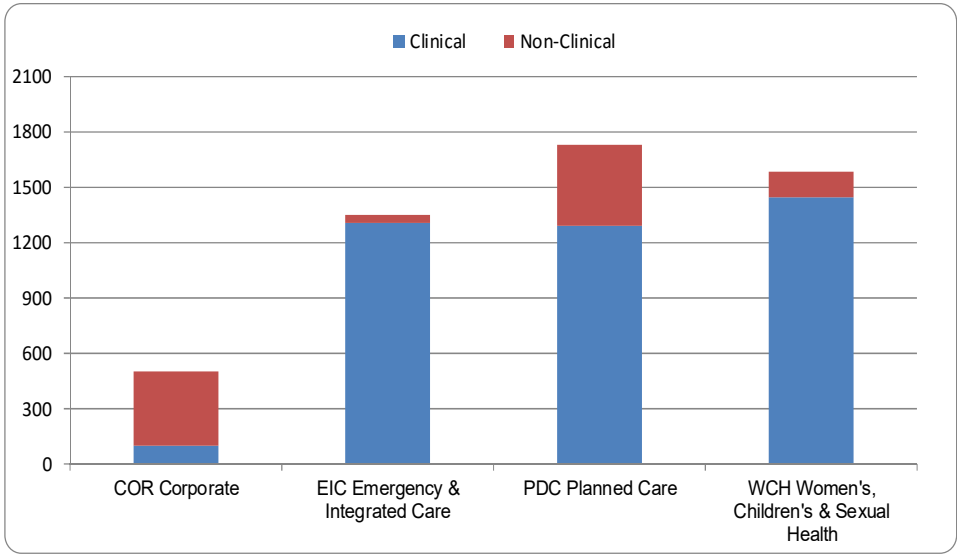
[1]Figures shown are just for Chelsea Site in the same month of the previous year

Current Staffing Profile

The data below displays the current staffing profile of the Trust







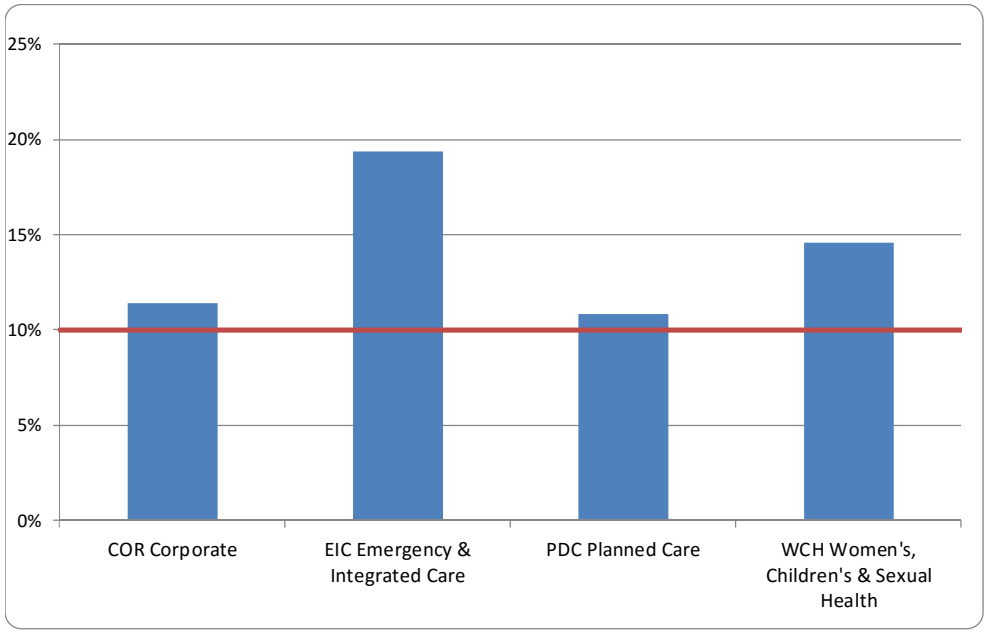
COMMENTARY

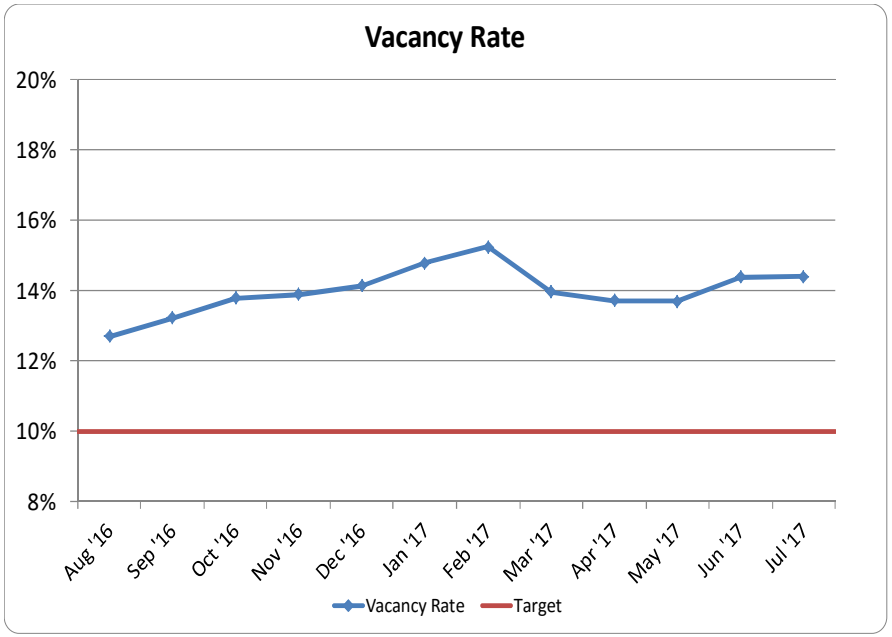
The Trust currently employs 5665 people working a whole time equivalent of 5166 which is 15 WTE fewer than June.

There were 1757 WTE staff assigned to the West Middlesex site and 3409 WTE to Chelsea.

The largest professional group at the Trust is Qualified Nursing & Midwifery employing 1906 WTE.

Section 1: Vacancies





Vacancies by Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	8.7%	12.0%	17.7%	11.4%	↘
EIC Emergency & Integrated Care	21.0%	16.3%	18.4%	19.3%	↗
PDC Planned Care	6.1%	9.5%	11.0%	10.8%	↘
WCH Women's, Children's & Sexual Health	16.1%	16.3%	13.2%	14.6%	↗
Whole Trust	**13.7%**	**13.7%**	**14.4%**	**14.4%**	↔
West Mid Site	**15.2%**	**15.9%**	**16.7%**	**17.4%**	↗
Chelsea Site	**12.9%**	**12.6%**	**13.2%**	**12.8%**	↘

Vacancies by Professional Group	Apr '17	May '17	Jun '17	Jul '17	Trend
Administrative & Clerical	15.6%	18.5%	16.3%	10.2%	↘
Allied Health Professionals	10.2%	9.4%	16.4%	19.1%	↗
Medical & Dental	10.2%	9.6%	9.4%	14.2%	↗
Nursing & Midwifery (Qualified)	15.6%	14.4%	13.9%	15.5%	↗
Nursing & Midwifery (Unqualified)	13.6%	13.2%	20.0%	17.6%	↘
Other Additional Clinical Staff	16.2%	15.2%	20.5%	16.1%	↘
Scientific & Technical (Qualified)	7.2%	7.5%	9.6%	8.9%	↘
Total	**13.7%**	**13.7%**	**14.4%**	**14.4%**	↔

COMMENTARY

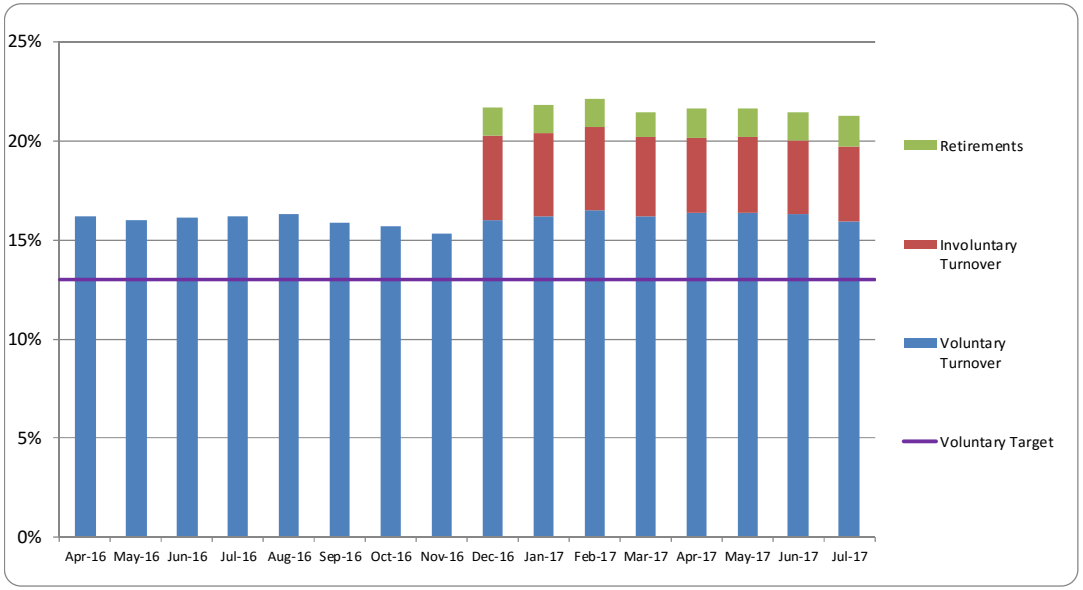
The vacancy rate has remained the same at 14.4% in July.

Work to reconcile ESR to the ledger is nearing completion. Posts are still being created, moved or closed within Planned Care which is creating significant variations across staff groups each depending upon the timing of reporting.

Divisions are now in the process of signing off their ESR Establishments. Once completed, the correct vacancy rate will be reported by professional group across the Trust.

Section 2a: Gross Turnover

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



COMMENTARY

The total trust turnover rate has decreased by 0.2% to 21.2% this month. In the last 12 months there have been 1076 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	**Apr '17**	**May '17**	**Jun '17**	**Jul '17**	**Trend**
COR Corporate	25.4%	24.7%	24.3%	24.4%	↗
EIC Emergency & Integrated Care	23.5%	22.9%	22.2%	21.7%	↘
PDC Planned Care	21.1%	21.6%	22.0%	21.5%	↘
WCH Women's, Children's & Sexual Health	19.5%	19.6%	19.4%	19.7%	↗
Whole Trust	**21.6%**	**21.6%**	**21.4%**	**21.2%**	↘

	Gross Turnover				
Professional Group	**Apr '17**	**May '17**	**Jun '17**	**Jul '17**	**Trend**
Administrative & Clerical	22.2%	21.9%	22.0%	21.8%	↘
Allied Health Professionals	20.5%	20.2%	18.2%	18.8%	↗
Medical & Dental	16.3%	16.9%	16.3%	16.2%	↘
Nursing & Midwifery (Qualified)	20.4%	20.3%	20.2%	20.0%	↘
Nursing & Midwifery (Unqualified)	25.2%	26.4%	28.3%	21.8%	↘
Other Additional Clinical Staff	18.6%	16.4%	15.1%	27.4%	↗
Scientific & Technical (Qualified)	37.1%	38.7%	38.1%	35.3%	↘
Whole Trust	**21.6%**	**21.6%**	**21.4%**	**21.2%**	↘

Section 2b: Voluntary Turnover

	Voluntary Turnover						Other Turnover Jul 2017	
Division	Apr '17	May '17	Jun '17	Jul '17	Trend	Leavers HC	In-voluntary	Retirement
COR Corporate	20.8%	20.1%	19.9%	20.4%	↗	101	2.8%	1.2%
EIC Emergency & Integrated Care	19.9%	19.6%	18.9%	18.3%	↘	232	2.5%	0.8%
PDC Planned Care	13.7%	13.9%	14.0%	13.4%	↘	222	6.0%	2.0%
WCH Women's, Children's & Sexual Health	14.9%	15.2%	15.4%	15.3%	↘	254	2.7%	1.7%
Whole Trust	**16.4%**	**16.3%**	**16.3%**	**16.0%**	↘	**809**	**3.7%**	**1.5%**
West Mid Site	**13.6%**	**13.2%**	**12.5%**	**12.1%**	↘	**214**		
Chelsea Site	**17.8%**	**18.0%**	**18.3%**	**18.0%**	↘	**595**		

	Voluntary Turnover						Other Turnover Jul 2017	
Professional Group	Apr '17	May '17	Jun '17	Jul '17	Trend	Leavers HC	In-voluntary	Retirement
Administrative & Clerical	16.6%	16.1%	16.0%	15.9%	↘	166	4.1%	1.8%
Allied Health Professionals	17.6%	17.3%	15.9%	16.6%	↗	51	1.9%	0.3%
Medical & Dental	5.1%	5.5%	5.7%	5.3%	↘	30	8.9%	2.0%
Nursing & Midwifery (Qualified)	17.8%	17.9%	17.9%	17.6%	↘	368	0.8%	1.6%
Nursing & Midwifery (Unqualified)	22.4%	23.2%	24.9%	18.7%	↘	114	2.1%	1.0%
Other Additional Clinical Staff	13.9%	11.9%	10.7%	19.9%	↗	32	6.2%	1.2%
Scientific & Technical (Qualified)	19.6%	20.5%	19.0%	16.3%	↘	48	17.3%	1.7%
Whole Trust	**16.4%**	**16.3%**	**16.3%**	**16.0%**	↘	**809**	**3.7%**	**1.5%**

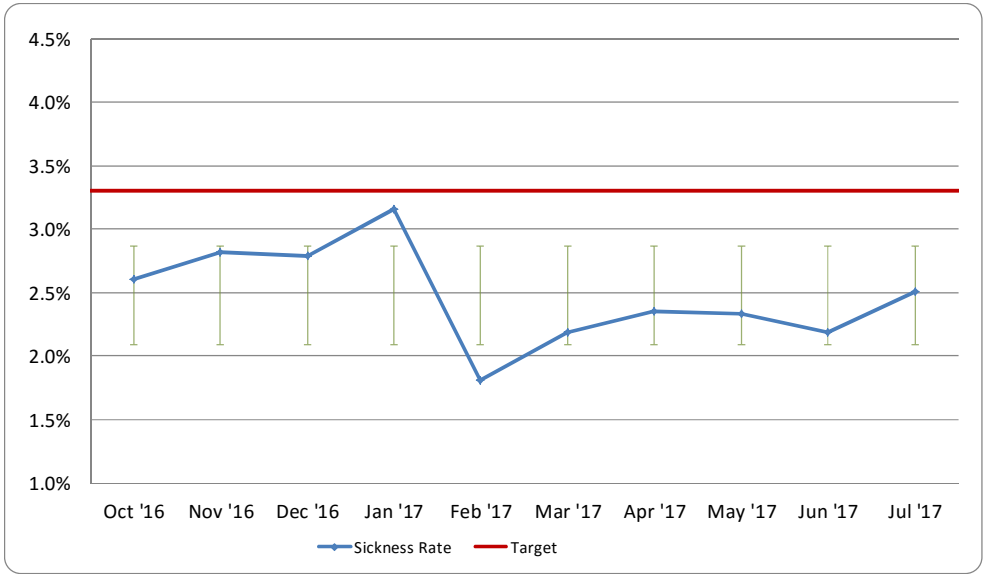
Service	Average Staff in Post HC	Leavers HC	Voluntary Turnover Rate
Osterley 1 - WM	31	11	36.1%
Ron Johnson - CW	26	9	35.3%
Acute Assessment Unit - CW	70	24	34.5%
John Hunter Clinic - CW	44	14	31.8%
Nell Gwynne - CW	37	11	29.7%

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 2.5% for July which is a increase of 0.3% 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 July 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	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	1.8%	1.5%	1.0%	1.7%	↗
EIC Emergency & Integrated Care	2.6%	2.0%	2.0%	2.2%	↗
PDC Planned Care	2.0%	2.5%	2.6%	2.7%	↗
WCH Women's, Children's & Sexual Health	2.8%	2.7%	2.3%	2.8%	↗
Whole Trust Monthly %	**2.4%**	**2.3%**	**2.2%**	**2.5%**	↗
Whole Trust Annual Rolling %	**2.5%**	**2.5%**	**2.6%**	**2.5%**	↘

Sickness by Professional Group	Apr '17	May '17	Jun '17	Jul '17	Trend
Administrative & Clerical	2.5%	3.1%	2.2%	3.0%	↗
Allied Health Professionals	1.3%	2.7%	3.2%	1.6%	↘
Medical & Dental	0.3%	0.4%	0.5%	0.4%	↘
Nursing & Midwifery (Qualified)	3.1%	2.5%	2.4%	3.0%	↗
Nursing & Midwifery (Unqualified)	4.1%	3.9%	3.7%	4.2%	↗
Other Additional Clinical Staff	2.1%	1.7%	2.1%	1.6%	↘
Scientific & Technical (Qualified)	1.8%	2.4%	2.7%	2.8%	↗
Total	**2.4%**	**2.3%**	**2.2%**	**2.5%**	↗

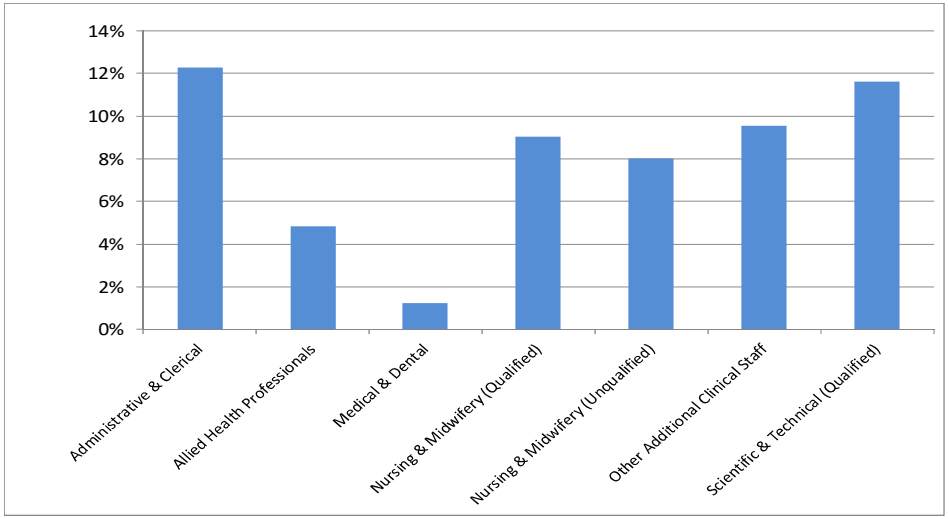
Service	Staff in Post WTE	Sickness WTE Days Lost	Sickness %
Dermatology - CW	26.04	102.40	12.6%
Syon 2 Pay - WM	32.01	100.36	10.4%
Medicine Discharge Suite - CW	33.45	104.59	10.2%
Private Maternity - CW	43.46	102.38	7.7%
Estates & Facilities - CW	30.04	62.00	6.7%

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S25 Gastrointestinal problems	22.87%
S13 Cold, Cough, Flu - Influenza	20.56%
S12 Other musculoskeletal problems	10.34%
S16 Headache / migraine	9.00%
S10 Anxiety/stress/depression/other psychiatric illnesses	4.99%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S25 Gastrointestinal problems	15.25%
S12 Other musculoskeletal problems	13.90%
S10 Anxiety/stress/depression/other psychiatric illnesses	13.26%
S13 Cold, Cough, Flu - Influenza	7.59%
S28 Injury, fracture	7.41%

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 July 44 staff were promoted, there were 93 new starters to the Trust (excluding Doctors in Training). In addition, 70 employees were acting up to a higher grade.

Over the last year 8.5% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Directorates.

The Admin & Clerical staff group have the highest promotion rate at 12.3% followed by at Scientific & Technical 11.6%.

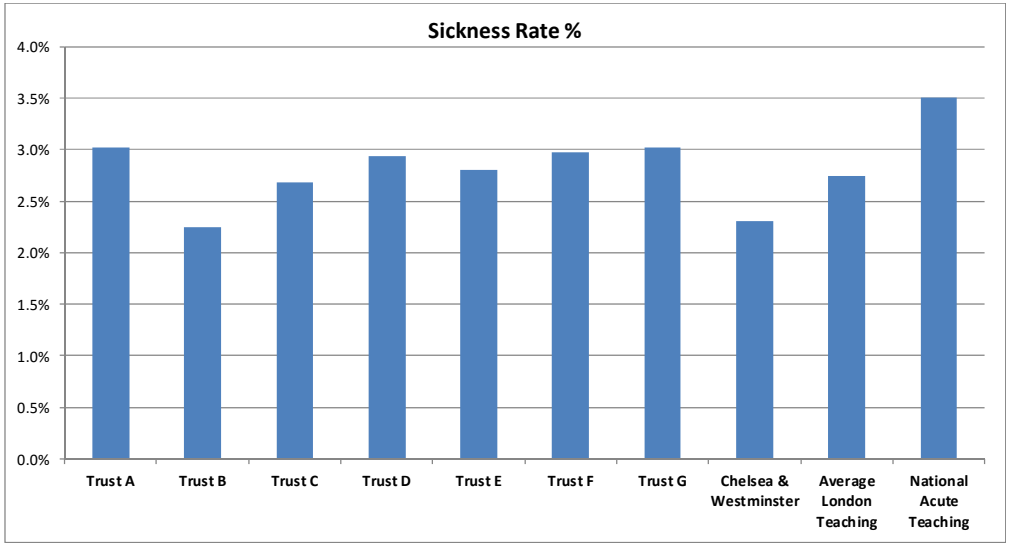
	Monthly No. of Promotions				
Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	8	7	10	7	↘
EIC Emergency & Integrated Care	9	11	9	13	↗
PDC Planned Care	8	11	9	10	↗
WCH Women's, Children's & Sexual Health	14	11	18	14	↘
Whole Trust Promotions	**39**	**40**	**46**	**44**	↘
New Starters (Excludes Doctors in Training)	**128**	**112**	**80**	**93**	↗

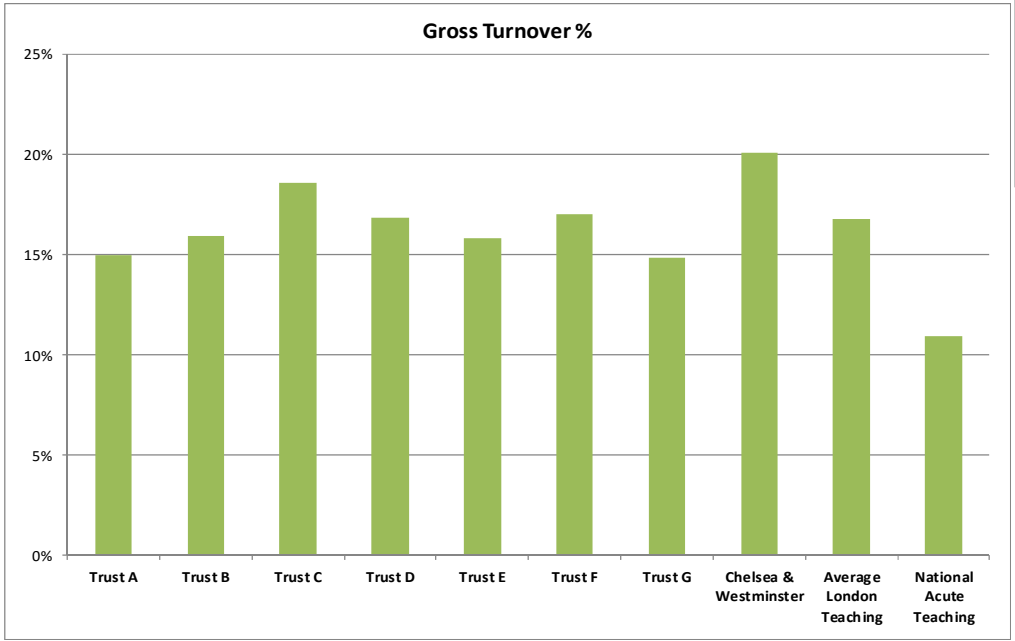
Division	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up
COR Corporate	367	45	12.3%	10
EIC Emergency & Integrated Care	979	97	9.9%	17
PDC Planned Care	1362	88	6.5%	24
WCH Women's, Children's & Sexual Health	1331	114	8.6%	19
Whole Trust	**4039**	**344**	**8.5%**	**70**
New Starters (Excludes Doctors in Training)		**1085**		

	No. of Promotions				
Professional Group	Apr '17	May '17	Jun '17	Jul '17	Trend
Administrative & Clerical	13	15	21	13	↘
Allied Health Professionals	2	1	1	1	↔
Medical & Dental	0	0	1	0	↘
Nursing & Midwifery (Qualified)	18	15	15	21	↗
Nursing & Midwifery (Unqualified)	2	3	6	6	↔
Other Additional Clinical Staff	2	2	1	2	↗
Scientific & Technical (Qualified)	2	4	1	1	↔
Whole Trust	**39**	**40**	**46**	**44**	↘

Professional Group	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up
Administrative & Clerical	791	97	12.3%	21
Allied Health Professionals	249	12	4.8%	12
Medical & Dental	481	6	1.2%	0
Nursing & Midwifery (Qualified)	1705	154	9.0%	29
Nursing & Midwifery (Unqualified)	474	38	8.0%	2
Other Additional Clinical Staff	115	11	9.6%	1
Scientific & Technical (Qualified)	224	26	11.6%	5
Whole Trust	**4039**	**344**	**8.5%**	**70**

Section 5: Workforce Benchmarking





COMMENTARY

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

Sickness data shown is from Apr'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 April.

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 May). 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	14.94%	84.66%	3.02%
Trust B	15.94%	83.69%	2.24%
Trust C	18.56%	81.27%	2.68%
Trust D	16.82%	83.06%	2.94%
Trust E	15.82%	84.01%	2.80%
Trust F	17.01%	82.76%	2.97%
Trust G	14.83%	84.95%	3.02%
Chelsea & Westminster	20.09%	79.91%	2.31%
Average London Teaching	16.75%	83.04%	2.75%
National Acute Teaching	10.93%	88.89%	3.51%

Section 6: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	76.4	76.4	104.9	80.5	↘
EIC Emergency & Integrated Care	970.8	951.1	978.3	1006.7	↗
PDC Planned Care	691.0	689.6	690.6	703.5	↗
WCH Women's, Children's & Sexual Health	1171.4	1161.9	1159.1	1160.5	↗
Total	**2909.5**	**2879.0**	**2933.0**	**2951.3**	↗

Nursing Staff in Post WTE

Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	85.6	86.0	71.6	73.3	↗
EIC Emergency & Integrated Care	765.1	766.9	788.5	790.7	↗
PDC Planned Care	614.9	616.7	615.1	606.1	↘
WCH Women's, Children's & Sexual Health	1004.2	1003.4	1007.9	1009.2	↗
Total	**2469.8**	**2472.9**	**2483.1**	**2479.3**	↘

Nursing Vacancy Rate

Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	-12.1%	-12.6%	31.8%	9.0%	↘
EIC Emergency & Integrated Care	21.2%	19.4%	19.4%	21.5%	↗
PDC Planned Care	11.0%	10.6%	10.9%	13.8%	↗
WCH Women's, Children's & Sexual Health	14.3%	13.6%	13.0%	13.0%	↘
Total	**15.1%**	**14.1%**	**15.3%**	**16.0%**	↗

Nursing Sickness Rates

Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	5.2%	1.7%	0.8%	2.2%	↗
EIC Emergency & Integrated Care	3.6%	2.7%	2.3%	2.9%	↗
PDC Planned Care	2.3%	2.4%	3.1%	3.3%	↗
WCH Women's, Children's & Sexual Health	3.6%	3.2%	2.9%	3.6%	↗
Total	**3.3%**	**2.8%**	**2.7%**	**3.3%**	↗

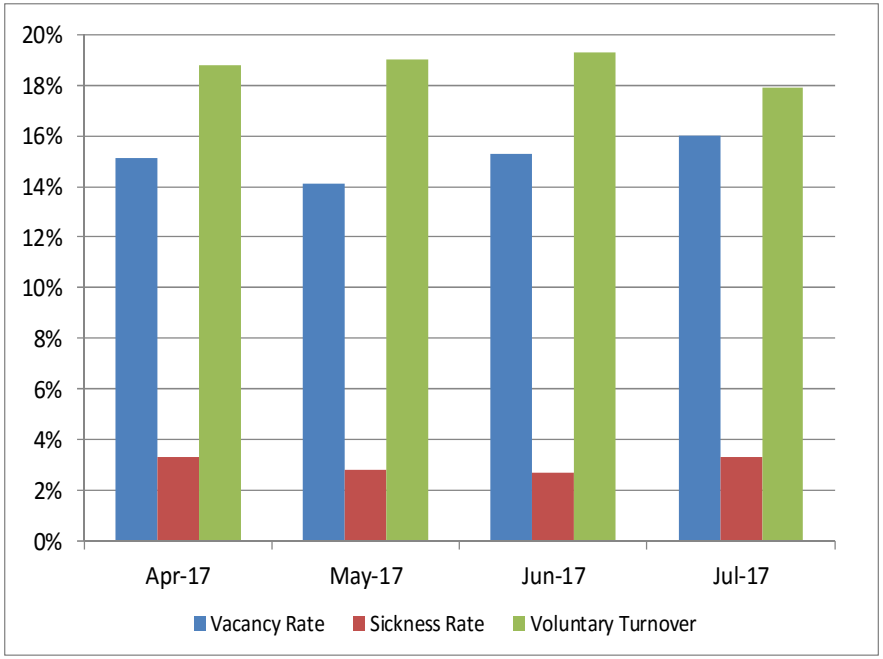
Nursing Voluntary Turnover

Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	14.42%	14.27%	16.47%	19.10%	↗
EIC Emergency & Integrated Care	22.82%	23.09%	22.26%	20.09%	↘
PDC Planned Care	17.12%	16.72%	17.54%	16.48%	↘
WCH Women's, Children's & Sexual Health	17.10%	17.60%	18.32%	16.92%	↘
Total	**18.8%**	**19.0%**	**19.3%**	**17.9%**	↘

COMMENTARY

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

The nursing workforce has decreased by 3.8 WTE in July.

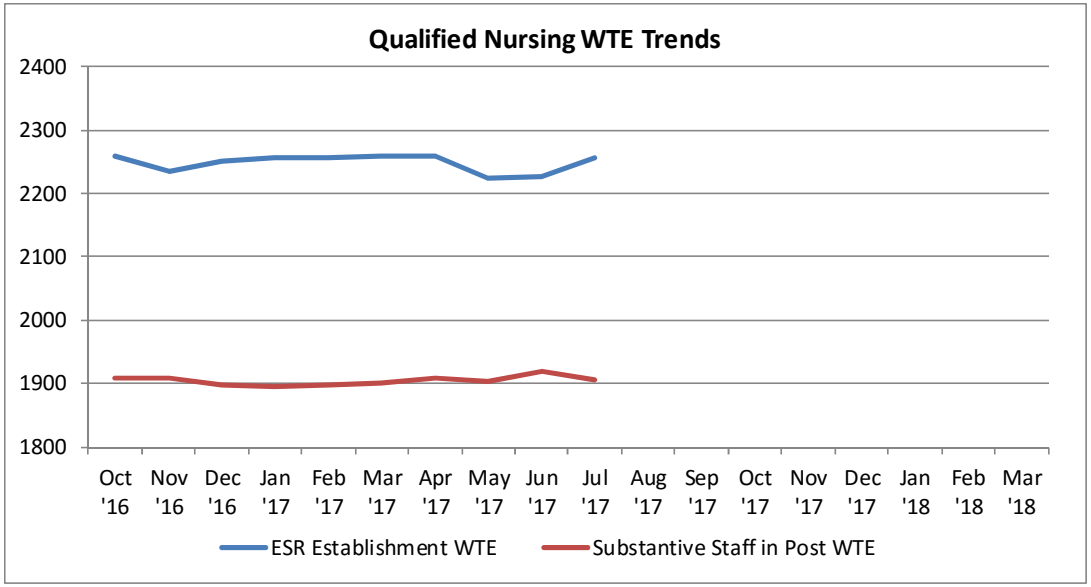


Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

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								
Substantive Staff in Post WTE	1894.3	1896.8	1900.4	1907.3	1904.0	1918.1	1905.6								
Contractual Vacancies WTE	361.1	359.6	357.1	351.2	319.7	309.0	349.4								
Vacancy Rate %	16.01%	15.94%	15.82%	15.55%	14.38%	13.87%	15.49%								
Actual/Planned Leavers Per Month*	25	20	28	41	36	29	31	32	32	32	32	32	32	32	32
Actual/Planned New Starters**	26	23	33	58	32	38	19	47	47	47	47	47	47	47	47
Pipeline: Agreed Start Dates								14	39	34	10	0	0	1	1
Pipeline: WTE No Agreed Start Date								114 - with no agreed start date							

* Based on Gross Turnover of 20%

** Number of WTE New Starters required per month to achieve a 10% Vacancy Rate by March 2018



COMMENTARY

This information tracks the current number of qualified nurses & midwives at the Trust and projects forward a pipeline based on starters already in the recruitment process.

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

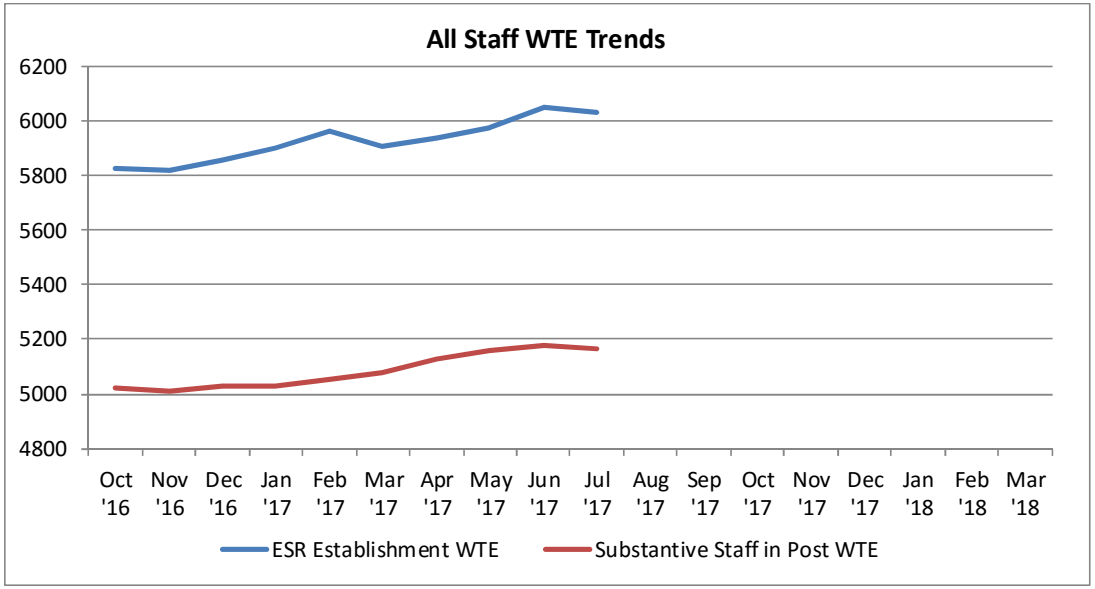
Section 8: All Staff Recruitment Pipeline

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								
Substantive Staff in Post WTE	5028.8	5054.8	5080.2	5125.6	5156.2	5180.3	5165.7								
Contractual Vacancies WTE	872.7	909.0	824.8	814.9	819.2	871.3	869.5								
Vacancy Rate %	14.79%	15.24%	13.97%	13.72%	13.71%	14.40%	14.41%								
Actual/Planned Leavers Per Month[2]	76	56	67	90	95	63	96	86	86	86	86	86	86	86	86
Actual/Planned New Starters[3]	118	120	127	151	130	86	94	119	119	119	119	119	119	119	119
Pipeline: Agreed Start Dates								48	70	55	20	1	0	1	2
Pipeline: WTE No Agreed Start Date								305 - 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	Apr '17	May '17	Jun '17	Jul '17	YTD
Actual Spend	£287,107	£129,363	£279,295	£128,916	£824,681
Target Spend	£241,308	£241,308	£241,308	£241,308	£965,232
Variance	£45,799	-£111,945	£37,987	-£112,392	-£140,551
Variance %	19.0%	-46.4%	15.7%	-46.6%	-14.6%

EIC Emergency & Integrated Care

Emergency & Integrated Care	Apr '17	May '17	Jun '17	Jul '17	YTD
Actual Spend	£738,857	£650,026	£759,878	£751,397	£2,900,158
Target Spend	£583,420	£583,420	£583,420	£583,420	£2,333,680
Variance	£155,437	£66,606	£176,458	£167,977	£566,478
Variance %	26.6%	11.4%	30.2%	28.8%	24.3%

PDC Planned Care

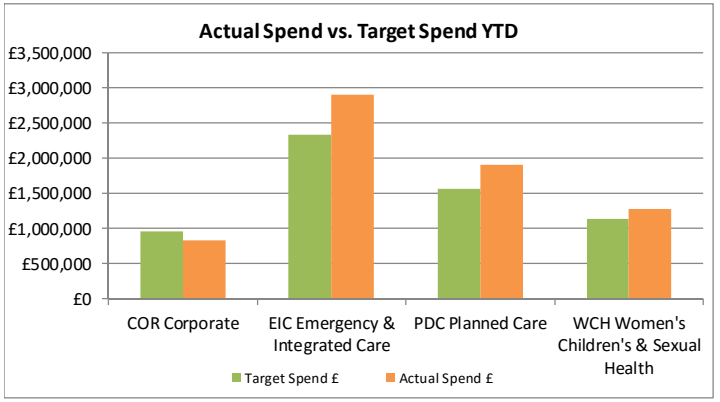
Planned Care	Apr '17	May '17	Jun '17	Jul '17	YTD
Actual Spend	£425,775	£485,704	£586,530	£398,385	£1,896,394
Target Spend	£392,436	£392,436	£392,436	£392,436	£1,569,744
Variance	£33,339	£93,268	£194,094	£5,949	£326,650
Variance %	8.5%	23.8%	49.5%	1.5%	20.8%

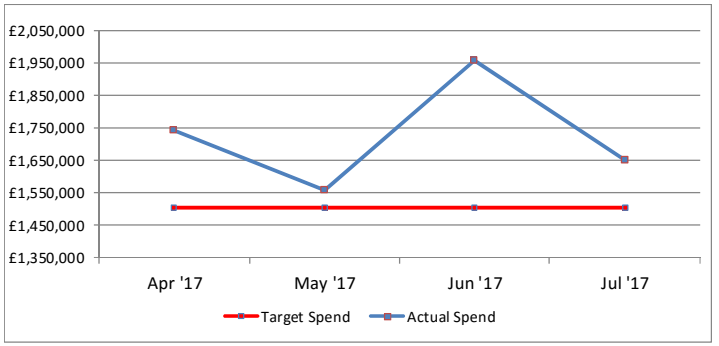
WCH Women's, Children's & Sexual Health

Women's, Children's & Sexual Health	Apr '17	May '17	Jun '17	Jul '17	YTD
Actual Spend	£291,730	£291,022	£332,285	£370,971	£1,286,008
Target Spend	£285,918	£285,918	£285,918	£285,918	£1,143,672
Variance	£5,812	£5,104	£46,367	£85,053	£142,336
Variance %	2.0%	1.8%	16.2%	29.7%	12.4%

Clinical Divisions and Corporate Areas

Trust	Apr '17	May '17	Jun '17	Jul '17	YTD
Actual Spend	£1,743,469	£1,556,115	£1,957,988	£1,649,669	£6,907,241
Target Spend	£1,503,082	£1,503,082	£1,503,082	£1,503,082	£6,012,328
Variance	£240,387	£53,033	£454,906	£146,587	£894,913
Variance %	16.0%	3.5%	30.3%	9.8%	14.9%





COMMENTARY

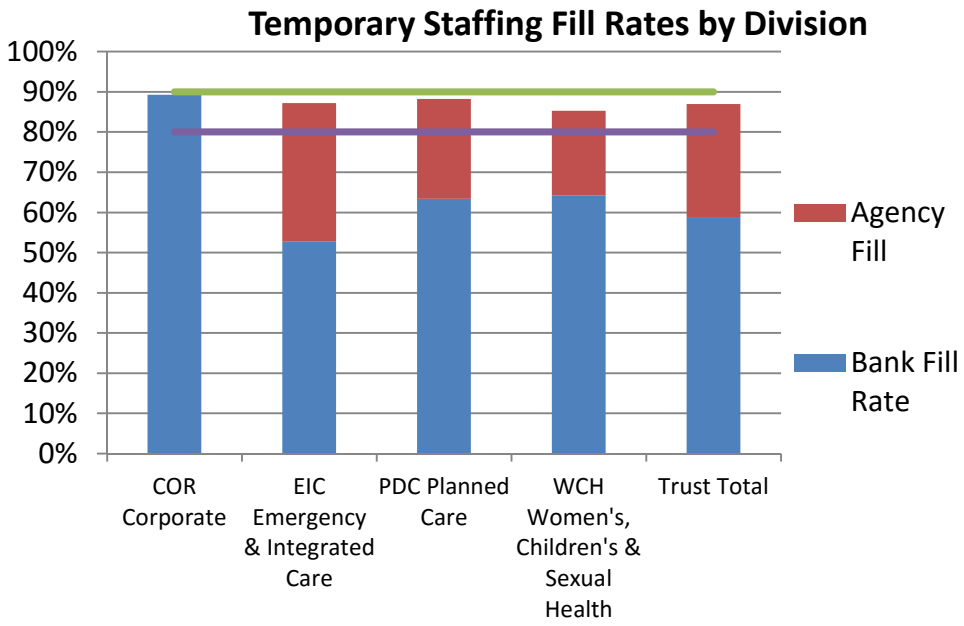
These figures show the Trust agency spend by Division compared to the spend ceilings which have been set for 17/18.

In Month 4, the Women's, Children's & Sexual Health Division spent 29.7% more than the target for the month.

Overall, the only Division below it's YTD target is Corporate, by 14.6%.

** 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.

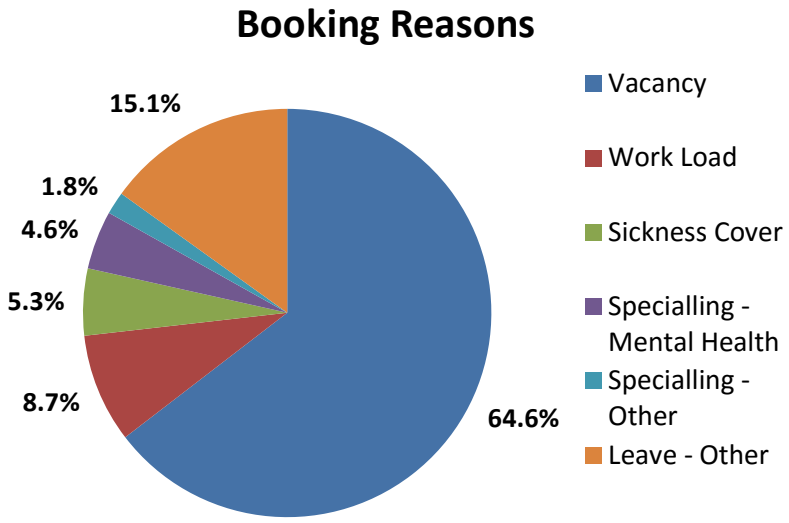
The Overall Fill Rate was 87% this month which 1.5% higher than June. The Bank Fill Rate was reported at 58.9% which is 1.2% higher than the previous month.

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

The Bank to Agency ratio for filled shifts was 68:32. The Trust target is 80:20.

The pie chart shows a breakdown of the reasons given for requesting bank shifts in July. This is very much dominated by covering existing vacancies, sickness, 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	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	83.6%	79.4%	86.0%	89.3%	↗
EIC Emergency & Integrated Care	84.4%	83.9%	84.1%	87.2%	↗
PDC Planned Care	87.6%	88.9%	88.8%	88.3%	↘
WCH Women's, Children's & Sexual Health	83.7%	85.7%	85.0%	85.3%	↗
Whole Trust	**84.9%**	**85.6%**	**85.5%**	**87.0%**	↗

Bank Fill Rate % by Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	52.5%	65.1%	86.0%	89.3%	↗
EIC Emergency & Integrated Care	49.7%	51.0%	50.7%	52.8%	↗
PDC Planned Care	60.2%	66.1%	62.8%	63.4%	↗
WCH Women's, Children's & Sexual Health	60.9%	65.3%	64.9%	64.3%	↘
Whole Trust	**55.2%**	**58.5%**	**57.7%**	**58.9%**	↗

Section 11: Core Training

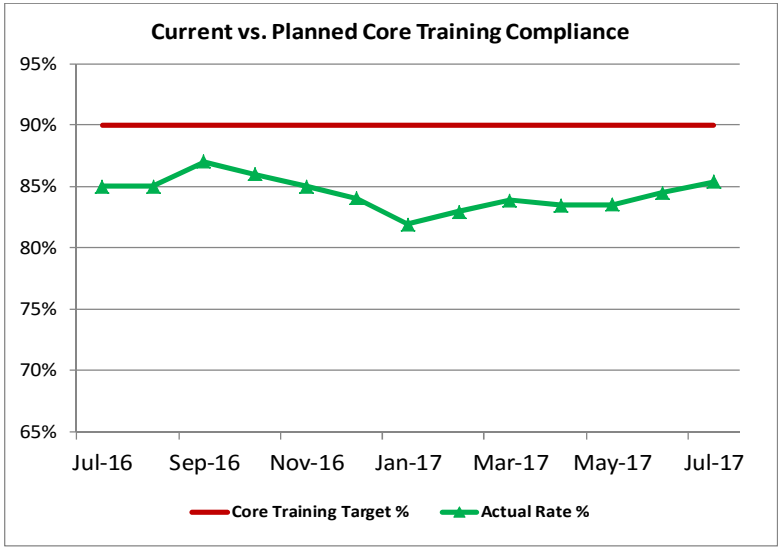
Core Training Topic	May '17	Jun '17	Trend
Basic Life Support	80.0	81.0	↗
Equality, Diversity and Human Rights	85.0	86.0	↗
Fire	85.0	87.0	↗
Health & Safety	83.0	85.0	↗
Inanimate Loads (M&H L1)	88.0	89.0	↗
Infection Control (Hand Hyg)	86.0	87.0	↗
Information Governance	83.0	84.0	↗
Patient Handling (M&H L2)	80.0	81.0	↗
Safeguarding Adults Level 1	88.0	88.0	↔
Safeguarding Children Level 1	88.0	89.0	↗
Safeguarding Children Level 2	80.0	81.0	↗
Safeguarding Children Level 3	84.0	85.0	↗

Core Training Compliance % by Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	83.0%	79.0%	82.0%	86.0%	↗
EIC Emergency & Integrated Care	83.0%	84.0%	85.0%	83.0%	↘
PDC Planned Care	83.0%	84.0%	85.0%	83.0%	↘
WCH Women's Children's & Sexual Health	84.0%	84.0%	84.0%	86.0%	↗
Whole Trust	**83.0%**	**84.0%**	**84.0%**	**85.0%**	↗

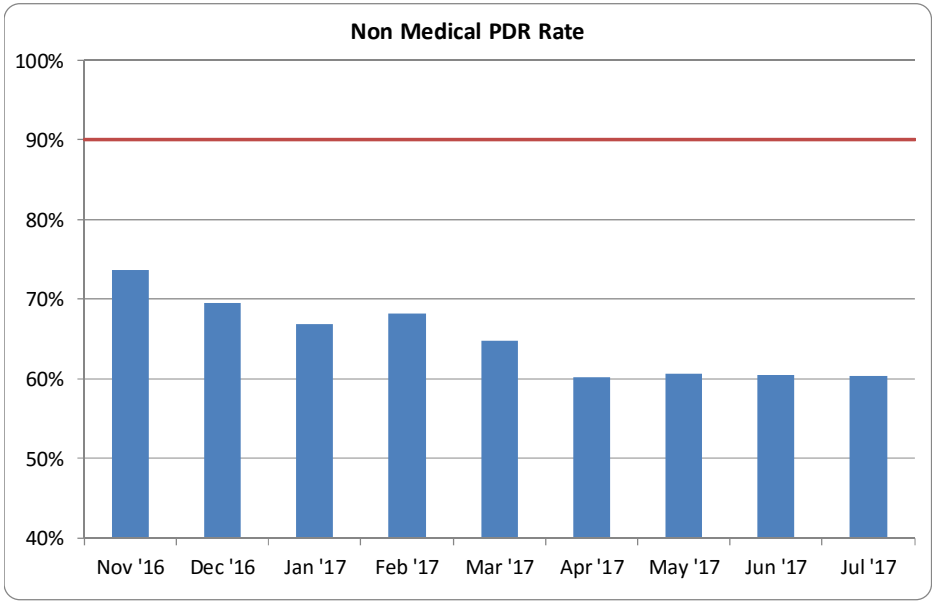
COMMENTARY

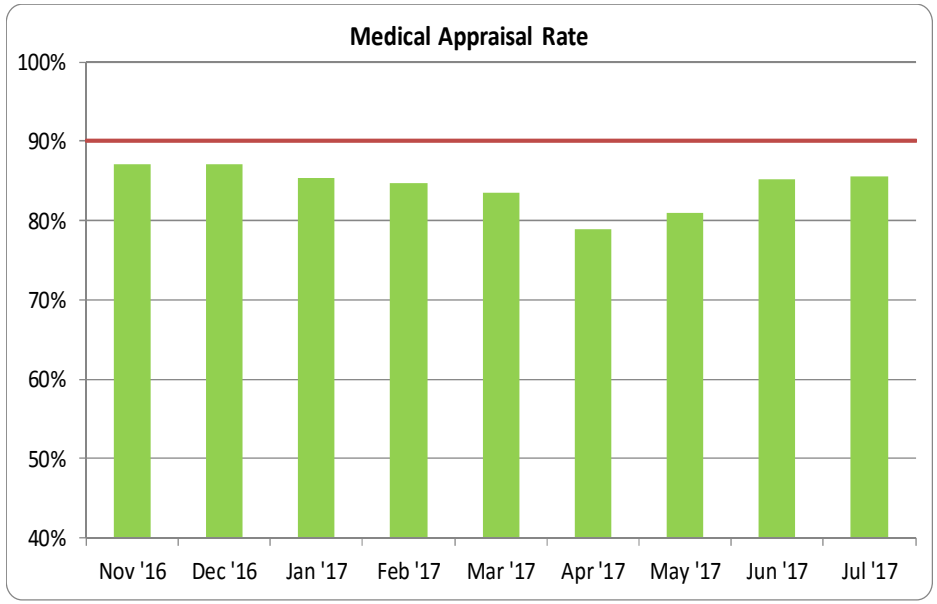
This month continues to see an overall upward trend in Core Training compliance.

Staff now have access to the e-Learning modules via the e-learning for Health (e-LfH) website. Sphere Services have upgraded the PCs in the Hub which once again provides a more reliable venue for staff to complete their online training. There is also a greater awareness of individual responsibility as a result of several senior managers holding staff to account for managing their own compliance status.



Section 12: Performance & Development Reviews





Rolling Annual PDR Rate

Non Medical PDRs by Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	60.3%	61.1%	61.5%	62.7%	↗
EIC Emergency & Integrated Care	61.8%	63.8%	59.5%	59.0%	↘
PDC Planned Care	57.0%	57.9%	59.3%	59.3%	↔
WCH Women's, Children's & Sexual Health	62.7%	61.1%	62.2%	61.4%	↘
Whole Trust	**60.2%**	**60.7%**	**60.5%**	**60.3%**	↘

Medical PDRs by Division	Apr '17	May '17	Jun '17	Jul '17	Trend
COR Corporate	100.0%	100.0%	100.0%	100.0%	↔
EIC Emergency & Integrated Care	80.8%	85.6%	86.9%	89.8%	↗
PDC Planned Care	79.9%	80.4%	85.9%	83.8%	↘
WCH Women's, Children's & Sexual Health	76.6%	78.3%	83.3%	84.4%	↗
Whole Trust	**79.0%**	**80.9%**	**85.2%**	**85.6%**	↗

PDRs From 1 April

Division	Band Group	%	Division	Band Group	%
COR	Band 2-6	16.2%	PDC	Band 2-6	10.5%
	Band 7-8b	23.8%		Band 7-8b	26.8%
	Band 8c +	92.7%		Band 8c +	100.0%
Corporate		**12.6%**	**PDC Planned Care**		**10.7%**
EIC	Band 2-6	9.3%	WCH	Band 2-6	7.7%
	Band 7-8b	22.5%		Band 7-8b	20.1%
	Band 8c +	66.7%		Band 8c +	80.0%
EIC Emergency & Integrated Care		**13.7%**	**WCH Women's, Children's & SH**		**13.8%**
Band Totals			**Band 2-6**	**Band 7-8b**	**Band 8c +**
			9.80%	23.1%	90.0%
Trust Total			**13.8%**		

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. More than 90% of staff in bands 8C-9 and director roles have had a PDR. Our focus is now on ensuring that at least 90% of band 7-8B staff have their PDR by the end of September. The rolling annual appraisal rate for non-medical staff is 60.3%.

Medical Commentary

The appraisal rate for medical staff was 85.6%, 0.4% more than last month.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	2.4/Sep/17
REPORT NAME	Learning from deaths; Mortality Review
AUTHOR	Alex Bolton, Safety Learning Programme Manager
LEAD	Zoe Penn, Medical Director
PURPOSE	This paper updates the Board on the Trust approach to learning from in-hospital deaths and provides key learning outcomes from mortality review.
SUMMARY OF REPORT	The 'Learning From Deaths; Mortality Review Procedure' and 'Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths' have been produced to support the Trust's learning from deaths agenda. Mortality review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group. Metrics from mortality review are providing a rich source of learning within clinical teams engaging well in the review process. The Trust has successfully reviewed 65% of all in-hospital deaths since 1st October 2016; the Medical Director and Divisional Medical Directors are working with clinical teams to further embed the review process. Clinical teams on both sites are identifying cases of suboptimal care (8 in Q1). Cases where different care MIGHT have affected the outcome (possibly avoidable death) and cases where different care would reasonably be expected to have affected the outcome (probable avoidable death) have been submitted for further in-depth review as serious incidents. The key theme arising from review relates to the identification, escalation and subsequent response to deteriorating patients.
KEY RISKS ASSOCIATED	Engagement: Lack of full engagement within mortality review processes 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
TO OBJECTIVES	• Deliver high quality patient centred care
DECISION/ ACTION	The Board is asked to note the approach to mortality review

Learning from deaths; Mortality Review

Background

A dedicated mortality review module operates within the Datix Safety Learning system; the module provides a repository for all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss) and provides a platform for the recording and analysis of consultant led case reviews.

Following initial case preparation by the named Consultant (or nominated colleague) each case should be discussed at a local specialty level M&M / MDT where teams can review expectations, outcomes and learning in an open manner. Local M&M is overseen by a mortality lead for each Specialty. 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).

Crude mortality rates

Crude mortality rates are reviewed by the mortality surveillance group. A spike in crude mortality was experienced in January 2017; Office of National Statistics data indicated that this increase was experienced nationally and within all local authorities in London. A rapid assessment of mortality reviews for this month provided assurance that sub-optimal care was not linked to this increase and Hospital Standardised Mortality Ratio (HSMR) data supported this conclusion (Trust within expected range for month).

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

Dr Foster's Healthcare Intelligence indicator for 12 months to March 2017 shows that outcomes have generally fallen within the expected range with the exception of February and March 2017 which showed low relative risk below the national benchmark. The overall relative risk of mortality within the period was 90 (85.2-95); this was below the expected range.

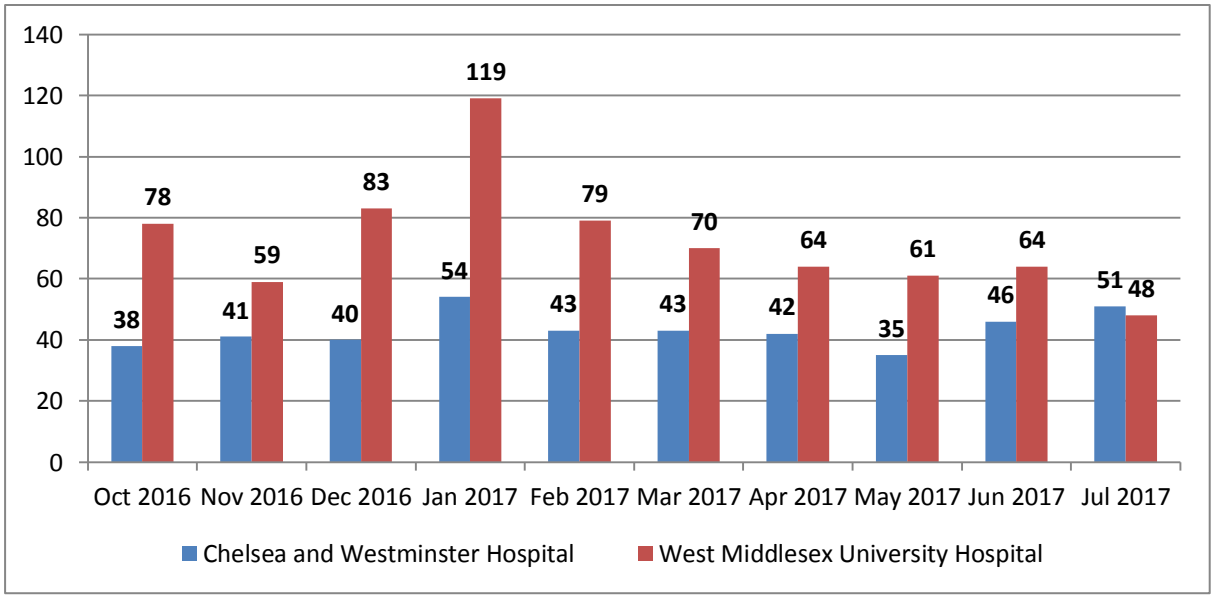


Fig 1: Mortality cases by site and month, Oct 16 – Jul 17

Learning from deaths; Q1 2017/18

Review completion rates

The completion of mortality reviews provides assurance that learning from in-hospital deaths is being identified, shared and used to drive service change.

Q1 2017/18 review completion rate

	Awaiting review by consultant	Being Reviewed by consultant	Awaiting Specialty M&M	Closed by Mortality Lead	Total	% Closed
ChelWest	61	11	14	37	123	30%
WestMid	44	16	16	113	189	60%
Total	105	27	30	150	312	48%

Q4 2016/17 review completion rate

	Awaiting review by consultant	Being Reviewed by consultant	Awaiting Specialty M&M	Closed by Mortality Lead	Total	% Closed
ChelWest	32	12	16	80	140	57%
WestMid	14	17	9	228	268	85%
Total	46	29	25	308	408	75%

In total 65% of in-hospital deaths recorded within the mortality review module between 1st October 2016 and 31st July 2017 have been reviewed, discussed at a specialty M&M and closed by the areas Mortality Lead. Levels of completion rate vary between the two sites (in total 48% of cases at ChelWest closed and 75% cases at WestMid closed).

Sub-optimal care identified

Reviewers are asked to assess outcome avoidability and / or suboptimal care provision using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories. The CESDI grades are:

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

Where mortality reviews conclude that significant suboptimal care occurred (e.g. CESDI grade 2 or 3) an in-depth investigation into the care provided to that patient is launched under the serious incident investigation process

Q1 2017/18 suboptimal care identified

	CESDI grade 1	CESDI grade 2	CESDI grade 3	Total
Chelsea and Westminster Hospital	1	0	0	1
West Middlesex University Hospital	4	2	1	7
Total	5	2	1	8

Q4 2016/17 suboptimal care identified

	CESDI grade 1	CESDI grade 2	CESDI grade 3	Total
Chelsea and Westminster Hospital	6	1	0	7
West Middlesex University Hospital	6	2	0	8
Total	12	3	0	15

Key specialties associated with the identification of sub-optimal care

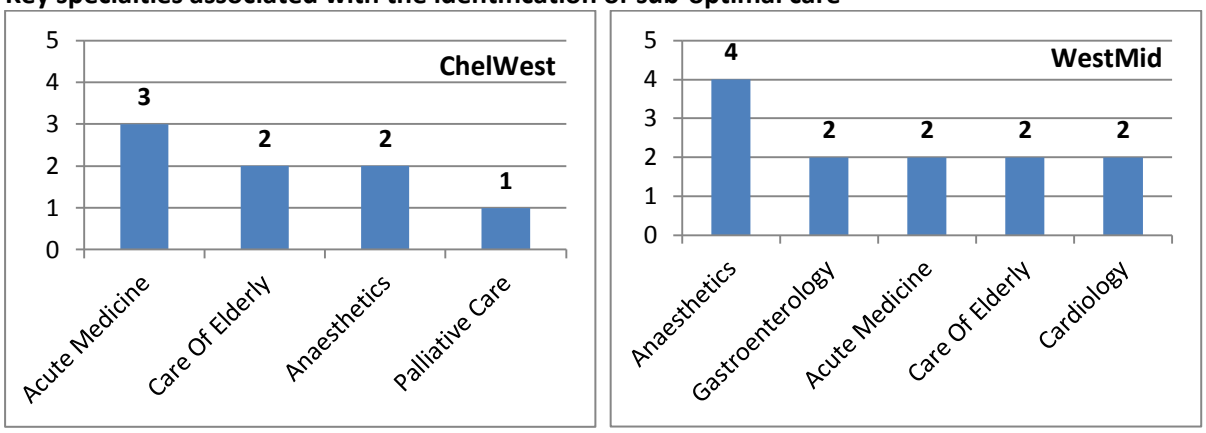


Fig 2: Top specialties linked to the identification of suboptimal care by site, Jan 17 – Jun 17

Acute Medicine, Care of the Elderly and Anaesthetics (critical care) and gastroenterology are key specialties on each site identifying areas for improvement in the care provided via the mortality review process; these specialties are also within the top 5 specialties (trust wide) for crude mortality. These are show good engagement with mortality review process based on review completion rates.

Key locations associated with the identification of sub-optimal care

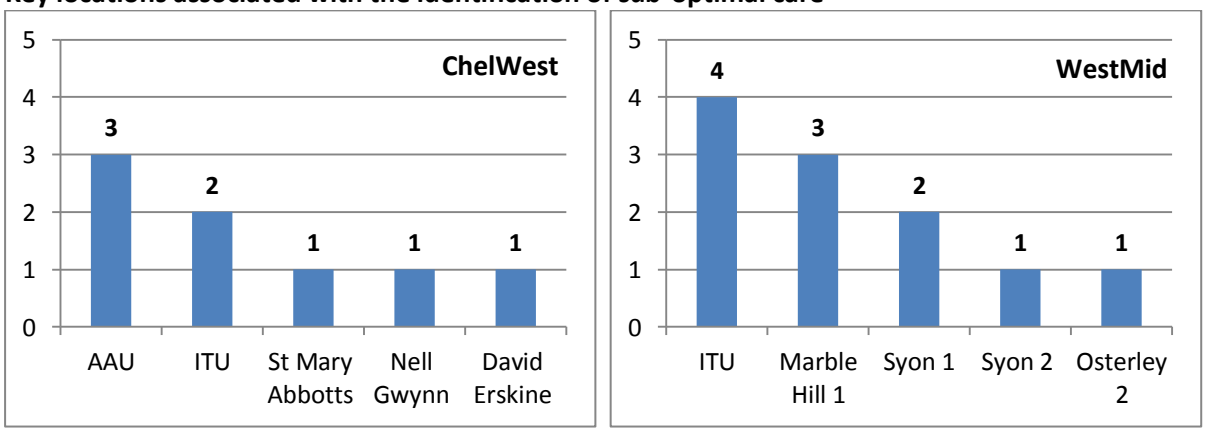


Fig 3: Top location linked to the identification of suboptimal care by site, Jan 17 – Jun 17

Overarching themes / issues linked to sub-optimal care
Review groups seek to identify the reasons for the outcome, how the cases or the outcome could have been prevented or better managed and make recommendations for further action required. Reviews are themed to support the identification of overarching themes.

ChelWest

- Issues with Assessment, investigation or diagnosis
- Issues with Treatment and management plan
- Issues with Escalation
- Issues with Operation / invasive procedure
- Issues with Medication / iv fluids / electrolytes / oxygen

WestMid

- Issues with Escalation
- Issues with Treatment and management plans
- Issues with Assessment, investigation or diagnosis
- Issues with Clinical monitoring
- Issues with Medication / iv fluids / electrolytes / oxygen

Key theme across both sites links to issues of recognising, escalating and responding to deteriorating patients. Further thematic review on the outcomes is being monitored by the mortality surveillance group and improvement action is being supported by the Patient Safety Committee (and sub-groups).

Next Steps
The outcome of review is providing a rich source of learning but closure rates must be improved so ensure all opportunities to learning from in-hospital mortality being identified and responded to appropriately.

The following steps are planned:

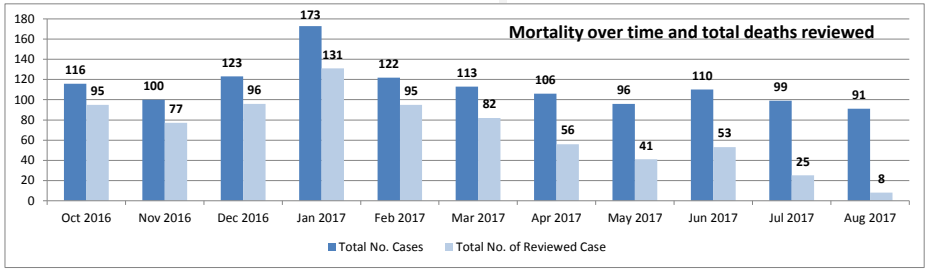
- Establishment of Divisional Mortality Review Group within Planned Care Division to oversee processes, support improvement action and facilitate cross specialty learning.
- Completion timescales at ChelWest site to be monitored by Mortality Surveillance Group and support provided via Divisional management teams.
- Engage clinical teams to undertake reviews in a timely manner

Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, 2017/18
Report produced: 29th August 2017

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

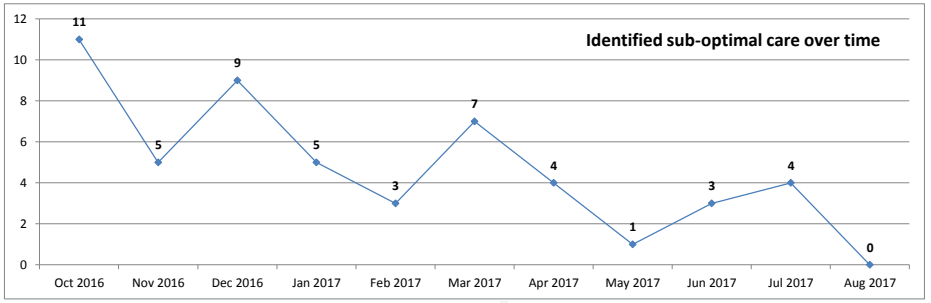
Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
This Month (MTD)	Last Month	This Month	Last Month	This Month	Last Month
91	99	8	25	0	4
This Quarter [QTD]	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
190	312	33	150	4	8
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
502	#	183	#	12	#



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)

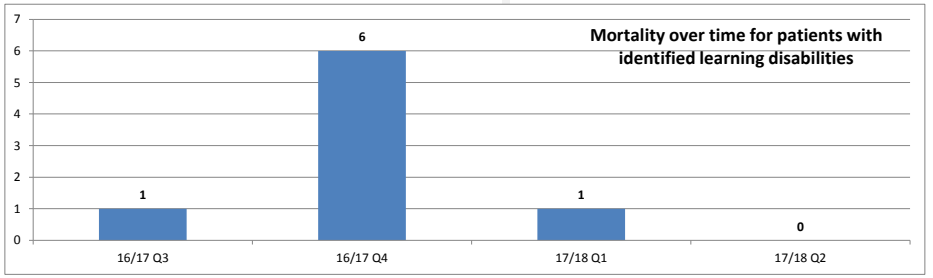
Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome		Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)		Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)	
This Month (MTD)	Last Month	This Month	Last Month	This Month	Last Month
0	4	0	0	0	0
This Quarter [QTD]	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	5	0	2	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	#	2	#	1	#



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

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

Total no. of in-hospital death		Total no. deaths reviewed		Total Number of deaths considered to involve sub-optimal care	
This Month (MTD)	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter [QTD]	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	#	1	#	0	#



Learning from deaths

Zoë Penn, Medical Director

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Introduction

Retrospective 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 any concerns and learning with colleagues

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Recording an initial review

Every in-hospital death is recorded in the Mortality Review system; this provides the platform to record consultant led case reviews.

Features:

- All in-hospital deaths logged by Bereavement department
- Named Consultant notified of the death
- Named Consultant or nominated colleague reviews case
- Review outcomes recorded within the review system
- Case shared with the Specialties M&M within 4 weeks.

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Sharing a case review

Every in-hospital death discussed at a multi-disciplinary Specialty Mortality Review Group (M&M). Service Director / Lead chair.

The group aims to:

- Provide an open and supportive learning environment
- Consider expectations and outcomes from each case
- Agree if anything could have been managed differently
- Agree whether there was any sub-optimal care

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Steering improvement

Specialty Mortality Review Group
Reviews all cases to consider and agree conclusions, learning and actions

Divisional Mortality Review Group
Reviews all cases with suboptimal care. Groups monitor mortality review process and support Divisional delivery of divisional actions and learning

Trust wide Mortality Surveillance Group
Reviews internal and external sources of mortality information. Group supports Trust wide improvement actions and learning.

Patient Safety / Quality Committee / Trust Board
Key messages from mortality review reported to Public Board

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Programme Outcomes

Key outcomes:

- All in-hospital deaths reviewed
- Standardise review process
- Standardise governance processes
- Trust responsive to trends from internal and external sources
- Feedback to staff involved in patient care provided
- Learning from every patient death

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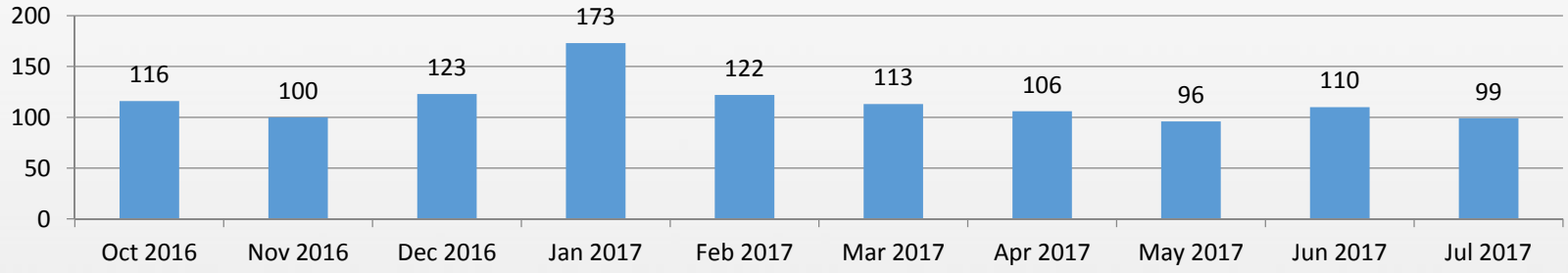
Key learning



Every death provides an opportunity to learn

Key themes from review:

- Issues with escalation of deteriorating patients
- Issues with response to escalated patients
- Issues with assessment and diagnosis
- Issues with treatment / management plans

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Reporting on outcomes

Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, 2017/18
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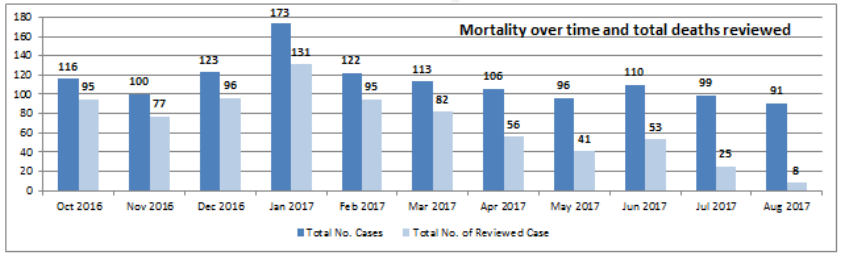

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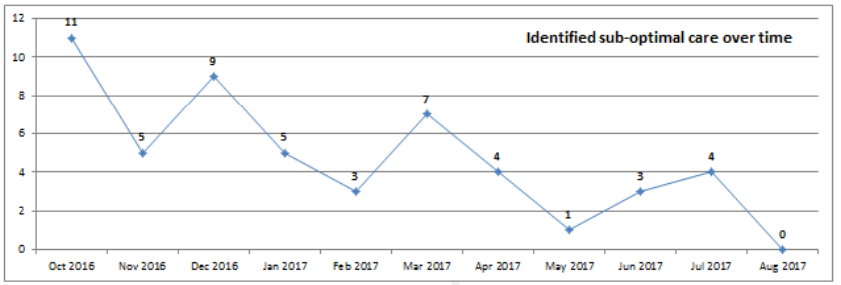
0	4	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	5	0	2	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	#	2	#	1	#



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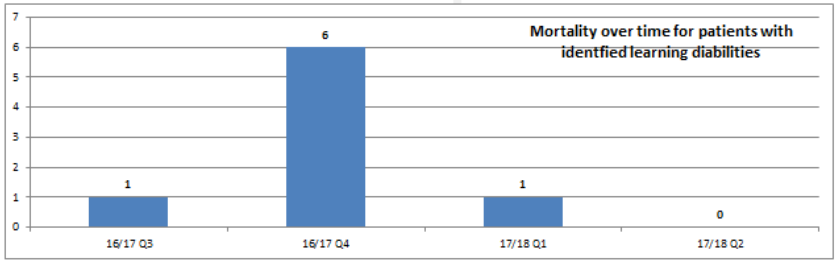
This Month (MTD)	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	#	1	#	0	#



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LEARNING FROM DEATHS
MORTALITY REVIEW PROCEDURE

START DATE:	**August 2016**	**NEXT REVIEW DATE:**	**February 2018**	**EXPIRY DATE:**	**May 2018**
COMMITTEE APPROVAL:		**NAME OF COMMITTEE** **Patient Safety Committee**		**NAME OF CHAIR OF APPROVING COMMITTEE** **Zoe Penn, Medical Director**	
		DATE APPROVED: 02/08/2017			
		ENDORSED BY: LEAVE BLANK IF NONE		**DATE:**	
DISTRIBUTION:	Trust-wide				
LOCATION:	Intranet – Trust Policies				
RELATED DOCUMENTS:	Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths Incident Reporting, Investigation and Management Policy Duty of candour policy				
AUTHOR / FURTHER INFORMATION:	Alex Bolton, Safety Learning Programme Manager				
STAKEHOLDERS INVOLVED:	This policy will be promoted through the Patient Safety Group and Mortality Surveillance Group.				
FRONT LINE STAFF APPROVAL (NAME AND DESIGNATION)					
DOCUMENT REVIEW HISTORY:					

Date	**Version**	**Responsibility**	**Comments**
August 2016	V1.0	Patient Safety Group	Procedure ratified
August 2017	V1.1	Safety Learning Programme Manager	Amended front sheet, summary, text font and size. Added sections relating to stakeholders, Datix mortality module, Deaths requiring mortality review, Identifying in-hospital mortality, Initial case review, Local / specialty mortality review group, Divisional mortality review group, Mortality surveillance group, Launching serious incident investigations from mortality reviews, Trust response to particular categories of patient death, Publication of mortality metrics, distribution and dissemination.

Contents

1. SUMMARY

This procedure describes the Trust wide process of retrospective case review that is to be implemented following all in-hospital deaths. The document outlines roles and responsibilities and provides guidance on the process of identifying, reviewing, sharing and escalating mortality case reviews.

2. INTRODUCTION

The Care Quality Commission published 'Learning, candour and accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England' in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted the reports recommendation and announced new measures designed to improve learning following patient deaths.

The NHS Quality Board published a Framework for NHS Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care in April 2017. To support this agenda the Trust has committed to review all in-hospital death at local / specialty level mortality group where teams will have the opportunity to review expectations, outcomes and learning in open discussion within a multi-disciplinary / multi-professional group. Where issues in care, trends or notable learning are identified action is to be steered through Divisional Mortality Review Groups and the trust wide Mortality Surveillance Group.

The learning from mortality case review will be used to drive service improvement and offer assurance to our patients, stakeholders and the Board that the causes and contributory factors of all deaths have been considered and appropriately responded to.

This Trust-wide approach to case review has been development with the aim of ensuring a standardised format and process. This will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning.

3. SCOPE

This procedure applies to all staff that may be involved in the provision of care or service to dying patients; this includes medical staff, nurses, allied healthcare professionals and support services such as Bereavement / Patient Affairs. Every member of must be empowered to engage with the mortality review / learning from deaths process. Where staff are uncertain of their requirements within this document or how to support the process of learning from deaths advice should be sought from their Service Director, Clinical Director or Divisional Medical Director. Further guidance is available from the Quality and Clinical Governance Department.

4. AIMS AND OBJECTIVES

- To improve patient safety and the quality of care provided by the Trust through the engagement of staff in a single, consistent and robust process of retrospective case record review following all in-hospital deaths.
- To establish multi-disciplinary and multi-professional forums within which potential areas of improvement in both individual cases and the way the Trust delivers services as a whole are considered.
- To ensure that there are clear reporting mechanisms in place to escalate any area of potential suboptimal care so that the Trust Board is aware and can support corrective action.
- To ensure mortality reviews are undertaken and the outcomes from review are securely recorded and accessible for audit, analysis and trend recognition via the Datix Mortality module.

5. DEFINITIONS

- **Case review**: A structured desktop review of a case record carried out by clinicians to determine whether there were any problems in the care provided to a patient or notable learning suitable for sharing with clinical colleagues.
- **CESDI**: Confidential Enquiry into Stillbirths and Deaths in Infancy categorisation used to identify whether deaths were avoidable or if there was suboptimal care.
- **DMRG**: Divisional Mortality Review Group
- **Learning Disabilities**: A person with learning disabilities has a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) and a reduced ability to cope

independently (impaired social functioning) which started before adulthood and had a lasting effect on their development.
- **M&M**: Mortality and Morbidity meeting held by clinical teams to discuss potential problems in care provision and learning following deaths, complication or unexpected clinical events.
- **MDT**: Multi-disciplinary team.

6. STAKEHOLDERS:

The Mortality Surveillance Group and Patient Safety Group will support development and distribution.

7. ROLES AND RESPONSIBILITIES

Medical Director
The Medical Director will assure the Board that the mortality review process is functioning correctly and ensure that arrangements are in place so that staff are aware of their responsibilities.

Associate Medical Director (WestMid)
The Associate Medical Director (WestMid) is the Trust lead for mortality; they have overarching responsibility to ensure the mortality review process is embedded across the organisation and learning is used to improve service delivery.

The Associate Medical Director (WestMid) will:
- Chair the Mortality Surveillance Group (MSG)
- Feedback concerns raised at the MSG to relevant Divisional management teams and the Patient Safety Committee
- Escalate urgent remedial actions or concerns to Executive team

Director of Quality Improvement
The Director of Quality Improvement is responsible for ensuring key governance outcomes are supported by the mortality review process.

The Director for Quality Improvement will deputise for the Trust Mortality Lead and will support the Mortality Surveillance Group in relation to:
- Issues relating to identification and escalation of Serious Incidents
- Issues relating to Being Open and Duty of Candour requirements
- Issues relating to the recognition of risks for recording within Divisional risk registers

Divisional Medical Director
The Divisional Medical Director (DMD) is responsible for ensuring the mortality review process is embedded within their Division.

The Divisional Medical Director will:
- Chair the Divisional Mortality Review Group (DMRG)
- Ensure all cases of identified suboptimal care (CESDI grade >0) are considered by the DMRG
- Support and advise colleagues involved with the mortality review process
- Monitor compliance with the mortality review process
- Establish systems of Division wide learning from mortality review
- Ensure that any actions identified in relation to mortality review are recorded, progressed and monitored appropriately

Specialty Mortality Leads (Service Directors / Leads)
Specialty Mortality Leads are appointed by the Divisional Medical Director as individuals with management responsibility or specialist knowledge appropriate to oversee the mortality review process within their clinical team(s).

Specialty Mortality Leads will:
- Chair the Specialty Mortality Review Group (SMRG)
- Support their teams to conduct timely / effective case presentations
- Ensure all in-hospital deaths aligned to the specialty are discussed by a multidisciplinary team
- Close / accept completed mortality reviews on the Datix mortality module

Case Reviewers - Named Consultants / Stillbirth & late fetal loss leads
Adult, child and neonatal death will be reviewed by the Consultant responsible for the patients care (last episode of care). Stillbirths & late fetal losses will be reviewed by the sites Stillbirths & late fetal loss leads.

Case reviewers will:
- Review cases within 4 weeks of assignment
- Record the situation, background, assessment, CESDI grade within the Datix mortality module
- Present the case to the Specialty mortality review group
- Report suboptimal care or unavoidable death on the Datix incident module.

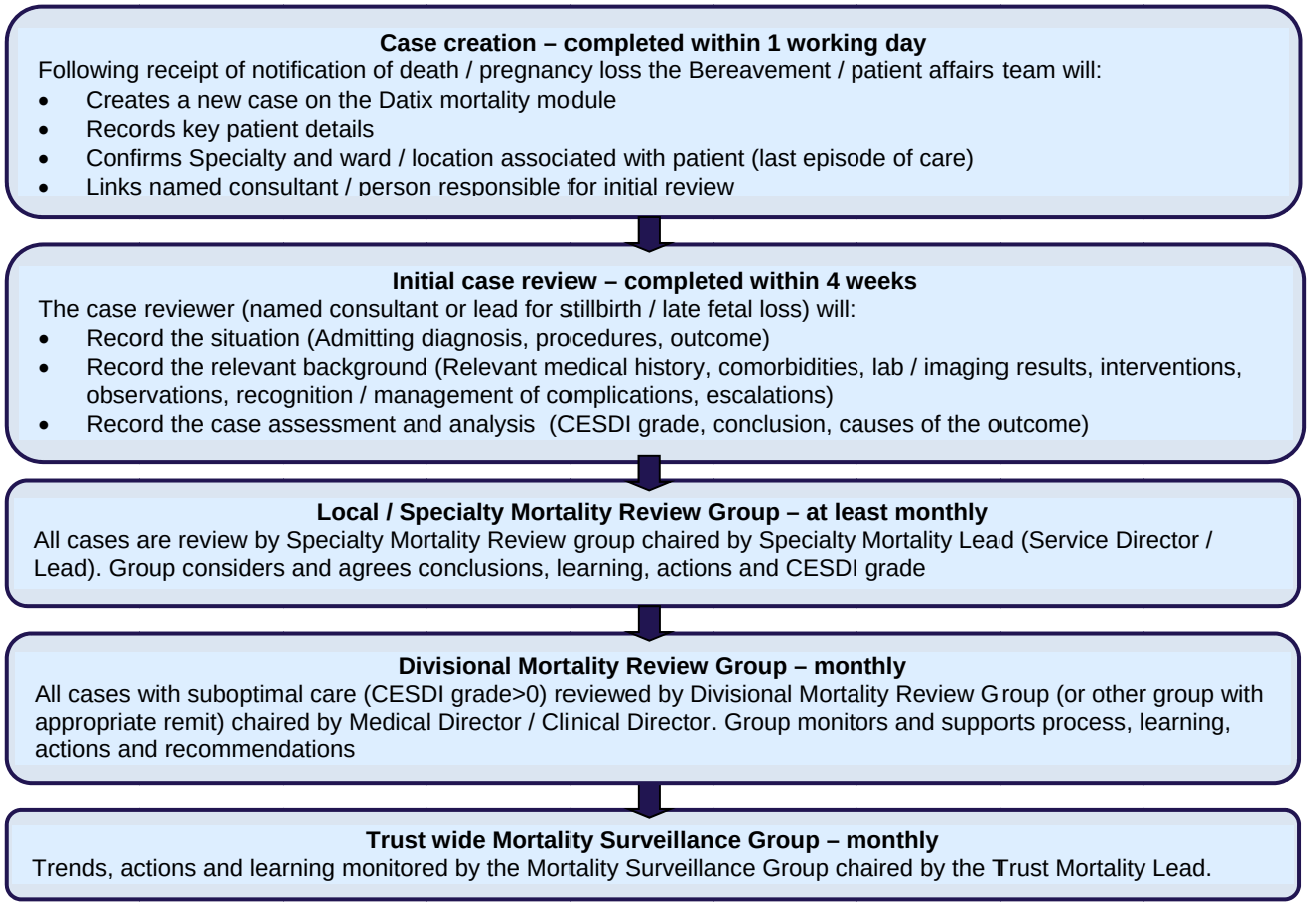
Learning Disabilities Mortality Lead (Lead Nurse for Learning Disabilities and Transition)
Reviews relating to patients with Learning Disabilities will be supported by / include the Learning Disabilities Mortality Lead. They will support consultants and specialty mortality leads consider learning disabilities issues when reviewing deaths.

The Learning Disabilities Mortality Lead will:
- Notify the National Learning Disabilities Mortality Review Programme of deaths of relevant deaths
- Support the initial review processes with named consultant
- Attend local / specialty mortality reviews when deaths of patients with learning disabilities scheduled
- Contact family members of people with learning disabilities to involve them in the review as appropriate
- Coordinate multiagency / organisation review arrangements where required
- Submit mortality reviews to the National Learning Disabilities Mortality Review Programme

Patient Affairs / Bereavement
All in-hospital deaths will be recorded within the Datix Mortality module by the Patient Affairs / Bereavement teams.

8. MORTALITY REVIEW PROCESS

8.1. MORTALITY REVIEW PROCESS FLOWCHART
The flowchart below outlines the process of undertaking a mortality review



8.2. DATIX MORTALITY MODULE

The Datix Mortality module provides a standardised platform for the recording and management of Consultant led mortality case reviews. The use of Datix promotes visibility, supports escalation and provides assurance that learning opportunities are being sought following every in-hospital death.

All staff registered with the General Medical Council have access to the Mortality Module and can review cases to which they have been logged as the patient's named Consultant (last episode of care) or where a colleague has specifically shared the case with them.

8.3. DEATHS REQUIRING MORTALITY REVIEW

All in-hospital adult / child / neonatal deaths, stillbirths and late fetal losses require mortality case review. For the purposes of this procedure these categories of in-hospital mortality are defined as:

- Adult death: Death of patient who is 18 or more years old
- Child death: Death of patient who is older than 28 days and younger than 18 years
- Neonatal death: Live baby delivered at 20+0 weeks gestation or later and dies within 28 days of birth
- Stillbirth: Baby delivered at/after 24+0 weeks gestation with no signs of life
- Late fetal loss: Baby delivered between 22+0 and 23+6 weeks gestation with no signs of life

Out of hospital deaths will be reviewed as per this procedure where an external organisation suggests that review of care previously provided by the Trust would support learning / process of coordinated multi-organisational mortality review. Where an external organisation identify issues / problems in care previously provided by the Trust the Incident Reporting and Investigation

8.4. IDENTIFYING IN-HOSPITAL MORTALITY

Notification of death / notification of pregnancy loss forms are completed by the patient's clinical team following in-hospital death; notification forms are processed by the Bereavement / Patient Affairs department. See linked 'Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths' for details of the notification process and supporting documentation.

Following receipt of a notification form the Bereavement / Patient Affairs team will generate a new case in the mortality module within one working day, when logged each case will include as a minimum:

- Enters key patient details (e.g. name, date of birth, date of admission, date of death, hospital number)
- Management team overseeing review (e.g. Specialty associated with last episode of care)
- Individual responsible for leading initial review (e.g. named consultant or lead for stillbirths / late fetal losses)

Causes of death and coroner referral outcomes will be logged to the case as this information becomes available to the Patient Affairs / Bereavement team.

Where external organisations request review of out of hospital deaths the Associate Medical Director (WestMid) will consider mortality learning from the external organisation and confirm applicability for further review / logging within Trust mortality module with the Bereavement / Patient Affairs department.

8.5. INITIAL CASE REVIEW

New cases trigger automatic email notifications to the person responsible for undertaking the initial review (e.g. the named consultant or stillbirth / late fetal losses lead) and the mortality lead for the associated specialty (e.g. person responsible for ensuring case is discussed at local / specialty mortality review group).

Case reviewers are asked to consider all aspects of patient care; including medical, nursing and allied health professional involvement; to determine whether there were any problems in the care provided or notable learning from the case.

Case reviewers are asked to record the outcomes from their review within a standardised electronic form in the Datix Mortality module within a target of 4 weeks from the date of death. Each review will include the following sections:

- Situation: mode of admission, admitting diagnosis, procedures undertaken, outcome)
- Background: relevant medical history, comorbidities, lab / imaging results, interventions, observations, recognition / management of complications, escalations, end of life care, learning disabilities
- Assessment and analysis: causes of outcome, conclusions regarding any problems in care provision.

When judging if problems in care occurred reviewers are asked to consider:
- Acts: such as incorrect treatment or management
- Omissions: such as failure to monitor, diagnose, escalate, treat or deliver the expected standard of care
- Harm: resulting from unintended or unexpected complications of healthcare.

Reviewers are asked to assess outcome avoidability and / or suboptimal care provision using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories. The CESDI grades are:
- Grade 0: Unavoidable death, no suboptimal care
- Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

In all cases where suboptimal care was judged to have occurred case reviewers are asked to consider how problems could have been prevented or better managed and to recommend improvement actions.

8.6. LOCAL / SPECIALTY MORTALITY REVIEW GROUP

Every in-hospital death should be discussed at a local / specialty meeting with responsibility for reviewing and sharing the outcome of mortality review e.g. mortality review groups, M&M, MDTs. Meetings should:
- Be chaired by the identified Mortality Lead
- Attended by multi-disciplinary members of the local / specialty team
- Be promoted to Junior Doctors aligned to the specialty
- Meet regularly (at least monthly)

The purpose of the local / specialty meeting is to:
- Discuss every mortality review linked to that local team / specialty
- Ensure that reviews are of a sufficient quality to reach conclusions / identify learning
- Consider expectations and outcomes from each in-hospital death
- Raise any relevant information relating to the patient not included in the case review
- Agree conclusions and outcome / CESDI grading from case review
- Provide a forum to share and disseminate learning from case review

Following local / specialty mortality review group discussion and agreement the chair / Mortality Lead is asked to close the case on the Datix mortality module. Closing a case confirms that outcomes have been discussed and agreed by the local clinical team.

See Appendix 1 for example of specialty mortality review group terms of reference

8.7. DIVISIONAL MORTALITY REVIEW GROUP

Every case with identified suboptimal care should be discussed at the associated Divisional Mortality Review Group, these meetings should:
- Be chaired by the Divisional Medical Director or Clinical Director
- Attended by Morality Leads from each Specialty (or representatives)
- Be promoted to senior Medical, Nursing and Allied Healthcare Professionals linked to the Division
- Meet monthly

The purpose of the Divisional Mortality Review Group is to:
- Monitor mortality review process compliance across the Division
- Discuss trend, actions and learning from mortality review
- Consider in detail all cases where suboptimal care has been identified
- Support the development and delivery of improvement actions
- Coordinate / disseminate cross specialty learning from mortality review
- Escalate identified issues, themes and notable learning to the Mortality Surveillance Group

See Appendix 2 for example of divisional mortality review group terms of reference

8.8. MORTALITY SURVEILLANCE GROUP

The Mortality Surveillance Group provides Executive led scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review / learning from death. The Mortality Surveillance Group (MSG) will:

- Provide assurance to the Board regarding patient mortality
- Monitor and consider mortality data / analysis from internal and external sources
- Oversee the Divisional Mortality Review Groups' processes and actions
- Assign clinical leads to address key trends / issues and monitor actions
- Oversee actions arising from alerts received from the Care Quality Commission or identified by other mortality monitoring information systems (i.e. Dr Foster)
- Consider reports and escalations from the Divisional Mortality Review Groups
- Support cross Divisional learning from death
- Ensure all cases graded as CESDI 2 / 3 have been resulted in Serious Incident Investigation

9. LAUNCHING SERIOUS INCIDENT INVESTIGATIONS FROM MORTALITY REVIEWS

Where mortality reviews conclude that significant suboptimal care occurred (e.g. CESDI grade 2 or 3) an in-depth investigation into the care provided to that patient will be launched under the serious incident investigation process. See the 'Incident Reporting, Investigation and Management Policy' for details relating to the management of serious incidents and the 'Duty of candour policy' for details of the Trust's commitment to include patient's families within the investigation process.

10. TRUST RESPONSE TO PARTICULAR CATEGORIES OF PATIENT DEATH

10.1. DEATHS OF PATIENTS WITH LEARNING DISABILITIES

The National Learning Disabilities Mortality Review (LeDeR) Programme was established in response to the recommendations from the Confidential Inquiry into premature deaths of people with learning disabilities; the inquiry found that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with had better quality healthcare been provided.

The LeDeR programme seeks to coordinate, collate and share information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward at both local and national levels. To support this aim the Trust is committed to ensure deaths of patients with known / pre-diagnosed learning disabilities are reported to the LeDeR programme and reviewed in line with the programme requirements. This process will be supported by the Trust Learning Disabilities Mortality Lead.

Case reviewers are asked to identify patients with known / previously diagnosed learning disabilities within the standard mortality review form. Where patients with learning disabilities are identified the Learning Disabilities Mortality Lead will be automatically notified.

All internal review arrangements outlined in section 8 of this procedure are to be undertaken, however, following the identification of a mortality review linked to a patient with learning disabilities:

- The Learning Disabilities Mortality Lead should be included in the initial review preparation by the named consultant
- The Learning Disabilities Mortality Lead should be invited to the local / specialty mortality review group when the case is scheduled for discuss by the Specialty Mortality Lead

The Learning Disabilities Mortality Lead will:

- Notify the LeDeR Programme of deaths of patients with learning disabilities
- Contact family members of people with learning disabilities to involve them in the review as appropriate.
- Coordinate multiagency / organisation review arrangements where required
- Submit mortality reviews to the National Learning Disabilities Mortality Review Programme

See Appendix 3 for outline of the LeDeR process

10.2. DEATHS OF PATIENTS WITH SIGNIFICANT MENTAL HEALTH DISORDERS

Case reviewers are asked to identify patients with known / previously diagnosed significant mental health disorders within the standard mortality review form. Trends relating to this cohort of patients will be considered by the Mortality Surveillance Group. NHS England is coordinating work to develop a mental health review methodology and supporting national guidance; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

10.3. INFANT AND CHILD DEATHS

Reviews of infant and child (under 18 years old) deaths are mandatory and must be undertaken in accordance with the 'Working together to safeguard children' guidance. New national child death review guidance is being developed and is scheduled to be published by the end of 2017; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

10.4. PERINATAL DEATHS

The Perinatal Mortality Review Tool (PMRT) is being developed by the Healthcare Quality Improvement Partnership (HQIP) and national guidance for standardised perinatal review is scheduled for publication by the end of 2017; the Trust's 'Learning from Deaths Procedure' will be reviewed and amended following publication.

11. PUBLICATION OF MORTALITY METRICS

The following mortality metrics will be published via a quarterly return to the public board:

- Number of deaths within the Trust
- Number of deaths subject to case record review
- Number of deaths investigated under the Serious Incident framework
- Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- Themes and issues identified from review and investigation
- Actions taken in response and actions planned

The review of mortality metrics at board level is mandated within the national Learning from Deaths framework.

12. DISTRIBUTION/DISSEMINATION

The document will be distributed via the Mortality Surveillance Group and Patient Safety Group. Divisional Management team will be requested to disseminate / discuss the requirements outlined in the document within their teams. The documents will be made available on the Trust intranet.

Staff will be supported to undertake mortality case review through the provision of further guidance on process, content of review and use of the Datix system. Specialty Mortality Leads will support members of their team produce quality reviews.

13. MONITORING AND AUDIT

Key process/part of this policy for which compliance or effectiveness is being monitored	**Monitoring method (i.e. audit, report, on-going committee review, survey etc.)**	**Job title and department of person responsible for leading the monitoring**	**Frequency of the monitoring activity**	**Monitoring Committee responsible for receiving the monitoring report/audit results etc.**	**Committee responsible for ensuring that action plans are completed**
Logging of all in-hospital deaths to Datix	Comparison of Datix mortality module with PAS	Safety Learning Programme Manager	Monthly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)
Case review process compliance	Report re timeframes for mortality case review completion	Safety Learning Programme Manager	Monthly	Divisional Mortality Review Group (DMRG)	Mortality Surveillance Group (MSG)

Grading of cases	Audit of cases with CESDI grade 0	Junior Doctor audit programme	Quarterly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)
Serious Incident declaration	Comparison of CESDI grade 2 / 3 mortality reviews in with declared Serious Incidents	Safety Learning Programme Manager	Quarterly	Mortality Surveillance Group (MSG)	Mortality Surveillance Group (MSG)

14. References

National Guidance on Learning from Deaths, April 2017
https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

NHS England National Learning Disabilities Mortality Review (LeDeR) Programme resources,
http://www.bristol.ac.uk/sps/leder/resources/

Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis, Hogan et al, 30 May 2015
http://www.bmj.com/content/351/bmj.h3239

Appendix 1 – Local / Specialty Mortality Review Group Terms of Reference (example)

Specialty Mortality Review Group

Terms of Reference

1. Constitution

The ***[INSERT NAME OF SPECIALTY]*** Specialty Mortality Review Group is established as a sub-group of the Divisional Mortality Review Group which reports to the Mortality Surveillance Group.

2. Authority

The Specialty Mortality Review Group is accountable to the Divisional Mortality Review Group and is authorised to:

- Carry out any activity within its terms of reference;
- Request any information it requires from any employee of the Trust (and all employees are directed to comply with any request of the Group);

3. Aim

The aim of the Specialty Mortality Review Group is to provide local senior clinical scrutiny to mortality review and to driving quality improvement by using a systematic approach to mortality review.

4. Objectives

Specific duties of the Specialty Mortality Review Group include:

- To provide a forum for open discussion of issues, outcomes, improvements and learning following mortality review.
- To ensure all deaths aligned to the Specialty are reviewed by the consultant / clinical team responsible for the patient (retrospective case review)
- To ensure all deaths aligned to the specialty are presented / discussed at the Specialty Mortality Review Group
- To agree the CESDI / Outcome grades for all deaths aligned to the Specialty
- To escalate identified issues, themes or notable learning to the Divisional Mortality Review Group
- To ensure suboptimal care or avoidable death identified through mortality review is recorded and investigated within the incident reporting system
- To provide assurance to the Divisional Mortality Review Group on all areas of its function

5. Method of working and monitoring effectiveness

The Divisional Mortality Review Group will have a standard agenda

The Group may request the presence of any Clinician to provide an update on individual case reviews.

The Group will receive regular Specialty mortality reports using the Datix Mortality Module as the reporting tool.

6. Membership

The Members of the Specialty Mortality Review Group shall comprise:

- Service Director / Lead (Chair)
- Consultants aligned to Specialty
- Nursing team representative

To foster leadership, learning and open communicate invitations are to be extended to all Junior Doctors aligned to the Specialty.

Meetings of the Specialty Mortality Review Group shall not be held in public.

7. Quorum

The quorum shall be 3 members, to include the chair or a deputy and 2 Consultants aligned to the Specialty.

8. Nominated Deputies

Members are expected to identify a deputy for occasions they are unable to attend.

9. Frequency of meetings

The Divisional Mortality Review Group will meet **[WEEKLY/BI-WEEKLY/MONTHLY – FREQUENCY TO BE NO LESS THAN MONTHLY].**

Attendance at meetings will be monitored and group members are expected to attend a minimum of 75% of meetings throughout the year. Attendance falling below this level will be reviewed by the chair.

10. Secretariat

Agenda are to be circulated by ***[ENTER JOB TITLE]***

11. Review process

The Divisional Mortality Review Group will review these Terms of Reference on an annual basis.

Reviewed by:
Date:
Approved by:
Date:
Next review date:

Appendix 2 – Divisional Mortality Review Group Terms of Reference (example)

Divisional Mortality Review Group

Terms of Reference

12. Constitution

The [**DIVISION / SITE]** is established as a sub-group of the Mortality Surveillance Group which reports to the Patient Safety Committee.

13. Authority

The Divisional Mortality Review Group is accountable to the Mortality Surveillance Group and is authorised to:

- Carry out any activity within its terms of reference;
- Request any information it requires from any employee of the Trust (and all employees are directed to comply with any request of the Group);
- Secure the attendance of outsiders with relevant experience and expertise as it considers necessary for the proper discharge of its duties.

14. Aim

The aim of the Divisional Mortality Review Group is to provide senior management team scrutiny to the outcome of mortality review and to provide a forum where learning from case review can be shared and acted upon by Divisional leads.

15. Objectives

Specific duties of the Mortality Review Group include:

- To oversee the Specialty Mortality Review processes
- To ensure all deaths aligned to the Division are reviewed at Specialty Mortality Review Groups
- To ensure all deaths aligned to the Division with identified sub-optimal care are presented / discussed at the Divisional Mortality Review Group
- To act on issue escalated from Specialty Mortality Review Groups
- To scrutinise the trends, actions and learning from Mortality Reviews
- To escalate identified issues, themes or notable learning to the Mortality Surveillance Group
- To ensure risks identified through mortality review are recorded and mitigated within the risk register
- To provide assurance to the Mortality Surveillance Group on all areas of its function
- To support the delivery of the Trust mortality management plan

16. Method of working and monitoring effectiveness

The Divisional Mortality Review Group will have a standard agenda

The Group may request the presence of any Clinician to provide an update on individual specialty reviews.

The Group will receive regular Divisional mortality reports using the Datix Mortality dashboard as the reporting tool.

17. Membership

The Members of the Divisional Mortality Review Group shall comprise:

- Divisional Medical Director / Clinical Director (Chair)
- Clinical Directors
- Specialty Mortality Leads
- Nursing representative
- Pharmacy representative
- Quality and Clinical Governance representative

To foster learning and open communicate invitations are to be extended to all doctors aligned to the Division, safeguarding and learning disability team representatives.

Meetings of the Divisional Mortality Review Group shall not be held in public.

18. Quorum

The quorum shall be 4 members, to include the chair or a deputy, 1 Clinical Directors or deputy, 2 Specialty Mortality Leads or deputies.

19. Nominated Deputies

Members are expected to identify a deputy for occasions they are unable to attend.

20. Frequency of meetings

The Divisional Mortality Review Group will meet monthly.

Attendance at meetings will be monitored and group members are expected to attend a minimum of 75% of meetings throughout the year. Attendance falling below this level will be reviewed by the chair.

21. Secretariat

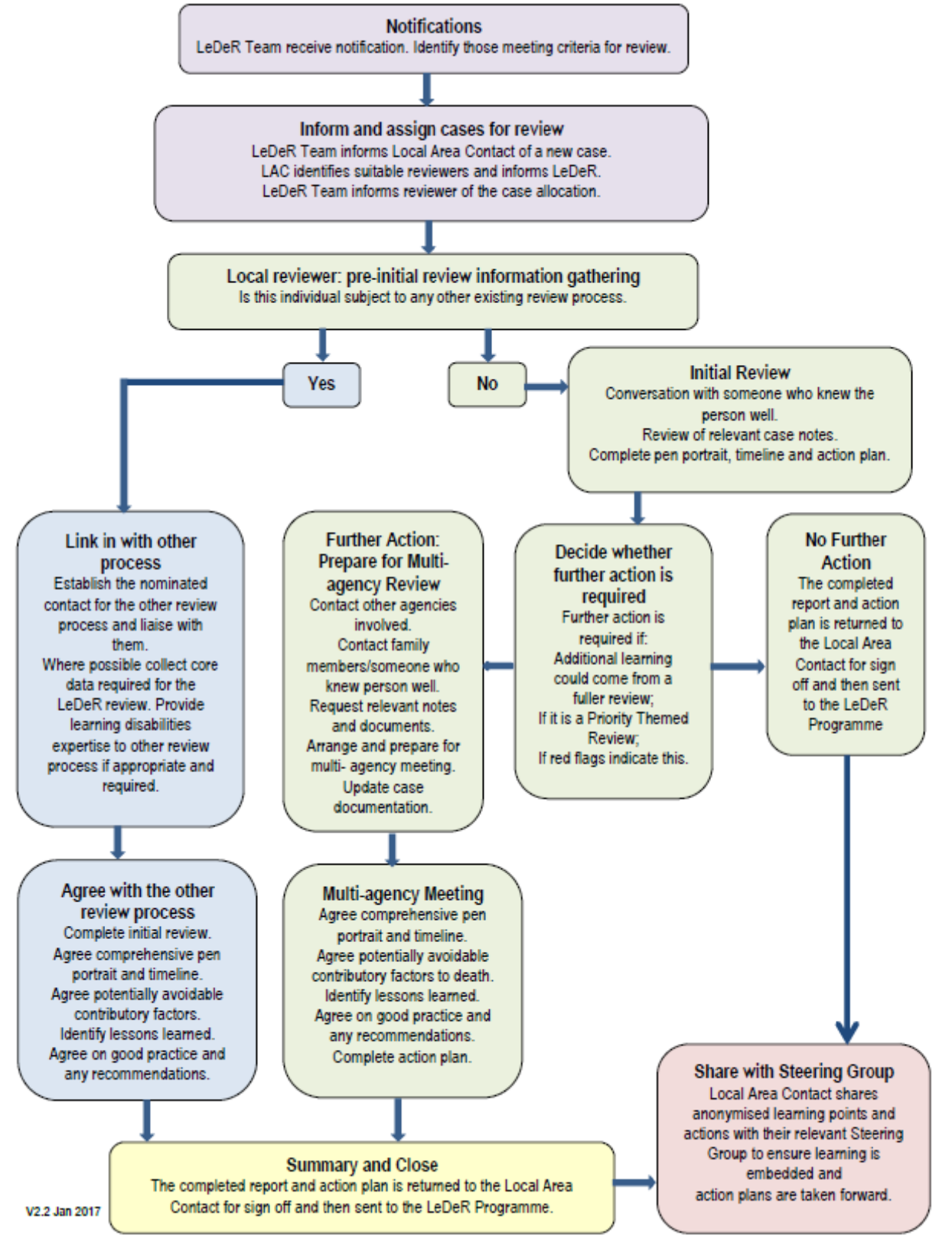
Papers, minutes, action tracker and agenda are to be circulated by ***[ENTER JOB TITLE]***

22. Review process

The Mortality Surveillance Group will review these Terms of Reference on an annual basis.

Reviewed by:
Date:
Approved by:
Date:
Next review date:

Appendix 3 - outline of the National Learning Disabilities Mortality Review (LeDeR) process



Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths

START DATE:	**July 2017**	**NEXT REVIEW DATE**	**June 2018**	**EXPIRY DATE**	**June 2019**
COMMITTEE APPROVAL:		**NAME OF COMMITTEE:** **Patient Safety Group**		**NAME OF CHAIR OF APPROVING COMMITTEE** **Zoe Penn, Medical Director**	
		DATE APPROVED: **Chairperson's Action: July 2017**			
		ENDORSED BY: Mortality Surveillance Group		**DATE: June 2017**	
DISTRIBUTION		Trust-wide			
LOCATION:		Intranet – Trust Policies			
RELATED DOCUMENTS:					
AUTHOR / FURTHER INFORMATION:		Safety Learning Programme Manager			
STAKEHOLDERS INVOLVED:		This policy will be promoted through the Patient Safety Committee and Mortality Surveillance Group. Stakeholders included Legal Services, Bereavement, Patient Affairs, Nursing Documentation and AHP Informatics Group.			

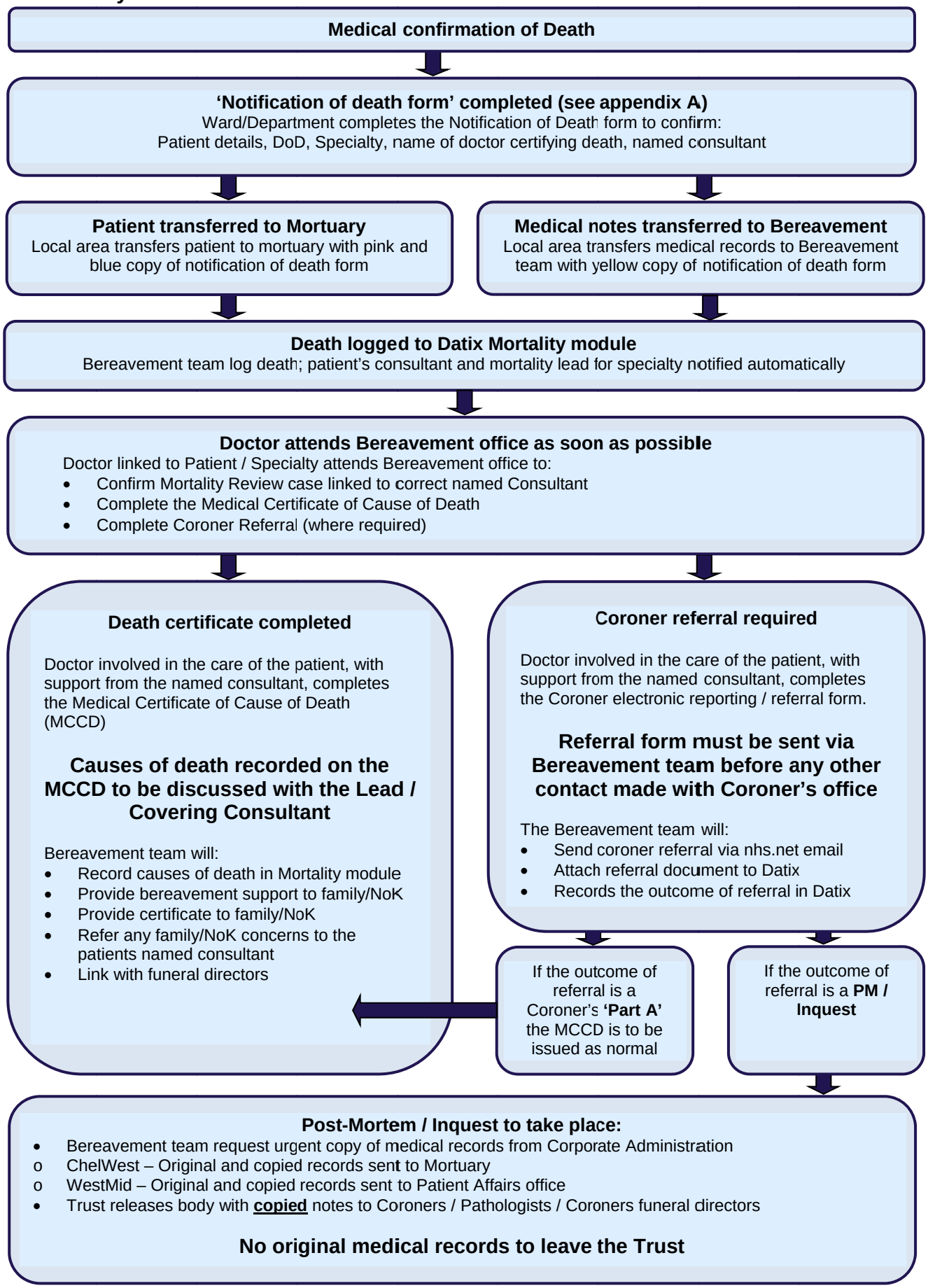
DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
June 2017	V1	Safety Learning Programme Manager	Draft reviewed, circulated for comment to stakeholders in June 2017. Document updated and approved by the Medical Director on behalf of the Patient Safety Group in July 2017.

Review June 2018 or at an earlier date if new guidance or recommendations are published.

Contents

1. Summary


Medical confirmation of Death
'Notification of death form' completed (see appendix A)
Ward/Department completes the Notification of Death form to confirm:
Patient details, DoD, Specialty, name of doctor certifying death, named consultant
Patient transferred to Mortuary
Local area transfers patient to mortuary with pink and blue copy of notification of death form
Medical notes transferred to Bereavement
Local area transfers medical records to Bereavement team with yellow copy of notification of death form
Death logged to Datix Mortality module
Bereavement team log death; patient's consultant and mortality lead for specialty notified automatically
Doctor attends Bereavement office as soon as possible
Doctor linked to Patient / Specialty attends Bereavement office to:
Confirm Mortality Review case linked to correct named Consultant
Complete the Medical Certificate of Cause of Death
Complete Coroner Referral (where required)
Death certificate completed
Doctor involved in the care of the patient, with support from the named consultant, completes the Medical Certificate of Cause of Death (MCCD)
Causes of death recorded on the MCCD to be discussed with the Lead / Covering Consultant
Bereavement team will:
Record causes of death in Mortality module
Provide bereavement support to family/NoK
Provide certificate to family/NoK
Refer any family/NoK concerns to the patients named consultant
Link with funeral directors
Coroner referral required
Doctor involved in the care of the patient, with support from the named consultant, completes the Coroner electronic reporting / referral form.
Referral form must be sent via Bereavement team before any other contact made with Coroner's office
The Bereavement team will:
Send coroner referral via nhs.net email
Attach referral document to Datix
Records the outcome of referral in Datix
If the outcome of referral is a Coroner's 'Part A' the MCCD is to be issued as normal
If the outcome of referral is a PM / Inquest
Post-Mortem / Inquest to take place:
Bereavement team request urgent copy of medical records from Corporate Administration
ChelWest – Original and copied records sent to Mortuary
WestMid – Original and copied records sent to Patient Affairs office
Trust releases body with copied notes to Coroners / Pathologists / Coroners funeral directors
No original medical records to leave the Trust

2. Introduction

The timely internal notification of deaths, completion of Medical Certificates of Cause of Death (Death certificates) and referral to HM Coroner's supports the provision of appropriate bereavement support, initiates and informs mortality review and ensure the Trust complies with our external reporting obligations.

A Trust-wide approach to internal notification, the completion of death certificates and referral of cases to HM Coroner's has been developed to provide a standardised format and process. This ensures consistent documentation and a robust process for internal and external notification.

3. Scope

This procedure applies to all employees who are involved in the internal notification, the completion of death certificates or referral of cases to HM Coroner's following in-hospital adult deaths. Guidelines for late fetal losses, stillbirth and neonatal deaths are contained within separate procedures.

4. Definitions

- **Medical Confirmation of Death** - the examination of a body by a medically qualified professional to confirm death, following the recommendations of The Academy of Medical Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death 2008.

- **Medical Certificates of Cause of Death (MCCD)** - a legal document involving the production of a medical certificate of cause of death (MCCD), otherwise known as a death certificate, that can only be undertaken by a qualified medical practitioner who attended the patient during their last illness and saw them within 14 days of death.

- **Part A** - Following a referral the Coroner may decide that a post mortem is not required and that the MCCD can be issued by the Trust. To give clearance to provide the MCCD the Coroner will send a Part A form.

- **Verification of death** – the confirmation by a competent non-medical practitioner that a patient has died.

5. Roles and responsibilities

- **The Medical Director** has overall responsibility for the process of notification of death, completion of Medical Certificates of Causes of Death and referral of cases to HM Coroner.

- **Nursing Staff** are responsible for verifying death (where applicable), informing patient's medical team of death, completing 'Notification of Death' form.

- **Medical staff** are responsible for attending the Bereavement / Patient Affairs office as soon as possible post death to complete Medical Certificates of Cause of Death and / or Coroner Referral forms.

- **Bereavement / Patient Affairs team** are responsible for providing the Medical Certificates of Causes of Death to the patient's next of kin, transmitting all Coroner referrals to the Coroner's Office, directing the copying of medical records before they leave the Trust, recording all relevant information within the Datix Mortality module.

- **Corporate Administration** team are responsible for copying latest episode of care notes on day of request to support Coroner referrals / Post Mortems.

6. Procedures

6.1. Internal notification of death

Following verification of death a member of the patient's medical team or covering consultant must be informed immediately. The verifying member of staff must ensure the death is documented in the patient's notes by completing the 'Notification of Death' form (appendix A).

Notification of death form distribution:

- White copy sent to Bereavement / Patient Affairs team immediately
- Pink and Blue copy sent to Mortuary with deceased
- Yellow copy included within the patients notes

Named consultant responsible: The notification of death form names the consultant responsible for the patient. This individual is the patient's lead consultant for their last episode of care and may not have been present at the death, staff should check the Patient Administration System or confirm relevant consultant with a member of the patient's medical team when completing the notification form.

Transferring medical records: The ward / department must ensure that medical records are appropriately updated and that the yellow copy of the 'Notification of Death' form is included at the front. The notes should then be transferred to the Bereavement / Patient Affairs team.

Transferring the deceased to mortuary: Porters should transfer the deceased patient to the mortuary with the pink and blue copies of the 'Notification of Death' form.

6.2. Medical Certificate of Cause of Death

A doctor from the patients' medical team who has cared for the deceased in their last illness and saw the patient in the last 14 days should attend the Bereavement / Patient Affairs office as soon as possible (by end of next day during the week / by Monday for deaths at the weekend) to complete the Medical Certificate of Causes of Death or to complete a coroner referral (see section 6.3). Whilst any member of the medical team can undertake this responsibility the patients named Consultant has the final responsibility for ensuring that the MCCD is completed appropriately. The attending doctor should discuss the causes of death to be listed on the certificate with the lead or covering consultant before completing the certificate.

There are 2 parts to the Medical Certificate of Cause of Death

Part 1:

- Part 1a: States the immediate condition or disease that directly led to the patient's death. If a single disease or condition led to the death then no further lines on the MCCD need to be completed.
- Part1b-c: State the sequence of conditions or diseases that led to the cause of death given in part 1a; these should be directly related e.g. Part 1c should lead to part 1b which should lead to part 1a.

Part 2:
States a significant condition or disease that contributed to the death but which is not part of any sequence leading directly to death.

Completed Medical Certificates of Causes of Death are held by the Bereavement / Patient Affairs team before they are provided to the patient's next of kin as a statutory notice of death.

Out of hours
Medical Certificates of Causes of Death are not routinely issued out of hours; if there is an urgent requirement to complete MCCD out of hours the site manager should be contacted. In exceptional circumstances an MCCD can be completed out of hours by a doctor who has cared for the deceased in their last illness and saw the patient in the last 14 days provided the death does not meet the Coroner referral criteria outlined below (6.3)

6.3. HM Coroner referrals

Under the law of England and Wales, an inquest must be held to investigate certain deaths. Coroners will lead this investigation and are obliged by law to investigate deaths where a person:

- has died a violent death
- has died a sudden death of unknown cause
- has died whilst in custody

A death must be referred to HM Coroner in the following circumstances:

- The cause of death is unknown;
- It cannot readily be certified as being due to natural causes;
- The deceased was not attended by the doctor during her/his last illness or was not seen within 14 days or viewed after death;
- Patient had been in hospital for less than 24 hours.
- There are any suspicious circumstances or history of violence;
- The death may be linked to an accident (whenever it occurred);
- There is any question of self-neglect or neglect by others;
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station);
- The deceased was detained under the Mental Health Act / Person deprived of their liberty or liberty was restricted by law at the time of death, in seven days preceding death, including a serving prisoner
- The death is linked with an abortion;
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose);
- The death could be due to industrial disease or related in any way to the deceased employment;
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred);
- The death may be related to a medical procedure or treatment whether invasive or not;
- The death may be due to lack of medical care;
- There are any other unusual or disturbing features to the case;
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care);
- It may be wise to report any death where there is an allegation of medical mismanagement;
- Cause of death may be due to trauma or unnatural cause e.g. Road Traffic accident, poisoning, self-harm, fracture, evidence of violence;
- Cause of death is due to a fall or there has been a fall in the three days prior to death.
- At time of death, a grade 3 or grade 4 pressure sore is present or more than one grade 2 pressure sores are present
- Significant medical procedure or treatment (inc chemotherapy or radiotherapy) during index admission.
- Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate

- Death during pregnancy or within a year of giving birth.
- All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. all paediatric deaths.
- If the patient is under the age of 80 and Old Age is given as the sole cause of death then you must report the death to the Coroner (please see note below)
- Any other unusual circumstances.

If there is any doubt about whether a Coroner's referral is required, the first point of contact should be the Consultant in charge of the care. The Consultant has the ultimate responsibility for decisions on referral. Where further guidance is required the Bereavement or Legal Services Offices should be contacted for further advice.

Deaths certified as Old Age

Please note that to give old age as a cause of death without referring to the Coroner you must:

- Have personally cared for the deceased over a long period of time
- Have observed a gradual decline in the patient's general health and functioning
- Not be aware of any identifiable disease or injury that contributed to the death.
- Be certain that there is no reason that the death should be referred to the Coroner

A doctor from the patient's medical team who has cared for the deceased in their last illness is responsible for referring cases to the Coroner via the Bereavement / Patient Affairs team. The doctor attending the Bereavement / Patient Affairs office will be provided with the relevant Coroner referral form, once completed this will be emailed to the Coroner's office by the Bereavement / patient Affairs team using a dedicated nhs.net email account.

No member of staff other than Bereavement / Patient Affairs Officers should contact the Coroner's directly before a referral form has been completed. All referrals to the coroner are to be made in writing and transferred to the Coroner's office via a dedicated secure nhs.net email account operated by the Bereavement / Patient Affairs team.

6.4. Response to HM Coroner referrals

Following referral the Bereavement / Patient Affairs team will receive the response from the Coroner's office regarding whether a Post Mortem is required.

No post mortem required: if the Coroner decides a Post Mortem is not required the Coroner will issue a 'Part A' allowing the Trust to release the MCCD (see section 6.2).

Post mortem required: if the Coroner decides a post mortem is required the deceased and their original medical records will be transported to the Coroner's pathologists, the following actions are required to support this process:

The Bereavement / Patient Affairs team will:

- Notify the mortuary of PM requirement
- Request a copy of the patient's medical record to be made by the corporate administration team

The corporate administration team will:

- Copy medical record on day of request
- At WestMid return original and copied medical record to the Patient Affairs Office
- At ChelWest return original and copied medical record to the Mortuary

The mortuary will:

- Release the deceased with the copied medical record to the Coroner's funeral directors

The results of PMs will be requested by Bereavement / Patient Affairs team and recorded within the Datix mortality review module.

7. Distribution / Dissemination

This guideline will be communicated to staff via the following means:

- Daily notice board communication
- Team brief

8. Monitoring compliance and effectiveness

Key process/part of this policy for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed
MCCDs completed within 1 working day of death	Audit from Datix Mortality Review Module	Legal Services / Bereavement	Yearly	Patient Experience Group	Patient Experience Group
All coroner referrals sent from Bereavement team	Audit from Datix Mortality Review Module	Legal Services / Bereavement	Yearly	Patient Experience Group	Patient Experience Group

9. References

- Academy of Medical Royal Colleges, A Code Of Practice For The Diagnosis And Confirmation Of Death, 2008
- Dorries, Coroners' Courts: A Guide to Law and Practice, 2004

Patient name: Hospital Number: DOB: (or add patient label)

Chelsea and Westminster Hospital NHS
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Notification of Death

Notification of Death and Identification Band checked by:

Nurse 1	Nurse 2 (for verification)
Print name:	Print name:
Signature:	Signature:
Job Title:	Job Title:
Patient identification band: Wrist ☐ Ankle ☐	Patient identification details correct? Yes ☐ No ☐

To be filled in by ward / department (BLOCK CAPITALS)

Ward:	Consultant responsible for patient:	
Religion:	Team bleep numbers:	
Date and time of admission:	DD / MM / YYYY	:
Date and time of operation:	DD / MM / YYYY	:
Date and time of death:	DD / MM / YYYY	:
Date and time of certification:	DD / MM / YYYY	:
Particulars of jewellery or other articles left on body (including clothing, toys, blankets and pictures, letters):		
Patient weight (kg):	Is patient an infection risk? Yes ☐ No ☐	
Does this case need to be referred to HM Coroner?	Yes ☐ No ☐ Not known ☐	
Is a post-mortem (PM) to be held?	Yes ☐ No ☐ Not known ☐	

Next of Kin Details

Name of official Next of Kin: Relationship to deceased:	Has the next of kin informed? Yes ☐ No ☐
Address:	Telephone number:

WHITE COPY – Bereavement / Patient Affairs Team
PINK COPY – Mortuary 1
BLUE COPY – Mortuary 2
YELLOW COPY – Patient notes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	3.1/Sep/17
REPORT NAME	Board Assurance Framework and Strategic Priorities Tracker
AUTHOR	Alex Bolton, Safety Learning Programme Manager Tom Rafferty, Head of Strategy
LEAD	Karl Munslow-Ong, Deputy Chief Executive
PURPOSE	To update the Board on the proposed introduction of a Board Assurance Framework and to track the Trust's Strategic Priorities
SUMMARY OF REPORT	The well led framework developed initially by Monitor, CQC and the Trust Development Authority requires the boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. The development of the Board Assurance Framework is intended to support the existing and well established Risk Assurance Framework that is already in place. The following key processes are intended to support this aim: The Risk Assurance Framework (RAF) seeks to escalate significant risks identified across the organisation (communication from ward to board). The risks within the RAF are principally operational in nature. The Board Assurance Framework (BAF) seeks to support the Board gain a clear and complete understanding of the barriers faced by the organisation in the pursuit of its strategic objectives and provides assurance that management action is appropriate and effective. Trust strategic objectives are aligned to an Executive Director and monitoring committee; Executive leads will consider a range of sources when identifying principle barriers to the achievement of strategic objectives. Oversight committees will be responsible for assessing the level of assurance offered that controls to address principle barriers / risks are effective. The Board Assurance Framework will be supported by the provision of strategic objective KPIs which are intended to be reviewed by the Board on a Quarterly basis. These are intended to support oversight of delivery.
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 proposed Board Assurance framework process and Strategic Priority Tracker and highlight any particular areas of focus for the Executive.

Board Assurance Framework

Purpose

The well led framework developed initially by Monitor, CQC and the Trust Development Authority requires the boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

The Trust's risk register process supports this aim by providing a channel to record and communicate risks (from ward to board); the risks identified via this route are primarily operational in nature. The Board views the most significant risks to the organisation within the Risk Assurance Framework (RAF).

The Trust is engaged in the achievement of its strategic objectives; to support the Board gain a clear and complete understanding of the principle barriers / risks faced by the organisation in the pursuit of these objectives a Board Assurance Framework (BAF) is being developed. Risk / barriers identified via this route are primarily strategic in nature.

The board assurance framework is developed by aligned Executive leads and overseen by aligned monitoring committees. It is intended to be the primary means that barriers to the delivery of the Trust's strategic objectives are communicated / escalated to the Board.

Strategic objectives

The Trust Board agreed the following priorities for 2017-18.

1. **Deliver high-quality patient-centred care**

Patients, their friends, family and carers will be treated with unfailing kindness and respect by every member of staff in every department and their experience and quality of care will be second to none.

How will we know we've achieved this priority?

- We will consistently have more than 30% of our patients completing the *Friends and Family Test* with more than 90% of those providing feedback saying they would recommend our services
- We will continue to have some of the lowest mortality rates in the NHS
- We will be the best performing London Trust for A&E, cancer and Referral to Treatment standards

2. **Be the employer of choice**

We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers, and we will recruit and retain people we need to deliver high-quality services to our patients and other service users.

How will we know we've achieved this priority?

- We will have more than 90% of our permanent jobs filled by permanent staff
- We will have less than 13% of our staff leaving each year
- We will achieve an above average score for staff engagement in the national Staff Survey

3**. Deliver better care at lower cost**

We will look to continuously improve the quality of care and patient experience through the most efficient use of our resources (financial and human, including staff, partners, stakeholders, volunteers and friends).

How will we know we've achieved this priority?

- We will deliver our financial plan in full
- We will be in the top 10% of NHS Trusts for financial efficiency based on national best practice

Risks and Barriers

Risks / barriers to the following strategic objectives are outlined within the Board Assurance Framework:

1. **Deliver high quality patient centred care**
   1a Deliver evidence based practice in all our services
   1b Support the promotion and delivery of self-care and prevention
   1c Focus on service improvement and enhancing quality
   1d Proactively seek, listen, respond and learn from all the feedback we receive
   1e Work with our partners to deliver integrated, coordinated care

2. **Be the employer of choice**
   2a Have an engaged, responsive & 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 and wellbeing of our workforce

3. **Deliver better care at lower cost**
   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 and Carter Model Hospital
   3c Deliver best value in quality and effectiveness
   3d Fully exploit digital health to support our pathways of care

Process outline

The Board Assurance Framework will be built into the integrated governance plan for the organisation. The process for the development of the BAF is outlined below:

- Strategic objectives aligned to a committee of the Board
- Strategic objectives aligned to Executive responsible for overseeing delivery
- Executive presents principle barriers to delivery of objective to the aligned committee
- Committee considers / challenges principle barriers and management actions addressing them
- Committee chair assesses level of assurance that management action is appropriate and effective
- Board Assurance Framework dashboard updated to reflect committee chairs comments and RAG rating
- Board reviews Strategic Objective key performance indicators quarterly
- Board reviews Board Assurance Framework Dashboard quarterly
- Board reviews strategic objectives in detail where oversight committee has limited assurance
- Audit Committee assesses Board Assurance Framework process and assurance levels quarterly
- Audit Committee / Executive team considers themes and Trust wide support available / required quarterly

Key performance Indicators

Key performance indicators support the Board monitor the deliver its strategic objectives. Each barrier / risk outlined within the BAF includes further evidence / indicators regarding the effectiveness of the controls in place; this additional evidence will be considered by the aligned oversight committee when reaching a conclusion regarding the level of assurance provided. KPI metrics are outlined in Appendix 1.

Reporting to oversight committee

Board Assurance returns will be developed within a standard template to include:

- **Principle barrier / risk:** Barriers / risks to the achievement of the Trust's strategic objectives identified though a range of sources by the aligned Executive lead.
- **Principle Controls (and gaps):** Controls that are in place to manage the barrier / risk to the achievement of the strategic objectives; these will typically be linked to policies, structures, staffing, projects, programmes, resources, governance arrangements etc.
- **Assurances/evidence (and gaps):** Evidence / indicators regarding the effectiveness of the control systems. Assurance is typically provided through KPIs, audit, surveys, training records, reports etc.

A BAF template is outlined in Appendix 2.

Reporting to Board

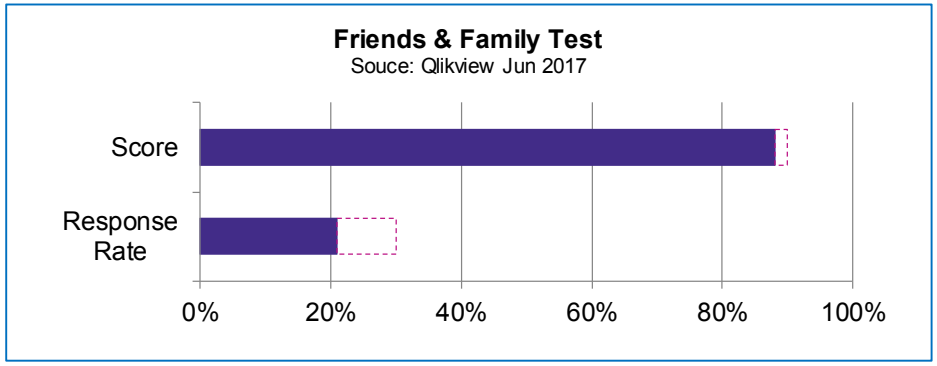
The committees of the Board will assess level of assurance in the management of barriers / risks to the strategic objectives. The Board will review an overview of these assessments within the BAF dashboard; outlined in Appendix 3.

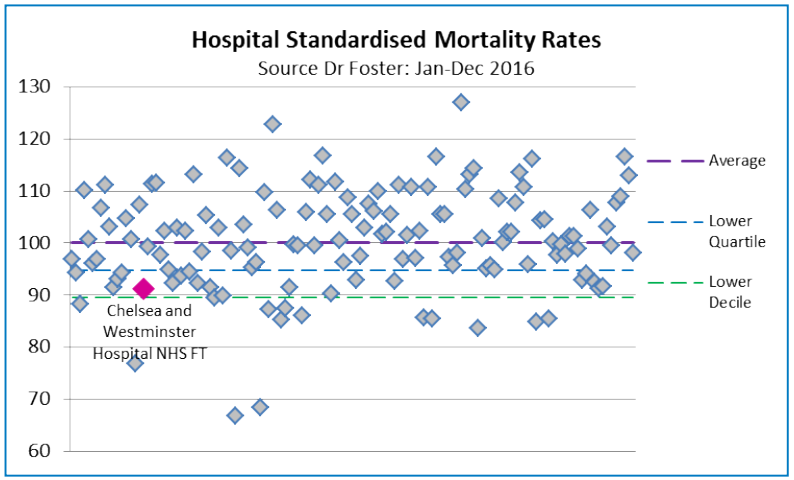
Next steps

The board is asked to consider and comment on the proposed board assurance framework process and Strategic Priorities Dashboard.

Strategic Priorities – Key Performance Indicators

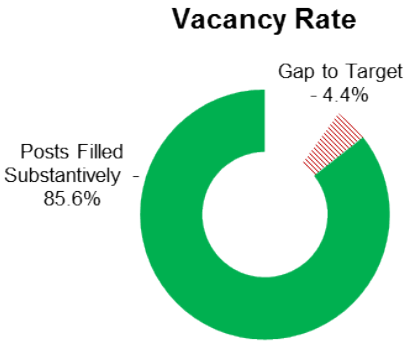
1. Deliver high-quality patient-centred care

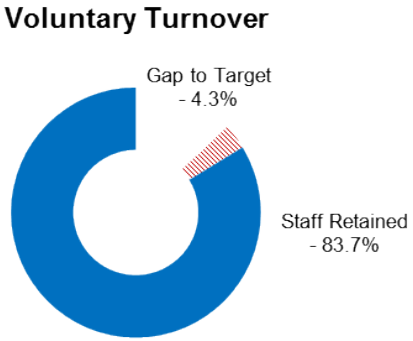




Jun 2017 (Source: NHS England)	A&E	18 weeks RTT	Cancer 62 day	Ave. Ranking
London Peer[1] Ranking	1st	4th	6th	1st

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**

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Appendix 1a – 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.

Appendix 2 - Board assurance Framework template

Aim:	**1. PRINCIPLE AIM**		P Positive Assurance N Negative Assurance * Awaiting measure	**Oversight Committee**	
Objective:	**1a. PRINCIPLE OBJECTIVE**			**Executive Lead**	
PRINCIPAL BARRIERS & RISKS What could prevent this Objective being achieved?	**KEY CONTROLS** What controls / systems do we have in place to address the barriers & risks?	**KEY GAPS IN CONTROL & ACTIONS TO ADDRESS** Where we are failing to put key controls / systems in place? What actions are needed	**KEY SOURCES OF ASSURANCE** How can we gain evidence that our control systems are effective?	**KEY GAPS IN ASSURANCE & ACTIONS TO ADDRESS** Where we are failing to gain evidence that our assurance systems are effective?	**RAG**
1. Internal Example Example of principle internal barrier to the achievement of strategic objective	• Example systems / control in place to address this barrier	• Example systems / control planned for implementation to address this barrier	**Internal** P Evidence to confirm if controls are effective (positive) **External** N Evidence to confirm if controls are effective (Negative)	• Other evidence plan to use to monitor effectiveness of controls	**TBA**
2. External Example Example of principle external barrier to the achievement of strategic objective	• Example systems / control in place to address this barrier •	Example systems / control planned for implementation to address this barrier			**TBA**

Appendix 3 - Board Assurance Framework Dashboard

Aim	Strategic objective	Responsible Director	Oversight	Committee chair assurance comment	Assurance change	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		↑ ↓ ↔	
	1b. Support the promotion and delivery of self-care and prevention	R Hodgkiss / Z Penn				
	1c. Focus on service improvement and enhancing quality	R Chinn				
	1d. Proactively seek, listen, respond and learn from all the feedback we receive	P Nightingale				
	1e. Work with our partners to deliver integrated, coordinated care	K Munslow Ong				
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			
	2b. Develop innovative roles and career opportunities for all our workforce	Z Penn / P Nightingale				
	2c. Improve the health, wellbeing of our workforce	K Loveridge				
3. Deliver better care at lower cost	3a. Drive out waste, duplication and errors.	R Hodgkiss / S Easton	Finance and Investment Committee			
	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				
	3c. Deliver best value in quality and effectiveness	R Hodgkiss / Z Penn				
	3d. Fully exploit digital health to support our pathways of care	K Jarrold				

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

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	3.2/Sep/17
REPORT NAME	Shaping a Healthier Future and North West London Sustainability and Transformation Partnership
AUTHOR	Virginia Massaro, Deputy Director of Finance Tom Rafferty, Head of Strategy
LEAD	Sandra Easton, Chief Financial Officer Karl Munslow-Ong, Deputy Chief Executive
PURPOSE	To provide an update on the latest progress regarding the Shaping a Healthier Future Business (SaHF) Case and to align within the context of the North West London Sustainability and Transformation Partnership (STP).
SUMMARY OF REPORT	The implementation business case for the Outer NW London SaHF programme has been progressing through national approval processes and while final approval is still outstanding, there have been some indications of progress. To optimise the chances of securing access to national support, the sector are asking the Trust to proactively prepare the next iteration of our business case. This is expected to need to review: • Total capital funding required • Explore alternative funding sources • Improved integrated plan with the out of hospital clinical model The Trust has costed the resources required to do this and will also align with the wider site and strategic plan in light of our own 'Downside case', short to medium term capacity and workforce issues, and the wider STP environment. Regular reporting will be re-established to Finance & Investment Committee (FIC) and full Board as the work programme is re-established
KEY RISKS ASSOCIATED	As above - wider risks remain that total activity assumptions and supporting income and the need to realign with latest population and demographic position and with revised projections on out of hospital models
FINANCIAL IMPLICATIONS	As above - main impact of business case revisions is likely to be on alternative funding sources, which assumes fully loan funded.
QUALITY IMPLICATIONS	N/A

EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	All
DECISION/ ACTION	The Board is asked to: 1) Note the latest position regarding the Shaping a Healthier Future business case 2) Note the need to align with the NWL STP 3) Note that Regular reporting will be re-established to Finance & Investment Committee (FIC) and full Board as the work programme is re-established

Shaping a Healthier Future and North West London Sustainability and Transformation Plan

1. Introduction

This report provides an update on the latest progress regarding the Shaping a Healthier Future (SaHF) Business Case and aligns the likely re-established work programme and objectives within the context of the North West London Sustainability and Transformation Partnership (STP).

2. Summary

The Implementation Business Case for the Outer North West London SaHF programme has been to the relevant investment committees at NHS England (NHSE) and NHS Improvement (NHSI) in August. Final approvals and sign off at HM Treasury are still outstanding but some indications of what any final case should include have been received.

The Business Case covers the outer NWL acute reconfiguration and out of hospital hubs model and primary care investment across the whole NWL sector, with a total capital requirement of £529m (£329m for acute reconfiguration, £141m for out of hospital hubs and £69m for primary care).

The Chelsea & Westminster Hospital NHS Foundation Trust (CWFT) case makes provision for the redevelopment of A&E, an additional 72 general beds and 7 critical care beds all at the West Middlesex site at the cost of £43.1m. This additional capacity is intended to address an increase in demand as a result of the reconfiguration of services at other North West London sites. The original modelling for the business case also assumed some natural growth and the predicted impact of new out-of-hospital services aimed at reducing demand on acute hospitals. The case assumed that the capital costs would be loan funded.

3. Revisions to Business Case

As preparation for any invitation for final business case, the NWL sector are considering likely areas of enquiry. This is likely to focus on:

- Minimising capital funding required and exploring alternative funding sources – through exploring further capital receipts opportunities, areas indicated by Naylor Review and alternative financing opportunities to PDC; including loan funding, PFI and LIFT schemes and affordability to providers.
- Integrated plan to review the out of hospital clinical model – to set out the process to evidence the out of hospital clinical model and its impact on non-elective admissions. The Trust believes that alignment with the principles, assumptions and latest work programmes of the STP are pivotal.

While recognising the risks of the programme, CWFT is proposing to support redevelopment of any final business case as it represents a significant opportunity to secure national funding sources for North West London. The Trust is preparing a bid to commissioners for this area of work, the majority of which will be required to develop the detailed building plans. Given the length of time that has

passed since the original activity modelling, and the need to better align with the STP and specifically out of hospital models of care, The Trust will also include within this review:

- Changes to our Model of Care and workforce development
- Refreshed activity modelling (including changes in demographics and current trends)
- Revised use of Estate
- The need to address the short-term pressures on the site and fit with the Trust's wider strategic plans and the trajectory to SaHF implementation by 2024/25.

4. Impacts for CWFT

The main impacts will be re-assessed as part of the revised modeling including the impact of different funding option. .

5. NWL Sustainability and Transformation Plan

The Trust recognises that SaHF essentially is a strategic reconfiguration programme, and that the case for change drivers and outcomes are consistent with the goals, ambitions and work programmes of the NWL STP.

For context and information Appendix 1 sets out the current Position on NWL STP inc the Trust's main contribution. This is as part of wider Delivery Area development or as part of an aligned work programme and is provided to demonstrate where progress is being made on assimilating principles and way of working into our core models of care and business.

The key risk is that these programmes become fragmented and it is critical that, as the SaHF work programme is re-established, there is coherence across planning assumptions, changing models of care and the supporting enablers.

6. Next Steps and Board Decision

The Board is asked to:

- Note the latest position regarding the Shaping a Healthier Future business case
- Note the need to align with NWL STP
- Note that Regular reporting will be re-established to Finance & Investment Committee (FIC) and full Board as the work programme is re-established

Appendix 1

NWL Sustainability & Transformation Plan:
Position Statement re CWFT work programmes

Since the submission of the NW London STP in October 2016 (and its publication online in November) five key implementation themes have been identified and Delivery Area Groups (DA) have been established:

1. Radically upgrading prevention and wellbeing
2. Eliminating unwarranted variation and improving LTC management
3. Achieving better outcomes and experiences for older people
4. Improving outcomes for children &adults with mental health needs
5. Ensuring we have safe, high quality sustainable acute services

Each DA has a further series of sub-groups and work streams as a means of developing the required granular detail and of engaging the right people/organisations (essentially key clinician and managerial input and leadership). Given the focus of DA5 on acute services the Trust is proportionately more engaged in this set of programmes.

The main impacts (and alignment with the Trust Strategic Priorities) have been:

Radically Upgrading Prevention and Wellbeing (Delivery Area 1)
This Delivery Area incorporates a number of projects led by public health colleagues across North West London. The current priorities are smoking and alcohol interventions, supporting existing progress on re-ablement and return to work and extending training and development for NHS staff in Making Every Contact Count.

The main CWFT engagement has been through a funded project in Maternity where staff are being trained in Stop Smoking interventions to test:

1) This methodology to reduce numbers of mothers smoking in pregnancy
2) The impact on low birth weight
3) Any subsequent impact on access to SCBU and NICU

Impact: Approx 300 staff have been through the Brief Interventions training programme. And the results in Q1 show that referrals to Smoking Cessation Training have doubled against 2016/17 baseline

Local Services Transformation
This section combines Delivery Areas 2 & 3 and has been predominantly focussed on strengthening the Out of Hospital models

- Enhanced Primary Care (eg Extended 7 day access, at scale models/Federations)
- Supporting Self Care
- Intermediate Care/Rapid Response
- Transfer of Care (eg NWL social care protocols to better support acute discharge)
- Last Phase of Life

Impact: CWFT's main engagement has been:

1) The workstream to support people with diabetes

2) Re-designing inpatient care of the elderly to move towards the Frailty Network model inc deployment of Clinical Innovation Fellows
3) Building up best practice discharge models such as Red to Green, Discharge to Assess

Improving outcomes for children, and adults with mental health needs (Delivery Area 4)

This workstream has focussed on modelling across partners and co-production including with service users, carers, social care, clinicians and commissioner. No changes to models of care are envisaged until April 2018.

From a CWFT perspective our main engagement and interest of work undertaken to date is in perinatal service and a new specialist community services that will be provided by CNWL from April

Possible Next Steps: Increased focus on A&E Liaison Services and more engagement/alignment with mental health in MDT planning for many of our at risk patients and how this is aligned with Discharge to Assess

Ensuring we have safe, high quality sustainable services (Delivery Area 5)

MSK Transformation

CWFT has proposed (and broadly supported by other Trusts) that we shift the main focus of the group to support areas that would provide material benefit to the 2 year Operating Plan period rather than to continue to develop plans to implement the Briggs Report through the establishment of an Elective Orthopaedic Centre. Examples of more immediate improvement include:

- Theatre Productivity
- Length of Stay
- Virtual Fracture Clinics
- Fragility Fracture Liaison Service
- Procurement

Impact: The most tangible output thus far has been the award of a single contract for core trauma consumables (nails, screws and plates) across North West London. The focus on the other workstreams is to share best practice and standardise pathways.

Seven day services

NWL has led the country in developing alternative models of care to implement the standards. The principle of the new model is to address the most challenging standards by cohorting/categorising patients into four groups:

- **Patients on AAU, SAU, and Intensive care** – these patients will receive twice daily review from a consultant.
- **Category 1 patients** – patients on downstream wards that require daily consultant review. These patients need daily review to ensure that they are progressing along their care pathway and any adverse health issues are quickly and appropriately addressed.
- **Category 2 patients** – these patients require daily review from a clearly delegated individual. This may be a junior doctor, a nurse, or an allied health professional. Their pathway should be clearly defined, and these patients should be escalated back to category 1 if their planned care pathway is not progressing at the expected rate.
- **Category 3 patients** – these patients are medically fit for discharge and no longer require on-going review.

Impact: The Trust benchmarks well against the national indicators on safety an out of hours and the effect of this patient categorisation is to reduce the burden of consultant review across all patients and focus it where it is most clinically appropriate. FIC has reviewed the proposals and agreed the FT should continue to lead on NWL pilot work and to develop solutions that reduce variation and make best use of workforce and available resource.

NB The next 7 Day audit is scheduled across Sept-Oct and is focussed on CS4 (Inpatient Review)

Specialised Services

The main focus of the SpecCom Programme has been to take forward the opportunities for greater collaboration of key services so that – as a group of providers – we can make the step 'at scale' developments to support sustainable delivery. The group is using national service reviews, national standards, Carter KPI's and other best practice indicators to triangulate plans.

Impact: Initial focus has been on:

- Renal
- HIV

Further work is in progress to consider the longer term NWL position and the ability to position/demonstrate progress and ambition against national review criteria/specifications.

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Board of Directors Meeting, 7 September 2017

AGENDA ITEM NO.	4.1/Sep/17
REPORT NAME	Key Risks: Medical Workforce Presentation
AUTHOR	Zoe Penn, Medical Director
LEAD	Zoe Penn, Medical Director
PURPOSE	To inform the Board of Directors about the national and local context of medical workforce risks that currently lie on the Trust Risk Register, but also to inform the Board of the local mitigations in place or planned.
SUMMARY OF REPORT	The Trust Risk register documents the risk that there will be 'insufficient junior medical cover both out of hours, and during the in hours period, to provide safe care for patients'. This presentation notes the national context for insufficient number of junior doctors progressing over a 15-18 year period from entry to medical school to consultant status, which includes no increase in admissions to medical school despite rising numbers in the population, but also 'drop out rates' from training at all stages. This leads to medical rotas that are hard to fill safely and increased levels of spend on temporary medical staff. Some of the background to this is poor morale and dissatisfaction with the environment in which service is being provided, rather than with educational experience. We outline the immediate actions in respect of improving engagement with our junior doctor work force and the improvements in educational opportunity and improvements in working environment that are either in place or planned.
KEY RISKS ASSOCIATED	Financial sustainability and failure to provide high quality care
FINANCIAL IMPLICATIONS	Increased spend on temporary medical staff
QUALITY IMPLICATIONS	Failure to provide high quality care.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	• Financial sustainability • Provision of high quality patient care • Being employer of choice
DECISION/ ACTION	The Board are asked if they are satisfied with the currently remediations and if the planned remediations are ambitious enough.

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Medical Workforce

Public Board – 7th September 2017

Dr Zoe Penn, Medical Director

Medical Staffing: The Risk to the Trust

Rated as "High Risk" as per the Risk Register

There will be insufficient junior medical cover both out of hours (via hospital at night) and during the in-hours period

Focus: Patient Safety

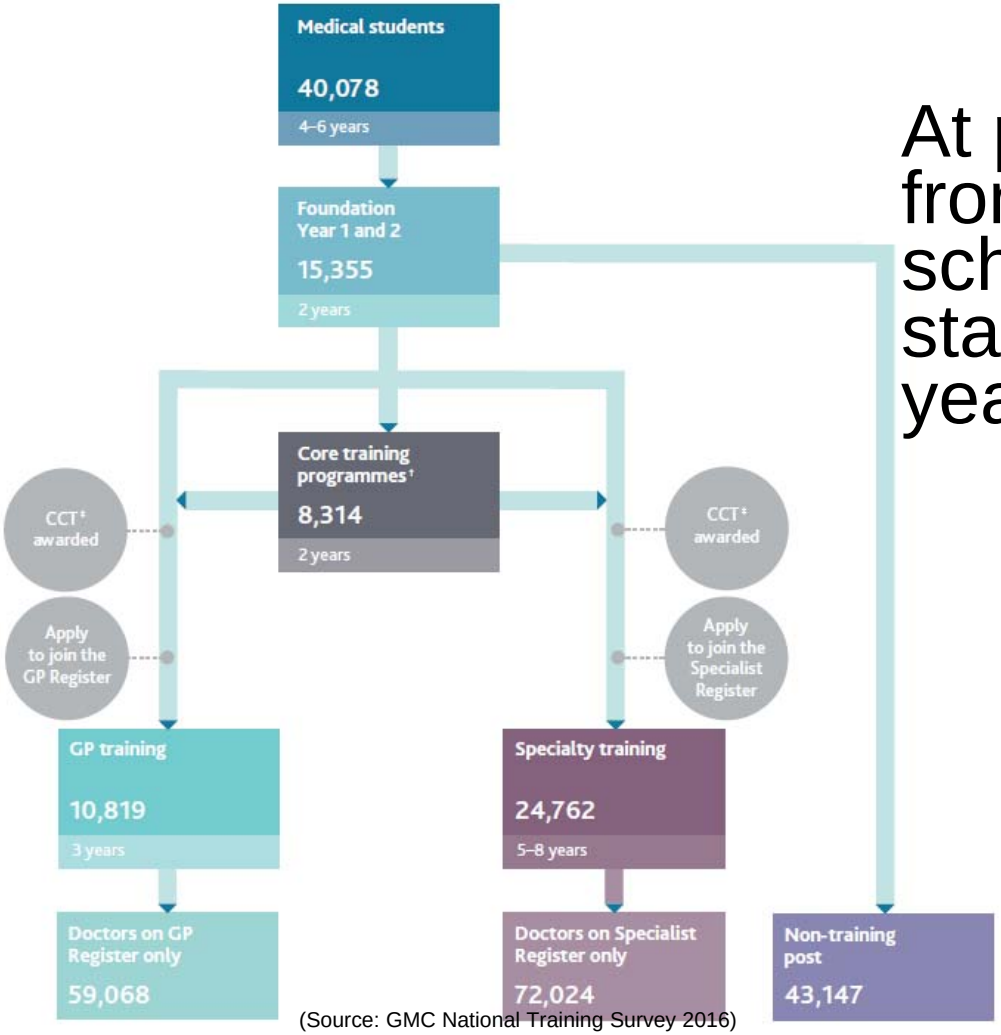
Glossary

IMG	International Medical Graduate	
CCT	Certificate of Completion of Training	Certificate doctors receive to indicate they have completed training in their chosen specialty and are eligible for entry onto the Specialist or GP Register
CESR	Certificate of Eligibility for Specialist Registration	Pathway for doctors to join the Specialist Register, with qualifications or experience acquired outside of an approved CCT programme
JD	Junior Doctor	
Staff Grade		Non-training doctors – lower grades
SAS	Speciality and Associate Specialist Doctors	Non-training doctors – higher grades
LAT	Locum Appointed to Training	Non-training doctors – post complies with training regulations
OOPE	Out of Programme Experience	Training doctors on non-training placement

Glossary

GMC	General Medical Council	Public body that maintains the official register of medical practitioners
HEE	Health Education England	Executive non-departmental public body of the Department of Health. Coordinate medical education and training
BMJ	British Medical Journal	Peer reviewed medical journal
RCP	Royal College of Physicians	Professional medical accreditation by examination

The Pipeline for Medical Training



(Source: GMC National Training Survey 2016)

At present the journey from entry to medical school to consultant status takes 14 -18 years

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The Pipeline: Medical Students

- **National:**
  - There fewer medical students at UK universities (down 3% since 2012). This decrease is due to a planned reduction in medical school intakes in England from 2013.(GMC 2016) Why?
  - The government has promised to increase the number of medical student places by 25% from 6000 to 7,500 per year

	2012		% change	2015	
	% total	Number of medical students		% total	Number of medical students
TOTAL	100%	41,422	-3%	100%	40,078

(Source: GMC Survey 2016)

Approximate projection 2023

41,250

  - Against this backdrop there is an increase in numbers withdrawing or failing exams.(BMJ 2016)
  - The number of trainees applying directly into core training after the foundation programme is 52% and dropping steadily. Junior doctors are taking breaks from training citing burnout (50%) and need for a work-life balance (87%) as the reasons.(HEE 2016)
  - This number has not kept up with the 2.2% growth in the UK population, from 63.7 million to 65.1 million.

The Local Context

	Number or percentage
Junior doctors in recognised training posts (%)	545 (76%)
Junior doctors in non-training posts	129 (24%)
Medical vacancy rate	9-10%
Medical voluntary turnover rate	5.7%
Medical Locum fill rate: Bank	69%
Medical locum fill rate: agency	28%
Unfilled positions	3%
Medical locum spend (2016/17)	£13m

The National Context

‘Trainee morale is at an all time low’:

- **GMC:** The State of medical Education and Practice in the UK - Annual Report 2016

  “The levels of dissatisfaction across the profession has reached a different order”

- **BMA:** Workforce Survey 2016

  “50 per cent of respondents described their morale as low or very low”

2015 GMC Survey - 83% of doctors in training rated the quality of experience in their post as ‘excellent’ or ‘very good’

Within a matter of months - 98% of those doctors who responded to a ballot called by the BMA voted not only to take industrial action but also to support all-out action

The National Context

New Junior Doctor Contract Implementation Impact – "Unsafe and Unfair"

- Extension of standard time hours for junior doctors
- Unmanageable or unsustainable workloads
- Inflexibility of working time and location

Millennials (Generation Y) - do we understand this demographic cohort?

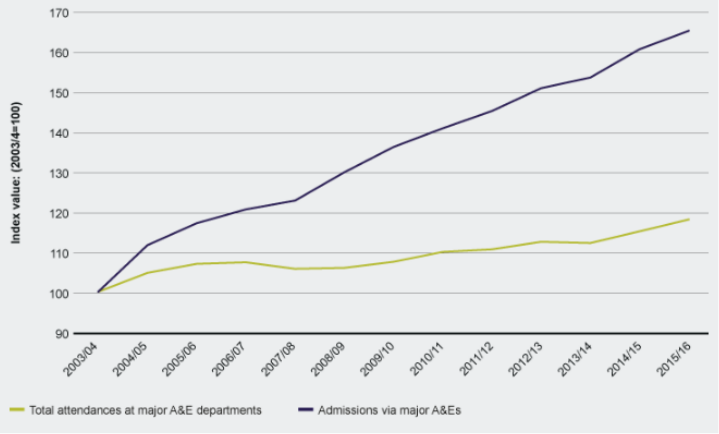
- "a generation generally marked by an increased use and familiarity with communications, media, and digital technologies"
- "Millennials … consider work life balance issues very important in making career decisions"
- "Millennials… have a preference for immediate feedback"

The Context

We are experiencing an increase in non-elective demand: previous Board Paper on Non-Elective Demand locally

Both attendances (*1*) at major A&E units and admissions into emergency care (*2*) have increased over time (Figure 1).

Figure 1: Attendances at, and emergency admissions from, major A&E departments (2003/4=100)



Attendances at major A&E departments

- Between 2003/4 and 2015/16, the number of attendances at major A&Es increased by 18 per cent, from 12.7 million to 15 million.
- This represents an average annual increase of 1.4 per cent.
- Attendances have increased more sharply in recent years – in fact, nearly a third of the overall increase in attendances at major A&Es took place in the past two years (with the average annual increase rising to 2.6 per cent in 2014/15 and 2015/16).

(Source: Kings Fund Demand and Activity in the NHS: Still Rising 2016)

The Challenges

Rising Expectations

- 7/7 Services
- 24/7 Services
- Reducing ‘The Weekend Effect’
- Regulatory Environment
- Political Environment

The Junior Doctor Workforce – our influence

	Permanent		Temporary	
	Training	Non-Training	Bank	Agency
Quantity	Limited due to JD rotations	Ability to attract and retain	Ability to attract and retain	Limited ability to attract and retain
Quality	Opportunity to improve educational experience	Opportunity to improve educational experience	Some opportunity to improve educational experience (if also substantive)	Limited

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What are we doing now?

- **Increase the number of non-training placements**
  - OOPE
  - Staff Grade
  - LAT
  - Clinical Fellowships
  - Education Fellow
  - SAS
  - CESR Training Route Portfolio, Assistance and Mentorship

- **Improve quality and availability of temporary staff**
- Flexistaff / Locum Tap

- **Improving Education, Learning and Development**
  - Developing a virtual as well as physical learning environment
  - Improve the quality of training
  - Improve the attendance at training

What are we doing now?

- **<u>Improving working environment and support</u>**
- **24/7 Hospital Programme Board**
  - Investigating sustainable solutions and optimising skill mix: Hospital @ Night, Hospital @ Weekend, Hospital @ Day, Deteriorating Patients
- **Guardian of Safe Working**
  - Generating meaningful information from exception reporting
  - Listening to and learning from the experiences of junior doctors in training
  - Actions taken in response to common themes
- **Health and Wellbeing Strategy**
  - Changing the way we look after our employees

What are we planning on doing?

Developing a prospectus of our offer: ensuring our organisation is the employer of choice

- **Learning & Development Offer**
  - Simulation and Resus courses / Instructor Courses (BLS, ILS, ALS, ATLS)
  - Emerging and Established Leadership Courses

- **Undergraduate Department Offer**
  - Local, regional and national teaching opportunities at a major teaching hospital for Imperial College London
  - Teaching awards and certificates

- **Postgraduate Centre Offer**
  - CMT & GP-VTS teaching site
  - Foundation & departmental teaching
  - Clinical skills teaching for all SHO grade staff
  - E-portfolio support
  - Grand rounds and Schwartz rounds
  - Consultant courses on educational supervision

What do we plan on doing?

Developing a prospectus of our offer: ensuring our organisation is the employer of choice

- **Embedding an Improvement Culture**
  - Increasingly efficient and effective working practices attract employees
  - Innovation & Improvement Clinical Fellowship
  - Divisional Service Improvement & Efficiency Structure
  - Assistance and guidance on running improvement projects
  - CW+ Grants for Improvement Programme and continuing support
  - Imperial Innovations – guidance and assistance on commercially viable innovations
  - Research & Development opportunities

- **Further SAS / Out-of-Training Doctor Opportunities**
  - CESR Training Route Portfolio, Assistance and Mentorship to extend beyond ED
  - SAS doctor conferences
  - Flexible working schedule / less-than-full-time job opportunities

What are we planning on doing?

Developing a prospectus of our offer: ensuring our organisation is the employer of choice

- **Locum opportunities**
  - Online shift booking and automated weekly payment
  - Referral scheme
  - Credit for training courses

- **General Offer**
  - Location
  - Prestige
  - Specialist services (plastics, burns etc)
  - Major teaching hospital
  - Links to specialist centres (Brompton, Marsden, Imperial etc)
  - Staff discounts at local shops, pubs, restaurants and gyms
  - Staff benefits – cycle to work scheme, car scheme, gym, dr bike etc
  - Very well-funded doctors mess + events
  - Senior leadership team who listen to clinical staff
  - The Hub
  - The Library

What are we planning on doing?

Options:

- **Future Hospital Model & New Models of Medical Staffing Recommendations**
  - Looking into options for radical re-design of our staffing model
  - Seeking out best international and national practice in medical cover and optimal medical practise
  - To consider the use of new clinical workforce roles
  - To consider the seamless Medical Management journey from 1° to 2° and back to 1°care
- **Create our own Training Programme**
  - Partner with organisations in NWL to provide a regional recognised training pathway

References

HEE - Junior doctor morale: Understanding best practice working environments (2016)

GMC – National Training Survey (2016)

RCP – Being a Junior Doctor: Experiences from the front line (2016)

BMA – Workforce Survey (2016)

Kings Fund - Demand and Activity in the NHS: Still Rising (2016)

NHS Employers - Staff Experience And Patient Outcomes: What Do We Know? (2014)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 7 September 2017

PUBLIC

AGENDA ITEM NO.	4.2/Sep/17
REPORT NAME	Raising Concerns (Whistleblowing) Incidents: January - August 2017
AUTHOR	Nicole Porter-Garthford –Associate Director of HR : ER and Business Partnering
LEAD	Keith Loveridge, Director of HR & OD
PURPOSE	To give assurance that the trust has processes for encouraging staff to raise concerns and for acting on concerns to drive improvement. To provide an update to the executive board on the serious concerns that have been raised under this policy since the beginning of the year.
SUMMARY OF REPORT	The following report provides details of the qualifying disclosures that have been 'live' since 1 January 2017. It summarises the incident, the site to which the disclosure relates to, when it was reported, action taken and the outcome achieved. In July 2017 we published our new raising concerns (whistleblowing) policy which clarifies our obligations under the Public Interest Disclosure Act (PIDA) and takes into account Sir Robert Francis' Freedom to Speak recommendations. The central thrust of the policy is to encourage everyone to raise concerns openly as part of normal day-to-day practice so that action can be taken to ensure high quality, compassionate care based on individual human rights. The policy outlines the different steps people can take if they want to raise a concern. • Step 1: Raise the concern with immediate management team and log on datix. • Step 2: Report the concern in confidence to the employee relations team • Step 3: Raise the concern with an executive director or Vanessa Sloane, our freedom speak up guardian. Step 2 and step 3 qualifying disclosures are reported to the quality committee on a quarterly basis. In the period 1 January – 25 August we recorded six step 2 and 3 protected disclosures, of which five were raised after 1 January 2017. Four of the cases are closed, one is the subject of an on-going employee relations procedure and one requires an update. The concerns recorded in this report relate to a variety of clinical and non-clinical issues, details of which can be found in the report. It should be noted that this report does not include concerns relating to fraud which are handled by the counter-fraud team and reported to the audit committee.

	The growing importance attached to the proper handling of concerns raised under PIDA was emphasised in a recent employment appeal decision which found that two non-executive directors were personally liable for losses flowing from the dismissal a member of staff who had made protected disclosures. The effect of this case (*International Petroleum and ors v Osipov and ors)* is to make *s*enior managers and board members jointly and severally liable for the decisions they make in respect to whistleblowing cases. **Key messages to the senior managers and board members:** • encourage everyone to raise concerns as a way of improving practice, service user experience and safety. • treat all concerns seriously and sensitively and ensure that people who raise concerns and the subjects of concerns are supported; • undertake a timely investigation of any concern or assign an appropriate person to investigate; • register concerns with the employee relations team; • ensure that the people who raise concerns are kept updated.
KEY RISKS ASSOCIATED	To deliver high quality and compassionate care based on individual human rights we need our people to have the confidence to raise concerns through confidential, easy to use, well managed processes.
FINANCIAL IMPLICATIONS	Note any financial implications, not covered in above.
QUALITY IMPLICATIONS	Note any quality implications, not covered in above.
EQUALITY & DIVERSITY IMPLICATIONS	Note any equality & diversity implications, not covered in above.
LINK TO OBJECTIVES	State the main corporate objectives from the list below to which the paper relates. • Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For the committee to policy and review the concerns raised

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Appendix 1: Raising concerns (whistleblowing) incidents

January 2017 – August 2017

Concern #		Site	Division	When	Actions	Outcome
#1	Concerns raised by a doctor that M&M reviews not properly managed	**CW**	**EIC**	**8 Dec 2016**	Independent investigation of three CW M&M cases	Investigation concluded that no concerns about care or management of cases. Recommended changes to M&M processes accepted. Outcome reported back to doctor. CLOSED
#2	Concerns raised by individual in context of wider grievance that two managers breached fire safety rules.	**CW**	**Corporate**	**18 May 2017**	Investigated with the fire safety advisor.	No issues fire safety issues identified CLOSED
#3	Junior medical staff raised concerns about the demand on the medical FY's at night	**WMUH**	**EIC**	**23 March 2017**	Review of hospital at night and additional staff medical resource allocated.	CLOSED
#4	Nurse said that ward was unsafe. Concern raised in the context of a disciplinary process.	**CW**	**W&C**	**21 April 2017**	Investigated as part of a wider employee relations case.	Reassurance received on safety of the ward area CLOSED

Concern #		Site	Division	When	Actions	Outcome
#5	Consultant raised concern about ability to provide safe ward because of difficulty recruiting sufficient junior doctors to a speciality.	**CW**	**EIC**	**7th July 2017**	Concerns addressed. Junior doctor team strengthened; pathway redesign and reassignment of responsibilities	CLOSED
#6	Former member of staff raised concerns about a surgeon's ability to practice safely. Letter to CQC.	**WMUH**	**Planned Care**	**12th July 2017**	The doctor's practice is already subject a formal process and GMC referral. The doctor had already been excluded.	On going employee relations issue.