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

Room A, West Middlesex Hospital

11 January 2018 11:00 - 11 January 2018 13:00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting (PUBLIC SESSION)**
Location: Room A, West Middlesex Hospital
Date: Thursday, 11 January 2018
Time: 11.00 – 13.00

**Agenda**

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| | **1.0** | **GENERAL BUSINESS** | | |
| 11.00 | 1.1 | Welcome & Apologies for Absence | Verbal | Chairman |
| 11.03 | 1.2 | Declarations of Interest | Verbal | Chairman |
| 11.05 | 1.3 | Minutes of the Previous Meeting held on 2 November 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 | Report | Chief Executive |
| | **2.0** | **QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE** | | |
| 11.25 | 2.1 | Patient Experience Story | Verbal | Chief Nurse |
| 11.40 | 2.2 | Patient Experience update | Report | Director of Nursing |
| 11.45 | 2.3 | Patient Services Team update | Pres. | Chief Operating Officer |
| 11.55 | 2.4 | Quality Improvement Programme | Report | Chief Nurse |
| 12.05 | 2.5 | Serious Incidents Report | Report | Chief Nurse |
| 12.15 | 2.6 | Integrated Performance Report, including:<br>2.6.1 Workforce performance report | Report<br>Report | Chief Operating Officer,<br>Chief Financial Officer |
| 12.30 | 2.7 | Mortality Surveillance Q3 Report | Report | Medical Director |
| | **3.0** | **STRATEGY** | | |
| 12.40 | 3.1 | Communications Strategy | Pres. | Director of Communications |
| | **4.0** | **GOVERNANCE AND RISK** | | |

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| 12.45 | 4.1 | Board Assurance Framework | Report | Deputy Chief Executive |
| | **5.0** | **ITEMS FOR INFORMATION** | | |
| 12.50 | 5.1 | Questions from Members of the Public | Verbal | Chairman |
| 12.55 | 5.2 | Any Other Business | Verbal | Chairman |
| 13.00 | 5.3 | Date of Next Meeting – 1 March 2018 | | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Minutes of the Board of Directors (Public Session)**
**Held at 11.00 on 2 November 2017, Boardroom, Chelsea and Westminster Hospital**

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

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| **1.0** | **GENERAL BUSINESS** |
| 1.1 | **Welcome and Apologies for Absence**<br><br>Apologies: noted.<br>The Chairman welcomed all to the Board, which had been extended in public by 30 minutes to bring more matters in public session than in closed session. The Chairman welcomed Colleen Roach, attending for the Care Quality Commission, Gill Holmes who had now joined as Director of Communications, Steve Gill who had now started as Non-Executive Director, with Gary Sims who had sent apologies. The Chairman noted that Jeremy Loyd had now retired as Non-executive Director, but would attend the Governor Away Day where the Trust would say goodbye to him and to Lead Governor, Susan Maxwell. Jeremy attended without a vote. |
| 1.2 | **Declarations of Interest** |

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| | Dr Andy Jones was due to become CEO of Ramsay Healthcare UK, a member of the Global Executive and director of Ramsay Healthcare UK Operations Ltd. The company is listed on the Australian stock exchange. Formerly Dr Andy Jones had worked for Nuffield Health.<br><br>Sir Thomas Hughes-Hallett reported his interest in HelpForce CIC which appeared later on the agenda. He is the Founder, Chair and main funder of Helpforce. He reminded the Board he is an adviser to Optum. |
| 1.3 | **Minutes of the Previous Meeting held on 7 September 2017**<br><br>Minutes of the previous meeting were approved as a true and accurate record of the meeting. |
| 1.4 | **Matters Arising and Action Log**<br><br>All actions marked green were accepted as complete and to be removed from the action log.<br>1.5.a KJ confirmed discussions were underway - complete<br>2.3.a KL confirmed there was a link in the workforce report provided at item 2.5.2 - complete |
| 1.5 | **Chairman's Report**<br><br>The Chairman presented his report, which was noted and highlighted:<br><br>• Lead governor elections: Nominations closes later today<br>• Governor elections: There is no candidate from the Richmond Upon Thames constituency. NG will discuss with the local authority.<br>• Annual Members Meeting: PN would brief THH on follow up to questions from the audience.<br>• Health and Wellbeing: This group would not be a Board Committee and would report into People and Organisational Development Committee. |
| 1.6 | **Chief Executive's Report, including:**<br>• 1.6.1 Hammersmith & Fulham Integrated Care Partnership: Approval of Partnership Agreement<br>LW presented her report, which was noted and highlighted:<br>• Trust response to terrorist incidents was commendable.<br>• A&E and cancer targets achieved, referral to treatment target (RTT) was not meeting the standard but was a key focus for the organisation..<br>• Winter planning was underway and NHSI & NHSE had complemented the plans so far. The Trust anticipated increased non-elective volumes during the second half of the year.<br>• Staff awards were always a great opportunity to recognise our team, this year there was particular feedback that we felt like one organisation.<br>• THH wished to speak to finance. THH took the opportunity to highlight the achievements of SE and her team in the face of some very considerable financial challenges.<br><br>EH complemented the Team briefing. On the 'You Said, We Did' section, she asked if learning boards were now placed throughout the hospital? PN replied that learning boards now exhibit Team briefing and Local learning across all ward areas. THH noted that the Membership report needs improvement to mirror the progress made with Team briefing and GH would take this forward. |

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| | JJ asked what the measure of success was for Frailty actions under Winter Planning? RH noted these would be a reduction in readmissions, length of stay, acquisition of infections, with a particular focus in volunteering strategy.<br><br>SG asked whether there were any objectives for the visit from Simon Stevens, Chief Executive of NHS England. LW said this was about Winter planning. Opportunities would be taken to highlight financial performance. NG noted the Shaping a Healthier Future, Strategic Outline Case (SOC 1) had been submitted although as the recent press coverage stated, the case had not been approved by NHSI in its current form.<br><br>• 1.6.1 Hammersmith & Fulham Integrated Care Partnership: Approval of Partnership Agreement<br>LW noted this was not a significant amount of work to the organisation in its current form.<br>JJ confirmed Finance and Investment Committee (FIC) looked at this on 31.10.17 and were reassured, noting that the value NHS funding for this partnership was circa £40m.. EH noted FIC were reassured on bandwith and workload in the short to medium term. It was noted the informal Strategy Group were considering integrated care proposals and were report back to Board in due course.<br>NG supported the proposal but queried how those not within the geographical coverage would be affected. LW noted this was a difficult question. London wide work was underway to ensure consistency and standard agreements eg on elective patient pathways which may help.<br><br>The Board approved the proposal with enthusiasm, noting that there was no separate legal entity created. |
| **2.0** | **QUALITY/PATIENT EXPERIENCE & TRUST PERFORMANCE** |
| 2.1 | **Patient Experience Story**<br><br>Bryony Martin community neonatal sister, and Belinda, mother of Nicholas were welcomed to the meeting. Belinda explained how Nicholas had been a neonatal inpatient for three and a half months after birth at 25 weeks, with 2 months ventilation. She praised the care provided, feeling that Nicholas' good health now was a direct result of the Trust's treatment.<br>Belinda had provided a patient voice to the design team for the neonatal rebuild with the aim of giving parents as much time as possible with their babies. This had included looking at the parents' room being closer to the entrance; improved visibility to let parents in to the unit more quickly; better breast feeding facilities, including for expressing milk; parental chairs which allow holding babies on ventilation for long periods; lockers for parents to avoid infection on the unit but allow security and bed placement to recognise more premature or sicker babies.<br>PN noted the Trust had been very keen to have patient input in to the design, which had definitely brought up things which may have been overlooked and thanked Belinda for her very valuable contribution. The Trust had a rare opportunity to rebuild a whole area. Bryony added that from 16 years' experience of working on the unit, it had definitely outgrown the space. If it can be made world class, it will be easier to attract and retain staff.<br><br>The Board thanked Bryony and Belinda for coming to present, noting that work had begun on the building project, and wished them well for the future. |
| 2.2 | **Our approach to improvement culture** |

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| | PN and RC gave the presentation, highlighting<br>• The three phases: standardisation, implementation and sustainability<br>• Support from the Kings Fund, lessons for NHS Board<br>• Support from NHS improvement<br>• Culture of continuous improvement<br>• Staff enthused, enabled and empowered<br>• Better visibility of improvement work<br>SG asked about gathering feedback from staff. RC said this is built into the Care Quality Programme (CQP) asking for ideas for improvement; team briefing; Personal Development Reviews (PDRs) including Objective Setting. We are building components of this in our induction programme<br>ND said it would be good to have case studies of improvements and LW confirmed staff regularly present on improvements as part of Team Brief.<br>JJ highlighted this is an area where technology can help.<br><br>**Action:** To investigate how technology can assist with Friends and Family Test and possible wider feedback. PN GH<br>EH and PN noted Quality Committee are considering this. LS was keen to look at this as part of a wider communications issue. THH asked SG to help shape it |
| 2.3 | **IMPACT Study**<br><br>David Asboe (DA), Ann Sullivan (AS) and Michael Rayment (MR) attended for this item.<br>AS introduced the project as 'game changer' in the HIV epidemic in London. The Trust is working with the National Institute for Health Research (NIHR), NHS England, Public Health England (PHE). 150 clinics would open across country. Last year C & W largest recruiter to infectious diseases research.<br>MR explained PrEP was a bio medical intervention as part of combination prevention; behavioural intervention has the most significant impact. The placebo controlled trial was complete, this was a real world implementation trial. Men who had received the PrEP immediately had an 86% reduction risk. There had been complications around discrepancies on commissioning, which NHS England were looking at.<br>This was a large study which went live at 5 months, not the normal 12 months. The first three clinics were through the Trust and the Trust now had >600 patients in the trial. There was a need to roll out to populations beyond that of men who had sex with men. The group would like to report back to the Board in 2-3 years.<br>LW said this was a great example of the Trust's commitment to an improvement culture and staff working frontline to improve patient care and outcomes<br>THH congratulated the group and thanked them for the presentation. |
| 2.4 | **Serious Incidents Report**<br>PN presented the paper which was noted. She highlighted:<br>• 2 never events:<br>• One medication wrong route. No harm resulted. Medication was not delivered. Remedial action: training and supply of nasogastric tube EnFIT syringe.<br>• One ABO incompatible blood component. No harm resulted. Remedial action: training. This was reported previously but not as a never event. |

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| | • 3 serious incidents this month<br>• Hospital Acquired Pressure Ulcers (HAPU) Grade 3 & 4 continued to reduce: 19 this time last year, 9 now. Reduction initiatives now extending to grade 1 & 2 sores.<br>• Patient falls were another priority. Patient bundles were in use. The Trust is starting to see the benefits.<br>• At the report date there were 41 outstanding actions. Shan Jones had worked closely with the teams and there were now only 8 outstanding actions.<br>EH said Quality Committee had scrutinised the reports in more depth. She commended the Trust on HAPU results and there had been some reduction falls. She also commended the progress in closing SI actions and in learning.<br><br>No questions |
| 2.5 | **Integrated Performance & Quality Report, including**<br>**2.5.1 Winter Preparedness**<br>RH presented the report which was noted and highlighted:<br>• A&E targets: achieved in October, not September<br>• In the last 7 months, an additional 11,000 patients had been seen at A&E<br>• Cancer 2 weeks: both sites achieved<br>• Cancer 62 days: achieved September. October sitting at 96% but yet to close the month<br>•<br>• A&E Delivery Board met yesterday. NHS I highly complementary about the functioning of the Board<br>THH congratulated the Trust on performance and asked what degree of self-funding there was. RH confirmed capital contribution of £900,000 from NHS I, but we are paying for the additional staffing. SE said this would be off-set by income from additional activity volume. On-going costs, had just been locked down with commissioners.<br><br>JL asked about design capacity of A & E. On current trends when would capacity be reached? RH confirmed built capacity has tolerance, and he would have to come back on a projection to capacity.<br><br>**Action:** model when A&E will reach capacity on current trends RH<br><br>EH asked when RTT targets will be in line, noting the human factor on patients waiting. RH confirmed trajectory for compliance by January 2018. The Trust is seeing patients in the right order, so backlog is lowest it has been. No 52 week wait for over a year.<br>LW confirmed she had focussed pressure on backlog and was much happier. JL noted these were compliance targets, not a measure of experience.<br>NG said he had raised at Quality Committee MRSA: PN replies there had been a Root Cause Analysis about MRSA and CDiff. MRSA had been addressed by implementing a sampling process. Incorrect CDiff sampling had been used at the West Middlesex site, which had been addressed through training.<br><br>**Action:** THH asked Quality Committee to look at how the Trust can constantly improve the patient experience around postponed interventions or operations. PN confirmed she will bring a paper to the Board.<br><br>**2.5.2 Workforce Performance Report - Month 6**<br>KL presented the Workforce Performance report, which was noted and highlighted: |

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| | • The vacancy rate was improving. Qualified nurse and midwifery categories were still a challenge, but overseas recruitment should help.<br>• Core training compliance stands at 85% against our target of 90%<br>• Not in the report, the flu vaccination target is 70% of front line workers. The Trust's internal target is 75%. By the end of Oct we had 31%, which is better than this time last year. We aim to achieve target by mid December.<br><br>JJ asked about the quite high turnover rates. KL said some issues are specific to those areas, which is picked up by HR business teams. PN confirmed no ward constantly has higher turnover rates. The Trust is participating in the NHSi nursing and midwifery retention programme: our plan has been well received by NHSi. LW added there are deep dives for every ward / area looking at what remedial actions are needed.<br>SG asked if the Trust gathers feedback from leavers. KL confirmed that had started recently. SG queried the timing of performance and development reviews(PDRs). KL confirmed the until April 2017 timing was linked to increments but this has been changed so that staff now have their PDRs at set times of the year which are determined by seniority.<br><br>EH said one of the biggest risks was to not achieve reduction in vacancies, improve retention etc. Can there be a Board focus on this topic? KMO: confirmed KL and LS are setting the scope for that work to start in early 2018. THH queried if financial investment would bring about quicker improvement.<br><br>**Action**: Board focus in early 2018.<br><br>EH referenced discussion in Quality Committee and asked if by today's date, Winter Planning reds were now green. RH confirmed no but said they soon would be. |
| 2.6 | **Mortality Surveillance Q2 Report**<br><br>RC presented the report, which was noted.<br>One case involved possible deficiencies in care. This had been automatically flagged to report and investigate as serious incident.<br><br>No questions |
| **3.0** | **STRATEGY** |
| 3.1<br><br>a. | **Volunteering Strategy Implementation Update**<br><br>Rachael Allsop, Head of Volunteering Services presented the report, which was noted, and she highlighted:<br>• Local partnerships were engaged<br>• The workforce was very helpful<br>• Since the report, two more roles were requested<br>• More applications were rejected than previously.<br>• The current target was to reduce application to start time from 27 weeks to 6 weeks, but this |

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| | would be reviewed further.<br>EH welcomed the work as part of the patient experience portfolio organisationally. The challenge was how to accelerate the pace to achieve in this in less time. |
| 3.2 | **EPR Programme Update**<br><br>KJ presented the paper, which was noted, and highlighted:<br>• Virtual hospital was being built.<br>• Staff engagement is stepping up<br>• Risks and issues were exactly what you would expect, same as other Trusts. Grounds for optimism on all of these.<br>THH asked for priority briefing 2 new NEDs.<br>**Action:** KMO to arrange SG, GS, ND, KJ meeting, thinking about demonstrable expertise<br>GS to then review governance arrangements in Audit Committee<br><br>ND asked if the data quality work programme was looking ready for April 2018 live date at West Middlesex site. KJ confirmed the team was working through all issues. At this point they were making good progress and were on track.<br>LW asked if we are learning about what we might have missed from other EPR roll outs. KJ confirmed we are. EH asked for the presentation of risks to include actions taken to ameliorate them at the next presentation. |
| **4.0** | **GOVERNANCE AND RISK** |
| 4.1 | **Board Assurance Framework**<br><br>KMO presented the report, which was noted, and he highlighted:<br>• By January Board we will have a risk rating for all of the strategic priorities<br>• Board agendas are picking up the strategic issues on the BAF.<br>• There will be a report back on strategic tracker every other board, which should enable a trend analysis.<br><br>**Action:** THH asked KMO to circulate black swan list sop that the Board can contribute to it.<br>EH noted this was discussed at Chair's triangulation meeting and it was very helpful to use. |
| 4.2 | **Business planning 2018/19**<br>SE presented the report, which was noted, she highlighted:<br>• In April 2017 the Trust agreed a 2 year financial plan.<br>• In the refresh, the high level financial plan will be in line with the control total of £12.9m<br>• Normally at this stage the Board would see a first draft, with a full plan in January/ February, but for a report by January Board it is not clear the Trust will have certainty around inflation and pay awards.<br><br>THH referred to other Trusts and noted the Trust can only agree to what it can actually achieve.<br>LW agreed and noted that central discussions were on-going. |

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| | **Action:** Bring back to Jan Board SE |
| **5.0** | **ITEMS FOR INFORMATION** |
| 5.1 | **Questions from members of the public**<br><br>Governor Tom Pollock referred to the Chief Executive's report and the underlying deficit of £13.2 m, asking how this could be bridged. SE confirmed the Trust expects £14m sustainability and transformation plans (STPs) funding and some transactional funding. There was a planned surplus of £11.9. If this funding were lost, there would be a deficit position, but STP funding is agreed to the end of the next financial tear. LW said the STP money in essence was put in place to recognise the marginal rate paid for emergency care and should continue. JJ said the big risk next year was the Cost Improvement Programme (CIP) requirement of £25.1m.<br><br>Governor Anna Hodson-Pressinger asked about staff recruitment and pay. She had been approached by band 6 & 7 nurses who said their earnings had not been properly communicated in the recruitment process. Was there an issue and how could this be improved?<br>LW said that the governor had written to her today about one person, which was an agency nurse. The Trust did not mislead staff in terms of what they would be paid or their grade. When recruiting overseas, the Trust sent its own nurses and doctors. Payment of staff is set nationally by band.<br><br>Governor Tom Pollock raised the issue of bicycles at the entrance. Can this issue be raised with Transport for London and the Royal Borough of Kensington and Chelsea.<br><br>**Action:** KMO will see if anything can be done. Governor Tom Pollock to assist. |
| 5.2<br><br>a. | **Any Other Business**<br><br>None.<br>Meeting closed at 13.31 |
| 5.3 | **Date of Next Meeting – 11 January 2018** |

**Trust Board Public – 2 November 2017 Action Log**

| Meeting | Minute Number | Action | Current Status | Lead |
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| **Nov 2017** | **2.2** | Our approach to improvement culture<br>Action: To investigate how technology can assist with Friends and Family Test and possible wider feedback. | Complete. Included in Patient Experience Report. | **PN/GH** |
| | **2.5** | Integrated Performance & Quality Report, including 2.5.1 Winter Preparedness<br>Action: Model when A&E will reach capacity on current trends. | Verbal update under Performance Report item | **RH** |
| | | Action: THH asked Quality Committee to look at how the Trust can constantly improve the patient experience around postponed interventions or operations. PN confirmed she will bring a paper to the Board. | Quality Committee to discuss with Forward Plan at Committee 26 January. | **PN** |
| | | 2.5.2 Workforce Performance Report - Month 6<br>Action: Board focus in early 2018, to include proposals eg expenditure. | Complete. This is on Forward Plan for March Board. | **KL** |
| | **3.2** | EPR Programme Update<br>Action: KMO to arrange SG, GS, ND, KJ meeting, thinking about demonstrable expertise. | Complete. NED IT Lead confirmed collective capability; included in Business Strategy Group discussion. | **KMO** |
| | | GS to then review governance arrangements in Audit Committee. | Complete. Verbal update at meeting (GS). | **KMO** |
| | **4.1** | Board Assurance Framework<br>Action: THH asked KMO to circulate black swan list sop that the Board can contribute to it. | Complete.<br>Emailed on 14 November 2017. | **KMO** |
| | **4.2** | Business planning 2018/19<br>Action: Bring back to Jan Board. | This is on current agenda. | **SE** |

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| | **5.1** | Questions from members of the public<br>Action: KMO will see if anything can be done. Governor Tom Pollak to assist. | We are liaising with the RBKC and awaiting a date for a site visit. In the meantime Trevor Post has been reviewing the signage outside the hospital to help direct cycle users to avail of the cycle facilities in the car park, together with making improvements to our existing spaces. Governor Tom Pollak has been invited to assist. | **KMO** |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

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| **AGENDA ITEM NO.** | 1.5/Jan/18 |
| **REPORT NAME** | Chairman's Report |
| **AUTHOR** | Sir Thomas Hughes-Hallett, Chairman |
| **LEAD** | Sir Thomas Hughes-Hallett, Chairman |
| **PURPOSE** | To provide an update to the Public Board on high-level Trust affairs. |
| **SUMMARY OF REPORT** | As described within the appended paper.<br><br>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**
**January 2018**

## 1.0 Welcome

I would like to take this opportunity to wish everyone a Happy New Year! As I look back as Chairman over the Trust's achievements in 2017, I am incredibly proud of the contribution and commitment to improvement which the Board has seen across the Trust. 2018 will bring considerable challenges, but I am confident we have the ability to meet them.

## 2.0 Christmas

I really enjoyed attending the Christmas events at both West Middlesex and Chelsea sites, with the chance to meet patients and staff. We are thankful as ever to the Governors and staff for the time and effort they put in to make these events a success. I was particularly grateful to our wonderful school choirs who sang so beautifully.

I join the Chief Executive in thanking all those staff who worked over Christmas to bring care and attention to all patients, and would add my thanks to Lesley, who herself was in the Trust on Christmas Day, as she has been since her appointment.

## 3.0 Care Quality Commission (CQC) inspection

I defer to the Chief Executive for comment, but would like to say that I have been very impressed by the preparation which I have seen, including the opening presentation to CQC, which I was keen to circulate; it was such a good summary of our Trust's work. We are moving into the 'Well Led' CQC inspection this month and hope that we have the chance to show our progress and commitment to values.

## 4.0 Governor Elections

New Governors have been elected in five constituencies: Christopher Digby-Smith, Patient governor; Martin Lewis, Public Governor, City of Westminster; Mark Nelson, Staff Governor, Class: Medical and Dental; Richard Ballerand, Public Governor, Royal Borough of Kensington and Chelsea; Jodiene Grinham, Staff Governor, Class: Contracted. The Council of Governors meeting of 30 November 2017 noted with particular thanks the contribution of former governor Philip Owen, which I heartily endorse. Governor Paul Harrington resigned on 30 November, and I would also like to thank Paul for his public service to the Trust. There are now two governor vacancies for the London Borough of Richmond as there was no candidate in the previous election and nominations will have closed by the time the Trust Board meets.

## 5.0 Lead Governor Elections

I was pleased to hear that both candidates, Anna Hodson-Pressinger and Dr Simon Dyer gave inspirational presentations prior to the Council of Governors' election of lead governor. Simon was duly elected and I look forward to working with him as Lead Governor.

## 6.0 Update on Board Committee Groups

I have considered further how the Non-Executive can best contribute to the Board and have rearranged some responsibilities to take account of our new NEDs, Steve Gill and Gary Sims. To allow time for handover, any changes are effective from 1 February. Quality Committee will be chaired by Eliza Hermann, supported by Nick Gash and Dr Andrew Jones; People and Organisational Development Committee will be chaired by Steve Gill, supported by Eliza Hermann, Gary Sims and Martin Lupton; Finance and Investment Committee will be chaired by Jeremy Jensen, supported by Nick Gash and Nilkunj Dodhia; Audit and Risk Committee will be chaired by Gary Sims, supported by Liz Shanahan and Nilkunj Dodhia. In addition, Non-Executive portfolios will be: Estates, led by Dr Andrew Jones; Information technology, led by Nilkunj Dodhia, supported by Steve Gill and Gary Sims; Marketing and Communications, led by Liz Shanahan; Strategy, to include succession planning, led by Jeremy Jensen, supported by Steve Gill, Dr Andrew Jones, Liz Shanahan and Nick Gash; Health and Wellbeing, myself; Raising Concerns, Nick Gash and for the Charity, CW+, Nick Gash.

**7.0 Company Secretary**

I am delighted that we are able to welcome Julie Myers as Trust Company Secretary. Julie joins us from the Legal Services Board, where she was Corporate Director. We will bid farewell to Sarah Ellington who returns to Weightmans solicitors after her secondment with us. Sarah has done a tremendous job in her time with us and has become an admired member of the executive team. We will all miss her.

**8.0 Commissioner, regulator and local partner developments**

After a very short spell as Chief Executive of Imperial NHS Trust, Ian Dalton CBE has left to become Chief Executive of NHS Improvement and Professor Julian Redhead has become interim Chief Executive pending a substantive appointment. I look forward to seeing Ian shortly in his new role.

We are also mindful that there are changes taking place at NW London CCG level, and Lesley, in her provider lead role, is supporting colleagues to ensure we continue with our stated objectives as part of the STP.

There have also been changes at both CQC and NHS Improvement and Lesley and I will meet with our new counterparts by the end of this financial year.

Sir Thomas Hughes-Hallett
**Chairman**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting, 11 January 2018**

**PUBLIC SESSION**

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| **AGENDA ITEM NO.** | 1.6/Jan/18 |
| **REPORT NAME** | Chief Executive's Report |
| **AUTHOR** | Karl Munslow-Ong, Deputy Chief Executive Officer |
| **LEAD** | Lesley Watts, Chief Executive Officer |
| **PURPOSE** | To provide an update to the Public Board on high-level Trust affairs. |
| **SUMMARY OF REPORT** | As described within the appended paper.<br><br>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**

**November 2017**

## 1.0 Care Quality Programme

The CQC Inspectors spent three days across both sites at the beginning of December, and it was good to hear a lot of very positive comments. The CQC team was impressed with our dedicated and caring staff and positive culture. They noticed the end-of-life care had improved a great deal and was now well-embedded and compassionate. There were two unannounced visits in the two weeks that followed inspection, and we still have the Well Led inspection as the final stage of the process to complete in mid to late January. On behalf of the Trust Board I wanted to extend a huge thank you to our staff for all of their endeavours, it makes us all feel very PROUD.

## 2.0 Performance

Despite a very challenging month, especially with Paediatric demand, the Trust achieved all regulatory Quality Indicators; one of the few trusts in the country to do so. The A&E Waiting Time figure was met for November at 95.02% with the Chelsea Site achieving 95.7% and West Middlesex 94.4%. The 95.02% compares favourably with the 91.1% reported for the same month in 2016 despite nearly an 8% increase in demand for our services. For the first time this financial year, the RTT incomplete target was achieved in November at 92.3% with the Planned Care Division on the Chelsea site continuing to demonstrate month on month improvements, which is now enabling the overall Trust to report a compliant position. All reportable Cancer Indicators met the targets again in November. This is a fantastic achievement in the context of increased demand and system pressures and demonstrates the amazing efforts of all of our staff in giving our patients the very best of care.

## 3.0 Staff Achievements and Awards

Council of Governors' Autumn Quality Awards:

- Dr Rashmi Kaushal and her team for their outstanding work on a new online endocrine referrals system.
- Dr Dominika Dabrowska for adapting and introducing the "gentle" caesarean section protocol to the Trust.
- The Specialist Palliative Care Team for greatly improving the Fast Track discharge process for end of life patients, so they can be cared for in the setting of their choice.
- The David Erskine Ward Team received a highly commended.

Our latest PROUD award winners:

- Dawn Bishop, Women & Children
- Charmaine Robinson, Carolyn Lye-La and Rajesh Thaplial, Planned Care
- Hannah Balcombe, Emergency/Integrated Care

Cheer Award winners:

Chelsea and Westminster Hospital:

- Aleck Dalrymple, Senior ODP, Treatment Centre
- Cristina Sagun, Staff Nurse, David Erskine Ward
- Donna Omanjo-Dormer, Staff Nurse, Ron Johnson
- Emily Hague, Midwife, Antenatal Department
- Gina Fernandes, Receptionist, Medical Day Unit
- Hosein Farzanekhoo, Diagnostic Radiographer
- Ian Barrow, Ultrasonographer, Radiology
- Juliet Bance, Healthcare Assistant
- Linda Date, Receptionist, MDU
- Marie Courtney, Deputy Director of Estates
- Sharon Aylott, Play Specialist, Mars Ward
- Shockema Roberts, Healthcare Assistant
- Irfan Mohammed, Deputy Director of Finance
- Catherine Sands, Head, Emergency Preparedness
- Therapy Team
- Ron Johnson Ward (special mention)
- ISS Team (special mention)

Our Children's Therapies, Jupiter & Neptune and Saturn wards received best decorated awards (first-third place respectively).

West Middlesex University Hospital:

- Beau Honour, Administrator, Estates and Facilities.
- Beverley Snee, Senior Midwife/Ward Coord
- Cristina Dalumpines, Maternity Assistant
- Jessica Wickens, Occupational Therapist
- Linda Cobbing, Patient Administrator
- Naheed Ahmad, Medical Secretary, Cardiology
- Olivia Green, Physiotherapist, Orthopaedics
- Sally Dauncey, Practice Development Midwife,
- Tracy Armstrong, Paediatrics Matron, Starlight Ward
- Coronary Care Team
- Syon Ward 2 Team (special mention)
- ISS Team (special mention)

Our Gynaecology, Paediatrics and Coronary Care Unit received best decorated awards (first-third place respectively).

## 4.0 Health and Safety Executive

Following the tragic death of Damian Bowen, a laboratory technician employed by Trust at St. Stephen's Centre in October 2011 a number of internal and external investigations have taken place. The final stage of this process was the Health and Safety Executive prosecution brought against both the Trust and Imperial College. The first hearing of the case took place on 28th June 2017 at Westminster Magistrates Court. Both the Trust and Imperial College entered guilty pleas. The first court hearing to decide on sentencing took place on 16th November 2017. At the subsequent and final hearing on 12th December 2017 the Judge's summary findings were as follows;

- The court agreed with the parties' respective assessment of medium culpability;
- The Judge recognised the degree of cooperation given by the Trust to HSE; its prompt notification of the police; extensive improvements made at St Stephens, its "profound regret and heartfelt apology" to Mr Bowen's family
- The Judge acknowledged the Trust and Imperial College's submission of early guilty pleas.

Prior to the HSE case there was an Inquest to establish the circumstances surround the death of Mr Bowen held in October 2016. Mr Bowen was working alone out of hours and accessed the liquid nitrogen (LN) room at the St Stephen's Centre. He was exposed to a fatal dose of liquid nitrogen. During the Inquest, procedures surrounding the use of LN at St Stephen's were criticised, and questions were raised about the Trust and Imperial College's lone working policy and the ventilation systems at St Stephen's Centre. These provided the base of the HSE prosecution. The outcome of the Inquest was a narrative conclusion.

We have made clear at both the Inquest and subsequent HSE prosecution that the Trust has reviewed it's systems to ensure that robust and rigorous policies and procedures have been put in place to avoid this situation from ever happening again.

Finally, and most importantly, Karl Munslow-Ong, our Deputy Chief Executive, spoke in person to the family to express our deepest regret and sincere condolences.

## 5.0 Communications and Engagement

We had a packed agenda at our monthly all staff briefing sessions with staff presenting on standing against gender based violence (launching our new domestic abuse policy and referral pathways), getting ready for Cerner EPR, end of life care, sepsis and flu. Alongside the monthly CEO Newsletter there will be regular newsletters from each Division and one for Nurses and Midwives as well as all the usual team meetings and huddles to make sure everyone is fully informed of the latest Trust news. The latest all staff briefing is attached to my report.

We're working hard to ensure our new recruits are made to feel welcome with special divisional breakfasts to get to know each other, social activities such as special cinema nights in the C&W medi-cinema. Looking after all our staff is a top priority and a special Proud action group has been set up to focus on their health and wellbeing, which is chaired by Sir Tom Hughes-Hallett.

There have been many ideas and innovations from our staff all of which help with our quality of care. This has included a campaign to improve dental hygiene, a hand app developed by one of our senior occupational therapists and a new service with therapy dogs. We also marked awareness days around health with World Diabetes Day, Prematurity Day and Worldwide Stop Pressure Ulcer Day, where we have seen a significant reduction in pressure ulcers across the Trust.

We also received positive coverage in the press for our sexual health clinic at 56 Dean Street (an 80% reduction in new HIV diagnoses), and for the incredible transformation our maternity facilities will undergo thanks to a generous donation from the Reuben Foundation.

We held two successful Christmas events last month – with carol services, music and entertainment, informative stands, Santa's Grotto and more – they were well-attended and enjoyed by patients, school children, staff, volunteers and community members alike. We also had a host of wonderful VIP visits in the lead up to Christmas, and we're incredibly grateful to Chelsea FC, England Rugby Sevens and Brentford FC in particular for helping spread festive cheer.

A special thank you goes to our estates and facilities teams, as well as our contractors, for their work in developing Grottos. Particular mention should also go to our new Lead Governor Simon Dyer, and a number of other Governors for their efforts around the Grotto Christmas presents. We are, as ever grateful, to the Friends of Chelsea and Westminster Hospital for funding prizes for the Christmas Cheer and Best Decorated Ward/Department competitions.

Resources:
We have developed a video that showcases our Trust and why we are so proud of who we are and what we do: http://www.chelwest.nhs.uk/about-us/organisation/video-proud-to-care

A sepsis screening framework has also been created. The form is a very important tool for all of our clinical staff to help identify any patients who have suspected, confirmed or low-risk sepsis.

## 6.0 Update from Strategic Partnerships Board

As I have previously reported to Trust Board, the Strategic Partnerships Board (SPB) continues to monitor our various strategic work programmes. In November and December the SPB received updates on:

- Board Strategy Working Group and how we should reflect existing and future partnerships and relationships
- The North West London Sustainability & Transformation Partnership
- Our exploratory work with Accountable Care Partnerships including in Hammersmith & Fulham where, as agreed at the November Board, the FT has now signed a formal Partnership Agreement
- Other key items included:
    - Pan provider productivity programmes and in particular the NWL Joint Pathology service
    - Estate development on the West Middlesex site and the relationship with the wider *Shaping a Healthier Future* programme.

Board Strategy Working Group (BSWG)

The BSWG, led by Jeremy Jensen our Deputy Chair, has met three times between September and December as it considers our purpose, vision and brand; and the wider environment and a strategic framework for the refresh of the Clinical Services Strategy and Quality Strategy (both due in 2018). To support the work the BSWG has received *deep dive* backing packs for:

- Integrated Care
- Urgent & Emergency Care
- Planned Care
- Women's, Children's and HIV and Sexual Health

The BSWG is due to meet one final time in January and will then report back to Trust Board thereafter with its overview and recommendations.

North West London Sustainability & Transformation Partnership (STP)

The STP continues, broadly, on its twin track process:

1) A series of detailed service/system improvement initiatives focussed on closing current quality and financial gaps. The guiding principles of consolidation, scale, and standardisation where they deliver improvements are being applied to clinical and clinical support areas.
2) A smaller number of transformational programmes focussed on fundamental population health priorities such as Diabetes, Mental Health and Older Adults; and core enablers such as the Care Information Exchange, Business Principles and Workforce Development

In parallel – and as a component part of the STP – the Shaping a Healthier Future progamme continues through a complex assurance process. Strategic Outline Case (SOC) 1 which relate to outer North West London, was considered at the NHS Improvement Board in September and, in response to their questions on assumptions on the proposed reductions in non-elective admissions, four 'risk and mitigation' scenarios are being developed for return to NHSI by 19 January:

- a shortfall in the reduction in non-elective activity of 20%
- a shortfall in the reduction in non-elective activity to 16/17 plan levels
- revising assumed level of non-elective (and other activity) down to a floor financial level (where the additional cost to the health economy did not exceed 0.5% of total CCG spend)
- maximising the physical bed capacity as indicated by providers

The Trust continues to take a prominent leadership position in the STP. The CEO chairs the Provider Board, a number of our clinicians are leading the specialty based re-design programmes, and the Trust's quality, operational and financial performance helps to support our position in shaping and influencing the wider design of the health and care system.

Hammersmith and Fulham Integrated Care Partnership

As agreed at the November Board the FT has now signed the Integrated Care Partnership Agreement.

Using the learning from national Vanguard programmes such as Nottingham and Frimley, the Partnership Programme Board is now engaged in joint work with the CCG with the intent to agree a first generation contract in 2018/19. The impact on the FT will be considered by SPB and in detailed Business Planning.

Congenital Heart Disease

At the end of November NHS England announced its plans to implement new standards related to the care of congenital heart disease (CHD) patients. After an extended consultation period, commissioners have relaxed the original timelines for full achievement of these plans.

We are very pleased that NHS England has not proceeded to decommission paediatric congenital heart disease services from Royal Brompton Hospital (RBH) by April 2019 as had previously been outlined.

As part of the CHD consultation process, RBH submitted ambitious plans for a proposed collaboration with King's Health Partners across cardiac and respiratory medicine and research, which includes adult and children's congenital heart disease services. This would also involve a proposed long term relocation of all Brompton's services on to the St Thomas' Hospital site.

The provision of specialist respiratory and cardiac services by the Brompton forms part of a complex and vitally important network of services that ensure the highest quality care to patients in our sector. We remain firmly committed along with our other academic and health partners to find a long term solution within North West London for the benefits of patients and our world leading research.

Paediatric Surgery

The Trust has continued to work with both Imperial College Healthcare Trust and NHS England on the future provision of paediatric surgery in the sector and the wider issue of tertiary paediatrics more generally for the population of North West London. One of the central challenges has been coordinating care across three principle centres in North West London (Brompton, St Marys and Chelsea and Westminster)

The Trust is engaging both RBH and ICHT in the development of long term plans for paediatric surgery and paediatric critical care and will begin work on a second tranche of service lines from January 2018.

## 7.0 External Reviews

A list of the external reviews for the next few months is appended to this report.

## 8.0 Electronic Patient Record

The EPR Gateway 2 report has been produced by E&Y at the request of the Trust Board to provide external assurance on the progress of the EPR programme. The report notes that the gateway criteria have been met and that the level of risk being carried into the next stage of the programme is low. Overall this is very positive but we remain focused on the scale of the challenge ahead of us. There is a series of events from 9 to 11 January for representative staff to review the Cerner EPR system as well as a second Countdown to Cerner event for the leadership team. All WMUH staff will be attending familiarisation training over the coming few weeks ahead of further classroom based training in preparation of the go live in Quarter 1 of 2018-19.

## 9.0 Finance

In November, we achieved a £1.4m surplus, with a year to date position of £4.6m surplus (on a control total basis), which is in line with our plan. The Use of Resources rating is 1, in line with plan and the Trust performed in line with plan for all areas except for agency spend which is adverse to plan. However, there has been a reduction in agency costs in November compared to the average for the first 7 months of the year.

The year to date underlying financial position is a deficit of £14.9m, so we need to continue our efforts to control pay costs and treat the planned number of patients. We have achieved 51.34% of our 2017/18 savings target of £25.9m against planned year to date achievement of 58%. We need to continue to work hard in the remainder of the year to improve CIP delivery and achieve our target.

**Lesley Watts**
Chief Executive Officer
January 2017

**APPENDIX 1 - 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 | Info/ Timetable |
|---|---|---|---|---|---|---|---|---|---|---|
| **January 2018** | 9th January 2018 | NHSE | CW/WM | Neonatal Critical Care Peer Review | Zoe Penn | James Beckett | Dr Mark Thomas | WCHGDPP Divisional Board | Trust Compliance Group | |
| | 16th Jan 10:30-12:30 | GRIFT | | ENT | | Bruno Botelho | | | Trust Quality Improvement Board | |
| | 22nd, 23rd & 24th January | Well led inspection | CW/WM | | Pippa Nightingale | | | | | |
| **February 2018** | | | | | | | | | | |
| **March 2018** | 12th to 14th of March 2018. | United Kingdom Accreditation Service ( UKAS) | Audiology, West Middlesex University Hospital Site | Physiological Services accreditation (IQIPS) | Mr Peter Dawson | Faizal Mohomed -Hossen | Karlien Van Staden Deputy Head of Audiology/Gillian Ross, Head of Audiology 020 8321 5681 | Planned Care Division Board | Trust Compliance Group | March 2018 |

# All staff briefing

December 2017

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

**CQC**
Care Quality Commission inspection will be on both sites during 5th, 6th and 7th December. We should anticipate there will be an out of hours visit and some unannounced visits between 7– 17 December. Please contact your line manager and Site Manager if the inspectors visit your area. There's more details on the intranet under Staff Handbook, and you can pick up a little 'Top tips' guide (available from the Communications offices on each site.) New ID holders are also available for your lanyards from the Security desk on each site.

Thank you all for your hard work and commitment leading up to this inspection, the teamwork has been very visible over the past months. The inspection is an opportunity to highlight our services and staff, as well as learning about where we need to put our efforts to continue our quality journey together. Don't forget to reflect upon all the positive things you do in your roles in delivering high quality care to patients.

If you would like any more information, please speak to your line manager or access the Care Quality Programme intranet page:
http://connect/departments-and-mini-sites/cqp/

**Quality care update**
Our latest performance for the month of October shows that we are doing well across our key measures, including:

| | Target | CWH | WMUH | Combined | YTD |
|---|---|---|---|---|---|
| | % | % | % | % | % |
| A&E 4 hour wait | >95 | 94.4 | 95.5 | 95.0 | 94.4 |
| Cancer 2 week | >93 | 95.6 | 94.7 | 95.1 | 92.6 |
| Cancer 31 days | >96 | 97.8 | 100 | 99.0 | 99.2 |
| RTT incomplete | >92 | 90.8 | 93.1 | 91.8 | 91.0 |

**Uniform and Dress Code – Scrubs**
There has been an increase in the number of staff who wear scrubs inside and outside of the hospital which is not in line with the policy. Areas that wear scrubs do so primarily to protect patients as part of infection control procedures. The wearing of scrubs to the restaurants, coffee shops and outside the hospital is not permitted. Staff should ensure that they read the relevant section of the policy which can be accessed on the intranet here.

In addition there has been an increase in staff working in wards and departments who should wear uniform being seen to wear scrubs. If you are having difficulty in obtaining a uniform this should be escalated to the Directors of Nursing for each site: Nathan Askew (CWH) and Vanessa Sloane (WMUH). Agency staff should arrive with an appropriate uniform and should not expect to be issued with scrubs on arrival.

**New Adult Sepsis Screening Tool**
Sepsis is a dangerous and potentially fatal abnormal response to an infection. It is estimated there are around 200,000 cases a year. Without rapid treatment, sepsis can lead to multiple organ failure and death with a mortality rate of 29%. So it's vital we catch it as quickly as possible. We now have a new screening tool to help spot the signs of Sepsis early. It can be found on the intranet at http://connect/departments-and-mini-sites/sepsis/ and should be used for adult patients at both sites – inpatients and ED. Please familiarise yourself with the guidance. Training for clinical staff will begin very soon and there will be an on-going audit of compliance. Separate policies for paediatrics and maternity are available on the intranet.

**Financial Performance**
In October, month 7 of the financial year, we achieved a small surplus of £0.09m against our monthly plan. However, the over spend on pay continues. The year to date underlying financial position is a deficit of £13.5m so we need to continue our efforts to control pay costs and treat the planned number of patients.
We have achieved 44.7% of our 2017/18 savings target of £25.9m against planned year to date achievement of 53.6%. We need to continue to work hard in the remainder of the year to improve CIP delivery and achieve our target.

**Flu vaccination**
It is vital that all staff working in frontline, patient facing services receive the flu jab. We all have a responsibility to protect our patients, colleagues and family members from infection, so please make sure you have the flu vaccine. Our target this year is to immunise 75% of our frontline health care staff and we are up to 51% at the moment, compared to 36% at the same time last year.
The flu vaccine is also offered to staff who don't work directly with patients.

The flu jab works, it doesn't give you flu, it's safe and easy to get. Just ask your line manager or pop into any number of drop in sessions, or check the intranet for details.
Just because you haven't had flu in the past, or are perfectly healthy, doesn't mean you couldn't find yourself with a serious flu infection. Don't risk the health of patients, your family and yourself – be safe, have the flu jab.

If you have any questions or are worried about the vaccine then just contact Occupational Health and Wellbeing (WMUH x 5044 and CWH x 58830).

**Cerner EPR (electronic patient record) update:**
We successfully passed a second external review of our Cerner EPR programme in November. The message was we are doing well but there is still a lot of work to do. There is a series of events from 9 to 11 January for representative staff to review the Cerner EPR system as well as a second Countdown to Cerner event for the leadership team. All WMUH staff will need to attend a familiarisation session in the coming weeks ahead of attending their classroom training. See the Cerner EPR intranet site for more information.

## Staffing

**Performance development reviews**
The cornerstone of our approach to making the Trust a great place to develop a career is good quality performance and development reviews and appraisals. Managers are therefore reminded that everyone in non-medical roles must have had a performance and development review by December 2017.

**Mandatory and statutory training**

| Division | Compliance |
|---|---|
| **Corporate** | **93%** |
| **Emergency and Integrated Care** | **85%** |
| **Planned Care Division** | **86%** |
| **Women, Neonatal, CYP, HIV/GUM etc** | **83%** |
| **Overall compliance** | **86%** |

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

Face to face sessions, where needed, can be booked: learninganddevelopmentadmin@chelwest.nhs.uk

**Staff wellbeing**
In your response to the 2016 Staff Survey 36% of our staff reported that they had experienced harassment, bullying or abuse from patients and/or their relatives and 16% said that they had experienced physical violence. We take the safety of our staff very seriously and as a result of this feedback we have held staff security focus groups with relevant staff on each site to understand more about the issue and to explore what could be done to improve things. Actions to address this issue are now in progress including reviewing security presence, training for staff on how to manage difficult situations and reviewing the literature available for patients highlighting our expectations of how they treat our staff. Further initiatives are underway and more details will be provided on this going forward.

**Latest CW+ PROUD award winners**
Well done to our latest winners who have all demonstrated how they are living our PROUD values.

- Planned Care – The knee clinic team, nominated by a patient who has been attending the clinic for many years and who described the clinical and clerical staff as being 'simply fantastic'. 'As a team they work together seamlessly. Their attitude is extremely professional' and they are 'friendly, competent and slick in the running of the department. Nothing fazes them'.
- Emergency and Integrated Care – Hannah Balcombe. Hannah joined the Trust approximately 6 months ago as lead occupational therapist for older people. From the moment she joined she has embraced the PROUD values, putting patients first by initiating and driving a number of projects within older people's services. These include 'Get up and go', an initiative to encourage older patients to get out of bed when in hospital to prevent functional deterioration. She has shown real determination to lead new innovation approaches like this to improve the care of older people, drawing upon good practice she has seen in other trusts.
- Women and Children – Dawn Bishop. This is a unique role which Dawn has made her own. Dawn is passionate about providing an excellent service to young people. In a short time she has increased uptake of chlamydia screening in Sutton by over 60%. She has achieved this in challenging times by forging new relationships with primary care, pharmacy and voluntary sector colleagues and demonstrates the PROUD values in everything she does.

Visit the intranet to nominate a team or individual.

**Council of Governors awards**
The aim of the Trust's Council of Governors' Quality Awards is to recognise and reward initiatives from an individual or team who have made an improvement to the quality of care given to patients, or whose initiative has greatly enhanced the working methods of Trust staff. The Awards are presented for projects meeting all or some of the established criteria set by the governors: Patient Safety, Patient Experience, Clinical Effectiveness and the Trust Values. This autumn there are two winning teams and one individual winner that have been selected for their work:

- Dr Rashmi Kaushal and her team, for their outstanding work on a new, on-line endocrine referrals system, which has resulted in much improved and quicker patient referrals and reviews.
- Dr Dominika Dabrowska, for adapting and introducing the 'Gentle' Caesarean Section Protocol to the Trust.
- The Specialist Palliative Care Team, for greatly improving the Fast Track discharge process of patients at the end of life.

The next Trust Quality Awards will be launched during spring 2018 - further details nearer the time.

**Christmas events**
At each of our hospitals we will be holding our popular Christmas events:

- Friday 8 December 3 – 5pm at CWH
- Wednesday 13 December 3 – 5pm at WMUH

These will be fun, festive events, with carol services, music and entertainment, stands, Santa's Grotto and much more! The events are free to attend and open to everybody, so please invite your family and friends and tell your patients.

**Please note that there will be no All Staff Briefing in January 2018**

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.2/Jan/18 |
| **REPORT NAME** | Patient Experience Report |
| **AUTHOR** | Nathan Askew, Director of Nursing |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | To provide update and assurance to the Public Board |
| **SUMMARY OF REPORT** | This report provides an update on the performance and improvement work currently in progress for the various aspects of patient experience.<br>There are currently several improvement plans in place to address issues around policy, process and performance of the various functions of the patient experience team including the restructure of the team. |
| **KEY RISKS ASSOCIATED** | Reputational risk associated with poor performance in relation to patient experience metrics |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | There needs to be continued sustained improvement in the Trust position to improve the quality of care and service received by our patients |
| **EQUALITY & DIVERSITY IMPLICATIONS** | The group is supported by the E&D manager |
| **LINK TO OBJECTIVES** | Excel in providing high quality, efficient clinical services |
| **DECISION/ ACTION** | This report is provided for information |

**Public Board Patient and Public Engagement and Experience Update**

**Introduction**

This paper will provide an update and assurance to the board on the functions of the patient experience team together with a summary of the improvement work underway within the team. The paper is in response to previous concerns highlighted to the board through the quality committee in relation to the performance of the patient experience team.

**Patient experience team structure**

The current team structure sees all aspects of patient experience reporting to the associate director of patient experience in a site based model. All other support functions within the Trust such as Finance and HR have moved to a division aligned business partner model. The current structure causes duplication of work and is not efficient.

The proposed new structure will see the team split into two main parts; the complaints, PALS and bereavement team and the FFT, national surveys and PREMS team. All teams will work across site and be aligned to the divisions with the exception of the PALS and bereavement services which will remain site based. This proposal has been well received by the team and the divisional management teams, providing more support particularly to the complaints functions of the service.

The patient experience team are undergoing a formal consultation on the proposed new structure and ways of working which ends on the 31st December 2017. There will be a period of notice of the change and some training for staff which will see the new structure in place during March 2018. The new structure will also require some recruitment to new posts which should be filled early April 2018.

**National Surveys**

The Trust has participated in four national surveys which focus on the Emergency Department, Adult inpatients, Maternity services and children and young people's services. The results for the ED survey and Maternity services have been very positive with excellent feedback about the care that our patients receive.

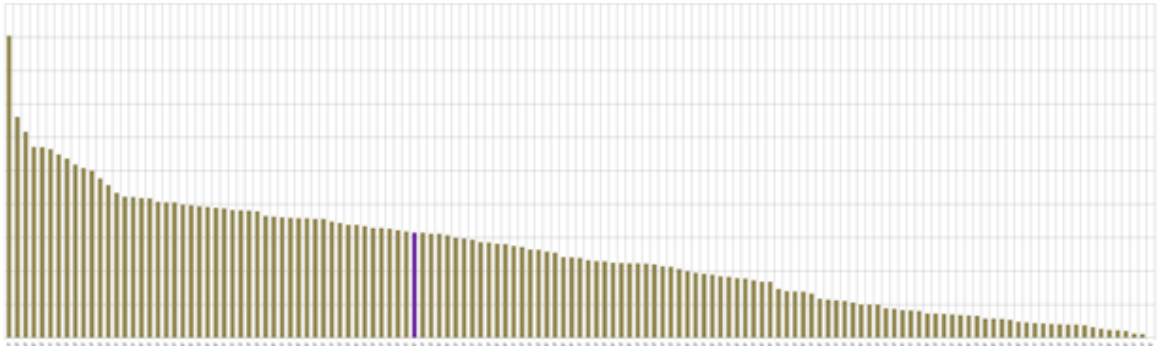
The children's and young people services survey has been received by the Trust and the directorate are currently finalising the action plan associated with the survey results. The adult inpatients data has been collected and will be available in 2018 to the Trust.

**FFT**

The Trust consistently meets the FFT target on 30% response rate and 90% recommended rate for inpatient areas. The qualitative feedback is also used within departments to make changes and improve services, displayed on the PROUD boards.

The trust continues to struggle to meet the 30% response rate target in ED, Sexual Health, Maternity and paediatrics. The trust currently has a blanket target across all areas of a 30% response rate and 90% recommended score which may need to be negotiated.

For Example only 3 Trusts nationwide achieve over a 30% response rate with only an additional 18 Trusts achieving above 20% response rate for their ED departments. Nationally CWFT is ranked 50 out of 139 trusts. The average response rate nationally in 12.5% and CWFT sit above this at >15% response rate.



The average E recommended score is 88% and CWFT achieve 90%, above the average. Interestingly of the Trust who utilise SMS messaging as their primary means of FFT survey CWFT is the 2nd best performing Trust nationally.

The Trust therefore have 3 strands of work which aim to address these issues:

*1 – Contract negotiation*

The Director of Nursing has begun discussion with the lead for Quality at the CCG in respect of the contract targets and possible need for variation. Given the national picture it is suggested that the current targets should be adjusted for each of the areas to provide stretch and challenge but to also be achievable. It is anticipated that any contract variation can be agreed for the start of the next financial year.

*2 – Data collection*

The current method of data collection relies heavily on SMS messaging and is outsourced to an external provider. The contract for this provider is under review and the decision has been made to change the data collection method and retender the contract.

The Trust will maintain an SMS service for specific areas of the Trust which will be supplemented with an in house solution for FFT data collection. The retendering process and switch to alternative supplier / method of collection is expected to be in place by the end of this financial year.

*3 – Service Redesign*

The service currently relies heavily on external resources and the feeding of data to departments and divisions. By retendering the service above this allows the team to invest in a patient experience officer at each site who will have 3 main areas of responsibility:

- Supporting the data collection with hand held devices on wards and departments

- Collecting supplementary Patent Reported Experience Measures (PREMS) across all Trust services
- Working with department leads to review data and trends and make changes in practice to improve patient experience.

These changes in service provision are reliant on the change in FFT supplier contact and therefore will be in place towards the end of Q1 2018.

**PREMS**

Traditionally the Trust response to national surveys has been heavily reliant on the development of an action plan to address areas of poor feedback or performance. For some questions measured this has resulted in little or no improvement. This is often attributed to the aggregated data which is not ward or department specific.

The patient experience team are about to undertake a change in methodology from annual survey and action plan to continuous measurement and improvement with data available at ward and department level.

For the first wave of trials the feedback form the children's and young people survey and the adult inpatient survey has been utilised. Themes which evaluated less positively have been selected. Each day the patient experience officers will ask a selected number of patients in each ward and department the 5 questions with data available in real time represented in SPC run charts. Ward and department managers will have feedback each day for their which in collaboration with the PE officer can be utilised to improve experience at ward level.

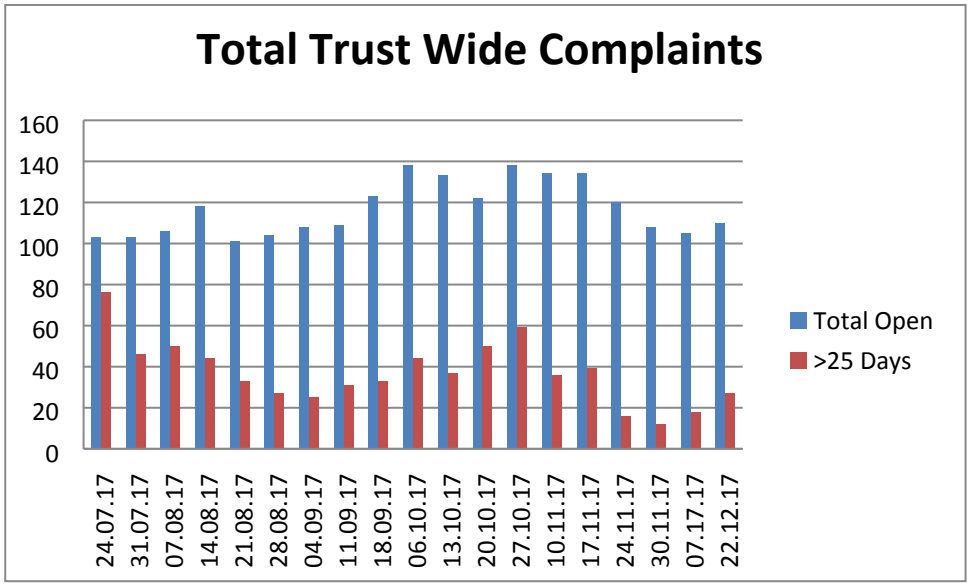
The pilot will focus on the roll out of questions to 2 paediatric areas (1 at each site) and 8 adult areas (2 medical, 2 surgical) at each site. The pilot should run through Q1 and Q2 with rapid expansion in the second half of the next financial year. The questions are currently being refined and the data collection software tested.

**Complaints**

The Trust performance in respect of formal complaints continues to be a challenge. There has been a sustained improvement in meeting the target of 2 workings days response time for acknowledgement of complaints, responding within 25 working days continues to need improvement.

There has been an improvement in clearing the backlog of overdue complaints which at its peak saw in excess of 80 complainants waiting more than 25 days for a response. The longest waiting complaint has now also reduced to be from the end of September (3 months) which is an improvement from previous longest wait of 11 months.

There was a small rise in overdue complaint responses following the CQC visit and around the Christmas period. This was caused partly due to an increase in complaints logged in October / November and some sickness in the complaints team. Planned care division continue to be most challenged in terms of performance, with large increases seen in Emergency and integrated care performance who have reduced their backlog from 26 to 3.




| Formal Complaints | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2017-18** | Q1 | | | Q2 | | | Q3 | | | Q4 | | | **Total** |
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | |
| Corp | 0 | 0 | 3 | 1 | 0 | 1 | 6 | 3 | | | | | **14** |
| EIC | 11 | 15 | 17 | 13 | 25 | 19 | 32 | 15 | | | | | **147** |
| PC | 17 | 13 | 18 | 16 | 18 | 23 | 28 | 15 | | | | | **148** |
| WCHGDPP | 16 | 15 | 21 | 11 | 21 | 20 | 15 | 11 | | | | | **130** |
| Total | **44** | **43** | **59** | 41 | 64 | 63 | **81** | **44** | **0** | **0** | **0** | **0** | **439** |
| | | | | | | | | | | | | | |
| Ack <2 days | 43 | 42 | 48 | 36 | 61 | 60 | 77 | 40 | | | | | 407 |
| % | 98 | 98 | 81 | 88 | 95 | 95 | 95 | 91 | 0 | 0 | 0 | 0 | 92.71 |
| Res <25 days | 14 | 13 | 13 | 17 | 23 | 15 | 21 | 1 | | | | | 95 |
| % | 32 | 30 | 22 | 41 | 36 | 24 | 26 | 0 | 0 | 0 | 0 | 0 | 22 |

*Please note: November reporting period not currently completed

In an attempt to address some of the performance issues the patient experience team are undergoing a restructure through a formal consultation process as detailed above. The support offered to each division in the new model will increase drastically and by moving to a business partner model it is envisaged that each division will have the support and ownership of their complaints to improve performance. As outlined above this new structure should be fully operational in April 2018.

In addition the current policy and process of complaint management is not meeting the needs of our patient or the Trust. There is a current blanket 25 working days target for all complaints. If a complaint is lined to a serious incident (which has a 65 day investigation time) it is impossible to address fully the issues in the complaint until the incident has been investigated.

Therefore the complaint policy and process will change to include appropriate time extensions to complaints, communicated effectively to the complainant, and an escalation for complaints which

are breaching investigation time to prevent where possible those complaints breaching the response deadline.

The process for identifying incidents through complaints is currently being reviewed and will formulate part of the revised policy.

These changes will be in place in parallel to the formal consultation process and fully operational by April 2018.

**Bereavement**

CW+ have kindly provided a £10K grant to improve the mortuary viewing facilities at the CW site, to include a refurbishment of the family viewing room and also to widen the doorway to make the transfer of bariatric patients easier. In addition business cases for the expansion of cold storage facilities in both mortuaries are in process. These changes, if agreed will be facilitated in the next financial year.

As the bereavement and patient affairs teams across both sites come together under the patient experience team structure there will be the development of a cross site care of the deceased adult and care of the deceased child policy and process. The current training model for staff will also be reviewed and refreshed. Utilising best practice in the development of these services the new policies and process should be completed in Q1 and 2 of 2018-19.

There are now 4 completed butterfly rooms, for care of patients in their last hours of life, on the CW site and 1 completed room on the WM site with discussion already underway on which areas will benefit next from the development of these rooms, kindly supported by the Friends charity.

**Patient and Public Engagement and Experience Group**

The PPEEG has been renamed to reflect the full range of the work undertaken by the group, revised terms of reference agreed and membership refreshed. The group benefit from active participation of 2 patient representatives and a patient governor as key members.

The group now have a structured agenda which covers all aspects of patient experience and provide a level of oversight and challenge to the divisional teams on all aspects of their work.

The PPEEG receive quarterly reports from the following groups and report formally quarterly to the Quality Committee

- End of Life Care
- Children's Board
- Learning Disabilities
- Volunteers
- PLACE
- Equality and Diversity

The group is currently also receiving feedback form the Youth Forum, Maternity voice and patient voices groups who provide updates on a wide range of issues to the group.

**Patient information**

The trust currently do not have an agreed process for the production, management and archiving of patient information. In addition there is considerable work needed to fully meet the Accessible Information Standards (AIS). Funding has been secured for a fully time 1 year fixed term patient information officer role to ensure that the following actions are achieved:

- The collation, cataloguing and archiving of all current information including the rationalisation of information across all sites including moving to a single leaflet where current site specific leaflets exist
- The development of a structured process and policy for the development of patient information, including the sign off and ordering authorisation process
- The support of the accessible information standards implementation and where possible moving our information to an online format, reducing printing and production costs to the Trust.

The post will be recruited two following the outcome of the formal team consultation process, however the collation and archiving part of this project has been started to prevent any delay to the time frames of this work stream.

**Strategy Development**

The current patient experience strategy has been identified as not meeting the needs of our patients or the Trust fully and as such needs to be reviewed and refreshed. A decision was taken and supported by the Executive Management Board to defer this work until the Trust receives their formal CQC feedback report. It is anticipated that Patient Experience as a service will be instrumental in implementing recommendations from this report and as such delaying the development of a Trust wide strategy until its completion was supported.

**Conclusion**

Patient experience as a service covers a broad range of activities and work plans which are not always reflected in the FFT or complaints monitoring metrics. There have been improvements in aspects of the service with clear plans for the continued improvement. The quality committee will continue to monitor the work programmes and performance of the team moving forward and will be provided with a detailed action plan and timeframes they can monitor.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

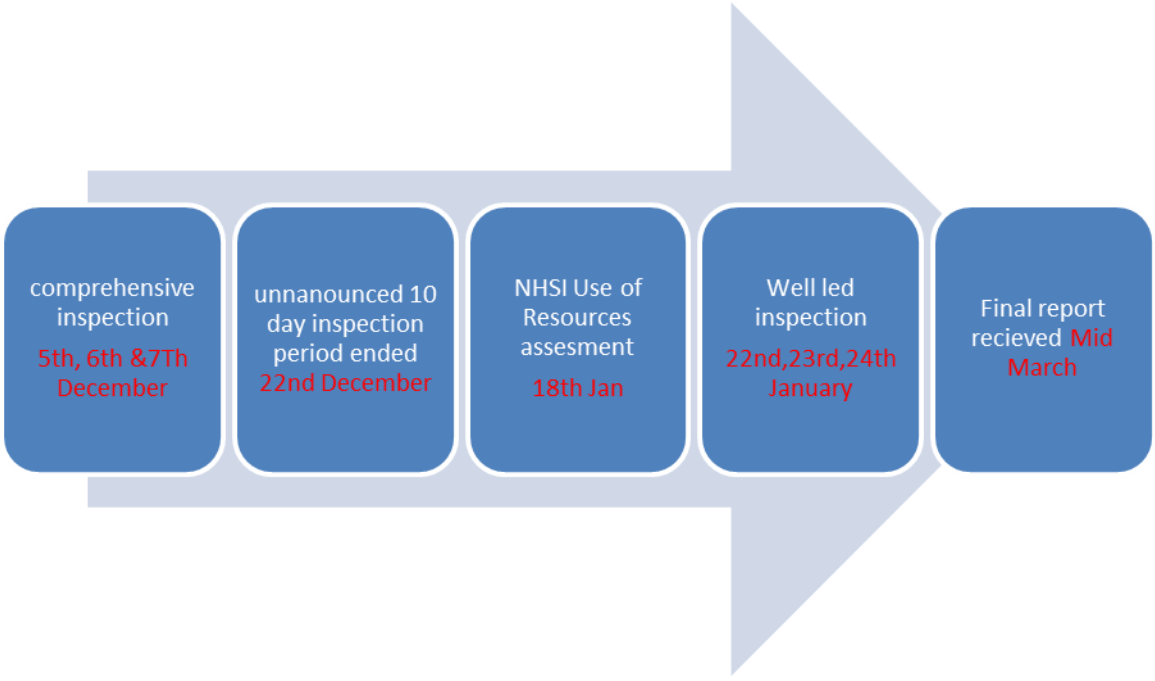
| | |
|---|---|
| **AGENDA ITEM NO.** | 2.4/Jan/18 |
| **REPORT NAME** | Care quality programme progress update |
| **AUTHOR** | Pippa Nightingale Chief Nurse |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | This paper updates the Board on progress and continuing development of the care quality programme. |
| **SUMMARY OF REPORT** | This report updates the board on the progress of the care quality programme and the CQC inspection as well as the future steps for the CQP structure.<br><br>The paper outlines the progress and next steps of the CQC trust assessment. |
| **KEY RISKS ASSOCIATED** | Delivery of the Quality Strategy and Maintenance of Quality Standards<br>Reputational risks |
| **FINANCIAL IMPLICATIONS** | none |
| **QUALITY IMPLICATIONS** | not achieving a good outcome in the CQC inspection and not continuing to deliver quality improvement |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | • Excel in providing high quality, efficient clinical services<br>• Improve population health outcomes and integrated care<br>• Deliver financial sustainability<br>• Create an environment for learning, discovery and innovation |
| **DECISION/ ACTION** | The Board is asked to note and comment upon the progress to date. |

## Care Quality Programme update December 2017

## CQC

The clinical comprehensive review was completed on the 5th, 6th and 7th of December with 56 CQC inspectors on site for the three days; this was followed by two unannounced visits one on each site. The initial feedback was positive with no identified issues requiring immediate attention. Of particular note was the inspection found 100% compliance with medicine management and WHO safety check list as well as all clinical guidelines and policies being in date. The most consistent finding by the team was that all staff were welcoming, professional and friendly. Additionally, repeated comments from the inspection team about how well staff cared for each other as well as their patients.

## Next Steps



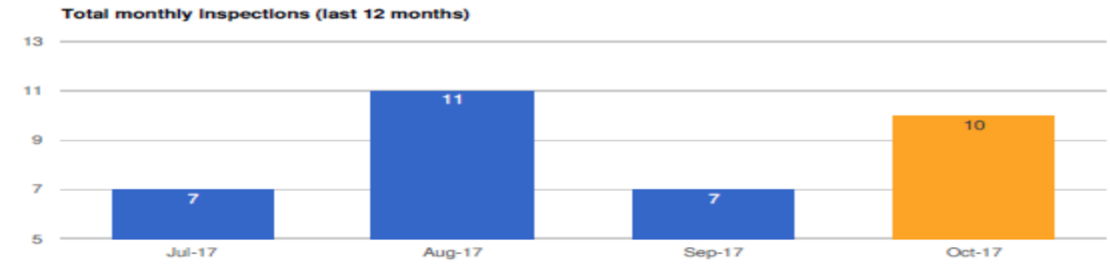

## Ward accreditation

The second wave of ward accreditation assessments have begun, the tool has been adapted and refined to include the learning from last year's assessments and to reflect the CQC core framework. All 63 clinical areas will have an assessment undertaken by December 2018. All 4 clinical areas that received a white in the last assessment have already been re assessed 3 moved to Bronze and 1 moved to Sliver.

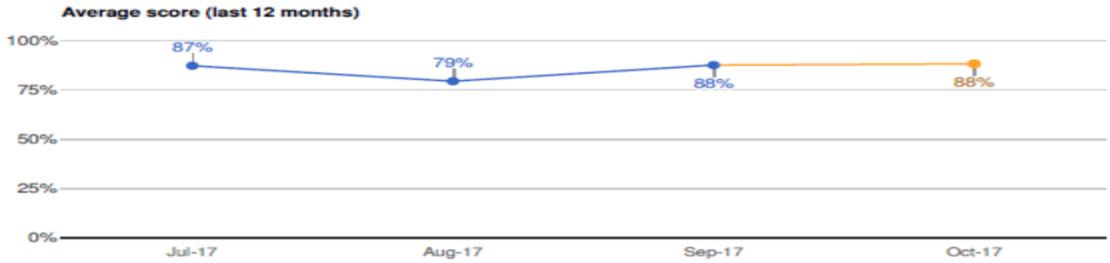
## Perfect Ward continuous assessment

We have embedded the perfect ward application in 22 of our 43 clinical areas across the two sites; this is now starting to generate real time improvement quality data. We will continue with the role out of the tool and aim to have all clinical areas using the quality application by the end of March 2018.

The below examples are the quality real time data which the quality improvement tool produces.




The average score across the organisation this month was 88%.



## Appendix B: Questions

| Rank | Question | Score this month | Score last 12 |
|---|---|---|---|
| 1 | Call bells answered within 3 minutes? | 100% (6) | 96% (25) |
| 2 | Are there any medications left out at patient bedside? | 100% (6) | 85% (26) |
| 3 | CD register show a daily checks | 100% (6) | 97% (29) |
| 4 | Are medicine trolleys left unsecured and open? | 100% (1) | 64% (11) |
| 5 | Is hazardous clinical waste disposed of appropriately? | 100% (10) | 94% (35) |
| 6 | Sharps bins assembled and dated/signed correctly? | 100% (10) | 94% (35) |
| 7 | Any drugs cupboards locked when staff aren't in attendance? | 100% (4) | 100% (6) |
| 8 | Are intravenous fluids kept in a locked room? | 100% (9) | 94% (34) |
| 9 | Check 3 random medications (IV/oral) packaging is intact? | 100% (10) | 100% (35) |
| 10 | Check 3 random medications (IV/oral) are in date? | 100% (10) | 94% (35) |
| 11 | Resuscitation equipment and trolley checked daily, seal intact and checks documented? | 100% (10) | 97% (34) |
| 12 | Are the theatres cleaned beetween cases by the porters/theatre staff? | 100% (4) | 100% (6) |
| 13 | Are the Anaesthetic machines daily checked before each theatre List? | 100% (4) | 100% (6) |
| 14 | Is the Clinell green sticker displayed on the anaesthetic and theatre equipment with the dated correctly? | 100% (3) | 100% (5) |
| 15 | Are the floors clear of loose materials? | 100% (4) | 83% (6) |
| 16 | Are the assessment cubicles fit for purpose? | 100% (1) | 100% (1) |
| 17 | Has the check for emergency bells been done today? | 100% (4) | 83% (6) |
| 18 | Are clinical area doors closed? | 100% (10) | 100% (34) |
| 19 | Barrier nursing - correct PPE? | 100% (8) | 92% (24) |
| 20 | Medical notes and skin folders kept secure during admission period? | 100% (1) | 100% (2) |
| 21 | Theatres Lists with confidential information are kept safe and disposed into confidential waste | 100% (4) | 100% (6) |
| 22 | Are there toilets for disable patients? | 100% (2) | 100% (3) |
| 23 | Is there alcohol/ hand gel in the staff toilets, staff coffee rooms and staff offices? | 100% (4) | 100% (6) |
| 24 | Is alcohol/hand gel available in the waiting and assessment areas? | 100% (2) | 100% (3) |
| 25 | Notes are kept secure and not left open? | 100% (8) | 73% (30) |
| 26 | Are noticeboards, ward boards and leaflet display well presented with up to date information | 100% (10) | 97% (34) |
| 27 | Is there hand gel available at every theatre? | 100% (4) | 100% (6) |
| 28 | Hand gel for visitors and staff at entrance to ward/department? | 100% (10) | 97% (35) |

| Rank | Question | Score this month | Score last 12 |
|---|---|---|---|
| 29 | Is the admitting clerk/receptionist at the reception area? | 100% (4) | 100% (6) |
| 30 | Does the ward feel calm? | 100% (10) | 88% (34) |
| 31 | Were you made to feel welcome on arrival? | 100% (10) | 97% (34) |
| 32 | Good signage to and within unit? | 100% (10) | 91% (35) |
| 33 | Any overfill sharps bins? | 90% (10) | 86% (35) |
| 34 | Are there any intravenous fluids on floor? | 90% (10) | 74% (35) |
| 35 | Is the ambient temperature being monitored? | 90% (10) | 80% (35) |
| 36 | Are any unattended pcs unlocked and information visible? | 90% (10) | 69% (35) |
| 37 | Barrier nursing signage? | 88% (8) | 91% (23) |
| 38 | Is there hand gel available at the bedside? | 83% (6) | 80% (25) |
| 39 | Drugs cupboard locked? | 83% (6) | 82% (28) |
| 40 | Drug fridge daily recording of temperature? | 80% (10) | 82% (33) |
| 41 | Check 3 other items of medical equipment for electrical compliance testing? | 80% (10) | 88% (34) |
| 42 | Are infusion pumps cleaned, have a green sticker and have an in date PAT/service date? | 80% (10) | 87% (30) |
| 43 | Fire exits are clear and in good working order? | 80% (10) | 80% (35) |
| 44 | Check 3 items of equipment at random and ensure they are clean and have a clinell green sticker on and dated today. | 80% (10) | 71% (35) |
| 45 | ISS daily cleaning schedule visible or can staff say where it is? | 78% (9) | 68% (34) |
| 46 | Are any drugs left out when staff aren't in attendance? | 75% (4) | 67% (6) |
| 47 | Is there any clutter in corridors around nurses' station, anaesthetic rooms, theatres, recovery areas or fire exits? | 75% (4) | 83% (6) |
| 48 | Observe 3 staff hand hygiene, is it correct and appropriate? | 70% (10) | 76% (34) |
| 49 | Drugs fridge locked? | 70% (10) | 74% (31) |
| 50 | Check Glucometer QA book is being signed daily. | 70% (10) | 82% (34) |
| 51 | Is there any clutter in corridors, around the nurses' station, store room or patient bedsides? | 70% (10) | 71% (35) |
| 52 | Is there anyone at the nurses station? | 67% (6) | 86% (28) |
| 53 | Have weighing scales been calibrated, are clean and have in date service sticker? | 67% (6) | 85% (26) |
| 54 | Are all commodes clean and have a green sticker with today's date? | 67% (6) | 54% (24) |
| 55 | Is the temperature of the fluids warming cabinet checked daily? | 67% (3) | 80% (5) |
| 56 | Check hoists are clean, with in date service sticker and are being charged. | 60% (5) | 68% (19) |
| 57 | Are hazardous materials locked away in sluice? | 60% (10) | 60% (15) |
| 58 | Is the call cord accessible in the bathrooms? | 0% (0) | 0% (0) |

*Numbers in brackets show number of inspections score is calculated from.*

## Next Steps for CQP and Continuous Quality Improvement

A great deal of momentum and commitment from the MDT teams has been established over the last year of preparing for the CQC inspection. The executive team are committed to continuing this momentum to deliver continuous improvement which is the third phase of our quality improvement journey. The next steps are that both the chief nurse and Medical director are reviewing the options for merging the CQP improvement team with the QI team to establish a permanent quality improvement structure.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.5/Jan/18 |
| **REPORT NAME** | Serious Incident Report |
| **AUTHOR** | Shân Jones, Director of Quality Improvement |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | The purpose of this report is to provide the Board with assurance that serious incidents are being reported and investigated in a timely manner and that lessons learned are shared. |
| **SUMMARY OF REPORT** | This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2015. Comparable data is included for both sites. |
| **KEY RISKS ASSOCIATED** | There are two IT incidents reported in this paper which should be considered by the CERNER implementation group.<br>There has been a reduction in the number of overdue actions from 49 to 8 and all actions 8 actions are being addressed currently. |
| **FINANCIAL IMPLICATIONS** | N/A |
| **QUALITY IMPLICATIONS** | There are two incidents of unexpected death where no care or service delivery problems were identified. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Excel in providing high quality, efficient clinical services<br>• Create an environment for learning, discovery and innovation |
| **DECISION/ ACTION** | The Quality Committee is asked to note and comment on the report in advance of Trust Board. |

**SERIOUS INCIDENTS REPORT**
**November**

## 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. All complaints that have a patient safety concern are reviewed discussed, escalated and reported as required. In addition as part of the mortality review process any deaths that have a CESDI grade of 1 or above are considered and reviewed as potential serious incidents.

## 2.0 Never Events

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

There have been 3 'Never Events' reported to date. One 'Never Event' was reported in June 2017 (Wrong route administration of medication) oral medication was administered via an intravenous route. The patient suffered no harm.

The second 'Never Event' was not originally reported as a 'Never Event', however, following a discussion with the Commissioners, the transfusion incident reported in June 2017 (StEIS ref. 2017/14670) which involved a patent unintentionally being given a transfusion of platelets, there was no harm to the patient.

The third 'Never Event' was reported in November 2017 (Retained foreign object post-procedure, StEIS ref. 2017/27311).

The Trust Care Quality Programme has had a focus on 'Never Events'. This is intended to raise awareness of these incident categories, which are serious and typically preventable. The senior nurse and midwifery quality round will have a scheduled session on Never Events in the New Year.

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 November 2017. There were 5 reports submitted across the 2 sites. A précis of the incidents can be found in Section 7.

Table 1

| STEIS No. | Date of incident | Incident Type (STEIS Category) | External Deadline | Date SI report submitted | Site |
|---|---|---|---|---|---|
| 2017/20178 | 12/07/2017 | Diagnostic incident including delay meeting SI | 06/11/2017 | 06/11/2017 | WM |
| 2017/20918 | 13/08/2017 | Diagnostic incident including delay meeting SI | 14/11/2017 | 14/11/2017 | WM |
| 2017/21438 | 24/08/2017 | Slips/trips/falls meeting SI criteria | 20/11/2017 | 20/11/2017 | WM |
| 2017/21856 | 29/08/2017 | Maternity/Obstetric incident meeting SI criteria: | 24/11/2017 | 24/11/2017 | WM |
| 2017/22077 | 05/12/2016 | Diagnostic incident including delay meeting SI | 28/11/2017 | 28/11/2017 | CW |

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

Table 2

| Incident Type (STEIS Category) | WM | C&W | Total |
|---|---|---|---|
| Diagnostic incident including delay | 1 | | 1 |
| Maternity/Obstetric incident: mother only | | 1 | 1 |
| Maternity/Obstetric incident: baby only | 1 | 1 | 2 |
| Pressure ulcer | 1 | 1 | 2 |
| Slips/trips/falls | | 1 | 1 |
| Treatment delay | | 1 | 1 |
| **Grand Total** | **3** | **5** | **8** |

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 = 22

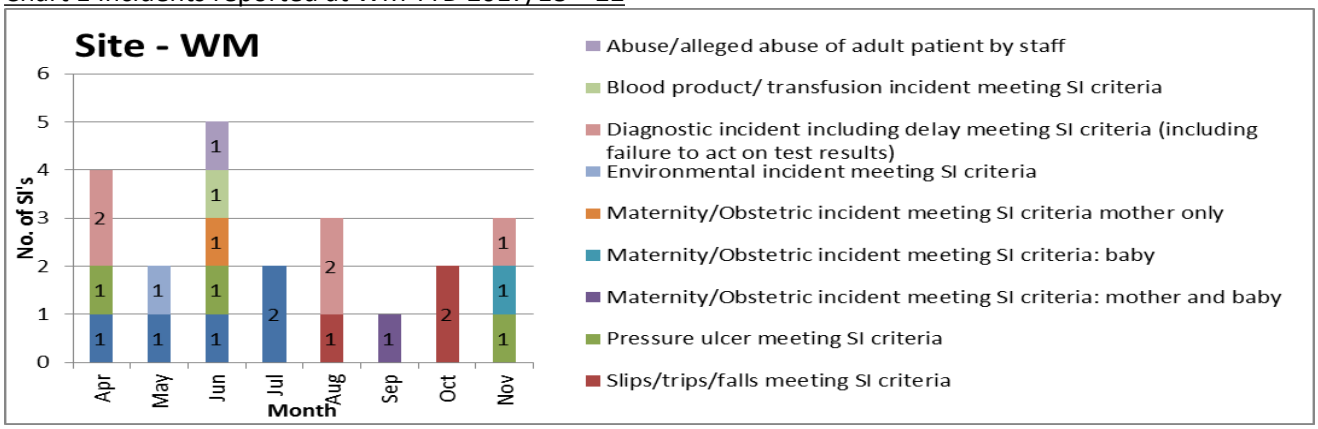
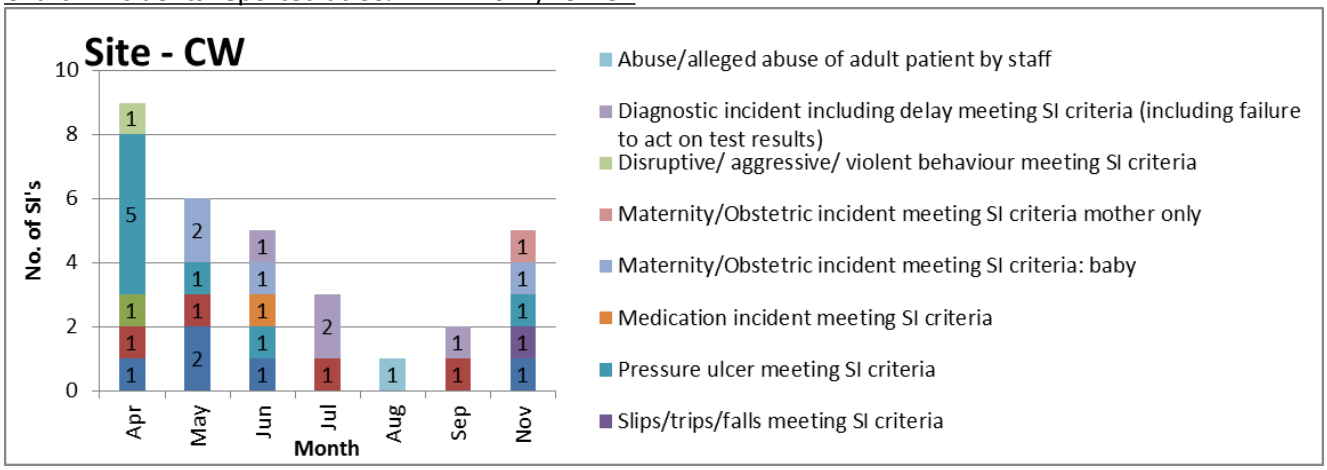



Chart 2 Incidents reported at C&W YTD 2017/18 = 31




There was an increase in the number of SIs reported in November 2017 (8) compared to October 2017 (2).

During November the trust reported two hospital acquired pressure ulcers and two Maternity/Obstetric incident meeting SI criteria: baby only. The Trusts has not reported against either category since June 2017.

Charts 3 and 4 show the comparative reporting, across the 2 sites, for 2015/16, 2016/17 and 2017/18.
The total number of incidents reported on each site year to date is 22 at WM and 31 at C&W. For both sites this is a reduction in the number reported compared to the same period last year. C&W did not report any serious incidents during October 2017.

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

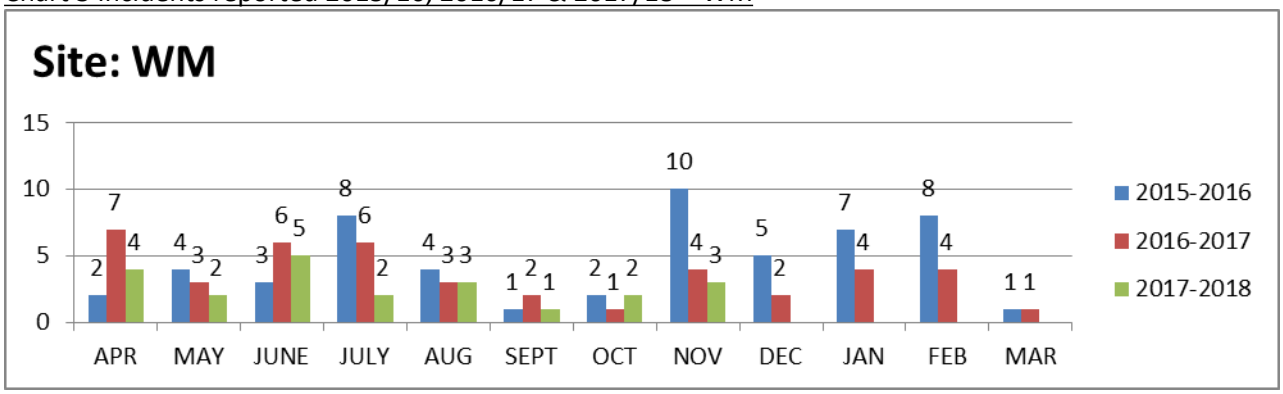
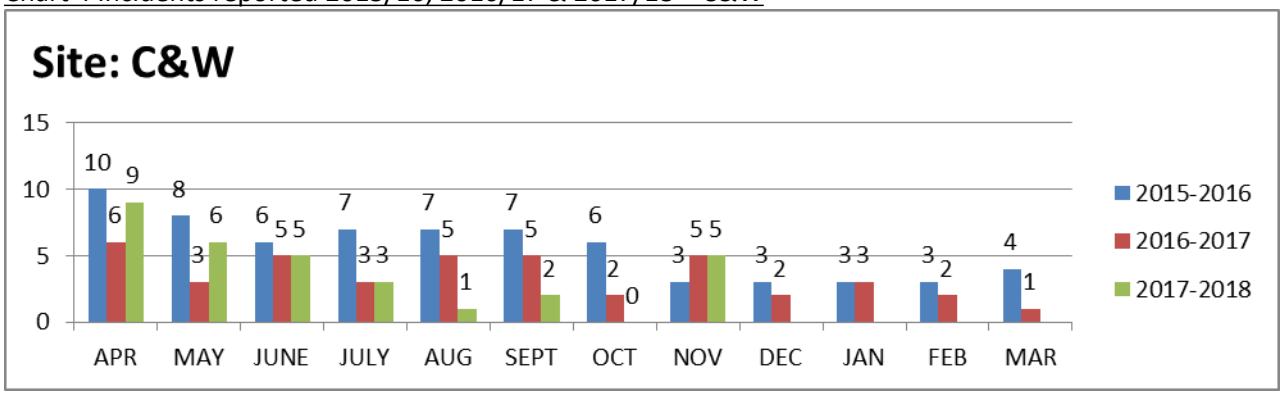



Chart 4 Incidents reported 2015/16, 2016/17 & 2017/18 – C&W



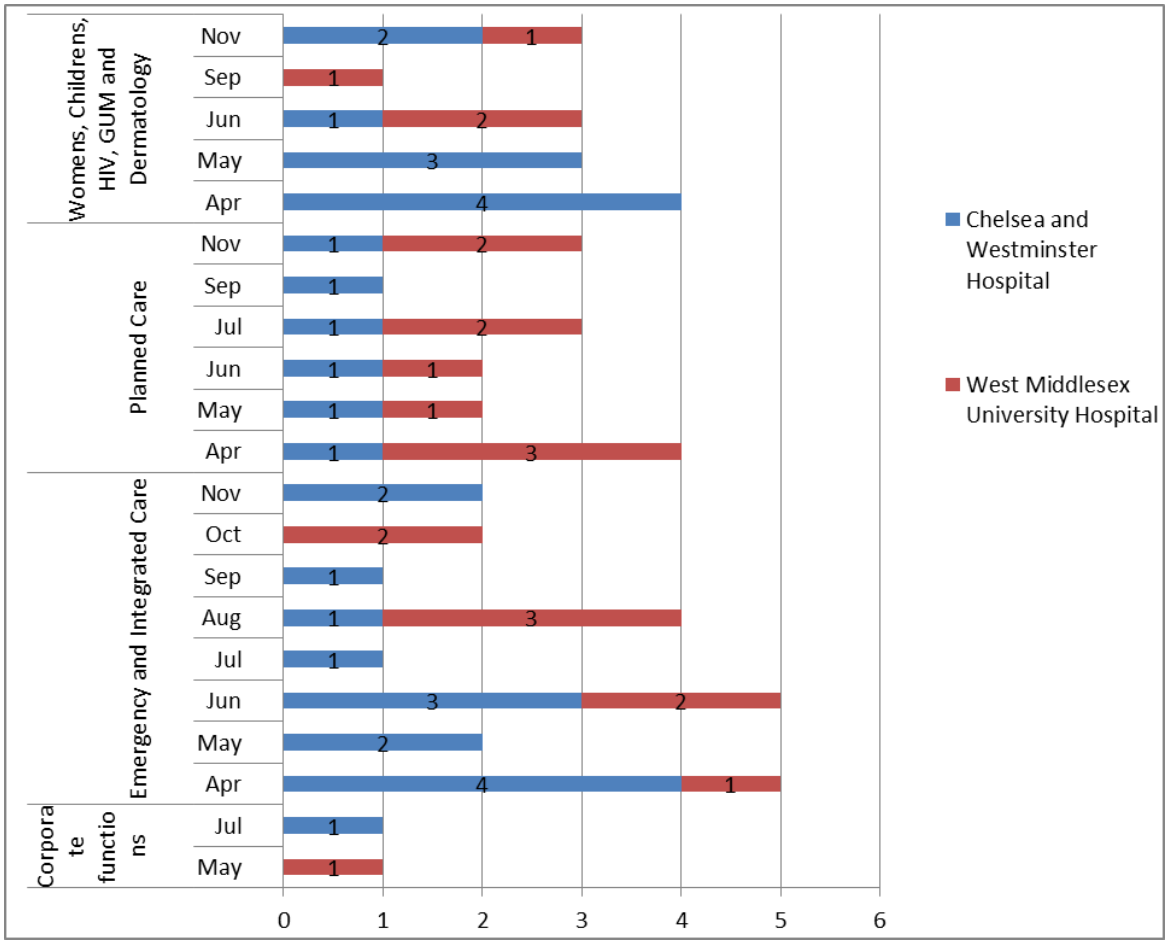

### 3.1 SIs by Clinical Division and Ward

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 22 SIs (C&W 14, WM 8). The Women's, Children's, HIV, GUM and Dermatology Division have reported 14 SIs (C&W 10, WM 4) and the Planed Care Division have reported 15 SIs (C&W 6, WM 9).

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

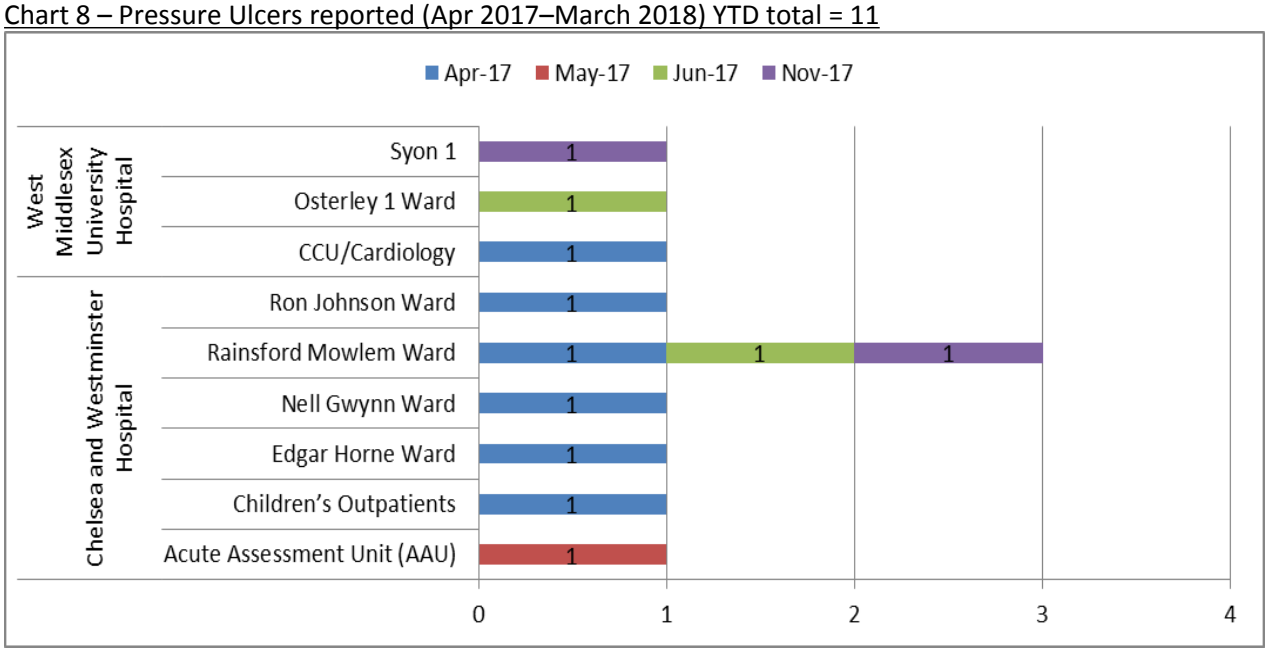
Chart 5 Incidents reported by Division and Site 2017/18




### 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. Rainsford Mowlem Ward at CWH is showing a higher number of reported hospital acquired pressure ulcers. 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 11 compared to 19 for the same period last year.

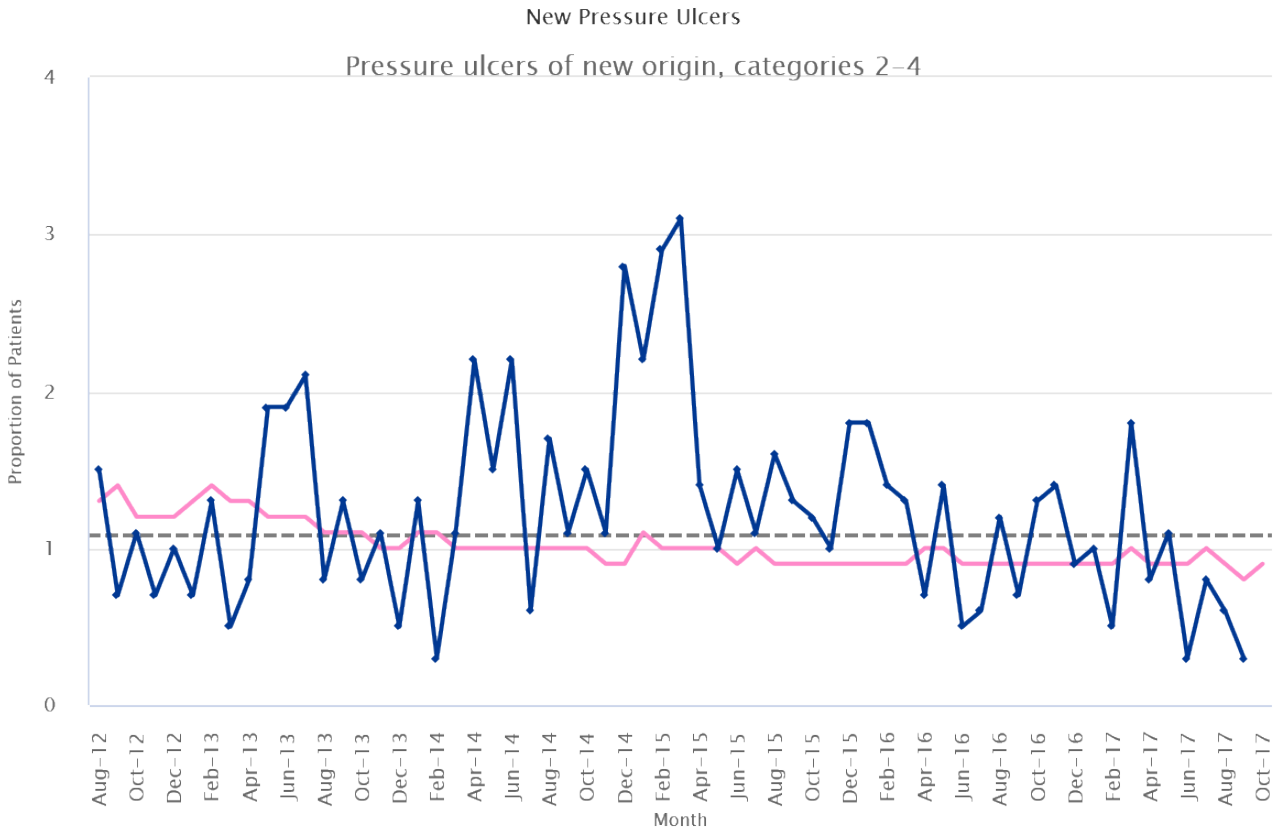
Chart 8 – Pressure Ulcers reported (Apr 2017–March 2018) YTD total = 11



### 3.2.1 Safety Thermometer Data

The national safety thermometer data provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers. The nationally reported data for Chelsea and Westminster Hospital NHS Foundation Trust is as a combined organisation and is showing a favourable position below the national average. National data is published up to October 2017 however C&W is only published for September 2017.

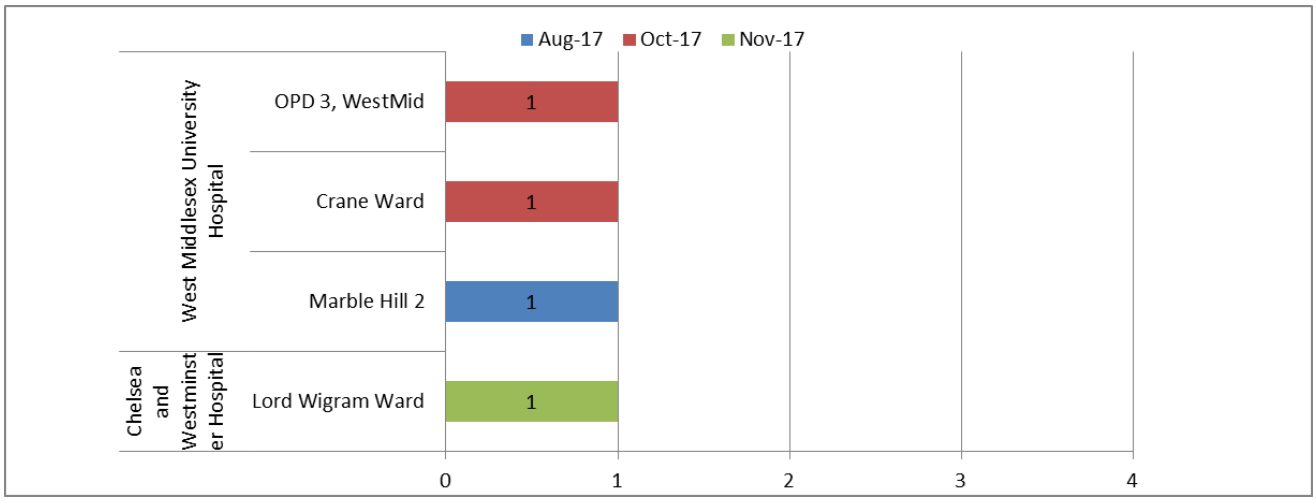
Graph 1 – New Pressure ulcers of new origin, categories 2-4 (Comparison with national average)




### 3.3 Patient Falls

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

Chart 9 Patient Falls by Location (exact) 2017/18



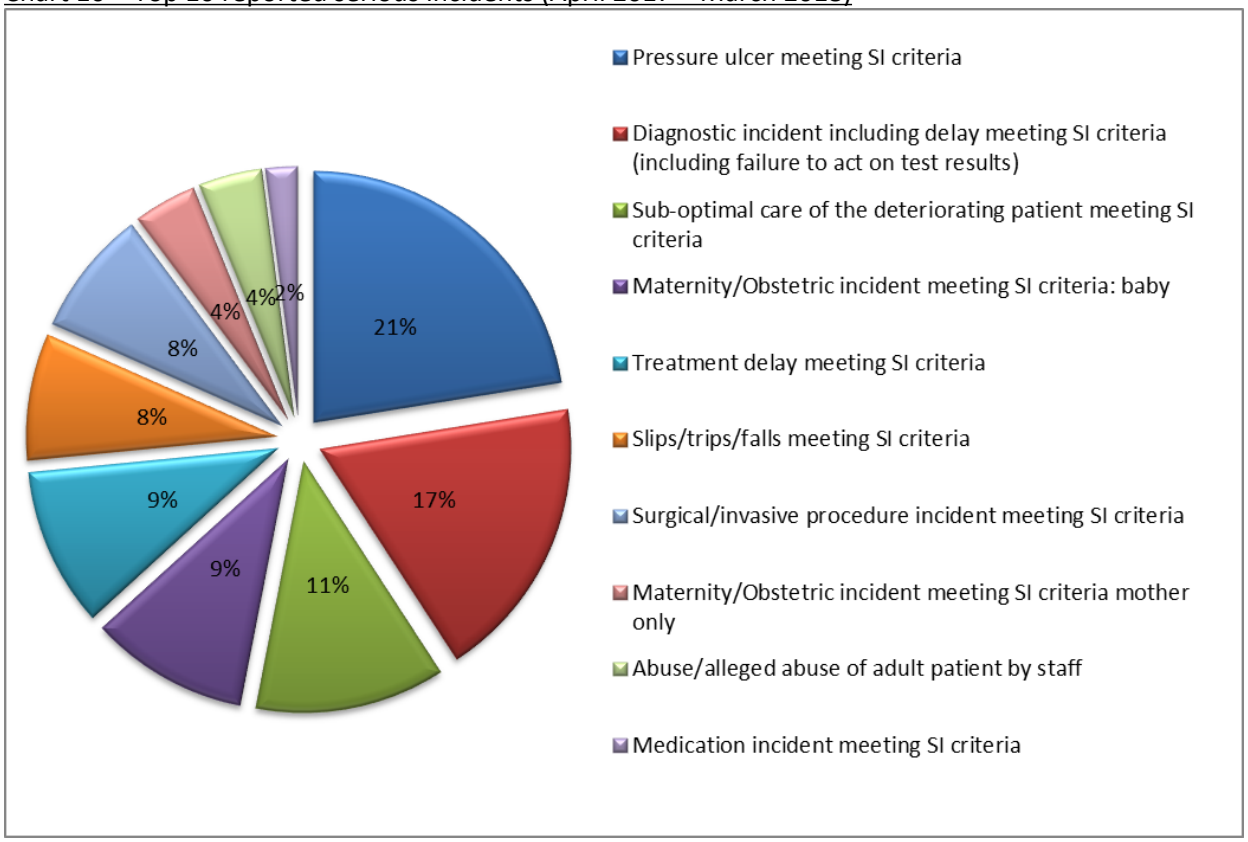

Since the 1st of April 2017, the Trust has reported four patient falls meeting the serious incident criteria. The YTD position is 4 compared to 7 for the same period last year.

### 3.4 Top 10 reported SI categories

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

Year to date pressure ulcers continue to be the most commonly reported incident despite the significant reduction from last year. Diagnostic incidents including delay are the second most reported serious incident (9). Sub-optimal care of the deteriorating patient is the third most reported incidents with 6 incidents reported.

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



### 3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (11).

| STEIS No. | Date of incident | Clinical Division | Incident Type (STEIS Category) | Site | External Deadline |
|---|---|---|---|---|---|
| 2017/23484 | 20/09/2017 | PC | Surgical/invasive procedure incident | CW | 14/12/2017 |
| 2017/25828 | 19/10/2017 | EIC | Slips/trips/falls | WM | 17/01/2018 |
| 2017/26392 | 24/10/2017 | EIC | Slips/trips/falls | WM | 22/01/2018 |
| 2017/27318 | 05/11/2017 | EIC | Pressure ulcer | CW | 02/02/2018 |
| 2017/27311 | 19/08/2017 | W&C,HG | Maternity/Obstetric incident: mother only | CW | 02/02/2018 |
| 2017/28908 | 14/05/2017 | PC | Diagnostic incident including delay | WM | 21/02/2018 |
| 2017/28378 | 17/07/2017 | EIC | Treatment delay | CW | 15/02/2018 |
| 2017/27430 | 24/10/2017 | W&C,HG | Maternity/Obstetric incident: baby | CW | 05/02/2018 |
| 2017/27566 | 05/11/2017 | W&C,HG | Maternity/Obstetric incident: baby | WM | 06/02/2018 |
| 2017/28841 | 12/11/2017 | PC | Slips/trips/falls | CW | 21/02/2018 |

### 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 39 actions overdue at the time of writing this report. This is an increase on last month when there were 27. Women's, Children's, HIV, GUM and Dermatology Division has 8 outstanding actions, Emergency and Integrated Care Division have 28 and the Planned Care Division has 3 outstanding actions.

Table 4 - SI Actions

| | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 | Sep 2017 | Oct 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | Mar 2018 | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **EIC** | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 7 | 17 | 11 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **42** |
| **PC** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 8 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **13** |
| **W&C,HGD** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 4 | 3 | 3 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | **16** |
| **Total** | **3** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **11** | **24** | **22** | **7** | **1** | **0** | **0** | **0** | **1** | **0** | **1** | **71** |

Table 4.1 The Divisions have been managing their SI actions more productively and the number of overdue actions has reduced to 8, these are all being managed currently. 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.

Table 4.1 – Type of actions overdue

| Emergency and Integrated Care | Planned Care | Womens, Childrens, HIV, GUM and Dermatology | Total |
|---|---|---|---|
| 0 | 0 | 1 | 1 |
| 3 | 1 | 1 | 5 |
| 1 | 0 | 0 | 1 |
| 0 | 1 | 0 | 1 |
| 4 | 2 | 2 | 8 |

## 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 number of reported serious incidents is 53 which is slightly less compared to the same reporting period last year and significantly less compared to 2015/2016. (2105/16 = 88, 2016/17 = 66). The reduction in reported pressure ulcers and falls is a significant factor in lower number reported.

Table 5 – Total Incidents

| Year | Site | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2015-2016** | **WM** | 2 | 4 | 3 | 8 | 4 | 1 | 2 | 10 | 5 | 7 | 8 | 1 | **55** |
| | **CW** | 10 | 8 | 6 | 7 | 7 | 7 | 6 | 3 | 3 | 3 | 3 | 4 | **67** |
| | | **12** | **12** | **9** | **15** | **11** | **8** | **8** | **13** | **8** | **10** | **11** | **5** | **122** |
| **2016-2017** | **WM** | 7 | 3 | 6 | 6 | 3 | 2 | 1 | 4 | 2 | 4 | 4 | 1 | **43** |
| | **CW** | 6 | 3 | 5 | 3 | 5 | 5 | 2 | 5 | 2 | 3 | 2 | 1 | **42** |
| | | **13** | **6** | **11** | **9** | **8** | **7** | **3** | **9** | **4** | **7** | **6** | **2** | **85** |
| **2017-2018** | **WM** | 4 | 2 | 5 | 2 | 3 | 1 | 2 | 3 | | | | | **22** |
| | **CW** | 9 | 6 | 5 | 3 | 1 | 2 | 0 | 5 | | | | | **31** |
| | | **13** | **8** | **10** | **5** | **4** | **3** | **2** | **8** | | | | | **53** |

Table 6 - Categories 2015/16

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

Table 8 - Categories 2017/18

| Incident Category | A | M | J | J | A | S | O | N | D | J | F | M | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure ulcer | 6 | 1 | 2 | | | | | 2 | | | | | 11 |
| Diagnostic incident including delay | 2 | | 1 | 2 | 2 | 1 | | 1 | | | | | 9 |
| Sub-optimal care of the deteriorating patient | 2 | 1 | 1 | 2 | | | | | | | | | 6 |
| Maternity/Obstetric incident: baby | | 2 | 1 | | | | | 2 | | | | | 5 |
| Treatment delay | 1 | 2 | 1 | | | | | 1 | | | | | 5 |
| Surgical/invasive procedure incident | 1 | 1 | | 1 | | 1 | | | | | | | 4 |
| Slips/trips/falls | | | | | 1 | | 2 | 1 | | | | | 4 |
| Maternity/Obstetric incident: mother only | | | 1 | | | | | 1 | | | | | 2 |
| Abuse/alleged abuse of adult patient by staff | | | 1 | | 1 | | | | | | | | 2 |
| Environmental incident | | 1 | | | | | | | | | | | 1 |
| Medication incident | | | 1 | | | | | | | | | | 1 |
| Blood product/ transfusion incident | | | 1 | | | | | | | | | | 1 |
| Maternity/Obstetric incident: mother and baby | | | | | | 1 | | | | | | | 1 |
| Disruptive/ aggressive/ violent behaviour | 1 | | | | | | | | | | | | 1 |
| Grand Total | 13 | 8 | 10 | 5 | 4 | 3 | 2 | 8 | | | | | 53 |

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.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.6/Jan/18 |
| **REPORT NAME** | Integrated Performance Report – November 2017 |
| **AUTHOR** | Robert Hodgkiss, Chief Operating Officer |
| **LEAD** | Robert Hodgkiss, Chief Operating Officer |
| **PURPOSE** | To report the combined Trust's performance for November 2017 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward. |
| **SUMMARY OF REPORT** | The Integrated Performance Report shows the Trust performance for November 2017.<br><br>**Regulatory performance** – Despite a very challenging month, especially with Paediatric demand, the A&E Waiting Time figure was met for November at 95.02%. The Chelsea Site achieved 95.7% and West Middlesex 94.4%. The 95.02% compares favourably with the 91.1% reported for the same month in 2016.<br><br>The RTT incomplete target was achieved in November for the Trust, with an improvement in performance to 92.3%. This was the first month in this financial year that this metric achieved the national target with Planned Care on the Chelsea site continuing to demonstrate month on month improvements.<br><br>There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue.<br><br>All reportable Cancer Indicators met the target in November – this constitutes the third month in succession that the Trust has achieved these standards.<br><br>Chelsea and Westminster NHS FT have therefore achieved all 3 National Access standards, being one of the few Trusts to do so. This is a fantastic achievement in the context of increased demand and system pressures.<br><br>There was one reported CDiff infection in November at the West Middlesex site which has been the subject of the requisite root cause analysis.<br><br>**Access**<br>Due to issues in non-Obstetric Ultrasound at West Middlesex, the Trust has failed to reach the 99% standard in Diagnostic Waits Under 6 weeks at 92.5%. These issues are being addressed. |
| **KEY RISKS** | There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer |

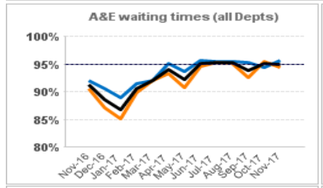
| | |
|---|---|
| **ASSOCIATED:** | 62 days waits remains a high priority. The Trust is focussing on the Diagnostic Waiting time issues in the weeks to come. |
| **FINANCIAL IMPLICATIONS** | The Trust is reporting a YTD surplus of £4.7m which is £0.3m favourable against the plan. The Use of Resources rating is 1 against a plan of 1. |
| **QUALITY IMPLICATIONS** | As outlined above. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | Improve patient safety and clinical effectiveness<br>Improve the patient experience<br>Ensure financial and environmental sustainability |
| **DECISION/ ACTION** | The Board is asked to note the performance for November 2017 and to note that whilst a number of indicators were not delivered in the month, the overall YTD compliance remained good. |

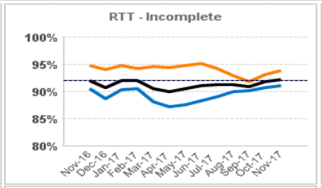
# TRUST PERFORMANCE & QUALITY REPORT

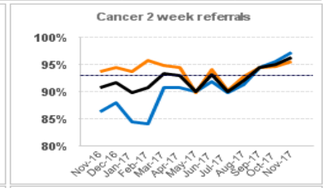
## November 2017

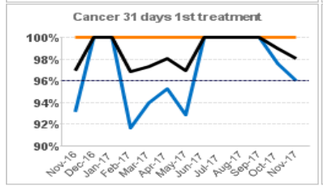
## Regulatory Compliance

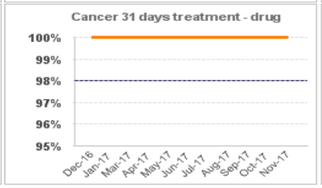
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined Trust data: last Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Quarter | YTD | Trend |
| A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 95.2 | 94.4 | 95.7 | 92.6 | 95.5 | 94.4 | 93.7 | 95.0 | 95.0 | 95.0 | 94.4 | |
| RTT - Incomplete (Target: >92%) | 90.3 | 90.8 | 91.1 | 91.8 | 93.1 | 93.8 | 90.9 | 91.8 | 92.3 | 92.0 | 91.1 | |
| Cancer 2 week urgent referrals (Target: >93%) | 94.5 | 95.6 | 97.2 | 94.4 | 94.6 | 95.5 | 94.5 | 95.0 | 96.2 | 95.6 | 93.1 | |
| Cancer 2 week Breast symptomatic (Target: >93%) | n/a | n/a | n/a | 97.7 | 96.1 | 100 | 97.7 | 96.1 | 100 | 97.8 | 93.3 | |
| Cancer 31 days first treatment (Target: >96%) | 100 | 97.6 | 96.0 | 100 | 100 | 100 | 100 | 99.0 | 98.1 | 98.5 | 99.0 | |
| Cancer 31 days treatment - Drug (Target: >98%) | 100 | 100 | n/a | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 31 days treatment - Surgery (Target: >94%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 62 days GP ref to treatment (Target: >85%) | 91.7 | 91.2 | 96.6 | 98.0 | 100 | 94.1 | 94.5 | 97.2 | 95.3 | 96.2 | 87.7 | |
| Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 0 | 3 | 0 | 1 | 3 | 0 | 1 | 1 | 9 | |
| Average Emergency PreOp LoS | 0.65 | 0.67 | 0.71 | 1.67 | 1.35 | 1.17 | 1.16 | 0.98 | 0.94 | 0.96 | 0.96 | |
| Average Elective PreOp LoS | 0.24 | 0.17 | 0.08 | 0.27 | 0.15 | 0.14 | 0.24 | 0.16 | 0.10 | 0.13 | 0.16 | |

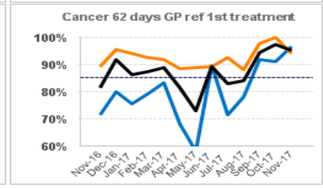


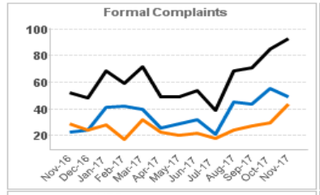



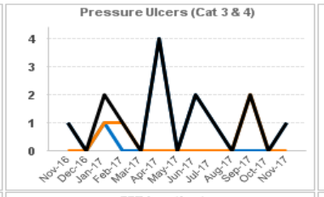



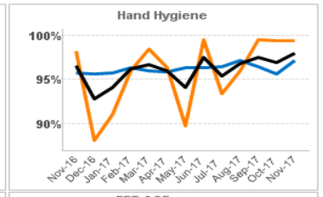



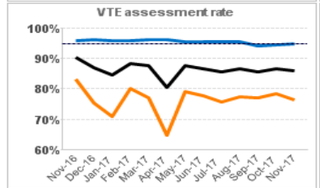

## Quality

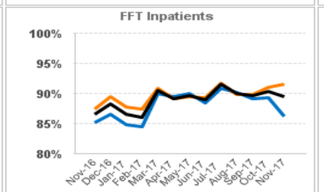
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Quarter | YTD | Trend |
| Hand Hygiene (Target: >=90%) | 96.5 | 95.6 | 97.2 | 99.5 | 99.4 | 99.4 | 97.5 | 96.9 | 98.0 | 97.4 | 96.5 | |
| Pressure Ulcers (Cat 3 & 4) | 0 | 0 | 1 | 2 | 0 | 0 | 2 | 0 | 1 | 1 | 10 | |
| VTE assessment % (Target: >=95%) | 94.0 | 94.4 | 94.9 | 77.1 | 78.5 | 76.4 | 85.8 | 86.5 | 86.0 | 86.3 | 85.7 | |
| Formal complaints number received | 44 | 55 | 49 | 27 | 30 | 44 | 71 | 85 | 93 | 178 | 509 | |
| Formal complaints responded to <25days | 19 | 35 | 14 | 8 | 9 | 9 | 27 | 44 | 23 | 67 | 185 | |
| Serious Incidents | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Never Events (Target: 0) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 3 | |
| FFT - Inpatients recommend % (Target: >90%) | 89.1 | 89.3 | 86.2 | 89.9 | 91.0 | 91.5 | 89.6 | 90.3 | 89.5 | 89.9 | 89.9 | |
| FFT - A&E recommend % (Target: >90%) | 84.6 | 89.5 | 88.8 | 83.8 | 90.0 | 83.6 | 84.4 | 89.5 | 88.1 | 88.8 | 85.9 | |
| Falls causing serious harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

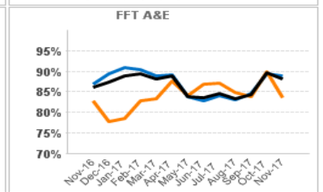


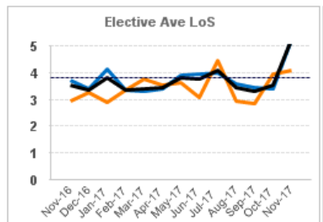



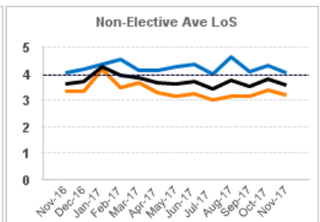



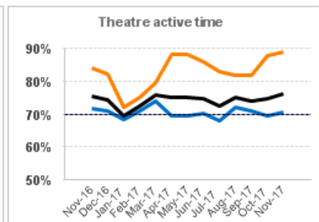



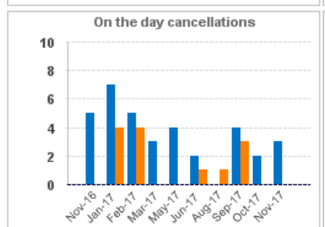

## Efficiency

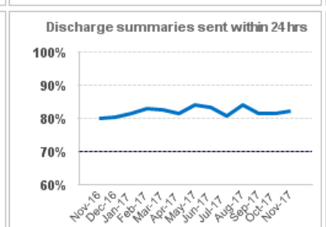
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Quarter | YTD | Trend |
| Elective average LoS (Target: <3.8) | 3.4 | 3.4 | 6.5 | 2.8 | 4.0 | 4.1 | 3.3 | 3.5 | 5.8 | 4.7 | 3.9 | |
| Non-Elective average LoS (Target: <3.95) | 4.1 | 4.3 | 4.0 | 3.1 | 3.4 | 3.2 | 3.5 | 3.8 | 3.6 | 3.7 | 3.6 | |
| Theatre active time (Target: >70%) | 70.9 | 69.4 | 70.7 | 81.6 | 87.8 | 89.1 | 73.9 | 74.6 | 76.0 | 75.3 | 74.6 | |
| Discharge summaries sent within 24 hours (Target: >70%) | 81.5 | 81.4 | 82.1 | dev | dev | dev | 81.5 | 81.4 | 82.1 | 81.7 | 82.4 | |
| Outpatient DNA rates (Target: <11.1%) | 13.6 | 11.5 | 10.8 | 10.6 | 10.2 | 9.8 | 12.5 | 11.0 | 10.4 | 10.7 | 11.4 | |
| On the day cancelled operations not re-booked within 28 days (Target: 0) | 4 | 2 | 3 | 3 | 0 | 0 | 7 | 2 | 3 | 5 | 20 | |

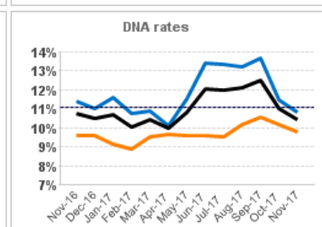


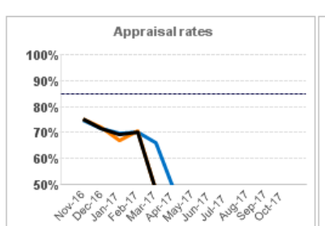



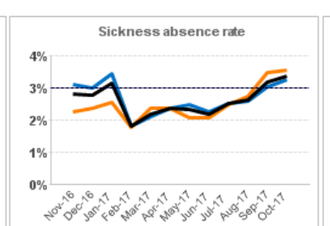



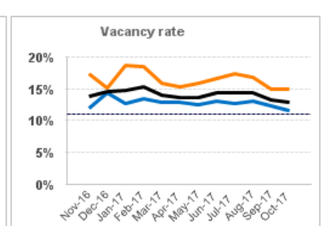



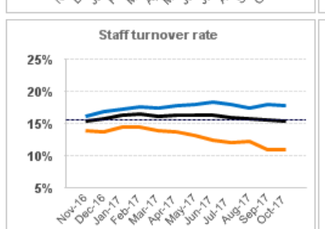

## Workforce

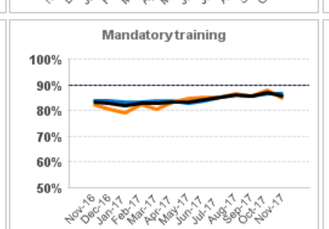
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Sep-17 | Oct-17 | Nov-17 | Quarter | YTD | Trend |
| Appraisal rates (Target: >85%) | 40.4 | 45.6 | | 34.6 | 2.1 | | 38.4 | 3.4 | | 3.4 | 7.2 | |
| Sickness absence rate (Target: <3%) | 3.05 | 3.25 | | 3.47 | 3.57 | | 3.19 | 3.36 | | 3.36 | 2.66 | |
| Vacancy rates (Target: CW<12%; WM<10%) | 12.3 | 11.6 | | 14.9 | 15.0 | | 13.2 | 12.8 | | | | |
| Turnover rate (Target: CW<18%; WM<11.5%) | 18.0 | 17.7 | | 10.9 | 10.9 | | 15.5 | 15.4 | | | | |
| Mandatory training (Target: >90%) | 85.5 | 86.5 | 86.5 | 85.7 | 87.9 | 84.5 | 85.6 | 87.0 | 85.8 | 86.4 | 85.2 | |
| Bank and Agency spend (£ks) | £2,209 | £2,707 | £2,343 | £2,548 | £2,404 | £2,326 | £4,757 | £5,111 | £4,669 | £9,781 | £38,818 | |
| Nursing & Midwifery: Agency % spend of total pay (Target: tbc) | 9.5 | 8.9 | 7.1 | 14.5 | 11.5 | 10.3 | 11.4 | 9.9 | 8.3 | 9.1 | 9.4 | |

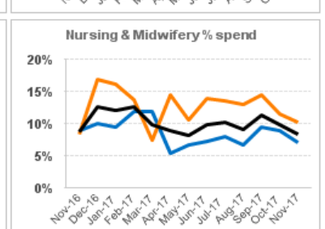


# NHSI Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| A&E | A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 95.2% | 94.4% | 95.7% | 95.1% | 92.6% | 95.5% | 94.4% | 94.0% | 93.7% | 95.0% | 95.0% | 95.0% | 94.4% | | - |
| RTT | 18 weeks RTT - Admitted (Target: >90%) | 69.6% | 74.0% | 75.2% | 67.6% | 84.4% | 88.9% | 84.3% | 85.0% | 77.7% | 82.0% | 80.0% | 81.0% | 77.2% | | ! |
| | 18 weeks RTT - Non-Admitted (Target: >95%) | 92.1% | 92.4% | 93.0% | 92.6% | 91.1% | 86.4% | 87.9% | 90.8% | 91.7% | 90.0% | 91.0% | 90.5% | 91.9% | | ! |
| | 18 weeks RTT - Incomplete (Target: >92%) | 90.3% | 90.8% | 91.1% | 89.3% | 91.8% | 93.1% | 93.8% | 93.8% | 90.9% | 91.8% | 92.3% | 92.0% | 91.1% | | ! |
| Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Nov-17) in this report) | 2 weeks from referral to first appointment all urgent referrals (Target: >93%) | 94.5% | 95.6% | 97.2% | 92.7% | 94.4% | 94.6% | 95.5% | 93.3% | 94.5% | 95.0% | 96.2% | 95.6% | 93.1% | | - |
| | 2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%) | n/a | n/a | n/a | n/a | 97.7% | 96.1% | 100% | 93.3% | 97.7% | 96.1% | 100% | 97.8% | 93.3% | | - |
| | 31 days diagnosis to first treatment (Target: >96%) | 100% | 97.6% | 96.0% | 97.9% | 100% | 100% | 100% | 100% | 100% | 99.0% | 98.1% | 98.5% | 99.0% | | - |
| | 31 days subsequent cancer treatment - Drug (Target: >98%) | 100% | 100% | n/a | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Surgery (Target: >94%) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Radiotherapy (Target: >94%) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |
| | 62 days GP referral to first treatment (Target: >85%) | 91.7% | 91.2% | 96.6% | 80.7% | 98.0% | 100.0% | 94.1% | 92.7% | 94.5% | 97.2% | 95.3% | 96.2% | 87.7% | | - |
| | 62 days NHS screening service referral to first treatment (Target: >90%) | n/a | n/a | n/a | n/a | 66.7% | 80.0% | 87.5% | 89.1% | 66.7% | 80.0% | 87.5% | 84.6% | 89.1% | | ! |
| Patient Safety | Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 9 | 3 | 0 | 1 | 1 | 9 | | - |
| Learning difficulties Access & Governance | Self-certification against compliance for access to healthcare for people with Learning Disability | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | | - |
| | Governance Rating | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |

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

**Trust commentary**

**A&E Waiting Times – Performance against the 4 hour target wait**

The Trust maintained its compliance with this metric for another month with the Chelsea Site making a marked improvement from October. This is all the more noteworthy given the continued increase in activity. West Middlesex performance in November is above the year-to-date performance and aided the Trust to report the second best figures in London against its peers, the one Trust reporting a better figure having only 40% of the activity numbers reported at Chelsea and Westminster through its doors.

The London average was 87.2% for November.

**18 week RTT Incomplete pathways - % waiting over 18 weeks**

After a considerable amount of work the Trust was able to report a compliant position for the first time in 2017/18 against this metric. The West Middlesex site improved its performance with the Chelsea Site maintaining an upward trajectory, with its performance in November being the best reported since 2015/2016. Both sites have put considerable effort into treating their longest waiting patients which has supported this improvement.

**Cancer Indicators**

All reportable Cancer metrics met the target for the third month in succession. Validated October performance saw CWFT as the No.1 performing Trust in the country with good, strong performance continuing into November.

**Clostridium difficile infections**

There was one case of hospital-acquired CDiff at West Middlesex in November. A root cause analysis was completed. The outcome of the review were as follows; antibiotics were appropriately prescribed in accordance with microbiology advice

# Safety Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts |
| Hospital-acquired infections | MRSA Bacteraemia (Target: 0) | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 3 | 2 | 1 | 0 | 1 | 3 | |
| | Hand hygiene compliance (Target: >90%) | 96.5% | 95.6% | 97.2% | 96.4% | 99.5% | 99.4% | 99.4% | 96.7% | 97.5% | 96.9% | 98.0% | 97.4% | 96.5% | |
| Incidents | Number of serious incidents | 2 | 0 | 5 | 31 | 1 | 2 | 3 | 22 | 3 | 2 | 8 | 10 | 53 | |
| | Incident reporting rate per 100 admissions (Target: >8.5) | 7.4 | 6.9 | 7.8 | 7.5 | 9.4 | 9.7 | 10.0 | 9.3 | 8.4 | 8.2 | 8.8 | 8.5 | 8.3 | |
| | Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0) | 0.00 | 0.02 | 0.03 | 0.01 | 0.00 | 0.00 | 0.00 | 0.02 | 0.00 | 0.01 | 0.02 | 0.01 | 0.01 | |
| | Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280) | 498.03 | 404.22 | 716.01 | 515.28 | 344.56 | 285.00 | 375.85 | 288.43 | 425.19 | 345.04 | 552.63 | 445.43 | 407.58 | |
| | Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%) | 15.3% | 10.2% | 14.9% | 10.9% | 4.4% | 17.1% | 6.1% | 14.1% | 11.1% | 13.0% | 12.0% | 12.4% | 12.0% | |
| | Never Events (Target: 0) | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 3 | |
| Harm | Safety Thermometer - Harm Score (Target: >90%) | 95.2% | 97.9% | 97.4% | 96.1% | 87.9% | 94.6% | 96.9% | 92.9% | 90.7% | 95.7% | 97.1% | 96.4% | 94.1% | |
| | Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6) | 0 | 0 | 1 | 8 | 2 | 0 | 0 | 2 | 2 | 0 | 1 | 1 | 10 | |
| | NEWS compliance % | 96.5% | 96.2% | 97.1% | 96.7% | 98.8% | 97.3% | 97.4% | 96.9% | 97.2% | 96.6% | 97.2% | 96.9% | 96.8% | |
| | Safeguarding adults - number of referrals | 22 | 15 | 25 | 165 | 32 | 15 | 25 | 203 | 54 | 30 | 50 | 80 | 368 | |
| | Safeguarding children - number of referrals | 21 | 25 | 49 | 226 | 106 | 83 | 94 | 831 | 127 | 108 | 143 | 251 | 1057 | |
| 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 | 28 | 38 | 38 | 267 | 53 | 71 | 66 | 450 | 81 | 109 | 104 | 213 | 717 | |
| | Number of hospital deaths - Paediatric | 0 | 2 | 1 | 7 | 0 | 0 | 0 | 1 | 0 | 2 | 1 | 3 | 8 | |
| | Number of hospital deaths - Neonatal | 1 | 0 | 3 | 11 | 0 | 0 | 1 | 9 | 1 | 0 | 4 | 4 | 20 | |
| | Number of deaths in A&E - Adult | 1 | 2 | 5 | 19 | 4 | 6 | 12 | 48 | 5 | 8 | 17 | 25 | 67 | |
| | Number of deaths in A&E - Paediatric | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 2 | |
| | Number of deaths in A&E - Neonatal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | |

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

**Trust commentary**

**Number of serious incidents**

There were 8 serious incidents reported to STEIS (STrategic Executive Information System) in November – 5 at the Chelsea Site and 3 at the West Middlesex Site

A breakdown shows that 1 was a diagnostic incident; 2 were Maternity/Obstetric incidents relating to the baby only' 1 was a Maternity/Obstetric incident relating to the mother only; 2 were surrounding pressure ulcers; 1 was reported regarding slips / trips / falls; with the last round regarding delay in treatment

Further information relating to serious incidents can be found in the SI Report prepared for the Board

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

The Trust has achieved an overall reporting rate of NRLS reportable medication-related incidents of 571/100,000 FCE bed days in November. This is higher than the Trust target of 280/100,000. There were 634 and 376 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively. There has been an increase in reporting of medication incidents this month compared to recent months

**Trust commentary continued**

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

Overall there were 17 incidents that caused harm; 14 occurred at CW site and 3 at WM site. Two incidents caused moderate harm; one involved an incorrect duloxetine prescription which precipitated a hypertensive crisis, the other related to a patient with Type 1 diabetes who experienced a hypoglycaemic episode because they did not receive prednisolone prior to an endoscopy procedure. The incidents that resulted in low harm mainly involved antibiotics, analgesia, insulin, testosterone and antiretroviral medication.

The Medication Safety Group continues to monitor trends and aim to improve learning from medication related incidents.

**Never Events**

There was one Never Event reported to STEIS in November and subsequently reported to NRLS in December. This was a Maternity incident that occurred in August and concerned a retained swab following a forceps delivery. This was identified following attendance at a perineal appointment at St. George's Hospital.  From a CWFT perspective, all system controls were in place and adhered to and the SI investigation is complete with an inconclusive outcome.

**Incidence of newly acquired category 3 & 4 pressure ulcers**

Preventing Hospital Acquired Pressure Ulcers remain high priority for both C&W and WM sites.

There was one newly acquired pressure ulcer categorised as 3 or 4 reported to STEIS during November2017 at the Chelsea site.

**Safeguarding Adults - number of referrals**

Following a drop in the number of referrals made in October, consistent levels of referral across both Sites have resumed in November

# Patient Experience Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| Friends and Family | FFT: Inpatient recommend % (Target: >90%) | 89.1% | 89.3% | 86.2% | 89.2% | 89.9% | 91.0% | 91.5% | 90.3% | 89.6% | 90.3% | 89.5% | 89.9% | 89.9% | | ! |
| | FFT: Inpatient not recommend % (Target: <10%) | 5.2% | 5.0% | 5.4% | 5.4% | 4.0% | 4.0% | 3.1% | 4.4% | 4.4% | 4.4% | 3.9% | 4.2% | 4.8% | | - |
| | FFT: Inpatient response rate (Target: >30%) | 38.3% | 38.2% | 32.9% | 34.9% | 31.6% | 31.2% | 32.3% | 32.5% | 33.8% | 33.8% | 32.5% | 33.2% | 33.3% | | - |
| | FFT: A&E recommend % (Target: >90%) | 84.6% | 89.5% | 88.8% | 85.9% | 83.8% | 90.0% | 83.6% | 86.0% | 84.4% | 89.5% | 88.1% | 88.8% | 85.9% | | ! |
| | FFT: A&E not recommend % (Target: <10%) | 6.1% | 6.3% | 6.5% | 6.0% | 8.5% | 5.4% | 11.5% | 8.7% | 6.5% | 6.2% | 7.2% | 6.7% | 6.4% | | - |
| | FFT: A&E response rate (Target: >30%) | 17.0% | 17.3% | 17.9% | 17.4% | 11.7% | 10.3% | 10.7% | 12.4% | 15.8% | 15.7% | 16.4% | 16.1% | 16.3% | | ! |
| | FFT: Maternity recommend % (Target: >90%) | 93.3% | 86.7% | 93.0% | 91.7% | 95.5% | 94.2% | 86.9% | 94.8% | 93.8% | 88.1% | 91.6% | 89.8% | 92.4% | | - |
| | FFT: Maternity not recommend % (Target: <10%) | 4.8% | 6.7% | 2.5% | 5.2% | 1.5% | 1.9% | 13.1% | 3.8% | 4.0% | 5.8% | 5.0% | 5.4% | 4.9% | | - |
| | FFT: Maternity response rate (Target: >30%) | 18.6% | 19.8% | 19.0% | 20.6% | 15.8% | 12.6% | 15.2% | 17.2% | 17.8% | 17.9% | 18.0% | 17.9% | 19.7% | | ! |
| 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 | 44 | 55 | 49 | 301 | 27 | 30 | 44 | 208 | 71 | 85 | 93 | 178 | 509 | | - |
| | Complaints formal: Number responded to < 25 days | 19 | 35 | 14 | 132 | 8 | 9 | 9 | 53 | 27 | 44 | 23 | 67 | 185 | | - |
| | Complaints (informal) through PALS | 78 | 101 | 73 | 744 | 45 | 94 | 178 | 626 | 123 | 195 | 251 | 446 | 1370 | | - |
| | Complaints sent through to the Ombudsman | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | | - |
| | Complaints upheld by the Ombudsman (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 3 | | - |

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

**Trust commentary**

**Inpatients**

Recommend %: There was a decline in the number of wards achieving over 90% at the Chelsea site whereas the West Middlesex site achieved its target of >90% in more areas
Not recommend %: The Trust continues to meet the target of less than 10% of patients, therefore the average ratings ('neither likely', 'unlikely' or 'don't know') decreased the overall recommendation rate
Response rate %: The inpatient areas achieved the response rate of >30%

**A&E**

Recommend %: The A&E departments continue to struggle to reach the 90% recommended target
Not recommend %: The West Middlesex site breeched <10% non-recommendation. The comments/themes relating to these scores were waiting times and subsequent communication.
Response rate %: Both sites have not achieved the >30% target. At Chelsea site the ED response rate increased to 25% however the UCC score of 17% decreased the overall score. Kiosks are situated in UCC and main reception, and the hand held devices (on-line surveys) re-commenced Mid-December. Volunteers are also supporting the surveys.

West Middlesex survey kiosk was installed November which has resulted in only a 1% increase in responses. More face to face support is needed in the department.
41% of texts sent to WM ED attendees failed due to either invalid phone number or no phone number – administration checks are needed at point of registration at reception.

**Maternity**

Recommend %: The 90% target was reached in November on both sites following a dip in performance the previous month
Not recommend %: West Middlesex have historically only provided the Birth touchpoint in the Board Report. This shows in month as 8/61 patients 'not recommending' and is under review.
Response rate %: Response remains low <10%. Volunteer support is being identified for FFT and hand- held surveys will re-commence end of December.

# Efficiency & Productivity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| Admitted Patient Care | Average length of stay - elective (Target: <3.7) | 3.45 | 3.37 | 3.23 | 3.61 | 2.83 | 3.97 | 4.09 | 3.59 | 3.30 | 3.52 | 3.46 | 3.49 | 3.60 | | - |
| | Average length of stay - non-elective (Target: <3.9) | 4.09 | 4.29 | 4.03 | 4.22 | 3.14 | 3.39 | 3.22 | 3.20 | 3.54 | 3.77 | 3.57 | 3.67 | 3.63 | | ! |
| | Emergency care pathway - average LoS (Target: <4.5) | 5.01 | 5.05 | 4.83 | 5.09 | 3.88 | 4.14 | 3.87 | 3.86 | 4.28 | 4.48 | 4.25 | 4.37 | 4.32 | | ! |
| | Emergency care pathway - discharges | 197 | 220 | 214 | 1644 | 350 | 363 | 335 | 2749 | 547 | 583 | 549 | 1133 | 4394 | | - |
| | Emergency re-admissions within 30 days of discharge (Target: <2.8%) | 3.27% | 3.60% | 3.56% | 3.44% | 8.22% | 9.74% | 9.11% | 9.16% | 5.59% | 6.42% | 6.08% | 6.25% | 6.06% | | ! |
| | Non-elective long-stayers | 451 | 505 | 481 | 3482 | 300 | 322 | 246 | 2308 | 751 | 827 | 727 | 1554 | 5790 | | - |
| Theatres | Daycase rate (basket of 25 procedures) (Target: >85%) | 84.5% | 82.0% | 80.9% | 83.3% | 81.8% | 86.9% | 85.3% | 87.5% | 83.5% | 83.8% | 82.7% | 83.2% | 85.0% | | ! |
| | Operations canc on the day for non-clinical reasons: actuals | 20 | 11 | 14 | 115 | 10 | 3 | 4 | 39 | 30 | 14 | 18 | 32 | 154 | | - |
| | Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%) | 0.74% | 0.35% | 0.47% | 0.49% | 0.89% | 0.23% | 0.32% | 0.40% | 0.78% | 0.32% | 0.42% | 0.37% | 0.47% | | - |
| | Operations cancelled the same day and not rebooked within 28 days (Target: 0) | 4 | 2 | 3 | 15 | 3 | 0 | 1 | 6 | 7 | 2 | 4 | 6 | 21 | | ! |
| | Theatre active time (C&W Target: >70%; WM Target: >78%) | 70.9% | 69.4% | 70.8% | 70.0% | 81.6% | 87.8% | 89.1% | 85.8% | 73.9% | 74.6% | 76.1% | 75.3% | 74.6% | | - |
| | Theatre booking conversion rates (Target: >80%) | 84.9% | 85.1% | 85.3% | 85.0% | 73.4% | 74.6% | 75.4% | 74.3% | 80.5% | 81.1% | 81.6% | 81.3% | 80.9% | | ! |
| Outpatients | First to follow-up ratio (Target: <1.5) | 1.56 | 1.48 | 1.48 | 1.55 | 1.26 | 1.23 | 1.21 | 1.24 | 1.34 | 1.29 | 1.28 | 1.29 | 1.32 | | - |
| | Average wait to first outpatient attendance (Target: <6 wks) | 7.9 | 7.7 | 7.8 | 7.7 | 10.0 | 9.7 | 8.2 | 9.4 | 8.9 | 8.7 | 8.0 | 8.3 | 8.6 | | ! |
| | DNA rate: first appointment | 15.7% | 13.2% | 12.3% | 13.9% | 11.3% | 11.0% | 10.1% | 10.4% | 13.6% | 12.1% | 11.2% | 11.7% | 12.2% | | - |
| | DNA rate: follow-up appointment | 12.9% | 10.8% | 10.3% | 11.6% | 10.1% | 9.6% | 9.5% | 9.5% | 12.0% | 10.4% | 10.0% | 10.2% | 10.9% | | - |

| 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 LoS**

The average Elective Length of Stay for patients discharged in November at the Chelsea Site continues to fall.

**Non-Elective and Emergency Care Pathway average LoS**

Non-Elective average length of stay at both hospitals has shifted below the target and this reflects the concentrated work to address this through a number of schemes: (improving discharge, focussed work on Top 20 longest stayers, better Out of Hours engagement for delayed transfers). This remains an absolute focus for the ECIST (Emergency Care Intensive Support Team) action plan and will be closely monitored as we progress through winter.

**Non-Elective Long Stayers**

The number of patients staying longer than the national 75th percentile for the admitting diagnosis has fallen for those discharged on November at both sites. This is the result of discharge planning initiatives across the Trust.

**Outpatient DNA rates**

DNA rates remain high, especially on the Chelsea site. An action plan is in place to address this through the outpatient innovation workstream. The rate of failure to attend at both Chelsea and Westminster and West Middlesex sites continues a trend downwards which is a positive outcome for the action plan

# Clinical Effectiveness Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| Best Practice | Dementia screening case finding (Target: >90%) | 81.0% | 96.0% | 95.5% | 87.6% | 93.5% | 98.0% | 96.3% | 95.3% | 87.5% | 97.1% | 95.9% | 96.5% | 91.8% | | - |
| | #NoF Time to Theatre <36hrs for medically fit patients (Target: 100%) | 95.5% | 92.3% | 85.0% | 94.9% | 58.8% | 69.2% | 91.7% | 84.1% | 79.5% | 80.8% | 87.5% | 84.5% | 90.0% | | ! |
| | Stroke care: time spent on dedicated Stroke Unit (Target: >80%) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 97.8% | 100.0% | 91.7% | 100.0% | 96.3% | 98.6% | | - |
| VTE | VTE: Hospital-acquired (Target: tbc) | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| | VTE risk assessment (Target: >95%) | 94.0% | 94.4% | 94.9% | 95.2% | 77.1% | 78.5% | 76.4% | 76.0% | 85.8% | 86.5% | 86.0% | 86.3% | 85.7% | | ! |
| TB Care | TB: Number of active cases identified and notified | 4 | 5 | 3 | 29 | 3 | 1 | 11 | 44 | 7 | 6 | 14 | 20 | 73 | | - |
| | TB: % of treatments completed within 12 months (Target: >85%) | | | | | | | | | | | | | | | - |

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

**Trust commentary**

**Fractured Neck of Femur – time to theatre within 36 hours for medically fit patients**

**CW Site:** November had 21 patients admitted with #NOF- 2nd highest month to date. 3 patients failed to have surgery within 36h. High number of overall trauma cases and lack of theatre time have contributed to the delays. Work is on-going to improve access to theatres.

**WMUH Site:** There was 1 breach due to anaesthetic availability- patient was operated on 1 hour after breaching the 36 hour target.

**VTE Hospital-acquired**

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

WMUH site: Data information team developing a programme to identify hospital associated VTE events via radiology reports that is linked to admission episode. Datix team support required to improve reporting of HATs on DATIX for appropriate root cause analysis investigation. Actions in progress and gaps requiring additional supported highlighted at the VTE deep dive.

**VTE Risk assessments completed**

C&W site: Performance has declined. Performance has been disseminated by the Medical Director directly to clinical teams and areas to highlight those not meeting ≥ 95% target. Weekly and monthly VTE performance reports continue to be circulated to all divisions.

WMUH site: Target not achieved due to current IT infrastructure. RealTime VTE whiteboard in development to highlight patients with outstanding VTE risk assessment. Information team continuing to work to incorporate cohorting arrangements (low risk patients/procedures excluded from VTE risk assessment) and new performance reports to feedback to divisions in a timely and accurate manner

# Access Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site Sep-17 | Oct-17 | Nov-17 | 2017-2018 | West Middlesex University Hospital Site Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Combined Trust Performance Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trust data 13 months 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%) | 99.38% | 99.07% | 98.53% | 97.54% | 99.52% | 92.79% | 88.53% | 96.73% | 99.47% | 94.90% | 92.25% | 93.50% | 97.04% | | - |
| | Diagnostic waiting times >6 weeks: breach actuals | 17 | 22 | 43 | 501 | 20 | 337 | 565 | 1059 | 37 | 359 | 608 | 967 | 1560 | | - |
| A&E and LAS | A&E unplanned re-attendances (Target: <5%) | 8.1% | 7.9% | 8.2% | 8.0% | 8.5% | 8.4% | 8.6% | 8.5% | 8.2% | 8.1% | 8.4% | 8.2% | 8.2% | | ! |
| | A&E time to treatment - Median (Target: <60') | 01:04 | 01:05 | 01:07 | 01:03 | 00:42 | 00:50 | 00:39 | 00:41 | 00:59 | 01:01 | 01:00 | 01:00 | 00:57 | | ! |
| | London Ambulance Service - patient handover 30' breaches | 17 | 33 | 16 | 184 | 32 | 27 | 25 | 280 | 49 | 60 | 41 | 101 | 464 | | - |
| | 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 Sep-17 only for issues) | Choose and book: appointment availability (average of daily harvest of unused slots) | 1095 | 881.3 | 313.6 | 1033 | 0 | 0 | 0 | 0 | 1095 | 881.3 | 313.6 | 597.5 | 1033 | | - |
| | Choose and book: capacity issue rate (ASI) | 50.6% | 51.5% | | 48.6% | | | | | 50.6% | 51.5% | | 51.5% | 48.6% | | - |
| | Choose and book: system issue rate | | | | | | | | | | | | | | | - |

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

**Trust commentary**

**Diagnostic waits under 6 weeks**

The Trust failed to achieve the diagnostic waiting time standard of 99% tests completed within 6 weeks of referral for the second consecutive month. As in October this was mainly due to non-compliance on the WM site. The combined YTD position is also non-compliant.

Across both sites 608 breaches were reported.

The CW site was responsible for 43 breaches. 33 of the breaches were in Endoscopy with the remaining 10 from Urology

The WM site reported 565 breaches, 527 of which were imaging patients. The majority of the remainder coming from Respiratory Physiology

As with October the majority of the breaches 526 were in non-obstetric ultrasound. The loss of scanning capacity (staffing issues) experienced in October has had a knock on effect into November and this will continue until the end of the calendar year. However, several actions have been taken to address the issue including:

- Recruitment of temporary staff
- Introduction of additional evening and weekend lists
- Closer and more regular monitoring of backlog
- Addition of extra patients onto existing lists; beginning and end so as not to impact upon existing appointments
- Equipment and staff loaned from Chelsea site

Certain examinations are to be redirected to Chelsea site

**London Ambulance Service – 30' patient handover breaches**

November saw a 50% drop in breaches of the 30 minute handover target at the Chelsea Site in November from the previous month, with both sites remaining in the Top 3 London Trusts for handovers.

# Maternity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| Birth indicators | Total number of NHS births | 536 | 497 | 481 | 3840 | 430 | 424 | 413 | 3414 | 966 | 921 | 894 | 1815 | 7254 | | - |
| | Total caesarean section rate (C&W Target: <27%; WM Target: <29%) | 33.4% | 38.2% | 36.8% | 33.5% | 27.1% | 25.7% | 28.4% | 26.1% | 30.6% | 32.5% | 32.9% | 32.7% | 30.0% | | ! |
| | Midwife to birth ratio (Target: 1:30) | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | | - |
| | Maternity 1:1 care in established labour (Target: >95%) | 96.9% | 100.0% | 96.2% | 98.3% | 97.0% | 93.3% | 97.7% | 96.4% | 96.9% | 96.7% | 96.9% | 96.8% | 97.3% | | - |
| Safety | Admissions of full-term babies to NICU | 28 | 29 | 20 | 168 | n/a | n/a | n/a | n/a | 28 | 29 | 20 | 49 | 168 | | - |

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

**Trust commentary**

**Total number of NHS births**

Births remain high at the Chelsea site. The combined position is slightly under plan in month. This slightly offsets the two previous months where the deliveries were above plan

**Total C-Section rate**

The trend continues of the West Middlesex section rate being compliant but the Chelsea site being above the indicator target. The newly appointed Director of Midwifery will be tasked with looking at any actions possible to address this.

**Midwife to birth ratio - births per WTE**

The midwife to birth ratio remains static and consistent at both sites after the equalising of ratios for the 17/18 financial year. The vacancy rate has improved and agency spend has reduced.

**Maternity 1:1 care in established labour**

The 1:1 care in labour was compliant in November on both sites. This was expected given the slight reduction in births and strong staffing levels throughout the month

# Workforce Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 2017-2018 | Trend charts | |
| Staffing | Vacancy rate (Target: CW <12%; WM <10%) | 12.3% | 11.6% | 11.2% | 11.2% | 14.9% | 15.0% | 16.0% | 16.0% | 13.2% | 12.8% | 12.9% | 12.9% | 12.9% | | ! |
| | Staff Turnover rate (Target: CW <18%; WM <11.5%) | 18.0% | 17.7% | 17.9% | 17.9% | 10.9% | 10.9% | 11.0% | 11.0% | 15.5% | 15.4% | 15.6% | 15.6% | 15.6% | | - |
| | Sickness absence (Target: <3%) | 3.0% | 3.3% | 2.8% | 2.7% | 3.5% | 3.6% | 3.3% | 2.8% | 3.2% | 3.4% | 3.0% | 3.2% | 2.7% | | ! |
| | Bank and Agency spend (£ks) | £2,209 | £2,707 | £2,343 | £19,451 | £2,548 | £2,404 | £2,326 | £19,368 | £4,757 | £5,111 | £4,669 | £9,781 | £38,818 | | - |
| | Nursing & Midwifery Agency: % spend of total pay (Target: tbc) | 9.5% | 8.9% | 7.1% | 7.5% | 14.5% | 11.5% | 10.3% | 12.7% | 11.4% | 9.9% | 8.3% | 9.1% | 9.4% | | - |
| Appraisal rates | % of Performance & Development Reviews completed - medical staff (Target: >85%) | 80.7% | 81.0% | 81.6% | 80.7% | 79.2% | 85.3% | 89.2% | 84.6% | 80.1% | 82.7% | 84.5% | 83.6% | 82.2% | | ! |
| | % of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%) | 35.7% | 41.6% | 55.5% | 23.8% | 28.8% | 35.7% | 50.5% | 18.1% | 33.3% | 39.6% | 53.8% | 46.7% | 21.8% | | - |
| Training | Mandatory training compliance (Target: >90%) | 85.5% | 86.5% | 86.5% | 85.1% | 85.7% | 87.9% | 84.5% | 85.4% | 85.6% | 87.0% | 85.8% | 86.4% | 85.2% | | ! |
| | Health and Safety training (Target: >90%) | 85.6% | 94.0% | 94.4% | 86.6% | 87.2% | 90.3% | 86.9% | 86.5% | 86.2% | 92.8% | 91.8% | 92.3% | 86.5% | | - |
| | Safeguarding training - adults (Target: 90%) | 89.7% | 90.4% | 91.1% | 89.8% | 86.9% | 90.0% | 87.3% | 86.8% | 88.7% | 90.3% | 89.8% | 90.0% | 88.7% | | ! |
| | Safeguarding training - children (Target: 90%) | 88.2% | 88.3% | 88.5% | 88.4% | 88.9% | 91.6% | 87.4% | 89.0% | 88.4% | 89.4% | 88.1% | 88.8% | 88.6% | | ! |

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

**Trust commentary**

**Staff in Post**

In November we employed 5318 whole time equivalent (WTE) people on substantive contracts, 3 WTE less than last month. Taking into account bank and agency workers our WTE workforce was 6030.

**Turnover**

Our voluntary turnover rate was 15.6%, 0.2% higher than last month with 17.9% at Chelsea and 11% at West Middlesex. The Trust continues to work in partnership with NHSI to address this.

**Vacancies**

Our general vacancy rate for November was 12.9%, which is slightly higher than October but still an improvement on September. The vacancy rate is 16% at West Middlesex and 11.2% at Chelsea.

**Sickness Absence**

Sickness absence in the month of November was 3.1%, 0.3% lower than October, which is a continued improvement.

**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 86% against our target of 90%. We have launched the new learning platform across the organisation which is receiving very positive feedback from staff.

**Performance and Development Reviews**

90% of all non-medical staff should have had their PDR by the end of December. The PDR compliance rate for all non-medical staff since April 2017 increased by 14.2% in November and now stands at 53.8%.
The rolling annual appraisal rate for medical staff was 84.5%, 1.8% higher than last month. For non-medical appraisal rates, we have seen an improvement with compliance and all Divisions have until the end of January 2018 to have 90% of their staff completed.

# 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 | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | YTD breaches | Sep-17 | Oct-17 | Nov-17 | 2017-2018 | YTD breaches | Sep-17 | Oct-17 | Nov-17 | 2017-2018 Q3 | 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 | 100% | 100% | 0 | | - |
| | Breast | n/a | n/a | n/a | n/a | 0.5 | 100% | 100% | 100% | 100% | 0 | 100% | 100% | 100% | 100% | 99.2% | 0.5 | | - |
| | Colorectal / Lower GI | 87.5% | 100% | 100% | 90.0% | 2.5 | 85.7% | 100% | 100% | 74.5% | 6 | 86.7% | 100% | 100% | 100% | 82.5% | 8.5 | | - |
| | Gynaecological | n/a | n/a | 100% | 94.4% | 0.5 | 100% | 100% | 75.0% | 96.4% | 0.5 | 100% | 100% | 87.5% | 88.9% | 95.7% | 1 | | - |
| | Haematological | 100% | 100% | 100% | 100% | 0 | n/a | 100% | 100% | 93.5% | 1 | 100% | 100% | 100% | 100% | 95.1% | 1 | | - |
| | Head and neck | 100% | n/a | n/a | 100% | 0 | 100% | 100% | 100% | 85.7% | 1 | 100% | 100% | 100% | 100% | 90.0% | 1 | | - |
| | Lung | 100% | n/a | n/a | 73.3% | 2 | 100% | n/a | 100% | 95.8% | 0.5 | 100% | n/a | 100% | 100% | 87.2% | 2.5 | | - |
| | Sarcoma | n/a | n/a | 100% | 100% | 0 | n/a | n/a | n/a | n/a | | n/a | n/a | 100% | 100% | 100% | 0 | | - |
| | Skin | 100% | 100% | 92.9% | 94.2% | 3.5 | n/a | 100% | 88.9% | 93.8% | 2 | 100% | 100% | 91.9% | 94.5% | 94.1% | 5.5 | | - |
| | Upper gastrointestinal | 100% | 100% | 100% | 81.0% | 2 | 100% | 100% | 0.0% | 92.9% | 0.5 | 100% | 100% | 66.7% | 85.7% | 85.7% | 2.5 | | - |
| | Urological | 71.4% | 70.0% | 100% | 52.2% | 21.5 | 100% | 100% | 100% | 90.5% | 5.5 | 84.6% | 92.1% | 100% | 95.3% | 73.8% | 27 | | - |
| | Urological (Testicular) | n/a | n/a | n/a | 100% | 0 | 100% | n/a | n/a | 100% | 0 | 100% | n/a | n/a | n/a | 100% | 0 | | - |
| | Site not stated | n/a | n/a | 100% | 71.4% | 1 | n/a | 100% | 90.0% | 94.1% | 0.5 | n/a | 100% | 93.3% | 94.7% | 87.5% | 1.5 | | - |

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

**Trust commentary**

For the 62 day GP Cancer referrals to first treatment pathway the Trust has an unvalidated position of 95.3% for November, slightly down on the validated 97.2% reported nationally in October which rated as the best performance in England

The unvalidated breaches in November by Tumour site are as follows:

Note that a pathway can be shared between organisation hence the fractions of a breach

Gynaecological: WMUH: 0.5 of a breach of 2 patients treated

Skin: C&W: 1 breach of 15 patients treated
WMUH: 0.5 of a breach of 5.5 patients treated

Upper Gastrointestinal: WMUH: 0.5 of a breach of 0.5 patients treated

All other pathways on both sites were treated within the 62 day target

# QUALITY PRIORITIES DASHBOARD

## Quarter 2 2017/2018

### Patient Safety

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Forecast Q2 | Forecast Q3 | Forecast Q4 | 2nd Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 1 | Reduction in falls (Frailty Quality Plan) | Director of Nursing | | | | | There has been a slight rise in falls this quarter but we have also witnessed an upturn in activity, the main falls reduction work is due to start this month as shown in the updated plan. The division expects the incidents to decrease overall during Q3 and 4. The status remains rag rated as green as this quarter there have been zero falls with severe harm requiring external reporting. |
| 2 | Antibiotic administration in Sepsis (Sepsis Plan) | Medical Director | | | | | There has been a slight drop this quarter 56.7% compared to 56.8% in Q1 although the eligible number of patients was higher. The sepsis screening tool and sepsis six pathway is being relaunched in Q3. This re launch is expected to demonstrate an increse in compliance. |
| 3 | National Early Warning Score (Sepsis Plan) | Medical Director | | | | | There has been a reduction in this measure this quarter but with the relaunch it is anticipated that there will be an increase in Q3. |
| 4 | National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan) | Divisional Medical Director | | | | | The divison has made significant progress in Q2. 61 LocSIp bundles have been identified for devleopment and each has been prioritised accoriding to the number of incidetns asscoiated with the bundle. The aim is to have all LocSips develoepd by the emnd of March with a trajectory of 15 per month. |

### Clinical Effectiveness

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Forecast Q2 | Forecast Q3 | Forecast Q4 | 2nd Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 5 | Reduction in still births (Maternity Plan) | Director of Midwifery | | | | | C&W continues to remain below the national still birth rate. |

### Patient Experience

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Forecast Q2 | Forecast Q3 | Forecast Q4 | 2nd Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 1 | Focus on complaints and demonstrate learning from complaints | Director of Midwifery | | | | | Complaints turnaround remains a concern however significant progress has been made in reducing the number of overdue complaints. We continue to aspire to the stretched target of 90%. |
| 2 | FFT improvements with new FFT provider | Director of Midwifery | | | | | Response rates remain low with only inpatient areas achieving the >30%. Recommendation rates are above the 90% in all areas apart from ED which is currenlty at 84% year to date. |

# Nursing Metrics Dashboard

## Safe Nursing and Midwifery Staffing

### Chelsea and Westminster Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 92.6% | 75.0% | 91.5% | 90.4% | 10.8 | 3.6 | 14.4 | 7 – 17.5 |
| Annie Zunz | 92.4% | 75.6% | 101.7% | 96.6% | 5.2 | 2.0 | 7.2 | 6.5 - 8 |
| Apollo | 96.6% | 100.0% | 94.7% | 113.9% | 12.4 | 2.8 | 15.2 | |
| Jupiter | 182.1% | 59.9% | 181.5% | - | 11.7 | 1.9 | 13.6 | 8.5 – 13.5 |
| Mercury | 92.9% | 99.6% | 85.0% | 10.0% | 7.0 | 0.6 | 7.6 | 8.5 – 13.5 |
| Neptune | 97.9% | 83.3% | 95.0% | 6.7% | 7.7 | 0.8 | 8.4 | 8.5 – 13.5 |
| NICU | 88.8% | - | 90.5% | - | 13.4 | 0.0 | 13.4 | |
| AAU | 104.0% | 75.7% | 100.8% | 93.3% | 9.7 | 2.1 | 11.9 | 7 - 9 |
| Nell Gwynn | 144.0% | 89.3% | 202.2% | 118.9% | 5.3 | 3.2 | 8.5 | 6 – 8 |
| David Erskine | 106.6% | 93.6% | 112.0% | 96.6% | 3.4 | 2.8 | 6.3 | 6 – 7.5 |
| Edgar Horne | 110.3% | 94.4% | 114.5% | 98.3% | 3.5 | 3.2 | 6.7 | 6 – 7.5 |
| Lord Wigram | 103.9% | 99.3% | 102.2% | 103.3% | 3.6 | 2.6 | 6.2 | 6.5 – 7.5 |
| St Mary Abbots | 122.3% | 92.2% | 141.1% | 143.0% | 4.3 | 2.4 | 6.8 | 6 – 7.5 |
| David Evans | 82.5% | 71.1% | 103.7% | 102.1% | 5.8 | 2.4 | 8.2 | 6 – 7.5 |
| Chelsea Wing | 96.0% | 72.2% | 100.0% | 102.1% | 8.3 | 4.5 | 12.8 | |
| Burns Unit | 97.1% | 100.0% | 100.0% | 96.8% | 13.0 | 3.0 | 16.0 | |
| Ron Johnson | 99.2% | 101.7% | 107.9% | 94.8% | 4.9 | 2.5 | 7.5 | 6 – 7.5 |
| ICU | 100.0% | 100.0% | 99.7% | - | 29.5 | 0.8 | 30.3 | 17.5 - 25 |
| Rainsford Mowlem | 87.1% | 94.1% | 100.8% | 100.8% | 3.2 | 2.8 | 6.0 | 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 | 91.6% | 70.1% | 104.1% | 96.3% | 6.7 | 1.7 | 5.6 | 6 – 7.5 |
| Lampton | 111.3% | 123.0% | 114.3% | 113.0% | 3.2 | 2.4 | 8.6 | 6 – 7.5 |
| Richmond | 92.8% | 93.2% | 75.3% | 49.9% | 5.8 | 2.9 | 6.0 | 6 – 7.5 |
| Syon 1 | 98.3% | 131.7% | 98.3% | 141.7% | 3.8 | 2.2 | 6.9 | 6 – 7.5 |
| Syon 2 | 101.3% | 151.3% | 100.0% | 232.1% | 3.2 | 3.7 | 8.1 | 8.5 – 13.5 |
| Starlight | 83.1% | 106.7% | 88.1% | 93.3% | 7.0 | 1.1 | 7.6 | 6 – 8 |
| Kew | 77.5% | 121.8% | 98.9% | 229.9% | 3.0 | 4.6 | 6.6 | 6 – 7.5 |
| Crane | 106.7% | 133.9% | 100.0% | 151.7% | 3.0 | 3.5 | 6.7 | 6 – 7.5 |
| Osterley 1 | 105.7% | 129.9% | 101.1% | 186.2% | 2.9 | 3.7 | 7.6 | 6 – 7.5 |
| Osterley 2 | 101.3% | 125.8% | 105.8% | 212.3% | 3.8 | 3.8 | 8.2 | 7 – 9 |
| MAU | 93.8% | 92.5% | 94.8% | 98.4% | 5.3 | 2.8 | 6.2 | 6.5 – 10 |
| CCU | 101.7% | 110.0% | 100.0% | - | 5.4 | 0.8 | 8.4 | 7 – 17.5 |
| Special Care Baby Unit | 95.3% | - | 95.9% | - | 7.8 | 0.0 | 7.8 | |
| Marble Hill 1 | 107.7% | 98.9% | 112.8% | 146.7% | 3.8 | 2.6 | 6.4 | 6 - 8 |
| Marble Hill 2 | 102.0% | 119.1% | 101.6% | 156.6% | 3.1 | 3.4 | 6.5 | 5.5 - 7 |
| ITU | 88.2% | - | 93.6% | - | 28.3 | 0.0 | 28.3 | 17.5 - 25 |

**Summary for November 2017**

High fill rates on SMA due to the new staffing model for SAU. David Evans showing low fill rates as staffing levels were reduced when elective lists were not fully booked. Nell Gwynn showing high fill rates to care for patients with a tracheostomy requiring additional staffing and additional shifts for escalation beds. High number of paediatrics on Jupiter with mental health needs requiring RMNs.

CHPPD is showing an overly generous amount on Richmond due to bed census data being counted at midnight and therefore not accounting for day surgery activity, low fill rates for HCAs on night due to escalation shifts not always being filled. Additional HCAs booked to care for confused patients at risk of falls on Kew, Crane, Osterley 1, Marble Hill 1 & 2, and Syon 1 &2. High acuity due to increased numbers of patients with NIV on Osterley 2. Senior leadership team working clinically in Starlight to supplement staffing. A number of off framework agency requests made to keep Starlight ward safe; not reflected in CHPPD.

# CQUIN Dashboard

## October 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 Therapy | 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 & participation in networks | Chief Operating Officer | |

**2017/18 CQUIN Performance**

The Trust has agreed 12 CQUIN schemes (6 national schemes for CCGs, 6 NHS England schemes) for 2017/18. Most of these schemes are 2 year schemes across the 2017-19 contracts; with the exception of NHS e-referrals, which is a 2017/18 only scheme. Senior Responsible Officers and operational leads have been established for all schemes.

**Quarter 1 Performance**

The quarter 1 performance has been signed off at 100% for NHSE schemes and 92% for CCG schemes. The only scheme that did not achieve 100% in quarter 1 was the Sepsis CQUIN scheme, which reported partial achievement in line with forecast. Quarter 2 reports were submitted at the end of October and the commissioner assessment is expected in December.

**National Schemes**

There is a continued risk to delivery of the Sepsis screening and review scheme, in line with 2016/17 and Q1 delivery, and the Trust is forecasting partial achievement.

There are also risks around some of the other 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 NHS e-referrals and implementation of the Emergency Care Data Set.

**NHS England Schemes**

The schemes are all on track for the year to date. 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.

# Finance Dashboard

## Month 8 2017/2018

## Integrated Position

### Financial Position (£000's)

| £'000 | Combined Trust | | |
|---|---|---|---|
| | Plan to Date | Actual to Date | Variance to Date |
| Income | 416,159 | 422,277 | 6,118 |
| Expenditure | (390,470) | (396,637) | (6,168) |
| | | | |
| **Adjusted EBITDA** | 21,508 | 21,599 | 90 |
| | | | |
| Adjusted EBITDA % | 6.173% | 6.072% | -0.10% |
| Interest/Other | (3,504) | (3,454) | 50 |
| Depreciation | (11,533) | (11,188) | 346 |
| PDC Dividends | (6,333) | (6,334) | (1) |
| Other | 0 | 0 | 0 |
| **Trust Deficit** | **4,319** | **4,665** | **345** |

**Comments**

The Trust is reporting a YTD surplus of £4,664k which is £345k favourable against the internal plan.

Income over-performance is driven by A&E attendances which led to more emergency admissions in general medicine, paediatrics and general surgery. Outpatients was the other area of high performance.

Pay is adverse by £8,442k year to date, The Trust continues to use bank and agency staff to cover vacancies. Temporary staffing is also used to cover sickness, pressure shifts and additional activity, including unfunded beds in escalation areas on both sites which remain open at month 8. Under achievement against pay CIP targets has also contributed to this variance (these are largely compensated for by overachievement against income and non-pay CIPs.

Non-pay is £2,275k favourable YTD. Included in this position is an adverse variance against clinical supplies which is mainly activity driven.

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

### Risk rating (year to date)

| Use of Resource Rating (UORR) | M07 (Before Override) | M07 (After Override) |
|---|---|---|
| Use of Resource Rating | 1 | 1 |
| | RAG rating | |

**Comments**

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

At the end of November, the Trust is performing in line with plan for all areas of measurement except against its agency rating, where YTD expenditure was £13.48m against a ceiling of £12.65m, an adverse variance of £0.83m. As the Trust did not score a "4" in any of its risk ratings, the override does not apply and the Trust achieved its planned UORR rating of "1".

### Cost Improvement Programme (CIPs)

| Theme | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Plan £'000 | Actual £'000 | Var £'000 | Plan £'000 | Actual £'000 | Var £'000 |
| Service Developments/Business Cases | 121 | 0 | (121) | 452 | 0 | (452) |
| Targeted Specialities | 709 | 886 | 177 | 4,712 | 5,915 | 1,203 |
| Residual % Based Savings | 1,205 | 819 | (386) | 9,504 | 7,383 | (2,121) |
| Unidentified | 304 | 0 | (304) | 1,556 | 0 | (1,556) |
| **Trust Total** | 2,339 | 1,705 | (634) | 16,224 | 13,298 | (2,925) |

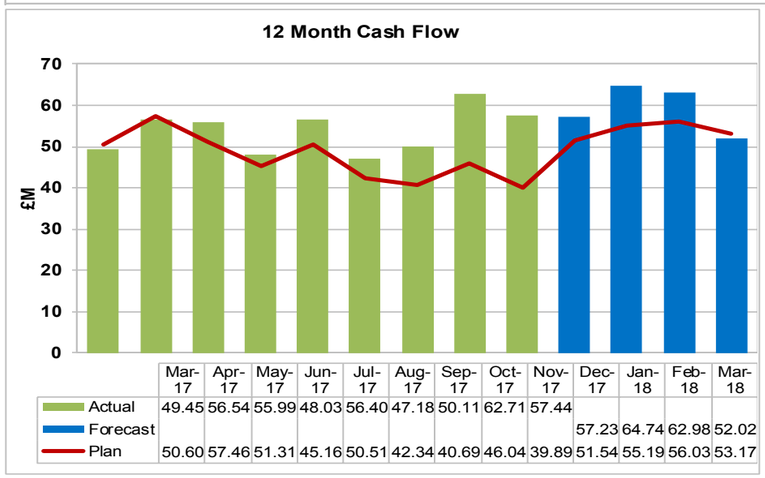
**Comments** RAG rating

The Trust has achieved YTD CIPs of £13.30m against an internal target of £16.22m, an adverse variance of £2.93m. The Trust has found it challenging maximising pay CIP plans within target speciality areas such as Care of the Elderly, Obstetrics and Gynaecology and Paediatrics. However new schemes totalling £7.06m have been added to mitigate any risk of underachievement. Through new schemes identified, the Trust aims to close the gap on unidentified schemes and achieve the target plan of £25.9m.

### Cash Flow

**Comments** RAG rating

The cash balance at the end of month 8 is £57.44m which is £17.55m more than plan of £39.89m. The main drivers of this increase are: Receipt of £0.27m of additional STF relating to the 2016/17 post accounts reallocation, reduction in opening cash figure compared to plan of £(1.15m), decrease in capital expenditure on a cash basis of £8.31m, increase in investment in Joint Venture compared to plan £(0.4m), increase in working capital compared to plan of £12.36m, decrease in loan drawdown compared to plan £(3.24m), increase in PDC received compared to plan by £0.88m and decrease in PDC dividend paid compared to plan £0.67m. The Trust is forecasting to end the year with a cash balance of £52.02m, an adverse variance to plan of £1.15m representing the difference between the closing cash balance at 31st March 2017 and that assumed as the 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 | 47.18 | 50.11 | 62.71 | 57.44 | | | | |
| Forecast | | | | | | | | | | 57.23 | 64.74 | 62.98 | 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 |

### Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later, unless other payment terms have been agreed with the supplier. The Trust's year to date performance at 31st October against the Better Payment Practice code, as reported to NHS Improvement, is as follows:

| At Month 7 | | YTD Number | YTD £'000 |
|---|---|---|---|
| Non- NHS | Total bills paid in the year | 66,874 | 165,447 |
| | Total bills paid within target | 541,117 | 122,701 |
| | % bills paid within target | **80.9%** | **74.2%** |
| NHS | Total bills paid in the year | 2,651 | 24,825 |
| | Total bills paid within target | 1,589 | 11,200 |
| | % bills paid within target | **59.9%** | **45.1%** |
| Total | Total bills paid in the year | 69,525 | 190,272 |
| | Total bills paid within target | 55,706 | 133,901 |
| | % bills paid within target | **80.1%** | **70.4%** |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.6.1/Jan/18 |
| **REPORT NAME** | Workforce Performance Report - Month 8 |
| **AUTHOR** | Keith Loveridge. Director of human resources and organisational development |
| **LEAD** | Keith Loveridge. Director of human resources and organisational development |
| **PURPOSE** | The workforce performance report highlights current KPIs and trends in workforce related metrics at the Trust. |
| **SUMMARY OF REPORT** | **Staff in Post**<br>In November we employed 5318 whole time equivalent (WTE) people on substantive contracts, 4 less than last month. Taking into account bank and agency workers our WTE workforce was 6238.<br><br>**Vacancies**<br>Our general vacancy rate for November was 12.9%, which is 0.1% higher than October. The vacancy rate is 16% at West Middlesex and 11.2% at Chelsea. Our nursing/midwifery vacancy rate is currently 15.5%.<br><br>**Establishment vs. WTE Worked**<br>This data compares the ESR budgeted establishment WTE against the total worked WTE of substantive staff and the WTE of Bank plus Agency worked in that month.<br><br>This data shows that in the month of November 135 WTE were used above the overall establishment.<br><br>**Turnover**<br>Our voluntary turnover rate was 15.6%, 0.2% higher than last month. Voluntary turnover is 17.9% at Chelsea and 11%% at West Middlesex.<br><br>**Sickness Absence**<br>The annual sickness absence rate stands at 2.7%. Sickness absence in the month of November was 3.0% compared to 3.4% in October 2017.<br><br>**Agency spend**<br>Our year to date agency spend of £13,483,216 at the end of November is 6.6% over target.<br><br>**Core training (statutory and mandatory training) compliance**<br>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 87% against our target of 90%. The trust has introduced a new electronic platform which will improve both user access and our ability to capture records of completion.<br><br>**Performance and Development Reviews and Appraisals** |

| | |
|---|---|
| | The rolling annual appraisal rate for medical staff was 84.5%, 1.8% higher than last month. Since 1 April 2017 all non-medical staff have been required to have their PDR in a set period, starting first with the most senior staff. At the end of November the PDR rate for staff in band 8c-9 roles was 97.6% and for band 7-8b was 92.3%. 90% of all staff in band 2-6 roles should have had their PDR by December 2017. The PDR compliance rate for all non-medical staff now stands at 53.8%. |
| **KEY RISKS ASSOCIATED** | The need to reduce vacancy and turnover rates. |
| **FINANCIAL IMPLICATIONS** | Costs associated with high vacancy and turnover 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<br>• Improve population health outcomes and develop integrated care<br>• Deliver financial sustainability<br>• 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 8 - November 2017

# Workforce Performance Report Dec ‘16 - Nov ‘17

# Performance Summary

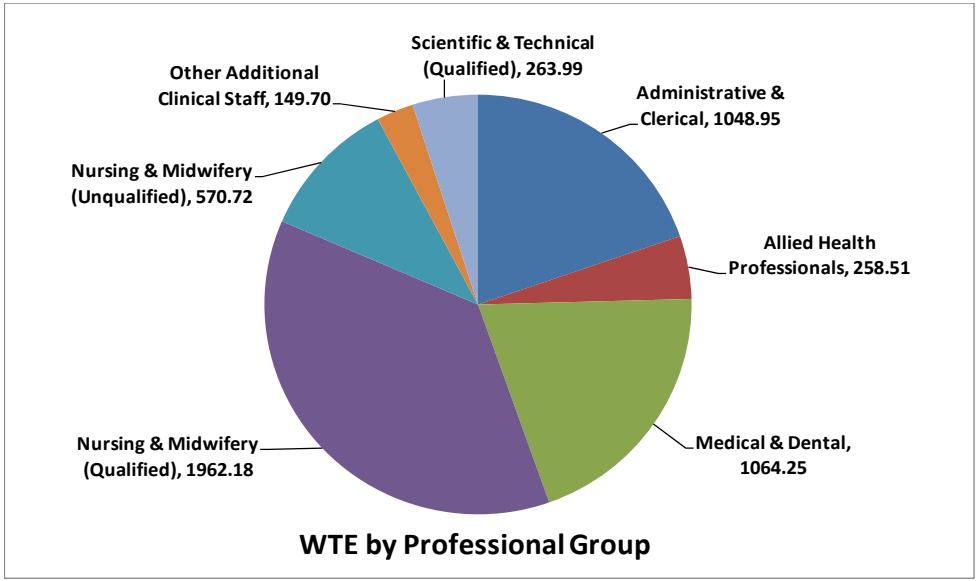
Summary of overall performance is set out below

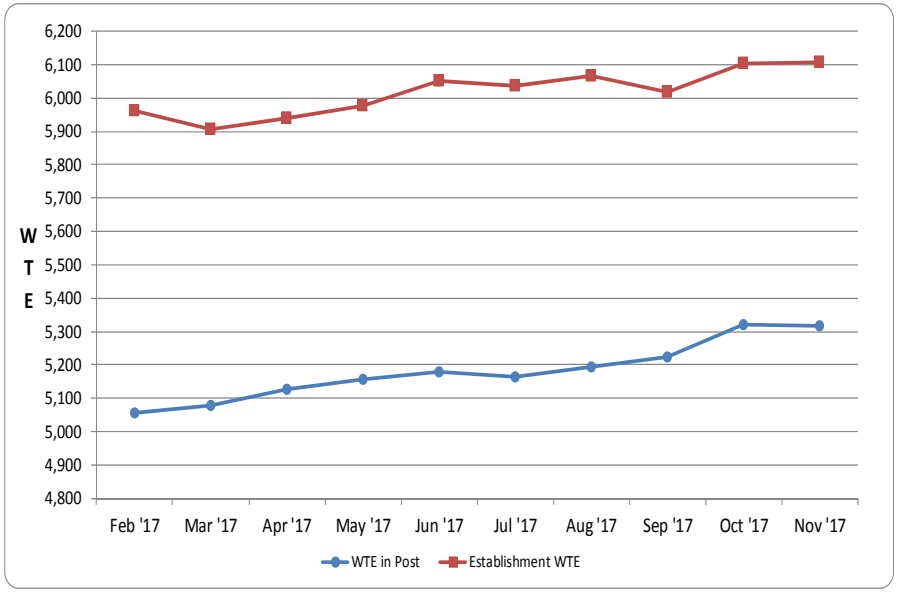
| Page | Areas of Review | Key Highlights | Previous Year | Previous Month | In Month | Target | Change |
|---|---|---|---|---|---|---|---|
| 5 | Vacancy | Vacancy rate has increased by 0.1% | 13.9% | 12.8% | 12.9% | 10.0% | ↗ |
| 6 | Turnover | Turnover has increased by 0.2% | | 20.3% | 20.5% | | ↗ |
| 7 | Voluntary Turnover | Voluntary turnover has increased by 0.2% | 15.3% | 15.4% | 15.6% | 13.0% | ↗ |
| 10 | Sickness | Sickness has decreased by 0.4% | 2.8% | 3.4% | 3.0% | 3.3% | ↘ |
| 15 | Temporary Staffing Usage (FTE) | Temporary Staffing % usage has decreased by 0.9% this month | | 15.7% | 14.8% | | ↘ |
| 17 | Core Training | Core Training compliance has decreased by 1.2% | 85.0% | 87.0% | 85.8% | 90.0% | ↘ |
| 18 | Staff PDR | The percentage of staff who have had a PDR since 1st April '17 has increased by 14.2% | 73.7% | 39.6% | 53.8% | 90.0% | ↗ |

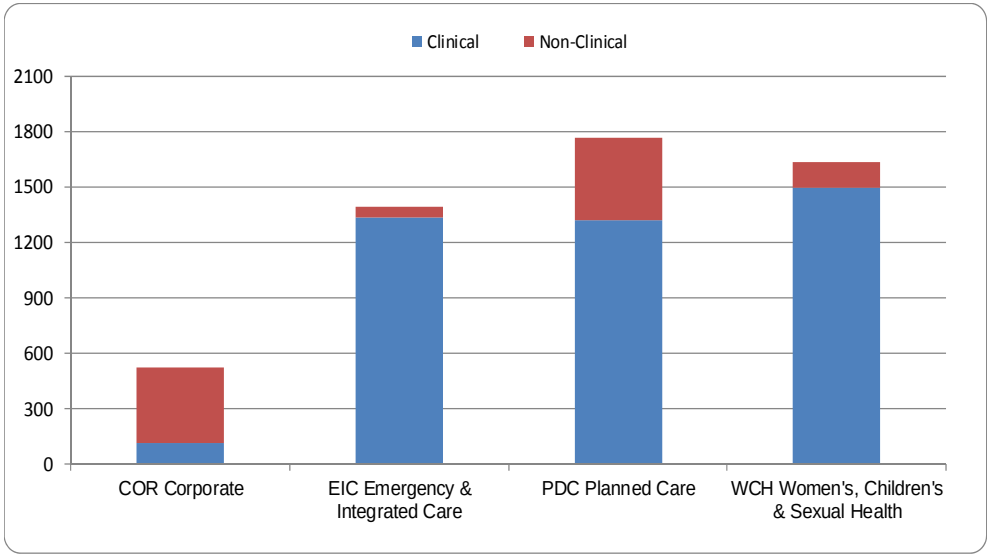
In addition to the information in this report, the trust monitors its workforce data by protected characteristics as defined by the Equality Act. To view the most recent annual workforce equality report please click this link http://connect/departments-and-mini-sites/equality-diversity/

# Current Staffing Profile

The data below displays the current staffing profile of the Trust



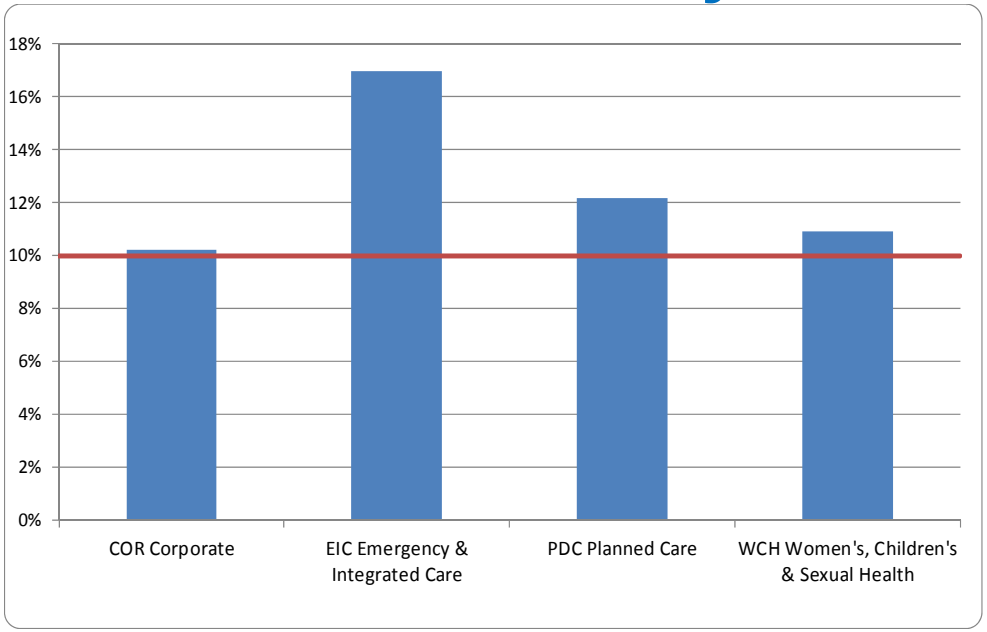

## COMMENTARY

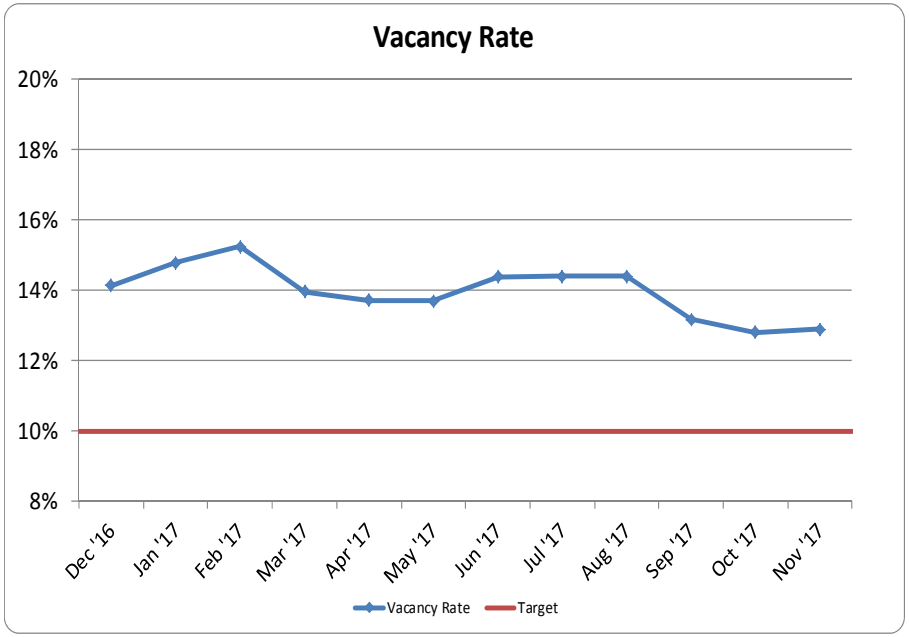
The Trust currently employs 5804 people working a whole time equivalent of 5318 which is 4 WTE less than October.

There were 1791 WTE staff assigned to the West Middlesex site and 3528 WTE to Chelsea.

The largest professional group at the Trust is Qualified Nursing & Midwifery employing 1962 WTE.

# Section 1a: Vacancy Rates




| Vacancies by Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 11.2% | 9.9% | 10.6% | 10.2% | ↘ |
| EIC Emergency & Integrated Care | 16.6% | 14.0% | 16.4% | 16.9% | ↗ |
| PDC Planned Care | 13.6% | 12.2% | 11.5% | 12.2% | ↗ |
| WCH Women's, Children's & Sexual Health | 14.3% | 14.6% | 11.6% | 10.9% | ↘ |
| **Whole Trust** | **14.4%** | **13.2%** | **12.8%** | **12.9%** | ↗ |
| **West Mid Site** | **16.8%** | **14.9%** | **15.0%** | **16.0%** | ↗ |
| **Chelsea Site** | **13.1%** | **12.3%** | **11.7%** | **11.2%** | ↘ |

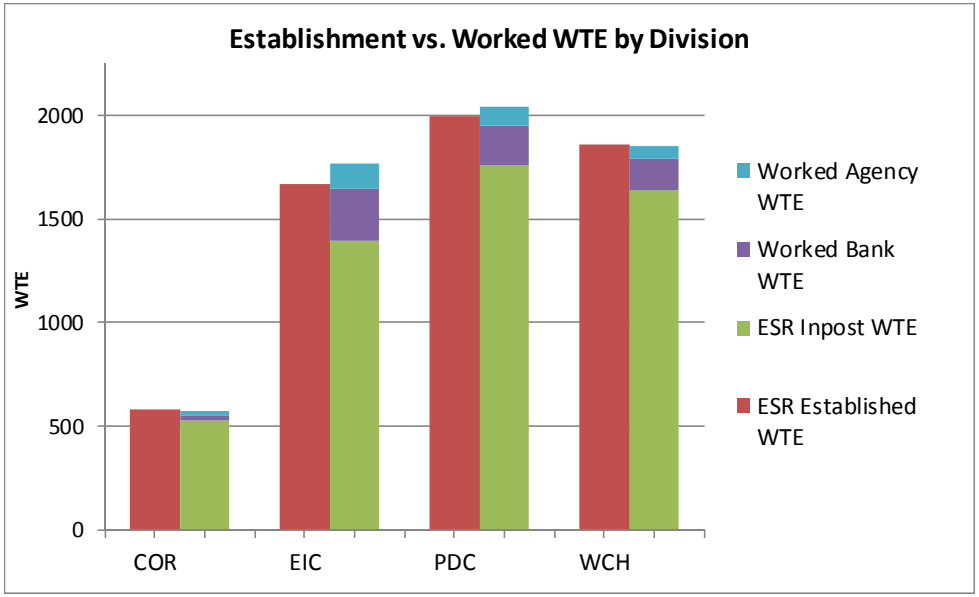
| Vacancies by Professional Group | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 16.0% | 11.8% | 12.4% | 12.1% | ↘ |
| Allied Health Professionals | 11.9% | 10.8% | 13.8% | 15.1% | ↗ |
| Medical & Dental | 11.0% | 8.8% | 9.0% | 9.2% | ↗ |
| Nursing & Midwifery (Qualified) | 16.8% | 16.5% | 15.0% | 14.8% | ↘ |
| Nursing & Midwifery (Unqualified) | 16.1% | 16.0% | 16.2% | 17.8% | ↗ |
| Other Additional Clinical Staff | 10.9% | 7.5% | 7.8% | 5.7% | ↘ |
| Scientific & Technical (Qualified) | 2.4% | 8.1% | 6.1% | 5.2% | ↘ |
| **Total** | **14.4%** | **13.2%** | **12.8%** | **12.9%** | ↗ |

**COMMENTARY**

The vacancy rate has increased by 0.1% in November.

The vacancy rate currently is highest in the Unqualified Nursing & Midwifery professional group at 17.8% and in the Emergency & Integrated Care Division at 16.9%.

# Section 1b: Establishment vs. WTE Worked




**COMMENTARY**

This data compares the ESR budgeted establishment WTE against the total worked WTE of substantive staff and the WTE of Bank plus Agency worked in that month.

The Establishment on ESR does not include budgeted WTE for Maternity or any allowance for specialling.

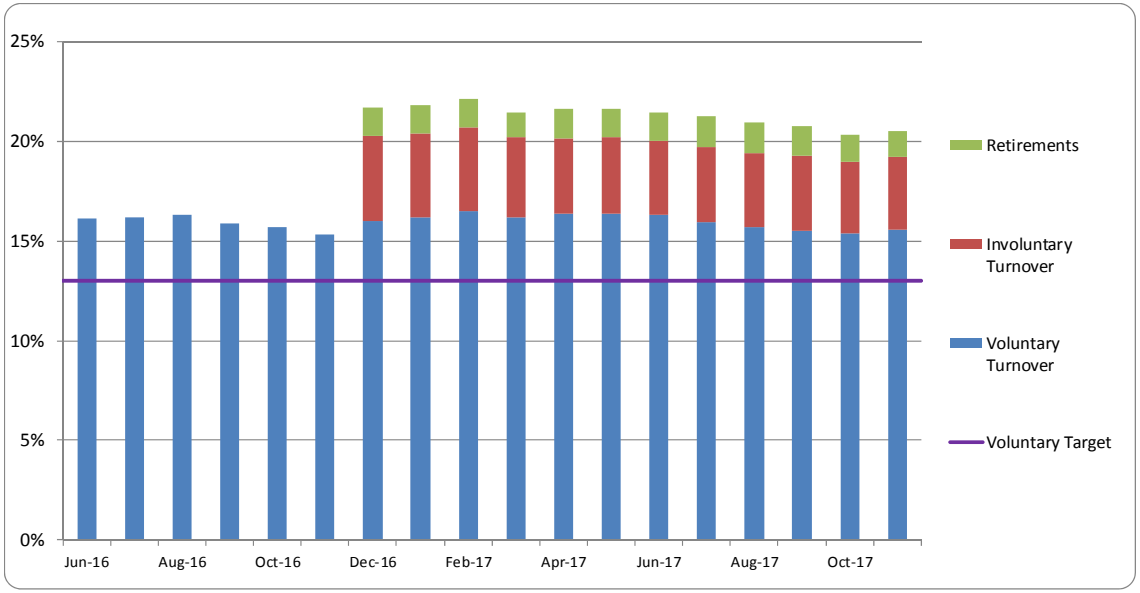
In November there were 157 WTE staff on maternity leave and the equivalent of 92 WTE shifts worked with a booking reason that indicates specialling.

| Division | ESR Established WTE | ESR Inpost WTE | Worked Bank WTE | Worked Agency WTE | Total Worked WTE | Variance vs. ESR Established WTE | Contractual Vacancy Rate % |
|---|---|---|---|---|---|---|---|
| COR Corporate | 580.1 | 527.1 | 26.9 | 21.0 | 575.0 | -5.1 | 10.2% |
| EIC Emergency & Integrated Care | 1672.1 | 1391.7 | 254.0 | 119.3 | 1765.0 | +92.9 | 16.9% |
| PDC Planned Care | 1996.1 | 1763.6 | 188.1 | 92.2 | 2043.8 | +47.7 | 12.2% |
| WCH Women's Children's & Sexual Health | 1855.0 | 1635.9 | 157.9 | 60.9 | 1854.7 | -0.3 | 10.9% |
| **Whole Trust** | **6103.3** | **5318.3** | **626.8** | **293.4** | **6238.5** | **+135.2** | **12.9%** |

| Professional Group | ESR Established WTE | ESR Inpost WTE | Worked Bank WTE | Worked Agency WTE | Total Worked WTE | Variance vs. ESR Established WTE | Contractual Vacancy Rate % |
|---|---|---|---|---|---|---|---|
| Administrative & Clerical | 1175.4 | 1048.9 | 79.2 | 53.5 | 1181.7 | +6.3 | 12.1% |
| Allied Health Professionals | 302.8 | 258.5 | 10.9 | 14.1 | 283.5 | -19.3 | 15.1% |
| Medical & Dental | 1179.2 | 1064.3 | 101.5 | 7.4 | 1173.1 | -6.0 | 9.2% |
| Nursing & Midwifery (Qualified) | 2294.4 | 1962.2 | 243.8 | 181.0 | 2386.9 | +92.5 | 14.8% |
| Nursing & Midwifery (Unqualified) | 703.6 | 570.7 | 177.3 | 30.8 | 778.8 | +75.2 | 17.8% |
| Other Additional Clinical Staff | 162.8 | 149.7 | 6.4 | 1.0 | 157.1 | -5.6 | 5.7% |
| Scientific & Technical (Qualified) | 285.2 | 264.0 | 7.7 | 5.6 | 277.3 | -7.9 | 5.2% |
| **Whole Trust** | **6103.3** | **5318.3** | **626.8** | **293.4** | **6238.5** | **+135.2** | **12.9%** |

# Section 2a: Gross Turnover

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




**COMMENTARY**

The total trust turnover rate has increased by 0.2% to 20.5% this month. In the last 12 months there have been 1051 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** | **Aug '17** | **Sep '17** | **Oct '17** | **Nov '17** | **Trend** |
| COR Corporate | 23.5% | 23.4% | 22.2% | 21.5% | ↘ |
| EIC Emergency & Integrated Care | 20.3% | 19.8% | 20.0% | 20.7% | ↗ |
| PDC Planned Care | 21.9% | 21.7% | 21.2% | 21.1% | ↘ |
| WCH Women's, Children's & Sexual Health | 19.7% | 19.8% | 19.1% | 19.4% | ↗ |
| **Whole Trust** | **20.9%** | **20.7%** | **20.3%** | **20.5%** | ↗ |

| | Gross Turnover | | | | |
|---|---|---|---|---|---|
| **Professional Group** | **Aug '17** | **Sep '17** | **Oct '17** | **Nov '17** | **Trend** |
| Administrative & Clerical | 21.5% | 20.9% | 20.2% | 19.6% | ↘ |
| Allied Health Professionals | 20.1% | 21.0% | 22.4% | 25.1% | ↗ |
| Medical & Dental | 14.3% | 14.3% | 13.3% | 14.2% | ↗ |
| Nursing & Midwifery (Qualified) | 20.3% | 20.4% | 20.1% | 19.9% | ↘ |
| Nursing & Midwifery (Unqualified) | 20.2% | 19.6% | 19.6% | 22.3% | ↗ |
| Other Additional Clinical Staff | 26.4% | 27.7% | 27.1% | 23.5% | ↘ |
| Scientific & Technical (Qualified) | 34.9% | 33.7% | 31.9% | 31.0% | ↘ |
| **Whole Trust** | **20.9%** | **20.7%** | **20.3%** | **20.5%** | ↗ |

# Section 2b: Voluntary Turnover

| | Voluntary Turnover | | | | | | Other Turnover Nov 2017 | |
|---|---|---|---|---|---|---|---|---|
| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend | Leavers HC | In-voluntary | Retirement |
| COR Corporate | 19.6% | 19.0% | 17.8% | 17.5% | ↘ | 91 | 3.5% | 0.6% |
| EIC Emergency & Integrated Care | 17.6% | 16.9% | 17.2% | 18.0% | ↗ | 227 | 2.1% | 0.6% |
| PDC Planned Care | 13.7% | 13.5% | 13.5% | 13.4% | ↘ | 228 | 6.0% | 1.7% |
| WCH Women's, Children's & Sexual Health | 15.1% | 15.5% | 15.3% | 15.4% | ↗ | 253 | 2.3% | 1.8% |
| **Whole Trust** | **15.7%** | **15.5%** | **15.4%** | **15.6%** | ↗ | **799** | **3.6%** | **1.3%** |
| **West Mid Site** | **12.3%** | **10.9%** | **10.9%** | **11.0%** | ↗ | **190** | | |
| **Chelsea Site** | **17.5%** | **18.0%** | **17.7%** | **17.9%** | ↗ | **609** | | |

| | Voluntary Turnover | | | | | | Other Turnover Nov 2017 | |
|---|---|---|---|---|---|---|---|---|
| Professional Group | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend | Leavers HC | In-voluntary | Retirement |
| Administrative & Clerical | 15.5% | 15.0% | 14.5% | 14.5% | ↔ | 153 | 3.7% | 1.4% |
| Allied Health Professionals | 18.2% | 19.0% | 21.1% | 23.1% | ↗ | 70 | 1.7% | 0.3% |
| Medical & Dental | 4.1% | 4.2% | 3.9% | 4.8% | ↗ | 28 | 8.0% | 1.4% |
| Nursing & Midwifery (Qualified) | 18.0% | 17.9% | 17.9% | 17.7% | ↘ | 376 | 0.8% | 1.4% |
| Nursing & Midwifery (Unqualified) | 17.2% | 16.9% | 16.7% | 18.8% | ↗ | 113 | 2.2% | 1.3% |
| Other Additional Clinical Staff | 18.9% | 18.9% | 17.2% | 13.6% | ↘ | 21 | 6.8% | 3.1% |
| Scientific & Technical (Qualified) | 15.0% | 14.5% | 13.8% | 12.8% | ↘ | 38 | 17.8% | 0.3% |
| **Whole Trust** | **15.7%** | **15.5%** | **15.4%** | **15.6%** | ↗ | **799** | **3.6%** | **1.3%** |

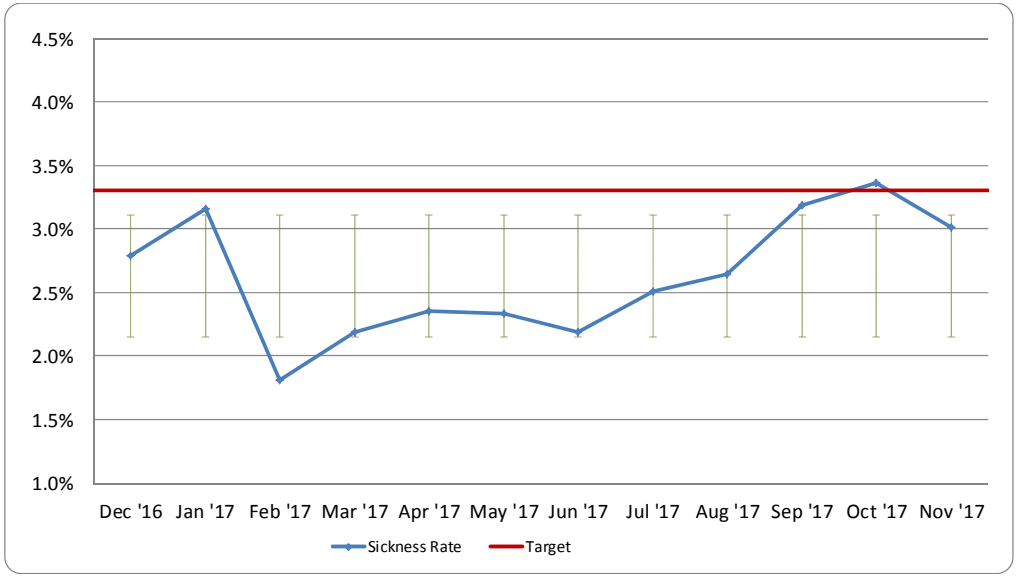
| Service | Average Staff in Post HC | Leavers HC | Voluntary Turnover Rate |
|---|---|---|---|
| John Hunter Clinic - CW | 43 | 17 | 39.5% |
| Endoscopy Service - CW | 21 | 8 | 38.1% |
| Acute Assessment Unit - CW | 66 | 24 | 36.6% |
| Paediatric Starlight Unit - WM | 42 | 14 | 33.3% |
| Ron Johnson - CW | 22 | 7 | 32.6% |

**COMMENTARY**

The 5 services with more than 20 staff with the highest voluntary turnover rates are shown in the bottom table. Divisional HR Business Partners are working within divisions to tackle any issues within these areas.

# Section 3: Sickness

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




**COMMENTARY**

The monthly sickness absence rate is at 3.0% in November which is an decrease of 0.4% on the previous month.

The Women's & Children's Division had the highest sickness rate in November at 3.5%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 5.7%.

The table below lists the services with the highest sickness absence percentage during November 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 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 2.2% | 2.7% | 2.4% | 2.6% | ↗ |
| EIC Emergency & Integrated Care | 2.0% | 2.6% | 2.4% | 2.3% | ↘ |
| PDC Planned Care | 2.8% | 3.4% | 4.2% | 3.3% | ↘ |
| WCH Women's, Children's & Sexual Health | 3.2% | 3.5% | 3.5% | 3.5% | ↔ |
| **Whole Trust Monthly %** | **2.6%** | **3.2%** | **3.4%** | **3.0%** | ↘ |
| **Whole Trust Annual Rolling %** | **2.6%** | **2.6%** | **2.7%** | **2.7%** | ↔ |

| Sickness by Professional Group | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 3.6% | 3.9% | 4.8% | 4.2% | ↘ |
| Allied Health Professionals | 1.7% | 1.8% | 1.6% | 1.3% | ↘ |
| Medical & Dental | 0.5% | 0.7% | 0.9% | 0.4% | ↘ |
| Nursing & Midwifery (Qualified) | 2.7% | 3.5% | 3.2% | 3.3% | ↗ |
| Nursing & Midwifery (Unqualified) | 4.8% | 5.4% | 5.6% | 5.7% | ↗ |
| Other Additional Clinical Staff | 3.2% | 3.6% | 5.0% | 3.0% | ↘ |
| Scientific & Technical (Qualified) | 2.8% | 3.8% | 4.4% | 2.5% | ↘ |
| **Total** | **2.6%** | **3.2%** | **3.4%** | **3.0%** | ↘ |

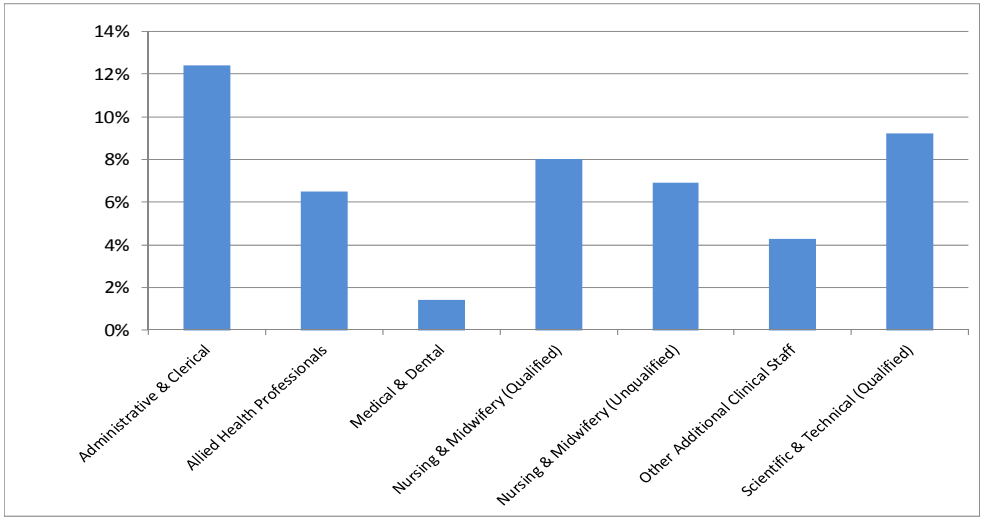
| Service | Staff in Post WTE | Sickness WTE Days Lost | Sickness % |
|---|---|---|---|
| Syon 2 - WM | 27.73 | 122.20 | 14.8% |
| John Hunter Clinic - CW | 41.89 | 157.20 | 13.2% |
| Dermatology - CW | 26.59 | 95.00 | 11.6% |
| Clin Admin Emergency - CW | 51.76 | 138.49 | 9.5% |
| Genito Urinary Med. Nursing - WM | 23.87 | 56.24 | 8.1% |

| Top 5 Sickness Reasons by Number of Episodes | % of all Episodes |
|---|---|
| S13 Cold, Cough, Flu - Influenza | 29.81% |
| S25 Gastrointestinal problems | 17.02% |
| S10 Anxiety/stress/depression/other psychiatric illnesses | 8.57% |
| S12 Other musculoskeletal problems | 8.23% |
| S16 Headache / migraine | 7.45% |

| Top 5 Sickness Reasons by Number of WTE Days Lost | % of all WTE Days Lost |
|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 20.82% |
| S12 Other musculoskeletal problems | 14.36% |
| S13 Cold, Cough, Flu - Influenza | 13.29% |
| S25 Gastrointestinal problems | 9.80% |
| S28 Injury, fracture | 8.22% |

# 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 November 54 staff were promoted, there were 82 new starters to the Trust (excluding Doctors in Training). In addition, 69 employees were acting up to a higher grade.

Over the last year 7.9% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Division.

Admin & Clerical currently have the highest promotion rate at 12.4% followed by Scientific & Technical staff group at 9.2%

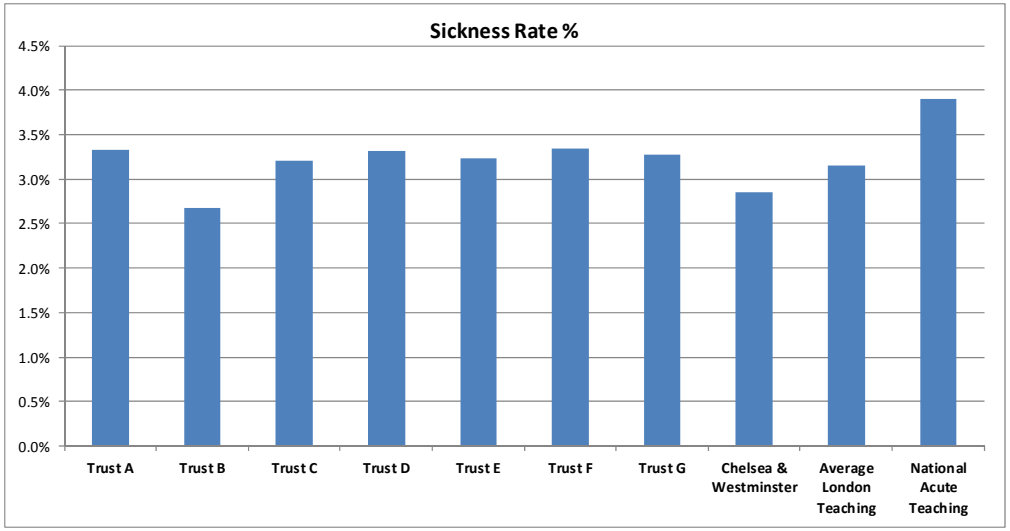
| | Monthly No. of Promotions | | | | |
|---|---|---|---|---|---|
| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
| COR Corporate | 0 | 6 | 9 | 7 | ↘ |
| EIC Emergency & Integrated Care | 6 | 10 | 12 | 7 | ↘ |
| PDC Planned Care | 15 | 12 | 12 | 16 | ↗ |
| WCH Women's, Children's & Sexual Health | 11 | 13 | 20 | 24 | ↗ |
| **Whole Trust Promotions** | **32** | **41** | **53** | **54** | ↗ |
| **New Starters (Excludes Doctors in Training)** | **72** | **121** | **137** | **82** | ↘ |

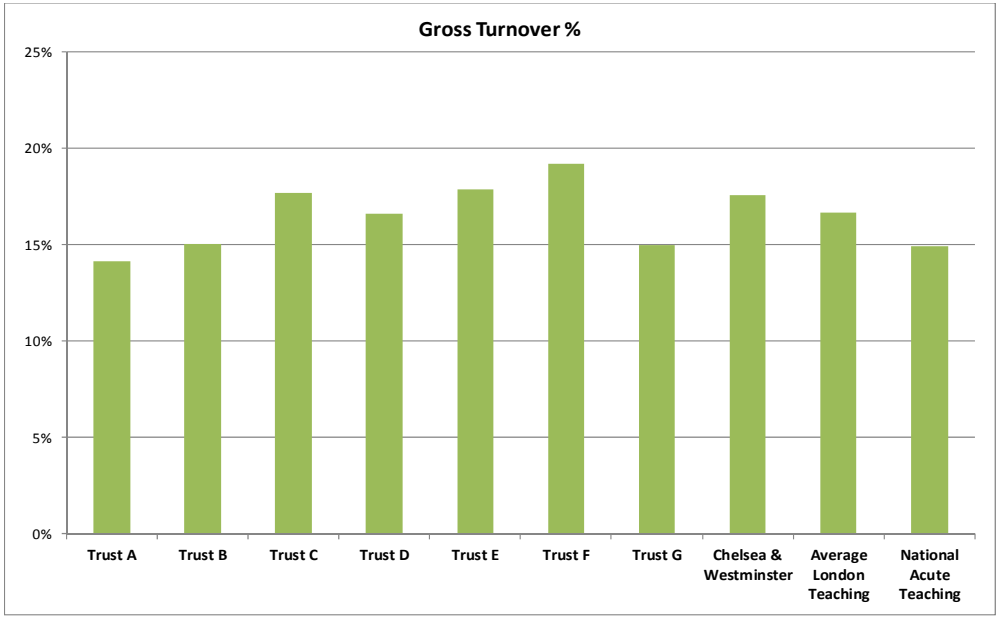
| Division | Staff in Post + 1yrs Service | No. of Staff Promoted (12 Months) | % of Staff Promoted | Currently Acting Up | BME % Overall Division | BME % Promoted |
|---|---|---|---|---|---|---|
| COR Corporate | 399 | 38 | 9.5% | 8 | 40.1% | 50.0% |
| EIC Emergency & Integrated Care | 989 | 85 | 8.6% | 19 | 47.8% | 47.1% |
| PDC Planned Care | 1360 | 88 | 6.5% | 26 | 47.4% | 43.2% |
| WCH Women's, Children's & Sexual Health | 1344 | 111 | 8.3% | 16 | 32.1% | 18.0% |
| **Whole Trust** | **4092** | **322** | **7.9%** | **69** | **41.8%** | **36.3%** |
| **New Starters (Excludes Doctors in Training)** | | **1161** | | | | |

| | No. of Promotions | | | | |
|---|---|---|---|---|---|
| Professional Group | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
| Administrative & Clerical | 10 | 11 | 17 | 26 | ↗ |
| Allied Health Professionals | 2 | 0 | 6 | 2 | ↘ |
| Medical & Dental | 3 | 3 | 4 | 1 | ↘ |
| Nursing & Midwifery (Qualified) | 10 | 14 | 19 | 19 | ↔ |
| Nursing & Midwifery (Unqualified) | 4 | 8 | 2 | 4 | ↗ |
| Other Additional Clinical Staff | 1 | 1 | 2 | 2 | ↔ |
| Scientific & Technical (Qualified) | 2 | 4 | 3 | 0 | ↘ |
| **Whole Trust** | **32** | **41** | **53** | **54** | ↗ |

| Professional Group | Staff in Post + 1yrs Service | No. of Staff Promoted (12 Months) | % of Staff Promoted | Currently Acting Up | BME % of Prof Group | BME % Promoted |
|---|---|---|---|---|---|---|
| Administrative & Clerical | 821 | 102 | 12.4% | 24 | 38.6% | 38.2% |
| Allied Health Professionals | 230 | 15 | 6.5% | 14 | 20.0% | 13.3% |
| Medical & Dental | 492 | 7 | 1.4% | 1 | 36.2% | 14.3% |
| Nursing & Midwifery (Qualified) | 1741 | 140 | 8.0% | 23 | 42.3% | 28.6% |
| Nursing & Midwifery (Unqualified) | 463 | 32 | 6.9% | 0 | 59.4% | 59.4% |
| Other Additional Clinical Staff | 117 | 5 | 4.3% | 1 | 47.0% | 40.0% |
| Scientific & Technical (Qualified) | 228 | 21 | 9.2% | 6 | 44.7% | 66.7% |
| **Whole Trust** | **4092** | **322** | **7.9%** | **69** | **41.8%** | **36.3%** |

# Section 5: Workforce Benchmarking




**COMMENTARY**

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

Sickness data shown is from Sep'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 2.9%. 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 September.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). Chelwest currently has higher than average turnover (12 months to end October). 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 3% 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 | 14.12% | 85.37% | 3.33% |
| Trust B | 15.02% | 84.48% | 2.67% |
| Trust C | 17.67% | 82.07% | 3.21% |
| Trust D | 16.61% | 83.22% | 3.32% |
| Trust E | 17.86% | 82.34% | 3.24% |
| Trust F | 19.20% | 80.96% | 3.35% |
| Trust G | 14.97% | 84.74% | 3.28% |
| Chelsea & Westminster | 17.53% | 82.02% | 2.86% |
| Average London Teaching | 16.62% | 83.15% | 3.16% |
| National Acute Teaching | 14.93% | 85.15% | 3.90% |

# Section 6: Nursing Workforce Profile/KPIs

**Nursing Establishment WTE**

| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 86.1 | 84.1 | 84.1 | 87.1 | ↗ |
| EIC Emergency & Integrated Care | 1003.7 | 1004.7 | 1032.3 | 1022.0 | ↘ |
| PDC Planned Care | 713.1 | 708.5 | 708.6 | 711.6 | ↗ |
| WCH Women's, Children's & Sexual Health | 1155.4 | 1168.8 | 1173.0 | 1178.2 | ↗ |
| **Total** | **2958.3** | **2966.0** | **2998.0** | **2998.8** | ↗ |

**Nursing Staff in Post WTE**

| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 75.6 | 75.1 | 75.3 | 80.3 | ↗ |
| EIC Emergency & Integrated Care | 797.2 | 810.6 | 820.8 | 809.4 | ↘ |
| PDC Planned Care | 602.2 | 614.0 | 621.8 | 623.6 | ↗ |
| WCH Women's, Children's & Sexual Health | 990.2 | 979.2 | 1022.2 | 1019.6 | ↘ |
| **Total** | **2465.2** | **2478.9** | **2540.2** | **2532.9** | ↘ |

**Nursing Vacancy Rate**

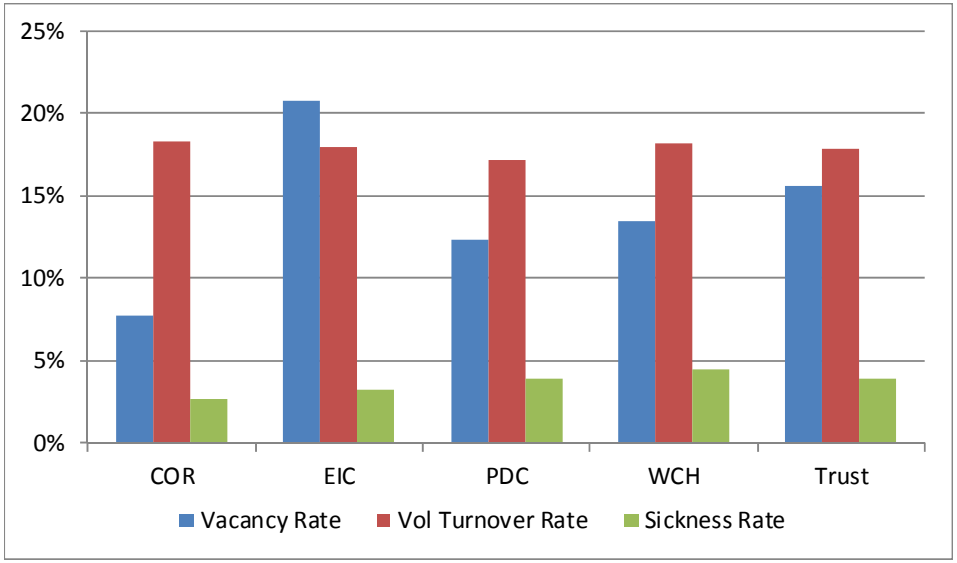
| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 12.2% | 10.7% | 10.4% | 7.8% | ↘ |
| EIC Emergency & Integrated Care | 20.6% | 19.3% | 20.5% | 20.8% | ↗ |
| PDC Planned Care | 15.5% | 13.3% | 12.2% | 12.4% | ↗ |
| WCH Women's, Children's & Sexual Health | 14.3% | 16.2% | 12.9% | 13.5% | ↗ |
| **Total** | **16.7%** | **16.4%** | **15.3%** | **15.5%** | ↗ |

**Nursing Sickness Rates**

| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 1.7% | 2.3% | 2.0% | 2.6% | ↗ |
| EIC Emergency & Integrated Care | 2.6% | 3.7% | 3.1% | 3.2% | ↗ |
| PDC Planned Care | 2.9% | 3.9% | 4.3% | 3.9% | ↘ |
| WCH Women's, Children's & Sexual Health | 4.0% | 4.4% | 4.1% | 4.5% | ↗ |
| **Total** | **3.2%** | **4.0%** | **3.8%** | **3.9%** | ↗ |

**Nursing Voluntary Turnover**

| Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 17.89% | 19.20% | 18.80% | 18.24% | ↘ |
| EIC Emergency & Integrated Care | 19.09% | 17.42% | 17.36% | 17.93% | ↗ |
| PDC Planned Care | 17.26% | 16.92% | 17.11% | 17.16% | ↗ |
| WCH Women's, Children's & Sexual Health | 16.90% | 17.56% | 17.73% | 18.17% | ↗ |
| **Total** | **17.7%** | **17.4%** | **17.5%** | **17.8%** | ↗ |
| **West Mid Site** | | | | **11.8%** | ↗ |
| **Chelsea Site** | | | | **21.5%** | ↗ |




**COMMENTARY**

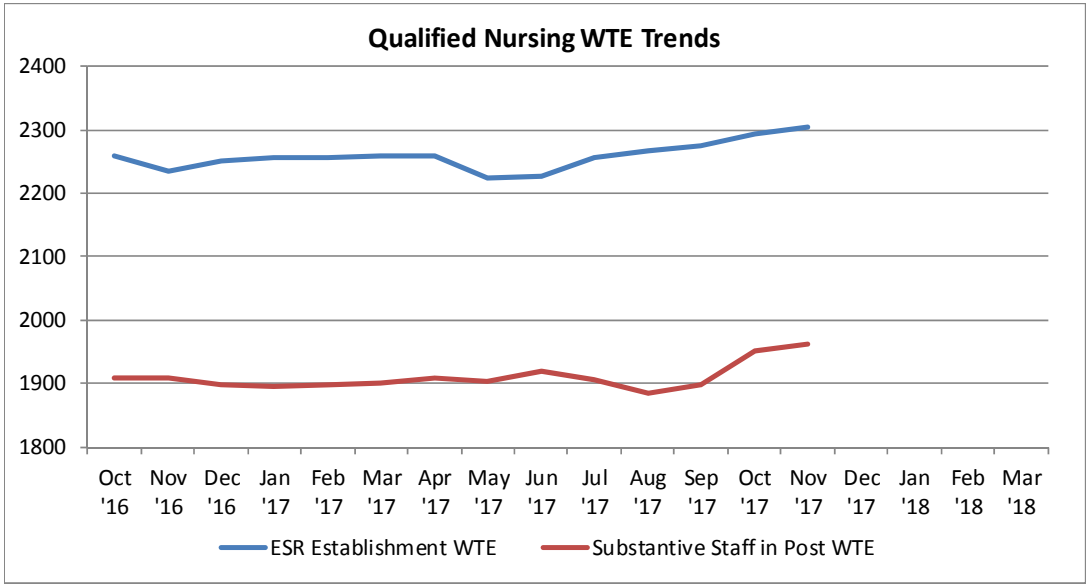
This data shows a more in-depth view of our nursing workforce (both qualified and unqualified).

The nursing workforce has decreased by 7 WTE in November

# Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

| Measure | Jan '17 | Feb '17 | Mar '17 | Apr '17 | May '17 | Jun '17 | Jul '17 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Dec '17 | Jan '18 | Feb '18 | Mar '18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE | 2255.5 | 2256.4 | 2257.5 | 2258.6 | 2223.7 | 2227.0 | 2255.0 | 2266.1 | 2273.5 | 2294.4 | 2304.3 | | | | |
| Substantive Staff in Post WTE | 1894.3 | 1896.8 | 1900.4 | 1907.3 | 1904.0 | 1918.1 | 1905.6 | 1884.5 | 1897.4 | 1950.5 | 1962.2 | | | | |
| Contractual Vacancies WTE | 361.1 | 359.6 | 357.1 | 351.2 | 319.7 | 309.0 | 349.4 | 381.6 | 376.1 | 343.8 | 342.1 | | | | |
| Vacancy Rate % | 16.01% | 15.94% | 15.82% | 15.55% | 14.38% | 13.87% | 15.49% | 16.84% | 16.54% | 14.99% | 14.85% | | | | |
| Actual/Planned Leavers Per Month* | 25 | 20 | 28 | 41 | 36 | 29 | 31 | 44 | 31 | 45 | 28 | 33 | 33 | 33 | 33 |
| Actual/Planned New Starters** | 26 | 23 | 33 | 58 | 32 | 38 | 19 | 19 | 39 | 73 | 25 | 61 | 61 | 61 | 61 |
| Pipeline: Agreed Start Dates | | | | | | | | | | | | 21 | 38 | 36 | 2 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | | | | | 303 - with no agreed start date | | | |

* Based on Gross Turnover of 20%




**COMMENTARY**

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

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

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

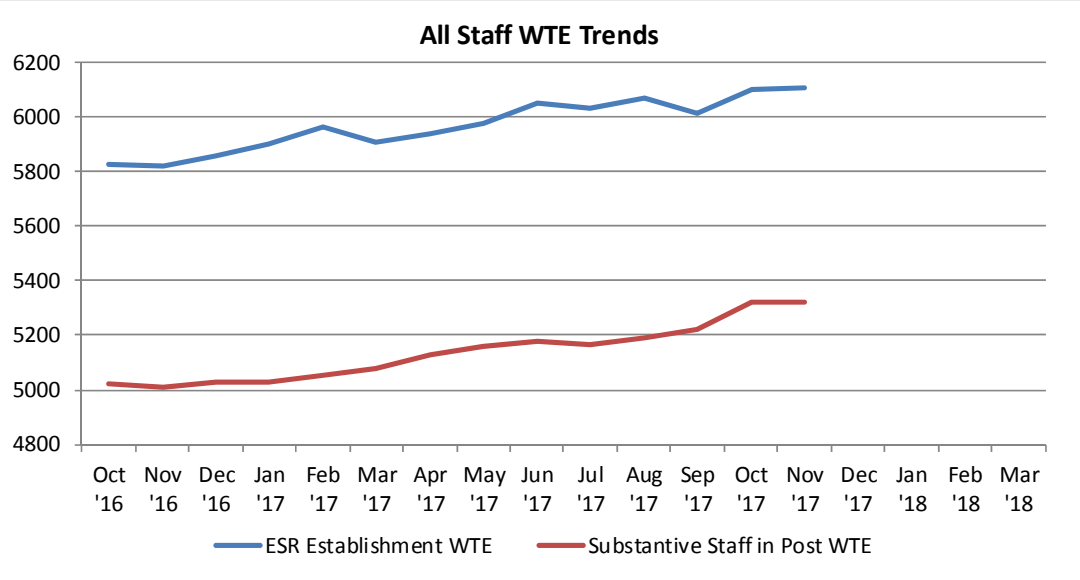
# Section 8: All Staff Recruitment Pipeline

| Measure | Jan '17 | Feb '17 | Mar '17 | Apr '17 | May '17 | Jun '17 | Jul '17 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Dec '17 | Jan '18 | Feb '18 | Mar '18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE[1] | 5901.5 | 5963.8 | 5905.0 | 5940.6 | 5975.5 | 6051.6 | 6035.3 | 6067.5 | 6016.5 | 6103.3 | 6106.3 | | | | |
| Substantive Staff in Post WTE | 5028.8 | 5054.8 | 5080.2 | 5125.6 | 5156.2 | 5180.3 | 5165.7 | 5193.0 | 5223.4 | 5321.8 | 5318.3 | | | | |
| Contractual Vacancies WTE | 872.7 | 909.0 | 824.8 | 814.9 | 819.2 | 871.3 | 869.5 | 874.5 | 793.1 | 781.5 | 788.0 | | | | |
| Vacancy Rate % | 14.79% | 15.24% | 13.97% | 13.72% | 13.71% | 14.40% | 14.41% | 14.41% | 13.18% | 12.80% | 12.90% | | | | |
| Actual/Planned Leavers Per Month[2] | 76 | 56 | 67 | 90 | 95 | 63 | 96 | 280 | 128 | 146 | 92 | 89 | 89 | 89 | 89 |
| Actual/Planned New Starters[3] | 118 | 120 | 127 | 151 | 130 | 86 | 94 | 252 | 179 | 210 | 94 | 133 | 133 | 133 | 133 |
| Pipeline: Agreed Start Dates | | | | | | | | | | | | 59 | 94 | 46 | 4 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | | | | | 565 - 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 of staff at the Trust and projects forward a pipeline based on starters already in the recruitment process.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the vacancy rate down to 10% by 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 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £181,449 | £175,460 | £113,691 | £81,457 | £1,376,738 |
| Target Spend | £245,148 | £245,148 | £233,749 | £233,749 | £2,030,539 |
| Variance | -£63,699 | -£69,688 | -£120,058 | -£152,292 | -£653,801 |
| Variance % | -26.0% | -28.4% | -51.4% | -65.2% | -32.2% |

## EIC Emergency & Integrated Care

| Emergency & Integrated Care | Aug '17 | Sep '17 | Oct '17 | Nov '17 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £715,007 | £708,043 | £730,714 | £557,358 | £5,611,280 |
| Target Spend | £592,704 | £592,704 | £565,145 | £565,145 | £4,909,310 |
| Variance | £122,303 | £115,339 | £165,569 | -£7,787 | £701,970 |
| Variance % | 20.6% | 19.5% | 29.3% | -1.4% | 14.3% |

## PDC Planned Care

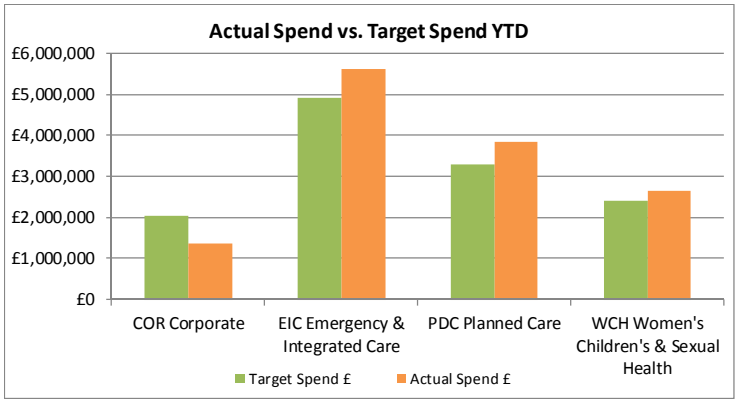
| Planned Care | Aug '17 | Sep '17 | Oct '17 | Nov '17 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £539,858 | £349,986 | £478,500 | £583,076 | £3,847,814 |
| Target Spend | £398,680 | £398,680 | £380,143 | £380,143 | £3,302,233 |
| Variance | £141,178 | -£48,694 | £98,357 | £202,933 | £545,581 |
| Variance % | 35.4% | -12.2% | 25.9% | 53.4% | 16.5% |

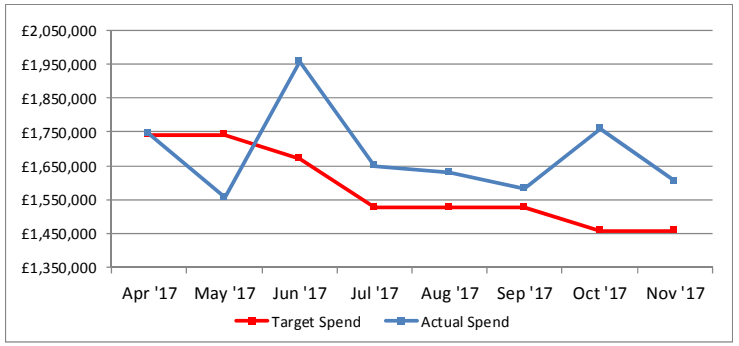
## WCH Women's, Children's & Sexual Health

| Women's, Children's & Sexual Health | Aug '17 | Sep '17 | Oct '17 | Nov '17 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £194,186 | £348,533 | £434,636 | £384,021 | £2,647,384 |
| Target Spend | £290,468 | £290,468 | £276,962 | £276,962 | £2,405,916 |
| Variance | -£96,282 | £58,065 | £157,674 | £107,059 | £241,468 |
| Variance % | -33.1% | 20.0% | 56.9% | 38.7% | 10.0% |

## Clinical Divisions and Corporate Areas

| Trust | Aug '17 | Sep '17 | Oct '17 | Nov '17 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £1,630,500 | £1,582,022 | £1,757,541 | £1,605,912 | £13,483,216 |
| Target Spend | £1,527,000 | £1,527,000 | £1,455,999 | £1,455,999 | £12,647,998 |
| Variance | £103,500 | £55,022 | £301,542 | £149,913 | £835,218 |
| Variance % | 6.8% | 3.6% | 20.7% | 10.3% | 6.6% |




### COMMENTARY

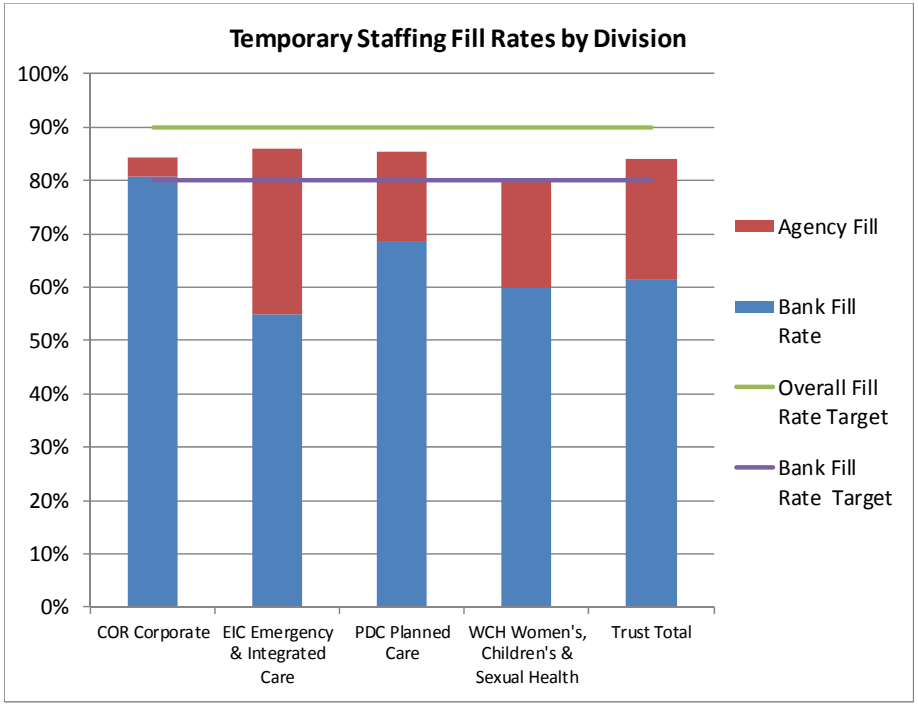
These figures show the Trust agency spend by Division compared to the spend ceilings which have been set for 17/18.

In Month 8, the Emergency & Integrated Care Division spent 53.4% more than the target for the month.

Overall, the only Division below it's YTD target is Corporate, by 32.2%.

** please note that the agency cap plan figures are phased differently in the NHSI monthly returns. This summary shows performance against the equally phased plan.*

# Section 10: Temporary Staff Fill Rates




## COMMENTARY

The “Overall Fill Rate” measures our success in meeting temporary staffing requests, by getting cover from either bank or agency staff. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests that were filled by bank staff only, not agency.

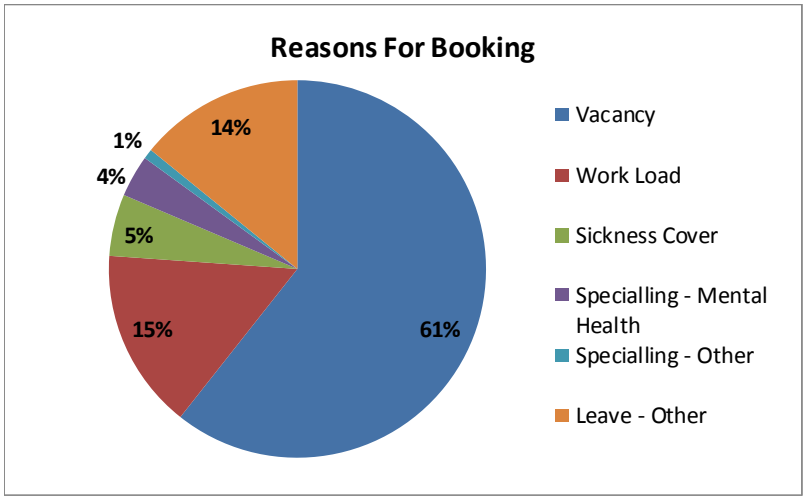
The Overall Fill Rate was 85.5% this month which is 1.5% higher than October. The Bank Fill Rate was reported at 63.2% which is 1.6% higher than the previous month.

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

The Bank to Agency ratio for filled shifts was 74:26. The Trust target is 80:20.

The pie chart shows a breakdown of the reasons given for requesting bank shifts in November. This is very much dominated by covering existing vacancies, workload and other leave.

This data only shows activity requested through the Trust's bank office that has been recorded on HealthRoster




| Overall Fill Rate % by Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 91.0% | 91.4% | 84.4% | 76.5% | ↘ |
| EIC Emergency & Integrated Care | 87.7% | 87.0% | 85.9% | 86.2% | ↗ |
| PDC Planned Care | 86.1% | 86.3% | 85.4% | 86.6% | ↗ |
| WCH Women's, Children's & Sexual Health | 80.8% | 77.0% | 80.2% | 85.1% | ↗ |
| **Whole Trust** | **85.4%** | **84.0%** | **84.0%** | **85.5%** | ↗ |

| Bank Fill Rate % by Division | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 88.1% | 87.6% | 80.8% | 73.0% | ↘ |
| EIC Emergency & Integrated Care | 54.5% | 53.3% | 54.8% | 55.8% | ↗ |
| PDC Planned Care | 69.7% | 70.7% | 68.6% | 69.9% | ↗ |
| WCH Women's, Children's & Sexual Health | 65.2% | 60.2% | 59.8% | 63.4% | ↗ |
| **Whole Trust** | **64.0%** | **62.2%** | **61.6%** | **63.2%** | ↗ |

# Section 11: Core Training

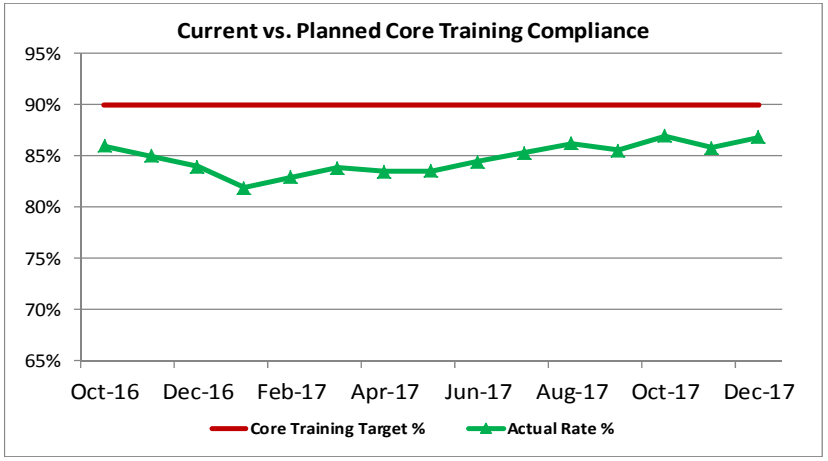
| Core Training Topic | Nov '17 | Dec '17 | Trend |
|---|---|---|---|
| Basic Life Support | 77.0 | 82.0 | ↗ |
| Conflict Resolution | 81.0 | 83.0 | ↗ |
| Equality, Diversity and Human Rights | 87.0 | 87.0 | ↔ |
| Fire | 87.0 | 87.0 | ↔ |
| Health & Safety | 92.0 | 92.0 | ↔ |
| Inanimate Loads (M&H L1) | 90.0 | 91.0 | ↗ |
| Infection Control (Hand Hyg) | 88.0 | 89.0 | ↗ |
| Information Governance | 80.0 | 81.0 | ↗ |
| Patient Handling (M&H L2) | 83.0 | 84.0 | ↗ |
| Safeguarding Adults Level 1 | 90.0 | 91.0 | ↗ |
| Safeguarding Children Level 1 | 88.0 | 89.0 | ↗ |
| Safeguarding Children Level 2 | 81.0 | 83.0 | ↗ |
| Safeguarding Children Level 3 | 80.0 | 89.0 | ↗ |

**COMMENTARY**

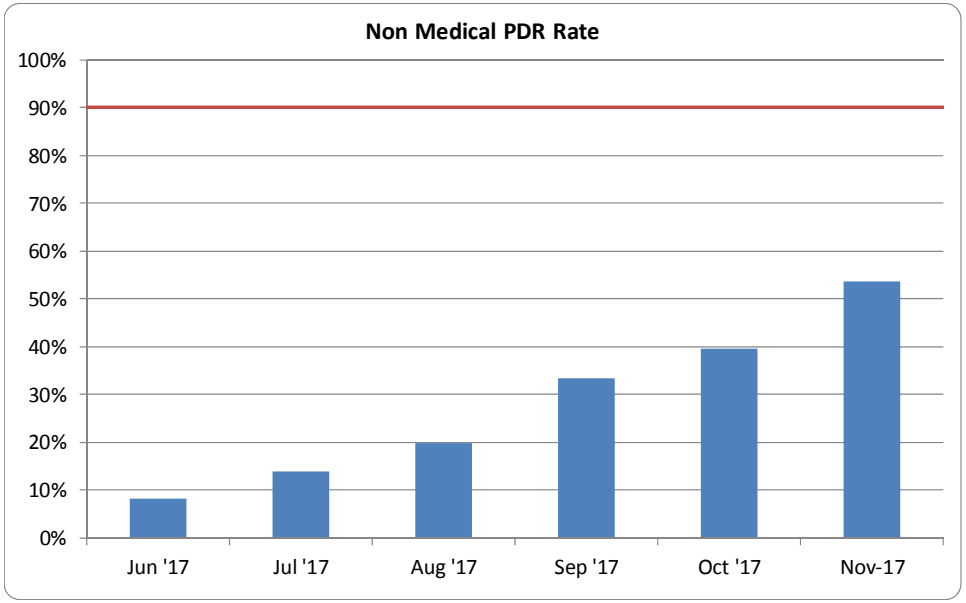
December figures have been included in the report as some issues with the November figures lead to compliance being slightly under reported for that month.

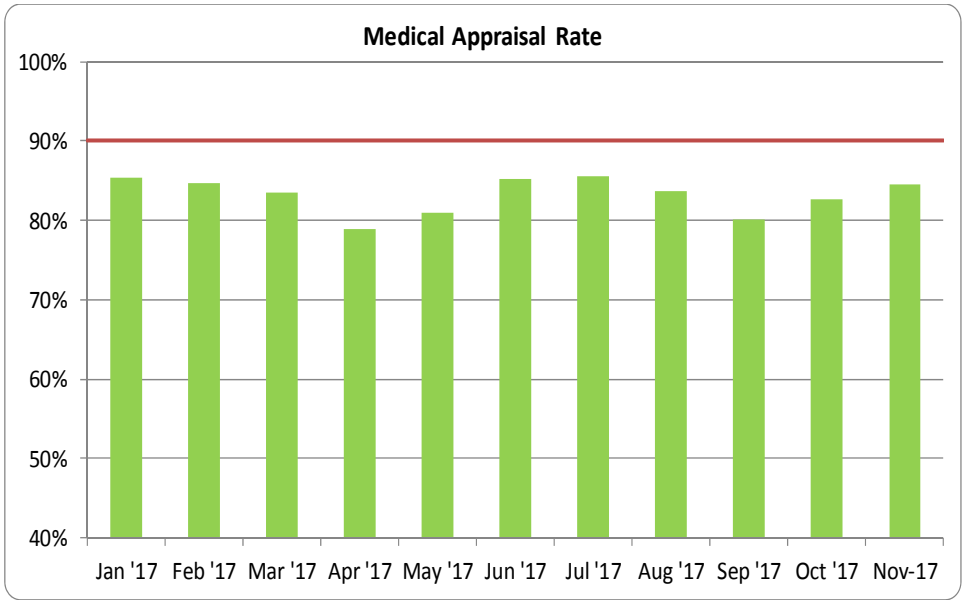
The new e-learning platform (Learning.Chelwest) was launched as scheduled on 22nd November but IT issues required that the portal was disabled for a few days whilst further investigations were carried out. A new launch date was agreed (and met) for December. This delay had minimal impact on the figures as staff were advised to continue using e-Learning for Health website in the interim.

| Core Training Compliance % by Division | Sep '17 | Oct '17 | Nov-17 | Dec-17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 89.0% | 91.0% | 90.0% | 87.0% | ↘ |
| EIC Emergency & Integrated Care | 83.0% | 85.0% | 85.0% | 86.0% | ↗ |
| PDC Planned Care | 85.0% | 87.0% | 86.0% | 87.0% | ↗ |
| WCH Women's Children's & Sexual Health | 86.0% | 86.0% | 85.0% | 87.0% | ↗ |
| **Whole Trust** | **86.0%** | **87.0%** | **86.0%** | **87.0%** | ↗ |



# Section 12: Performance & Development Reviews




## PDRs From April '17

| Division | Band Group | % | Division | Band Group | % |
|---|---|---|---|---|---|
| COR | Band 2-6 | 38.5% | PDC | Band 2-6 | 41.2% |
| | Band 7-8b | 94.0% | | Band 7-8b | 90.2% |
| | Band 8c + | 98.1% | | Band 8c + | 100.0% |
| **Corporate** | | **64.6%** | **PDC Planned Care** | | **48.9%** |
| EIC | Band 2-6 | 41.2% | WCH | Band 2-6 | 46.6% |
| | Band 7-8b | 91.3% | | Band 7-8b | 93.9% |
| | Band 8c + | 100.0% | | Band 8c + | 90.9% |
| **EIC Emergency & Integrated Care** | | **52.9%** | **WCH Women's, Children's & SH** | | **56.1%** |
| **Band Totals** | | | **Band 2-6** | **Band 7-8b** | **Band 8c +** |
| | | | 42.70% | 92.3% | 97.6% |
| **Trust Total** | | | **53.8%** | | |

## Medical Appraisals

| Medical Appraisals by Division | Aug '17 | Sep '17 | Oct '17 | Nov-17 | Trend |
|---|---|---|---|---|---|
| COR Corporate | - | - | - | - | - |
| EIC Emergency & Integrated Care | 84.4% | 80.8% | 86.6% | 91.7% | ↗ |
| PDC Planned Care | 85.9% | 80.2% | 80.3% | 80.2% | ↘ |
| WCH Women's, Children's & Sexual Health | 81.0% | 79.6% | 82.5% | 84.1% | ↗ |
| **Whole Trust** | **83.7%** | **80.1%** | **82.7%** | **84.5%** | ↗ |

## Non-Medical Commentary

From 1 April 2017 employees are required to have their PDR in a set period, starting first with the most senior staff. Staff in bands 7 and above should all have had a PDR by the end of September and those in bands 2-6 are due to be completed by the end of December. The PDR compliance rate has increased by 14% in November.

## Medical Commentary

The appraisal rate for medical staff was 84.5%, 1.8% higher than last month.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting, 11 January 2018**

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.7/Jan/18 |
| **REPORT NAME** | Mortality Surveillance – Q3 2017/18 |
| **AUTHOR** | Alex Bolton, Safety Learning Programme Manager |
| **LEAD** | Zoe Penn, Medical Director |
| **PURPOSE** | This paper updates the Board on the process compliance and key metrics from mortality review. |
| **SUMMARY OF REPORT** | Metrics from mortality review are providing a rich source of learning; review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG).<br><br>The Trust aims to review 80% of all mortality cases within 2 months of death. 67% of cases occurring within Q2 2017/18 have been closed, 31% of cases in Q3 have been closed.<br><br>42 cases of suboptimal care were identified between January 2017 and December 2017. 4 cases of suboptimal care were identified in Q2 2017/18, 8 cases have been identified as occurring within Q3 2017/18. Identified sub-optimal care cases have been discussed at local specialty Morbidity and Mortality (M&M) meetings and themes have been identified at MSG. Key themes include: recognition and response to deteriorating patient; establishment and agreement of ceilings of care.<br><br>7 consecutive months of low relative risk, where the HSMR upper confidence limit fell below the national benchmark, were experienced between March 2017 and September 2017. This indicates a step change improvement in the relative risk of mortality within the Trust. |
| **KEY RISKS ASSOCIATED** | Engagement: Lack of full engagement with process of recording mortality reviews within the centralised database impacting quality of output and potential missed opportunities to learn / improve. |
| **FINANCIAL IMPLICATIONS** | Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training. |
| **QUALITY IMPLICATIONS** | Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Deliver high quality patient centred care |
| **DECISION/ ACTION** | The Board is asked to note and comment on report |

# Mortality Surveillance – Q3 2017/18

## 1. Background

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

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

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

## 2. Relative risk

The Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHMI) are used by the Mortality Surveillance Group to compare relative mortality risk.

The Trust wide relative risk of mortality between October 2016 and September 2017 was 80.9 (76.5-85.5); this is below the expected range. 7 consecutive months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced between March 2017 and September 2017. This indicates a step change improvement in the relative risk of mortality within the Trust.

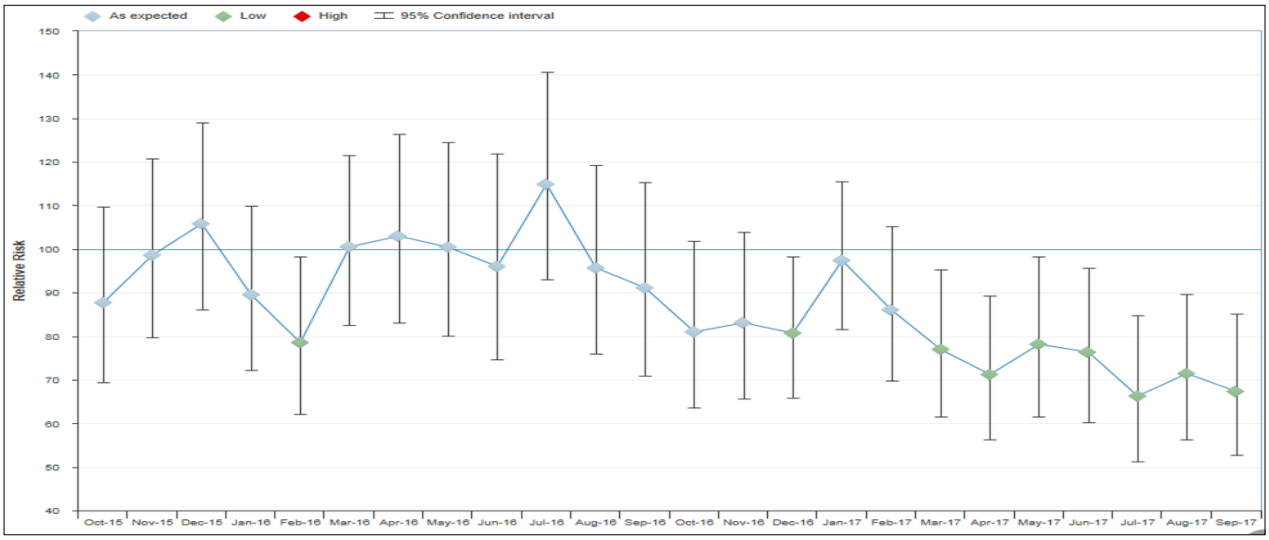



*Fig 1: Trust HSMR 24-month trend (October 2015 to September 2017)*

Improving relative risk of mortality has been experienced across both sites. At ChelWest HSMR outcomes were within the expected range or lower, between October 2016 and September 2017 there were 7 months of low relative risk (where the upper confidence limit sat below the national benchmark). At WestMid site relative risk outcomes were generally within the expected range with an apparent step change improvement since March 2017.

## 3. Crude rate

Crude mortality should not be used to compare risk between the sites; crude rates are influenced by differences in population demographics, services provided and intermediate / community care provision in the surrounding areas. Crude rates are monitored by the Mortality Surveillance Group to support trend recognition and resource allocation.

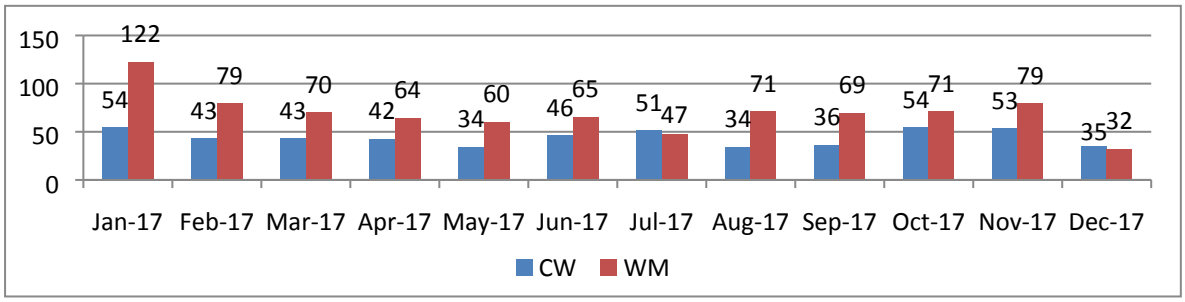



*Fig 2: Total mortality cases logged to Datix by site and month, January 2017 – December 2017*

## 4. Review completion rates

### 4.1. Closure target

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

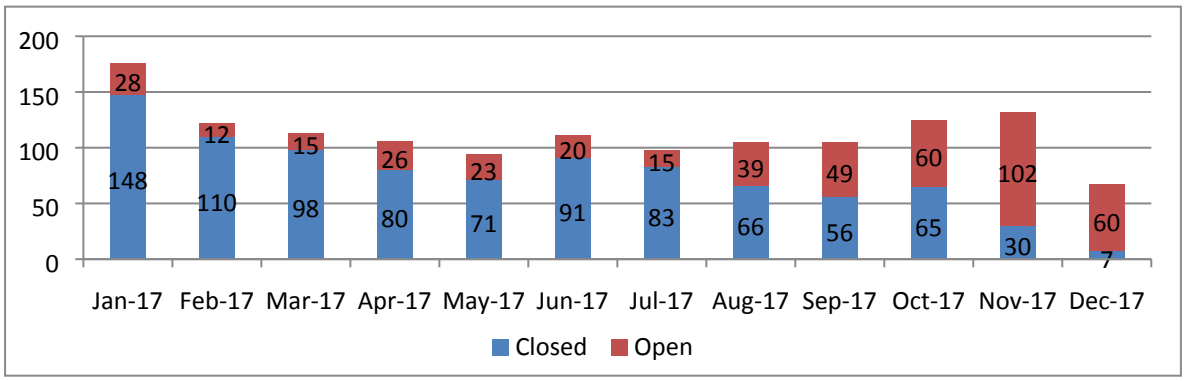



*Fig 3: Open and Closed mortality cases by month, January 2017 – December 2017*

1354 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period; of these 905 (67%) have been reviewed by the named consultant (or nominated colleague) and closed following M&M/MDT.

| | Q4 2016/17 | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Total |
|---|---|---|---|---|---|
| Total | 411 | 311 | 308 | 324 | 1354 |
| open | 55 | 69 | 103 | 222 | 449 |
| closed | 356 | 242 | 205 | 102 | 905 |
| % | 87% | 78% | 67% | 31% | 67% |

*Table 1: Cases by financial quarter, January 2017 – December 2017*

Total of cases reviewed and closed by Division for the 12 month period:

- Emergency and Integrated Care: 70%
- Planned Care: 61%
- Women's, Children's, HIV, GUM and Dermatology: 49%

Actions to support completion, discussion and closure of cases:

- Divisional Medical Directors supporting the engagement of clinical teams
- Divisional Mortality Review groups established within PCD and EIC
- Director of Patient Safety review of M&M/MDT arrangements
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- WCHGD leads engaging clinical teams to fully transition from legacy mortality review recording arrangements to new process.
- WCHGD leads utilising existing governance meetings to monitor progress and share learning from death.

## 5. Sub-optimal care

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

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

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

42 cases of suboptimal care were identified via the mortality review process between January 2017 and December 2017

**CESDI grades for closed cases occurring in Q3 *2017/18***

| | CESDI grade 0 | CESDI grade 1 | CESDI grade 2 | CESDI grade 3 |
|---|---|---|---|---|
| EIC | 87 | 6 | 0 | 0 |
| PCD | 7 | 1 | 0 | 0 |
| WCHGD | 0 | 1 | 0 | 0 |
| Total | **94** | **8** | **0** | **0** |

**CESDI grades for closed cases occurring in Q2 *2017/18***

| | CESDI grade 0 | CESDI grade 1 | CESDI grade 2 | CESDI grade 3 |
|---|---|---|---|---|
| EIC | 154 | 2 | 0 | 0 |
| PCD | 36 | 2 | 0 | 0 |
| WCHGD | 11 | 0 | 0 | 0 |
| Total | **201** | **4** | **0** | **0** |

Acute Medicine and Anaesthetics / ITU are the key specialties identifying opportunities for improvement via the mortality review process; these specialties identified 46% of all suboptimal care cases. Both specialties are within the top three areas for crude mortality due to the complexity of patients admitted to these areas.

Both specialties have regular M&Ms and proactively seek improvement opportunities via review; when reviewing deaths the specialties consider the patient's full episode of care (e.g. sub-optimal care identified may have occurred within previous specialties involved in that patients care rather than the specialty undertaking the review).

### 5.1. Overarching themes / issues linked to sub-optimal care

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

The key themes across both sites link to;

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

## 6. Learning / Engagement

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

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

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

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

## 7. Conclusion

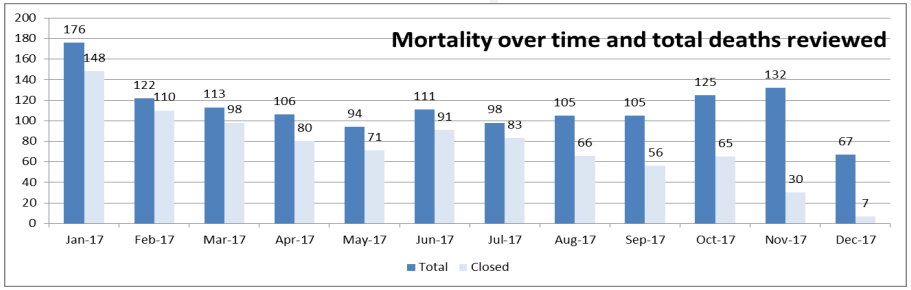
The outcome of mortality review is providing a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality has been experienced since March 2017; this is an indicator of improving outcomes and safety.

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

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

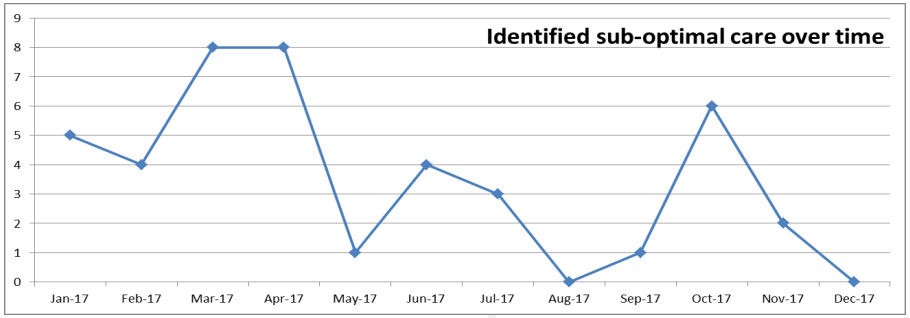
### Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care

| Total no. of in-hospital death | | Total no. deaths reviewed | | Total Number of deaths considered to involve sub-optimal care | |
|---|---|---|---|---|---|
| Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) |
| 67 | 132 | 7 | 30 | 0 | 2 |
| This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] |
| 324 | 308 | 102 | 205 | 8 | 7 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 943 | # | 549 | # | 25 | # |




### 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)

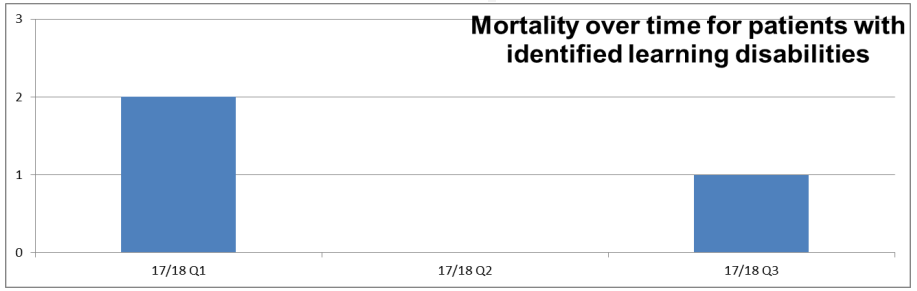
| Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome | | Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death) | | Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death) | |
|---|---|---|---|---|---|
| Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) |
| 0 | 2 | 0 | 0 | 0 | 0 |
| This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] |
| 8 | 4 | 0 | 0 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 22 | # | 3 | # | 0 | # |




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

### 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 | |
|---|---|---|---|---|---|
| Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) | Last Month (December) | Previous Month (November) |
| 0 | 1 | 0 | 1 | 0 | 0 |
| This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] | This Quarter [Q3] | Last Quarter [Q2] |
| 1 | 0 | 1 | 0 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 3 | # | 3 | # | 0 | # |



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 11 January 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 4.1/Jan/18 |
| **REPORT NAME** | Board Assurance Framework |
| **AUTHOR** | Alex Bolton, Safety Learning Programme Manager<br>Tom Rafferty, Head of Strategy |
| **LEAD** | Karl Munslow-Ong, Deputy Chief Executive |
| **PURPOSE** | To update the Board on the identification, response and scrutiny of risks / barriers to the achievement of the Trust's strategic objectives. |
| **SUMMARY OF REPORT** | The well-led framework developed initially by Monitor, CQC and the Trust Development Authority requires the boards of provider organisations to ensure they have effective and comprehensive processes in place to identify, understand, monitor and address current and future risks.<br><br>The Board Assurance Framework supports the Board gain a clearer understanding of the principle risks or barriers faced by the organisation in the pursuit of its strategic objectives.<br><br>Trust strategic objectives are aligned to an Executive Director and monitoring committee. Executive leads have considered a range of sources to identify principle barriers to the achievement of the strategic objectives; in November 2017 the committees of the Board initially assessed the level of assurance offered that controls to address the principle barriers / risks were effective.<br><br>The outcome of committee scrutiny is outlined in the Board Assurance Dashboard (Appendix 2). Risks / barriers that required more detailed review by the aligned committee are being scheduled for examination at subsequent committee meetings.<br><br>Key performance indicators support the Board monitor the delivery of the strategic objectives (Appendix 1). The principle changes to the KPIs since last reported to the Board include:<br>• A significant improvement in waiting time performance resulting in the Trust being the highest performer amongst peer organisation on each of the 3 key constitutional standards.<br>• The Trust's NHS Improvement Overall Use of Resources Score has improved from 3 to 2 primarily due to an improved in-year financial position. The most recent submission to NHSI for month 8 has seen a further improvement and the Trust now has a score of 1; the best possible rating.<br>• An improvement in the workforce metrics with the percentage of posts filled substantively up 1.5 percentage points to 87.1%, retention rate is also up slightly to 84.4%. |

| | |
|---|---|
| | • A slight reduction in the response rate to the Friends and Family test from 21% down to just under 19%. The overall recommendation rate has increased by 1 percentage point to over 89% and did reach the 90% target in October. |
| **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<br>• Be the employer of choice<br>• Deliver better care at lower cost |
| **DECISION/ ACTION** | The Board is asked to:<br>• Comment on the KPI metrics (Appendix 1) and Board Assurance Framework Dashboard (Appendix 2). |

# Board Assurance Framework

## 1. Purpose

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

The Trust's risk assurance mechanism includes:

- **Risk Register:** The risk register is a management tools that support the Trust understand the totality of risks that threatens it; they are intended to feed risk information from Ward to Board.
- **Board Assurance Framework (BAF):** The BAF provides focus to the principle risks / barriers that may threaten the achievement of the Trust's strategic objectives; it is intended to support communication between the Executives and the Board.

## 2. Strategic objectives

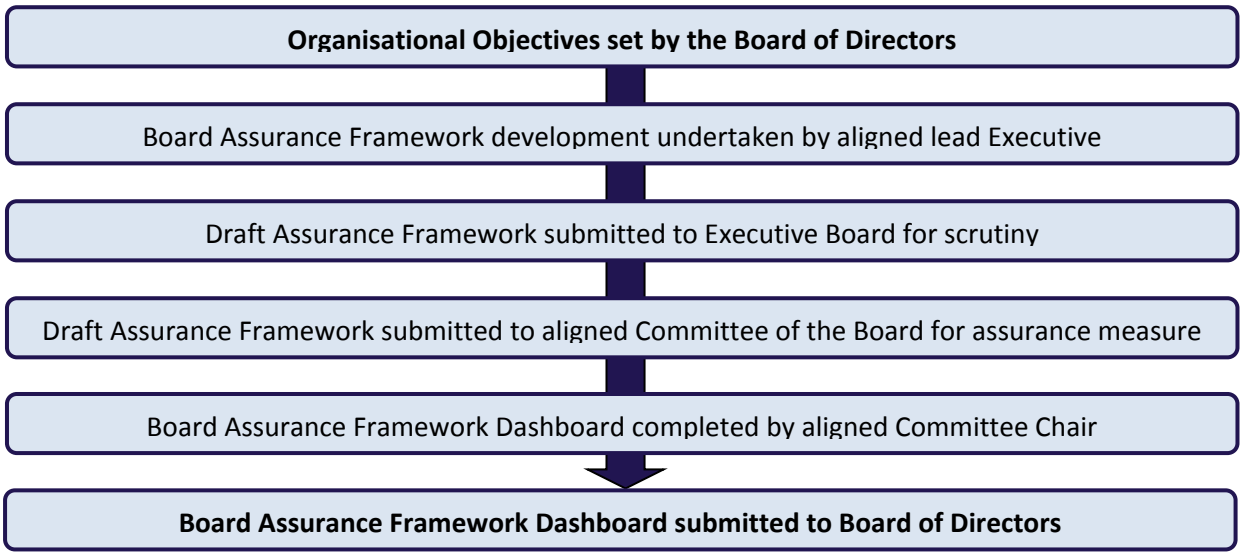
The Board agreed the following objectives for 2017-18.

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

## 3. Development Process

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

The Board Assurance Framework is developed via the following route:




## 4. Assessing assurance

The committees of the Board assess the:

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

The committee chair updates the Board Assurance Framework Dashboard to provide an overall assurance / RAG rating for each strategic objective. Where committee chairs report limited assurance that risks are being identified and or managed effectively (RED grading) the board will be asked to undertake a detailed review of the objective.

## 5. Key performance Indicators

Key performance indicators support the Board monitor the delivery of the 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.

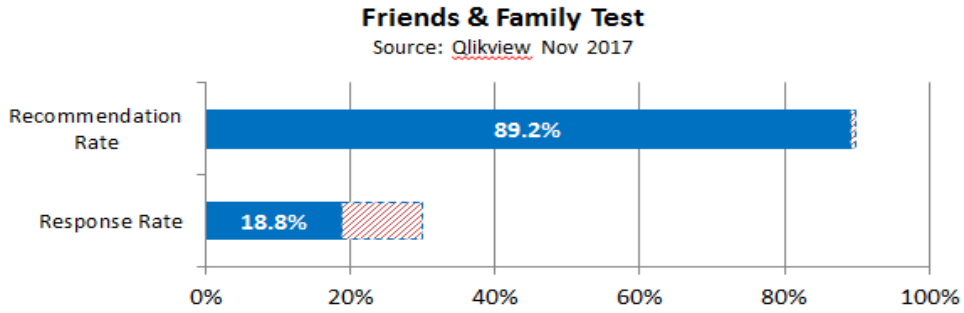
## 6. Reporting to Board

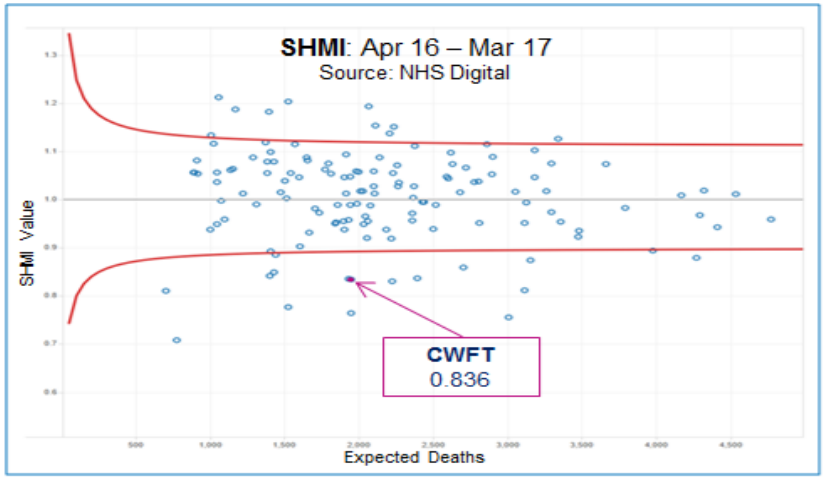
The Board Assurance Framework was reviewed by the committees of the Board in November 2017. Initial development action has been commenced; risks / barriers that require further committee scrutiny are planned for consideration at subsequent committee meetings following which assurance / RAG rating will be communicated to the Board. No risks are currently assessed as offering limited / RED assurance.

The Board is asked to consider and comment on the KPI metrics (Appendix 1) and Board Assurance Framework Dashboard (Appendix 2).

# Strategic Priorities – Key Performance Indicators

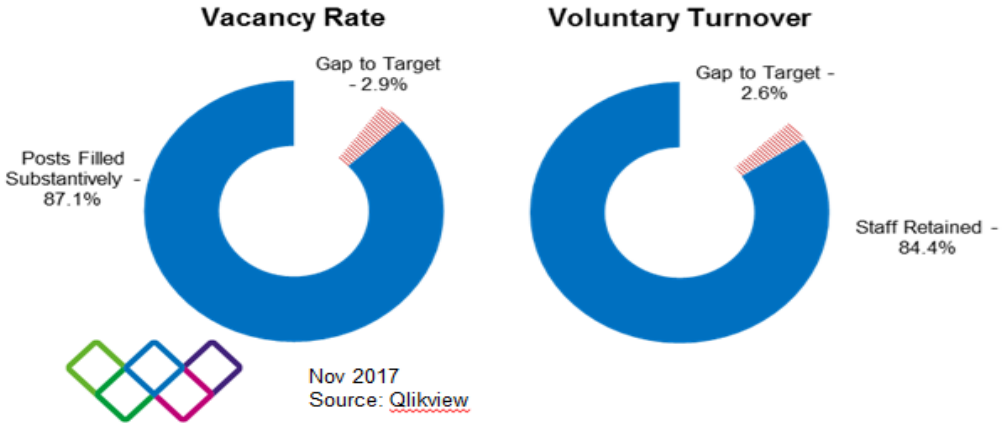
## 1. Deliver high-quality patient-centred care




| Oct/Nov 2017 (Source: NHS England) | A&E | 18 weeks RTT | Cancer 62 day | Ave. Ranking |
|---|---|---|---|---|
| **London Peer[1] Ranking** | 1st | 1st | 1st | 1st |

## 2. Be the employer of choice




## 3. Delivering better care at lower cost

| Dec 2017 (Source: Model Hospital) | |
|---|---|
| NHS I Use of Resources Score – Overall[2] | **2** |
| NHS I Use of Resources Score – Distance from Control Total | **1** |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**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 organisation 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 average 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. 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 2, which is driven by lower scores against capital service capacity, income and expenditure surplus/deficit rating and agency spend.

**Appendix 1b – Strategic Priorities Key Performance Indicators (Explanatory Notes)**

**Explanatory Notes**

**3. 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:

c. The Model Hospital Peer Group for CWFT (large, multi-site acute trusts)
d. 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).

**4. 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.

**5. 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 Dashboard

**Key:**

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

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

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

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. Deliver better care at lower cost | 3a. Drive out waste, duplication and errors. | R Hodgkiss / S Easton | Finance and Investment Committee | Risks to objective initially reviewed at Finance and Investment Committee. Items scheduled to future agendas for further analysis and development prior to assurance level confirmation. | ↔ | TBC |
| | 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 | | | ↔ | TBC |
| | 3c. Deliver best value in quality and effectiveness | R Hodgkiss / Z Penn | | | ↔ | TBC |
| | 3d. Fully exploit digital health to support our pathways of care | K Jarrold | | | ↔ | TBC |