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

Boardroom, Chelsea & Westminster

3 May 2018 11:00 - 3 May 2018 13:30

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting (PUBLIC SESSION)**
**Location:** Boardroom, Chelsea & Westminster
**Date:** Thursday, 3 May 2018
**Time:** 11.00 – 13.30

**Agenda**

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| | **1.0** | **GENERAL BUSINESS** | | |
| 11.00 | 1.1 | Welcome and apologies for absence<br>Apologies received from Jeremy Jensen and Andy Jones. | Verbal | Chairman |
| 11.03 | 1.2 | Declarations of Interest | Verbal | Chairman |
| 11.05 | 1.3 | Minutes of the previous meeting held on 1 March 2018 | Report | Chairman |
| 11.07 | 1.4 | Matters arising and 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 AND TRUST PERFORMANCE** | | |
| 11.25 | 2.1 | Staff Experience Story – Winter in A&E | Verbal | Chief Operating Officer / Chief Nurse |
| 11.40 | 2.2 | Care Quality Commission report | Report | Chief Nurse |
| 11.50 | 2.3 | Serious Incidents Report | Report | Chief Nurse |
| 12.00 | 2.4 | Integrated Performance Report including:<br>2.4.1 Workforce performance report | Report<br>Report | Chief Operating Officer<br>Chief Financial Officer |
| 12.10 | 2.5 | Mortality Surveillance Q4 Report | Report | Medical Director |
| 12.20 | 2.6 | Sexual Health E-Services | Present. | Chief Operating Officer |
| 12.30 | 2.7 | Growth in Non-Elective demand | Present. | Chief Operating Officer |
| 12.40 | 2.8 | NICU/ICU developments | Verbal | Chief Operating Officer / Chief Executive CW+ |
| | **3.0** | **GOVERNANCE** | | |
| 12.50 | 3.1 | Risk Register | Report | Deputy Chief Executive |

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| 13.00 | 3.2 | Modern Slavery Act 2015 and Statement | Report | Chief Nurse |
| 13.05 | 3.3 | EPR go live | Verbal | Chief Information Officer / Chief Operating Officer |
| | **4.0** | **ITEMS FOR INFORMATION** | | |
| 13.15 | 4.1 | Questions from members of the public | Verbal | Chairman |
| 13.25 | 4.3 | Any other business | Verbal | Chairman |
| 13.30 | 4.4 | Date of next meeting – 5 July 2018 | | |

**Minutes of the Board of Directors (Public Session)**
**Held at 11.00 on 1 March 2018, Boardroom, Chelsea and Westminster**

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| **Present:** | Sir Thomas Hughes-Hallett | Trust Chairman | (THH) |
| | Nilkunj Dodhia | Non-Executive Director | (ND) |
| | Sandra Easton | Chief Financial Officer | (SE) |
| | Nick Gash | Non-Executive Director | (NG) |
| | Stephen Gill | Non-Executive Director | (SG) |
| | Eliza Hermann | Non-Executive Director | (EH) |
| | Rob Hodgkiss | Chief Operating Officer | (RH) |
| | Andrew Jones (from item 1.6) | Non-Executive Director | (AJ) |
| | Karl Munslow-Ong | Deputy Chief Executive | (KMO) |
| | Pippa Nightingale | Chief Nurse | (PN) |
| | Zoe Penn | Medical Director | (ZP) |
| | Liz Shanahan | Non-Executive Director | (LS) |
| | Gary Sims | Non-Executive Director | (GS) |
| | Lesley Watts | Chief Executive | (LW) |
| **In attendance:** | Roger Chinn | Deputy Medical Director | (RC) |
| | Chris Chaney | CEO, CW+ | (CC) |
| | Gillian Holmes | Director of Communications | (GH) |
| | Kevin Jarrold | Chief Information Officer | (KJ) |
| | Julie Myers | Company Secretary | (JM) |
| | Vikram Palit | Clinical Fellow | (VP) |
| | Nathan Post | Clinical Fellow | (NP) |
| | Ronan Doherty | Clinical Fellow | (RD) |
| | Aseem Ghaghda | Clinical Fellow | (AG) |
| | Robbie Cline | Director of ICT Programmes Imperial College Healthcare NHS Trust | (RCl) |
| | Vida Djelic | Board Governance Manager | (VD) |

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| **1.0** | **GENERAL BUSINESS** |
| 1.1 | **Welcome and apologies for absence**<br><br>The Chairman welcomed Members and those in attendance to the meeting.<br>Apologies for absence had been received from Jeremy Jensen and Martin Lupton, and from Andrew Jones, who would arrive slightly late. |
| 1.2 | **Declarations of interests**<br><br>The Chairman advised that Helpforce, a Community Interest Company of which he is Executive Chairman, had entered into a pro bono contract with Deloittes. Deloittes provide external audit services to the Trust. |
| 1.3 | **Minutes of the previous meeting held on 11 January 2018**<br><br>The minutes of the previous meeting were approved as a true and accurate record of the meeting subject to the following change:<br>- Page 8, paragraph 5.1 - replace 'neurology' with 'urology' |

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| | **Action: VD to correct the minutes** |
| 1.4 | **Matters arising and Board action log**<br><br>Progress on the Board action log was noted. It was agreed to revert to red, amber and green shading to draw attention to the status of actions.<br>**Action: VD to reinstate action log shading** |
| 1.5 | **Chairman's Report**<br><br>The Chairman reported, with great sadness, that Tony Bell OBE, former CEO of Chelsea and Westminster Hospital, had passed away. Mr Bell had been a great servant of the hospital and of the NHS, with which he had over four decades of service, after starting his career as a nurse. The Board asked that the enormous gratitude of the Board be extended to Mr Bell's family.<br>**Action: CEO to convey the Board's deepest sympathies to Mr Bell's family**<br><br>In addition to matters recorded in his report, the Chairman reported that he had recently met the CEO and Deputy CEO of the Royal College of Nursing (RCN), who had been delighted to accept an invitation to visit the hospital and meet Members. The CEO was leading on the arrangements for the visit and would provide details in due course.<br>**Action: CEO to circulate details of arrangements for the RCN visit**<br><br>In response to a question, the Chairman advised that details of the service to be held at Westminster Abbey to celebrate the 300th anniversary of the hospital are still to be confirmed and will be circulated in due course. Arrangements are being led by Chris Chaney, CEO of CW+, and Martin Lewis, Governor. |
| 1.6 | **Chief Executive's Report**<br><br>**Care Quality Commission**. The CEO opened her report by noting that the draft Care Quality Commission (CQC) report was expected in the next few weeks. The immediate action would be to review and to comment on factual accuracy. The Trust remained committed to a programme of continuous improvement and to maintaining high standards. The CEO observed that she saw these in evidence every day, which speaks to the commitment of staff and the embedding of good practice. Her message to staff continued to be that what matters is the service we deliver to patients every day, irrespective of inspections.<br><br>**Flu vaccination programme**. Tribute was paid to the Chief Nurse and her team for their work in helping the Trust achieve its vaccination target. This was a good example of 'well led' activity.<br><br>**Staff recognition**. Members' attention was drawn to the staff recognised internally and externally for their achievements.<br><br>**Staff Nurse Matilda Baffour Awuah**. It was with great sadness that the CEO reported the passing of this well-loved and well-regarded colleague. Contact had been made with the family and support offered to her family, friends and colleagues within the Trust.<br><br>**Communication and engagement**. Thanks were extended to the Director of Communications and her team for their work to engage patients, the public and staff. Positive feedback was being received for |

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| | the stepped up activity in this area. EH commended the team for their work and it was confirmed that copies of published material would be provided to Board Members, either at Board Meetings or electronically.<br><br>**Action: GH to ensure Members receive copies of 'going beyond' and other Trust material on an ongong basis**<br><br>**Getting It Right First Time (GIRFT).** This programme was rolling out to all surgical, and then to all medical, areas. It provided valuable feedback on best practice and use of resources and the Board would be kept informed of reports of inspections.<br><br>**Strategic partnerships**. The CEO advised that no appointment had been made as yet to the role of Accountable Officer for the North West London Sustainability and Transformation Plan (STP). She remained the provider lead and the Trust continues to work with its partners to keep the programme moving forward whilst essential appointments are made. With regard to the Royal Brompton and Harefield Foundation Trust, the CEO reported that, along with the Trust's North West London partners, a proposal would be made the NHS England (NHSE) as to how services should be provided in this geographical area.<br><br>In response to a question from the Chairman, ZP and PN confirmed that the Trust was not currently experiencing problems with visas for overseas doctors and nurses. The more significant problem was identifying potential recruits.<br><br>In response to a question from the Chairman, KMO advised that discussions were on going with Imperial College Health Trust, and with other providers across London, as regards the estates position. This was happening in the context of the Shaping A Healthier Future (SAHF) programme. The CEO noted that these discussions reflected the need to ensure that providers don't simply consider their own position but work collaboratively to secure the best value from resources for the public as a whole across the NHS and to drive out unnecessary duplication. Discussions on estates needed to look at both short and long term requirements, bearing in mind physical constraints. The CEO confirmed that options were being developed by KMO and the Director of Strategy. |
| **2.0** | **QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE** |
| 2.1 | **Serious Incidents Report**<br><br>In introducing her report, PN advised that her team had conducted a review of serious incidents over the past two years. At the beginning of the period, the largest number of incidents reported had been in maternity, which then shifted to pressure ulcers, and then to falls. Now the most common serious incidents related to diagnostic incidents. The latter were being looked at in depth by ZP and the Clinical Director for Patient Safety. PN's reflection was that there had been sustained improvement in preventing serious incidents in earlier areas of concern and a recurrence of incidents was not being seen.<br><br>PN noted that the paper appeared to show a spike in serious incidents at West Middlesex, where there had been five in the last two months with four on one ward. PN confirmed that she had reviewed all of these incidents with senior nursing and pharmacy staff. There appeared to be no trend or theme, including staffing, and the analysis would continue. She reflected that, when considered across the whole of the year, the number of serious incidents was balanced across both sites and that |

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| | she had no immediate concerns that there were trends in incidents occurring that were not being picked up. The CEO reiterated the speed with which spikes were spotted and interrogated by the executive and confirmed that they would always be reported to the Board.<br><br>The Board asked whether future data could reflect the presentation made by NHS Improvement (NHSI) and include statistical process control (SPC) charts.<br><br>**Action: RC to report on progress to adopt SPC analysis across the Trust at the next Board meeting**<br><br>In response to a question from SG, PN confirmed that there was nothing unusual on the ward where four serious incidents had occurred, and that analysis had shown that there were no common themes: each case was distinct. In response to a question from GS, EH confirmed that Quality Committee scrutinises all of the underlying data in detail on behalf of the Board, allowing the Board-level report to remain high-level. This scrutiny including whether patterns of causation could be observed and over the past two years this had included clinician hand-over and failure to recognise deterioration.<br><br>ZP observed that it was important to remember that the report referred to crude numbers that needed to be seen in the context of the increase in underlying numbers of patients being treated by the Trust: the data did not represent a rate of serious incidents.<br><br>PN drew the Board's attention to the positive results being observed for pressure ulcers, where the Trust's performance was well within national averages. This reflected the embedding of good practice meaning that not just grade three and four pressure ulcers were reducing but pressure ulcers overall. Positive results were also being seen with regard to fall reduction, where benefits of a new pathway and new technology were being felt. Work was continuing in this area and would also be considering the community setting.<br><br>In response to a question from SG, PN confirmed that she and the Director of Quality Improvement had revised the process for ensuring actions were completed and regular meetings now took place with relevant Directors to chase overdue actions arising from serious incidents. Whilst the table in the report had reported 31 overdue actions as at the date of the Board, there were now only nine. |
| 2.2 | **Integrated Performance Report**<br><br>RH introduced his report and noted that January 2018 had been the busiest month ever in A&E. Both sites had worked incredibly hard. Whilst the Trust had not met the national A&E target in January, it was the fifth highest performing Trust in the country. He noted:<br>- As regards elective performance, the Trust had not suspended its elective programme as many others had over the winter period. Performance against the national Referral To Treatment (RTT) target remained strong, in part due to careful planning which saw some cases moved between sites to maintain service performance. This had resulted in RTT performance being the best since the two hospitals merged in 2015. Additionally, the backlog was at the lowest point since the merger.<br>- All cancer targets had been met on both sites, although there were some issues regarding the diagnostic standard where the Trust's performance as at 98.12% against a target of 99%. Problems with West Middlesex's obstetric diagnostics were now resolved, and issues with endoscopy and urology at the Chelsea site were being reviewed.<br>RH was pleased to note that the Trust was the highest performing Trust in London and in the top ten |

nationally for some indicators.

The Chairman asked whether the Trust was doing enough to capture learning about why the Trust was doing so well, both for the Trust and for the NHS as a whole, and so that, were things to decline, we could quickly get back on track. The CEO observed that each local area conducts its own reflective learning, noting that ED do it particularly well. She agreed that serious thought needed to be given about how to do this at a global level, to make sure that there was a good embedded process and commitment. SE noted that this was beginning to happen. For instance, the ED team had shared their learning to all staff through the team briefing programme and had been asked to share their experience externally through the NHS Confederation.

The Board agreed that the staff and the leadership team were to be commended for the outstanding performance of the Trust and recorded their curiosity about making sure that ways were found to embed learning.

SE reported to the Board that the Trust had been ranked as '1' for its use of resources, which was a very positive achievement.

In response to a question from GS, RH reported that there appeared to be a coding issue with 're-admittance' figures at the West Middlesex site. This was being investigated and the figures were expected to reduce once this was fixed. The CEO noted that these figures were subject to annual audit and that it was critical that they were correct as Trust's were fined when targets were missed.

In response to a question from SG, SE noted that the reason the Integrated Performance Report was for month 10 but the Workforce Performance Report was for month 9 was because of the timing of Committee scrutiny.

**Action: SE and Company Secretary to review Committee meeting scheduling from 2019**

In response to a question from NG, PN confirmed that the Director of Nursing at the Chelsea site was reviewing the Friends and Family Test process to generate improved response rates. She reminded the Board that whilst the rate might appear low, the actual numbers of people were responding were significant. EH confirmed that this had been discussed at Quality Committee, where the importance of getting good, nuanced patient feedback was stressed.

**2.2.1 Workforce performance report**

SE introduced the workforce performance report noting the positive news that the decrease in turnover has continued. Core training rates have also continued to increase and this has been helped by the online platform. In addition, now that old system and new system PDR completion rates have been combined, the Trust's completion rate is above the 90% target for all staff. SE noted that there has been a slight spike in sickness rates and, whilst this was not of concern at present, a deep dive has been scheduled to review the figures. Finally, whilst the vacancy rate continues to be of concern, the Trust has started to see the arrival of some newly recruited overseas nurses.

In response to a query from AJ regarding activity based resourcing, PN confirmed that there was a national process which the Trust engaged in. This required establishment figures to be set and reported against twice yearly. The Trust was on track against these. In addition, the Trust also reviews resourcing by ward three times each day to allow for real time resource allocation. PN confirmed that

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| | this would be discussed by the next People and Organisation Development Committee (PODCom). In response to a query from EH, the CEO advised that these resourcing adjustments would not in and of itself resole the Trust's performance on 'time to theatre' for fractured neck of femur patients, but it would help.<br><br>In response to a query from SG, SE confirmed that the Trust does offer exit interviews and collects leaver data. She confirmed that where there appeared to be unusual patterns of turnover, deep dives would be completed. PN noted that work to retain new starters was starting to deliver results.<br><br>NG observed that there would be merit reviewing the diversity data for promotions of qualified nurses and midwifes as a preliminary review suggested an under-representation of BAME staff being promoted. SE confirmed that this would be reviewed at PODCom and that metrics would also be expanded to cover access to training.<br><br>**Action: Equality data for qualified nurses and midwives promotion, and access to training, to be reviewed by PODCom and a report brought to the Board in six months.**<br><br>LS advised that PODCom had asked for gender statistics to be included in the career development table, which the CEO confirmed had been the subject of discussion within the executive director team.<br><br>**Action: Staff career development tables to also include breakdown by gender.**<br><br>In response to a question from ND, the CEO confirmed that management roles were not automatically replaced and efficiencies were always sought. Bechmarking against Carter confirms that the Trust is performing well in this regard.<br><br>PN confirmed that involuntary turnover was scrutinised by PODCOm. SE confirmed that a report on the pay by gender in the Trust would be prepared by the end of March, reviewed by PODCom and then be reported to the Board.<br><br>**Action: Report on gender pay to be added to Board forward agenda.** |
| 2.3 | **Clinical fellows projects 2017/18**<br><br>RC introduced the work of the Trust's four Clinical Innovation Fellows, which demonstrated the Trust's commitment to continuous improvement; helping us to identify what works well and share best practice. Some of the projects were being delivered in conjunction with partners, including local authorities.<br>- Dr Nathan Post outlined his work on community and in-hospital falls prevention, work to model demand at West Middlesex and healthcare at home.<br>- Dr Vikram Patel outlined his work on a children's oral health initiative, presumed sepsis, coding and MRSA re-screening. In response to a query from THH, Dr Patel confirmed that this project may also have benefits as regards rates of Type 2 diabetes and obesity.<br>- Dr Aseem Ghaghda outlined his work to improve theatre finance through review of planned procedures with a threshold, to improve theatre efficiency and throughput, the introduction of national and local safety standards for invasive procedures and the electronic patient records system (EPR). In response to a question from NG, the CEO confirmed that CCG thresholds for planned procedures were not alike and the challenge was to make sure that |

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| | when patients were referred to us for a procedure, there was a guarantee that payment would be made.<br>- Dr Ronan Doherty outlined his work on sepsis screening and treatment, noting he was also involved in a number of the projects reported above. In response to a question from GS, RD advised that the data which indicated a medium-sized general hospital could save £1.25m through improved management of sepsis was externally provided data.<br><br>The CEO encouraged all of the Fellows to reflect on how to measure the success of each project.<br><br>On behalf of the Board, the Chairman thanked all of the Clinical Innovation Fellows for their presentations and for the impressive improvement work being undertaken. The Medical Director was commended for her foresight in developing the programme and the CEO confirmed that thought was being given to the future of the programme. |
| **3.0** | **GOVERNANCE** |
| 3.1 | **Business planning 2018/19**<br><br>SE confirmed that national guidance on planning for 2018/19 had now been received and the Board had received its proposed control total. A draft plan was required to be submitted by 8 March 2018 with a final plan in place by 30 April 2018.<br><br>The Trust's proposed control total was in line with expectations at £14.8m (surplus) and on the basis of £19.9m Sustainability and Transformation Funding. This was an increase of £2.9m on the 2017/18 total. There were some matters still to be resolved, including the accounting treatment of the donation from CW+ for ICU/NICU redevelopment, but this would not alter the control total. Additionally, the slippage this year on the ICU/NICU programme would mean an adjustment to the 2018/19 capital programme. SE noted that the risks to delivering the control total were similar in kind to those identified at the start of the 2017/18 planning period, with the additional risks attached to Cerner EPR implementation.<br><br>ND advised the Board that the Finance and Investment Committee (FIC) had scrutinised the draft plan at its recent meeting and endorsed acceptance of the control total. Their main concern had been the Cost Improvement Plan (CIP) target of 4%, noting that this year's target was proving hard to deliver and this would only be compounded in future years. It was important that the Board understood this and confirmed its appetite for risk.<br><br>The CEO agreed that there was a balance to be struck in assessing the risk around securing discretionary funding and the ask on the CIP. This was the subject of robust debate within the executive and a CIP was being developed for 2018/19. Her view was that bearing in mind the increase in STF, the broader operating context and our position being in line with that of every other Trust, we should accept the total. This was however caveated with the proviso that early and robust discussions would be needed with Commissioners if demand profiles changed significantly and if Commissioner QIPP did not materialise.<br><br>The CEO also confirmed that, if in year, it became apparent that there was a risk the control total would be missed, the executive would implement immediately a turnaround strategy, including additional controls on operational expenditure. If, however, the cost pressure was as a consequence of increasing demand, then the Trust would go immediately to Commissioners and to NHSI. |

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| | The Chairman reported that there appeared to be some sympathy for this position from NHSI, who were encouraging planning to be based on need rather than the control total. In discussion the Board noted:<br>- The paper had been informed by discussions with Commissioners<br>- The importance of maintaining focus on quality of patient care even if this meant there was risk to achieving the control total, in the context of sound financial management<br>- That if discretionary funding was achieved, there would be a relatively low risk to achieving the control total<br>- The relative stability of the senior team gave confidence<br>- The proposed capital spend was greater than the rate of depreciation which therefore allowed for a degree of control over the Trust's future direction<br>- The savings anticipated by the impact of the Clinical Innovation Fellows were included within the plan.<br><br>The Chairman confirmed that the Board supported the recommendation to approve the draft Plan and accept the control total, as advised by FIC and subject to the CEO informing the Chairman immediately if discussions with Commissioners deviated from what was expected. |
| 3.2 | **Patient Experience Story**<br><br>Due to severe weather conditions, the patient had been unable to travel to the hospital. This item would be deferred to a future Board meeting. |
| 3.3 | **EPR cut-over plan**<br><br>Robbie Cline, Director of ICT Programmes, Imperial College Healthcare NHS Trust (ICHT), presented an overview of the plans for the period before the close-down of current systems and the immediate start-up of the new EPR. This would take place over May Bank Holiday weekend.<br><br>In discussion of the plans, the Board noted:<br>- An adequate contingency plan was in place should North West London Pathology not implement its system change in time for the Cerner EPR go live<br>- The Chief Information Officer had done similar system implementations a number of times previously but noted that each one was unique<br>- Lessons had been learnt from implementation at ICHT, including where things should be done differently<br>- There had been some significant improvement in data quality and, at go live, it would be in the best place possible. That said, it was inevitable that there would still be some data quality issues<br>- Key decision points had been identified for go live, and plans were ready should there need to be any reductions in activity on the West Middlesex site.<br><br>The Board confirmed that they understood such cut-overs involved a degree of risk but were reassured about the status of the programme and wished the team well for a successful implementation.<br><br>**Action: GH to consider how best to celebrate the implementation of Cerner EPR at West Middlesex**<br>**Action: HR to consider how best to reflect the significant amount of Bank Holiday working that** |

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| | **would be required from staff at the West Middlesex site** |
| **4.0** | **ITEMS FOR INFORMATION** |
| 4.1 | **Risk and assurance process summary**<br><br>KMO introduced the paper which illustrated the Board's risk and assurance processes as simply as possible, in response to a commission from GS. The schematic reflected current practice only, and will be enhanced by further work expected to emerge from the Integrated Governance Risk Review.<br><br>The Board noted the paper and discussed the frequency it expected to see the risk register and the Board Assurance Framework. The Chairman confirmed that the Board should expect to see the risk register twice yearly.<br><br>**Action: The risk register to be presented to the next Board and then in six months**<br>**Action: The executive to consider how risk and assurance relating to sites is addressed within the framework** |
| 4.2 | **Questions from members of the public**<br><br>Cerner EPR: training – KJ confirmed that local champions for EPR training have been identified and a detailed training programme was about to start. Floor walkers would be operating at go live.<br><br>Cerner EPR: roll-out to Chelsea site – KJ advised that the two sites have very different IT infrastructures. West Middlesex had been identified as the easiest system to transition to EPR, as there was more work to do at the Chelsea site.<br><br>Complaint numbers: patterns and response rate – The CEO reported that the team was working very hard to make sure complaints were responded to well and in a timely manner. She personally reviews every complaint received, every day, along with the Director of Nursing. Divisions now phone complainants on the day a complaint is received. It was important to learn from complaints. Patient expectations were increasing which was resulting in more complaints being made. There were a small number of themes being observed:<br>- Speed of being seen<br>- Attitude and approach of staff<br>- Technical care matters, such as diagnostics<br><br>She stressed the importance of every member of staff playing a part in resolving complaints and this was now being stressed at induction. |
| 4.3 | **Any other business**<br><br>There was none. |
| 4.4 | **Date of next meeting – 3 May 2018** |

Meeting closed at 13.05

**Trust Board Public – 1 March 2018 Action Log**

| Meeting Date | Minute number | Subject matter | Action | Lead | Outcome/latest update on action status |
|---|---|---|---|---|---|
| 01.03.18 | 1.3 | Minutes of the previous meeting held on 11 January 2018 | Page 8, paragraph 5.1 - replace 'neurology' with 'urology' | VD | Complete. |
| | 1.4 | Matters arising and Board action log | Action: VD to reinstate action log shading | VD | Complete. |
| | 1.5 | Chairman's Report | Action: CEO to convey the Board's deepest sympathies to Mr Bell's family. | LW | Complete. |
| | | | Action: CEO to circulate details of arrangements for the RCN visit. | LW | Complete. |
| | 1.6 | Chief Executive's Report: Communication and engagement | Action: GH to ensure Members receive copies of 'going beyond' and other Trust material on an ongong basis. | GH | Going Beyond is made widely available across Trust sites so as to be available to as many Members as possible. The Communications team have increased digital channel engagement by over 20% in the last six months which should help communicate more widely with members and potential members, as well as the website having more up to date information across its pages, however comms will continue to look at additional ways of effectively getting messages to all stakeholders. |
| | 2.1 | Serious Incidents Report | Action: RC to report on progress to adopt SPC analysis across the Trust at the next Board meeting. | RC | The Information and Clinical Governance teams are meeting soon to discuss opportunities to present the Serious Incident output in the appropriate format. A further update will be provided at the meeting. |
| | 2.2 | Integrated Performance Report | Action: SE and Company Secretary to review Committee meeting scheduling from 2019. | SE/JM | Apr 18: Not yet commenced. |

| Meeting Date | Minute number | Subject matter | Action | Lead | Outcome/latest update on action status |
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| | 2.2.1 | Workforce performance report | Action: Equality data for qualified nurses and midwives promotion, and access to training, to be reviewed by PODCom and a report brought to the Board in six months. | SE | Equality report on POD forward plan. |
| | | | Action: Staff career development tables to also include breakdown by gender. | SE | This is under review. |
| | | | Action: Report on gender pay to be added to Board forward agenda. | SE | This is on the forward plan. |
| | 3.3 | EPR cut-over plan | Action: GH to consider how best to celebrate the implementation of Cerner EPR at West Middlesex | GH | Working with Paul Harrison (CernerComms) on this, and there will be a Cerner update in the main board discussion and Kevin will update. |
| | | | Action: HR to consider how best to reflect the significant amount of Bank Holiday working that would be required from staff at the West Middlesex site | PN/SE | Adequate provision has been made. |
| | 4.1 | Risk and assurance process summary | Action: The risk register to be presented to the next Board and then in six months | KMO | This is on the forward plan for 3 May and 1 November Board. |
| | | | Action: The executive to consider how risk and assurance relating to sites is addressed within the framework. | Executive Directors | The RAF allows risks to be attributed to specific sites. An example of this is the enhanced non-elective risk flagged for the West Mid site. |
| 11.01.18 | 1.6 | Serious Incident (SI) Panel | The Board agreed that AJ should chair a final Serious Incident (SI) Panel to ensure that all recommendations arising from this incident had been addressed and embedded. The Panel would report through Quality Committee (QC) to the Board. | AJ | Action complete. |
| | | Patient Voices | The Board agreed to receive a report on what patient voices are telling us instead of a patient experience story at a future Board meeting. | NA | Action ongoing.<br>This is on the forward plan for September Board. |

| Meeting Date | Minute number | Subject matter | Action | Lead | Outcome/latest update on action status |
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| 11.01.18 | 3.1 | Delivery of the communications strategy | POD to review delivery of the communications strategy. | SG/GH | Action ongoing.<br>To be put on the People and OD Committee forward plan. |
| | | Membership | Membership growth to be added as a KPI to communications strategy. | GH | Action ongoing. |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

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| **AGENDA ITEM NO.** | 1.5/May/18 |
| **REPORT NAME** | Chairman's Report |
| **AUTHOR** | Sir Thomas Hughes-Hallett, Chairman |
| **LEAD** | Sir Thomas Hughes-Hallett, Chairman |
| **PURPOSE** | To provide an update to the 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**
**May 2018**

## 1.0 Governor update

I hosted an informal lunch session with a number of Governors in late April, at West Middlesex Hospital. As always, this provided an opportunity to discuss matters of mutual interest in an informal and frank way. I was also pleased to hold an induction session for some of our new Governors which also provided a useful opportunity for discussion. I am also aware that those Governors who were able to attend, appreciated the separate in-depth briefing session on Trust finances.

## 2.0 Care Quality Commission (CQC) inspection report and NHSI use of resources

The report is on the agenda for discussion today. I want to place on my record my personal thanks to everyone who contributed to delivering such positive outcomes for our patients, staff and the public at large.

## 3.0 Board's April 2018 strategy session

The Board held a strategic discussion on 12 April 2018. This provided an early opportunity to consider the Care Quality Commission report which had been issued just two days prior to the meeting. The Board also reviewed its strategic priorities and its annual plan. Our strategy board also rehearsed the main topics that we will choose to discuss in June at our Board away day. The session also provided an opportunity for an update on progress towards the implementation of the Electronic Patient Record (EPR) system, which we will consider in public Board today.

## 4.0 External engagements

Since the last Board meeting I have:

- Met Peter Wyman, Chairman of the Care Quality Commission
- With the CEO, met our equivalents at Guy's and St Thomas' NHS Foundation Trust
- Held discussions re: North West London STP Transformation Board with the Chairs' Group
- Met Lord Prior, Chairman of University College Hospitals London NHS Foundation Trust
- Met Dominic Dodd, Chair of the Royal Free London NHS Foundation Trust

## 5.0 Volunteering

I have now spent two days as a 'Bleep volunteer' at Chelsea and Westminster Hospital. Working with two other volunteers, our key role was to get prescribed drugs swiftly to the wards from pharmacy. Our professional pharmacy team are convinced the 'Bleep' service gets people home earlier, freeing up beds we need urgently for other patients. Meanwhile our nurses can focus on the jobs they were trained to do. The wards welcomed us, as did ICU, and we were told that as a result of our speedy delivery a gentleman would get back to his home in the north-west of England before darkness fell. One lady was so thrilled by getting her drugs so quickly that she signed up on the spot to become a Bleep. Finally, and most significantly, we were bleeped from Reception to support a very anxious patient. We spent time with this patient, talking to them and calming them. I am absolutely sure that the appointment would not have been kept if we had not gone with him and introduced him to the clinician the patient was seeing in clinic.

I also discussed with our nursing team on one ward how they could have freed up an urgently needed bed occupied by a patient who wanted to go home but was unable to as no member of his family was going to be there to receive him until late evening – one of HelpForce's strategic objectives is to complete a companion service which would have taken this patient home and sat with him until the return of their family member.

**Sir Thomas Hughes-Hallett**
Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting, 3 May 2018**

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 1.6/May/18 |
| **REPORT NAME** | Chief Executive's Report |
| **AUTHOR** | Karl Munslow Ong, Deputy Chief Executive Officer |
| **LEAD** | Lesley Watts, Chief Executive Officer |
| **PURPOSE** | To provide an update to the 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**

**May 2017**

## 1.0 Care Quality Commission and Use of Resources Assessment

I'm delighted to report that we have been rated 'Good' overall across both hospitals and in all the 5 main CQC domains - safe, effective, caring, responsive and well-led. This gives the Trust a 'Good' rating overall. We've also been awarded an 'Outstanding' rating for 'use of resources' by an NHS Improvement inspection which was completed during the same period as the CQC assessment.

It's a fantastic result and is a tribute to the hard work and dedication of our staff to deliver the highest quality care to our patients both today and into the future.

It's a proud moment to be the first NHS hospital foundation trust to gain 'Good' across all categories under the CQC's new framework and outstanding from NHSI. Looking back over the past year we've performed incredibly well, consistently delivering on our national access standards and ranking in the top ten best performing trusts in the country. I know the organisation is very committed to continuing our improvement journey and providing the very highest quality of care both today and into the future.

In light of the recent regulatory assessments we have also had the very positive news that NHSI have moved us in to Segment 1 in line with their Single Oversight Framework (SOF). This means that the Trust is recognised as one of the highest performing providers and is afforded maximum autonomy with no support needs identified and will have only very light touch regulation.

## 2.0 Performance

During 2017/18, the Trust has performed very well against the key regulatory and contractual performance metrics, including quality and workforce KPIs. The start of the financial year was challenging in the delivery of all 3 regulatory standards but during the year compliance has shown continuous improvement. Of particular note is the Trust's continued strong performance in delivering A&E, RTT and Cancer access standards, despite unprecedented demand during Q3 and Q4.

Throughout 2017/18, the RTT performance has been increasing and from November 2017, the aggregate performance has been compliant with the National 92% standard. Quarter 4 represented the best performance since the merger of the two sites in September 2015 which is significant given the challenges the organisation faced with non-elective demand. During 2017/18, there were no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue into 2018/19.

Performance against the A&E 95% standard has been particularly challenging during the year, most notably during Q3 & Q4 across both sites. The non-elective demand facing the NHS has been

the subject of much national media scrutiny and whilst the aggregate yearly performance for Chelsea and Westminster only met 94.3%, this is in no way reflective of the efforts of our staff. Demand has increased by c.9.4% compared to 2016/17 and Chelsea and Westminster in is the upper decile nationally in terms of overall performance.

Our performance in relation to the 62-day cancer GP referrals to first treatment standard has been excellent during the year, with 2 months being the Number 1 performing Trust in the UK (November 2017 and January 2018). Our compliance with the 2 week wait standard has also been excellent. Both of our sites have experienced significant growth in demand with increased referrals compared to 2016/17 yet the organisation has responded well to deliver timely care for our patients.

## 3.0 Quality Priorities

In 2017/18 we set ourselves 7 quality priorities linked to patient safety, clinical effectiveness or patient experience:

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

Clinical effectiveness
Priority 5: Reduction in stillbirths (Maternity Plan)

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

Significant progress has been made with all 7. Some of the highlights are: There has been a 38% reduction on falls with severe harm; the implementation of the sepsis plan is showing improvements in screening; and treatment of patients and our still birth rate is lower than the national average. 3 of the priorities have been rolled over to 2018/19 and others are now being managed as part of 'business as usual'.

## 4.0 Staff Achievements and Awards

Celebrating long service
This month we announced that the Trust is introducing long service awards, which will be sponsored by our charity CW+. These awards aim to show our sincere appreciation for our staff and their loyalty to our hospitals, clinics and the NHS as a whole.

The first round of awards will be given in May, coinciding with Chelsea and Westminster Hospital's 25th anniversary. Members of staff with 25 years or more of service will receive a badge, certificate and a special Trust notebook. Awards for 10, 15 and 20 years will be given out via the Divisions throughout the rest of the year. These awards will celebrate our staff and support our engagement efforts.

Our latest CW+ PROUD award winners:
February 2018:

- Rachel Sharkey, Emergency and Integrated Care
- Jupiter Ward, Women's and Children's
- Avril Blenman and Aine Lennon, Planned Care
- Vida Djelic and Barbara Kasprzyzk, Corporate

External recognition:

56 Dean Street was recognised in the well-renowned Boyz Awards:

- It was named as the 'Best sexual health organisation or clinic' for the fourth year running
- Leigh Chislett, Clinic Manager at 56 Dean Street, was awarded for his 'Outstanding Contribution' for his services to people with HIV, longstanding leadership and commitment to sexual health.

Music Therapists, Grace Watts and Claire Flower, received a Jessica Kingsley Publishers Poster Prize for 'Music While You Wait', which is a music therapy and maternity project across the antenatal clinic, and the antenatal and post labour wards.

## 5.0 Communications and Engagement

CQC result summary

Our social media comms including several videos and photos reached nearly 100,000 social media users. One video alone being seen by 15,000 people within the first 24 hours. It was the best ever engagement seen on our social media channels, generating several hundred new followers on the results day.

Ongoing activity
Our monthly all staff briefings at the start of April were well-attended, covering improvement initiatives in theatres, our charity's innovation programmes, and a new core training compliance system, Qlikview. Our new podcasts of each briefing, which were introduced this year, have been very well-received by staff, increasing exposure and engagement. The latest all staff briefing is attached to my report.

We issued press releases on CQC, getting coverage in the Evening Standard, the staff survey and the introduction of 'bleep volunteers'. In March, we were pleased to host Jeremy Hunt, Secretary of State for Health, who toured our busy CWH A&E and spoke to staff about important safety initiatives across the NHS.

Our increasing use of video has led to higher engagement across all digital channels such as:

- Our HOME initiative linking to the national #endPJparalysis challenge, featuring Theo, a West Mid patient, and his road to recovery. NHS England have picked up his story and asked to use this in their promotional material.
- We continue to promote and support CernerEPR ahead of its go-live on May 4, rolling out a series of countdown videos in the final 10 days.

- Highlighted the work of our Paediatrics team at West Mid, ahead of their open day to aid in nursing recruitment.

We are continuing to update the Trust's website, key recent changes include:

- Featuring our new CQC 'PROUD' result video on the homepage of our website
- Launching an innovative new tool for staff to report excellence – initially covering A&E/UCC/AAU at Chelsea and A&E at West Mid
- Creating a new video library, to showcase some of the Trust's key videos
- Fresh information on our medicine services including A&E, Haematology, Rheumatology
- Various updates made to wards and departments list, including visiting times and location/contact information updated
- Added eReferral information, tailored for patients, public and GPs and health professionals
- Updated information on our sexual health clinics
- Updated prescription charges information

Update on the Comms Strategy (KPIs and more detail in appendix)

Over last 6 months, the Comms team have delivered:

- Five regular newsletters instead of one
- Podcasts of Staff Team Brief
- Video content on all channels
- Increased staff engagement via social media, with 4,000 more followers across all channels in last 6 months, a 20% increase
- Increased number of positive media stories, eg London Standard CQC result, Use of Robots in Orthopaedic surgery, new EPR systems in the Digital press.
- Higher number of visitors to our webpages, often viewing new videos or directed to our website via social media content (making a better user journey)
- Going Beyond 50% more pages and content
- More prominent and consistent branding
- Announcement of new long service awards

We continue to lift our communications and engagement activity, with a focus on brand identity and consistency.

## 6.0 General Data Protection Regulation Preparations

As I have previously reported to Trust Board, on 25th May new legislation will be coming into effect to safeguard the use of an individual person's data. The new legislation seeks to protect the fundamental rights and freedoms through the processing of personal data and safeguarding the secure transfer of data within and across organisational boundaries. There are also significant financial consequences for organisations that get this wrong. There will be a wider definition of personal data which includes anything that discloses identity and is unique to the individual.

As a large healthcare provider we have access to a large amount of personal data of staff and patients and we are very clear about our responsibilities to kept this secure and accessible only to those who professionally need it. The new legislation will bring about a number of changes in the

way we process the personal information of our staff, patients and the public as well as giving people more control over how their personal data is used. A significant amount of work has been completed in preparation for GDPR. As with other NHS organisations, we will not yet been able to state full compliance with all standards, particularly as some of the legislation is still be clarified. We do however have a plan that addresses the gaps in compliance and that has been reviewed by the Information Commissioners Office and will be monitored on an ongoing basis by the Audit and Risk Committee.

## 7.0 Strategic Partnerships Update

Strategy Development

The Board Strategy Working Group has made its outline recommendations which were discussed at the March Board Strategy meeting. It was agreed that the Executive Team would develop an options appraisal with more detailed supporting analysis, using the *matrix* methodology employed by the Board in 2014 when the Acquisition Business Case was adopted. This will ultimately support the wider strategy development discussions at the Board away day in June.

North West London Sustainability & Transformation Partnership

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

1. A series of detailed service/system improvement initiatives where NWL providers are coming together to focus on closing current gaps on quality and financial performance. The guiding principles of consolidation/scale and standardisation are being applied to clinical and clinical support areas. Work programmes include the Outpatient Transformation Programme and North West London Radiology Network
2. The 5 Delivery Areas which are more population and prevention based and where the Trust is engaged in a smaller number of transformational programmes remain focussed on long term conditions and population health priorities such as Diabetes, Mental Health and Older Adults. This continues to be supported by supporting programmes such as the Care Information Exchange, Business Principles and Workforce Development.

Paediatric Services

NHSE (London) have set out their proposed approach to engaging stakeholders following the consultation on Children's Congenital Heart Disease. Broadly there are two areas where the Trust is engaged:

1. NHSE (London) have indicated that they believe there are still a number of viable options which should be explored as alternatives to the Royal Brompton and Harefield(RBH) preferred model of co-location with St Thomas'. These options are to be developed and tested in parallel with the larger RBH preferred case
2. The work led by the Trust in developing Paediatric Surgical Services is seen as a leadership model for network development. Discussions are focusing on Critical Care and Surgery and NHSE (London) are keen to explore the potential scale of a North Thames leadership

model based on the work we have undertaken to date.

Integrated Care Partnerships

The Strategic Partnerships Board (SPB) continues to monitor these strategic work programmes. These programmes currently remain proportionate to the wider priorities of the Trust and small scale/evaluatory in nature but do provide opportunities for early engagement and learning. At this stage they are borough based CCG sponsored initiatives rather than STP wide:

1. Hammersmith & Fulham ICP. Partnership Agreement in place with H&F GP's, ICHT, CLCH and WLMHT. Working assumption from H&F CCG is that an Outcomes Framework and alliance contract will be in place from Q2 of this year. This will not transfer resources from current contracts but will set out incentives. Three likely programmes:
   **a)** Establishment of multidisciplinary team (MDT) model in Child Health of 1 per network (3 across H&F)
   **b)** Adult Care project likely to review re-admissions in long term conditions
   **c)** Older Adults to support Frailty and End of Life
2. My Care; My Way (West London over 65s hub): Proposed alliance contract (CW value between 60-200k). This would support MDT working in south hub and would target consultant and other workforce support to ambulatory care. Builds on existing Older Adult Support Team (OAST) and possible initiatives in 18/19 include hosting of post A&E 'hot clinics'; post discharge OP activity.
3. Hounslow STP Implementation: This is focussing on review of urgent care pathways and the development of the Emergency Care Portal on WMUH site. CCG support for development of WMUH Estate and (first phase) ambulatory care is being managed through this programme.
   Dialogue with CCG and NHSE on primary care models was curtailed over CQC inspection period and wider winter focus but is being re-initiated
4. Kingston & Richmond Care Transformation Board: the alignment of the 2 CCGs and creation of a sub SWL STP footprint. This is effectively replacing the Richmond OBC as a change programme but remains at very early stages while the proposed model of care is developed. End of Life indicated as an early priority area.

Imperial College Healthcare NHS Trust

We continue to make good progress with a number of our clinical service workstreams. We have now formalised our joint paediatric surgical arrangements with the shared appointment of two new paediatric surgical consultant posts. We have also looked to integrate our two service governance structures including the appointment of a single Clinical Service Director.

Work has begun on exploring areas of collaboration in paediatric critical care. Three areas have been chosen; patient pathway alignment, clinical governance and management and education and training.

Imperial College Health Partners have over the last few months been supporting our two HIV services to identify areas of closer collaboration with a specific focus on inpatient care. A proposal will be brought to our Exec to Exec meeting in mid May with the intention to then engage

commissioners, STP colleagues, and other stakeholders in any proposed services changes to support improvements to care and patient experience.

Northwest London Pathology

NWL Pathology went live with their new Laboratory Information Management System (LIMS) on 7th and 8th April. During the weekend activity took place to switch over from the old IT laboratory system to the new SunQuest LIMS product on the Imperial and Chelsea & Westminster sites. This is the first 'go live' of the LIMS project that started back in September 2016 and constitutes a significant milestone for NWLP and its transformation plans. The new LIMS covers many elements of service including Blood Sciences, Infection and Immunity, Cellular Pathology and specialist services.

As with any new system we have experienced some ongoing issues that are being dealt with in conjunction with North West London Pathology team although these are now largely resolved.

There are further 'go lives' that are required to complete this work that will take place over the next few months. These include roll out at the West Middlesex site which we chose to delay in light of the Cerner roll out plan at the beginning of May.

## 8.0 Implementation of the Cerner Electronic Patient Record – Phase 1

We are now on track to take Phase 1 of the Cerner Electronic Patient Record live over the early May Bank Holiday. This will involve replacing the Patient Administration System and implementing new functionality for the emergency department and theatres at the West Middlesex Hospital. This is the first step on our journey towards having a single electronic patient record across the whole trust. Phase 2 is schedule for next year and will see the replacement of the LastWord system on the Chelsea site.

We have been tracking progress through a series of Gateway reviews and the outcome of the final one of these for Phase 1 is scheduled for review by the EPR and Digital Transformation Board on Friday 4th May. Subject to the outcome of the review our expectation then is that we will initiate the process of taking the existing West Middlesex Patient Administration System down so that the data migration process can complete. A very detailed plan has been developed for managing the cut over to the Cerner system and continuing to deliver care throughout this transition phase. The new system should be live across the whole of the West Middlesex site by start of business on Tuesday 8th May. We have a very detailed plan for 'at the elbow' support from our team of floorwalkers as users get familiar with the new system.

A high proportion of staff have now completed their training and the communication campaign for staff, patients and stakeholders has really ramped up.

## 9.0 External Inspections

Appended to this report is a list of external inspections over the coming few months.

## 10.0 Finance

The financial position is £25.6m adjusted surplus on a control total basis, which includes £27.4m of Sustainability and Transformation Funding (STF). The Trust has over-delivered against the control total for 2017/18 and the appeal for the A&E quarter 4 STF was upheld. It should be noted that the numbers are draft and subject to External Audit.

**Lesley Watts**
Chief Executive Officer
May 2017

**Appendix**

# Timetable of External Inspections, Visits and Accreditations 2018

| Month | Specific Date | Reviewing Authority | Where Will the Inspection Take Place? | Aspects of Compliance to be Tested | Executive Lead | Lead Director | Operational Lead | Reporting Group | Group overseeing compliance | Info/ Timetable |
|---|---|---|---|---|---|---|---|---|---|---|
| **May** | 14th May All Day Soft Services Visit 09:00am – 15:30pm | All Day Visit 09:00am – 15:30pm | CW | Covering meal Service - Cleaning Standards and Fabric | | | | | | |
| | 24th of May | United Kingdom Accreditation Service (UKAS) | Audiology, WM | Physiological Services accreditation (IQIPS) | Mr Peter Dawson | Faizal Mohomed-Hossen | Karlien Van Staden Deputy Head of Audiology/ Gillian Ross, Head of Audiology 020 8321 5681 | Planned Care Division Board | Trust Compliance Group | Timetable |
| **June** | | Society for Endocrinology | CW/WM | ? Specific Endocrinology standards | Zoe Penn | Dilys Lai | Daniel Morganstein | EMIC Division Board | Trust Compliance Group | Attach here |
| | 6th of June | North West London Trauma Network (St. Mary's Hospital ) | A&E CW | Trauma Network Guidelines | Miss Zoe Penn | Dilys Lai | Dr Peta Longstaff | EMIC Division Board | Trust Compliance Group | |

**Inspections to be confirmed**

**CQC- 2018/19 -** Critical Care; Maternity; Diagnostic Imaging; and HIV/Sexual Health

# All staff briefing

April 2018

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

## How will Cerner EPR change what you do?

What is going to change for you when we go live with Cerner EPR from May 4th? The way to find out is to attend your Cerner EPR training. As we get into the final weeks, places on training are becoming more scarce. So don't waste yours!

You are not expected to be an expert after your training. There will be support after go-live from floorwalkers and champions and the ICT service desk and we have a collection of quick reference guides to show how to complete tasks on Cerner.

Do you know who your champion is? Do you know where to find the quick reference guides?
Each day in daily noticeboard we are publishing a tip for a particular role. For example, for clinicians in outpatients setting up favourites for the procedures and follow-up appointments you routinely order is a real time saver. You'll see these tips in posters, flyers and screensavers.

## Care Quality Programme (CQP)

The Care Quality Commission (CQC) draft report has been reviewed by the Trust, from here our final report and grading is expected imminently. Once this is published, the news will be available to Trust staff - and on the Trust website for the public to see the rating and report on the Trust's services.

Current work continues to enhance quality and standards of care and meeting the CQC core standards. This will help the Trust work to the next unannounced inspections on our services that were not inspected in December and January. The CQP team have commenced a series of updates and briefings for staff. Further information is available on the intranet page, http://connect/departments-and-mini-sites/cqp/ or via cqp@chelwest.nhs.uk. The updated staff information handbook 'Contributing to a successful Care Quality Commission inspection' is available from the Communications Offices on both main sites, or the CQP Lower Ground floor on the Chelsea site.

It is a good time to reflect on the positive changes to improving quality, safety and performance over the last 12 months, and ensure they continue! Inspectors can arrive to inspect any of our services at any time, but more importantly, we will be continuing our quality journey because it is the right thing to do for our patients and ourselves.

## Financial Performance

The 2017/18 financial year is coming to a close and our February year to date adjusted financial position is £1.36m ahead of plan. As in previous months, pay costs continue to be over plan with the year to date overspend increasing to £12.56m. Pay overspends are offset by underspends in non-pay. The year to date underlying financial position, after adjusting for non-recurrent income, is a deficit of £21.51m.
We have achieved 81.5% of our 2017/18 savings target of £25.9m.

## Anniversaries in 2018

We will be celebrating four special anniversaries this year:

- 25th anniversary of Chelsea and Westminster Hospital—13 May
- 70th anniversary of the NHS—5 July
  On this date we will be holding open days at both hospital sites
- 30th anniversary of the Kobler Centre—13 September
- 15 anniversary of West Middlesex University Hospital—17 November

Plans are now well underway but we would love to hear from you, if you have any great historical photos or stories to share, please email communications@chelwest.nhs.uk

## Staffing

### Nursing Recruitment

The first couple of months of the year has been pretty busy for nursing recruitment at the Trust. We have offered a total of 78 nursing posts so far this year, travelling up to Manchester and Birmingham to attend the RCN jobs fairs, attending university open days at Kingston and Kings College and holding on site and Skype interviews.

The capital nurse programme is proving very popular for both graduates thinking of moving to London and for graduates completing their nursing degree/post graduate diploma in London. We are showcasing our innovative work with recruitment and retention with the rest of London at the Capital Nurse Expo last month.

Internal transfer continues to be available to Band 5s and Band 2s to broaden depth of experience and do remember to book into the weekly career clinics held on Tuesdays at Midday if you would like some careers advice. Contact Julie.Pie@chelwest.nhs.uk

If you are keen to increase your experience in carrying out interviews we have regular on site recruitment days for Band 2s and Band 5s and will also be attending RCN fairs in London and Glasgow in the coming month so please contact Cariosa.Murray@chelwest.nhs.uk if you are interested.

We take care to ensure that our new starters settle in and feel part of our team especially for those coming from overseas who have left family and friends behind for the first time. On 13 April we are repeating our successful new starters cinema event at the CW+ MediCinema where they will get to see the latest movie screening and spend time getting to know each other. Please contact Cariosa.Murray@chelwest.nhs.uk for more details.

### Core (mandatory and statutory) training

Although we have made good progress with core training compliance this has declined recently and all staff are reminded of the importance of making sure they are up to date. We are rolling-out access for all compliance records on a revamped QlikView reporting platform (and removing Wired). Please see the intranet to access this.

Staff can complete the Core Training e-learning modules online at the Learning.Chelwest website learning.chelwest.nhs.uk—which is available from both within and outside the Trust, across a variety of devices. We will be adding additional topics in the coming months. The Cerner team are developing some refresher eLearning modules which will also be available via Learning.Chelwest shortly.

### Latest CW+ PROUD award winners

Well done to our latest winners who have all demonstrated how they are living our PROUD values.

- **Planned Care:** Avril Blenman, Technician in Decontamination Services, and Aine Lennon, Ward Manager - Lord Wigram Ward
- **Emergency and Integrated Care:** Rachel Sharkey, Acute Oncology Clinical Nurse Specialist
- **Women and Children:** Jupiter Ward
- **Corporate:** Vida Djelic, Board Governance Manager, and Barbara Kasprzyzk, ISS Hostess on AAU

Visit the intranet to nominate a team or individual.

**May *All Staff Briefing* dates:**

- Thu 10 May, 10:00 – 11:00, HY
- Thu 10 May, 13:00–14:00 — CWH Gleeson lecture theatre
- Due to Cerner EPR Go Live there will be no WMUH session in May

# Communications Strategy Update

## Gill Holmes
## April 2018

proud to care

# Comms Strategy Timeline

## Year 1 (2018)
## Focus & Grip

- **Focus and centralise:**
  - Media and external requests
  - Staff engagement
- **Grip and Planning**
  - Divisional and priority area comms plans in place by end January
  - Website content & updates
  - Staff recruitment and retention campaign
  - Improvement/Innovation
  - Press activity
- **Consistent brand identity**
  - 'World Class'
  - 'Hospital of Choice'
  - 'Outstanding Specialist care'

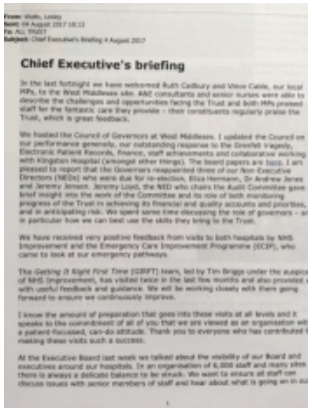
## Year 2 (2019)
## Strengthen & Promote

- **Strengthen :**
  - Staff engagement initiatives eg educational videos; newsletters, group events
  - Quality and reach of 'Going Beyond'
  - Improvement and innovation comms and coverage
  - External relationships and partnerships
  - Website
- **Promote**
  - Brand
  - Staff
  - Specialist services
  - Improvement, Innovation, Research

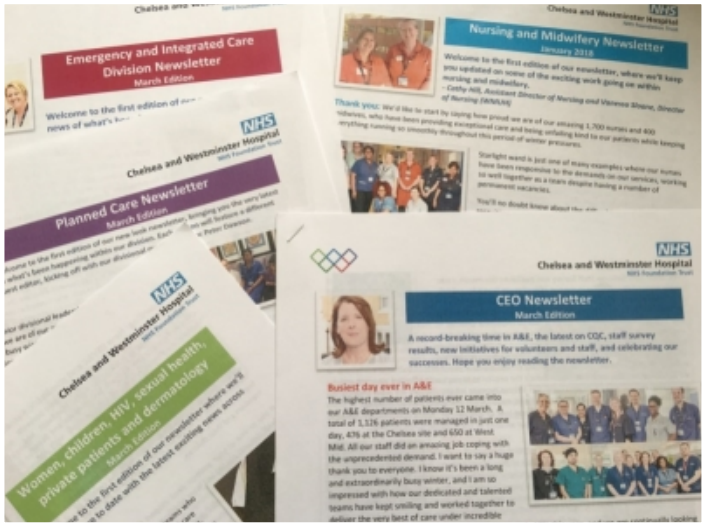
## Year 3 (2020)
## Grow & become 'Outstanding'

- **Grow**
  - Staff opportunities
  - Press coverage
  - Brand awareness
  - Innovation/Improvement
  - Income initiatives
- **'Outstanding'**
  - Support delivery of 'Outstanding' services and staffing
  - Successful integrated internal and external website
  - Delivery of high performing KPIs

## October 2017


Chief Executive's briefing

## End March 2018





**1 CEO briefing every 2-3 weeks**
***No video content***
***No consistent branding or social media promotion***

- **5 Newsletters instead of 1**
- **Podcasts of Staff Team Brief**
- **Video content on all channels**
- **Increased staff engagement via social media**
- **Going Beyond 50% more pages and content**
- **More prominent and consistent branding**

# Monitoring Performance: KPIs

| KPI | C&W Trust | C&W (NHS 17 survey) | Target end 2018 | Benchmark |
|---|---|---|---|---|
| **NHS staff survey: % completing survey (2016)** | 40% | **32%** | 45% | 43% (Nationally) |
| **NHS staff survey: % reporting good comms btw senior mgrs and staff** | 34% | **41%** | 40% | 33% (other Acute Trusts) |
| **Items of positive media coverage** | n/a | **10-12 (last 5 months)** | 24 pa | Two per month |
| **Staff engagement % opening all staff emails** (use of comms tool 'Poppulo') | n/a | Launch in May | 50% | 40-50% |
| **Website: number of sessions (added 12 new videos)** | 100k per month | **10% increase last 3 months** | 120k per month | 120-150k p/m |

| KPI | C&W (Oct 17) | C&W (March 18) | Target end 2018 | West Mid (Oct 17) | WMUH (March 18) | Target end 2018 | Benchmark (other London Trusts) |
|---|---|---|---|---|---|---|---|
| **Twitter: Number of followers** | 8,200 | **9,300** | 10,000 | 7,800 | **8,600** | 9,000 | 17,000 |
| **Facebook: Number of followers** | 1,800 | **2,100** | 2,200 | 1,020 | **1,200** | 1,300 | 4,000 |
| **Linkedin**<br>**Instagram** | 3,800<br>100 | **5,000**<br>**500** | 5,000<br>500 | n/a | n/a | n/a | 8-10,000 |

# Comms Strategy 6 Month Progress

**Year 1 (2018)**
**Focus & Grip**

- **Focus and centralise:**
  - Media and external requests
  - Staff engagement
- **Grip and Planning**
  - Divisional and priority area comms plans in place by end January
  - Website content & updates
  - Staff recruitment and retention campaign
  - Improvement/Innovation
  - Press activity
- **Consistent brand identity**
  - 'World Class'
  - 'Hospital of Choice'
  - 'Outstanding Specialist care'

- **FOCUS AND GRIP:**
  - **Divisional newsletters in place alongside CEO Newsletter**
  - **Nursing and Midwives newsletter to focus on retention/recruitment**
  - **Poppulo staff engagement tool to be launched in May**
- **KPIs show increased social media engagement**
  - **4,000 total extra followers**
  - **UP 20% in 6 months**
- **High quality videos available and being shared across all channels**
- **Website being updated**
- **Pick up in positive media articles**
- **Consistent brand look/style developed**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.2/May/18 |
| **REPORT NAME** | Care Quality Commission (CQC) Report |
| **AUTHOR** | Serena Stirling, Quality Improvement Manager |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | To report the outcome of the Trust's comprehensive Care Quality Commission inspection. |
| **SUMMARY OF REPORT** | **Background**<br><br>In 2017/18 the Trust underwent the first comprehensive CQC inspection since integration to assess the quality of care being delivered to patients. This occurred in December 2017 (onsite inspection) and January 2018 (Well-Led and Use of Resources inspections).<br><br>This regulator asks five key questions of all organisations: Is it Safe; Is it Effective; Is it Caring; Is it Responsive; and Is it Well-Led.<br><br>The services which were inspected on both hospital sites are as follows: Urgent and Emergency Care; Medicine (including older people's care); Surgery; Services for Children and Young People; End of Life Care; and Outpatients.<br><br>**Outcome**<br><br>Both the Chelsea and West Middlesex sites improved their ratings from 'Requires improvement' to 'Good'; and the Trust improved the overall rating from 'Requires Improvement' to 'Good'. The Trust is also rated as 'Outstanding' for Use of Resources.<br><br>Urgent and Emergency Care, Services for Children and Young People, and therefore the Chelsea site overall, is rated as 'Outstanding' for the Caring domain.<br><br>**Themes of positive feedback include:**<br><br>• The trust had learned from previous inspections;<br>• Delivery of a successful integration;<br>• Maintained financial surplus as well as achieving all major targets;<br>• Staff are proud to work for the organisation;<br>• Culture of openness and honesty;<br>• The trust engages with the wider health and care economy;<br>• Examples of innovation and research; |

| | |
|---|---|
| | • Continued determination to improve; and<br>• Patients and carers all gave positive feedback about the care they received.<br><br>The CQC identified 57 'Should Do' actions for the organisation, however, did not believe that any of the identified issues constituted a breach in organisational compliance with the Health and Social Care Act 2008.<br><br>**Themes for further improvement include:**<br><br>• Workforce (Recruitment and retention, management and support of temporary staff, appraisals, mandatory and statutory training compliance)<br>• Patient Experience (Complaints and Friends and Family Test - response times and learning from patient feedback)<br>• Medicines Management (Fridge temperature monitoring, ambient room temperatures, safe storage of medicines)<br>• Clinical documentation<br>• Clinical audit<br><br>**Areas of outstanding practice which were identified include:**<br><br>• 'On medical wards at West Middlesex Hospital, the Kew ward team had developed an innovative mouth care project following feedback from patients and relatives and a review of patient outcomes. This had resulted in a reduction in cases of acquired pneumonia as a result of poor mouth care.'<br>• 'End of life care had a high profile throughout the Hospitals on both sites. There was a focus on improving the experience for patients nearing the end of life and there appeared to be a widespread commitment to achieving this.'<br>• 'On medical wards at Chelsea and Westminster Hospital the work on Nell Gwynne and David Erskine ward in relation to elderly patients including those living with dementia was outstanding. Staff engaged patients in a wide range of activities and were passionate about the needs of these patients.'<br><br>**Next steps**<br><br>The Care Quality Programme has developed a 'CQC Quality Improvement Plan' to monitor and track the Trust's progress addressing the 57 'Should Do' actions. This will support the Trust's continuous quality improvement journey and subsequent ongoing regulatory compliance.<br><br>The CQC inspection regime is now a continuous cycle of monitoring and regulating. Providers should expect some interaction with CQC inspections on an annual basis.<br><br>The CQC will return to the Trust 2018/19 to inspect those services not included in this latest inspection, those being: Critical Care; Maternity; Diagnostic Imaging; and HIV/Sexual Health. These services will be inspected on an unannounced basis, which is anticipated in Q1/Q2 2017/18. |

| | |
|---|---|
| | Preparations have commenced and include:<br><br>• Service self-assessment against CQC core standards<br>• Completion of historic actions from 2014/15 CQC inspection<br>• Ward/Department Accreditations<br>• Senior Partner Programme visits<br>• Senior Nursing and Midwifery Rounds<br>• Out of Hours unannounced reviews<br><br>This work stream will continue to be monitored and reported through the embedded governance structure via Executive Management Board and Quality Committee. |
| **KEY RISKS ASSOCIATED** | • Delivery of the Quality Strategy<br>• Maintenance of quality standards and regulatory compliance<br>• Reputational impact |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | As outlined above |
| **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. |

# Chelsea and Westminster Hospital NHS Foundation Trust

## Inspection report

369 Fulham Road
London
SW10 9NH
Tel: 02087468000
www.chelwest.nhs.uk

Date of inspection visit: 5 Dec 2017 to 24 Jan 2018
Date of publication: xxxx> 2017

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

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

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

## Ratings

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

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

# Summary of findings

## Background to the trust

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

- Chelsea and Westminster Hospital
- West Middlesex Hospital

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

The trust has 1007 beds including;

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

## Overall summary

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

## What this trust does

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

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

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

## What we inspected and why

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

# Summary of findings

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

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

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

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

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

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

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

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

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

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

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

## What we found

### Overall trust

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

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

# Summary of findings

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

## Are services safe?

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

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

# Summary of findings

## Are services effective?

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

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

## Are services caring?

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

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

## Are services responsive?

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

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

# Summary of findings

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

## Are services well-led?

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

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

**However the trust had further opportunities for improvement:**

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

# Summary of findings

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

## Ratings tables

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

## Outstanding practice

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

## Areas for improvement

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

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

## What happens next

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

## Outstanding practice

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

and young people at Chelsea and Westminster Hospital.

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

# Summary of findings

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

## Areas for improvement

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

**Action the trust SHOULD take to improve**

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

**In Urgent and emergency services:**

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

# Summary of findings

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

**In Medical care:**

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

**In Surgery:**

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

**In Children and young people's services:**

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

# Summary of findings

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

**In End of life care:**

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

# Summary of findings

**In Outpatients:**

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

## Is this organisation well-led?

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

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

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

# Summary of findings

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

## Ratings tables

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

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

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

### Ratings for the whole trust

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

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

### Rating for acute services/acute trust

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

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

## Ratings for Chelsea and Westminster Hospital

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

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

## Ratings for West Middlesex Hospital

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

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

# Chelsea and Westminster Hospital

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## Key facts and figures

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

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

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

Chelsea and Westminster Hospital provide the following services:

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

## Summary of services at Chelsea and Westminster Hospital

**Good** ↑

# Summary of findings

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

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

# Urgent and emergency services

**Good** ↑

## Key facts and figures

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

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

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

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

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

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

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

## Summary of this service

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

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

# Urgent and emergency services

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

However:

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

## Is the service safe?

**Good** ↑

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

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

# Urgent and emergency services

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

However:

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

## Is the service effective?

**Good**

We rated it as good because:

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

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

However:

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

## Is the service caring?

**Outstanding** ☆ ↑

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

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

## Is the service responsive?

**Good** ● ↑

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

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

# Urgent and emergency services

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

However:

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

## Is the service well-led?

**Good** 

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

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

# Outstanding practice

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

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

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Medical care (including older people's care)

**Good** ↑

## Key facts and figures

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

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

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

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

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

## Summary of this service

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

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

# Medical care (including older people's care)

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

However:

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

# Medical care (including older people's care)

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

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

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

## Is the service safe?

**Good**  

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

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

However:

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

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

## Is the service effective?

**Good** 

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

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

However:

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

# Medical care (including older people's care)

## Is the service caring?

**Good** 

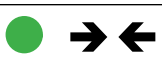
Our rating of caring stayed the same. We rated it as good because:

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

However:

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

## Is the service responsive?

**Good** 

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

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

However:

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

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

## Is the service well-led?

**Good** 

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

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

However:

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

# Outstanding practice

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

# Medical care (including older people's care)

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

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Surgery

**Good** ↑

## Key facts and figures

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

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

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

## Summary of this service

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

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

# Surgery

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

However,

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

# Surgery

## Is the service safe?

**Good** ↑

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

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

However

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

## Is the service effective?

**Good** ↑

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

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

# Surgery

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

However:

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

## Is the service caring?

**Good** ➔➔

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

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

## Is the service responsive?

**Good** ↑

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

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

However

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

# Surgery

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

## Is the service well-led?

**Good** ↑

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

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

However:

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

# Outstanding practice

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

# Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Services for children and young people

**Good** ↑

## Key facts and figures

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

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

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

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

## Summary of this service

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

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

# Services for children and young people

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

# Services for children and young people

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

However:

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

## Is the service safe?

**Good**  

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

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

However:

# Services for children and young people

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

## Is the service effective?

**Good**  

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

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

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

However:

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

## Is the service caring?

**Outstanding** ☆ ↑

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

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

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

## Is the service responsive?

**Good**  

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

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

However:

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

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

## Is the service well-led?

**Good** ↑

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

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

However:

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

# Services for children and young people

## Outstanding practice

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

## Areas for improvement

Action the provider SHOULD take to improve:

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

# Services for children and young people

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

# End of life care

Good

## Key facts and figures

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

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

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

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

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

## Summary of this service

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

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

# End of life care

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

However:

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

## Is the service safe?

**Good** ↑

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

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

# End of life care

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

However:

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

## Is the service effective?

**Good** 

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

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

# End of life care

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

However:

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

## Is the service caring?

**Good**  

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

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

# End of life care

## Is the service responsive?

**Good** ↑

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

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

However:

# End of life care

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

## Is the service well-led?

**Good**  

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

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

However:

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

# Outstanding practice

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

# End of life care

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

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Outpatients

**Good**

## Key facts and figures

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

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

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

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

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

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

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

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

## Summary of this service

We rated it as good because:

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

# Outpatients

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

However:

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

## Is the service safe?

**Good**

We rated it as good because:

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

# Outpatients

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

However:

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

## Is the service effective?

**Not sufficient evidence to rate**

We do not rate this domain:

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

# Outpatients

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

## Is the service caring?

**Good**

We rated it as good because:

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

## Is the service responsive?

**Good**

We rated it as good because:

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

However:

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

# Outpatients

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

## Is the service well-led?

**Requires improvement**

We rated it as requires improvement because:

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

However:

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

# West Middlesex Hospital

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## Key facts and figures

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

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

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

West Middlesex Hospital provides the following services:

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

## Summary of services at West Middlesex Hospital

**Good** ↑

# Summary of findings

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

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

# Urgent and emergency services

**Good** ↑

## Key facts and figures

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

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

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

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

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

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

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

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

## Summary of this service

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

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

# Urgent and emergency services

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

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

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

## Is the service safe?

**Good** ↑

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

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

# Urgent and emergency services

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

However

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

## Is the service effective?

**Requires improvement**  ➔➔

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

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

# Urgent and emergency services

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

However:

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

## Is the service caring?

**Good** 

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

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

## Is the service responsive?

**Good** 

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

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

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

However:

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

## Is the service well-led?

**Good** ↑

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

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

However:

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

# Outstanding practice

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

# Urgent and emergency services

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Medical care (including older people's care)

**Good** ➔➔

## Key facts and figures

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

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

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

We told the trust they must:

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

## Summary of this service

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

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

# Medical care (including older people's care)

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

However:

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

# Medical care (including older people's care)

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

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

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

## Is the service safe?

**Requires improvement** 

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

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

# Medical care (including older people's care)

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

However:

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

## Is the service effective?

**Good**  

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

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

# Medical care (including older people's care)

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

However:

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

## Is the service caring?

**Good** 

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

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

However:

# Medical care (including older people's care)

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

## Is the service responsive?

**Good** 

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

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

However:

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

# Medical care (including older people's care)

## Is the service well-led?

**Good** ➔➔

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

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

However:

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

# Outstanding practice

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

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

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Surgery

**Good** ↑

## Key facts and figures

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

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

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

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

## Summary of this service

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

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

However:

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

# Surgery

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

## Is the service safe?

**Requires improvement** 

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

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

However:

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

# Surgery

## Is the service effective?

**Good** ↑

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

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

However:

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

# Surgery

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

## Is the service caring?

**Good** ➔➔

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

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

However:

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

## Is the service responsive?

**Good** ➔

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

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

# Surgery

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

However:

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

## Is the service well-led?

**Good** 

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

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

# Surgery

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

However:

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

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Surgery

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

# Services for children and young people

**Good** ↑

## Key facts and figures

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

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

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

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

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

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

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

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

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

## Summary of this service

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

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

# Services for children and young people

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

However:

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

# Services for children and young people

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

## Is the service safe?

**Good** 

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

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

However:

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

# Services for children and young people

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

## Is the service effective?

**Good**  

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

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

However:

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

# Services for children and young people

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

## Is the service caring?

**Good** 

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

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

However:

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

## Is the service responsive?

**Good** 

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

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

# Services for children and young people

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

However:

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

## Is the service well-led?

**Good**  

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

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

# Services for children and young people

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

However:

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

## Areas for improvement

Action the provider SHOULD take to improve:

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

# Services for children and young people

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

# End of life care

Good ↑

## Key facts and figures

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

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

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

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

## Summary of this service

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

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

# End of life care

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

However:

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

## Is the service safe?

**Good** ↑

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

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

However:

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

## Is the service effective?

**Good** ↑

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

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

# End of life care

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

However:

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

## Is the service caring?

**Good** 

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

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

## Is the service responsive?

**Good** 

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

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

However:

# End of life care

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

## Is the service well-led?

**Good**  

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

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

# Outstanding practice

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

# Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Outpatients

**Good**

## Key facts and figures

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

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

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

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

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

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

## Summary of this service

We rated it it as good because:

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

# Outpatients

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

## Is the service safe?

**Good**

We rated it as good because:

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

# Outpatients

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

However:

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

## Is the service effective?

**Not sufficient evidence to rate**

We rated it as good because:

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

However:

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

## Is the service caring?

**Good**

We rated it as good because:

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

# Outpatients

## Is the service responsive?

**Good**

We rated it as good because:

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

However

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

## Is the service well-led?

**Requires improvement**

We rated it as requires improvement because:

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

However

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

# Outpatients

## Areas for improvement

**Action the trust SHOULD take to improve:**

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

# Our inspection team

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

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

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.3/May/18 |
| **REPORT NAME** | Serious Incident Report |
| **AUTHOR** | Shân Jones, Director of Quality Improvement<br>Stacey Humphries, Quality and Clinical Governance Assurance Manager |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | The purpose of this report is to provide the Trust Board with assurance that serious incidents are being reported and investigated in a timely manner and that lessons learned are shared. |
| **SUMMARY OF REPORT** | This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2015. Comparable data is included for both sites. |
| **KEY RISKS ASSOCIATED** | • The Trust has now reported 6 Never Events during 2017/18 (2 were reclassified following discussion with CWHHE)<br>• Pressure ulcers, Diagnostic incidents and Maternity/Obstetric incident affecting baby only are the top 3 reported incident categories<br>• Labour ward (Chelwest) have report 9 serious incidents and Rainsford Mowlem Ward have reported 7 serious incidents |
| **FINANCIAL IMPLICATIONS** | N/A |
| **QUALITY IMPLICATIONS** | • The reduction in Hospital Acquired Pressure Ulcers continues<br>• During the first 4 months of the year West Middlesex reported 5 incidents of Sub-optimal care of the deteriorating patient. There have not been any reported incidents in this category since July 2017.<br>• Year to date there has been a reduction in falls with severe harm, 7 compared to 13 for the same period last year. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Delivering high quality patient centred care<br>• Be the Employer of Choice<br>• Delivering better care at lower cost |
| **DECISION/ ACTION** | The Trust Board is asked to note and comment on the report. |

**SERIOUS INCIDENTS REPORT**
**Public Trust Board 3rd May 2018**

## 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 6 Never Events reported to date.

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

The second incident 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 patient unintentionally being given a transfusion of platelets which was considered to be an ABO-incompatible blood component has been reclassified as a Never Event'. The patient suffered no harm. This incident occurred on the Acute Assessment Unit at the West Middlesex Hospital site. Immediate action arising from this incident included extra training provided for MAU/AAU including temporary staff re: 'safe blood transfusion sampling', with inclusion of no distraction during blood sampling.

The third incident was reported in September 2017 as a Surgical/invasive procedure incident. Following discussions with the commissioners this incident was classified as a Never Event in January 2018 (StEIS ref. 2017/23484). The incident occurred at Chelsea and Westminster Hospital site. This incident involved a patient undergoing emergency abdominal surgery for a perforated appendix. Intraoperative the patient was hypotensive and a decision was made to insert a CVC line prior to transfer to ITU. The X-ray to confirm correct placement of the CVP line was performed in ITU. The X-ray was reviewed before the CVP line was used and the guide wire was still in situ, this was removed prior to the CVP line being used. The patient suffered no harm as a result of this incident. A LocSIP for CVC insertion will be developed.

The fourth incident was reported in November 2017 (Retained foreign object post-procedure, StEIS ref. 2017/27311). Patient attended perineal clinic appointment at St Georges Hospital following a forceps delivery at Chelsea and Westminster for on-going perineal concerns. During a vaginal examination a swab was identified and removed from the vaginal cavity. This incident occurred on the Labour ward at the Chelsea and Westminster (C&W) site. There were no immediate actions required following this incident.

The fifth incident was reported in February 2018 (Surgical - Wrong implant/prosthesis, Steis ref. 2018/5183) An 85 year old patient underwent a total hip replacement at West Middlesex Hospital. During the procedure the surgeon asked for a 32 mm femoral head, he was inadvertently given a 28 mm head which was incorrectly

checked and as a consequence the wrong prosthesis was implanted. All intraoperative checks of stability were satisfactory so the error was not noted until after the operation was completed. The risk of dislocation is thought at this stage to be marginal.

The sixth incident was reported in March 2018 (Retained foreign object post-procedure, StEIS ref. 2018/8001). Patient presented to St Helier hospital following a forceps delivery at Chelsea and Westminster. During a vaginal examination a swab was identified and removed from the posterior fornix. This incident occurred on the Labour ward at the Chelsea and Westminster (C&W) site. Patient is systemically well and was given a course of oral antibiotics.

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 another scheduled session on Never Events in early 2018. Never Events will feature at the Clinical Governance half day in March.

### 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 March 2018. There were 7 reports submitted. 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 report submitted | Site |
|---|---|---|---|---|---|
| 2017/29993 | 23/01/2017 | Diagnostic incident including | 06/03/2018 | 06/03/2018 | WM |
| 2017/30338 | 12/11/2017 | Diagnostic incident including | 09/03/2018 | 09/03/2018 | WM |
| 2017/30141 | 09/09/2017 | Pressure ulcer | 07/03/2018 | 07/03/2018 | CW |
| 2017/31030 | 19/12/2017 | Unexpected Child Death | 19/03/2018 | 20/03/2018 | WM |
| 2017/31475 | 24/12/2017 | Slips/trips/falls | 22/03/2018 | 22/03/2018 | WM |
| 2017/31633 | 26/12/2017 | Maternity/Obstetric incident: mother | 23/03/2018 | 23/03/2018 | CW |
| 2018/921 | 18/12/2017 | Diagnostic incident including | 06/04/2018 | 29/03/2018 | CW |

Table 2 shows the number of incidents reported on StEIS (Strategic Executive Information System), across the Trust, in March 2018.

Table 2 – Incidents reported by category

| Incident Type (STEIS Category) | WM | C&W | Total |
|---|---|---|---|
| *Abuse/alleged abuse of adult patient by staff | 1 | 1 | 2 |
| Diagnostic incident | 1 | | 1 |
| Maternity/Obstetric incident: baby only | 1 | | 1 |
| Maternity/Obstetric incident: mother only | | 1 | 1 |
| Slips/trips/falls | | 1 | 1 |
| **Unauthorised absence | 1 | | 1 |
| **Grand Total** | **4** | **3** | **7** |

The number of SIs reported in March (7) is comparative to the number of incidents reported in February (7). During both months the Trust reported against the categories; Slips/trips/falls and Maternity/Obstetric incident: baby only.

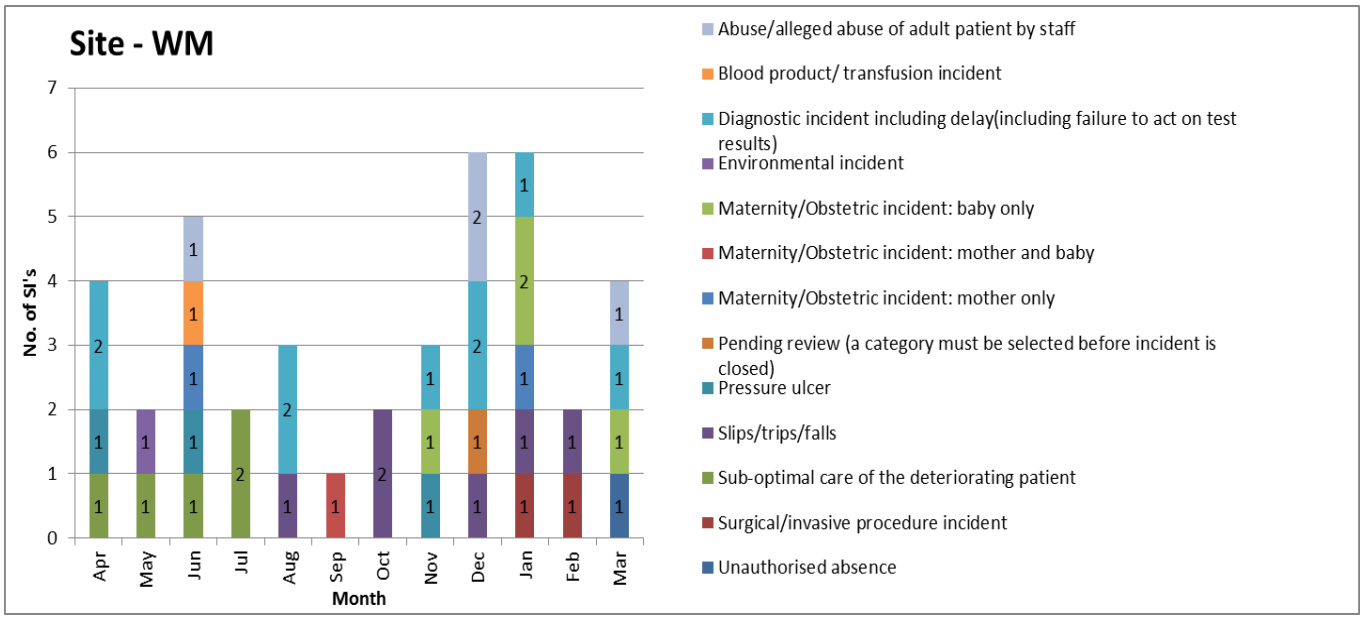
*Alleged abuse of adult patient by staff incidents: The first incident was reported on Rainsford Mowlem Ward (CW site). Patient has alleged they were sexually assaulted by a member of staff. Member of staff is currently

doing non-clinical duties until the investigation is completed. The second incident was reported on Syon 1 Ward (WestMid site). Patient has alleged they were sexually assaulted by an agency nurse. The Nurse bank advised to suspend the nurse in question from all bank shifts with immediate effect and until further notice.

** The unauthorised absence incident reported on Starlight ward (WestMid site) concerns a vulnerable child who absconded from the ward.

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

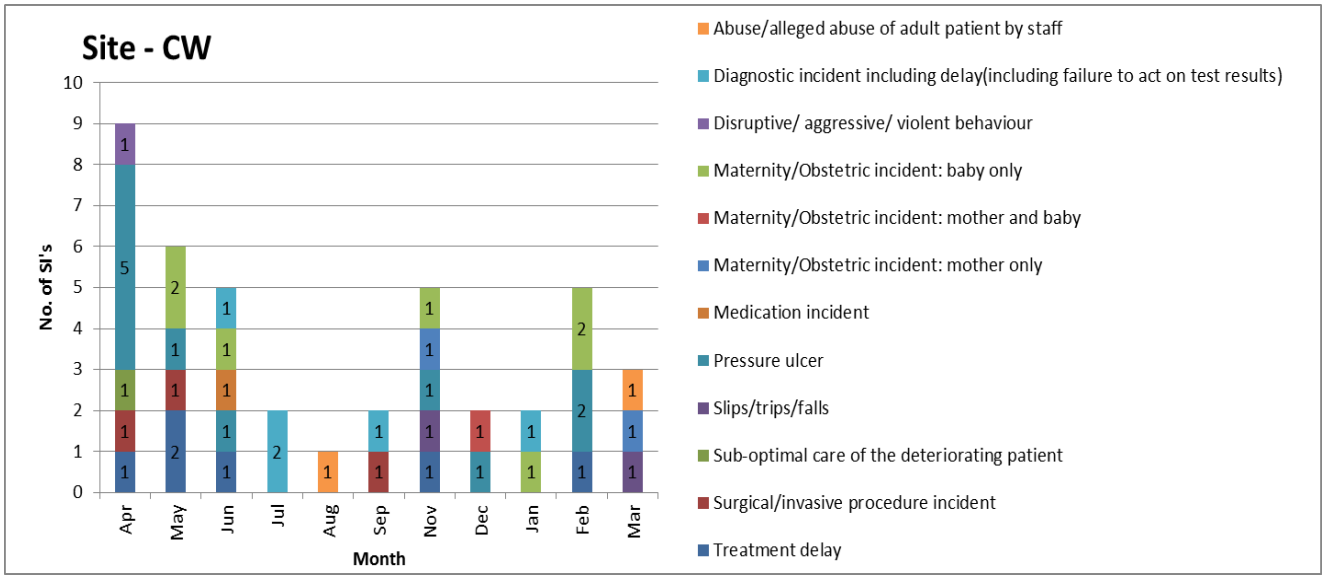
Chart 1 Incidents reported at WM by category YTD 2017/18 = 40




During 2017/18 West Middlesex Hospital's top 3 reporting categories are as follows; Diagnostic incidents (9), Slips/trips/falls (6) and Sub-optimal care of the deteriorating patient (5).

During the first 4 months of the year West Middlesex reported 5 incidents of Sub-optimal care of the deteriorating patient. There have not been any reported incidents in this category since July 2017.

Chart 2 Incidents reported at C&W YTD 2017/18 = 42



During 2017/18 Chelsea and Westminster Hospital's top reporting categories are as follows; Pressure ulcers (11), Maternity/Obstetric incident: baby only (7) and Treatment delay (6).

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 for 2017/18 is 40 at WM and 42 at C&W. For the WestMid site this is a slight reduction in the number reported compared to the same period last year (WM 43 and C&W 42).

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

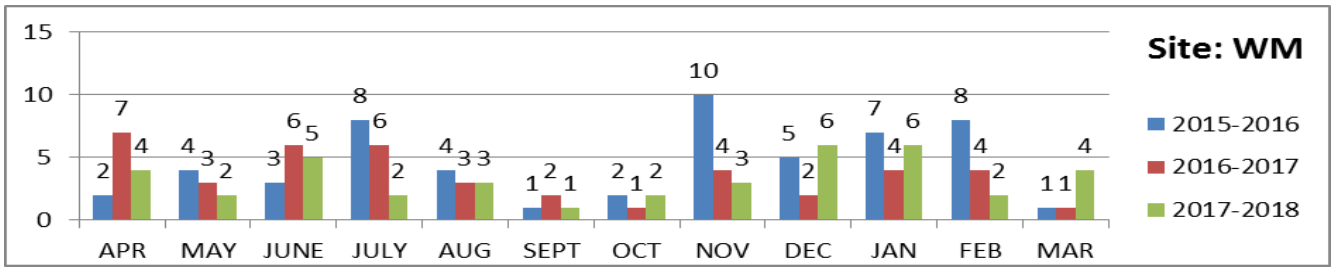
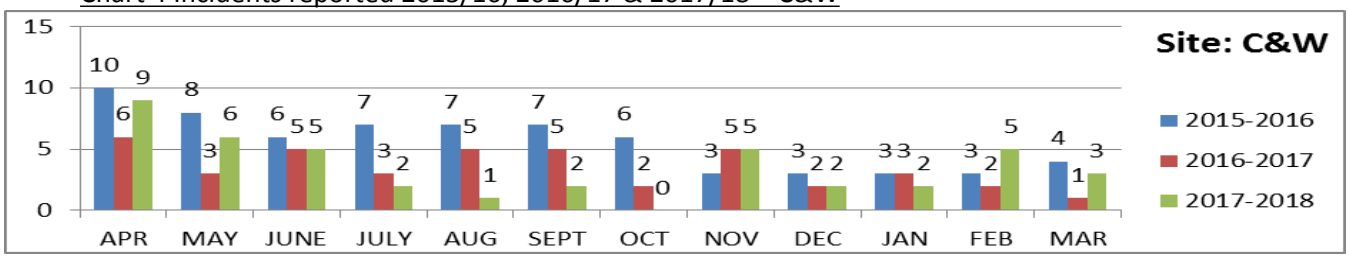



Chart 4 Incidents reported 2015/16, 2016/17 & 2017/18 – C&W

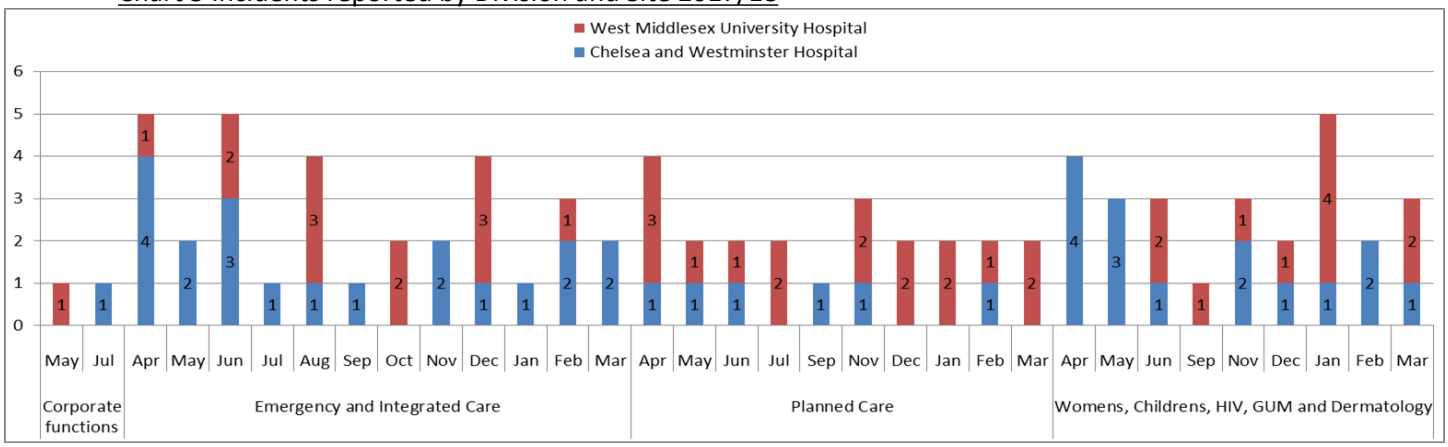



### 3.1 SIs by Clinical Division and Ward

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 has reported 32 SIs (C&W 20, WM 12. The Women's, Children's, HIV, GUM and Dermatology Division have reported 26 SIs (C&W 15, WM 11) and the Planed Care Division have reported 22 SIs (C&W 6, WM 16). The Corporate division has reported 2 serious incidents; a power failure affecting the WM site only and an 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



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

Beside labour ward, Rainsford Mowlem Ward at CWH is showing a higher number of reported SIs than other areas. The divisional management team have been working to address the concerns on this ward with support from the Quality and Clinical Governance Manager.

Labour Ward at CWH is showing a higher number of incidents affecting baby only. This will be discussed at the patient safety group.

Chart 6 –Incident category and location exact, C&W 2017/2018

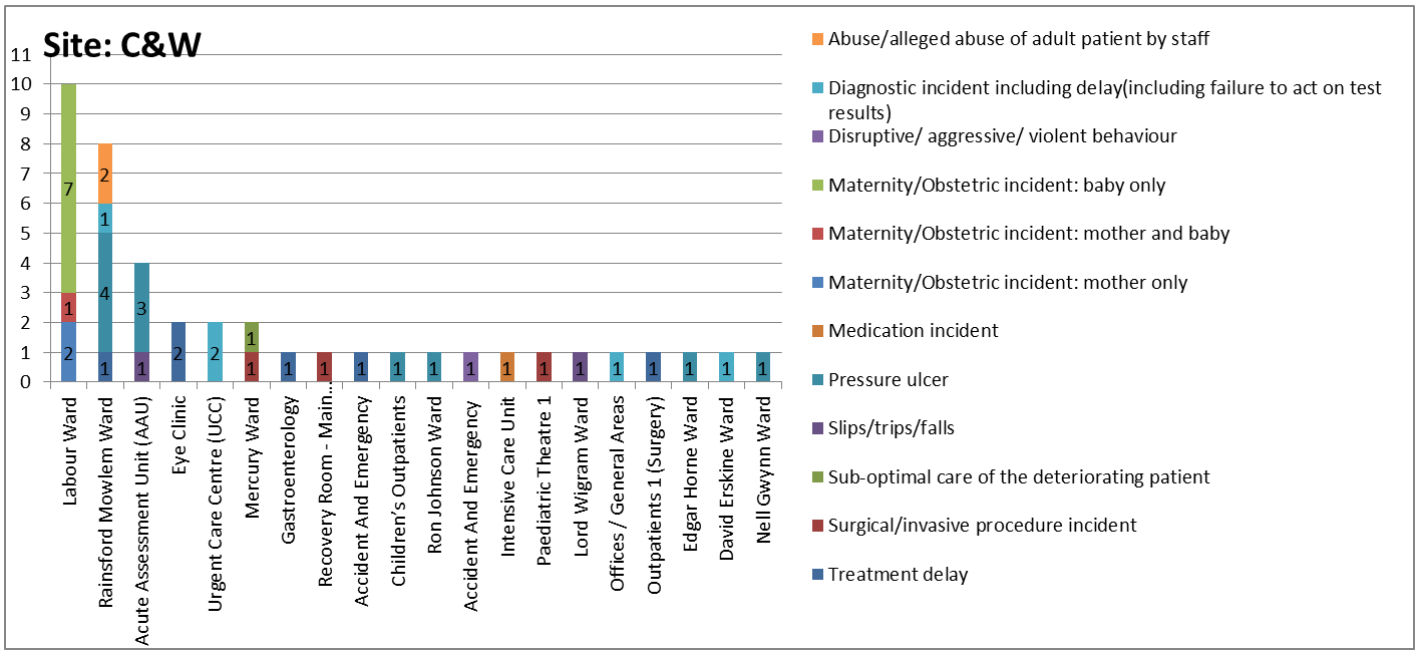
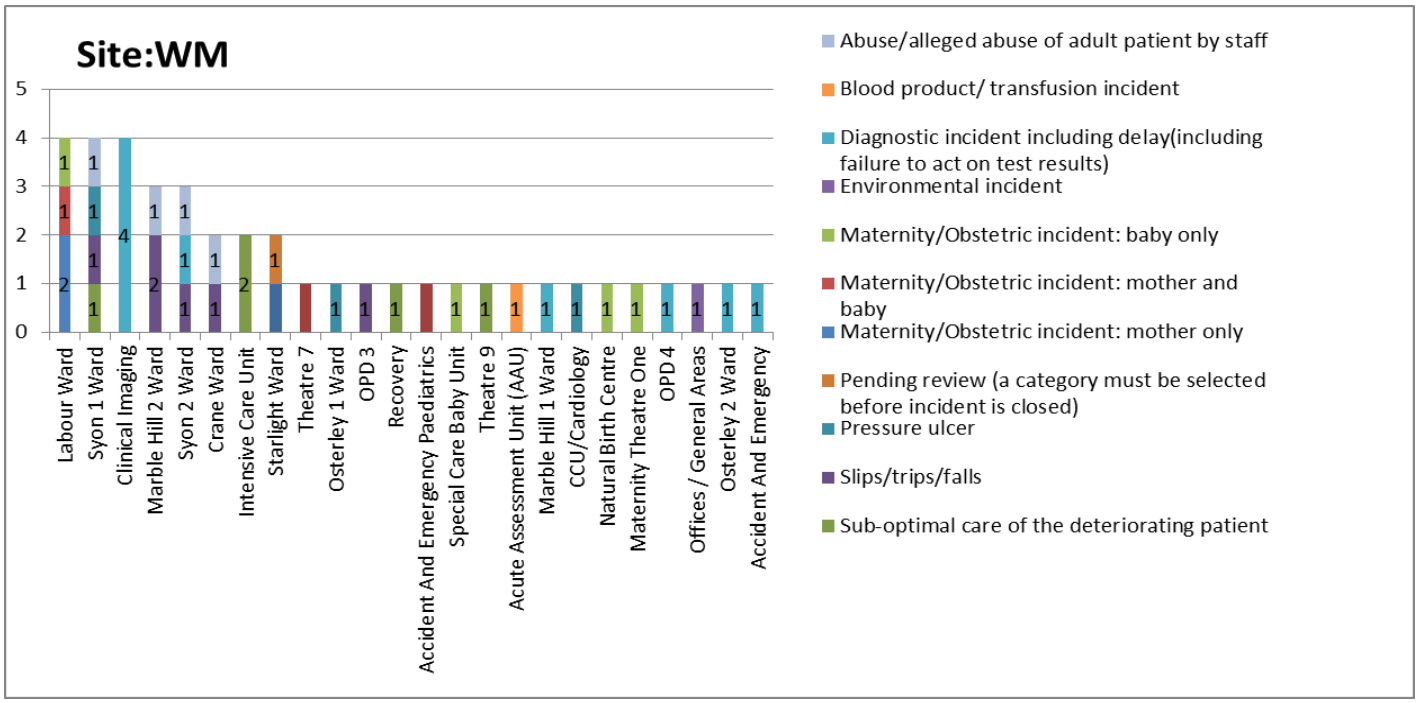


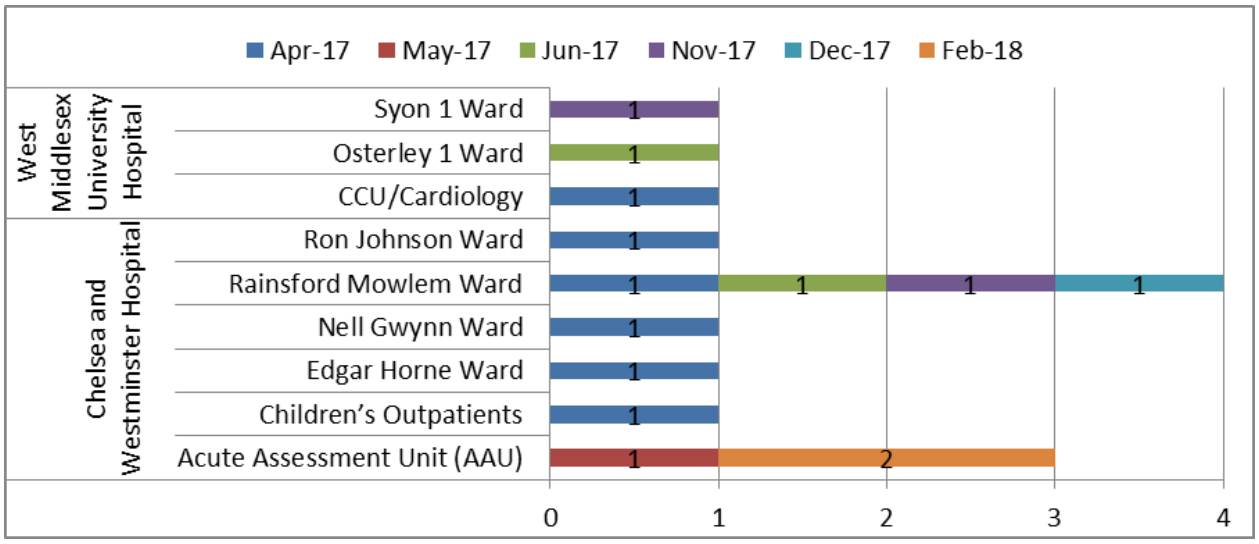

Chart 7 - Incident category and location exact, WM 2017/2018




### 3.2 Hospital Acquired Pressure Ulcers

Hospital Acquired Pressure Ulcers (HAPUs) remain high profile for both C&W and WM sites. The following graphs reflect the volume and areas where pressure ulcers classified as serious incidents are being reported. Rainsford Mowlem Ward and Acute Assessment Unit (AAU) at CWH are 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 position for 2017/18 is 14 compared to 20 for 2016/17.

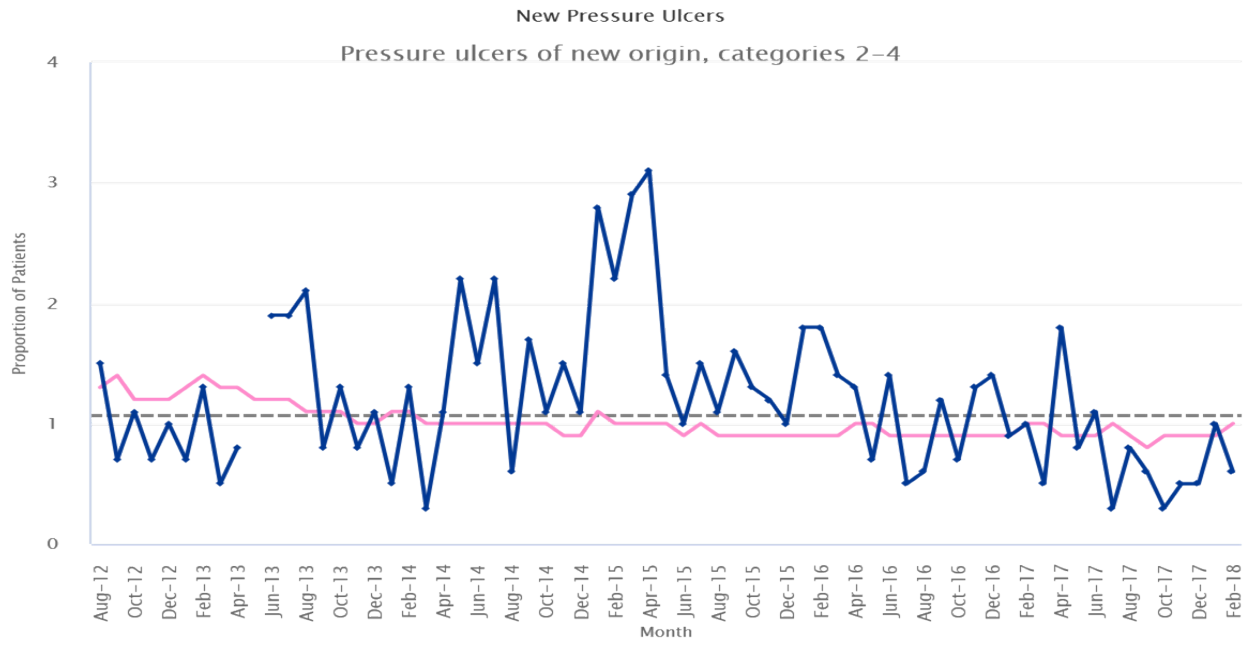
Chart 8 – Pressure Ulcers reported (Apr 2017–March 2018) YTD total = 14




### 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 February 2018.

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

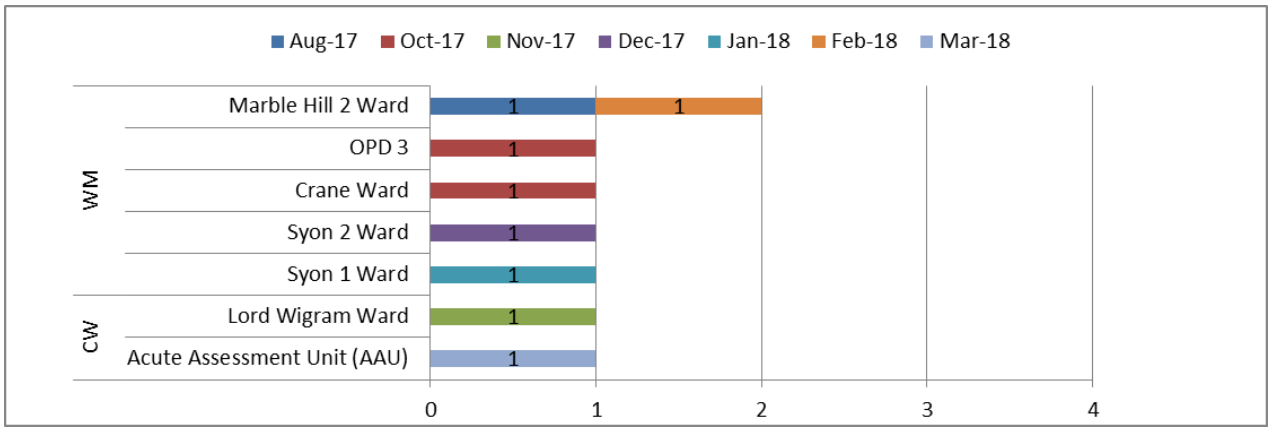


### 3.3 Patient Falls

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.

Since the 1st of April 2017, the Trust has reported 8 patient falls meeting the serious incident criteria. The 2017/18 position is 8 compared to 13 for the same period last year.

Chart 9 Patient Falls by Location (exact) (Apr 2017–March 2018) YTD total =8

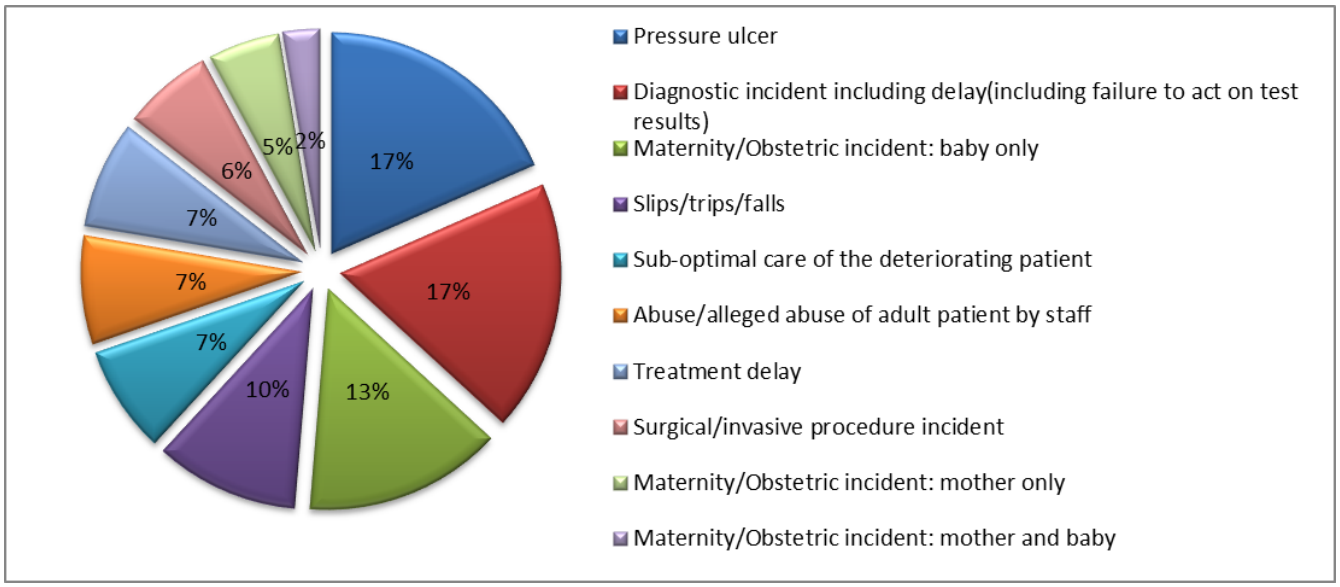



### 3.4 Top 10 reported SI categories

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 sixteen of the SI categories.

Pressure ulcers (14) and Diagnostic incidents (14) are the most commonly reported incidents for 2017/18, although pressure ulcers are much reduce from last year. Maternity/Obstetric incident: baby only is the second most reported incident category with 11 incidents and Slips/trips/falls incidents are third with 8 incidents reported since April 2017.

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 (23). There are two SIs that were due for submission in March. Both of these investigations have been held up because of police investigation. CWHHE have been kept informed.

Table 3

| STEIS No. | Date of incident | Clinical Division | Incident Type (STEIS Category) | Site | External Deadline |
|---|---|---|---|---|---|
| 2017/30108 | 29/11/2017 | EIC | Abuse/alleged abuse of adult patient by staff | WM | 07/03/2018 |
| 2017/30662 | 09/12/2017 | EIC | Abuse/alleged abuse of adult patient by staff | WM | 13/03/2018 |
| 2018/913 | 29/12/2017 | W&C,HG | Maternity/Obstetric incident: baby only | WM | 06/04/2018 |
| 2018/915 | 30/12/2017 | PC | Slips/trips/falls | WM | 06/04/2018 |
| 2018/986 | 09/01/2018 | W&C,HG | Surgical/invasive procedure incident | WM | 09/04/2018 |
| 2018/992 | 10/01/2018 | W&C,HG | Maternity/Obstetric incident: baby only | CW | 09/04/2018 |
| 2018/1446 | 15/01/2018 | PC | Diagnostic incident including delay(including failure to act | WM | 13/04/2018 |
| 2018/1526 | 11/01/2018 | W&C,HG | Maternity/Obstetric incident: baby only | WM | 16/04/2018 |
| 2018/1876 | 13/10/2017 | W&C,HG | Maternity/Obstetric incident: mother only | WM | 19/04/2018 |
| 2018/3018 | 20/01/2018 | W&C,HG | Maternity/Obstetric incident: baby only | CW | 01/05/2018 |
| 2018/3040 | 30/01/2018 | W&C,HG | Maternity/Obstetric incident: baby only | CW | 01/05/2018 |
| 2018/3363 | 04/02/2018 | EIC | Slips/trips/falls | WM | 03/05/2018 |
| 2018/4436 | 13/02/2018 | PC | Treatment delay | CW | 17/05/2018 |
| 2018/4861 | 04/02/2018 | EIC | Pressure ulcer | CW | 23/05/2018 |
| 2018/4967 | 21/02/2018 | EIC | Pressure ulcer | CW | 24/05/2018 |
| 2018/5183 | 23/02/2018 | PC | Surgical/invasive procedure incident | WM | 25/05/2018 |
| 2018/5597 | 10/02/2018 | PC | Diagnostic incident including delay(including failure to act | WM | 04/06/2018 |
| 2018/6023 | 05/03/2018 | EIC | Abuse/alleged abuse of adult patient by staff | CW | 07/06/2018 |
| 2018/6980 | 18/03/2018 | EIC | Slips/trips/falls | CW | 15/06/2018 |
| 2018/7169 | 13/03/2018 | PC | Abuse/alleged abuse of adult patient by staff | WM | 19/06/2018 |
| 2018/7324 | 18/03/2018 | W&C,HG | Maternity/Obstetric incident: baby only | WM | 20/06/2018 |
| 2018/7655 | 22/03/2018 | W&C,HG | Unauthorised absence | WM | 26/06/2018 |
| 2018/8001 | 06/03/2018 | W&C,HG | Maternity/Obstetric incident: mother only | CW | 26/06/2018 |

### 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, however significant progress has been made. There are 14 actions overdue at the time of writing this report. This is a significant decrease compared to last month when there were 32. Women's, Children's, HIV, GUM and Dermatology Division has 3 outstanding action, the Planned Care Division has 7 outstanding, and the Emergency and Integrated Care Division has 4.

Table 4 - SI Actions

| | Month due for completion | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Dec 2017 | Jan 2018 | Feb 2018 | Mar 2018 | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Total |
| **EIC** | 0 | 0 | 3 | 1 | 1 | 0 | 1 | 0 | 2 | **8** |
| **PC** | 1 | 1 | 1 | 4 | 0 | 0 | 0 | 0 | 1 | **8** |
| **W&C,HGD** | 0 | 1 | 0 | 2 | 2 | 1 | 1 | 0 | 0 | **7** |
| **Total** | **1** | **2** | **4** | **7** | **3** | **1** | **2** | **0** | **3** | **23** |

Table 4.1 highlights the type of actions that are overdue. Divisions are encouraged to note realistic time scales for completing actions included within SI action plans. Divisions have been asked to focus on providing evidence to enable closure of the actions so an updated position can be provided to the Quality Committee.

Table 4.1 – Type of actions overdue

| Action type | EIC | PC | W&C,HGD | Grand Total |
|---|---|---|---|---|
| Create/amend/review - Policy/Procedure/Protocol | 3 | 1 | 3 | 7 |
| Duty of Candour - Patient/NOK notification | 1 | 2 | | 3 |
| Share learning | | 1 | | 1 |
| Create/amend/review - proforma or information sheet | | 1 | | 1 |
| Review existing equipment | | 1 | | 1 |
| Set up ongoing training | | 1 | | 1 |
| **Grand Total** | **4** | **7** | **3** | **14** |

## 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 82 which is slightly less compared to the same reporting period last year and significantly less compared to 2015/2016. (2105/16 = 106, 2016/17 = 77). The reduction in reported pressure ulcers and falls is a significant factor in the lower number reported.

Table 5 – Total Incidents reported

| 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 | 6 | 6 | 2 | 4 | 40 |
| | **CW** | 9 | 6 | 5 | 2 | 1 | 2 | 0 | 5 | 2 | 2 | 5 | 3 | 42 |
| | | **13** | **8** | **10** | **4** | **4** | **3** | **2** | **8** | **8** | **8** | **7** | **7** | **82** |

Table 6 – Reported 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 – Reported Categories 2016/17

| Incident Category | A | M | J | J | A | S | O | N | D | J | F | M | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure ulcer | 5 | 1 | 4 | 4 | 3 | 2 | | | | | 1 | | 20 |
| Slips/trips/falls | 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 | 1 | 1 | | | 1 | 4 | | | 1 | | | | 8 |
| Maternity/Obstetric incident: baby only | 1 | | 1 | | | 1 | | 1 | | | 1 | 1 | 6 |
| Maternity/Obstetric incident: mother only | 2 | 1 | | | | | | 2 | | 1 | | | 6 |
| Treatment delay | | 1 | | | 1 | | | | 2 | 1 | | | 5 |
| Surgical/invasive procedure incident | | | 2 | 1 | | | | 1 | | | | | 4 |
| 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 |
| HCAI/Infection control incident | | | 1 | | | | | | | | | | 1 |
| Confidential information leak/IG breach | | | | | | | | 1 | | | | | 1 |
| Maternity/Obstetric incident: mother and baby | | | | | | | 1 | | | | | | 1 |
| Grand Total | 13 | 6 | 11 | 9 | 8 | 7 | 3 | 9 | 4 | 7 | 5 | 2 | 84 |

Table 8 – Reported Categories 2017/18

| Incident Category | A | M | J | J | A | S | O | N | D | J | F | M | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure ulcer | 6 | 1 | 2 | | | | | 2 | 1 | | 2 | | 14 |
| Diagnostic incident | 2 | | 1 | 2 | 2 | 1 | | 1 | 2 | 2 | | 1 | 14 |
| Maternity/Obstetric incident: baby only | | 2 | 1 | | | | | 2 | | 3 | 2 | 1 | 11 |
| Slips/trips/falls | | | | | 1 | | 2 | 1 | 1 | 1 | 1 | 1 | 8 |
| Abuse/alleged abuse of adult patient by staff | | | 1 | | 1 | | | | 2 | | | 2 | 6 |
| Sub-optimal care of the deteriorating patient | 2 | 1 | 1 | 2 | | | | | | | | | 6 |
| Treatment delay | 1 | 2 | 1 | | | | | 1 | | | 1 | | 6 |
| Surgical/invasive procedure incident | 1 | 1 | | | | 1 | | | | 1 | 1 | | 5 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity/Obstetric incident: mother only | | | 1 | | | | | 1 | | 1 | | 1 | 4 |
| Maternity/Obstetric incident: mother and baby | | | | | | 1 | | | 1 | | | | 2 |
| Environmental incident | | 1 | | | | | | | | | | | 1 |
| Unauthorised absence | | | | | | | | | | | | 1 | 1 |
| Blood product/ transfusion incident | | | 1 | | | | | | | | | | 1 |
| Medication incident | | | 1 | | | | | | | | | | 1 |
| Pending review | | | | | | | | | 1 | | | | 1 |
| Disruptive/ aggressive/ violent behaviour | 1 | | | | | | | | | | | | 1 |
| Grand Total | 13 | 8 | 10 | 4 | 4 | 3 | 2 | 8 | 8 | 8 | 7 | 7 | 82 |

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

### 6.0 Serious Incidents De-escalations

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

Table 9 De-escalation requests

| De-escalation Status | STEIS No. | Date reported | Incident Type (STEIS Category) | Date SI report submitted | Site |
|---|---|---|---|---|---|
| **De-escalation confirmed** | 2017/16909 | 05/07/2017 | Surgical/invasive procedure incident | 06/10/2017 | CW |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.4/May/18 |
| **REPORT NAME** | Integrated Performance Report – March 2018 |
| **AUTHOR** | Robert Hodgkiss, Chief Operating Officer |
| **LEAD** | Robert Hodgkiss, Chief Operating Officer |
| **PURPOSE** | To report the combined Trust's performance for March 2018 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward. |
| **SUMMARY OF REPORT** | The Integrated Performance Report shows the Trust performance for March 2018.<br><br>**Regulatory performance** – The A&E Waiting Time figure was not met for March with 94.0%. The figure, however, compares favourably with a 2% increase on that reported for the same month in 2017, with a 12% increase in attendances. National figures show that Chelsea and Westminster ranked 7th of the 137 reporting Trusts.<br><br>The RTT incomplete target was achieved in March for the Trust, with performance of 93.0% and both of our sites in a complaint position. This represents the fifth consecutive month the national standard was reached and represents the best performance since the merger of the two sites in September 2015.<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 March which helped deliver a strong Q4 position in the delivery of the of 62 Day standard.<br><br>There was one reported CDiff infection in March. However, the Trust remained within its target for this indicator for the full year.<br><br>**Access**<br>Issues in Urology at the Chelsea Site plus Cardiology and Endoscopy at West Middlesex continue to be addressed.<br><br>These issues saw the Trust's performance against the Diagnostic Wait metric slip to 98.17% |
| **KEY RISKS ASSOCIATED:** | There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer 31 and 62 day waits remains a high priority. The Trust will continue to focus on the Diagnostic Waiting time issues in the weeks to come. |

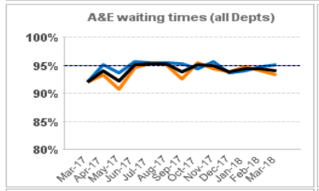
| | |
|---|---|
| **FINANCIAL IMPLICATIONS** | To be confirmed |
| **QUALITY IMPLICATIONS** | As outlined above. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | • Improve patient safety and clinical effectiveness<br>• Improve the patient experience<br>• Ensure financial and environmental sustainability |
| **DECISION/ ACTION** | The Board is asked to note the performance for March 2018 and to note that whilst some indicators were not delivered in the month, the overall YTD compliance remained good. |

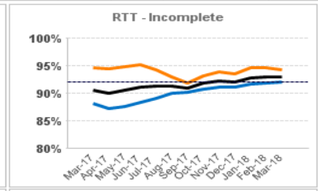
# TRUST PERFORMANCE & QUALITY REPORT

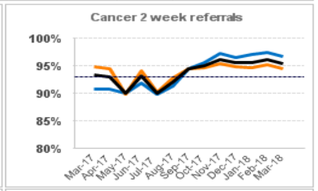
## March 2018

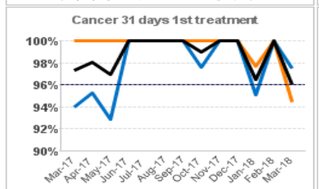
## Regulatory Compliance

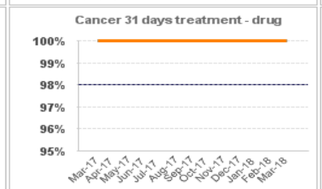
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined Trust data: last Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Quarter | YTD | Trend |
| A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 94.0 | 94.7 | 95.0 | 94.8 | 94.1 | 93.3 | 94.4 | 94.4 | 94.0 | 94.3 | 94.3 | |
| RTT - Incomplete (Target: >92%) | 91.6 | 91.8 | 92.1 | 94.6 | 94.5 | 94.3 | 92.9 | 93.0 | 93.0 | 92.9 | 91.7 | |
| Cancer 2 week urgent referrals (Target: >93%) | 97.0 | 97.4 | 96.7 | 94.6 | 95.2 | 94.5 | 95.5 | 96.1 | 95.4 | 95.7 | 93.9 | |
| Cancer 2 week Breast symptomatic (Target: >93%) | n/a | n/a | n/a | 93.5 | 94.6 | 96.1 | 93.5 | 94.6 | 96.1 | 95.1 | 93.8 | |
| Cancer 31 days first treatment (Target: >96%) | 95.1 | 100 | 97.5 | 97.7 | 100 | 94.4 | 96.5 | 100 | 96.1 | 97.5 | 98.9 | |
| Cancer 31 days treatment - Drug (Target: >98%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 31 days treatment - Surgery (Target: >94%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 62 days GP ref to treatment (Target: >85%) | 91.5 | 97.0 | 94.3 | 95.5 | 92.3 | 80.0 | 93.8 | 93.7 | 86.7 | 91.4 | 88.8 | |
| Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16) | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 2 | 1 | 3 | 12 | |
| Average Emergency PreOp LoS | 0.60 | 0.59 | 0.88 | 1.27 | 1.08 | 1.38 | 0.91 | 0.82 | 1.10 | 0.94 | 0.96 | |
| Average Elective PreOp LoS | 0.19 | 0.16 | 0.12 | 0.50 | 0.03 | 0.13 | 0.27 | 0.12 | 0.13 | 0.17 | 0.19 | |

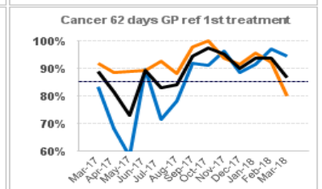


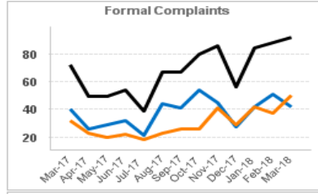



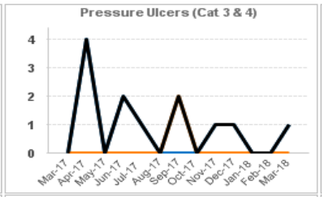



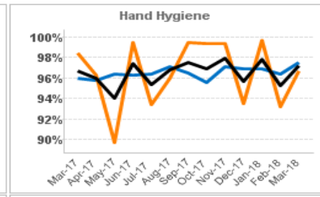



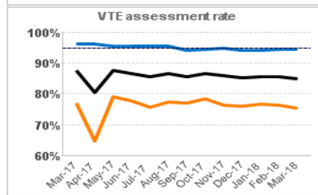

## Quality

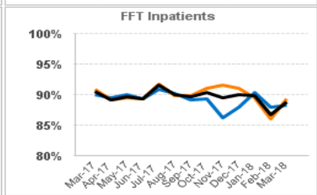
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Quarter | YTD | Trend |
| Hand Hygiene (Target: >=90%) | 96.8 | 96.4 | 97.5 | 99.7 | 93.2 | 96.7 | 97.8 | 95.2 | 97.2 | 96.8 | 96.5 | |
| Pressure Ulcers (Cat 3 & 4) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 12 | |
| VTE assessment % (Target: >=95%) | 94.2 | 94.7 | 94.6 | 76.9 | 76.5 | 75.4 | 85.7 | 85.6 | 84.8 | 85.4 | 85.6 | |
| Formal complaints number received | 42 | 51 | 42 | 42 | 37 | 50 | 84 | 88 | 92 | 264 | 811 | |
| Formal complaints responded to <25days | 28 | 30 | 21 | 19 | 13 | 17 | 47 | 43 | 38 | 128 | 347 | |
| Serious Incidents | 2 | 5 | 3 | 6 | 2 | 4 | 8 | 7 | 7 | 22 | 83 | |
| Never Events (Target: 0) | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 2 | 6 | |
| FFT - Inpatients recommend % (Target: >90%) | 90.4 | 87.9 | 88.2 | 89.4 | 86.0 | 89.3 | 89.8 | 86.7 | 88.9 | 88.5 | 89.6 | |
| FFT - A&E recommend % (Target: >90%) | 91.1 | 90.7 | 89.4 | 89.1 | 84.7 | 82.3 | 90.8 | 89.8 | 88.3 | 89.5 | 87.1 | |
| Falls causing serious harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

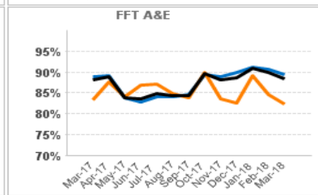


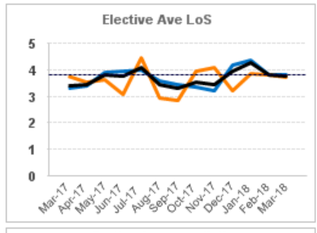



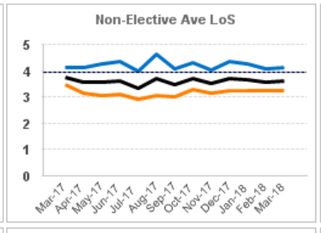



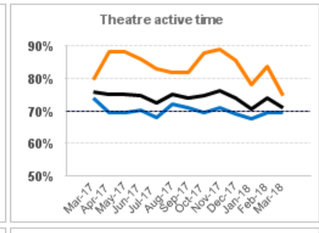



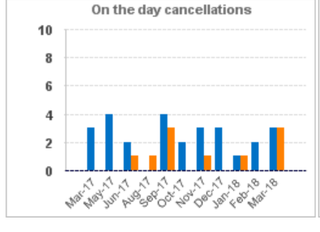

## Efficiency

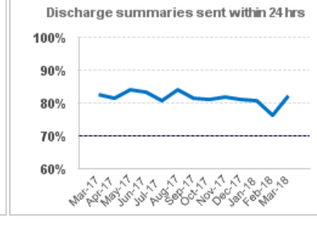
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Quarter | YTD | Trend |
| Elective average LoS (Target: <3.8) | 4.4 | 3.8 | 3.8 | 3.9 | 3.8 | 3.7 | 4.3 | 3.8 | 3.8 | 3.9 | 3.7 | |
| Non-Elective average LoS (Target: <3.95) | 4.3 | 4.1 | 4.1 | 3.2 | 3.2 | 3.2 | 3.7 | 3.6 | 3.6 | 3.6 | 3.6 | |
| Theatre active time (Target: >70%) | 67.6 | 69.5 | 69.3 | 77.9 | 83.7 | 74.8 | 70.6 | 73.8 | 70.9 | 71.7 | 73.9 | |
| Discharge summaries sent within 24 hours (Target: >70%) | 80.8 | 76.5 | 82.1 | dev | dev | dev | 80.8 | 76.5 | 82.1 | 79.8 | 81.6 | |
| Outpatient DNA rates (Target: <11.1%) | 10.4 | 10.2 | 10.8 | 9.9 | 10.4 | 10.6 | 10.2 | 10.3 | 10.7 | 10.4 | 11.1 | |
| On the day cancelled operations not re-booked within 28 days (Target: 0) | 1 | 2 | 3 | 1 | 0 | 3 | 2 | 2 | 6 | 10 | 34 | |

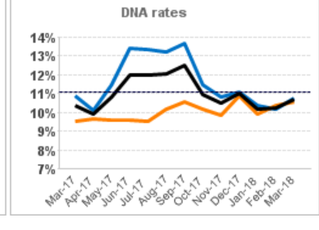


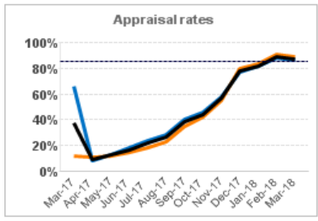



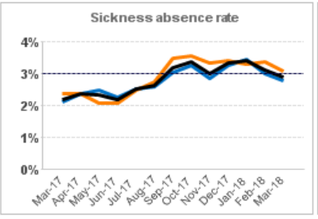



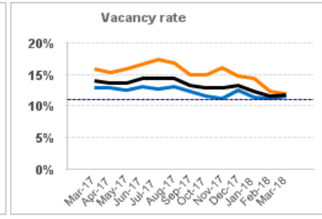



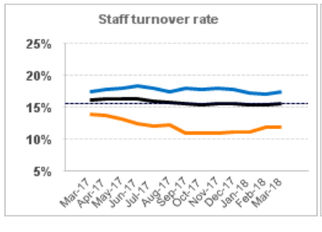

## Workforce

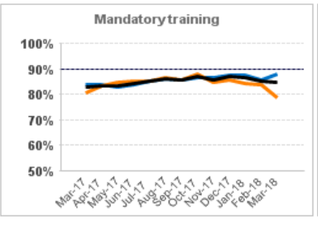
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Jan-18 | Feb-18 | Mar-18 | Quarter | YTD | Trend |
| Appraisal rates (Target: >85%) | 81.2 | 87.7 | 86.4 | 83.1 | 90.7 | 88.7 | 81.9 | 88.7 | 87.2 | 85.9 | 47.1 | |
| Sickness absence rate (Target: <3%) | 3.44 | 2.98 | 2.78 | 3.28 | 3.36 | 3.08 | 3.39 | 3.11 | 2.89 | 3.13 | 2.86 | |
| Vacancy rates (Target: CW<12%; WM<10%) | 11.3 | 11.2 | 11.5 | 14.5 | 12.3 | 12.0 | 12.4 | 11.6 | 11.7 | 11.7 | 11.7 | |
| Turnover rate (Target: CW<18%; WM<11.5%) | 17.3 | 17.1 | 17.4 | 11.1 | 11.8 | 11.8 | 15.3 | 15.3 | 15.5 | 15.5 | 15.5 | |
| Mandatory training (Target: >90%) | 87.6 | 85.7 | 88.1 | 84.4 | 84.0 | 78.7 | 86.5 | 85.1 | 84.6 | 85.4 | 85.4 | |
| Bank and Agency spend (£ks) | £2,702 | £2,703 | £2,963 | £2,518 | £2,451 | £2,964 | £5,220 | £5,154 | £5,926 | £16,301 | £59,825 | |
| Nursing & Midwifery: Agency % spend of total pay (Target: tbc) | 8.6 | 9.2 | 9.0 | 13.1 | 10.1 | 12.6 | 10.4 | 9.5 | 10.4 | 10.1 | 9.5 | |

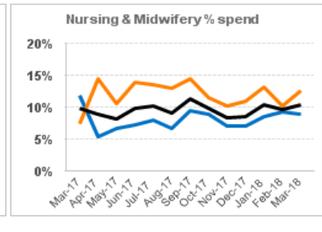


# NHSI Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| A&E | A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 94.0% | 94.7% | 95.0% | 94.8% | 94.8% | 94.1% | 93.3% | 94.0% | 94.4% | 94.4% | 94.0% | 94.3% | 94.3% | | ! |
| RTT | 18 weeks RTT - Admitted (Target: >90%) | 72.7% | 69.0% | 72.3% | 69.2% | 89.1% | 87.4% | 87.7% | 86.1% | 81.8% | 79.6% | 81.8% | 81.1% | 78.7% | | ! |
| | 18 weeks RTT - Non-Admitted (Target: >95%) | 93.5% | 93.8% | 95.0% | 93.0% | 90.2% | 91.9% | 91.7% | 90.8% | 92.2% | 93.1% | 93.6% | 92.9% | 92.2% | | ! |
| | 18 weeks RTT - Incomplete (Target: >92%) | 91.6% | 91.8% | 92.1% | 90.1% | 94.6% | 94.5% | 94.3% | 93.9% | 92.9% | 93.0% | 93.0% | 92.9% | 91.7% | | - |
| Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-18) in this report) | 2 weeks from referral to first appointment all urgent referrals (Target: >93%) | 97.0% | 97.4% | 96.7% | 94.1% | 94.6% | 95.2% | 94.5% | 93.8% | 95.5% | 96.1% | 95.4% | 95.7% | 93.9% | | - |
| | 2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%) | n/a | n/a | n/a | n/a | 93.5% | 94.6% | 96.1% | 93.8% | 93.5% | 94.6% | 96.1% | 95.1% | 93.8% | | - |
| | 31 days diagnosis to first treatment (Target: >96%) | 95.1% | 100% | 97.5% | 98.3% | 97.7% | 100% | 94.4% | 99.4% | 96.5% | 100% | 96.1% | 97.5% | 98.9% | | - |
| | 31 days subsequent cancer treatment - Drug (Target: >98%) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Surgery (Target: >94%) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Radiotherapy (Target: >94%) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |
| | 62 days GP referral to first treatment (Target: >85%) | 91.5% | 97.0% | 94.3% | 84.6% | 95.5% | 92.3% | 80.0% | 91.7% | 93.8% | 93.7% | 86.7% | 91.4% | 88.8% | | - |
| | 62 days NHS screening service referral to first treatment (Target: >90%) | n/a | n/a | n/a | n/a | 50.0% | 100% | 100% | 88.9% | 50.0% | 100% | 100% | 88.9% | 88.9% | | - |
| Patient Safety | Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16) | 0 | 1 | 1 | 2 | 0 | 1 | 0 | 10 | 0 | 2 | 1 | 3 | 12 | | - |
| Learning difficulties Access & Governance | Self-certification against compliance for access to healthcare for people with Learning Disability | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | | - |
| | Governance Rating | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |

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

**Trust commentary**

**A&E 4 Hours waiting time**

The Trust did not achieve the 95% standard but significantly improved the position from March last year by a 2% increase, despite a 12% rise in attendances. Nationally this placed CWFT 7/133 Trusts and top in London for the month. To improve further, the plan is to use the LOS/Bed productivity work stream to continue current schemes and provide an enhanced ambulatory offering on both sites ahead of winter 2018/19.

**18 Weeks RTT – Incomplete**

Trust wide compliance was achieved for March at 93.0% with both sites individually achieving compliance. This was the first time since July 2015 that both sites have achieved this.

18 weeks or RTT awareness sessions have continued at the West Middlesex site with clinical training to support build awareness pre Cerner launch. This will improve data quality and aid clinical input post Cerner go-live.

**Cancer Indicators**

The Trust once again met the national target for all cancer indicators in March (unvalidated position) – although there was pressure on the 62 day standard at West Middlesex.

The breakdown of performance against this metric by tumour site can be found on page 12 of this document

# Safety Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| Hospital-acquired infections | MRSA Bacteraemia (Target: 0) | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 | 1 | 0 | 0 | 1 | 3 | | - |
| | Hand hygiene compliance (Target: >90%) | 96.8% | 96.4% | 97.5% | 96.6% | 99.7% | 93.2% | 96.7% | 96.4% | 97.8% | 95.2% | 97.2% | 96.8% | 96.5% | | - |
| Incidents | Number of serious incidents | 2 | 5 | 3 | 43 | 6 | 2 | 4 | 40 | 8 | 7 | 7 | 22 | 83 | | - |
| | Incident reporting rate per 100 admissions (Target: >8.5) | 7.6 | 7.2 | 7.8 | 7.6 | 9.2 | 9.2 | 9.7 | 9.3 | 8.4 | 8.1 | 8.7 | 8.4 | 8.4 | | ! |
| | Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0) | 0.05 | 0.03 | 0.05 | 0.02 | 0.05 | 0.02 | 0.07 | 0.02 | 0.05 | 0.03 | 0.06 | 0.05 | 0.02 | | ! |
| | Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280) | 430.26 | 521.48 | 469.20 | 502.33 | 260.38 | 264.86 | 246.43 | 286.49 | 349.20 | 397.11 | 363.03 | 368.32 | 399.67 | | ! |
| | Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%) | 9.0% | 13.4% | 7.2% | 10.9% | 5.4% | 6.3% | 18.2% | 12.9% | 7.7% | 11.1% | 10.8% | 9.8% | 11.6% | | - |
| | Never Events (Target: 0) | 0 | 0 | 1 | 4 | 0 | 1 | 0 | 2 | 0 | 1 | 1 | 2 | 6 | | - |
| Harm | Safety Thermometer - Harm Score (Target: >90%) | 95.4% | 95.5% | 95.6% | 96.0% | 93.6% | 96.5% | 92.0% | 93.0% | 94.3% | 96.2% | 92.9% | 94.6% | 94.1% | | - |
| | Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6) | 0 | 0 | 1 | 10 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 1 | 12 | | - |
| | NEWS compliance % | 96.6% | 97.2% | 98.4% | 97.1% | 98.2% | 99.2% | 98.0% | 97.0% | 97.3% | 98.1% | 98.2% | 97.8% | 97.1% | | - |
| | Safeguarding adults - number of referrals | 18 | 31 | 19 | 241 | 8 | 5 | 4 | 219 | 26 | 36 | 23 | 85 | 460 | | - |
| | Safeguarding children - number of referrals | 52 | 7 | 15 | 321 | 77 | 73 | 54 | 1100 | 129 | 80 | 69 | 278 | 1421 | | - |
| Mortality | Summary Hospital Mortality Indicator (SHMI) (Target: <100) | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | 81.7 | | - |
| | Number of hospital deaths - Adult | 45 | 29 | 40 | 425 | 85 | 69 | 72 | 731 | 130 | 98 | 112 | 340 | 1156 | | - |
| | Number of hospital deaths - Paediatric | 2 | 0 | 2 | 11 | 0 | 0 | 0 | 2 | 2 | 0 | 2 | 4 | 13 | | - |
| | Number of hospital deaths - Neonatal | 2 | 1 | 2 | 17 | 0 | 0 | 0 | 11 | 2 | 1 | 2 | 5 | 28 | | - |
| | Number of deaths in A&E - Adult | 1 | 2 | 3 | 30 | 8 | 10 | 10 | 81 | 9 | 12 | 13 | 34 | 111 | | - |
| | Number of deaths in A&E - Paediatric | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | | - |
| | Number of deaths in A&E - Neonatal | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 1 | 2 | | - |

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

**Trust commentary**

**Number of serious incidents**

Seven Serious Incidents were reported in March 2018; three at the Chelsea site with a further four at West Middlesex

Table 2 within the SI Report prepared for the Board reflects the number of incidents, by category reported on each site during the month.

**Incident reporting rate per 100 admissions**

Of the 1041 patient safety incidents reported, 503 relate to incidents occurring on the Chelsea site, 525 at West Middlesex,13 in Community clinics.

**Trust commentary continued**

**Rate of patient safety incidents resulting in severe harm or death**

Two incidents causing severe harm were reported in March 2018. One is categorised as a Patient fall land the other is categorised as Failure to rescue. Both incidents reported on the CWH site.

Three incidents causing death were reported in March 2018. One incident was reported on the Chelsea site and categorised as Failure to rescue. The other two incidents were reported at West Middlesex and were categorised as: Airway (Aspiration) and Venous thromboembolism (VTE) incidents.

Comprehensive investigations are currently underway relating to these incidents. Degrees of harm are yet to be confirmed.

**Medication-related safety incidents**

Of the 127 medication related safety incidents reported, 83 relate to incidents occurring on the CWH site and 44 on WMUH site.

WMUH site medication related safety incident reporting is improving. The pharmacy team are working with teams

**Never Events**

The one 'Never Event' reported in March 2018 was a retained vaginal swab post-delivery.

A comprehensive investigation is currently underway relating to this incident.

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

The Trust has achieved an overall reporting rate of NRLS reportable medication-related incidents of 355/100,000 FCE bed days in March 2018.

This is higher than the Trust target of 280/100,000. There were 459 and 239 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively.

There has been a decrease in reporting of medication incidents this month compared to recent months; reporting at WM site is lower than the Trust target

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

The Trust had 11% medication-related safety incidents with harm in March 2018. This figure is similar to the previous month and is above the Carter dashboard National Benchmark (10.3%). The year to date figure is 11.6%.

Overall there were 10 incidents that caused low harm; 4 occurred at CW site and 6 at WM site. The low harm incidents mainly involved disconnected furosemide infusion, sedative effect of medication post bronchoscopy procedure, omission of opioid analgesia administration, administration of medication (codeine, penicillin) with a known documented allergy, incorrect administration dose of IV metronidazole, lack of monitoring of amikacin levels prior to prescribing, and incorrect prescribing of levothyroxine.

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

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

Preventing Hospital Acquired Pressure Ulcers remain high priority for both sites.

There was 1 grade 3 pressure ulcer reported on the CWH site. This is currently being validated as a potential serious incident

# Patient Experience Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| Friends and Family | FFT: Inpatient recommend % (Target: >90%) | 90.4% | 87.9% | 88.2% | 89.1% | 89.4% | 86.0% | 89.3% | 89.8% | 89.8% | 86.7% | 88.9% | 88.5% | 89.6% | | ! |
| | FFT: Inpatient not recommend % (Target: <10%) | 4.3% | 6.7% | 5.1% | 5.3% | 4.2% | 5.0% | 3.7% | 4.3% | 4.2% | 5.6% | 4.3% | 4.7% | 4.7% | | - |
| | FFT: Inpatient response rate (Target: >30%) | 38.6% | 36.8% | 31.6% | 35.3% | 32.4% | 36.2% | 27.4% | 32.8% | 34.6% | 36.4% | 28.9% | 33.1% | 33.7% | | - |
| | FFT: A&E recommend % (Target: >90%) | 91.1% | 90.7% | 89.4% | 87.5% | 89.1% | 84.7% | 82.3% | 85.5% | 90.8% | 89.8% | 88.3% | 89.5% | 87.1% | | ! |
| | FFT: A&E not recommend % (Target: <10%) | 5.1% | 5.3% | 5.9% | 5.8% | 5.3% | 7.3% | 8.1% | 8.4% | 5.1% | 5.6% | 6.2% | 5.7% | 6.2% | | - |
| | FFT: A&E response rate (Target: >30%) | 16.3% | 18.7% | 18.1% | 17.4% | 9.9% | 12.6% | 12.9% | 12.2% | 14.9% | 17.5% | 17.0% | 16.4% | 16.3% | | ! |
| | FFT: Maternity recommend % (Target: >90%) | 92.0% | 91.8% | 88.1% | 91.4% | 93.1% | 92.5% | 90.0% | 94.1% | 92.3% | 92.0% | 88.6% | 90.7% | 92.1% | | - |
| | FFT: Maternity not recommend % (Target: <10%) | 6.7% | 5.7% | 7.3% | 5.5% | 5.2% | 7.5% | 7.1% | 4.3% | 6.3% | 6.1% | 7.3% | 6.6% | 5.2% | | - |
| | FFT: Maternity response rate (Target: >30%) | 14.8% | 17.5% | 22.0% | 19.7% | 14.5% | 15.1% | 19.1% | 16.7% | 14.7% | 16.8% | 21.2% | 17.6% | 18.9% | | ! |
| Experience | Breach of same sex accommodation (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| Complaints | Complaints formal: Number of complaints received | 42 | 51 | 43 | 455 | 42 | 37 | 51 | 359 | 84 | 88 | 94 | 266 | 814 | | - |
| | Complaints formal: Number responded to < 25 days | 28 | 30 | 20 | 230 | 19 | 13 | 14 | 113 | 47 | 43 | 34 | 124 | 343 | | - |
| | Complaints (informal) through PALS | 136 | 129 | 133 | 1202 | 171 | 178 | 112 | 1194 | 307 | 307 | 245 | 859 | 2396 | | - |
| | Complaints sent through to the Ombudsman | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | | - |
| | Complaints upheld by the Ombudsman (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 3 | | - |

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

**Trust commentary**

**Inpatient Indicators**

The recommend rate, having seen a slight decline in February, saw the Trust moving back towards the target in March.

**Accident and Emergency Indicators**

The decline in recommend rates at West Middlesex seen in February continued into March. This has led the Trust as a whole to fail to reach the target. Though not meeting the target the response rate continues to improve with the West Middlesex site in line with the national average and the Chelsea site above the national average

**Maternity Indicators**

The Maternity services fail to meet the target for response rate though this is in line with the national average

**Complaints (formal) responded to within 25 working days**

The Trust continue to struggle to meet the 25 day target. The new structure and process for formal complaints will be in place for the 30th April 2018

# Efficiency & Productivity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| Admitted Patient Care | Average length of stay - elective (Target: <3.7) | 4.37 | 3.82 | 3.81 | 3.75 | 3.86 | 3.79 | 3.69 | 3.60 | 4.26 | 3.81 | 3.78 | 3.94 | 3.72 | | ! |
| | Average length of stay - non-elective (Target: <3.9) | 4.26 | 4.07 | 4.13 | 4.21 | 3.24 | 3.22 | 3.24 | 3.14 | 3.67 | 3.57 | 3.62 | 3.62 | 3.59 | | ! |
| | Emergency care pathway - average LoS (Target: <4.5) | 5.15 | 4.70 | 4.94 | 5.02 | 3.67 | 3.89 | 3.82 | 3.76 | 4.22 | 4.19 | 4.23 | 4.21 | 4.23 | | ! |
| | Emergency care pathway - discharges | 227 | 196 | 218 | 2494 | 386 | 336 | 377 | 4278 | 613 | 533 | 595 | 1742 | 6772 | | - |
| | Emergency re-admissions within 30 days of discharge (Target: <2.8%) | 3.79% | 3.79% | 3.61% | 3.59% | 10.35% | 10.27% | 9.41% | 9.85% | 6.87% | 6.83% | 6.36% | 6.68% | 6.52% | | ! |
| | Non-elective long-stayers | 470 | 404 | 498 | 5319 | 383 | 392 | 380 | 4690 | 853 | 796 | 878 | 2527 | 10009 | | - |
| Theatres | Daycase rate (basket of 25 procedures) (Target: >85%) | 83.1% | 80.7% | 81.4% | 82.8% | 91.7% | 87.0% | 83.1% | 87.3% | 86.1% | 83.1% | 82.1% | 83.7% | 84.5% | | ! |
| | Operations canc on the day for non-clinical reasons: actuals | 12 | 13 | 16 | 165 | 5 | 5 | 17 | 70 | 17 | 18 | 33 | 68 | 235 | | - |
| | Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%) | 0.40% | 0.46% | 0.55% | 0.48% | 0.42% | 0.41% | 1.23% | 0.47% | 0.40% | 0.44% | 0.77% | 0.54% | 0.48% | | - |
| | Operations cancelled the same day and not rebooked within 28 days (Target: 0) | 1 | 2 | 3 | 24 | 1 | 0 | 3 | 10 | 2 | 2 | 6 | 10 | 34 | | ! |
| | Theatre active time (C&W Target: >70%; WM Target: >78%) | 67.6% | 69.5% | 69.3% | 69.7% | 77.9% | 83.7% | 74.8% | 84.0% | 70.6% | 73.8% | 70.9% | 71.7% | 73.9% | | ! |
| | Theatre booking conversion rates (Target: >80%) | 84.3% | 85.9% | 85.5% | 85.0% | 69.9% | 71.4% | 68.6% | 72.8% | 78.7% | 80.0% | 78.2% | 78.9% | 80.3% | | ! |
| Outpatients | First to follow-up ratio (Target: <1.5) | 1.48 | 1.51 | 1.50 | 1.58 | 1.32 | 1.27 | 1.30 | 1.26 | 1.36 | 1.33 | 1.35 | 1.35 | 1.34 | | - |
| | Average wait to first outpatient attendance (Target: <6 wks) | 7.5 | 7.2 | 6.7 | 7.5 | 7.1 | 6.8 | 6.7 | 8.6 | 7.3 | 7.0 | 6.7 | 7.0 | 8.0 | | ! |
| | DNA rate: first appointment | 11.3% | 11.5% | 11.6% | 13.2% | 10.6% | 10.4% | 10.8% | 10.6% | 11.0% | 11.0% | 11.2% | 11.1% | 12.0% | | - |
| | DNA rate: follow-up appointment | 10.0% | 9.7% | 10.5% | 11.1% | 9.5% | 10.3% | 10.4% | 9.7% | 9.8% | 9.9% | 10.4% | 10.0% | 10.7% | | - |

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

**Trust commentary**

**Elective length of stay**

Elective LOS on the CW site remained at 3.8 days against a target of 3.7 days. Driving this period there were 2 patients under Urology and General Surgery who on discharge had remained as inpatients for over 100 days after their elective procedure due to the requirement for post-operative critical care requirements and planned extended recovery.

**Non-Elective and Emergency Care length of stay**

NEL LOS has suffered a frustrating dip at Chelsea site in March while continuing to improve (and be below target) at West Middlesex. This may reflect the concentrated work at West Middlesex to address this through a number of schemes: (improving discharge, focussed work on Top 20 longest stayers, better OOH engagement for delayed transfers), while suggesting the programme may not have delivered to the same extent at Chelsea. If this indication continues for more than 1 month, then more radical action may be required at CW site, but the data may be being skewed by 2 very long stay patients at Chelsea.

Overall, the current model hospital and other peer data, suggest the Trust benchmarks very well (top quartile) when compared with peer group hospitals for NEL LOS and further details are provided within the FIC/ Board paper on NEL growth. Improving this further (especially at the Chelsea site) remains an absolute focus for the BEDS/LOS work stream and will be closely monitored as we progress out of winter and into May 2018

**Average wait to first outpatient appointment**

Work on access has continued throughout the year and has lead not only to the increase in the reportable 18 week wait for treatment percentage but also a fall in the average wait for first attendance. Both sites ended the financial year with wait times well below the average for the year as a whole

# Clinical Effectiveness Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site Jan-18 | Feb-18 | Mar-18 | 2017-2018 | West Middlesex University Hospital Site Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Combined Trust Performance Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trust data 13 months Trend charts | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Best Practice | Dementia screening case finding (Target: >90%) | 93.5% | 93.3% | 90.8% | 89.7% | 93.6% | 92.6% | 92.6% | 94.6% | 93.5% | 92.9% | 91.8% | 92.8% | 92.3% |  | - |
| | #NoF Time to Theatre <36hrs for medically fit patients (Target: 100%) | 81.8% | 80.0% | 84.0% | 91.8% | 81.8% | 94.1% | 81.5% | 84.9% | 81.8% | 86.5% | 82.7% | 83.6% | 88.5% | | ! |
| | Stroke care: time spent on dedicated Stroke Unit (Target: >80%) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.7% | 100.0% | 100.0% | 100.0% | 100.0% | 99.2% | | - |
| VTE | VTE: Hospital-acquired (Target: tbc) | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| | VTE risk assessment (Target: >95%) | 94.2% | 94.6% | 94.6% | 95.0% | 76.9% | 76.5% | 75.4% | 76.1% | 85.7% | 85.6% | 84.8% | 85.4% | 85.6% |  | ! |
| TB Care | TB: Number of active cases identified and notified | 2 | 4 | 0 | 42 | 4 | 5 | 8 | 68 | 6 | 9 | 8 | 23 | 110 |  | - |
| | TB: % of treatments completed within 12 months (Target: >85%) | | | | | | | | | | | | | | | - |

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

**Trust commentary**

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

West Middlesex sustained over 80% performance despite an increase of 10 fractures in the month due to cold weather.

The Chelsea site also saw an increase in fractures – 25% more than in February. There were 4 breaches of the 36 hour standard – all of which were in Theatre within 40 hours. Three were delays waiting reversal of drugs; one is noted as 'other'

**VTE Hospital-acquired**

C&W site: Backlog due to clinical commitments/no dedicated resources. Radiology reports are manually screened to identify positive VTE events. Retrospective data analysis required to identify hospital associated VTE events for root cause analysis investigation.

WMUH site: Ambulatory Emergency Care have introduced a thrombosis pathway, and includes the identification and reporting of hospital associated VTE events on Datix.
Data information team agreed to develop a programme to identify hospital associated VTE events via radiology reports linked to admission episode *(resources required to complete work)*

**VTE Risk assessments completed**

C&W site: Performance has declined. Performance has been disseminated to divisions to highlight amongst clinical teams and areas not meeting ≥ 95% target. Weekly and monthly VTE performance reports continue to be circulated to all divisions. Divisional Medical Directors are due to highlight at divisional meetings.

WMUH site: Target not achieved due to current IT infrastructure. RealTime VTE whiteboard developed to highlight patients with outstanding VTE risk assessments. Information team continuing to work to incorporate cohorting arrangements (low risk patients/procedures excluded from VTE risk assessment) and new performance reports (work in progress) to feedback to divisions in a timely and accurate manner. A gap analysis is planned to compare current service provision and (RealTime/Lastword) and Cerner.

# Access Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| RTT waits | RTT Incompletes 52 week Patients at month end | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| | Diagnostic waiting times <6 weeks: % (Target: >99%) | 97.56% | 98.82% | 98.95% | 97.86% | 98.62% | 97.91% | 97.60% | 96.96% | 98.12% | 98.34% | 98.17% | 98.21% | 97.32% | | ! |
| | Diagnostic waiting times >6 weeks: breach actuals | 72 | 35 | 33 | 690 | 46 | 70 | 104 | 1449 | 118 | 105 | 137 | 360 | 2139 | | - |
| A&E and LAS | A&E unplanned re-attendances (Target: <5%) | 8.3% | 8.5% | 8.4% | 8.2% | 7.9% | 7.9% | 8.3% | 8.3% | 8.2% | 8.3% | 8.4% | 8.3% | 8.2% | | ! |
| | A&E time to treatment - Median (Target: <60') | 01:05 | 01:04 | 01:08 | 01:04 | 00:39 | 00:48 | 00:51 | 00:42 | 00:58 | 01:01 | 01:05 | 01:01 | 00:58 | | ! |
| | London Ambulance Service - patient handover 30' breaches | 30 | 29 | 29 | 284 | 63 | 73 | 53 | 498 | 93 | 102 | 82 | 277 | 782 | | - |
| | London Ambulance Service - patient handover 60' breaches | 1 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 2 | | - |
| Choose and Book (available to Jan-18 only for issues) | Choose and book: appointment availability (average of daily harvest of unused slots) | 2172 | 2145 | 1567 | 1455 | 0 | 0 | 0 | 0 | 2172 | 2145 | 1567 | 1959 | 1455 | | - |
| | Choose and book: capacity issue rate (ASI) | | | | 48.6% | | | | | | | | | 48.6% | | - |
| | Choose and book: system issue rate | | | | | | | | | | | | | | | - |

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

**Trust commentary**

**RTT Incomplete 52 week waiters at month end**

The Trust ended the financial year with no patients waiting greater than 52 weeks for treatment.

**Diagnostic waiting times**

Diagnostics remains challenging for the Trust. March ended with an increase in the number of patients breaching the 6 week standard. This was marked at the West Middlesex site.

24 of the breaches at the Chelsea site were for Cystoscopy, the reasons for which are being addressed. Echocardiography had 45 breaches at West Middlesex; with Colonoscopy, Cystoscopy and Gastroscopy contributing a further 87. Radiology remains compliant on both sites with only 5 breaches in March.

Diagnostics remains of the highest priority for the Trust with ongoing work to address capacity issues

**A&E unplanned re-attendances**

The Trust continues to work with its Commissioners in addressing this metric. There has been little movement in the percentages in the last 12 months so identifying individual patients and patterns is of the highest priority

**A&E Time to Treatment – median**

March saw the highest daily average of attendances on both sites across 2017/2018. This lead to an increase in the time taken to begin treatment, but the Trust overall fir the year was able to post a median time of 58 minutes thereby delivering against the one hour standard

# Maternity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| Birth indicators | Total number of NHS births | 505 | 399 | 458 | 5663 | 419 | 361 | 383 | 5006 | 924 | 760 | 841 | 2525 | 10669 |  | - |
| | Total caesarean section rate (C&W Target: <27%; WM Target: <29%) | 34.9% | 37.0% | 36.6% | 34.0% | 29.4% | 28.6% | 29.6% | 27.1% | 32.4% | 33.0% | 33.5% | 32.9% | 30.8% |  | ! |
| | Midwife to birth ratio (Target: 1:30) | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | 1:30 | | - |
| | Maternity 1:1 care in established labour (Target: >95%) | 96.9% | 99.3% | 95.4% | 98.0% | 98.5% | 97.1% | 98.4% | 96.7% | 97.7% | 98.2% | 96.8% | 97.5% | 97.3% |  | - |
| Safety | Admissions of full-term babies to NICU | 21 | 13 | 22 | 251 | n/a | n/a | n/a | n/a | 21 | 13 | 22 | 56 | 251 |  | - |

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

**Trust commentary**

**Total number of NHS births**

The Maternity target is based on mothers who deliver rather than the number of babies born shown in the table above. The Chelsea target for mothers for the full year was 5664; with 5542 mothers delivering children – a shortfall of 122.

There was a similar shortfall against plan at West Middlesex.

In total 10464 mothers gave birth to 10669 children across the Trust in 2017/2018

**Total C-Section rate**

Caesarean section rates slightly decreased at the Chelsea site. However, each of the last three months saw a rate higher than that for the year as a whole. The Service is continually looking at ways to decrease the rates

West Middlesex site showed an increased section rate in March, but was within its target rate for the year

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

The midwife to birth ratio is consistent throughout the year and across site at 1:30

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

Both sites were compliant for with 1:1 in established labour

# Workforce Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | Trend charts | |
| Staffing | Vacancy rate (Target: CW <12%; WM <10%) | 11.3% | 11.2% | 11.5% | 11.5% | 14.5% | 12.3% | 12.0% | 12.0% | 12.4% | 11.6% | 11.7% | 11.7% | 11.7% | | ! |
| | Staff Turnover rate (Target: CW <18%; WM <11.5%) | 17.3% | 17.1% | 17.4% | 17.4% | 11.1% | 11.8% | 11.8% | 11.8% | 15.3% | 15.3% | 15.5% | 15.5% | 15.5% | | - |
| | Sickness absence (Target: <3%) | 3.4% | 3.0% | 2.8% | 2.8% | 3.3% | 3.4% | 3.1% | 2.9% | 3.4% | 3.1% | 2.9% | 3.1% | 2.9% | | - |
| | Bank and Agency spend (£ks) | £2,702 | £2,703 | £2,963 | £30,177 | £2,518 | £2,451 | £2,964 | £29,648 | £5,220 | £5,154 | £5,926 | £16,301 | £59,825 | | - |
| | Nursing & Midwifery Agency: % spend of total pay (Target: tbc) | 8.6% | 9.2% | 9.0% | 7.8% | 13.1% | 10.1% | 12.6% | 12.3% | 10.4% | 9.5% | 10.4% | 10.1% | 9.5% | | - |
| Appraisal rates | % of Performance & Development Reviews completed - medical staff (Target: >85%) | 78.7% | 76.3% | 70.6% | 79.3% | 87.6% | 89.2% | 90.1% | 86.1% | 82.1% | 81.3% | 77.9% | 80.4% | 82.0% | | ! |
| | % of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%) | 81.5% | 89.0% | 88.4% | 88.4% | 82.5% | 90.9% | 88.5% | 88.5% | 81.8% | 89.6% | 88.4% | 88.4% | 88.4% | | - |
| Training | Mandatory training compliance (Target: >90%) | 87.6% | 85.7% | 88.1% | 85.8% | 84.4% | 84.0% | 78.7% | 84.6% | 86.5% | 85.1% | 84.6% | 85.4% | 85.4% | | ! |
| | Health and Safety training (Target: >90%) | 95.2% | 93.7% | 95.4% | 89.4% | 88.0% | 88.0% | 87.7% | 86.9% | 92.8% | 91.7% | 92.6% | 92.4% | 88.5% | | ! |
| | Safeguarding training - adults (Target: 90%) | 91.6% | 90.6% | 91.5% | 90.3% | 88.1% | 88.1% | 87.6% | 87.2% | 90.4% | 89.7% | 90.1% | 90.1% | 89.2% | | ! |
| | Safeguarding training - children (Target: 90%) | 88.7% | 88.5% | 90.1% | 88.6% | 87.1% | 87.9% | 85.5% | 88.4% | 88.2% | 88.3% | 88.4% | 88.3% | 88.5% | | ! |

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

**Trust commentary**

**Staff in Post**

In March we employed 5405 whole time equivalent (WTE) people on substantive contracts, 3 WTE less than last month. Taking into account bank and agency workers our WTE workforce was 6536 WTE.

**Turnover**

Our voluntary turnover rate was 15.5%, 0.2% higher than last month. Voluntary turnover is 17.4% at Chelsea and 11.8% at West Middlesex.

**Vacancies**

Our general vacancy rate for March was 11.7%, which is 0.1% higher than February. The vacancy rate is 12.3% at West Middlesex and 11.2% at Chelsea.

**Sickness Absence**

Sickness absence in the month of March was 2.9%, 0.2% lower than February.

**Core training (statutory and mandatory training) compliance**

The Trust reports core training compliance based on the 10 Core Skills Training Framework (CSTF) topics to provide a consistent comparison with other London trusts. Our compliance rate stands at 85% against our target of 90%.

**Performance and Development Reviews**

From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to have had a PDR by the end of December. The PDR rate decreased by 1.2% in March and now stands at 88.41%.

The rolling annual appraisal rate for medical staff was 77.9%, 3.4% lower than last month.

# 62 day Cancer referrals by tumour site Dashboard

## Target of 85%

| | | Chelsea & Westminster Hospital Site | | | | | West Middlesex University Hospital Site | | | | | Combined Trust Performance | | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Tumour site | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | YTD breaches | Jan-18 | Feb-18 | Mar-18 | 2017-2018 | YTD breaches | Jan-18 | Feb-18 | Mar-18 | 2017-2018 Q4 | 2017-2018 | YTD breaches | Trend charts | |
| 62 day Cancer referrals by site of tumour | Brain | n/a | n/a | n/a | 100% | | n/a | n/a | n/a | n/a | 0 | n/a | n/a | n/a | n/a | 100% | 0 | | - |
| | Breast | n/a | n/a | n/a | n/a | 0.5 | 100% | 100% | 90.9% | 99.5% | 0.5 | 100% | 100% | 90.9% | 98.0% | 99.0% | 1 | | - |
| | Colorectal / Lower GI | 100% | 100% | n/a | 89.2% | 3.5 | 85.7% | 80.0% | 57.1% | 74.4% | 11 | 89.5% | 88.9% | 57.1% | 78.6% | 80.8% | 14.5 | | - |
| | Gynaecological | 100% | 100% | 75.0% | 92.0% | 1 | 100% | n/a | 0.0% | 88.1% | 2.5 | 100% | 100% | 50.0% | 72.7% | 89.6% | 3.5 | | - |
| | Haematological | 100% | n/a | 100% | 100% | 0 | 100% | 100% | 100% | 91.8% | 2 | 100% | 100% | 100% | 100% | 94.0% | 2 | | - |
| | Head and neck | n/a | n/a | n/a | 100% | 0 | 100% | 100% | 66.7% | 82.6% | 2 | 100% | 100% | 66.7% | 83.3% | 86.2% | 2 | | - |
| | Lung | 100% | 0.0% | n/a | 77.3% | 2.5 | 100% | 100% | 100% | 96.7% | 0.5 | 100% | 66.7% | 100% | 90.0% | 88.5% | 3 | | - |
| | Sarcoma | n/a | n/a | n/a | 100% | 0 | n/a | n/a | n/a | n/a | | n/a | n/a | n/a | n/a | 100% | 0 | | - |
| | Skin | 100% | 100% | 100% | 96.2% | 3.5 | 83.3% | 100% | 100% | 93.8% | 2.5 | 95.0% | 100% | 100% | 98.3% | 95.4% | 6 | | - |
| | Upper gastrointestinal | n/a | 100% | 50.0% | 81.3% | 3 | n/a | 100% | 50.0% | 88.2% | 1 | n/a | 100% | 50.0% | 77.8% | 83.7% | 4 | | - |
| | Urological | 78.9% | 100% | 94.7% | 66.2% | 25 | 100% | 82.8% | 94.1% | 91.1% | 9 | 91.1% | 87.5% | 94.4% | 90.9% | 80.6% | 34 | | - |
| | Urological (Testicular) | n/a | n/a | n/a | 100% | 0 | n/a | 100% | n/a | 100% | 0 | n/a | 100% | n/a | 100% | 100% | 0 | | - |
| | Site not stated | 100% | 100% | 100% | 84.6% | 1 | n/a | 100% | 100% | 100% | 0 | 100% | 100% | 100% | 100% | 92.6% | 1 | | - |

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

**Trust commentary**

For the 62 day GP Cancer referrals to first treatment pathway the Trust has an unvalidated position of 86.73% for March

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

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

Breast: WMUH: 0.5 of a breach of 5.5 patients treated

Gynaecological: C&W: 0.5 of a breach of 2 patients treated
WMUH: 1breach of 1 patient treated

Head & Neck: WMUH: 0.5 of a breach of 1.5 patients treated

Colorectal / Lower GI: WMUH: 3 breaches of 7 patients treated

Upper Gastrointestinal: C&W: 0.5 of a breach of 1 patient treated
WMUH: 0.5 of a breach of 1 patient treated

Urological: C&W: 0.5 of a breach of 9.5 patients treated
WMUH: 0.5 of a breach of 8.5 patients treated

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

# QUALITY PRIORITIES DASHBOARD

## Quarter 4 2017/2018

### Patient Safety

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Q2 | Q3 | Q4 | 4th Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 1 | Reduction in falls (Frailty Quality Plan) | Director of Nursing | | | | | The status is rated as green as the year end position for 2017/18 has continued to show a reduction in falls requiring external reporting compared to 2016/7. Falls as a priority is being continued in 2018/19. |
| 2 | Antibiotic administration in Sepsis (Sepsis Plan) | Medical Director | | | | | Q4 data is not yet available |
| 3 | National Early Warning Score (Sepsis Plan) | Medical Director | | | | | Q4 data is not yet available |
| 4 | National Safety Standards for Invasive Procedures (NatSSIPs) (Planned Care Plan) | Divisional Medical Director | | | | | The division has continued to make significant progress in Q4. |

### Clinical Effectiveness

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Q2 | Q3 | Q4 | 4th Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 5 | Reduction in still births (Maternity Plan) | Director of Midwifery | | | | | C&W continues to remain below the national still birth rate. |

### Patient Experience

| QP No | Description of Goal | Responsible Executive (role) | Forecast Q1 | Q2 | Q3 | Q4 | 4th Quarter Commentary |
|---|---|---|---|---|---|---|---|
| 1 | Focus on complaints and demonstrate learning from complaints | Director of Midwifery | | | | | Complaints turnaround remains a concern however significant progress has been made in reducing the number of overdue complaints. We continue to aspire to the stretched target of 90%. . |
| 2 | FFT improvements with new FFT provider | Director of Midwifery | | | | | Response rates remain low with only inpatient areas achieving the >30%. Recommendation rates are above the 90% in all areas apart from ED which is currently at 84% year to date. |

# Nursing Metrics Dashboard

## Safe Nursing and Midwifery Staffing

### Chelsea and Westminster Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 96.7% | 82.0% | 92.9% | 87.5% | 9.3 | 3.3 | 12.6 | 7 – 17.5 |
| Annie Zunz | 100.1% | 78.7% | 97.1% | 97.3% | 5.1 | 2.0 | 7.2 | 6.5 - 8 |
| Apollo | 96.8% | 100.0% | 92.3% | 87.1% | 16.7 | 3.3 | 20.0 | |
| Jupiter | 173.6% | 48.1% | 167.9% | - | 12.7 | 1.1 | 13.8 | 8.5 – 13.5 |
| Mercury | 80.7% | 83.7% | 82.8% | 25.8% | 6.7 | 0.7 | 7.4 | 8.5 – 13.5 |
| Neptune | 98.3% | 57.2% | 97.6% | 0.0% | 8.1 | 0.5 | 8.6 | 8.5 – 13.5 |
| NICU | 95.7% | - | 100.0% | - | 12.8 | 0.0 | 12.8 | |
| AAU | 105.9% | 70.5% | 99.9% | 97.5% | 9.4 | 2.0 | 11.3 | 7 - 9 |
| Nell Gwynn | 169.2% | 127.9% | 249.5% | 206.2% | 5.3 | 4.2 | 9.4 | 6 – 8 |
| David Erskine | 100.1% | 83.8% | 111.8% | 98.9% | 3.3 | 2.7 | 6.0 | 6 – 7.5 |
| Edgar Horne | 95.4% | 87.9% | 96.8% | 96.8% | 3.0 | 3.1 | 6.1 | 6 – 7.5 |
| Lord Wigram | 94.3% | 92.4% | 97.8% | 105.4% | 3.4 | 2.5 | 6.0 | 6.5 – 7.5 |
| St Mary Abbots | 90.5% | 95.7% | 93.5% | 98.7% | 3.6 | 2.5 | 6.1 | 6 – 7.5 |
| David Evans | 85.5% | 81.5% | 95.3% | 104.1% | 5.0 | 2.3 | 7.3 | 6 – 7.5 |
| Chelsea Wing | 91.1% | 96.2% | 100.0% | 96.8% | 10.3 | 6.1 | 16.4 | |
| Burns Unit | 94.3% | 98.4% | 100.0% | 100.0% | 9.0 | 4.5 | 13.5 | |
| Ron Johnson | 110.8% | 113.3% | 124.9% | 119.3% | 5.4 | 2.9 | 8.2 | 6 – 7.5 |
| ICU | 98.6% | - | 98.6% | - | 30.0 | 0.0 | 30.0 | 17.5 - 25 |
| Rainsford Mowlem | 88.2% | 94.0% | 126.0% | 100.8% | 3.5 | 2.8 | 6.3 | 6 - 8 |

### West Middlesex University Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 95.3% | 71.3% | 100.5% | 91.4% | 10.2 | 2.1 | 12.3 | 7 – 17.5 |
| Lampton | 100.0% | 141.8% | 98.9% | 101.6% | 2.8 | 2.6 | 5.4 | 6 – 7.5 |
| Richmond | 98.2% | 122.8% | 73.3% | 103.3% | 5.3 | 3.8 | 9.2 | 6 – 7.5 |
| Syon 1 | 89.8% | 150.3% | 101.6% | 165.6% | 3.3 | 2.8 | 6.1 | 6 – 7.5 |
| Syon 2 | 95.5% | 187.7% | 115.5% | 231.5% | 3.6 | 4.3 | 7.9 | 6 – 7.5 |
| Starlight | 95.4% | 38.7% | 112.5% | 57.5% | 9.1 | 0.6 | 9.6 | 8.5 – 13.5 |
| Kew | 94.3% | 88.9% | 144.0% | 148.4% | 4.1 | 3.4 | 7.5 | 6 - 8 |
| Crane | 107.0% | 138.3% | 95.7% | 162.9% | 3.0 | 3.7 | 6.7 | 6 – 7.5 |
| Osterley 1 | 114.0% | 149.1% | 122.8% | 220.8% | 3.2 | 4.3 | 7.6 | 6 – 7.5 |
| Osterley 2 | 102.5% | 129.0% | 111.3% | 232.4% | 3.8 | 3.9 | 7.7 | 6 – 7.5 |
| MAU | 93.7% | 104.8% | 92.3% | 99.8% | 5.9 | 3.5 | 9.4 | 7 - 9 |
| CCU | 99.3% | 105.8% | 99.8% | - | 5.2 | 0.8 | 6.0 | 6.5 - 10 |
| Special Care Baby Unit | 94.9% | | 95.8% | | 7.7 | 0.0 | 7.7 | |
| Marble Hill 1 | 91.2% | 97.7% | 106.5% | 101.4% | 3.3 | 2.2 | 5.6 | 6 - 8 |
| Marble Hill 2 | 102.4% | 109.4% | 104.3% | 121.0% | 3.3 | 3.1 | 6.4 | 5.5 - 7 |
| ITU | 95.8% | 0.0% | 92.6% | - | 29.0 | 0.0 | 29.0 | 17.5 - 25 |

**Summary for March 2018**

Nell Gwynne is showing high fill rates to cover the escalation beds and to care for patients tracheostomies.

Patient on Rainsford Molem and Ron Johnson requiring RMN contributing to increased fill rates for qualified nurses. High number of paediatrics on Jupiter requiring RMNs.

CHPPD is showing an overly generous amount on Richmond due to bed census data being counted at midnight and therefore not accounting for day surgery activity. Lower fill rates on RNs on nights due to staff being shared with escalation ward.

Low fill rates for HCAs for paediatric wards due to skills mix review and need for compliance with ratio of 1RN:4 patients. Additional HCAs booked to care for confused patients at risk of falls on Kew, Crane, Osterley 1, Syon1 &2. High acuity on Osterley 1&2 due to patients on NIV an d chemotherapy. RMN usage on Osterley 1 for a sectioned patient.

# CQUIN Dashboard

## March 2018

### National CQUINs

| No. | Description of goal | Responsible Executive (role) | Forecast RAG Rating |
|---|---|---|---|
| A.1 | Improvement of health and wellbeing of NHS staff | Director of HR & OD | |
| A.2 | Healthy food for NHS staff, visitors and patients | Deputy Chief Executive | |
| A.3 | Improving the uptake of flu vaccinations for front line staff within Providers | Director of HR & OD | |
| B.1 | Sepsis (screening) - ED & Inpatient | Medical Director | |
| B.2 | Sepsis (antibiotic administration and review) - ED & Inpatient | Medical Director | |
| B.3 | Anti-microbial Resistance - review | Medical Director | |
| B.4 | Anti-microbial Resistance - reduction in antibiotic consumption | Medical Director | |
| C.1 | Improving services for people with mental health needs who present to A&E | Chief Operating Officer | |
| D.1 | Offering Advice and guidance for GPs | Medical Director | |
| E.1 | NHS e-Referrals | Chief Operating Officer | |
| F.1 | Supporting safe & proactive discharge | Chief Operating Officer | |

### NHS England CQUINs

| No. | Description of goal | Responsible Executive (role) | Forecast RAG Rating |
|---|---|---|---|
| N1.1 | Enhanced Supportive Care | Chief Operating Officer | |
| N1.2 | Nationally standardised Dose banding for Adult Intravenous Anticancer Thera | Chief Operating Officer | |
| N1.3 | Optimising Palliative Chemotherapy Decision Making | Chief Operating Officer | |
| N1.4 | Hospital Medicines Optimisation | Chief Operating Officer | |
| N1.5 | Neonatal Community Outreach | Chief Operating Officer | |
| N1.6 | Dental Schemes - recording of data, participation in referral management & p | Chief Operating Officer | |

**2017/18 CQUIN Performance**

The Trust has agreed 12 CQUIN schemes (6 national schemes for CCGs, 6 NHS England schemes) for 2017/18.

**Quarter 1 & 2 Performance**

The quarter 1 & 2 performance has been signed off by NHSE and CCGs at 100% for NHSE schemes and 92% for Q1 and 86% for Q2 for CCG schemes. Partial achievement was reported for the Sepsis, improving services for people with mental health needs who present to A&E, NHS e-Referrals and supporting proactive and safe discharge CQUIN schemes in quarter 2, which was in line with forecast achievement. Quarter 3 reports have been submitted and the commissioner outcome is expected to be known in April 2018.

**National Schemes**

There is a continued risk to delivery of the a number of schemes, including Sepsis screening and review scheme, in line with the year to date delivery, and the Trust is forecasting partial achievement. However the associated financial risk is partly mitigated by a local payment agreement with NWL CCGs.

**NHS England Schemes**

The schemes are all on track for the year to date. There is a risk regarding the specification for the neonatal community outreach scheme, which is being jointly developed between commissioners and providers, to ensure that an agreed quality improvement scheme is in place across all organisations in the neonatal network.

**2018/19 CQUINs**

Planning guidance has now been issued for 2018/19 and there are some changes identified for national schemes, including:
- Removal of the Supporting Safe & Proactive Discharge schemes for 2018/19, with the values of the other schemes increasing to compensate. This is a temporary measure for next year only.
- Minor adjustments to a few other schemes, including the Improvement of health and wellbeing of NHS staff and Sepsis and Anti-microbial resistance schemes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Workforce Performance Report
to the Workforce Development Committee

**Month 12 – March 2018**

# Workforce Performance Report Apr ‘17 - Mar ‘18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# Performance Summary

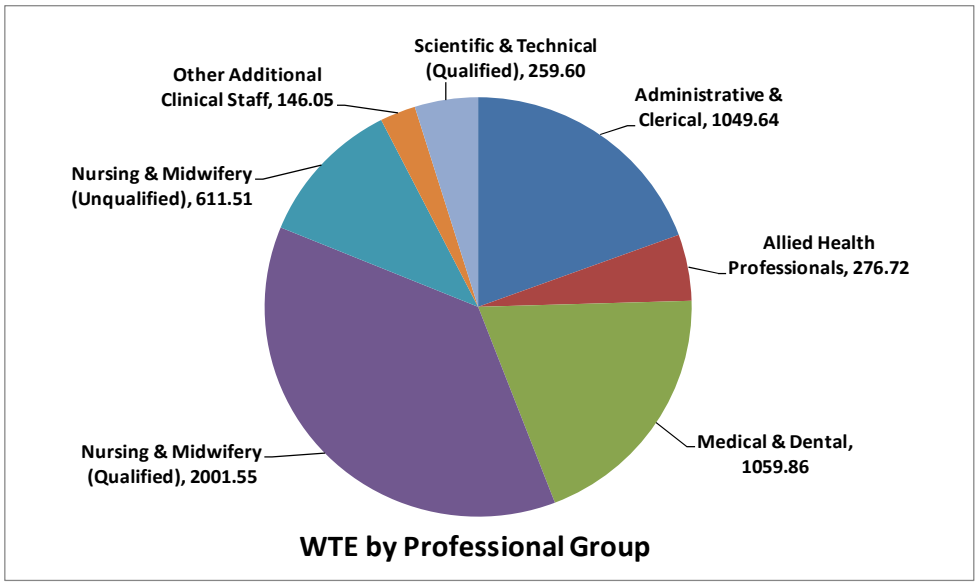
Summary of overall performance is set out below

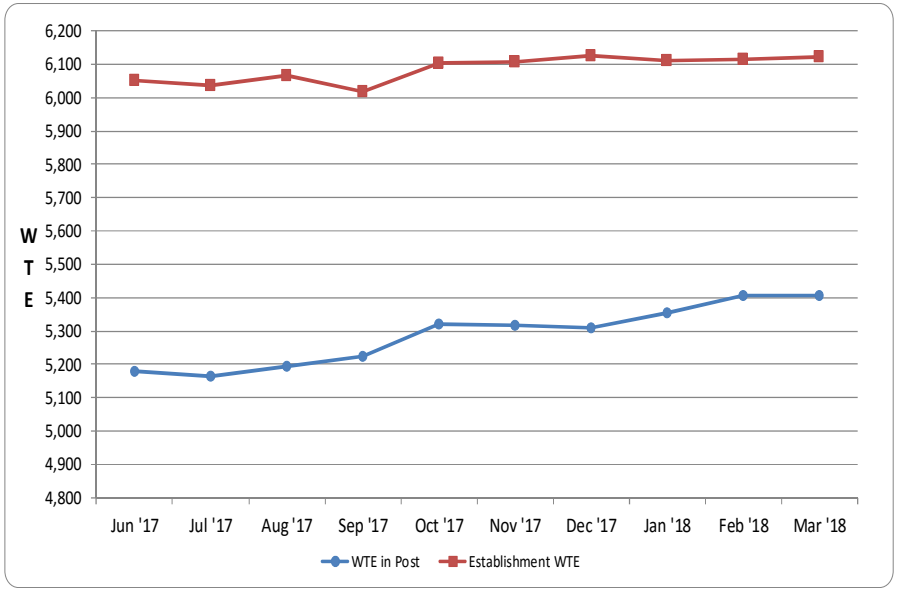
| Page | Areas of Review | Key Highlights | Previous Year | Previous Month | In Month | Target | Change |
|---|---|---|---|---|---|---|---|
| 5 | Vacancy | Vacancy rate has increased by 0.1% | 14.0% | 11.6% | 11.7% | 10.0% | ↗ |
| 6 | Turnover | Turnover has increased by 0.1% | 21.5% | 19.4% | 19.5% | | ↗ |
| 7 | Voluntary Turnover | Voluntary turnover has increased by 0.2% | 16.2% | 15.3% | 15.5% | 13.0% | ↗ |
| 10 | Sickness | Sickness has decreased by 0.2% | 2.2% | 3.1% | 2.9% | 3.3% | ↘ |
| 15 | Temporary Staffing Usage (FTE) | Temporary Staffing % usage has increased by 1.5% this month | | 15.8% | 17.3% | | ↗ |
| 17 | Core Training | Core Training compliance has decreased by 0.5% | 83.9% | 85.1% | 84.6% | 90.0% | ↘ |
| 18 | Staff PDR | The percentage of staff who have had a PDR since 1st April '17 has decreased by 1.2% | 64.8% | 89.6% | 88.4% | 90.0% | ↘ |

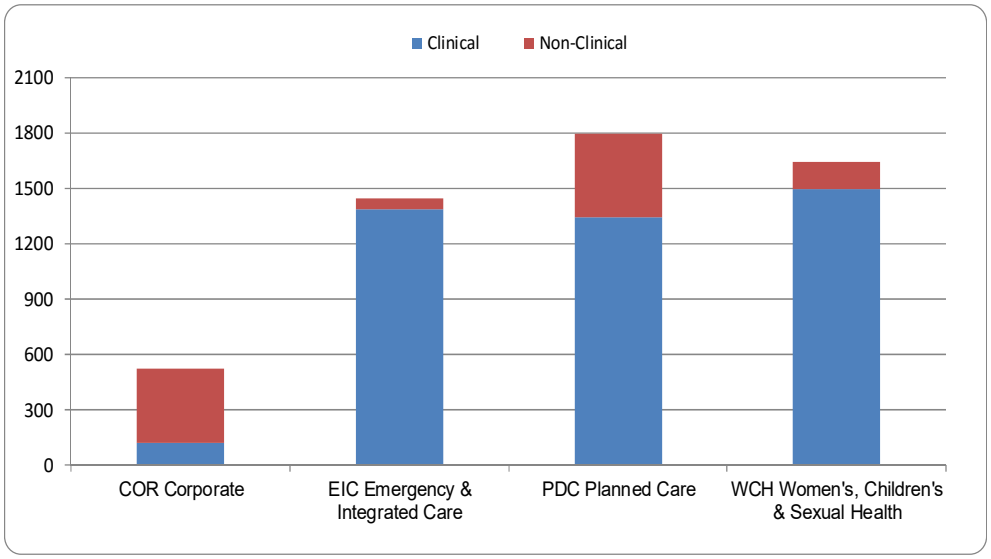
In addition to the information in this report, the trust monitors its workforce data by protected characteristics as defined by the Equality Act. To view the most recent annual workforce equality report please click this link http://connect/departments-and-mini-sites/equality-diversity/

# Current Staffing Profile

The data below displays the current staffing profile of the Trust



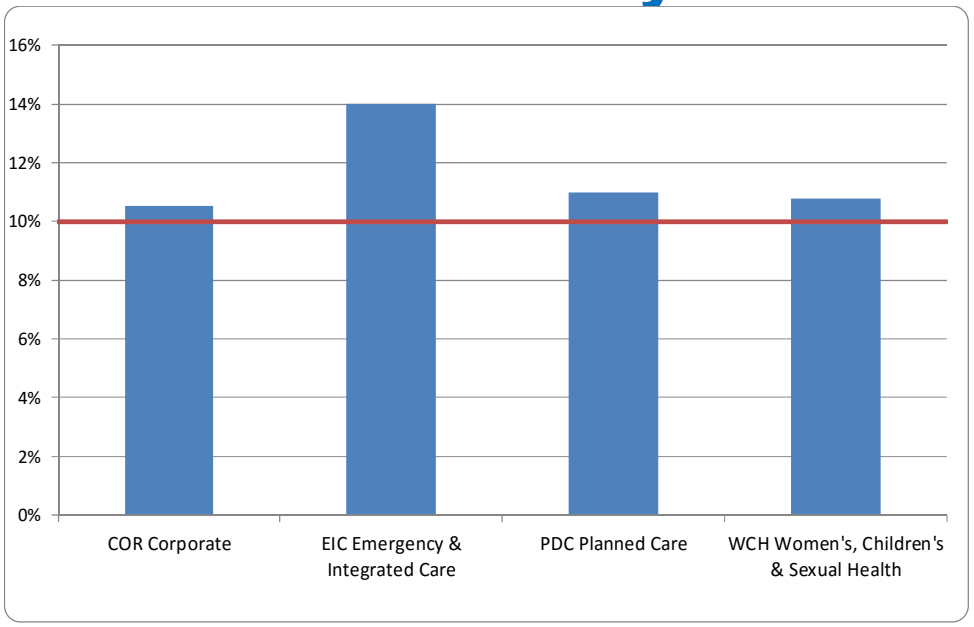

## COMMENTARY

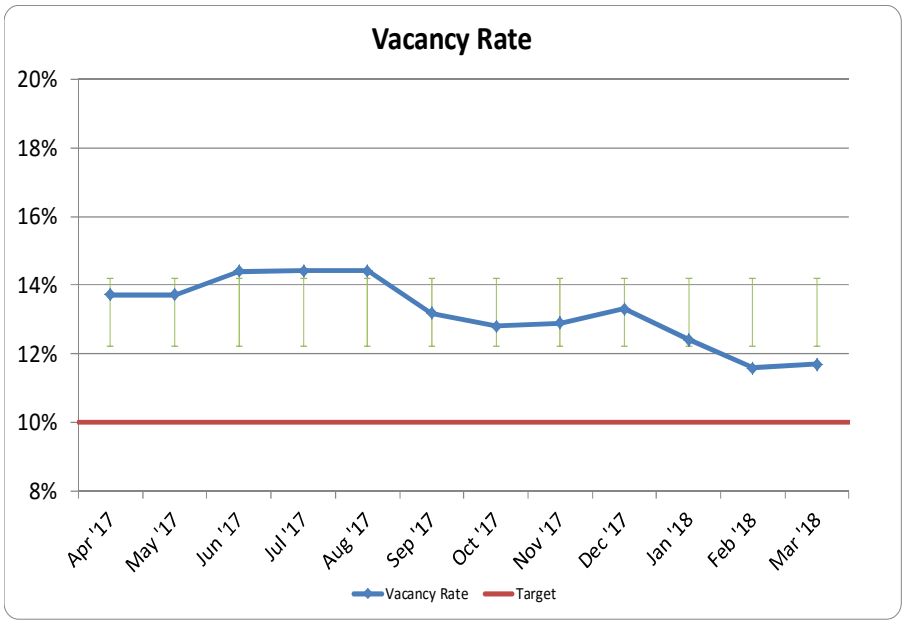
The Trust currently employs 5876 people working a whole time equivalent of 5405 which is 3 WTE less than February. The largest increase in March was in Qualified Nursing (16 WTE), whilst Admin & Clerical staff reduced by 12 WTE.

Since April '17 staff numbers have increased by 279 WTE with the highest increase being in the EIC Division (138 WTE). The professional group with the highest increase has been Qualified Nursing & Midwifery (94 WTE).

In March there were 1867 WTE staff assigned to the West Middlesex site and 3538 WTE to Chelsea.

# Section 1: Vacancy Rates




| Vacancies by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 11.8% | 9.7% | 9.9% | 10.5% | ↗ |
| EIC Emergency & Integrated Care | 16.1% | 15.0% | 14.0% | 14.0% | ↔ |
| PDC Planned Care | 12.8% | 12.0% | 10.6% | 11.0% | ↗ |
| WCH Women's, Children's & Sexual Health | 11.7% | 11.4% | 11.0% | 10.8% | ↘ |
| **Whole Trust** | **13.3%** | **12.4%** | **11.6%** | **11.7%** | ↗ |
| **West Mid Site** | **14.9%** | **14.5%** | **12.3%** | **12.0%** | ↘ |
| **Chelsea Site** | **12.5%** | **11.3%** | **11.2%** | **11.5%** | ↗ |

| Vacancies by Professional Group | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 12.3% | 10.7% | 10.8% | 11.5% | ↗ |
| Allied Health Professionals | 14.1% | 12.2% | 10.0% | 10.8% | ↗ |
| Medical & Dental | 9.5% | 9.4% | 9.3% | 10.1% | ↗ |
| Nursing & Midwifery (Qualified) | 15.6% | 15.4% | 13.5% | 12.8% | ↘ |
| Nursing & Midwifery (Unqualified) | 18.0% | 14.1% | 13.5% | 14.0% | ↗ |
| Other Additional Clinical Staff | 3.2% | 6.4% | 8.3% | 7.5% | ↘ |
| Scientific & Technical (Qualified) | 7.7% | 7.3% | 7.5% | 7.8% | ↗ |
| **Total** | **13.3%** | **12.4%** | **11.6%** | **11.7%** | ↗ |

| Service | Establishment WTE | Staff in Post WTE | Vacancy Rate % | Trend |
|---|---|---|---|---|
| WM T&O | 32.4 | 19.7 | 39.1% | ↗ |
| WM Paediatric Starlight Unit | 59.2 | 36.8 | 37.8% | ↗ |
| CW Cardiology | 22.3 | 14.6 | 34.5% | ↘ |
| WM Radiology | 57.7 | 38.7 | 32.9% | ↗ |
| CW Ron Johnson | 31.1 | 21.4 | 31.2% | ↗ |

**COMMENTARY**

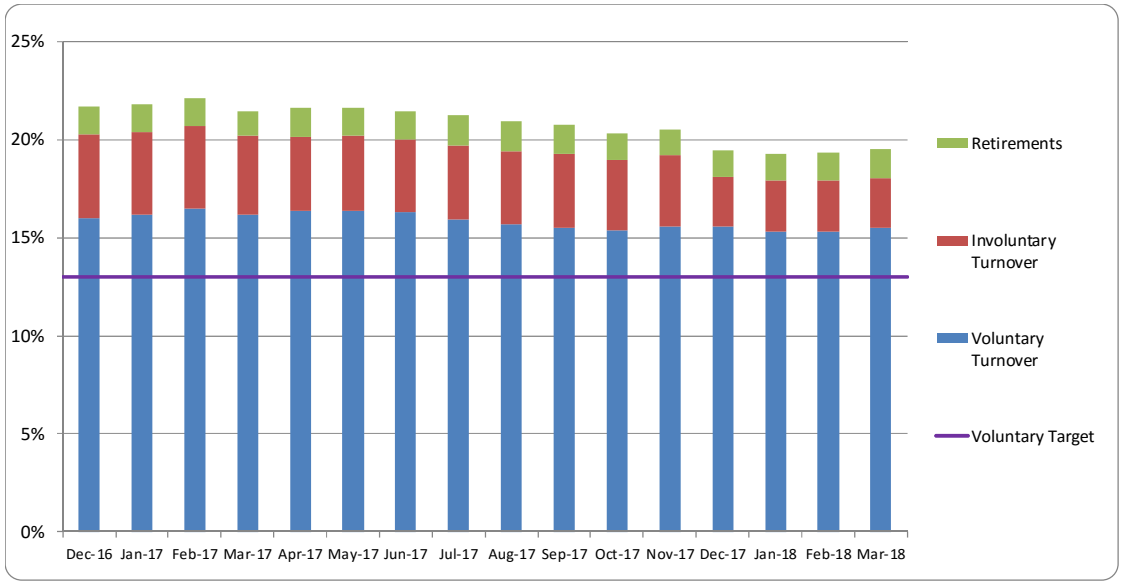
The vacancy rate has increased by 0.1% in March corresponding with an small decrease in staff in post.

The vacancy rate currently is highest in the Nursing & Midwifery (Unqualified) professional group at 14% and in the Emergency & Integrated Care Division also at 14.0%.

The table above shows the services with more than 20 staff which currently have the highest vacancy rates at the Trust.

# Section 2a: Gross Turnover

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




**COMMENTARY**

The total trust turnover rate has increased slightly by 0.1% to 19.5% this month. In the last 12 months there have been 996 leavers. In December a decrease of 1% can be seen due to the leavers from a TUPE of Scientific staff moving into the previous rolling year calculation.

The Trust now has data from responses to exit surveys to enable more focused work on retention.

| | Gross Turnover | | | | |
|---|---|---|---|---|---|
| **Division** | **Dec '17** | **Jan '18** | **Feb '18** | **Mar '18** | **Trend** |
| COR Corporate | 21.2% | 21.5% | 21.0% | 23.3% | ↗ |
| EIC Emergency & Integrated Care | 19.7% | 19.5% | 19.6% | 20.0% | ↗ |
| PDC Planned Care | 18.5% | 17.8% | 18.0% | 17.8% | ↘ |
| WCH Women's, Children's & Sexual Health | 19.8% | 19.9% | 20.0% | 19.7% | ↘ |
| **Whole Trust** | **19.5%** | **19.3%** | **19.4%** | **19.5%** | ↗ |

| | Gross Turnover | | | | |
|---|---|---|---|---|---|
| **Professional Group** | **Dec '17** | **Jan '18** | **Feb '18** | **Mar '18** | **Trend** |
| Administrative & Clerical | 18.8% | 18.4% | 18.2% | 19.9% | ↗ |
| Allied Health Professionals | 24.3% | 22.2% | 21.6% | 20.9% | ↘ |
| Medical & Dental | 13.9% | 14.7% | 15.7% | 14.6% | ↘ |
| Nursing & Midwifery (Qualified) | 19.7% | 19.7% | 19.8% | 19.3% | ↘ |
| Nursing & Midwifery (Unqualified) | 22.5% | 21.5% | 21.1% | 21.8% | ↗ |
| Other Additional Clinical Staff | 25.0% | 24.5% | 25.7% | 25.5% | ↘ |
| Scientific & Technical (Qualified) | 17.2% | 17.3% | 18.2% | 19.1% | ↗ |
| **Whole Trust** | **19.5%** | **19.3%** | **19.4%** | **19.5%** | ↗ |

# Section 2b: Voluntary Turnover

| | Voluntary Turnover | | | | | | Other Turnover Mar 2018 | |
|---|---|---|---|---|---|---|---|---|
| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend | Leavers HC | In-voluntary | Retirement |
| COR Corporate | 17.5% | 17.0% | 16.4% | 18.0% | ↗ | 94 | 4.0% | 1.3% |
| EIC Emergency & Integrated Care | 17.0% | 16.9% | 16.8% | 17.2% | ↗ | 221 | 1.9% | 0.9% |
| PDC Planned Care | 13.7% | 13.2% | 13.4% | 13.3% | ↘ | 228 | 3.0% | 1.6% |
| WCH Women's, Children's & Sexual Health | 15.8% | 15.7% | 15.7% | 15.7% | ↔ | 258 | 2.1% | 1.8% |
| **Whole Trust** | **15.6%** | **15.3%** | **15.3%** | **15.5%** | ↗ | **801** | **2.5%** | **1.5%** |
| **West Mid Site** | **11.0%** | **11.1%** | **11.8%** | **11.8%** | ↘ | **206** | | |
| **Chelsea Site** | **17.7%** | **17.3%** | **17.1%** | **17.4%** | ↗ | **581** | | |

| | Voluntary Turnover | | | | | | Other Turnover Mar 2018 | |
|---|---|---|---|---|---|---|---|---|
| Professional Group | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend | Leavers HC | In-voluntary | Retirement |
| Administrative & Clerical | 14.5% | 14.3% | 14.3% | 15.7% | ↗ | 169 | 2.9% | 1.4% |
| Allied Health Professionals | 22.3% | 20.2% | 19.9% | 18.9% | ↘ | 58 | 1.6% | 0.3% |
| Medical & Dental | 4.6% | 5.1% | 5.9% | 5.7% | ↘ | 33 | 7.6% | 1.4% |
| Nursing & Midwifery (Qualified) | 17.6% | 17.6% | 17.5% | 17.1% | ↘ | 363 | 0.7% | 1.6% |
| Nursing & Midwifery (Unqualified) | 18.9% | 17.8% | 17.2% | 18.0% | ↗ | 114 | 2.1% | 1.7% |
| Other Additional Clinical Staff | 13.8% | 13.8% | 14.7% | 14.6% | ↘ | 24 | 7.3% | 3.6% |
| Scientific & Technical (Qualified) | 13.5% | 12.6% | 13.2% | 14.1% | ↗ | 40 | 4.2% | 0.7% |
| **Whole Trust** | **15.6%** | **15.3%** | **15.3%** | **15.5%** | ↗ | **801** | **2.5%** | **1.5%** |

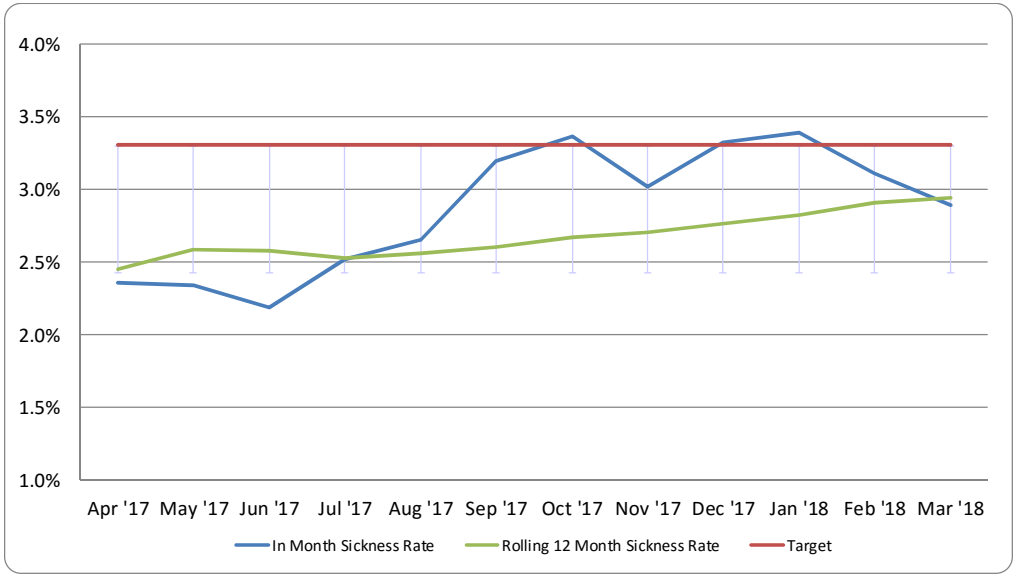
| Service | Average Staff in Post HC | Leavers HC | Voluntary Turnover Rate |
|---|---|---|---|
| CW Ron Johnson | 23 | 11 | 48.9% |
| CW Mercury Ward | 29 | 10 | 35.1% |
| CW Acute Medicine | 62 | 21 | 33.9% |
| CW Outpatients | 21 | 7 | 33.3% |
| CW John Hunter Clinic | 53 | 17 | 32.4% |

**COMMENTARY**

Voluntary Turnover has increased by 0.2% this month. Chelsea Site has a voluntary turnover rate consistently about 5 % higher than West Mid. The 5 services with more than 20 staff with the highest voluntary turnover rates are shown in the bottom table. Divisional HR Business Partners are working within divisions to tackle any issues within these areas. The Trust is also taking part in the NHSi Retention Support Program to help reduce turnover.

# Section 3: Sickness

The chart below shows performance over the last 11 months, the tables by Division and Staff Group are below.




**COMMENTARY**

The monthly sickness absence rate is at 2.9% in March which is a decrease of 0.3% on the previous month. The rolling 12 month sickness percentage at the Trust is seen to be increasing as data collection has improved. A new system was implemented in August 2017.

The Planned Care Division had the highest sickness rate in March at 3.3%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 4.8%.

The table below lists the services with the highest sickness absence percentage during March 2018. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

| Sickness by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 2.54% | 2.88% | 2.58% | 2.82% | ↗ |
| EIC Emergency & Integrated Care | 2.50% | 2.77% | 2.81% | 2.46% | ↘ |
| PDC Planned Care | 3.61% | 3.37% | 3.15% | 3.29% | ↗ |
| WCH Women's, Children's & Sexual Health | 3.96% | 4.10% | 3.51% | 2.84% | ↘ |
| **Whole Trust In Month %** | **3.32%** | **3.38%** | **3.11%** | **2.89%** | ↘ |
| **Whole Trust Annual Rolling %** | **2.76%** | **2.82%** | **2.90%** | **2.94%** | ↗ |
| **Long Term Sickness Rate %** | **1.75%** | **1.75%** | **1.60%** | **1.49%** | ↘ |
| **Short Term Sickness Rate %** | **1.57%** | **1.63%** | **1.51%** | **1.40%** | ↘ |

| Sickness by Professional Group (In Month) | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 3.99% | 3.74% | 3.42% | 3.67% | ↗ |
| Allied Health Professionals | 1.93% | 2.19% | 2.07% | 1.83% | ↘ |
| Medical & Dental | 0.63% | 0.69% | 0.73% | 0.59% | ↘ |
| Nursing & Midwifery (Qualified) | 3.80% | 4.16% | 3.66% | 3.20% | ↘ |
| Nursing & Midwifery (Unqualified) | 6.27% | 5.73% | 5.24% | 4.81% | ↘ |
| Other Additional Clinical Staff | 2.98% | 4.06% | 4.36% | 1.53% | ↘ |
| Scientific & Technical (Qualified) | 2.87% | 2.51% | 2.87% | 4.07% | ↗ |
| **Whole Trust In Month %** | **3.32%** | **3.38%** | **3.11%** | **2.89%** | ↘ |
| **Chelsea Site %** | **3.26%** | **3.44%** | **2.98%** | **2.78%** | ↘ |
| **West Mid Site %** | **3.43%** | **3.28%** | **3.36%** | **3.08%** | ↘ |

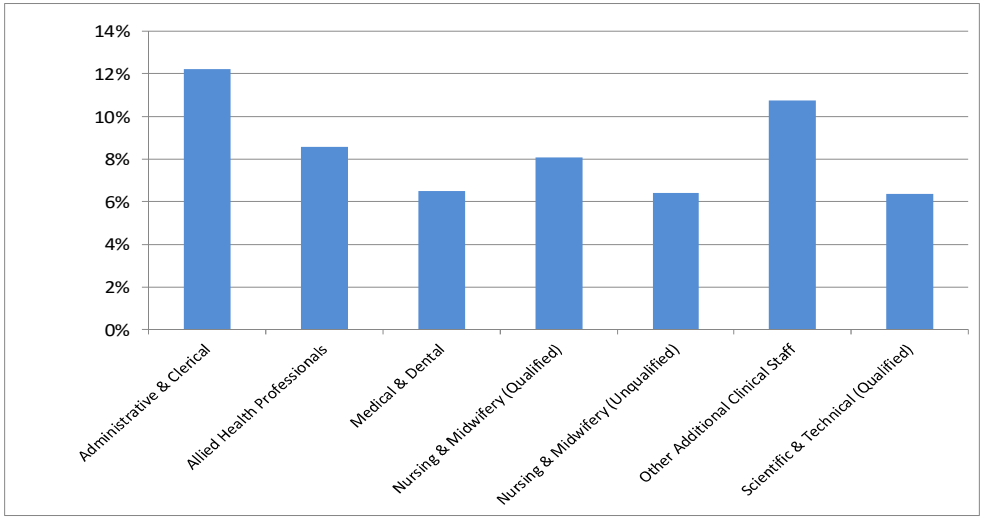
| Service | Staff in Post WTE | Sickness WTE Days Lost | WTE Days Available | Sickness % |
|---|---|---|---|---|
| CW Edgar Horne Ward | 40.01 | 184.24 | 1195.41 | 15.4% |
| WM Syon 2 Pay | 33.73 | 125.12 | 972.73 | 12.9% |
| CW Dermatology | 28.79 | 66.00 | 881.57 | 7.5% |
| WM Pharmacy | 49.88 | 111.59 | 1544.05 | 7.2% |
| CW David Erskine Ward | 26.61 | 61.00 | 853.01 | 7.2% |

| Top 5 Sickness Reasons by Number of Episodes | % of all Episodes |
|---|---|
| S13 Cold, Cough, Flu - Influenza | 30.01% |
| S25 Gastrointestinal problems | 18.52% |
| S12 Other musculoskeletal problems | 8.32% |
| S10 Anxiety/stress/depression/other psychiatric illnesses | 8.09% |
| S16 Headache / migraine | 7.62% |

| Top 5 Sickness Reasons by Number of WTE Days Lost | % of all WTE Days Lost |
|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 22.14% |
| S13 Cold, Cough, Flu - Influenza | 12.44% |
| S25 Gastrointestinal problems | 11.36% |
| S12 Other musculoskeletal problems | 11.21% |
| S28 Injury, fracture | 8.67% |

# Section 4: Staff Career Development

The chart below shows the percentage of current staff promoted in each staff group over the last 12 months.




**COMMENTARY**

In March, 36 staff were promoted, there were 89 new starters to the Trust (excluding Doctors in Training). In addition, 67 employees were acting up to a higher grade.

Over the last year 8.6% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Division.

Admin & Clerical currently have the highest promotion rate at 12.2% followed by the Other Additional Clinical Staff group at 10.7%.

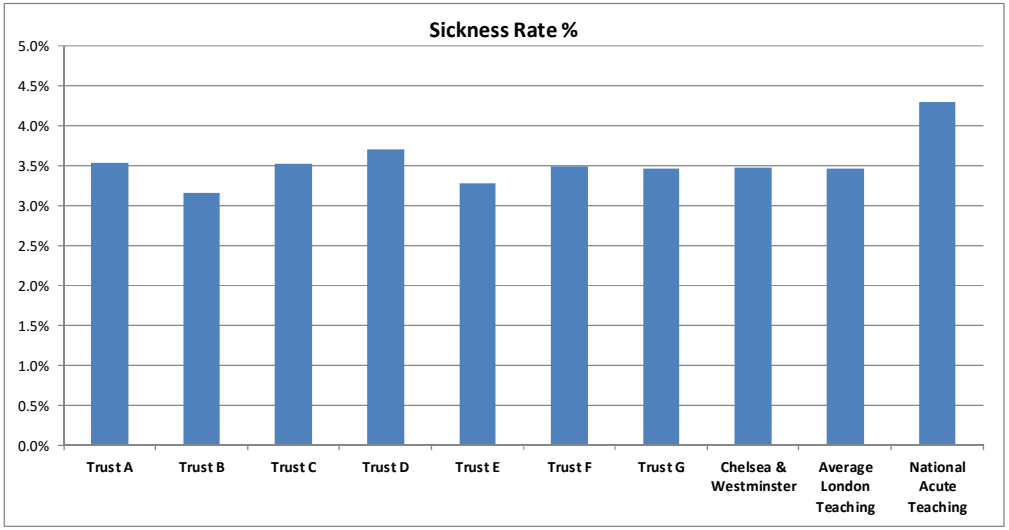
| | Monthly No. of Promotions | | | | |
|---|---|---|---|---|---|
| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
| COR Corporate | 9 | 10 | 6 | 3 | ↘ |
| EIC Emergency & Integrated Care | 6 | 13 | 9 | 6 | ↘ |
| PDC Planned Care | 16 | 14 | 7 | 13 | ↗ |
| WCH Women's, Children's & Sexual Health | 17 | 16 | 10 | 14 | ↗ |
| **Whole Trust Promotions** | **48** | **53** | **32** | **36** | ↗ |
| **New Starters (Excludes Doctors in Training)** | **52** | **116** | **92** | **89** | ↘ |

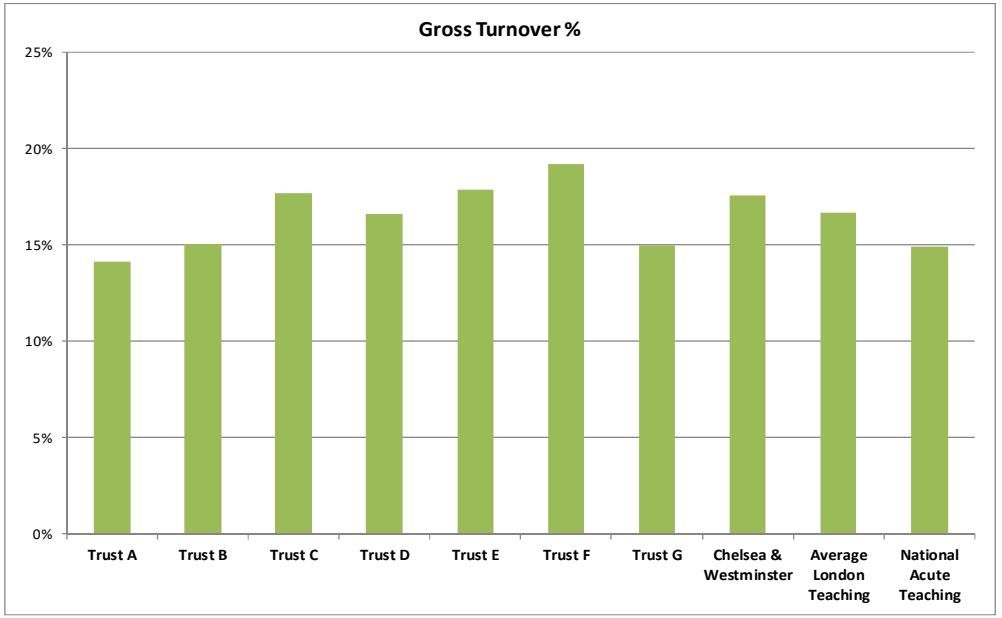
| Division | Staff in Post + 1yrs Service | No. of Staff Promoted (12 Months) | % of Staff Promoted | Currently Acting Up | BME % Overall Division | BME % Promoted |
|---|---|---|---|---|---|---|
| COR Corporate | 417 | 51 | 12.2% | 6 | 43.8% | 41.2% |
| EIC Emergency & Integrated Care | 1001 | 99 | 9.9% | 21 | 44.7% | 41.4% |
| PDC Planned Care | 1417 | 94 | 6.6% | 19 | 48.2% | 41.5% |
| WCH Women's, Children's & Sexual Health | 1346 | 114 | 8.5% | 21 | 34.2% | 18.4% |
| **Whole Trust** | **4181** | **358** | **8.6%** | **67** | **42.5%** | **34.1%** |
| **New Starters (Excludes Doctors in Training)** | | **1184** | | | | |

| | No. of Promotions | | | | |
|---|---|---|---|---|---|
| Professional Group | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
| Administrative & Clerical | 15 | 18 | 10 | 10 | ↔ |
| Allied Health Professionals | 1 | 5 | 2 | 4 | ↗ |
| Medical & Dental | 1 | 0 | 0 | 2 | ↗ |
| Nursing & Midwifery (Qualified) | 20 | 23 | 19 | 16 | ↘ |
| Nursing & Midwifery (Unqualified) | 0 | 3 | 0 | 1 | ↗ |
| Other Additional Clinical Staff | 9 | 4 | 0 | 0 | ↔ |
| Scientific & Technical (Qualified) | 2 | 0 | 1 | 3 | ↗ |
| **Whole Trust** | **48** | **53** | **32** | **36** | ↗ |

| Professional Group | Staff in Post + 1yrs Service | No. of Staff Promoted (12 Months) | % of Staff Promoted | Currently Acting Up | BME % of Prof Group | BME % Promoted |
|---|---|---|---|---|---|---|
| Administrative & Clerical | 876 | 107 | 12.2% | 21 | 44.0% | 41.1% |
| Allied Health Professionals | 233 | 20 | 8.6% | 11 | 18.0% | 20.0% |
| Medical & Dental | 494 | 32 | 6.5% | 1 | 36.2% | 12.5% |
| Nursing & Midwifery (Qualified) | 1736 | 140 | 8.1% | 27 | 42.0% | 29.3% |
| Nursing & Midwifery (Unqualified) | 485 | 31 | 6.4% | 0 | 60.4% | 58.1% |
| Other Additional Clinical Staff | 121 | 13 | 10.7% | 7 | 48.8% | 23.1% |
| Scientific & Technical (Qualified) | 236 | 15 | 6.4% | 0 | 46.5% | 53.3% |
| **Whole Trust** | **4181** | **358** | **8.6%** | **67** | **42.5%** | **34.1%** |

# Section 5: Workforce Benchmarking




**COMMENTARY**

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

Sickness data shown is from Dec '17 which is the most recent available on iView. Compared to other Acute teaching trusts in London, Chelwest had a rate just above the average at 3.47%. In the top graph, Trusts A-G are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in December.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). Chelwest currently has higher than average turnover (12 months to end January). Stability is lower than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 1.5% lower than Chelwest.

**As with all benchmarking information, this should be used with caution. Trusts will use ESR differently depending on their own local processes and may not consistently apply the approaches. Figures come direct from the ESR data warehouse and are not subject to the usual Trust department exclusions and so on.

| Reference Group | Gross Turnover Rate % | Stability Rate % | Sickness Rate % |
|---|---|---|---|
| Trust A | 14.14% | 85.32% | 3.54% |
| Trust B | 14.94% | 84.66% | 3.16% |
| Trust C | 16.09% | 83.54% | 3.52% |
| Trust D | 17.72% | 82.23% | 3.70% |
| Trust E | 17.99% | 82.25% | 3.27% |
| Trust F | 20.21% | 80.00% | 3.49% |
| Trust G | 15.26% | 84.48% | 3.46% |
| Chelsea & Westminster | 16.57% | 82.85% | 3.47% |
| Average London Teaching | 16.62% | 83.17% | 3.45% |
| National Acute Teaching | 14.96% | 85.14% | 4.29% |

# Section 6: Nursing Workforce Profile/KPIs

**Nursing Establishment WTE**

| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 88.1 | 88.1 | 89.1 | 88.1 | ↘ |
| EIC Emergency & Integrated Care | 1022.0 | 1020.3 | 1024.3 | 1024.3 | ↔ |
| PDC Planned Care | 712.2 | 712.4 | 711.9 | 712.0 | ↗ |
| WCH Women's, Children's & Sexual Health | 1183.9 | 1183.9 | 1181.7 | 1182.4 | ↗ |
| **Total** | **3006.1** | **3004.7** | **3007.0** | **3006.7** | ↘ |

**Nursing Staff in Post WTE**

| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 81.2 | 87.2 | 86.0 | 85.0 | ↘ |
| EIC Emergency & Integrated Care | 812.9 | 825.2 | 848.2 | 852.2 | ↗ |
| PDC Planned Care | 618.2 | 628.3 | 645.7 | 651.6 | ↗ |
| WCH Women's, Children's & Sexual Health | 1008.3 | 1011.4 | 1021.2 | 1024.2 | ↗ |
| **Total** | **2520.6** | **2552.1** | **2601.0** | **2613.1** | ↗ |

**Nursing Vacancy Rate**

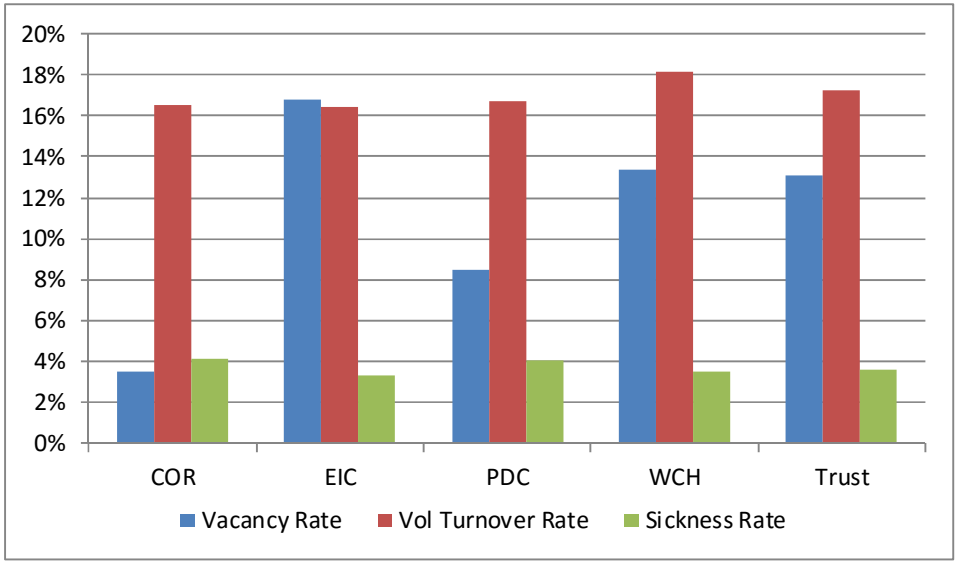
| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 7.8% | 1.0% | 3.5% | 3.5% | ↘ |
| EIC Emergency & Integrated Care | 20.5% | 19.1% | 17.2% | 16.8% | ↘ |
| PDC Planned Care | 13.2% | 11.8% | 9.3% | 8.5% | ↘ |
| WCH Women's, Children's & Sexual Health | 14.8% | 14.6% | 13.6% | 13.4% | ↘ |
| **Total** | **16.2%** | **15.1%** | **13.5%** | **13.1%** | ↘ |

**Nursing Sickness Rates**

| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 4.2% | 6.8% | 3.7% | 4.2% | ↗ |
| EIC Emergency & Integrated Care | 3.3% | 4.1% | 3.7% | 3.3% | ↘ |
| PDC Planned Care | 4.1% | 3.6% | 4.0% | 4.0% | ↗ |
| WCH Women's, Children's & Sexual Health | 5.4% | 5.3% | 4.4% | 3.5% | ↘ |
| **Total** | **4.4%** | **4.5%** | **4.0%** | **3.6%** | ↘ |

**Nursing Voluntary Turnover**

| Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 19.48% | 18.60% | 18.17% | 16.52% | ↘ |
| EIC Emergency & Integrated Care | 16.71% | 16.94% | 15.97% | 16.44% | ↗ |
| PDC Planned Care | 17.60% | 16.87% | 17.21% | 16.72% | ↘ |
| WCH Women's, Children's & Sexual Health | 18.81% | 18.38% | 18.35% | 18.18% | ↘ |
| **Total** | **17.9%** | **17.6%** | **17.3%** | **17.2%** | ↘ |
| **West Mid Site** | **11.6%** | **11.4%** | **12.5%** | **12.5%** | ↔ |
| **Chelsea Site** | **21.6%** | **21.2%** | **20.3%** | **20.1%** | ↘ |




**COMMENTARY**

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

The nursing workforce has increased by 12 WTE in March and the combined vacancy rate has gone down across all Divisions.

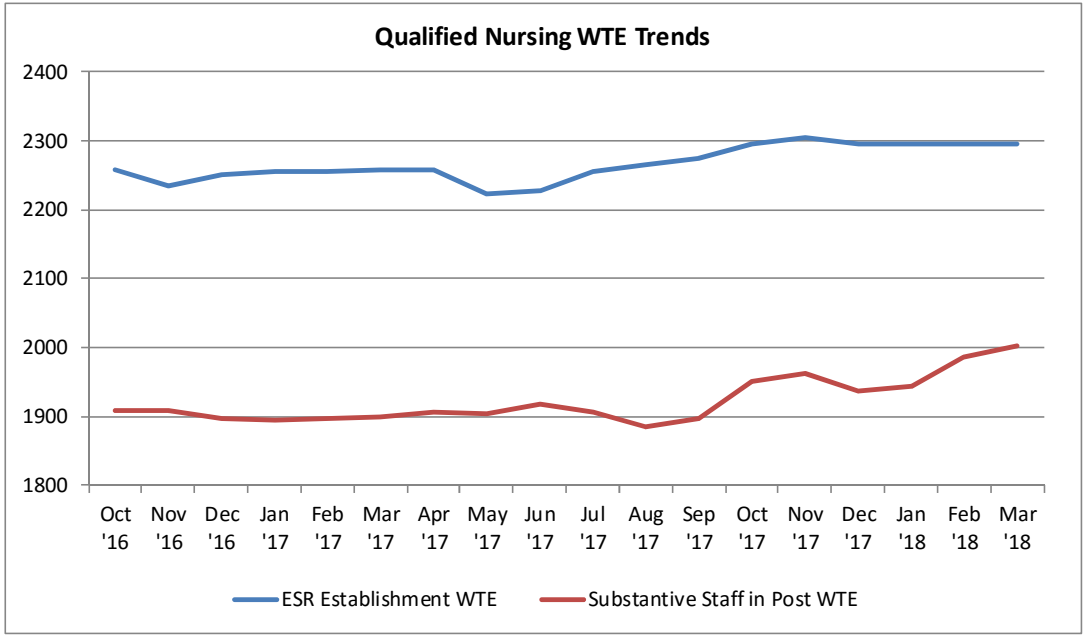
Voluntary Turnover is much higher at the Chelsea site compared to West Mid.

# Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

| Measure | Mar '17 | Apr '17 | May '17 | Jun '17 | Jul '17 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Apr '18 | May '18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE | 2257.5 | 2258.6 | 2223.7 | 2227.0 | 2255.0 | 2266.1 | 2273.5 | 2294.4 | 2304.3 | 2294.4 | 2296.2 | 2295.6 | 2296.0 | | |
| Substantive Staff in Post WTE | 1900.4 | 1907.3 | 1904.0 | 1918.1 | 1905.6 | 1884.5 | 1897.4 | 1950.5 | 1962.2 | 1937.1 | 1943.3 | 1985.3 | 2001.5 | | |
| Contractual Vacancies WTE | 357.1 | 351.2 | 319.7 | 309.0 | 349.4 | 381.6 | 376.1 | 343.8 | 342.1 | 357.4 | 353.0 | 310.3 | 294.4 | | |
| Vacancy Rate % | 15.82% | 15.55% | 14.38% | 13.87% | 15.49% | 16.84% | 16.54% | 14.99% | 14.85% | 15.58% | 15.37% | 13.52% | 12.82% | | |
| Actual/Planned Leavers Per Month* | 28 | 41 | 36 | 29 | 31 | 44 | 31 | 45 | 28 | 34 | 28 | 27 | 23 | 32 | 32 |
| Actual/Planned New Starters** | 33 | 58 | 32 | 38 | 19 | 19 | 39 | 73 | 25 | 20 | 34 | 53 | 42 | 64 | 64 |
| Pipeline: Agreed Start Dates | | | | | | | | | | | | | | 31 | 7 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | | | | | | | 200 - with no agreed start date | |

* Based on Gross Turnover of 20%

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




**COMMENTARY**

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

March saw more starters than leavers which has resulted in a 0.7% reduction in the vacancy rate. There are 200 nurses in the pipeline without a start date, 69 of which are from overseas.

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

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

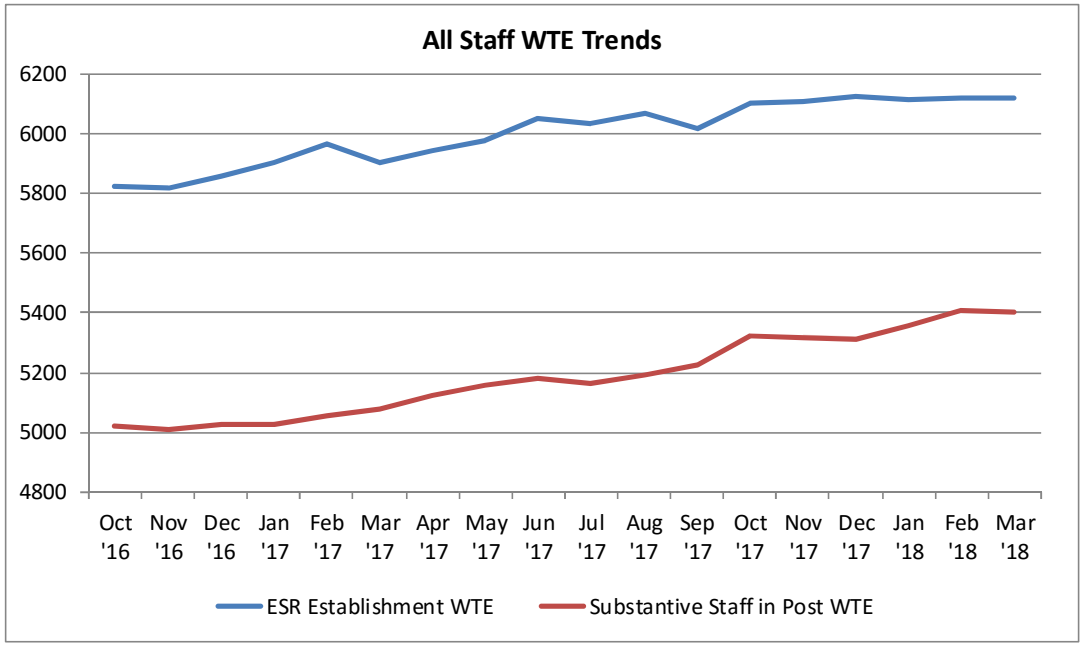
# Section 8: All Staff Recruitment Pipeline

| Measure | Mar '17 | Apr '17 | May '17 | Jun '17 | Jul '17 | Aug '17 | Sep '17 | Oct '17 | Nov '17 | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Apr '18 | May '18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE[1] | 5905.0 | 5940.6 | 5975.5 | 6051.6 | 6035.3 | 6067.5 | 6016.5 | 6103.3 | 6106.3 | 6124.5 | 6112.7 | 6116.2 | 6120.7 | | |
| Substantive Staff in Post WTE | 5080.2 | 5125.6 | 5156.2 | 5180.3 | 5165.7 | 5193.0 | 5223.4 | 5321.8 | 5318.3 | 5309.9 | 5354.6 | 5407.7 | 5404.9 | | |
| Contractual Vacancies WTE | 824.8 | 814.9 | 819.2 | 871.3 | 869.5 | 874.5 | 793.1 | 781.5 | 788.0 | 814.6 | 758.1 | 708.5 | 715.7 | | |
| Vacancy Rate % | 13.97% | 13.72% | 13.71% | 14.40% | 14.41% | 14.41% | 13.18% | 12.80% | 12.90% | 13.30% | 12.40% | 11.58% | 11.69% | | |
| Actual/Planned Leavers Per Month[2] | 67 | 90 | 95 | 63 | 96 | 280 | 128 | 146 | 92 | 89 | 71 | 103 | 96 | 89 | 89 |
| Actual/Planned New Starters[3] | 127 | 151 | 130 | 86 | 94 | 252 | 179 | 210 | 94 | 62 | 124 | 129 | 114 | 137 | 121 |
| Pipeline: Agreed Start Dates | | | | | | | | | | | | | | 60 | 13 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | | | | | | | 412 - with no agreed start date | |

[1] Doctors in Training are included in the Establishment, Staff in Post and Actual Starters/Leavers figures

[2] Based on Gross Turnover of 20%

[3] Number of WTE New Starters required per month to achieve a 10% Vacancy Rate by May 2018




**COMMENTARY**

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

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

*NB Starters & Leavers do not always add up to the change in staff in post due to existing staff changing their hours. Staff becoming substantive from Bank may also not be reflected*

# Section 9: Agency Spend

## COR Corporate

| Corporate | Dec '17 | Jan '18 | Feb '18 | Mar '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £90,839 | £90,825 | £143,845 | £204,960 | £1,907,207 |
| Target Spend | £222,190 | £222,190 | £210,631 | £210,150 | £2,895,700 |
| Variance | -£131,351 | -£131,365 | -£66,786 | -£5,190 | -£988,493 |
| Variance % | -59.1% | -59.1% | -31.7% | -2.5% | -34.1% |

## EIC Emergency & Integrated Care

| Emergency & Integrated Care | Dec '17 | Jan '18 | Feb '18 | Mar '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £646,947 | £640,862 | £588,256 | £770,487 | £8,257,832 |
| Target Spend | £537,198 | £537,198 | £509,252 | £508,087 | £7,001,045 |
| Variance | £109,749 | £103,664 | £79,004 | £262,400 | £1,256,787 |
| Variance % | 20.4% | 19.3% | 15.5% | 51.6% | 18.0% |

## PDC Planned Care

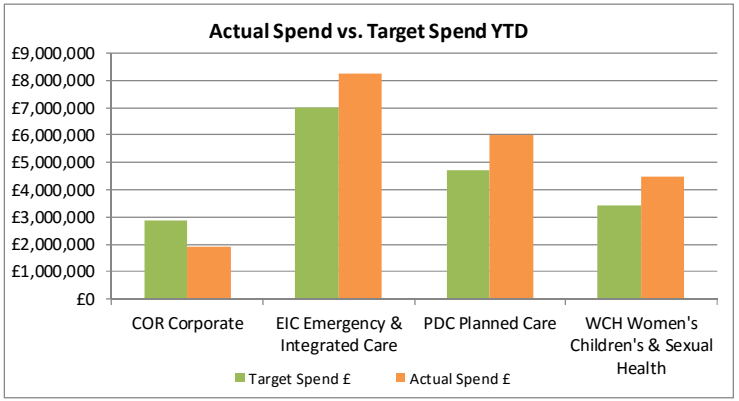
| Planned Care | Dec '17 | Jan '18 | Feb '18 | Mar '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £492,285 | £550,771 | £484,656 | £637,825 | £6,013,351 |
| Target Spend | £361,345 | £361,345 | £342,547 | £341,763 | £4,709,233 |
| Variance | £130,940 | £189,426 | £142,109 | £296,062 | £1,304,118 |
| Variance % | 36.2% | 52.4% | 41.5% | 86.6% | 27.7% |

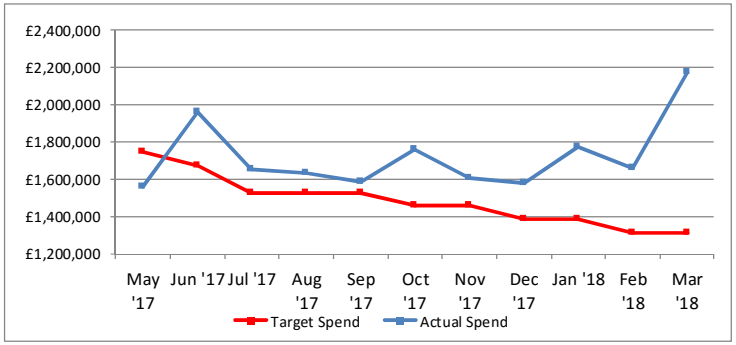
## WCH Women's, Children's & Sexual Health

| Women's, Children's & Sexual Health | Dec '17 | Jan '18 | Feb '18 | Mar '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £345,443 | £491,362 | £444,066 | £558,385 | £4,486,640 |
| Target Spend | £263,266 | £263,266 | £249,570 | £248,999 | £3,431,017 |
| Variance | £82,177 | £228,096 | £194,496 | £309,386 | £1,055,623 |
| Variance % | 31.2% | 86.6% | 77.9% | 124.3% | 30.8% |

## Clinical Divisions and Corporate Areas

| Trust | Dec '17 | Jan '18 | Feb '18 | Mar '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £1,575,514 | £1,773,820 | £1,660,823 | £2,171,657 | £20,665,030 |
| Target Spend | £1,383,999 | £1,383,999 | £1,312,000 | £1,308,999 | £18,036,995 |
| Variance | £191,515 | £389,821 | £348,823 | £862,658 | £2,628,035 |
| Variance % | 13.8% | 28.2% | 26.6% | 65.9% | 14.6% |




### COMMENTARY

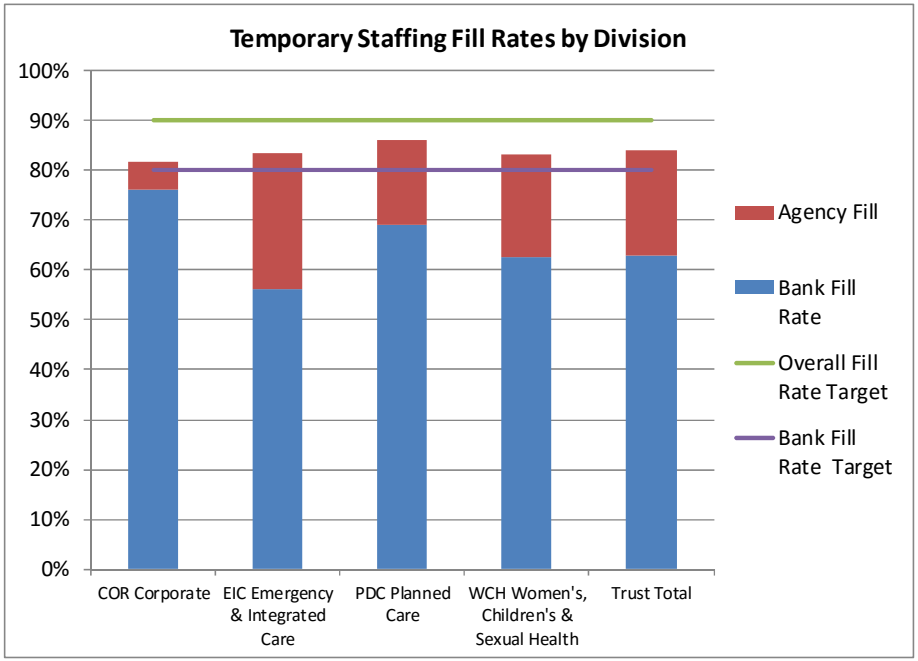
These figures show the Trust agency spend by Division compared to the spend ceilings which have been set for 17/18.

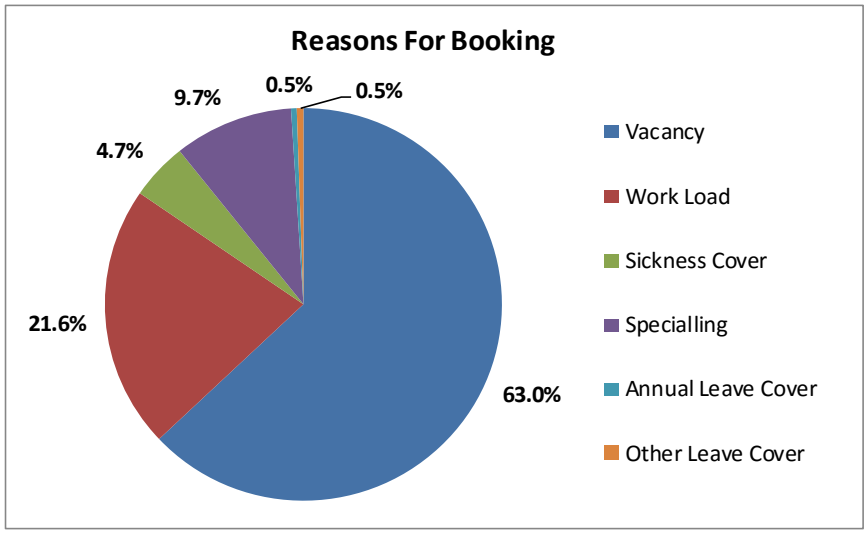
In Month 12, the Women's Children's & Sexual Health Division spent 124.3% more than the target for the month.

Overall, the only Division below it's annual target is Corporate, by 34.1%.

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

# Section 10: Temporary Staff Fill Rates




## COMMENTARY

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

The Overall Fill Rate was 84.1% this month which is a 0.9% decrease since February. The Bank Fill Rate was reported at 62.9% which is 0.8% lower than the previous month. The number of shifts requested in March was almost 2500 more than in February. The Planned Care Division is currently meeting the demand for temporary staff most effectively.

The Bank to Agency ratio for filled shifts was 75:25. The Trust target is 80:20.

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

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

| Overall Fill Rate % by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 82.8% | 72.6% | 79.9% | 81.7% | ↗ |
| EIC Emergency & Integrated Care | 86.2% | 83.8% | 85.0% | 83.5% | ↘ |
| PDC Planned Care | 85.6% | 80.7% | 87.4% | 86.1% | ↘ |
| WCH Women's, Children's & Sexual Health | 77.5% | 81.4% | 83.2% | 83.1% | ↘ |
| **Whole Trust** | **83.4%** | **81.5%** | **85.0%** | **84.1%** | ↘ |

| Bank Fill Rate % by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 79.5% | 69.9% | 76.0% | 76.2% | ↗ |
| EIC Emergency & Integrated Care | 54.6% | 55.5% | 57.3% | 56.2% | ↘ |
| PDC Planned Care | 70.5% | 64.3% | 70.6% | 69.0% | ↘ |
| WCH Women's, Children's & Sexual Health | 58.9% | 62.9% | 61.8% | 62.7% | ↗ |
| **Whole Trust** | **61.6%** | **61.2%** | **63.7%** | **62.9%** | ↘ |

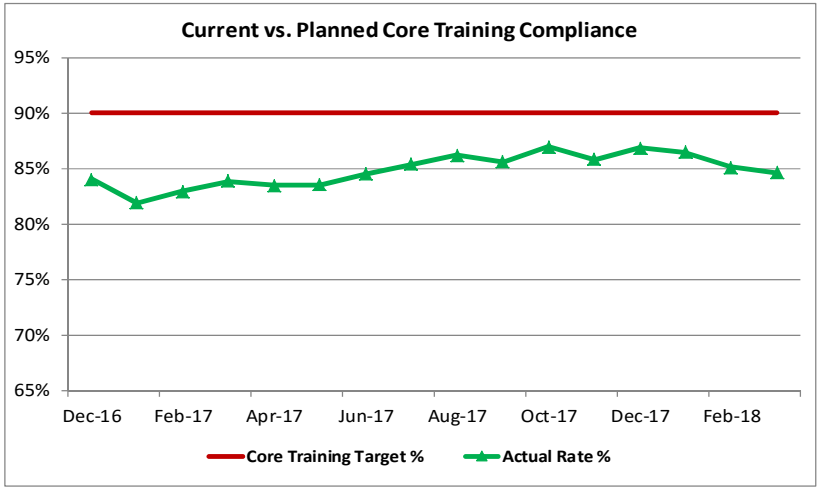
# Section 11: Core Training

| Core Training Topic | Feb '18 | Mar '18 | Trend |
|---|---|---|---|
| Basic Life Support | 81.0 | 81.0 | ↔ |
| Conflict Resolution | 82.0 | 84.0 | ↗ |
| Equality, Diversity and Human Rights | 86.0 | 87.0 | ↗ |
| Fire | 86.0 | 84.0 | ↘ |
| Health & Safety | 92.0 | 93.0 | ↗ |
| Inanimate Loads (M&H L1) | 85.0 | 83.0 | ↘ |
| Infection Control (Hand Hyg) | 87.0 | 90.0 | ↗ |
| Information Governance | 78.0 | 82.0 | ↗ |
| Patient Handling (M&H L2) | 80.0 | 67.0 | ↘ |
| Safeguarding Adults Level 1 | 90.0 | 90.0 | ↔ |
| Safeguarding Children Level 1 | 88.0 | 88.0 | ↔ |
| Safeguarding Children Level 2 | 81.0 | 73.0 | ↘ |
| Safeguarding Children Level 3 | 83.0 | 84.0 | ↗ |

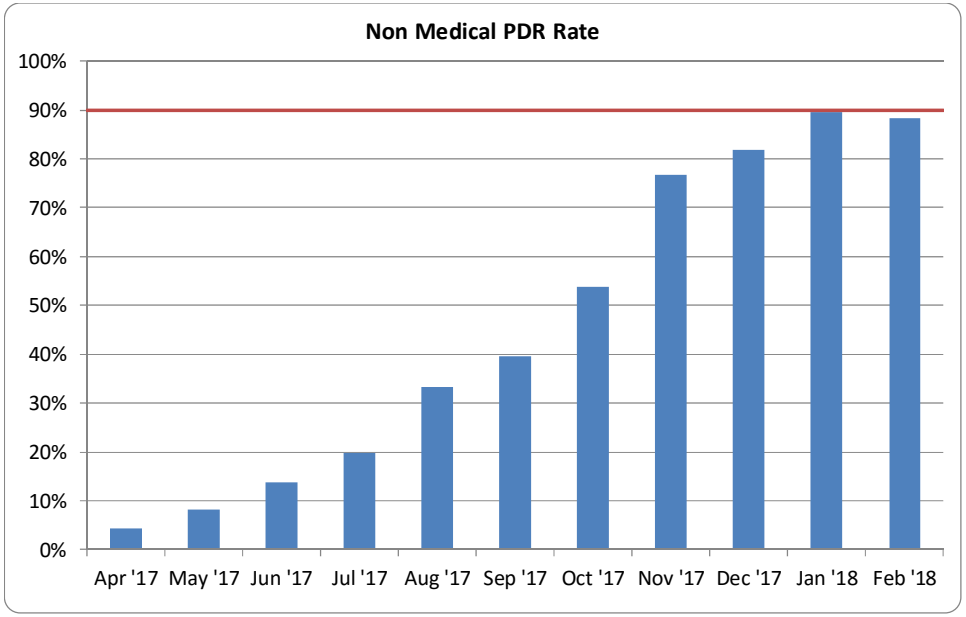
**COMMENTARY**

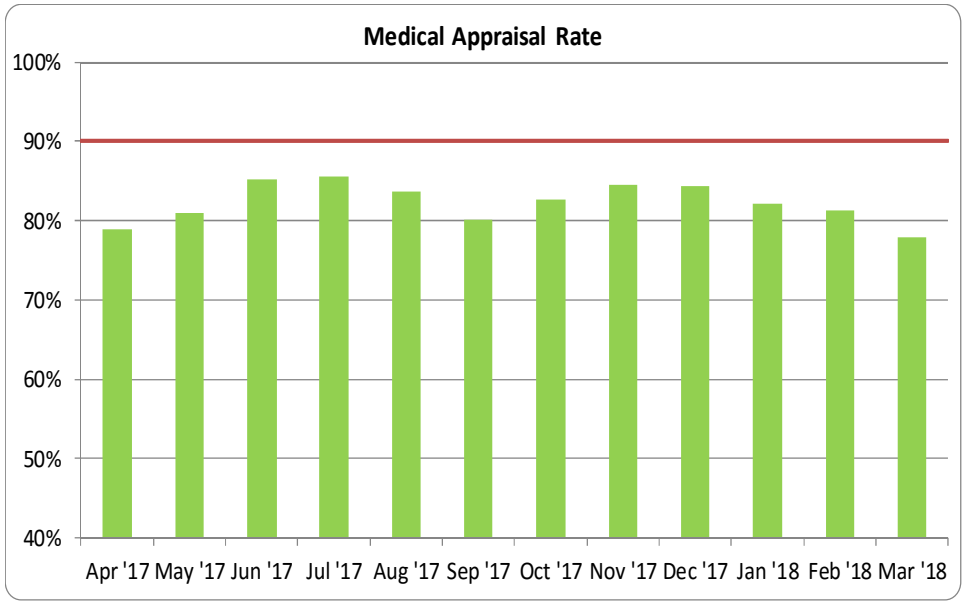
The overall Trust position is static, although there are noticeable improvements across a number of subjects. The fall in compliance for Patient Handling is as a result of consolidating the requirements for WM-based staff and bringing this into line with the Trust standard of 2-year refresher (as opposed to a "one-off" requirement which was set for all Moving & Handling at WM). A rationalisation of requirements for all the Safeguarding levels was undertaken and has impacted the Safeguarding Children Level 2 compliance; it is anticipated this will recover in the coming few months as staff awareness is raised via the new QlikView reporting platform.
A significant improvement for Information Governance has been achieved following a number of awareness-raising approaches by the IG and L&D teams. Smaller, but equally important progress has been made in other subjects.

| Core Training Compliance % by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 87.0% | 88.0% | 86.0% | 91.0% | ↗ |
| EIC Emergency & Integrated Care | 86.0% | 85.0% | 85.0% | 82.0% | ↘ |
| PDC Planned Care | 87.0% | 86.0% | 84.0% | 84.0% | ↔ |
| WCH Women's Children's & Sexual Health | 87.0% | 86.0% | 84.0% | 86.0% | ↗ |
| **Whole Trust** | **87.0%** | **86.0%** | **85.0%** | **85.0%** | ↔ |



# Section 12: Performance & Development Reviews




PDRs From April '17

| Division | Band Group | % | Division | Band Group | % |
|---|---|---|---|---|---|
| COR | Band 2-6 | 85.5% | PDC | Band 2-6 | 87.5% |
| | Band 7-8b | 94.8% | | Band 7-8b | 96.8% |
| | Band 8c + | 97.9% | | Band 8c + | 100.0% |
| **Corporate** | | **90.3%** | **PDC Planned Care** | | **88.9%** |
| EIC | Band 2-6 | 87.1% | WCH | Band 2-6 | 84.5% |
| | Band 7-8b | 95.4% | | Band 7-8b | 95.1% |
| | Band 8c + | 100.0% | | Band 8c + | 85.7% |
| **EIC Emergency & Integrated Care** | | **89.0%** | **WCH Women's, Children's & SH** | | **86.6%** |
| **Band Totals** | | | **Band 2-6** | **Band 7-8b** | **Band 8c +** |
| | | | 86.30% | 95.5% | 96.4% |
| **Trust Total** | | | **88.4%** | | |

Medical Appraisals

| Medical Appraisals by Division | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | - | - | - | - | - |
| EIC Emergency & Integrated Care | 88.6% | 88.4% | 84.1% | 89.4% | ↗ |
| PDC Planned Care | 83.3% | 76.5% | 77.3% | 72.1% | ↘ |
| WCH Women's, Children's & Sexual Health | 82.7% | 83.4% | 83.4% | 76.7% | ↘ |
| **Whole Trust** | **84.4%** | **82.1%** | **81.3%** | **77.9%** | ↘ |

## Non-Medical Commentary

From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to have had a PDR by the end of December. The PDR rate decreased by 1.2% in March and now stands at 88.4%.

## Medical Commentary

The appraisal rate for medical staff was 77.9%, 3.4% lower than last month.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.5/May/18 |
| **REPORT NAME** | Mortality Surveillance – Q4 2017/18 |
| **AUTHOR** | Alex Bolton, Safety Learning Programme Manager |
| **LEAD** | Zoe Penn, Medical Director |
| **PURPOSE** | This paper updates the Trust 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 of completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG) and reported up to the Patient Safety Group (PSG).<br><br>The Trust aims to review 80% of all mortality cases within 2 months of death. 29% of cases occurring within Q4 2017/18 have been closed, 55% of cases in Q3 have been closed.<br><br>49 cases of suboptimal care were identified between April 2017 and March 2018. 5 cases of suboptimal care have been identified in Q4 2017/18, 16 cases have been identified as occurring within Q3. 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; the timely transportation of patients between Trust sites and other organisations.<br><br>10 consecutive months of low relative risk, where the HSMR upper confidence limit fell below the national benchmark, were experienced between March 2017 and December 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 Trust Board is asked to note and comment on the report |

**Public Trust Board 3rd May 2018**
**Mortality Surveillance – Q4 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 and late fetal loss). Learning from the reviews 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 / or 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 January 2017 and December 2017 was 79.1 (74.7 – 83.6); this is below the expected range. 10 consecutive months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced between March 2017 and December 2017. This indicates a step change improvement in the relative risk of mortality within the Trust.

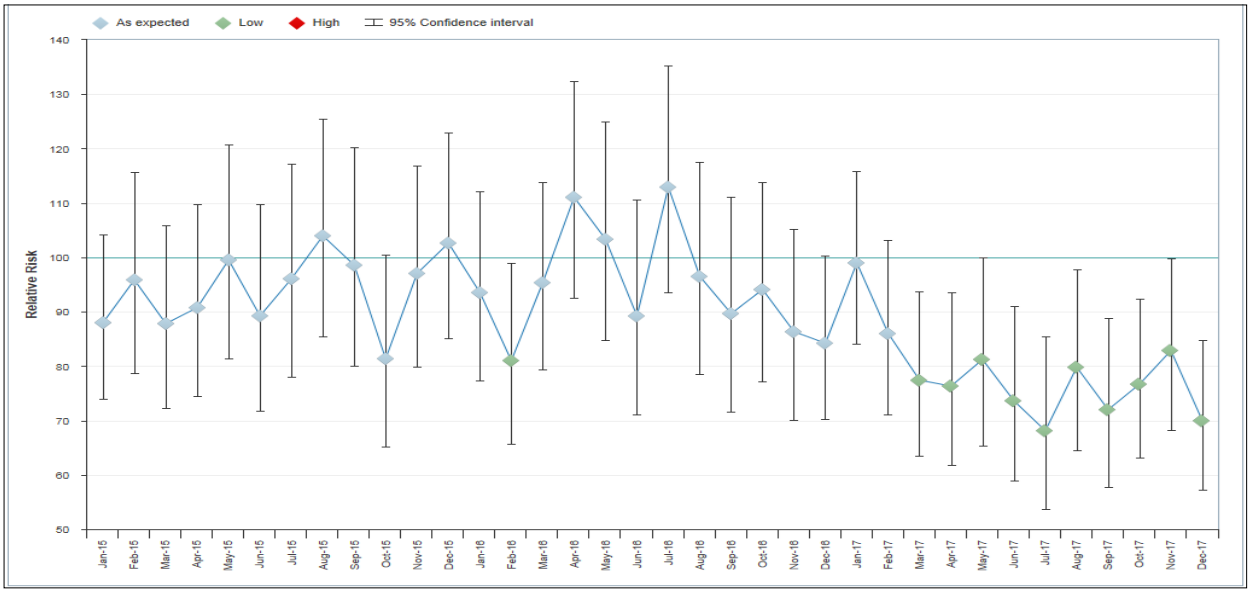



*Fig 1 – Trust HSMR 24-month trend (Jan 2014 to Dec 2017) based on a report refreshed on the 6th April 2018*

Improving relative risk of mortality has been experienced across both sites. Between January and December 2017 the overall relative risk of mortality at ChelWest was 79.1 (74.7 – 83.6) and at WestMid it was 84 (78.2-90.1); these are both below the expected range.

## 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.

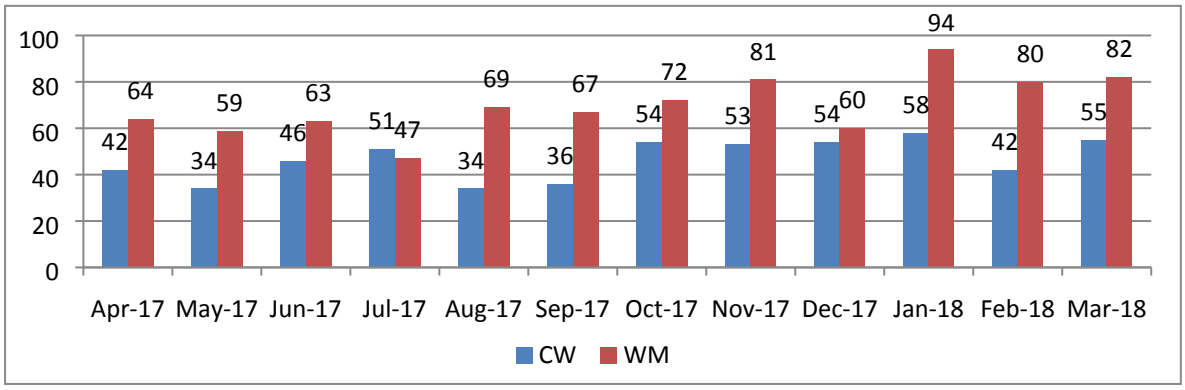



*Fig 2: Total mortality cases logged to Datix by site and month, April 2017 – March 2018*

## 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.

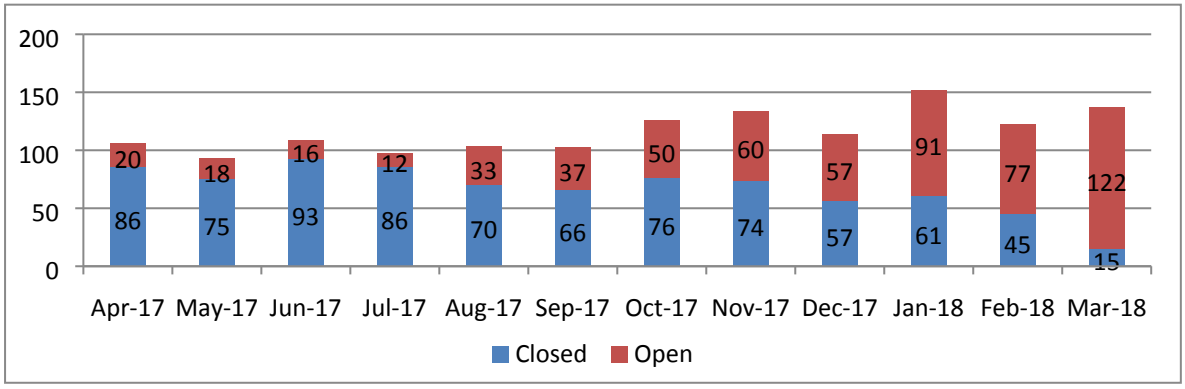



*Fig 3: Open and Closed mortality cases by month, April 2017 – March 2018*

1397 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period; of these 593 (58%) have been reviewed by the named consultant (or nominated colleague) and closed following M&M/MDT.

| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
|---|---|---|---|---|---|
| Total | 308 | 304 | 374 | 411 | **1397** |
| open | 54 | 82 | 167 | 290 | **593** |
| closed | 254 | 222 | 207 | 121 | **804** |
| % closed | **82%** | **73%** | **55%** | **29%** | **58%** |

*Table 1: Total case review completion by financial quarter, April 2017 – March 2018*

### 4.2. Closure by Division

**Emergency and Integrated Care**

| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
|---|---|---|---|---|---|
| Total | 229 | 228 | 285 | 331 | **1073** |
| open | 43 | 64 | 121 | 219 | **447** |
| closed | 186 | 164 | 164 | 112 | **626** |
| % closed | **81%** | **72%** | **58%** | **34%** | **58%** |

**Planned Care Division**

| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
|---|---|---|---|---|---|
| Total | 49 | 53 | 55 | 54 | **211** |
| open | 9 | 9 | 20 | 45 | **83** |
| closed | 40 | 44 | 35 | 9 | **128** |
| % closed | **82%** | **83%** | **64%** | **17%** | **61%** |

**Women's, Children's, HIV/GUM, Dermatology and Private Patients**

| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
|---|---|---|---|---|---|
| Total | 30 | 23 | 34 | 26 | **113** |
| open | 2 | 9 | 26 | 26 | **63** |
| closed | 28 | 14 | 8 | 0 | **50** |
| % closed | **93%** | **61%** | **24%** | **0%** | **44%** |

The reducing rate of review closure has been noted by the mortality surveillance group; the following actions to support completion and closure of cases have been introduced:

- Divisional Medical Directors supporting the engagement of clinical teams
- Divisional Mortality Review groups established within EIC
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- Bereavement midwife engaged at ChelWest to support review completion

### 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.

| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
|---|---|---|---|---|---|
| CESDI 1 | 14 | 11 | 15 | 4 | **44** |
| CESDI 2 | 3 | 0 | 1 | 1 | **5** |
| CESDI 3 | 0 | 0 | 0 | 0 | **0** |
| Total | **17** | **11** | **16** | **5** | **49** |

49 cases of suboptimal care were identified via the mortality review process between April 2017 and March 2018.

Acute Medicine and Anaesthetics / ITU are the key specialties identifying opportunities for improvement via the mortality review process; these specialties identified 33% 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
- The timely transportation of patients between Trust sites and other organisations.

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

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

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

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

## 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 steer 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. 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. Planned Care Division and Women's, Children's, HIV/GUM, Dermatology, Private Patients 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. The learning from death dashboard is included for reference in Appendix 1 (page 7).

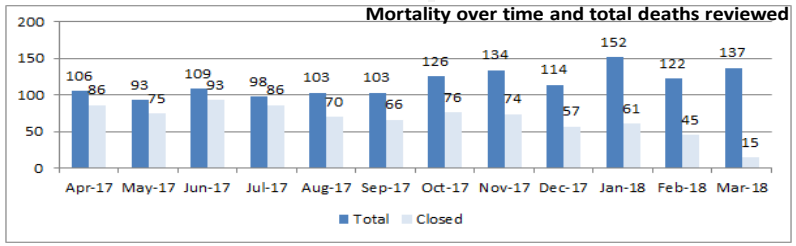
Appendix 1

## Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, April 2018

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

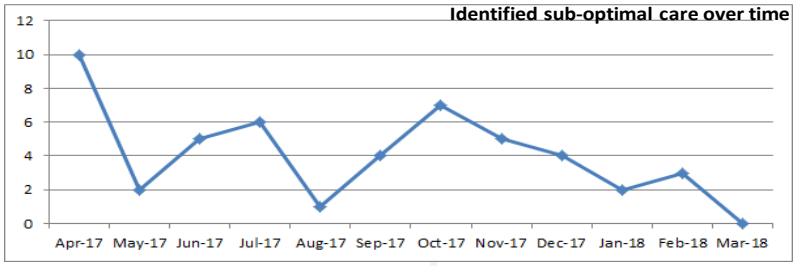
**Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care**

| Total no. of in-hospital death | | Total no. deaths reviewed | | Total Number of deaths considered to involve sub-optimal care | |
|---|---|---|---|---|---|
| Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) |
| 137 | 122 | 15 | 45 | 0 | 3 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 83 | 411 | 9 | 121 | 0 | 5 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 83 | 1397 | 9 | 804 | 0 | 49 |




**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)**

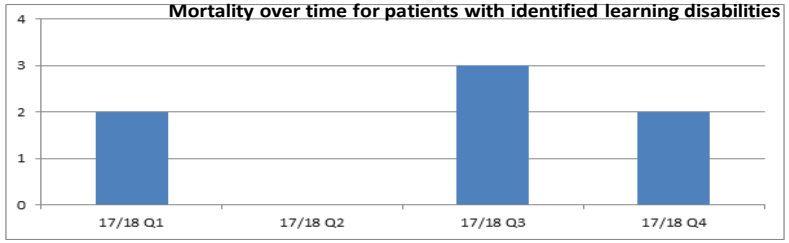
| Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome | | Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death) | | Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death) | |
|---|---|---|---|---|---|
| Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) |
| 0 | 3 | 0 | 0 | 0 | 0 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 0 | 4 | 0 | 1 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 0 | 44 | 0 | 5 | 0 | 0 |




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

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

| Total no. of in-hospital death | | Total no. deaths reviewed | | Total Number of deaths considered to involve sub-optimal care | |
|---|---|---|---|---|---|
| Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) | Last Month (March) | Previous Month (February) |
| 0 | 0 | 0 | 0 | 0 | 0 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 0 | 2 | 0 | 1 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 0 | 7 | 0 | 6 | 0 | 0 |



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO** | 3.1/May/18 |
| **REPORT NAME** | Risk Register Assurance Report |
| **AUTHOR** | Alex Bolton, Safety Learning Programme Manager |
| **LEAD** | Karl Munslow-Ong, Deputy Chief Executive |
| **PURPOSE** | To provide an overview of the risks recorded within the risk register system to support the provision of risk management assurance across all organisational activities. |
| **SUMMARY OF REPORT** | There are currently 231 live risks being managed / mitigated across the organisation, of these 2 have been identified as extreme risks:<br>• **ID3**: Growth in non-elective demand above plan<br>• **ID444**: Failure to successfully implement the new EPR system<br><br>Corporate functions / non-clinical areas currently hold the latest number of risks (35% of total); all Divisions have demonstrated risk identification (22 new risks added to the live register and 23 draft risks recorded awaiting Divisional management team discussion / confirmation to make live).<br><br>Patient Safety risks account for 31% of all live risks identified; the Divisions of Planned Care and Emergency and Integrated Care are currently identifying and managing the majority of patient safety risks (EIC 26 risks / 38% of total, PCD 25 risks / 36% of total).<br><br>The Trust's risk register system and supporting processes are under development; a pilot has been launched to support risk identification and escalation from all areas of the organisation. |
| **KEY RISKS ASSOCIATED** | Patient safety is the most commonly identified risk type.<br>Highest graded risk (extreme) relate to non-elective demand and Cerner EPR delivery. |
| **FINANCIAL IMPLICATIONS** | Financial impact relating to risk mitigation actions required |
| **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** | None |

| | |
|---|---|
| **IMPLICATIONS** | |
| **LINK TO OBJECTIVES** | Objective 1:Deliver high quality patient centred care<br>Objective 2: Be the employer of choice<br>Objective 3: Deliver better care at lower cost |
| **DECISION/ ACTION** | For information |

**Risk Register Assurance Report**

## 1.0 Introduction

The risk register is a management tool that supports the organisation recognise and respond to the risks that could, or are, affecting patients, staff or the delivery of services. Risk identification and management action is recorded within a central repository to support monitoring and analysis. Operational oversight of the register is provided by Divisional Quality Boards and supported by the committee sub-groups (Patient Safety, Health Safety Environment Risk Group). The Audit and Risk Committee and Executive Board views the most significant risks to the organisation.

This report provides an overview of the risks recorded within the Trust's risk register system; the spread of risks across operational areas and by risk grading are highlighted to support the provision of risk management assurance across all organisational activities (both clinical and non-clinical).

## 2.0 Trust Wide Risk Register

There are currently 231 live risks recorded across the organisation; non-clinical / corporate departments have logged the most risks for mitigation (35% of total). Risks are graded according to a five-by-five matrix; of the 231 risk recorded 3 have been graded as extreme.

| | Low Risk (1-3) | Moderate Risk (4-6) | High Risk (8-12) | Extreme Risk (15-25) | Total | % of Total |
|---|---|---|---|---|---|---|
| Corporate functions | 1 | 23 | 56 | 1 | 81 | **35%** |
| Emergency and Integrated Care | 3 | 18 | 40 | 1 | 62 | **27%** |
| Planned Care | 6 | 33 | 13 | 0 | 52 | **23%** |
| Women's, Children's, HIV, GUM and Dermatology | 2 | 13 | 21 | 0 | 36 | **16%** |
| Total | **12** | **87** | **130** | **2** | **231** | |

## 3.0 Extreme Risks

Extreme risks could seriously impact upon the achievement of the organisation's objectives, financial stability and reputation. Examples of these could include significant harm to patients, service loss / closure, failure to meet national targets, statutory breaches or loss of financial stability.

There are currently 2 extreme risks identified across the organisation

| ID | Lead Division | Title | Date identified | Date reviewed | Date of next review | Trend |
|---|---|---|---|---|---|---|
| 3 | EIC | Growth in non-elective demand above plan | Jun-15 | Mar-18 | Apr-18 | ↔ |
| 444 | Corp functions | Failure to successfully implement the new EPR system | Nov-17 | Apr-17 | May-18 | ↔ |

**Risk 3, Emergency and Integrated Care,**
**Growth in Non-Elective demand above plan**

**Current risk score:** Consequence 4 (Major) x Likelihood 4 (Likely) = 16 (Extreme Risk)
**Target risk score**: Consequence 3 (Moderate) x Likelihood 4 (Likely) = 12 (High Risk)
**Aim to reach target score by:** 31 May 2018

**Description:**

Multiples risks to patient quality, delivery of access standards and financial implications (STF funding) due to continued growth in non-elective demand. The Trust is continuing to utilise additional operational capacity (escalation space) in order to respond to its excess number of non-elective admissions. This has led to an increase in premium staffing, and poses the risk of a reduced quality of service and the potential cancellation of further elective procedures. There is a risk that sector-wide planned admission avoidance schemes and delayed discharge improvement schemes will not be achieved as demand for non-elective admissions has not reduced in line with predictions.

**Controls in place**

- System-wide A&E delivery boards supplemented by 2 x site specific operational boards monitoring system -wide agreed trajectories
- Trust wide LOS/Bed productivity work stream
- 'Stretch' CoE & ED/AAU specific improvement schemes for 2017/18+
- Local/daily measures: R/G, 2b412, escalation, discharge, choice policies implemented
- Site + discharge team reconfigurations
- Discharge + Mental Health improvement CQUINS
- Expanded discharge and flow team - complete from Oct 2018
- Ambulatory review both sites - pathway and hours of services being reviewed
- ECIST visit to both sites (July 2017) and report developed into action plan
- Acute frailty steering group meeting monthly
- Physical reconfiguration of both sites ED completed (Feb/Mar 2017)

**Actions to be undertaken:**

- Emergency Care Transformation Plan being implemented, including a discharge to assess model.
- On-going work with local partners to improve rates of discharge to community care providers and reduce readmission rates.
- Daily/local actions include Red/Green, 2b412, earlier escalation of MH patient delays
- Ensure over performance income offsets cost of providing bed capacity.
- Deep dive and actions into ED and CoE to provide near term progress.
- Longer term (new model hospital) paper published and workstream established under HaN.
- Expanded ambulatory offering at both sites being developed - 2018 timeline to follow.
- Site expansion plans for West Mid including additional NEL bed base and expanded RESUS.
- Winter monies bid achieved additional finance for managing NEL during 2017/18 winter - primarily aimed at West Mid schemes.

**Assurances:**

Growth in Non-Elective demand and Trust response / mitigation to be presented to the Trust Board in May 2018.

Monitoring: Executive Board, Divisional Quality Board
Management oversight: Divisional, LOS/Bed Management CIP Workstream Steering Group, Exec/Divisional bi-lateral.
Daily management: Actions implemented and tracked via bed meetings, DTOC/med optimised daily updates and weekly performance management group.

**Risk 444, Corporate functions, Clinical Systems & Information Technology**
**EPR / Cerner**

| |
|---|
| **Current risk score:** Consequence 5 (Catastrophic) x Likelihood 3 (Possible) = 15 (Extreme Risk)<br>**Target risk score**: Consequence 5 (Catastrophic) x Likelihood 2 (Unlikely) = 10 (High Risk)<br>**Aim to reach target score by:** 31 May 2018 |
| **Description:** |
| Failure to successfully implement the new EPR system (Cerner) caused by<br>• Insufficient organisational engagement<br>• Supplier fails to deliver<br>• Failure of programme deliverables<br><br>Effect:<br>• Patient administrative and clinical processes are disrupted<br>• Adverse impact on data quality<br><br>Impact:<br>• Harm to patients<br>• Inability to report on activity to commissioners<br>• Negative media coverage resulting in loss of reputation |
| **Controls in place** |
| • Cerner Programme Board is in place with Chief Operating Officer as the Senior Responsible Owner for the Programme<br>• Clearly defined criteria that have to be met before the system is taken into live operation<br>• Internal and external audit of business readiness prior to commencing live operation<br>• Delay go live until the trust and the system are fully ready<br>• Detailed plan to provide pre and post-go live support including a familiarisation and training programme for staff, floor walkers to help end users adapt to the new system etc.<br>• A set of Key Performance Indicators to track data quality and enable management action to address any emerging problems |
| **Actions to be undertaken:** |
| Regular board meetings to monitor progress. |

### 3.1 New High Impact Risks

High impact risks are graded with a consequence of major or catastrophic and have an overall risk rating of at least 12. Risks which fall into this group are presented to the Audit and Risk Committee due to the potential for them to become extreme risks.

The following high impact risks have been identified across the organisation since January 2018.

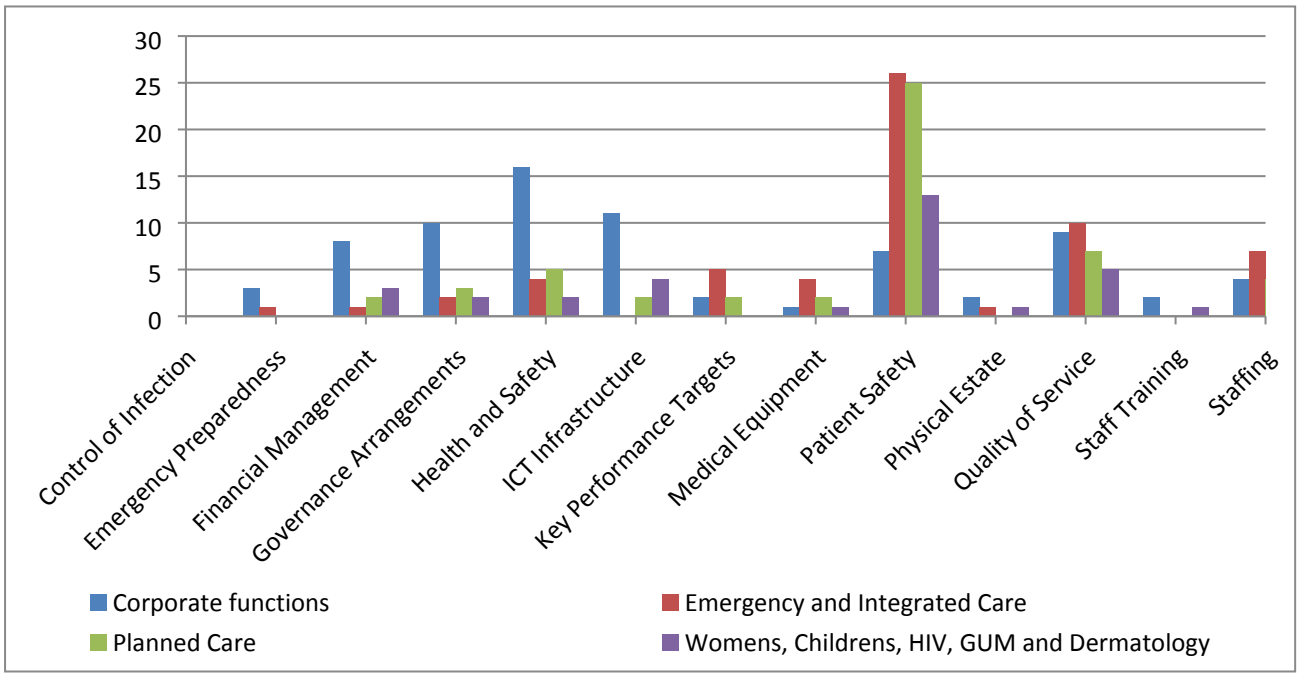
| | High Risk | Total |
|---|---|---|
| Planned Care Division | 1 | 1 |
| Total | 1 | 1 |

## 4.0 New risks

22 new risks have been added to the register since January 2018; new risks are initially reviewed within the organisations governance department prior to agreement / confirmation by the management team from the area affected. Risk identification work is being undertaken across the organisation and there are 23 draft risks awaiting management team confirmation, these draft risks will be added to the Trust's live risk register following this initial review.

## 5.0 Trends and Themes from the Trust Wide Risk Register

The charts below depict the risk type across the Divisions. Patient Safety is the largest category of risk recorded within the registers (31% of all live risks). Section 6 identifies the specialties where these patient safety risks have been identified. Scrutiny of these risks will be by the Divisional Quality Boards and supported by the Patient Safety Group.



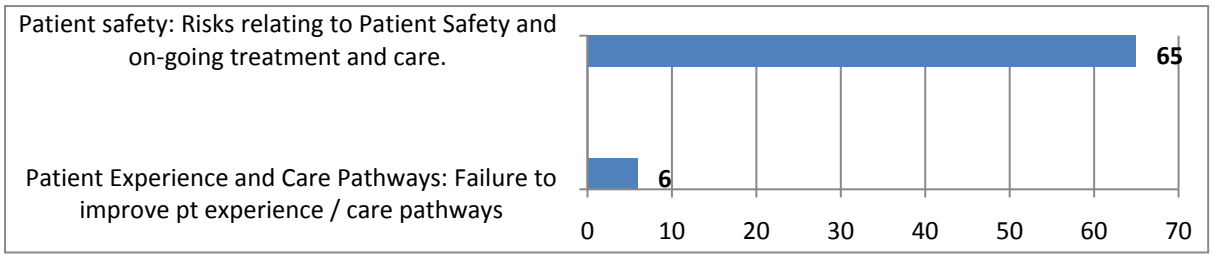

## 5.1 Patient Safety Risks

Patient Safety is the largest category of risk recorded within the register, 71 risks logged (31% of total); the following table below indicates the grading of these risks.

| | Low Risk (1-3) | Moderate Risk (4-6) | High Risk (8-12) | Extreme Risk (15-25) | Total |
|---|---|---|---|---|---|
| Corporate functions | 0 | 3 | 4 | 0 | **7** |

| | | | | | |
|---|---|---|---|---|---|
| Emergency and Integrated Care | 2 | 5 | 19 | 0 | **26** |
| Planned Care | 2 | 18 | 5 | 0 | **25** |
| Women's, Children's, HIV, GUM and Dermatology | 1 | 4 | 8 | 0 | **13** |
| **Total** | **5** | **30** | **36** | **0** | **71** |

Patient safety risks are sub-categorised as follows:




Amendment to the risk categorisation system is being developed to improve targeted analysis and review by Committee sub-groups.

### 5.2 Highest rated patient safety risks

12 patient safety risks have a current risk grading of 12 (High Risk); these are the highest rated patient safety risks recorded within the register. Management actions are overseen by Divisional Quality Boards; the Patient Safety Group will consider assurance evidence.

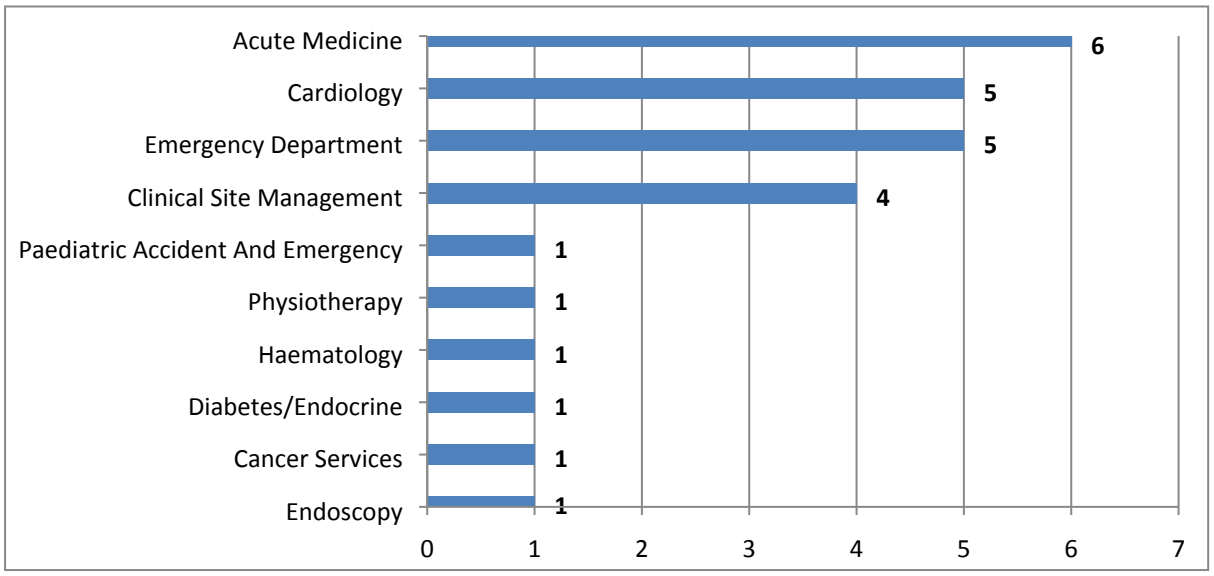
| ID | Site | Division | Title | Rating (current) | Risk level (current) |
|---|---|---|---|---|---|
| 345 | CW, COMM, WM | CORP | ADT not carried out in real time | 12 | High Risk |
| 252 | CW, COMM, WM | CORP | EPR Domain Share with Imperial Hospital | 12 | High Risk |
| 402 | WM | EIC | Lack of senior cover in the Emergency department | 12 | High Risk |
| 373 | CW | EIC | Mental Health bed provision/Violence & Aggression | 12 | High Risk |
| 449 | WM | EIC | Root cause analysis (RCA) for hospital associated venous thromboembolism (VTE) | 12 | High Risk |
| 413 | CW, WM | EIC | The safe and effective management of patients at risk of falls. | 12 | High Risk |
| 414 | CW, WM | EIC | Accurate and consistent completion of assessment of risk - Patient Risk Assessment documentation | 12 | High Risk |
| 337 | CW, WM | EIC | Hospital at Night | 12 | High Risk |

| | | | | | |
|---|---|---|---|---|---|
| 2 | CW, WM | EIC | Delayed Discharge due to lack of specialist beds and nursing homes | 12 | High Risk |
| 179 | WM | EIC | Recruitment and Retention - Nursing staff AMU WM site | 12 | High Risk |
| 489 | WM | PCD | Restricted access to Agfa historical images. | 12 | High Risk |
| 4 | CW, WM | PCD | Identification and Escalation of the Deteriorating Patient | 12 | High Risk |

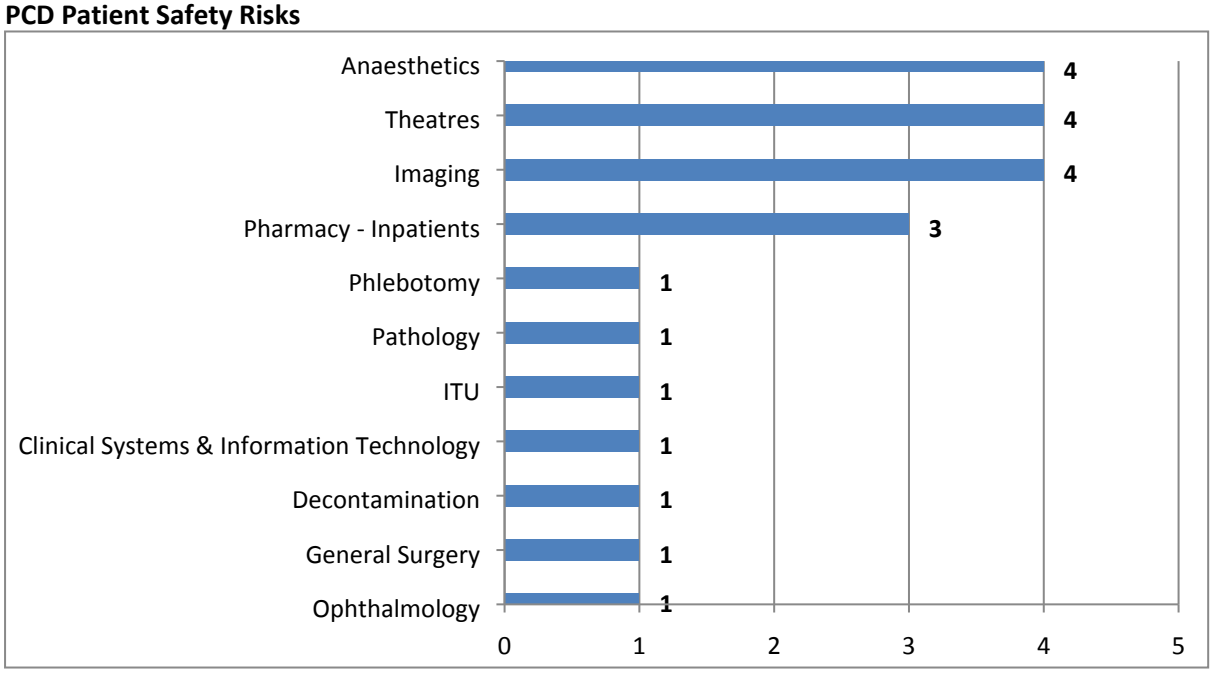
## 6.0 Patient Safety Risks by Specialty / team

The following charts indicate the specialties / teams where these patient safety risks have been identified.

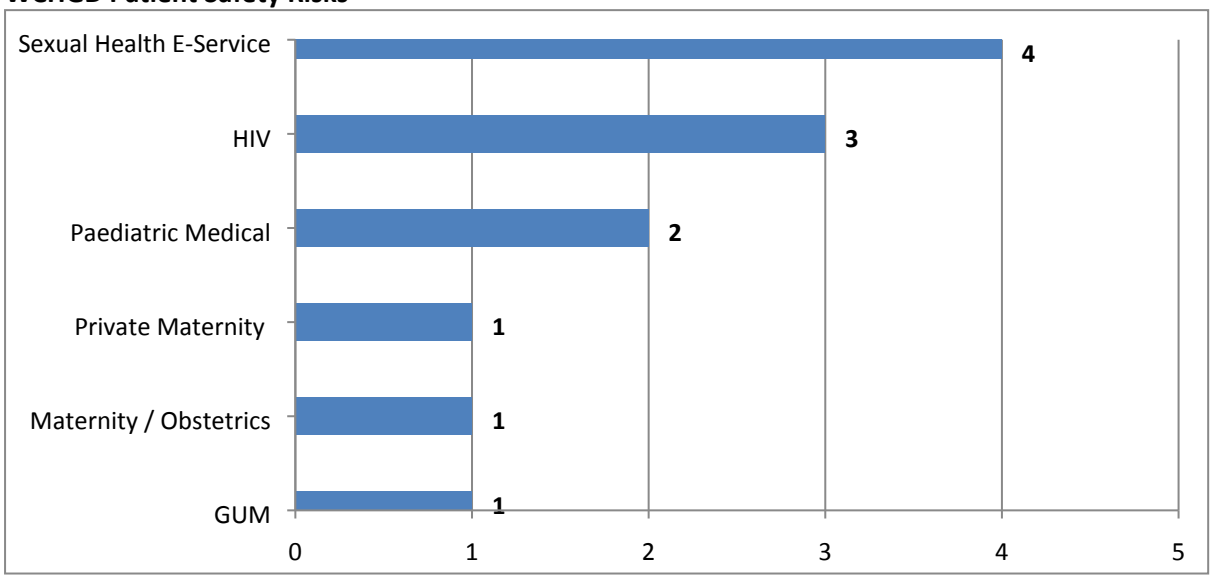
**EIC**



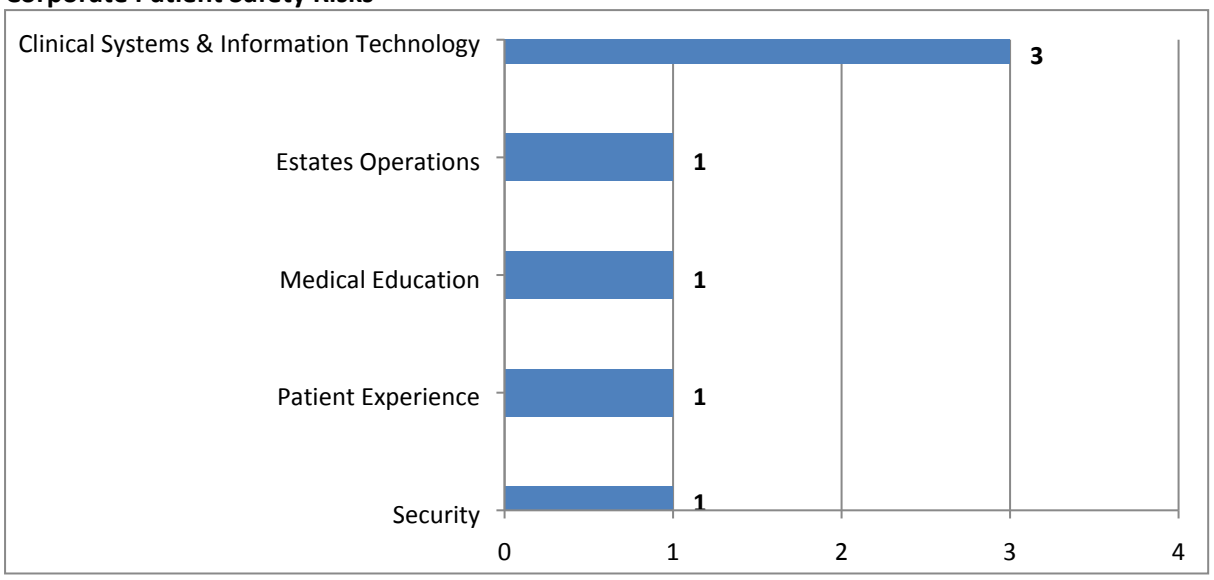

**PCD Patient Safety Risks**



**WCHGD Patient Safety Risks**




**Corporate Patient Safety Risks**




## 7.0 Risk Management Process

The risk register provides the vehicle for staff to record the specific risks affecting their area / management team; risks are scrutinised by Divisional Quality Board / risk meetings and specific risk categories are reviewed by dedicated subject groups (i.e. patient safety risks, health and safety risks)

The monitoring and management of departmental and Divisional risk registers has been reviewed and a pilot approach is being introduced to support and engage staff in the identification, review and escalation of risk.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 3 May 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 3.2/May/18 |
| **REPORT NAME** | Modern Slavery Act 2015 and Statement |
| **AUTHOR** | Harry Sarsah, Equality and Diversity Manager |
| **LEAD** | Nathan Askew, Director of Nursing |
| **PURPOSE** | The Trust is required under the Modern Slavery Act 2015 to publish on external Trust website a position statement on modern slavery. |
| **SUMMARY OF REPORT** | The Modern Slavery Act 2015 sets out specific requirements that organisations need to comply with, specifically:<br><br>**A commercial organisation needs to prepare a slavery and human trafficking statement for each financial year of operation.**<br><br>This must include<br>• The steps the organisation has taken in the financial year to ensure that slavery and human trafficking is not taking place<br>  ○ In any part of its supply chain<br>  ○ In any part of its own business<br><br>The statement should include:<br><br>a) Information about the business and its supply chain<br>b) Its policy in relation to human trafficking<br>c) Its due diligence process in relation to human trafficking in its supply chain and business<br>d) The parts of the business at risk of human trafficking and steps taken to reduce this<br>e) The effectiveness of the organisation against modern slavery and human trafficking reported against such measures which are possible<br>f) That training about human trafficking and modern slavery is available to staff<br><br>**This must be published on the website with a prominent link on the home page**<br><br>Attached is the proposed statement and a copy of the relevant section of the Modern Slavery Act 2015. |

| | |
|---|---|
| **KEY RISKS ASSOCIATED** | Legal and reputational risks of not publishing the statement |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | None |
| **EQUALITY & DIVERSITY IMPLICATIONS** | As an employer of a large diverse workforce it is essential that we are compliant with this act |
| **LINK TO OBJECTIVES** | Be the employer of choice |
| **DECISION/ ACTION** | For approval. |

**Modern Slavery Act Statement**

**Slavery and Human Trafficking Policy Statement**

**Financial year 2017-18**

## 1. Introduction

At Chelsea & Westminster NHS Foundation Trust (CWFT) we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by CWFT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

## 2. Organisational Structure

Chelsea & Westminster NHS Foundation Trust is an organisation of approximately 6,000 staff and is a major, multi--site north west London healthcare provider. It is comprised of two main teaching hospital sites consisting of Chelsea and Westminster Hospital situated in the borough of Kensington and Chelsea, and West Middlesex University Hospital, situated in Hounslow. The Trust serves a local population of 1.56 million, with combined acute admissions across both sites of 290,000 per annum. Our services reach 6 key London boroughs: Hammersmith and Fulham, Hounslow, Kensington and Chelsea, Richmond, Wandsworth and Westminster. The Trust is the largest provider of HIV and Sexual Health services in the UK and in addition to the multiple Sexual Health Clinical sites and are the lead provider for on line sexual health testing across London.

We are also leading Trust for teaching, training and research, with close links to Imperial College London and Imperial College Health Partners, as well as other Higher Education Institutions (HEI's).

Our supply chains enable the procurement of a wide range of goods and services on behalf of our clients and service users.

## 3. Our Policy on Slavery and Human Trafficking

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking to their line manager and management are expected to act upon them in accordance with our policies and procedures.

## 4. Due Diligence

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

• Undertake appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff

• Implement a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and access to training and development opportunities.

• Consult and negotiate with Trade Unions on proposed changes to employment, work organisation and contractual relations.

• Purchase most of our products from UK or EU based firms, who may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.

• Purchase a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour

• With effect from January 2017, require all suppliers to comply with the provisions of the UK Modern Slavery Act (2015), through our purchase orders and tender specifications. All of which set out our commitment to ensuring no modern slavery or human trafficking related to our business

• Uphold professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply

• Where possible and consistent with the Public Contracts Regulations, build long-standing relationships with suppliers

**5. Training**

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our Safeguarding policies and procedures and our Safeguarding Leads.

**6. Board of Directors' Approval**

This statement has been approved by the Board of Directors of CWFT, who will review and update it on an annual basis.

Further information about Chelsea & Westminster NHS Foundation Trust can be found on the following website: http://www.chelwest.nhs.uk/

Published April 2018.

# Modern Slavery Act 2015

**2015 CHAPTER 30**

## PART 6

TRANSPARENCY IN SUPPLY CHAINS ETC

### 54 Transparency in supply chains etc

(1) A commercial organisation within subsection (2) must prepare a slavery and human trafficking statement for each financial year of the organisation.

(2) A commercial organisation is within this subsection if it—

(a) supplies goods or services, and

(b) has a total turnover of not less than an amount prescribed by regulations made by the Secretary of State.

(3) For the purposes of subsection (2)(b), an organisation's total turnover is to be determined in accordance with regulations made by the Secretary of State.

(4) A slavery and human trafficking statement for a financial year is—

(a) a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place—

(i) in any of its supply chains, and

(ii) in any part of its own business, or

(b) a statement that the organisation has taken no such steps.

(5) An organisation's slavery and human trafficking statement may include information about—

(a) the organisation's structure, its business and its supply chains;

(b) its policies in relation to slavery and human trafficking;

(c) its due diligence processes in relation to slavery and human trafficking in its business and supply chains;

(d) the parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk;

(e) its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;

(f) the training about slavery and human trafficking available to its staff.

(6) A slavery and human trafficking statement—

(a) if the organisation is a body corporate other than a limited liability partnership, must be approved by the board of directors (or equivalent management body) and signed by a director (or equivalent);

(b) if the organisation is a limited liability partnership, must be approved by the members and signed by a designated member;

(c) if the organisation is a limited partnership registered under the Limited Partnerships Act 1907, must be signed by a general partner;

(d) if the organisation is any other kind of partnership, must be signed by a partner.

(7) If the organisation has a website, it must—

(a) publish the slavery and human trafficking statement on that website, and

(b) include a link to the slavery and human trafficking statement in a prominent place on that website's homepage.

(8) If the organisation does not have a website, it must provide a copy of the slavery and human trafficking statement to anyone who makes a written request for one, and must do so before the end of the period of 30 days beginning with the day on which the request is received.

(9) The Secretary of State—

(a) may issue guidance about the duties imposed on commercial organisations by this section;

(b) must publish any such guidance in a way the Secretary of State considers appropriate.

(10) The guidance may in particular include further provision about the kind of information which may be included in a slavery and human trafficking statement.

(11) The duties imposed on commercial organisations by this section are enforceable by the Secretary of State bringing civil proceedings in the High Court for an injunction or, in Scotland, for specific performance of a statutory duty under section 45 of the Court of Session Act 1988.

(12) For the purposes of this section—

"commercial organisation" means—

(a) a body corporate (wherever incorporated) which carries on a business, or part of a business, in any part of the United Kingdom, or

(b) a partnership (wherever formed) which carries on a business, or part of a business, in any part of the United Kingdom,

and for this purpose "business" includes a trade or profession;

"partnership" means—

(a) a partnership within the Partnership Act 1890,

(b) a limited partnership registered under the Limited Partnerships Act 1907, or

(c) a firm, or an entity of a similar character, formed under the law of a country outside the United Kingdom;

"slavery and human trafficking" means—

(a) conduct which constitutes an offence under any of the following—

(i) section 1, 2 or 4 of this Act,

(ii) section 1, 2 or 4 of the Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 (c. 2 (N.I.)) (equivalent offences in Northern Ireland),

(iii) section 22 of the Criminal Justice (Scotland) Act 2003 (asp 7) (traffic in prostitution etc),

(iv) section 4 of the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 (trafficking for exploitation),

(v) section 47 of the Criminal Justice and Licensing (Scotland) Act 2010 (asp 13) (slavery, servitude and forced or compulsory labour), or

(b) conduct which would constitute an offence in a part of the United Kingdom under any of those provisions if the conduct took place in that part of the United Kingdom.