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

Boardroom, Chelsea & Westminster

1 November 2018 11:00 - 1 November 2018 13:40

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Location: Boardroom, Chelsea & Westminster
Date: Thursday, 1 November 2018
Time: 11.00 – 13.40

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence Apologies received from Martin Lupton.	Verbal	Chairman
11.03	1.2	Declarations of Interest, including register of interests	Report	Chairman
11.05	1.3	Minutes of the previous meeting held on 6 September 2018	Report	Chairman
11.07	1.4	Matters arising and Board action log	Report	Chairman
11.10	1.5	Chairman's Report	Report	Chairman
11.20	1.6	Chief Executive's Report	Report	Chief Executive Officer
	2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**		
11.30	2.1	Volunteer Experience Story	Verbal	Chief Nurse
11.45	2.2	Improvement update	Report	Chief Nurse
11.55	2.3	Serious Incidents Report	Report	Chief Nurse
12.05	2.4	Integrated Performance Report including: 2.4.1 Winter Plan 2.4.2 Workforce performance report	Report Report Report	Chief Operating Officer Chief Operating Officer Chief Financial Officer
12.20	2.5	Report on volunteering	Report	Chief Nurse/Nathan Askew
12.30	2.6	Complaints update	Report	Chief Nurse/Nathan Askew
	3.0	**PEOPLE**		
12.40	3.1	Annual Workforce Equality and Diversity Report 2017/2018 (Incorporating Workforce Race Equality Standard)	Report	Chief Financial Officer
	4.0	**STRATEGY**		
12.50	4.1	EPR Programme update	Report	Chief Information Officer

	5.0	**GOVERNANCE**		
13.00	5.1	Business planning 2019/20	Report	Chief Financial Officer
13.10	5.2	Risk Register / RAF	Report	Deputy Chief Executive
13.20	5.3	Half-year report on use of the Company Seal	Report	Company Secretary
	6.0	**ITEMS FOR INFORMATION**		
13.25	6.1	Questions from members of the public	Verbal	Chairman
13.35	6.2	Any other business	Verbal	Chairman
13.40	6.3	Date of next meeting – 10 January 2019		

Board of Directors Register of Interests – updated 6 September 2018

VOTING BOARD MEMBERS	INTEREST(S)
Sir Tom Hughes-Hallett Chairman	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: HelpForce Community Ownership or part-ownership of private companies, businesses of consultancies: THH Consultancy advising the Deputy Chair of United Health Group Position of authority in a charity or voluntary body: Chair & Founder HelpForce; Chair – Advisory Council, Marshall Institute; Trustee of Westminster Abbey Foundation Connections with a voluntary or other organisation contracting for or commissioning NHS Services: Chair & Founder HelpForce Son and Daughter-in-law – NHS employees Visiting Professor at the Institute of Global Health Innovation, part of Imperial College
Nilkunj Dodhia Non-executive Director	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: Turning Points Ltd; Express Diagnostic Imaging Ltd; Express Healthcare; Macusoft Ltd (Sponsored by Imperial College London comprising incubation and access to the Data Science Institute, machine learning labs and Imperial College Healthcare NHS Trust); Ownership or part-ownership of private companies, businesses of consultancies: Turning Points Ltd; Express Diagnostic Imaging Ltd; Macusoft Ltd (Sponsored by Imperial College London comprising incubation and access to the Data Science Institute, machine learning labs and Imperial College Healthcare NHS Trust); Position of Authority in a charity or voluntary body: Independent Examiner of St. John the Baptist Parish Church, Old Malden Spouse – Senior Nurse at University College London Hospitals NHS FT
Nick Gash Non-executive Director	Trustee of CW + Charity Associate Director Interel (Public Affairs Company) Lay Advisor to HEE London and South East for medical recruitment and trainee progress Lay member North West London Advisory Panel for National Clinical Excellence Awards Spouse - Member of Parliament for the Brentford and Isleworth Constituency

Stephen Gill Non-executive Director	Owner of private company: S&PG Consulting Positions of authority in a charity or voluntary body: Chair of Trustees; Age Concern Windsor Shareholder: HP Inc; HP Enterprise; DXC Services; Microfocus Plc
Eliza Hermann Non-executive Director	Positions of authority in a charity or voluntary body: Board Trustee: Campaign to Protect Rural England – Hertfordshire Branch (2013 – present) Committee Member, Friends of the Hertfordshire Way (2013 – present) Close personal friend – Chairman on Central & North West London NHS Foundation Trust
Jeremy Jensen Non-executive Director	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: Stemcor Global Holding Limited; Frigoglass S.A.I.C Ownership or part-ownership of private companies, businesses or consultancies: JMJM Jensen Consulting Connections with a voluntary or other organisation contracting for or commissioning NHS services: Member of Marie Curie (Care and Support Through Terminal Illness)
Dr Andrew Jones Non-executive Director	Directorships held in the following: Ramsay Health Care (UK) Limited (6043039) Ramsay Health Care Holdings UK Limited (4162803) Ramsay Health Care UK Finance Limited (07740824) Ramsay Health Care UK Operations Limited (1532937) Ramsay Diagnostics UK Limited (4464225) Independent British Healthcare (Doncaster) Limited (3043168) Ramsay UK Properties Limited (6480419) Ramsay Global Sourcing Limited (11316940) Ramsay Health Care (UK) N0.1 Limited (11316318) Linear Healthcare UK Limited (9299681) Ramsay Health Care Leasing UK Limited (Guernsey) (39556) Ownership or part-ownership of private companies, businesses or consultancies: A&T Property Management Ltd Additional employment: Chief Executive Officer of Ramsay Health Care UK Other relevant interests: Board member NHS Partners Network

Liz Shanahan Non-executive Director	Owner of Santé Healthcare Consulting Limited Shareholder in: GlaxoSmithKline PLC, Celgene, Gilead, Exploristics, Official Community, Park & Bridge, Captive Health, some of whom have an interest in NHS contracts/work
Lesley Watts Chief Executive Officer	Trustee of CW + Charity Husband — consultant cardiology at Luton and Dunstable hospital Daughter – member of staff at Chelsea Westminster Hospital Son – Director of MTC building constructor
Sandra Easton Chief Financial Officer	Sphere (Systems Powering Healthcare) Director representing the Trust Treasurer — Dartford Gymnastics Club Chair — HfMA Sustainability
Robert Hodgkiss Chief Operating Officer	No interests to declare
Karl Munslow-Ong Deputy Chief Executive	Director of North West London Pathology (an arms-length organisation, owned by three partner Trusts) Director of Imperial College Health Partners Wife – GP Partner, Springfield Health Centre, Stamford Hill N16 6LD
Pippa Nightingale Chief Nurse	Trustee in Rennie Grove Hospice CQC specialist advisor Specialist advisor PSO
Zoë Penn Medical Director	Trustee of CW + Charity Daughter – employed by the Trust Member of the Independent Reconfiguration Panel, Department of Health (examines and makes recommendations to the Secretary of State for Health on proposed reconfiguration of NHS services in England, Wales and Northern Ireland)
Kevin Jarrold Chief information Officer	CWHFT representative on the SPHERE board Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust

Martin Lupton Honorary NED, Imperial College London	Employee, Imperial College London
Dr Roger Chinn Deputy Medical Director	Private consultant radiology practice is conducted in partnership with spouse. Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)
Gillian Holmes Director of Communications	None.
Julie Myers Company Secretary	Trustee, Cambridge House Fellow, Royal Society of Arts Member, Chartered Institute of Trading Standards

Minutes of the Board of Directors (Public Session)
Held at 11.00 on 6 September 2018, Meeting Room A, West Middlesex

Present:	Sir Tom Hughes-Hallett	Chairman	(THH)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Sandra Easton	Chief Financial Officer	(SE)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Non-Executive Director	(SG)
	Rob Hodgkiss	Chief Operating Officer	(RH)
	Andy Jones	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)
	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)
	Martin Lupton	Imperial College	(ML)
	Julie Myers	Company Secretary	(JM)
	Renuka Jeyarajah-Dent	NExT Director	(RJD)
	Professor Mark Johnson	Director of Research and Development	(MJ)
	Tom Ridgeway	Public View	(TR)
	Vanessa Sloane	Director of Nursing (WM)	(VS)
	Vida Djelic	Board Governance Manager	(VD)
	Dr Louise Robinson	Palliative Care Consultant	(LR)
	Jacquei Scott	Palliative Care Nurse	(JS)
	Natasha Jobz	Occupational Therapist	(NJ)

1.0	GENERAL BUSINESS
1.1	**Welcome and apologies for absence** THH welcomed members and those in attendance to the meeting. Apologies had been received from Eliza Hermann. She had provided written comments on papers to the Chairman and these would be reflected in discussion.
1.2	**Declarations of interest** THH reminded the Board that he was Executive Chairman, of the charity Helpforce. He reported that Helpforce was in receipt of a £2.5million grant from NHS England, as it was now the official volunteering partner of NHSE. Helpforce would be opening a tender to award grant funding and, as this represented a conflict, THH would recuse himself from any aspect of a bid by this Trust to Helpforce.
1.3	**Minutes of the previous meeting held on 5 July 2018**

	The minutes of the previous meeting were approved as a true and accurate record of the meeting.
1.4	**Matters arising and Board action log** Meeting 05.07.2018 Action 2.2 – PN confirmed that she was working closely with GH to develop the compelling narrative for the Improvement Programme. Action 2.2 – the Company Secretary confirmed that a schedule of meetings for 2019 had been prepared and would be distributed in week beginning 10 September 2018. **Action: VD to circulate schedule of meetings**. **Action: JM/VD to ensure that there is a rolling 12 month meeting programme always in place.** **North West London Pathology (NWLP) update** KMO advised the Board that there had been a number of issues with the service received from NWLP primarily due to IT system changes. Meetings had been held with NWLP to discuss incidents, how to resolve them and future service provision. The Trust had seen a steady improvement in service quality and a reduction in new incidents. A close watch was being kept on service provision, particularly as there was a need to go live with new IT requirements at West Middlesex and it was important that NWLP was able to keep pace. Dialogue was also taking place between the three owner Trusts (Chelsea and Westminster, Imperial College Healthcare NHS Trust and Hillingdon Hospitals NHS Foundation Trust) about the service, an update on which would be provided to the Finance and Investment Committee (FIC) of this Trust in November 2018. LW added that it was inevitable that development of joint ventures such as this would throw up challenging scenarios. It was important to make sure learning was spread across the NHS and to be robust in discussion.
1.5	**Chairman's Report** THH asked attendees to note the nomination of LW for the Health Service Journal's 'Chief Executive Officer of the year' award. The Chairman's report was noted.
1.6	**Chief Executive's Report** The CEO opened her report by noting that, whilst it had been the busiest summer ever, performance had remained good, which was due to the enormous efforts of staff. She highlighted the following items from her written report: - the decision to introduce a fourth division into the Trust's structure which will co-locate clinical support services under a single Divisional leadership structure to provide greater focus and support; - the great pleasure given by the large number of nominations made for the 2018 staff awards; - the great progress being made by the Trust in integrating volunteers into its operations. She stressed the importance of the whole organisation needing to really appreciate the value volunteers can add; - the Trust's new strategic partnership with Sensyne Health;

	- the ongoing work with Imperial College, Imperial College Healthcare Trust and other sector partners to develop an alternative proposal to the move of Royal Brompton's services from the Fulham Road; and - the bid by North West London for funding for one of 13 Collaboration for Leadership in Applied Health Research and Care (CLAHRC) initiatives. The CEO also reported that the Trust had recently hosted the new Secretary of State for Health and Social Care, Matt Hancock, who had visited for a night shift. He had referred to his visit, and the Trust, in very positive terms in a piece in the Daily Telegraph. She advised that the November CEO report would include an update on developments in the STP. In response to a question from JJ, ZP confirmed that the Operations and Oversight Group referred to in relation to the new Sensyne Health partnership would not just be for the Sensyne arrangement. The Board thanked LW for her report, welcoming in particular the report on the RM Partners arrangements, the Cancer Alliance for West London.
2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**
2.1	**Patient experience story** PN welcomed members of the family of Antonia, a patient who had received palliative care at the end of her life from the Trust. They also welcomed Dr Louise Robinson, Palliative Care Consultant, Jacquei Scott, Palliative Care Nurse, and Natasha Jobz, Occupational Therapist to the meeting. Collectively they told the story of Antonia and how the Trust had provided her palliative care at the end of her life. The team stressed the importance of finding 'the person in the patient' so that they could provide individualised care. They noted that, often, by the time a patient reached the stage of palliative care, they would have had many conversations about what was no longer possible; the real challenge was therefore to change the language to focus on the positive improvements that could be delivered by understanding the person's physical, spiritual, social and emotional needs. This approach had enabled Antonia to pursue her love of music whilst in the Trust's care, and to receive bedside therapies from the Mulberry Centre. Occupational therapy support had focused on how best to support Antonia's meaningful occupations and how best to maintain those. This included setting goals: playing the piano; singing; and going outside. All of these had been achieved and the team played a moving video of Antonia, recorded before her death. This focus on Antonia as a 'whole person' had been a truly multi-disciplinary approach. Antonia's sister, Gillian, spoke movingly to the Board about Antonia's time with the Trust which had included lengthy stays at West Middlesex Hospital. She told the Board that Antonia had been an opera singer, and a Graduate of the Royal Academy of Music. The family had been really impressed by the care and support provided by the Trust to Antonia and her family. That two members of the team had attended Antonia's funeral had really meant a lot. On behalf of the family, the Trust was thanked for the care and support that had been provided. The Board thanked Gillian and her family for sharing Antonia's story, and the team for their presentation.
2.2	**Freedom to speak up (FTSU) report and self-assessment**

	NG introduced the report explaining that the Board was required to complete a self-review of leadership and governance arrangements in relation to FTSU and identify if there are areas where improvements need to be made. He also highlighted the first annual report to the Board of FTSU activity. The Report did not show any meaningful trends as the instances of reporting were small in number. NG advised that he would complete a first draft of the self-review tool with PN and Vanessa Sloane, Director of Nursing and FTSU Guardian which would then be shared with the Board for comment and agreement. He stressed the importance of being honest about how well, or otherwise, the Trust was doing in this regard. In this regard, the words 'freedom to' were unhelpful, it was important that staff understand that there is absolute encouragement to speak up, and that it is welcomed. In response to a question from JJ, VS advised that the number of cases were small and were dispersed across the Trust. Whilst some may have raised specific issues for specific areas, they did not necessarily reveal lessons from the whole organisation. She observed that the number of whistleblowing reports to the Care Quality Commission (CQC) had decreased and that she had been approached by staff in all areas and at all levels. SG noted that the People and Organisation Development Committee (PODC) had discussed FTSU and were interested to know if there was a 'typical' reporting level. VS advised that a quarterly report was issued by the National Guardian's Office and that, compared to other Trusts of this size, our numbers were around the median. She confirmed that all of the cases were different. The Board discussed the numbers of staff reporting that they knew where to raise concerns within the Trust, acknowledging that this might also include reporting to line managers and HR. The Board also discussed whether there were any examples of where colleagues had suffered harm as a consequence of speaking up, noting that issues were often complex and multi-faceted. NG advised that he was not aware of any such examples. LW added that, conversely, there were a number of examples where the Trust could point to firm action that had been taken as a consequence of a FTSU report, although these could rarely be discussed because of the personal nature of the cases. LW confirmed that the subject would form part of a future team brief, to remind staff that they are encouraged to report anything that 'doesn't feel right' and that issues are often easier to resolve when they are not raised anonymously. NG agreed and suggested that in 12 months, it would be great if it were to be possible to report a FTSU story to the Public Board in the same way as Patient stories.
2.3	**Patient Voices** PN presented the paper noting that the Trust had found that a single Patient Voices Committee had not been as successful as hoped for and that a much better way of engaging with patients was on a subject specific basis. These would be explored more going forward, building on the success of a number of co-design workshops and the 'whose shoes?' workshops, the last of which had been attended by 46 people. LW stressed the importance of commitment to this work. ML advised the Board that Imperial College had been working with Citizens UK, a body with a large membership, which was successful in engaging with a broad spectrum of the public and equipping them with skills. This had proved very successful. The Chairman reported that EH had provided comment that good progress was being made in

	relation to patient experience and there was great candour about where things were not working well. THH thanked PN for the frank paper and encouraged close working with the Director of Communications to ensure links were made between this work and the Membership.
2.4	**Improvement Programme** The Board welcomed the new Clinical Fellows who were in attendance as observers to the Trust. PN outlined progress against the Trust's Improvement Programme as detailed in the paper. This included financial improvement and quality improvement and progress against the Trust's Care Quality Commission (CQC) action plan. She noted that the team was currently exploring how to put a monetary value on quality improvement work. AJ confirmed that the Quality Committee (QC) had assurance on quality improvement continually on its agenda and that it was a clear priority. LW stressed that quality improvement was not solely about safety but about realising efficiencies. In her absence, THH noted that EH had commented that good progress was being made on all five quality priorities but that the QC wanted to see more progress reducing in-hospital falls. In response to a question from SG, SE confirmed that the Executive had significant confidence that the CIP target would be delivered and that mitigating actions had been identified should they be needed.
2.5	**Serious Incidents report** PN introduced the paper noting that there had been an increased in the number of incidents from June to July but that overall numbers were still lower than at this point last year. She confirmed that, whilst there were a higher number of incidents at West Middlesex Hospital than at Chelsea and Westminster Hospital, a review had not identified any trends. A review was currently being undertaken into diagnostic delay incidents which was the largest number of reported incidents. In response to a question from RJD, PN advised that the Trust was seeing increasing numbers of challenging mental health cases, with patients having to stay longer in the Trust as they waited for specialist beds to become free elsewhere. NG advised the Board that the QC was looking at reporting levels as it was a concern of the Commissioners that this Trust's reporting levels were lower than that of others. He noted that the Committee had also reviewed a paper on medicine incidents at its most recent meeting. The Board noted the report and was pleased to see the reduction in pressure ulcers was being maintained.
2.6	**Integrated Performance Report (IPR)** **Operational performance**. RH introduced Tom Ridgeway founder of Public View Ltd to the Board, whose services provided a new and informative way of benchmarking Trust performance against that of others, beyond statutory measures. There was interest from across the sector as to how the

	NHS might adopt the methodology. TR explained that Public View Ltd provides a performance benchmarking tool which gathers all publically available data sets and aggregates into a single dashboard. He took the Board through a presentation of how the Trust's data looks from the outside when all publically available data was collated using the Public View tool. The algorithm created a Hospital Combined Performance Score (HCPS), which was calculated based on the principles used in scoring the decathlon and correlated to the ten main metrics used by the CQC. The Trust was one of only three Trusts to be compliant against all three access standards: A&E four hour waits; cancer; and 18 week wait. The scoring mechanism showed that he Trust was in the 100th centile and was a great all-rounder. The Board noted in particular that every CQC 'outstanding'-rated Trust had a lower HCPS than Chelsea and Westminster, and that 12 months ago, the Trust scored 5th in the country and was now first with increases on all metrics. The HCPS correlated to CQC ratings in that: good equated to a HCPS of circa 7000; and outstanding to circa 8300. Chelsea and Westminster's current HCPS was 9500. TR explained that the mismatch could be accounted for because the HCPS only looked at quantitative data whereas the CQC also considered qualitative factors. As such, whilst there was a correlation, there was not necessarily a match. Public View was talking to CQC about how to use the HCPS as part of its monitoring regime. The Board discussed the following points: • the Trust performed least well on: outpatient 'did not attend' rates; Friends and Family Test; complaints; and hip fracture best practice tariff; • the imperative of focusing on how it 'feels' to be a patient here as well as providing the best and safest care. It would be important for the Trust to improve the way it collects data in these areas to be able to understand and demonstrate its levels of customer service. The value volunteers can add to this was noted as was the need to make sure communications, membership and 'patient voices' worked well together. This would all help to shape the Trust's improvement journey. The Chairman thanked TR for attending the Board and demonstrating that the Trust was currently not only the number one performing Trust, but also the second most improved. The methodology was really valuable in showing the Board where it would need to focus in the coming 12 months. It was suggested that a further session may be held at a point in the future once the methodology had been refined. **Action: Add session on Public View data to future Board strategy session.** The Board noted the Integrated Performance Report and the Workforce Performance Report.
2.7	**Mortality Surveillance Q1 report** NG advised the Board that the QC had reviewed the quality aspects of the mortality surveillance report in detail at its recent meeting. ZP introduced the paper explaining the positive news that mortality statistics continue to fall. Data had been reviewed by detail, including by day of the week, and no issues had been identified. The primary theme was the response to the deteriorating patient, which linked to escalation of care plans. The Trust's mortality review process was linked into the process recommended by the Royal College of Physicians and was well-ahead of most hospitals.

	ZP updated the Board on the introduction of Medical Examiners (ME). The current expectation was the Trust would host five of these, and that they would be based in the Bereavement Office. MEs would look at all deaths. The policy was in discussion and consultation stage and the Department of Health and Social Care were keen to progress. Current thinking on funding was that they would be funded by fees from cremations. SG asked if the Trust understood why it was below ie better than, the national benchmark. ZP said that this was not wholly clear but was inevitably linked to the Trust's aim to get care right the first time and its all-round approach to performance. NG noted that QC had recognised that the HSMR may hide issues by specialism and these would be kept under close watch; there were no issues at present. AJ commended the executive on the mature approach in place to these reviews. The Board noted the report which they agreed showed results to be proud of.
2.8	**Health and safety – six month report** KMO introduced the report which provided the Board with an assurance report on health and safety within the Trust. AJ commented that there had been considerable focus on health and safety over the past 18 months and that processes were much better. The challenge now was to maintain performance and ensure the improvements became business as usual. In response to a question, KMO confirmed that both hospital sites had appropriate Fire Safety Officer cover arrangements in place. The CEO added that, in addition, there was always a Director On Call and a Gold Command on site. RH added that site teams were fully trained and provided 24 hour cover. The Board noted the report.
3.0	**STRATEGY**
3.1	**Research strategy** The Board welcomed Professor Mark Johnson, Director of Research and Development to the meeting. MJ presented the Trust's proposed research strategy focusing on three areas: • the benefits of research to the Trust in which he highlighted the impact that being an inquisitive organisation could have on healthcare, noting in particular the Trust's world-class work in HIV and sexual health; • the relationship with Imperial College, which had indicated that it would support the Trust's approach, not by providing direct funding, but by increasing the number of academics available and helping to develop donor relationships; • the importance of focus to ensure research and innovation stayed at the front of the Trust's priorities. ZP continued, referencing the work undertaken at the Board's June strategy away day, where it had been agreed that the Board would search for excellence in all areas based on research. This would also form the basis of the refreshed clinical services strategy. The mantra needed to be 'bench to

	bed': how to get the outcomes of research delivered to patients. In response to a question from SG, MJ explained that the next steps were to complete a research baseline assessment, which would lead to a proposal. ZP added that this would establish the 'ask'; where are we now and where do we want to be. Different specialisms would have different asks. JJ added that this would also need to be factored into the capital programme. The CEO noted that all of this work linked to the Trust's overall strategy but that more work was needed to identify where to focus, revenue streams and costs. Positive first steps were being taken. ML noted: the importance of cultural change; the need to focus on one area, to get it right and then expand; his support for an approach that focused on a single area initially; and the imperative to work closely with Imperial College, which is the fourth best faculty in the world. The Chairman echoed this last point firmly and welcomed the news of the College's willingness to work with the Trust. The Chairman noted the Board's view that research has to be at the heart of the Board's strategy. He urged the executive to focus on a small number of key areas, not everything that might be possible, making clear that these areas had to align with the overall strategy for the Trust. With regard to budget, the Chairman noted that the current budget would be unlikely to support the Board's research ambitions. Funding was unlikely to come from the CCGs and so new revenue streams would need to be identified; the role of CW+ was therefore crucial to the success of the research strategy. Thanks were extended to CC for the advice he had already provided in this regard. In concluding the discussion, the following points were noted: • the need to make links between this work, what had been learned earlier in the meeting from Public View and the interests of the new Secretary of State in innovation – could this Trust be a test-bed? • The importance of making sure governance arrangements were fit for purpose, in particular around new and innovative joint venture arrangements. This would be considered by the Audit and Risk Committee; • The need to maintain frequent contact with Imperial College. The Board endorsed the research strategy. **Action: Research gap analysis and proposal to be presented to Finance and Investment Committee before returning to the Board in circa six months.**
4.0	**GOVERNANCE and RISK**
4.1	**EPR and Digital Transformation Board update (including Board governance)** RH advised that the Trust was now 18 weeks past go-live at West Middlesex. Overall the deployment had gone well. Close working with NHS Improvement was taking place to remedy the deployment's impact on PTLs. He commended the team's hard work and commitment to maintaining performance levels. KJ advised the Board that EY had recently undertaken a Gateway 6 review of the programme. The outcome of this had been discussed in detail with SG and ND for the Board, with EY present. This

	review had concluded with a status of amber. Key risks identified related to: income, where the establishment of a block contract with Commissioners was mitigating the impact; outpatient performance; and workflow. To provide some context, KJ noted that when deployment had taken place at ICHT, the gateway six review had taken place at 10 months. ND confirmed that he and SG had considered the Review in detail. He noted that the amount of progress that had been made was encouraging. Migration had been successful and the main issue now was about delivering the benefits of transformation. It would be important to: • Manage staff expectations around functionality; • Ensure the right decision was made about timing of coming off the block contract – the risks of staying versus exiting had to be understood and balanced. With regard to the contracting position, RH confirmed that this would be subject to detailed discussions with the Chief Financial Officer. LW made three points: • That there would need to be a very strong case made for the Trust to stay on the block contract • The need to learn all it was possible to learn from the West Middlesex implementation before commencing at Chelsea and Westminster • The need to make sure the differences in culture between the two sites was addressed by the Chelsea implementation programme. In response to a question from SG, RH explained that the issue attached to the PTL was that there had always been a known risk that the implementation might lead to an artificial increase in the PTL. Pre-implementation, the PTL was 15,500. Post-implementation it was 20,500. It had been expected to rise to 17,500. Recent work had reduced this significantly and the Trust was working with NHSI to make sure this was done safely and transparently. With regard to Board governance for the EPR programme and the Trust's digital programme more generally, the Board agreed that ND and SG should continue to act as Board leads on the EPR programme, reviewing progress and offering advice. ND would be the primary Board lead for these matters and FIC would remain the primary Board Committee for these matters. The Board noted the update on the EPR programme and the outcome of the Gateway Six review.
4.2	**Capital programme update** SE introduced the paper which provided the Board with an overview of the Trust's capital programme. The Board noted the report.
5.0	**ITEMS FOR INFORMATION**
5.1	**Questions from members of the public** There were none.
5.2	**Any other business** There was none.

5.3	**Date of next meeting** – 1 November 2018

Meeting closed at 13.32

Trust Board Public – 6 September 2018 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
06.09.18	1.4	Matters arising – schedule of meetings	Action: VD to circulate schedule of meetings.	VD	Complete.
			Action: JM/VD to ensure that there is a rolling 12 month meeting programme always in place.	JM/VD	Noted.
	2.6	Operational performance	Action: Add session on Public View data to future Board strategy session.	JM	This is on forward plan for the February Board Strategy.
	3.1	Research strategy	Action: Research gap analysis and proposal to be presented to Finance and Investment Committee before returning to the Board in circa six months.	ZP/SE	This is on the forward plan for January FIC and March Board.
05.07.18	1.4	Patient voice	Action: The Board requested that information on what the Trust is learning from 'patient voices' is reported in addition to a patient experience story at the September Board, not instead of. Action: VD to amend action log and forward plan.	VD	Complete.
		Communications strategy	Implementation of the communications strategy to be reviewed by PODC and an update to report to return to the Board. Action: VD to add to PODC and Board forward plan.	VD	Update provided to July PODC and is scheduled for January Board.
	2.4.1	Workforce performance report	Action: Deep dive into staff turnover to be scheduled for discussion at a future Board strategy session.	SE/PN	This is on forward plan for the June Board Strategy.
	3.1	Gender pay	Action: Update on actions on gender pay to return to the Board in the Autumn, after PODC	SE/VD	This is on forward plan for the May Board.

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
			consideration, and then in six months.		
	2.2.1	Workforce performance report	Action: Equality data for qualified nurses and midwives promotion, and access to training, to be reviewed by PODC and a report brought to the Board in six months.	SE	The Workforce performance report has been revamped. The suggested amendments will now be included in the operational report used by the executive.
			Action: Staff career development tables to also include breakdown by gender.	SE	The Workforce performance report has been revamped. The suggested amendments will now be included in the operational report used by the executive.
		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, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	1.5/Nov/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. 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.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chairman's Report
November 2018

1.0 NED succession planning

The Council of Governors' (CoG) Nominations and Remuneration Committee is due to meet on 5 November 2018 to discuss plans to identify my successor, as well as the wider requirements for non-executive director succession planning.

2.0 Staff Awards

I was delighted to attend the Staff Awards ceremony on 18 October. It was inspiring to see so many of our staff genuinely delighting in the achievements of their peers. I am grateful to the whole organisation for their work in putting on such an impressive event. We can be very proud.

3.0 Board committees

Further to my report at the September meeting I can confirm that Board Committee memberships will be changing from 1 November and will look as follows:

Audit and Risk		**Quality**		**Finance and Investment**		**People and OD**	
CURRENT	**NEW**	**CURRENT**	**NEW**	**CURRENT**	**NEW**	**CURRENT**	**NEW**
Nick Gash (Chair)	Nick Gash (Chair)	Eliza Hermann (Chair)	Eliza Hermann (Chair)	Jeremy Jensen (Chair)	Jeremy Jensen (Chair)	Steve Gill (Chair)	Steve Gill (Chair)
Nilkunj Dodhia	Nilkunj Dodhia	Andy Jones	Andy Jones	Nilkunj Dodhia	Nilkunj Dodhia	Eliza Hermann	Eliza Hermann
Liz Shanahan	Andy Jones	Nick Gash	Liz Shanahan	Liz Shanahan	Steve GIll		Nick Gash
						Martin Lupton	Martin Lupton

4.0 Governor elections

Elections are currently being held for 15 seats across our Council of Governors. This comprises: seven patient governors; one public governor for Ealing; one public governor for Hammersmith and Fulham; two public governors for Hounslow; one public governor for Wandsworth; one staff governor for management; and one staff governor for nursing and midwifery. All of the seats are contested which shows the enthusiasm our Members have for getting involved in the Trust. The polls close at 5pm on Friday 9 November 2018 and we will know the results on 12 November 2018. We wish all of the candidates the very best of luck.

5.0 Governor Away Day

Our Council of Governors will be holding its annual Away Day on 15 November at Cadogan Hall. We will have a challenging day as we work through the Trust's future strategy in addition to a session led by NHS Providers' Governwell unit on the role of Council. This will bring in some useful external perspective.

6.0 Annual Members Meeting

We enjoyed a well-attended Annual Members Meeting on 27 September 2018 in the Gleeson Lecture Theatre at Chelsea and Westminster Hospital. As ever, we spoke with a packed room of passionate patients, staff and members of the public. Alongside presentations on our Annual Report and Accounts and the work of Council, attendees heard thought-provoking presentations on end of life care and the role volunteers can play within it, and our planning for Winter.

As always, we took questions from those in attendance and the range of matters raised reiterates the importance of engaging with all who use and provide our services.

7.0 Internal and external engagements

Since the last Board meeting (6 September 2018) I have undertaken the following engagements:

- 20 Sept – call with Royal Wolverhampton re dementia volunteers
- 25 Sept – London Chairs' meeting
- 26 Sept – Chairman and Governors' meeting
- 3 Oct – Meeting with NHS Scotland
- 3 Oct – Meeting with NHS Lothian
- 9 – 10 Oct – NHS Providers Conference
- 15 Oct – visit to St Mary's Trust with Chair of British Red Cross
- 16 Oct – Kings Fund Breakfast
- 18 Oct – Chairs' advisory group with Baroness Harding, Chair, NHS Improvement (NHSI)
- 25 Oct – Speaker at Westminster Health Forum
- 25 Oct – meeting with Baroness Harding, NHSI and Peter Wyman, Care Quality Commission (CQC)

Sir Thomas Hughes-Hallett
Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018 **PUBLIC SESSION**

AGENDA ITEM NO.	1.6/Nov/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. 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.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chief Executive's Report

November 2018

1.0 Performance

September was another very challenging month with the continued growth in non-elective and elective demand. Despite these challenges both of our sites responded incredibly well and whilst the A&E Standard was narrowly missed at 94.9%, we remain one of the top performers. The Referral to Treatment incomplete target was achieved on both sites as was the 62 Cancer Standards. We were however, non-compliant with the 2 week wait performance standard and the Diagnostic 6 week standard. Given some recent capacity challenges and increased demands in certain specialities, Rob Hodgkiss has invited the Intensive Support team in to work with the operational teams to undertake a thorough review of Demand and Capacity across the Trust to ensure we have the right capacity available to meet our demands.

2.0 Staff Achievements and Awards

Annual Staff Awards

On 18 October, we held our annual Staff Awards at Rooms on Regents Park, where we recognised the contribution of staff across both hospital sites. A record 800 nominations were received and a total of 17 awards were presented including Nurse of the Year, Team of the Year, Inspiring Leadership Award and the Chief Executive's Special award. The awards are supported by our fantastic charity, CW+. See this short clip of our patients thanking staff members. All winners and photos can be found on our website.

Long Service Awards

In September, we held ceremonies at Chelsea, West Mid and Harbour Yard to recognise staff working in our corporate division and contract staff. The long service awards were re-introduced in the summer when we recognised long service staff working in each of our clinical divisions.

Our latest CW+ PROUD award winners:

- **Planned Care**: Peter Temple, Anatomical Pathology Technician, Sue Bellars, Health Records and Systems Manager and Kieran Penn, Senior Patient Administrator
- **Emergency and Integrated Care**: Suzzet Armstrong, Senior Staff Nurse, Endoscopy
- **Women and Children**: Madoussou Dosso, Caseload Midwife and the Paediatric High Dependency Unit team
- **Corporate**: Danielle McNeish, Temporary Staffing Team Leader

External recognition:

- The **financial planning and sexual health service teams** won the Innovative Project Award for sexual health eServices at the Finance for the Future Awards.
- The **Anticoagulation Team** at West Mid won an award for Best Comprehensive Thrombosis Management Centre at the prestigious Anticoagulation Achievement Awards.
- **Dr Olivera Potparic**, one of our anaesthetic associate specialists, won a national award from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for her role as national representative of associate specialists.
- **Staff at 56 Dean Street** won an award in September for their work supporting the sexual health of London's homeless community. The award was presented to Dr Tara Suchak, Joe Phillips and Julie Ross.
- Our Chief Executive **Lesley Watts** has been shortlisted for a HSJ award for CEO of the Year.
- **Dean Street PRIME** has been shortlisted in the HSJ Awards 2018 in the Patient Digital Participation category. Judging takes place in October with the awards on 21 November.

3.0 Communications and Engagement

We held our 2017/18 annual members meeting on Thursday 27 September at Chelsea and Westminster Hospital. Attendees heard presentations from the Chief Executive, Chief Financial Officer and Council of Governors. There was a chance to hear about the Trust's progress and performance over the last year, and plans for 2018/19. Before the meeting, attendees had the opportunity to take an art tour of works on display in the hospital.

Current key communication areas include

- Winter including staff flu immunisation
- Freedom to Speak up
- NHS staff survey
- Critical Care project
- Volunteering

Press coverage

- BBC Breakfast featured our maternity unit on 7 Sept as part of their three-part series looking back at the heat wave. They interviewed Claire Davidson, Maternity Matron & Gubby Ayida, Associate Medical Director.
- The BMJ in August featured an interview with consultant Physician Anton Pozniak, who runs the HIV service at our Chelsea site, as he became the first British president of the International AIDS Society.

Media requests:

MTV Digital recorded a feature on Dean Street's sexual health services on 24 October. As part of the filming they interviewed consultant Dr Tara Suchak. The piece is part of a series of programmes aimed at young people and will feature on their website and social media channels.

BBC's Victoria Darbyshire programme interviewed Dr Abtehale Al-Hussaini on 21 Sept on her work to treat women who have suffered SCAD heart attacks and want to have children. Broadcast date TBC.

Obstetrician Natasha Singh and Midwife Debora Alcayde took part in Health Foundation-sponsored filming on our maternity unit on 22nd October. Natasha has been leading a Quality Improvement project in the hospital alongside midwifery colleagues and this was an opportunity to showcase this work.

Hand Surgeon Max Horwitz was filmed in surgery as part of a documentary called 'Our brilliant hands' by Beach View films. Date of broadcast TBC.

Internal communications / ongoing activity

We are continuing to receive positive feedback to our new internal communications tool, Poppulo, and this is providing valuable data to help shape our strategy. All-staff messages such as the daily noticeboard and CEO newsletter regularly receive open rates in excess of 50% with more targeted communications such as the new divisional newsletters having even higher rates.

We are now well underway with our winter/flu campaign and have been communicating key messages across all of our communications channels, particularly encouraging staff to get their flu jab. This has supported Occupational Health to vaccinate over 1,800 staff to date.

Following our Staff Awards, we will shortly be releasing a survey for all attendees to fill out, helping us to improve the event in future years.

We are now working on the next edition of our Trust magazine Going Beyond, which will include features on winter planning and our staff awards. This will be published within the next few weeks.

The next all staff briefing will take place in the first week of November and will cover winter planning, outpatient transformation and enhanced supportive care. Podcasts are made available on the intranet and are being promoted for those who were unable to attend. The latest all staff briefing is attached to my report.

We also celebrated the ten year anniversary of the West Mids birth centre, the first hospital in London to achieve UNICEF Baby Friendly accreditation. We were joined by the Mayor of Hounslow and the first baby born at the birth centre.

In early October, we hosted a party for children and young people who were previously patients on our NICU. The story will be featured in the Chief Executive's newsletter, divisional newsletters and on social media.

Other key events

- #IWill Volunteers Week – Pears Foundations – West Mids from 12 November.
- 15 year anniversary of the redevelopment of West Mid hospital – 19 November.
- World AIDS Day – I Dec.
- Xmas Open Day: 11 Dec at Chelsea and 12 Dec at West Mids (TBC by Cabinet).

Social media

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

- **Critical Care –** video with Trystan Hawkins, director of Director of Patient Environment at CW+ talking about his role in the project.
- **Flu campaign launch**: Live tweets including a series of videos were produced to encourage staff to get vaccinated. Engagement has been high as the flu trolley has worked its way around wards. Videos featuring frontline clinicians and our Medical Director also performed well.
- **#BlackHistoryMonth** – showcasing our black role models during the month of October. Videos with Dr Brent Bartholomew and Nelly Adjei performed well.
- **Sepsis Day 2018**: We featured a series of videos for World Sepsis Day to launch our new screening tool. We produced videos featuring consultants at West Mid and Chelsea, a pharmacist, and nurse

We recorded a high number of Twitter impressions over the past 28- day period (310k), driven by our flu campaign, staff awards, Black History Month and celebrations around the West Mid 10 year anniversary. This continues our upward trend and has been achieved by featuring exciting and prominent campaigns and increasing the number of videos produced.

Website:

In September the Trust website had 132,000 visits, of which 2/3s were new and 1/3 were returning visitors. The top sections were 56 Dean St, 10 Hammersmith Broadway and John Hunter clinics, travel directions and contact info, and our clinical services.

2/3s of our visitors use mobile devices. 3/4s of users visit our website via a search engine, and Facebook remains the key driver on social media. The stats are consistent with this period one year ago.

Our program of revamping key pages on the website is on-going in line with demand and divisional priorities.

4.0 2019-20 Planning Assumptions

We have started planning for next year and detailed guidance and control totals for 2019/20 will be issued in December 2018, with the final plan due to NHS Improvement at the beginning of April 2019. Key risks for the Trust relate to the potential impact of tariff changes, particularly proposals to update high cost area uplifts (Market Forces Factor), which would have a significant impact on CWFT, identification and delivery of CIP plans, and commissioner affordability. The Executive will be considering the implications of these

changes in more detail once the guidance is issued with the Board asked to consider the potential impact early in the new calendar year.

5.0 Senior Team Changes

I am delighted to announce that Thomas Simons will be joining our Board as the new Executive Director of Human Resources and Organisational Development. Thomas is currently the Chief People Officer at East and North Hertfordshire NHS Trust, and has extensive experience working in the NHS which includes several years at Barts Health NHS Trust.

It's expected Thomas will take up his new role in early 2019 and in the meantime Sandra Easton, Chief Financial Officer, will continue to provide leadership for the HR and OD portfolios. I look forward to welcoming Thomas into our Trust.

Karl Munslow-Ong, our Deputy Chief Executive Officer, is leaving the Trust to take up the position of Chief Operating Officer at The Royal Marsden. While his departure is tinged with sadness, we are delighted that he is joining an outstanding institution and of course a very close partner of ours on the Fulham Road. He will start his new role on 5 November.

He has done a fantastic job here over the past three and half years, and brought with him a huge wealth of healthcare and organisational experience from working at Hillingdon Hospital and a variety of other NHS Trusts.

We have sadly also seen the recent departure of Gill Holmes, our Director of Communications. Gill has made a tremendous impact during her time with us. This is aptly demonstrated by the immense growth in our comms and engagement activities that I have outlined earlier in my report. Gill unfortunately has departed for personal reasons and we would like to wish her all the very best for the future.

After a significant period of stability amongst the senior team we are going through some transition and I am taking the opportunity to think carefully with my Exec colleagues about ensuring we have the right resources in place to deliver on all of our priorities. I will provide a further update at the January Board meeting.

6.0 Strategic Partnerships Update

<u>STP update</u>

As reported to Board in September, I indicated that there was a significant STP workstream being commissioned to review and refresh the clinical vision and look to better articulate a clinical strategy for the whole of North West London (NWL). Our Medical Director and Chief Nurse represented the Trust at an initial NWL clinical workshop on 19 October to help take this forward. The group were joined by colleagues from the London Clinical Senate so that our thinking is also able to inform, and be informed by, the Clinical Strategy for London.

I would expect this strategic workstream to be completed and be in a position to share a summary with Board in January where I propose to:

1. Reflect on an updated set of NWL strategic intentions and any emerging analysis of the NHS 10 Year Plan
2. How they align with our own developing strategy
3. How any revised priority areas better address the issue of scale and sustainability across NWL

To support this session I would also propose to ask clinical colleagues to present case studies as to how we have contributed to the NWL STP to date and where we have improved care and delivered benefits for the local population.

Integrated Care in Hounslow

Hounslow CCG has been working on an Integrated Care business case which they envisage would be developed into an operating and contract model for April 2020. The CCG Governing Body approved the approach set out in the form of an outline business case (OBC) in September and, subsequently, the CCG has been facilitating an emerging provider partnership to:

1. Establish a programme management approach; and to
2. Develop a model of governance that recognises the responsibilities of sovereign organisations but seeks to create a form of delegated authority for joint decision making.

The approach to date from the Trust has been to support this development. We believe it brings the following benefits:

- Is (indicatively) of sufficient scale to ensure our engagement given the population the proposal seeks to serve and the impact on our contract with Hounslow CCG
- Is consistent with our emerging ambitions to develop WMUH site as a hub for Integrated Care
- The clinical priority areas are aligned to our own strategic priorities and operating plan including:
    - Improving outcomes across the population we serve (Quality)
    - Career/workforce development to deliver integrated care (Employer of Choice)
    - Focus on reducing impact of loss making emergency care pathways (Use of Resource)

The proposal to sign a Memorandum of Understanding was discussed at our Strategic Partnership Board in October and while the Executive identified a number of risks the recommendations are:

1. Sign the MoU as a neutral and inclusive step
2. Continue to support the work programme through the Emergency & Integrated Care Division and site leadership at WMUH (including appropriate risk/benefit analysis)
3. Update Board on progress

<u>External Work Programmes</u>

The senior team continue to be engaged in a variety of external work programmes at a local, regional and national level. I am committing a significant amount of time to my STP leadership role and continue to chair the elective care programme for London, the national NHS Visitor & Migrant Cost Recovery Programme Senior Advisory Board and the NW London Outpatient Transformation Board.

All of my Exec team continue to contribute and lead a variety of STP work programmes. Rob Hodgkiss chairs the COO NW London network; Sandra Easton is chairing the national Healthcare Finance Managers Association (HFMA) Sustainability Committee; Zoe Penn is a member of Independent Reconfiguration Panel (Department of Health); Pippa is national advisor to the CQC and leads the maternity workstream for NW London; and Karl leads the joint work with Imperial College and Imperial College Healthcare Trust on developing a North West London option to retain the Royal Brompton Hospital in the sector.

<u>Royal Brompton Hospital</u>

We have continued our work with Imperial College, Imperial College Healthcare Trust and other sector partners to develop an alternative proposal to the move of Royal Brompton's services from the Fulham

Road to the St Thomas' site. We recently attended the Royal Borough of Kensington and Chelsea, Health Overview and Scrutiny Committee where we heard from NHS England (NHSE) on their role as the commissioner of the largest elements of Royal Brompton's clinical services. We have also met separately with NHSE to update them on our work and better understand how they intend to oversee the consultation process. We plan to submit our joint outline feasibility document to NHSE at the end of November.

7.0 Finance

At the end of September, month 6, our year to date adjusted position is a surplus of £1.84m which is in line with plan. Pay costs are £6.6m adverse to plan offset, in part, by underspends in non-pay. We have achieved 79% of our year to date savings target, so we are focussing on getting our delivery of savings back on track to deliver our overall financial position in 2018/19.

The Trust has revised the year-end forecast which now includes a non-cash receipt of £4m from the acquisition of shares from a company where the Trust, in return, provides it with research data and a strategic relationship. It has been agreed that the additional forecast £4m surplus will attract 2 for 1 bonus Sustainability and Transformation funding (£8m).

Lesley Watts
Chief Executive Officer
November 2018

All staff briefing

October 2018

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

CernerEPR—upcoming events

Over the next year we'll be taking our CernerEPR system to the next level as we expand the system at West Middlesex and introduce the full range of functionality at Chelsea and Westminster. On 10 and 11 October there is a vital opportunity to see what our digital future looks like and to help shape the implementation. Each of the divisions is asking representatives—including medical, nursing, operational and AHP staff—to attend the event and to verify that the system will enable delivery of safe and effective patient care. You can find more information about this event on the Cerner EPR intranet site. Talk to your manager if you think you need to be there.

Thank you to all our long serving staff

In May, we recognised staff with 25 or more years' service through the reintroduction of our long service awards. Throughout July and August each clinical division has held awards ceremonies at both hospitals for their staff with 10, 15 and 20 years' service. On 11, 25 and 26 September last week we held similar awards at Chelsea, West Mid and Harbour Yard for the corporate division and our contracted staff. Thank you to each of every one of you for your dedication and commitment to our organisation and we look forward to recognising more of our long serving staff next year. If you feel someone from your team has been missed off, please contact: communications@chelwest.nhs.uk

Latest CW+ PROUD award winners

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

- Planned Care: **Peter Temple**, Anatomical Pathology Technician (C&WH); **Sue Bellars**, Health Records and Systems Manager (C&WH) and **Kieran Penn**, Senior Patient Administrator (C&WH)
- Emergency and Integrated Care: **Suzzet Armstrong**, Senior Staff Nurse, Endoscopy (C&WH)
- Women and Children: **Madoussou Dosso,** Caseload Midwife (C&WH) and the **Paediatric High Dependency Unit** team (C&WH)
- Corporate: **Danielle McNeish,** Temporary Staffing Team Leader (C&WH)

Visit the intranet to nominate a team or individual.

Nursing recruitment and retention

Recruitment continues apace as the Trust attended a Royal College of Nursing (RCN) recruitment fair two weeks ago in central London and offered 17 posts to Registered Nurses & Registered Mental Health Nurses. We have a team of nurses in the Philippines who are currently recruiting to the Chelsea Site. Over the past year we have seen a 7% reduction in nursing and midwifery vacancies within the Trust so a big thank you to all those who help with our recruitment events.

We recruited 18 new Health Care Assistants to the Trust in September and continue to recruit for the Nursing Associate Apprenticeship. Please contact cathy.hill@chelwest.nhs.uk if you are interested in applying.

Many of our student nurses have chosen have decided to stay on with us as they qualify, so please do make them feel very welcome in the Trust.

We are working hard on improving our staff retention and have been congratulated by NHSI for our improvement over the last year, but we have much more to do in this area. Teamwork and friendliness of staff at work is a key driver that determines whether nurses will stay in post or not, so please remember this in your interactions with each other.

Mandatory and statutory training

The Trust has maintained 92% compliance for the 3rd Qlikview reporting period with all divisions now reaching 90% or above.

Information Governance continues to hover at 88%—the Trust target is 95% compliance. Patient handling compliance rates continue to rise following the alignment of the requirements to the national best practice.

Please note that there will be a new intercollegiate safeguarding children document released in Autumn which could significantly affect the numbers of staff needing to be trained at the higher levels.

Current compliance figures (at 16 September) are as follows:

Division	Compliance
Corporate	**94%**
Emergency and Integrated Care	**92%**
Planned Care	**92%**
Women, Neonatal, Children, Young People, HIV/Sexual Health	**92%**
Overall compliance	**92%**

NHS National Staff Survey

Please take time to fill in the national NHS staff survey which will be launched this week, on Tuesday 2 October. We value your feedback and have worked very hard to respond to the issues raised last year.

We know that the positive survey last year was mentioned by many staff in why they decided to come and work here. Let's work together, continue to improve and make this a wonderful place to work.

Financial performance

At the end of July, month 5, our year to date adjusted position is a £0.3m ahead of plan giving an overall surplus of £2m. Pay costs are over plan by £5.35m offset, in part, by underspends in non-pay and revenue in excess of plan. The Trust has achieved year to date CIPs of £7.37m against a target of £7.78m. The Trust needs to continue to work hard to get our CIP delivery back on plan as it is required to deliver £25.1m CIPs and has delivered 29% at month 5.

October *All Staff Briefing*:

- Mon 1 Oct, 9:30–10:30am—Harbour Yard
- Tue 2 Oct, 4-5pm—C&WH
- Thu 4 Oct, 10-11am —WMUH

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.2/Nov/18
REPORT NAME	Improvement Programme update
AUTHOR	Serena Stirling, Director of Improvement
LEAD	Pippa Nightingale, Chief Nurse Sandra Easton, Chief Finance Officer
PURPOSE	To report on the progress of the Improvement Programme
SUMMARY OF REPORT	**Trust-level progress: Cost Improvement Programme (CIP)** The Trust is forecasted to achieve a full year forecast of £22m – 12% or £3.1m below the target of £25.1m. This is an improvement of £0.3m from the prior month. Month 6 shows that the in-month performance has delivered £1.67m against a target £2.25m which is an in-month under achievement of £0.59m or 26%. 78% or £17.1m of the £22m full year improvement forecast is rated green, with the expectation that these schemes will fully deliver against plans.
KEY RISKS ASSOCIATED	Failure to continue to deliver high quality patient care Failure to deliver 2018/19 improvement and efficiency targets
FINANCIAL IMPLICATIONS	These are regularly considered as part of the risk assessment and review process of Cost Improvement Schemes through the divisional structures and Improvement Board.
QUALITY IMPLICATIONS	These are considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
EQUALITY & DIVERSITY IMPLICATIONS	Equality and Diversity implications have been considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
LINK TO OBJECTIVES	State the main corporate objectives from the list below to which the paper relates. • Deliver high-quality patient-centred care • Deliver better care at lower cost
DECISION/ ACTION	For assurance

This report provides an update on the progress of the Improvement Programme since the last update to Trust Board in October 2018.

1. Summary of Financial Improvement Programme
2. Addressing unidentified opportunities by division
3. Getting It Right First Time
4. CQC Improvement Plan
5. Deep Dive programme

1. Summary of Financial Improvement Programme – M06

The Trust is forecasted to achieve a full year forecast of £22m – 12% or £3.1m below the target of £25.1m. There has been an improvement of £0.3m from the prior month.

- Month 6 shows that the in-month performance has delivered £1.67m against a target £2.25m; this is an in-month under achievement of £0.59m or 26%.
- There is a YTD adverse variance of £2.39m against the target which is largely driven by unidentified projects (£1.65m or 70%) – EIC £0.7m, PC £0.93m.
- 78% or £17.1m of the £22m full year improvement forecast is rated green, with the expectation that these schemes will fully deliver against plans.

2. Addressing unidentified opportunities by Division

Emergency and Integrated Care update:

- Weekly CIP meetings identify further opportunities for improvement. Non-pay spend review is being undertaken against particular supplier expenditure for clothing, furniture, printing, stationary and transport.
- The division continues to hold fortnightly Divisional Integration Group meetings covering specialties and service areas (i.e. discharge, nursing, quality priorities), which include reviewing CIP schemes and quality improvement opportunities. This meeting informs the Division's forward plan for specialty Trust-level Deep Dives with the Executive Team.

Planned Care update:

- Development of a cross site clinical integration plan through the Divisional Integration Group.
- Further development of plan and timescales for the Elective Theatre Productivity Programme.
- Continued work to reconfigure theatre schedules to improve productivity and patient experience.
- Develop improvement opportunities offered by Getting It Right First Time national programme, commencing with Urology and Trauma and Orthopaedics.

Women's and Children's update:

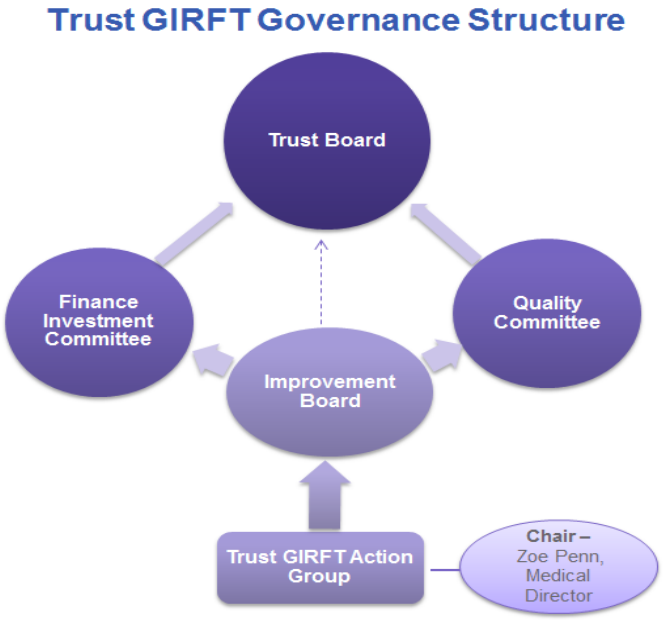
- Challenging CIPs continue to be tracked and monitored in Divisional Finance Issues and Actions log. On-going regular review by Divisional Management Team to drive the progress of schemes to ensure they deliver against plans.
- Wider portfolio of on-going quality improvement projects being developed and will be validated to realise both quality and financial improvement benefits.

Corporate update:

- There is still a shortfall of £1,252k recurrently and potential improvement opportunities to reduce this have been presented to Improvement Board and will be progressed as appropriate.

3. Getting It Right First Time (GIRFT)

The approach to GIRFT has been revised by the Medical Director and updated with the following structure. The Trust GIRFT Action Group meets monthly, with the national GIRFT team joining quarterly:



GIRFT Process

Introduction – GIRFT send letter to Chief Exec Letter

- Introduction and request for organisation to nominate GIRFT speciality clinical leads

Information Gathering – to be completed and submitted identified clinical lead

- Questionnaire (if applicable)
- Data set collection – analysis of data sets to identify unwarranted variations in the way services are delivered

Setting visit dates

- Agreement of potential dates for GIRFT team to come and review the pathway/s

GIRFT Report

- GIRFT sends report and dashboard to the Trust summarising the analysis of the data submission which will form the basis of the GIRFT review on site
- Speciality team to review summary report and prepare for the GIRFT visit. This should include engagement with executive team.

GIRFT Visit – onsite clinical review

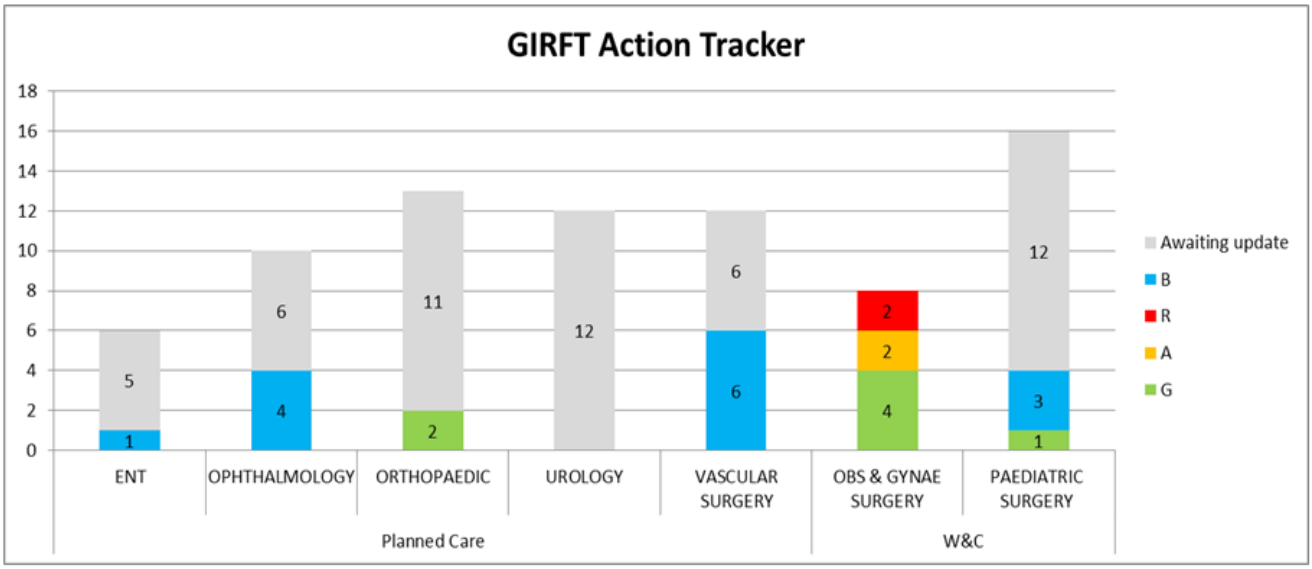
- GIRFT conducts on site 'Deep Dive' which includes all MDT members and management
- Feedback offered to clinical team and executives about the initial findings.

Actions and recommendations to the Trust

- GIRFT issue summary report detailing the findings of the clinical review and recommendations/opportunities for improvement.
- Speciality team review the report and recommendations for factual accuracy, and accept/reject the recommendations. For these which are accepted, a GIRFT Improvement Plan should be developed with clear interventions and timescales for delivery. The improvement plan should be completed and signed off within 4 weeks of receiving the report.
- Progress with improvement plan to be reported within the divisional structures, and monthly to Trust GIRFT Action Group.

Overall Trust progress update for September – Active GIRFT work streams

BRAG Progress Rating	
Blue	Action has been completed and there is evidence that the action has embedded in daily practice.
Red	The action is off track and unrecoverable on the current timescale. Requires a re-plan.
Amber	The action is off track and plans are in place to mitigate the delay. The action is expected to return to the planned delivery date.
Green	Action is on track to deliver on time.



In addition to these live worksterams, the Trust is also building a pipeline of GIRFT activity as the national team increase their scope of review. The Trust is expecting a speciality review in the following areas:

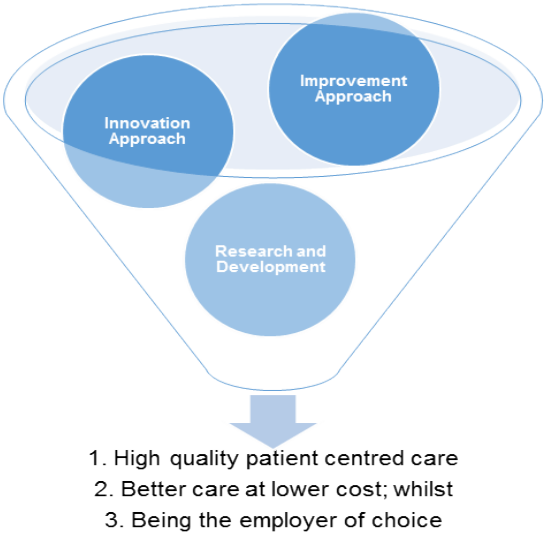
- General Surgery
- Radiology
- Accident and Emergency
- Cranial Neurosrugery
- Cardiothoracic
- Frailty
- Outpatients
- Critical Care
- Veterans Care

4. Quality improvement framework

An MDT task and finish group have been working closely with Communications to finalise and launch the Trust improvement approach. The group have finalised the improvement branding and framework which will be the quadruple aim framework with a strap line of engage, improve and inspire:

Improvement

Framework



The improvement approach will be launched with an improvement road show at the end of November.

5. CQC action plan

The overall breakdown of the CQC 'Should Do' actions and additional actions are updated for October as below:

CQC Improvement Plan Summary					
Number of 'Should Do' actions	57				
Number of additional actions (extracted from report)	90				
Total number of actions	**147**				
Progress - August Update	**Red**	**Amber**	**Green**	**Complete**	**Awaiting update**
'Should Do' actions Summary	0	18	34	5	0
Additional actions Summary	0	26	38	23	3

The Divisional Directors of Nursing provide a monthly update on the progress made so far for each of the CQC actions. A 'BRAG' dashboard for each of these is provided for October below:

a) Progress made for 'Should Do' actions:

Division	CQC Domain	Amber	Green	Complete	Grand Total
EIC	Safe	4	7	1	12
	Effective	1	4	1	6
	Responsive	-	-	1	1
	Well-Led	1	-	-	1
PC	Safe	-	4	-	4
	Effective	1	-	-	1
	Caring	-	1	-	1
	Responsive	2	1	1	4
	Well-Led	1	3	-	4
W&C	Safe	-	2	1	3
	Effective	2	3	-	5
	Responsive	5	2	-	7

	Well-Led	-	4	-	4
Trustwide	Well-Led	1	1	-	2
Corporate	Effective	-	1	-	1
	Well-Led	-	1	-	1
Grand Total		**18**	**34**	**5**	**57**

Completed 'Should Do' actions update:

The following actions for divisions are marked complete for October, details are listed below:

Ref No.	CQC Recommendation	CQC Domain	Division
7	The Emergency Department at West Middlesex should provide more information to patients to help them lead healthier lives.	Effective	EIC
25	The Trust should have a clear policy on the opening and closing of escalation areas at Chelsea and Westminster Hospital.	Responsive	EIC
27	The Trust should ensure that agency staff has access to electronic patient records.	Safe	EIC
105	The West Middlesex Hospital should ensure they are monitoring clinic waiting times for patients. 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.	Responsive	PC
132	The Trust should ensure agency staff have access to electronic patient information.	Safe	W&C

Progress with the CQC Improvement plan will be tested as part of our external Peer Reviews on both main hospital sites in October and November 2018.

6. Deep Dive programme – October's schedule

At the time of writing, the following planned and targeted deep dives have been scheduled for October. Opportunities for improvement which have been identified in Deep Dives are now included in Unidentified Improvement Boards for consideration by divisions for quality improvement projects.

Division	Name of Deep dive	Deep Dive Category	Deep Dive *Scheduled*
Planned Care	Craniofacial	Targeted	01-Nov-18
Trustwide	Outpatients Productivity	Planned	02-Nov-18
Trustwide	Research Funding Follow Up	Planned	06-Nov-18
Planned Care	National NOF Audit Compliance	Planned	07-Nov-18
W&C	Nursing Chelsea Wing	Planned	12-Nov-18
EIC	Neurology/Stroke	Planned	13-Nov-18
W&C	St Stephen's Centre and John Hunter Clinic	Planned	15-Nov-18
PC	Ophthalmology 100 day challenge	Targeted	16-Nov-18
W&C	Neonatal Services	Targeted	19-Nov-18
PC	Veterans GIRFT project	Targeted	27-Nov-18
EIC	Nursing Ambulatory Emergency Care Wards	Planned	29-Nov-18

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.3/Nov/18
REPORT NAME	Learning from Serious Incidents
AUTHOR	Shân Jones – Director of Quality Governance 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 2018. Comparable data is included for both sites.
KEY RISKS ASSOCIATED	• There is a reputational risk associated with the retained vaginal swab Never Event reported in September
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	• There has been an increase in falls with harm year to date compared to last year • Reduction in hospital acquired pressure ulcers has been maintained
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Delivering high quality patient centred care • Be the Employer of Choice • 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 1st November 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 2018. 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 has been 1 Never event reported since the 1st April 2018. The Never Event was reported in September 2018 (Retained foreign object post-procedure, StEIS reference 2018/22293). The incident involved a 36 year old patient who had a spontaneous vaginal delivery at 38 weeks with an episiotomy due to suspected fetal compromise delivery. The episiotomy was sutured in the labour ward room under epidural analgesia. The retained vaginal swab was found after attending an appointment with her GP. Patient has been reviewed, is systemically well and has been given a course of oral antibiotics. The Trust was informed of the retained swab by the GP.

3.0 SIs submitted to CWHHE and reported on STEIS

Table 1 outlines the SI investigations that have been completed and submitted to the CWHHE Collaborative (Commissioners) in September 2018. There were 3 reports submitted. A précis of the incidents can be found in Section 7.

Table 1 – Reports submitted to CWHHE

STEIS No.	Date of incident	Incident Type (STEIS Category)	External Deadline	Date report submitted	Site
2018/16596	02/07/2018	Maternity/Obstetric incident: baby only	28/09/2018	11/09/2018	WM
2018/16475	26/06/2018	Sub-optimal care of the deteriorating	27/09/2018	27/09/2018	WM
2018/17749	13/07/2018	Pressure ulcer	12/10/2018	27/09/2018	WM

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

Table 2 – Incidents reported by category

Incident Type (STEIS Category)	WM	C&W	Total
Maternity/Obstetric incident: baby only	1		1
Maternity/Obstetric incident: mother only		1	1
Sub-optimal care of the deteriorating patient	2		2
Treatment delay	1		1
Grand Total	**4**	**1**	**5**

The number of SIs reported in September (5) is slightly lower compared to the previous month, August (6). During both months the Trust reported against the category Maternity/Obstetric incident: baby only. A month by month comparison of reported categories can be found in table 8.
Charts 1 and 2 show the number of incidents, by category reported on each site during this financial year 2018/19.

Chart 1 Incidents reported at WM by category YTD 2018/19 = 20

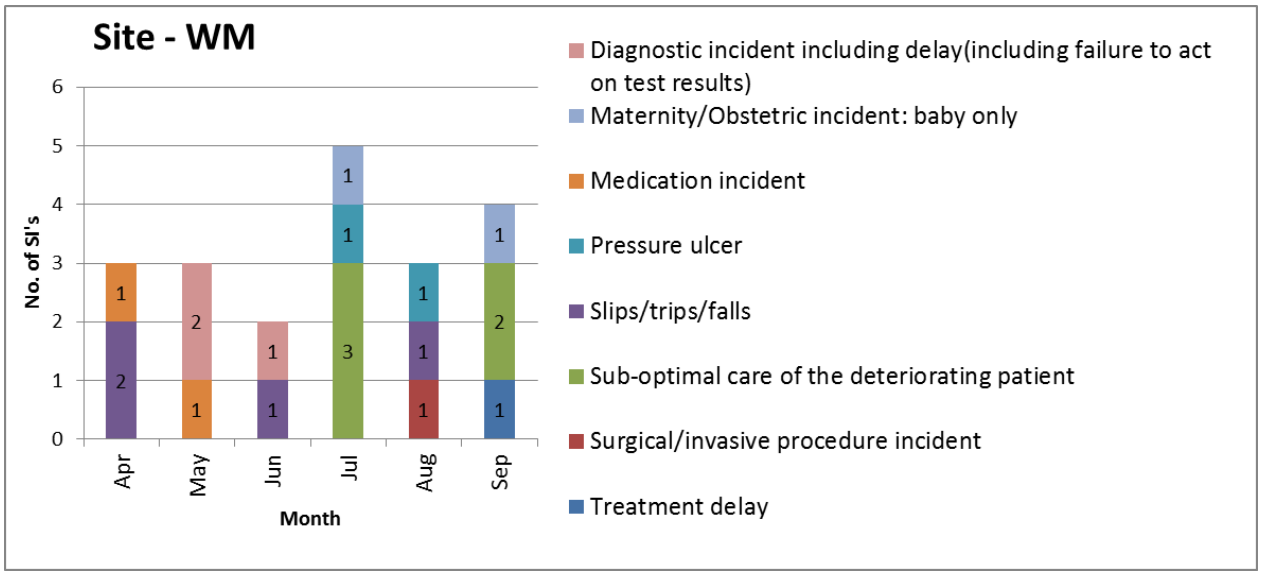
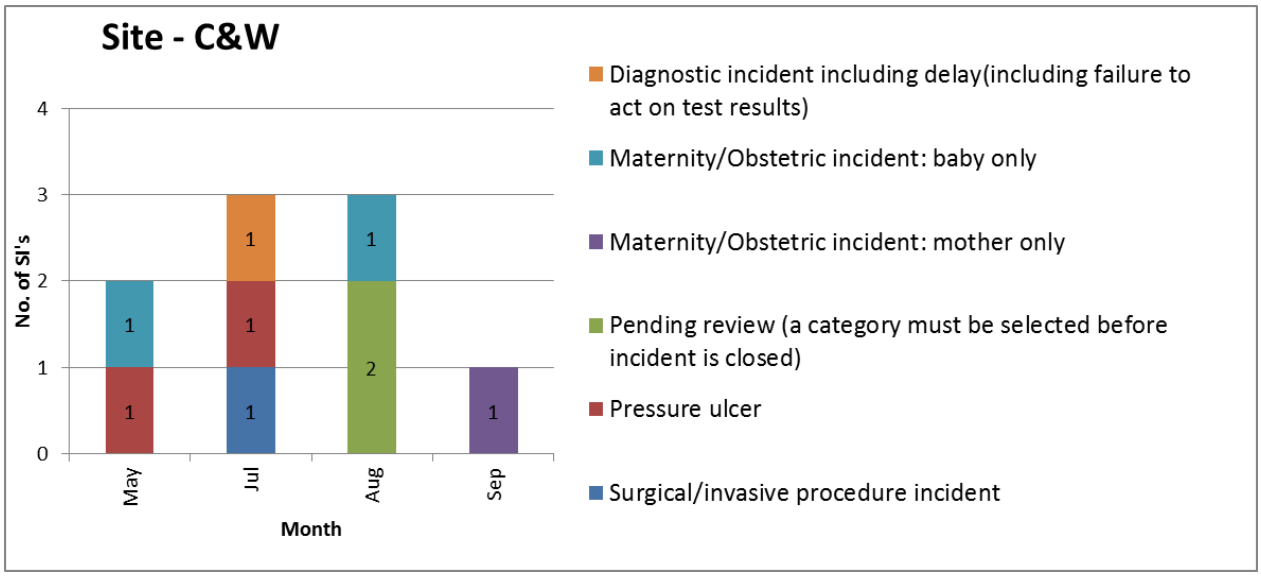


Chart 2 Incidents reported at C&W by category YTD 2018/19 = 9



Charts 3 and 4 show the comparative reporting, across the 2 sites, for 2016/17, 2017/18 and 2018/19.

Chart 3 Incidents reported 2016/17, 2017/18 & 2018/19 – WM

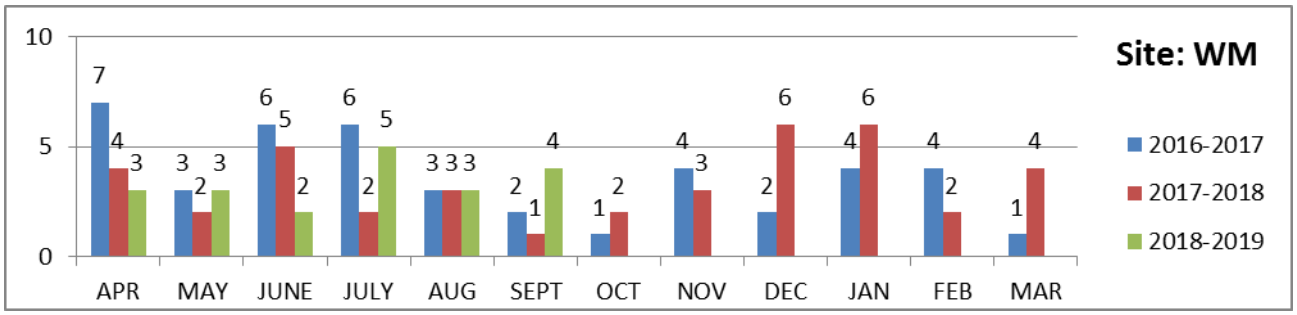
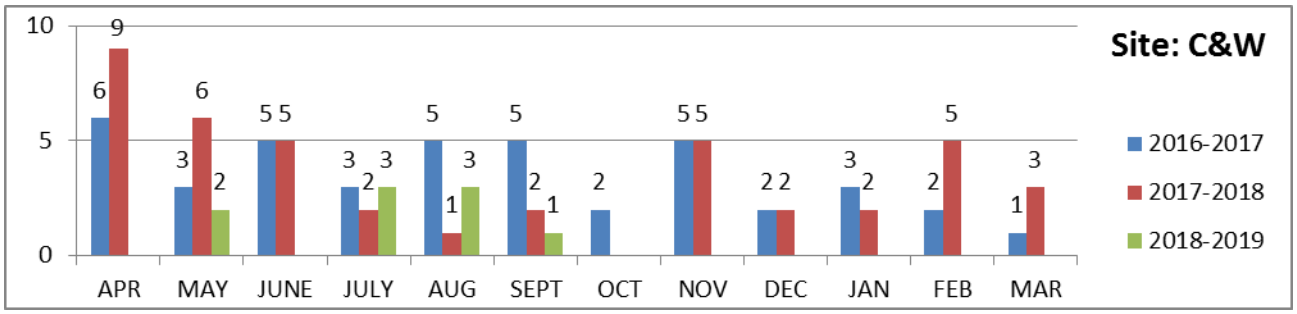


Chart 4 Incidents reported 2016/17, 2017/18 & 2018/19 – C&W

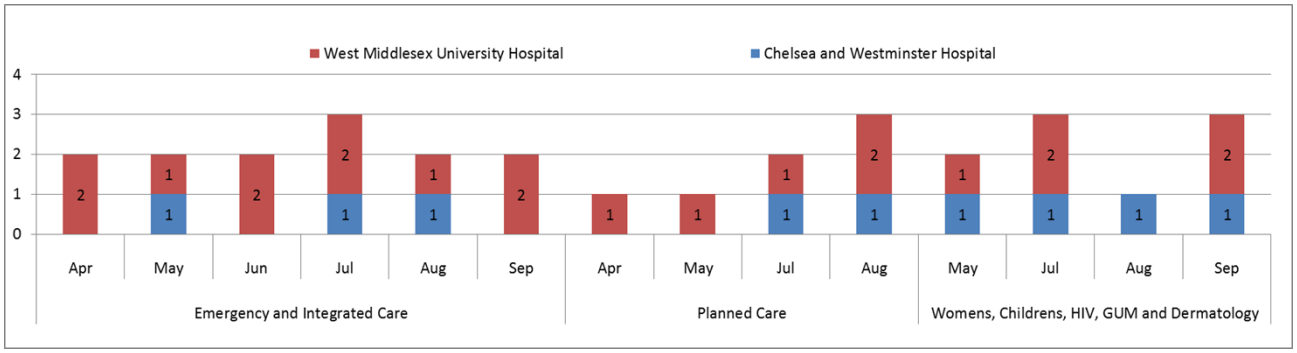


3.1 SIs by Clinical Division and Ward/Department

Chart 5 displays the number of SIs reported by each division, split by site, since 1st April 2018. As the year progresses we will be able to compare the number of incidents reported by each division.

Since April 1st 2018, the Emergency and Integrated Care Division has reported 13 SIs (C&W 3, WM 10). The Women's, Children's, HIV, GUM and Dermatology Division have reported 9 SIs (C&W 4, WM 5) and the Planed Care Division have reported 7 SIs (C&W 2, WM 5).

Chart 5 Incidents reported by Division and Site 2018/19



Charts 6 and 7 display the total number of SIs reported by each ward/department. No patterns of concern are emerging to date. All themes are reviewed at divisional governance meetings.

Chart 6 - Incident category and location exact, WM 2018/19

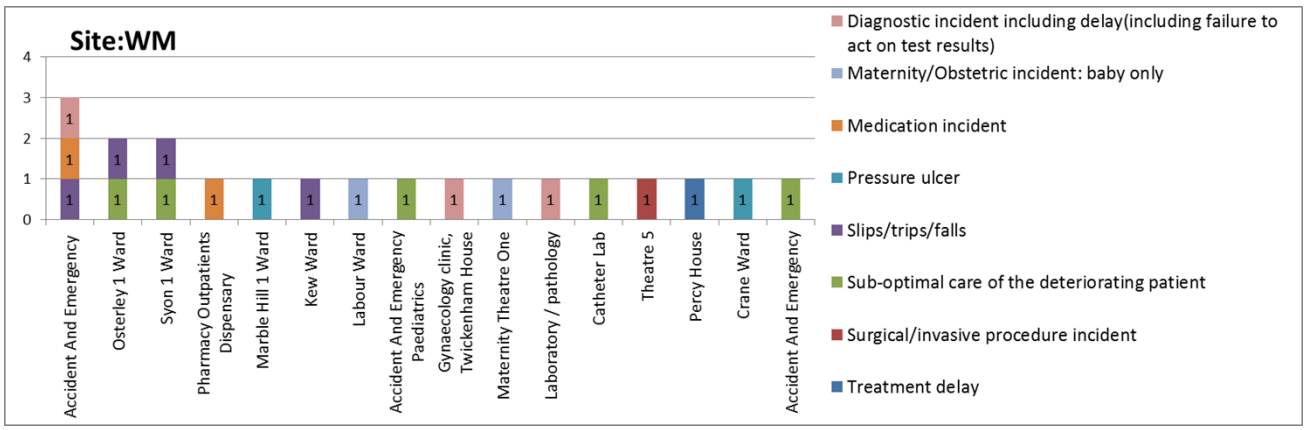
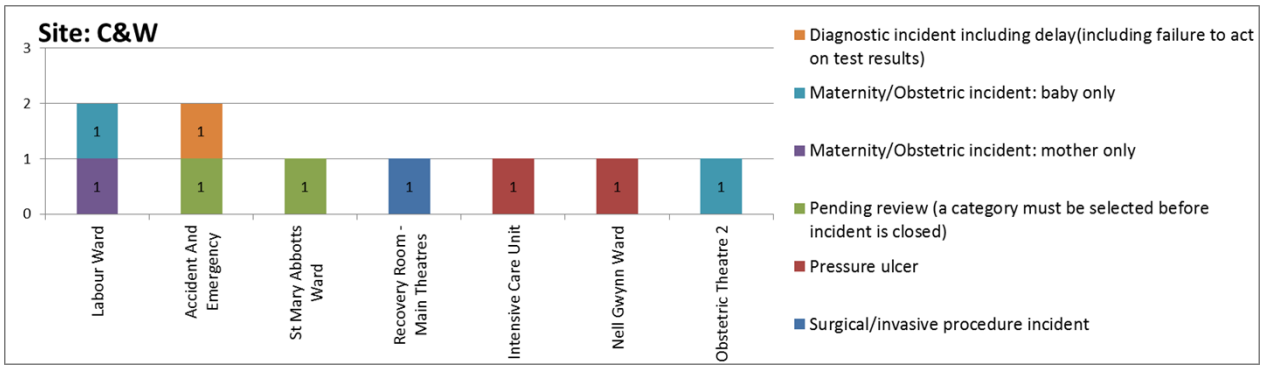
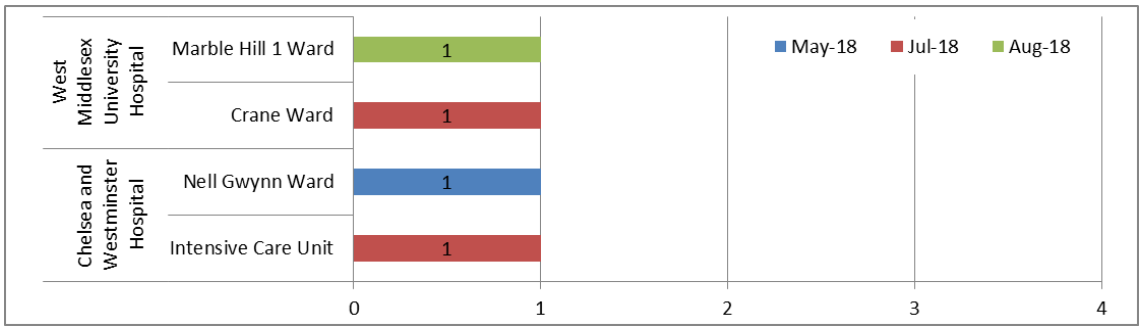


Chart 7 - Incident category and location exact, C&W 2018/19



3.2 Hospital Acquired Pressure Ulcers

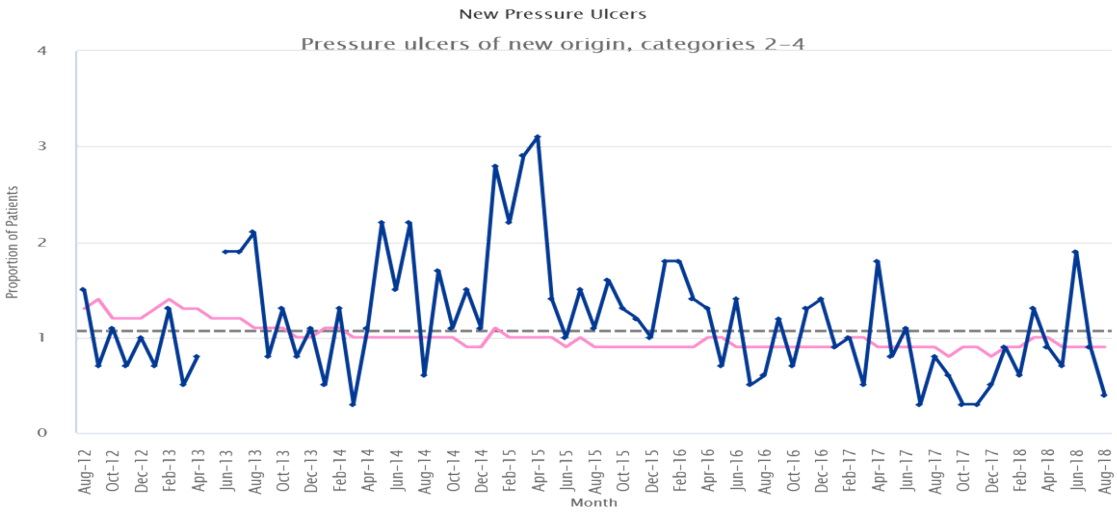
Hospital Acquired Pressure Ulcers (HAPUs) remain high profile for both C&W and WM sites. The reduction in HAPU remains a priority for both sites and is being monitored by the Trust Wide Pressure Ulcer working group. The position for 2018/19 year to date is 4 compared to 9 for the same time period in 2017/18. Very positive reflections that the interventions put in place are working.



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 August 2018.

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

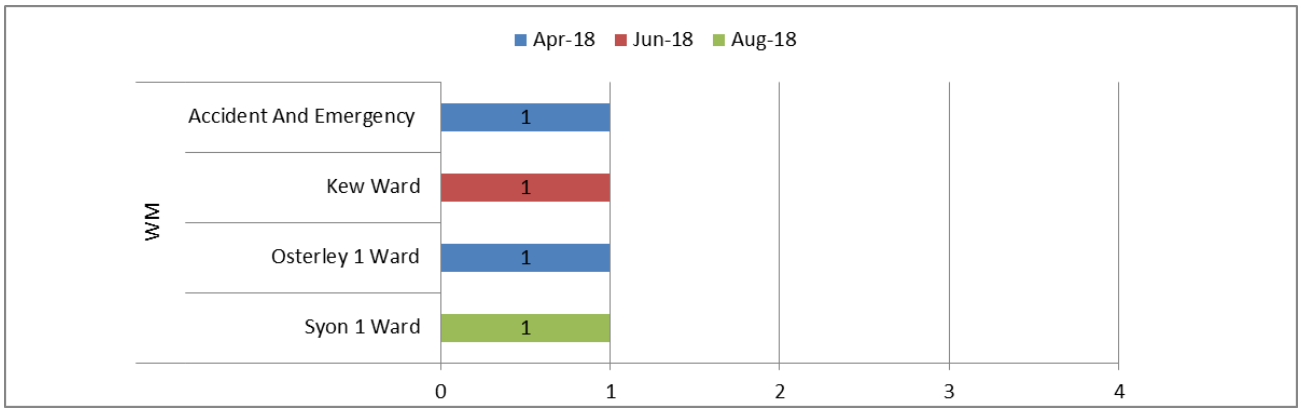


3.3 Patient Falls

Inpatient Falls continue to be a quality priority for 2018/19 and will therefore be a focus for both C&W and WM sites during 2018/19.

Since the 1st of April 2018, the Trust has reported 4 patient falls meeting the serious incident criteria. Disappointingly the 2018/19 year to date position is 4 compared to 1 for the same period last year. All 4 falls have happened on the WM site but in different locations. Learning from the SIs will be shared and reviewed at the falls steering group. In addition the falls steering group is reviewing all incidents of falls, not just the serious incidents.

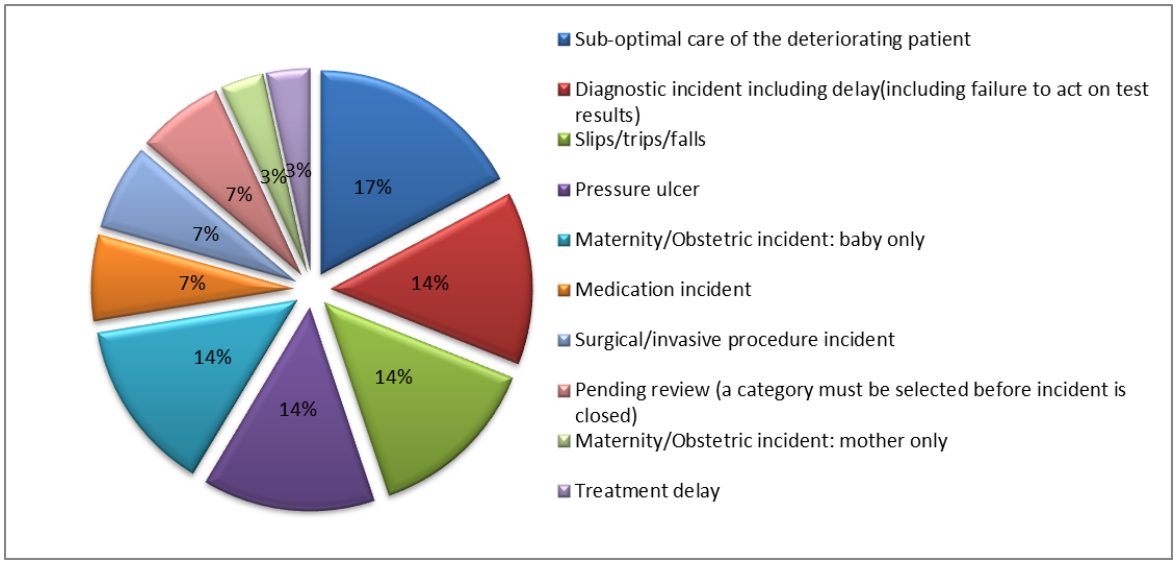
Chart 9 Patient Falls by Location (exact) (Apr 2018–March 2019) YTD total =4



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 10 of the SI categories.

Chart 10 – Top 10 reported serious incidents (April 2018 – March 2019)



At present, the category 'Sub-optimal care of the deteriorating patient 'is the most reported category with 5 incidents reported since 1st April 2018.

3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (12).

Table 3

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2018/17618	04/07/2018	EIC	Diagnostic incident including delay	CW	11/10/2018
2018/19525	13/07/2018	PC	Pending review	CW	02/11/2018
2018/18987	01/08/2018	PC	Slips/trips/falls	WM	26/10/2018
2018/20223	12/08/2018	EIC	Pending review	CW	12/11/2018
2018/20712	19/08/2018	W&C,HGD	Maternity/Obstetric incident: baby only	CW	16/11/2018
2018/20845	20/08/2018	EIC	Pressure ulcer	WM	19/11/2018
2018/21307	30/08/2018	PC	Surgical/invasive procedure incident	WM	23/11/2018
2018/22807	12/09/2018	W&C,HGD	Maternity/Obstetric incident: baby only	WM	13/12/2018
2018/22293	20/07/2018	W&C,HGD	Maternity/Obstetric incident: mother only	CW	06/12/2018
2018/23223	23/09/2018	EIC	Sub-optimal care of the deteriorating patient	WM	19/12/2018
2018/23331	22/12/2016	W&C,HGD	Treatment delay	WM	20/12/2018
2018/23366	22/09/2018	EIC	Sub-optimal care of the deteriorating patient	WM	20/12/2018

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 9 actions overdue at the time of writing this report, all are assigned to the Emergency and Integrated Care Division.

The divisions have been asked to review these actions in advance of the Trust Board so a verbal update on progress can be provided.

Table 4 - SI Actions

	Month due for completion									
	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
EIC	1	2	6	2	0	3	0	0	0	**14**
PC	0	0	0	7	8	3	0	0	0	**18**
W&C,HGD	0	0	0	7	6	1	1	0	2	**17**
Total	**1**	**2**	**6**	**16**	**14**	**7**	**1**	**0**	**2**	**49**

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.

Table 4.1 – Type of actions overdue

Action type	EIC
Share learning (inc. feedback to staff involved)	3
Create/amend/review - Policy/Procedure/Protocol	2
One-off training	1
Recruitment	1
Audit	1
Create/amend/review - proforma or information sheet	1
Total	**6**

5.0 Analysis of categories

Table 5 shows the total number of Serious Incidents for 2016/2017, 2017/18 and the current position for 2018/19. Tables 6, 7 and 8 provide a breakdown of incident categories the Trust has reported against.

Since April 2018 the number of reported serious incidents is 29 which is significantly less compared to the same reporting period last year and the year before (2016/17 = 54, 2017/2018 = 42). The reduction can be attributed to a reduction in the following categories: Pressure Ulcers, Alleged abuse, Treatment Delay and sub optimal care.

Table 5 – Total Incidents reported

Year	Site	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
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**
2018-2019	**WM**	3	3	2	5	3	4							20
	CW	0	2	0	3	3	1							9
		3	**5**	**2**	**8**	**6**	**5**							**29**

Table 6 - 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 7 – 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

Table 8 – Reported Categories 2018/19

Incident Category	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Diagnostic incident including delay		2	1	2									5
Slips/trips/falls	2		1		1								4
Pressure ulcer		1		2	1								4
Maternity/Obstetric incident: baby only		1		1	1	1							4
Sub-optimal care of the deteriorating patient				2		2							4
Medication incident	1	1											2
Surgical/invasive procedure incident				1	1								2
Pending review					2								2
Maternity/Obstetric incident: mother only						1							1
Treatment delay						1							1
Grand Total	3	5	2	8	6	5							29

The quality and clinical governance team continues to scrutinise all reported incidents to ensure that SI reporting is not compromised.

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. So far during 2018/2019 no incidents have been requested for de-escalation by the commissioners.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.4/Nov/18
REPORT NAME	Integrated Performance Report – September 2018
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for September 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 September 2018. **Regulatory performance** – The A&E Waiting Time figure for September was 94.9% against the 95% standard. National figures show that this was the second highest performance in London and an improvement upon performance compared to September 2017 when we achieved 93.7%. The two Emergency Departments continue to be challenged by a year to date increase in attendances of 5.6%, which equates to 10,000 additional attendances in the last six months compared to the same period last year. The RTT incomplete target was achieved in September for the Trust, with performance of 92.03% following significant efforts by the operational and clinical teams after August's non-complaint position. There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue. Delivery of the 62 Day standard met the target in September. Each month of 2018/19 we have exceeded the national target. There are currently no reported breaches in the 31 day diagnosis to first treatment metric. However, work is required around the 2 week referral to first appointment metric. There were two reported CDiff infections in September – no lapse in care was identified in one case; the second noted a delay in isolation was noted. **Access** The Diagnostic wait metric returned 97.76% - missing the target due to issues in Radiology and Endoscopy at the West Middlesex site. A recovery plan is in place but the standard is unlikely to return to compliance in October but we are confident it will be back in a complaint position for November 2018.

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 2 week, 31 and 62 day waits remains a high priority. The Trust will continue to focus on the Diagnostic Waiting time issues – especially Endoscopy - in the weeks to come.
FINANCIAL IMPLICATIONS	The Trust is reporting a YTD surplus of £1.84 which is £0.04m favourable against the internal plan.
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure financial and environmental sustainability
DECISION/ ACTION	The Board is asked to note the performance for September 2018 and to note that whilst some indicators were not delivered in the month, the overall YTD compliance remained good.

TRUST PERFORMANCE & QUALITY REPORT

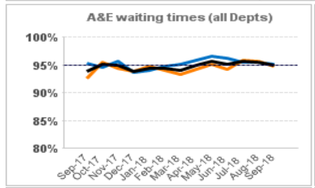
September 2018

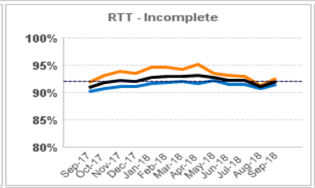
September 2018
Performance Dashboard

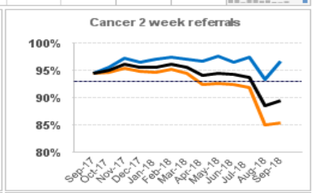
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

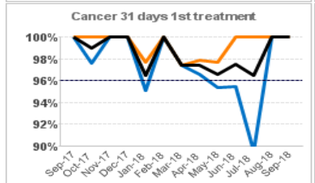
Regulatory Compliance

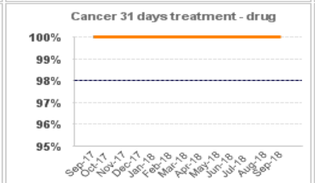
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.5	95.4	95.1	95.8	95.6	94.7	95.6	95.5	94.9	95.3	95.3	
RTT - Incomplete (Target: >92%)	91.6	90.8	91.4	92.9	91.3	92.6	92.2	91.1	92.0	91.8	92.2	
Cancer 2 week urgent referrals (Target: >93%)	97.5	93.3	96.7	91.9	85.0	85.5	93.8	88.6	89.4	90.7	92.4	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	91.1	93.3	89.3	91.1	93.3	89.3	91.4	92.0	
Cancer 31 days first treatment (Target: >96%)	88.9	100	100	100	100	100	96.5	100	100	98.6	97.8	
Cancer 31 days treatment - Drug (Target: >98%)	n/a	n/a	n/a	100	100	100	100	100	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	100	100	100	100	100	100	100	100	100	100	100.0	
Cancer 62 days GP ref to treatment (Target: >85%)	82.6	89.5	100	89.9	94.4	82.7	87.6	92.7	87.8	89.4	88.9	
Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16)	1	1	1	0	0	1	1	1	2	4	7	
Average Emergency PreOp LoS	0.57	0.51	0.40	0.87	1.08	1.15	0.70	0.79	0.75	0.75	0.77	
Average Elective PreOp LoS	0.09	0.11	0.23	0.08	0.03	2.54	0.09	0.09	0.82	0.31	0.22	

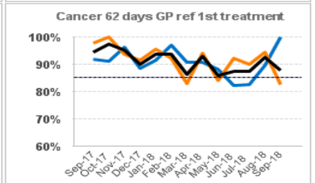






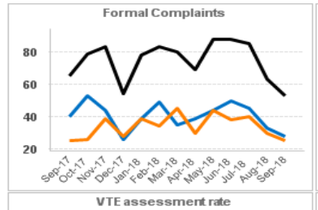


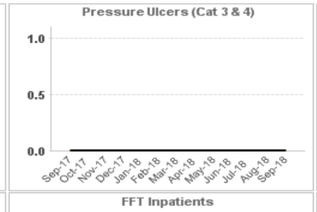


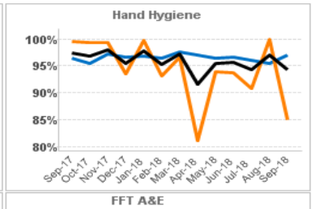


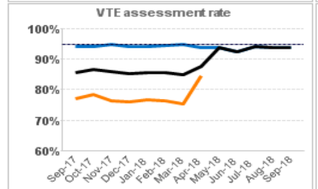
Quality

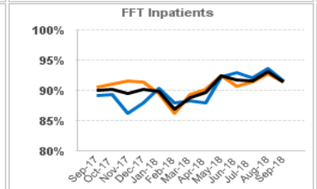
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	96.1	95.5	97.0	90.9	100.0	85.0	94.3	97.1	94.3	95.3	94.8	
Pressure Ulcers (Cat 3 & 4)	0	0	0	0	0	0	0	0	0	0	0	
VTE assessment % (Target: >=95%)	94.2	93.7	94.0				94.2	93.7	94.0	94.0	91.5	
Formal complaints number received	45	33	28	40	30	25	85	63	53	201	446	
Formal complaints responded to <25days	33	24	11	30	21	9	63	45	20	128	316	
Serious Incidents	3	3	1	5	3	4	8	6	5	19	29	
Never Events (Target: 0)	0	0	1	0	0	0	0	0	1	1	1	
FFT - Inpatients recommend % (Target: >90%)	92.0	93.6	91.5	91.3	92.7	91.4	91.6	93.1	91.4	92.1	91.6	
FFT - A&E recommend % (Target: >90%)	89.9	90.8	91.4	88.6	89.9	89.9	89.7	90.6	91.1	90.5	89.6	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	0	

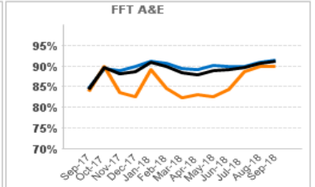






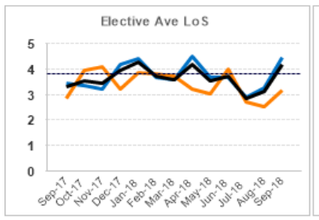


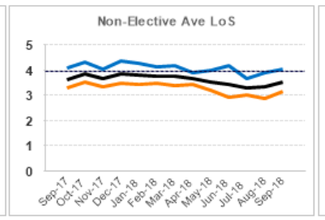


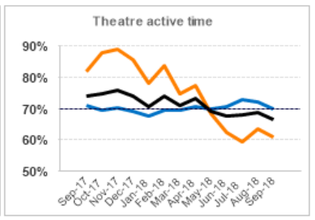


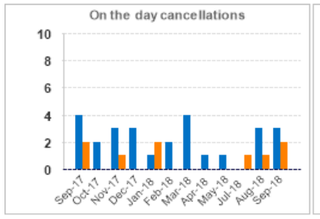
Efficiency

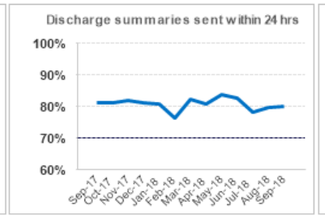
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	2.9	3.3	4.4	2.7	2.5	3.2	2.8	3.1	4.2	3.4	3.6	
Non-Elective average LoS (Target: <3.95)	3.7	3.9	4.0	3.0	2.9	3.1	3.3	3.3	3.5	3.4	3.4	
Theatre active time (Target: >70%)	73.0	72.1	69.9	59.5	63.4	60.7	67.9	68.7	66.5	67.7	68.8	
Discharge summaries sent within 24 hours (Target: >70%)	78.2	79.7	80.0	dev	dev	dev	78.2	79.7	80.0	79.3	80.9	
Outpatient DNA rates (Target: <11.1%)	13.7	11.8	12.8	12.1	11.6	11.0	13.1	11.8	12.1	12.4	12.0	
On the day cancelled operations not re-booked within 28 days (Target: 0)	0	3	3	1	1	2	1	4	5	10	12	

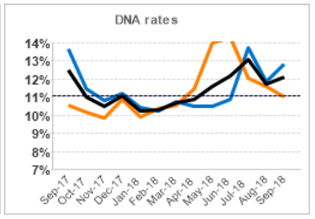






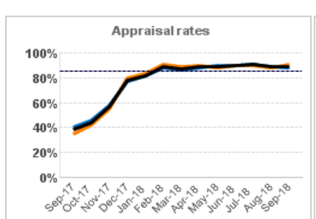


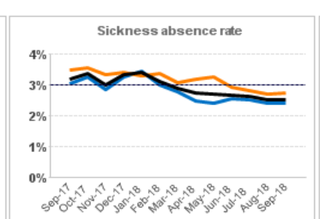


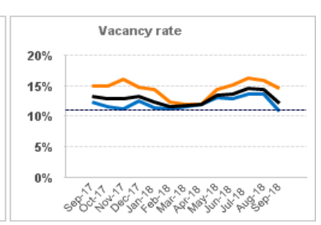


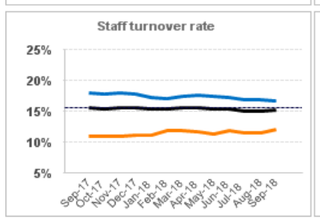
Workforce

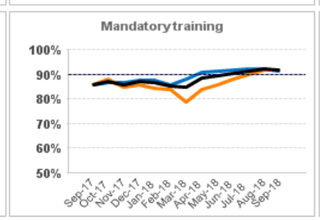
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Jul-18	Aug-18	Sep-18	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	90.5	88.7	87.9	90.1	88.3	90.4	90.4	88.6	88.7	89.2	89.3	
Sickness absence rate (Target: <3%)	2.52	2.41	2.41	2.80	2.69	2.73	2.61	2.50	2.52	2.54	2.62	
Vacancy rates (Target: CW<12%; WM<10%)	13.7	13.6	10.8	16.2	15.9	14.5	14.6	14.4	12.1	12.1	12.1	
Turnover rate (Target: CW<18%; WM<11.5%)	16.9	16.9	16.7	11.5	11.4	12.0	15.1	15.0	15.2	15.2	15.2	
Mandatory training (Target: >90%)	92.0	92.2	91.3	89.7	91.6	91.7	91.2	92.0	91.5	91.6	90.4	
Bank and Agency spend (£ks)	£3,035	£2,527	£2,137	£2,282	£2,191	£2,295	£5,317	£4,718	£4,432	£14,467	£28,691	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	6.0	5.3	4.5	7.1	5.0	5.2	6.4	5.2	4.8	5.5	6.3	

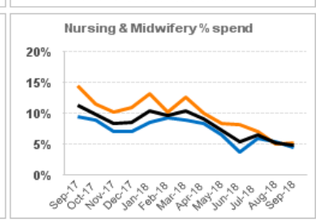












NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.5%	95.4%	95.1%	95.8%	98.8%	95.6%	94.7%	95.8%	96.8%	95.5%	94.9%	95.7%	95.8%		-
RTT	18 weeks RTT - Admitted (Target: >90%)	76.1%	73.3%	73.2%	74.4%	71.7%	73.4%	70.2%	78.7%	74.2%	73.4%	71.8%	73.2%	76.5%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	93.7%	94.7%	93.5%	94.3%	88.1%	84.9%	81.4%	87.6%	91.6%	90.9%	88.7%	90.4%	91.9%		!
	18 weeks RTT - Incomplete (Target: >92%)	91.6%	90.8%	91.4%	91.5%	92.9%	91.3%	92.6%	93.0%	92.2%	91.1%	92.0%	91.8%	92.2%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	97.5%	93.3%	97.0%	96.3%	91.9%	85.0%	84.3%	89.8%	93.8%	88.6%	89.4%	90.7%	92.4%		!
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	91.1%	93.3%	77.4%	90.5%	91.1%	93.3%	77.4%	88.4%	90.5%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Sep-18) in this report	31 days diagnosis to first treatment (Target: >96%)	88.9%	100%	97.0%	95.8%	100%	100%	96.0%	98.6%	96.5%	100%	96.4%	97.6%	97.4%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	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%)	82.6%	89.5%	94.7%	87.5%	89.9%	94.4%	83.6%	89.5%	87.6%	92.7%	87.4%	89.1%	88.8%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	87.5%	100%	100%	91.4%	87.5%	100%	100%	94.4%	91.4%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	1	1	1	3	0	0	1	4	1	1	2	4	7		!
Learning difficulties Access & Governance	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-
	Governance Rating	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-

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

Trust commentary

A&E Waiting Times - % of patients waiting >4 hours in Department

The A&E 4hr standard was narrowly missed in September, with performance of 94.9% against the 95% standard. This was the second highest performance in London and an improvement upon performance in September 2017 of 93.7%
The two Emergency Departments continue to be challenged by a year to date increase in attendances of 5.6%, which equates to 10,000 additional attendances in the last six months compared to the same period last year.

Cancer Indicators

Cancer - 2 Weeks from referral to first appointment all urgent referrals - the September position is unvalidated but is currently non-compliant and is not expected to achieve the 93% standard. This has been driven by breaches in colorectal and skin. The trust is forecasting returning to a compliant position in October.

Breast Symptomatic is expected to be non-compliant in September, with 12 patient choice related breaches. In all instances patients were offered dates within two weeks, either declining or rescheduling appointments planned on target. The trust is looking to make more offers within the first week of the pathway to try and allow for reschedules and working with a script to highlight the importance of attending on within 2 weeks to patients

The 62 day screening standard is 100% compliant

Cancer - 62 days GP referral to first treatment - the September position is unvalidated but is currently compliant and expected to achieve the 85% standard. Currently performance is at 87.8%.

Clostridium difficile infections

2 case of healthcare associated *Clostridium difficile* infections on Nell Gwynn and Kew wards in September 2018. No lapse in care identified on Kew patient. A delay in sending a specimen and a delay is isolation was noted during the Root Cause Analysis on the Nell Gwynn patient.

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Hand hygiene compliance (Target: >90%)	96.1%	95.5%	97.0%	96.5%	90.9%	100.0%	85.0%	91.3%	94.3%	97.1%	94.3%	95.3%	94.8%		-
Incidents	Number of serious incidents	3	3	1	9	5	3	4	20	8	6	5	19	29		-
	Incident reporting rate per 100 admissions (Target: >8.5)	8.8	8.4	8.5	8.1	9.7	9.4	9.8	9.5	9.2	8.9	9.1	9.1	8.8		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.02	0.02	0.07	0.02	0.00	0.02	0.04	0.01	0.01	0.02	0.05	0.03	0.02		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	511.63	560.31	411.87	503.64	319.44	407.40	200.62	263.69	412.01	489.84	308.64	399.96	385.98		-
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	10.9%	16.2%	15.5%	13.2%	18.6%	13.0%	7.4%	13.4%	14.0%	15.0%	12.9%	14.1%	13.3%		!
	Never Events (Target: 0)	0	0	1	1	0	0	0	0	0	0	1	1	1		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	97.2%	96.3%	96.6%	96.4%	90.7%	91.2%	95.9%	94.0%	93.5%	93.1%	96.2%	94.3%	95.0%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	NEWS compliance %	100.0%	96.0%	98.3%	97.5%	100.0%	97.8%	95.2%	98.1%	100.0%	96.8%	97.0%	97.4%	97.8%		-
	Safeguarding adults - number of referrals	28	23	31	149	15	17	0	60	43	40	31	114	209		-
	Safeguarding children - number of referrals	42	33	35	186	36	57	71	318	78	90	106	274	504		-
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	37	23	37	198	62	41	54	319	99	64	91	254	517		-
	Number of hospital deaths - Paediatric	1	1	2	5	0	0	0	0	1	1	2	4	5		-
	Number of hospital deaths - Neonatal	2	3	2	14	0	0	0	1	2	3	2	7	15		-
	Number of deaths in A&E - Adult	3	4	1	12	8	2	7	32	11	6	8	25	44		-
	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	1	0	0	0	0	0	0	0	0	1		-

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

Trust commentary

Hand Hygiene Compliance

Hand hygiene compliance 91% (target 95%); Hand hygiene audit completion 91.5%(target 100%)

Chelsea and Westminster Site – 97% completion, 97% compliance

West Middlesex Site – 86% completion, 85% compliance*

* It is believed that the low rates for completion at WM are due to changes in the audit process. The number of clinical areas undertaking hand hygiene audits is increasing.

Trust commentary continued

Number of serious incidents

5 Serious Incidents were reported during Sep-18; compared to 6 reported in Aug-18.

4 incidents occurred on the WMH site with the remaining 1on the CWH site. Table 2 within the SI report prepared for the Board reflects further detail regarding SI's, including the learning from completed investigations.

Incident reporting rate per 100 admissions

There is continued improvement in performance, with an overall reporting rate of 9.1% in Sept-18 (compared to 8.9% in Aug-18); higher than the target of 8.5%.

Higher reporting rates are associated with a more positive safety culture.

Work is underway to encourage the incident reporting rate at the CWH site, as this is below target.

Rate of patient safety incidents resulting in severe harm or death

6 incidents recorded as resulting in severe harm in Sept-18 (compared with one in Aug-18).

One incident led to a patient death; this is currently being investigated and is linked to recognition and rescue of a deteriorating patient.

2 out of the 6 incidents recorded as 'severe harm' relate to ophthalmology patients, where the degree of harm will be confirmed following clinical assessment, which may include surgical intervention.

Medication-related safety incidents

There is sustained improvement in the proportion of medication-related safety incidents reported.

The Medication Safety Group is leading a campaign to encourage staff to report no harm and near miss incidents, along with those that lead to harm.

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 309/100,000 FCE bed days in September 2018. This is higher than the Trust target of 280/100,000. There were 412 and 201 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively.

At both sites, there was a decline in reporting of medication incidents in this month compared to the previous months.

Medication-related (reported) safety incidents % with harm

The Trust had 12.9% medication-related safety incidents with harm in September 2018. This figure is lower than previous month, and is above the Carter dashboard National Benchmark (10.3%). The year to date figure is 13.3%.

There were 11 incidents with harm, 9 at CW site and 2 at WM site.

- Themes CW site (low harm): Incorrect preparation of medication administered; omitted doses due to incorrect documentation on administration chart; administration of medication when clinically not indicated; buprenorphine patch not changed; delayed prescribing of oxycodone PCA; delayed administration of pyridostigmine; incorrect prescribing of medications due to confusion between two patients on the ward; and misses doses of antibiotics.
- Themes CW site (moderate harm): Pharmacy dispensary error involving two antibiotics resulted in the incorrect administration of doses following hospital discharge
- Themes WM site (low harm): Discharge medications misplaced in pharmacy dispensary which were delivered to an incorrect ward resulting in a failed discharge and cancellation of package of care; and extravasation injury following amiodarone infusion

The Medication Safety Group continues to encourage medication-related incident reporting, monitor trends and aims to improve learning from medication related incidents.

Never Events

1 Never Event was reported, which relates to a unintended retained swab in the maternity unit at CWH. This incident is referred to within the Serious Incident Report and the outcome of the investigation will be reported to the Board.

Incidence of newly acquired category 3 & 4 pressure ulcers

The position for 2018/19 year to date is 4 compared to 9 for the same time period in 2017/18. This is a very positive reflection that the interventions put in place are working.

Safety Thermometer - Harm Score

The national safety thermometer data provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers. The nationally reported data for the Trust is showing a favourable position below the national average.

Safeguarding Adults

Recently appointed Adult safeguarding project officer will improve reporting from WM site. (12 were reported for September) WM capture of Domestic Abuse referral to IDVA continues to be a challenge.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	92.0%	93.6%	91.5%	91.9%	91.3%	92.7%	91.4%	91.4%	91.6%	93.1%	91.4%	92.1%	91.6%		-
	FFT: Inpatient not recommend % (Target: <10%)	4.2%	3.0%	3.5%	4.0%	3.6%	3.1%	3.8%	3.5%	3.9%	3.1%	3.7%	3.5%	3.7%		-
	FFT: Inpatient response rate (Target: >30%)	45.6%	48.8%	40.5%	43.7%	39.5%	38.9%	37.4%	42.4%	41.9%	42.7%	38.5%	41.0%	42.9%		-
	FFT: A&E recommend % (Target: >90%)	89.9%	90.8%	91.4%	90.2%	88.6%	89.9%	89.9%	86.8%	89.7%	90.6%	91.1%	90.5%	89.6%		!
	FFT: A&E not recommend % (Target: <10%)	5.9%	5.8%	5.1%	6.0%	5.8%	5.4%	5.6%	7.2%	5.9%	5.7%	5.2%	5.6%	6.2%		-
	FFT: A&E response rate (Target: >30%)	21.0%	21.8%	23.6%	21.2%	19.4%	23.6%	18.1%	18.1%	20.7%	22.1%	22.3%	21.7%	20.5%		!
	FFT: Maternity recommend % (Target: >90%)	92.4%	91.2%	89.3%	91.0%	95.3%	93.8%	96.7%	95.3%	93.0%	91.6%	90.3%	91.5%	91.9%		-
	FFT: Maternity not recommend % (Target: <10%)	3.6%	4.7%	6.7%	5.3%	3.5%	4.1%	0.0%	2.5%	3.6%	4.6%	5.8%	4.8%	4.7%		-
	FFT: Maternity response rate (Target: >30%)	26.4%	22.8%	22.8%	23.2%	21.4%	25.3%	24.5%	25.0%	25.3%	23.1%	23.1%	23.6%	23.5%		!
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	45	33	28	239	40	30	25	207	85	63	53	201	446		-
	Complaints formal: Number responded to < 25 days	33	24	11	177	30	21	9	139	63	45	20	128	316		-
	Complaints (informal) through PALS	172	145	135	801	50	27	51	428	222	172	186	580	1229		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	1	1	0	0	1	1	1		-

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

Trust commentary

Friends and Family Test

Inpatient areas across both sites of the Trust continue to achieve above the 30% response rate and the 90% recommendation score. The West Middlesex Emergency Department narrowly missed the 90% recommendation score but the Trust achieved the target at an aggregate level. The response rate continues to increase for the Emergency Department at the Chelsea site but has decreased at West Middlesex. The recommendation score dropped slightly at the CW site this month though overall there continues to be improvement against the response rate target.

Same Sex accommodation

There have been no breaches in same sex accommodation

Complaints

96% of complaints were acknowledged within the 2 day target and 70% of complaints were responded to within 25 working days for September. Plans are in place for October to ensure that an effective escalation process is embedded to prevent further decline in performance.

Parliamentary and Health Service Ombudsman

1 complaint has been upheld by the PHSO and the Trust is currently working to address the actions raised by the ombudsman.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.88	3.27	4.44	3.73	2.73	2.52	3.18	3.12	2.84	3.11	4.16	3.37	3.59		-
	Average length of stay - non-elective (Target: <3.95)	3.67	3.89	4.04	3.94	3.02	2.88	3.14	3.09	3.29	3.31	3.53	3.37	3.45		-
	Emergency care pathway - average LoS (Target: <4.5)	4.01	3.85	4.92	4.45	3.41	3.22	3.61	3.53	3.62	3.45	4.08	3.71	3.86		-
	Emergency care pathway - discharges	225	219	207	1284	418	390	378	2307	643	609	585	1839	3592		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	3.98%	3.41%	3.75%	3.77%	12.12%	11.20%	10.32%	10.52%	7.86%	7.16%	6.96%	7.34%	6.98%		!
	Non-elective long-stayers	455	391	391	2500	368	334	377	2085	823	725	768	2316	4585		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	91.3%	78.4%	86.8%	83.5%	84.1%	82.3%	84.1%	85.6%	88.9%	79.8%	85.8%	84.9%	84.3%		!
	Operations canc on the day for non-clinical reasons: actuals	7	10	8	68	16	12	13	57	23	22	21	66	125		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.24%	0.38%	0.32%	0.41%	1.34%	1.00%	1.15%	0.75%	0.57%	0.57%	0.58%	0.57%	0.52%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	3	3	8	1	1	2	4	1	4	5	10	12		!
	Theatre active time (Target: >70%)	73.0%	72.1%	69.9%	71.0%	59.5%	63.4%	60.7%	65.0%	67.9%	68.7%	66.5%	67.7%	68.8%		!
	Theatre booking conversion rates (Target: >80%)	85.9%	85.4%	86.1%	85.5%	93.7%	94.2%	90.9%	91.1%	88.5%	88.6%	87.8%	88.3%	87.5%		-
Outpatients	First to follow-up ratio (Target: <1.5)	1.41	1.52	1.52	1.48	1.43	1.43	1.50	1.40	1.42	1.45	1.50	1.46	1.42		-
	Average wait to first outpatient attendance (Target: <6 wks)	6.7	6.7	7.1	6.8	5.8	5.4	5.9	6.3	6.3	6.1	6.6	6.3	6.6		!
	DNA rate: first appointment	14.1%	12.7%	12.9%	12.3%	11.8%	11.4%	11.1%	12.4%	13.1%	12.1%	12.1%	12.4%	12.3%		-
	DNA rate: follow-up appointment	13.5%	11.5%	12.8%	11.5%	12.3%	11.8%	11.0%	12.4%	13.1%	11.6%	12.2%	12.3%	11.8%		-

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

Trust commentary

Average Length of Stay – Elective

The average length of data Chelsea Site has seen a large rise as a result of two Paediatric High Dependency patients discharged in September having stayed a total of 475 days. At the West Middlesex Site, one long stayer has been validated as correct.

Non-Elective and Emergency Care LoS

The September figures for the Chelsea site are being skewed by two very long-stayers. There have also been rises against these two metrics at the West Middlesex site. The Trust will continue to pursue and deliver improvement ahead of winter 18/19 and is a strong focus for the BEDS/LOS work stream, and is being tracked via the system-wide AE Delivery Board.

Procedures carried out as Daycases - basket of 25 procedures

The Chelsea site saw a rise in September to more normal levels. At West Middlesex it was slightly below target due to an all-day oral list being cancelled because of anaesthetist sickness.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	84.9%	89.6%	89.2%	88.3%	88.9%	86.0%	88.9%	85.7%	86.8%	88.0%	89.1%	87.8%	87.3%		!
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	90.9%	100.0%	100.0%	96.8%	93.3%	85.7%	100.0%	88.2%	92.3%	92.9%	100.0%	95.2%	92.7%		-
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	95.6%	100.0%	100.0%	92.9%	97.8%	97.6%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	94.2%	93.7%	94.0%	93.7%				84.7%	94.2%	93.7%	94.0%	94.0%	91.5%		!
TB Care	TB: Number of active cases identified and notified	3	5	2	19	5	10	4	29	8	15	6	29	48		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

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Trust commentary

Dementia Screening Case Finding

We recognise there is an issue with Data Quality in relation to this indicator. A manual audit undertaken in August/September demonstrated 93% compliance across the Trust.

Fracture Neck of Femur Time to Theatre within 36 hours

At the Chelsea Site no patient failed to meet the 36 hour target when medically fit. Four others were delayed for their surgery but they were awaiting medical reviews prior to Surgery and were deemed unfit at the 36 hour mark and are therefore excluded from the analysis.

At the West Middlesex site, all patients deemed medically fit were seen in Theatre within 36 hours. There were 4 patients in the categories outlined above who were again excluded from the analysis.

VTE Hospital-acquired

C&W site: Manual identification of positive VTE events from radiology reports in progress, with review of hospital records to establish hospital associated VTE events for root cause analysis investigation. HATs reported on Datix.

WMUH site: A multidisciplinary thrombosis pathway implemented in Ambulatory Emergency Care review all VTEs on a weekly basis; potential HATs are identified and reported on Datix by AEC staff. Further discussion is ongoing with Information Department to capture performance.

VTE Risk assessments completed

C&W site: Performance slightly increased compared to previous month but target not achieved. Performance has been disseminated to divisions to highlight amongst clinical teams, with support for areas not meeting ≥95% target. Weekly and monthly VTE performance reports continue to be circulated to all divisions for dissemination and action, with inclusion in divisional quality reports. VTE magnets are displayed on ward patient noticeboard to inform of VTE risk assessment status. Lists of patients will outstanding assessments are circulated to medical teams for action.

WMUH site: Performance is not reported since May 2018 as new reporting queries require development by EMIC Information Business Partner (issues with reporting solution and integration complications with eCamis, RealTime and Cerner); thus unable to provide commentary.

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	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%)	98.85%	98.82%	98.66%	98.83%	99.33%	99.35%	97.34%	98.60%	99.15%	99.17%	97.76%	98.73%	98.69%		!
	Diagnostic waiting times >6 weeks: breach actuals	32	30	28	188	30	31	118	390	62	61	146	269	578		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.1%	9.2%	9.1%	9.0%	8.4%	8.8%	8.3%	8.3%	8.9%	9.0%	8.8%	8.9%	8.8%		!
	A&E time to treatment - Median (Target: <60')	01:09	01:04	01:02	01:06	00:47	00:39	00:57	00:47	01:02	00:56	01:01	01:00	01:00		!
	London Ambulance Service - patient handover 30' breaches	13	13	8	63	30	72	54	315	43	85	62	190	378		-
	London Ambulance Service - patient handover 60' breaches	0	1	0	1	0	0	0	2	0	1	0	1	3		-
Choose and Book (available to Jul-18 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	1172	2257	2580	1737	0	0	0	0	1172	2257	2580	1989	1737		-
	Choose and book: capacity issue rate (ASI)															-
	Choose and book: system issue rate	133	130	143	126											-

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Trust commentary

Diagnostic waiting times % <6weeks

The Trust disappointingly failed to meet the 99% target for this metric in September, following from three consecutive successful months. There were pressures at the West Middlesex site in Endoscopy and Computed Tomography which are being looked into.

Diagnostic waiting times >6weeks: breach actuals

As referred to above, the West Middlesex site saw a large increase in breach actuals in September. Gastroscopy; Cystoscopy and Sigmoidoscopy accounted for 77 or 65% of the 118 breaches. There were similar issues in Radiology with 18 or 16% of the breaches showing in CT. The Chief Operating Officer has engaged the Intensive Support team to help support a thorough review of demand ad capacity across a number of challenged specialities, including Imaging.

RTT Incomplete 52 week waiters at month end

The Trust is again reporting no breaches of this metric and has reported no breaches for over 2 years

London Ambulance Service handover breaches

The number of 30 minute breaches dropped to 8 at the Chelsea Site and from 72 to 54 at the West Middlesex Site – the latter being a 25% drop. There were no breaches of the 60 minute target.

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Birth indicators	Total number of NHS births	526	480	529	2918	410	393	390	2316	936	873	919	2728	5234		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	33.2%	31.5%	37.7%	34.5%	30.5%	30.2%	31.6%	29.2%	32.0%	30.9%	35.1%	32.7%	32.2%		!
	Midwife to birth ratio (Target: 1:30)	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30		-
	Maternity 1:1 care in established labour (Target: >95%)	98.6%	96.4%	95.1%	96.6%	95.6%	97.3%	96.3%	97.5%	97.3%	96.8%	95.7%	96.6%	97.0%		-
Safety	Admissions of full-term babies to NICU	19	21	13	96	n/a	n/a	n/a	n/a	19	21	13	53	96		-

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

In September there were a total of 520 mothers delivering 529 births at the Chelsea site and 383 mothers delivering 390 births at West Middlesex

Caesarean Section rates

Chelsea and Westminster Site

There was a total of 37.7%

There were a total of 108 elective CS at the Chelsea site. 36 births (33.3%) were for previous Caesarean birth, (18) 16.7% for breech presentation, (14) 13% for maternal health reasons and (15) 13.9% were for maternal choice, (6) 5.6% were for multiple pregnancy.

A total of 88 women had an emergency C/S. The main reason for this was for failure to progress in labour 36 (40.9%). 23 (26.1%) were for fetal distress. 7 (7.95) women had a C/S for unsuccessful instrumental birth.

West Middlesex site

There was a total of 31.6%

At the West Middlesex site there was a total of 36 elective CS performed. 18 (50%) were for previous Caesarean birth. 6 (16.7%) were for breech presentation, 3 (8.3%) were for a malposition of the baby and 3 (8.3%) were for a transverse lie of baby.

85 women had an emergency C/S birth. 29 (34%) failed to progress throughout labour. 20 (23.5%) had fetal distress, whilst 11 (12.9%) showed signs of an abnormal fetal heart rate. 10 women (11.8%) had a breech presentation requiring emergency birth whilst 8 (9.4%) had the procedure for previous C/S birth.

The service continues to support women who choose to have a C/S by providing the birth choice clinic. This clinic is run by experienced consultant midwives who guide the woman in her choice. There is a current review of 'Birth after Caesarean section' guideline and pathway in order to support increased uptake of vaginal birth after Caesarean.

There was a good Caesarean section divisional plan throughout September which led to excellent planning for elective surgery, as well as balancing the need for emergency procedures.

Admissions of full-term babies to NICU

It is of note that there was a significant reduction in term babies admitted to NICU at CW during September, despite the significant increase in births at this time. This triangulates with the low activity within NICU for September.

Workforce Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	13.7%	13.6%	10.8%	10.8%	16.2%	15.9%	14.5%	14.5%	14.6%	14.4%	12.1%	12.1%	12.1%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	16.9%	16.9%	16.7%	16.7%	11.5%	11.4%	12.0%	12.0%	15.1%	15.0%	15.2%	15.2%	15.2%		-
	Sickness absence (Target: <3%)	2.5%	2.4%	2.4%	2.5%	2.8%	2.7%	2.7%	2.9%	2.6%	2.5%	2.5%	2.5%	2.6%		-
	Bank and Agency spend (£ks)	£3,035	£2,527	£2,137	£15,060	£2,282	£2,191	£2,295	£13,631	£5,317	£4,718	£4,432	£14,467	£28,691		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	6.0%	5.3%	4.5%	5.7%	7.1%	5.0%	5.2%	7.3%	6.4%	5.2%	4.8%	5.5%	6.3%		-
Appraisal rates	% of Performance & Development Reviews completed - medical staff (Target: >85%)	93.1%	93.7%	90.2%	89.9%	86.0%	84.9%	100.0%	86.9%	90.2%	90.4%	93.4%	91.4%	88.7%		-
	% of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%)	90.2%	87.9%	87.4%	87.4%	90.9%	88.9%	88.9%	88.9%	90.4%	88.2%	87.9%	87.9%	87.9%		-
Training	Mandatory training compliance (Target: >90%)	92.0%	92.2%	91.3%	91.5%	89.7%	91.6%	91.7%	88.3%	91.2%	92.0%	91.5%	91.6%	90.4%		-
	Health and Safety training (Target: >90%)	96.5%	96.5%	95.6%	96.0%	94.8%	95.4%	95.1%	94.2%	95.9%	96.1%	95.4%	95.8%	95.4%		-
	Safeguarding training - adults (Target: 90%)	94.5%	94.4%	93.9%	94.3%	94.1%	94.5%	94.3%	93.6%	94.3%	94.5%	94.0%	94.3%	94.1%		-
	Safeguarding training - children (Target: 90%)	94.4%	94.8%	94.3%	93.7%	93.7%	94.9%	94.9%	93.0%	94.2%	94.9%	94.5%	94.5%	93.4%		-

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

Trust commentary

Workforce Commentary September 2018 Figures

Staff in Post

In September we employed 5481 whole time equivalent (WTE) people on substantive contracts, 29 WTE more than last month.

Turnover

Our voluntary turnover rate was 15.16%, increase of 0.11% from last month. Voluntary turnover is 16.74% at Chelsea and 12.01% at West Middlesex.

Vacancies

Our general vacancy rate for July was 12.1%, which is 2.2% lower than last month. The vacancy rate is 10.81% at West Middlesex and 14.53% at Chelsea.

Sickness Absence

Sickness absence in the month of August was 2.52%, 0.17% lower than July. (we will now be reporting sickness two months in arrears due to timing issues)

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 91% against our target of 90%.

Performance and Development Reviews

The PDR rate decreased by now stands at 87.92%.

The rolling annual appraisal rate for medical staff was 93.41%, 2.98% higher than last month.

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	Jul-18	Aug-18	Sep-18	2018-2019	YTD breaches	Jul-18	Aug-18	Sep-18	2018-2019	YTD breaches	Jul-18	Aug-18	Sep-18	2018-2019 Q2	2018-2019	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Brain	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a	n/a	0		-
	Breast	n/a	n/a	n/a	n/a		100%	100%	100%	100%	0	100%	100%	100%	100%	100%	0		-
	Colorectal / Lower GI	100%	100%	n/a	94.6%	1	94.1%	100%	100%	89.7%	2	96.0%	100%	100%	96.8%	92.1%	3		-
	Gynaecological	100%	100%	100%	81.3%	1.5	83.3%	100%	n/a	73.3%	2	87.5%	100%	100%	91.7%	77.4%	3.5		-
	Haematological	n/a	100%	100%	100%	0	100%	100%	n/a	85.2%	2	100%	100%	100%	100%	88.6%	2		-
	Head and neck	0.0%	100%	n/a	87.5%	0.5	n/a	100%	100%	75.0%	1.5	0.0%	100%	100%	80.0%	80.0%	2		-
	Lung	n/a	50.0%	100%	80.0%	0.5	50.0%	100%	0.0%	57.1%	1.5	50.0%	66.7%	66.7%	62.5%	66.7%	2		!
	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	92.3%	100%	100%	94.1%	2	100%	100%	100%	97.1%	0.5	95.2%	100%	100%	97.9%	95.1%	2.5		-
	Upper gastrointestinal	0.0%	66.7%	100%	76.9%	1.5	100%	75.0%	100%	92.9%	0.5	66.7%	71.4%	100%	75.0%	85.2%	2		-
	Urological	76.2%	60.0%	100%	78.1%	8	80.0%	71.4%	66.7%	82.3%	10	78.6%	66.7%	73.1%	75.5%	80.6%	18		!
	Urological (Testicular)	n/a	n/a	n/a	100%	0	100%	n/a	n/a	100%	0	100%	n/a	n/a	100%	100%	0		-
	Site not stated	n/a	n/a	100%	66.7%	0.5	100%	100%	0.0%	66.7%	0.5	100%	100%	66.7%	80.0%	66.7%	1		-

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

Trust commentary

The current unvalidated performance for September for the 62 day target to first treatment for GP referrals stands at 87.8%.

No breaches of this metric are showing at the Chelsea site from 11 treatments identified.

At the West Middlesex site, 4.5 breaches are reported from 37 treatments.

Broken down by Site, the breaches are as follows:

Lung
0.5 breaches from 0.5 treatments

Site not yet identified by coding
0.5 breaches from 0.5 treatments

Urological
3.5 breaches from 10.5 treatments

Please note: a breach can be shared between organisations, hence the fractions above

CQUIN Dashboard

September 2018

National CQUINs

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
A.1	Improvement of health and wellbeing of NHS staff	Chief Financial Officer	
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	Chief Financial Officer	
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	Chief Operating Officer	
E.1	Preventing ill health through harmful behaviours - alcohol and tobacco consu	Deputy Chief Executive	
F.1	STP Local Engagement	Chief Financial Officer	

NHS England CQUINs

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
N1.1	Enhanced Supportive Care	Medical Director	
N1.2	Nationally standardised Dose banding for Adult Intravenous Anticancer Thera	Medical Director	
N1.3	Optimising Palliative Chemotherapy Decision Making	Medical Director	
N1.4	Hospital Medicines Optimisation	Medical Director	
N1.5	Neonatal Community Outreach	Chief Operating Officer	
N1.6	Dental Schemes - recording of data, participation in referral management & p	Chief Operating Officer	
N1.7	Armed Forces Covenant	Chief Operating Officer	

CQUIN Scheme Overview

2018/19 CQUIN Scheme Overview

The Trust has agreed 12 CQUIN schemes (5 national schemes for CCGs, 7 national schemes for NHS England) for 2018/19. Relative to 17/18, there is a new 1 year CCG scheme replacing a previous 1 year scheme, and the withdrawal of a further CCG scheme was confirmed in the 18/19 Planning Guidance.

Q1 reports were submitted to Commissioners on time at the end of July 2018 and have received a provisional assessment from each Commissioner. Final achievement for Q1 will be confirmed in the October report.

2018/19 National Schemes (CCG commissioning)

Forecasting an outcome for these schemes will be more difficult this year. The Trust has reached agreement with Commissioners for CQUIN funds to be paid in full, on the understanding that delivery will be on the basis of 'reasonable endeavours' and will not incur additional investment. Where possible within existing resources, scheme leads will be aiming to meet the requirements set out for those schemes, but will otherwise prioritise which aspects to work on. Whilst the actual delivery achievements of last year are unlikely to be matched, there will be no financial risk associated with the schemes. The forecast RAG rating for each scheme relates to expected delivery of the specified milestones, rather than financial performance. The requirements of the Local Scheme relating to Trust engagement with STP planning and development work are expected to be met in full.

2018/19 National Schemes (NHSE Specialised Services commissioning)

The Trust is expecting good results for 6 of the 7 schemes, and in line with last year's achievement in the case of the 2 year schemes. Discussion with the Commissioner about tailoring the Neonatal Community Outreach scheme to the Trust's circumstances were successfully concluded and an implementation plan has subsequently received approval from the Executive board. The forecast RAG rating for each scheme reflects expected delivery of the milestones, as well as the associated financial performance.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Nursing Metrics Dashboard

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	92.5%	91.5%	94.1%	90.3%	7.4	2.9	10.3	13.0
Annie Zunz	98.7%	87.5%	96.7%	99.8%	5.4	2.3	7.7	8.6
Apollo	88.1%	76.7%	89.3%	10.3%	20.5	2.0	22.5	
Jupiter	103.4%	87.5%	105.0%	-	11.7	4.3	15.9	12.6
Mercury	70.7%	83.3%	66.1%	13.3%	8.5	0.9	9.5	8.3
Neptune	76.2%	64.6%	69.2%	0.0%	8.5	0.8	9.4	12.6
NICU	108.9%	-	108.0%	-	13.8	0.0	13.8	
AAU	105.3%	76.6%	99.5%	103.2%	9.7	2.2	11.9	10.8
Nell Gwynn	110.4%	86.0%	134.7%	101.1%	4.3	3.3	7.7	7.8
David Erskine	110.9%	99.8%	123.3%	115.3%	3.8	3.2	7.0	6.4
Edgar Horne	96.9%	94.9%	98.9%	99.1%	3.1	3.3	6.5	7.6
Lord Wigram	92.4%	90.5%	98.9%	103.3%	3.7	2.7	6.5	6.7
St Mary Abbots	99.8%	91.4%	101.2%	103.3%	3.9	2.7	6.5	7.4
David Evans	90.9%	84.5%	88.8%	120.0%	5.6	2.3	7.9	7.4
Chelsea Wing	89.3%	96.1%	100.1%	103.4%	11.3	7.5	18.8	7.4
Burns Unit	105.4%	95.3%	112.1%	100.0%	17.8	3.6	21.4	
Ron Johnson	93.1%	126.7%	99.0%	118.5%	4.5	3.1	7.7	7.9
ICU	99.1%	-	99.6%	-	23.4	0.0	23.4	22.9
Rainsford Mowlem	96.8%	92.0%	110.0%	107.5%	3.4	3.1	6.5	7.8

West Middlesex University Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	90.9%	92.5%	91.3%	96.8%	8.0	1.9	9.9	13.0
Lampton	104.1%	105.4%	99.8%	106.7%	2.9	2.6	5.6	7.8
Richmond	94.5%	89.8%	77.0%	51.7%	6.4	3.1	9.4	7.4
Syon 1	108.0%	97.1%	112.0%	108.3%	4.0	2.1	6.1	7.4
Syon 2	100.6%	127.9%	100.2%	160.1%	3.5	2.9	6.4	6.7
Starlight	75.5%	244.0%	109.6%	-	6.3	0.8	7.0	12.6
Kew	95.1%	91.8%	131.9%	156.2%	3.8	3.4	7.2	7.8
Crane	100.3%	95.2%	100.0%	98.3%	3.1	2.4	5.5	7.6
Osterley 1	116.4%	105.4%	98.3%	136.6%	3.6	2.8	6.4	7.8
Osterley 2	101.6%	97.0%	101.7%	200.0%	3.6	3.1	6.7	7.8
MAU	96.8%	89.4%	92.6%	96.4%	6.1	3.1	9.3	10.8
CCU	99.2%	93.3%	98.6%	28.6%	5.4	0.7	6.1	6.6
Special Care Baby Unit	112.5%	-	100.7%	-	8.6	0.0	8.6	12.6
Marble Hill 1	82.9%	96.7%	93.6%	106.7%	3.5	2.7	6.2	7.8
Marble Hill 2	104.8%	107.2%	105.6%	150.0%	3.2	3.2	6.4	8.8
ITU	99.4%	0.0%	91.1%	-	29.4	0.0	29.4	22.9

Summary for September 2018

Summer bed closures on Neptune, Mercury and Apollo resulted in lower staffing requirements on these wards, therefore staffing reduced.

HCAs recently introduced on Starlight ward – but not yet in roster template so showing over-filled.

David Erskine, Nell Gwynne & Kew show high fill rates for registered staff due to RMN usage for patients with mental health needs.

Additional HCAs booked to care for confused patients at high risk of falls on Osterley 1, Marble Hill 2 and Kew and for high acuity on Osterley 2.

Increased HCAs booked for dependency of patients on Syon 2 and Kew.

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 and on ITU due to a number of new starters supernumerary shifts.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

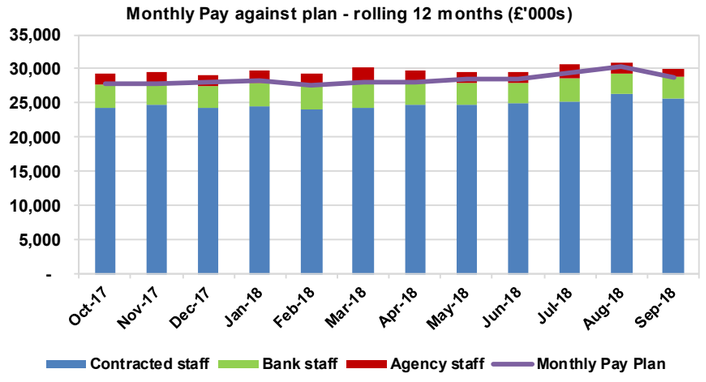
Finance Dashboard

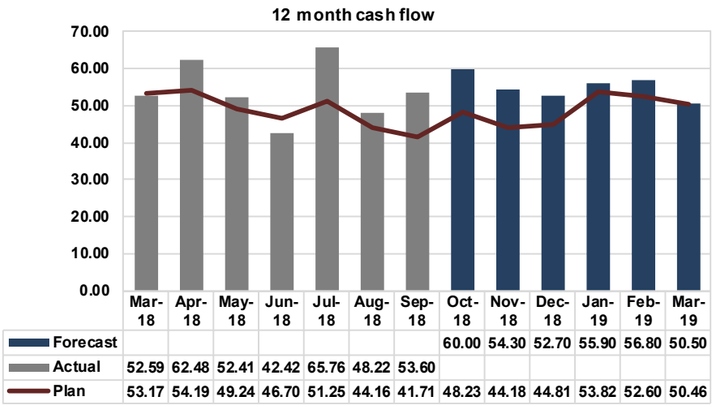
Month 6 2018-19 Integrated Position

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	330,472	333,472	3,000
Expenditure			
Pay	(173,676)	(180,309)	(6,632)
Non-Pay	(137,417)	(134,236)	3,181
EBITDA	19,379	18,928	(451)
EBITDA %	5.86%	5.68%	-0.19%
Depreciation	(9,320)	(8,952)	368
Non-Operational Exp-Inc	(8,252)	(8,132)	120
Surplus/Deficit	1,807	1,844	37
Control total Adj - Donated asset, Impairment & Other		224	224
Surplus/Deficit on Control Total basis	1,807	2,068	260

Comments

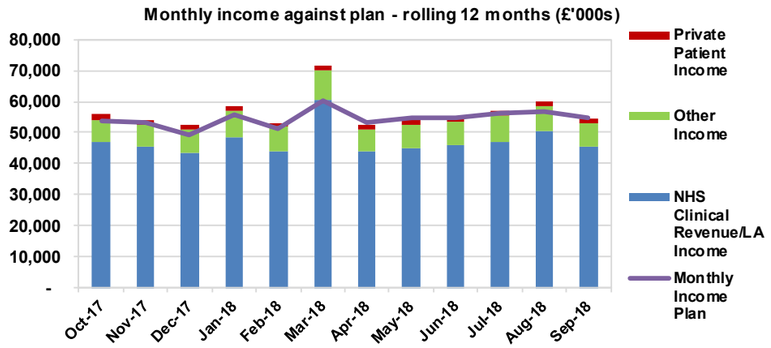
The Trust is reporting a YTD surplus of £1.84 which is £0.04k favourable against the internal plan. Income favourable variance is driven by A&E, Emergency admissions, obstetric deliveries and settlement of the 2017/18 position with CCGs. Elective and critical care continue to underperform. Pay is adverse by £6,632k year to date, The Trust continues to use bank and agency staff to cover vacancies, sickness and additional activity. There has also been supernumery staffing to cover new medical starter post rotation. The largest contributor to this position has been under achievement against CIP targets. Non-pay is £120k favourable year to date. Included in this position is a deficit against clinical supplies which is activity driven.

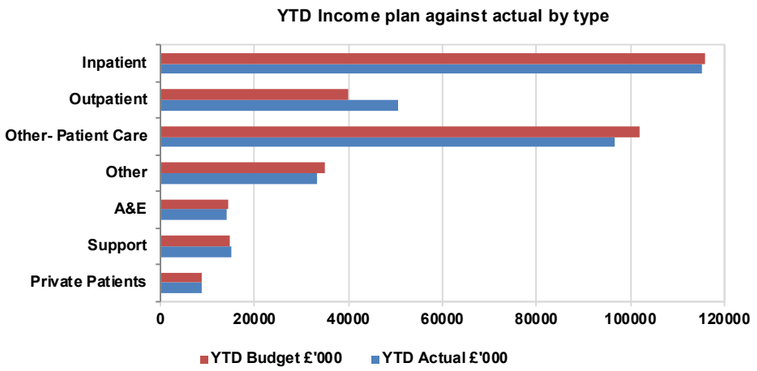


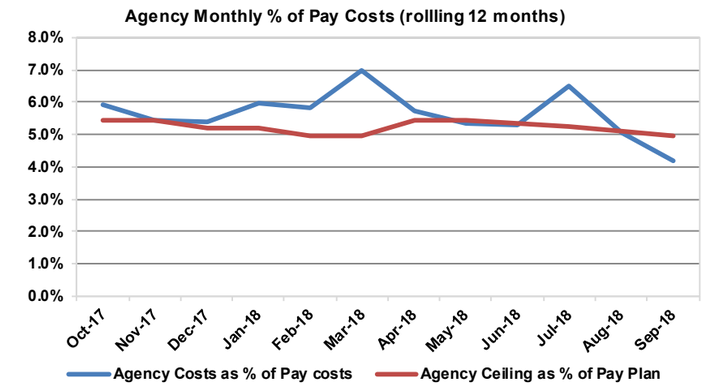


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Forecast								60.00	54.30	52.70	55.90	56.80	50.50
Actual	52.59	62.48	52.41	42.42	65.76	48.22	53.60						
Plan	53.17	54.19	49.24	46.70	51.25	44.16	41.71	48.23	44.18	44.81	53.82	52.60	50.46

Comment: The higher cash balance (compared to plan) is cash b/fwd @ £4m plus receipts of £14m (mainly: 2 months VAT reclaims @ £3.9m; setllement of prior year invoices @ £5.5m; earlier receipt of Q1 PSF @ £2.9m and maternity incentice @ £1.1m); offset by capital funding received in October @ £5.6m and other outflows @ £0.7m.

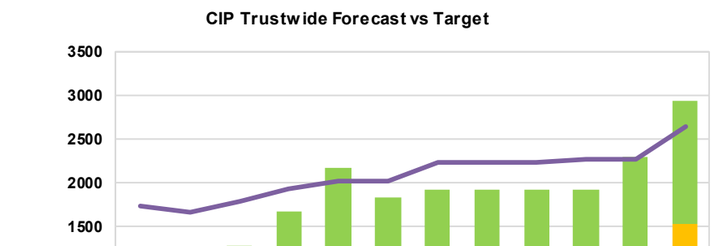




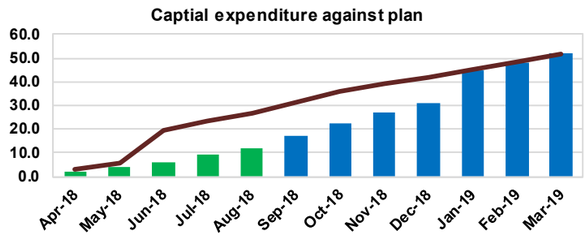


Comment

The increase in agency costs in July is predominantly related to non-recurrent EPR implementation and floor walker costs (£0.2m).



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Green	1026	1102	1162	1571	1990	1387	1442	1435	1432	1372	1378	1404
Amber	52	56	123	99	163	338	434	443	464	529	549	1091
Red	0	0	0	0	25	107	44	44	25	25	370	439
Target	1732	1669	1791	1941	2029	2029	2230	2236	2242	2267	2280	2653



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	1.7	4.1	6.0	9.0	11.6							
Forecast						17.0	22.5	26.9	31.1	45.0	48.1	51.90
Plan	2.7	5.6	19.4	23.1	26.9	31	36	39	42	45	48	51.90

Comment: Underspend against plan, to the end of M6, is mainly due to delays in securing a contractor for the NICU project as well as securing funding arrangements for the Modular Maternity Building

Use of Resources rating

Rating	Aug-18 YTD Plan	Aug-18 YTD Actual
Capital Service rating	2	2
Liquidity rating	1	1
I&E Margin rating	2	2
I&E distance from plan	1	1
Agency rating	1	2
UORR before override M4	1	2
UORR after override M4	1	2

BPPC % of bills paid within target

Year to Date	Current Month %	Previous Month %	Variance %
By number	89.1%	88.6%	0.6%
By value	80.4%	78.8%	1.6%
Creditor days	92	97	(5)
Debtor Days	46	46	(2)

Date Time of Production: 29/10/2018 13:15

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.4.1/Nov/18
REPORT NAME	Winter Plan
AUTHOR	Laura Bewick, General Manager, Acute and Emergency Care
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	The Winter Plan sets out the Trust's arrangements for ensuring service delivery throughout winter 2018-19
SUMMARY OF REPORT	The Winter Plan details a number of initiatives to help meet the challenges of winter, as well as service specific plans for each of the effected service areas. Key initiatives include: • Expansion of Ambulatory Care services on both hospital sites • Development of an Enhanced Care area at West Middlesex • Focus on internal flow, Delayed Discharges and Long Stay Patients • Management of escalation beds • Phasing of elective activity • Improved senior support to site, 7 days per week
DECISION/ ACTION	The Board is asked to note this report.

Winter Plan – 2018/19

Chelsea and Westminster Hospital NHS Foundation Trust

Contents

1 Introduction

1.1 Aims of the Plan

The Trust-wide Winter Plan sets out the organisations arrangements for ensuring service delivery throughout winter 2018-19. For the purposes this document 'winter' is defined as November through until March.

Although not an emergency or unexpected event, the winter period sees an increase in emergency and non-elective demand and increased clinical acuity of patients, resulting in increased pressure on patient flow and hospital resources.

The winter period also often brings with it untoward events such as widespread infectious diseases including Norovirus, and there is the risk of the onset of pandemic flu.

The plan follows guidance from the NHS England and NHS Improvement in terms of content and approach and recognises key risks to patient care, safety and experience, as well as to the organisation.

In partnership with winter plans across the wider health and social care system, the Trust plan sets out a number of initiatives to help meet the challenges of winter, as well as service specific plans for each of the effected service areas. Key initiatives include:

Front Door Schemes

- Expansion of Ambulatory Care services on both hospital sites
- Development of an Enhanced Care area within the AMU at West Middlesex

Bed Occupancy Schemes

- Focus on internal flow, Delayed Discharges and Long Stay Patients
- Increased discharges through Home First
- Management of escalation beds
- Phasing of elective activity

Trust Wide Schemes

- Improved senior support to site, 7 days per week
- Infection Prevention & Control
- Influenza
- Weather

2 Context

2.1 The Trust

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT, the 'Trust') is a major, multi-site North West London healthcare provider and teaching hospital consisting of Chelsea and Westminster Hospital situated in the borough of Kensington and Chelsea, and West Middlesex University Hospital, situated in Hounslow.

Both hospitals offer core local services including 24/7 adult and paediatric A&E services with co-located Urgent Care Centres (UCCs), a full maternity service and a range of medical and surgical specialties.

The Trust has 1,000 beds and serves a local population of 1.1m. In 2017/18 there were over 300,000 attendances to the A&E and Urgent Care Centres across both sites; the 5th highest number of attendances at an acute Trust in England.

2.2 Performance

The Trust has continued to perform well against the 4 hour unscheduled care target (95%) in 2018/19, having achieved the target in all months to date. This is despite a 7% increase in emergency attendances.

Winter is historically the most challenging time in terms of our performance; however it is our expectation that we will continue to maintain a 95% achievement against the 4 hour target throughout the winter period as a minimum. This is reflected in a challenging STF trajectory:

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Trajectory	93.8	93.8	93.8	94.8	94.8	94.8	94.6	94.6	94.6	94.6	94.4	95.0
Performance	95.0	95.7	95.1	95.7	95.5							

3 Front Door Schemes

Evidence suggests that the longer patients wait in the Emergency Department the greater risk there is to morbidity and mortality, and that 'boarding' (patients remaining in the department whilst waiting for a suitable inpatient bed to become available) is likely to increase length of stay, detract from overall patient experience and risk breakdown in communications because of the number of hand offs/transfers involved. Patients waiting in the Emergency Department for an inpatient bed also reduce the capacity in the department to see and treat patients, resulting in longer waiting times in the department and impacting on the ability of ambulance teams to unload patients.

A number of schemes will therefore be in place for the winter period to maintain patient flow through, and safety in, the Emergency Department. This includes an increased ambulatory care offering, providing an alternative setting to care in the Emergency Department, and the creation of Enhanced Care Unit at West Middlesex for patients requiring admission from A&E resus. Opportunities to increase use of volunteers to support patient flow are also being explored.

3.1 Expansion of Ambulatory Care services on both hospital sites

The Trust currently runs an ambulatory care service on both sites but from November 2018 will be expanding the service to offer initially a 6 day clinically led service from 8am to 8pm with a nurse led service remaining on Sundays. The Trust will then shortly look to increase to a 7 day clinically led service. The expansion of services on both sites will help mitigate the forecasted growth in NEL activity by redirecting patients from ED into Ambulatory Care to avoid an admission, as well as enabling patients to be discharged from an inpatient stay with rapid follow up in AEC. The expanded services allow for a 30% increase from current activity on the West Mid site and 50% on the CW site.

The Trust is developing a standardised set of pathways that will be offered on both sites, with additional pathways already in place at the West Mid site. Each site is establishing hot clinics with a number of medical specialty teams to enable patients to be followed up in a more timely way.

To accommodate this expansion, the physical footprint of the service on both sites will increase and capital works have already commenced to enable the new ambulatory care services to be operational from November 2018. Key outcomes for the services will be

maintaining A&E 4 hour target, reducing avoidable non-elective admissions, and reducing LOS by providing a timely follow up in ambulatory care.

Table 1: Standardised cross site Ambulatory care pathways

DVT	Anaemia
Atrial Fibrillation	Cellulitis
OPAT(inc pyelonephritis and community acquired pneumonia and other)	Pulmonary Embolism
Deranged LFTs	Low risk chest pain
Headache	First Seizure

3.2 Development of an Enhanced Care Unit at West Middlesex

Over the winter period a 6 bedded Enhanced Care Unit (ECU) will be provided within the Acute Medical Unit (AMU) at West Middlesex. Adopting the model already in place on the Chelsea site, the ECU will be staffed with a 1:2 nurse to patient ratio, creating an area to bridge the current gap in service for patients at risk of deteriorating between Level 0 care (provided on the ward) or Level 2/3 care provided on the Intensive Care Unit (ICU). This will include patients with complex multi-organ general medical problems who are currently cared for in the Coronary Care Unit (CCU), and patients requiring Non-invasive Ventilation, who are cared for on either the AMU or Osterley 2 ward.

Medical staffing for the unit will be provided by a dedicated Medical Emergency Team created from within the current AMU staffing establishment. Funding for the increased nursing staffing has been agreed over the winter period.

In is anticipated that this Unit will be open from November and will have the following benefits to support the hospital site in dealing with winter pressures:

- Timely management of critically unwell patients, thereby decreasing overall inpatient length of stay
- Decrease in A+E resus breaches as there will be beds available to provide level 1 care outside of ITU

- Allow more timely discharge of patients from ITU through expedited discharges to an intermediate care facility

- Clear escalation pathways for acutely unwell patients on the ward, mitigating a recurrent theme in clinical incidents documented

4 Bed Occupancy Schemes

4.1 Internal Flow - Delayed Discharges and Long Stay Patients

A long stay patient is defined as an adult patient who has been in an acute bed for 21 days or longer. There is strong evidence that long stays in hospital lead to patient deconditioning, harm to patients and unnecessary additional demands on health services. The aim is to therefore discharge patients as soon as they no longer will benefit from acute hospital care, ideally to their original place of residence.

Delayed Discharges result in poor experience and greater risk for the patients concerned and prevents others accessing appropriate care settings for treatment in a timely way.

A number of initiatives will be used to help identify those patients who, with proactive management, will achieve a reduced length of stay:

- Daily senior led ward board rounds ensuring accuracy of EDD and recording of Red:Green

- Timely Care Huddles providing a daily review of individual delays and focus on resolution on the same day where appropriate with representatives from all those area that can support.

- Weekly review of the twenty patients with the longest stay in each hospital and proactive management of any blocks to their patient journey

- Daily DTOC conference calls discussing those patients who are medically optimised but have the greatest complexities to their discharge

- Aiming to have weekly ward rounds at West Middlesex with ICRS (others TBC) to review all medically optimised patients to understand if there are services in the community that could support an earlier discharge

4.2 Increased discharges through Home First

The Trust has established Home First pathways which enable patients to be discharged on the same day as they become medically optimised with assessment in their own home within two hours of discharge. This ensures that patients are not remaining in hospital awaiting further assessment particularly for therapies and social care and these assessments can be carried out back in their own home. At the CW site, patients are transferred from the acute provide to the Community Independence Service who undertake the initial assessment in the patient's home. For the WM site, the acute therapies team follow the patient home and undertake the initial assessment then handing over care provision to ICRS.

For winter the Trust will continue to maximise discharges through the Home First pathway for suitable patients who meet the criteria. Trajectories for the numbers of patients to be discharges have been set, and are monitored, by the A&E Operational Boards on each site.

The target number of patients to be discharged on the Home First pathway is 15 per week for West Mid and 30 per week for the CW site. At the CW site, this number includes referrals for reablement services being part of the Home First pathway which has not currently started. To support this:

- Regular Home First meetings between acute, community, social care providers and CCG representatives
- Dedicated Home First therapy lead as part of the discharge team at West Mid site
- Home First pathway introduced as part of nursing and therapies local induction
- Daily identification of patients suitable for Home First as part of MDT board rounds

4.3 Escalation Beds

It is known that the winter period will see an increased number of non-elective admissions at both hospitals, and that during the winter of 2017/18 escalation beds were opened on both sites to cope with this demand. On the Chelsea site this comprised of the use of Kobler Day Care beds at night (4 beds) and the use of Nightingale ward (28 beds), managed as escalation from Nell Gwynne Ward. On West Middlesex site, Day

Surgery Unit elective beds were used as escalation for non-elective patients, opening up to 10 beds for 21 days over the winter months and impacting on the ability to deliver elective care.

In anticipation of the need for additional escalation beds during winter 18/19, a review of the bed base on both sites has been completed an approach to opening escalation areas agreed.

On Chelsea site, the first area of escalation area to be use will be Nightingale ward, with capacity to open to 28 beds. The ward will be managed under the Medicine Division with consultant cover provided by the Care of the Elderly team and junior doctor cover provided by Gastroenterology. A Ward Manager has been recruited to manage this area and the band 6 workforce has been provided through over recruitment to the medical ward establishments. In opening these additional beds it is expected that the 6 medical beds on Saint Mary Abbott's (SMA) ward will be reprovided within the extended medicine bed base, with SMA becoming a purely surgical ward. The subsequent order of escalation areas is as follows:

- Nightingale 10 beds
- Nightingale increased to 28 beds (from 1st Nov)
- Kobler Day Care 4 beds
- Kobler Day Care open to 7 beds (recognising impact on Chemotherapy delivery)
- Endoscopy Recovery Unit to 10 beds (recognising the impact on endoscopy cancellations)

Due to a lack of physical space, there is limited ability to open an escalation area on West Middlesex site. During winter 17/18, elective activity on the West Middlesex site was reduced to allow conversion of a proportion of the existing elective bed base to non-elective beds, and this is also planned for winter 18/19.

To increase capacity for emergency surgical admission, a 6 bedded bay on Richmond will be converted to increase capacity in the Surgical Assessment Unit from 10 beds to 16. Reduced demand on elective beds will be achieved through a reduction in elective activity on week days. It is also planned that Day Surgery Unit will be used as escalation overnight, with the ability to open to 10 patients.

To increase capacity for emergency medical admissions, 11 beds on Syon 1 ward will be ring fenced for medical patients, reducing the need to 'outlie' medical patients in surgical beds. Consultant cover for these 11 beds will be provided by the medical specialty teams.

A checklist for opening escalation areas safely has been agreed and must be used when opening escalation beds, and can be found on the Trust intranet:

http://connect/EasysiteWeb/getresource.axd?AssetID=28380&type=Full&servicetype=Attachment

4.4 Phasing of Elective Activity

There is a significant risk to the cancellation of elective care if winter results in increased emergency admissions, especially at West Middlesex Hospital where the only physical escalation space is the Day Surgery Unit.

To mitigate this risk, there will be a planned reduction in elective cases at West Middlesex during week days. This will be achieved through moving lists to weekends or to the Chelsea site, and will be managed through the weekly 6-4-2 theatre scheduling meeting. Any cancelled elective theatre sessions will be replaced with outpatient clinics or additional ward rounds.

5 Trust-wide Schemes

5.1 Improved senior support to site, 7 days per week

With increased demand over winter, particularly out of hours, it is anticipated that additional on-site cover will be needed from the senior management team during weekends and evenings.

During the winter of 17/18 this was provided through the voluntary 'late' rota, with the Divisional Directors and General Managers providing on-site cover 17:00 – 22:00 to support the A&E and site teams. This rota was run separately to the Senior Manager On Call (SMOC) and Director On Call (DOC) Rotas.

For the winter of 18/19 it is felt that a more robust out of hours rota is needed, providing cover to both sites. A proposal has therefore been put forward to introduce a clinical late

and weekend rota, staffed separately to the SMOC and DOC rotas. This will be discussed with the staff involved and an agreed rota in place for November.

5.2 Infection Prevention & Control

Supply of beds was affected by diarrhoea and vomiting (D&V) and Norovirus at West Middlesex Hospital in winter 2017/18. Five Norovirus outbreaks occurred on five wards during the period September 2017 to January 2018 affecting 93 patients and 15 staff in total. No outbreaks were reported due to D&V and Norovirus in February, March and April, as seen in previous years (NHS Improvement and NHS England, 2017).

Chelsea and Westminster hospital has already seen one significant Norovirus outbreak in May 2018 - this saw 36 individuals affected on one ward including patients, staff and visitors. Twelve outbreak meetings were convened during the outbreak which lasted from 2nd to the 24th May. The IPC team visited the ward at least once a day to ensure that the recommended control measures were being followed. The team provided support, advice and feedback where practice needed to be improved, and education as required. There was a delay in identifying that there was an outbreak on the ward and therefore an 'outbreak decision tree' was developed by the IPC team which will help staff to identify outbreak situations sooner. This document will be available on the trust intranet.

A second Norovirus outbreak occurred at Chelsea and Westminster hospital in September 2018 which resulted in the closure of 1 bay for 11 days; 3 patients were diagnosed with confirmed Norovirus. This outbreak was quickly identified and infection control and containment measures were put in place immediately.

5.3 Influenza

The Trust has a comprehensive seasonal flu plan covering aspects relevant to patients, visitors and staff. Each winter staff are offered the flu vaccination to protect them from contracting the predicted circulating virus strains and transmitting it to vulnerable patients, as well as family and friends. Although not mandatory like certain other vaccines for clinical staff, we strongly encourage all staff to get the flu jab each year as part of their duty of care to our patients. The CQUIN (Commissioning for Quality and Innovation) target covering 2017/18 target was to immunise 70% of frontline healthcare

staff and we achieved this, reaching 72%. For the year 2018/19, the target is to immunise 75% of frontline healthcare workers.

There is also a plan to immunise inpatients over 65 years or those who meet the risk factor criteria with a hospital stay greater than 14 days and all maternity patients will be offered flu immunisation as part of their antenatal care.

The trust has also introduce the option of on-site influenza testing for patients which will speed up patient diagnosis; providing point of care testing with 2 hour processing turnaround time. This will have a positive impact on bed management and cross infection rates.

5.4 Business Continuity

The Trust has business continuity strategies and plans in place to deal with a range of challenges that might affect services and functions at any time – this includes staff shortages, denial of access, failure in technology and loss of utility. These plans enable a response to a disruptive challenge to take place in a coordinated manner including processes for recovery and restoration of essential functions and services.

Strategic and tactical level business continuity plans have been established. The roles and responsibilities of individuals are detailed and the recovery priorities summarised. The following of these plans will assist recovery, ensuring a return to business as usual in as timely a manner as is possible.

If operational activities were adversely impacted, without appropriate business continuity arrangements in place, the Trust could be considered not to be adequately prepared. This lack of preparedness could lead to a missed opportunity to mitigate poor resilience. Legislative measures and the main tools linked to business continuity are noted below:

- Civil Contingencies Act 2004. *http://www.legislation.gov.uk/ukpga/2004/36/contents*

- Emergency Preparedness, Resilience and Response (Trust Intranet) (containing multiple documents). *http://connect/departments-and-mini-sites/eprr/*

5.5 Weather

The Trust has a comprehensive Cold Weather Plan which comes into force on 1st Nov annually. The latest version can be found here - http://connect/departments-and-mini-sites/eprr/cold-weather/. Our Cold Weather Plan contains trigger points and associated required actions for all Trust staff, including Estates and PFI partners.

At the time of writing Public Health England have not produced their annual advice. Once this has happened our plans will be modified to reflect such guidance.

6 Service Specific Action Plans

6.1 Emergency Medicine

Action	Lead	Action due date	Risk assessment	Update
Internal Escalation Plan to be agreed for managing demand within the Emergency Department	Kris Pillay	October 18	Green	
SOP to be developed for managing ambulance arrivals in order to maintain ambulance handover times	Michelle Earby	October 18	Green	
Agree procedure for managing mental health patients awaiting mental health bed to become available	Paul Morris	October 18	Green	'Deep Dive' into mental health delays to be held 21/09/18
Ensure junior doctor rotas are matched to demand on the Emergency Department	Laura Bewick	October 18	Green	Review of middle grade rota complete
Introduction of Band 4 'flow' coordinators to support the ED department	Andrea Fernandes/Charlotte Travill	November 18	Amber	Funding identified for 1 WTE from the West Middlesex ED budget
Increased streaming capacity at CW through addition of a 3rd streaming nurse	Andrea Travers	October 18	Red	Previously funded through winter money – not currently identified for 18/19
Additional medical shifts during busy periods	Laura Bewick	October 18	Red	Previously funded through winter money

				– not currently identified for 18/19

6.2 Medical Specialties

Action	Lead	Action due date	Risk assessment	Update
Review senior ward cover on medical wards with the view to increase consultant cover at ward/board rounds	Tom Cornwell	October 18	Green	Review of job plans to be completed following changes in the General Medicine On Call rota
Christmas specific outpatient and endoscopy capacity plan to be developed to ensure sufficient capacity for 2ww cancer patients	Sohib Ali/Elaine Elliott	November 18	Green	
Agree configuration of medical beds following the opening of Nightingale ward and the transfer of 6 medical beds on SMA to surgery	Tom Cornwell/Dilys Lai	October 18	Green	Options appraisal complete and to be agreed by divisional management team
Nursing staffing model for Nightingale ward to be agreed	Lizzie Wallman	September 18	Green	Ward Manager and band 6 posts recruited to. Band 5 model to be agreed

6.3 Discharge Teams

Action	Lead	Action due date	Risk assessment	Update
Support Discharge to Assess Pathway 3 model with early identification of suitable patients. Potentially developing the Band 7 Discharge Nurse role as an assessor	Richard Turton	Throughout winter period	Amber	
Ensure discharge concerns raised by the community continue to be discussed on a monthly basis and fed into the bimonthly clinical governance meeting	Sima Sheth	Throughout winter period	Green	
2B412 – ensuring early discharges in the day to ensure flow as well as reducing to 20% or fewer the number of discharges after 5pm	Richard Turton	Throughout winter period	Red	Requires greater view at all meetings and monitoring on a daily basis.
Daily Timely Care Huddles in place to allow resolution of 'red' days	Richard Turton	September 2018	Amber	Ongoing PDSA, to continue to develop and understand how red:green supports proactive patient pathway management
DTOC Calls in place with all relevant partners	Richard Turton	August 2018	Green	
Ensuring community beds are utilised to their maximum	Richard Turton	Throughout Winter	Amber	CW – CP to ensure close links with all care homes and liaise closely with CCG re. Trusted Assessor

				WM – RRRT developing a Trusted assessor model for admissions to TMH

6.4 Emergency Surgery

Plan	Lead	Action completion date	Risk assessment	Action
Create DSU Escalation capacity to accommodate 10 patients	Faizal/Nuno	1st November 2018	Green	1. Draw up Escalation process, ensuring right patients are transferred to DSU. 2. Identify patients suitable for DSU daily by 3.00 pm. 3. Identify correct staffing for DSU escalation
Increase SAU capacity to cope with emergency demand	Nuno/Tina	1st November2018	Green	1. Turn one elective bay (6 beds) into SAU. Remainder 6 beds to be used for electives. 2. Ensure right number/skill of nurses.
Ring-fence 11 beds (2 bays for Medicine on syon 1	Nuno/Dharmen	1st November 2018	Green	1. Syon 1 to staff for 19 surgical beds and use any remainder staff to staff DSU escalation. 2. Medicine to identify core medical nurses to staff ring-fenced medical beds on syon1.
Review need for extra SHO from 5 pm -10 pm to cope with increase demand in surgical emergency cases	Jason/Faizal	1st November 2018	Green	1. Review surgical emergency demand and flex staff accordingly. 2. Cover unfilled shifts with bank/ agency doctors if required.

Resident on call Registrars to cover surgery overnight supported by SHO to cover Surgery and T+O. Senior clinical advice for ED and IP to facilitate early morning discharges and appropriate admissions out of hours.	Gareth Teakle	Oct-18		1. Establishment of on call reg rota (6WTE) with start dates by October 2018. 2. Highlight vacancies 4 weeks in advance and seek internal or bank cover.
Move Gastro and Medical patients from SMA/SAU to creat the additional trolly space and treatment area for surgical speacities to admit direct to from ED including plastics.	Gareth Teakle	Nov-18		1. Move existing medical patients from SMA/SAU to allocated inpatient beds. 2. Conversion of one space to treatment area to support reviews, ambulatory care other than that provided in new area on ground floor and minor plastics treatments. 3. Convert additional spaces and one other bay to trolleys to create the SAU rapid flow model.
Use of ambulatory care on ground floor for surgical ED patients needing surgical or plastic review that may potentially breach.	Gareth Teakle	Nov/Dec -18		1. Guidelines to be created for those patients suitable to move from ED in hours to ambulatory care for surgical or plastics review. 2. Resource to be identified to review patients from existing staff groups. Plastics change of roles and the additional funding for Surgical SHO to provide cover for ambulatory care and ED in hours.

6.5 Elective Surgery

Plan	Lead	Action completion date	Risk assessment	Action
Reduce elective activity from average of 36 to 24 per day.	Faizal/Paul/Kelly	1st November 2018	Green	1. Review elective list /patients to be moved to Chelsea. 2. Liaise with GM for Paeds and Gynae 3. Review Daily catch up meeting at 3.15 pm to review next day elective list and capacity required.
Run weekly Saturday list x2 to accommodate reduced elective activity during the week.	Faizal/Paul	1st November 2018	Amber	1. Offer Saturday list to specialities where RTT performance is pressured. 2. Ensure Theatre, Nursing, surgeons and ward staff available.
At weekly theatre scheduling meeting review list to be sto0d down 4 weeks in advance and seek capacity from Chelsea	Paul/Gareth/Faizal/ Sunaina	1st October 2918	Amber	1. Identify speciality list to be moved t Chelsea. 2. Respective GMs to liaise with clinical team and agree
Replace cancelled theatre lists with Opd activities and/ or ward duties	Jason/Faizal	1st November 2018	Green	1. Communication to clinicians 2. Set up additional clinics to replace cancelled theatre lists
Limit overnight stays elective patients during pressured periods and/or require ITU/HDU.	Gareth Teakle	1st November 2018	Green	1. Patients requiring elective admission with a LOS over 1 night to be limited on a Monday to support emergency admission over weekend. 2. HDU/ITU elective admissions limited to 1 per day with review the day before with site team and GM/DGM.
At 6-4-2 un-allocated theatre lists to be offered to WM surgery to support the reduction of elective flow on the WM site.	Gareth/Faizal	1st November 2018	Green	1. Emailed lists sent to operational team at WM with the expectation that they will agree if the list is required a minimum of 4 weeks before date. 2. Movement of elective capacity to CW for day case patients especially those in

				pressured RTT positions on WM site with a reduction in operative capacity on Mondays on WM - planned.

6.6 Plastics (General, Hands and Craniofacial)

Action	Lead	Action due date	Risk assessment	Update
Creation of admitting capacity on SMA/SAU direct from ED.	Gareth Teakle	1st November 2018	Green	1. Movement of Medical and Gastro patients from existing planned care bed base. 2. Agreement that patients requiring admission come direct to SMA/SAU rather than AAU."
Increase Cold capacity for post ED patients reducing un-necessary admissions	Gareth Teakle	1st November 2018	Green	1. ESP to run additional clinics adjacent to existing Consultant clinics. This is a cost pressure that is off set by income for an SP clinic with a minimum of 6 patients seen.
Plastic on-call Consultant review post admission to ensure patients cannot be ambulated.	Gareth Teakle	1st November 2018	Green	1. Current job plans means on call midweek consultant is on site until 7pm, they will review ALL plastic admissions through the day to ensure the patient needs to be in a bed overnight and has a plan for the following day.

Pilot e-trauma referral service in plastics	Gareth Teakle	1st November 2018	Green	1. e-trauma enables CW and WM patients to be reviewed virtually to ensure admission is required and if not the appropriate follow up is arranged the following day.
Saturday or Sunday plastic trauma list in TC	Gareth Teakle	1st November 2018	Green	1. To save patients sitting in a bed over the weekend opening up a dedicated trauma list for plastics over the weekend would potentially free beds up on Monday. Anaesthetist to be agreed weekly for session to run and either plastic reg or Consultant to run list.

6.7 Therapies

Action	Lead	Action due date	Risk assessment	Update
Support Home First model with early identification of suitable patients. Band 7 or above regular review of all patients with stay of over 14 days.	Chris Richards	Throughout winter period	Green	Bigger push on discharge to assess pathway 2 referrals to support more appropriate discharge planning to appropriate location
Review of outlier cover	Hannah Balcombe	End of November 2018	Green	

Senior therapy presence in ED to ensure early therapy intervention	Thomas Edwards	Throughout winter period	Green – WM Amber – C&W	Limited resources at C7W
Development of a frailty pathway	Chris Richards		Green – WM Amber - C&W	No identified frailty resource at C&W
ED & AAU therapy cover 08:00 to 20.00 daily	Thomas Edwards		Green	
Timely care huddle attendence	Chris Richards	End of September 2018	Amber	
Review of 7 day services following CW pilot	Chris Richards	End September 2018	Amber	

6.8 Maternity and Women's Services

Action	Lead	Action due date	Risk Rating	Update
Review of maternity capacity daily during winter months to potentially provide escalation beds for Gynae patients	Maternity bleep holder	01/12/2018	Green	Bookings appear to be on the increase – forecast being reworked to get clear picture of Dec, Jan deliveries.

Maternity team to attend daily 9am and 5pm bed meetings	Maternity bleep holder	1/11/2018	Green	
Maternity LoS –MCIG work	Sally Sivas	ongoing	Green	Continued work on Maternity PN and antenatal LoS reduction to support creation of capacity for Early pregnancy admissions where clinical and psychologically appropriate for Women
Continuation of acute gynae pathway through Elizabeth Suite – Ambulatory area (2 recliners) being created to support shorter LOS for Women	Sunaina Bhatia	01/11/2018	Green	Recliners approved by the charity.
Gynae theatre cases to be reviewed to minimalize number of Inpatients per list – max 2 inpatients per list.	Shaun D'Souza	17/12/18	Amber	Risk – Service trying to get work form other trusts. This may impact this initiative
Ensuring capacity for ERPC lists to reduce admissions	Shaun D'Souza	01/11/2018	Green	ERPC activity being reviewed and worked into every Gyane list available.

6.9 Paediatrics

Site	Action	Lead	Action due date	Risk assessment	Update
WM	Open ward to 24 beds	Tracy Armstrong	21-Sep	Green	complete
WM	Issue updated nursing rota for increased beds/ lines of work to agency	Tracy Armstrong	21-Sep	Green	complete
WM	Financial implications of income/ pay costs	Nicola Sprigens/Geraldine Cochrane	21-Sep	Green	complete
WM	HR change consultation for nursing staff (flexdibility to work across all areas)	Melanie Guinan	end oct	Amber	underway
WM	Completion of TNA and delivery of training (nursing) PILS APLS	Viviette Wallen-Mitchell	01-Nov	Amber	partially complete
WM	Update PSSU criteria to reflect new area	GB/DS/ Rasvana Akram	21-Sep	Green	complete
WM	Implement new PSSU area (aim open 22 Oct)	Rasvana Akram	19-Oct	Amber	underway
WM	Progress HDU plans with estates	Nicola Sprigens	ongoing	Amber	underway
WM	Implement new medical workforce plans	Anne Davies /Nicola Sprigens	15-Oct	Green	complete
WM	Confirm WM paeds elective programme accomodated	George Anastaopoulos/Tracy Armstrong	end oct	Green	complete
WM	Confirm weekend PED Consultant bank shifts covered with Emergency Medicine	Laura Bewick /Nicola Sprigens	12-Oct	Red	not complete
WM	Confirm 4th nurse per shift in PED with Emergency Medicine	Geraldine Cochrane/ Lizzie Wallman	12-Oct	Red	not complete
WM	Confirmaiton of Trust bank incentive scheme	Tom Strickland	23-Oct	Amber	not complete

CW	Implement 24/7 band 7 bleepholders	Melanie Guinan	mid Jan	Amber	underway
CW	Open Mecury escalation beds	Melanie Guinan/Simone Hunit		Amber	underway
CW	Ringfence PHSU for NHS-E winter pressure support	Melanie Guinan	01-Nov	Amber	underway
CW	update bed escalation policy	Melanie Guinan	26-Oct	Amber	underway
CW	Increase PAC capacity	Nicola Sprigens/Melanie Guinan	12-Nov	Amber	underway
CW	Implement COMET short stay pathway stage 1	James Ross	01-Aug	Green	complete
CW	Implement COMET short stay pathway stage 2	James Ross	mid Jan	Amber	underway

6.10 Pathology

Action	Lead	Action due date	Risk assessment	Update 28.08.2018
Monitoring of pathology KPIs by Pathology Service Manager	Saeed Parviz	Ongoing		Pathology Governance Group Meeting in place with KPIs shared with Divisions/Directorates.

6.11 Pharmacy

Action	Lead	Action due date	Risk assessment	Update
WMUH Achieve TTA turnaround time of completing 85% of TTAs within 90 minutes Have 60% of TTAs screened on the ward (for targeted wards) At WMUH we have a critical shortage of technical support staff, sue to a large number of vacancies. We have gone out to advert twice with no success so are in the process of reviewing our current structure and looking at changing the job roles, to make recruitment easier	Chisha McDonald & Deirdre Linnard			Average turnaround time for 17/18 67% of TTAs completed within 90 minutes For Q1 18/19 average turnaround time for TTAs was 80% of TTA completed within 90 minutes Currently using bank and agency staff as an interim measure
CW Business case for additional pharmacy staff on AEC approved for December. This will provide extra resource to support winter pressures	Vanessa Marvin & Iun Grayston			No other business cases approved as AEC taken priority

Action	Lead	Action due date	Risk assessment	Update
Plan at CW now is to have the new AEC bands 7 and 5 working under the LDP Medicine on rota in Ambulatory and Acute care. Adverts are out this week.	Vanessa Marvin			Adverts are out in September
Plan to have 2 x additional Medicines Management Technicians for AAU CW (8am to 8pm weekdays) to support nursing vacancies and IV administration.	Vanessa Marvin			Funding for AAU CW site pilot from AAU budget, staff recruited and commence on AAU October 2017. Plan to roll out to WM site after 3 months, if pilot successful. Pilot was successful and in August 2018 the two fixed term MMT post were put onto permanent staff. NB MMTs are NOT administering IVs but are present at the time of the drug admin rounds to source out of stock items, keep stock tidy/manageable and counsel patients on anticoags etc. Need to review
Review of weekend service across both sites	Chisha McDonald/ Deirdre			Part of the pharmacy Hospital Pharmacy Transformation Plan for 18/19.

Action	Lead	Action due date	Risk assessment	Update
	Richardson			With additional staff starting, we are planning to have a pharmacist on WMUH- AMU for a couple of hours on Saturday.

6.12 Mortuary

There are 31 adult body storage spaces (including 4 bariatric) at the Chelsea site and 49 (including 4 bariatric) at the West Middlesex site. There are 20 baby storage spaces at West Middlesex and 20 baby spaces at Chelsea. This takes the total capacity across the Trust to 80 adult spaces. An escalation policy is in place which is triggered when there at <10 spaces on any given site. There are 12 spaces in temporary mortuary fridges (Nutwells) at the Chelsea site and 12 spaces in temporary mortuary fridges (Nutwells) at the West Middlesex site (24 in total across both sites). A contract with local funeral directors (Barnes and Hicks) for five storage spaces. Additional Nutwell capacity can be hired in on an ad hoc basis. During working hours the mortuary staff will liaise with local funeral directors for the transfer of bodies to them or between sites. At weekends and out of hours the clinical site managers will coordinate.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.4.2/Nov/18
REPORT NAME	Workforce performance report
AUTHOR	Natasha Elvidge, Associate Director of HR; Resourcing
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	The People and OD Committee KPI Dashboard highlights current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	The dashboard to provide assurance of workforce activity across eight key performance indicator domains; • Workforce information – establishment and staff numbers • HR Indicators – Sickness and turnover • Employee relations – levels of employee relations activity • Temporary staffing usage – number of bank and agency shifts filled • Vacancy – number of vacant post and use of budgeted WTE • Recruitment Activity – volume of activity, statutory checks and time taken • PDRs – appraisals completed • Core Training Compliance
KEY RISKS ASSOCIATED	The need to reduce turnover rates.
FINANCIAL IMPLICATIONS	Costs associated with high turnover rates and reliance on temporary workers.
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability.
EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For noting.

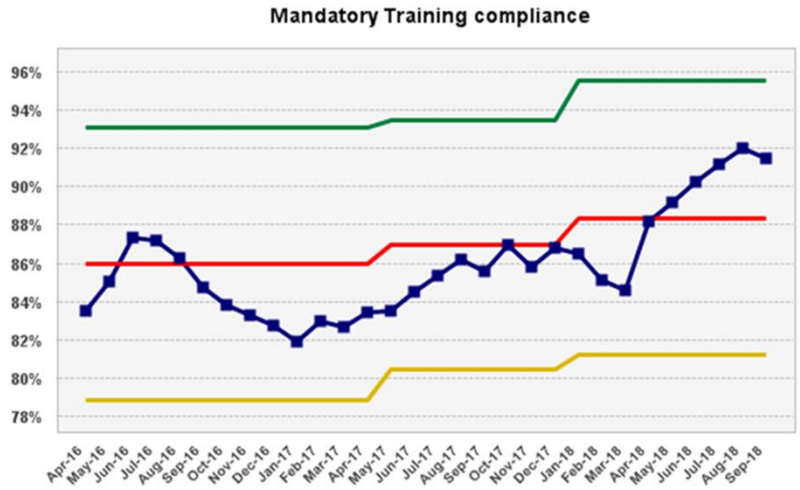
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

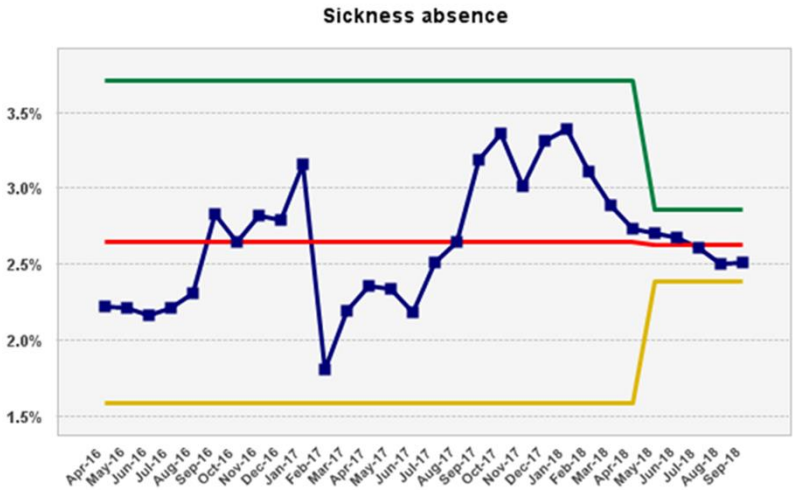
Workforce Performance Report
to the People and Organisational Development Committee

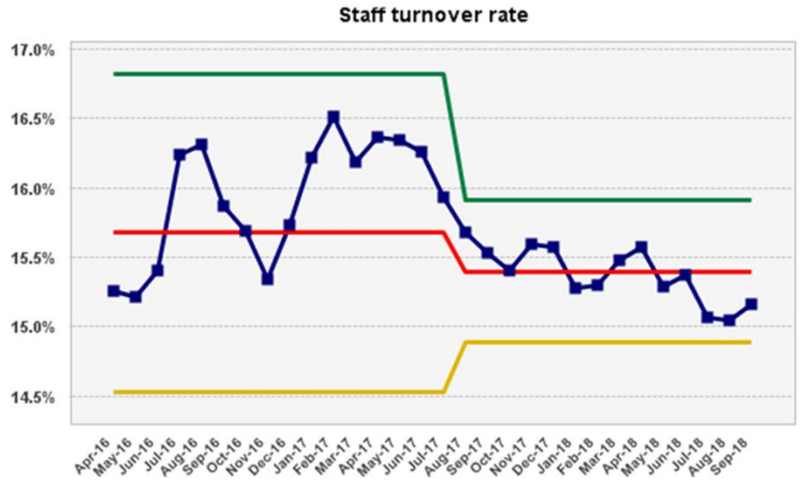
Month 06 – September 2018

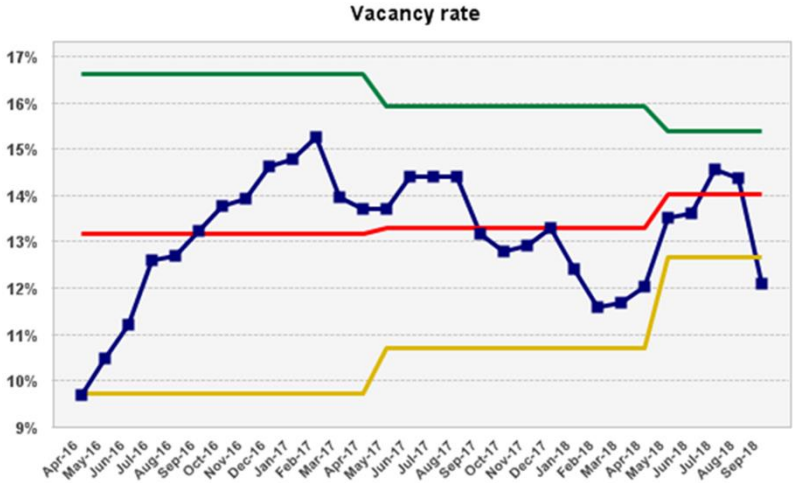
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Statistical Process Control – April 2016 to September 2018









Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People and Organisational Development Workforce Performance Report September 2018
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

Item	Units	This Month Last Year	Last Month	This Month	Target	RAG Status			Trend	Risk / Comment
						Red	Amber	Green		
1. Workforce Information										
1.1 Establishment	No.	6016.53	6352.98	6367.13					↑	Increase in WTE
1.2 Whole time equivalent	No.	5223.45	5427.68	5481.88					↑	Increase in WTE
1.3 Headcount	No.	5715	5904	5951					↑	Increase in Headcount
1.4 Overpayments	No.								↔	
2. HR Indicators										
2.1 Sickness absence	%	3.19%	2.52%	2.61%	<3.3%				↑	Limited Risk- (Please refer to Appendix 1 for detailed analysis)
2.2 Long Term Sickness absence	%		1.05%	1.06%					↑	Limited Risk- (Please refer to Appendix 1 for detailed analysis)
2.3 Short Term Sickness absence	%		1.56%	1.55%					↓	Limited Risk- (Please refer to Appendix 1 for detailed analysis)
2.4 Gross Turnover	%	20.74%	19.45%	19.61%	<13%				↑	Limited Risk- (Please refer to Appendix 1 for detailed analysis)
2.5 Voluntary Turnover	%	15.53%	15.07%	15.16%	<13%				↑	Limited Risk - (Please refer to Appendix 1 for breakdown of data by division)
3. Employee Relations										
3.1 Live Employment Relations Cases	No.			155					↑	
3.2 Formal Warnings	No.			0					↔	Limited Risk
3.3 Dismissals	No.			4					↑	
4. Temporary Staffing Usage										
4.1 Total Temporary Staff Shifts Filled	No.		14351	13133					↓	Limited Risk
4.2 Bank Shifts Filled	No.		11673	11243					↓	Limited Risk
4.3 Agency Shifts Filled	No.		2678	1890					↓	Moderate Risk
5. Vacancy										
5.1 Trust Vacancy Rate	%	13.18%	14.56%	12.10%	<10%				↓	Limited Risk
5.2 Corporate	%	9.88%	15.62%	8.90%	<10%				↓	Limited Risk
5.3 Emergency & Integrated Care	%	13.96%	14.96%	12.17%	<10%				↓	Limited Risk
5.4 Planned Care	%	12.22%	13.65%	12.98%	<10%				↓	Limited Risk
5.5 Women's, Children and Sexual Health	%	14.58%	14.83%	12.09%	<10%				↓	Limited Risk
6. Recruitment (Non-medical)										
6.1 Offers Made	No.		183	162					↓	Limited Risk
6.2 Pre-employment checks (days)	No.		30.70	24.60	<20				↓	Moderate Risk
6.3 Time to recruit (weeks)	No.		9.62	8.04	<9				↓	Limited Risk
7. PDRs Undertaken (AfC Staff over 12 months)										
7.1 Trust PDRs Rate (AFC Staff)	%	49.78%	90.42%	87.92%	≥90%				↓	Limited Risk
7.2 Corporate	%		90.78%	83.21%	≥90%				↓	Limited Risk
7.3 Emergency & Integrated Care	%		92.40%	90.99%	≥90%				↓	Limited Risk
7.4 Planned Care	%		90.82%	90.32%	≥90%				↓	Limited Risk
7.5 Women's, Children and Sexual Health	%		88.24%	84.38%	≥90%				↓	Limited Risk
8. Mandatory Training										
8.1 See Appendix 1 for details on Mandatory Training										

Chelsea and Westminster Hospital NHS Foundation Trust

People and Organisational Development Workforce Performance Report September 2018
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NHS
Chelsea and Westminster Hospital
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August 18 SICKNESS									
Division	Sickness Abs.	RAG Status	Available FTE	Abs. FTE	Episodes	Long Term (FTE Lost)	%Long Term	Prev. Month	%+/-
Corporate	1.43%		17172.75	278.13	55	75.64	0.44%	1.62%	-0.2%
Emergency & Integrated Care	2.08%		46239.15	881.93	214	336.72	0.73%	1.91%	0.2%
Planned Care	2.86%		55272.86	1442.95	306	654.24	1.18%	2.61%	0.3%
Women's, Children and Sexual Health	3.20%		50126.02	1643.81	312	720.06	1.44%	3.28%	-0.1%
Trust	2.61%		168810.78	4246.82	887	1786.66	1.06%	2.52%	0.1%

September 18 Mandatory Training					
Course	Last Month	This Month	Target	RAG Status	Tread
Basic Life Support	85%	85%	<90%		↔
Conflict Resolution - Level 1	95%	95%	<90%		↔
Equality and Diversity	94%	93%	<90%		↓
Fire	90%	88%	<90%		↓
Health and Safety	96%	95%	<90%		↓
Moving & Handling - Inanimate Loads	92%	90%	<90%		↓
Infection Control	94%	93%	<90%		↓
Information Governance	90%	89%	<95%		↓
Moving & Handling - Patient Handling	83%	86%	<90%		↑
Safeguarding Adults Level 1	94%	94%	<90%		↔
Safeguarding Children Level 1	95%	94%	<90%		↓
Safeguarding Children Level 2	90%	91%	<90%		↑
Safeguarding Children Level 3	82%	77%	<90%		↓

September 18 Vacancy / Bank and Agency Ratio on "Fill Rate"								
Division	Budgeted FTE	Staff in Post	Vacancy (FTE)	Bank Usage (FTE)	Agency Usage (FTE)	Total FTE Used	Budget minus Used FTE	RAG Status
Corporate	603.85	550.12	53.73	27.79	1.43	579.34	24.51	
Emergency & Integrated Care	1729.50	1518.97	210.53	233.42	63.98	1816.37	-86.87	
Planned Care	2064.26	1796.30	267.96	185.74	30.60	2012.65	51.61	
Women's, Children and Sexual Health	1838.80	1616.48	222.32	168.29	28.49	1813.27	25.53	
TRUST	6236.41	5481.87	754.54	615.24	124.50	6221.62	14.79	

September 18 Voluntary Turnover			
Division	Turnover	Prev Month	%+/-
Corporate	17.93%	16.77%	1.16%
Emergency & Integrated Care	16.35%	16.64%	-0.29%
Planned Care	12.21%	12.06%	0.15%
Women's, Children and Sexual Health	16.40%	16.32%	0.08%
TRUST	15.16%	15.05%	0.1%

Key to Sickness Figures
Sickness Absence = Calendar days sickness as percentage of total available working days for past 3 months (days x ave FTE)
Episodes = number of incidences of reported sickness
A Long Term Episode is greater than 27 days

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People and Organisation Development Workforce Performance Report September 2018

Mandatory Training Compliance :

Overall a small drop (1%) in compliance in-month with SG Children L3 having the largest drop resulting from almost 10% of the target population lapsing during September. As the target population for this topic is relatively small, the impact on compliance is consequently magnified.
Moving & Handling L2 continues on an upward trend (+3%) due to an increase in sessions particularly at WMUH, which has off-set the fluctuations of 1-2% across most other topics this month.
Information Governance remains below the national target of 95% and, historically, Q3 and Q4 is when 63% of staff are due to lapse, so a concerted effort will be required to achieve the 95% by March 2019.

Staff Turnover Rate:

The voluntary turnover rate is currently 15.07% a decrease of 0.61% over the past year. The voluntary turnover rate suggests that approximately 1 in 7 members of staff have left the trust over the past 12 months. The turnover rates are consistent with the London region and are above our trust target of 13%.

Voluntary turnover is slightly trending upwards from last month to this month an increase of 0.09%. February '17's voluntary turnover rate (16.5%) was the highest month during the last year with the previous month the lowest – this downward (see SPC chart page 2) trend could be attributed to the increased productivity and reduction of time to recruit by the recruitment team. In addition, the trust has undertaken a project as part of the NHSI Retention Programme to improve our turnover rate.

Sickness Absence: (August)

The trust's sickness rate, currently at 2.61%, has only breeched its target (3.3%) three times over the last 12 months peaking at 3.36% in November 17, 3.32% in January and 3.38% in February '18. Sickness absence has declined every month from February 18 until August 18.
The staff group consistently reporting the highest level of sickness absence each month is unqualified nursing and midwifery staff (2.72%) whilst medical and dental staff are consistently reporting the lowest level of sickness (below 1%).
The Women's, Children & Sexual Health Division had the highest sickness rate in August at 3.20%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 4.70%.

Vacancy Rate:

The current vacancy position of the trust is 12.10%. We have had a considerable improvement with a 2.74% decrease in the rate and have been on a downward trend for most of the last 12 months. Our vacancy rate has improved due to increased activity within the recruitment team and a readjustment to our establishment following a detailed reconciliation process. There has been a significant increase in establishment over the past 12 months 350.6wte, a gain of 6%, which has had an impact on vacancy and recruitment particularly during the months of April '18 until June '18.

The vacancy rate at West Middlesex is 15.92% and 13.55% at Chelsea and Westminster. The Nursing and Midwifery qualified staff group vacancy rate 10% which means we have achieved our target for nursing.

People and Organisation Development Workforce Performance Report
September 2018

PDR's Completed Since 1st April 2018 (18/19 Financial Year)					
Division	**Band Group**	**%**	**Division**	**Band Group**	**%**
COR	Band 2-5	23.66%	**PDC**	Band 2-5	35.28%
	Band 6-8a	37.93%		Band 6-8a	66.90%
	Band 8b +	56.34%		Band 8b +	94.29%
Corporate		**36.54%**	**PDC Planned Care**		**47.84%**
EIC	Band 2-5	45.22%	**WCH**	Band 2-5	19.38%
	Band 6-8a	55.81%		Band 6-8a	23.94%
	Band 8b +	66.67%		Band 8b +	35.00%
EIC Emergency & Integrated Care		**50.45%**	**WCH Women's, Children's & SH**		**22.20%**

Band 2-5	Band 6-8a	Band 8b +		
33.06%	44.82%	63.95%	**Trust Total**	**39.61%**

PDRs:

During the previous financial year we achieved our target of appraisals completed (90%).

At Month 6 / September, we are slightly behind target for the completion of PDRs by our banding windows. The divisions have been asked to give greater focus and attention to the completion of PDRs within the banding windows and they have been tasked with produce a plan of how they will achieved their PDR target.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.5/Nov/18
REPORT NAME	Volunteer Services Update
AUTHOR	Nathan Askew, Director of Nursing
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	This paper provides an update and assurance to the board on the progress of the volunteer service
SUMMARY OF REPORT	The Trust has an ambitious target to have 900 volunteers in post by 2020 to increase the support offered to our patients and staff. The Volunteer service is championed by the executive team who are supporting the implementation of this vision. The Trust has exceeded the year to date deployment target of volunteers and are on track to fully meet the annual target. There has been impressive progress in the provision of volunteering across the organisation although work with individual departments continues. Issues of governance and supporting structures have been address and the strategic vision is in development. The Trust will focus on the following areas moving forward: **Volunteering Service Development** Development of the volunteer forum, strategy, appropriate steering group and the implementation of the volunteering policy. **End of Life Care** The Trust is keen to develop a team of volunteers who will be able to support end of life care patients and their families. **Support to patients with dementia/frailty** The role will support the elements of the HOME project and in practice will see volunteers helping in nutrition and hydration, mobilisation, engagement activities and normalisation for patients. **Bleep Volunteers** The focus for bleep volunteering will be on the development of a 7 day service at the Chelsea site in Q4 with a plan to roll out the service at the West Middlesex site in March 2019. **Youth volunteering** The focus for youth volunteering will be to embed the service at the West Middlesex site in Q4 and to roll out the service in March 2019 to the Chelsea Site.

	<u>Brighter futures</u> Brighter futures provide volunteer supported mentoring for young people affected with life long illness. The brighter future team of volunteers would assist young people at both hospital sites with a bespoke programme of mentoring and support in an attempt to minimise the effects of hospitalisation. The following four areas will assist with increasing the spread of the volunteer services: • Dedicated substantive volunteer service manager and administrative support – in place by December 2018 • An improved OH process to expedite recruitment – currently in development and should be in place by January 2019 • Focus on a reduced number of programs to enable more resource to support these to deliver at scale • Learning from what works well currently at each site and rolling this out across the other site to assist with spread and growth.
KEY RISKS ASSOCIATED	The use of volunteers in all aspects of the work of the organisation is essential to meeting our key objectives.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Achievement of the target will increase the experience of our patients and staff.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Employer of choice and high quality patient care
DECISION/ ACTION	For information and discussion

Volunteering Services Update

Introduction

This paper will provide an update to the Trust Board on the progress of the Volunteering services and provide assurance in line with the Trust vision to utilise the full potential of volunteers to support the work of the organisation.

Background

Chelsea and Westminster NHS Foundation Trust has an ambition to deploy 900 volunteers across the organisation by 2020. The volunteer service will not replace roles undertaken by paid staff but will enhance the services offered to our patients and their families. The volunteer service supports our staff to deliver the best possible care to our patients.

Historically the various charities that support the Trust have recruited, trained and deployed volunteers in isolation for the specific needs of their organisations with no overarching governance structure or strategic vision.

The Trust seeks to align the volunteer's service across the Trust and ensure that all volunteers are recruited, trained and deployed safely and that the service consistently meets the high standards set by the organisation. Volunteers will have a clear identity, will be recognised for their contribution and will work across all areas of the organisation to augment and enhance the experience of care for our patients.

Executive Support

In order to achieve the above ambition it is essential that volunteers are viewed as part of the trusts workforce and become part of the culture within every area in the organisation. To this end the use of volunteers and the roles they are supporting is discussed at each departmental deep dive. The 2019 revision of the ward and department accreditation process will contain a specific focus on the use of volunteers, this process being in place by April 2019.

The volunteer service has been a focus of Team brief, with clear messaging from the CEO on the importance of the volunteering service. In December 2018 the CEO will commence and lead a strategic board in relation to volunteering. The volunteer strategy is expected to be finalised and presented to the board in Q4 2018-19.

The wider executive team take a keen interest in the volunteer service, supporting its development and spending time with individual volunteers understanding their role. This has created a clear organisational message regarding the importance of the service.

Team Structure and Methodology

The volunteer service has secured funding for a full time voluntary services manager (VSM) and a full time administrator. Both positions have been recruited to and the successful candidates will be in post by December 2018. This core team will be essential to the on-going management of the volunteer services and will lead on recruitment to the programmes and support of volunteers in their day to day contribution to the organisation.

The VSM will have a specific role in building relationships with all departments in the organisation, and ensuring high quality supportive placements for our volunteers.

The volunteer services will develop targeted volunteer projects which will be supported by a project management structure. These roles will be supported in association with external partners (such as Helpforce). The Project manager will be required to set up the new programme and also contribute to the overall running of the volunteer service.

The project manager will work in partnership with the volunteer service to recruit to the programme, implement the service and undertake some evaluation of the programme before moving this to business as usual. This approach has worked successfully in both of our externally supported current programme, detailed later in the report.

Governance and Process

In February 2018 the Volunteer Steering Group (VSG) was convened with a specific role to oversee the development of the volunteering service across the Trust. With membership from Trust staff, volunteers and relevant subject matter experts it was tasked to develop the policy and process of all aspects of the service.

The VSG has been utilising quality improvement methodology to trial small cycles of change, continually improving and refining the practices and processes. This may have led to some delay in the speed of recruitment and deployment of volunteers but it has led to more robust processes which are now being embedded.

It is envisaged that this group will now provide the forum where all Trust partners who utilise volunteers will come together to discuss issues and work on the future model of volunteering in the organisation.

The sections below provide an update on the work of the VSG:

Role development

Role descriptions and specifications have been developed in line with service need and have been used to outline to volunteers the various options and opportunities available to them. As part of the role development a volunteer has been working with ward and department managers to challenge the traditional view of volunteering and ensure that roles are developed that safely meet the needs of the service.

The process of developing role specifications helps the service really understand what they are requiring volunteers to undertake and ensures a more streamlined approach to volunteer recruitment. This level of planning also demonstrates a commitment to supporting volunteers in the clinical area. They have also demonstrated that a well thought out placement leads to a better volunteer and staff experience.

The volunteer service now have a range of department based role descriptions which can be used for recruitment and can form the initial template for other departments seeking to utilise volunteers.

Recruitment

Various methods of the application and recruitment process have been piloted and refined by the group. The current process has reduced the average recruitment time from 26 weeks to 12 weeks and there is scope to reduce this further.

The recruitment process meets the requirements of safe recruitment, has a robust plan for the advertising and recruitment to certain roles as well as supporting a process for people who attend at the front desk on either site to be signposted accordingly though the application process.

Recruitment has moved to a values based model and has linked to a refined occupational health process. Once the Volunteer Management System goes live in January 2019 recruitment will move from a heavily paper based system to a more efficient on line process, which should continue to reduce the recruitment time.

Occupational health screening

The process has now been rationalised and filters volunteers into 2 groups; those who need no intervention and are able to proceed to the next step, or those who require an appointment with Occupational Health. The OH team are working hard to meet the needs of the volunteers but this is often challenging for those who require an appointment or need additional OH input (BCG vaccination for example).

Work continues with the OH team to identify the best way of progressing this work and developing a model that works both for the team and for the volunteer service. Getting this process right will be a key area of work over Q4 2018-19 to really refine and optimise this process.

Core Training

A refined trust induction has been developed which ensures the core content is delivered at an appropriate level to the volunteers before they commence in the Trust. All mandatory training sessions are covered on the day and volunteers are also issued with their uniform and ID badge at this time. Volunteers are required to access on-line modules appropriate for their role within their first 6 months of working with the service.

There volunteer service is now developing an on-going programme of training, education and support. This will allow volunteers to access additional training that may develop a personal interest or will enable them to carry out additional roles. The education programme is being trialled with the youth volunteers before being made available to the wider volunteers. The on-going training portfolio will be available in January 2019.

Volunteering policy

The volunteering policy has been completed and approved by the steering group, it was presented to the Patient Experience Group in September and covers a range of issues pertinent to volunteers. As volunteers are not paid employees the current Trust polices may not always adequately cover all aspects of the service and therefore the policy has been developed to address this. This Policy will be presented to the Quality Committee in December for final approval.

Volunteer Management System

Helpforce have supported the Trust to purchase a volunteer management system to will allow all charity organisations and the Trust to have an overview of their volunteers. This will include the ability to collect data on where volunteers are working and the number of hours the volunteers are contributing. It will also provide a communication tool for the Trust to draw on volunteers easily when needed.

Once the tool is in use should the Trust have an acute rise in activity and need more support, for example to move patients around the hospital or to provide support with meal times, the trust will be able to use the system to put out a call to volunteers asking for those who are able to attend and support the site. Currently this is only possible through a very labour intensive manual process.

The tool is currently progressing through information governance and will be in place by January 2019 at the latest. The platform also gives the Trust the opportunity to collect feedback from volunteers and will assist in work to understand the volunteer experience.

Volunteer numbers

The Trust acknowledge that several areas are already well supported by teams of volunteers linked to our partner organisations and charities. The VSG has spent a considerable time working with these partners to build relationships and to work together to align the volunteering services.

The volunteer service has oversight of the numbers of volunteers who are already supporting our patients and families. There has also been considerable effort to bring together these teams under the Trust volunteer identity. Currently there are a total of 503 volunteers in the organisation with a further 163 in the recruitment process, which will result in 666 volunteers to be in place by the end of November.

The table below shows the breakdown of the Trust volunteer service to date:

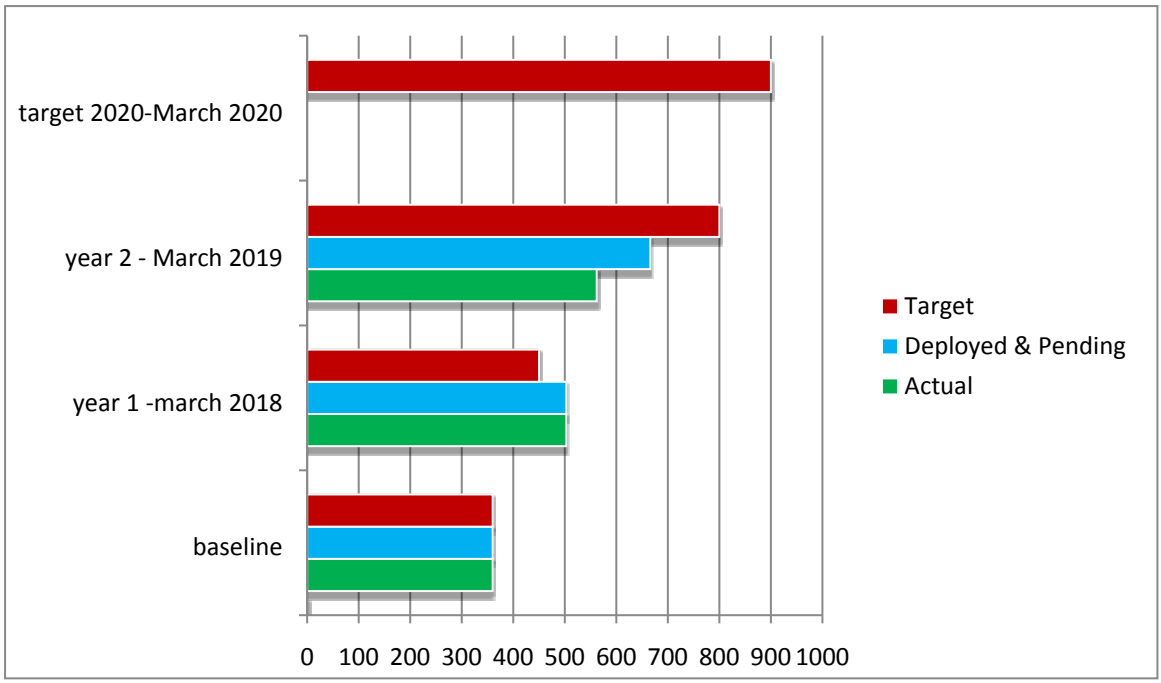
Service	Total
Medicinema	50
Macmillan	6
CW+	20
Mulberry	117
Friends	20
St Stephens	33
Radio West Midd	13
Radio Chelsea	33
Children's Hospital	35
Chaplaincy	33
Hospital *	143
Total	**503**

*Hospital Breakdown	
Service	**Total**
Bleep	20
Youth	13
Pharmacy	5
Maternity	20
ED	16
Wards/Clinical services	30
Research	4
ISS/Reception	12
Admin (clinical)	14
Admin (back office)	6
Pets as Therapy	3
Total	**143**
Ready to be placed (a further)	23
In process (a further)	140

Equality and diversity information will be captured as the service moves to better impact but of the recent recruits to the hospital volunteering service the majority (approximately 70%) are young people from a range of BAME backgrounds.

Recruitment trajectory

The volunteer service has a clear objective to recruit and deploy 900 volunteers by 2020. The graph below illustrates progress against the recruitment plan for each of the first three years. Year one saw the service exceed its recruitment target. Year two is on track and requires an additional 134 recruits by March 2019



Current project updates

This section provides an update on the 2 main projects supported by the Trust:

Hepforce Project

The number of volunteers exclusively for the bleep role has doubled since the project manager started in the spring. Most of these are as a result of a summer recruitment campaign. Recruitment to the role continues and we have 90% of slots filled enabling a rota to run Monday to Friday.

We will move to a model which is volunteer managed and relieves the current burden on the ISS helpdesk, implementation plans for this are currently in development and will be in place by January 2019.

There is an ambition to move to a 7 day service once the week day cover is more robust, this may enhance the out of hours provision and could assist with more befriending and other opportunities at the weekend. This will be assessed in Q4 with a plan for a 7 day service to be fully recruited to by Q1 2019-20.

Focus groups and surveys have been undertaken and are helping to shape and develop the service. Volunteers value feeling part of a team, they want to give time and be kept busy, and they enjoy doing activities with patients whilst talking to them. The volunteers report that more recognition of their role from staff would be appreciated.

> *"It can be quite difficult to just 'strike up a conversation' with a patient when you know nothing about them and have no introduction"*

> *"I've noticed different levels of kindness with different colours of uniforms… Staff sometimes ignore you, you stand there waiting for ages for them to recognise or even look at you".*

A guide has been drafted on how to be a bleep volunteer which has been used an induction manual. The training has also been formalised and includes robust training in relation to moving and handling patients, specifically in relation to safe wheelchair transfers. The team are in the process of setting up regular educational / training opportunities according to the interests of the volunteers as mentioned above.

There has been an impact evaluation undertaken between pharmacy and HelpForce looking at TTO deliveries, the time that is released for care and any impact on LoS. Initial feedback demonstrates that where volunteers deliver a TTO to the ward this saves on average 12 minutes of clinical staff time per patient. During the study period this was approximately 2 hours of clinical time saved. This represented approximately 730 hours annually which can be reinvested into patient care, this staff time is valued at approximately £8k.

Between March 2018 and July 2018 a retrospective study was undertaken comparing bleep volunteer supported patients required TTO on the day of discharge and those patients who were not supported by the bleep volunteer service. The study of 450 patients indicated that the length of stay was 6.3 hours shorter in those patients supported by the bleep volunteer service. Although the study acknowledges its limitations in terms of excluding other factors that may have affected the length of stay the impact of reducing length of stay and releasing clinical time is worthy of additional study.

The bleep volunteers also support the memory. The Memory clinic had a high rate of DNA's and the volunteers were asked to assist in calling patients the day before to remind them of their appointment. Prior to the volunteer intervention the DNA rate was approximately 32%. Following the introduction of the volunteer support the DNA rate has been approximately 15% over 4 months demonstrating a 50% reduction in DNA's. October to date is reporting a 100% attendance rate or in other words a 0% DNA rate.

Work is currently being undertaken with clinical and ISS staff to ensure there is maximum usage of the bleep volunteers as there is hesitation by some staff groups in using the service.

The next step of this project is once the full time volunteer manager commences in post on the 4th of December, recruiting to bleep volunteering for the west Middlesex site will commence in January 2019.

Pears Foundation project

The project manager started in June and 37 Youth Volunteers have been recruited for West Middlesex Hospital. Young people will rotate around 5 roles – Patient Activity, Mealtime Support, Welcomer, Library trolley and CW+ fundraiser. A second round of recruitment has been undertaken in October and November as there has been a lot of external interest in these roles from the local community.

The project manager has been working on exciting new partnerships – two highlights include volunteers being trained by the Wallace Collection to bring the museum to our patients. The second is our local GP practices and we are looking to educate our volunteers in understanding social prescribing with training being delivered by Hounslow Your Voice self-care and prevention

coordinator. The project manager is attending a number of events at local schools in September and October.

The youth volunteers commit to the organisation for one year and are drawn from the local community.

"[my first shift] was amazing. I got to meet a Nepalese patient and we had a conversation in Nepalese" Youth Volunteer, Kew Ward

The youth volunteering project plan is to roll out youth Volunteering on the CW site once the pilot is completed in March and the project stabilised.

Estates

At the Chelsea Site the aim is for the volunteering service to have a location in the main atrium close to the community Hub, this will be possible in Q4 when the new PALS area is complete and the volunteer Hub will be in the current PALS office.

At the West Middlesex site the volunteer service has dedicated office space and the service is currently sourcing a suitable public space.

Lockers have been provided for volunteers in the lower ground floor at the Chelsea site. Radios are also on order for the bleep volunteers so that they are easily reached and can be coordinated by volunteers rather than the ISS helpdesk, these should be in use at the beginning of November 2018.

Future developments

Over the last calendar year the volunteer service has trialled and refined many of the processes and practices of the service. The service has tried to use this approach to engage as widely as possible. This has however led to reduced focus of the service.

Moving forward the volunteer service will be more focussed to ensure that we maximise the opportunities available. A full action plan with time frames will be developed as part of the upcoming strategy work. The focus of the service falls into 6 key areas:

Volunteering Service

The VSG will now look to develop a forum which will work with all volunteer organisations in the Trust and will also ensure that the drive and focus of the programme continue.

The team will develop the Trust strategy for volunteering and have an initial workshop planned in November which will be supported by the strategy team. This will clearly articulate the vision and goals of the organisation and will also contain the 3 year programme of activity and development.

The deployment of the volunteering policy and the implementation of volunteer management system will be a key area of focus.

End of Life Care

The Trust are keen to develop a team of volunteers who will be able to support end of life care patients and their families. The palliative care team have been working closely with the volunteer services to adapt models from elsewhere across the country.

Currently the team are working with two volunteers in a pilot capacity to assess how this service may work best at Chelsea and Westminster NHS Foundation Trust. The initial feedback has been positive and will continue to shape the role. Once a final model has been formed then recruitment and training will commence.

Support to patients with dementia/frailty

A program of training and education is being developed to equip volunteers with specific skills in caring for and supporting patients with dementia in engagement activities. This will greatly support the clinical staff at ward level in providing care to these patients.

The focus will not be on replacing the clinical assessment and skills of the substantive staff but enhancing the patient experience through a programme of targeted activity. The role will support the elements of the home project and in practice will see volunteers helping in nutrition and hydration, mobilisation, engagement activities and normalisation for patients. The full scope of this program is being prepared and will be presented back to the executive board in Q4.

Bleep Volunteers

The focus for bleep volunteering will be on the development of a 7 day service at the Chelsea site in Q4 with a plan to roll out the service at the West Middlesex site in March 2019. The service will also develop to provide assistance to vulnerable patients who require supports getting around our sites similar to that offered at airports.

Youth volunteering

The focus for youth volunteering will be to embed the service at the West Middlesex site in Q4 and to roll out the service in March 2019 to the Chelsea Site. Ensuring appropriate levels of support for the young people and refining this model will be essential before the spread of this programme.

Brighter futures

Brighter futures provide volunteer supported mentoring for young people affected with life long illness. The brighter future team of volunteers would assist young people at both hospital sites with a bespoke programme of mentoring and support in an attempt to minimise the effects of hospitalisation.

A full proposal and implementation plan are being prepared and will be presented to the executive management board by the end of 2018.

Accelerating the spread of the volunteer service

The volunteer service has achieved a vast amount in the last 12 months. The current areas of focus which should assist in the acceleration of the service are:

- Dedicated substantive volunteer service manager and administrative support – in place by December 2018
- An improved OH process to expedite recruitment – currently in development and should be in place by January 2019
- Focus on a reduced number of programmes to enable more resource to support these to deliver at scale
- Learning from what works well currently at each site and rolling this out across the other site to assist with spread and growth.

Conclusion

The volunteer service is developing and continuing to spread throughout the organisation and has excellent executive support. The appointment of dedicated resource to manage the service will enable the growth to accelerate. However the service is focussed on delivering a high quality patient and volunteer experience which will not be compromised by expanding too rapidly.

The volunteer service is on track to ensure that the Trust target is realised within the time frame. The next phase of the service development will be to ensure there is a clear visible space in the trust at each site for the service, the continued development of volunteers into suitable roles in all departments and to ensure that the volunteer management system is in place to better understand the daily provision and contribution of the service.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.6/Nov/18
REPORT NAME	Concerns, Compliment's and Complaints Report
AUTHOR	Nathan Askew, Director of Nursing
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	This report will provide an update to the board on the changes and improvements made within the complaints service, including an update on themes and performance of the team.
SUMMARY OF REPORT	The changes in the team structure and process have been completed and implemented resulting in a reduction in the number of formal complaints received and an increase in compliance with the 2 working day acknowledgement timeframe. There is more work required to ensure sustained compliance with the 25 working days response rate and a robust action plan is currently in place to address this area. There continues to be an increase in informal concerns raised within the Trust however there has been little Improvement in the resolution of these within 5 working days. This will be an area of focus for the teams on both sites.
KEY RISKS ASSOCIATED	Reputational risk associated with poor patient experience and resolution of complaints and concerns.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Poor patient experience
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	To provide excellent patient care
DECISION/ ACTION	The board are asked to note the contents of this report

Concerns, Compliments and Complaints Report

1. Introduction

This report will provide the Trust board with an update on the changes that have been implemented within the complaints department, including an update on performance against the Trust targets and the future developments for the service.

The report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation, and service standards expected by the Parliamentary and Health Service Ombudsman.

2. Background

Following concerns about the performance of the Trust complaints service the Team were restructured in April 2018, in addition to the policy and process being changed to provide a better process for the management of complaints.

The restructure saw the complaints team resources aligned to each clinical division in a business partner model, similar to model provided by HR and finance teams. In addition the 'Head of Complaints' role was created and has been recruited to with the successful applicant commencing in post in June 2018.

The complaints performance has formed one of the 5 key quality priorities for the 2018-19 financial year resulting regular oversight and scrutiny within the divisional and executives teams of the Trust.

3. Complaints performance

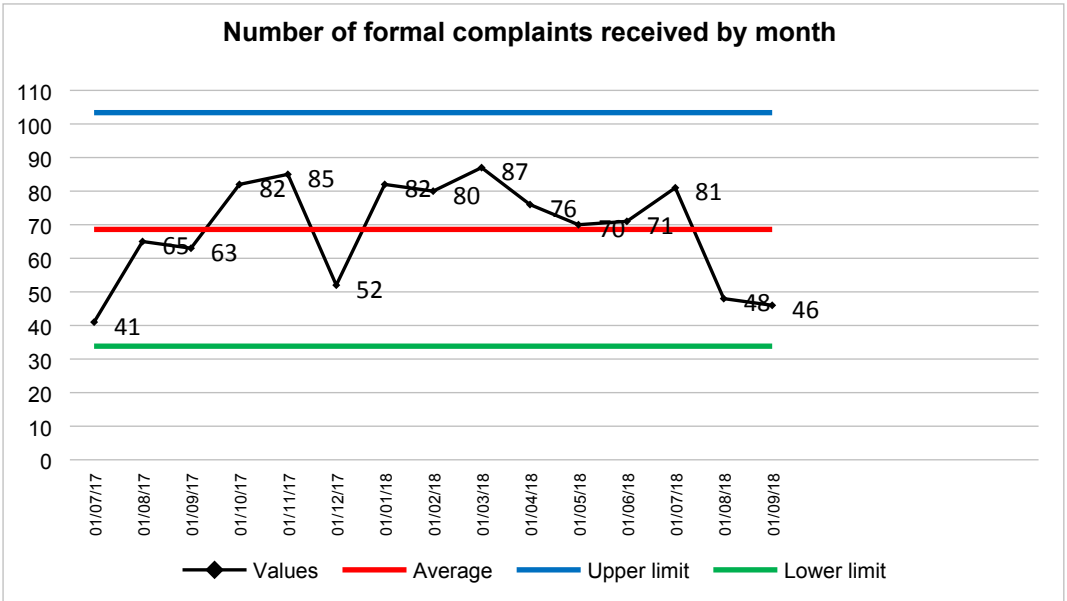


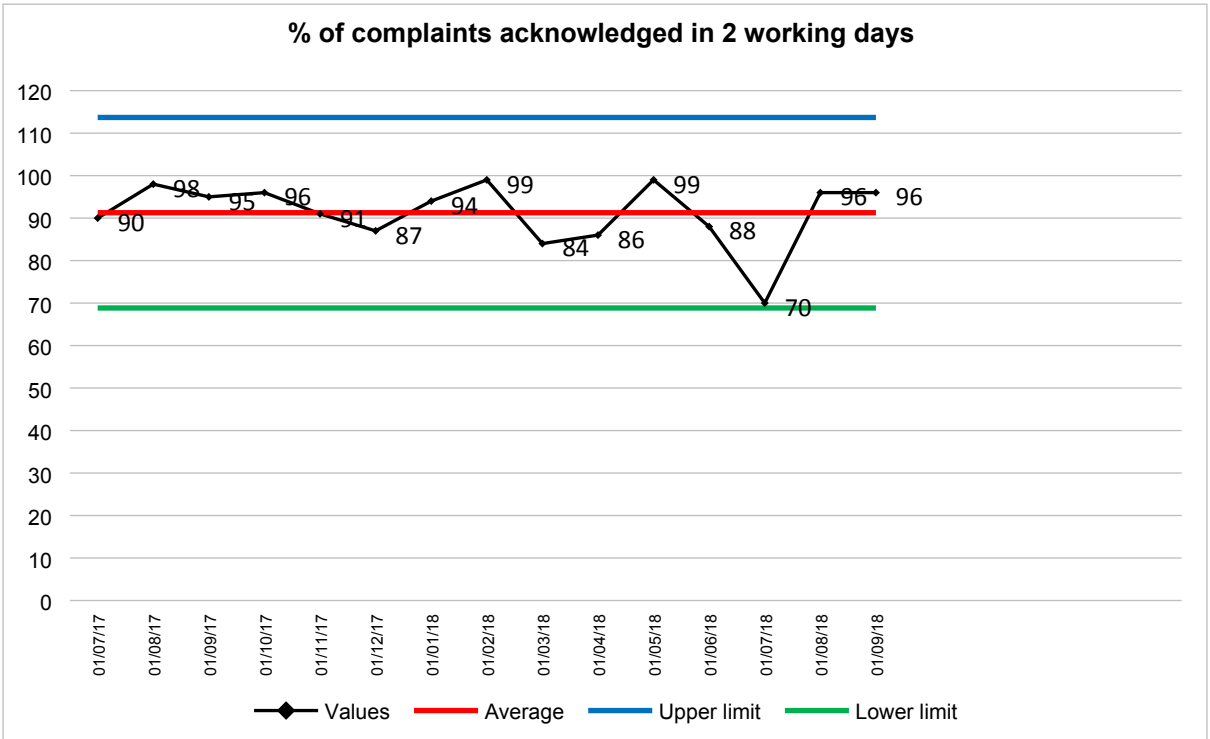
Fig 1: Formal complaints by month and year, 1st July 2017 – 30th September 2018

There has been a continued reduction in the number of formal complaints compared to previous months and the same Augusta and September period last financial year. The complaints officers now discuss every complaint received with the complainant and agree the best way for each complaint being managed, including being dealt with informally where this is appropriate.

Every complaint has an agreed terms of reference which allows the operational and clinical teams to be much clearer of the issues of the complaint and what action is required to address or remedy them. This has also led to increased compliance with the Trust target to acknowledge all complaints within 2 working days.

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total received	63	82	85	52	82	80	87	76	70	73	77	48	46
No acknowledged in 2 working days	60	79	77	45	77	79	73	65	69	64	54	46	44
% acknowledged in 2 working days	95%	96%	91%	87%	94%	99%	84%	86%	99%	88%	70%	96%	96%

Tab 1: Trust wide formal complaints performance; acknowledgement, 1st September 2017 – 30th September 2018



The Trust have a target of responding to complaints within 25 working days, except where complaints fall under one of the 3 categories within section 9 of the complaints policy that allow for an extension of the complaint beyond this time frame which are outlined below:

Coroners Inquests

Cases referred to the coroner will usually result in a delay in the ability of the Trust to respond within the standard time frame. Cases may be with the Coroner for an extended time and as such no definitive time frame should be given to the family.

For complaints which have been referred to the coroner the Trust will provide a complaint response 20 working days after the outcome of the coroner investigation / inquest is complete. The

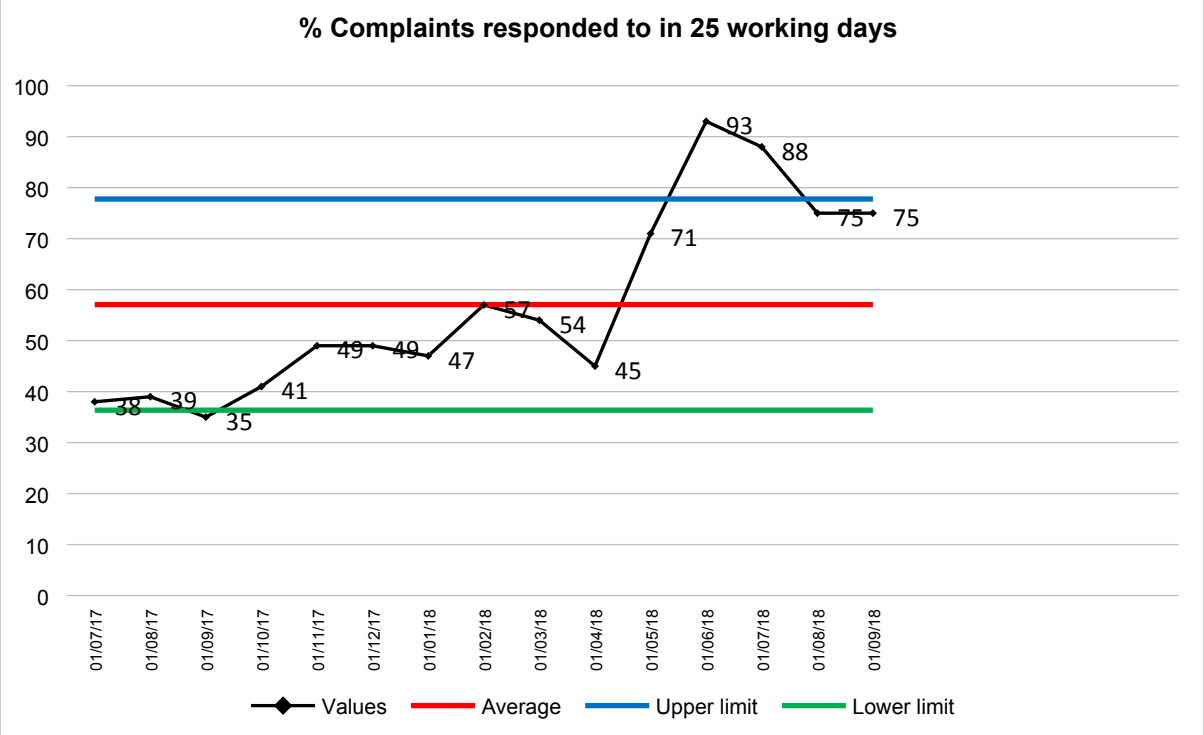
complainant should be kept in contact with as to the progress of the case at least monthly by the complaints team.

Serious Incident Investigations
Complaints that are linked to a serious incident will be extended to 70 working days for a response. The application should include evidence of the case being linked to a SI and the complaint or their representative must be kept updated throughout the process.

Complex Complaints
It is acknowledged that some complaints can be complex when they span 2 or more directorates or different divisions. In these case an application for a 10 working day extension (35 says total) may be made.

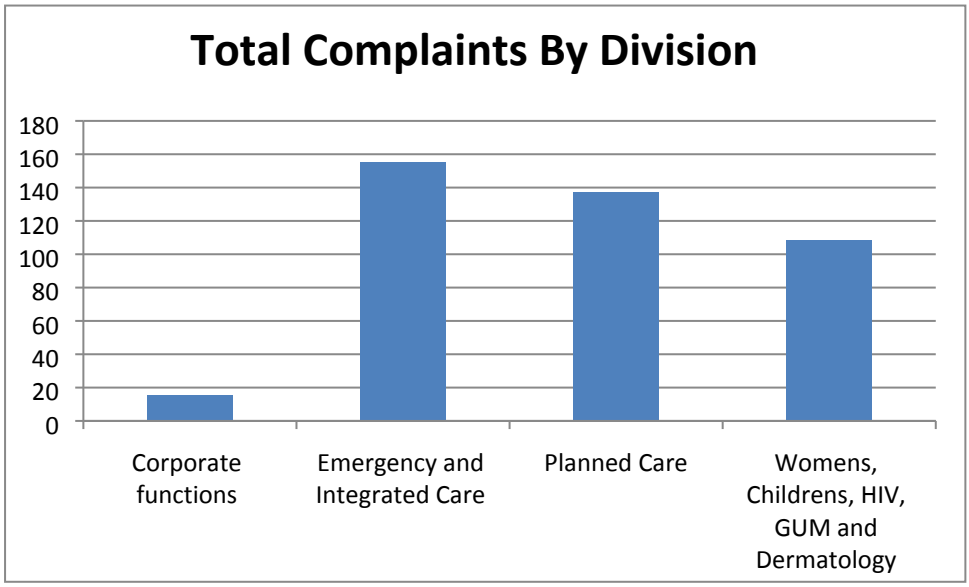
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total due to be closed	74	73	79	82	94	82	93	93	102	78	88	63	40
No. closed within timeframe	26	30	39	40	44	47	50	42	72	84	77	47	30
% closed within timeframe	35%	41%	49%	49%	47%	57%	54%	45%	71%	93%	88%	75%	75%

Tab 2: Trust wide formal complaints performance; closure, 1st September 2017 – 30th September 2018



Initially the new process received a dramatic improvement with the compliance with the 25 day response time frame. However this decreased in August and September. An escalation process is being put into place to ensure that all complaints that will not be delivered in the 25 working days will be escalated to the Director of Nursing and Chief Nurse before they breach the deadline. This

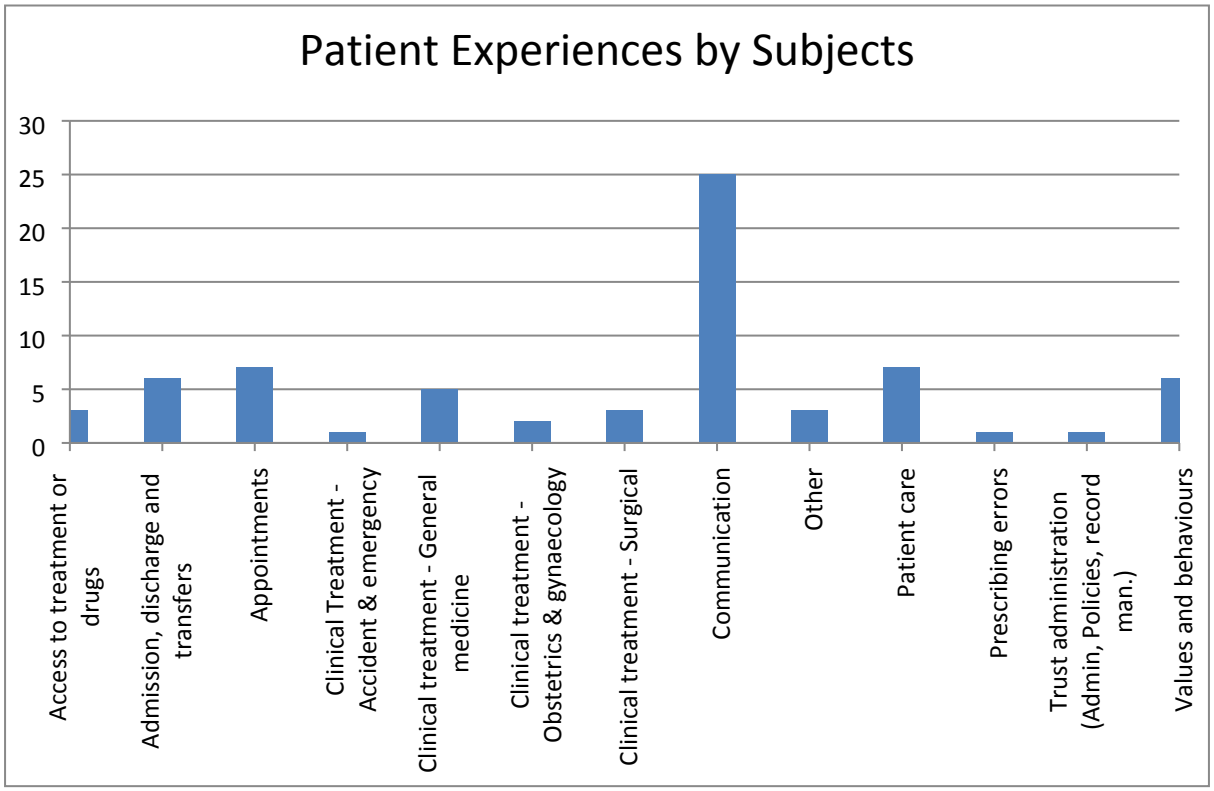
will be in place before the end of October and will result I better performance being reported in November.



EIC continue to receive the largest number of complaints in the organisation followed closely by Planned Care.

Themes of complaints:

Complaints are categorised using the NHS Digital complaints categorisation system. Each complaint may raise several issues, all concerns expressed by patients are categorised within the record but only the primary issue is used within this report to monitor key trends.



The top 5 most reported themes in complaints are:

- Communication
- Values and behaviours
- Appointments
- Patient Care
- Admission, Discharge and Transfer

4. Formal complaints in progress

As at 12th October 2018 there are 75 open formal complaints awaiting response/closure across the organisation; at the previous report to committee there were 64 open complaints.

	Chelsea and Westminster Hospital	West Middlesex University Hospital	Total
Corporate functions	1	1	**2**
Emergency and Integrated Care	14	18	**32**
Planned Care	9	7	**16**
Women's, Children's, HIV, GUM and Dermatology	17	8	**25**
Total	**37**	**34**	**75**

Tab 3: Open formal complaints as of 12th October 2018 by division and site

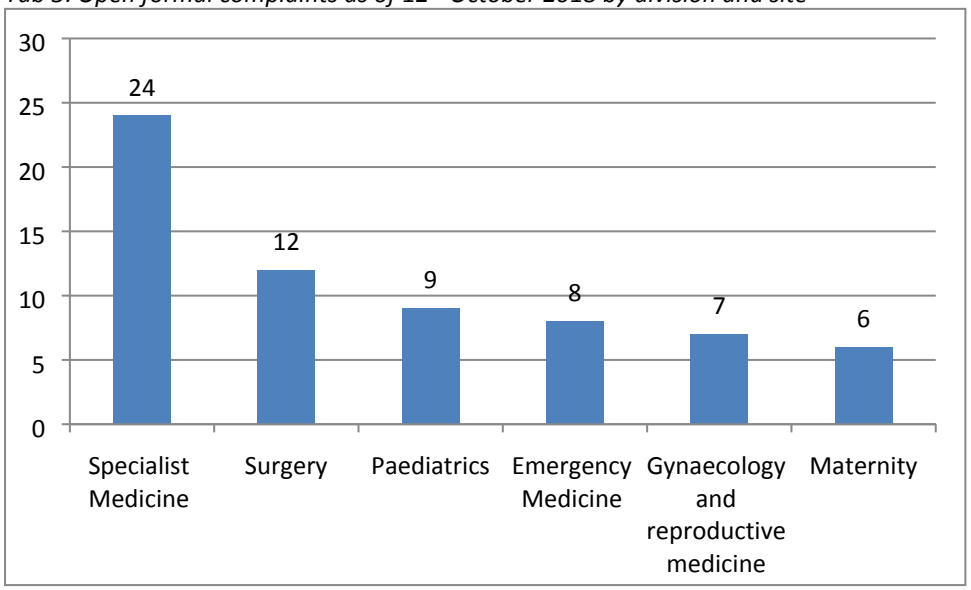


Fig 6: Open formal complaints as of 12th October 2018 by Directorate

5. Parliamentary and Health Service Ombudsman

There are currently nine cases open with the Parliamentary and Health Service Ombudsman for review.

Final reports have been received by the Trust in respect of two of these cases. One case is in the process of completing the PHSO actions, in the second case the Trust are preparing to appeal the PHSO decision.

6. Complaints Audit Actions

The external audit of the complaints process and procedure in March 2018 graded the Trust as significant assurance with minor improvements required. There were 5 recommendations from the audit, an update of each is provided below.

Lessons learned from complaints
The trust should produce a monthly newsletter which gives an overview of the common themes of complaints that have been received and this should be shared widely through the organisation

Update: This is in the process of being developed and in the interim the monthly complaints report is now shared through the executive management board meeting and reported to quality committee, which includes thematic analysis of complaints.

Monitoring complaint actions
The Trust should develop a system that allows for the monitoring of actions agreed as part of the complaint investigation process

Update: The action tracking function has been developed and activated in Datix and is currently being piloted in the Women's services directorate. Once the process is refined it will be rolled out to the other parts of the organisation, to be completed in Q4.

Formal staff training on responding to complaints
Currently the complaints team support staff on a one to one basis as they are required to answer complaints. This should be augmented through a formal training programme.

Update: This is currently in development and should be offered to staff in Q4.

Complaints Policy Update
The complaints policy required t be updated to reflect some of the practice and processes within the Trust

Update: This action has been completed and the policy is in use within the organisation.

Complaints performance reporting
The Trust should develop a more robust method of reporting outside of the Trust dashboard, giving more information in relation to the compliance with the 25 working day target.

Update: This action has been implemented through the monthly complaints report shared with the executive management board and the Quality Committee.

7. Informal concerns

One hundred and eighty one informal concerns were received in September 2018; this is an increase compared with the previous three months. However over the last 12 months there has been a trend for increasing numbers of informal concerns from patients and their families/representatives.

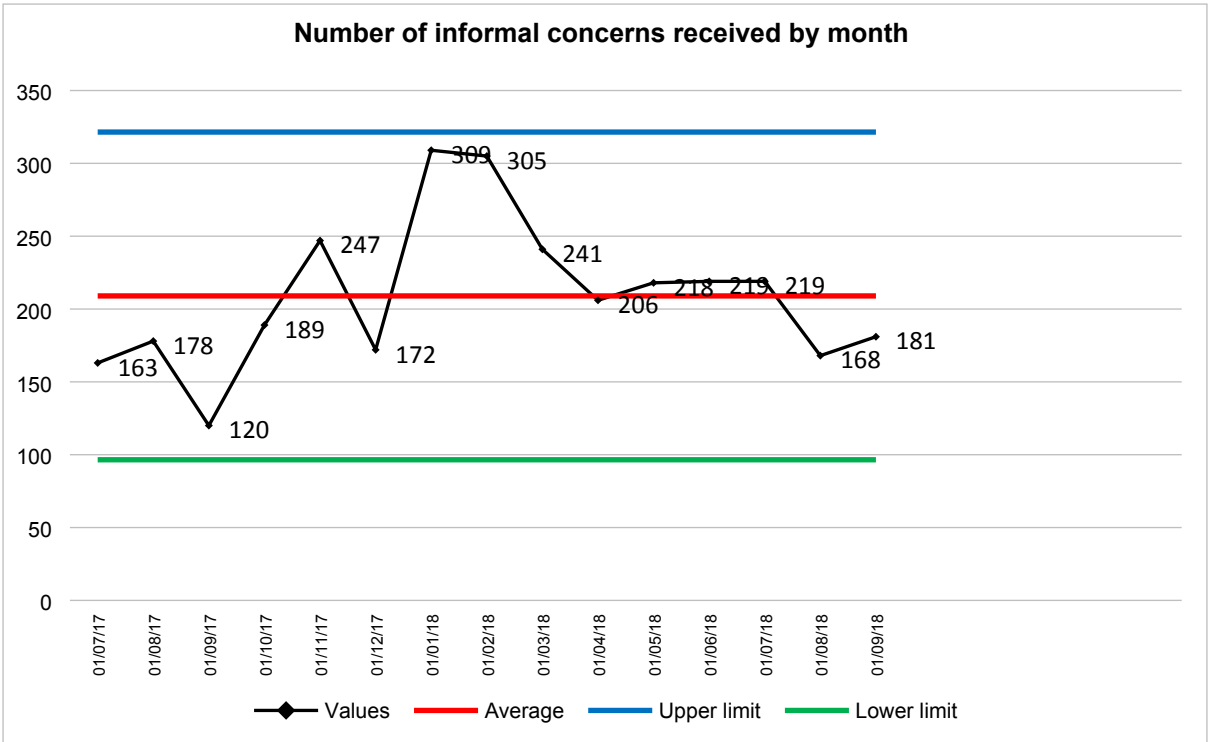


Fig 7: Informal concerns by month and year, 1st June 2017 – 30th September 2018

Concerns are categorised using the same system as formal complaints, this supports data analysis and monitoring. Each concern may raise several issues, all aspects of the concern are categorised within the Datix record but only the primary issue raised is used within this report to monitor key trends.

Work is ongoing with the PALS teams to increase the rate of immediate resolution and to improve performance with closing concerns within five working days.

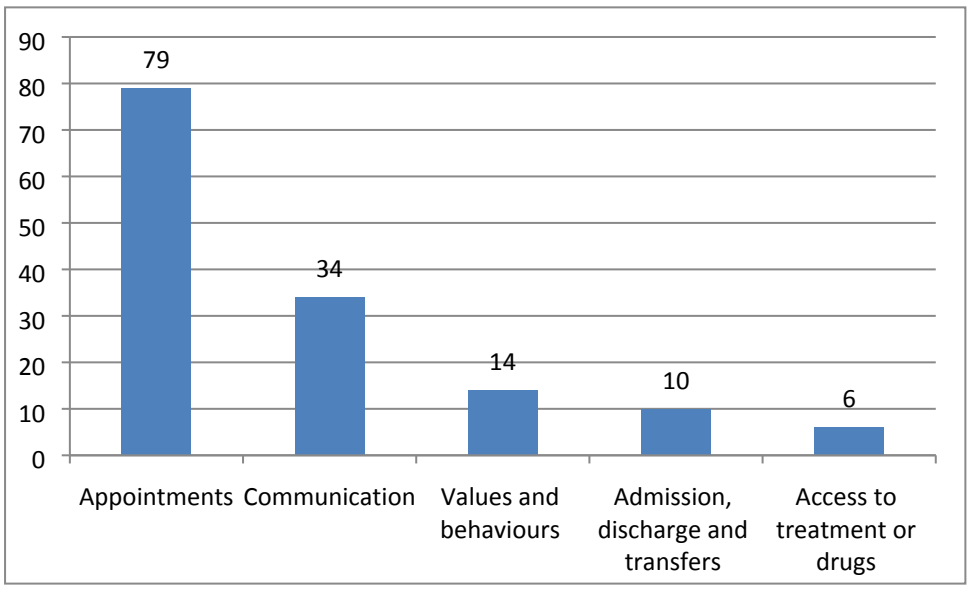
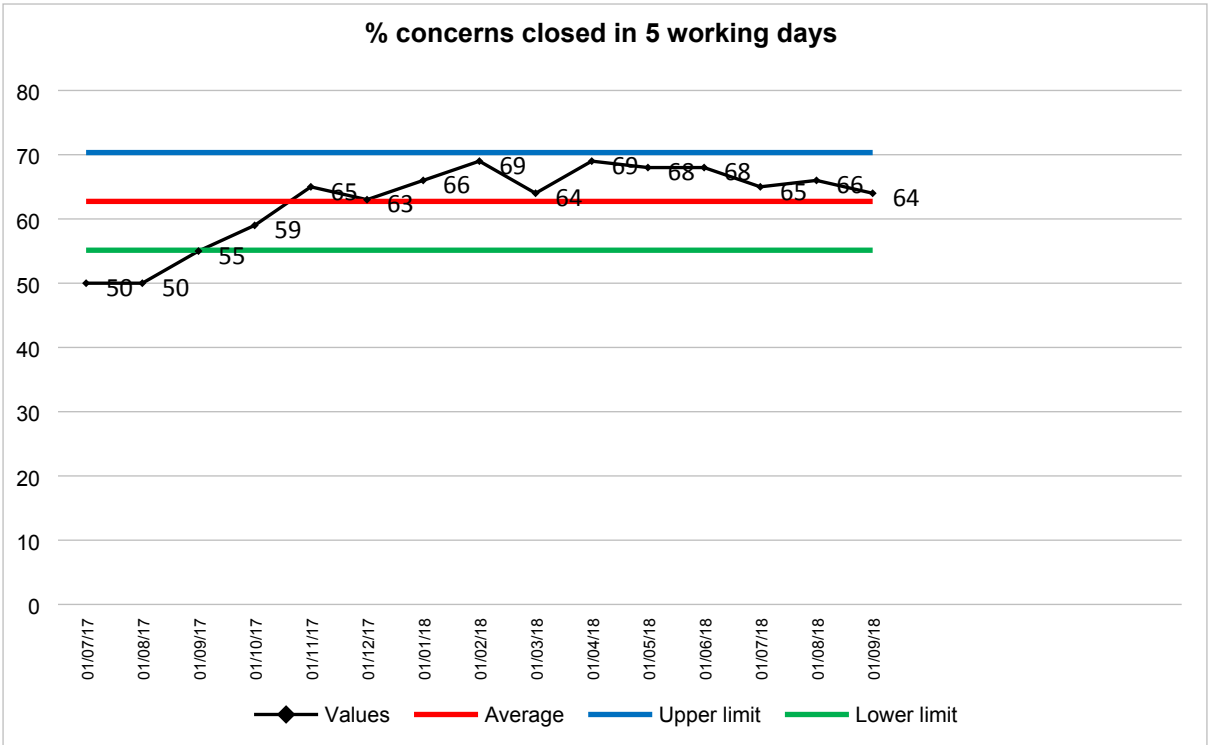


Fig 8: Informal concerns by primary subject, August 2018

Informal concerns: Trust performance

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total received	163	178	120	189	247	172	309	305	241	206	218	219	219	168	182
No. closed within 5 working days	81	89	66	111	160	108	205	211	154	142	148	149	143	111	116
% closed within 5 working days	50%	50%	55%	59%	65%	63%	66%	69%	64%	69%	68%	68%	65%	66%	64%

Tab 4: Trust wide informal concerns performance, 1st June 2017 – 30th September 2018



8. Compliments

Forty four compliments were recorded from a patient or their family/representative within the Datix patient experience module during September 2018.

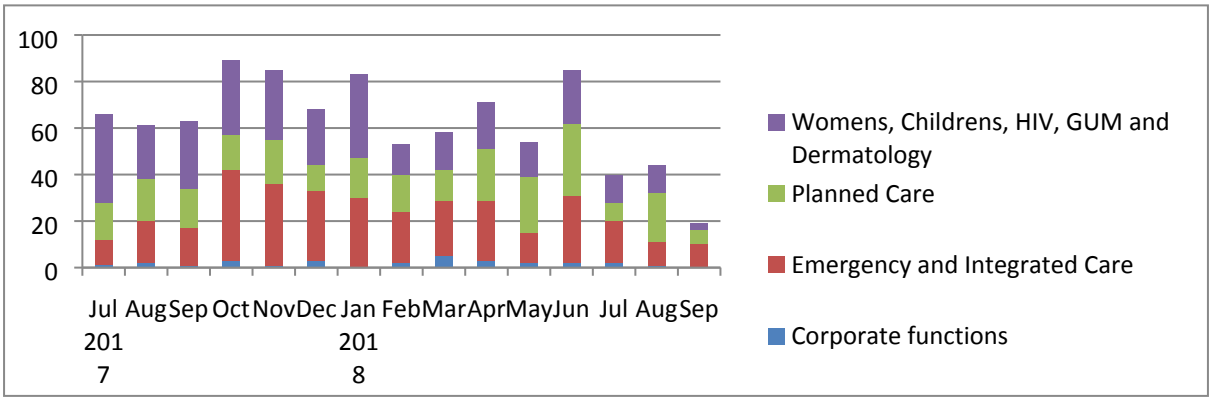


Fig 8: Compliments by month and year, 1st July 2017 – 30th September 2018

Below are some examples of compliments received during September:

EIC Division:

Patient wrote to thank consultant for his time, patience and expert advice, all very much appreciated. Patient said he will follow the helpful advice and recommendations, and look forward to contacting consultant's secretary once the stress test has been done to then advise whether he should take the new medication.

Patient expressed thanks to the staff who treated his eye when he attended the emergency department. He did not have to wait long to be seen and found the staff to be "amazing -- efficient, friendly and reassuring".

Planned Care Division:

Patient expresses how fantastic her stay was on the ward. Patient reports the staff were compassionate, kind and devoted to their tasks. Patient states all the staff were attentive which is proof that a good ward manager knows how to treat her staff and patients. Patient reports she has had other experiences on other wards but the service has never been this good. Patient reports this was the best experience she has had in this hospital.

Patient wrote to CEO to express his gratitude for the professional care received by the Day Surgery Team and Richmond Ward Team. He was wheeled in as a patient and walked out as a friend.

WCHGD Division:

Patient reports they could not be any happier as they received such caring, friendly and professional service from staff member. patient reports they have learnt a lot from the staff member especially the passion for being a healthcare professional was totally outstanding.

The patient had her 1st baby in early May and a brief baby related stay about a month before. She would like to say that she was "super impressed with the staff" and her care. The patient says "Everyone was so lovely and I felt very safe, consequently I had an amazing and positive birthing experience, I loved it. Thank you so much for helping create that for me." She says her baby girl and her are doing brilliantly.

9. Conclusion

There has been a lot of change and improvement within the complaints service which is now embedded into practice. The team are now fully recruited to all roles including the PALS service at both sites.

There is more work required to ensure that the closure of both formal and informal complaints within the agreed timeframe and to complete some of the actions that were required as part of the external audit.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	3.1/Nov/18
REPORT NAME	Annual Workforce Equality and Diversity Report 2017/2018 (Incorporating Workforce Race Equality Standard)
AUTHOR	Nicole Porter-Garthford-Associate Director of HR
LEAD	Sandra Easton, Chief Finance Officer
PURPOSE	This report is published to ensure that Chelsea and Westminster Hospital NHS Foundation Trust has the information it needs to promote workforce equality and meet its public sector equality duty, as outlined in the Equality Act 2010. This report incorporates the information required by the Workforce Race Equality Standard (WRES). Our 2 year action plan to promote workforce equality and address any issues identified in our WRES return can be found in Appendix 1. This was developed as part of the 2017 report and has been reviewed in light of this year's data. Our WRES return can be seen in Appendix 2
SUMMARY OF REPORT	The annual report looks at a number of different aspects of the workforce in relation to equality and diversity data and protected characteristics including workforce composition, recruitment procedures, non-mandatory training, promotions and leavers, application for formal employee relations procedures, staff experience (Staff Survey results) and Clinical Excellence Awards. This year the report also includes a summary of the Trusts Gender Pay gap reporting as well as information on the performance development reviews (PDR's) and review outcomes. The report shows that the Trust employs an ethnically diverse workforce in comparison to the local population in London with 2959 (50%) of staff identifying as white and 2531 (42%) identifying as BAME (Black, Asian and Minority Ethnic). There are still 474 staff (8%) of staff for who we do no hold data on in terms of ethnicity and this is an issue that needs to be addressed for this as well as a number of other areas including disability (where only 2% of the workforce have declared a disability and we do not hold data for 1610 staff and religion where we do not hold data for almost 25% of our staff). The report also provides the data for our WRES return. Last year one of our main areas of concern was the indicator that showed the likelihood of non-BAME candidates being appointed from shortlisting which was showing as 2.4 times greater than for BAME candidates. This meant the Trust was above the national average as well as above the median for our peer Trusts. There has been an improvement this year and the figure has dropped to 1.66 times greater which is more in line with the national average. We do not know at this time however how we compare to other peer Trusts this year. The other area of concern in terms of WRES was the indicator relating to relative likelihood of staff entering the formal disciplinary process which last year was 2.84 and this year has dropped to 2.49.

KEY RISKS ASSOCIATED	Failure to address concerns identified in the report will have an effect on staff engagement which may hinder our bid to increase staff recruitment and retention.
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	The Trust employs a diverse workforce and we need to value all staff and provide equal opportunities for everyone
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and develop integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Annual Workforce Equality and Diversity Report 2017/2018

(Incorporating Workforce Race Equality Standard)

July 2018

1.0 Introduction

This report is published to ensure that Chelsea and Westminster Hospital NHS Foundation Trust has the information it needs to promote workforce equality and meet its public sector equality duty, as outlined in the Equality Act 2010. This report incorporates the information required by the Workforce Race Equality Standard (WRES).

Our 2 year action plan to promote workforce equality and address any issues identified in our WRES return can be found in Appendix 1. This was developed as part of the 2017 report and has been reviewed in light of this year's data.

Our WRES return can be seen in Appendix 2

2.0 Workforce Composition

The Trust had a headcount of 5964 staff at the end of the financial year 2017/18 which is an increase of 370 WTE staff and a 6% increase over the same period last year. The following pages provide a high level summary of the workforce information by protected characteristics.

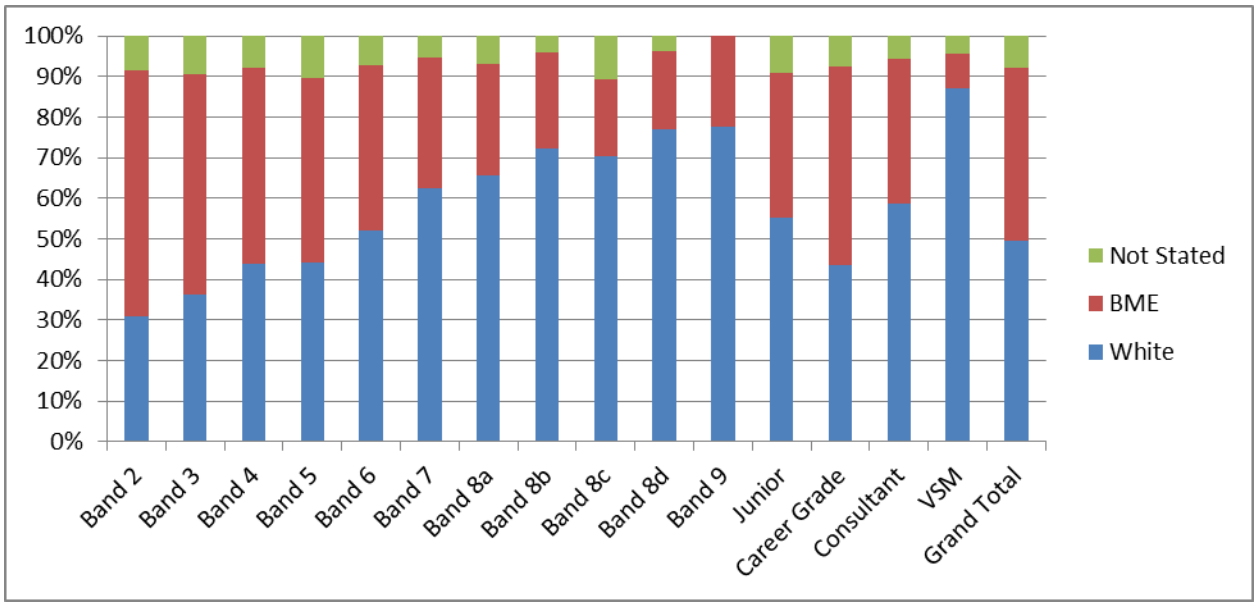
For the purposes of this report, the Trust has combined staff categories as White, BAME (Black, Asian and Minority Ethnic) and Not Stated. The national electronic staff record does not give the option of "Do Not Wish to Declare" ethnicity so these are recorded by default as Not Stated.

The White category incorporates staff that identify as White British, White Irish and Any Other White background. BAME includes staff who identify as Asian (Indian, Pakistani, Bangladeshi), Mixed (White Black/Asian), Black (Caribbean, African) and Other (Chinese and Any Other). This is in line with the Office of National Statistics' Census categories.

2959 (50%) of the workforce identify as Non BAME compared with 2531 (42%) as BAME staff. This compares with 51% and 41% respectively at the same point last year. 8% (474) of our staff are recorded as Not Stated, which is marginally different to last year when the overall percentage figure for Not Stated last year was 9%. The Trust employs an ethnically diverse workforce in comparison to the local population in London.

Figure 1 shows the grade distribution of white and BAME staff across all staff groups across the organisation. BAME staff form the majority of staff in Bands 2 to Band 6. White staff form the majority of staff from Bands 7 to VSM.

Figure 1: Ethnicity Profile by Grade

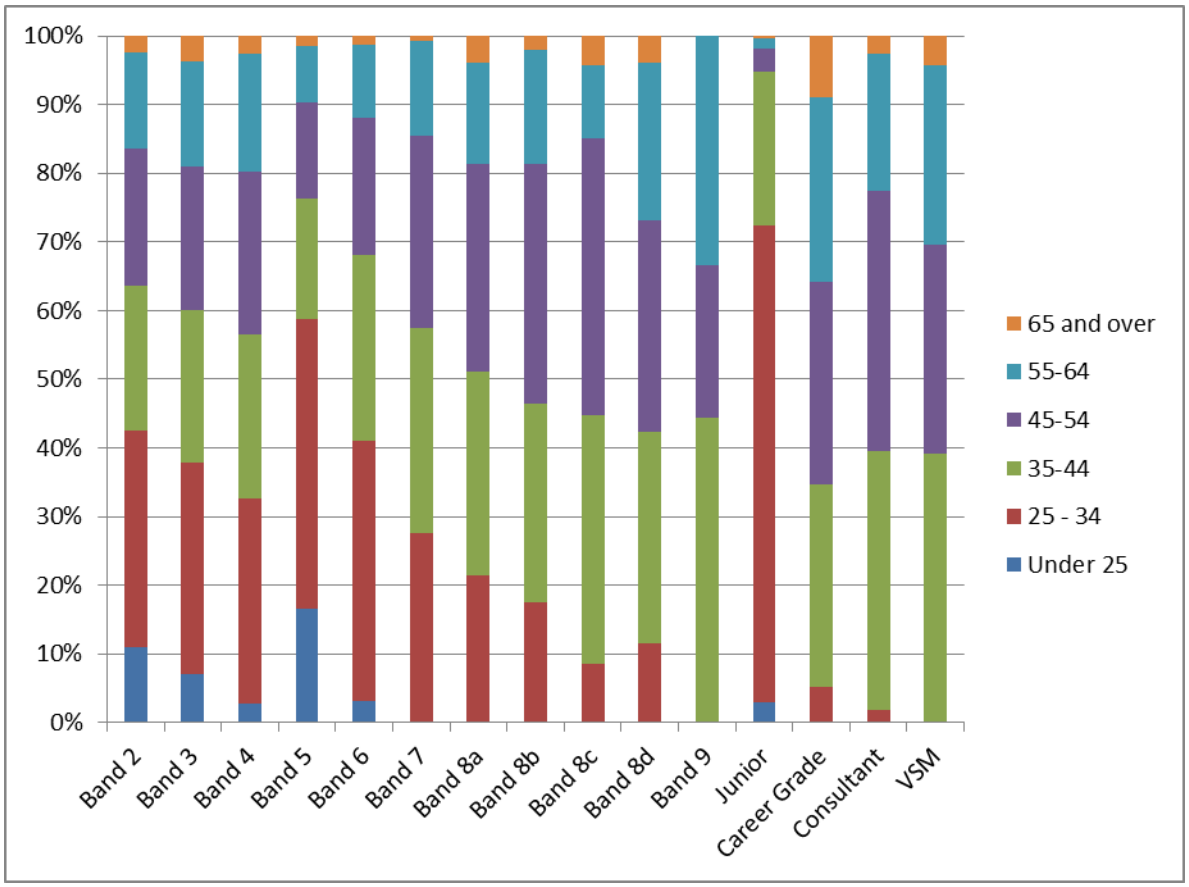


2.2 Workforce Composition by Age

The 25 – 34 age group makes up the single largest age group across the Trust, accounting for 34% of the workforce. The Trust seeks to increase its attractiveness to people of all age groups through a range of measures including the widespread provision of work experience opportunities, apprenticeships and the promotion of flexible working.

Figure 2 below shows the distribution by age across the pay bands

Figure 2: Age Profile by Grade



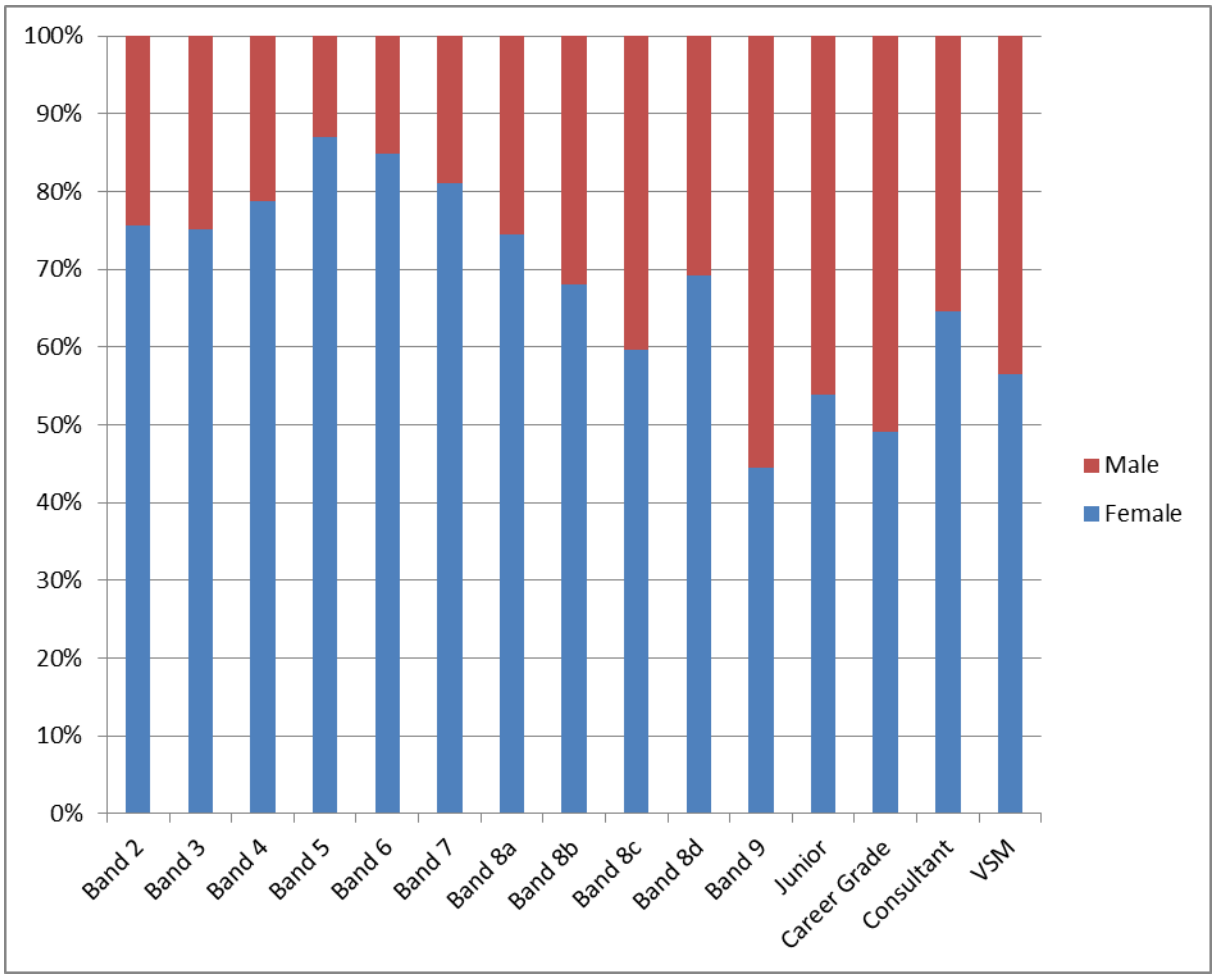
2.3 Workforce Composition By Gender

There were 4543 females employed across the organisation who make up 76% of the total workforce and there were 1421 males who make up 24% of the workforce. This has not changed from the previous year and remains consistent with the national profile.

Figure 3 below shows the distribution by gender across the Bands. This shows that for the majority of bands there are more females than makes, the only area in which males (56%) outnumber females (44 %) is at Band 9 where 56% of post holders are male compared to 44% being female. This is a group of nine employees with a gender balance of 5 males to 4 females. It should be noted that this group includes staff working for another company which the Trust were hosting at the time of this data being collected.

In the Very Senior Manager grade the balance is 56% female to 43% male.

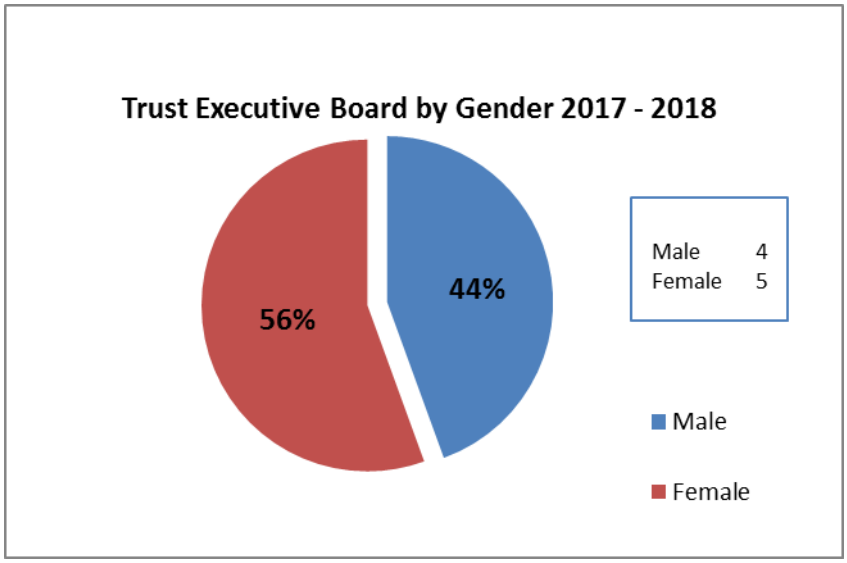
Figure 3: Gender Profile by Band



2.4 Trust Board of Directors Composition by Gender and Ethnicity

The Board of Executive Directors comprises of 9 posts, the Chief Executive and 8 Executive directors. The gender balance is 56% female and 44% male compared to the overall workforce profile of 76% female and 24% male.

Figure 4: Trust Executive Board by Gender



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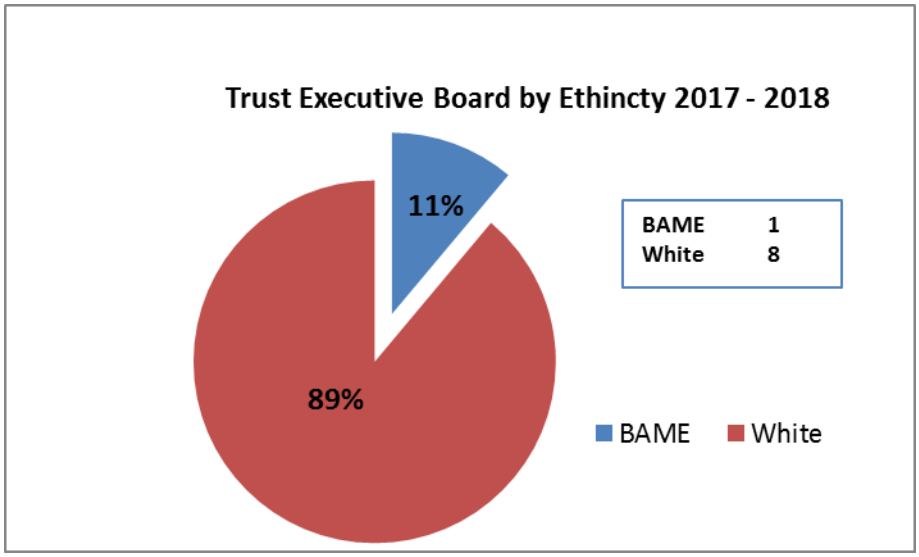
The ethnicity profile of the Board of Executive Directors is 89% White staff and 11% BAME staff.

Figure 5: Trust Executive Board by Ethnicity



The Trust Chairman and 7 Non-executive directors complete the Trust board. Of these 6 are male and 2 female. 7 are white and 1 is BAME which equates to 87.5% white and 12.5% BAME.

2.5 Workforce Composition by Religious Belief

Table 1 below shows the data held on the religious beliefs of staff. The majority of staff identify as Christian with 39% of staff giving this as their belief. Christians were also the

largest group last year at 35% so we have increased as a proportion of the total by 4% and is the biggest change in the data.

The other religious groups have all increased slightly but these are very small increases, on average less than 1% from last year. The percentage of staff recorded as undefined, meaning no data is recorded on ESR is 24.43%, which has reduced from 31.23% the previous year.

Table 1: Religion Profile

Religious Belief	Total	%
Atheism	515	8.64%
Buddhism	54	0.91%
Christianity	2344	39.30%
Hinduism	265	4.44%
I do not wish to disclose my religion/belief	658	11.03%
Islam	303	5.08%
Jainism	10	0.17%
Judaism	23	0.39%
Other	243	4.07%
Sikhism	92	1.54%
Undefined	1457	24.43%
Grand Total	5964	

2.6 Workforce Composition by Sexual Orientation

Table 2 below shows the data held on the sexual orientation of staff. The majority of staff identify as heterosexual at 62%. This was also the largest single category last year and has increased by 6% as a proportion of the total from 56% last year.

The other groups have all increased slightly but these are very small increases on average, again less than 1% from last year. The percentage in the undefined category is 24.33%, which has reduced from 31.05% the previous year.

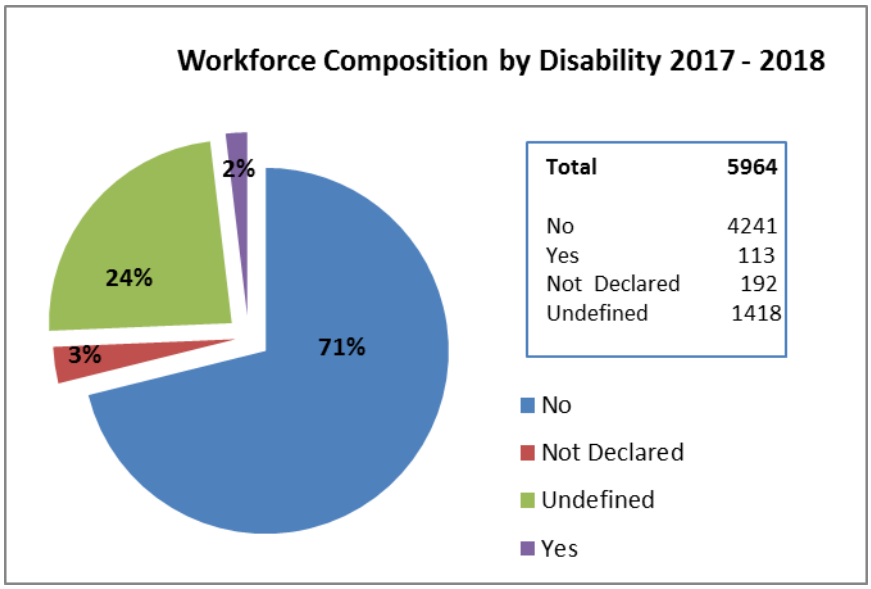
Table 2: Sexual Orientation profile

Sexual Orientation	Total	%
Bisexual	27	0.45%
Gay	121	2.03%
Heterosexual	3724	62.44%
I do not wish to disclose my sexual orientation	621	10.41%
Lesbian	20	0.34%
Undefined	1451	24.33%
Grand Total	5964	

2.7 Workforce Composition by Disability

Figure 6 shows that 2% of the workforce population recorded on the electronic staff record have declared that they have a disability. However we do not hold any data for 1610 staff (based on the numbers in the “Not Declared” and “Undefined” categories). It is also worth noting that whilst only 113 staff of our entire workforce have declared a disability that has been formally recorded on ESR, 229 of the respondents to the Staff Survey in 2017 have stated that they have a disability.

Figure 6:



2.8 Data Quality for Disability, Sexual Orientation and Religion - 2017/18

We are committed to improving our data quality and there have been improvements this year with the number of staff who we hold demographic information for.

The number of staff for whom we do not hold information on their ethnic status decreased from 9% to 8% since the last year. Our data on disability, sexual orientation and religion has also improved since last year (see Table 3 below).

The Trust holds demographic information on 76% of staff in relation to disability which has increased from 73%, 89% in relation to sexual orientation, an increase from 69% in the previous year and 88% in relation to religion an increase from 69% in the previous year.

We will continue to highlight the importance of completing data by promoting the use of self-service via ESR and by putting in more robust data capture processes when new employees join the Trust.

With respect to disability we will encourage staff who may become disabled over the course of their employment to declare their disability and also ensure that when it is identified that a member of staff has a disability this is recorded on their ESR record if it wasn't at the time of them starting in the Trust.

Table 3: Disability, Sexual Orientation and Religion records for all staff

Protected Characteristic	Known status for all staff
Disability	76%
Sexual Orientation	89%
Religion	88%

3.0 Recruitment

The Trust is committed to open, transparent recruitment processes that do not discriminate against people on the grounds of their protected characteristics. In support of this commitment the Trust monitors the progress of applicants through the selection process. For the purposes of clarification the Trust uses the NHS jobs website as its main source of advertising posts and Trac is used as our recruitment management programme.

3.1 Recruitment by Ethnicity

64% of all job applications in 2017/18 were from candidates from a BAME background. This is a reduction from 65% in the previous year. 31% of all applications were from Non BAME candidates which is no change from the previous year. Almost 5 % of applicants choose not to disclose their ethnicity at application stage.

At shortlisting stage the ratio is 59.6% of BAME candidates are shortlisted, this is a reduction by 7.4% from 67% the previous year. For non BAME candidates the ratio is 36.7% who are shortlisted which is an increase of 7.7% from 29% the previous year.

In regards to being appointed following shortlisting the ratio is 39.6% for BAME applicants, a decrease of 4.72% on the previous year. For Non BAME candidates the ratio to being appointed from shortlisting is 40.5% which is an increase of 4.91% on the previous year which was 45.41%.

We don't hold information on ethnicity for 19.83% of candidates, this will include those who have chosen not to declare their ethnicity at the application or shortlisting stage of the recruitment process as well those who have been added onto Trac as off line applications following open days and oversees recruitment activity.

Table 4: Recruitment Analysis by Ethnicity

	Percentage of		
Ethnic Group	**Applicants**	**Shortlisted**	**Appointed**
BAME	64%	59.6%	39.6%
Not stated	5%	3.62%	19.83%
Non BAME	31%	36.7%	40.5%
Grand Total (number)	29464	6961	1482

Note: the data on applicants and shortlisted candidates comes from TRAC *and covers the period from 31/07/2017 to 30/07/2018.* Junior doctors on rotation to the Trust are appointed via Health Education England and will not be included in the applications, shortlisted or appointed candidates.

The likelihood of Non BAME candidates being appointed from shortlisting in 207/2018 is 1.66 times greater than BAME staff. This is a decrease from 2016/17 when the likelihood was 2.40 times greater.

This change has occurred predominantly because it has been identified that the way the information for this was ascertained in 2017 was incorrect. In 2017 the information for shortlisting was based on information held on Trac but the data for those appointed was based purely on those who started in the Trust using ESR figures for new starters. However this would not have taken into account that a number of new starters on ESR, namely junior doctors on rotation would not have come through the Trust recruitment process on Trac and therefore the figures being compared were showing different data.

This year the figures for shortlisting to appointment have been based solely on candidates who have come through the recruitment process on Trac. The ratio of 1.66 is far more in line with the figures being reported in the 2016 when the Trust reported that the likelihood of Non BAME candidates being appointed from was 1.76 times more likely.

Whilst this is a reduction from last year however this is still an area that the Trust will continue to focus on in order to improve this ratio.

Table 5 : Relative likelihood of being appointed from shortlisting by Ethnicity – 2017/18

Descriptor	Non BAME	BAME
Number of shortlisted applicants	2559	4150
Number appointed from shortlisting	601	587
Relative likelihood of Non BAME candidates being appointed over BAME staff at shortlisting stage	1.66	

3.2 Recruitment by Gender

Recruitment analysis by gender shows that 66.8% of applications were from female applicants and 32.8%from male applicants.

Table 6: Recruitment Analysis by Gender 2017-18

	Percentage of		
Group	Applicants	Shortlisted	Appointed
Female	66.8%	71.8%	73.3%
Male	32.8%	27.8%	26.5%
Not stated	0.4%	0.4%	0
Grand Total (number)	29464	6961	1482

3.3 Recruitment by Age, Disability, Sexual Orientation and Religion

Analysis by religion, age, sexual orientation and disability shows the conversion rates from shortlisting to appointment are broadly in line with the breakdown of applicants and the Trust profile for age and disability.

For example:

- The 25-34 age group make up the largest percentage of applicants and appointees
- 2% of appointees declare a disability compared with 2% of the workforce.
- 86.4% of applicants identified themselves as heterosexual
- 48.3% of applicants were Christian

The tables below give more detail on recruitment by these characteristics.

Table 7: Recruitment Analysis by Age 2017-18

	Percentage of		
Group	**Applicants**	**Shortlisted**	**Appointed**
Under 25	16%	13.4%	14.2%
25-34	46.7%	44.1%	49%
35-44	20.7%	23.1%	20%
45-54	12.6%	14.8%	12.6%
55-64	3.8%	4.4%	4.1%
65+	0.2%	0.2%	0.1%
Not stated	0%	0%	0%
Grand Total (number)	29464	6961	1482

Table 8: Recruitment analysis by Disability 2017-18

	Percentage of		
Group	**Applicants**	**Shortlisted**	**Appointed**
No	95.2%	95.6%	78.4%
Not stated	1.4%	0.3%	19.6%
Yes	3.4%	4.1%	2.0%
Grand Total (number)	29464	6961	1482

Table 9: Recruitment analysis by Sexual Orientation 2017-18

	Percentage of		
Group	**Applicants**	**Shortlisted**	**Appointed**
Bisexual	1.2%	1%	0.4%
Gay	2.4%	3.3%	3.6%
Heterosexual	86.4%	86.6%	70%
Lesbian	0.5%	0.5%	0.5%
Not stated	9.5%	8.6%	25.5%
Grand Total (number)	29464	6961	1482

Table 10: Recruitment analysis by Religion 2017-18

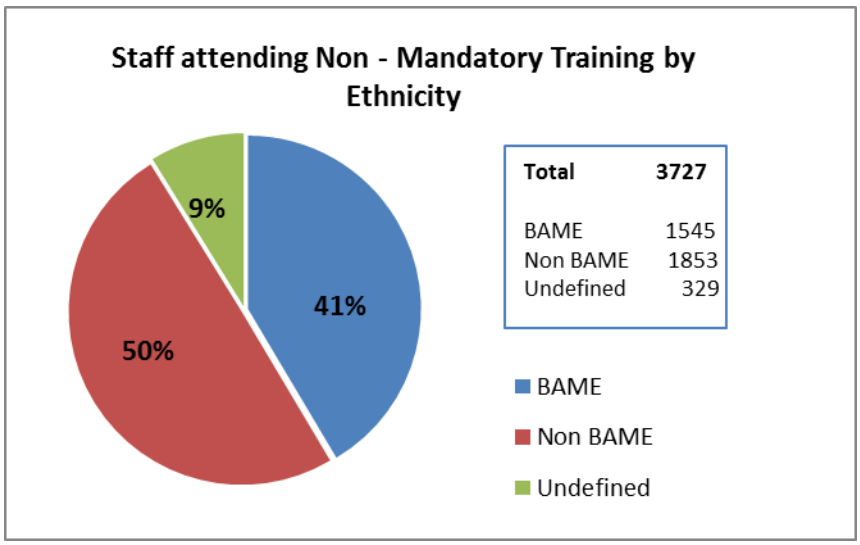
	Percentage of		
Group	**Applicants**	**Shortlisted**	**Appointed**
Atheism	7.5%	9.5%	11.1%
Buddhism	1.5%	1.4%	0.9%
Christianity	48.3%	49.6%	42.2%
Hinduism	7.3%	6.5%	4.3%
I do not wish to disclose my religion / belief	9.7%	10.4%	9.7%
Islam	16.3%	13.4%	5.5%
Jainism	0.2%	0.2%	0.1%
Judaism	0.3%	0.4%	0.5%
Not stated	1.4%	0.3%	18.8%
Other	6%	6.8%	5.5%
Sikhism	1.6%	1.5%	1.2%
Grand Total (number)	29464	6961	1482

4.0 Non-Mandatory Training

The Trust offers training through a variety of methods - eLearning, internal courses, apprenticeships and access to external courses. The training that is offered is across a wide spectrum of topics from clinical specialist topics to personal and management development. It should be noted that a large proportion of our professional development training is provided by external organisations from whom we may not always receive participation rates based on demographic data and this is something we are reviewing.

The data below is based on substantive staff and leavers only throughout the 2017-2018 financial years. An additional 194 non-substantive staff (e.g. bank, honorary or secondee staff) attended non mandatory training during this period but are not included in the above statistics.

Figure 7: Staff attending Non - Mandatory Training by Ethnicity



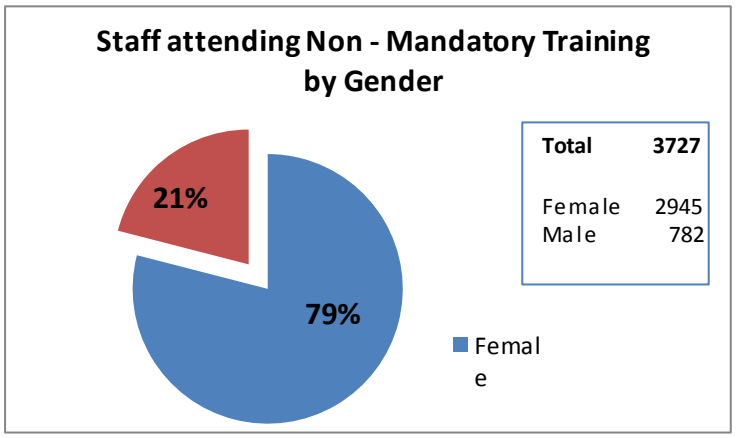
Analysis of non-mandatory training shows that the relative likelihood of Non-BAME staff accessing non mandatory training compared to BAME staff is 0.95. The ratio was 1.08 the previous year.

Table 11: Relative likelihood of accessing non-mandatory training by Ethnicity (WRES)

Descriptor	Non-BAME	BAME
Number of staff in organisation	4177	3310
Number staff that have accessed non mandatory training	1853	1545
Relative likelihood of Non- BAME staff accessing non mandatory training over BAME staff	0.95	

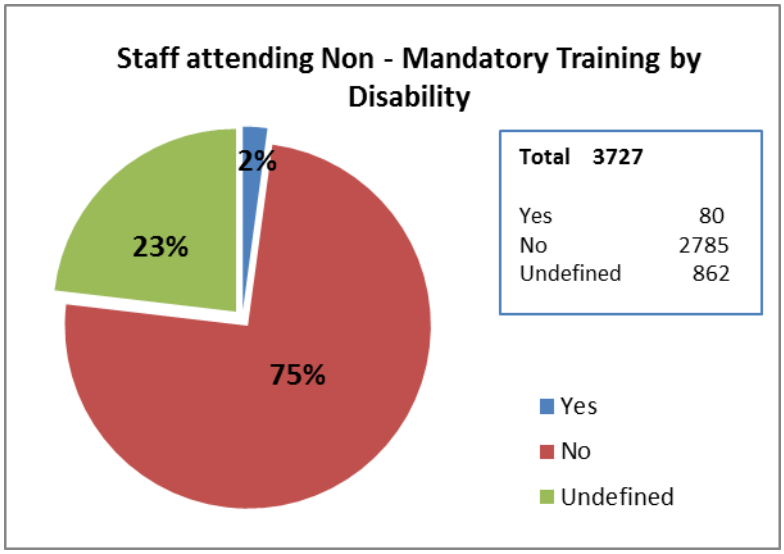
Female staff account for 79% of staff accessing non –mandatory training and males accounted for 21% of staff accessing this training. The previous year the split was 71% females and 29% male.

Figure 8: Staff attending Non - Mandatory Training by Gender



Disabled staff account for 2% of the staff accessing non-mandatory training which is in line with the percentage of the of staff recorded as having declared a disability.

Figure 9: Staff attending Non - Mandatory Training by Disability

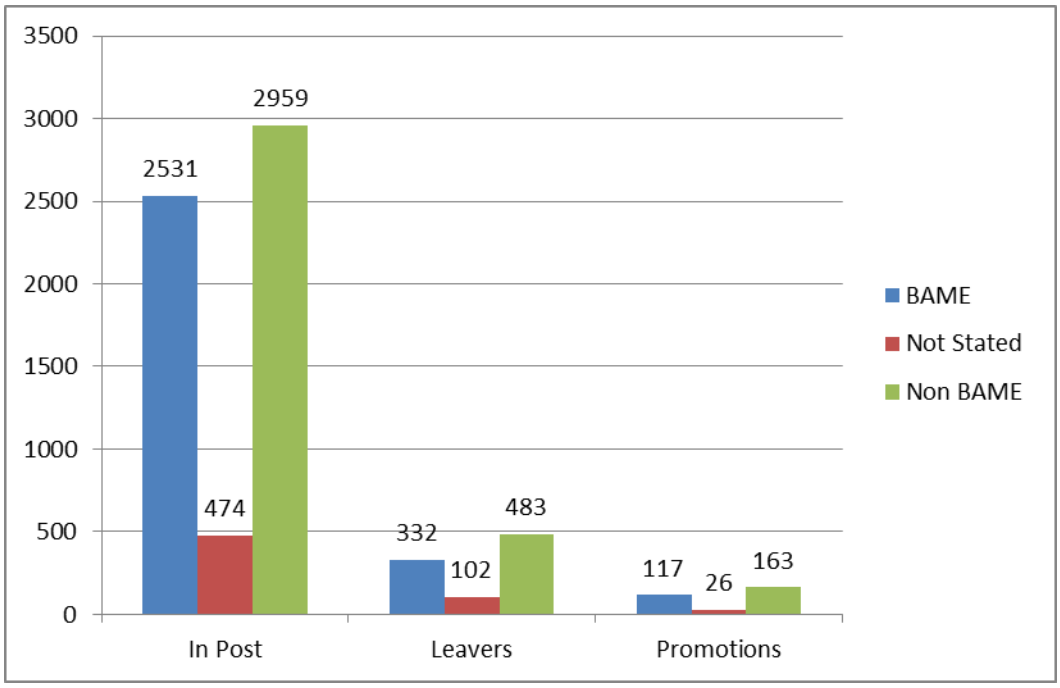


5.0 Promotions and Leavers by Ethnicity

Figure 10 shows that Non BAME staff are more likely to leave the Trust than BAME staff. However non BAME staff are also more likely to be promoted than BAME staff.

There are a number of staff who leave or are promoted for whom we do not hold details of their ethnicity.

Figure 10: Promotions and Leavers by Ethnicity

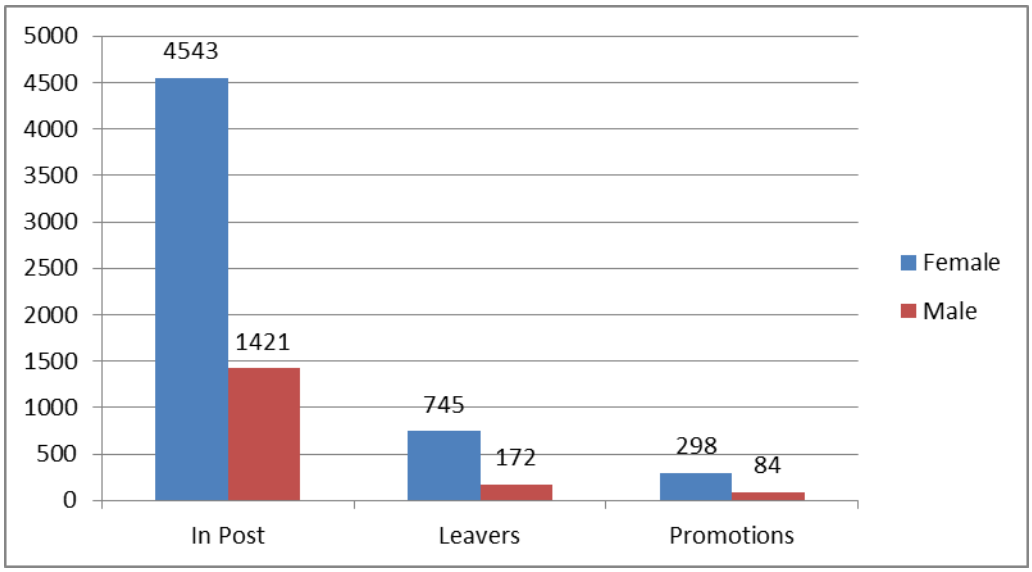


Group	Leavers	Promotions
BAME	13.12%	4.62%
Not Stated	21.52%	5.49%
Non BAME	16.32%	5.51%

5.1 Promotions and Leavers by Gender

The data in Figure 11 shows that female staff are more likely to leave the Trust and are also more likely to be promoted.

Figure 11: **Promotions and Leavers by Gender**



Group	Leavers	Promotions
Female	16.40%	6.56%
Male	12.10%	5.91%

6.0 Performance Development Reviews (PDR's) –Non Medical Staff

Employee Performance Development Reviews (PDR's) and outcomes have been included in this report for the first time. A new system for PDR's was implemented in April 2017 at which time a ratings system was introduced. The below charts shows the number of Non-Medical PDR's completed within the 12 month period between April 2017 – March 2018.

Excluding medical staff and those on maternity leave or career break a total of 4778 staff were eligible to have a PDR within the 12 month period. 3918 were completed which is an 87% completion rate although the PDR rate reported here will also have been affected by leavers and joiners throughout the year.

The below figures show the breakdown of PDR's by ethnicity and gender.

Figure 12: Total PDR's in the last 12 months by Ethnicity

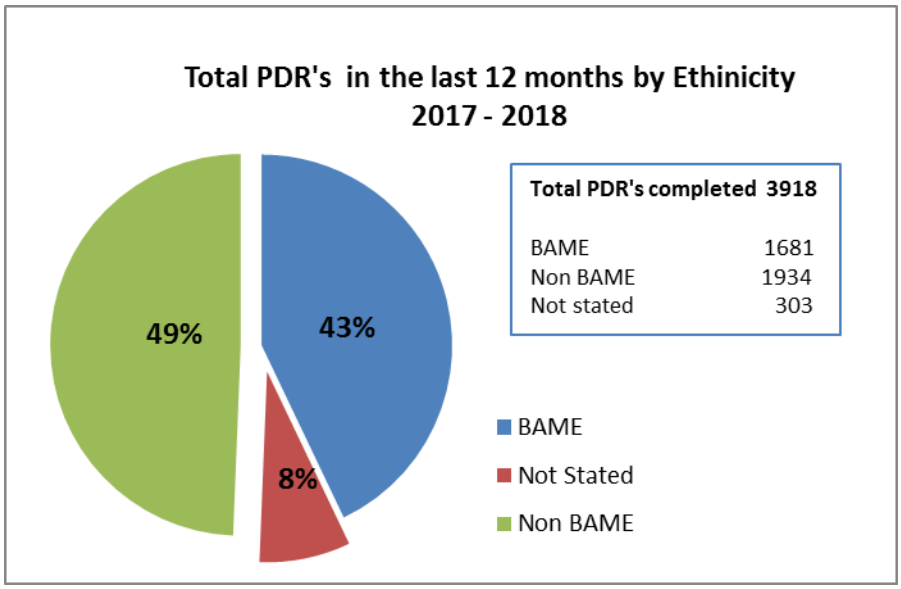
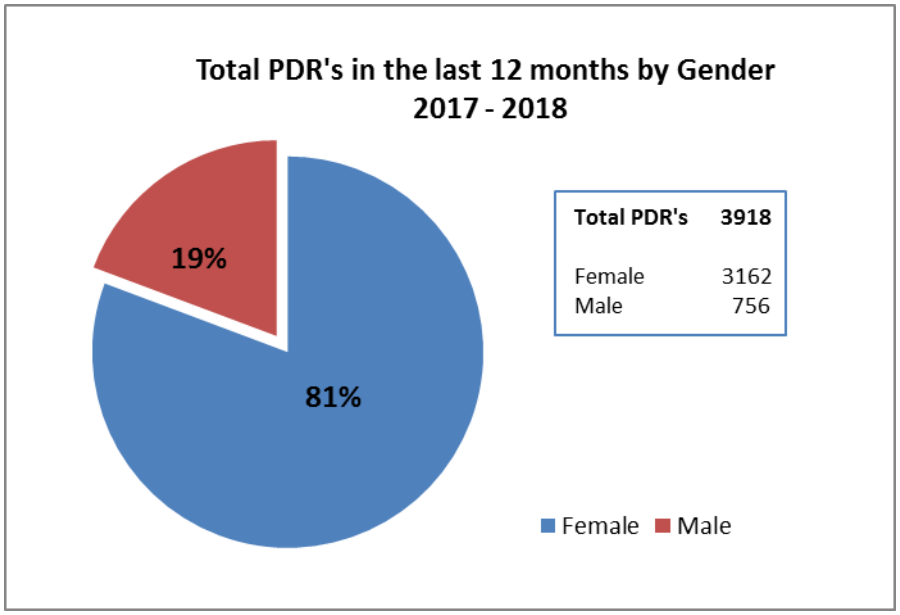


Figure 13:Total PDR's in the last 12 months by Gender

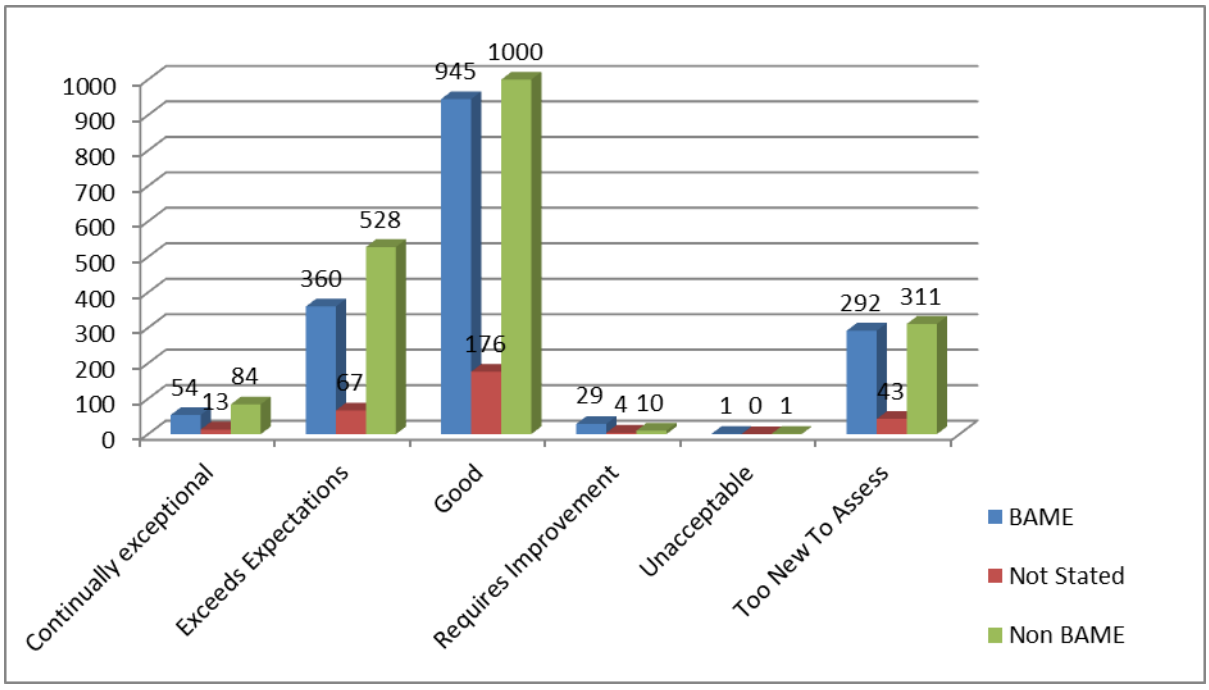


6.1 Performance Development Review Outcomes by Ethnicity

The new PDR process that was introduced in 2017 introduced a rating system for staff for the first time. In 2017 there were six possible outcomes (in the 2018 cycle the too new to assess category has been removed).

- Continually Exceptional
- Exceeds Expectations
- Good
- Requires Improvement
- Unacceptable
- Too New To Assess

Figure 14: Performance Development Review Outcomes by Ethnicity



The above shows that good was the most common PDR rating across the Trust with exceeds expectations the second and too new to assess the third. Of the good rating 47% of these related to non BAME staff and 45% related to BAME staff. Of the exceeded expectations rating 55% of these related to non BAME staff and 37% were BAME. The too new to assess rating shows almost equal levels between non BAME and BAME staff at 48% and 45% respectively.

Although smaller numbers the requires improvement rating of those scored at this level related to 23% non BAME staff and 67% of BAME staff which is a 44% difference between the two. The numbers of staff recorded with an unacceptable rating are in single figures and shows a 50% split between non BAME and BAME staff.

The highest PDR rating which is continually exceptional which are also smaller numbers shows 55% of those scored at this level were non BAME staff and 35% BAME which is a 20% difference.

7.0 Application of Formal Employee Relations Procedures 2017/18

During 2017 the Trusts Employee Relations Team acquired a software programme to provide a more robust recording of employee relations cases. All employee relations cases are recorded by the following categories:

- Disciplinary
- Sickness Absence
- Probation
- Performance (Capability)
- Grievance and Bullying & Harassment.

In the financial year 2017/2018 there were 341 formal employee relations cases and these are broken down by category:

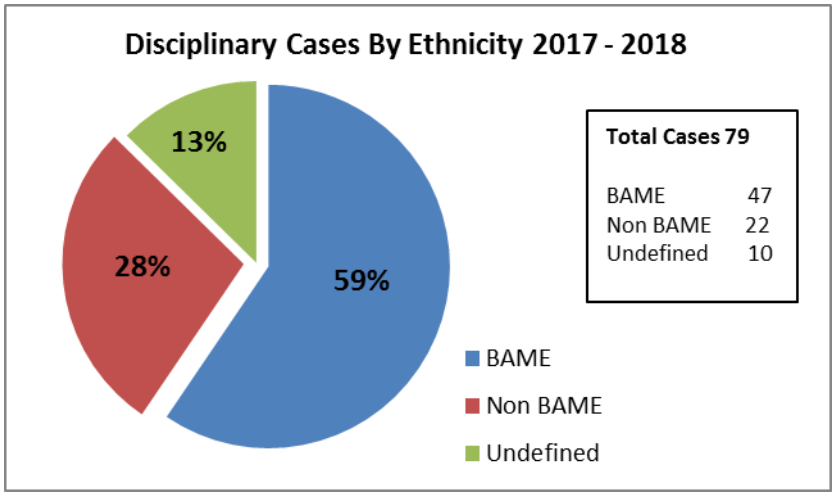
- Disciplinary: 79 cases,
- Sickness Absence: 169 cases
- Probation: 48 cases
- Performance (Capability): 15 cases
- Grievance (including formal Bullying & Harassment) 17 cases involving 30 employees

The cases in each of the above categories are broken down by ethnicity, gender and age to give an indication of how these relate to the breakdown of the workforce.

7.1 Disciplinary Cases

BAME staff accounted for 59% of the disciplinary cases in comparison to being 42% of the total workforce. Although this is a decrease from 68% of cases the previous year it means that staff from BAME backgrounds are still more likely to be subject to disciplinary proceedings in comparison to the Trust's ethnic profile. Undefined indicates that the information has not been recorded on the electronic staff record.

Fig 15: Disciplinary Cases By Ethnicity



The table below shows that the relative likelihood of BAME staff entering the formal disciplinary procedure is 2.49 times greater than for white staff. This a slight decrease from 2.84 times greater last year although the number of recorded disciplinary cases has increased from 31 to 79 a percentage increase of 155%.

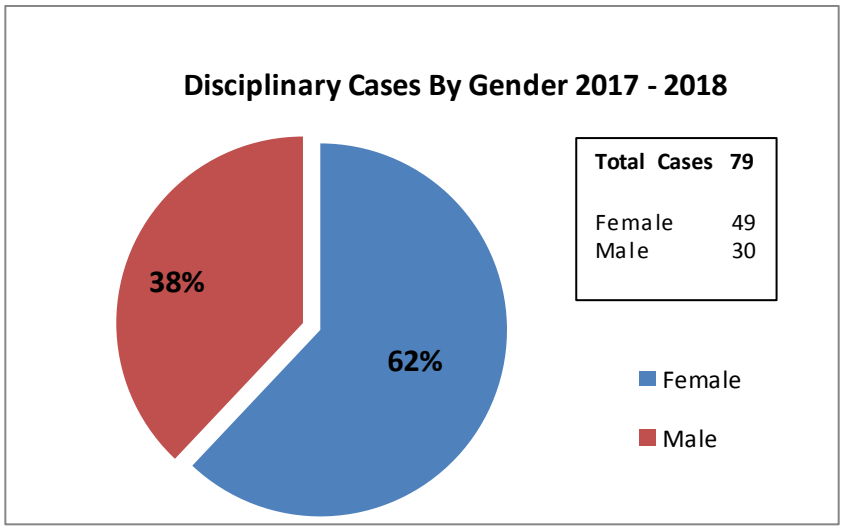
Table 12: Likelihood of entering the formal disciplinary hearing by Ethnicity 2017/18 (WRES)

Descriptor	White	BAME
Number of staff in organisation	2959	2531
Number staff that have entered into disciplinary proceedings	22	47
Relative likelihood of BAME staff entering into disciplinary proceedings compared to White staff	2.49	

Analysis of disciplinary cases by gender shows the females account for 62% of cases and males account for 38% although males make up 24% of the total workforce.

This is a significant change from the previous year which showed the number of females as 42% and males as 58%.

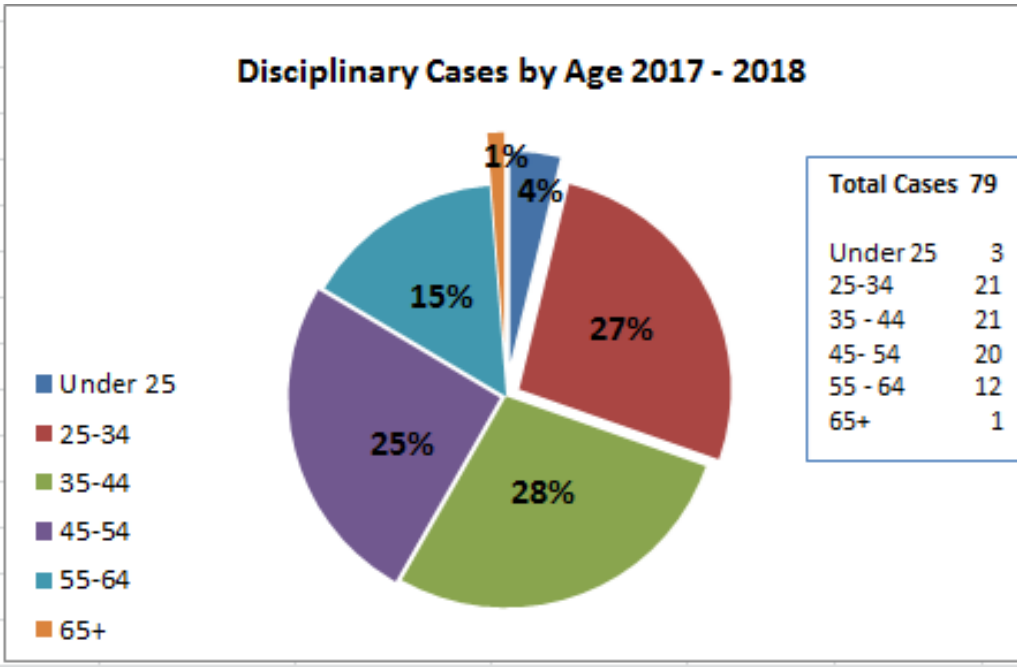
Figure 16: Disciplinary Cases By Gender



Disciplinary cases by age shows a fairly even spread across three age groups (25 – 54)
In the previous year 71% of disciplinary cases involved staff across the 25-44 age groups.
As a comparison this year that has reduced to 55% of cases across the same age groups.

The 45 – 54 age group last year accounted for 12% if cases, however this year that has
Increased to 25% of cases.

Figure 17: Disciplinary Cases by Age



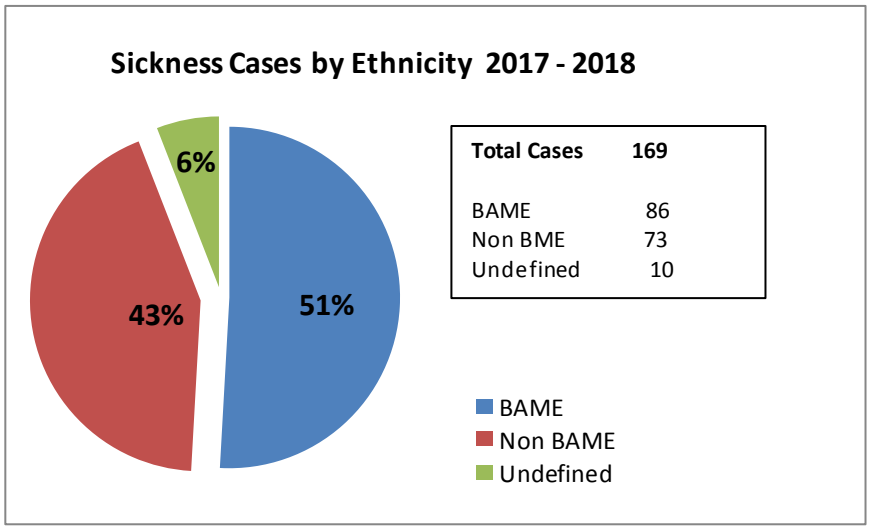
7.2 Sickness Cases

The number of sickness absence cases increased from 82 in the previous year to 169 for
2017/2018, an increase of 106%.

Analysis of sickness absence by ethnicity shows the number of cases broadly in line with the
ethnicity profile of the workforce as 51% of cases relating to BAME staff and 43% to Non BAME
staff.

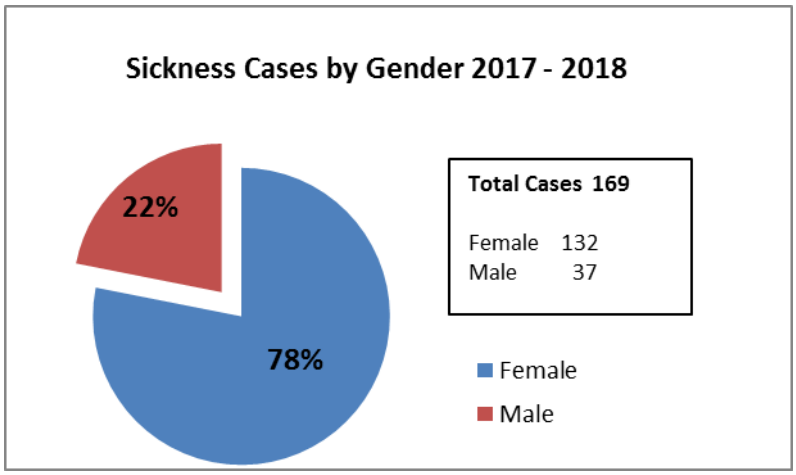
The number of undefined, which indicates that the information has not been recorded on the
electronic staff record has increased from 4% last year to 6% this year.

Figure 18: Sickness Cases by Ethnicity



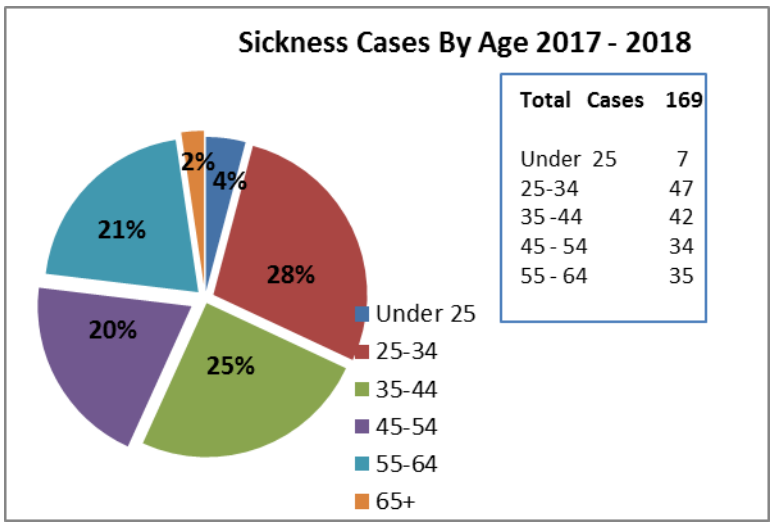
Sickness Absence by gender reflects the workforce gender profile with females
accounting for 78% of cases and males 22%. This has changed from 87% female
and 13% the previous year.

Figure 19: Sickness Case by Gender



Sickness Cases by Age shows that the 25 – 34 age group, which is the largest age group in the
Trust, account for 28% of cases although they make up 34% of the workforce

Figure 20: Sickness Cases by Age



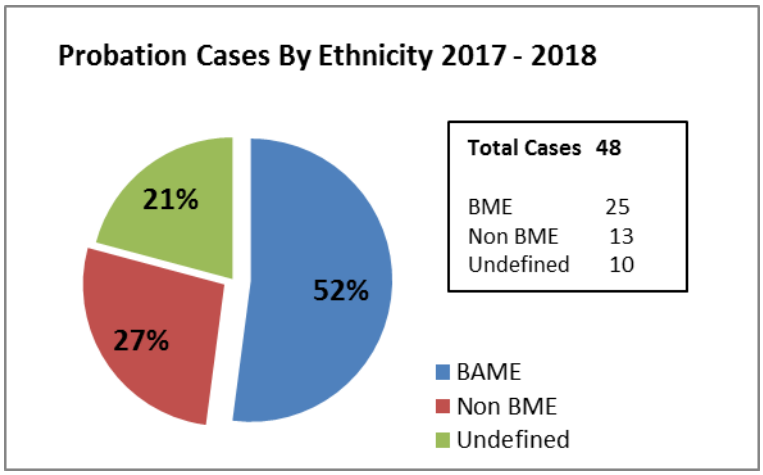
7.3 Probationary Cases

Probationary cases are included this year in the report but they were not included in the previous year
so a comparison cannot be made.

The majority of probationary cases relate to BAME staff which accounts for 52% of cases,
which is a higher percentage than the ethnicity workforce profile. White staff account for 27% of cases
which is below the workforce profile for these staff

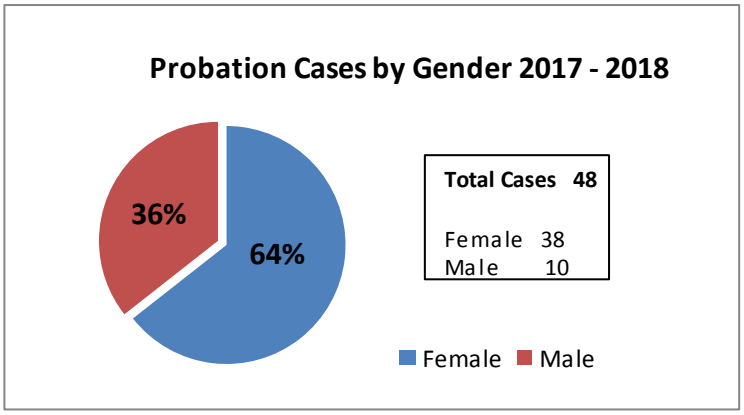
The number of undefined where the information has not been recorded on the electronic staff
record is 21% of cases

Figure 21:Probationary Cases by Ethnicity



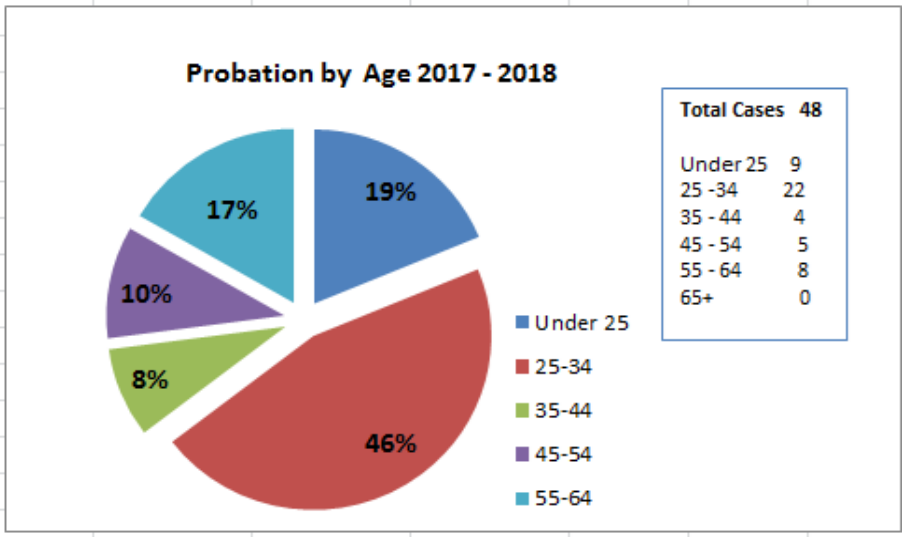
Female staff accounted for 64% of the probation cases and males 36% although males make up 24% of the workforce.

Figure 22: Probationary Cases by Gender



Probation cases by age show that the 25 -34 age group makes up 46% of the cases.
This age group are also the largest age group within the workforce.

Figure 23 : Probationary Cases by Age



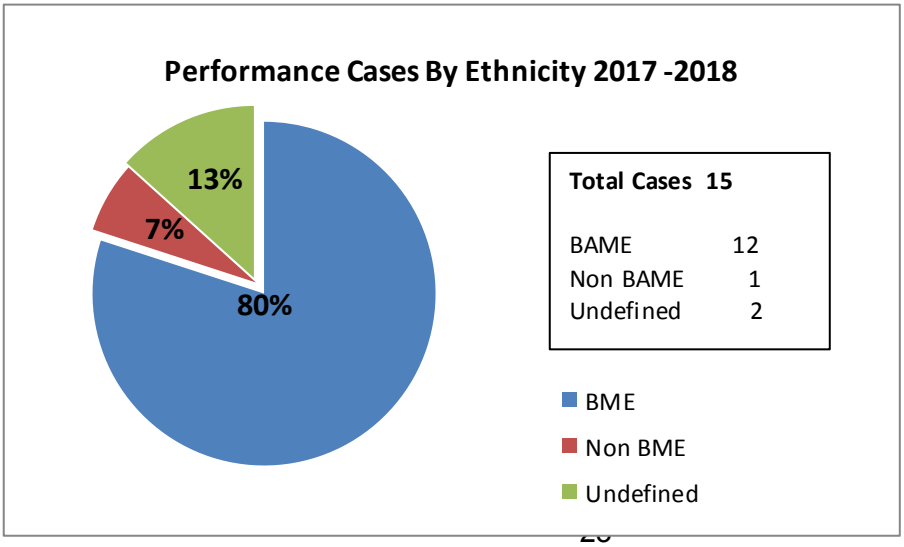
7.4 Performance cases

There were 15 cases reported this year compared to 6 last year. Performance cases
by ethnicity shows that BAME staff make up 80% of these cases although BAME staff
make up 42% of the workforce

In the previous year BAME staff accounted for 17% of cases. Non BAME accounted for
7% of cases this year but were 83% of cases in the previous year.

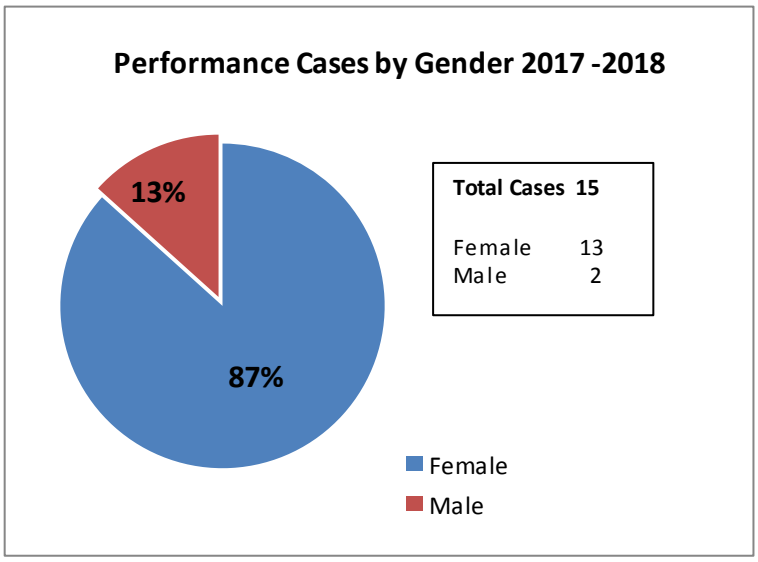
13% of cases were for staff whose ethnicity has given as undefined on ESR this year whilst
none were undefined in the previous year.

Figure 24: Performance Cases by Ethnicity



Performance cases by gender shows that 87% of cases were related to female
staff and 13% male. The data in the previous year was 17% male and 83% female.

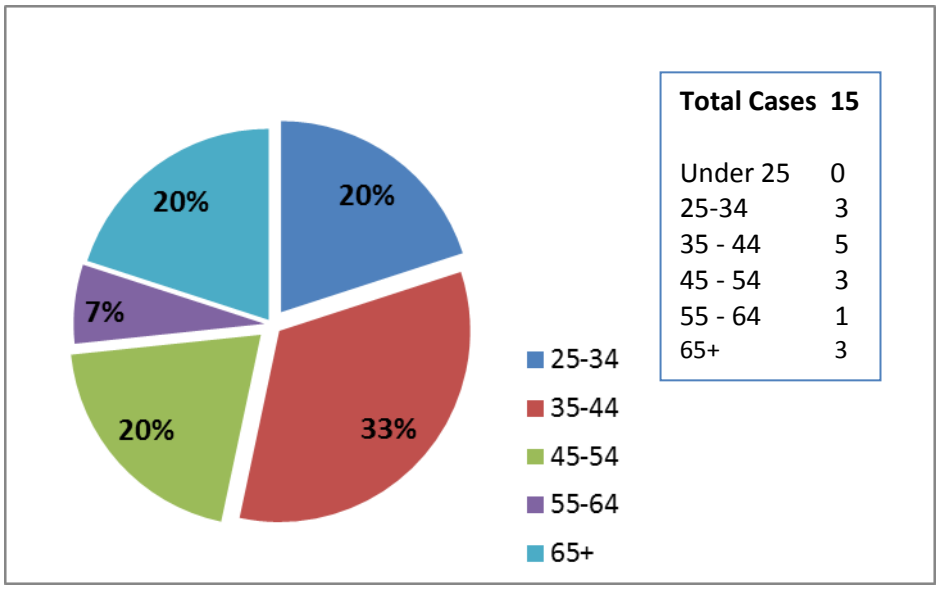
Figure 25:Performance Cases by Gender



Performance case by age shows that the 35 – 44 age group make up the largest single group at 33%
which is the same percentage as the previous year with an equal spread of 20% across three age groups
25—34, 45-54 and 65+.

The previous year the 45-54 age group accounted for 50% the performance cases so this has been a 30%
reduction with this particular age group.

Figure 26:Performance Cases by Age 2017 - 2018

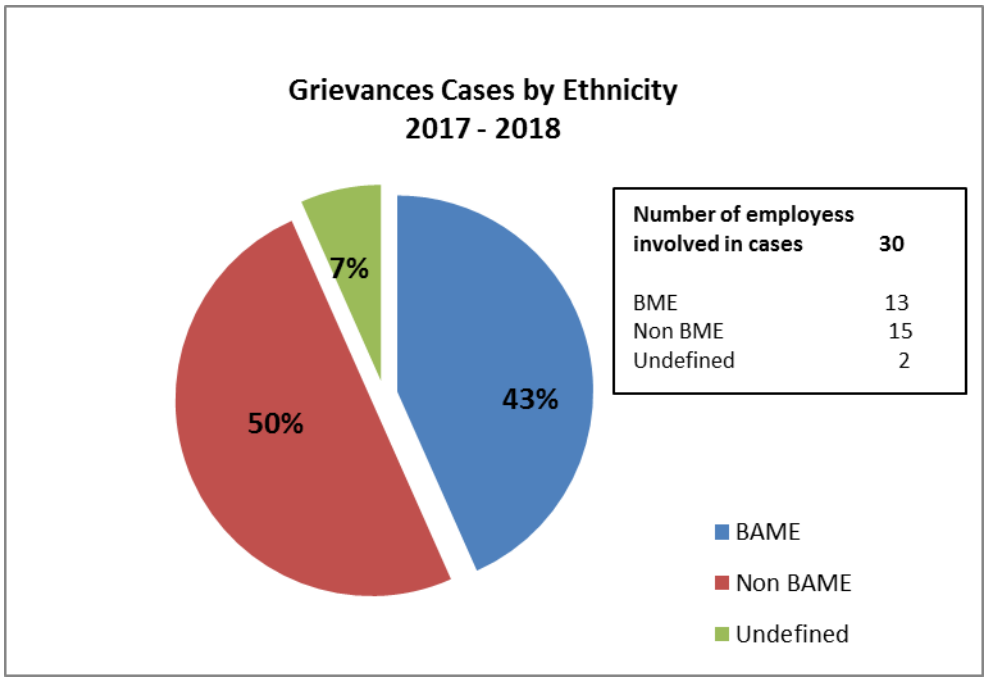


7.5 Grievance Cases (including bullying and harassment)

Grievance (which also includes bullying harassment cases in this report) can involve multiple employees
Including the individual submitting the complaint and the person who may be accused of inappropriate
behaviour by that individual.

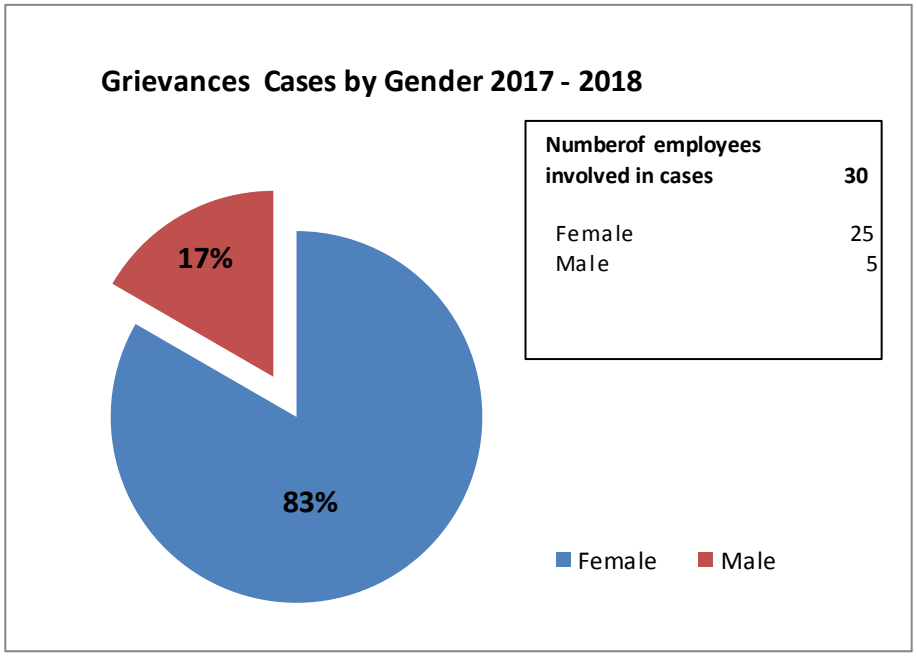
The date for grievance cases shows that 50% of those involved were Non BAME staff whilst 43%
were BAME staff. The spilt in the previous year was 50% each.

Figure 27: Grievance Cases by Ethnicity



Female staff account for 83% of grievance cases which is a higher percentage than
76% of the workforce profile.

Figure 28:Grievance Cases by Gender



8.0 Staff Experience: 2017 NHS Staff Survey Results

The Trust monitors staff experience by protected characteristics through the annual NHS Staff Survey. The 2017 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender.

The full results of the 2017 staff survey can be found at:-

http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/

Gender

There are few significant differences in experience by gender. Overall men report less incidents of experiencing bullying, harassment or abuse. Females and males are equally engaged with scores of 3.94 in the 2017 staff survey. These engagement scores were 3.84 and 3.80, respectively the previous year.

Disability

Disabled staff were the least likely group to report positive experiences across a range of indicators. Discrimination at work, lack of career progression, work related stress, pressure to attend work and experiences of bullying and harassment were all bigger issues of concern for disabled staff in comparison to non-disabled staff.

Disabled staff were more likely than non-disabled people to report work related stress at 62% compared to the previous year score of 56%. Non-Disabled staff scored 36% in this category in 2017 and 38% the previous year.

Disabled staff also report lowest levels of engagement across the protected characteristics. We have recently launched a new policy (Maintaining the Employment of People with Disabilities) to support our staff with disabilities as well as provide guidance to their managers. This policy was created as a result of a series of focus groups held with staff with disabilities last year and was ratified in June 2018.

Age

According to the results, staff aged between 16-30 and 31-40 were more equally likely to report discrimination at work. This is a change from the previous year when it was just the 31-40 age group. Staff aged 16-30 are more likely to report that the Trust offers career progression which is the same as the previous year.

Staff aged 16-30 remain the age group most likely to report experiencing violence or feeling bullied and harassed by patients in the 2017 staff survey and continues the trend with previous years.

We are committed to enhancing the support for all new staff but these results flag up the potential need for additional support tailored to the needs of our younger members of staff.

The most engaged group is people aged 41-50, with an overall rating of 3.96 followed by people 51 and over with an overall rating of 3.95. The least engaged group is people aged 16-30 with a rating of 3.87.

Ethnicity

BAME staff overall reported higher levels of satisfaction at work. They report more positively on engagement (3.96 as opposed to 3.91 for Non BAME staff) and motivation, quality of appraisals, fairness of reporting procedures, and are more likely to recommend the Trust as a place to receive treatment and work.

BAME staff are however more likely to experience discrimination at work with 12%reporting this compared to 6% for Non BAME Staff . BAME staff are also less satisfied about equal opportunities for career progression. There was no significant difference between BAME and Non BAME staff in experience of bullying from other staff.

8.1 NHS National Survey questions mandated by the WRES

Under the Workforce Race Equality Standard the Trust is required to publish the responses cut by ethnicity to the following NHS staff survey results:

5. Percentage of staff experiencing bullying, harassment or abuse from patients or relatives	White	40%
	BAME	36%
6. Percentage of staff experiencing bullying, harassment or abuse from staff	White	27%
	BAME	28%
7. Percentage believing that trust provides equal opportunities for career progression or promotion	White	88%
	BAME	74%
8. Percentage of staff experiencing discrimination at work from managers or colleagues	White	6%
	BAME	12%

The Trust has developed a 2 year staff experience action plan in response to the themes and concerns outlined in the 2016 Staff Survey and this has been updated in light of the 2017 results. These actions also include the actions that has been identified specifically for our Equality Action plan.

Actions in the staff experience plan will be monitored by the Workforce Development Committee.

The 8 themes included in the action plan, with associated actions against each one are:

- Better information on staff engagement
- Dignity and respect in the workplace
- Staff security
- Workforce equality and diversity (the actions from this report are incorporated into this plan)
- Health and well-being
- Fair process for reporting incidents and feedback

- Performance and development review
- Staff recognition

9.0 Local Clinical Excellence Awards for Consultants – 2017/18

There were 31 local clinical excellence applications received in 2017/18 compared to 58 applications which were received the previous year. The analysis by gender and ethnicity is below:

Table 13: CEA Awards by Ethnicity

Ethnic Origin	Workforce profile Percentage	CEA Applicants	Successful Applicants
Non BAME Consultants	54.91%	(20) 64.52%	(11) 50%
BAME Consultants	34.21%	(11) 35.48%	(11) 50%
Unknown	10.88%		
Total	**100%**	**(31) 100%**	**(22) 100%**

The percentage of BAME consultants applying for the local CEA award has increased to 35.48% from 28% the previous year. The percentage of Non BAME consultants applying has decreased from 72% the previous year.

The percentage of successful applicants shows a 50% split in ethnicity. The previous year this was 76% of successful applicants were Non BAME Consultants and 24% BAME Consultants.

Table 14: CEA Awards by Gender

Gender	Percentage	CEA applicants	Successful Applicants
Female	45.96%	(16) 51.61%	(13) 59%

Male	54.04%	(15) 48.39%	(9) 41%
Total	**100%**	**(31)100%**	**(22) 100%)**

The percentage of female consultants applying for the local CEA award reduced to 51.61% from 53% the previous year and male consultants increased from 48.39% from 47%.

The percentage of successful female applicants has increased to 59% from 55% and males has reduced to 41% from 45%.

10.0 Gender Pay Gap 2017/2018

Introduction

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The results must be published on both the employer's website and the government website- https://gender-pay-gap.service.gov.uk/Viewing/ .

The requirements of the legislation are that employers must publish six calculations:-

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Trust Data

The Trust complied with the requirements to submit our data and we are currently developing actions in conjunction with our Women's Network to address any key areas of concern.

The snapshot date for the purposes for the gender pay gap report is 31st March 2017 and as at this date, Chelsea and Westminster Hospitals NHS Foundation Trust (the Trust) total relevant paid workforce was 5681 across all sites and staff groups.

The Trust has reported a mean pay gap of 20.75% in favour of male employees and a median pay gap of 16.35% in favour of males. This data has also been considered in terms of staff groups and this showed that is all staff groups aside from scientific and technical staff the mean pay gap was favourable for males. The staff groups where the gap was highest was in admin and clerical (18.02%), and Medical and Dental Staff (12.49%).

The Trusts bonus gender pay gap has been identified as 31.95% for the mean average in favour of males and 31.78% for the median average pay gap in favour of males. For the purpose of this report the bonus payments referred to are those made to medical staff in the form of Clinical Excellence Awards or Discretionary Points.

Analysis of Trust data

The first point to note is that the reference point used for the gender pay gap report (31st March 2017) was also the first month in which the two payrolls of Chelsea & Westminster Hospital and West Middlesex Hospital (both monthly and weekly) which had been separate up to that month merged into one. Therefore this may have meant that there may have been some slight anomalies within the data.

The gender pay gap analysis also does not take into account age or length of service (either at the Trust or other NHS organisations) which is important when considering that the majority of staff are paid on incremental pay scales that means their salaries increase on an annual basis.

The data has been reviewed based on the individual staff groups where the largest pay gaps in favour of male employees are in order to identify where the issues are.

Administrative & Clerical
In this group an 18% pay gap in favour of male employees, which is the highest gap of all of the staff groups even though there are more females that males employed in these roles.

The analysis for this group of staff shows that for the majority of pay bands, the pay gap on average is in favour of females. However this changes particularly in the higher pay bands (bands 8d and 9) where the pay gap is in favour of male employee despite the fact there are fewer males than females in post at this level.

On further analysis of this the figure has been slightly skewed as there are employees in this group who are employed by the Trust but whose salary is set by an external organisation and recharged to them. Without these the pay gap would be significantly reduced although would potentially still be marginally in favour of male employees.

Medical staff
The pay gap across the Medical and Dental staff group is 12.49%. Based on the data, the Trust has more female than male medical staff overall in the Trust at the time of the report, including all junior level posts and non-training grades. However at Consultant level there are more male Consultants than there are females. It is also interesting to note that when looking at length of service there are considerably more male Consultants, than female who have been employed in the Trust for 10 years or more meaning it is likely their basic salary would be higher.

The analysis across the medical workforce actually shows that in the junior medical grades the pay gap is in favour of females, however this reverses as careers progress and when including the more senior grades (ST3+ and Consultant level) the pay gap is overall average in favour of males. Whilst this may be in part due to the issue of Consultant length of service it is less clear why this gap exists in the ST3+ level (where the average gap appears to be that male employees received around £0.72 more per hour).

AHP's
The pay gap for this staff group is 4.63% and from the analysis of this this shows the overall pay gap is marginally in favour of males across 6 of the 11 pay bands despite the fact the majority of the workforce is female.

The largest pay gap in favour of males appears at the Band 7 level, where there are also slightly more male employees than appear at any other AHP grade.

Nursing and Midwifery (Qualified)
The nursing and midwifery (qualified) staff group is the single biggest staff group in the Trust with female staff making up almost 90% of this. However overall the pay gap for this staff group is shown as 4.53% in favour of male employees.

From reviewing this at a pay band by pay band level there pay gap is a marginally in favour of male employees at both Band 5 and Band 6 level. The data shows that of the male employees at this grade a high proportion of them are paid towards the top end of their pay

band which may be linked to length of service or service from another Trust. There is also a gap at higher bands (8a and 8c) although at an 8b and 8d level the gap is in favour of females.

Bonus pay gap
As has been highlighted earlier in this report the bonus payments referred to are those made to medical staff in the form of Clinical Excellence Awards (CEA) or Discretionary Points.

Clinical Excellence Awards recognise and reward NHS consultants who perform 'over and above' the standard expected of their role. There are 12 Levels of award with Levels 1-8 being awarded locally (employer based awards) and Levels 10-12 (Silver, Gold and Platinum) being awarded nationally. Level 9 Awards in England can be awarded locally as employer based awards or nationally as Bronze. Those who are eligible to apply are Consultants who are substantive and who have at least one year in service at the time to applications process opens. It is up to individual Consultants if they choose to apply and once a CEA is awarded the Consultant will continue to receive the payment associated with this level until they retire or claim their pension. Those in receipt of a CEA can also apply for the next level of award in any following year.

The data shows that of the 192 Consultants, who received a bonus in March 2017, 85 of these were female and 107 were male. At every level aside from CEA level 3, more males than females are in receipt of a CEA.

In 2017 58 Consultants applied for a CEA of which 27 were female (53% of applications) and 31 (47% of applications) were male. Of these 23 female Consultants were successful and 19 male Consultants were successful. This was similar to the 2016 cycle.

This demonstrates that there does not appear to be a current issue with female Consultants applying for and receiving CEA awards. However based on what we know about length of service the difference in bonus pay may stem from the fact generally male Consultants have a longer length of service in the Trust and therefore will have had more years in which to apply for these awards. As more female Consultants are appointed and as our current female Consultants continue to apply for these awards the imbalance may therefore rectify itself although this is something that will be monitored.

Appendix 1 Workforce Equality Action Plan for 2017/19 19

This plan was originally developed in 2017 and has been updated in light of the data in the 2018 report.

Area of Focus	Action (s)	Owner	Timeframe	Progress
Fair processes for addressing workplace conflict	1. Deliver employee relations training to 100+ managers per year to enable managers to apply policies fairly and effectively.	Associate Director – ER & HRBP	March 18	Completed
	2. Review content of ER training to ensure discrimination is adequately covered.	Associate Director – ER & HRBP	September 17	Completed
	3. Participate in the Pan London "Improving equalities outcomes through better practices project which is aiming to review the issues of BAME staff being more likely to go through the disciplinary process than White staff. The Trust is planning to undertake and post action audit recommendation.	Equality & Diversity Manager Associate Director – ER & HRBP	July 2019	
	4. Review all current training available to managers on how to manage low level conflict between staff and propose changes as appropriate	Associate Director – ER & HRBP Assistant Director – Learning and Development	December 17	Completed-the ER team have now received train the trainer on having difficult conversations. We are reviewing if an external company should be used to roll this out across the Trust or if the team will cover this as part of their ER training.

Data Collection and reporting systems	5. Streamline processes to ensure collection of protected characteristic data for 95%+ new starters	Associate Director Resourcing & Planning	April 2019	
	6. Expand the range of information items in workforce equality report 2018/19 report: • PDR outcomes • Gender pay gap • Participation rates for externally delivered training	Equality and Diversity Manager	July 2018	Completed –although there may still be some more work to do in relation to data from external training
	7. Improve the process for collecting data of staff who develop a disability during the course of their employment to ensure this is recorded on ESR	Equality & Diversity Manager Associate Director – ER & HRBP Head of Health and Wellbeing	December 18	
	8. Review process of data collection for staff who are recruited as part of international recruitment campaigns	Equality & Diversity Manager	April 2019	
Recruitment and promotions	9. Launch recruitment and selection training for managers.	Associate Director Resourcing & Planning	January 2018	Completed
	10. Develop a clearly articulated approach for internal recruitment	Associate Director Resourcing &	January 2018	Completed

	to support career development and internal promotions.	Planning		
	11. Implement requirement that all panels must have 1+ person who has received recruitment training	Associate Director Resourcing & Planning	July 2019	In progress
	12. Recruit 100+ apprentices through the delivery of systematic apprenticeship work programme	Assistant Director of L & D	July 2019	
Dignity and Respect at Work	13. Work with TU partners to develop a Dignity and Respect at Work Policy	Associate Director of HR: ER and HRBP's	September 18	Currently going through ratification process and due to go to POD in September
	14. Create Respect at Work Service staffed by trained respect at work champions to provide confidential support to staff who experience inappropriate behaviour from colleagues.	Associate Director of HR: ER and HRBP's	2018/19	It has been agreed with Staffside/ HR not to pursue this at this time due to issues with how the service would be monitored
	15. Apply the NHS Equality Delivery System tool to bullying and harassment and flexible working and devise actions as appropriate	Equality and Diversity Manager	Nov 17	Completed
	16. Prepare for and ensure the Trust submits Workforce Disability Equality Standard and identify and develop actions to identify issues raised	Equality & Diversity Manager	August 19	
	17. Work with Divisional teams to identify local E&D issues and develop action plans to address	Equality & Diversity Manager	2018/19	

	any areas of concern			
Staff Networks and focus groups	18. Set up a focus group for staff with disabilities to identify issues affecting staff experience and use the findings to develop guidance on supporting staff with disabilities and long term health conditions	Equality and Diversity Manager	Sept 17	Completed
	19. Set up a working group with BME staff to understand low staff survey rating for equal opportunities and develop actions as appropriate	Equality and Diversity Manager	Sept 18	
	20. Establish level of interest for / support the establishment of LGBT network	Equality and Diversity Manager	Sept 18	
Gender pay gap	21. Identify issues in 2017 Gender Pay Gap results and develop action plan to inform Trust Board and improve Trust results for 2018 report	Equality & Diversity Manager	October 2018	

Appendix 2

WRES data 2017/18

Background

The table below summarises the Trust's first annual WRES return which will be submitted to the national WRES team in August 2018 by the Equality and Diversity Manager.

WRES Indicator	Ethnicity	Headcount	Explanatory notes
1. Workforce reporting	Non BAME	2959	As at 31 March 2018
	BAME	2531	
	UNKNOWN	474	
2. Relative likelihood of staff being appointed from shortlisting across all posts	Non BAME staff 1.66 times more likely		Based on NHS Jobs and TRAC data captured during 2017/2018
3. Relative likelihood of staff entering the formal disciplinary process	BAME staff 2.49 times more likely		Based on 2017/2018 cases
4. Relative likelihood of staff accessing non-mandatory training and CPD	Non BAME staff 0.95 times more likely		Data should be read with caution, as not all non-mandatory is captured through the current training databases across both sites.
5. Percentage of staff experiencing bullying, harassment or abuse from patients or relatives	Non BAME	38%	2017 Staff Survey
	BAME	32%	
6. Percentage of staff experiencing bullying, harassment or abuse from staff	Non BAME	24%	
	BAME	28%	
7. Percentage believing that trust provides equal opportunities for career progression or promotion	Non BAME	89%	
	BAME	75%	
8. Percentage of staff experiencing discrimination at work from managers or colleagues	Non BAME	7%	
	BAME	13%	
9. Percentage difference between BME Board voting membership and overall BME workforce	BAME Board Members	10%	As at 31 March 2018
	Overall BAME workforce	42%	

Improving equalities outcomes-WRES Indicator 3 Project

1. Background

In 2015 the Workforce Race Equality Standard (WRES) was introduced as part of the NHS contract marking the first time that race equality was made mandatory in the NHS. It was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace as well as to highlight, using data , that in general the treatment and experiences in the workplace of BME staff often falls short of those of non BME staff.

The national annual WRES return includes 9 indicators, four of which relate to workforce data (measuring the numbers of BME staff compared to white staff as a percentage of the overall workforce, the relative likelihood of BME staff being appointed from shortlisting, the likelihood of BME staff entering formal disciplinary processes in comparison to non BME staff and the percentage of BME staff accessing non mandatory training). Another four of the indicators are based on data from the national staff survey and relate to staff experience and the final one considers BME representation on Trust boards.

The data for WREs is uploaded on an annual basis for individual Trusts and is then considered at organisational, regional and national level.

WRES Indicator 3 specifically focuses on the proportion of BME staff entering formal disciplinary processes compared to non BME staff and it is this indicator that has resulted in this project being commissioned. In 2017 across England the relative likelihood of BME staff entering the formal disciplinary process over non BME staff was 1.37 times more likely, whilst in the London region this was 1.80 times more likely.

2. Chelsea and Westminster Hospital NHS Foundation Trust

Further analysis was carried out by NHS England on the 2017 WRES data comparing the information provided by 10 “peer” London Trusts (including Chelsea and Westminster Hospital NHS Foundation Trust (C& W) as well as UCLH, Barts Health, Guys and St Thomas’, Imperial College Healthcare, Kings College, Lewisham and Greenwich, London North West, The Royal Free and St Georges) . This showed that when comparing these 10 organisations the median score was 2.08 which was above the national as well as the London average. Furthermore C & W scored the highest of these 10 Trusts with BME staff being 2.84 times more likely to enter the disciplinary process than their non BME colleagues. It is also worth noting that in comparison to these other 9 Trusts, C & W’s proportion of BME staff compared to the rest of the workforce (40%) is lower than the majority of the others with only Guys and St Thomas’s showing a smaller percentage (34.06%).

The WRES data for 2018 does show a slight improvement in C & W’s figures and in this year BME staff are reported as being 2.49 times more likely to enter the disciplinary process than their non BME colleagues; however this is still above the other Trusts based on their data from 2017.

3. What is the WRES Indicator 3 Project?

Due to the WRES indicator 3 position, the London HR Directors Network and the Equality & Diversity Leads Network came together to commission a project to address the issue.
This project, which is supported by NHS England, has two strands, one relating to data collection and analysis and the other is the suggestion of 4 different interventions that Trusts may choose to use in order to make a positive impact in this area.

The data collection side of this project aims to provide a more in depth analysis of the position and will enable Trusts to look at comparisons of employees entering the disciplinary process, the demographics of hearing managers and the outcomes of disciplinary hearings using a standardised minimum data set for employee relations activity. This data will be collected from participating Trusts over a 12 – 18 month period and will then be reviewed by an academic partner who will then share the results.

In terms of the suggested interventions there is no obligation for Trusts to use these and participation in the project can solely be to be part of the data collection. However if Trusts do wish to trial one of the 4 interventions, a combination of one or more of the interventions or an intervention of their choice, they are able to do so.

4. Suggested Intervention Models for the Project

There are 4 suggested intervention models as part of the project and their respective pros and cons as published by NHS England are outlined below:-

Model	Pros	Cons
Decision Tree Checklist - The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether formal action is essential or whether alternatives might be feasible. It was developed by the National Patient Safety Agency (NPSA)	Keeps responsibility for considering all evidence with frontline managers. Offers them a very clear, evidence-based framework for considering the evidence	No way to reduce or eliminate subjective variations in decisions.
Post action audit - In this model, managers are made aware that all decisions to put staff through the formal disciplinary process will be reviewed on a quarterly or bi-annual basis using robust information on each case to discern any systemic weaknesses, biases or underlying drivers of adverse treatment of any staff group	Keeps responsibility with the frontline managers If supported by good evaluation, feedback and development can help embed better practice in those areas identified as needing support.	In the short term it cannot prevent unnecessary formal action.
Pre-formal action check by a director level member of staff – In this model, a single person, the Director of Nursing for example, reviews all cases and decides whether they should go to formal action.	Consistency of approach.	Reduces responsibility of frontline managers to make the appropriate decision and take responsibility for it.

Pre-formal action check by a trained lay member of staff - In this model a specially trained lay member of staff reviews cases and challenges any perceived bias in the process before cases go to formal action.	'External' scrutiny approach reduces the risks of unconscious bias.	Increased risk of loss of confidentiality. Maintaining consistence across cases and different lay staff considering the cases.

The project paper published in April 2018 highlights two Trusts, Barts and the Royal Free who have begun implementing intervention models. In the case of Barts Health who have chosen the decision tree checklist supplemented with pre –formal action review they have yet to complete the roll out or have robust outcome data.

The Royal Free are currently using the Pre-Formal Action Check and they are utilising the Director of Nursing in this role. The process currently only applies formally to nursing staff, but according to the briefing the employee relations team informally apply the process to other staff groups. The Royal Free have some evidence of a downward trend in cases but the process has not yet been codified. Therefore at this present time there is no evidence based data to support the impact or effectiveness of the models used.

5. Assessment of Suggested Intervention Models

Three of the models, the Decision Tree Checklist, the Pre-formal action check by a director level member of staff and the Pre-formal action check by a trained lay member of staff all require an additional step in the process before an investigation can get underway. This would therefore cause a potential issue with timely completion of the disciplinary process at a time when we are looking at ways in which to improve this.

Two of the three models (pre-formal action check by a director level member of staff and pre-formal action check by a trained lay member of staff) would require a level of additional resource for each case as well as an adjustment to the current Trust disciplinary process and internal training. There may also be a need for negotiation in order to gain agreement with staffside before they could be implemented.

Furthermore with these two models the decision to instigate formal disciplinary action is taken away from the line managers which may then become an issue in itself.

The Decision Tree checklist model is a good initiative but was initially designed to deal with clinical incidents and patient safety and therefore may not be entirely practical at this stage particularly as there is not yet any data available to show how it has worked in practice

For these reason at this time the trust is looking to implement the post action audit model which still allows managers to retain the decision making around potential disciplinary action This model also does not add any additional steps and follows the Trusts current disciplinary processes. Should any evidence come to light over the course of the year regarding successes with the other interventions this will be reviewed to see if this could be something that is trialled.

6. Recommendation

Of the four suggested intervention models the post action audit appears to lean towards a more long term organisational learning model where decision making is still made by frontline managers, whilst the models which involve pre-formal actions focus more on

intervention and have an element of devolving decision making away from frontline managers. All of the other 3 models add additional steps to the disciplinary process.

In order to successfully implement this intervention the trust will need to ensure that :-

- There is a central record of disciplinary hearing dates, hearing managers and outcomes to ensure that the required data is readily available, all of which is available using the ER case management tracker
- We agree what the post action audit parameters will be, how this will operate, methods of evaluation and feedback and who would be involved
- We engage managers and build in review/learning into the formal disciplinary process.

Learning from the post action audit will be reviewed on a quarterly basis. After 6 months a review will be undertaken to determine if pre action intervention would have improved performance.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	4.1/Nov/18
REPORT NAME	EPR Update
AUTHOR	Roger Chinn, Deputy Medical Director & CCIO
LEAD	Kevin Jarrold, Chief Information Officer
PURPOSE	To advise the Board of current status of the EPR programme.
SUMMARY OF REPORT	This paper is to brief board about the stabilisation of Phase 1 implementation of Cerner EPR Patient Administration System on West Middlesex site and the progress of subsequent phases of implementation.
KEY RISKS ASSOCIATED	This is a major programme is delivering a new electronic patient record to the organisation which carries risk across clinical, operational and financial domains
FINANCIAL IMPLICATIONS	
QUALITY IMPLICATIONS	
EQUALITY & DIVERSITY IMPLICATIONS	
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	The board is asked to note the report

Phase 1 Stabilisation - Outcome

- Patient Administration System Stabilisation progressing
  - Recovery plan and actions to improve data quality and performance delivering reduction in PTL from peak in August
  - RTT at WM for September at 92.5%, 1.5% reduction compared to average delivery prior to Cerner implementation.
  - First tranche of focussed operational DQ implemented
  - System fixes for coding issues deployed

Launch of Phase 2

Two day event:
Broad engagement - 150 staff attended

- 90% Positive feedback
- Patient pathway scenarios presented by West Middlesex users
- Opportunity to show what teams are currently doing
- To see what the future will bring co designed with ICHT

Phase 1b –Scope and Plan

Phase 1b Nov

- Improve the theatres workflow
- Improve Outpatient workflows

To June 2019

- Iterative rollout to improve workflows and maximise benefits

Phase 2 - On track

Oct / Nov	Localising the Cerner system for Chelsea	System testing
Oct /Dec	Baseline requirements	Gaps for improvement
Oct / Feb	Preparing for new workflows	Data Quality Preparation
Oct /July	Improvements to the system and workflows	Jointly optimising
June/ Oct	End user training, testing, familiarisation, creating experts	Organisational readiness: people, processes, system

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	5.1/Nov/18
REPORT NAME	Business planning 2019/20
AUTHOR	Virginia Massaro, Deputy Director of Finance – Financial Planning & Strategy
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	Our approach to 2019/20 business planning and high level financial plan.
SUMMARY OF REPORT	• Although NHS Improvement (NHSI) has not yet released its planning guidance for 2019/20, they have recently sent an approach to planning letter to Trusts. Trusts will be required to submit a 1 year plan covering 2019/20 only. • A coordinated approach and detailed plan for business planning will be put in place, monitored by a steering group to align financial, operational and strategic objectives. • Planning guidance and control totals are expected to be published by NHS Improvement in early December 2018. • The Trust continues to receive significant levels of non-recurrent funding in 2018/19, predominately the transaction funding (which ends in 2019/20) and Sustainability & Transformation Funding (which is currently assumed to end in 2018/19). Therefore there is a planned underlying deficit of £13.3m in 2018/19. • Next steps include updating the financial assumptions once the planning guidance has been published, including bottom up activity planning, cost pressures review, service developments and analysis of inflation assumptions, as well as working with the divisions to update the high level plan and detailed budgets.
KEY RISKS ASSOCIATED	• Impact of tariff changes, particularly proposals to update high cost area uplifts (MFF), which would have a significant impact on CWFT • Commissioner affordability • Delivery of CIP target and financial plan • Impact of the EPR roll out on income reporting at the CW site • Continuing increase in demand for loss-making emergency care
FINANCIAL IMPLICATIONS	See above
QUALITY IMPLICATIONS	None noted
EQUALITY & DIVERSITY	None noted

IMPLICATIONS	
LINK TO OBJECTIVES	• Excel in providing high quality clinical services • Deliver financial sustainability
DECISION/ ACTION	For information and discussion only.

1.0 Introduction

1.1 This paper sets out our approach to 2019/20 business planning process.

2.0 Background

2.1 Although NHS Improvement (NHSI) has not yet released its planning guidance for 2019/20, an approach to planning letter has been sent to all Trusts. Trusts will be required to submit a 1 year plan covering 2019/21 only. Planning guidance and control totals are expected to be issued in December. It is also anticipated that a STP financial and operational plan refresh will be required.

3.0 Approach and timeline

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

- A plan for strategic projects and an operational plan for each division which sets out 2019/20 priorities that can be more easily communicated and monitored in year
- A robust financial work-stream that brings together all key elements (e.g. activity planning, budget setting and capital planning)
- Early CIP allocation of targets and longer term CIP thematic planning

3.2 The draft milestone plan for the 2019/20 planning round is set out below (dates are draft, pending receipt of the planning guidance and timetable):

Milestone	**Date**
Commissioning intentions received	30th Sept 2018
First draft 19/20 tariff engagement published	Oct 2018
Approach to Planning letter from NHSI	Oct 2018
NHS Long Term Plan published	Late Nov 2018
Publication of the following for 2019/20: • Planning guidance • CCG allocations (5 years) • 2019/20 tariffs • Contract consultation & CQUIN guidance • Control totals	Mid December 2018
Initial 2019/20 plan submitted to NHSI (activity & efficiency only)	14 Jan 2019
National tariff consultation	Jan 2019
Draft Submission of 2019/20 Trust Operating Plans	12 Feb 2019
System 2019/20 Operating Plans	19 Feb 2019
Deadline for contract signatures	21 March 2019
Trust Boards to sign off Trust 2019/20 plans	By 29 March 2019
Final Submission of 2019/20 Trust Operating Plans	4 April 2019
Final System plans to be submitted	11 April 2019
Detailed divisional business plans	Dec – March 2019
Detailed 2019/20 Budgets sign-off by Divisions	Mar 2019
Systems to submit 5 year plans	Summer 2019

4.0 2019/20 and longer term financial plan

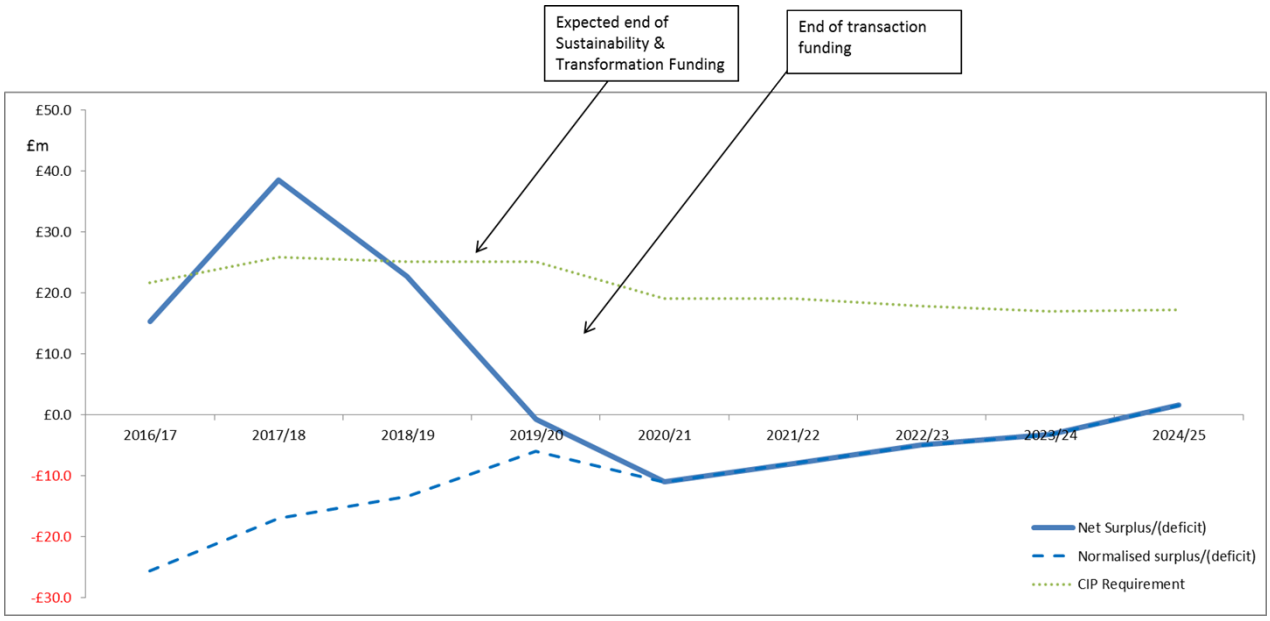
4.1 The Trust continues to receive significant levels of non-recurrent funding in 2018/19, predominately the transaction funding (which ends in 2019/20) and Sustainability & Transformation Funding (which

is currently assumed to end in 2018/19). Therefore there is a planned underlying deficit of £13.3m in 2018/19. The numbers have not been refreshed for proposed national tariff changes.

4.2 The key findings are as follows:

- The Trust is forecast to be in a deficit position from 2020/21, when the transaction funding ends. This assumes that STF is non-recurrent and is not received beyond 2018/19.
- The Trust will need to continue to deliver high levels of CIPs of £25.1m in 2019/20 and £19.0m until 2021/22 to get back to a surplus position by 2024/25.
- If STF funding is nationally made recurrent into Trust baselines from 2019/20 at the current levels, the Trust would continue to report a surplus position (c£19m surplus in 2019/20).
- Planned cash reduces by £10.0m to £29.4m by 2024/25 due to the impact of the reduced cash plan in 2018/19, partly offset by increased CIPs in future years.
- The chart below outlines the planned net surplus/ (deficit), normalised surplus/ (deficit) and CIP plans up to 2024/25. The associated long term financial figures are included in appendix 1.

Chart 1 – Long Term Financial Plans and CIPs 2016/17 to 2024/25



5.0 Key Risks

5.1 There are a number of financial risks to the financial plan for 2019/20, including:

- Impact of tariff changes, particularly proposals to update high cost area uplifts (MFF), which would have a significant impact on CWFT
- Commissioner affordability
- Delivery of CIP target
- Impact of the EPR roll out on income reporting at the CW site
- Continuing increase in demand for loss-making emergency care

6.0 Budget Setting Principles

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

- Roll forward of recurrent 2018/19 budgets
- Adjust for specific existing and new unavoidable cost pressures and quality investments, where approved by the Executive Team

- Adjust for any service developments, only those that generate a contribution and are approved by commissioners (where associated with changes in activity levels and funding)
- CIPs allocated to divisions and service lines in line with overall CIP plan
- Activity planning based on forecast activity data, adjusting for planned service developments, commissioning intentions and demand management schemes, growth etc.
- Inflation and tariff changes, as per planning guidance

7.0 Summary and next steps

- Although NHS Improvement (NHSI) has not yet released its planning guidance for 2019/20, an approach to planning letter has been sent to all Trusts. Trusts will be required to submit a 1 year plan covering 2019/21 only.
- A coordinated approach and detailed plan for business planning will be put in place, monitored by a steering group to align financial, operational and strategic objectives.
- Planning guidance and control totals are expected to be published by NHS Improvement in December 2018.
- The Trust continues to receive significant levels of non-recurrent funding in 2018/19, predominately the transaction funding (which ends in 2019/20) and Sustainability & Transformation Funding (which is currently assumed to end in 2018/19). Therefore there is a planned underlying deficit of £13.3m in 2018/19.
- Next steps include updating the financial assumptions once the planning guidance has been published, including bottom up activity planning, cost pressures review, service developments and analysis of inflation assumptions, as well as working with the divisions to update the high level plan and detailed budgets.

8.0 Decision/action required

For information and discussion only.

Appendix 1 – Summary Long Term Financial Analysis

	2016/17	*2017/18*	*2018/19*	*2019/20*	*2020/21*	*2021/22*	*2022/23*	*2023/24*	*2024/25*
Net Surplus/(deficit)	£15.3	£38.4	£22.7	-£0.7	-£11.0	-£8.0	-£5.0	-£3.2	£1.6
Normalised surplus/(defici	-£25.6	-£17.0	-£13.3	-£5.9	-£11.0	-£8.0	-£5.0	-£3.2	£1.6
CIP Requirement	£21.6	£25.9	£25.1	£25.1	£19.0	£19.0	£17.8	£17.0	£17.3
Cash & Cash Equivalents	£49.5	£52.6	£50.5	£53.0	£39.9	£25.8	£33.6	£26.2	£29.4

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	5.2/Nov/18
REPORT NAME	Risk Register Process Assurance Report
AUTHOR	Alex Bolton, Head of Health Safety and Risk
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 266 live risks being managed / mitigated across the organisation, of these one has been identified as an extreme risk: • ID3, Growth in non-elective demand above plan Operational risk register assurance is provided via the Divisional Quality Boards within each clinical Division; these groups ensure the Divisional risk register process is embedded and mitigation actions are undertaken within appropriate timescales. Process and mitigation assurance is provided via the committees of the board and sub-groups; risk updates are forwarded to the overarching groups based on risk type or risk grading. These groups ensure that trust wide learning from risk is cascaded and support risk identification and delivery of mitigation actions. Patient safety, Staffing and ICT infrastructure are recognised as key risk themes from analysis of the Trust highest rated risks (graded equal to or above 12).
KEY RISKS ASSOCIATED	Patient safety is the most commonly identified risk type.
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 IMPLICATIONS	None
LINK TO OBJECTIVES	Objective 1:Deliver high quality patient centred care Objective 2: Be the employer of choice Objective 3: Deliver better care at lower cost
DECISION/ ACTION	For information

Risk Register Process Assurance Report

1.0 Introduction

This report provides an overview of the risks recorded within the Trust's Datix 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 organisational activities.

2.0 Trust Wide Risk Register

There are currently 266 live risks recorded across the organisation, this is an increase of 50 since the last report to the committee. Risks are graded according to a five-by-five matrix; of the risks recorded one has 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	30	40	0	**71**	**27%**
Emergency and Integrated Care	4	24	34	1	**63**	**24%**
Planned Care	9	41	22	0	**72**	**27%**
Women's, Children's, HIV, GUM and Dermatology, Private Patients	7	26	27	0	**60**	**23%**
Total	**21**	**121**	**123**	**1**	**266**	**100%**

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.

ID	Lead Division	Risk Type	Title	Date identified	Date reviewed	Date of next review	Trend
3	EIC	Quality of Service	Growth in non-elective demand above plan	Jun-15	Sept-18	Nov-18	↔

3.1 Risk 3, Growth in Non-Elective demand above plan

Lead Division: Emergency and Integrated Care **Date identified:** 1 June 2015 **Date reviewed:** 18 September 2018 **Current risk score:** Consequence Major x Likelihood Likely = 16 **Target risk score**: 12 **Aim to reach target score by:** 31 October 2020
Description:
Multiple risks to patient care, service delivery and financial stability due to continuing growth in non-elective demand. Causes: • Aging population: Between 2003/4 and 15/16, the number of people aged over 85 increased by nearly 40%. • Financial constraints: Between 2003/4 and 15/16, the average annual increase in admissions was 3.6 per cent, while funding increased by an average of 3.1% per year nationally. • Limited physical capacity to expand services / provision of treatment areas. • Reduction in seasonal funding 2018/19 • Patient expectation and choice driving additional demand beyond peer organisations • Sector-wide admission avoidance & delayed discharge improvement schemes had limited impact on demand. Impacts: • Increased operational capacity (routine use of escalation space) • Increase in locum / agency staffing to support additional demand • Sub-optimal care of patients due to demand out stripping resource • Cancellation of elective procedures to support non-elective demand
Controls in place
•Over performance income utilised to offset cost of providing bed capacity. •Business cases for development of ambulatory care service approved both sites (June 18). •Trust wide Length of Stay / Bed productivity work stream: Local/daily measures: Red/Green[1], 2b412[2], escalation, discharge, choice policies implemented, Site & Discharge team reconfigurations •Stretch Care of the Elderly, Emergency Department and Acute Assessment Unit specific improvement schemes for 2017/18+; Emergency Care Transformation Plan being implemented, including a discharge to assess model. •Acute frailty steering group meeting monthly •Physical reconfiguration of both sites Emergency Departments completed (Feb/Mar 2017)
Actions to be undertaken:
•On-going work with local partners to improve rates of discharge to community care providers and reduce readmission rates. •Site expansion plans for WestMid including additional non-elective demand bed base and expanded RESUS. •Length of stay reduction opportunities in certain specialties to reduce bed capacity (Care of the elderly / Stroke); via Length of Stay / Productivity work stream. Due Nov 2018.
Assurances:
Assurance: Executive Management Board, Divisional Quality Board, Ambulatory Programme Board Management oversight: Divisional, Length of Stay/Bed Management Cost Improvement Programme Workstream, Executive/Divisional bi-lateral. Daily management: Actions implemented and tracked via bed meetings, Delayed transfer of Care/medically optimised daily updates and weekly performance management group

Red/Green[1]: 'Red and Green Bed Days' are a management approach to assist in the identification of wasted time in a patient's journey. Applicable to in-patient wards in both acute and community settings, this approach is used to reduce internal and external delays as part of the SAFER patient flow bundle.

2b412[2]: The Two Before Twelve (2B412) initiative is a campaign to support trust discharge processes. Each ward has to identify three patients each day who are likely to be discharged from an acute bed the following day. This is to ensure that at least two patients are discharged before midday. This excludes intensive care, labour ward and the coronary care unit

4.0 Risk register process and mitigation assurance

The risks register supports the organisation to recognise and respond to risks that could, or are, affecting it. All trust areas are being engaged in proactive risk identification and escalation.

A review of the organisations risk management process will be presented to the Audit and Risk Committee in January 2019; one of the outcomes from this review is to confirm the pathways by which the Board receives assurance that the risk register process is operating effectively and items within the register are being mitigated in an appropriate manner. These functions of both process and mitigation assurance are currently supported by the Committees of the Board, Executive Management Board, Divisional Quality Boards and sub-groups.

4.1 Role of the Divisional Quality Boards

Operational risk register assurance is provided via the Divisional Quality Boards within each clinical Division; these groups ensure the Divisional risk register process is embedded and mitigation actions are undertaken within appropriate timescales.

The organisations Corporate Division is comprised of comprise disparate management teams from non-clinical departments; as such there is no overarching Divisional Quality Board. Risk identification and management action is overseen by the individual management teams; the deep dive review into the Trust risk management processes will also consider the risk assurance mechanisms within the corporate functions areas.

4.2 The role of the Committees of the Board

The Committees of the Board receive process and mitigation assurance directly or via their sub-groups based on the aligned risk domain associated with each item on the register. The Committees receive assurance for the following domains:

4.2.1 Audit and Risk Committee (ARC)

The Audit and Risk Committee receive assurance information regarding the functioning of the organisations risk register process across all organisational areas.

4.2.2 Quality Committee

The Quality Committee receives process and mitigation assurance via the operation of its sub-groups; the sub-groups are aligned to the following risk domains:

- **Patient Safety Group (PSG):** Patient safety Risks
- **Health Safety and Environment Risks (HSERG):** Health Safety, Physical Estate risks
- **Infection Prevention and Control Committee (IPCC):** Infection Control risks
- **Medical Device Group (MDG):** Medical Device risks

4.2.3 People and Organisational Development (POD)

The People and Organisational Development Committee receives metrics relating to all staffing and staff training risks recorded within the register; full details of all risks linked to these domains graded as equal to or greater than 12 are presented to the Committee for scrutiny.

4.2.4 Finance and Investment Committee (FIC):

The Finance and Investment Committee receives metrics relating to all financial management risks recorded within the register; full details of all risks linked to this domain graded as equal to or greater than 12 are presented to the Committee for scrutiny.

4.2.5 Digital Transformation Board (DTB)

From November 2018 the Digital Transformation Board will receives metrics relating to all ICT infrastructure risks recorded within the register; full details of all risks linked to this domain graded as equal to or greater than 12 will be presented to the group for scrutiny.

4.2.6 Executive Management Board (EMB):

The Executive Management Board receives metrics relating to all Quality of Service, Governance Arrangements and Key Performance Target risks within the register; full details of all risks linked to these domains graded as equal to or greater than 12 are presented to the group for scrutiny. EMB also receives any risk items escalated from the Divisional Quality Boards for mitigation support or enhanced awareness.

4.3 Executives responsible for risk domains

Executive oversight of risks supports risk escalation and mitigation; the risk domains are aligned to the following Executives.

- Control of infection risks – Medical Director
- Emergency Preparedness risks – Chief Operating Officer
- Financial Management risks – Director of Finance
- Governance Arrangements risks – Chief Nurse
- Health and Safety risks – Chief Nurse
- ICT Infrastructure risks – Chief Information Officer
- Key performance Targets risks - Chief Operating Officer
- Medical Equipment risks – Medical Director
- Patient Safety risks – Medical Director
- Physical Estate risks - Chief Operating Officer
- Quality of Service risks – Chief Nurse/Medical Director
- Staff Training risks – Director of Finance (Director of HR)
- Staffing risks – Director of Finance (Director of HR)

The deep dive review into the Trust risk management processes will consider the current risk domains and the aligned executives.

5.0 Highest level risks

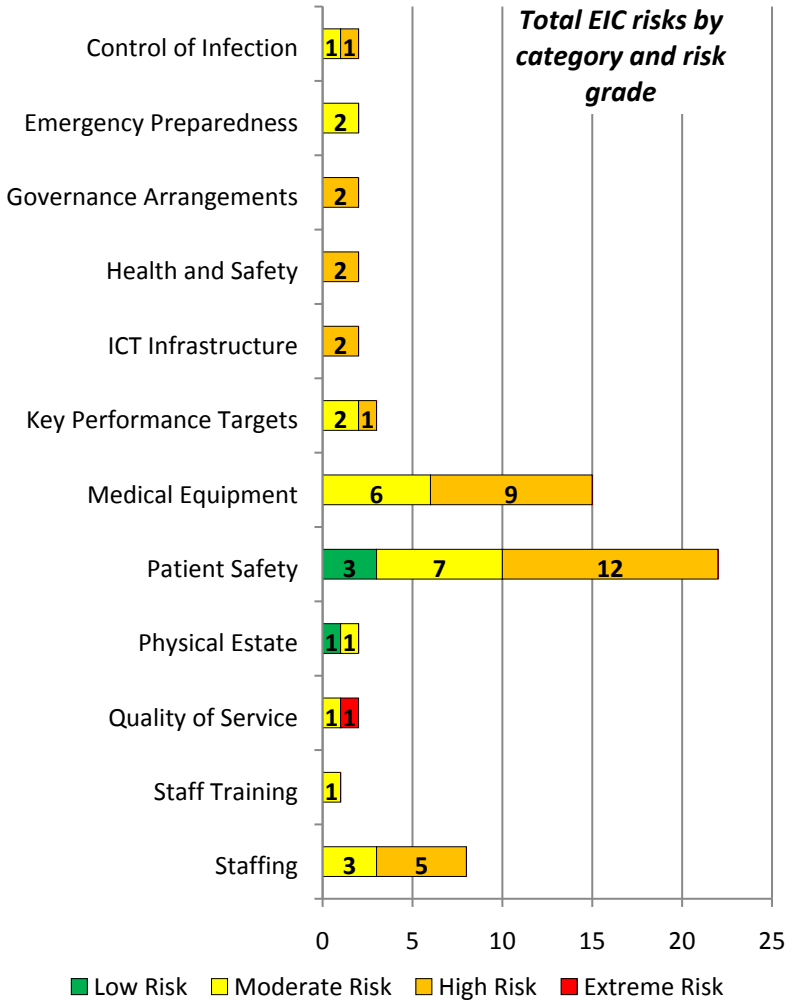
High level risks (scored equal to or greater than 12) are outlined below to demonstrate current position by Division and provide assurance of aligned committee / sub-group oversight.

5.1 Emergency and Integrated Care; Highest level risks (items scored 12-25 / items mitigated from dashboard since last report to ARC, July 2018)

Highest risks: These are risks scored equal or greater than 12		Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
3	Growth in Non-Elective demand above plan	Quality Service	12					◊		●		01/06/2015	31/10/2020	18/09/2018	EMB
2	Delayed Discharge due to lack of specialist beds and nursing homes	Patient Safety	9	◊				●				04/04/2016	25/12/2017	18/09/2018	PSG
134	Intermittent Bleep Issues across ChelWest site	Patient Safety	16	◊				●				03/10/2012	31/12/2018	18/09/2018	PSG
136	Pandemic Influenza continuity risk	Infection Control	16			◊		●				29/07/2016	01/11/2018	18/09/2018	IPCC
373	Mental Health bed provision/Violence & Aggression	Patient Safety	12			◊		●				03/07/2017	31/12/2017	12/06/2018	PSG
411	Dementia care provision and strategy	Patient Safety	12	◊				●				18/09/2017	30/09/2018	18/09/2018	PSG
417	Provision of Allied Healthcare Professional services to the Neonatal Intensive Care Unit /Special Care Baby Unit and follow-up	Staffing	12	◊				●				25/09/2017	28/09/2018	02/10/2018	WDC
449	Root cause analysis for hospital associated venous thromboembolism	Patient Safety	12	◊				●				01/03/2017	31/03/2019	04/10/2018	PSG
460	Violence & Aggression in the Emergency Department	Health & Safety	12			◊		●				04/12/2017	31/01/2019	25/05/2018	HSERG
487	Obsolete Patient monitors (Endoscopy) **– New**	Medical Equip.	12	◊	→	→	→	●				23/01/2018	28/09/2018	07/09/2018	MDG
554	Interface with Cerner and Somerset **– New**	ICT	12	◊				●				14/06/2018	14/06/2018	17/07/2018	DTB
616	Medical registrar gaps in Acute Assessment Unit /Emergency Department on call rotas **– New**	Staffing	12		◊			●				18/09/2018	31/12/2018	18/09/2018	WDC
617	Compliance with IV drug administration protocol **– New**	Patient Safety	12	◊				●				18/09/2018	31/12/2018	18/09/2018	PSG
337	Medical cover at night (Mitigated from highest level risk dashboard, 20/08/2018)	Patient Safety	12	◊		●	←					15/05/2017	31/01/2019	22/08/2018	PSG

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

Emergency and Integrated Care



Emergency and Integrated Care (EIC) have 63 live risks recorded within the register (24% of organisational total); assurance relating to identification and mitigation action is provided via the monthly Divisional Quality Board. The division is well represented at the overarching governance groups with a remit for risk (e.g. committees, groups and sub-groups).

All EIC directorates (Cancer, Emergency Medicine, Site Operations, Specialist Medicine, Therapies) have identified risks; 87% of which are within review deadline. Where risks are not reviewed to schedule support is provided via the local management team and the Divisional Quality Board.

Since the last report to ARC in July 2018 the Division has identified or escalated four new risks scored equal to or greater than 12 to their highest level risk dashboard (risks 487, 554, 616, 617); one item, previously reported, has been mitigated and removed from the dashboard (risk 337) though it remains locally managed and overseen by the Divisional Quality Board.

The Division notes six risks within the dashboard that have passed their expected target date; this is the date that the risk owner aimed to have mitigated the risk by. Management teams are reviewing actions associated with these risk to ensure planned mitigation is achievable and time bound. The Quality Board will track delivery of action plans to published timescales or oversee the escalation of high level risks with significant mitigation barriers to the Executive Management Board (EMB).

Risk ID 2:-Delayed Discharge due to lack of specialist beds and nursing homes and ID 373:- Mental Health bed provision/Violence & Aggression have been escalated for EMB awareness as action required to ultimately control is outside the direct remit of the Trust; local management action and interlink with external partners is in place to support mitigation.

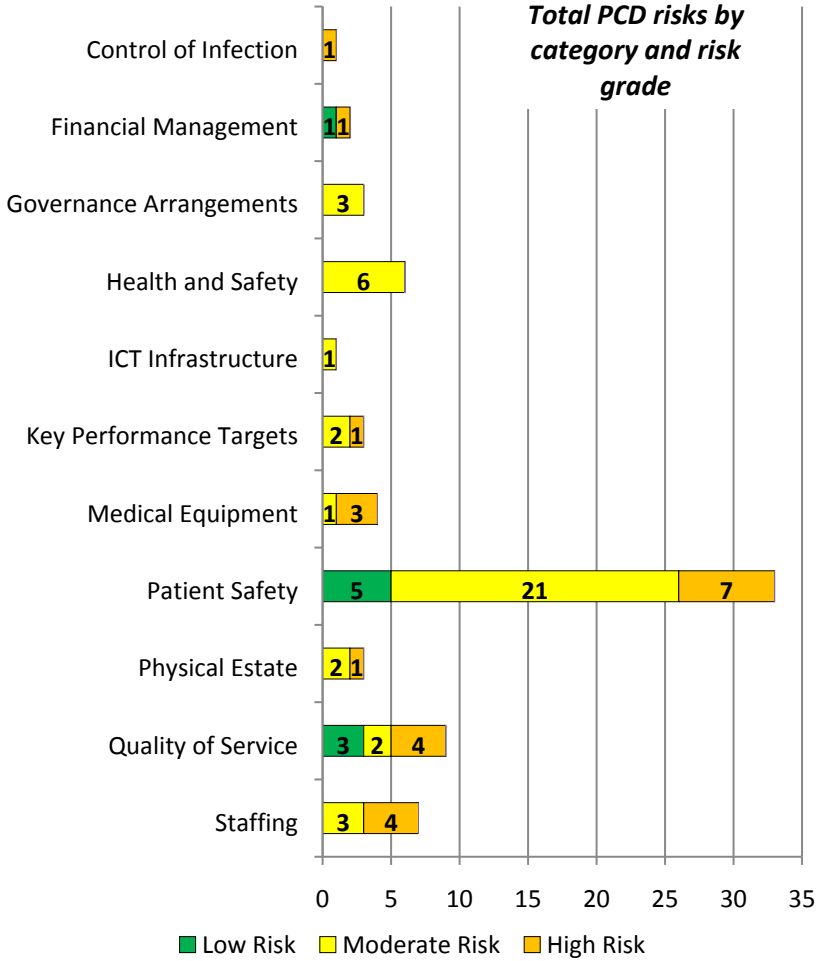
Evidence of risk identification, contemporary review, changing risk scores and appreciation for indicators of potential barriers to action plan delivery indicate a functional risk review process. The Division has noted need to increase low level risk reporting which is being supported at ward level.

5.2 Planned Care Division; Highest level risks (items scored 12-25 / items mitigated from dashboard since last report to ARC, July 2018)

	Highest risks: These are risks scored equal or greater than 12	Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
4	Identification and Escalation of the Deteriorating Patient	Patient Safety	12	◊				●				01/02/2015	26/04/2019	13/03/2018	PSG
37	Backlog in outpatient letters - turnaround delays	Staffing	9	◊				●				01/06/2016	01/06/2018	10/07/2018	POD
38	Non-compliance with referral to Treatment (RTT) performance **– increasing risk**	Targets	12	◊			→	●				01/06/2016	16/12/2018	06/08/2017	EMB
407	Unable to meet overall financial targets as a result of ongoing challenges with Elective throughput and Non-elective demand	Financial Mgmt.	12	◊				●				01/09/2017	28/06/2018	17/04/2018	FIC
489	Restricted access to some historical images within the Agfa Picture Archiving and Communication System at WestMid	Patient Safety	12	◊				●				22/01/2018	30/11/2018	11/09/2018	PSG
508	Radiology computer hardware and Video Conference equipment unable to support radiology multidisciplinary team review **– increasing risk**	ICT	8	◊		→	→	●				08/03/2018	30/11/2018	26/09/2018	DTB
538	Inadequate staffing levels on Surgical wards	Staffing	12	◊				●				16/05/2018	31/05/2019	06/08/2018	WDC
571	Mammography unit equipment failure **– increasing risk**	Medical Equip	9	◊			→	●				28/05/2018	31/07/2018	11/09/2018	MDG
573	Unreliability of dental x-ray units - both sites **– new addition to live register**	Medical Equip	12	◊				●				17/05/2018	02/10/2018	11/09/2018	MDG
600	Condition of Main Operating Theatres and Treatment Centre **– new addition to live register**	Estate	12	◊				●				14/08/2018	28/08/2020	22/08/2018	HSERG
603	Breach of British Orthopaedic Association guideline for follow up within 72hours **– new addition to live register**	Quality of Service	12	◊				●				15/08/2018	14/12/2018	30/08/2018	EMB
58	Inability to recruit qualified and experienced staff to substantive roles **– Risk mitigated and awaiting closure by Divisional Board**	Staffing	12	●	←	←	←					27/06/2016	10/12/2018	23/08/2018	WDC
552	Risk of Service Delivery due to lack of Permanent Sonographer Team **– Live risk mitigated to 9, removed from dashboard**	Staffing	12	◊		●	←					11/06/2018	30/11/2018	11/09/2018	WDC

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

Planned Care Division



Planned Care Division (PCD) has 72 live risks recorded within the register (27% of organisational total and 19 more than reported to the Committee in July 2018); assurance relating to identification and mitigation action is provided via the monthly Divisional Quality Board. The division is well represented at the overarching governance groups with a remit for risk.

All PCD Directorates (Clinical Support, Critical Care, Patient Access, Pharmacy, Surgery, Theatres) are managing live risks within the organisations register; 100% of which are within the review deadline.

Since the last report to ARC in July 2018 the Division has identified or escalated six risks scored equal to or greater than 12 to their highest level risk dashboard (risks 38, 508, 571, 573, 600, 603); two items have been mitigated and removed from the dashboard (risk 58, 552).

Risk ID 4 Identification and Escalation of the Deteriorating Patient is the Divisions most aged high level risk; the Patient Safety Group monitors the actions associated with the management of this item to ensure mitigation plans remain on trajectory and cross divisional communication is supported.

During this reporting period the division's risk registers has been significantly updated; this is evidenced by the identification of new risks at all risk grades, the escalation of previously reported risks based on newly acquired information and the achievement of 100% compliance with scheduled risk review dates. The Division has noted the need to focus on setting achievable rather than aspirational target risk score dates, this is being supported via the Divisional Quality Board to address slipped action plan targets (risk IDs 37, 407, 571, 573).

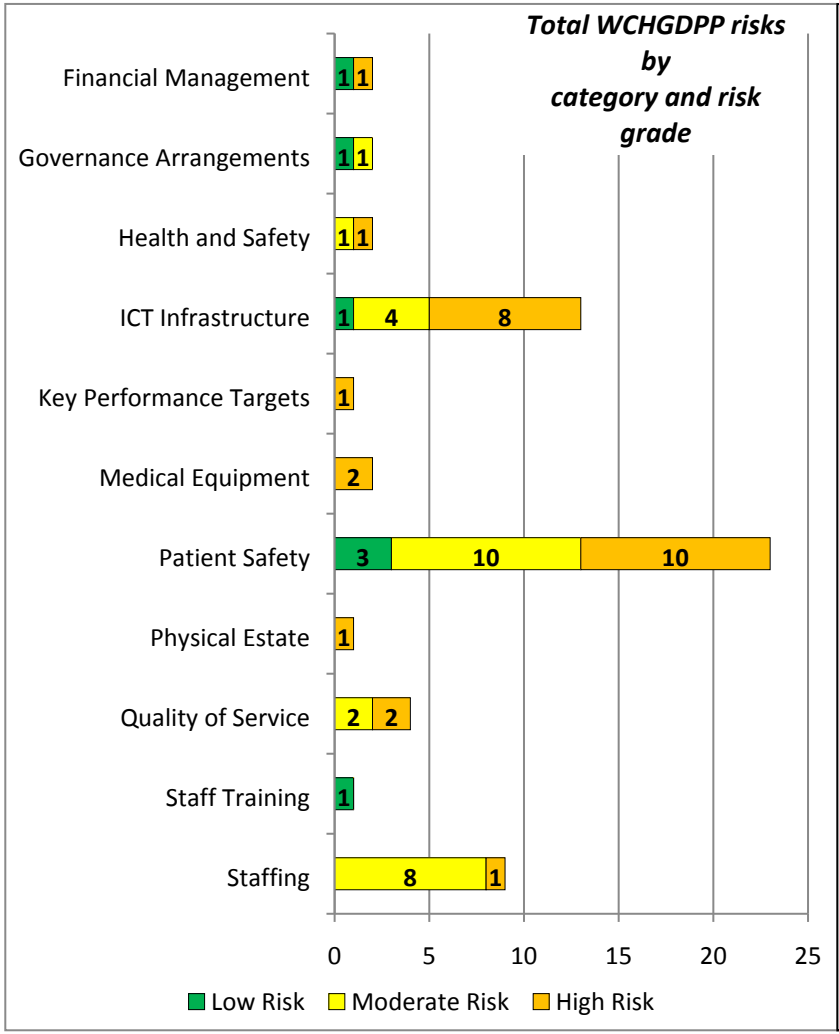
Engagement in risk review and escalation is an indicator of a functional risk management process.

5.3 Women's, Children's, HIV/GUM, Dermatology, Private Patients ; Highest level risks (items scored 12-25 / items mitigated from dashboard since last report to ARC, July 2018)

Highest risks: These are risks scored equal or greater than 12		Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
318	Shortage of Sonographers at West Middlesex Hospital	Staffing	9	◊				●				04/04/2017	09/08/2018	26/09/2018	WDC
333	GUM Commissioning - Reduction in Tariff	Financial Mgmt.	12			◊		●				05/05/2017	28/02/2018	18/07/2018	FIC
352	Lastword HIV disclosure flags and associated risks	ICT	12	◊				●				23/05/2017	31/07/2017	05/09/2018	DTB
367	Security of the WestMid Queen Mary Maternity Unit	Estate	12	◊				●				10/06/2017	26/02/2018	09/05/2018	HSERG
493	Cerner Implementation lacks pathology/ Imaging function for medical referral **– new addition to live register**	ICT	12	◊				●				13/02/2018	04/05/2018	15/08/2018	DTB
496	Out dated ultrasonography equipment (early pregnancy unit) **– new addition to live register**	Patient Safety	12	◊				●				22/02/2018	31/10/2018	09/07/2018	PSG
507	Temperature Monitoring Solution - No Disaster Recovery / Single Point of Failure, HIV service	ICT	12	◊				●				05/03/2018	30/11/2018	20/09/2018	DTB
565	Handling emergency patients from British Pregnancy Advisory Service with late terminations >18 weeks **– new addition to live register**	Patient Safety	12	◊				●				05/07/2018	14/09/2018	04/10/2018	PSG
630	Retained swab following delivery (Maternity) **– new addition to live register**	Patient Safety	12	◊				●				04/10/2018	01/01/2019	08/10/2018	PSG
297	Risk of delaying reporting requirements to the governing body (Human Fertilisation & Embryology Authority; HFEA) by the Assisted **– Live risk mitigated to 9, removed from dashboard, managed locally**	ICT	12	◊		●	←					16/01/2017	01/10/2018	06/08/2018	DTB
390	Nitrous Oxide exposure; Maternity cross site risk **– Live risk mitigated to 9, removed from dashboard, managed locally and monitored by HSERG / EMB**	H&S	12	◊		●	←					01/08/2017	31/12/2018	04/10/2018	HSERG
468	Starlight Ward Staffing Vacancies **– Live risk mitigated to 6, removed from dashboard, managed locally**	Staffing	12	●	←							04/09/2017	07/05/2018	17/09/2018	WDC
515	Activity outstripping and Staffing resource within Sexual Health E-Service **– Live risk mitigated to 9, removed from dashboard, managed locally**	Patient Safety	12	●	←							15/03/2018	31/10/2018	11/09/2018	PSG

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

Women's, Children's, HIV/GUM, Dermatology, Private Patients



Women's, Children's, HIV/GUM, Dermatology, and Private Patients (WCHGDPP) has 60 live risks recorded within the register (23% of organisational total and 21 more than reported to the Committee in July 2018); assurance relating to identification and mitigation action is provided via the monthly Divisional Quality Board and supporting management meetings.

All WCHGDPP Directorates (Gynae and reproductive medicine, HIV / Sexual Health, maternity, Paediatrics, and Private Patients) are managing live risks within the organisations register. It is noted that HIV / Sexual health and Maternity have identified the majority of risks within the Division (22 and 18 respectively); low identification areas (Dermatology and Private Patients) are being supported via the Divisional Quality Board to ensure an accurate risk profile is maintained.

Since the last report to ARC in July 2018 the Division has identified or escalated four risks scored equal to or greater than 12 to their highest level risk dashboard (risks 493, 496, 565, 630); four items have been mitigated and removed from the dashboard (risk 297, 390, 468, 515), these items remain live on the divisions register and are being managed locally and overseen by the linked governance groups.

During this reporting period the Division have identified 21 more live risks; this indicates improving engagement with the Trust's risk management process. The division notes the need to ensure risks are reviewed to schedule and that realistic action plan delivery dates are maintained.

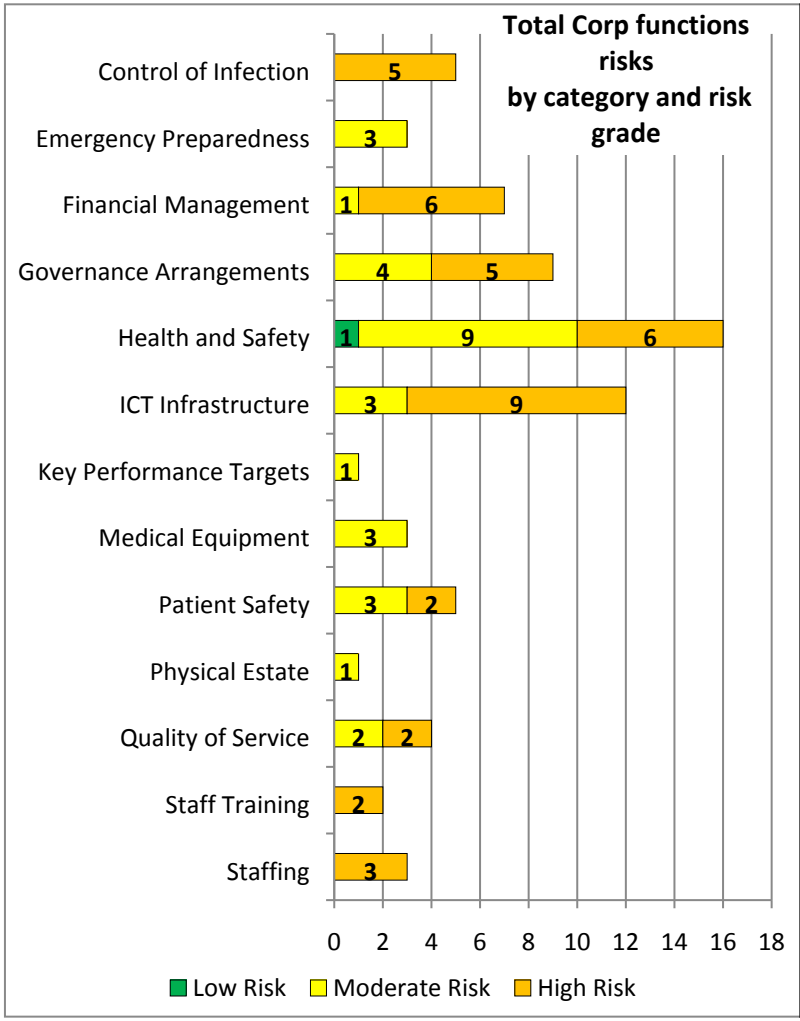
5.4 Corporate functions / Non-clinical departments; Highest level risks (items scored 12-25 / items mitigated from dashboard since last report to ARC, July 2018)

Highest risks: These are risks scored equal or greater than 12		Type	Initial score	<= 6	8	9	10	12	15	16	>= 20	Identified date	Target date	Date reviewed	Oversight Group
76	Staffing Capacity **Human Resources**	Staffing	16	◊				●				01/02/2016	30/04/2018	21/03/2018	WDC
78	Risk of delivering the 3 year quality improvement journey at pace, **Nursing Directorate**	Governance	12	◊				●				01/02/2016	26/02/2018	29/11/2017	EMB
202	MRSA trajectory, **Medical Directors Office**	Control of Infection	12			◊		●				05/10/2016	12/09/2019	19/07/2018	ICG
252	EPR Domain Share with Imperial Hospital **Clinical Systems & Information Technology**	Patient Safety	16		◊			●				08/12/2016	31/12/2018	28/09/2018	PSG
261	Cerner implementation costs may over run in 2019/20 **Clinical Systems & Information Technology**	Financial Mgmt.	9	◊				●				28/11/2016	31/12/2018	28/09/2018	EMB
263	Chelsea and Westminster and Imperial Implementation Dependencies (Cerner) **– Clinical Systems & Information Technology**	Quality of Service	9	◊		→		●				28/11/2016	31/12/2018	28/09/2018	EMB
410	Ventilation verification non-conformities **Estates**	Health and Safety	12	◊				●				14/09/2017	31/03/2019	03/09/2018	HSERG
440	IT Systems not available as insufficient backups **Clinical Systems & Information Technology**	ICT	12	◊				●				10/11/2017	28/02/2018	29/11/2017	DTB
441	IT Systems not available due to a Cyber security issue **Clinical Systems & Information Technology**	ICT	12	◊				●				10/11/2017	28/02/2018	02/01/2018	DTB
444	Failure to successfully implement the new EPR system (Cerner) **Clinical Systems & Information Technology**	ICT	15				◊	●				10/11/2017	31/12/2018	28/09/2018	DTB
476	Variances in reported activity pre and post go live **Clinical Systems & Information Technology**	Financial Mgmt.	12	◊				●				31/08/2017	31/12/2018	28/09/2018	EMB
572	Governance of strategic partnerships **Corporate functions**	Governance	12	◊				●				18/07/2018	31/07/2019	18/07/2018	EMB
580	CW Hub utilisation impacting Mandatory & Statutory Training: **New Human Resources**	Staff Training	12	◊				●				25/07/2018	31/12/2018	06/08/2018	WDC

34	Cost Improvement Plan/ Synergies 2017/18 - Closed risk, new risk for 18/19 under development	Financial Mgmt.	15		◊			●				14/12/2015	23/03/2018	19/07/2018	EMB
98	Lack of an adequate replication solution for the CaMIS PAS application. - Risk mitigated (cerner) and closed	ICT	8	●	←							26/02/2016	01/11/2017	13/08/2018	DTB
475	Sufficient level of nursing engagement to deliver Cerner programme - Risk mitigated and closed	ICT	12	●	←							14/08/2017	31/07/2018	13/08/2018	DTB
477	Device Association, Charting and Disassociation within Millennium system – Mitigated live risk, locally managed	Medical Equip / ICT	6	●	←							16/11/2017	31/12/2018	30/08/2018	MDG

Key: ● – Current risk score ◊ - Target risk score → - Change from last report

Corporate functions / Non-clinical departments



71 risks have been identified for mitigation within the Trust's non-clinical / corporate functions division; all corporate directorates demonstrate some engagement with the identification and recording of risk within the organisations registers.

As the organisations corporate functions are comprised of disparate management teams there is no overarching Divisional Quality Board as per the clinical divisions. Risk identification and management action is currently overseen by the individual management teams.

Since the last report to ARC in July 2018 the departments that make up the Corporate functions Division have identified or escalated two risks scored equal to or greater than 12 to their highest level risk dashboard (risks 263 and 582, these items are overseen by the EMB and POD respectively). Four items have been mitigated and removed from the dashboard (risk 34, 98, 475, 477).

It is noted that 66% of the risks aligned to non-clinical / corporate functions have passed their scheduled review date; this is a reduction of 13 percentage points from the position reported in to the committee in July 2018 but further progress required. Support to heads of departments and individual risk handlers is being provided by the Head of Health Safety and Risk. The overarching governance of risk associated with the corporate functions division is taking place as part of the deep dive into the risk management strategy to be scheduled for the committee in January 2019.

6.0 Conclusions

There are 48 risks graded as 12 or above being managed across the organisations risk register; the key themes from high level risks relate to:

- Patient safety (25% of high level risks)
- ICT infrastructure (17% of high level risks)
- Staffing (13% of high level risks)

Risks are operationally managed by the area predominantly affected and assurance is provided via the Divisional Quality Boards and linked oversight committees, group or sub-group.

7.0 Next steps

1. Oversight committees / groups to support engagement in risk management process and the identification and recording of risks arising within the groups agenda / remit.
2. Heads of non-clinical / corporate functions departments to establish regular meetings to identify and review risks that could, or are, impacting service delivery.
3. Risk management strategy deep-dive to be reported to ARC January 2019.

Appendix A: Risk rating guidance

A 5x5 risk matrix is used to assess risk in a consistent and systematic way.

When considering risk scoring the consequence and likelihood of the risk occurring must be considered, the following review process should be used to assist completion:

Consequence
If the harm or detriment does occur what are the likely consequences to the person, trust, service, project etc. This is a matter of judgement but the consequence should be the most probable outcome to occur not just the potential worst case scenario.

The table on page 17 provides guidance to support decisions making regarding consequence.

Likelihood
What is the probability that the consequence will occur given the existing controls or precautions that are already in place?

The table below should be used to assist support decision making regarding likelihood.

Likelihood	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency - How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possible frequently
Frequency - timeframe	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability - Will it happen or not?	<0.1%	0.1 - 1.0%	1 - 10%	10 - 50%	>50%

LEVEL	STATUTORY DUTIES	INJURY/HARM/ PATIENT SAFETY	SERVICE DELIVERY	FINANCIAL/ LITIGATION	REPUTATION/ PUBLICITY	BUSINESS INTERUPTION / ENVIRONMENTAL	BUSINESS OBJECTIVES/ PROJECTS	QUALITY COMPLAINTS AUDIT	WORKFORCE DEVELOPMENT
Catastrophic Extreme 5	Multiple breeches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report	Serious incident involving a large number of patients Incident leading to death	Permanent closure/loss of a service	Loss of >£5M	Removal of Chair/CEO or exec team Long term or repeated adverse national publicity	Permanent loss of service or facility. Catastrophic impact on environment.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met	Totally unacceptable level or quality of treatment/ service. Gross failure of patient safety if findings not acted on. Inquest/Healthcare Commission/ombuds man inquiry. Gross failure to meet national standards	Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an ongoing basis
Major 4	Enforcement action. Multiple breeches in statutory duty. Improvement notices. Performance rating low. Critical report	Major injury leading to long term incapacity requiring significant increased length of stay.	Significant underperformance of a range of key targets Intermittent failures in a critical service	Loss of between £50,001 and £5M	National media coverage and increased level of political/public scrutiny Total loss of public confidence	Loss/interruption of >1 week. Major impact on environment	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low performance rating. Critical report	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/ key training
Moderate 3	Single breech in statutory duty. Challenging external recommendations/ improvement notice	RIDDOR reportable incident Moderate injury requiring professional intervention	Sustained period of disruption to services/sustained breach of key target	Loss of between £101,000 and £500,000	Local media coverage with reduction in public confidence	Loss/interruption of >1 day. Moderate impact on environment	5–10 per cent over project budget. Schedule slippage	Treatment or service has significantly reduced effectiveness. Formal complaint (stage 2) complaint. Local resolution (with potential to go to independent review). Repeated failure to meet internal standards. Major patient safety implications if not acted on.	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day). Low staff morale Poor staff attendance for mandatory/key training
Minor 2	Breech of statutory legislation. Reduced Performance rating if unresolved	Minor injury or illness requiring minor intervention. < 7 days off work if staff	Short disruption to services affecting patient care or intermittent breach of key target	Loss of between £10,000 and £100,000	Local media coverage	Loss/interruption of >8 hours. Minor impact on environment	<5 per cent over project budget. Schedule slippage	Overall treatment or service suboptimal. Formal complaint. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved	Low staffing level that reduces the service quality

Insignificant 1	No or minimal impact or breech of guidance/ statutory duty	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Less than £10,000	Rumours.	Loss/interruption of >1 hour. Minimal or no impact on the environment	Insignificant cost increase/ schedule slippage	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry	Short-term low staffing level that temporarily reduces service quality (< 1 day)

Board of Directors Meeting, 1 November 2018

PUBLIC SESSION

AGENDA ITEM NO.	5.3/Nov/18
REPORT NAME	Half yearly report on use of the Company Seal 2017/18
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Julie Myers, Company Secretary
PURPOSE	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Report on use of the Company Seal 2017/18

1. The Constitution, at Annex 7 (Standing Orders), Section 11 refers to the sealing of documents. This section states:

Custody of Seal and Sealing of Documents

11.1. **Custody of Seal** – the common seal of the Trust shall be kept by the Company Secretary in a secure place.

11.2. **Sealing of documents** - where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.

11.3. **Register of sealing** - an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.

11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

2. During the period 1 April 2018 – 30 September 2018, the seal was affixed to the following documents:

Seal Number	Description of the document	Date of sealing	Affixed and attested by
189	Chelsea and Westminster Hospital NH Foundation Trust and Anil Kumar sub-underlease relating to Units E and F, 369 Fulham Road, London SW10 (post office premises) (2 copies)	05.04.2018	Karl Munslow-Ong Deputy Chief Executive Pippa Nightingale Chief Nurse
190	The Lord Mayor and Citizens of the City of Westminster as authority and Chelsea and Westminster Hospital NHs foundation Trust Framework Agreement for the provision of Genito-urinary medicine (GUM) and Sexual and reproductive health (SRH) services. (2 copies)	08.05.2018	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer

191	The Deed of Novation Agreement between 1) Merck Sharp & Dohme Limited, 2) St Stephen's AIDS Trust and 3) Chelsea and Westminster Hospital NHS Foundation Trust (1 copy)	05.07.2018	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer
192	The Mayor and Burgesses of the Royal Borough of Kensington and Chelsea and Westminster Hospital NHS Foundation Trust call-off contract for the provision of Genito-urinary medicine (GUM) and Sexual and reproductive health (SRH) services. (2 copies)	11.07.2018	Sandra Easton Chief Financial Officer Karl Munslow-Ong Deputy Chief Executive
193	The Lord Mayor and Citizens of the City of Westminster as authority and Chelsea and Westminster Hospital NHs foundation Trust call-off contact for the provision of Genito-urinary medicine (GUM) and Sexual and reproductive health (SRH) services. (2 copies)	11.07.2018	Sandra Easton Chief Financial Officer Karl Munslow-Ong Deputy Chief Executive
194	London Borough of Hammersmith and Fulham and Chelsea and Westminster Hospital NHS Foundation Trust call–off contract for the provision of Genito-urinary medicine (GUM) and Sexual and reproductive health (SRH) services. (2 copies)	11.07.2018	Sandra Easton Chief Financial Officer Karl Munslow-Ong Deputy Chief Executive
195	(1) Chelsea and Westminster Hospital NHS Foundation Trust and (2) Anil Kumar rent deposit deed relating to Units E and F, 369 Fulham Road, London SW10 (1 copy)	16.08.2018	Karl Munslow-Ong Deputy Chief Executive Julie Myers Company Secretary
196	Grant Agreement between (1) Chelsea and Westminster Hospital NHS Foundation Trust (2) Westminster City Council (3) Royal Borough of Kensington and Chelsea, and (4) London Borough of Hammersmith and Fulham for London Sexual Health and GUM Services Provision. (1 copy)	12.10.2018	Sandra Easton Chief Financial Officer Karl Munslow-Ong Deputy Chief Executive