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

Room A, West Middlesex Hospital

6 September 2018 11:00 - 6 September 2018 13:40

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting (PUBLIC SESSION)**
**Location:** Room A, West Middlesex Hospital
**Date:** Thursday, 6 September 2018
**Time:** 11.00 – 13.40

**Agenda**

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| | **1.0** | **GENERAL BUSINESS** | | |
| 11.00 | 1.1 | Welcome and apologies for absence<br>Apologies received from Andy Jones. | 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 5 July 2018 | Report | Chairman |
| 11.07 | 1.4 | Matters arising and Board action log, including<br>1.4.1 Update on NWLP | Report<br>Verbal | Chairman<br>Deputy Chief Executive |
| 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 | Patient Experience Story (video) | Verbal | Chief Nurse |
| 11.45 | 2.2 | Freedom to speak up report and self-assessment | Report | Chief Nurse |
| 11.55 | 2.3 | Patient Voices | Report | Chief Nurse |
| 12.05 | 2.4 | Improvement Programme | Report | Chief Nurse/Chief Financial Officer |
| 12.15 | 2.5 | Serious Incidents Report | Report | Chief Nurse |
| 12.25 | 2.6 | Integrated Performance Report including:<br>2.6.1 Workforce performance report | Report<br>Report | Chief Operating Officer<br>Chief Financial Officer |
| 12.35 | 2.7 | Mortality Surveillance Q1 Report | Report | Medical Director |
| 12.45 | 2.8 | Health and safety – six monthly report | Report | Deputy Chief Executive |
| | **3.0** | **STRATEGY** | | |

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| 12.55 | 3.1 | Research Strategy | Report | Medical Director |
| | **4.0** | **GOVERNANCE & RISK** | | |
| 13.10 | 4.1 | EPR and Digital Transformation Board update (including Board governance) | Verbal | Chief Operating Officer/Chief Information Officer |
| 13.20 | 4.2 | Capital programme update | Report | Chief Financial Officer |
| | **5.0** | **ITEMS FOR INFORMATION** | | |
| 13.25 | 5.1 | Questions from members of the public | Verbal | Chairman |
| 13.35 | 5.2 | Any other business | Verbal | Chairman |
| 13.40 | 5.3 | Date of next meeting – 1 November 2018 | | |

# Board of Directors Register of Interests – updated 9 July 2018

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

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

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| Liz Shanahan<br>Non-executive Director | Owner of Santé Healthcare Consulting Limited<br>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<br>Chief Executive Officer | Trustee of CW + Charity<br>Husband — consultant cardiology at Luton and Dunstable hospital<br>Daughter – member of staff at Chelsea Westminster Hospital<br>Son – Director of MTC building constructor |
| Sandra Easton<br>Chief Financial Officer | Sphere (Systems Powering Healthcare) Director representing the Trust<br>Treasurer — Dartford Gymnastics Club<br>Chair — HfMA Sustainability |
| Robert Hodgkiss<br>Chief Operating Officer | No interests to declare |
| Karl Munslow-Ong<br>Deputy Chief Executive | Director of North West London Pathology (an arms-length organisation, owned by three partner Trusts)<br>Director of Imperial College Health Partners<br>Wife – GP Partner, Springfield Health Centre, Stamford Hill N16 6LD |
| Pippa Nightingale<br>Chief Nurse | Trustee in Rennie Grove Hospice<br>CQC specialist advisor<br>Specialist advisor PSO |
| Zoë Penn<br>Medical Director | Trustee of CW + Charity<br>Daughter – employed by the Trust<br>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<br>Chief information Officer | CWHFT representative on the SPHERE board<br>Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust |

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Minutes of the Board of Directors (Public Session)**
**Held at 10.00 on 5 July 2018, Meeting Room A, West Middlesex**

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| **Present:** | 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) |
| | Eliza Hermann | Non-Executive Director | (EH) |
| | 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) |
| | Julie Myers | Company Secretary | (JM) |
| | Renuka Jeyarajah-Dent | NExT Director | (RJD) |
| | Kathryn Mangold | Lead Nurse for Learning Disabilities and Transition | (KM) |
| | Vida Djelic | Board Governance Manager | (VD) |

| 1.0 | GENERAL BUSINESS |
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| 1.1 | **Welcome and apologies for absence**<br><br>JJ confirmed that he was chairing the meeting in the absence of THH. He welcomed Board Members, and those in attendance, including Governors, staff and members of the public to the meeting, on this special day for the NHS.<br><br>Apologies for absence had been received from Sir Thomas Hughes-Hallett and Professor Martin Lupton.<br><br>Congratulations were extended to PN for her inclusion in a list of seventy influential nurses and midwives.<br><br>JJ informed those in attendance that the private Board meeting, due to be held later in the day, included the following items on its agenda:<br>- Serious incidents in more detail<br>- Minutes of Board Committees<br>- A new contract for 'hard' facilities management services<br>- Data use for healthcare solutions<br>- Trust finances in more detail |
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| 1.2 | **Declarations of interest**<br><br>ND reported that he was an owner and director of a business that had recently won an award from Imperial College to provide business incubation support. This was declared in full on the Register of Interests. |
| 1.3 | **Minutes of the previous meeting held on 3 May 2018**<br><br>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**<br><br>Meeting 03.05.2018<br>Action 2.5 – RC confirmed that SPC charts were not the correct tool for some types of data: mortality surveillance data was one example. Other techniques were used to interpret this data. It was noted that the Trust's performance was better than the national average (at 0.81).<br><br>Meeting 01.03.2018<br>Action 2.2 – the Company Secretary confirmed that a draft schedule of meetings for 2019 had been prepared for non-executive member review.<br><br>Action 2.2.1 – SE confirmed that details of the Trust's action plan on its gender pay gap report were on the agenda today. People and OD Committee (PODC) would be reviewing other aspects of equality data, including the WRES report, and information would be brought to the Board on a rolling basis.<br><br>Action 2.2.1 – SE confirmed that a new format report was in development. This would include the use of SPC charts and information on gender.<br><br>Action 3.3 – LW advised that celebration of Cerner EPR implementation at West Middlesex would take place after the next phase of development.<br><br>Action 3.3 – 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.<br>**Action: VD to amend action log and forward plan**.<br><br>Meeting 11.01.18<br>Action 3.1 – Implementation of the communications strategy to be reviewed by PODC and an update to report to return to the Board.<br>**Action: VD to add to PODC and Board forward plan**.<br>The Board discussed whether there was a way to keep non-executives better informed of the increasing amount of communications activity suggesting perhaps a weekly or monthly look back/look ahead.<br>**Action: GH to consider best approach to routine updating of non-executives**.<br>The Board noted the widespread use of Twitter for Trust communications updates and members committed to exploring their own use of the tool. |
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| 1.5 | **Chairman's Report**<br>The report was noted. |
| 1.6 | **Chief Executive's Report**<br><br>The CEO opened her report by noting that there had not been a year like the one just passed for a considerable time in London. It was important that Board were aware of the preparations the Trust made for such events and RH reported on the EMERGO exercise that had taken place the day before the Board meeting. Representatives from the Trust, Public Health England, police and ambulance services amongst others had attended a major off-site training event to train for such events. It had been a huge cohort and feedback had confirmed that it was very well received. The CEO noted that any member of the Executive team may be on call when such an event occurred so it was important that they were all prepared.<br><br>**Communications**: It had been a very busy period. Sky had broadcast live from West Middlesex and staff had been well-supported so that they could be involved. Representatives had attended an event at Number 10 with the Prime Minister and Secretary of State for Health and Social Care to celebrate 70 years of the NHS. Nominations for staff awards would soon be open.<br><br>**External initiatives and partnerships**: LW reported that she had been involved in the Williams Review, which was now published. This was an interesting topic that was generating lots of discussion. With regard to the STP, LW reported that she was now providing overall leadership.<br><br>She concluded her report by paying tribute to all of her executive colleagues and to the non-executive members of the Board, who provide robust challenge, which was welcome.<br><br>AJ made reference to the article in that day's Times newspaper which referenced the strong performance of the Trust and its leadership approach. The CEO was grateful for the acknowledgement, which she attributed to hard work and commitment and fruitful partnerships. She made specific reference to the Trust's relationship with CW+, which was widely acknowledged as being one of the most productive Trust/charity relationships in London.<br><br>In response to a question from EH, the Board discussed the performance of North West London Pathology. LW confirmed that close monitoring of NWLP performance was taking place, including monthly CEO meetings, and the impact of recent delays was being investigated by ZP and RC to identify whether there had been any patient safety impact. KMO confirmed that no negative impact had been identified to date and noted that there had been an improvement in performance in recent weeks. A new Managing Director had also taken up post. Non-executive scrutiny was being provided by SG and AJ to ensure that NWLP provided the expected level of service now and in the future. The partnership would remain on the Trust's watch-list with regular reports to go to the Finance and Investment Committee (FIC) and updates to be provided to the Board.<br><br>**Action: NWLP report to be added to FIC September agenda and Board November agenda (JM).**<br><br>In response to a question from NG on the Williams Review, which LW had been involved in, LW confirmed that there was still some way to go within the Trust to ensure all staff always felt able to reflect openly on concerns. She noted that a response was awaited from the Secretary of State on the Review but general expectations were that the majority of recommendations would be accepted and that limited legislative change would be required. She also reflected that there was not a clear understanding within the regulated professions of what would happen in a regulatory |

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| | scenario. In particular, they may not be aware that there had been clear commitments given by the prosecuting authorities, such as the General Medical Council, that they would not, ever, ask for private reflections as part of disciplinary proceedings, although appraisal records would be sought. She also noted that all of the professional representative bodies, such as the British Medical Association, had been provided with a copy of the Williams Report. |
| **2.0** | **QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE** |
| 2.1 | **Patient experience story**<br><br>PN introduced Kathryn Mangold, Trust lead on learning disabilities and Sue, parent of Tessie, a patient with learning disabilities. PN reminded the Board that the patient experience story was presented to the Board to help understand how services were provided, what we do well and what we could do better.<br><br>Sue explained that her daughter, Tessie, would not have been able to cope with being at this meeting and shared details of her daughter with the Board. Tessie is in her mid-twenties and has been a patient of the Trust since she was 2 ½ when she had a grand mal seizure. From this point, Tessie had experienced circa 250 seizures a day and had experienced skull fractures as a consequence of fitting. She had spent six months in the hospital at that time and, even though there had been tense periods, lifelong friends had been made with nurses who remained in touch. Tessie has a mental age of a 3, 4 or 5 year old, but also shows great wisdom.<br><br>One challenging period had been Tessie's transition from being a child patient to being an adult patient. For instance, from being seen in paediatric A and E to adult A and E, where parents were told they could go home and leave their child. Sue had made clear that this was not appropriate. She had worked with the Trust to develop the flag and passport systems to help staff do they best they can for patients with learning disabilities, most of whom wanted to be in and out of hospital as quickly as possible to minimise distress. When a person with learning disabilities was in hospital, it was really important to be able to manage their experience as well as possible. Parents and carers are integral to that.<br><br>Sue made the following points for the Board to be aware of:<br>- that it was important to pay attention to the needs of siblings whilst their brothers and sisters were in hospital<br>- that this Trust had worked hard to make sure Tessie was seen straight away and, where she needed to be an inpatient, a bed was provided for a parent/carer<br>- working together between staff and parents was critical: staff could never be expected to know everything about a child and parents had a responsibility to share this<br>- staff training to ensure they were alert to behaviour was very important<br>- people with behavioural difficulties were often fragile and vulnerable, often they could not remember things and were highly sensitive to certain sights and sounds. The parallels with eg patients with dementia were noted: what worked for people with learning disabilities would be of much wider benefit.<br><br>Sue concluded by commenting that the culture at Chelsea and Westminster always felt 'right'. This was integral to providing the best possible care. In Tessie's case, this meant that she now let people take her blood: she felt the calmness cross staff. She commended the care and support provided by KM to her and to many other parents, many of whom would alert KM directly if they needed to attend hospital. Where KM was not available, a system was in place for other nurses to take such |

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| | calls and make appropriate preparations.<br><br>KM thanked Sue for her presentation and for the contribution she had made personally to training over 4000 members of staff. Hearing directly about Tessie from Sue had a powerful impact. Whilst staff may leave, if they have been trained, they will take their learning with them.<br><br>PN thanked both Sue and M for their presentation and for the contribution they make to the Trust. Feedback from staff on the training was very positive and Sue's work with the Trust to develop the learning disabilities passport had been invaluable.<br><br>Opening discussion, NG thanked Sue for her powerful presentation. It demonstrated why a strong connection between staff, patients and carers was so important. He asked whether the systems were the same at both hospital sites. KM confirmed that they were, with a sticker taking the place of the electronic flag at West Middlesex. A Changing Places unit had been a success at Chelsea and work was underway to build one at West Middlesex.<br><br>RJD asked how the Trust helped less skilled parents to get the best outcomes for their children. KM confirmed that work needed to take place in the community and with GPs. She also noted that medical training needed to improve; the vast majority of F1 doctors had never received any training about learning disabilities. The passport helped, however, as it ensures quick and fair access irrespective of parental skills. Sue commented that charities such as Full of Life also help to train parents and provide a forum for sharing information and providing support.<br><br>JJ thanked Sue for her important contribution to the Trust and for attending the Board meeting. |
| 2.2 | **Quality improvement**<br><br>PN took the Board through the approach being adopted by the Trust as it continued on its journey to outstanding, which would involve a single methodology for all improvement work. This would be overseen by a Director of Improvement, and her team now incorporated the Project management Office and the Clinical Innovation Fellows. The new team had now been working together for a month and had been co-located.<br><br>The Improvement Board met every two weeks, with the focus of meetings alternating between identified improvement opportunities and unidentified improvement opportunities. The deep dive programme would continue, but the process had been refined with a new format and structure. Work was beginning on quantifying the financial benefits of quality improvements. The new structure meant a truly multi-disciplinary team.<br><br>ND welcomed the update but challenged the executive to explain how the team would capture all of the 'bottom-up' improvements. PN accepted that this was a fair challenge and noted that in previous years, work had to be delivered at pace. The new approach was about sustainability and 'bottom-up 'involvement was essential for this. The team would soon be launching an app to capture ideas from anywhere within the Trust and support there development. A large number of staff has also been trained in improvement methodology.<br><br>In response to a question from CC about how the improvement programme worked with the charity, CC explained that there was close alignment: sometimes the charity helped to bring in ideas and input from external sources; sometimes it was about supporting internal initiatives. |

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| | LW stated the importance of grip to the improvement programme. She noted that many of the initiatives seen by the Board eg work to improve mouth care to prevent hospital acquired infection, was all driven from the bottom-up. What was needed was a way of capturing these ideas more systematically and embedding them to ensure the benefits could be realised fully.<br><br>EH confirmed that the approach had been scrutinised by the Quality Committee which would continue to provide oversight. She challenged the executive to develop a more compelling communications narrative around the programme, including how it relates to research and to innovation.<br>**Action: PN/GH to consider whether a more compelling narrative can be built around the improvement programme and to update the Board at the next meeting**.<br><br>JJ thanked the team for their report. |
| 2.3 | **Serious Incident Report**<br><br>PN presented the Serious Incidents Report noting that six had been reported to Commissioners in May. She drew the Board's attention to the sustained performance of the Trust in relation to pressure ulcers, where performance as better than the national benchmark. NHSI were using work done by this Trust as best practice examples. Additionally, PN noted that prevention of falls was an important priority for the Trust this year.<br><br>LW commended the staff for their work in these areas and reported on a recent visit to a ward where she had seen really good examples of care provided to patients with dementia. She observed that there may be lessons for the Trust to learn from eg nursing homes in relation to falls.<br><br>In response to a question from NG, PN confirmed that the Trust did not have any of the prohibited syringe drivers which had been a factor in the cases reported at Gosport. They had not been used by this Trust, at either site, for some time. |
| 2.4 | **Integrated Performance Report (IPR)**<br><br>**Operational performance**. RH introduced the integrated performance report, noting that the Trust had met the regulatory standards in May whilst also rolling out the new Cerner EPR system at the West Middlesex site. The Board confirmed that they were pleased to see this level of performance being maintained for patients.<br><br>RH alerted the Board to:<br>- the omission of statistics for dementia care. This was due to difficulties in extracting reliable data from the system and they would be reintroduced as soon as the problem was remedied<br>- work to improve the presentation of metrics through the use of SPC charts. Quality Committee had reviewed some early models earlier this week.<br>- the continuing growth in demand illustrated by the Trust now receiving more two week wait referrals than Imperial. He noted that, of the ten busiest days since the merger, eight had been in the last three months. A&E had had its second busiest day ever earlier this week. The Trust was alert to the impact of such increasing demand. |

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| | - strong performance by inpatient departments as regards the Friends and Family Test<br>- the Trust missing the diagnostic standards in May and June by a handful of patients. He confirmed that the Trust should be in compliance by July.<br><br>JJ reminded the Board that points of details could always be raised with RH directly as the IPR was a document rich in data.<br><br>**2.4.1 Workforce performance report.** SE presented the workforce report noting that it now included SPC charts to assist with interrogation of the data. She alerted the Board to:<br>- Trust performance in meeting mandatory training targets, where performance was at 90% in June.<br>- Sickness rates which showed a six-month downward trend. The chart showed that there had been significant increase at the point where the Trust had improved its approach to sickness reporting and the executive were now confident that reporting rates were accurate.<br>- Turnover statistics where figures were improving but more work was still required<br>- Vacancy rates where HR and finance had worked together to confirm the correct establishment figures.<br><br>SG commended the team on the introduction of SPC charts which helped to provide a much richer narrative than raw data alone. As Chair of the Performance and Organisation Development Committee (PODC), he informed the Board that the workforce report was being redesigned so that better information could be provided which would help the organisation to take action.<br><br>JJ asked about voluntary leavers, noting that 804 out of 1000 leavers over the past 12 months had been voluntary. SE explained that the Trust runs a leavers' survey, and offers face to face interviews, and that analysis was due to be reviewed by PODC which would in turn feed into the retention strategy. Work was underway to improve response rates to the survey. EH agreed how important it was for PODC to interrogate this metric. SE noted the irony in positive staff survey results and the rate of voluntary turnover. JJ requested that a paper on this subject return to Board once PODC had had chance to review the subject.<br><br>**Action: Deep dive into staff turnover to be scheduled for discussion at a future Board strategy session.**<br><br>LW reflected that great progress in the HR work stream has been made under SE and PN leadership with mandatory training rates the best they have been for ten years. |
| 2.5 | **Reducing sugar sweetened beverages declaration**<br><br>KMO reported on the progress being made by the Trust on an NHS England initiative to try and reduce the sale the sugar sweetened beverages on NHS premises. This initiative has a Commissioning for Quality and Innovation (CQUINs) payment attached to it.<br><br>The Board noted the report. |
| **3.0** | **PEOPLE** |
| 3.1 | **Gender pay** |

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| | SE presented analysis and actions arising from the Trust's gender pay gap report, published in March 2018. The analysis had been broken down by staff group to aid understanding. A number of internal discussions had already taken place on the paper, including at Partnership Forum and with Trade Unions. SE was also due to meet the Chair of the Trust's Women's Group.<br><br>Two clear areas for investigation had been identified:<br>- How to ensure the integrity of Agenda for Change when staff move roles<br>- Making sure the composition to the Clinical Excellence Awards panel was as diverse as it could be.<br><br>The Board discussed the drivers behind the Trust's gender pay gap, noting:<br>- the prevalence of senior men with long tenure in the medical workforce as a key contributing factor<br>- The impact of Clinical Excellence Awards<br>- The need to consider factors other than gender when considering fair pay.<br><br>**Action: Update on actions on gender pay to return to the Board in the Autumn, after PODC consideration, and then in six months**. |
| **4.0** | **GOVERNANCE** |
| 4.1 | **People and OD Committee Terms of Reference**<br><br>The Board approved the revised Terms of Reference. |
| 4.2 | **Annual report on the use of the Company Seal**<br><br>The Board noted the report on the use of the Company Seal. |
| 4.3 | **Updated Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers**<br><br>The Board noted that the updated documents had been scrutinised by the Audit and Risk Committee and that a more comprehensive review was due imminently. The Board approved the amended documents. |
| **5.0** | **ITEMS FOR INFORMATION** |
| 4.1 | **Questions from members of the public**<br><br>**Governor Kush Kanodia** congratulated the Trust on behalf of the Governors for the performance levels delivered, noting how appropriate it was to do so on the 70th Birthday of the NHS. He asked what measures the Trust has in place to help staff survive and flourish and to avoid compassion fatigue.<br><br>LW agreed with the importance of this question, stressing how essential supporting staff with their health and well-being was to the Trust. The ward accreditation process helped to systematically |

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| | assess the atmosphere on wards and weekly ward rounds also sought feedback from staff. She was pleased to find that the atmosphere was positive around the Trust and that commitment to health and well-being had been included in recent team briefs. She confirmed that this was an area of focus for the Trust. RH added that the work of the Communications Team had really helped to maintain a positive environment with success acknowledged and celebrated. PN confirmed that nearly 500 staff had received resilience training.<br><br>JJ thanked KK for the question, noting that health and well-being had been added explicitly to the revised Terms of Reference for PODC and that the Board at its recent away day had spent considerable time on workforce matters.<br><br>**Governor Fiona O'Farrell** asked what measures the Trust had in place to regulate the temperature on wards for patients. KMO advised that whilst this Trust did have a number of more modern buildings than many others, regulating the temperature on the hottest of days still represented a challenge. Where necessary mobile air conditioning units were brought in, and fans (although the latter presented infection control risks and could not be used in every environment. PN confirmed that bespoke heat plans were in place for different wards. Patients were able to feedback on temperature through the wards.<br><br>**A member of the public, Peter Bell**, asked questions addressing the following matters:<br>- Why he had not received a response to his emails to the Trust in May suggesting improvements to the way public Board meetings were arranged<br>- Why members of the public were not asked for comments on items during the course of the meeting<br>- What the Trust was doing to capture improvement ideas from patients along with clinicians<br><br>JM responded to the first point, noting that his emails had been acknowledged by the Board Governance Manager and apologising if there had been confusion on that point. His suggestions for improvements were helpful and some would be actioned.<br><br>JJ responded to the second point, noting that it was this Trust's practice to invite questions at the end of the meeting rather than during discussion.<br><br>LW responded to the final point, pointing to the patient experience story that had been on the agenda today as a pertinent example of the way the Trust engages with the public, patients and carers to improve services. Other examples, such as the project to improve mouth care, had also been inspired by patient feedback. PN noted that there had been three co-design workshops, including one on mental health, in the past month. The Trust also participated in 'Whose Shoes' workshops which involved staff and service users. JJ remarked on the 4000 staff trained, in part, by a carer, mentioned earlier in the meeting.<br><br>**Governor Fiona O'Farrell** asked the Trust to bear in mind that a number of people were not users of social media. GH acknowledged the point and confirmed that the Trust uses a variety of media to reach out to the public including the press. There was a desire to reach out as widely as possible. |
| 5.2 | **Any other business**<br><br>JJ closed the meeting by asking the Board to join him in congratulating Lesley Watts who had been named as one of the top 70 women leaders in the NHS. |

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| 5.3 | **Date of next meeting** – 6 September 2018 |

Meeting closed at 12.30

**Trust Board Public – 5 July 2018 Action Log**

| Meeting Date | Minute number | Subject matter | Action | Lead | Outcome/latest update on action status |
|---|---|---|---|---|---|
| 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.<br>Action: VD to add to PODC and Board forward plan. | VD | Update provided to July PODC. |
| | | Communication update to Non-Executive Directors | Action: GH to consider best approach to routine updating of non-executives. | GH | A monthly updates will be circulated to the Non-Executive Directors. |
| | 1.6 | CEO Report - External initiatives and partnerships: | Action: NWLP report to be added to FIC September agenda and Board November agenda. | JM | Complete. |
| | 2.2 | Quality improvement | Action: PN/GH to consider whether a more compelling narrative can be built around the improvement programme and to update the Board at the next meeting. | PN/GH | Verbal update. |
| | 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 will be put on forward plan. |
| | 3.1 | Gender pay | Action: Update on actions on gender pay to return to the Board in the Autumn, after PODC consideration, and then in six months. | SE/VD | This will be put on forward plan. |

| | | | | | |
|---|---|---|---|---|---|
| 01.03.18 | 2.2 | Integrated Performance Report | Action: SE and Company Secretary to review Committee meeting scheduling from 2019. | SE/JM | Complete. |
| | 2.2.1 | Workforce performance report | Action: Equality data for qualified nurses and midwives promotion, and access to training, to be reviewed by PODCom and a report brought to the Board in six months. | SE | Equality report to be on PODC forward plan. |
| | | | Action: Staff career development tables to also include breakdown by gender. | SE | This is under review. |
| | | 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, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 1.5/Sep/18 |
| **REPORT NAME** | Chairman's Report |
| **AUTHOR** | Sir Thomas Hughes-Hallett, Chairman |
| **LEAD** | Sir Thomas Hughes-Hallett, Chairman |
| **PURPOSE** | To provide an update to the Public Board on high-level Trust affairs. |
| **SUMMARY OF REPORT** | As described within the appended paper.<br><br>Board members are invited to ask questions on the content of the report. |
| **KEY RISKS ASSOCIATED** | None |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | None |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | NA |
| **DECISION/ ACTION** | This paper is submitted for the Board's information. |

**Chairman's Report**
**September 2018**

## 1.0 NED re-appointment and succession planning

I was delighted that the Council of Governors (CoG) agreed to reappoint Nick Gash for a second three-year term at their meeting on 26 July 2018. Nick's second term will run from 1 November 2018 to 31 October 2021.

As was also reported at the July CoG meeting, plans to identify my successor are also beginning to be developed by the Council of Governors' non-executive Nomination and Remuneration Committee, as well as the wider requirements for non-executive director succession planning.

## 2.0 Staff Awards

Members of the Board have been spending recent weeks considering nominations for the annual staff awards, kindly sponsored by CW+. This is always an uplifting experience and we have been delighted that the number of nominations has been greater than ever.

## 3.0 Non-executive directors' and Chief Executive's annual appraisals

I have used the summer months to complete the appraisals of all of our non-executive directors as well as of our Chief Executive. It was a pleasure to be able to discuss the contribution of all my most senior colleagues, to thank them for their great commitment and to agree their priorities for the year to come.

Following these discussions, we will be making some minor changes to the composition of our Board committees which will be brought to the Public Board for information.

## 4.0 Strategic planning

Informed by the output of the Board's awayday in June, we will be discussing our future strategy over the coming months and I have spent time during the summer with the CEO and my Vice-Chair, Jeremy Jensen, agreeing how we will set about prioritising and evolving our existing strategy to underpin the work of our Foundation Trust in the longer term. We will be spending time in November with our Council of Governors to shape this.

## 5.0 Internal and external engagements

Since the last Board meeting (5 July2018) I have undertaken the following engagements:

- 1 August – CEO Appraisal
- 17 August – Volunteer of the Year award judging
- 20 August – Lifetime Achievement award judging
- 23 August – Catch-up with Neil Churchill – Head of Patient Experience – NHSE

## 6.0 NExT Director scheme

Finally, this will be the last Board meeting to be attended by Renuka Jeyarajah-Dent before her placement with us ends on 30 September. Renuka has been taking part in NHS Improvement's NExT

Director scheme, which is designed to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS. Renuka has added a fresh perspective to Board and Committee discussion and we wish her well - she has made many helpful contributions to our Board in her time with us.

**Sir Thomas Hughes-Hallett**
Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Board of Directors Meeting, 6 September 2018** **PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 1.6/Sept/18 |
| **REPORT NAME** | Chief Executive's Report |
| **AUTHOR** | Karl Munslow Ong, Deputy Chief Executive Officer |
| **LEAD** | Lesley Watts, Chief Executive Officer |
| **PURPOSE** | To provide an update to the Public Board on high-level Trust affairs. |
| **SUMMARY OF REPORT** | As described within the appended paper.<br><br>Board members are invited to ask questions on the content of the report. |
| **KEY RISKS ASSOCIATED** | None. |
| **FINANCIAL IMPLICATIONS** | None. |
| **QUALITY IMPLICATIONS** | None. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None. |
| **LINK TO OBJECTIVES** | NA |
| **DECISION/ ACTION** | This paper is submitted for the Board's information. |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Chief Executive's Report**

**September 2017**

## 1.0 Performance

June and July saw continued growth in non-elective demand and increased operational challenges following the implementation of the new Cerner EPR at our West Middlesex Site. Despite these challenges both of our sites continue to respond well and we continue to deliver on the A&E waiting time standard (the best performing Trust in London) and the Referral to Treatment incomplete target was achieved on both sites. Also, as a Trust we were compliant with all reportable Cancer Indicators other than the 2 week wait (2ww) for Breast Symptomatic. Our 6ww Diagnostic position has returned back to a compliant position for both June and July. Overall, this is a fantastic achievement and demonstrates the amazing efforts of all of our staff to ensure we give our patients the very best, timely care. This was echoed by the Secretary of State himself, when he visited last week.

## 2.0 Divisional Changes

Following discussions at Executive level and with the Divisional Management teams we have taken the decision to create a fourth division with appropriate management support to ensure the continued delivery of high quality services across the Trust. In the last 3 years the Trust has experienced significant growth, and in particular an increase in cancer referrals and non-elective demand. Consequently, the increase in activity is felt none more so than within the clinical support specialties. Additionally, a range of recruitment and other operational challenges, e.g. non-compliance with the Diagnostic 6 week standard, now require a much greater degree of focus and support, hence the proposal to create a 4th Division which aims to co-locate the clinical support services under a single Divisional leadership structure. It is not proposed to lose any of the current management structure - some managers and professional leads will report to new line managers as a result transfer from either the Planned Care or Emergency & Integrated Medical Care Divisions to the new Division.

After an extensive recruitment process for a Divisional Director of Operations, we have successfully appointed Tara Argent and she will be taking up her post in early November. The next stage of the recruitment process is to recruit a Divisional Medical Director and Head of Professions role along with the supporting roles for Finance, HR, information and Governance.

## 3.0 Staff Achievements and Awards

<u>Celebrating our staff – long service awards</u>
In May, we recognised staff with 25 years or more 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 11th, 25th and 26th September we will be holding similar awards at Chelsea, West Mid and Harbour Yard for the corporate division as well as our contracted staff.

Staff awards

Our internal annual staff awards will take place on 18 October. This year we have received significantly more nominations – 794 compared to 491 last year. Judging has taken place and the shortlisted staff will be invited to the awards ceremony which will be at Rooms on Regents Park, following positive feedback on the venue last year.

Celebrating our history – NHS70

On 5 July we celebrated 70 years of the NHS with tea parties/mini open days at both sites with staff treated to cakes and refreshments. Local school children performed songs and read out poems they had written especially for the event. At Chelsea we officially launched the Critical Care project. A fully restored vintage ambulance at West Mid attracted lots of interest and local media coverage. Both events generated very significant social media engagement.

Our latest CW+ PROUD award winners:

- **Emergency and Integrated Care:** Khurram Aleem, service manager, and Sohib Ali, assistant service manager, Wed Mid site
- **Women and Children's:** Ria Vernon, maternity IMIT specialist, and Sakin Syed, assistant patient administrator, Chelsea site
- **Planned Care:** Richmond ward staff team, West Mid site
- **Corporate:** Postgraduate team across site

External recognition:

- **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

- **The Finance team** has been shortlisted for the Finance for the Future Awards. Winners will be announced at the awards ceremony held at The Banking Hall in London on Tuesday, 16 October 2018

**The Trust** has been shortlisted in the first Nursing Times Workforce Awards as the 'Best place to work for employee satisfaction' with the awards taking place on 4 October.

## 4.0 Communications and Engagement

Current key communication areas include:

- Critical Care project – construction now underway
- Winter including staff flu immunisation – launching in September
- Patient flow
- NHS staff survey – launching in September
- Volunteering

Press coverage

- NHS70 celebrations - Sky broadcast live throughout their flagship breakfast show, Sunrise, from the Queen Mary Maternity Unit. ITV news story from NICU at Chelsea on a former paediatric patient reuniting with the staff member who cared for her. The Times mentioned the Trust as the only hospital to hit all three key targets for cancer, A&E and surgery over the past year. There has been significant VIP engagement including Amanda Holden, who was interviewed during the Sky Sunrise

programme talking about her positive experiences of our maternity service, Sarah-Jane Mee (Sky Sunrise presenter), Georgia Jones (former Miss England) and Izzy Judd (celebrity wife and violinist)

- New Secretary of State for Health – extensive coverage following Matt Hancock's overnight shift at Chelsea hospital, which he shared on social media across Twitter and Facebook
- BBC Breakfast three-part series looking back at the heat wave due to broadcast in early September. We feature in the health section with a focus on maternity
- Katie Gee, five years on. Positive media for the burns unit in the Mail on Sunday (printed and online) as well as The Sun, Victoria Derbyshire etc
- Kensington Wing - coverage in Evening Standard (print and online) by journalist and expectant mum who is chronicling her pregnancy

Internal communications / ongoing activity

Our new internal communications tool, Poppulo, has received positive feedback and 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.

Planning for the next edition of the Trust magazine Going Beyond is underway, which will be timed to include a feature on our staff awards.

Following a summer break our monthly all staff briefings will recommence in September, covering the critical care project, grants and innovation programme, NHS 100 day challenge and our annual report. 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.

Other key events

- Kobler Clinic 30th anniversary – 13 September CW+ event, 14 September Kobler event
- Annual Members Meeting – 27 September
- 15 year anniversary of the redevelopment of West Mid hospital – 19 November

Social media

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

- **#CriticalCareCW –** video with senior sister Charlie Brown and ongoing positive content about the project
- **Why it's great to work in HR** – new staff video produced
- **Thank you to finance** – new video produced by Sandra Easton to recognise and thank the finance team for their recent achievements
- **#WorldBreastfeedingWeek** – video from our NICU nurse encouraging mums to breastfeed
- **#PerfectDay** – continued coverage of Perfect Day focusing on the different divisions

Together with our tweets, these generated significant engagements - we reached more than 390,000 social media users with 15,000 interactions in a 28-day period. This continues our upward trend with a peak at the end of July as we welcomed our junior doctors and promoted heatwave messaging, made possible by video content, celebrity endorsement and good staff engagement.
Our program of revamping key pages on the website is ongoing in line with demand and divisional priorities.

**5.0 NHS 10 Year Plan**

NHS England and NHS Improvement have published a briefing document outlining how the long term plan for the NHS will be developed. Broadly this will be the response to the Prime Minister's commitment to a "sustainable long term plan" for the NHS backed by "a multi-year funding settlement". This has been reviewed by the Executive and we have noted:

- Designated priorities of Life Course Programmes; Cancer; Cardio-vascular; mental health and 'enabler programmes'
- Likely short term 'system tests' around sustainability such as managing provider deficits and "getting back on the path to delivering agreed performance standards" – locking in and further building on the recent progress made in the safety and quality of care
- Possible replacement of Control Totals with a new financial architecture from April 2019 (NHSI have commented that the current approach to control totals encourages non-recurrent savings rather than a focus on underlying financial sustainability)
- A short 'Task & Finish' approach which will align development of the 10 Year Plan with current timetable for system guidance. It is expected that the plan will be published in early November. Following this NHS England and NHS Improvement will establish the NHS Assembly to oversee the delivery of the plan

The Executive will continue to monitor this to ensure coherence with the refresh of the Quality and Clinical Services Strategy and our overarching Strategy Development.

**6.0 St Stephen's Aids Trust**

We are continuing to work with St Stephen's Aids Trust (SSAT) as they look to wind down both the charity and research company (St Stephen's Clinical Research) and ensure the legacy of 30 years of pioneering research in sexual health. We are supporting CW+ who will be taking on as much of SSAT's existing research and charitable commitments. It is anticipated that this transition period will be completed over the next month or so.

**7.0 Pay Awards**

We are delighted to announce that the NHS Staff Council has reached agreement on a refresh of the NHS Terms and Conditions of Service (Agenda for Change) and following a consultation exercise, trade union members have voted to accept the proposed changes.

This will result in a three year pay deal, as well as the reform of the pay structure and changes to terms and conditions. The keys changes are as follows:

- Starting salaries increased across all pay bands

- New pay structure with fewer pay points—overlapping pay points removed initially followed by further pay points
- New system of pay progression
- Top of pay bands to be increased by 6.5 per cent over the three years (apart from band 8d and 9 which will be capped at the increase of Band 8c)
- Minimum rate of pay in the NHS to be set at £17,460 from 1 April 2018—ahead of the Living Wage Foundation Living Wage rates

There is further work being undertaken in relation to performance related pay progression and other terms and conditions which we will keep you up-dated on as this progresses.

**8.0 Volunteers**

Good progress continues in line with the Trust Volunteering Strategy. We have appointed a full time volunteer service manager to commence in November 2018 and substantive admin support to the team with a specific focus on the recruitment process. The team have recruited an additional 160 volunteers to the end of June 2018 who are regularly providing support in a growing number of wards and departments bringing the total number of volunteers to approximately 450 - The Trust is in line to meet its ambitious target of 900 volunteer by 2020. The introduction of the new volunteer management system (Better Impact) will assist with real time information on volunteer activity and a clear understanding of the number of active volunteers across the organisation.

The Helpforce bleep volunteer project continues to progress at the CW site and is currently being evaluated prior to planned roll out at the West Mid (WM) site. The Pears young person project at the WM site which sees young people (aged 16-25) provide befriending service to older patients has begun and successfully recruited the first 36 volunteers from local schools and colleges. In addition, volunteers are increasing their support to wards. The role profiles developed for volunteering include ward based help, befriending, administrative support and a range of other activities. A full report on progress with the Volunteering Service will come to the Trust Board in November.

**9.0 Strategic Partnerships Update**

<u>Sensyne Health</u>

The Board approved entry into a partnership with Sensyne Health (formerly Drayson Health) at its special meeting on 25 July. The underpinning Strategic Research Agreement (SRA) will allow the analysis of anonymised patient data using clinical artificial intelligence (Clinical AI) technology and consolidation with other partner Trusts into aggregated datasets. The agreement also includes a funded research collaboration between the parties in digital health and biomedical research. The purpose of the research is to derive new insights that will improve the care of the Trust's patients and help to find new treatments - This is in line with the Trust's vision of developing an organisation driven by research, innovation and discovery.

The Executive have taken forward a number of actions to conclude the mechanics and contractual steps of the partnership. The formal Strategic Research Agreement and other supporting documentation have been signed and we have also entered the Subscription Agreement which has confirmed our entitlement to a £5m equity share in the new company, which was accepted onto the Alternative Investment Market (AIM) on 17 August.

The Executive have also taken steps to establish an Operations and Oversight Group who will:

- Act as owners of the relationship and process with Sensyne including:
    - Our role as Data Controller
    - Assurance of submission of datasets to consolidated dataset
- Support our participation in Trust User Group
- Fulfill the required Clinical Oversight and Purpose function indicated to Board
- Provide assurance in respect of legislative and regulatory compliance (eg Caldicott) and lessons learnt from the ICO review and recent audit report
- Recommend the deployment of resource provided through the Strategic Research Agreement
- Provide clinical and managerial oversight and
- Account to the Trust Innovations Board which is the forum for similar research and digitally driven developments. The Board assurance process will be to Executive Management Board and to Finance & Investment Committee

Royal Brompton Hospital

We have continued our work with Imperial College, Imperial College Health Care 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 are told that NHSE are "currently working through our hurdle and evaluation criteria" and that "specifics of how the consultation will be run have not as yet been hammered out". Despite some of this uncertainty we have been given a deadline of November to provide an alternative outline option for this consultation.

The collaborative have set ourselves three overall aims:

1. To ensure proposals deliver improved overall outcomes for our patients and public
2. Provide a credible alternative option to the current RBH proposal which aligns with the long-term strategy of the NWL health and academic sectors
3. To ensure that receipts from estate changes represent the best possible value to the taxpayer

All partners are committed to supporting the option that provides the best overall services outcomes and value for money for NHS patients and taxpayers irrespective of current organisational boundaries. If this is ultimately found to be the RBH proposal we will offer it our full support but we believe the only way to judge this is for there to be a proper, transparent and balanced consideration of the options.

Whilst work continues to develop an alternative option, NW London partners are clear that there will be some unique elements to our offer on contrast to that of the RBH and GSTT proposition. This would include:

- Ability to maintain existing clinical networks and interdependencies with other services developed over 100 years of collaboration within North West London
- Integration with high quality, local acute and community services run by ICHT and ChelWest
- Better access for the large numbers of NWL patients who need to travel from outer North West London.
- Potential to create better value for money by avoiding the need for complete new build facilities. Our approach will focus on the vision for future services rather than the need for a new facility.
- Ability to co-locate a broader range of specialist services than on the Evelina site.
- Full involvement and support of Imperial College

Applied Research Collaboration (ARC) Application

The National Institute for Health Research (NIHR) has launched a new, single-stage, open competition to designate and fund NIHR Applied Research Collaborations (NIHR ARCs) nationally. NIHR ARCs will undertake high-quality applied health and care research, work across local health and care systems to support implementation of research, and will work collectively to ensure national impact.
This follows the previous designation and funding of 13 Collaboration for Leadership in Applied Health Research and Care (CLAHRCs) initiatives nationally. North West London was a designated centre which is hosted by the Trust on behalf of our partners. The current CLAHRC contracts come to an end on 30 September 2019 and as a result NW London has collectively developed and recently submitted a bid to be one of the new designated ARCs.

The NIHR is evolving their approach to supporting applied health and care research, addressing a number of identified needs as highlighted by the Future of Health and other reports, including: the need to increase research in public health, social care and primary care; the challenges of an ageing society; multimorbidity; and the increasing demands placed on our health and care system.

RM Partners

The attached report (appendix 1) provides the Board with an update on the Trust's work as part of RM Partners (RMP), the Cancer Alliance for west London.

**10.0 Finance**

At the end of July, month 4, our year to date adjusted position is a surplus of £1.3m which is in line with plan. Pay costs are £4.7m adverse to plan offset, in part, by underspends in non-pay.

We have achieved 73% 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.

**Lesley Watts**
Chief Executive Officer
September 2018

# All staff briefing

July 2018

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

## Celebrating 70 years of the

On Thursday 5 July, we'll be joining NHS organisations across the country to celebrate the proud 70-year history of the NHS, with mini open days at both sites. We're inviting staff to raise a cuppa and enjoy the big7tea with tea, cake, special performances and some of our favourite visitors, our therapy dogs. There will be stalls on recruitment, innovation and improvement, our Critical Care Development at the Chelsea site, and the CW+ Suns and Stars appeal at West Mid. Our CEO Lesley Watts will also be announcing special NHS70 CW+ PROUD award winners, with activities taking place in the morning at West Mid and in the afternoon at Chelsea.

## Care Quality Programme (CQP) and Care Quality Commission (CQC)

Our quality improvement work with the CQC continues - this summer there will be further inspection visits to both main sites. It is understood this will focus on maternity, gynaecology, critical care, diagnostics and imaging; also to sexual health and HIV services at main sites and off-site locations. **These visits will be unannounced**.
To support this work, the CQP team are working with key leads and staff in the areas concerned. If you work in any of the areas listed, link with your manager to understand your role in working with on-going quality improvement and working with the CQC during an inspection.
Further information is available on the intranet page, http://connect/departments-and-mini-sites/cqp/ or email cqp@chelwest.nhs.uk. The staff handbook is helpful in explaining your role and can also be found on the intranet.
Recent ward and department accreditation activity has been focussed on the services listed above. This work is assisting the clinical areas' understanding of areas of outstanding practice and areas that need further on-going quality improvement. If you have not been an assessor in the ward and department accreditation teams that review our clinical services, please get involved. The teams are accrediting some of the clinical areas on the next Perfect Day on 27th July. Contact: warddepartment.accredation@chelwest.nhs.uk

## Financial performance

At the end of May, month 2, our year to date adjusted position is a deficit of £1.14m which is to £0.32m adverse to the internal plan. Pay costs are over plan by £2.6m offset, in part, by underspends in non-pay and revenue in excess of plan.
We had planned to achieve 10% of our savings target for 2018/19 of £25.1m by the end of month 2 but actually achieved 9%. We will be focusing on getting our CIP delivery back on plan and to ensure we achieve our yearend target.

## Mandatory and statutory training

The Trust has achieved its coverall compliance target of 90% with three of the Divisions having surpassed this figure. More work is needed on Information Governance compliance which has a Trust target of 95% - it currently stands at 90% overall.

The new QlikView reporting platform was launched on 2nd April, providing staff and managers easy access to their compliance status. The new platform also displays competence expiry dates, allowing managers / staff to plan ahead to ensure their compliances do not lapse.

Staff are reminded they are responsible for ensuring they are up to date with their mandatory and statutory training, and managers will ensure their staff have this in hand.

The current compliance figures (as at 19th June) are as follows:

| Division | Compliance |
|---|---|
| Corporate | **95%** |
| Emergency and Integrated Care | **89%** |
| Planned Care | **91%** |
| Women, Neonatal, Children, Young People, HIV/Sexual Health | **92%** |
| **Overall compliance** | **91%** |

Work is currently on-going to review all other mandatory training requirements, which will then be mapped within ESR to all positions within the Trust to provide better clarity for staff regarding their training requirements.

The learning.chelwest system was unavailable for 5 days towards the end of June for emergency maintenance.

## Two months of Cerner EPR

Thank you so much to all of the admin teams and all of the clinicians for making such a big effort to get the new system up and running, and to make it as seamless as we could for patients over the first two months.

Please keep logging issues and suggesting updates and improvements so that we can make the new system work for us in the best possible way.

## Latest CW+ PROUD award winners

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

- Planned Care: **Miriam Segawa**, Sister, Outpatients (C&WH)
- Emergency and Integrated Care: **Dr Cerys Morgan**, Specialty Registrar (C&WH)
- Women and Children: **Marina Wingham,** Matron, Maternity (WHUH)
- Corporate: **Iheoma Asoluka**, Receptionist, C&WH, and **Lisa Macey**, HR Service Centre Manager, **HY**

Visit the intranet to nominate a team or individual.

### September *All Staff Briefing*:

(Please note that there will be no August sessions)

- Tue 4 September, 10-11am - Meeting Room A, WMUH
- Thu 6 September, 10-11am - Harbour Yard
- Thu 6 September, 1-2pm - C&WH

RM Partners
Accountable Cancer Network

NHS

# RM Partners Update

## Executive summary

This report provides the Board with an update on the Trust's work as part of RM Partners (RMP), the Cancer Alliance for west London. The Trust has played a key role in improving outcomes and working in partnership to deliver sector wide operational performance and transformation in cancer services.

2017/18 was an exciting year in which RMP transitioned from being one part of the national Cancer Vanguard to becoming one of the 19 Cancer Alliances across England. Serving a population of over 3.9m, we have had some significant successes, and overall our population has the highest one year cancer survival rate of any Alliance in the country. Building on this success, and using our nationally acclaimed analytics, we are identifying further areas of work to reduce variation in outcomes and access, in order to continue to improve survival and quality of life for our population.

The Trust has received support to maintain Trust cancer operational performance in both prostate and colorectal pathways. During 2018/19, it will also implement the RMP new colorectal diagnostic service. Trust patients are also participating in world leading clinical trials, such as our NICE FIT (National Institute for Health and Care Excellence, Faecal Immunochemical Test). The research study, the largest in England, examines the effectiveness of FIT, an innovative non-invasive test, in ruling out bowel cancer, reducing the need for patients to have unpleasant and invasive colonoscopies. Through trials like this, Chelsea and Westminster Hospital NHS Foundation Trust (CWH) clinicians and patients have the opportunity to contribute to important national research programmes, improving outcomes for future generations.

## Background

CWH Trust is a partner in RM Partners, the Cancer Alliance across west London, hosted by The Royal Marsden. Over the last two years, RMP has partnered with colleagues in University College London Hospitals Cancer Collaborative and Greater Manchester Cancer Vanguard Innovation as part of the Cancer Vanguard to trial new technologies and new ways of working to improve cancer outcomes. RMP has built further on these strong relationships in west London to ensure that cancer priorities are aligned across stakeholders in our geography. Our successful bid for transformation funding in March 2017 has secured more than £20m of ring-fenced money over a two year period to improve and provide earlier and faster diagnosis for our cancer patients.

Together we are working to improve outcomes for all our population, using data to identify opportunities to reduce variation and transform pathways. Our model is one of collaborative working and putting patients first. Patient engagement is at the heart of all our work, with an engaged and dedicated Patient Advisory Group, who guide and shape our overall programme and provide targeted input to all our projects. The Clinical Oversight Group includes experts and professionals from cancer and research, drawn from across our geography, to advise on best practice and drive innovation. The programme of work is implemented through project teams made up of subject matter experts, clinicians, managers and commissioners. Our work is overseen by RMP's Executive Group, made up of 10 acute Trust Chief Executives, alongside commissioners and primary care leads.

As an established Cancer Alliance with a track record of delivery, we contribute to the National Cancer Programme and support other emerging Alliances by sharing our work and learning. The aim over the coming years is to continue to deliver our vision of working in partnership to achieve world-class cancer outcomes for the population we serve.

## RM Partners Wide Progress 2017/18

2017/18 has been an eventful year for RM Partners. We have been working together to sustain and improve on our operational performance, supported by an investment in diagnostic capacity, alongside transforming key pathways. We have set up over 20 projects, spanning all of our partner Trusts and CCGs.

**Successes to date**

- Number one ranked Cancer Alliance for one year survival
- Number one ranked Cancer Alliance in Q3 for system delivery of 62 day standard
- One of the few Cancer Alliances to secure early diagnosis cancer transformation funding for both 17/18 and 18/19
- Circa 2,800 patients through our redesigned colorectal diagnostic pathway pilot
- Over 25 hospitals across England recruiting to our NICE FIT research study, and nearly 1,600 patients returned FIT tests
- Over 570 patients seen by the RAPID prostate pathway, in three hospitals sites
- Over 30 cancers identified through multi diagnostic clinics (MDC) pilots at Croydon, Epsom and St George's hospitals
- Over 70% of patients having an Holistic Needs Assessment (HNA) within 31 days of diagnosis in Q2
- Our biosimilar web-based education tool contributed to over 80% of Trusts in England switching to bioisimilar rituximab, saving the NHS around £80m in just six months
- More than 40 pathway group meetings held in west London
- Around 7,000 responses from patients through our patient experience feedback tool
- 17 enthusiastic volunteers joined our Patient Advisory Group
- Over 7,300 downloads from our informatics cloud
- Leading the national design of a new oesophageal pathway
- Working to implement the National Optimal Lung Cancer Pathway
- One of the first Cancer Alliances to trial low dose CT scans to find cases of lung cancer
- Shaping an innovative Radiology Reporting Network

## CWH Specific Programmes and Achievements

The Trust has been pivotal to the achievements in redesigning a number of high volume cancer pathways, ensuring that patients benefit from the latest technologies and innovations available in diagnostics and treatment. These include:

- CWH has received support to maintain the Trusts operational performance in both the prostate and colorectal pathways
- Working with RM Partners gives CWH's patients access to world-leading clinical trials, such as NICE FIT. Through trials like this, CWH's clinicians and patients have the opportunity to contribute to important national research programmes, improving outcomes for future generations.
- Significant investment to support diagnostic services supported the Trust to continue to deliver faster diagnosis at the front end of patients' cancer 62 day pathways.
- During 2018/19, CWH will launch RMP's new colorectal diagnostic pathway. In this service, specialist nurses work to an algorithm to support patients and ensure they have the most appropriate diagnostic test. The new pathway improves patient experience, allows a speedier diagnosis, and avoids unnecessary invasive tests.

## Priorities for 2018/19

We have a busy work plan for 2018/19, with a number of exciting developments on the horizon. We are delivering year two of our transformation programme whilst continuing to support Trusts with the operational delivery of their constitutional cancer targets. The majority of our work will be to improve early diagnosis (ED), with continued focus on piloting and roll out of rapid diagnostic models for prostate, lung, colorectal. We will also be one of the first Cancer Alliances to pilot low dose CT scanning in CCGs where survival rates are lowest, to identify cases of lung cancer early. We are leading a new Radiology Reporting Network, increasing uptake of bowel and cervical screening. Our work with primary care clinicians, including GP education and training, digital solutions and redesigned and more streamline referral routes, all support our aim to diagnose cancers earlier in our population.

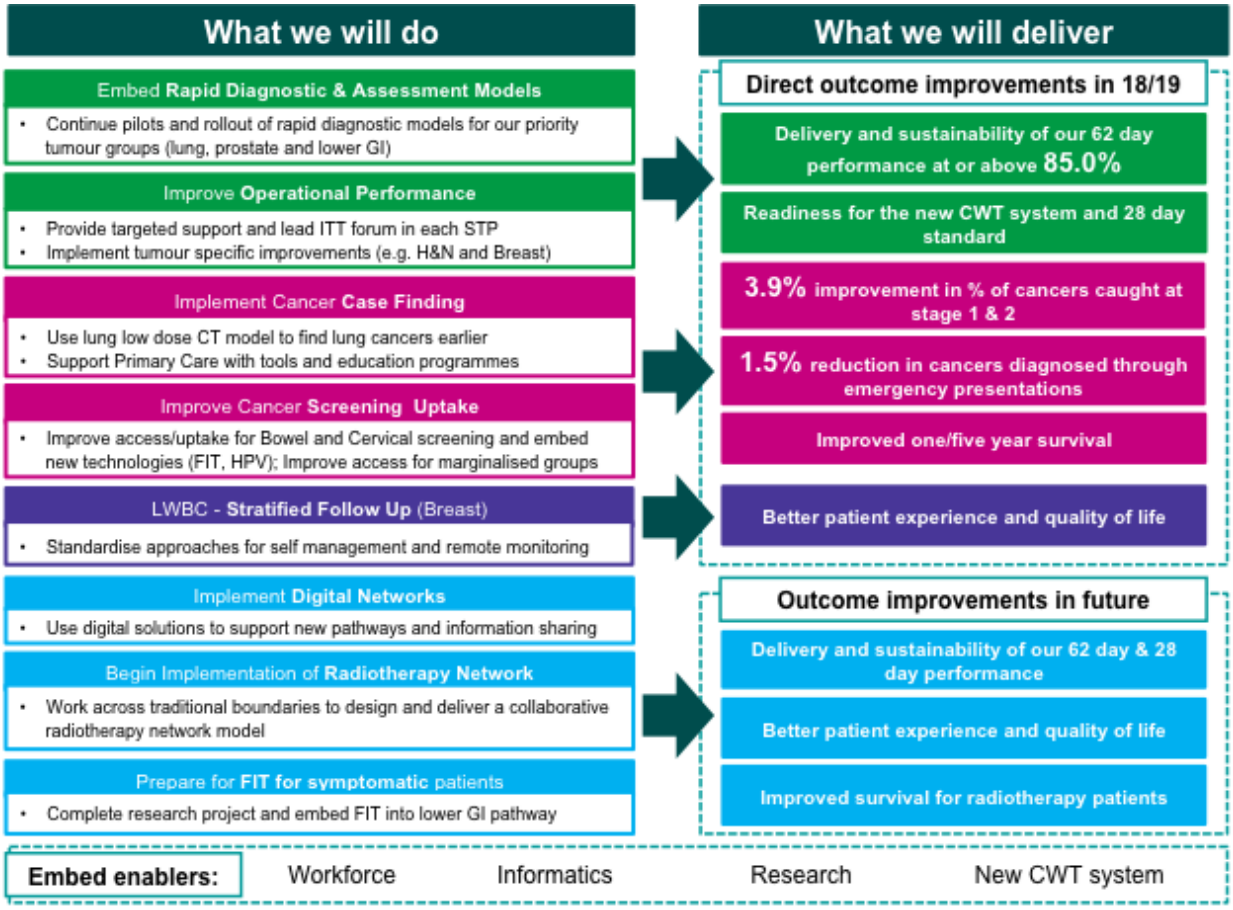
Underpinning this work, we have an active and committed research and innovation strategy, translating cutting edge technologies for our patients as quickly as possible. We are privileged to benefit from the research expertise at our host Trust, The Royal Marsden, and across our Academic Health Science Centre partners. The NICE FIT trial and RAPID prostate work would not have been possible without such close partnership working relationships between researchers, clinicians, and managers.

Working pan London we secured £2.8m of funding to improve care for those in our communities who are living with and beyond cancer. As part of this, RMP will work with individual Trusts and pan-London colleagues to implement the Recovery Package and risk-stratified follow up pathways for breast cancer patients.

Our transformation funding for Q3 and Q4 is dependent on 62 day performance across west London. RMP is facilitating its Trusts to deliver this sustainably in a number of ways, including providing targeted intensive support to Trusts where required. We are also leading on system level redesign including a head and neck task and finish group, maximising diagnostic capacity, and improving processes for the transfer of patients between Trusts. We will provide leadership in the move towards the 28 day Faster Diagnosis Standard, of which the 2018/19 deliverables include implementing a new national cancer waiting times system and the capture of new data to support the standard.

Cancer workforce will also be a key focus during 2018/19, and we are responding as a partnership to Health Education England (HEE)'s Cancer Workforce Strategy, published in December 2017. Work is already underway to support the priority professions which HEE has identified as having capacity issues over the next two years. Across RMP we are accessing education funding for reporting radiographers, and investigating innovative models of clinical mentorship. We also have projects looking at histopathology, and how to support retired consultants to continue to contribute to the NHS workforce.

The below infographic sets out our programme of work and the outcomes it will deliver:




## Recommendations

The Board is asked to:

- Note the progress in 2017/18
- Endorse the 2018/19 work programme, and support the Trust's continued contribution to delivery of the programme
- Discuss how it would like to be informed of future progress.

## Appendix

1. Cancer Scorecard May 2018

# Appendix 1:
# Cancer Scorecard May 2018

| Domain | Measure | Benchmark | Period | North West London STP | South West London STP | **RM Partners overall** | Change since last period | Providers/ sites meeting standard | CCGs meeting standard | England average | Ranking against other Alliances |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Best Practice Care | 1. 2 week wait: Urgent suspected cancer GP referral to 1st seen (Population) | 93% | March 2018 | 93.2% | 97.3% | **95.0%** | +0.5% | 9/10 | 12/14 | 93.2% | |
| | 2. 2 week wait Breast symptomatic referral to 1st seen (Population) | 93% | March 2018 | 89.4% | 97.4% | **92.4%** | +0.6% | 5/8 | 8/14 | 91.0% | |
| | 3. 62 day: Urgent suspected cancer GP referral to 1st treatment (Population) | 85% | March 2018 | 85.7% | 89.1% | **87.2%** | +3.2% | 8/10 | 11/14 | 84.5% | 4/19 |
| | 4. 62 day: Screening referral to 1st treatment (Population) | 90% | Q4 2017/18 | 81.0% | 88.5% | **84.2%** | -7.3% | 2/8 | 5/14 | 88.7% | |
| | 5. Bowel screening coverage (60-74 year olds) | 60% | May 2017 | 47.4% | 54.1% | **50.2%** | +0.3% | | 0/14 | 59.1% | 18/19 |
| | 6. Breast screening coverage (50-70 year olds) | 70% | May 2017 | 64.4% | 65.8% | **65.3%** | +.0.2% | | 1/14 | 72.3% | 18/19 |
| | 7. Cervical screening coverage (25-64 year olds) | 80% | May 2017 | 61.4% | 68.7% | **64.4%** | -0.8% | | 0/14 | 71.8% | 19/19 |
| Positive experience | 8. NCPES - Q2 – How do you feel about the time you had to wait for your 1st appointment? | England average | NCPES 2016 - Admissions Q1 2016/17 | 78.7% | 80.0% | **79.%** | +1.4% | 4/10 | 2/14 | 83.3% | 18/19 |
| | 9. NCPES – Q9 – How do you feel about the way you were told you had cancer. | | | 84.2% | 81.1% | **82.1%** | -0.6% | 6/10 | 8/14 | 84.2% | 14/19 |
| | 10. NCPES – Q59 – Overall, how would you rate your care? | | | 8.46 | 8.76 | **8.66** | +0.02 | 4/10 | 4/14 | 8.74 | 17/19 |
| Best Clinical Outcomes | 11. Proportion of cancers stage 1 or 2 (Taskforce definition) | England average | 2016 | 52.1% | 55.1% | **53.5%** | -0.4% | | 6/14 | 53.7% | 12/19 |
| | 12. Proportion of cancers stage 1 or 2 (CCG IAF definition) | England average | 2016 | 48.6% | 53.6% | **50.9%** | +1.6% | | 4/14 | 52.9% | 15/19 |
| | 13. Proportion of patients diagnosed via an emergency (population based) | England average | October 2016 to September 2017 | 20.9% | 17.0% | **19.2%** | -1.5% | | 7/14 | 19.2% | |
| | 14. 1 year cancer survival index | England average (95% CI) | 2015 | 74.6% | 74.6% | **74.6%** | +0.8/0.9 % | | | 72.3% | 1/19 |
| Quality of life | 15. Proportion of patients receiving a Holistic Needs Assessment around diagnosis | 70% | Q3 2017/18 | 64.6% | 65.8% | **65.0%** | -5.4% | 4/10 | | | |
| | 16. Proportion of patients receiving an End of Treatment Summary at end of treatment | 70% | Q3 2017/18 | 17.0% | 25.2% | **21.0%** | +5.4% | 0/10 | | | |
| Data quality | 17. % completeness of stage at diagnosis – COSD level 2 | 70% | 2017 | 54.7% | 66.3% | **60.1%** | -1.1% | 3/10 | | 57.4% | |
| | 17. % completeness of performance status – COSD level 2 | 70% | 2017 | 48.7% | 58.4% | **53.1%** | -12.6% | 4/10 | | 48.3% | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.2/Sep/18 |
| **REPORT NAME** | Freedom to Speak Up (FTSU) |
| **AUTHOR** | Vanessa Sloane, Director of Nursing |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | Annual report of Freedom to Speak Up activity giving numbers, themes and future plans.<br><br>Presenting the self-assessment tool which will be completed by the Chief Nurse with the Board. |
| **SUMMARY OF REPORT** | Numbers of concerns raised fluctuate, and there is a need for more publicity to raise awareness of the FTSU Guardian role as well as increasing numbers of champions.<br>There are common themes which triangulate with complaints and the staff survey. |
| **KEY RISKS ASSOCIATED** | The risk of staff being unaware of how to escalate concerns, particularly hard to reach groups of staff.<br><br>The risk of delay in completion of the self-assessment tool (NHSI recognise there may be delays due to the timing of publication) |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | State the main corporate objectives from the list below to which the paper relates.<br>• Excel in providing high quality, efficient clinical services<br>• Create an environment for learning, discovery and innovation |

| | |
|---|---|
| **DECISION/ ACTION** | For information & completion of self-assessment tool. |

# Freedom to Speak Up Annual Board Report

## Vanessa Sloane, Director of Nursing & Freedom to Speak Up Guardian

## September 2018

### 1. Overview

The purpose of this paper is to provide an annual report to the Trust Board in respect of our Freedom to Speak Up arrangements

### 2. Background

The NHS Contract for 2016/17 required every NHS Trust to have a Local Freedom to Speak Up Guardian (FTSUG) from 1 October 2016. Trusts were also required to have a Non-Executive Director Lead for Freedom to Speak Up.

National guidance for trust boards on Freedom to Speak Up was published by NHSI and the National Guardian's Office in early May 2018, accompanied by a self-review tool. The National Guardian's Office sits under the Care Quality Commission, and Freedom to Speak Up was assessed as part of the Well Led domain of our recent CQC inspection.

### 3. Appointment of Freedom to Speak Up Guardian

In October 2016 Vanessa Sloane, Director of Nursing, was asked to act as the Trust Freedom to Speak Up Guardian. The role specification set by the National Guardian's Office includes:

- Developing an open culture in the organisation
- Ensuring processes are in place to empower and encourage staff to speak up safely
- Delivering education on how to raise concerns and how to respond when concerns are raised
- Working with the Executive team and Board providing challenge where required
- Being available as an additional individual to whom staff can raise concerns
- Ensure staff who raise concerns are treated fairly and their concerns are investigated
- Reporting on concerns raised to the Chief Executive, Board and Executive team.

Nick Gash is our non-executive director lead for Freedom to Speak Up.

We currently also have 6 trained Freedom to Speak Up Champions in the Trust who are available to listen to concerns raised by staff, ensure appropriate action is taken to address concerns, and implement any learning arising from any concerns raised.

Our champions are from a variety of roles and sites – on West Middlesex site 2 are specialist nurses, on Chelsea & Westminster site 1 is a therapy lead, 1 is from the communications team, 1 an ODP from theatres & 1 a sister. We are still keen to expand the team of champions.

The Executive Lead for Freedom to Speak Up is Pippa Nightingale, Chief Nurse

This report covers September 2017 – August 2018.

## 4. Reporting

There is a requirement for quarterly and annual submissions to the National Guardian's office (NGO) which are submitted by Vanessa Sloane. These are then collated with other Trusts for comparison and made available on the NGO website. This allows some benchmarking of basic data, total numbers of approaches, and number by staff group.

Internal reporting is through People and Organisational Development Committee on a quarterly basis.

The FTSU Guardian and Non-Executive Lead were interviewed by the CQC as part of the Well Led Inspection.

## 5. Policy Framework

The Trust's Whistleblowing Policy was rewritten in line with the new national policy, and renamed as the Raising Concerns (Whistleblowing) Policy in July 2017. The policy is due for review in 2020 but will be regularly reviewed during this period to ensure it meets changing local and national requirements.

Information sessions have been delivered to groups of staff through induction, ward meetings and clinical governance half days. Also to new consultants through GMC led training sessions which the FTSU Guardian was invited to join.

**6. Concerns Raised through Freedom to Speak Up September 2017 – August 2018**

During the period September 2017 to August 2018 a total of 17 concerns were raised through FTSU in the organisation compared with 4 from October 2016 (when FTSU commenced in the organisation) – August 2017.
The table below shows the broad themes covered

| Theme | Number |
|---|---|
| Ways of working / practices | 7 |
| Staffing | 2 |
| Behaviour | 4 |
| Grievance | 4 |

Looking at these broad themes they do align with both our complaints / Patient feedback in terms of behaviours, and with our staff survey regarding grievances and staffing concerns. A number of concerns affect just the individual; others affect a larger team but are raised by an individual. On a small number of occasions the concerns have been raised anonymously, in these cases all bar one of the individuals raising concerns did come forwards and identify themselves to the guardian.

All concerns have been followed up and feedback is provided to the individual staff members. Of the concerns raised in the last year all are closed apart from 1 very complex case which continues to be addressed, and 3 very recent cases.

Concerns are addressed either via an investigation by a senior manager through the appropriate division or outside the division if more appropriate, or through liaison with the employee relations team to support staff where grievances or bullying and harassment are cited. Some cases contain both aspects.

Numbers of concerns raised each quarter fluctuate and are difficult to predict. It is acknowledged that more work is needed to ensure all staff are aware of the Guardian's role, and feel able to make contact.

A breakdown of concerns by site, division and role are below.

| Concerns by site | Chelsea & Westminster | West Middlesex | Cross site | Other sites |
|---|---|---|---|---|
| | 8 | 6 | 3 | |
| | | | | |

| Concerns by division | EIMC | Planned care | W, C, H,G,D, PP. | Corporate |
|---|---|---|---|---|
| | 1 | 9 | 3 | 4 |
| | | | | |

| Concerns by role | Medic | Nurse / HCA | AHP | Admin | Other |
|---|---|---|---|---|---|
| | 1 | 7 | 2 | 3 | 4 |
| | | | | | |

**7. Staff Feedback/Indicators in Respect of our Freedom to Speak Up Culture**

In order to get a baseline of the awareness and confidence of staff in the Freedom to Speak Up arrangements, a survey has been carried out in April 2018 as one of the Nursing & Midwifery Quality Rounds, using Survey Monkey. The survey was completed by 93 members of staff so a small representation, the key findings can be seen below:

- 96% of staff questioned knew how to raise concerns
- 80% would raise concerns with their line manager initially, 34% with a senior manager or matron
- 40% of those questioned knew that Vanessa Sloane is the Freedom to Speak Up Guardian or where to find information on the intranet
- Staff felt there were a range of concerns they would raise through Freedom to Speak Up but 93% recognised this as a way to raise patient safety concerns.

This survey will be repeated in October.

**8. Next Steps - Actions for 2018-19**

Actions over the last 12 months have focused on the embedding the Guardian role and way of working, establishing strong working links with HR , networking, and learning from good practice nationally.

The next phase of work is focused on making sure all staff are aware of the arrangements, and increasing numbers and visibility of the Trust Freedom to Speak Up Champions. The aim is to have at least 1 champion in each of our outlying sites.

Publicity is vital through new poster campaigns, an updated intranet page, photos of the team, and engagement through ward/ department meetings, open forums and clinical governance sessions. October is National Speak Up Month, #speakuptome and we will be promoting this through stands, Daily Noticeboard and newsletters.

Work over the next year will focus on:

- Education and awareness raising
- Review of FTSU Guardian role
- Launch our champion roles through Team Brief and Going Beyond.
- Improve links with minority groups.
- Promoting a Speaking Up culture.

The National Guardian's Office has published guidance for NHS trust and NHS foundation trust boards on Freedom to Speak Up. This guidance which has been produced jointly by the National Guardian's Office and NHS Improvement sets out expectations of boards and board members in relation to Freedom to Speak Up. A self-assessment tool has also been produced. This guidance and action plan following self-assessment will clearly influence the Guardians' priorities and work plan for the next year. The Executive Lead, Pippa Nightingale, will be completing the self-assessment with the Board and the action plan and progress will be brought back to the Board.

National Guardian
Freedom to Speak Up

NHS
Improvement

# Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

# Contents

# Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

# About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

## Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

# Our expectations

## Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

## Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

## Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

## Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

## Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

## Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

## Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

## Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

# Individual responsibilities

## Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

## Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

## Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

## Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

## Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

# FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

**Assessment of issues**

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

**Potential patient safety or workers experience issues**

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

**Action taken to improve FTSU culture**

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

**Learning and improvement**

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

**Recommendations**

- suggestions of any priority action needed.

# Resources


Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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This publication can be made available in a number of other formats on request.

May 2018 Publications code: CG 64/18

National Guardian
Freedom to Speak Up

NHS
Improvement

# Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

# How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

| Self review indicator<br><br>(Aligned to well-led KLOEs) | To what extent is this expectation being met? | What are the principal actions required for development? | How is the board assured it is meeting the expectation?<br><br>Evidence |
|---|---|---|---|
| **Our expectations** | | | |
| **Leaders are knowledgeable about FTSU** | | | |
| Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. | | | |
| Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. | | | |
| They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. | | | |
| Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy. | | | |
| **Leaders have a structured approach to FTSU** | | | |
| There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient | | | |

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| safety, staff experience and continuous improvement. | | | |
| There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. | | | |
| The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian. | | | |
| Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures. | | | |
| **Leaders actively shape the speaking up culture** | | | |
| All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. | | | |
| They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. | | | |
| Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. | | | |

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| Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. | | | |
| Senior leaders model speaking up by acknowledging mistakes and making improvements. | | | |
| The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly. | | | |
| **Leaders are clear about their role and responsibilities** | | | |
| The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. | | | |
| They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. | | | |
| Other senior leaders support the FTSU Guardian as required. | | | |
| **Leaders are confident that wider concerns are identified and managed** | | | |
| Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to | | | |

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| proactively identify potential concerns. | | | |
| The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate. | | | |
| **Leaders receive assurance in a variety of forms** | | | |
| Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process. | | | |
| Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers | | | |
| Speak up issues that raise immediate patient safety concerns are quickly escalated | | | |
| Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority | | | |

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| Lessons learnt are shared widely both within relevant service areas and across the trust | | | |
| The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented | | | |
| FTSU policies and procedures are reviewed and improved using feedback from workers | | | |
| The board receives a report, at least every six months, from the FTSU Guardian. | | | |
| **Leaders engage with all relevant stakeholders** | | | |
| A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan. | | | |
| Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. | | | |
| Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). | | | |

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| The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. | | | |
| Reviews and audits are shared externally to support improvement elsewhere. | | | |
| Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture | | | |
| Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians | | | |
| Senior leaders request external improvement support when required. | | | |
| **Leaders are focused on learning and continual improvement** | | | |
| Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. | | | |

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| Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. | | | |
| Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. | | | |
| Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation. | | | |
| The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success. | | | |
| The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. | | | |
| A sample of cases is quality assured to ensure:<br>• the investigation process is of high quality; that outcomes and recommendations are reasonable | | | |

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| and that the impact of change is being measured<br><br>• workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome<br><br>• Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored | | | |
| Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. | | | |
| **Individual responsibilities** | | | |
| **Chief executive and chair** | | | |
| The chief executive is responsible for appointing the FTSU Guardian. | | | |
| The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. | | | |

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| The chief executive and chair are responsible for ensuring the annual report contains information about FTSU. | | | |
| The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office. | | | |
| Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly. | | | |
| **Executive lead for FTSU** | | | |
| Ensuring they are aware of latest guidance from National Guardian's Office. | | | |
| Overseeing the creation of the FTSU vision and strategy. | | | |
| Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian. | | | |

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| Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence. | | | |
| Ensuring that a sample of speaking up cases have been quality assured. | | | |
| Conducting an annual review of the strategy, policy and process. | | | |
| Operationalising the learning derived from speaking up issues. | | | |
| Ensuring allegations of detriment are promptly and fairly investigated and acted on. | | | |
| Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process. | | | |
| **Non-executive lead for FTSU** | | | |
| Ensuring they are aware of latest guidance from National Guardian's Office. | | | |
| Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up | | | |

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| strategy. | | | |
| Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement. | | | |
| Role-modelling high standards of conduct around FTSU. | | | |
| Acting as an alternative source of advice and support for the FTSU Guardian. | | | |
| Overseeing speaking up concerns regarding board members. | | | |
| **Human resource and organisational development directors** | | | |
| Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up. | | | |

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| Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust. | | | |
| Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively. | | | |
| **Medical director and director of nursing** | | | |
| Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues. | | | |
| Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up. | | | |
| Ensuring learning is operationalised within the teams and departments that they oversee. | | | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.3/Sep/18 |
| **REPORT NAME** | Patient Voices Update |
| **AUTHOR** | Nathan Askew, Director of Nursing |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | This paper provides an update to the board on the patient voices group, the challenges that have been faced trying to get this forum functioning and provides an overview of the suggested process of obtaining patient feedback moving forward.<br><br>The report provides an overview of some of the specialist feedback forums that are in place across the Trust and the feedback and activities they have been engaged with. |
| **SUMMARY OF REPORT** | Despite several attempts the patient voices group have failed to have a fruitful meeting and therefore the approach needs to be modified. There are many reasons cited for this but the primary driver has been that patients prefer to offer their feedback on a narrower range of topics that are relevant to the services that they use.<br><br>The Trust are committed to developing an approach to patient feedback that enables it to respond to and develop services in line with feedback from the patients and their families that use our services.<br><br>The Report includes feedback from the maternity, end of life care, youth forum and learning disability group.<br><br>The paper suggests an alternative method of collecting patient feedback moving forward which is supported by the executive management board and the Patient and Public Engagement and Experience committee. |
| **KEY RISKS ASSOCIATED** | Reputational risks associated with patient feedback. |
| **FINANCIAL IMPLICATIONS** | None |
| **QUALITY IMPLICATIONS** | Patient feedback enables us to develop responsive services to our patient need. |

| | |
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| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | • Excel in providing high quality, efficient clinical services |
| **DECISION/ ACTION** | This paper is for information |

# Patient Voices Report

## Introduction

In January 2018 as part of the patient experience update the board were informed that the Trust had formed a new forum entitled patient voices. The purpose of the forum was to provide a space where patients from a range of services were able to feedback to the trust and provide advice on how to improve aspects of our services.

This report is intended to provide the board with an update against this work and to detail the future plan of how this will be managed.

## Patient Voices

A patient governor agreed to chair the patient voices forum and trust staff engaged with advertising to patients. Despite multiple attempts to formulate the group it has never met with enough attendance to make the work useful.

Feedback from patients who were planning to attend and then did not was that the forum was too broad and covered too vast a range of service for them to feel it would be useful. They stressed that they were keen to provide feedback but wanted this to be more focussed on the services that they used and that had an impact on the care they received.

## Current forums

There are a range of forums across the organisation that seeks feedback from patients specifically to improve and develop their services. They are all service or disease / condition focussed, meet to review a range of issues that relate to patients using that service and then seek to improve the quality of the service. Feedback is either sought through regular surveys, or in many cases through the use of focus groups.

Therefore the proposal moving forward is to hold at least one focus group per quarter to gather feedback on a range of issues pertaining to a service or specific patient group. This will be hosted jointly by patient experience and the service. The outcome will be the development of a set of actions to move specific areas of improvement forward, with an opportunity for follow up from the patient group.

This approach has been widely used in maternity services with excellent results. The team have been able to demonstrate changes in service design and delivery which have been rooted in patient feedback. The challenge will be to trial this approach in a group of patients with an illness and potentially a longer course of treatment with the organisation.

The Foundation Trust Membership will be used as a means of recruiting forum members and there will be the opportunity for relevant training for members who take part in the forum.

## Feedback from some of the current forums

<u>Learning disabilities</u>

The Trust have engaged in a project with Queensmill school (Project Search) which seeks to give suitable work experience to young people with a learning disability to prepare them for employment and to develop life skills. Through discussion with the school the Trust became aware that it was well placed to help with this issue and to seek to improve the experience of work for the young people.

The young people will begin in September on the West Middlesex site and will be undertaking roles in ISS support services, medical records and administration. The group will be supported by the lead nurse for learning disabilities and will have regular opportunity to feedback on their experience.

This pilot will then shape the opportunity for future students and will lead to more placements.

End of Life Care

The end of life care team receives a lot of praise and recognition through letters into the Trust usually from family members once the patient has passed away. The majority of the positive feedback relates to the care and compassion of staff working with people in the last days of life.

The team are constantly looking to improve their service and as end of life care covers all areas of the Trust feedback form patients has been that information on services and support available can differ depending on your primary diagnosis.

The team have therefore developed and trialled a 'comfort bag' which includes information on support available, chaplaincy, specialist palliative care team and car parking for relatives. In addition it includes some aromatherapy sticks for nausea and also some words of comfort to be read in times of distress.

Initial feedback from patients is overwhelmingly positive and the team are in the process of securing funding to roll this initiative out more widely.

Youth Forum

The hospital Youth Forum is a focus group for 11 – 16 year olds providing an opportunity to shape and develop services for adolescents within the Trust. The group is led by the Youth Worker and the forum has recently decided that moving forward it will be called "Our Voice".

The forum has been instrumental in the introduction of new adolescent food menus to the Trust and was involved in the design and tasting of the options available. They have also designed the adolescent common rooms on both sites which have been updated to be more reflective of the needs of young people.

Maternity

Maternity voice partnership have a long history of engagement and hold twice yearly 'walk the patch' events in the hospital and community settings. User reps with trust support get feedback from face to face conversations with women and focus on a specific part of the pathway such as postnatal or antennal care.

This year there have been two ‘whose shoes’ events with a focus on postnatal care and perinatal mental health.

Post natal feedback included the difficulty in obtaining timely pain relief during labour and post-delivery which has led to a plan to improve communication on the importance of adequate pain relief in the areas, communication to women about when and how to ask for pain relief and a plan exploring the use of self administration in the area.

The group has been able to change information provision and the leaflets given to women and members have been involved in the design of the new maternity hand held notes.

The perinatal mental health group advocate what women want from the services and the perinatal mental health pathway and has this year led to the introduction of wellbeing events. These have been positively evaluated by the service users.

Over the last 18 months the maternity voices group has also been actively involved in the better births project. Getting feedback on the type of continuity of care and what aspects of continuity are important. This has been instrumental in the design of the model that is being put forward for this service.

**Conclusion**

There are varying models of feedback currently used across the organisation and these can all be expanded and enhanced. The Trust suggestion of specific focussed events for feedback would mirror that of the maternity services. The maternity services approach has been instrumental in influencing change for the users of that service.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.4 /Sep/18 |
| **REPORT NAME** | Improvement Programme update |
| **AUTHOR** | Serena Stirling, Director of Improvement |
| **LEAD** | Pippa Nightingale, Chief Nurse<br>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)**<br>The Trust anticipates achievement of a full year forecast of £21.8m – 13% or £3.3m below the target of £25.1m. There has been an improvement of £200k from the prior month. Month 04 shows that the in-month performance has delivered £1.67m against a target £1.94m, this is an in-month under achievement of 14%.<br><br>**CQC assessment of Quality Improvement cultures in provider organisations**<br>In March 2018 the CQC released brief guidance on how they will assess the maturity of quality improvement cultures in provider organisations. This will be assessed as part of Core Service and Well-Led inspections.<br><br>The Trust has completed a self-assessment against these high level standards and is considering appropriate actions to strengthen the improvement culture within the organisation, in line with the agreed Improvement Approach. |
| **KEY RISKS ASSOCIATED** | Failure to continue to deliver high quality patient care<br>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.<br>• Deliver high-quality patient-centred care<br>• 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 July 2018.

1. Summary of Improvement Programme
2. Additional Opportunities
   - Getting it Right First Time (GIRFT)
   - Quality Improvement Projects
3. CQC action plan
4. Deep Dive programme
5. Communications and Engagement
6. Additional work in progress
7. Regulator update

## 1. Summary of Improvement Programme

The Trust anticipates achievement of a full year forecast of £21.8m – 13% or £3.3m below the target of £25.1m. This is a £0.2m improvement from prior month. The recurrent shortfall position was reported as £8.8m in Month 03, which has reduced to £6.9m in Month 04.

72% or £15.8m of the £21.8m full year improvement forecast is rated green, with the expectation that these schemes will fully deliver their plans.

Month 04 shows that the in-month performance has delivered £1.67m against a target £1.94m, this is an in-month under achievement of £0.27m or 14%. £0.14m of the in-month underachievement relates to unidentified projects. Taking this into account, the Trust has achieved 93% of plans identified in M04.

*Quality Impact Assessments (QIA) Update*

- A QIA panel was held on 23rd August 2018 and consisted of 13 PIDs comprising of 23 projects valued at £1.16m.
- The next QIA panel is on 12th September 2018 and will focus on:
  - Mid-year Quality Impact Assessment review of high risk projects; and
  - Remaining 2018/19 Improvement Programme projects.

## 2. Additional Opportunities

### ➢ Getting it Right First time (GIRFT)

- Opportunities to strengthen governance and oversight of work streams have been identified, and are currently being reset by the Director of Improvement, with executive leadership from the Medical Director.
- The Trust has engaged with the national GIRFT team to inform this work and learn from other organisations about successful approaches and structures to manage GIRFT work streams.

### ➢ Quality Improvement Projects

- Divisions are currently establishing quality improvement portfolios. On-going support will be provided by the Improvement Fellows, and progress reported regularly to the Improvement Board.
- Templates have been provided to divisions to support intention to pursue decisions and quality and financial benefits realisation.

## 3. Care Quality Commission (CQC) Improvement Plan

The overall breakdown of the CQC 'Should Do' actions and additional actions are detailed below. The Divisional Directors of Nursing provide a monthly update on the progress of each action.

| 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** | 1 | 24 | 30 | 2 | 0 |
| **Additional actions Summary** | 0 | 41 | 31 | 15 | 3 |

### a) 'Should Do' Actions progress:

| Division | CQC Domain | Complete | Red | Amber | Green | Grand Total |
|---|---|---|---|---|---|---|
| EIC | Safe | 1 | - | 5 | 6 | 12 |
| | Effective | 1 | - | 2 | 3 | 6 |
| | Responsive | - | - | - | 1 | 1 |
| | Well-Led | - | - | 1 | - | 1 |
| PC | Safe | - | - | 1 | 3 | 4 |
| | Effective | - | 1 | - | - | 1 |
| | Caring | - | - | - | 1 | 1 |
| | Responsive | - | - | 3 | 1 | 4 |
| | Well-Led | - | - | 3 | 1 | 4 |
| W&C | Safe | - | - | - | 3 | 3 |
| | Effective | - | - | 3 | 2 | 5 |
| | Responsive | - | - | 5 | 2 | 7 |
| | Well-Led | - | - | - | 4 | 4 |
| Corporate | Effective | - | - | - | 1 | 1 |
| | Well-Led | - | - | - | 1 | 1 |
| Trustwide | Well-Led | - | - | 1 | 1 | 2 |
| **Grand Total** | | **2** | **1** | **24** | **30** | **57** |

### Completed 'Should Do' actions:

Two of the 'Should Do' actions are now complete in the EIC division, details are listed below:

| CQC Recommendation | CQC Domain | Corporate theme |
|---|---|---|
| The Trust should ensure that agency staff has access to electronic patient records. | Safe | Temporary Staffing |
| The Emergency Department at West Middlesex should provide more information to patients to help them lead healthier lives. | Effective | Health Promotion |

### Red rated 'Should Do' Action:

Currently one of the 'Should Do' actions is listed Red and is held by Planned Care:

| CQC Recommendation | CQC Domain | CQC Core Service | Division | Progress Update (incl person and date of entry) |
|---|---|---|---|---|
| The West Middlesex Hospital should conduct starvation audits to access how many patients were starved for the recommended number of hours, and to assess whether or not practice complies with the Trust's protocol. | Effective | Surgery | PC | New Lead Nurse will lead on introducing the audit across the division for implementation – August 2018 |

**b) Progress made for 'Additional' actions:**

| Division | CQC Domain | Complete | Amber | Green | Awaiting update | Grand Total |
|---|---|---|---|---|---|---|
| EIC | Safe | 4 | 2 | 6 | 1 | 13 |
| | Effective | 5 | 4 | 3 | 1 | 13 |
| | Caring | - | 2 | 2 | - | 4 |
| | Responsive | 3 | 4 | 3 | 1 | 11 |
| | Well-Led | 3 | - | 2 | | 5 |
| PC | Safe | - | 13 | 2 | - | 15 |
| | Effective | - | 7 | 2 | - | 9 |
| | Caring | - | - | 1 | - | 1 |
| | Responsive | - | 6 | 3 | - | 9 |
| | Well-Led | - | 2 | 1 | - | 3 |
| W&C | Safe | - | - | 2 | - | 2 |
| | Caring | - | - | 1 | - | 1 |
| | Responsive | - | 1 | 1 | - | 2 |
| | Well-Led | - | - | 2 | - | 2 |
| Grand Total | | 15 | 41 | 31 | 3 | 90 |

**Completed 'Additional' actions:**

Fifteen of the additional actions are now complete in the EIC division, details are listed below:

| CQC Recommendation | CQC Domain | Actions identified | BRAG Rating |
|---|---|---|---|
| In the Urgent Care Centre FP10SS prescriptions were available but NHS Protect guidance was not being followed in regards to the security of these prescriptions. | Safe | Printer lock in place. FP10 blanks now locked away in a cupboard in the UCC office | Complete |
| Royal College of Emergency Medicine (RCEM) vital signs in children audit was in the lower quartile for three standards. | Effective | Observation policy for paediatric ED introduced. New PEWs chart introduced. For continued auditing to monitor effect | Complete |
| The numbers of staff with up to date training in high-level child safeguarding needed to increase | Safe | Working to ensure staff are up to date- we project all staff to be compliant within the next month. All mandatory training records will be checked monthly and chased by Dr Friedman (doctors) Sister Packman (nursing) | Complete |
| Staff did not document episodes of restraint as incidents in line with trust policy. | Safe | All cases of physical or chemical restraint will now be recorded via a datix submission this information is being disseminated to all staff. | Complete |
| Some data was collected manually which made data analysis difficult and potentially unreliable. | Effective | New paperless computer system has now been implemented (Cerner) will negate need for manual data collection. | Complete |
| On this inspection we saw staff asking patients about pain and that pain scoring tools were available, but not always completed. | Effective | Pain scores now recorded on paperless computer system should ensure compliance - compliance will be maintained by regular teaching on pain management. Pain score documentation will be audited by nursing audits. | Complete |
| There was little information for patients in the waiting room or the inside department itself about what to expect in ED. The information board for majors patients was not visible to most patients in the department. | Responsive | Patient information poster has been designed and due for installation in next few weeks. | Complete |
| Inherited paper-based systems from the previous Trust limited the analysis of clinical data to understand performance and bring about improvement. However we were aware that plans for a new electronic system were well-advanced. | Well-Led | New electronic system now in place this should negate this concern. | Complete |
| Due to staff shortages, ambulatory emergency care (AEC) staff were not | Safe | Full review of ambulatory care done. Staffing and service increased. New online process for | Complete |

| CQC Recommendation | CQC Domain | Actions identified | BRAG Rating |
|---|---|---|---|
| always able to follow up patients requiring urgent investigation or on-going support following discharge from AAU. | | booking and reviewing patients | |
| Between September 2016 and August 2017 three of eight medical specialties performed worse than the national average for referral to treatment within 18 weeks. | Responsive | New Cross Site governance process established within the Medicine Directorate to manage all under performing specialties. Active recruitment on going with Specialties where a Capacity issue has been identified, decisions being made on a specialty basis as to whether locums are required. | Complete |
| On some medical areas, staff said they did not feel they were part of the service, for example the diagnostic centre. | Well-Led | Focus on integration within the division. Executive lead allocated. Increased visibility bu senior management team. Inclusion into trust wide activities such as ward accreditation | Complete |
| Neurology services were limited and staff described delays in patients being seen by this team. However the trust told us after the inspection that a new consultant neurologist had been appointed. | Effective | New consultant at both WM and CW. No reported delays | Complete |
| The infection control team found inconsistent practice in relation to the treatment and prevention of Clostridium difficile in two cases in 2016/17. | Effective | Policy reviewed and updated to be harmonised cross site. New process in place to ensure outbreaks are managed consistently across the organisation | Complete |
| Patients in general medicine had a much higher than expected risk of readmission for elective admissions, with rates for respiratory medicine also higher. | Responsive | 100 day respiratory project underway. Respiratory CNS has improved links with community partners which has led to a 0 readmission rate since the project begun | Complete |
| Information management processes did not always ensure patient confidentiality was maintained. | Well-Led | New GDPR guidance in place. Divisional GDPR lead appointed and increased awareness of information governance processes | Complete |

## 4. Deep Dive programme

Deep Dive Terms of Reference and templates have been refreshed. Deep Dive dates have been reviewed and programmed across the financial year, with capacity in-built for targeted Deep Dives to support emerging issues and ensure timely organisational response.

The following planned and targeted deep dives have been scheduled for the next month:

| Division | Name of Deep dive | Deep Dive Category | Deep Dive *Scheduled* |
|---|---|---|---|
| Planned Care | **Fractured NOF - meeting national standards** | Targeted | 21-Aug-18 |
| W&C | **INWL GUM Contract** | Targeted | 23-Aug-18 |
| Planned Care | **Craniofacial** | Targeted | 03-Sep-18 |
| W&C | **Community Paediatrics** | Targeted | 04-Sep-18 |
| W&C | **Obstetrics / Maternity Finances** | Targeted | 06-Sep-18 |
| Trustwide | **Medical Agency Spend** | Targeted | 07-Sep-18 |
| Planned Care | **Critical Care** | Planned | 07-Sep-18 |
| W&C | **St Stephen's Centre and John Hunter Clinic** | Targeted | 10-Sep-18 |
| Planned Care | **Radiology** | Targeted | 11-Sep-18 |
| Planned Care | **Vascular + GIRFT action progress** | Targeted | 12-Sep-18 |
| Planned Care | **Anaesthetics** | Targeted | 13-Sep-18 |
| EIC | **Mental Health Delays (ED)** | Targeted | 21-Sep-18 |
| Trustwide | **Research funding** | Targeted | 25-Sep-18 |
| Trustwide | **Information Governance Team** | Targeted | 26-Sep-18 |

## 5. Communications and Engagement

The Improvement Programme has provided input/updates to the following forums in July/August:

- Quality Committee
- Finance and Investment Committee
- People and OD Committee
- Hounslow CCG Care Quality Group

## 6. Additional work in progress

- Reset fortnightly Divisional and Improvement Team meetings to focus on sharing learning and opportunities for improvement.
- Improvement Core Group established to develop Improvement Approach, Education and Training and Communications and Engagement Plan etc. Draft expected end of August 2018 for review by Senior Nursing and Medical Cabinets, in addition to Improvement Board and Executive Management Board.
- Improvement Fellow work plan and induction programme developed to ensure alignment with corporate quality and financial objectives.

## 7. Regulator update

In March 2018 the CQC released some guidance on how they will assess the maturity of quality improvement cultures in provider organisations ('Brief guide: assessing quality improvement in a healthcare provider'). The Trust has completed a self-assessment against these high level standards is considering appropriate actions to strengthen the improvement culture within the organisation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.5/Sep/18 |
| **REPORT NAME** | Learning from Serious Incidents |
| **AUTHOR** | Shân Jones, Director of Quality Improvement<br>Stacey Humphries, Quality and Clinical Governance Assurance Manager |
| **LEAD** | Pippa Nightingale, Chief Nurse |
| **PURPOSE** | The purpose of this report is to provide the Trust Board with assurance that serious incidents are being reported and investigated in a timely manner and that lessons learned are shared. |
| **SUMMARY OF REPORT** | This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2018. Comparable data is included for both sites. |
| **KEY RISKS ASSOCIATED** | • Written account of events should be taken at the time of the incident to facilitate an accurate reflection of events.<br>• The increase in falls reporting year to date puts the quality priority reduction in falls at risk |
| **FINANCIAL IMPLICATIONS** | N/A |
| **QUALITY IMPLICATIONS** | • There is a sustained reduction in hospital acquired pressure ulcers<br>• The number of outstanding actions has improved significantly in July |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Delivering high quality patient centred care<br>• Be the Employer of Choice<br>• Delivering better care at lower cost |
| **DECISION/ ACTION** | The Trust Board is asked to note and comment on the report. |

**SERIOUS INCIDENTS REPORT**
**Public Trust Board 6th September 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. For ease of reference, and because the information relates to the two acute hospital sites, the graphs have been split to be site specific. Reporting of serious incidents follows the guidance provided by the framework for SI and Never Events reporting that came into force from April 1st 2015. All incidents are reviewed daily by the Quality and Clinical Governance Team, across both acute and community sites, to ensure possible SIs are identified, discussed, escalated and reported as required. All complaints that have a patient safety concern are reviewed discussed, escalated and reported as required. In addition as part of the mortality review process any deaths that have a CESDI grade of 1 or above are considered and reviewed as potential serious incidents.

## 2.0 Never Events

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

Since the 1st April 2018, there have been no Never Events reported.

## 3.0 SIs submitted to CWHHE and reported on STEIS

Table 1 outlines the SI investigations that have been completed and submitted to the CWHHE Collaborative (Commissioners) in July 2018. There were 5 reports submitted. A précis of the incidents can be found in Section 7.

Table 1

| STEIS No. | Date of incident | Incident Type (STEIS Category) | External Deadline | Date report submitted | Site |
|---|---|---|---|---|---|
| 2018/10181 | 25/03/2018 | Slips/trips/falls | 18/07/2018 | 18/07/2018 | W |
| 2018/9766 | 12/04/2018 | Slips/trips/falls | 13/07/2018 | 13/07/2018 | W |
| 2018/10193 | 23/03/2018 | Medication incident | 18/07/2018 | 18/07/2018 | W |
| 2018/10774 | 16/08/2017 | Diagnostic incident including | 26/07/2018 | 26/07/2018 | W |
| 2018/11572 | 10/05/2018 | Pressure ulcer | 02/08/2018 | 24/07/2018 | CW |

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

Table 2 – Incidents reported by category

| Incident Type (STEIS Category) | WM | C&W | Total |
|---|---|---|---|
| Diagnostic incident including delay | 1 | 1 | 2 |
| Maternity/Obstetric incident: baby only | 1 | | 1 |
| Pressure ulcer | 1 | 1 | 2 |
| Sub-optimal care of the deteriorating patient | 2 | | 2 |
| Surgical/invasive procedure incident | | 1 | 1 |
| **Grand Total** | **5** | **3** | **8** |

The number of SIs reported in July (8) is higher compared to the previous month, June (2). During both months the Trust reported against the category; diagnostic incident including delay.
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 = 13

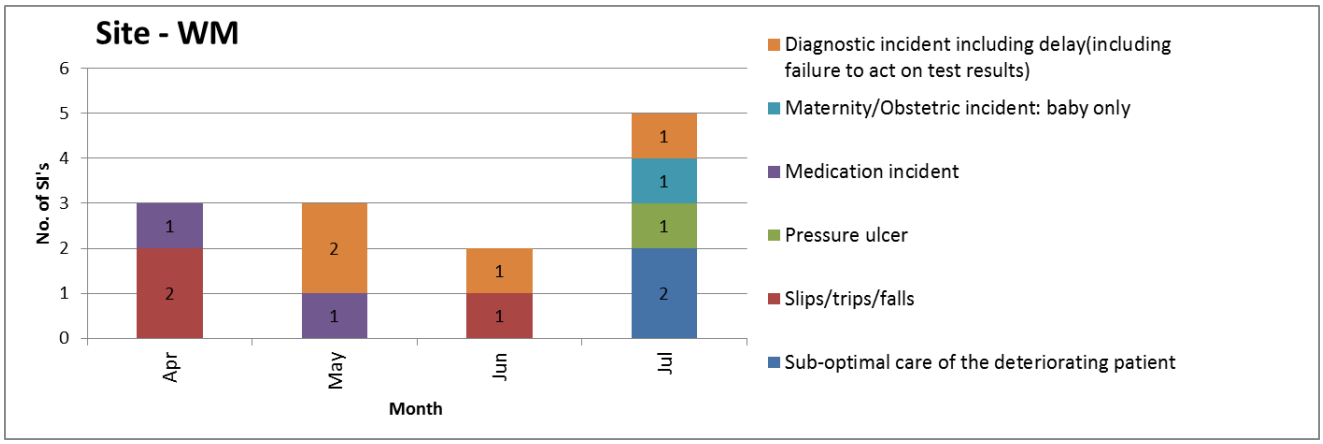
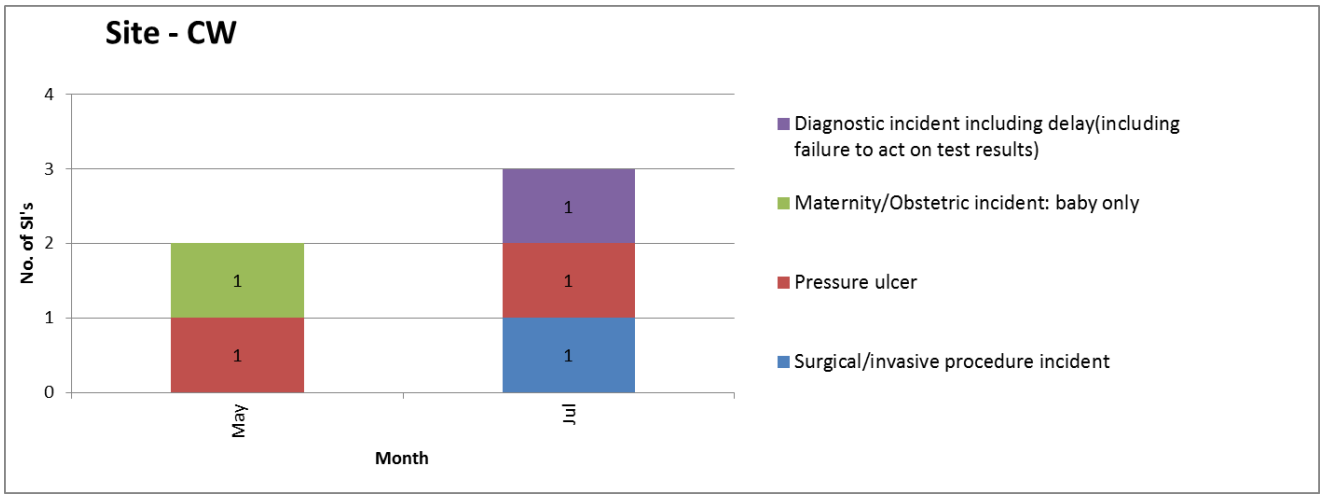



Chart 2 Incidents reported at C&W by category YTD 2018/19 = 5




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

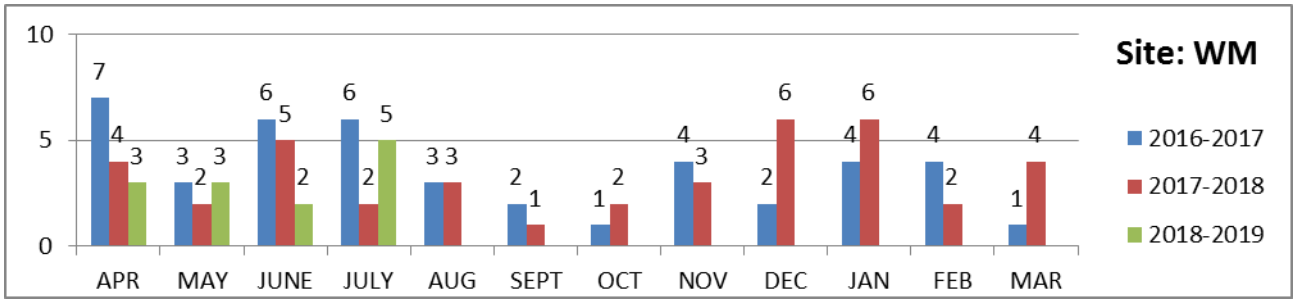
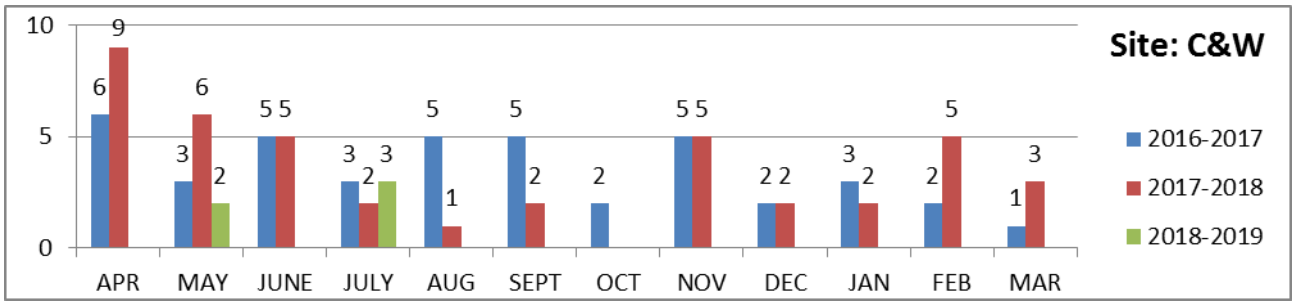



Chart 4 Incidents reported 2016/17, 2017/18 & 2018/19 – C&W

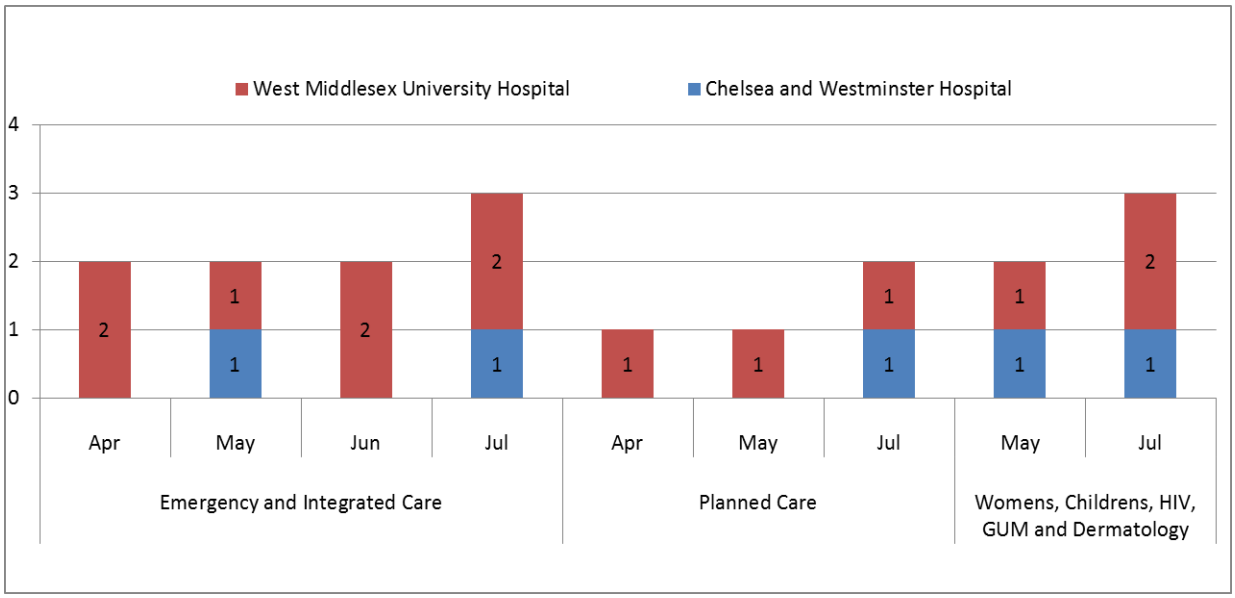



### 3.1 SIs by Clinical Division and Ward

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 compare the number of incidents reported by each division.

Since April 1st 2018, the Emergency and Integrated Care Division has reported 4 SIs (C&W 1, WM 3). The Women's, Children's, HIV, GUM and Dermatology Division have reported 2 SIs (C&W 1, WM 1) and the Planed Care Division have reported 2 SIs (C&W 0, WM 2).

Chart 5 Incidents reported by Division and Site 2018/19



Charts 6 and 7 displays the total number of SI's reported by each ward/department. All themes are reviewed at divisional governance meetings. No one ward or department has reported more than one serious incident except A&E at WM. In the three incidents the categories are different.

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

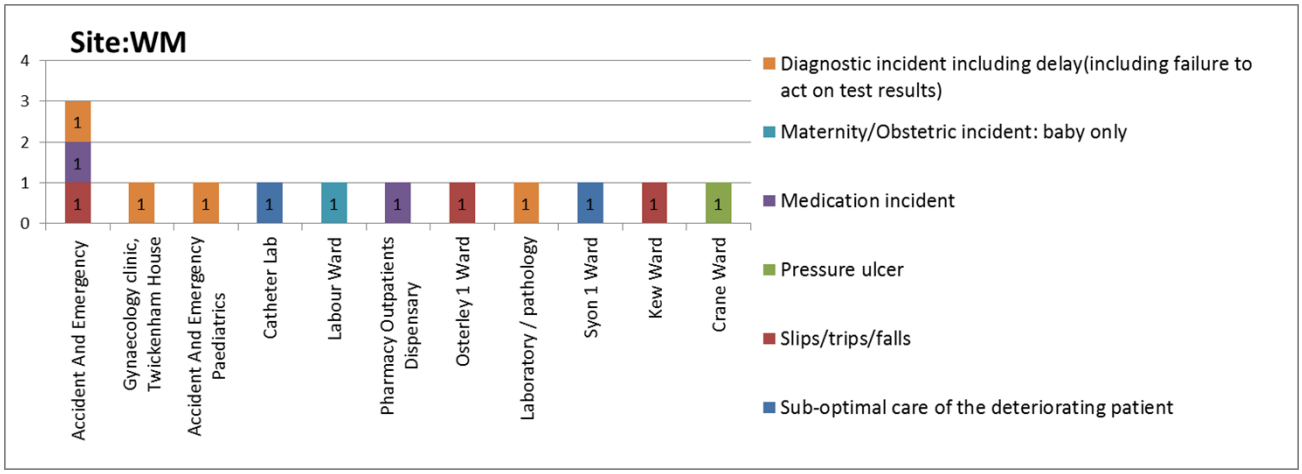
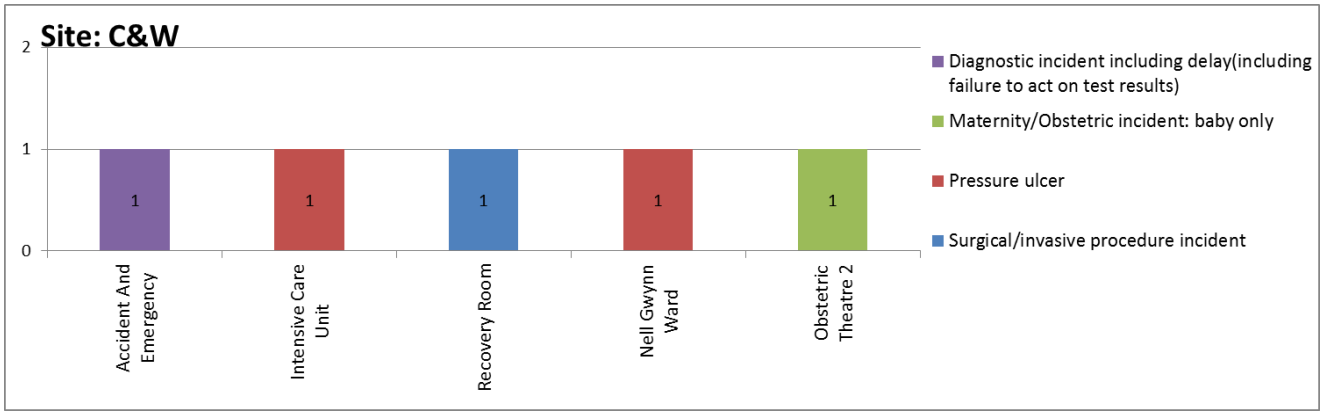


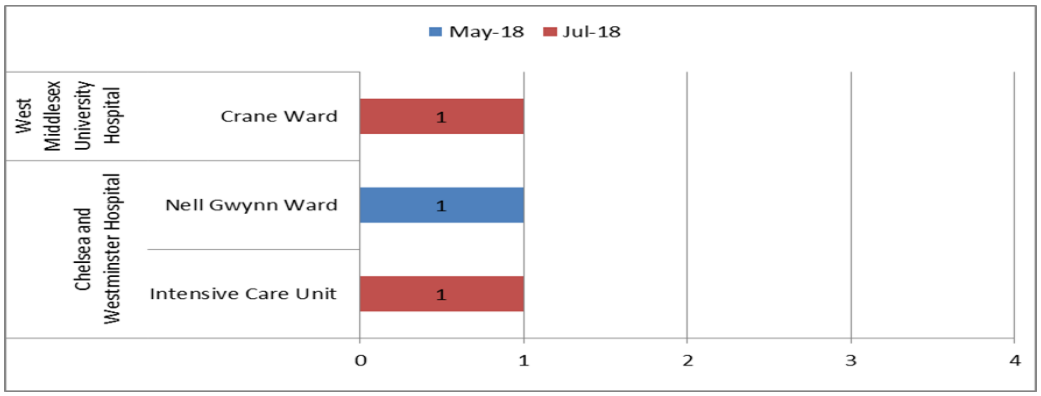

Chart 7 - Incident category and location exact, C&W 2018/19




### 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 3 compared to 9 for the same time period in 2017/18. A very positive reflection the interventions put in place are working.

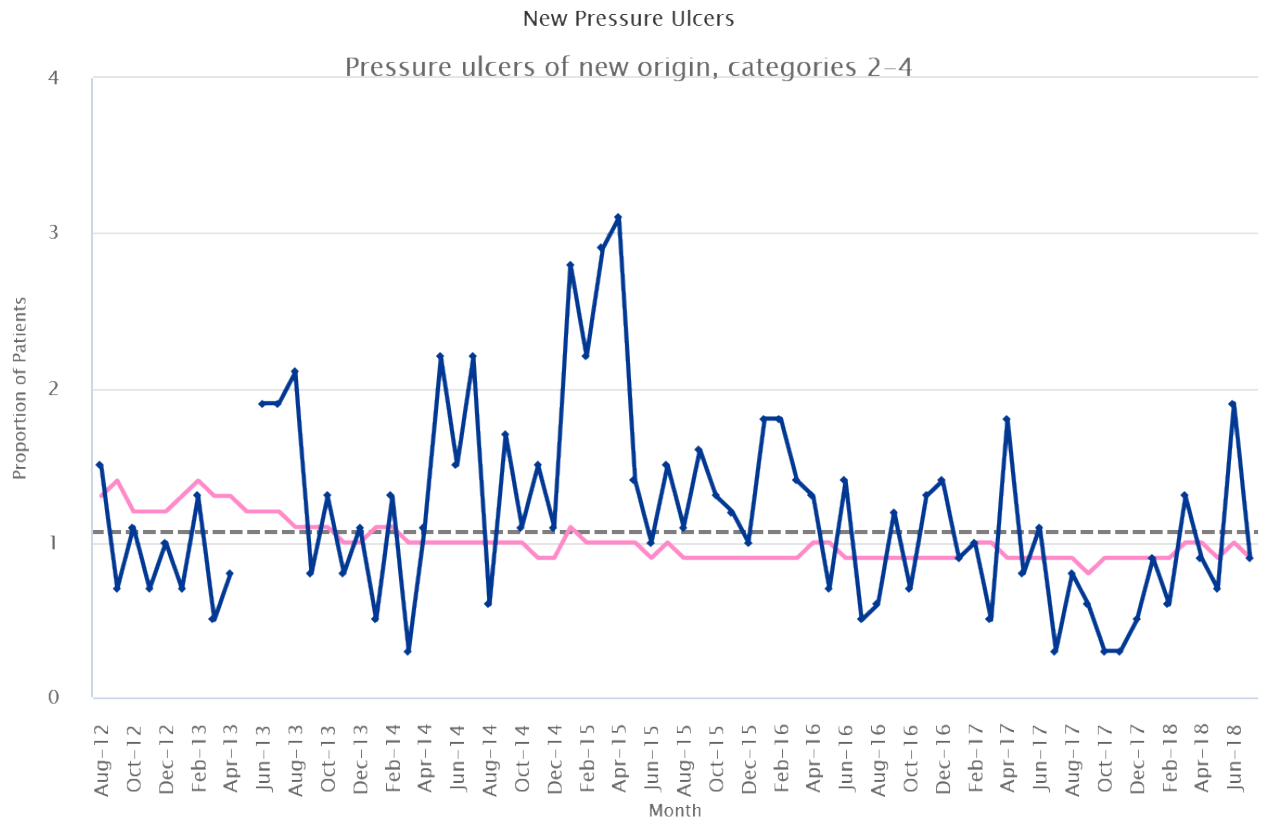
Chart 8 – Pressure Ulcers reported (Apr 2018–March 2019) YTD total = 3




### 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 June 2018.

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

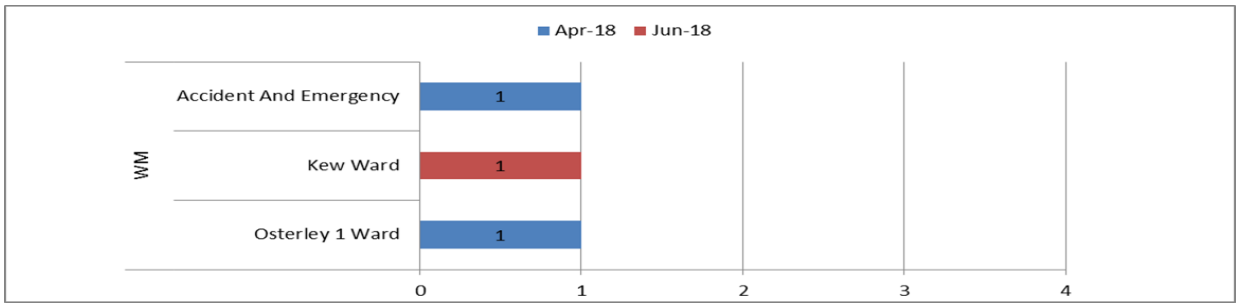



### 3.3 Patient Falls

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 3 patient falls meeting the serious incident criteria. Disappointingly the 2018/19 year to date position is 3 compared to 0 for the same period last year. All 3 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.

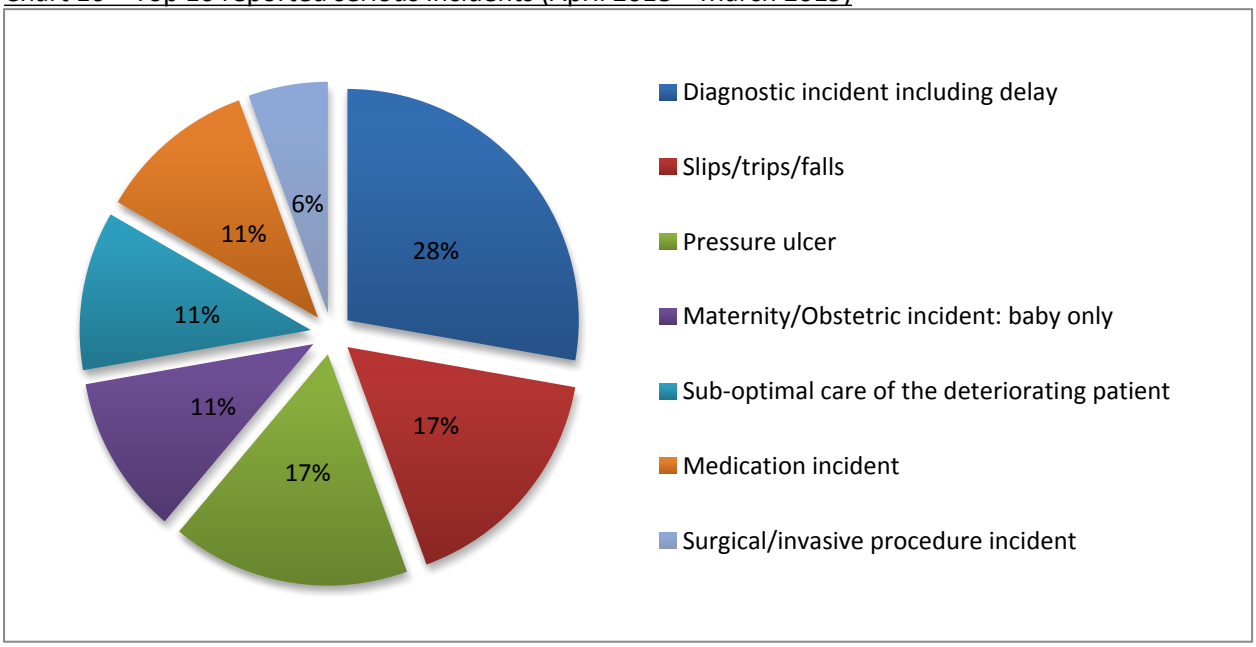
Chart 9 Patient Falls by Location (exact) (Apr 2018–March 2019) YTD total =3




### 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 7 of the SI categories.

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




At present, the category 'Diagnostic incident including delay' is the most reported category with 5 incidents reported since 1st April 2018. Slips/trips/falls and Pressure ulcer related incidents are the second most reported categories.

### 3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (13). There is one SI report that was due for submission in March. The investigation has been held up because of police investigation. CWHHE have been kept informed. This has now been completed and submitted in August.

Table 3

| STEIS No. | Date of incident | Clinical Division | Incident Type (STEIS Category) | Site | External Deadline |
|---|---|---|---|---|---|
| 2017/30662 | 09/12/2017 | EIC | Abuse/alleged abuse of adult patient by staff | WM | 13/03/2018 |
| 2018/12499 | 18/05/2018 | W&C,HGD | Maternity/Obstetric incident: baby only | CW | 13/08/2018 |
| 2018/12918 | 22/05/2018 | EIC | Medication incident | WM | 17/08/2018 |
| 2018/13671 | 09/09/2017 | EIC | Diagnostic incident including delay | WM | 24/08/2018 |
| 2018/14100 | 24/05/2018 | EIC | Slips/trips/falls | WM | 31/08/2018 |
| 2018/16836 | 04/06/2018 | PC | Pressure ulcer | CW | 02/10/2018 |
| 2018/16434 | 24/06/2018 | PC | Sub-optimal care of the deteriorating patient | WM | 27/09/2018 |
| 2018/16596 | 02/07/2018 | W&C,HGD | Maternity/Obstetric incident: baby only | WM | 28/09/2018 |
| 2018/16475 | 26/06/2018 | W&C,HGD | Diagnostic incident including delay | WM | 27/09/2018 |
| 2018/16841 | 04/07/2018 | EIC | Sub-optimal care of the deteriorating patient | WM | 02/10/2018 |
| 2018/16904 | 05/07/2018 | W&C,HGD | Surgical/invasive procedure incident | CW | 03/10/2018 |
| 2018/17618 | 04/07/2018 | EIC | Diagnostic incident including delay | CW | 11/10/2018 |
| 2018/17749 | 13/07/2018 | EIC | Pressure ulcer | WM | 12/10/2018 |

## 4.0 SI Action Plans

All action plans are recorded on DATIX on submission of the SI investigation reports to CWHHE. This increases visibility of the volume of actions due. The Quality and Clinical Governance team work with the Divisions to highlight the deadlines and in obtaining evidence for closure.

As is evident from table 4 there are a number of overdue actions across the Divisions, 9 actions overdue at the time of writing this report. This is a significant decrease compared to last month when there were 38. Women's, Children's, HIV, GUM and Dermatology Division has 6 outstanding actions and the Emergency and Integrated Care Division has 4. The Planned Care Division does not have any actions outstanding.

Table 4 - SI Actions

| | Month due for completion | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | Jan 2019 | Feb 2019 | Mar 2019 | Total |
| **EIC** | 0 | 4 | 6 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | **13** |
| **PC** | 0 | 0 | 2 | 3 | 2 | 1 | 2 | 0 | 0 | 0 | **10** |
| **W&C,HGD** | 1 | 5 | 8 | 7 | 0 | 5 | 0 | 1 | 0 | 2 | **29** |
| **Total** | **1** | **9** | **16** | **12** | **2** | **6** | **3** | **1** | **0** | **2** | **52** |

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

Table 4.1 – Type of actions overdue

| Action type | EIC | PC | W&C,HGD | Grand Total |
|---|---|---|---|---|
| Share learning (inc. feedback to staff involved) | | | 4 | 4 |
| Personal reflection/Supervised practice | | | 1 | 1 |
| Create/amend/review - Policy/Procedure/Protocol | | | 1 | 1 |
| Create/amend/review - proforma or information sheet | 1 | | | 1 |
| Duty of Candour - Patient/NOK notification | 1 | | | 1 |
| One-off training | 1 | | | 1 |
| Set up ongoing training | 1 | | | 1 |
| **Grand Total** | **4** | **0** | **6** | **10** |

## 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 8 which is significantly less compared to the same reporting period last year and the year before (2016/17 = 19, 2017/2018 = 21).

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 | | | | | | | | | 13 |
| | **CW** | 0 | 2 | 0 | 3 | | | | | | | | | 5 |
| | | **3** | **5** | **2** | **8** | | | | | | | | | **18** |

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 | | | | | | | | | | 3 |
| Pressure ulcer | | 1 | | 2 | | | | | | | | | 3 |
| Maternity/Obstetric incident: baby only | | 1 | | 1 | | | | | | | | | 2 |
| Sub-optimal care of the deteriorating patient | | | | 2 | | | | | | | | | 2 |
| Medication incident | 1 | 1 | | | | | | | | | | | 2 |
| Surgical/invasive procedure incident | | | | 1 | | | | | | | | | 1 |
| Grand Total | 3 | 5 | 2 | 8 | | | | | | | | | 18 |

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 de-escalated by the commissioners.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.6/Sep/18 |
| **REPORT NAME** | Integrated Performance Report –June & July 2018 |
| **AUTHOR** | Robert Hodgkiss, Chief Operating Officer |
| **LEAD** | Robert Hodgkiss, Chief Operating Officer |
| **PURPOSE** | To report the combined Trust's performance for July 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 June & July 2018.<br><br>**Regulatory performance** – The A&E Waiting Time figure for June was 95.1% with a Q1 position of 95.3%, ahead of our 93.8% STF trajectory. National figures show that Chelsea and Westminster, in month, ranked 3rd of London Trusts. The Trust saw an 8% increase in attendances in June 2018 compared to the same month in 2017.<br><br>The A&E Waiting Time figure for July was 95.6%. National figures show that Chelsea and Westminster ranked 1st of London Trusts<br><br>The RTT incomplete target was achieved in both June & July for the Trust, with combined performance of 92.2%. This represents the eighth & ninth consecutive months the national standard was reached.<br><br>There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue.<br><br>It must be noted that the size of the PTL (Patient Tracking List) has increased post Cerner at the WMUH site by c.25%. It was always anticipated this would grow by c.10-15% (based on other Trusts' implementations) due to more sophisticated recording capabilities, however the level of growth is currently under investigation, in conjunction with NHSI colleagues, and a daily meeting is in place to correct known DQ issues.<br><br>Delivery of the 62 Day standards was met in both June and July. Each month in 2018/19 we have exceeded the national target. All other cancer indicators passed except Breast Symptomatic referrals passed due to an Administration issue, identified and now resolved. This involved the failure to check the ASI list for breast symptomatic and reduced visibility in Cerner (the PAS system used at West Middlesex) due to Breast 2ww not being separated by symptomatic and suspected cancer. It is expected that the Trust will return to compliance in August. |

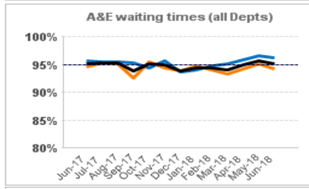
| | |
|---|---|
| | There was one reported CDiff infection in June.<br><br>**Access**<br><br>The Diagnostic wait metric returned 99.28% in June - the first reporting period the target has been met for 10 months. Focussing on issues in Urology at Chelsea and in Endoscopy, Urology and Cardiology at West Middlesex has paid dividends<br><br>July returned another complaint month at 99.15% |
| **KEY RISKS ASSOCIATED:** | There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer 31 and 62 day waits remains a high priority. |
| **FINANCIAL IMPLICATIONS** | The Trust is reporting a year to date surplus of £1.3m which is £0.04m favourable against the internal plan on a control total basis. The Trust is performing in line with or better than plan for all areas of measurement of the Use of Resources Rating, except against its agency rating, due to agency spend being 6.2% above the agency ceiling. This is primarily due to non-recurrent EPR implementation and floor walker costs.<br><br>The capital programme is underspent against plan for the year to date, mainly due to delays in the NICU/ITU and Modular Maternity Building projects; however the Trust is forecasting to deliver the full capital programme by the end of 2018/19. |
| **QUALITY IMPLICATIONS** | As outlined above. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | Improve patient safety and clinical effectiveness<br>Improve the patient experience<br>Ensure financial and environmental sustainability |
| **DECISION/ ACTION** | The Board is asked to note the performance for June & July 2018 and to note that whilst some indicators were not delivered in those months, the overall YTD compliance remained good. |

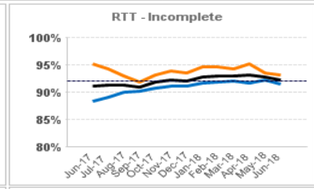
# TRUST PERFORMANCE & QUALITY REPORT

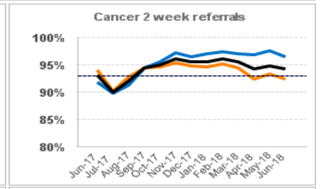
## June 2018

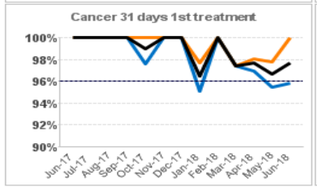
## Regulatory Compliance

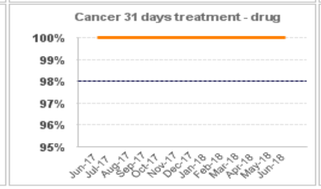
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined Trust data: last Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Quarter | YTD | Trend |
| A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 95.9 | 96.5 | 96.1 | 94.2 | 95.0 | 94.2 | 95.0 | 95.7 | 95.1 | 95.3 | 95.3 | |
| RTT - Incomplete (Target: >92%) | 91.7 | 92.2 | 91.4 | 95.2 | 93.6 | 93.1 | 93.2 | 92.8 | 92.2 | 92.7 | 92.7 | |
| Cancer 2 week urgent referrals (Target: >93%) | 96.8 | 97.6 | 96.5 | 92.5 | 93.3 | 92.4 | 94.2 | 94.9 | 94.2 | 94.4 | 94.4 | |
| Cancer 2 week Breast symptomatic (Target: >93%) | n/a | n/a | n/a | 93.8 | 94.4 | 89.2 | 93.8 | 94.4 | 89.2 | 92.4 | 92.4 | |
| Cancer 31 days first treatment (Target: >96%) | 97.0 | 95.5 | 95.8 | 98.1 | 97.8 | 100 | 97.6 | 96.6 | 97.7 | 97.3 | 97.3 | |
| Cancer 31 days treatment - Drug (Target: >98%) | n/a | 100 | n/a | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 31 days treatment - Surgery (Target: >94%) | n/a | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 62 days GP ref to treatment (Target: >85%) | 91.2 | 87.7 | 83.6 | 93.9 | 83.6 | 91.4 | 93.0 | 85.4 | 88.0 | 88.5 | 88.5 | |
| Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 3 | |
| Average Emergency PreOp LoS | 0.55 | 0.50 | 0.44 | 1.49 | 0.83 | 1.25 | 0.98 | 0.66 | 0.73 | 0.79 | 0.79 | |
| Average Elective PreOp LoS | 0.11 | 0.15 | 0.20 | 0.15 | 0.01 | 0.02 | 0.12 | 0.11 | 0.15 | 0.13 | 0.13 | |

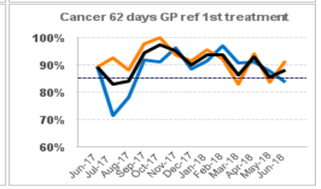


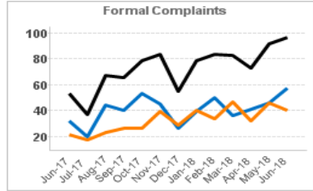



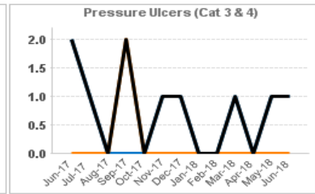



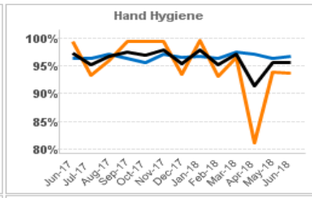



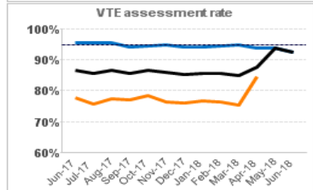

## Quality

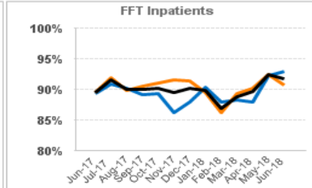
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Quarter | YTD | Trend |
| Hand Hygiene (Target: >=90%) | 97.1 | 96.4 | 96.7 | 81.1 | 93.9 | 93.8 | 91.5 | 95.6 | 95.7 | 94.3 | 94.3 | |
| Pressure Ulcers (Cat 3 & 4) | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 2 | |
| VTE assessment % (Target: >=95%) | 93.9 | 94.0 | 92.4 | 84.7 | | | 87.8 | 94.0 | 92.4 | 90.0 | 90.0 | |
| Formal complaints number received | 41 | 46 | 57 | 32 | 46 | 40 | 73 | 92 | 97 | 262 | 262 | |
| Formal complaints responded to <25days | 32 | 40 | 32 | 21 | 35 | 21 | 53 | 75 | 53 | 181 | 181 | |
| Serious Incidents | 0 | 2 | 0 | 3 | 3 | 2 | 3 | 5 | 2 | 10 | 10 | |
| Never Events (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| FFT - Inpatients recommend % (Target: >90%) | 87.9 | 92.3 | 92.8 | 90.2 | 92.5 | 90.6 | 89.6 | 92.4 | 91.7 | 91.1 | 91.1 | |
| FFT - A&E recommend % (Target: >90%) | 89.0 | 90.2 | 90.0 | 83.2 | 82.5 | 84.4 | 88.0 | 88.9 | 89.1 | 88.7 | 88.7 | |
| Falls causing serious harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

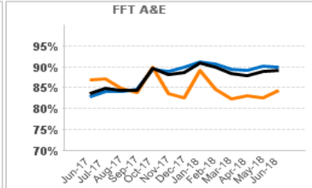


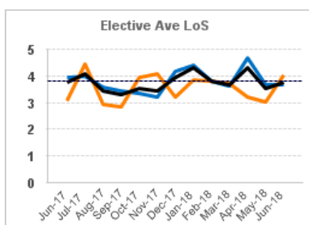



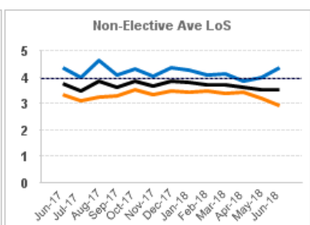



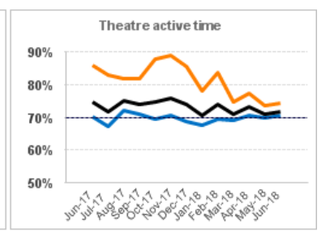



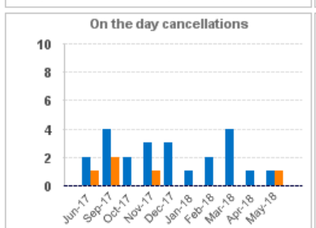

## Efficiency

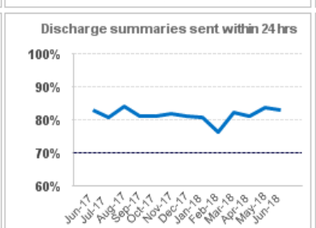
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Quarter | YTD | Trend |
| Elective average LoS (Target: <3.8) | 4.7 | 3.7 | 3.7 | 3.2 | 3.0 | 4.0 | 4.3 | 3.5 | 3.8 | 3.9 | 3.9 | |
| Non-Elective average LoS (Target: <3.95) | 3.8 | 4.0 | 4.3 | 3.4 | 3.2 | 2.9 | 3.6 | 3.5 | 3.5 | 3.5 | 3.5 | |
| Theatre active time (Target: >70%) | 70.6 | 69.6 | 70.7 | 77.3 | 73.5 | 74.3 | 73.0 | 70.8 | 71.8 | 71.9 | 71.9 | |
| Discharge summaries sent within 24 hours (Target: >70%) | 81.0 | 83.8 | 82.8 | dev | dev | dev | 81.0 | 83.8 | 82.8 | 82.6 | 82.6 | |
| Outpatient DNA rates (Target: <11.1%) | 10.5 | 10.5 | 10.9 | 11.5 | 14.1 | 14.1 | 10.9 | 11.7 | 12.1 | 11.6 | 11.6 | |
| On the day cancelled operations not re-booked within 28 days (Target: 0) | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 3 | 3 | |

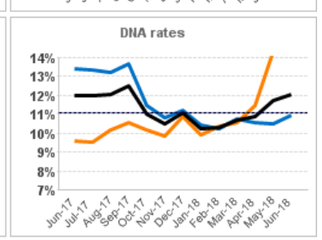


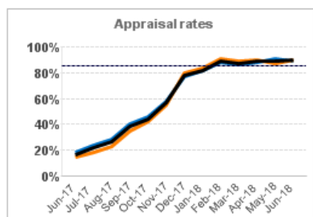



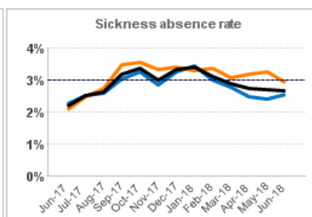



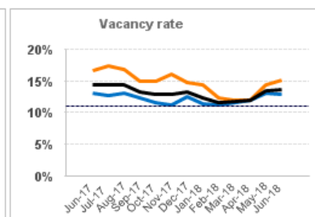



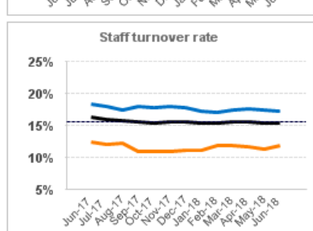

## Workforce

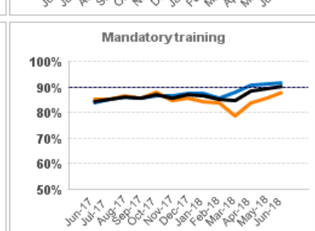
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Apr-18 | May-18 | Jun-18 | Quarter | YTD | Trend |
| Appraisal rates (Target: >85%) | 88.5 | 90.6 | 89.3 | 89.8 | 87.2 | 89.9 | 88.9 | 89.4 | 89.5 | 89.3 | 89.3 | |
| Sickness absence rate (Target: <3%) | 2.50 | 2.42 | 2.55 | 3.17 | 3.25 | 2.93 | 2.73 | 2.70 | 2.68 | 2.70 | 2.70 | |
| Vacancy rates (Target: CW<12%; WM<10%) | 12.1 | 13.1 | 12.8 | 12.0 | 14.3 | 15.1 | 12.0 | 13.5 | 13.6 | 13.6 | 13.6 | |
| Turnover rate (Target: CW<18%; WM<11.5%) | 17.5 | 17.3 | 17.2 | 11.7 | 11.3 | 11.9 | 15.6 | 15.3 | 15.4 | 15.4 | 15.4 | |
| Mandatory training (Target: >90%) | 90.9 | 91.1 | 91.6 | 83.7 | 85.8 | 87.8 | 88.2 | 89.1 | 90.2 | 89.2 | 89.2 | |
| Bank and Agency spend (£ks) | £2,652 | £2,311 | £2,398 | £2,397 | £2,312 | £2,154 | £5,049 | £4,623 | £4,552 | £14,224 | £14,224 | |
| Nursing & Midwifery: Agency % spend of total pay (Target: tbc) | 8.3 | 6.4 | 3.6 | 10.1 | 8.3 | 8.2 | 9.0 | 7.1 | 5.4 | 7.2 | 7.2 | |

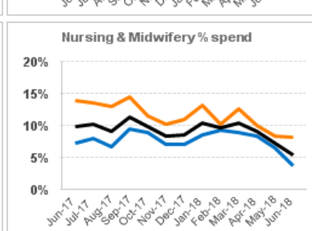


# NHSI Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts | |
| A&E | A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 95.9% | 96.5% | 96.1% | 96.2% | 94.2% | 95.0% | 94.2% | 94.5% | 95.0% | 95.7% | 95.1% | 95.3% | 95.3% | | - |
| RTT | 18 weeks RTT - Admitted (Target: >90%) | 74.4% | 75.4% | 73.5% | 74.5% | 86.4% | 86.3% | 74.1% | 83.6% | 82.2% | 79.8% | 73.8% | 79.2% | 79.2% | | ! |
| | 18 weeks RTT - Non-Admitted (Target: >95%) | 94.4% | 94.9% | 94.7% | 94.7% | 90.9% | 90.5% | 91.1% | 90.9% | 93.1% | 93.6% | 93.4% | 93.3% | 93.3% | | ! |
| | 18 weeks RTT - Incomplete (Target: >92%) | 91.7% | 92.2% | 91.4% | 91.8% | 95.2% | 93.6% | 93.1% | 93.9% | 93.2% | 92.8% | 92.2% | 92.7% | 92.7% | | - |
| Cancer<br><br>(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jun-18) in this report | 2 weeks from referral to first appointment all urgent referrals (Target: >93%) | 96.8% | 97.6% | 96.5% | 96.9% | 92.5% | 93.3% | 92.4% | 92.7% | 94.2% | 94.9% | 94.2% | 94.4% | 94.4% | | - |
| | 2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%) | n/a | n/a | n/a | n/a | 93.8% | 94.4% | 89.2% | 92.4% | 93.8% | 94.4% | 89.2% | 92.4% | 92.4% | | - |
| | 31 days diagnosis to first treatment (Target: >96%) | 97.0% | 95.5% | 95.8% | 96.0% | 98.1% | 97.8% | 100% | 98.5% | 97.6% | 96.6% | 97.7% | 97.3% | 97.3% | | - |
| | 31 days subsequent cancer treatment - Drug (Target: >98%) | n/a | 100% | n/a | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Surgery (Target: >94%) | n/a | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | - |
| | 31 days subsequent cancer treatment - Radiotherapy (Target: >94%) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |
| | 62 days GP referral to first treatment (Target: >85%) | 91.2% | 87.7% | 83.6% | 87.0% | 93.9% | 83.6% | 91.4% | 89.5% | 93.0% | 85.4% | 88.0% | 88.5% | 88.5% | | - |
| | 62 days NHS screening service referral to first treatment (Target: >90%) | n/a | n/a | n/a | n/a | 66.7% | 100% | 100% | 87.5% | 66.7% | 100% | 100% | 87.5% | 87.5% | | - |
| Patient Safety | Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 3 | 1 | 1 | 1 | 3 | 3 | | ! |
| 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**

The Trust again achieved the 4 hour target in June with performance of 95.1%. This performance was above our STF trajectory of 93.8% and placed the Trust 3rd across London.

.

The target continues to be challenged by increasing attendances to the Emergency Departments at both of our hospitals, with an 8% increase in attendances compared to June 2017.

**2 weeks from referral to first appointment all Breast symptomatic referral**

Two challenges in achieving this standard and anticipated to be non-compliant in June & July, returning to compliance in August

The issues related to:

- Admin error where patients were not checked against the ASI list resulting in multiple breaches in June.
- Breast symptomatic field in Cerner (PAS – Patient Access System) not being visible to MDT coordinators.

Both issues have been resolved and are not expected to cause issues again and we expect to return to compliance in August 2018

**Cancer - 62 days GP referral to first treatment**

The trust's unvalidated performance for Q1 2018/19 is 88.5% (compared to 82.8% for Q1 2017/18) against a backdrop of increased demand (166.5 treatments in Q1 18/19 compared to 125 treatments in Q1 17/18). The Trust is compliant against this indicator for June. However July looks to be more challenging and work continues to meet the target for this metric. A breakdown of breaches by tumour site can be found in the additional dashboard on page 12

# Safety Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 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%) | 97.1% | 96.4% | 96.7% | 96.7% | 81.1% | 93.9% | 93.8% | 89.6% | 91.5% | 95.6% | 95.7% | 94.3% | 94.3% | | - |
| Incidents | Number of serious incidents | 0 | 2 | 0 | 2 | 3 | 3 | 2 | 8 | 3 | 5 | 2 | 10 | 10 | | - |
| | Incident reporting rate per 100 admissions (Target: >8.5) | 7.1 | 7.4 | 8.1 | 7.5 | 10.1 | 8.9 | 8.7 | 9.2 | 8.4 | 8.1 | 8.4 | 8.3 | 8.3 | | ! |
| | Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0) | 0.00 | 0.03 | 0.00 | 0.01 | 0.04 | 0.00 | 0.02 | 0.02 | 0.02 | 0.02 | 0.01 | 0.01 | 0.01 | | ! |
| | Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280) | 535.05 | 495.27 | 514.43 | 514.79 | 234.01 | 165.69 | 268.48 | 220.09 | 386.06 | 327.12 | 398.71 | 369.70 | 369.70 | | ! |
| | Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%) | 10.0% | 16.7% | 8.7% | 11.7% | 13.3% | 8.7% | 15.6% | 12.9% | 11.0% | 14.6% | 10.9% | 12.1% | 12.1% | | - |
| | Never Events (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| Harm | Safety Thermometer - Harm Score (Target: >90%) | 97.1% | 95.6% | 93.2% | 95.7% | 96.5% | 93.5% | 97.7% | 95.7% | 96.8% | 94.2% | 96.0% | 95.7% | 95.7% | | - |
| | Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6) | 0 | 1 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 2 | | - |
| | NEWS compliance % | 97.7% | 98.0% | 96.7% | 97.4% | 98.8% | 98.7% | 97.7% | 98.3% | 98.2% | 98.3% | 97.1% | 97.8% | 97.8% | | - |
| | Safeguarding adults - number of referrals | 26 | 17 | 28 | 71 | 17 | 4 | 7 | 28 | 43 | 21 | 35 | 99 | 99 | | - |
| | Safeguarding children - number of referrals | 28 | 22 | 26 | 76 | 63 | 37 | 54 | 154 | 91 | 59 | 80 | 230 | 230 | | - |
| 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 | 35 | 35 | 31 | 101 | 56 | 56 | 50 | 162 | 91 | 91 | 81 | 263 | 263 | | - |
| | Number of hospital deaths - Paediatric | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | | - |
| | Number of hospital deaths - Neonatal | 3 | 1 | 3 | 7 | 0 | 0 | 1 | 1 | 3 | 1 | 4 | 8 | 8 | | - |
| | Number of deaths in A&E - Adult | 2 | 1 | 1 | 4 | 5 | 3 | 6 | 14 | 7 | 4 | 7 | 18 | 18 | | - |
| | Number of deaths in A&E - Paediatric | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 | 0 | 1 | 2 | 2 | | - |
| | Number of deaths in A&E - Neonatal | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 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**

**Number of serious incidents**

2 Serious Incidents were reported during Jun-18; compared to 5 reported in May-18. Both SI's occurred on the WMH site; one concerned a delayed diagnosis of Cancer and one was a patient fall.

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 an improvement in performance, with an overall reporting rate of 8.4% in Jun-18; marginally lower than the target of 8.5%.

We continue to encourage reporting across all staff groups, with a focus on the reporting of no harm or near miss incidents.

**Trust commentary continued**

**Medication-related safety incidents**

81 Medication-related incidents were reported at the Chelsea site compared to 48 such incidents at the West Middlesex.

The Medication Safety Group is working to increase the reporting of medication related incidents at the WMH site, particularly no harm and near miss incidents.

**Never Events**

There were no Never Events reported in June

**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 288/100,000 FCE bed days in June 2018. Performance has achieved the Trust target of 280/100,000. There were 313 and 261 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively. The WM rate (261) has improved since previous month but remains lower than that for CW site (313) for June 2018.

At CW site, there has been a decrease in reporting of medication incidents this month compared to recent months; with decreased reporting at WM site

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

The Trust had 10% medication-related safety incidents with harm in June 2018. This figure is lower than in previous months and is below the Carter dashboard National Benchmark (10.3%). The year to date figure is 11.5%.
There were 11 incidents with no harm, 6 at CW site and 5 at WM site.

- Themes CW site (low harm): Lack of monitoring for aminoglycoside levels; delay in ordering medications; incorrect administration of medication due to patient receiving two discharge summarises and multiple strengths of medication supplied (dose changed on discharge date); misinterpretation of paracetamol dosing and units in paediatrics resulted in incorrect prescription and administration; and lack of monitoring of injection site.
- Themes WM site (low harm): Delayed prescribing and administration due to missing medication chart; administration of an incorrect medication when not prescribed; adverse reaction to medication; incorrect labelling instructions of a dispensed medication; and a critical medication not available on ward or emergency drug cupboard resulting in delayed administration.

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

**NEWS compliance**

Compliance continues to be monitored weekly, but will be moving to monthly to allow time for actions to take place. The audits monitor both completion & accuracy of escalation. Figures remain over 95% for both sites.

# Patient Experience Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts | |
| Friends and Family | FFT: Inpatient recommend % (Target: >90%) | 87.9% | 92.3% | 92.8% | 91.3% | 90.2% | 92.5% | 90.6% | 90.9% | 89.6% | 92.4% | 91.7% | 91.1% | 91.1% | | - |
| | FFT: Inpatient not recommend % (Target: <10%) | 6.0% | 4.6% | 3.1% | 4.4% | 3.5% | 3.1% | 4.0% | 3.5% | 4.2% | 3.8% | 3.6% | 3.9% | 3.9% | | - |
| | FFT: Inpatient response rate (Target: >30%) | 34.0% | 44.4% | 49.0% | 42.4% | 59.7% | 45.6% | 34.7% | 46.8% | 49.6% | 45.0% | 40.3% | 45.0% | 45.0% | | - |
| | FFT: A&E recommend % (Target: >90%) | 89.0% | 90.2% | 90.0% | 89.8% | 83.2% | 82.5% | 84.4% | 83.4% | 88.0% | 88.9% | 89.1% | 88.7% | 88.7% | | ! |
| | FFT: A&E not recommend % (Target: <10%) | 7.2% | 5.9% | 6.1% | 6.3% | 7.1% | 11.3% | 9.4% | 9.3% | 7.2% | 6.8% | 6.6% | 6.8% | 6.8% | | - |
| | FFT: A&E response rate (Target: >30%) | 18.2% | 20.3% | 22.4% | 20.3% | 14.6% | 15.7% | 17.2% | 15.8% | 17.4% | 19.4% | 21.4% | 19.4% | 19.4% | | ! |
| | FFT: Maternity recommend % (Target: >90%) | 92.7% | 90.7% | 91.4% | 91.5% | 93.9% | 96.6% | 95.6% | 95.4% | 93.1% | 92.5% | 92.3% | 92.6% | 92.6% | | - |
| | FFT: Maternity not recommend % (Target: <10%) | 4.2% | 6.3% | 5.5% | 5.4% | 3.0% | 1.7% | 2.9% | 2.5% | 3.8% | 4.9% | 4.9% | 4.6% | 4.6% | | - |
| | FFT: Maternity response rate (Target: >30%) | 17.9% | 24.9% | 24.0% | 22.3% | 26.8% | 32.7% | 19.5% | 26.4% | 20.2% | 26.8% | 22.9% | 23.3% | 23.3% | | ! |
| Experience | Breach of same sex accommodation (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| Complaints | Complaints formal: Number of complaints received | 41 | 46 | 57 | 144 | 32 | 46 | 40 | 118 | 73 | 92 | 97 | 262 | 262 | | - |
| | Complaints formal: Number responded to < 25 days | 32 | 40 | 32 | 104 | 21 | 35 | 21 | 77 | 53 | 75 | 53 | 181 | 181 | | - |
| | Complaints (informal) through PALS | 115 | 113 | 127 | 355 | 93 | 107 | 101 | 301 | 208 | 220 | 228 | 656 | 656 | | - |
| | 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |

| | | | |
|---|---|---|---|
| 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 the Trust continue to exceed the response rate and recommendation score target. Ward level and department level information is now available through a Qlikview dashboard.

A&E continues to improve with the Chelsea site achieving the 90% recommended target for both May and June, whilst not meeting the 90% target the West Middlesex site continues to improve. Both sites fail to meet the 30% response rate but exceed the national average of 12.5%.

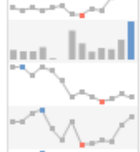
Maternity services continue to exceed the recommendation score but continue not to reach the response rate target.

**Same Sex Accommodation**
There have been no same sex accommodation breaches

**Complaints**
Formal complaints continue to improve with compliance with target response times.

**Ombudsman Referrals**
There have been no new referrals to the ombudsman and the Trust have not been informed of any current cases being upheld.

# Efficiency & Productivity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts | |
| Admitted Patient Care | Average length of stay - elective (Target: <2.9) | 4.67 | 3.68 | 3.68 | 4.01 | 3.21 | 3.03 | 4.04 | 3.42 | 4.30 | 3.53 | 3.76 | 3.87 | 3.87 |  | - |
| | Average length of stay - non-elective (Target: <3.95) | 3.84 | 3.99 | 4.33 | 4.05 | 3.44 | 3.19 | 2.94 | 3.17 | 3.63 | 3.51 | 3.51 | 3.55 | 3.55 |  | - |
| | Emergency care pathway - average LoS (Target: <4.5) | 4.62 | 4.47 | 4.86 | 4.65 | 3.98 | 3.71 | 3.37 | 3.66 | 4.24 | 3.97 | 3.88 | 4.02 | 4.02 |  | - |
| | Emergency care pathway - discharges | 212 | 209 | 211 | 632 | 316 | 400 | 404 | 1120 | 528 | 609 | 615 | 1752 | 1752 |  | - |
| | Emergency re-admissions within 30 days of discharge (Target: <7.6%) | 3.89% | 3.97% | 3.54% | 3.80% | 7.97% | 10.19% | 10.88% | 9.76% | 5.72% | 6.94% | 7.08% | 6.60% | 6.60% |  | ! |
| | Non-elective long-stayers | 432 | 412 | 410 | 1254 | 390 | 312 | 304 | 1006 | 822 | 724 | 714 | 2260 | 2260 |  | - |
| Theatres | Daycase rate (basket of 25 procedures) (Target: >85%) | 81.1% | 82.0% | 80.9% | 81.3% | 89.1% | 86.7% | 87.9% | 87.9% | 84.6% | 83.7% | 83.3% | 83.8% | 83.8% |  | ! |
| | Operations canc on the day for non-clinical reasons: actuals | 20 | 14 | 8 | 42 | 3 | 1 | 12 | 16 | 23 | 15 | 20 | 58 | 58 |  | - |
| | Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%) | 0.70% | 0.48% | 0.28% | 0.49% | 0.20% | 0.08% | 0.92% | 0.39% | 0.53% | 0.36% | 0.48% | 0.46% | 0.46% |  | - |
| | Operations cancelled the same day and not rebooked within 28 days (Target: 0) | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 1 | 1 | 2 | 0 | 3 | 3 |  | - |
| | Theatre active time (Target: >70%) | 70.6% | 69.6% | 70.7% | 70.3% | 77.3% | 73.5% | 73.9% | 75.0% | 73.0% | 70.9% | 71.7% | 71.9% | 71.9% |  | ! |
| | Theatre booking conversion rates (Target: >80%) | 84.5% | 85.6% | 85.6% | 85.2% | 83.4% | 92.7% | 93.9% | 89.5% | 84.0% | 88.1% | 88.5% | 86.8% | 86.8% |  | - |
| Outpatients | First to follow-up ratio (Target: <1.5) | 1.57 | 1.47 | 1.43 | 1.49 | 1.26 | 1.33 | 1.45 | 1.34 | 1.34 | 1.38 | 1.44 | 1.38 | 1.38 |  | - |
| | Average wait to first outpatient attendance (Target: <6 wks) | 6.6 | 6.9 | 6.6 | 6.7 | 7.0 | 7.5 | 7.4 | 7.3 | 6.8 | 7.2 | 7.0 | 7.0 | 7.0 |  | ! |
| | DNA rate: first appointment | 10.6% | 11.3% | 11.8% | 11.2% | 12.0% | 14.0% | 14.5% | 13.4% | 11.2% | 12.4% | 13.0% | 12.2% | 12.2% |  | - |
| | DNA rate: follow-up appointment | 10.5% | 10.2% | 10.6% | 10.4% | 11.1% | 14.2% | 13.7% | 13.0% | 10.7% | 11.4% | 11.6% | 11.2% | 11.2% |  | - |

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

**Elective and Non-Elective LOS (Incl. Emergency Care)**

LoS target revised and changed from June to 2.9 (previously 3.7). There was an increase in average Elective LoS across all Divisions at West Middlesex. Discharge delays to continue to be escalated with additional input from senior staff to daily ward board rounds. We expect an improvement for July.

For Non Elective, June has seen a small decline at Chelsea site and an improvement at West Middlesex, with this indicator remaining 'green' overall. However, work is continuing post Cerner to provide an agreed position for the WM data. As before, the recent NEL LOS review by division confirms that the Trust benchmarks well (top quartile) when compared with peer group hospitals for NEL LOS, but within Care of the Elderly and Stroke, there remains an opportunity to improve LOS further at both hospitals. Delivering this improvement ahead of winter 18/19 is a strong focus for the BEDS/LOS work stream, and is being tracked via the system-wide AE Delivery Board.

**Operations cancelled on the day for non-clinical reasons**

There were 8 such cancellations at the Chelsea Site, all of which were re-booked within the 28 day standard. At West Middlesex, 12 cases were cancelled on the day. Six of these were as a result of list overruns due to complications / complex cases; two where notes were not available; three due to equipment with the other being to accommodate a patient with a higher clinical priority. Again, all were re-booked within 28 days. We are currently reviewing the data leading to non-compliance at West Middlesex against the 0.8% target. We expect this to be resolved during month of July.

**Outpatient DNA rates**

Following the Cerner go live patients were marked as 'DNAS' due to a problem with the migrated data when these patients were cancelled rather than failing to attend. In addition there were problems through May and in to June with text reminders not being sent and Tomcat (cardiology system) letters not being sent. All these problems have now been rectified.

**Readmissions**

Operational managers are working with coding team to address challenges regarding readmission codes used at West Middlesex which is currently leading to non-compliance.

# Clinical Effectiveness Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts | |
| Best Practice | Dementia screening case finding (Target: >90%) | 92.1% | 93.1% | 79.9% | 88.3% | 84.0% | | | 84.0% | 87.7% | 93.1% | 79.9% | 87.1% | 87.1% | | - |
| | #NoF Time to Theatre <36hrs for medically fit patients (Target: 100%) | 100.0% | 93.3% | 94.1% | 95.9% | 66.7% | 87.5% | 100.0% | 84.8% | 86.2% | 89.7% | 96.3% | 90.5% | 90.5% | | ! |
| | Stroke care: time spent on dedicated Stroke Unit (Target: >80%) | 100.0% | 100.0% | 100.0% | 100.0% | 92.9% | 90.0% | 100.0% | 95.2% | 96.0% | 95.7% | 100.0% | 97.5% | 97.5% | | - |
| VTE | VTE: Hospital-acquired (Target: tbc) | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| | VTE risk assessment (Target: >95%) | 93.9% | 94.0% | 92.4% | 93.4% | 84.7% | | | 84.7% | 87.8% | 94.0% | 92.4% | 90.0% | 90.0% | | ! |
| TB Care | TB: Number of active cases identified and notified | 0 | 7 | 2 | 9 | 3 | 3 | 4 | 10 | 3 | 10 | 6 | 19 | 19 | | - |
| | TB: % of treatments completed within 12 months (Target: >85%) | | | | | | | | | | | | | | | - |

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

**Trust commentary**

**Time to Theatre for patients with a fractured neck of femur**

We have seen a significant improvement in performance for June. Of the 26 patients included in the best practice target, 1 patient at CW was delayed due a clinical prioritisation and operated at 42h.
Work is on-going to sustain improvement with medically well patients escalated to operational teams when waiting 24h for surgery.

**Dementia**

Data not fully completed due to staff absence this will be corrected for M4.

# Access Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 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%) | 98.79% | 98.52% | 99.33% | 98.88% | 97.62% | 98.67% | 99.26% | 98.51% | 98.09% | 98.61% | 99.28% | 98.65% | 98.65% | | - |
| | Diagnostic waiting times >6 weeks: breach actuals | 40 | 40 | 18 | 98 | 120 | 52 | 39 | 211 | 160 | 92 | 57 | 309 | 309 | | - |
| A&E and LAS | A&E unplanned re-attendances (Target: <5%) | 8.7% | 8.7% | 9.5% | 9.0% | 8.5% | 7.8% | 8.1% | 8.1% | 8.6% | 8.4% | 9.1% | 8.7% | 8.7% | | ! |
| | A&E time to treatment - Median (Target: <60') | 01:04 | 01:06 | 01:10 | 01:07 | 00:47 | 00:45 | 00:48 | 00:47 | 00:59 | 01:00 | 01:04 | 01:01 | 01:01 | | ! |
| | London Ambulance Service - patient handover 30' breaches | 8 | 9 | 12 | 29 | 40 | 63 | 56 | 159 | 48 | 72 | 68 | 188 | 188 | | - |
| | London Ambulance Service - patient handover 60' breaches | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 2 | 2 | 2 | | - |
| Choose and Book (available to Apr-18 only for issues) | Choose and book: appointment availability (average of daily harvest of unused slots) | 1347 | 1483 | 1629 | 1486 | 0 | 0 | 0 | 0 | 1347 | 1483 | 1629 | 1486 | 1486 | | - |
| | Choose and book: capacity issue rate (ASI) | | | | | | | | | | | | | | | - |
| | Choose and book: system issue rate | 119 | 123 | 108 | 117 | | | | | | | | | | | - |

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

**Trust commentary**

**RTT Incompletes 52 week waiters at Month End**

The Trust again reported no patients waiting more than one year for their elective treatment

**Diagnostic waiting times - % waiting under 6 weeks**

Continuing focus on problem areas has returned a compliant position for June, with the Trust reporting over 99% for the first time in ten months.

**London Ambulance Service – patient handover 60’ breaches**

There were two occasions in June when the 60 minute ambulance handover target was breached at West Middlesex.

These both occurred within a 24 hour period due to an issue with visibility of incoming ambulances caused by building works to facilitate the refurbishment of AE Majors. This has since been rectified, with no further breaches reported in July.

# Maternity Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts |
| Birth indicators | Total number of NHS births | 479 | 455 | 449 | 1383 | 371 | 377 | 375 | 1123 | 850 | 832 | 824 | 2506 | 2506 | - |
| | Total caesarean section rate (C&W Target: <27%; WM Target: <29%) | 39.1% | 31.1% | 34.0% | 34.8% | 27.8% | 29.0% | 26.0% | 27.6% | 34.1% | 30.1% | 30.4% | 31.6% | 31.6% | ! |
| | 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%) | 97.2% | 93.8% | 98.6% | 96.5% | 97.8% | 98.4% | 100.0% | 98.7% | 97.5% | 95.9% | 99.2% | 97.5% | 97.5% | - |
| Safety | Admissions of full-term babies to NICU | 12 | 15 | 16 | 43 | n/a | n/a | n/a | n/a | 12 | 15 | 16 | 43 | 43 | - |

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

**Trust commentary**

**Total caesarean section rate**

The Caesarean section rate for the CW site has increased to 34% (elective and emergency). This increase is linked to the 19% elective C/S rate for the month - this equates to 10 additional elective procedures for the month.

This average is higher than May but is reduced from April's report.

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

The 1:1 care reporting is improving so that women who attend in labour are offered 1:1 care whilst in established labour. Data such as births before arrival to hospital are removed from this data reporting so that a true picture of care offered is now captured within the system.

Data for WM site reports 100% of women offered 1:1 care. The dedicated midwifery teams are improving the experience for women and this is also impacting on the normal birth rate at home, with some women reporting improved confidence to birth at home.

# Workforce Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 2018-2019 | Trend charts | |
| Staffing | Vacancy rate (Target: CW <12%; WM <10%) | 12.1% | 13.1% | 12.8% | 12.8% | 12.0% | 14.3% | 15.1% | 15.1% | 12.0% | 13.5% | 13.6% | 13.6% | 13.6% | | ! |
| | Staff Turnover rate (Target: CW <18%; WM <11.5%) | 17.5% | 17.3% | 17.2% | 17.2% | 11.7% | 11.3% | 11.9% | 11.9% | 15.6% | 15.3% | 15.4% | 15.4% | 15.4% | | - |
| | Sickness absence (Target: <3%) | 2.5% | 2.4% | 2.5% | 2.5% | 3.2% | 3.2% | 2.9% | 3.1% | 2.7% | 2.7% | 2.7% | 2.7% | 2.7% | | - |
| | Bank and Agency spend (£ks) | £2,652 | £2,311 | £2,398 | £7,361.4 | £2,397 | £2,312 | £2,154 | £6,862.9 | £5,049 | £4,623 | £4,552 | £14,224 | £14,224 | | - |
| | Nursing & Midwifery Agency: % spend of total pay (Target: tbc) | 8.3% | 6.4% | 3.6% | 6.1% | 10.1% | 8.3% | 8.2% | 8.9% | 9.0% | 7.1% | 5.4% | 7.2% | 7.2% | | - |
| Appraisal rates | % of Performance & Development Reviews completed - medical staff (Target: >85%) | 83.2% | 87.7% | 87.7% | 86.2% | 84.1% | 84.0% | 84.0% | 84.0% | 83.6% | 86.2% | 86.2% | 85.3% | 85.3% | | ! |
| | % of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%) | 89.2% | 91.0% | 89.5% | 89.5% | 90.9% | 87.8% | 91.0% | 91.0% | 89.8% | 89.9% | 90.0% | 90.0% | 90.0% | | - |
| Training | Mandatory training compliance (Target: >90%) | 90.9% | 91.1% | 91.6% | 91.2% | 83.7% | 85.8% | 87.8% | 85.7% | 88.2% | 89.1% | 90.2% | 89.2% | 89.2% | | ! |
| | Health and Safety training (Target: >90%) | 96.2% | 95.6% | 95.8% | 95.9% | 92.5% | 93.4% | 94.3% | 93.4% | 94.8% | 94.8% | 95.3% | 95.0% | 95.0% | | - |
| | Safeguarding training - adults (Target: 90%) | 94.7% | 93.9% | 94.5% | 94.4% | 92.3% | 92.9% | 93.8% | 93.0% | 93.8% | 93.5% | 94.2% | 93.9% | 93.9% | | - |
| | Safeguarding training - children (Target: 90%) | 92.3% | 92.9% | 93.5% | 92.9% | 90.1% | 91.8% | 92.6% | 91.5% | 91.5% | 92.5% | 93.2% | 92.4% | 92.4% | | - |

| | | | | |
|---|---|---|---|---|
| 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**

**Staff in Post**

In May we employed 5405 whole time equivalent (WTE) people on substantive contracts, 2 WTE more than last month.

**Turnover**

Our voluntary turnover rate was 15.3%, 0.08% higher than last month. Voluntary turnover is 17.1% at Chelsea and 11.9% at West Middlesex.

**Vacancies**

Our general vacancy rate for May was 13.6%, which is 0.08% higher than May. The vacancy rate is 15.08% at West Middlesex and 13.6% at Chelsea. .

**Sickness Absence**

Sickness absence in the month of May was 2.68%, 0.02% lower than May.

**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 90% against our target of 90%.

**Performance and Development Reviews**

The PDR rate increased by 0.13% in June and now stands at 90.0%.

The rolling annual appraisal rate for medical staff was 87.72%, 3.72% 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 | Apr-18 | May-18 | Jun-18 | 2018-2019 | YTD breaches | Apr-18 | May-18 | Jun-18 | 2018-2019 | YTD breaches | Apr-18 | May-18 | Jun-18 | 2018-2019 Q1 | 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 | 85.7% | 87.5% | 100% | 90.3% | 1.5 | 66.7% | 100% | 100% | 87.5% | 1 | 76.9% | 90.0% | 100% | 89.4% | 89.4% | 2.5 | | - |
| | Gynaecological | 50.0% | 75.0% | 80.0% | 72.7% | 1.5 | 50.0% | 33.3% | 80.0% | 66.7% | 2.5 | 50.0% | 57.1% | 80.0% | 69.2% | 69.2% | 4 | | ! |
| | Haematological | n/a | n/a | 100% | 100% | 0 | 100% | 81.8% | 66.7% | 81.0% | 2 | 100% | 81.8% | 80.0% | 84.0% | 84.0% | 2 | | - |
| | Head and neck | 100% | 100% | 100% | 100% | 0 | 50.0% | 66.7% | 100% | 72.7% | 1.5 | 75.0% | 75.0% | 100% | 82.4% | 82.4% | 1.5 | | - |
| | Lung | n/a | n/a | n/a | n/a | | 100% | 100% | 50.0% | 75.0% | 0.5 | 100% | 100% | 50.0% | 75.0% | 75.0% | 0.5 | | - |
| | Sarcoma | n/a | n/a | n/a | n/a | | n/a | 100% | n/a | 100% | 0 | n/a | 100% | n/a | 100% | 100% | 0 | | - |
| | Skin | 100% | 85.0% | 100% | 91.9% | 1.5 | 100% | 75.0% | 100% | 93.8% | 0.5 | 100% | 83.3% | 100% | 92.5% | 92.5% | 2 | | - |
| | Upper gastrointestinal | 100% | 100% | 0.0% | 80.0% | 0.5 | 100% | 80.0% | 100% | 90.9% | 0.5 | 100% | 85.7% | 75.0% | 87.5% | 87.5% | 1 | | - |
| | Urological | 94.1% | 92.3% | 53.3% | 80.0% | 4.5 | 100% | 76.5% | 94.1% | 91.4% | 2.5 | 97.6% | 83.3% | 75.0% | 86.4% | 86.4% | 7 | | - |
| | Urological (Testicular) | 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 | | | - |
| | Site not stated | n/a | n/a | 100% | 100% | 0 | 100% | 100% | n/a | 100% | 0 | 100% | 100% | 100% | 100% | 100% | 0 | | - |

| | | | |
|---|---|---|---|
| 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 unvalidated breaches in June by Tumour site are as follows:

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

| | |
|---|---|
| Gynaecological: | C&W: 0.5 of a breach of 2.5 patients treated. Breach was unavoidable as the patient had multiple cancers requiring synchronised treatment<br>WMUH: 1 breach of 5 patients treated. Breach was unavoidable as patient delayed their diagnosis. |
| Haematological: | WMUH: 1 breach of 3 patients treated. Breach was unavoidable as patient was complex diagnosis, starting on the incorrect referral pathway. |
| Lung | WMUH: 0.5 breach of 1 patient treated. Breach was avoidable. Breach was unavoidable as patient was complex & high risk for biopsy leading to a delayed diagnosis. |
| Upper Gastrointestinal: | C&W: 0.5 of a breach of 0.5 of a patient treated. Delays to OPA and diagnostics could have been avoided. |
| Urological: | C&W: 3.5 breaches of 7.5 patients treated. Avoidable delays were due to delays in radiology & histology reporting and delays to biopsy. 0.5 was unavoidable due to patient lack of availability for tests<br>WMUH: 0.5 of a breach of 8.5 patients treated. 0.5 of a breach was unavoidable – patient choice to delay diagnostics for a holiday |

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

# Nursing Metrics Dashboard

## Safe Nursing and Midwifery Staffing

### Chelsea and Westminster Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 91.1% | 90.2% | 94.4% | 95.7% | 7.7 | 3.2 | 11.0 | 7 – 17.5 |
| Annie Zunz | 100.0% | 92.0% | 99.7% | 102.6% | 6.3 | 2.7 | 9.1 | 6.5 - 8 |
| Apollo | 93.2% | 100.0% | 95.3% | 106.7% | 18.0 | 3.9 | 21.9 | |
| Jupiter | 134.1% | 87.0% | 129.6% | - | 10.6 | 2.5 | 13.2 | 8.5 – 13.5 |
| Mercury | 76.0% | 96.9% | 67.8% | 30.0% | 7.5 | 1.0 | 8.5 | 8.5 – 13.5 |
| Neptune | 85.3% | 64.6% | 78.4% | 0.0% | 8.0 | 0.7 | 8.6 | 8.5 – 13.5 |
| NICU | 117.3% | - | 117.3% | - | 15.6 | 0.0 | 15.6 | |
| AAU | 105.6% | 82.0% | 100.0% | 99.9% | 9.2 | 2.1 | 11.4 | 7 - 9 |
| Nell Gwynn | 100.0% | 84.2% | 133.4% | 98.9% | 4.4 | 3.5 | 7.8 | 6 – 8 |
| David Erskine | 86.1% | 86.6% | 105.6% | 110.0% | 3.7 | 3.5 | 7.2 | 6 – 7.5 |
| Edgar Horne | 100.2% | 95.1% | 110.0% | 101.8% | 3.4 | 3.4 | 6.8 | 6 – 7.5 |
| Lord Wigram | 92.2% | 104.4% | 98.9% | 105.6% | 3.7 | 2.9 | 6.6 | 6.5 – 7.5 |
| St Mary Abbots | 115.0% | 96.1% | 96.6% | 98.8% | 4.3 | 2.5 | 6.8 | 6 – 7.5 |
| David Evans | 81.3% | 82.2% | 92.6% | 95.7% | 5.7 | 2.6 | 8.3 | 6 – 7.5 |
| Chelsea Wing | 92.9% | 105.7% | 100.0% | 105.0% | 12.2 | 7.8 | 20.0 | |
| Burns Unit | 99.4% | 95.7% | 99.0% | 96.1% | 10.1 | 3.8 | 13.8 | |
| Ron Johnson | 96.4% | 120.0% | 101.1% | 123.3% | 4.8 | 3.2 | 7.9 | 6 – 7.5 |
| ICU | 100.7% | 98.7% | 99.7% | - | 35.1 | 0.8 | 35.9 | 17.5 - 25 |
| Rainsford Mowlem | 77.5% | 78.4% | 98.3% | 99.2% | 3.3 | 3.1 | 6.4 | 6 - 8 |

### West Middlesex University Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 93.9% | 94.9% | 94.8% | 99.7% | 7.6 | 2.2 | 9.9 | 7 – 17.5 |
| Lampton | 100.0% | 133.7% | 100.0% | 98.3% | 2.8 | 2.4 | 5.2 | 6 – 7.5 |
| Richmond | 95.8% | 95.4% | 75.3% | 60.0% | 5.7 | 2.9 | 8.7 | 6 – 7.5 |
| Syon 1 | 97.7% | 100.7% | 98.3% | 114.9% | 3.6 | 2.2 | 5.8 | 6 – 7.5 |
| Syon 2 | 99.3% | 151.4% | 100.8% | 191.5% | 3.5 | 3.4 | 6.9 | 6 – 7.5 |
| Starlight | 101.9% | 35.0% | 108.9% | | 8.5 | 0.1 | 8.6 | 8.5 – 13.5 |
| Kew | 98.7% | 93.5% | 148.3% | 165.1% | 4.1 | 3.5 | 7.6 | 6 - 8 |
| Crane | 98.5% | 101.6% | 100.0% | 100.2% | 3.1 | 2.5 | 5.6 | 6 – 7.5 |
| Osterley 1 | 117.4% | 106.1% | 114.3% | 130.0% | 3.3 | 2.8 | 6.1 | 6 – 7.5 |
| Osterley 2 | 98.6% | 124.7% | 100.0% | 210.0% | 3.5 | 3.6 | 7.2 | 6 – 7.5 |
| MAU | 99.6% | 91.1% | 95.5% | 153.8% | 7.3 | 3.7 | 11.0 | 7 - 9 |
| CCU | 99.9% | 102.8% | 101.7% | | 5.3 | 0.8 | 6.1 | 6.5 - 10 |
| Special Care Baby Unit | 93.8% | - | 85.9% | | 6.4 | 0.0 | 6.4 | |
| Marble Hill 1 | 92.7% | 95.7% | 96.9% | 103.2% | 3.3 | 2.3 | 5.6 | 6 - 8 |
| Marble Hill 2 | 122.5% | 119.5% | 131.5% | 141.7% | 3.9 | 3.4 | 7.2 | 5.5 - 7 |
| ITU | 94.0% | 0.0% | 83.3% | | 28.1 | 0.0 | 28.1 | 17.5 - 25 |

**Summary for June 2018**

Low fill rates on Rainsford Molem, Mercury and Neptune due to bed closures in summer months with beds also reduced on Mercury at beginning of month due to an infection outbreak which is now resolved.

Nell Gwynne increased RN cover at night due to patient with tracheostomy requiring enhanced care.

High fill rates on Jupiter due to patients requiring RMN support. Increased CHPPD on ITU at Chelsea due to a higher than normal number of burns patients being nursed on there as they require a higher nurse: patient ratio than other ITU patients.

Additional HCAs booked to care for confused patients at risk of falls for Syon 2, Kew, Marble Hill 2 and Osterleys. Work underway with NHSI enhanced care collaborative. Increased number of patients with NIV on Osterley 2 requiring enhanced care levels. High fill rates for qualified nurses on Kew and Marble Hill 2 due to use of RMNs for patients with mental health needs. Increased HCA agreed for long days on Lampton by the EIC division due to dependency.

# CQUIN Dashboard

## June 2018

### National CQUINs

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

### NHS England CQUINs

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

### CQUIN Scheme Overview

The Trust agreed 12 CQUIN schemes (6 schemes with CCGs, 6 schemes with NHS England) for 2017/18. For 2018/19, CQUIN schemes will number 11 in total; CCG schemes will reduce to 5, but NHSE schemes are unchanged.

#### 2017/18 Quarterly Performance

For NHSE schemes, Q1 and Q2 performance was confirmed as 100%, Q3 as 85%. For CCG schemes, performance was 92% for Q1 and 86% for Q2. Confirmation from the CCGs of Q3 achievement was 73%, although 2 schemes had a zero weighting for the quarter. Partial achievement was reported for the 'Sepsis screening and Antimicrobial resistance', 'Improving services for people with mental health needs who present to A&E', 'NHS e-Referrals' and 'Supporting proactive and safe discharge' schemes in Q2, which was in line with forecast achievement. Submission of Q4 reports to both Commissioners is complete and confirmation of the outcomes is expected during July.

#### National Schemes (CCG commissioning)

There is a continued risk to delivery of certain schemes, including 'Sepsis screening and Anti-microbial resistance', in line with the year to date delivery, and the Trust is forecasting partial achievement. The 'e-Referrals' scheme performance is also likely to be less than 100% owing to a particularly challenging Q4 indicator. However the associated financial risk is partly mitigated by a local payment agreement with NWL CCGs.

#### National Schemes (Specialised Services commissioning)

The schemes are expected to achieve 100%, with the exception of the 'Neonatal Community Outreach' scheme. The Commissioner and Neonatal Network continue to co-design the specification, but the uncertainty could adversely affect full year performance.

#### 2018/19 CQUIN Schemes overview

2018/19 is the second year of delivery for the majority of the schemes. The 'Supporting safe & proactive discharge' scheme has been suspended for 2018/19, with the weighting given to the other schemes increasing as a result. Certain other scheme specifications have been updated following provider feedback. A new scheme is introduced for 18/19 only, replacing a previous scheme intended for 17/18 only. A similar local payment arrangement with NWL and SWL CCGs has been agreed for 18/19, which will mitigate the financial risk of under-performance. The Specialised Services schemes remain unchanged from 17/18.

# Finance Dashboard

## Month 3 2018-19 Integrated Position

### Financial Position (£000's)

| £'000 | Combined Trust | | |
|---|---|---|---|
| | **Plan to Date** | **Actual to Date** | **Variance to Date** |
| Income | 162,463 | 162,032 | (431) |
| Expenditure | (154,473) | (154,442) | 31 |
| | | | |
| **Adjusted EBITDA** | 7,991 | 7,590 | (400) |
| | | | |
| Adjusted EBITDA % | 4.918% | 4.684% | -0.23% |
| Interest/Other | (1,333) | (1,344) | (11) |
| Depreciation | (4,660) | (4,347) | 313 |
| PDC Dividends | (2,808) | (2,808) | 0 |
| Other | 0 | 0 | 0 |
| **Trust Deficit** | **(810)** | **(908)** | **(98)** |

**Comments**

The Trust is reporting a YTD deficit of £908k pre adjustments. After adjustments the deficit is £796k which is £14k above the Trust's control total.

Income is under performing YTD due to low inpatient activity levels (elective and emergency), which has led to low admissions into adult critical care and NICU. A&E and outpatients are on plan.

Pay is adverse by £3,482k 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 overseas nurses while they train to receive their pins. The largert contributor to this postiion has been under achievement against CIP targets.

Non-pay is £749k favourable in month and £3,513 year to date. Included in this position is a deficit against clinical supplies which is activity driven.

### Risk rating (year to date)

| Use of Resource Rating (UORR) | M03 (Before Override) | M03 (After Override) |
|---|---|---|
| Use of Resource Rating | **2** | **2** |

**Comments**

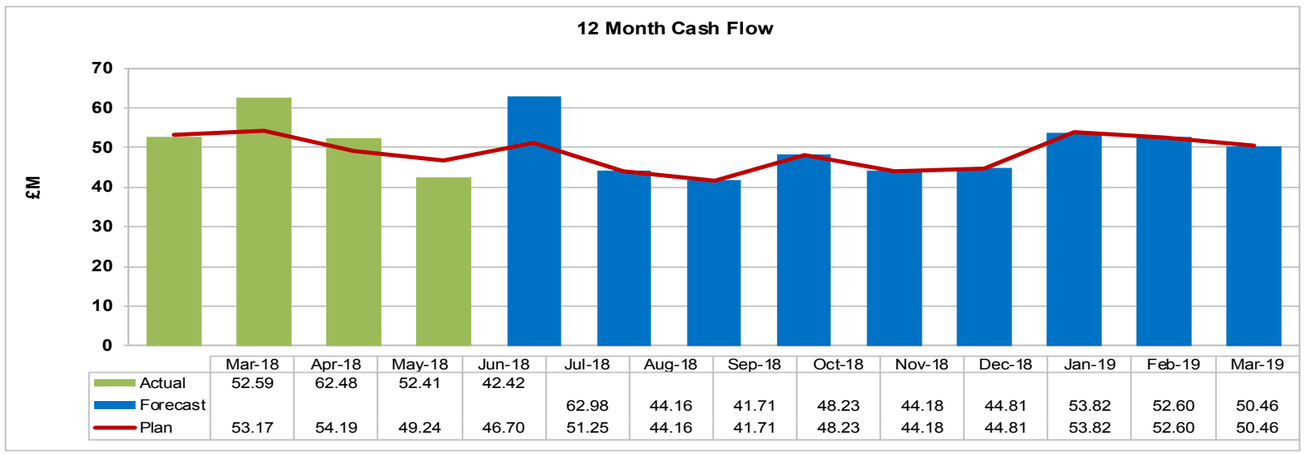
Under the Use of Resources Rating (UORR) the Trust is performing in line with plan for all areas of measurement.

As the Trust did not score a “4” in any of its risk ratings, the override does not apply and the Trust achieved a UORR rating of “2” in line with plan.

### Cash Flow

**Comments** RAG rating

The cash balance at the end of month 3 is £42.42m which is £4.27m lower than plan of £46.69m. The main drivers of this decrease are a decrease in cash flows from operating activities of £(0.19)m a decrease in capital expenditure on a cash basis of £9.35m (mainly due to delays in some projects) and a decrease in working capital compared to plan of £(13.43)m. The Trust is currently planning to achieve its planned year end cash balance of £50.46m. Currently forecast has been set to plan from August and this will be updated for the whole year next month. The Trust has a number of planned external funding requirements for capital projects which it will start to call upon from the end of Q2.




| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 52.59 | 62.48 | 52.41 | 42.42 | | | | | | | | | |
| Forecast | | | | | 62.98 | 44.16 | 41.71 | 48.23 | 44.18 | 44.81 | 53.82 | 52.60 | 50.46 |
| 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 |

### Cost Improvement Programme (CIPs)

| Theme | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | **Plan £'000** | **Actual £'000** | **Var £'000** | **Plan £'000** | **Actual £'000** | **Var £'000** |
| Targeted Specialities | 1,062 | 611 | (451) | 2,951 | 1,510 | (1,441) |
| Corporate savings | 221 | 166 | (55) | 716 | 486 | (230) |
| Residual % Based Savings | 508 | 508 | 0 | 1,525 | 1,525 | 0 |
| **Trust Total** | 1,791 | 1,285 | (506) | 5,192 | 3,521 | (1,671) |

**Comments** RAG rating

The Trust has achieved YTD CIPs of £3.52m against an interanl target of £5.19m with an adverse variance of £1.67m.

Key drivers for the adverse variance relate to underachieving clinical pay schemes.

Through new schemes identified the trust aims to achieve the target plan.

# TRUST PERFORMANCE & QUALITY REPORT

## July 2018

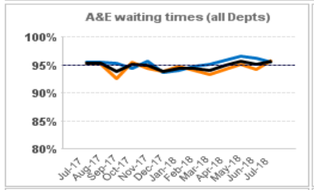
# July 2018
# Performance Dashboard

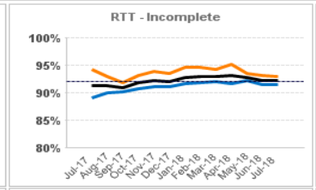
Draft Version

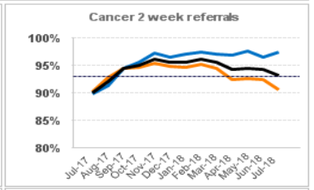
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

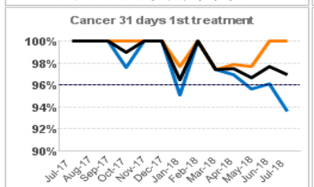
## Regulatory Compliance

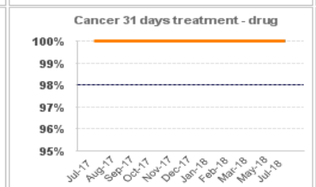
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined Trust data: last Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | Quarter | YTD | Trend |
| A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 96.5 | 96.1 | 95.5 | 95.0 | 94.2 | 95.8 | 95.7 | 95.1 | 95.6 | 95.6 | 95.3 | |
| RTT - Incomplete (Target: >92%) | 92.2 | 91.4 | 91.6 | 93.6 | 93.1 | 92.9 | 92.8 | 92.2 | 92.2 | 92.2 | 92.6 | |
| Cancer 2 week urgent referrals (Target: >93%) | 97.6 | 96.4 | 97.5 | 92.5 | 92.4 | 90.6 | 94.5 | 94.2 | 93.2 | 93.2 | 94.0 | |
| Cancer 2 week Breast symptomatic (Target: >93%) | n/a | n/a | n/a | 94.4 | 89.2 | 83.6 | 94.4 | 89.2 | 83.6 | 83.6 | 90.3 | |
| Cancer 31 days first treatment (Target: >96%) | 95.7 | 96.2 | 93.6 | 97.7 | 100 | 100 | 96.7 | 97.7 | 97.0 | 97.0 | 97.2 | |
| Cancer 31 days treatment - Drug (Target: >98%) | 100 | n/a | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 31 days treatment - Surgery (Target: >94%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100.0 | |
| Cancer 62 days GP ref to treatment (Target: >85%) | 87.7 | 83.9 | 84.3 | 84.1 | 92.2 | 86.2 | 85.7 | 87.9 | 85.5 | 85.5 | 87.7 | |
| Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 4 | |
| Average Emergency PreOp LoS | 0.50 | 0.45 | 0.57 | 0.83 | 1.22 | 0.86 | 0.66 | 0.73 | 0.70 | 0.70 | 0.76 | |
| Average Elective PreOp LoS | 0.15 | 0.19 | 0.09 | 0.01 | 0.02 | 0.07 | 0.11 | 0.15 | 0.09 | 0.09 | 0.12 | |

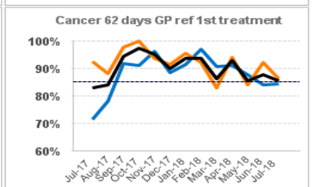


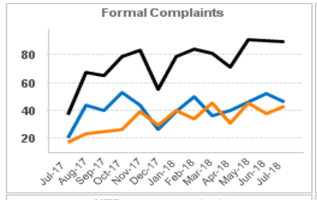



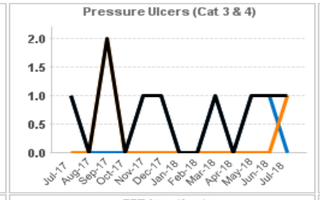



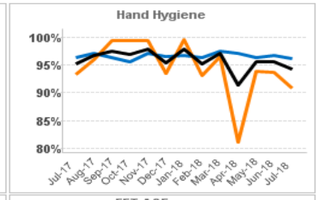



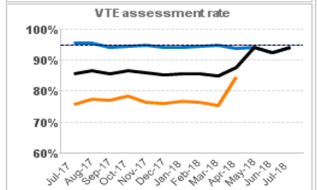

## Quality

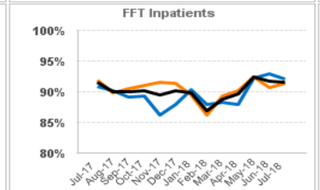
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | Quarter | YTD | Trend |
| Hand Hygiene (Target: >=90%) | 96.4 | 96.7 | 96.1 | 93.9 | 93.8 | 90.9 | 95.6 | 95.7 | 94.3 | 94.3 | 94.3 | |
| Pressure Ulcers (Cat 3 & 4) | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 3 | |
| VTE assessment % (Target: >=95%) | 94.0 | 92.5 | 94.1 | | | | 94.0 | 92.5 | 94.1 | 94.1 | 90.7 | |
| Formal complaints number received | 46 | 52 | 46 | 45 | 38 | 43 | 91 | 90 | 89 | 89 | 341 | |
| Formal complaints responded to <25days | 40 | 43 | 24 | 34 | 25 | 19 | 74 | 68 | 43 | 43 | 236 | |
| Serious Incidents | 2 | 0 | 3 | 3 | 2 | 5 | 5 | 2 | 8 | 8 | 18 | |
| Never Events (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| FFT - Inpatients recommend % (Target: >90%) | 92.3 | 92.8 | 92.0 | 92.5 | 90.6 | 91.3 | 92.4 | 91.7 | 91.6 | 91.6 | 91.2 | |
| FFT - A&E recommend % (Target: >90%) | 90.2 | 90.0 | 89.9 | 82.5 | 84.4 | 88.6 | 88.9 | 89.1 | 89.7 | 89.7 | 89.0 | |
| Falls causing serious harm | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

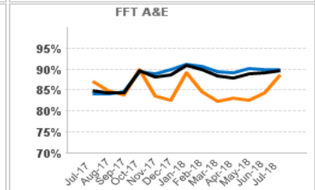


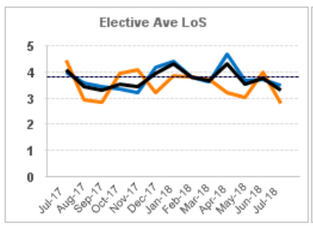



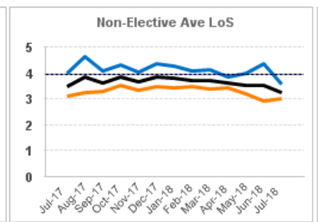



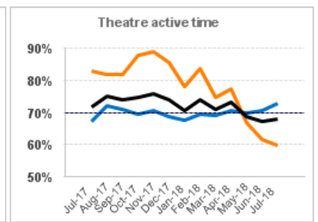



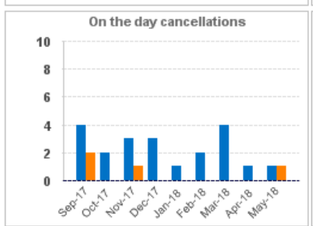

## Efficiency

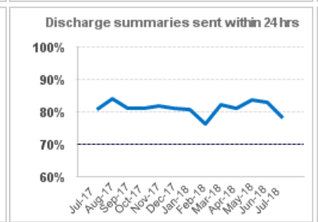
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | Quarter | YTD | Trend |
| Elective average LoS (Target: <3.8) | 3.7 | 3.7 | 3.5 | 3.0 | 4.0 | 2.8 | 3.5 | 3.8 | 3.3 | 3.3 | 3.7 | |
| Non-Elective average LoS (Target: <3.95) | 4.0 | 4.3 | 3.6 | 3.2 | 2.9 | 3.0 | 3.5 | 3.5 | 3.3 | 3.3 | 3.5 | |
| Theatre active time (Target: >70%) | 69.6 | 70.6 | 72.9 | 66.9 | 61.6 | 59.9 | 68.7 | 67.3 | 68.0 | 68.0 | 69.2 | |
| Discharge summaries sent within 24 hours (Target: >70%) | 83.8 | 83.0 | 78.3 | dev | dev | dev | 83.8 | 83.0 | 78.3 | 78.3 | 81.5 | |
| Outpatient DNA rates (Target: <11.1%) | 10.5 | 10.9 | 13.8 | 14.2 | 14.2 | 11.9 | 11.7 | 12.1 | 13.1 | 13.1 | 12.0 | |
| On the day cancelled operations not re-booked within 28 days (Target: 0) | 1 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 3 | |

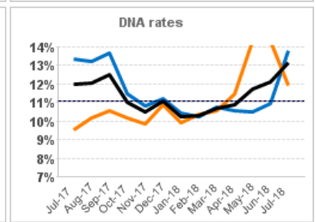


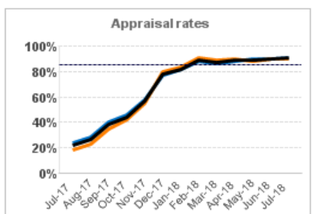



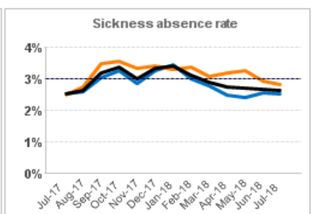



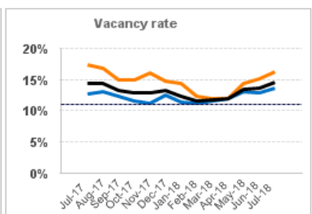



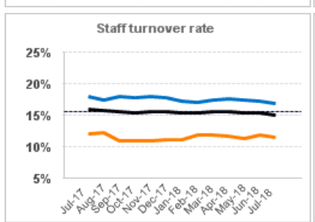

## Workforce

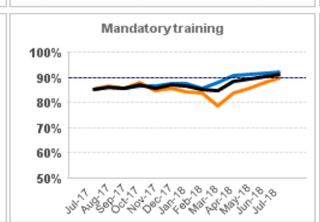
| Hospital Site | CWFT | CWFT | CWFT | WMUH | WMUH | WMUH | Combined: latest Quarter, YTD & 13m trend | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | May-18 | Jun-18 | Jul-18 | Quarter | YTD | Trend |
| Appraisal rates (Target: >85%) | 90.4 | 89.6 | 90.5 | 87.8 | 89.8 | 90.1 | 89.4 | 89.7 | 90.4 | 90.4 | 89.6 | |
| Sickness absence rate (Target: <3%) | 2.42 | 2.55 | 2.52 | 3.25 | 2.93 | 2.80 | 2.70 | 2.68 | 2.61 | 2.61 | 2.68 | |
| Vacancy rates (Target: CW<12%; WM<10%) | 13.1 | 12.8 | 13.7 | 14.3 | 15.1 | 16.2 | 13.5 | 13.6 | 14.6 | 14.6 | 14.6 | |
| Turnover rate (Target: CW<18%; WM<11.5%) | 17.3 | 17.2 | 16.9 | 11.3 | 11.9 | 11.5 | 15.3 | 15.4 | 15.1 | 15.1 | 15.1 | |
| Mandatory training (Target: >90%) | 91.1 | 91.6 | 92.0 | 85.8 | 87.8 | 89.7 | 89.1 | 90.2 | 91.2 | 91.2 | 89.7 | |
| Bank and Agency spend (£ks) | £2,311 | £2,398 | £3,035 | £2,312 | £2,154 | £2,282 | £4,623 | £4,552 | £5,317 | £5,317 | £19,541 | |
| Nursing & Midwifery: Agency % spend of total pay (Target: tbc) | 6.4 | 3.6 | 6.0 | 8.3 | 8.2 | 7.1 | 7.1 | 5.4 | 6.4 | 6.4 | 7.0 | |

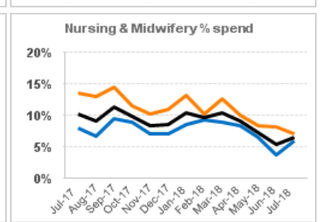


# NHSI Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| A&E | A&E waiting times - Types 1 & 3 Depts (Target: >95%) | 96.5% | 96.1% | 95.5% | 96.0% | 95.0% | 94.2% | 95.8% | 94.8% | 95.7% | 95.1% | 95.6% | 95.6% | 95.3% | | - |
| RTT | 18 weeks RTT - Admitted (Target: >90%) | 75.4% | 73.5% | 76.1% | 74.9% | 86.3% | 74.1% | 71.7% | 81.3% | 79.8% | 73.8% | 74.2% | 74.2% | 78.1% | | ! |
| | 18 weeks RTT - Non-Admitted (Target: >95%) | 94.9% | 94.7% | 93.7% | 94.4% | 90.5% | 91.1% | 88.1% | 90.1% | 93.6% | 93.4% | 91.6% | 91.6% | 92.9% | | ! |
| | 18 weeks RTT - Incomplete (Target: >92%) | 92.2% | 91.4% | 91.6% | 91.7% | 93.6% | 93.1% | 92.9% | 93.6% | 92.8% | 92.2% | 92.2% | 92.2% | 92.6% | | - |
| Cancer<br><br>(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jul-18) in this report | 2 weeks from referral to first appointment all urgent referrals (Target: >93%) | 97.6% | 96.4% | 97.5% | 97.0% | 92.5% | 92.4% | 90.6% | 91.9% | 94.5% | 94.2% | 93.2% | 93.2% | 94.0% | | ! |
| | 2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%) | n/a | n/a | n/a | n/a | 94.4% | 89.2% | 83.6% | 90.3% | 94.4% | 89.2% | 83.6% | 83.6% | 90.3% | | - |
| | 31 days diagnosis to first treatment (Target: >96%) | 95.7% | 96.2% | 93.6% | 95.5% | 97.7% | 100% | 100% | 98.9% | 96.7% | 97.7% | 97.0% | 97.0% | 97.2% | | - |
| | 31 days subsequent cancer treatment - Drug (Target: >98%) | 100% | 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%) | 87.7% | 83.9% | 84.3% | 86.4% | 84.1% | 92.2% | 86.2% | 88.6% | 85.7% | 87.9% | 85.5% | 85.5% | 87.7% | | - |
| | 62 days NHS screening service referral to first treatment (Target: >90%) | n/a | n/a | n/a | n/a | 100% | 100% | 87.5% | 88.0% | 100% | 100% | 87.5% | 87.5% | 88.0% | | - |
| Patient Safety | Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16) | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 3 | 1 | 1 | 1 | 1 | 4 | | ! |
| Learning difficulties Access & Governance | Self-certification against compliance for access to healthcare for people with Learning Disability | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | compliant | | - |
| | Governance Rating | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | | - |

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

**Trust commentary**

**A&E 4 Hours waiting time - % waiting under 4 hours in the department**

The 4hr A&E Target was achieved on both sites in July with a combined performance of 95.6%.This was the highest performance in London and the 13th highest performance nationally.

Attendances to A&E continue to increase, with a 5% growth compared to July 2017.

**18 weeks RTT – Incomplete pathways % under 18 weeks**

RTT Performance was maintained in July, with the Trust again meeting the national target as it has for each month in 2018/2019

**2 weeks from referral to first appointment all Breast symptomatic referral**

Non-Compliant: due to an Administration issue, identified and resolved. This involved the failure to check the ASI list for breast symptomatic and reduced visibility in Cerner (the PAS system used at West Middlesex) due to Breast TWR not being separated by symptomatic and suspected cancer. It is expected that the Trust will return to compliance in August.

**Cancer - 62 days NHS screening service referral to first treatment**

Non- compliant: single breach in breast service. Surgery was planned on target, however with a mammogram machine breakdown the patient was moved outside of the breach date by 9 days.

**All other Cancer indicators**

The Trust achieved the required standard in July for all other cancer metrics

# Safety Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-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%) | 96.4% | 96.7% | 96.1% | 96.6% | 93.9% | 93.8% | 90.9% | 89.9% | 95.6% | 95.7% | 94.3% | 94.3% | 94.3% | | - |
| Incidents | Number of serious incidents | 2 | 0 | 3 | 5 | 3 | 2 | 5 | 13 | 5 | 2 | 8 | 8 | 18 | | - |
| | Incident reporting rate per 100 admissions (Target: >8.5) | 7.4 | 8.2 | 8.7 | 7.9 | 9.0 | 9.0 | 9.6 | 9.4 | 8.2 | 8.6 | 9.1 | 9.1 | 8.6 | | - |
| | Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0) | 0.03 | 0.00 | 0.03 | 0.01 | 0.00 | 0.02 | 0.02 | 0.01 | 0.02 | 0.01 | 0.02 | 0.02 | 0.01 | | ! |
| | Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280) | 495.27 | 514.39 | 496.16 | 510.33 | 166.46 | 280.80 | 319.20 | 248.75 | 327.89 | 405.31 | 404.36 | 404.36 | 380.11 | | - |
| | Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%) | 16.7% | 10.1% | 9.7% | 11.6% | 8.7% | 15.2% | 18.6% | 14.7% | 14.6% | 11.8% | 13.3% | 13.3% | 12.6% | | - |
| | Never Events (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| Harm | Safety Thermometer - Harm Score (Target: >90%) | 95.6% | 94.6% | 97.2% | 96.3% | 93.5% | 97.7% | 90.7% | 94.2% | 94.2% | 96.4% | 93.5% | 93.5% | 95.1% | | - |
| | Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6) | 1 | 1 | 0 | 2 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | | - |
| | NEWS compliance % | 98.0% | 96.7% | 100.0% | 97.5% | 98.7% | 97.7% | 100.0% | 98.4% | 98.3% | 97.1% | 100.0% | 100.0% | 97.9% | | - |
| | Safeguarding adults - number of referrals | 17 | 25 | 32 | 99 | 4 | 7 | 15 | 43 | 21 | 32 | 47 | 47 | 142 | | - |
| | Safeguarding children - number of referrals | 22 | 26 | 42 | 118 | 37 | 54 | 36 | 190 | 59 | 80 | 78 | 78 | 308 | | - |
| 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 | 35 | 31 | 37 | 138 | 56 | 50 | 62 | 224 | 91 | 81 | 99 | 99 | 362 | | - |
| | Number of hospital deaths - Paediatric | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | | - |
| | Number of hospital deaths - Neonatal | 1 | 3 | 2 | 9 | 0 | 1 | 0 | 1 | 1 | 4 | 2 | 2 | 10 | | - |
| | Number of deaths in A&E - Adult | 1 | 1 | 3 | 7 | 3 | 7 | 8 | 23 | 4 | 8 | 11 | 11 | 30 | | - |
| | Number of deaths in A&E - Paediatric | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 2 | | - |
| | Number of deaths in A&E - Neonatal | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | | - |

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

**Trust commentary**

**Number of serious incidents**

There were 8 Serious Incidents were reported during July; compared to 2 reported in June.

5 of the incidents occurred at the West Middlesex site with the remaining 3 at the Chelsea 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 8.6% in July (compared to 8.4% in June); marginally higher than the target of 8.5%.Higher reporting rates are associated with a more positive safety culture.

**Trust commentary continued**

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

4 incidents recorded as resulting in patient death, of which 3 have been declared as a serious incident, and referred to within the SI report. The remaining 1 incident is linked to a complaint and is currently being investigated.

3 incidents recorded as resulting in severe harm, of which 2 have been declared as serious incidents (one external and one internal). The remaining incident will relates to an unexpected/rarely occurring event, rather than an error or omission in care. This will be presented at the specialty mortality review meeting where learning opportunities may be identified.

**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 404/100,000 FCE bed days in July 2018. This is higher than the Trust target of 280/100,000. There were 496 and 319 medication-related incidents per 100,000 FCE bed days at the Chelsea and West Middlesex sites respectively. The West Middlesex rate has continued to improve month on month

At the Chelsea site, there was a slight decrease in reporting of medication incidents in July compared to June.

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

The Trust had 13% medication-related safety incidents with harm in July 2018. This figure is higher than the previous month (11.8%) and is above the Carter dashboard National Benchmark (10.3%). The year to date figure is 12.6%.

There were 16 incidents with low harm, 7 at the Chelsea site and 9 at West Middlesex.

- Themes: Chelsea site (low harm): Omitted doses of antimicrobial therapy due to no intravenous access and no escalation/notification to medical staff; omission of supportive care for chemotherapy regimen; unsigned administration of medications; incorrect route of administration for streptokinase; analgesia not administered; delayed administration of a critical medicine (co-beneldopa); omitted insulin administration; and disconnected TPN bag.
- Themes: West Middlesex site (low harm): Incorrect medication used as a flush; co-prescribing of interacting medications leading to reduced seizure threshold; incorrect prescribing of tinzaparin dose; administration of medications when not prescribed; discharge summary with medications not updated and lack of communication to pharmacy to update dispensed TTA medications resulting in continued medication on discharge when stopped during admission; incorrect instructions labelled on medication; and unavailability of medication with no interim management requiring medication re-titration.

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

**Medication-related safety incidents**

71 Medication-related incidents were reported at the Chelsea site compared to the 58 such incidents at West Middlesex.

The Medication Safety Group is working to increase the reporting of medication related incidents particularly no harm and near miss incidents.

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

These are referred to within table 2 of the Serious Incident report prepared for the Trust Board.

**NEWS compliance %**

The Trust has recently moved to a monthly audit of its National Early Warning Score compliance and have achieved 100% on booth sites, having consistently scored 95% previously. The aim is to sustain this performance over the coming months.

# Patient Experience Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| Friends and Family | FFT: Inpatient recommend % (Target: >90%) | 92.3% | 92.8% | 92.0% | 91.5% | 92.5% | 90.6% | 91.3% | 91.0% | 92.4% | 91.7% | 91.6% | 91.6% | 91.2% | | - |
| | FFT: Inpatient not recommend % (Target: <10%) | 4.6% | 3.1% | 4.2% | 4.3% | 3.1% | 4.0% | 3.6% | 3.6% | 3.8% | 3.6% | 3.9% | 3.9% | 3.9% | | - |
| | FFT: Inpatient response rate (Target: >30%) | 44.4% | 49.0% | 45.6% | 43.3% | 45.6% | 34.7% | 39.5% | 44.8% | 45.0% | 40.3% | 41.9% | 41.9% | 44.2% | | - |
| | FFT: A&E recommend % (Target: >90%) | 90.2% | 90.0% | 89.9% | 89.8% | 82.5% | 84.4% | 88.6% | 85.0% | 88.9% | 89.1% | 89.7% | 89.7% | 89.0% | | ! |
| | FFT: A&E not recommend % (Target: <10%) | 5.9% | 6.1% | 5.9% | 6.2% | 11.3% | 9.4% | 5.8% | 8.2% | 6.8% | 6.6% | 5.9% | 5.9% | 6.6% | | - |
| | FFT: A&E response rate (Target: >30%) | 20.3% | 22.4% | 21.0% | 20.5% | 15.7% | 17.2% | 19.4% | 16.8% | 19.4% | 21.4% | 20.7% | 20.7% | 19.7% | | ! |
| | FFT: Maternity recommend % (Target: >90%) | 90.7% | 91.4% | 92.4% | 91.8% | 96.6% | 95.6% | 95.3% | 95.4% | 92.5% | 92.3% | 93.0% | 93.0% | 92.7% | | - |
| | FFT: Maternity not recommend % (Target: <10%) | 6.3% | 5.5% | 3.6% | 4.8% | 1.7% | 2.9% | 3.5% | 2.7% | 4.9% | 4.9% | 3.6% | 3.6% | 4.3% | | - |
| | FFT: Maternity response rate (Target: >30%) | 24.9% | 24.0% | 26.4% | 23.6% | 32.7% | 19.5% | 21.4% | 25.0% | 26.8% | 22.9% | 25.3% | 25.3% | 23.9% | | ! |
| Experience | Breach of same sex accommodation (Target: 0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| Complaints | Complaints formal: Number of complaints received | 46 | 52 | 46 | 184 | 45 | 38 | 43 | 157 | 91 | 90 | 89 | 89 | 341 | | - |
| | Complaints formal: Number responded to < 25 days | 40 | 43 | 24 | 138 | 34 | 25 | 19 | 98 | 74 | 68 | 43 | 43 | 236 | | - |
| | Complaints (informal) through PALS | 112 | 125 | 175 | 527 | 106 | 102 | 50 | 350 | 218 | 227 | 225 | 225 | 877 | | - |
| | 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |

| 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**

**Inpatients**
The Inpatient areas of the Trust continue to exceed the 30% response rate and 90% recommendation score.

**Emergency Department**
There have been improvements in both sites with the recommendation scores, with more work needed on the response rates to meet the Trust target of 30%. Both sites remain significantly above the 12.5% national average.

**Maternity Services**
Continue to exceed the 90% recommendation score and whilst there has been improvement at both sites in regards to the response rate there is still work to be undertaken to move this to the 30% trust target.

**Same sex accommodation**
There continues to be no same sex accommodation breaches

**Complaints**
There continues to be a reduction in the number of complaints received by the Trust throughout the first quarter of 2018-19. As a Trust quality priority there has been an improvement in compliance against the 25 working day target and for June compliance was 93% and July 88% against a target of 90%.The Trust quality committee receive a monthly report giving analysis of complaints performance and themes, trends and learning from complaints. There continue to be no cases upheld by the ombudsman service this year.

# Efficiency & Productivity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| Admitted Patient Care | Average length of stay - elective (Target: <2.9) | 3.68 | 3.70 | 3.47 | 3.88 | 3.03 | 4.01 | 2.80 | 3.25 | 3.53 | 3.77 | 3.31 | 3.31 | 3.73 | | - |
| | Average length of stay - non-elective (Target: <3.95) | 3.98 | 4.33 | 3.58 | 3.93 | 3.19 | 2.92 | 3.02 | 3.13 | 3.51 | 3.51 | 3.25 | 3.25 | 3.47 | | - |
| | Emergency care pathway - average LoS (Target: <4.5) | 4.47 | 4.96 | 4.01 | 4.51 | 3.71 | 3.36 | 3.41 | 3.59 | 3.97 | 3.91 | 3.62 | 3.62 | 3.92 | | - |
| | Emergency care pathway - discharges | 209 | 211 | 225 | 858 | 399 | 403 | 418 | 1537 | 609 | 614 | 643 | 643 | 2395 | | - |
| | Emergency re-admissions within 30 days of discharge (Target: <7.6%) | 3.97% | 3.59% | 3.96% | 3.85% | 10.34% | 10.95% | 12.08% | 10.42% | 7.01% | 7.14% | 7.82% | 7.82% | 6.95% | | ! |
| | Non-elective long-stayers | 412 | 417 | 443 | 1705 | 312 | 304 | 368 | 1374 | 724 | 721 | 811 | 811 | 3079 | | - |
| Theatres | Daycase rate (basket of 25 procedures) (Target: >85%) | 82.0% | 81.4% | 91.3% | 84.0% | 86.8% | 86.7% | 84.1% | 86.8% | 83.7% | 83.2% | 88.9% | 88.9% | 85.0% | | - |
| | Operations canc on the day for non-clinical reasons: actuals | 15 | 8 | 7 | 50 | 1 | 12 | 16 | 32 | 16 | 20 | 23 | 23 | 82 | | - |
| | Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%) | 0.51% | 0.28% | 0.24% | 0.43% | 0.08% | 0.91% | 1.34% | 0.61% | 0.38% | 0.48% | 0.56% | 0.56% | 0.49% | | - |
| | Operations cancelled the same day and not rebooked within 28 days (Target: 0) | 1 | 0 | 0 | 2 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 3 | | - |
| | Theatre active time (Target: >70%) | 69.6% | 70.6% | 72.9% | 71.0% | 66.9% | 61.6% | 59.9% | 66.1% | 68.7% | 67.3% | 68.0% | 68.0% | 69.2% | | ! |
| | Theatre booking conversion rates (Target: >80%) | 85.6% | 85.6% | 85.9% | 85.4% | 92.7% | 93.8% | 93.9% | 90.4% | 88.1% | 88.5% | 88.6% | 88.6% | 87.2% | | - |
| Outpatients | First to follow-up ratio (Target: <1.5) | 1.47 | 1.43 | 1.40 | 1.47 | 1.33 | 1.43 | 1.42 | 1.36 | 1.37 | 1.43 | 1.42 | 1.42 | 1.39 | | - |
| | Average wait to first outpatient attendance (Target: <6 wks) | 6.9 | 6.6 | 6.7 | 6.7 | 7.1 | 6.6 | 5.8 | 6.6 | 7.0 | 6.6 | 6.3 | 6.3 | 6.7 | | ! |
| | DNA rate: first appointment | 11.3% | 11.9% | 14.1% | 12.1% | 13.8% | 14.3% | 11.6% | 12.9% | 12.4% | 13.0% | 13.0% | 13.0% | 12.4% | | - |
| | DNA rate: follow-up appointment | 10.2% | 10.6% | 13.7% | 11.2% | 14.4% | 14.1% | 12.2% | 12.9% | 11.4% | 11.7% | 13.2% | 13.2% | 11.8% | | - |

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**Trust commentary**

**Elective average length of stay**

We have seen an overall improvement in LOS during month of July due to better communication within the multidisciplinary team and through daily focus at bed meetings. Work continues to achieve compliance with newly agree LOS target of 2.9d (reduction from 3.7d).

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

July has seen a strong improvement at Chelsea site, with this indicator remaining 'green' overall. Recent reviews confirm that the Trust benchmarks well (top quartile) when compared with peer group hospitals for Non-Elective LOS, but within Care of the Elderly and Stroke, there remains an opportunity to improve further at both hospitals; plans are being implemented around this to ensure delivery ahead of winter 18/19. This work is being tracked via the system-wide A&E Delivery Board.

**Procedures carried out as Daycases - basket of 25 procedures**

July saw a 10% rise in Daycase rates at the Chelsea site but a slight fall at West Middlesex which saw the latter drop below the 85% target by 0.9%. This was primarily due to the high number of cancellations on the day (16) and the higher than normal number of DNAs (14)

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

There were 7 such cancellations at the Chelsea site maintaining a trajectory of falling numbers. There were, however, 16 at West Middlesex, the reasons being: list overrun (7), staffing (5), missing notes (2) and equipment (2)

**Theatre Active Time**

There are currently Data Quality issues with the reporting of this indicator at West Middlesex. These are being actively investigated.

# Clinical Effectiveness Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| Best Practice | Dementia screening case finding (Target: >90%) | 93.1% | 81.6% | 83.8% | 87.6% | 76.2% | 73.5% | 89.4% | 84.8% | 86.8% | 79.1% | 86.0% | 86.0% | 86.6% | | ! |
| | #NoF Time to Theatre <36hrs for medically fit patients (Target: 100%) | 93.3% | 94.1% | 90.9% | 95.0% | 87.5% | 100.0% | 93.3% | 86.9% | 89.7% | 96.3% | 92.3% | 92.3% | 90.9% | | ! |
| | Stroke care: time spent on dedicated Stroke Unit (Target: >80%) | 100.0% | 100.0% | 100.0% | 100.0% | 90.0% | 100.0% | 83.3% | 91.7% | 95.7% | 100.0% | 91.4% | 91.4% | 95.6% | | - |
| VTE | VTE: Hospital-acquired (Target: tbc) | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | - |
| | VTE risk assessment (Target: >95%) | 94.0% | 92.5% | 94.1% | 93.6% | | | | 84.7% | 94.0% | 92.5% | 94.1% | 94.1% | 90.7% | | ! |
| TB Care | TB: Number of active cases identified and notified | 7 | 2 | 3 | 12 | 3 | 4 | 5 | 15 | 10 | 6 | 8 | 8 | 27 | | - |
| | TB: % of treatments completed within 12 months (Target: >85%) | | | | | | | | | | | | | | | - |

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|---|---|---|---|---|

**Trust commentary**

**Fractured Neck of Femur patients in Theatre within 36 hours when medically fit**

**Chelsea Site**

One patient who was medically fit for theatre was delayed beyond 36hours. There was no capacity to operate on Sunday 22nd July due to unavailability on the emergency list; there being multiple general surgery and gynaecology bleeding cases. On Monday 23rd July the patient was brought to theatre; however, prior to anaesthetic it was noted that both kits were unfit for use. The patient was operated on later that afternoon.

**West Middlesex Site**

As at Chelsea, there was one patient who was medically fit not in Theatre within the requisite 36 hours. This was due to an equipment issue. The patient was operated on within 48 hours.

# Access Dashboard

| Domain | Indicator | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-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%) | 98.52% | 99.33% | 98.85% | 98.87% | 98.67% | 99.26% | 99.33% | 98.71% | 98.61% | 99.28% | 99.15% | 99.15% | 98.77% | | - |
| | Diagnostic waiting times >6 weeks: breach actuals | 40 | 18 | 32 | 130 | 52 | 39 | 30 | 241 | 92 | 57 | 62 | 62 | 371 | | - |
| A&E and LAS | A&E unplanned re-attendances (Target: <5%) | 8.7% | 9.5% | 9.1% | 9.0% | 7.8% | 8.1% | 8.6% | 8.2% | 8.4% | 9.1% | 8.9% | 8.9% | 8.7% | | ! |
| | A&E time to treatment - Median (Target: <60') | 01:06 | 01:10 | 01:09 | 01:07 | 00:45 | 00:48 | 00:47 | 00:47 | 01:00 | 01:04 | 01:02 | 01:02 | 01:01 | | ! |
| | London Ambulance Service - patient handover 30' breaches | 9 | 12 | 13 | 42 | 63 | 56 | 30 | 189 | 72 | 68 | 43 | 43 | 231 | | - |
| | London Ambulance Service - patient handover 60' breaches | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 0 | 2 | 0 | 0 | 2 | | - |
| Choose and Book (available to May-18 only for issues) | Choose and book: appointment availability (average of daily harvest of unused slots) | 1483 | 1629 | 1172 | 1407 | 0 | 0 | 0 | 0 | 1483 | 1629 | 1172 | 1172 | 1407 | | - |
| | Choose and book: capacity issue rate (ASI) | | | | | | | | | | | | | | | - |
| | Choose and book: system issue rate | 123 | 108 | 133 | 121 | | | | | | | | | | | - |

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**Trust commentary**

**RTT Incomplete pathways – patients waiting >52 weeks at month end**

Once again, there are no reportable 52 week waiters

**Diagnostic waiting times <6 weeks: %**

There was a drop of 0.5% at Chelsea in July compared to June. This was mitigated by a continuing strong performance at West Middlesex which meant the metric across the Trust met the 99% target in July.

**Diagnostic waiting times <6 weeks: breach actuals**

Endoscopy on both sites was the main area where patients breached the 6 week wait at the end of July. 31 out of the 32 breaches at the Chelsea site were in Endoscopy with 24 of these being in Cystoscopy. On the West Middlesex site there were 22 Endoscopy breaches: 11 in Cystoscopy and 10 in Gastroscopy making up the vast majority

**A&E LAS 30 min handover breaches**

July saw a significant improvement in the number of 30 minute ambulance handover breaches on the West Middlesex site with an almost 50% drop in breaches compared to June. The Chelsea site saw 13 breaches which remained slightly higher than the monthly average year-to-date

**A&E LAS 60 min handover breaches**

After the 2 breaches of the 60 minute handover target in June, this metric once again returned to zero breaches.

# Maternity Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| Birth indicators | Total number of NHS births | 455 | 449 | 526 | 1909 | 377 | 375 | 410 | 1533 | 832 | 824 | 936 | 936 | 3442 | | - |
| | Total caesarean section rate (C&W Target: <27%; WM Target: <29%) | 31.1% | 34.0% | 33.2% | 34.4% | 29.0% | 26.0% | 30.5% | 28.4% | 30.1% | 30.4% | 32.0% | 32.0% | 31.7% | | ! |
| | 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%) | 93.8% | 98.6% | 98.6% | 97.1% | 98.4% | 100.0% | 95.6% | 97.9% | 95.9% | 99.2% | 97.3% | 97.3% | 97.4% | | - |
| Safety | Admissions of full-term babies to NICU | 15 | 16 | 19 | 62 | n/a | n/a | n/a | n/a | 15 | 16 | 19 | 19 | 62 | | - |

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

**Trust commentary**

**Total number of NHS births**

July saw the highest number of births at the trust in 2018/19. The Chelsea site was 47 births above plan, whilst the West Middlesex site was 12 births below plan.

**Total caesarean section rate**

The Caesarean section rate for the Chelsea site remains high at 33.2% (elective and emergency). Unvalidated data suggests there has been a reduction in elective caesareans from June down from 19% to 14%. The Caesarean section rate at West Middlesex has increased to 30.5% with unvalidated data suggesting this has been driven by acuity and emergency caesareans.

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

The 1:1 care reporting is improving so that women who attend in labour are offered 1:1 care whilst in established labour. Data such as births before arrival to hospital are removed from this data reporting so that a true picture of care offered is now captured within the system.

Data for West Middlesex site reports 100% of women offered 1:1 care. The dedicated midwifery teams are improving the experience for women and this is also impacting on the normal birth rate at home, with some women reporting improved confidence to birth at home.

# Workforce Dashboard

| | | Chelsea & Westminster Hospital Site | | | | West Middlesex University Hospital Site | | | | Combined Trust Performance | | | | | Trust data 13 months | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 | May-18 | Jun-18 | Jul-18 | 2018-2019 Q2 | 2018-2019 | Trend charts | |
| Staffing | Vacancy rate (Target: CW <12%; WM <10%) | 13.1% | 12.8% | 13.7% | 13.7% | 14.3% | 15.1% | 16.2% | 16.2% | 13.5% | 13.6% | 14.6% | 14.6% | 14.6% | | ! |
| | Staff Turnover rate (Target: CW <18%; WM <11.5%) | 17.3% | 17.2% | 16.9% | 16.9% | 11.3% | 11.9% | 11.5% | 11.5% | 15.3% | 15.4% | 15.1% | 15.1% | 15.1% | | - |
| | Sickness absence (Target: <3%) | 2.4% | 2.5% | 2.5% | 2.5% | 3.2% | 2.9% | 2.8% | 3.0% | 2.7% | 2.7% | 2.6% | 2.6% | 2.7% | | - |
| | Bank and Agency spend (£ks) | £2,311 | £2,398 | £3,035 | £10,396 | £2,312 | £2,154 | £2,282 | £9,145.3 | £4,623 | £4,552 | £5,317 | £5,317 | £19,541 | | - |
| | Nursing & Midwifery Agency: % spend of total pay (Target: tbc) | 6.4% | 3.6% | 6.0% | 6.1% | 8.3% | 8.2% | 7.1% | 8.4% | 7.1% | 5.4% | 6.4% | 6.4% | 7.0% | | - |
| Appraisal rates | % of Performance & Development Reviews completed - medical staff (Target: >85%) | 87.7% | 90.4% | 93.1% | 88.6% | 84.0% | 84.0% | 86.0% | 84.5% | 86.2% | 87.8% | 90.2% | 90.2% | 87.0% | | - |
| | % of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%) | 91.0% | 89.5% | 90.2% | 90.2% | 87.8% | 91.0% | 90.9% | 90.9% | 89.9% | 90.0% | 90.4% | 90.4% | 90.4% | | - |
| Training | Mandatory training compliance (Target: >90%) | 91.1% | 91.6% | 92.0% | 91.4% | 85.8% | 87.8% | 89.7% | 86.7% | 89.1% | 90.2% | 91.2% | 91.2% | 89.7% | | ! |
| | Health and Safety training (Target: >90%) | 95.6% | 95.8% | 96.5% | 96.0% | 93.4% | 94.3% | 94.8% | 93.7% | 94.8% | 95.3% | 95.9% | 95.9% | 95.2% | | - |
| | Safeguarding training - adults (Target: 90%) | 93.9% | 94.5% | 94.5% | 94.4% | 92.9% | 93.8% | 94.1% | 93.3% | 93.5% | 94.2% | 94.3% | 94.3% | 94.0% | | - |
| | Safeguarding training - children (Target: 90%) | 92.9% | 93.5% | 94.4% | 93.3% | 91.8% | 92.6% | 93.7% | 92.0% | 92.5% | 93.2% | 94.2% | 94.2% | 92.8% | | - |

| | | | | | |
|---|---|---|---|---|---|
| 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**

**Workforce Commentary July 2018 Figures**

**Staff in Post**

In July we employed 5428 whole time equivalent (WTE) people on substantive contracts, 23 WTE more than last month.

**Turnover**

Our voluntary turnover rate was 15.07%, 0.3% lower than last month. Voluntary turnover is 16.88% at Chelsea and 11.54% at West Middlesex.

**Vacancies**

Our general vacancy rate for July was 14.7%, which is 0.95% higher than last month. The vacancy rate is 16.21% at West Middlesex and 13.7% at Chelsea.

**Sickness Absence**

Sickness absence in the month of July was 2.61%, 0.07% lower than May.

**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%.

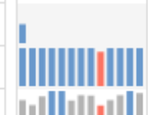
**Performance and Development Reviews**

The PDR rate decreased by now stands at 90.23%.

The rolling annual appraisal rate for medical staff was 90.42%, 0.41% 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 | May-18 | Jun-18 | Jul-18 | 2018-2019 | YTD breaches | May-18 | Jun-18 | Jul-18 | 2018-2019 | YTD breaches | May-18 | Jun-18 | Jul-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 | 87.5% | 100% | 100% | 92.3% | 1.5 | 100% | 100% | 92.9% | 90.0% | 1.5 | 90.0% | 100% | 95.5% | 95.5% | 91.3% | 3 | | - |
| | Gynaecological | 75.0% | 80.0% | 100% | 76.9% | 1.5 | 33.3% | 80.0% | 83.3% | 71.4% | 3 | 57.1% | 80.0% | 87.5% | 87.5% | 73.5% | 4.5 | | ! |
| | Haematological | n/a | 100% | n/a | 100% | 0 | 81.8% | 66.7% | 100% | 84.0% | 2 | 81.8% | 80.0% | 100% | 100% | 86.2% | 2 | | - |
| | Head and neck | 100% | 100% | 0.0% | 85.7% | 0.5 | 66.7% | 100% | n/a | 72.7% | 1.5 | 75.0% | 100% | 0.0% | 0.0% | 77.8% | 2 | | - |
| | Lung | n/a | 100% | n/a | 100% | 0 | 100% | 50.0% | 50.0% | 66.7% | 1 | 100% | 75.0% | 50.0% | 50.0% | 75.0% | 1 | | - |
| | Sarcoma | n/a | n/a | n/a | n/a | | 100% | n/a | n/a | 100% | 0 | 100% | n/a | n/a | n/a | 100% | 0 | | - |
| | Skin | 85.0% | 100% | 92.3% | 92.0% | 2 | 75.0% | 100% | 100% | 95.5% | 0.5 | 83.3% | 100% | 94.7% | 94.7% | 93.1% | 2.5 | | - |
| | Upper gastrointestinal | 100% | 0.0% | 0.0% | 66.7% | 1 | 80.0% | 100% | 100% | 92.9% | 0.5 | 85.7% | 75.0% | 75.0% | 75.0% | 85.0% | 1.5 | | - |
| | Urological | 92.3% | 53.3% | 77.3% | 79.1% | 7 | 76.5% | 94.1% | 71.9% | 84.4% | 7 | 83.3% | 75.0% | 74.1% | 74.1% | 82.2% | 14 | | ! |
| | Urological (Testicular) | 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 | | | - |
| | Site not stated | n/a | 100% | 100% | 100% | 0 | 100% | n/a | 100% | 100% | 0 | 100% | 100% | 100% | 100% | 100% | 0 | | - |

| 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 unvalidated breaches in July by Tumour site are as follows:

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

| | |
|---|---|
| Colorectal / Lower GI: | WMUH: 0.5 of a breach of 7 patients treated |
| Gynaecological: | WMUH: 0.5 of a breach of 3 patients treated |
| Head and Neck: | C&W: 0.5 of a breach of 0.5 patients treated |
| Lung: | WMUH: 0.5 of a breach of 1 patient treated |
| Skin: | C&W: 0.5 of a breach of 6.5 patients treated |
| Upper Gastrointestinal: | C&W: 0.5 of a breach of 0.5 patients |
| Urological: | C&W: 2.5 breaches of 11 patients treated<br>WMUH: 4.5 breaches of 16 patients treated |

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

# CQUIN Dashboard

## July 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 consumption | Deputy Chief Executive | |

### 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 Therapy | 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 & participatic | 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 NHS England schemes) 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.

#### 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 achievements of last year are unlikely to be matched, there will be only limited financial risk associated with the schemes.

#### 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 continues with the Commissioner about shaping the Neonatal Community Outreach scheme to ensure that it meets mutual aims.

#### 2018/19 CQUIN Performance - Full Year Achievement

The Trust achieved an aggregate result of 92.5% for the Specialised Services schemes. The aggregate result for the CCG schemes was 89.7% (including the STP and risk reserve elements).

# Nursing Metrics Dashboard

## Safe Nursing and Midwifery Staffing

### Chelsea and Westminster Hospital Site

| Ward Name | Average fill rate | | | | CHPPD | | | National bench mark |
|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | | | | |
| | Reg Nurses | Care staff | Reg Nurses | Care staff | Reg | HCA | Total | |
| Maternity | 91.5% | 95.7% | 99.6% | 83.1% | 9.9 | 3.8 | 13.7 | 13.0 |
| Annie Zunz | 100.8% | 89.1% | 101.6% | 93.5% | 5.6 | 2.2 | 7.8 | 8.6 |
| Apollo | 98.1% | 93.8% | 98.1% | 100.0% | 17.9 | 3.5 | 21.5 | |
| Jupiter | 109.5% | 69.2% | 109.6% | - | 9.9 | 1.8 | 11.6 | 12.6 |
| Mercury | 76.0% | 85.9% | 71.5% | 25.8% | 6.9 | 0.8 | 7.7 | 8.3 |
| Neptune | 80.0% | 45.2% | 73.4% | 0.0% | 7.0 | 0.5 | 7.5 | 12.6 |
| NICU | 99.8% | - | 101.1% | - | 12.6 | 0.0 | 12.6 | |
| AAU | 104.0% | 83.7% | 99.4% | 100.0% | 9.4 | 2.2 | 11.6 | 10.8 |
| Nell Gwynn | 96.1% | 86.5% | 131.0% | 102.2% | 4.0 | 3.4 | 7.5 | 7.8 |
| David Erskine | 141.3% | 91.1% | 128.0% | 115.1% | 4.0 | 3.2 | 7.2 | 6.4 |
| Edgar Horne | 96.9% | 99.2% | 100.0% | 100.0% | 3.0 | 3.3 | 6.3 | 7.6 |
| Lord Wigram | 94.7% | 98.6% | 100.0% | 100.0% | 3.5 | 2.6 | 6.1 | 6.7 |
| St Mary Abbots | 90.0% | 99.6% | 100.0% | 102.7% | 3.4 | 2.6 | 6.1 | 7.4 |
| David Evans | 79.9% | 78.5% | 91.5% | 91.7% | 5.6 | 2.4 | 7.9 | 7.4 |
| Chelsea Wing | 86.7% | 107.4% | 104.8% | 100.0% | 10.7 | 7.0 | 17.7 | 7.4 |
| Burns Unit | 98.1% | 98.4% | 100.0% | 100.0% | 10.9 | 5.3 | 16.1 | |
| Ron Johnson | 101.2% | 120.6% | 105.4% | 130.6% | 4.7 | 3.1 | 7.8 | 7.9 |
| ICU | 100.0% | 100.0% | 101.9% | - | 30.0 | 0.5 | 30.6 | 22.9 |
| Rainsford Mowlem | 93.0% | 100.0% | 111.4% | 116.0% | 3.3 | 3.2 | 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 | 98.9% | 91.9% | 91.1% | 75.5% | 8.2 | 2.2 | 10.4 | 7.8 |
| Lampton | 101.3% | 104.1% | 98.9% | 102.8% | 2.9 | 2.6 | 5.5 | 7.4 |
| Richmond | 97.9% | 96.5% | 75.9% | 61.1% | 5.9 | 3.1 | 9.0 | 7.4 |
| Syon 1 | 105.9% | 110.9% | 109.8% | 127.6% | 4.2 | 2.6 | 6.8 | 6.7 |
| Syon 2 | 105.4% | 130.2% | 102.5% | 169.4% | 3.8 | 3.1 | 6.9 | 12.6 |
| Starlight | 91.3% | 90.9% | 93.4% | - | 9.7 | 0.3 | 10.0 | 7.8 |
| Kew | 128.3% | 90.3% | 134.2% | 145.2% | 3.8 | 3.2 | 7.0 | 7.6 |
| Crane | 94.1% | 99.2% | 98.9% | 95.2% | 3.3 | 2.7 | 6.0 | 7.8 |
| Osterley 1 | 104.3% | 113.7% | 108.9% | 119.6% | 3.0 | 2.7 | 5.7 | 7.8 |
| Osterley 2 | 100.6% | 97.7% | 100.8% | 193.5% | 3.6 | 3.0 | 6.6 | 10.8 |
| MAU | 105.7% | 82.7% | 96.1% | 90.3% | 7.1 | 3.2 | 10.3 | 6.6 |
| CCU | 99.2% | 100.0% | 100.0% | - | 5.5 | 0.7 | 6.2 | 13.0 |
| Special Care Baby Unit | 91.2% | - | 83.0% | - | 7.0 | 0.0 | 7.0 | 12.6 |
| Marble Hill 1 | 74.4% | 87.1% | 77.0% | 95.2% | 3.4 | 2.7 | 6.1 | 7.8 |
| Marble Hill 2 | 99.4% | 120.5% | 107.5% | 146.8% | 3.5 | 3.8 | 7.3 | 8.8 |
| ITU | 104.8% | 0.0% | 98.2% | - | 28.6 | 0.0 | 28.6 | 22.9 |

**Summary for July 2018**

Increased fill rates on Nell Gwynne due to enhanced care for patient with tracheostomy.

High use of RMNs on David Erskine increasing fill rates for qualified nurses.

David Evans showing low fill rates on days as staffing reduced for reduction in elective lists.

Ron Johnson had two patients at very high risk of falls hence enhanced care by HCAs was implemented.

Some beds closed on Jupiter, Mercury and Neptune so fill rates reduced as more annual leave was allowed and vacancies not filled with temporary staff.

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. Kew, Osterley 2, Marble Hill 2 and Syon 2 showing high fill rates for HCAs due to a high number of mobile confused patients at high risk of falls. Staffing reduced on Marble Hill 1 as some beds closed.

# Finance Dashboard

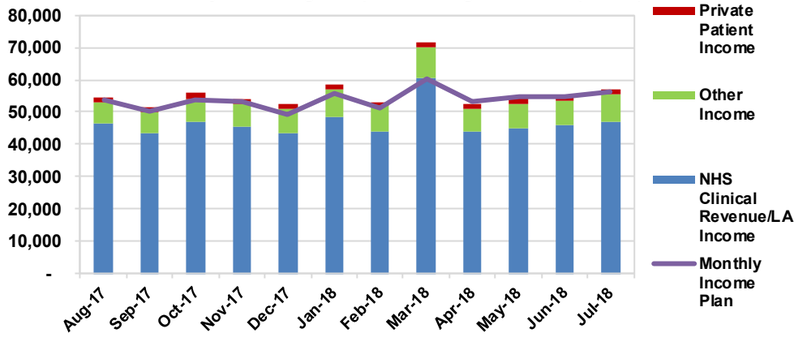
## Month 4 2018-19 Integrated Position

| £'000 | Combined Trust | | |
|---|---|---|---|
| | Plan to Date | Actual to Date | Variance to Date |
| Income | 218,902 | 218,853 | (50) |
| *Expenditure* | | | |
| Pay | (114,587) | (119,242) | (4,655) |
| Non-Pay | (91,347) | (87,231) | 4,116 |
| **EBITDA** | 12,968 | 12,381 | (588) |
| EBITDA % | 5.92% | 5.66% | -0.27% |
| Depreciation | (6,213) | (5,883) | 330 |
| Non-Operational Exp-Inc | (5,521) | (5,374) | 147 |
| Surplus/Deficit | 1,234 | 1,124 | (110) |
| Control total Adj - Donated asset, Impairment & Other | | 149 | 149 |
| **Surplus/Deficit on Control Total basis** | **1,234** | **1,273** | **39** |

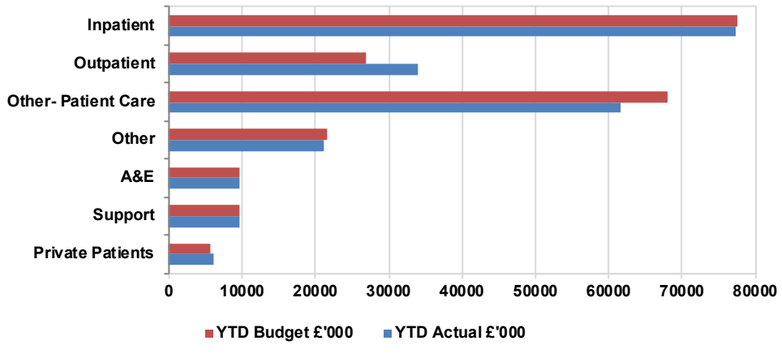
**Comments**

The Trust is reporting a YTD surplus of £1,273k which is £39k favourable against the internal plan on a control total basis. Income is under performing YTD due to adult critical care and NICU, which are categorised as other income on the graph below. Pay is adverse by £4,655k year to date, The Trust continues to use bank and agency staff to cover vacancies, sickness and additional activity. There remains supernumery staffing to cover new overseas nurses while they train to receive their pins. The largest contributor to this position has been under achievement against CIP targets. Non-pay is £4,116k favourable year to date. Included in this position is a deficit against clinical supplies which is activity driven.

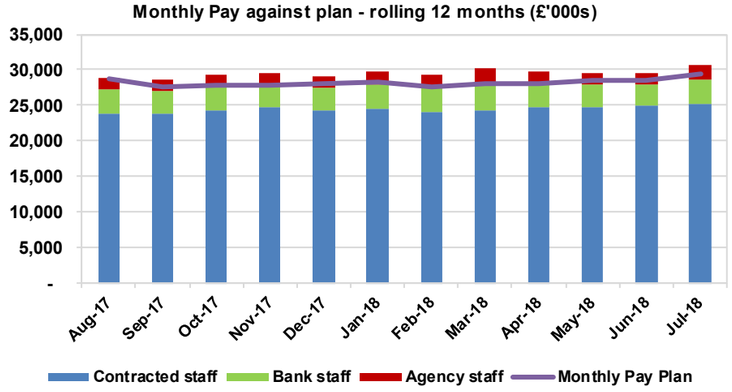
Monthly income against plan - rolling 12 months (£'000s)



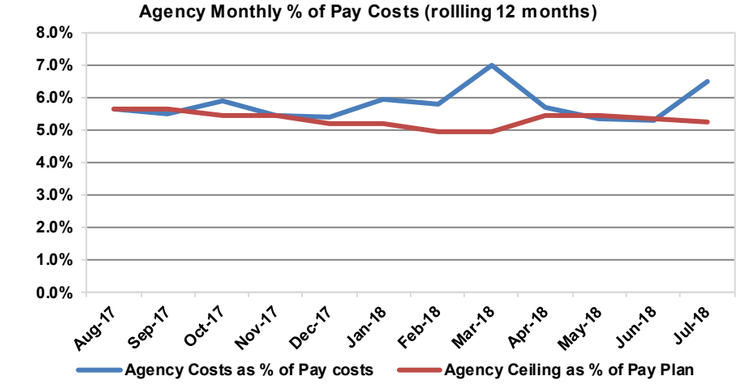

YTD Income plan against actual by type




Monthly Pay against plan - rolling 12 months (£'000s)



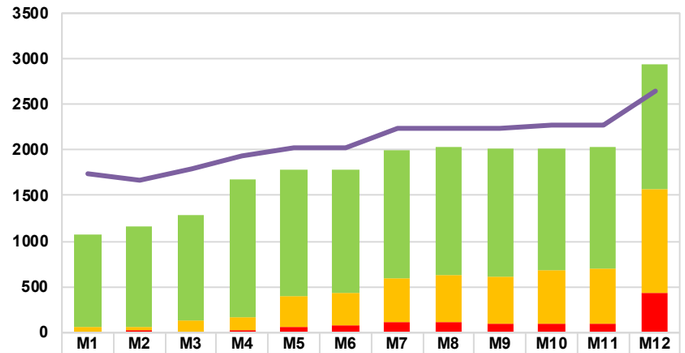

Agency Monthly % of Pay Costs (rollling 12 months)




**Comment**

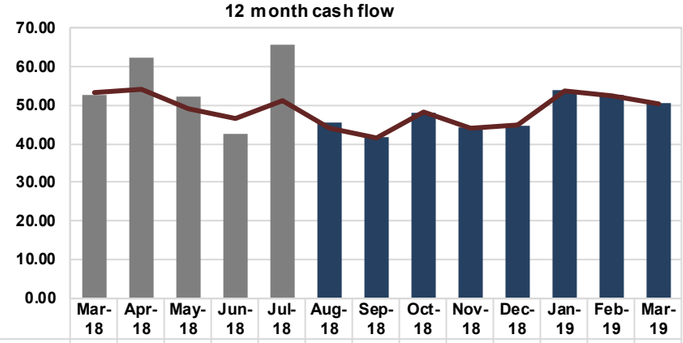
The increase in agency costs in July is predominantly related to non-recurrent EPR implementation and floor walker costs (£0.2m).

CIP Trustwide Forecast vs Target




| | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Green | 1024 | 1100 | 1160 | 1498 | 1390 | 1352 | 1414 | 1404 | 1400 | 1339 | 1342 | 1359 |
| Amber | 54 | 42 | 117 | 147 | 342 | 365 | 478 | 513 | 518 | 584 | 597 | 1139 |
| Red | 0 | 17 | 8 | 25 | 60 | 67 | 114 | 114 | 94 | 94 | 94 | 439 |
| Target | 1732 | 1669 | 1791 | 1941 | 2029 | 2029 | 2230 | 2236 | 2242 | 2267 | 2280 | 2653 |

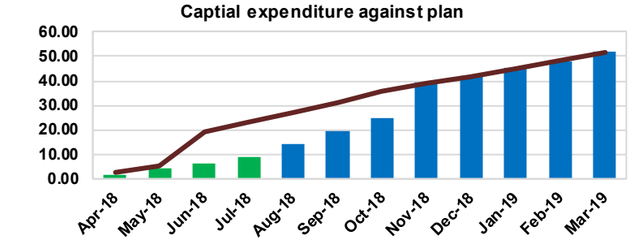
12 month cash flow




| | 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 | | | | | | 45.40 | 41.71 | 48.23 | 44.18 | 44.81 | 53.82 | 52.60 | 50.46 |
| Actual | 52.59 | 62.48 | 52.41 | 42.42 | 65.76 | | | | | | | | |
| 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 is mainly due to higher than planned receipt of Sustainability funding (£15m) increased VAT income received from ICHP for prior year salary recharge £1.2m) offset by an advance payment of EPR costs (£2m).

Captial expenditure against plan




| | 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 | 1.67 | 4.12 | 5.95 | 9.04 | | | | | | | | |
| Forecast | | | | | 14.01 | 19.39 | 24.87 | 39.14 | 41.91 | 45.02 | 48.14 | 51.88 |
| Plan | 2.66 | 5.56 | 19.36 | 23.15 | 26.85 | 31.23 | 35.71 | 39.14 | 41.91 | 45.02 | 48.14 | 51.88 |

**Comment:** Underspend against plan, to the end of M4, 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 | Jul-18 YTD Plan | Jul-18 YTD |
|---|---|---|
| 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 | 88.3% | 88.0% | 0.2% |
| By value | 77.9% | 76.4% | 1.4% |
| | | | |
| Creditor days | 114 | 111 | 3 |
| Debtor Days | 46 | 56 | -10 |

**Comments:** The Trust is performing in line with or better than plan for all areas of measurement of the Use of Resources Rating, except against its agency rating, where YTD expenditure was £6.82m against a ceiling of £6.42m, an adverse variance of £0.4m (6.2%).

**Note:** Creditor days include PDC, tax, national insurance and superannuation creditors, which are excluded from the Better Payment Practice Code (BPPC).

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.6.1/Sep/18 |
| **REPORT NAME** | Workforce Performance Report - Month 4 |
| **AUTHOR** | Natasha Elvidge, Associate Director of HR; Resourcing |
| **LEAD** | Sandra Easton, Chief Financial Officer |
| **PURPOSE** | The workforce performance report highlights current KPIs and trends in workforce related metrics at the Trust. |
| **SUMMARY OF REPORT** | **Staff in Post**<br>In July the trust employed 5428 whole time equivalent (WTE) people on substantive contracts, 23 WTE greater than last month. The trust's substantive workforce has grown by 5.07% (261.95 WTE) over the last twelve months.<br><br>**Turnover**<br>Our voluntary turnover rate was 15.07%, 0.3% lower than last month. Voluntary turnover is 16.88% at Chelsea and 11.54% at West Middlesex.<br><br>**Vacancies**<br>Our general vacancy rate for July was 14.6%, which is 0.95% higher than last month. The vacancy rate is 16.21% at West Middlesex and 13.7% at Chelsea. The Corporate division's vacancy rate has increase by 2.3% due to changes in the establishment, in particular the R&D department (11 new posts).<br><br>**Sickness Absence**<br>Sickness absence in the month of July was 2.61%, 0.07% lower than May.<br><br>**Agency spend**<br>In July agency spend was £1,557,620 which breached the total target agency spend by 2.1% for the month.<br><br>**Core training (statutory and mandatory training) compliance**<br>The Trust reports core training compliance based on the 10 Core Skills Training Framework (CSTF) topics to provide a consistent comparison with other London trusts. Our compliance rate stands at 91% against our target of 90%. The recent introduction of the single compliance reporting platform (QlikView) has coincided with the trust achieving and increasing its highest level of compliance since the introduction of core training reporting.<br><br>**Performance and Development Reviews**<br>From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to |

| | |
|---|---|
| | have had a PDR by the end of December. The PDR rate increased by 0.41% in July and now stands at 90.23%.<br><br>The rolling annual appraisal rate for medical staff was 90.42%, 0.41% higher than last month. |
| **KEY RISKS ASSOCIATED** | The need to reduce vacancy and turnover rates. |
| **FINANCIAL IMPLICATIONS** | Costs associated with high vacancy and turnover rates and high reliance on agency workers. |
| **QUALITY IMPLICATIONS** | Risks associated workforce shortage and instability. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics. |
| **LINK TO OBJECTIVES** | • Excel in providing high quality, efficient clinical services<br>• Improve population health outcomes and develop integrated care<br>• Deliver financial sustainability<br>• Create an environment for learning, discovery and innovation |
| **DECISION/ ACTION** | For noting |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Workforce Performance Report
to the Workforce Development Committee

**Month 4 – July 2018**

# Workforce Performance Report Aug‘17 - Jul‘18

# Performance Summary

Summary of overall performance is set out below

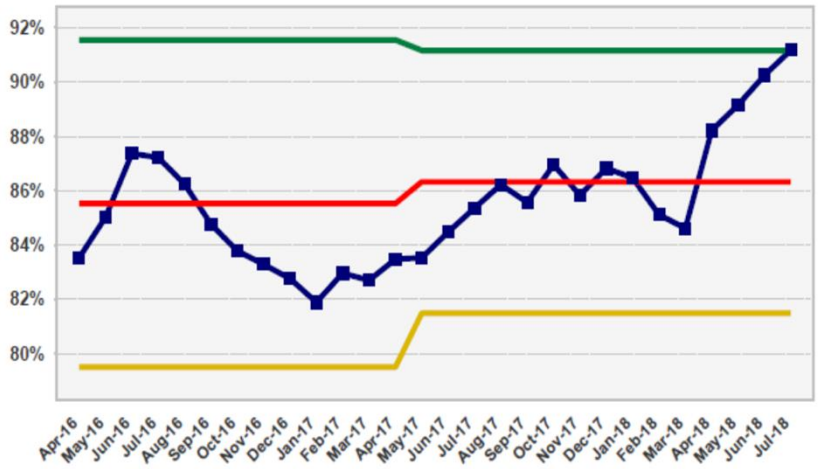
| Page | Areas of Review | Key Highlights | Previous Year | Previous Month | In Month | Target | Change |
|---|---|---|---|---|---|---|---|
| 5 | Vacancy | Vacancy rate has increased by 0.9% | 14.4% | 13.6% | 14.6% | 10.0% | ↗ |
| 6 | Turnover | Turnover has decreased by 0.3% | 21.2% | 19.7% | 19.5% | | ↘ |
| 7 | Voluntary Turnover | Voluntary turnover has decreased by 0.3% | 16.0% | 15.4% | 15.1% | 13.0% | ↘ |
| 10 | Sickness | Sickness has decreased by 0.07% | 2.5% | 2.7% | 2.6% | 3.3% | ↘ |
| 15 | Temporary Staffing Usage (FTE) | Temporary Staffing % usage has increased by 0.1% this month | | 16.2% | 16.3% | | ↗ |
| 17 | Core Training | Core Training compliance has increased by 1.2% | 85.4% | 90.0% | 91.2% | 90.0% | ↗ |
| 18 | Staff PDR | The percentage of staff who have had a PDR has increased by 0.2% | 13.8% | 90.0% | 90.2% | 90.0% | ↗ |

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

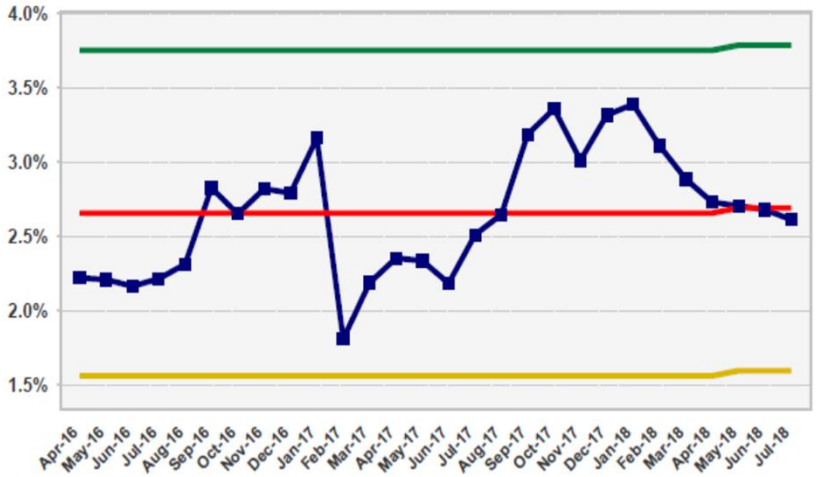
# Statistical Process Control – April 2016 to July 2018

Statistical Process Control Charts for the 28 months April 2016 to July 2018

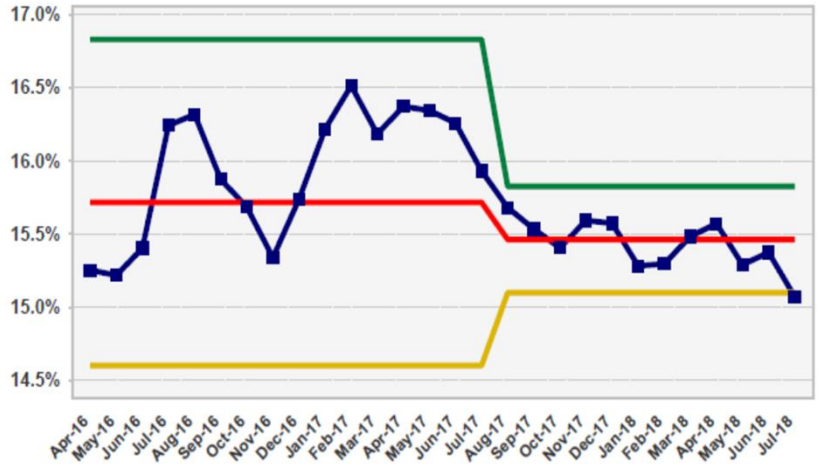
Mandatory Training compliance



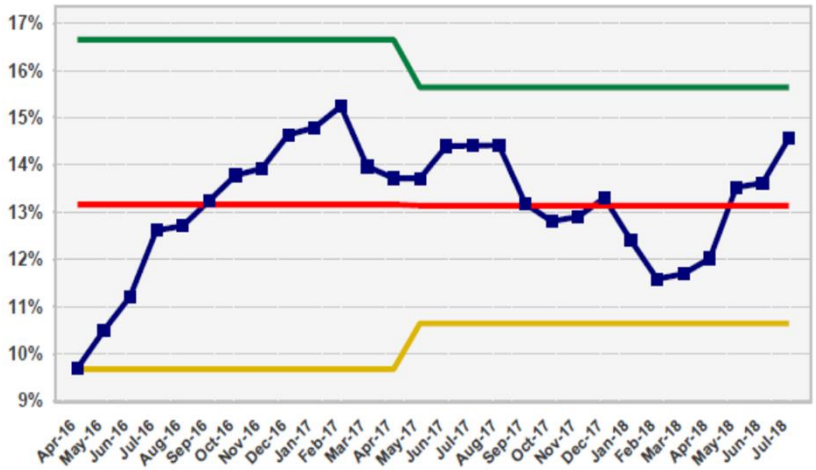

Sickness absence




Staff turnover rate

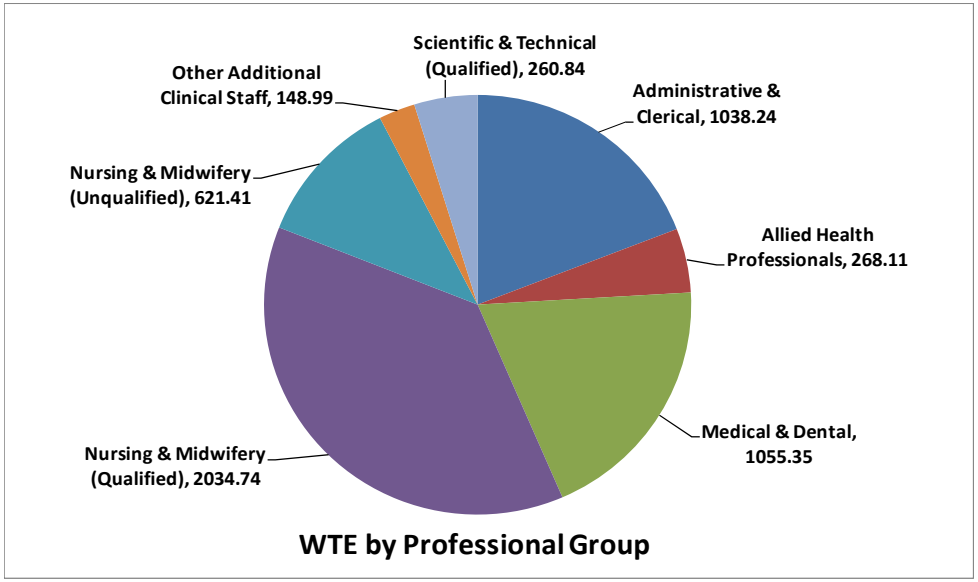


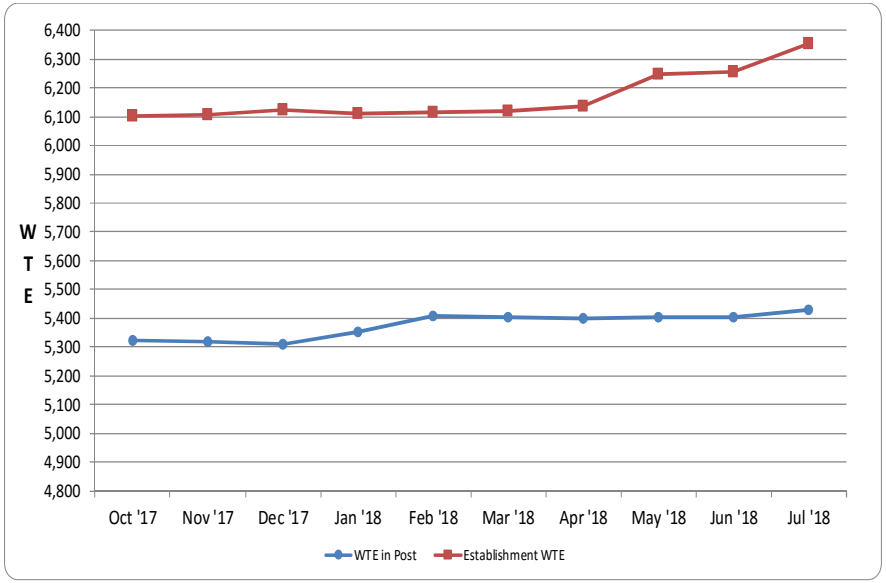

Vacancy rate

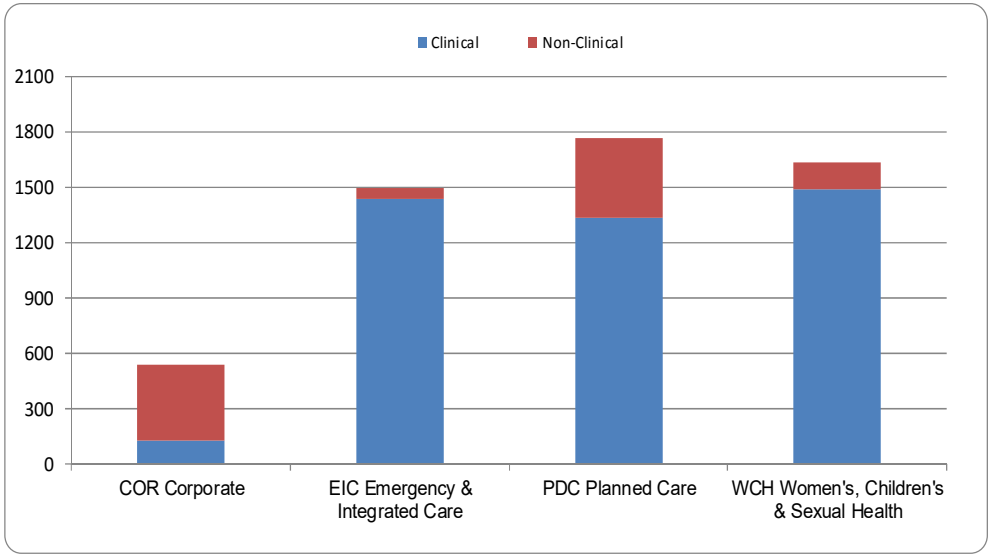


# Current Staffing Profile

The data below displays the current staffing profile of the Trust



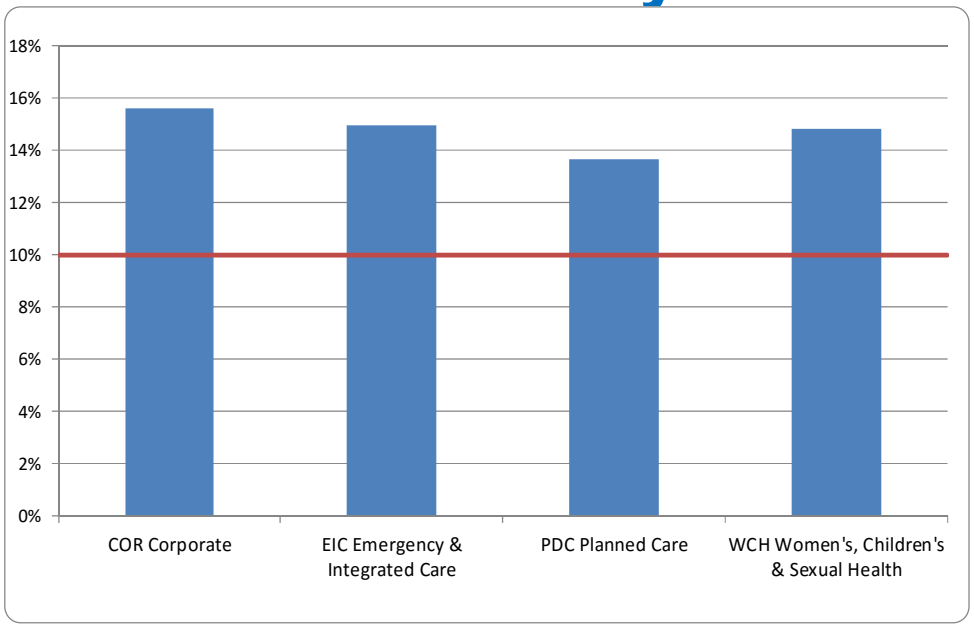

## COMMENTARY

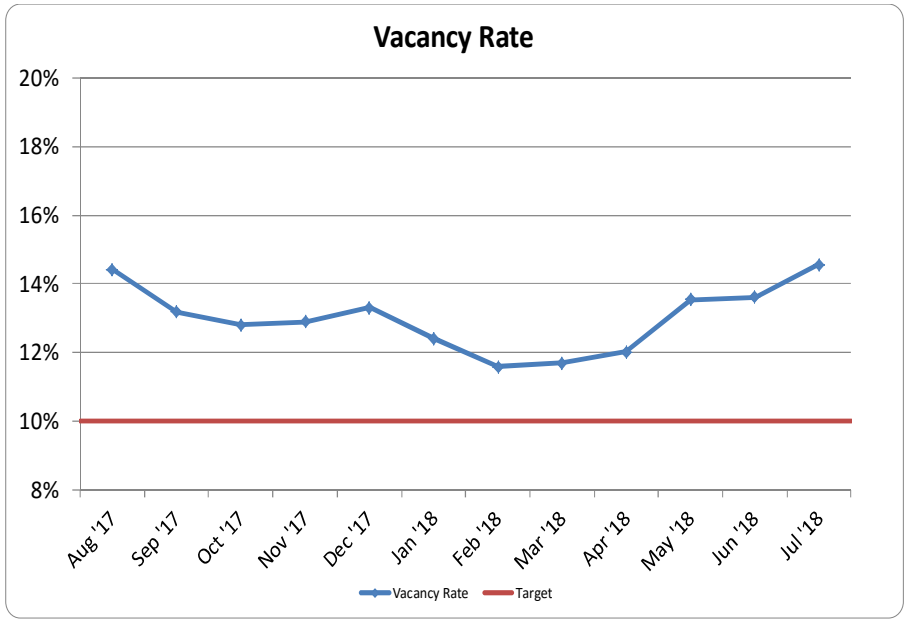
The Trust currently employs 5904 people working a whole time equivalent of 5428 which is 23 WTE greater than June. The largest increase in July was Qualified Nursing (5 WTE), whilst Other Allied Health Professionals staff reduced by 2.27 WTE.

Over the last year, staff numbers have increased by 261.95 WTE with the highest increase being in the EIC Division (231.5 WTE). The professional group with the highest increase has been Qualified Nursing & Midwifery (150.27 WTE).

In July there were 1852 WTE staff assigned to the West Middlesex site and 3576 WTE to Chelsea.

# Section 1: Vacancy Rates




| Vacancies by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 11.0% | 11.7% | 13.3% | 15.6% | ↗ |
| EIC Emergency & Integrated Care | 13.5% | 16.2% | 14.7% | 15.0% | ↗ |
| PDC Planned Care | 11.8% | 13.8% | 13.4% | 13.7% | ↗ |
| WCH Women's, Children's & Sexual Health | 11.2% | 11.3% | 12.9% | 14.8% | ↗ |
| **Whole Trust** | **12.0%** | **13.5%** | **13.6%** | **14.6%** | ↗ |
| **West Mid Site** | **12.0%** | **14.3%** | **15.1%** | **16.2%** | ↗ |
| **Chelsea Site** | **12.1%** | **13.1%** | **12.8%** | **13.7%** | ↗ |

| Vacancies by Professional Group | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 11.6% | 13.7% | 15.9% | 17.1% | ↗ |
| Allied Health Professionals | 13.1% | 14.5% | 12.3% | 13.1% | ↗ |
| Medical & Dental | 10.8% | 13.0% | 12.4% | 12.7% | ↗ |
| Nursing & Midwifery (Qualified) | 12.7% | 13.4% | 14.0% | 15.5% | ↗ |
| Nursing & Midwifery (Unqualified) | 14.5% | 16.2% | 13.1% | 13.4% | ↗ |
| Other Additional Clinical Staff | 5.0% | 6.1% | 8.4% | 8.2% | ↘ |
| Scientific & Technical (Qualified) | 9.8% | 12.1% | 11.3% | 11.4% | ↗ |
| **Total** | **12.0%** | **13.5%** | **13.6%** | **14.6%** | ↗ |

| Service | Establishment WTE | Staff in Post WTE | Vacancy Rate % | Trend |
|---|---|---|---|---|
| WM Paediatric Starlight Unit | 59.2 | 22.9 | 61.3% | ↗ |
| CW Medical Day Unit | 23.7 | 10.3 | 56.6% | ↗ |
| WM Radiology | 60.7 | 35.9 | 40.8% | ↔ |
| CW Estates | 41.2 | 27.6 | 33.0% | ↗ |
| WM T&O | 32.4 | 21.8 | 33.0% | ↔ |

**COMMENTARY**

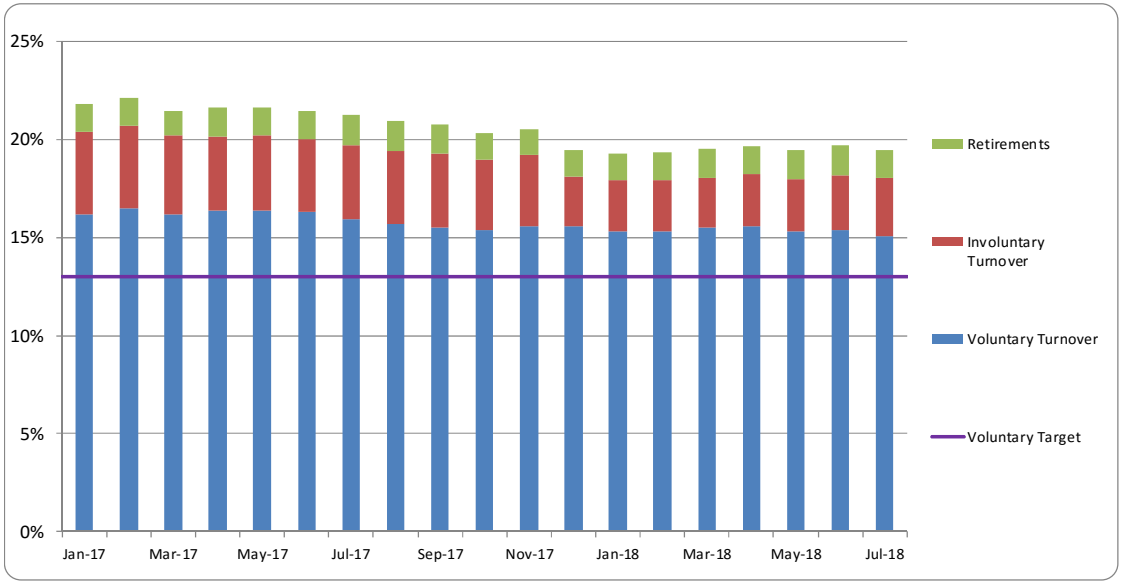
The vacancy rate has increased by 0.95% in July.

The vacancy rate currently is highest in the Administrative & Clerical professional group at 17.14% and in the Emergency & Integrated Care Division at 14.97%.

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

# Section 2a: Gross Turnover

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




**COMMENTARY**

The total trust turnover rate has decreased slightly by 0.2% to 19.5% this month. In the last 12 months there have been 1017 leavers.

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

| | Gross Turnover | | | | |
|---|---|---|---|---|---|
| **Division** | **Apr '18** | **May '18** | **Jun '18** | **Jul '18** | **Trend** |
| COR Corporate | 21.4% | 21.4% | 23.0% | 22.9% | ↘ |
| EIC Emergency & Integrated Care | 20.1% | 20.2% | 20.5% | 19.8% | ↘ |
| PDC Planned Care | 18.2% | 18.1% | 18.0% | 17.6% | ↘ |
| WCH Women's, Children's & Sexual Health | 20.2% | 19.7% | 19.9% | 20.1% | ↗ |
| **Whole Trust** | **19.6%** | **19.5%** | **19.7%** | **19.5%** | ↘ |

| | Gross Turnover | | | | |
|---|---|---|---|---|---|
| **Professional Group** | **Apr '18** | **May '18** | **Jun '18** | **Jul '18** | **Trend** |
| Administrative & Clerical | 18.8% | 19.4% | 21.0% | 20.0% | ↘ |
| Allied Health Professionals | 20.8% | 21.5% | 22.4% | 22.4% | ↔ |
| Medical & Dental | 16.3% | 16.1% | 15.8% | 16.5% | ↗ |
| Nursing & Midwifery (Qualified) | 19.5% | 19.2% | 18.8% | 18.9% | ↗ |
| Nursing & Midwifery (Unqualified) | 23.0% | 22.1% | 22.4% | 20.0% | ↘ |
| Other Additional Clinical Staff | 23.2% | 22.3% | 23.9% | 26.2% | ↗ |
| Scientific & Technical (Qualified) | 19.6% | 19.1% | 18.8% | 19.0% | ↗ |
| **Whole Trust** | **19.6%** | **19.5%** | **19.7%** | **19.5%** | ↘ |

| Leaver Category | Number of Leavers |
|---|---|
| Death in Service | 2 |
| Dismissal | 20 |
| Employee Transfer | 13 |
| End of Fixed Term Contract | 117 |
| Redundancy | 4 |
| Retirement | 66 |
| Voluntary Resignation | 795 |
| **Total** | **1017** |

# Section 2b: Voluntary Turnover

| | Voluntary Turnover | | | | | | Other Turnover July 2018 | |
|---|---|---|---|---|---|---|---|---|
| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend | Leavers HC | In-voluntary | Retirement |
| COR Corporate | 16.7% | 16.5% | 17.6% | 16.6% | ↘ | 89 | 4.7% | 1.7% |
| EIC Emergency & Integrated Care | 17.3% | 17.2% | 17.1% | 16.7% | ↘ | 222 | 2.2% | 0.8% |
| PDC Planned Care | 13.2% | 13.3% | 13.0% | 12.5% | ↘ | 214 | 3.4% | 1.7% |
| WCH Women's, Children's & Sexual Health | 16.3% | 15.5% | 15.7% | 16.0% | ↗ | 264 | 2.5% | 1.6% |
| **Whole Trust** | **15.6%** | **15.3%** | **15.4%** | **15.1%** | ↘ | **789** | **2.9%** | **1.4%** |
| **West Mid Site** | **11.7%** | **11.3%** | **11.9%** | **11.5%** | ↘ | **204** | | |
| **Chelsea Site** | **17.6%** | **17.4%** | **17.2%** | **16.9%** | ↘ | **585** | | |

| | Voluntary Turnover | | | | | | Other Turnover July 2018 | |
|---|---|---|---|---|---|---|---|---|
| Professional Group | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend | Leavers HC | In-voluntary | Retirement |
| Administrative & Clerical | 14.9% | 15.3% | 16.5% | 15.6% | ↘ | 179 | 2.9% | 1.6% |
| Allied Health Professionals | 18.6% | 19.0% | 19.2% | 19.5% | ↗ | 60 | 1.9% | 1.0% |
| Medical & Dental | 6.2% | 5.5% | 5.3% | 5.3% | ↔ | 31 | 9.9% | 1.4% |
| Nursing & Midwifery (Qualified) | 17.4% | 17.0% | 16.5% | 16.8% | ↗ | 355 | 0.8% | 1.4% |
| Nursing & Midwifery (Unqualified) | 19.0% | 18.5% | 18.3% | 16.3% | ↘ | 117 | 2.3% | 1.4% |
| Other Additional Clinical Staff | 12.2% | 11.5% | 12.8% | 14.3% | ↗ | 21 | 8.3% | 3.6% |
| Scientific & Technical (Qualified) | 14.3% | 13.4% | 13.5% | 13.4% | ↘ | 38 | 4.6% | 1.1% |
| **Whole Trust** | **15.6%** | **15.3%** | **15.4%** | **15.1%** | ↘ | **801** | **2.9%** | **1.4%** |

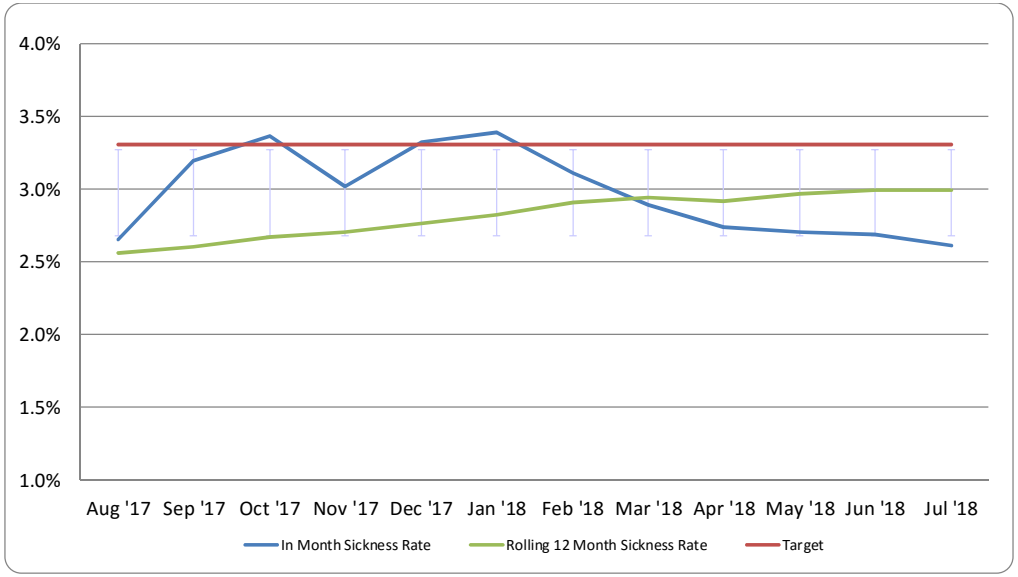
| Service | Average Staff in Post HC | Leavers HC | Voluntary Turnover Rate |
|---|---|---|---|
| CW Ron Johnson | 25 | 10 | 40.8% |
| CW Nell Gwynne Ward | 33 | 13 | 40.0% |
| CW David Erskine Ward | 29 | 10 | 35.1% |
| CW Mercury Ward | 28 | 9 | 32.1% |
| CW John Hunter Clinic | 51 | 16 | 31.7% |

**COMMENTARY**

Voluntary Turnover has decreased by 0.3% this month. Chelsea Site has a voluntary turnover rate consistently about 5% higher than West Mid. The 5 services with more than 20 staff with the highest voluntary turnover rates are shown in the bottom table. Divisional HR Business Partners are working within divisions to tackle any issues within these areas. The Trust is also taking part in the NHSi Retention Support Program to help reduce turnover.

# Section 3: Sickness

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




**COMMENTARY**

The monthly sickness absence rate is at 2.61% in July which is a decrease of 0.07% on the previous month.

The Women's, Children & Sexual Health Division had the highest sickness rate in June at 3.20%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 4.8%.

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

| Sickness by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 1.92% | 1.83% | 1.62% | 1.43% | ↘ |
| EIC Emergency & Integrated Care | 2.36% | 2.14% | 2.13% | 2.08% | ↘ |
| PDC Planned Care | 3.35% | 3.21% | 2.91% | 2.86% | ↘ |
| WCH Women's, Children's & Sexual Health | 2.65% | 2.89% | 3.27% | 3.20% | ↘ |
| **Whole Trust In Month %** | **2.73%** | **2.70%** | **2.68%** | **2.61%** | ↘ |
| **Whole Trust Annual Rolling %** | **2.91%** | **2.96%** | **2.99%** | **2.99%** | ↗ |
| **Long Term Sickness Rate %** | **1.36%** | **1.29%** | **1.21%** | **1.17%** | ↘ |
| **Short Term Sickness Rate %** | **1.37%** | **1.43%** | **1.45%** | **1.44%** | ↘ |

| Sickness by Professional Group (In Month) | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| Administrative & Clerical | 3.54% | 3.14% | 3.38% | 3.39% | ↗ |
| Allied Health Professionals | 1.91% | 1.53% | 2.26% | 2.24% | ↘ |
| Medical & Dental | 0.40% | 0.39% | 0.37% | 0.36% | ↘ |
| Nursing & Midwifery (Qualified) | 2.87% | 3.20% | 3.05% | 2.83% | ↘ |
| Nursing & Midwifery (Unqualified) | 4.71% | 4.65% | 4.82% | 4.80% | ↘ |
| Other Additional Clinical Staff | 2.33% | 2.61% | 1.33% | 1.99% | ↗ |
| Scientific & Technical (Qualified) | 4.32% | 2.97% | 2.57% | 2.57% | ↗ |
| **Whole Trust In Month %** | **2.73%** | **2.70%** | **2.68%** | **2.61%** | ↘ |
| **Chelsea Site %** | **2.50%** | **2.42%** | **2.55%** | **2.52%** | ↘ |
| **West Mid Site %** | **3.17%** | **3.25%** | **2.93%** | **2.80%** | ↘ |

| Service | Staff in Post WTE | Sickness WTE Days Lost | WTE Days Available | Sickness % |
|---|---|---|---|---|
| WM Syon 2 Pay | 32.13 | 92.52 | 927.00 | 10.0% |
| CW Edgar Horne Ward | 37.40 | 104.61 | 1123.84 | 9.3% |
| CW Outpatients | 21.20 | 55.00 | 623.00 | 8.8% |
| CW John Hunter Clinic | 45.43 | 110.24 | 1385.19 | 8.0% |
| WM Paediatric Starlight Unit | 22.92 | 78.80 | 1092.24 | 7.2% |

| Top 5 Sickness Reasons by Number of Episodes | % of all Episodes |
|---|---|
| S25 Gastrointestinal problems | 21.12% |
| S13 Cold, Cough, Flu - Influenza | 20.88% |
| S12 Other musculoskeletal problems | 10.26% |
| S16 Headache / migraine | 8.71% |
| S10 Anxiety/stress/depression/other psychiatric illnesses | 7.88% |

| Top 5 Sickness Reasons by Number of WTE Days Lost | % of all WTE Days Lost |
|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 21.84% |
| S11 Back Problems | 5.42% |
| S12 Other musculoskeletal problems | 11.62% |
| S13 Cold, Cough, Flu - Influenza | 11.33% |
| S14 Asthma | 0.85% |

# Section 4: Nursing Workforce Profile/KPIs

**Nursing Establishment WTE**

| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 89.1 | 89.1 | 91.1 | 92.1 | ↗ |
| EIC Emergency & Integrated Care | 1022.5 | 1060.0 | 1068.1 | 1085.6 | ↗ |
| PDC Planned Care | 716.4 | 716.9 | 692.9 | 694.6 | ↗ |
| WCH Women's, Children's & Sexual Health | 1189.8 | 1189.8 | 1223.9 | 1253.7 | ↗ |
| **Total** | **3017.8** | **3055.8** | **3076.0** | **3125.9** | ↗ |

**Nursing Staff in Post WTE**

| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 83.8 | 83.7 | 84.0 | 84.0 | ↔ |
| EIC Emergency & Integrated Care | 861.9 | 861.3 | 868.9 | 885.2 | ↗ |
| PDC Planned Care | 649.6 | 650.9 | 655.2 | 654.1 | ↘ |
| WCH Women's, Children's & Sexual Health | 1026.8 | 1029.6 | 1042.5 | 1032.8 | ↘ |
| **Total** | **2622.1** | **2625.6** | **2650.6** | **2656.1** | ↗ |

**Nursing Vacancy Rate**

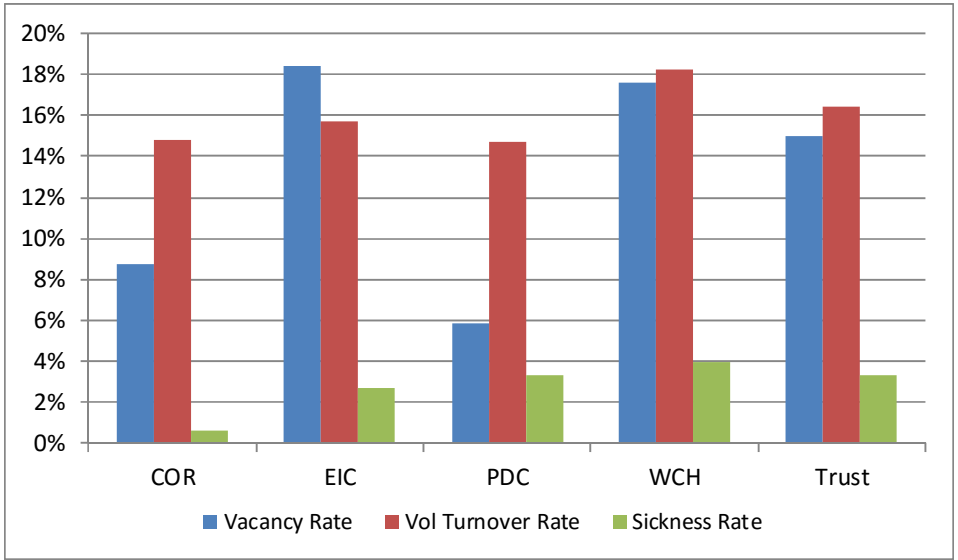
| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 5.9% | 6.0% | 7.7% | 8.7% | ↗ |
| EIC Emergency & Integrated Care | 15.7% | 18.7% | 18.7% | 18.5% | ↘ |
| PDC Planned Care | 9.3% | 9.2% | 5.4% | 5.8% | ↗ |
| WCH Women's, Children's & Sexual Health | 13.7% | 13.5% | 14.8% | 17.6% | ↗ |
| **Total** | **13.1%** | **14.1%** | **13.8%** | **15.0%** | ↗ |

**Nursing Sickness Rates**

| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 3.0% | 2.2% | 1.8% | 0.6% | ↘ |
| EIC Emergency & Integrated Care | 3.3% | 3.1% | 2.8% | 2.7% | ↘ |
| PDC Planned Care | 3.7% | 4.1% | 3.6% | 3.3% | ↘ |
| WCH Women's, Children's & Sexual Health | 3.1% | 3.7% | 4.0% | 3.9% | ↘ |
| **Total** | **3.6%** | **3.5%** | **3.5%** | **3.3%** | ↘ |

**Nursing Voluntary Turnover**

| Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 18.52% | 17.43% | 15.24% | 14.84% | ↘ |
| EIC Emergency & Integrated Care | 16.90% | 16.45% | 16.39% | 15.75% | ↘ |
| PDC Planned Care | 17.38% | 17.20% | 15.53% | 14.69% | ↘ |
| WCH Women's, Children's & Sexual Health | 19.07% | 18.08% | 18.39% | 18.24% | ↘ |
| **Total** | **17.9%** | **17.3%** | **16.9%** | **16.4%** | ↘ |
| **West Mid Site** | **12.1%** | **11.2%** | **11.9%** | **19.7%** | ↗ |
| **Chelsea Site** | **21.0%** | **20.8%** | **17.2%** | **11.9%** | ↘ |




**COMMENTARY**

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

The nursing workforce has increased by 4.93 WTE in July.

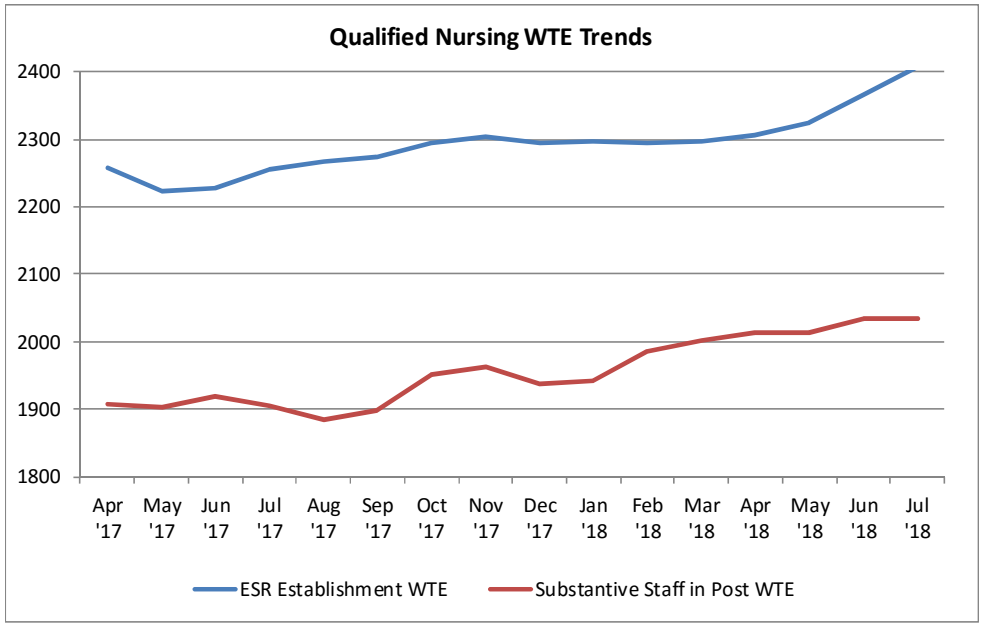
Voluntary Turnover is much higher at the Chelsea site compared to West Mid.

# Section 5: Qualified Nursing & Midwifery Recruitment Pipeline

| Measure | Jan '18 | Feb '18 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE | 2296.2 | 2295.6 | 2296.0 | 2306.1 | 2324.2 | 2366.4 | 2408.3 | | | | | | | | |
| Substantive Staff in Post WTE | 1943.3 | 1985.3 | 2001.5 | 2013.4 | 2012.5 | 2034.2 | 2034.7 | | | | | | | | |
| Contractual Vacancies WTE | 353.0 | 310.3 | 294.4 | 292.7 | 311.7 | 332.3 | 373.5 | | | | | | | | |
| Vacancy Rate % | 15.37% | 13.52% | 12.82% | 12.69% | 13.41% | 14.04% | 15.51% | | | | | | | | |
| Actual/Planned Leavers Per Month* | 28 | 27 | 23 | 44 | 48 | 23 | 34 | 34 | 34 | 34 | 34 | 35 | 35 | 35 | 35 |
| Actual/Planned New Starters** | 34 | 53 | 42 | 50 | 29 | 40 | 35 | 44 | 44 | 45 | 45 | 45 | 45 | 45 | 45 |
| Pipeline: Agreed Start Dates | | | | | | | | 29 | 24 | 39 | 2 | 0 | 0 | 0 | 0 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | 191 with no agreed start date | | | | | | | |

* Based on Gross Turnover of 20%

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




**COMMENTARY**

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

July saw more starters than leavers for consecutive months. There are 191 nurses in the pipeline without a start date, 77 of which are from overseas.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the nursing and midwifery vacancy rate down to 10% by March 2019.

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

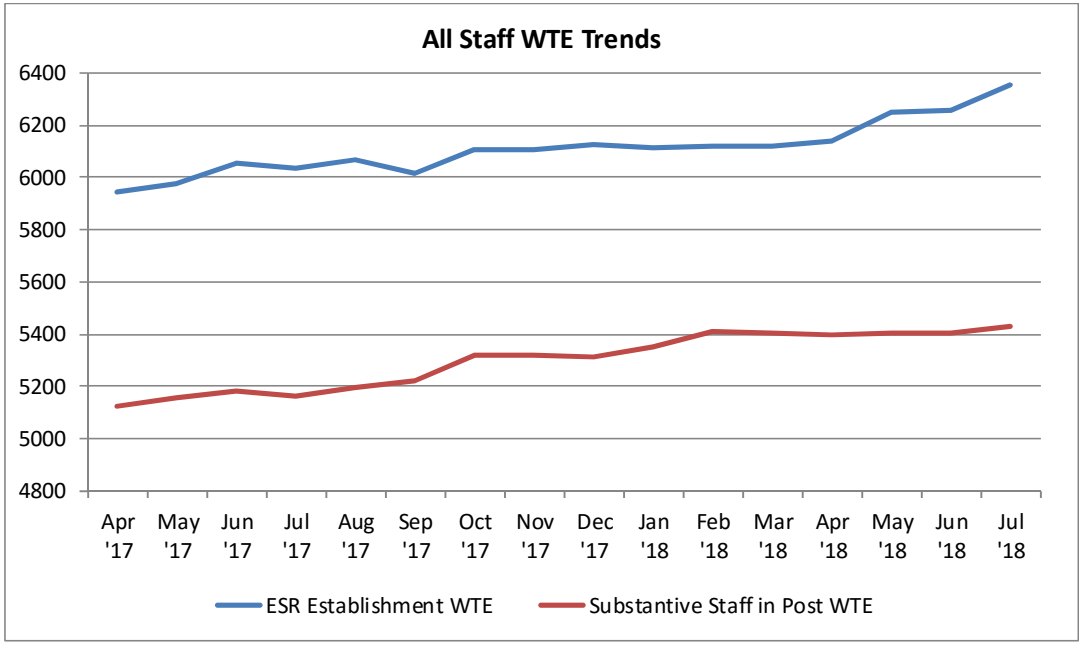
# Section 6: All Staff Recruitment Pipeline

| Measure | Jan '18 | Feb '18 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ESR Establishment WTE[1] | 6112.7 | 6116.2 | 6120.7 | 6136.1 | 6247.6 | 6257.6 | 6353.0 | | | | | | | | |
| Substantive Staff in Post WTE | 5354.6 | 5407.7 | 5404.9 | 5398.7 | 5402.6 | 5405.7 | 5427.7 | | | | | | | | |
| Contractual Vacancies WTE | 758.1 | 708.5 | 715.7 | 737.4 | 845.1 | 851.9 | 925.3 | | | | | | | | |
| Vacancy Rate % | 12.40% | 11.58% | 11.69% | 12.02% | 13.53% | 13.61% | 14.56% | | | | | | | | |
| Actual/Planned Leavers Per Month[2] | 71 | 103 | 96 | 131 | 75 | 74 | 90 | 90 | 91 | 91 | 91 | 91 | 91 | 92 | 92 |
| Actual/Planned New Starters[3] | 124 | 129 | 114 | 126 | 83 | 86 | 112 | 107 | 102 | 102 | 102 | 103 | 103 | 103 | 103 |
| Pipeline: Agreed Start Dates | | | | | | | | 71 | 52 | 42 | 2 | 0 | 0 | 0 | 0 |
| Pipeline: WTE No Agreed Start Date | | | | | | | | 675 with no agreed start date | | | | | | | |

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

[2] Based on Gross Turnover of 20%

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




**COMMENTARY**

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

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the vacancy rate down to 10% by March 2019.

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

# Section 7: Agency Spend

## COR Corporate

| Corporate | Apr '18 | May '18 | Jun '18 | Jul '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £157,047 | £224,261 | £410,779 | £571,836 | £1,363,923 |
| Target Spend | £0 | £0 | £0 | | |
| Variance | £157,047 | £224,261 | £410,779 | £571,836 | £1,363,923 |
| Variance % | | | | 0.0% | |

## EIC Emergency & Integrated Care

| Emergency & Integrated Care | Apr '18 | May '18 | Jun '18 | Jul '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £595,862 | £651,242 | £639,876 | £615,494 | £2,502,474 |
| Target Spend | £0 | £0 | £0 | | |
| Variance | £595,862 | £651,242 | £639,876 | £615,494 | £2,502,474 |
| Variance % | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

## PDC Planned Care

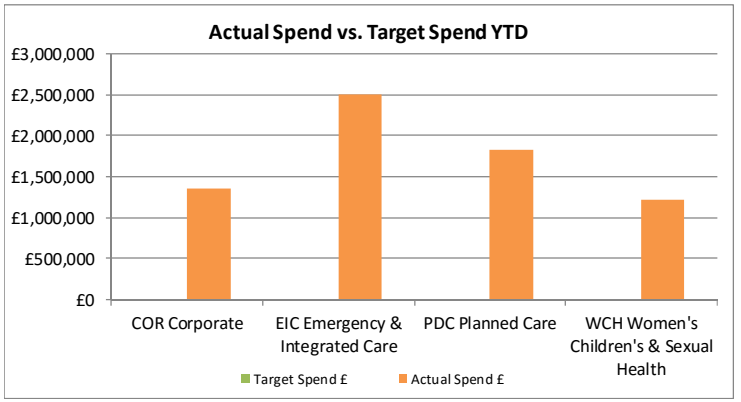
| Planned Care | Apr '18 | May '18 | Jun '18 | Jul '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £554,818 | £395,358 | £363,757 | £509,928 | £1,823,861 |
| Target Spend | £0 | £0 | £0 | £0 | £0 |
| Variance | £554,818 | £395,358 | £363,757 | £509,928 | £1,823,861 |
| Variance % | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

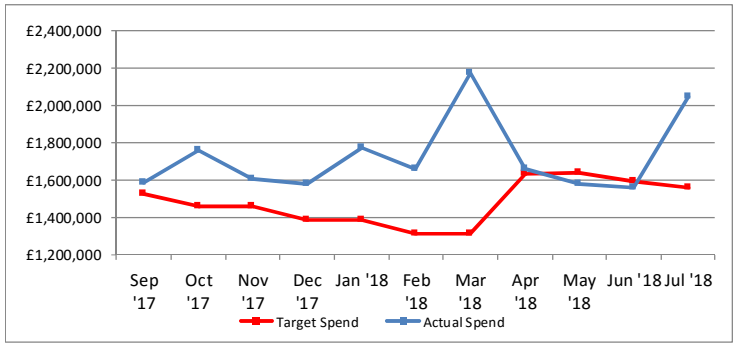
## WCH Women's, Children's & Sexual Health

| Women's, Children's & Sexual Health | Apr '18 | May '18 | Jun '18 | Jul '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £347,708 | £301,186 | £285,123 | £291,225 | £1,225,242 |
| Target Spend | £0 | £0 | £0 | | |
| Variance | £347,708 | £301,186 | £285,123 | £291,225 | £1,225,242 |
| Variance % | | | | 0.0% | |

## Clinical Divisions and Corporate Areas

| Trust | Apr '18 | May '18 | Jun '18 | Jul '18 | YTD |
|---|---|---|---|---|---|
| Actual Spend | £1,655,435 | £1,575,411 | £1,557,620 | £2,043,672 | £6,832,138 |
| Target Spend | £1,634,000 | £1,635,000 | £1,591,000 | £1,560,000 | £6,420,000 |
| Variance | -£21,435 | £59,589 | £33,380 | -£483,672 | -£412,138 |
| Variance % | 1.3% | -3.6% | -2.1% | 31.0% | 6.4% |



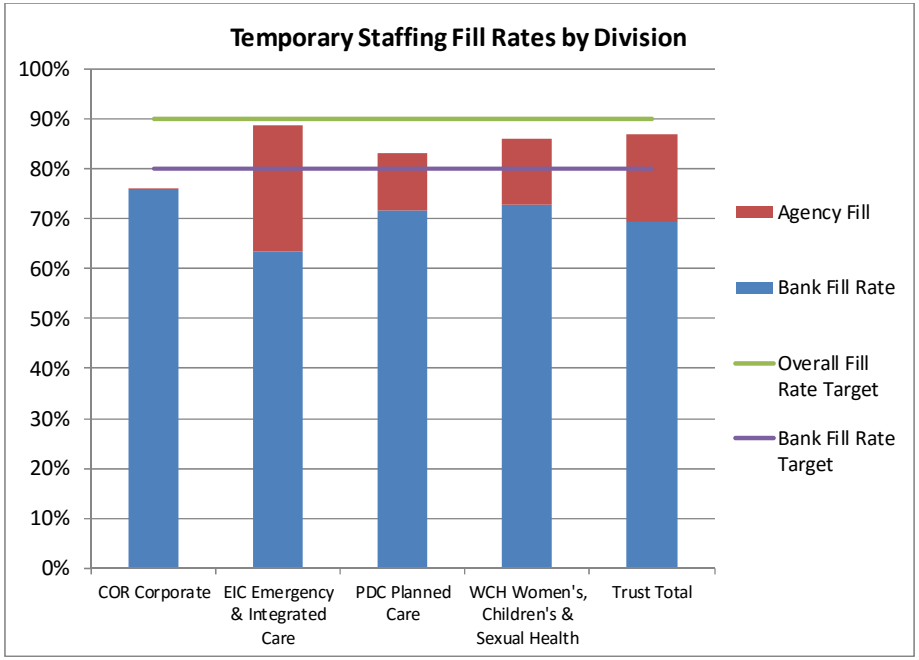

### COMMENTARY

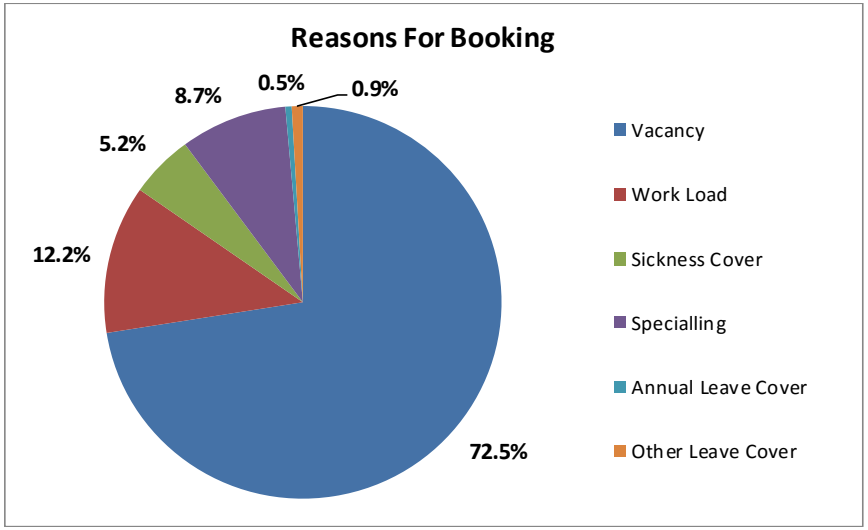
These figures show the Trust agency spend by Division. Spend ceilings by Division have not yet been set for 18/19.

In Month 4, the trust went over the total target spend by 31.0%. This represents a 6.4% increase in over target spending for the year to date. The highest spend was in the Emergency and Integrated Care Division.

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

# Section 8: Temporary Staff Fill Rates




## COMMENTARY

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

The Overall Fill Rate was 85.4% this month which is a 2.2% decrease since June. The Bank Fill Rate was reported at 69.4% which is 0.7% lower than the previous month. The EIC Emergency & Integrated Care is currently meeting the demand for temporary staff most effectively.

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

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

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

| Overall Fill Rate % by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 85.1% | 89.6% | 79.7% | 76.2% | ↘ |
| EIC Emergency & Integrated Care | 86.3% | 91.5% | 88.8% | 88.6% | ↘ |
| PDC Planned Care | 87.3% | 89.4% | 87.0% | 83.3% | ↘ |
| WCH Women's, Children's & Sexual Health | 85.6% | 86.3% | 88.1% | 86.0% | ↘ |
| **Whole Trust** | **86.4%** | **89.3%** | **87.6%** | **85.4%** | ↘ |

| Bank Fill Rate % by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 80.7% | 89.3% | 79.3% | 75.8% | ↘ |
| EIC Emergency & Integrated Care | 60.1% | 49.7% | 63.6% | 63.4% | ↘ |
| PDC Planned Care | 70.0% | 62.6% | 73.5% | 71.8% | ↘ |
| WCH Women's, Children's & Sexual Health | 67.1% | 65.6% | 72.8% | 72.8% | ↗ |
| **Whole Trust** | **66.1%** | **59.9%** | **70.1%** | **69.4%** | ↘ |

# Section 9: Core Training

| Core Training Topic | Jun '18 | Jul '18 | Trend |
|---|---|---|---|
| Basic Life Support | 83.0 | 85.0 | ↗ |
| Conflict Resolution | 92.0 | 94.0 | ↗ |
| Equality, Diversity and Human Rights | 93.0 | 93.0 | ↔ |
| Fire | 90.0 | 90.0 | ↔ |
| Health & Safety | 95.0 | 96.0 | ↗ |
| Inanimate Loads (M&H L1) | 91.0 | 91.0 | ↔ |
| Infection Control (Hand Hyg) | 94.0 | 94.0 | ↔ |
| Information Governance | 88.0 | 88.0 | ↔ |
| Patient Handling (M&H L2) | 76.0 | 79.0 | ↗ |
| Safeguarding Adults Level 1 | 94.0 | 94.0 | ↔ |
| Safeguarding Children Level 1 | 93.0 | 94.0 | ↗ |
| Safeguarding Children Level 2 | 83.0 | 87.0 | ↗ |
| Safeguarding Children Level 3 | 84.0 | 81.0 | ↘ |

## COMMENTARY

Compliance continues on an upward trend, now at 91%.

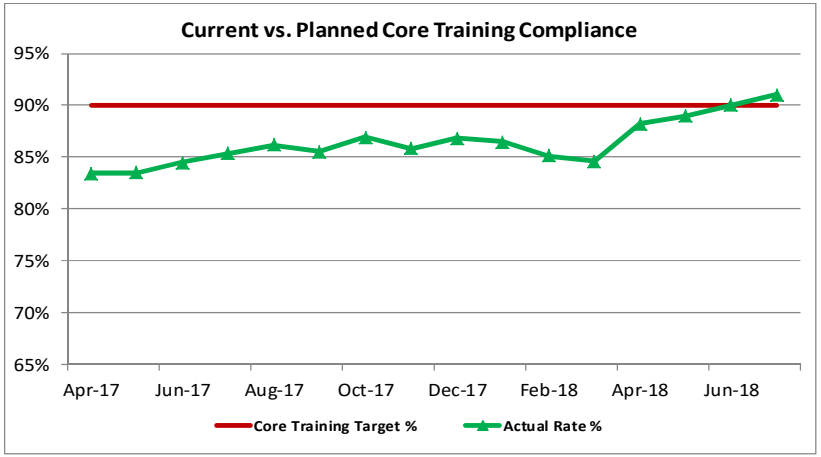
Moving & Handling (Patient Handling) continues to improve following the realignment of the requirements (national best practice) for WMUH based staff.

Information Governance (IG) remains static in part due to the relatively small number of staff needing to renew during Q2 of the year. EIC division has made continued progress in this area whilst the other three divisions are falling on their IG rates. There is approx. 5% of the substantive workforce who are more than 4 months out of date for IG.

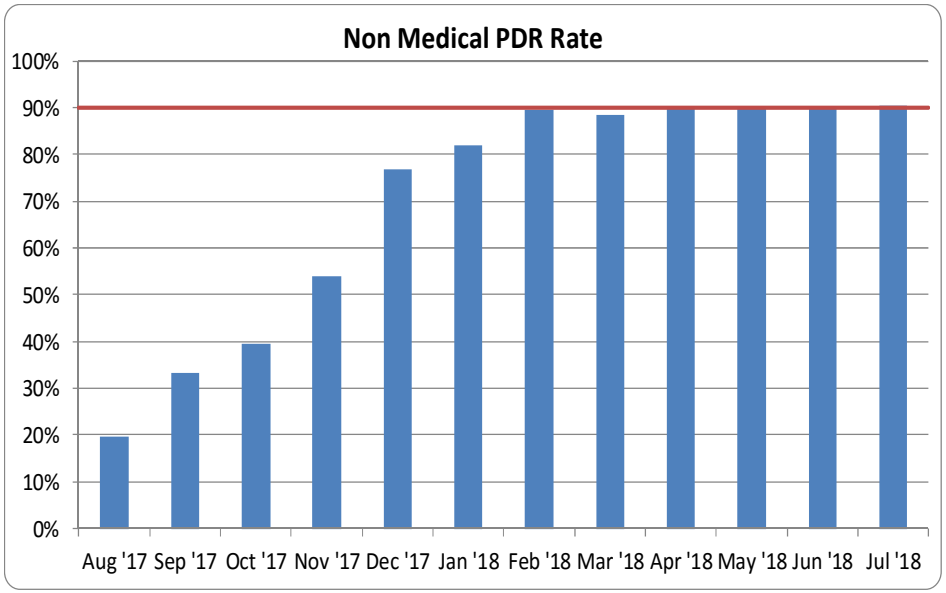
Whilst the Safeguarding children requirements lower levels have stabilised, the higher level requirements have resulted in more staff requiring the training, the requirements continue to be reviewed against the expected changes to the intercollegiate document due in the next few months.

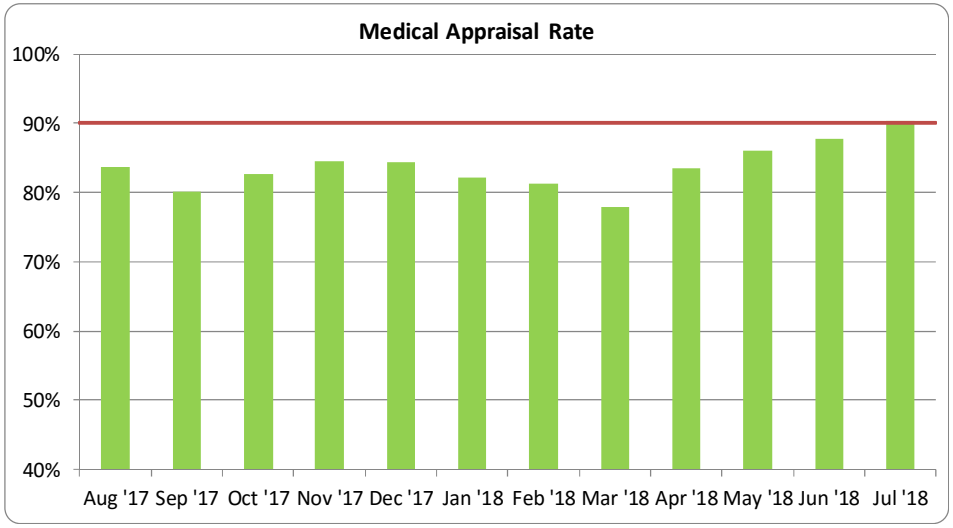
All four divisions have now reached 90% compliance overall.

| Core Training Compliance % by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 94.0% | 94.0% | 94.0% | 93.0% | ↘ |
| EIC Emergency & Integrated Care | 85.0% | 87.0% | 88.0% | 91.0% | ↗ |
| PDC Planned Care | 88.0% | 89.0% | 90.0% | 90.0% | ↔ |
| WCH Women's Children's & Sexual Health | 90.0% | 90.0% | 92.0% | 92.0% | ↔ |
| **Whole Trust** | **88.0%** | **89.0%** | **90.0%** | **91.0%** | ↗ |



# Section 10: Performance & Development Reviews




## PDR Compliance

| Non Medical PDRs by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | 92.8% | 94.0% | 91.0% | 90.8% | ↘ |
| EIC Emergency & Integrated Care | 91.4% | 88.3% | 91.7% | 92.4% | ↗ |
| PDC Planned Care | 89.6% | 90.1% | 90.3% | 90.8% | ↗ |
| WCH Women's, Children's & Sexual Health | 87.6% | 89.5% | 87.9% | 88.2% | ↗ |
| **Whole Trust** | **89.8%** | **89.9%** | **90.0%** | **90.4%** | ↗ |

## Medical Appraisals

| Medical Appraisals by Division | Apr '18 | May '18 | Jun '18 | Jul '18 | Trend |
|---|---|---|---|---|---|
| COR Corporate | - | - | - | - | - |
| EIC Emergency & Integrated Care | 86.9% | 87.0% | 88.7% | 93.0% | ↗ |
| PDC Planned Care | 82.0% | 85.0% | 88.0% | 89.0% | ↗ |
| WCH Women's, Children's & Sexual Health | 83.0% | 87.0% | 86.6% | 89.0% | ↗ |
| **Whole Trust** | **83.6%** | **86.0%** | **87.7%** | **90.2%** | ↗ |

### Non-Medical Commentary

From May '18 the PDR compliance rate include staff who have been working at the Trust 12 months or more. It increased by 0.20% in July and now stands at 90.4% which is at the Trust target of 90%.

### Medical Commentary

The appraisal rate for medical staff is 90.23%, 2.55% higher than last month.

**PDR's Completed Since 1st April 2018 (18/19 Financial Year)**

| Division | Band Group | % | Division | Band Group | % |
|---|---|---|---|---|---|
| COR | Band 2-5 | 9.4% | PDC | Band 2-5 | 12.6% |
| | Band 6-8a | 18.4% | | Band 6-8a | 30.7% |
| | Band 8b + | 47.9% | | Band 8b + | 68.6% |
| **Corporate** | | **21.0%** | **PDC Planned Care** | | **20.4%** |
| EIC | Band 2-5 | 13.1% | WCH | Band 2-5 | 7.4% |
| | Band 6-8a | 22.9% | | Band 6-8a | 9.6% |
| | Band 8b + | 30.0% | | Band 8b + | 21.1% |
| **EIC Emergency & Integrated Care** | | **17.8%** | **WCH Women's, Children's & SH** | | **8.8%** |
| **Band Totals** | | | **Band 2-6** | **Band 7-8b** | **Band 8c +** |
| | | | 11.19% | 19.4% | 49.9% |
| **Trust Total** | | | **16.4%** | | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 2.7/Sep/18 |
| **REPORT NAME** | Mortality Surveillance – Q1 2018/19 |
| **AUTHOR** | Alex Bolton, Head of Health Safety and Risk |
| **LEAD** | Zoe Penn, Medical Director |
| **PURPOSE** | This paper updates the Board on the process compliance and key metrics from mortality review. |
| **SUMMARY OF REPORT** | Metrics from mortality review are providing a rich source of learning; review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG).<br><br>The Trust aims to review 80% of all mortality cases within 2 months of death; 61% of cases occurring between July 2017 and June 2018 have been closed, 35% of cases occurring within Q1 2018/19 have been closed.<br><br>47 cases of suboptimal care were identified between July 2017 and June 2018. 5 cases of suboptimal care were identified in Q1 2018/19, 10 cases were identified as occurring within Q4 2017/18. Identified sub-optimal care cases have been discussed at local specialty Morbidity and Mortality (M&M) meetings and themes have been identified at MSG. Key themes include: recognition and response to deteriorating patient; establishment and agreement of ceilings of care.<br><br>9 months of low relative risk, where the HSMR upper confidence limit fell below the national benchmark, were experienced between April 2017 and March 2018. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust. |
| **KEY RISKS ASSOCIATED** | Engagement: Lack of full engagement with process of recording mortality reviews within the centralised database impacting quality of output and potential missed opportunities to learn / improve. |
| **FINANCIAL IMPLICATIONS** | Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training. |
| **QUALITY IMPLICATIONS** | Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Deliver high quality patient centred care |
| **DECISION/ ACTION** | The Board is asked to note and comment on report |

# Mortality Surveillance – Q1 2018/19

## 1. Background

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

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

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

## 2. Relative risk

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

The Trust wide HSMR relative risk of mortality, as calculated by the Dr Fosters 'Healthcare Intelligence indicator', between April 2017 and March 2018 was 76.9 (72.6 – 81.4); this is below the expected range. 9 months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced during this twelve month period. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust.

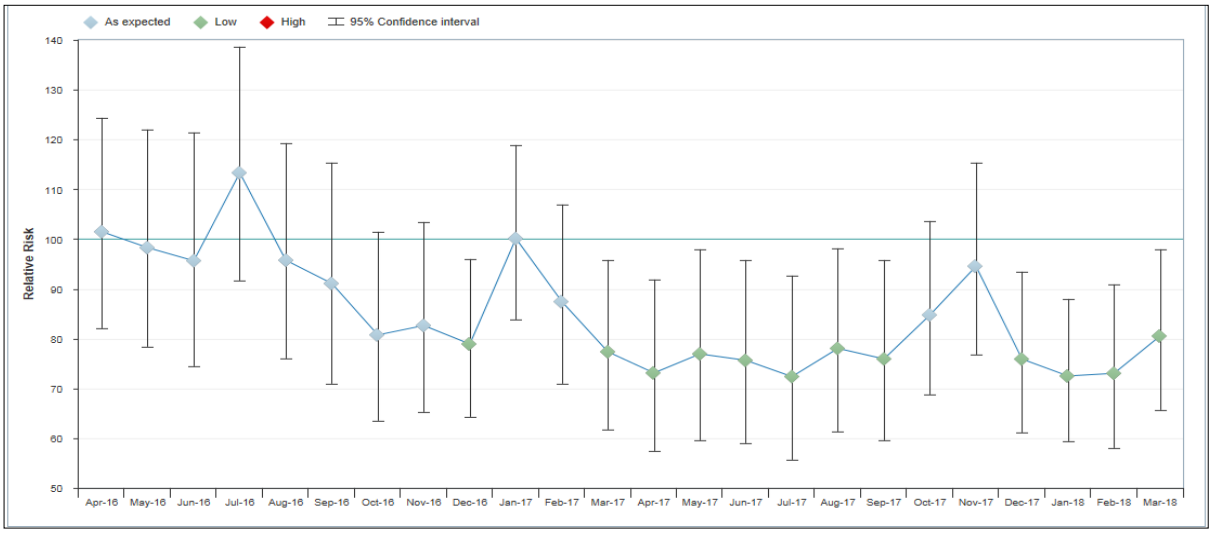



*Fig 1: Trust HSMR 24-month trend (April 2016 to March 2018)*

Improving relative risk of mortality has been experienced across both sites. During the 12 month period to March 2018 the HSMR relative risk of mortality at ChelWest was 72.2 (65.7-79.2); at WestMid it was 79.6 (74-85.5), both sites performed below the expected range.

Trends in relative risk associated with diagnostic groups, procedure groups, patient types and weekend variation are considered by the Trust's Mortality Surveillance Group on a monthly basis. The weekend effect on mortality is routinely reviewed; HSMR figures demonstrate that there is no significant increase in the relative risk of death of patients admitted on a weekend.

## 3. Crude rate

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

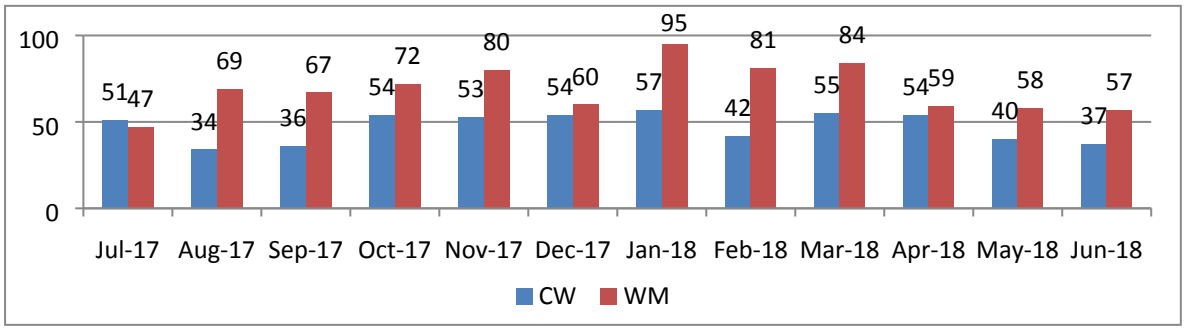



*Fig 2: Total mortality cases logged to Datix by site and month, July 2017 – June 2018*

## 4. Review completion rates

### 4.1. Closure target

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

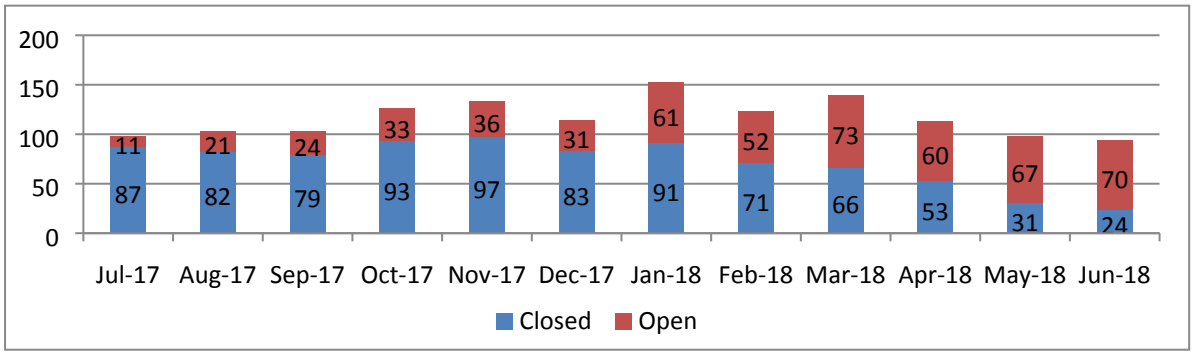



*Fig 3: Open and Closed mortality cases by month, July 2017 – June 2018*

1396 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period; of these 857 (61%) have been reviewed by the named consultant (or nominated colleague) and closed following M&M/MDT discussion and agreement.

| | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Q1 2018/19 | Total |
|---|---|---|---|---|---|
| Total | 304 | 373 | 414 | 305 | **1396** |
| open | 56 | 100 | 186 | 197 | **539** |
| closed | 248 | 273 | 228 | 108 | **857** |
| % | **82%** | **73%** | **55%** | **35%** | **61%** |

*Table 1: Cases by financial quarter, July 2017 – June 2018*

Cases reviewed and closed by Division during 12 month period to June 2018:

- Emergency and Integrated Care: 698 of 1076 closed (65%)
- Planned Care: 93 of 210 closed (44%)
- Women's, Children's, HIV, GUM and Dermatology: 66 of 110 closed (60%)

Actions to support completion, discussion and closure of cases:

- Mortality Surveillance Group monitoring and promoting review process
- Divisional Medical Directors supporting the engagement of clinical teams
- Divisional Mortality Review Groups established within EIC
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- WCHGD leads utilising existing governance meetings to monitor progress and share learning from death.

**5. Sub-optimal care**

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

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

Where cases are graded as CESDI 2 or 3 they are considered for Serious Incident investigation.

47 cases of suboptimal care were identified via the mortality review process between July 2017 and June 2018.

**CESDI grades for closed cases occurring in Q1 2018/19**

| | CESDI grade 0 | CESDI grade 1 | CESDI grade 2 | CESDI grade 3 |
|---|---|---|---|---|
| EIC | 88 | 2 | 0 | 0 |
| PCD | 0 | 0 | 0 | 0 |
| WCHGD | 15 | 2 | 1 | 0 |
| Total | **103** | **4** | **1** | **0** |

**CESDI grades for closed cases occurring in Q4 *2017/18***

| | CESDI grade 0 | CESDI grade 1 | CESDI grade 2 | CESDI grade 3 |
|---|---|---|---|---|
| EIC | 192 | 6 | 1 | 0 |
| PCD | 14 | 0 | 0 | 0 |
| WCHGD | 12 | 3 | 0 | 0 |
| Total | **218** | **9** | **1** | **0** |

Maternity and Acute Medicine are the key specialties identifying opportunities for improvement via the mortality review process; these specialties identified 40% of all suboptimal care cases. Both specialties have regular M&Ms and proactively seek improvement opportunities via review; when reviewing deaths the specialties consider the patient's full episode of care (e.g. sub-optimal care identified may have occurred within previous specialties involved in that patients care rather than the specialty undertaking the review).

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

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

The key themes across both sites link to;

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

## 6. Learning / Engagement

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

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

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

## 7. Conclusion

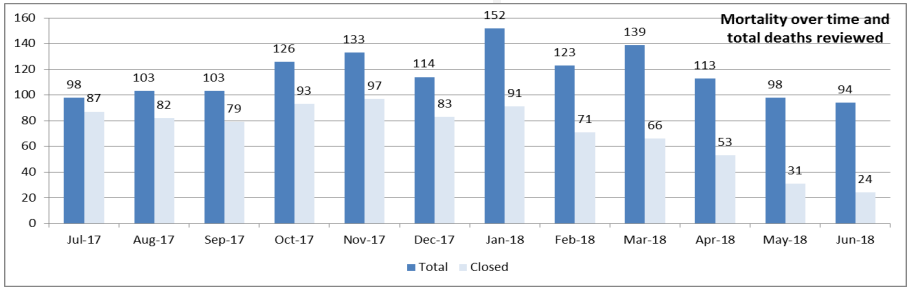
The outcome of mortality review is providing a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality has been experienced since March 2017 and has continued within Q1 2018/19; this is an indicator of improving outcomes and safety.

# Chelsea and Westminster Hospitals: Learning from Deaths Dashboard, 2018/19

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

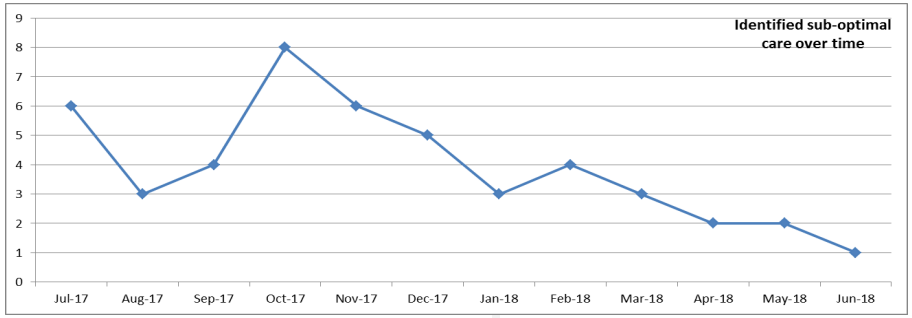
### Total Number of Deaths, Deaths Reviewed and Deaths considered to involve sub-optimal care

| Total no. of in-hospital death | | Total no. deaths reviewed | | Total Number of deaths considered to involve sub-optimal care | |
|---|---|---|---|---|---|
| Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) |
| 67 | 132 | 24 | 31 | 1 | 2 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 305 | 414 | 108 | 228 | 5 | 10 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 305 | 1401 | 108 | 1005 | 5 | 50 |




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

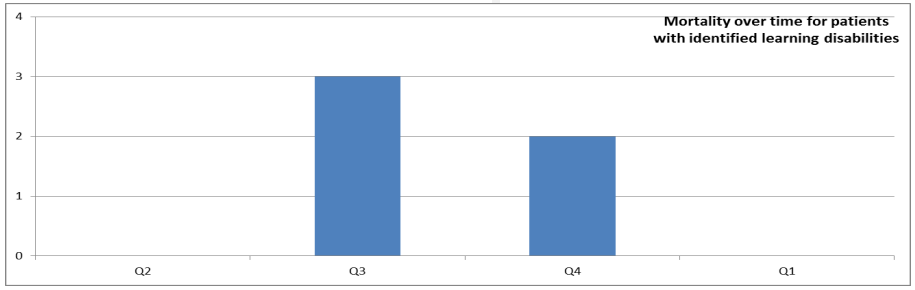
| Grade 1: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome | | Grade 2: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death) | | Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death) | |
|---|---|---|---|---|---|
| Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) |
| 1 | 2 | 0 | 0 | 0 | 0 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 4 | 9 | 1 | 1 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 4 | 54 | 1 | 5 | 0 | 1 |




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

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

| Total no. of in-hospital death | | Total no. deaths reviewed | | Total Number of deaths considered to involve sub-optimal care | |
|---|---|---|---|---|---|
| Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) | Last Month (June) | Previous Month (May) |
| 0 | 0 | 0 | 0 | 0 | 0 |
| This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] | This Quarter [Q1] | Last Quarter [Q4] |
| 0 | 2 | 0 | 2 | 0 | 0 |
| This Year (FYTD) | Last Year | This Year (FYTD) | Last Year | This Year (FYTD) | Last Year |
| 0 | 7 | 0 | 7 | 0 | 0 |



## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA** | 2.8/Sep/18 |
| **REPORT NAME** | Report to the Trust Board from the Health, Safety and Environment Risk Group for period February 2018 – July 2018. |
| **AUTHOR** | Alex Bolton, Head of Health, Safety and Risk |
| **LEAD** | Karl Munslow Ong, Deputy Chief Executive |
| **PURPOSE** | This report provides assurance to the Board of the work of the Health, Safety and Environmental Risk Group (HSERG) and updates the Board on progress developing, implementing and embedding the Trust's governance arrangements relating to the management of Health, Safety and Risk. |
| **SUMMARY OF REPORT** | This report provides the organisation with details of the work of Health, Safety and Environmental Risk Group (HSERG) between February 2018 and July 2018.<br>The report provides the Board with an overview of all key aspects of the HSERG agenda and the subgroups that report to the HSERG. |
| **KEY RISKS ASSOCIATED** | • Staff shortfall (fire officer, WestMid) |
| **FINANCIAL IMPLICATIONS** | N/A |
| **QUALITY IMPLICATIONS** | • Managing H&S at ward and department level is of paramount importance to protecting staff and patients. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | N/A |
| **LINK TO OBJECTIVES** | • Delivering high quality patient centred care<br>• Be the employer of choice<br>• Delivering better care at lower cost |
| **DECISION / ACTION** | For comment |

**Health, Safety and Environmental Risk Group**
**Summary of business; February 2018 – July 2018**

**Introduction**

This paper provides the Board with a summary of business undertaken by the Health, Safety and Environmental Risk Group between February 2018 and July 2018.

## 1. National Priorities

### 1.1 CAS Alerts; Estates and Facilities Notifications

20 Estates and Facilities Notifications were received by the Trust between 1st February 2018 and 31st July 2018; following review 1 notification was confirmed to be applicable to the Trust and the relevance of 1 is currently being assessed :

- **CLOSED: Schneider Electric - Notice of potential unsafe condition affecting Ringmaster (NHSI/2018/002)**

95% of these CAS alerts were closed within deadline; new tracking and management arrangements were introduced in February 2018 which have supported improvement in response time to Estates and Facilities Notifications; completion rates and outcomes monitored by the Health, Safety and Environmental Risk Group.

### 1.2 RIDDOR

17 incidents meeting the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) criteria were identified during this reporting period. No significant variation in the occurrence of RIDDOR applicable events has been identified; 17 cases were reported during the comparable time period within 2017.

RIDDOR events are considered by the Health, Safety and Environmental Risk Group (HSERG) to support trend recognition, shared learning and improvement action.

The following RIDDOR applicable incidents were investigated by the local management team with support from the Health & Safety and Occupational Health departments where required:

- Accident (finger caught in door), Syon 1, WM
- Accident (finger caught in car door), Maternity, WM
- Splash, Emergency Department, WM
- Splash, Osterley 1, WM
- Splash, ICU, C&W
- Needlestick, AAU, CW
- Needlestick, ICU, C&W
- Needlestick, Outpatients, WM
- Slip/trip/fall, Community maternity
- Slip/trip/fall, Education Centre, WM
- Slip/trip/fall, GUM clinic, St Helier Hospital
- Hit by moving / falling object, ITU, CW
- Patient fall, escalators, CW
- Physical assault, Osterley 1, WM
- Accidental substance release, Ron Johnson, C&W
- Accidental substance release, ICU, C&W
- Accidental substance release, Kobler, C&W

Incidents associated with needlestick injuries, splashed contaminated fluids and slips/trips/falls are key trends associated with RIDDOR reporting.

- The HSERG is attended by the Occupational Health Manager to support understanding and mitigation relating to needlestick and splash.
- A slips, trips and falls policy for non-patients has been developed to support risk reduction and is to be considered at the September HSERG.

## 2. Staff Safety Events

### 2.1 Incident Report

The Health, Safety and Environmental Risk Group (HSERG) receive quarterly reports regarding incidents affecting staff. The aim of this report is to highlight the types of incidents that are being reported across the organisation and the associated learning.

Learning from staff safety incident reporting within Q4 2017/18 was considered by the HSERG in May 2018; of note from this report:

There was a small increase in the number of incidents affecting staff reported in Q4 (359) compared with the previous quarter (339) and the same reporting period last year (Q4 2016/17; 331). The HSERG is coordinating the triangulation of learning from incidents and from staff contact with Occupational Health to provide increased assurance that the number of staff safety incidents matches actual occurrence rates within the Trust.

The top three reported incidents affecting staff are:

- **Assault, abuse and aggression**: 115 total, top 3 areas; A&E CW, Nell Gwynne, A&E WM
- **Staffing issues**: 93 total, top 3 areas; Nell Gwynne CW, Birth Centre CW, Syon 1, WM
- **Personal accidents, injuries and illness**: 93 total, top 3 areas; A&E WM, Neonatal unit CW, Lord Wigram CW

Learning from staff safety incidents is cascaded to via the HSERG membership.

### 2.2 Incident Thematic Reviews

The Health, Safety and Environmental Risk Group (HSERG) considered a thematic review relating to 'Assault, abuse and aggression'; a slight increase in the reporting of these types of staff safety incidents has been experienced during this reporting period (Q1 17/18 - 100 incident, Q1 18/19 – 135 incidents).

Themes arising from the review:

- Staff at times felt ill-equipped to deal with violent or aggressive situations
- Issues managing expectations of family members
- Miscommunication between staff
- Physical assaults involving patients with an underlying medical condition contributing to their aggressive behaviour (e.g. dementia, psychiatric needs, cerebral vascular event).

The following key mitigations to address violence and aggression are in progress:

- Establishment of the Violence and Aggression Staff Safety Group
- Review of conflict resolution and physical intervention training content
- Provision of enhanced training delivered by mental health specialist nurse
- Review of security staff role sand responsibilities to insure they have the training / skill level

- Review of the management of Violence and Aggression (Red and Yellow Card) Policy

The risk of harm to staff due to violence and aggression within the workplace is recorded within the organisations risk register (ID 48); the overarching risk for all staff is currently scored as 9 (consequence moderate 3 x likelihood possible 3). It is recognised that some trust areas operate with higher risks of violence and aggression; a location specific risk is recorded for the emergency department (ID 460); due to increasing occurrence of these events the risk grading for this area is scored 12 (consequence moderate 3 x likelihood likely 4). Controls and actions arising from these risks are recorded within the register and are tracked by the HSERG.

The Local Security Management Specialist, in collaboration with Divisional representatives, is developing the overarching strategy to support the management and mitigation of violence and aggression incidents, particularly for our front line services such as our Emergency Departments. The rationale for the current risk grading and overarching controls / actions are to be considered by the HSERG in September for onward reporting to the Quality Committee.

## 3. Health and Safety priority areas

**Divisional health and safety compliance**
Divisional Health and Safety updates and risk assessment monitoring reports were considered by the Health, Safety and Environmental Risk Group (HSERG) during this reporting period. Clinical Divisions updated the group on core Health and Safety activities and the completion / actions arising from core risk assessment.

The following key messages were described within the Divisional Health and Safety updates to support systematic organisational learning:

**WCHGDPP**
- Risk of staff being placed in unsafe situations from lone working in community
- Workplace exposure levels for Nitrous Oxide exceeded national guidelines in some labour rooms
- Fire exit doors in QMMU do not alarm when opened
- Increase risk of patient falls due to being in side rooms
- Equipment stored in fire exit may impede emergency evacuation

**PCD**
- ICU doors do not work consistently so there is a risk of tailgating (planned build in ITU will address)
- Theft – reported thefts from Lord Wigram and ICU male changing room
- Theft reported in Tent on the 4th Floor- Speak with Trevor about the need for CCTV
- Theatres – lack of CCTV
- Equipment stored in fire exits may impeded emergency evacuation

**EIC**
- Violence and aggression against staff
- General Housekeeping
- Fire Marshall Training

An overarching theme identified from this programme of work related to how risk assessments are undertaken, retained and shared with staff / the wider organisation. To support the management of risk assessment and the provision of assurance evidence the following are to be introduced:

- Development of standardised risk assessment forms for core subjects
- Review of risk assessment process / roles and responsibilities
- Review of risk assessment training provision
- Development of health and safety compliance framework to support monitoring

The proposal for the introduction of standardised subject specific risk assessment forms and centralised repository will be considered by the HSERG in September.

**Environmental Monitoring**

A programme of environmental monitoring to investigate the levels of nitrous oxide and other anaesthetic agents (sevoflurane, desflurane and isoflurane) is undertaken to satisfy the requirements of Regulation 10 of the Control of Substances Hazardous to Health 2002 Regulations (COSHH) and provide assurance that staff / patient safety is being maintained. External Environmental Monitoring specialists were engaged and outcomes have been considered by the HSERG during this reporting period.

A potential risk of increased exposure levels to nitrous oxide above the workplace recommended levels was identified within maternity areas and the MRI scanner room. This risk is tracked within the organisations risk register (ID 390). Based on best available information regarding the risk to staff from exposure and peer organisations response to nitrous oxide monitoring the probability of staff requiring professional intervention or the trust receiving challenging external recommendations is deemed to be low; therefore the consequence described is 'moderate' and the likelihood 'possible' within the standard risk matrix, the risk is therefore currently scored as 9.The following key actions have been initiated following monitoring:

- Ventilation upgrade within WestMid maternity unit, due for completion within September 2018
- Ventilation upgrade within ChelWest maternity and theatres, due for completion within October 2018
- Ventilation upgrade within ChelWest MRI room, works schedule under development
- Procedure for the safe use of Entonox to be reviewed, due for completion within October 2018

Monitoring will be undertaken following significant changes in ventilation arrangements outlined above and the annual programme and risk grading will be overseen by the HSERG.

## 4. Training compliance

**Health & Safety training**

The Trust wide health and safety training compliance is 96%; mandatory training compliance has increased slightly on each during this reporting period. Figures below were reported to the HSERG in July 2018:

| | ChelWest | WestMid |
|---|---|---|
| **Health and Safety training- mandatory** | 96% | 96% |

**Fire training**

There is currently a gap in the Fire Safety Advisor role aligned to the WestMid site due to long term sickness, training provision is being excellently supported by the ChelWest Fire Safety Advisor and WestMid Health and Safety Officer.

The Trust wide fire safety training compliance is 89%; during this reporting period mandatory training compliance has been maintained at the ChelWest site and increased on the WestMid site.

| | ChelWest | WestMid |
|---|---|---|
| **Fire training-mandatory** | 88% | 89% |

Weekly fire training sessions, fire marshal courses, targeted departmental sessions, bespoke ad-hoc course and online learning are provided to raise awareness and support a coordinated response to the provision of training

Training provision is monitored by the Fire Safety Group and the HSERG.

## 5. Sub-Groups

Reporting of the HSERG sub groups has been formalised and improvement in systematic reporting has been experienced within the reporting period. The following sub groups report to the HSERG:

- Radiation Safety Group
- Medical Gases Group
- Fire Action Group
- Security Group
- Safer Sharps Group
- Environmental Waste and Sustainability Group
- Moving and Handling

The Fire Safety Group has been reformed in August 2018 following 4 month gap; the meeting is chaired by the Estates Director and will now meet monthly on alternating sites.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 3.1/Sep/18 |
| **REPORT NAME** | Chelsea and Westminster Trust Research Strategy |
| **AUTHOR** | Professor Mark Johnson, Director of Research and Development |
| **LEAD** | Dr Zoe Penn, Medical Director |
| **PURPOSE** | Present the Research Strategy to the board for discussion and approval. |
| **SUMMARY OF REPORT** | The report sets out the Trust's Research strategy and the pathway to achieve the ambition to be a World Class Research Centre for Women's, Children's and Sexual Health. |
| **KEY RISKS ASSOCIATED** | Inactivity would fail to take advantage of the Trust's excellent clinical services and lose the opportunity to become a world-class centre for Women's, Children's and Sexual Health. |
| **FINANCIAL IMPLICATIONS** | Actively pursuing the proposed Research Strategy would increase patient numbers (both private and NHS). |
| **QUALITY IMPLICATIONS** | Being a research active Trust leads to improved outcomes, greater innovation, improves staff quality and retention. |
| **EQUALITY & DIVERSITY IMPLICATIONS** | None |
| **LINK TO OBJECTIVES** | It relates to all of the corporate objectives listed below:<br>• Excel in providing high quality, efficient clinical services<br>• Improve population health outcomes and integrated care<br>• Deliver financial sustainability<br>• Create an environment for learning, discovery and innovation |
| **DECISION/ ACTION** | For discussion and approval. |

**Chelsea and Westminster Trust Research Strategy**

*The Trust's ambition is to become a world class Women's and Children's Centre, delivering excellent clinical care, research and education. Imperial College has expressed its support for the development of Chelsea and Westminster Campus as a centre for research and education. Consequently, research must be of strategic importance to the Trust.*

*The Trust's Clinical and Research Strategies need to go hand-in-hand to deliver world class clinical care, research and education. Together, these Strategies need to focus on the following agenda:*

- *Shaping a healthier future for the communities that we serve;*
- *Improving clinical quality with new, more effective treatments and interventions;*
- *Capacity building in key areas of clinical specialisation in the Trust;*
- *Providing a sustainable financial future for the Trust.*

*The key features of the Research Strategy are:*

- *The trans-generational continuum of health (from pre-conception through adolescence and reproductive years to old age) is a key pathway to success. The theme is broad allowing many specialities to find synergy with and contribute to its success;*
- *Playing to our strengths: continuing to increase the recruitment of patients to our Clinical Research Network portfolio-linked research, grow commercial research, garner support through charitable funding and strengthen our strategic partnership with Imperial College and the Royal Brompton;*
- *Empower the Trust's Research Committee to capacity build, support investigator-led research within the hospital, ensure new consultants are research active and develop our own Chief Investigators through commercial and charitable funding;*
- *Remove barriers to research by winning hearts and minds to change attitudes to research, retain and support research active clinicians at every level to embed that vital understanding and culture of research across the Trust; and*
- *Strengthen our reputation by proactively working to secure admission to the Academic Health Science Centre as a peer to Imperial College, Imperial College Healthcare Trust, Royal Brompton and Harefield and Royal Marsden.*

*To succeed, the Chelsea and Westminster Hospital will have to dedicate itself to a research active culture, broadening its outlook so that success in research is seen to be as important as the provision of excellent clinical care for our patients.*

## 1. Introduction

This paper will outline how the Trust's Clinical Services Strategy and Values have influenced the development of the Research Strategy, before analysing the current situation in North West London (NWL) in the context of the NWL Sustainability and Transformation Plan and outlining the current level of research activity on the Chelsea and Westminster Campus. The Research Strategy will then be described, the central research theme explained, and the steps we need to take to achieve a world class research centre will be set out.

## 2. The Clinical Strategy

The Trust's Clinical Strategy, which aims "**to deliver excellent experience and outcomes for our patients**", has four main themes and priority areas chosen from each of these (Figure 1). The priority derived from the Innovation and Research theme is "**translating research from bench to bedside, bringing the best evidence to bear in respect of clinical care and patient experience**". Other themes identified Women's, Children's and HIV/Sexual health/infectious diseases Services and Integrated Care as priority areas for development. The Strategy specifically challenged the Trust to become **"one of the UK's leading Women's and Children's centres, delivering world class clinical care, research and education"** by 2020. The Trust Board approved the Clinical Strategy in October 2015.

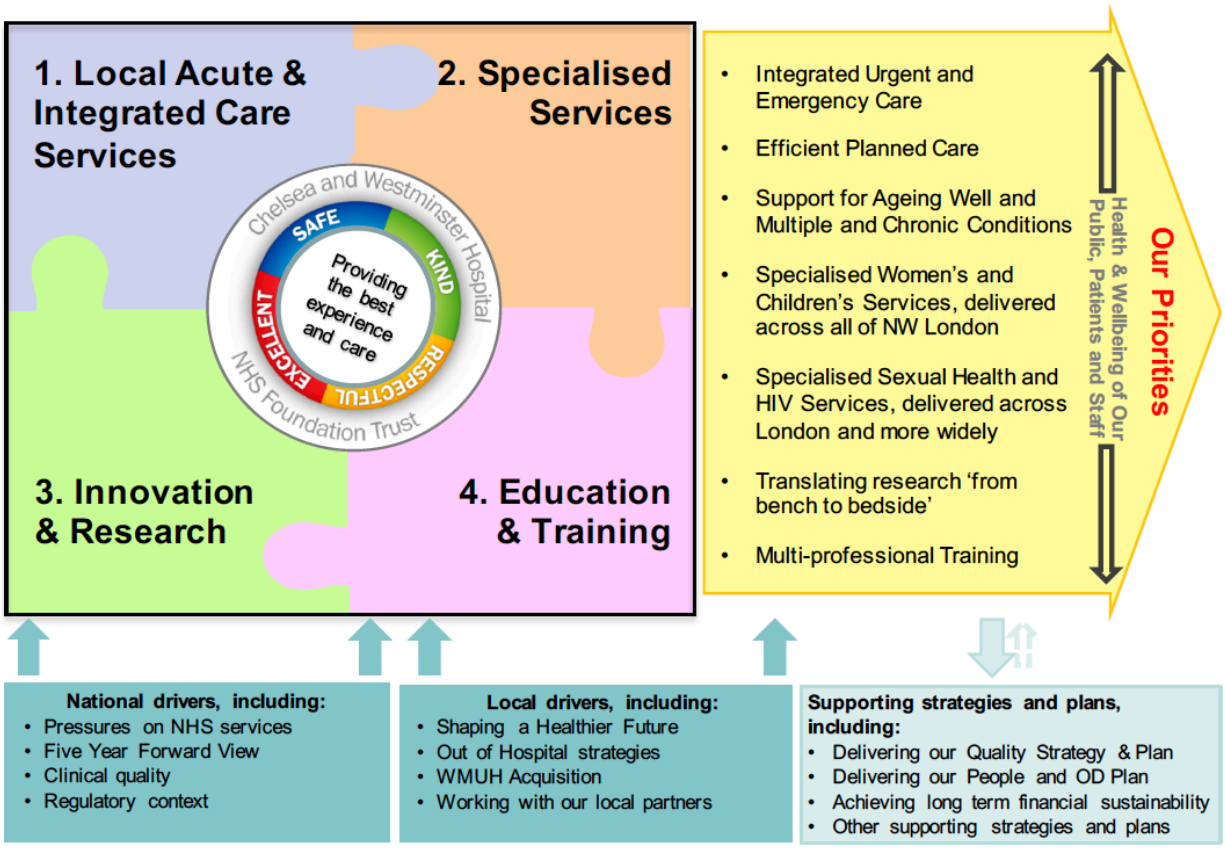
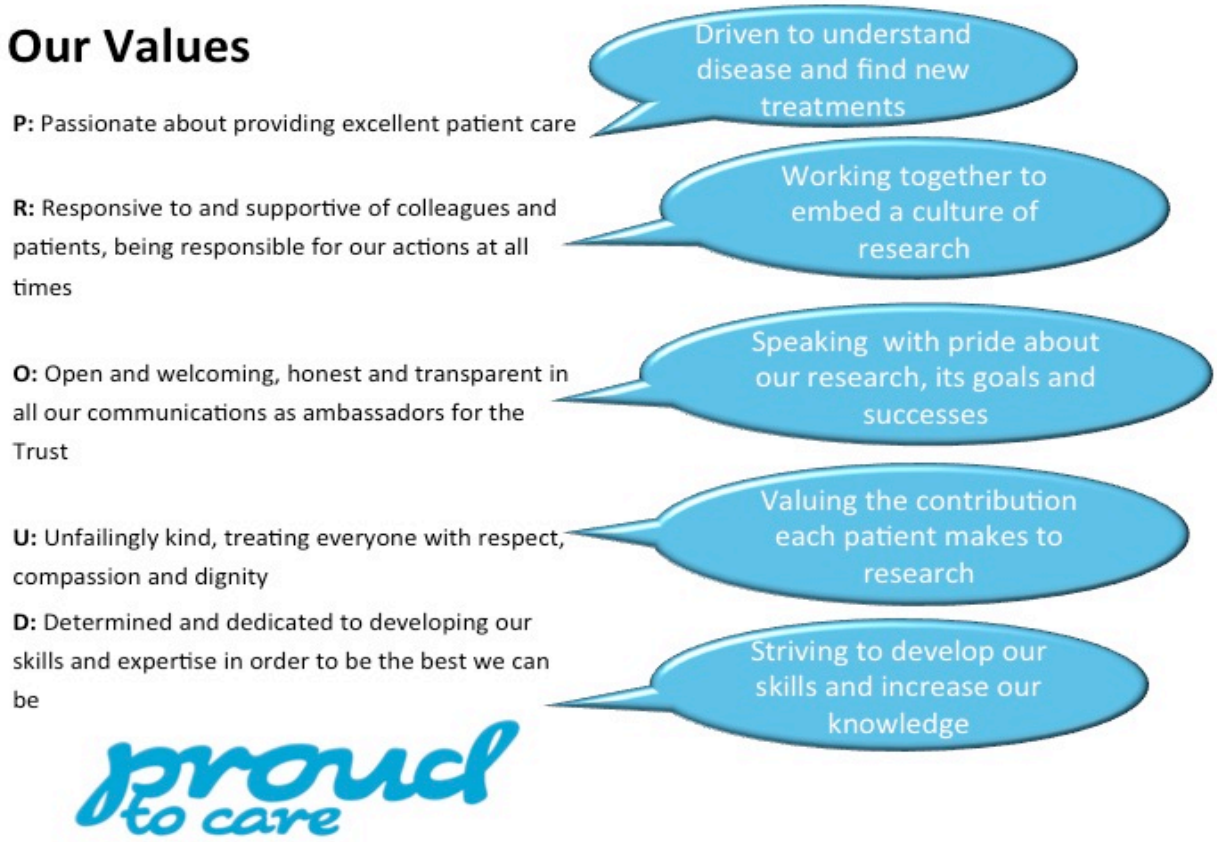



Figure 1 Summary of the Chelsea and Westminster Clinical Strategy 2015-2020

### 3. The Trust Values

The Trust Values have informed the development of the Research Strategy, resulting in a broadly inclusive central theme, which is dependent on collaboration between many different specialties to solve some of the most important problems affecting our patients. To succeed, we will all have to become advocates for research and for our Trust, communicating our aims and findings openly and honestly.



## 4. North West London Factors

### *a) Imperial College*

The Chelsea and Westminster Campus is the smallest campus in Imperial College (IC). Despite this, the Chelsea and Westminster Hospital Foundation Trust (CWHFT) provides a significant proportion of the clinical education to undergraduate medical students from IC. It is home to several academic groups, but these are not integrated and have not been placed here in any coherent pattern or following any management plan that takes into account the areas of clinical excellence in the Trust.

Local hospitals are linked to IC through one of two organisations: Imperial College Healthcare Trust (ICHT), the Royal Brompton and Harefield NHS Foundation Trust and the Royal Marsden NHS Trust, are linked through the Academic Health Science Centre (AHSC); and CWHFT, with Ealing, Hillingdon and Northwick Park Hospitals via the Academic Health Science Network (AHSN) in NWL and known as Imperial College Health Partners. The origin of the of the AHSC is dates back to October 2007, when ICHT was formed by the merger of St Mary's NHS Trust and Hammersmith Hospitals NHS Trust with Imperial College School Of Medicine, bringing all 3 organisations under one management structure. IC later separated from ICHT and developed the AHSC, maintaining the close link between IC and the ICHT. The Royal Brompton and Harefield NHS Foundation Trust and the Royal Marsden NHS Trust joined the AHSC in 2016. The AHSC-linked hospitals have a greater research output and coordinate more closely with IC.

### *b) Imperial College Healthcare NHS Trust*

As described above, ICHT has stronger links with IC with CWHFT being regarded as the weaker and less productive campus. Strong collaboration between the two largest providers of healthcare in NWL will be key to the success of the research ambition and effort of CWHFT.

### *c) Royal Brompton and Harefield NHS Foundation Trust*

The Royal Brompton Hospital (RBH) offers adult and paediatric respiratory and cardiac services with excellent outcomes. The paediatric services exist outside of a formal children's hospital and this lead to calls from within the NHS for the paediatric part of their service to move to be located within a children's hospital. Various plans were proposed to resolve the situation including moving RBH paediatric services to the CWHFT, however, RBH announced its preferred option was to move the entire hospital to St Thomas's campus of King's College London. This would be associated with a significant cost, currently estimated to be £800 million and a marked negative impact on the provision of paediatric care to the children of NWL.

We have weaker paediatric research on the Chelsea and Westminster campus, which could be strengthened by moving paediatric academics and their commissioned clinical activity from the RBH campus to the CWHFT. The NWL STP and local Clinical Commissioning Groups strongly support the retention of the tertiary cardiothoracic work of RBH in NWL. CWHFT is also committed to this goal and is working actively to achieve it.

## 5. Current Research

Current research on the CWHFT can be broadly divided into research linked to the Research and Development Department (R&D) including Clinical Research Network (CLRN) portfolio-linked research and Commercial Research, and Investigator Lead Research.

*a) R&D: Clinical Research Network portfolio-linked research*

CWHFT was involved in 282 portfolio studies in 2017/18, recruited 7141 patients 191% of target (7141/3739) involving virtually all clinical areas; 88% of studies closed to time and target (42/48) and 74% of studies were approved within 40 days (35/47). We are ranked the 2nd top recruiter Trust after ICHT, in NWL. The increase in recruitment continues this year, with 2308 patients (238% of target) recruited in the 1st quarter of this financial year. In the Research Activity League Table 2017/18, CWHFT was ranked in the top 20 nationally. We have increased our CLRN funding from £850K to £1.4M over the last 3 years, but in the year 2016-2017, despite recruiting 191% above target, we experienced a 5% drop in revenue. Currently, the entire Trust CLRN budget is spent on CLRN-related activity, predominantly nurses and midwifery staff recruiting to portfolio studies. This year, current levels of recruitment are being supported by funds generated from commercial research.

We want to maintain the current level of CLRN-linked activity, but to centralise the decision to open a portfolio study in the Trust to the research office; the decision will be based on whether the Chief Investigator is a member of staff, the accrual rate for the study, the intensity of the study and the availability of staff.

*b) R&D: Commercial Research*

The number of commercial studies open in the Trust has increased from 9 to 16 over the last 3 years. The Trust benefits from commercial research in a number of ways. Each patient brings an average income of £6.7K to the Trust. This may be through direct charges for procedures, which are charged at 20% above cost, through drug saving and through overheads, which are split between the Trust and the PI. The Trust overhead is currently re-invested into research and the PI-overhead used to purchase research sessions, employ research staff or to fund attendance at conferences.

We plan to grow commercial research in the Trust, as this will generate income to support research activity. We are employing a second member of staff working exclusively on commercial trials and we are approaching those teams who express an interest in taking part in commercial trials - to date these include gastroenterology, paediatrics, respiratory medicine and anaesthetics. We do not always know which patients with a given condition are available for research. Consequently, in the areas that we target for commercial research growth, we will help clinicians establish a database. We are also taking part in the CLRN-sponsored Discover programme, where patients consent to be contacted if a trial relating to their condition is opened in the Trust. In addition, we are working with TriNetX who will assess the numbers of patients in the Trust with a given condition and approach pharmaceutical companies who may want to work with us on a commercial study.

*c) R&D: St Stephen's Clinical Research*

With the closure of St Stephen's Clinical Research, R&D has taken over 24 active studies and the staff working on these studies. In addition, R&D has taken over the management of the Clinical Trial Facility and will open it for phase 1-4 studies to all of the departments in the Trust. We are developing the capacity to sponsor trials and will publicise this when we have the necessary approvals in place.

*d) R&D: Research Support*

To engage the academics on the Chelsea and Westminster Campus, a Research Committee has been established. The membership includes all professors on campus, the research leads and senior members of the R&D team. The Committee will advise on the Research Strategy and take on the role of the JRC committee. The Committee reports into the Research Strategy Board. It has met once to date and plans to meet each quarter.

All new consultants appointed to support the Research Strategy need to be research active and have a higher degree. They will be supported with 2 research PAs for the first 3 years of their post. Pump-priming grants will be made available and an academic mentor assigned who will provide the new consultant with laboratory space and technical support if required. The Research Committee will assess the use of the research sessions. Existing consultants will be encouraged and supported to take on commercial trials in order to generate income to pay for research sessions.

To support research on the Chelsea and Westminster Campus, R&D have employed a statistician, will employ a grant writer and have negotiated for the NIHR Research Design Service to be on site for 1 day per month.

*e) CLAHRC*

The NWL Collaboration for Leadership in Applied Health Research and Care (CLAHRC) was established in October 2008 under the leadership of Professor Derek Bell. It is currently based on The Chelsea and Westminster campus and its main academic partner is IC. In the next round, Professor Bell and Professor Azeem Majeed, Professor of Primary Care, will be co-leaders. All CLAHRCs undertake high quality applied health research and support the translation of research evidence into practice in the NHS and social care. In the 2014-2018 NWL CLAHRC secured £10 million with a further £10 million in matched funding from partner organisations. The NWL CLAHRC aims to make lasting improvements to healthcare by working with people in the health service, researchers and patients to improve patient outcomes, increase capacity, make cost savings and support collaboration.

*f) Investigator Lead Research*

There are several research active groups on the Chelsea and Westminster Campus, some examples are shown below with the number of publications in 2017:

i. *Immunology* lead by Professor Xiao-Ning Xu (2 papers in 2017)
ii. *HIV/Sexual health/infectious diseases* Dr Marta Boffito (23 papers in 2017); Mark Nelson (23 papers in 2017)
iii. *Anaesthetics* lead by Professor Masao Takata inflammation, intensive care (5 papers in 2017)
iv. *Pain* lead by Professor Andrew Rice (11 papers in 2017)
v. *Neonatal* lead by Professor Neena Modi (28 papers in 2017)
vi. *Obstetrics* lead by Professor Mark Johnson (17 papers in 2017)
vii. *Medicine* lead by Professor Derek Bell (7 papers in 2017)
viii. *Engagement and Simulation Science* lead by Professor Roger Kneebone (7 papers in 2017)
ix. *Infectious diseases* (Moore LSP, 6 papers in 2017)
x. *Gastroenterology* (Harbord M, 6 papers in 2017)
xi. *National Centre for HIV Malignancy* (Newsom-Davis T, 4 papers in 2017; Bower M, 15 papers in 2017)
xii. *Respiratory Medicine* (Shah P, 19 papers)
xiii. *Surgery* (Tekkis P, 28 papers).

A more in depth analysis of research strength on CW site will be undertaken to include research funding, impact, h-index, higher degree supervision.

## 6. World Class Research

The most comparable example of a world class research institution is Great Ormond Street Hospital (GOSH). GOSH is the acknowledged leader in paediatric care in the UK. The 2014-2015 report defines world class success (for more details: https://www.gosh.nhs.uk/our-research/our-vision). GOSH has a global reach with collaborations in more than 17 countries across the world. It employs 758 researchers, who gained £37.83 million in research grants during 2014-15 and published nearly 1000 papers, many in the highest-ranking medical journals. In another example, the SickKids Hospital in Toronto has similarly impressive figures, spending $212.4 million in 2016-17. Two thirds of this funding came from external grants and one third from the SickKids Foundation. They employ 1,702 research staff and 1,153 research trainees working on 1,637 research projects. Both GOSH and SickKids define world class research. To achieve this level of research activity and success, and to join these institutions as a truly world class hospital, will require an enormous effort.

## 7. The Research Strategy

The Trust's Clinical Strategy stated in 2015 that by 2020 "**we will be one of the UK's leading Women's and Children's centres, delivering world class clinical care, research and education**" and continued by suggesting that "**the Centre will provide a unique continuum of care from preconception through to adolescence and reproductive years to menopause in women that will increase the life expectancy and quality of life of the patients it serves**". Figure 2 illustrates this concept, demonstrating the multiple potential points of intervention to improve long-term health.


Figure 2 Potential points of intervention in the continuum of health

### *a) The Central Theme*

A recent Lancet article summarised the principles of our central theme when they said *"for measurement and research, routine information systems need to be woman and family based, and to link health states across time and between a woman and her children"*. This highlights the importance of cross-generational effects, which may be driven by nutrition, metabolism, inflammation, stress or drugs and mediated through changes in epigenetics, microbiome, metabolism or immune system to impact on an individual's and the subsequent generation's health. The importance of cross-generational effects is most clearly illustrated by the diabetes epidemic. Babies born of diabetic mothers have a much higher risk of developing type 2 diabetes; it is estimated that 35% of cases of type 2 diabetes in youths (11-19 years) can be attributed to having a mother with gestational diabetes

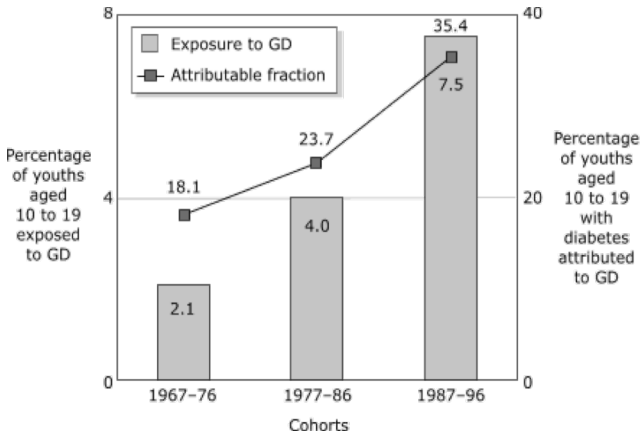



Figure 3 The intrauterine effect of maternal diabetes on the risk of developing diabetes

(Figure 3). The concept of the maternal environment influencing a child's health is not new; David Barker clearly and eloquently described it in his series of papers looking at the relationship between birthweight and disease in later life, including hypertension, cardiovascular disease, diabetes and lung disease. However, the idea that the maternal environment may have effects across generations is recent and striking, particularly in the context of increasing obesity, which may leave a legacy of ill health for generations to come.

Cross-generational effects may be triggered at any stage of the human life cycle from gamete generation to the perinatal period, so our research has to be agile enough to be able to target these periods and broad enough to be able to study the impact of the processes as the individual grows and develops. The Women's and Children's Centre will bring together clinicians and academics with a shared goal to understand the processes involved and to devise interventions to achieve our goal of a healthier population.

In addition to offering cross-generational research possibilities, pregnancy provides a window of prognostic opportunity for estimating the legacy of the pregnancy phenotype on downstream health. Pregnancy tends to be a time when individuals are invested in their own health by virtue of the consequence to the health of their offspring and, in terms of population screening, opportunity for longitudinal sampling would allow deep phenotypic characterization of the individual. We know that health issues during pregnancy are often predictive of long-term health outcomes. For example, gestational diabetes is associated with onset of type 2 diabetes later in life, preeclampsia increases risk of cardiovascular disease and cholestasis is associated with increased risk of developing chronic liver disease. Screening the metabolic response to pregnancy would provide a framework for patient stratification with respect to surveillance for downstream clinical outcomes.

*b) The Continuum of Health: A Trans-generational Approach*

As noted earlier, the Clinical Strategy states "**the Centre will provide a unique continuum of care from preconception through to adolescence and reproductive years to menopause in women that will increase the life expectancy and quality of life of the patients it serves**". CWHFT is unique in its existing portfolio of excellent clinical services that allow it to realise the vision of a continuum of care from pre-conception through to adulthood and old age. Within the existing provision of care, we have multiple points of potential intervention with the aim of improving an individual's long-term health. The principles of the theme **The Continuum of Health** are shown in Figure 4; whereby the maternal environment influences the health of the baby and, consequently, the environment in which the next pregnancy will occur. Interventions prior to conception, during pregnancy or during childhood will influence the adult health and the uterine environment for the next generation.

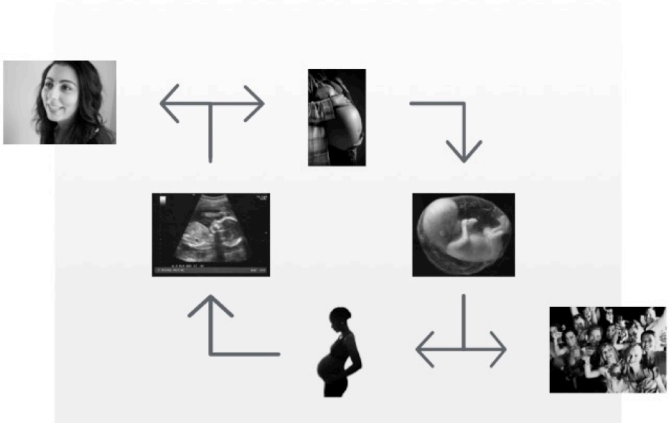


Figure 4 A trans-generational approach to health

For example, we can optimize health pre-conceptually: our work shows that the correct fatty acid balance in the diet can reduce the risk preterm

delivery, the most important cause of childhood death and disability. Similarly, we can offer obese women bariatric surgery to reduce their risks of gestational diabetes, which will give the baby a better metabolic inheritance, reducing the baby's risk of developing diabetes. The central theme of *trans-generational health* is essential as it will promote inter-departmental collaboration and establish the infrastructure through which the impact of pre-conception, pregnancy or neonatal interventions and/or complications can be assessed. The central theme can be extended into nutrition, population health, epidemiology, cardiovascular disease, metabolic health (most obviously diabetes), hypertension and lung disease. The mechanisms will involve multiple pathways and interactions between them and will include genetics, epigenetics, inflammation, immunology, and endothelial function.

*c) The Pathway to Success*

The essential first steps have been taken by the Trust by defining our level of ambition – world class – and the areas to concentrate on: Sexual, Women's and Children's Health. These primary themes will be supported by key areas including inflammation, immunology and infectious diseases, which are essential for their development. The Clinical Strategy also described a "continuum of care", which will provide the unifying research theme: **The Continuum of Health** – a consistent thread that runs through each research active area, promoting collaboration and establishing the essential infrastructure that can be used to follow the impact of interventions.

The next step is to measure the existing level of activity in these areas. Probably only HIV/Sexual health/infectious diseases is currently truly world class; Neonatology is closer, but needs some investment; Obstetrics is too dependent on the current professor and needs significant strengthening; both Assisted Conception and Paediatrics are essentially research free areas that will need considerable support. This assessment will allow us to define the level of investment that is needed and give us the information to develop a powerful appeal enabling us to raise the funds to develop a truly world class research centre.

*d) Define our Partners*

CWHFT has worked in partnership with IC for the last 25 years. The recent change in attitude towards CWHFT should bring with it a greater sense of partnership and engagement than hitherto experienced. It is clear that IC will support a successful and ambitious organisation, This strategy document is the next step to becoming a successful world class research-based organization, one that IC will want to work in partnership with. In the context of our central research theme, *The Continuum of Health: A Trans-generational Approach*, IC has particular strengths in Epigenetics, Metabolic Medicine and Immunology all of which will be essential to ensure the success of the Women's and Children's Centre.

*e) Define the Level of Investment*

Understanding the level of investment needed to bring our primary and supporting themes to a world class level will require an in-depth analysis. In each department research streams will exist which directly relate to the central theme and others that do not. Only those areas of research that relate to the central theme will receive support. Below is a limited analysis of current research activity and needs:

- *HIV/Sexual health/infectious diseases* is already highly research active with a worldwide reputation, but needs formal academic posts with a Professor and Senior Lecturer; both are planned, but may need support from the CWHFT.
- *Assisted Conception* has minimal research activity currently and will need clinical academics and academic embryologists; we are training 2 clinical academics and have the potential to attract another research active consultant to the currently available post. In terms of embryology, we either need to attract academic embryologists or give our existing lead research time and support.
- *Obstetrics and Gynaecology* has one research active Professor in Obstetrics; the department has an

international reputation. The Senior Lecturer in post works exclusively with the Hammersmith based Imperial Group. We have 2 research interested NHS consultants, one in fetal medicine and the other in maternal medicine. Two appointments are planned which will be mixed clinical and academic NHS obstetric consultants, but the department needs to succession plan and appoint more dedicated academics particularly in Obstetrics, Fetal Medicine and Gynaecology.

- *Neonatology* has a Professor, 3 Senior Lecturers and 2 research active NHS consultants; it has a global reputation and is highly research active. To integrate this area with work streams in inflammation, immunology, lung disease and cardiology, we will to need to add academics and scientists in these areas.
- *Paediatrics*, like Assisted Conception, has little research activity. We will need to develop the academic department completely. Key appointments will be in the areas of neurodevelopment, metabolism, lung disease and cardiology to allow us to follow up the impact of complications and our interventions.

Separately, the study of Inflammation will underpin much of the continuum work; Professor Masao Takata leads a group of researchers who study inflammation in the Intensive Care setting. Inflammation is probably the single most important process in pregnancy and the perinatal period, accounting for most deaths and long term disability in children. Immunology, lead by Professor Xu, plays a significant role in the development and regulation of inflammation; and infection, we currently have 5 Infectious Diseases Consultants, is the most important driver of inflammation. These 3 supporting themes will all need investment to appoint staff to integrate the immune system, inflammation and infection into the work on the central theme.

The CW has other areas of excellence, which will be integrated into the strategy. A good example is Pain, lead by Professor Andrew Rice, which is world class and consistently produces high quality research. Proposed developments include attracting a Professor of Psychology, with whom we will be able to develop work in neonatal pain, and a Professor of Physiotherapy, who has an expertise in wearable technology and who would make a considerable contribution to our Innovation strategy.

*f) Developing a Coherent Appeal and Fundraising*

To establish a world class research centre we have to build on areas of excellence and, in some cases, develop our own Chief Investigators (CI), but this cannot be paid for from clinical funds as this may lead to financial instability for the Trust. The CLRN system does not and will not provide any funds to support CI development. This leaves two potential sources of income: the first is commercial research (as described above) and the second is charitable funds.

The CWHFT is in a unique position to be able to raise substantial charitable funds from local residents and patients. This will require the development of a coherent, cogent and consistent appeal:

- Coherent, in terms of being a logical extension of our current clinical areas of expertise and in partnership with the scientific expertise of IC;
- Cogent, in terms of describing the urgent need for further research to improve outcomes and population health; and
- Consistent, in that all of our efforts and being directed towards research excellence, with the goal of improved patient outcomes.

If we are not consistent, this will significantly weaken our case. For example, CW+ has run a highly successful Critical Care Campaign, raising £11.5 million towards the refurbishment and expansion of ICU and NICU, but there is no dedicated research space in the redevelopment.

To engage patients in our cause we need advocates who will passionately describe our goals. These advocates should be at every level in the Trust, from the person cleaning the ward, to the consultant responsible for the care of the patient, to the Chief Executive. Inevitably, the most consistently powerful voice will be that of the consultant and this is most successful when the consultant is deeply involved in the

work, when they have a genuine passion for what we are trying to achieve. Ideally, then, the consultant will be research active in the area we are trying to raise funds for.

Inevitably, the patients that will be most able to support our cause are private patients. This is an added incentive to develop private practice particularly in the areas of Women's, Children's and HIV/Sexual health/infectious diseases. The standard of care and service provided will influence the patient's perception of the Trust and their subsequent engagement with our goals. This means that we need to attract and retain successful, motivated staff who provide an excellent level of service to private and NHS patients alike and who are engaged and invested in the future of the institution.

*g) Other Considerations*

i. Nursing, Midwifery, Physiotherapy, Pharmacy and Management Research

For the culture of research to be embedded in the Trust, research has to be encouraged in non-medical staff too. Research experience should be a requirement for senior posts and a higher degree preferable. Those with an active research interest should be given research time. We already have a Professor of Pharmacy, Professor Vanessa Marvin, is an Honorary Associate Professor at the UCL School of Pharmacy, but Professors of Nursing, Midwifery and Physiotherapy should be developed in the Trust, with the remit to initiate research in their areas and supervise higher degrees. Where possible, posts should have clinical and research components. For example, some nursing or midwifery posts could be split 50/50 between CLRN-funded posts and clinical posts. Once the Professors in Nursing and Midwifery are appointed and able to supervise higher degrees, similar posts could be made available for those doing part-time higher degrees.

ii. The Benefits of Research

What is the benefit to the organisation of engaging in research?

- Patient outcomes: Recent data prove that patients admitted to research active institutions have better outcomes (Ozdemir et al, 2015).
- Staff: The best example of the benefits of employing research active staff is shown in the HIV/Sexual health/infectious diseases Service based in the Trust. The consistently high level of innovation has delivered service improvement across the board with striking successes like Dean Street.
  The Trust will attract better staff if we are known to be research active.
  The Trust will improve staff retention and engagement.
- Income: On average, patient involvement in commercial studies benefits the Trust by £6.7K per patient. In 2014-15, the Trust provided hospital service to 725,000 patients. There is significant potential for the Trust to earn income through commercial studies (see above).
- Patients: More patients come to research active Trusts, especially private patients.
- Admission to the Academic Health Science Centre.

iii. Barriers to Research

- The Trust must be a research based organisation and positive attitudes to research need to be embedded across the Trust that will require a consistent campaign to change "Hearts and Minds" at every level.
- Research must be factored into every decision made about appointments, use of estate and equipment. Ideally, active researchers should be appointed to management positions.
- It is essential that dedicated research space is provided in clinical areas and the importance of research considered in all decision-making processes. The last will only be achieved when we appoint clinical and non-clinical managers with research experience and a proactive, positive attitude towards research.

- Retention of successful researchers must be made a priority. We need to attract staff with proven track records in research and develop our own research leaders.
- Consultant, senior manager and senior non-medical staff appointments should all have research experience as a requirement.

iv. Funding of the Centre

- Once the Centre is established each group would be expected to establish independent funding streams via MRC, BBSRC, Wellcome Trust, NIHR for example. The Centre would run in a similar manner to MRC funded Centres, where infrastructure, equipment and some running expenses are provided by the MRC, but groups are expected to raise funds from other sources too.

v. Innovation

- CWHFT has an active programme of health innovation lead by Dr Lawrence Petalidis working with members of staff and healthcare companies to bring new solutions to patient care. The Innovation and Impact group have promoted healthcare innovation partnering with the DigitalHealth.London Accelerator, Microsoft Accelerator and Drayson Technologies. Researchers in the CWHFT will integrate with the innovation programme to minimise the time from bench to bedside.

## 8. The Next Steps

- *Establish a Development Board*

The idea is to bring together a group of people not only to help to raise the funding for the Women's and Children's Centre, but also to influence its development, monitor its progress and advise on its programme of research. These individuals will have connections to pharmaceutical and biotech companies, scientists, health academics, leaders in education, politics and industry, they will have connections with high net worth individuals, foundations and leaders abroad.

In tandem, we will create a collaboration to bring together the charities working in CWHFT, to harness both their contacts and their associated clinicians to act as spokespeople for the appeal. In addition, we will approach other charities working in the fields of Women's and Children's Health, Diabetes and Population Health.

- *Initiate the research assessment*

The Research Committee will undertake an in-depth analysis of current research activity, its strengths and weaknesses, defining which areas need investment. The same team will explore collaborations within the groups currently based in CWHFT, defining where gaps exist in the Continuum of Care and establishing the clinical pathways necessary for the central research theme's work.

- *Explore partnerships including potential global partnerships*

IC has world class scientists in many fields including epidemiology, epigenetics, metabolism, endocrinology, immunology, microbiome, metabolome - all of whom will be necessary for the development of our central theme and have to be engaged and recruited to the collaboration. World class research centres have many international collaborations, which strengthen their research portfolio - in time we will explore potential international partners.

- *Define the level of immediate investment*

With the information from the in-depth analysis of current research activity we will be able to gauge the likely scale of the immediate investment needed and will be able to describe the different phases of the appeal.

- *Formulate the appeal*

Work on the appeal should begin immediately, describing the Central Research Theme, how it will work and the potential benefits that it will deliver.

- *Initiate the Hearts and Minds campaign in the Trust*

The culture of research has to be embedded in the Trust. To achieve this research has to be pushed to the top of the agenda. Immediate changes could include:

- Increase Trust Board awareness of research activity and the importance of research discussed regularly at Board level;
- Consideration should be given for each service lead to have a research counterpart to maximise research opportunities;
- Research experience made a requirement for senior posts (medical, non-medical and managerial) with a higher degree preferable;
- New appointees (medical, non-medical and managerial) in HIV/Sexual health/infectious diseases, Women's and Children's services who are research active given research time, funding and support;
- Professors of Nursing, Midwifery and Physiotherapy developed; and
- Dedicated research space provided in research active areas.

Professor Mark Johnson
Director of Research and Development

**References**

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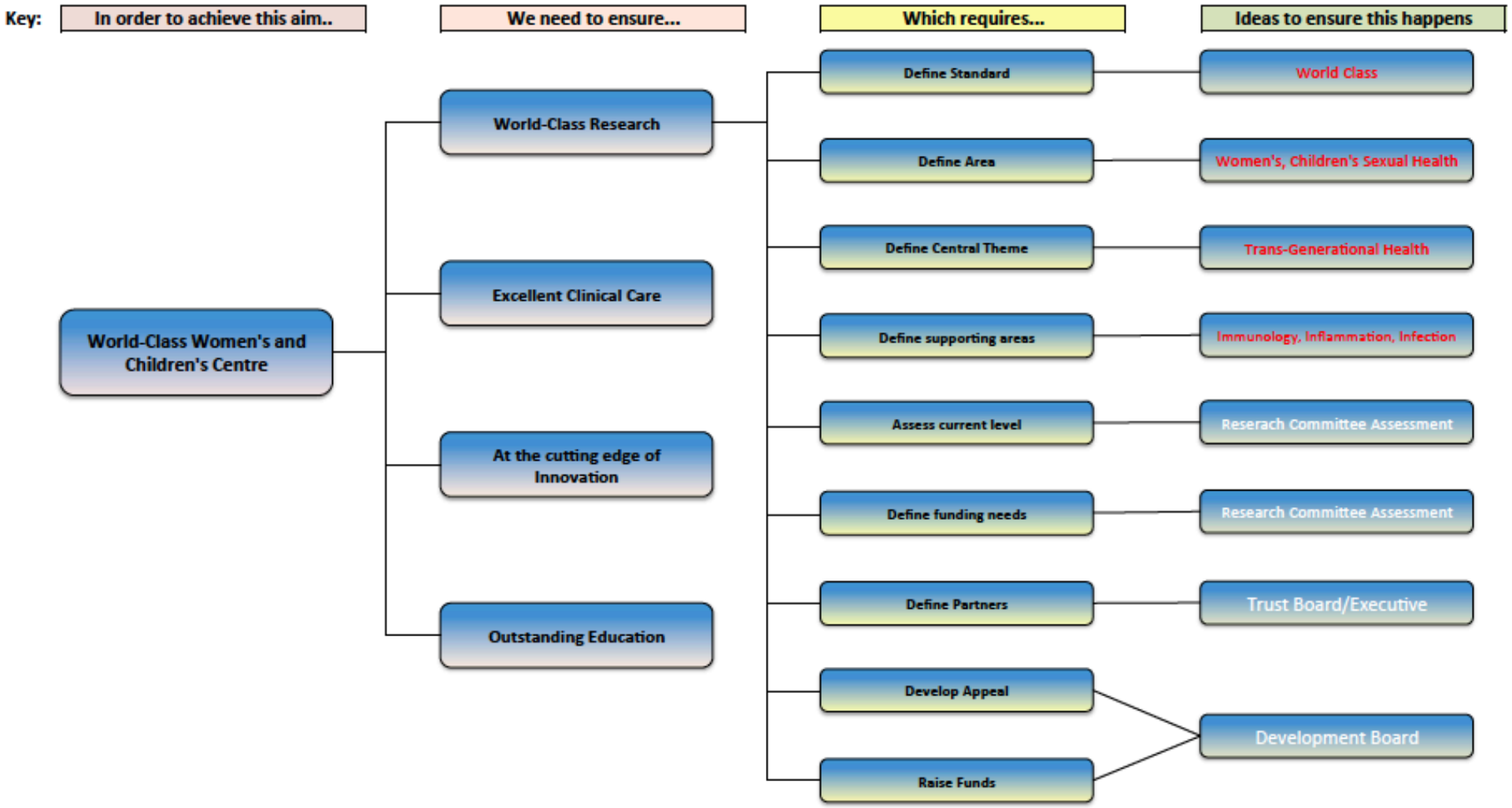


Figure 6. Driver Diagram: Steps to a World-Class Centre for Women's, Children's and Sexual Health

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Board of Directors Meeting, 6 September 2018

**PUBLIC SESSION**

| | |
|---|---|
| **AGENDA ITEM NO.** | 4.2/Sep/18 |
| **REPORT NAME** | 2018/19 Capital Programme |
| **AUTHOR** | Stephen Aynsley-Smith: Deputy Director of Finance, Financial Operations |
| **LEAD** | Sandra Easton: Chief Financial Officer |
| **PURPOSE** | To provide an update on the Trust's 2018/19 Capital Programme |
| **SUMMARY OF REPORT** | In 2018/19 the Trust is investing significantly in its IT and Estates as part of its Capital Programme at the Trust.<br><br>In 2018/19 the Trust has plans to spend £51.9m on capital an increase of £14m from 2017/18.<br><br>The reports sets out the top 5 capital plans (by spend) in 2018/19 and the Trust's current progress. |
| **DECISION/ ACTION** | The Board is requested to note the report. |

**Summary**

The Trust plans to spend £51.9m across a number of capital programmes which will support the enhancement and maintenance of the Trust's fixed assets as well as supporting future year's activities.

The table below is the Trust's the top 5 projects (by spend) in 2018/19

| **Description** | **Total Capital Programme** ***£'000s (2018/19)*** |
|---|---|
| Cerner – New EPR system | 9,000 |
| Critical Care Project (NICU/ITU) | 12,000 |
| A&E reconfiguration | 3,400 |
| Maternity Modular Building | 10,844 |
| Medical Equipment | 3,000 |

In order to fund this investment the Trust utilises a number of different sources from loans, internal cash reserves, depreciation and donated income. The Trust reports its capital spend on a monthly basis to its Capital Programme Board.

**Current Position**

The Trust is still forecasting to spend the whole £51.9m in 2018/19 but, at the end of July 2018, is behind plan due to 2 key reasons:

- A delay in purchasing the Maternity Modular Building as the Trust identifies the best funding source; and
- Delays in securing a contractor for the critical care programme which has now been resolved.