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Foreword by the Medical Director and Director of Quality

At Chelsea and Westminster Hospital NHS Foundation Trust, Quality is at the heart of our Vision, which is to, ‘deliver the best possible experience and outcomes for our patients’.

In achieving this vision, we are guided by our values, which are to provide safe, kind, respectful and excellent care.

Our Quality Report for 2014/15 reports on our progress during the last year and our key priorities for the year ahead. The report will focus on three domains:

- **Safety of Care**—for us this means eradicating harm and ensuring that care delivered is as safe as possible, regardless of when or where patients seek our services.

- **Effectiveness of Care**—for us this means ensuring that we deliver the best clinical outcomes possible for our patients, deploying evidence-based care processes and procedures consistently throughout the organisation.

- **Experience of Care**—for us this means ensuring that we treat all our patients, their families and carers with kindness and respect in all their interactions with us, all of the time.

We are relentless in our focus on quality and we set ourselves demanding plans and targets to achieve this. This process has gained further momentum through the actions we have taken to address the recommendations made to us by the Care Quality Commission following their inspection of our services in July 2014.

Delivery of our Quality Report priorities for 2014/15 aligns with the ambitions set out in our Quality Strategy. This is enabled by the development and training of our staff; the pursuit of systematic and rigorous processes and systems; and the development of applied research and innovation; all of which will support the delivery of excellent experience and quality outcomes for our patients.

We look forward to working with you now and in the future.

Zoë Penn
Medical Director and Director of Quality
About this report

What is a Quality Report?

This document, our Quality Report, provides Chelsea and Westminster Hospital NHS Foundation Trust with an opportunity to highlight how we measure and take forward quality for our patients and our stakeholders. This provides us with a yearly process to review and make sure that our services are the best they can be.

It is also a national statutory duty for all providers of NHS services in England to produce an annual report to the public about the quality of services they deliver.

Quality Reports aim to increase public accountability and drive quality improvement within NHS organisations. They do this by asking organisations to review their performance over the previous year, identify areas for improvement and publish that information along with a commitment to you about how those improvements will be made and monitored over the next year. In the report ‘year’ refers to the period April 2014 to March 2015 (2014/15).

Quality is often considered under the heading of three domains:

- Patient safety
- Clinical effectiveness (how successful is the care provided)
- Patient experience (how patients experience the care they receive)

The way we monitor and drive improvement across all of these domains will be described in the document.

Most of the information provided in this Quality Report is mandatory and reflects the obligations required of us by the Department of Health (DH) and our regulator, Monitor. Some content has been added as it is important to the Trust and our stakeholders. Our stakeholders include patients, parents and carers, Foundation Trust governors, staff, commissioners and regulators.

Scope and structure of the Quality Report

This report summarises how well Chelsea and Westminster Hospital NHS Foundation Trust did against the quality priorities and goals we set ourselves for 2014/15. It also sets out those we have agreed for 2015/16, and how we intend to achieve them.

In developing this report we have sought engagement and input from a number of key stakeholder groups including our Governors, our local Clinical Commissioning Groups (CCGs), and through the document review stage with local Healthwatch Groups and Overview and Scrutiny Committees.

A separate booklet in an easy to read form will be provided for the Annual Members Meeting. This will be called the ‘Annual Review’ and will combine the Quality Report and the Annual Report.
This report is divided into three parts:

**Part 1: Statement on quality from the Chief Executive**

This is a statement summarising the Trust’s view of the quality of the health services that we have provided or sub-contracted during 2014/15.

**Part 2: Priorities for improvement and statements of assurance for the Board**

- Sets out the quality priorities for improvement for 2014/15 and explains how we decided on them, how we intend to meet them and how we will track our progress—the section then reviews progress made since publication of the 2013/14 quality report including performance against the priorities selected that year
- Statements of Assurance from the board
- Shows how the Trust is performing/reporting against a core set of indicators

**Part 3: Other Information**

Overview of the quality of care of the Trust based on performance against indicators selected by the board in consultation with stakeholders

**Annex 1**

Statements from the Clinical Commissioning Group, Healthwatch, and the Overview and Scrutiny Committee

**Annex 2**

Statements of Directors’ responsibilities for the Quality Report

If you, or someone you know need help understanding this report or you would like a printed copy or would like the information in another format such as large print, easy read, audio or Braille, or in another language, please contact the Director of Nursing and Quality Team by calling 020 3315 6599 or by emailing quality@chelwest.nhs.uk.

**About the Trust**

The Trust is a modern, purpose-built hospital with more than 3,000 staff. It has three clinical divisions which are outlined in more detail in Annex 7.

The Trust provides general and specialist services for half a million people living in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Wandsworth. The Trust also provides specialist tertiary services to patients from a wider area in a range of specialties. These include: bariatric surgery, burns, HIV, paediatrics, neonatal care, orthopaedics—foot and ankle and sports injuries (eg knee conditions including multi-ligament instability) and plastics—craniofacial surgery, complex wrist and hands.

Most services are provided on the Chelsea and Westminster Hospital site, but the Trust also runs a highly successful network of community HIV and sexual health centres, dermatology clinics, community musculoskeletal therapy and community maternity.
services across our four local boroughs. Additionally, we provide women’s reproductive health (gynaecology) services in Richmond and Twickenham.

The hospital has the busiest and most extensive HIV and sexual health service in Europe based in three different centres across the capital.

Chelsea Children’s Hospital, (opened in Spring 2014 by Their Royal Highnesses The Prince of Wales and The Duchess of Cornwall), is a key part of the Trust. We are one of London’s largest providers of children’s services, catering for more than 75,000 children a year as inpatients, outpatients and as day cases. Chelsea Children’s Hospital is home to the UK’s only ‘da Vinci’ robot dedicated to the surgical care of babies and children. Our Neonatal Intensive Care Unit provides the most specialised level of medical and surgical neonatal care in the UK. We have a dedicated children’s A&E department and a High Dependency Unit. Pregnant women at high risk of complications are cared for in the Trust’s Maternity Unit. For those at low risk the midwife-led Birthing Unit helps mothers give birth in a less ‘medicalised’ setting while knowing that, should complications arise, specialist obstetrics and neonatal services are close at hand. This investment offers more choice to women with a full range of options for their birth plan—from homebirth all the way through to a consultant led delivery.

The Trust is one of two centres providing weight loss surgery services for London and the South East. It is also the Regional Burns Centre in London for adults and children and London’s only dedicated burns service for children that require care in a high dependency setting. A separate unit for children was newly commissioned in January 2013 which has greatly enhanced our children’s burns care.

Table 1: Key data for our Trust for 2014/15 with comparative data from 2013/14

<table>
<thead>
<tr>
<th>Data Item (note not all mutually exclusive)</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency attendances</td>
<td>116,200</td>
<td>112,500</td>
</tr>
<tr>
<td>NHS babies delivered</td>
<td>5,300</td>
<td>5,000</td>
</tr>
<tr>
<td>Private patient babies delivered</td>
<td>840</td>
<td>800</td>
</tr>
<tr>
<td>Trust total Number of babies delivered</td>
<td>6,140</td>
<td>5,800</td>
</tr>
<tr>
<td>Inpatient admissions (Elective and Emergency)</td>
<td>76,080</td>
<td>76,000</td>
</tr>
<tr>
<td>…of which day cases</td>
<td>37,400</td>
<td>34,000</td>
</tr>
<tr>
<td>Outpatient activity (including physiotherapy)</td>
<td>648,400</td>
<td>590,000</td>
</tr>
<tr>
<td>Radiology Direct Access from a General Practitioner referral</td>
<td>35,200</td>
<td>33,000</td>
</tr>
<tr>
<td>Radiology Examinations as a result of an outpatient attendance</td>
<td>44,300</td>
<td>44,000</td>
</tr>
<tr>
<td>Attendances at our HIV/Sexual Health Services</td>
<td>232,000</td>
<td>180,000</td>
</tr>
<tr>
<td>Culminating in services to approximately</td>
<td>724,500 patients</td>
<td>667,000 patients</td>
</tr>
</tbody>
</table>

2014 Inspection by the Care Quality Commission

Historically, Chelsea and Westminster has been viewed as being in the top tier for quality. In July 2014 the Care Quality Commission (CQC) carried out an inspection of the Trust. While the CQC found that the Trust provides good and outstanding care in many areas, its overall rating for the Trust was ‘Requires Improvement’.

In order to proactively address areas where action is required, specialty-specific action plans were developed, with the Trust’s Quality Committee responsible for monitoring progress and seeking assurance from divisional representatives that actions are being

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1 Our outpatient activity by CCG are split 24.0% NHS West London CCG; 17.7% NHS Hammersmith and Fulham CCG, 14.0% NHS Wandsworth CCG, 10.6% NHS Central London CCG and 33.8% other CCGs
implemented and completed. All feasible actions were completed by the end of March 2015, with appropriate actions and programmes in place to address the actions requiring longer term development (such as the reconfiguration of the Trust’s Emergency Department).

While not part of the mandated content of the Quality Report, we believe it essential that we provide a high level account of the steps being taken by the Trust to address the findings of the CQC. This is summarised on page 54.
Part 1: Statement on quality from the Chief Executive

I am pleased to present our Quality Report for 2014/15.

Patient experience and patient care are at the very heart of what we do. How patients feel looked after while in hospital is how I, as Chief Executive, judge whether we have delivered the right standards of care and experience. This also gives us independent feedback on our services that is vital when we assess whether we have succeeded for our patients, and this has never been so important when we consider the new regime of inspection undertaken by the Care Quality Commission (CQC) from 2014/15.

Our Quality Report provides a snapshot view of the improvements we have made to patient care and experience, as well as what we need to do better in the future. We always want to improve care for every patient where possible and this report details what we will be focussing on in 2015/16 to continue to improve standards and outcomes for the populations we serve.

The report is prepared in line with the requirements set out in the Quality Report legislation (part of the Health Act 2009) and Monitor’s annual reporting guidance. It is reviewed by key external stakeholders who hold us to account on what we said we’d do and what we’ve actually done for the benefit of patients.

This year saw an inspection of our Trust by the CQC in July 2014, reporting in October 2014. While the CQC found that the Trust provides good and outstanding care in many areas, their overall rating for the Trust was ‘Requires Improvement’. We have worked consistently to address the actions and embed the broader learnings raised by the CQC Report.

We recognise it is critical that we maintain a relentless focus on quality as we pursue our growth agenda which over the next year includes the proposed acquisition of West Middlesex University Hospital NHS Trust; our engagement in the Shaping a Healthier Future programme for reconfiguring hospital-based and out of hospital care; and the development of integrated care and community-based ‘accountable care’ models across our health system.

We have developed a Quality Strategy to set out our ambitions for improving the quality of our services over the next three years. This reflects our learnings from the CQC Report, plus our ongoing commitment to quality through delivering the best possible outcomes and experience for our patients. This Quality Report provides a more detailed insight into the objectives and priorities that underpin the first year of the Quality Strategy.

It has been a good year for many quality improvements that will mean better care and experience for patients. We have now gone more than a year without a case of MRSA, we have seen and treated the majority of patients in an emergency or urgent care setting within four hours and have had no ‘Never Events’ in 2015/16. But we are always seeking to improve, particularly in respect of the 18 week referral to treatment target.

It is important, from the onset of this report, to note that there are a number of inherent limitations in the preparation of Quality Reports which may impact the reliability or accuracy of the data reported. These include the following points.
Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.

National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board and Executive Team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported. However, due to data issues identified by the Trust on the 18 week RTT indicators and confirmed by the testing of the Trust’s external auditors in their testing of the incomplete pathway indicator (described on page 46 of this report), we are not able to confirm that this indicator is accurately stated. I am confident that the Trust is taking the steps required to address this. Following the steps taken, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the 18 week Referral to Treatment indicators.

I would like to take this opportunity to thank the people that make Chelsea and Westminster Hospital what it is today and who have all worked so hard to deliver the best care they possibly can for their patients. I am proud of what they have achieved. There will always be more to do and I sense a great commitment in our team to developing excellent care and experience that is in line with our values.

I hope that you enjoy reading the progress we have made against our priorities and what we plan to focus on next year to provide you, your families and friends with a health service you can all be proud of.

Elizabeth McManus
Chief Executive
Part 2: Priorities for improvement and statements of assurance from the Board

Priorities for improvement

Our priorities for 2015/16

Our priorities for 2015/16 have been identified though engagement across a number of areas:

- Engagement and feedback from our Council of Governors’ Quality Sub Committee that includes external stakeholders (for example commissioners and Healthwatch)
- Engagement and feedback from our Board’s Quality Committee

In addition to the above we are engaging with our local CCGs, Healthwatch groups and local Overview and Scrutiny Committees as part of the process for reviewing and refining this document.

Our 2015/16 priorities are set out below and then detailed in the remainder of this section. In each case we have aligned the priority to one of the three Quality domains (Patient Safety, Clinical Effectiveness and Patient Experience). However we recognise that in reality each priority is likely to impact on multiple domains—in particular patient experience which we are focusing on as an overarching objective of our Quality Strategy.

Priority 1: (Patient Safety) Reduction of acquired Pressure Ulcers both in Hospital and the Community

Objective: to see a reduction in hospital acquired pressure ulcers.

Priority 2: (Patient Safety) Embedding of the WHO surgical checklist

Objective: to fully embed use of the WHO checklist across the organisation, reflecting feedback from the CQC’s review of the services we provide and building on existing progress

Priority 3: (Patient Safety) Early Identification of the Deteriorating Patient

Objective: to rapidly identify potentially unwell and/or septic patients and institute prompt treatment, in order to reduce mortality and morbidity.

Priority 4: (Clinical Effectiveness) To Reduce Avoidable Admissions of Term Babies to the Neonatal Intensive Care Unit (NICU)

Objective: to deliver a 20% reduction in the number of term babies admitted unexpectedly to the neonatal unit

Priority 5: (Patient Experience) Friends and Family Test—uninpatient responses

Objective: use FFT as a key measure for our continued ambition to provide excellent experience of care in everything we do. This measure was chosen by our Governors.
The following section sets out the context, our plan, and our approach to measurement and tracking for each priority.

**Priority 1: Reduction of acquired pressure ulcers both in hospital and the community**

**What is the context?**

Pressure ulcers were subject to a national CQUIN during 2014/15 and will not be in 2015/16. Safety Thermometer data collection will continue to be a national requirement and this requires us to conduct a monthly point prevalence audit of a range of ‘harms’ including pressure ulcers. The Safety Thermometer measures all pressure ulcers regardless of whether these were acquired in the community or hospital setting.

Last year we set challenging targets in order to see a reduction in the incidence of hospital acquired pressure ulceration. Despite new documentation and evidence of good practice in some areas to support the management of patients, the Trust has seen a rise in reported pressure ulcers. This in part could be due to increased reporting and or inaccurate reporting of incidence ie wounds that are not pressure ulcers being reported as such. There is also a greater recognition of pressure ulceration.

**What is our plan for 2015/16?**

The area where we can make the most significant impact is the incidence of hospital acquired pressure ulcers.

- Safety Thermometer data collection will continue and the pressure ulcer data will be considered by the Preventing Harm Group (PHG)
- We will embed the approach of carrying out Comfort Rounds
- Root Cause Analysis (RCA) will continue for all grade 3, 4 and unstageable pressure ulcers
- Where a pressure ulcer is identified as avoidable lessons learnt will be cascaded across the whole organisation and targeted support from the tissue viability nurse will be offered to the clinical area where this occurred
- Lessons learnt and common themes from RCA will be cascaded through a new information sharing bulletin
- There will be a focus on grade 2 pressure ulcers as this is where we have the highest incidence
- We will explore what benchmarking information is available above and beyond that of Safety Thermometer
- Consideration will be given to an external review if our benchmarking information identifies us as an ‘outlier’ in terms of the incidence of hospital acquired pressure ulcers
- A review of training provision related to pressure ulcer prevention and pressure ulcer management will be undertaken to ensure that this is targeted appropriately
- We will participate in the North West London Pressure Ulcer Network to develop effective protocols, learning and education.

**During Quarter 2 we will:**

- benchmark our pressure ulcer incidence
- review our approach to Root Cause Analysis
- introduce a process for investigating and learning from grade 2 pressure ulcers
- determine an approach for ‘what good looks like’ for avoiding and treating pressure ulcers.

Should our benchmarking information identify us as an outlier in terms of the incidence of hospital acquired pressure ulcers, we will commission an external review during Quarter 3.

During Quarter 4 we will introduce the most appropriate methodology and approach for pressure ulcer reduction as determined by the external review or as observed by best practice sites.

By the end of Quarter 4 we will set evidence based stretch targets associated with a reduction in the incidence of hospital acquired pressure ulcers.

How will we track and report progress?

The PHG will provide oversight of performance in achieving this priority, including:

- Receiving monthly headlines in terms of the numbers and grades of hospital acquired pressure ulcers
- Receiving a ‘deep dive’ pressure ulcer report every three months
- The deep dive report will assist the PHG in terms of agreeing priorities for action and targeting effort where it is most needed.

Priority 2: Embedding of the WHO surgical checklist

What is the context?

In June 2008, the World Health Organisation (WHO) launched a second Global Patient Safety Challenge, ‘Safe Surgery Saves Lives’, to reduce the number of surgical deaths across the world. The WHO Surgical Safety Checklist is part of this initiative and is a tool to strengthen the commitment of clinical staff to address safety issues within the surgical setting. This includes improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication within the team. The checklist has been mandated across the NHS since February 2010.

Over the past two years, the Trust has been undertaking further work to ensure that the WHO Surgical Safety Checklist is embedded consistently and reliably across the organisation. The Trust has taken a prioritised approach, focusing initially on the theatre stage of surgery (‘sign in’ and ‘time out’ parts of the checklist).

The Trust uses the WHO checklist as a learning document—in particular to draw lessons in relation to serious untoward incidents (throat packs and tourniquets being recent examples).

Why focus on this priority during 2015/16?

The July 2014 CQC inspection highlighted that the hospital’s surgical safety checklist (based on the WHO checklist), which should be used at all stages of the surgical pathway, was not fully completed in three of five cases reviewed.
In response the Trust has committed to ensure that the surgical safety checklist is followed consistently at each stage of the surgical pathway.

The areas found through audit that need to be improved are the Team Brief (the meeting of the whole theatre team to discuss the patients on the scheduled operation list—to inform staff of equipment needed and any potential problems).

**What is our plan for 2015/16?**

The approach to rolling out the checklist consists of implementation, audit (at an individual consultant level of detail), and review to refine the process and ensure compliance. All audits are reviewed at the Theatre Improvement Management Board (TIMB) and appropriate actions taken. We are targeting compliance of 98% or more to be assured that the checklist is embedded.

Specific actions taken as part of the CQC action plan have included:

- undertaking monthly audits of specific specialities
- reviewing the use of a training video to outline best practice.

To help support and enable the rollout of the Surgical Safety Checklist the Trust is working with the Imperial College Simulation Centre to roll out a simulation package for theatre staff focusing on communication skills and leadership in the theatre environment. This approach is being piloted during Q1 2015/16 and will be rolled out over the year.

**How will we track and report progress?**

Progress against this priority will be measured through audit with frequent dissemination of results to all staff. Regular reports will be provided to the TIMB and through the Planned Care Improvement Programme.

**Priority 3: Sepsis—early identification of the deteriorating patient (electronic National Early Warning Score [NEWS], Maternity Early Warning Score [MEWS] and Paediatric Early Warning Score [PEWS])**

**What is the context?**

Sepsis is a significant driver of mortality and morbidity and it has been shown that early intervention and effective care will improve patient and clinical outcomes and reduce the chances of death. The Trust has an agreed pathway (care bundle) for patients with sepsis and the Emergency Department is taking part in a national research project on the treatment of sepsis. This priority will build on existing work, targeting a reduction in ITU admission, reduction in length of stay and reduction in infection rates.

The treatment of Sepsis across the Trust will be enhanced by utilising an electronic NEWS scoring and escalation system with prompts to identify potentially unwell and/or septic patients. It will enable the use of prompts and algorithms to initiate investigation and treatment according to a recognised sepsis algorithm (such as Sepsis 6). All stages in identification and treatment will be subject to audit of process—and patient impact will be recorded routinely in terms of deaths from sepsis, admissions to ITU with sepsis, and length of stay in hospital.
What is our plan for 2015/16?

This priority will be implemented across the organisation over 2015/16 through a number of overlapping phases.

- Phase 1 will consist of roll out of Electronic National Early Warning Score (ThinkVitals) to the hospital. **Planned to roll out to all wards by end of Q1 2015/16.**

- Phase 2 will focus on early identification, investigation and treatment algorithm for Sepsis (**planned to go live by end of Q1 2015/16**):
  - Mapping of diagnosis and treatment algorithm
  - Identification and training of Nurses to implement treatment and investigation
  - Identification of additional investigations into algorithm
  - Link to antibiotic guidelines
  - Computer generated appropriate antibiotic and dosage
  - Planning prompt completion of cannulation and blood cultures across the 24-hour period
  - Planning of who is to give first dose of antibiotics.

- Phases 3 and 4 will consist of production of Obstetric and Paediatric versions of ThinkVitals respectively. **Planned to roll out to all wards by end of Q2 2015/16.**

- Phase 5 will focus on increasing the scope of individuals to include performing the sepsis bundle while Phase 6 will consist of introduction of the AKI Bundle. **In planning with detailed timetable to be developed.**

How will we track and report progress?

The following actions will be tracked and reported regularly through the Sepsis Project Steering Group:

- Progress delivering project plan, as set out at high level above
- Establishing the baseline coding for sepsis on admission or during inpatient stay. The data will include the average Length of stay for these patients and numbers admitted to intensive care or who have died with this diagnosis
- Establishing from a literature review or international comparison the potential size of the improvements to be made by our intervention to set a challenging target and trajectory
- Planning for a reduction in deaths from sepsis, admissions to ITU with sepsis and length of stay in hospital
- Reviewing and developing a dashboard of ongoing process and outcome data

**Priority 4: Reducing avoidable admissions of term babies to the Neonatal Intensive Care Unit (NICU)**

What is the context?

The Maternity Department at Chelsea and Westminster Hospital delivered 6,140 babies during 2014/15. Of those babies which were structurally normal at term, approximately 3% (around 180) were admitted unexpectedly to the neonatal unit. The national rate of admission is quoted as 5% (NHS England) This is one of the top three incidents reported
within the department and although most babies are discharged home with an anticipated normal outcome, the period of separation creates anxiety for parents and involves additional bed days for the mother. For the small minority that have permanent brain injuries the impact for those families is immeasurable and the ongoing costs of care are significant.

Unexpected admissions to the neonatal unit are all reviewed using a root cause analysis approach by the Risk and Governance Midwife. Any admissions where care or service delivery issues are identified are escalated according to the Trust serious incident policy and investigated accordingly. Every six months all cases are reviewed as a group to identify any common themes and learning shared with staff. In the most recent audit of 88 cases, six were investigated via the serious incident process. Of the total number it was noted that 51% were admitted from the postnatal ward and 58% were hypothermic on admission. The main admission diagnoses were presumed sepsis and respiratory compromise. The length of stay ranged from 1-15 days.

What is our plan for 2015/16?

Our ambition is to achieve a 20% reduction in unexpected term admissions to NICU. To achieve this we will focus on the following objectives:

- **Improve identification of at-risk babies in the antenatal period.** Identify at risk babies ie those who are growth restricted prior to the onset of labour who will have limited reserve for the additional stress of labour

- **Ensure safe intrapartum care.** Review practice and target teaching and education regarding labour management and interpretation of the fetal heart rate in labour (both intermittent auscultation and CTG interpretation)

- **Improve postnatal care of vulnerable babies.** Review practice on the postnatal ward in caring for babies that are vulnerable to hypoglycaemia and hypothermia. To ensure babies receive IV antibiotics within the recommended timescale.

The outline approach for the project is as follows:

- **Quarter 1**—Increasing the information from existing audits and gathering evidence about current systems in place to support staff and women

- **Quarters 2 and 3**—Anticipated that the review and audit results will have clarified metrics that can be used in the following quarters. Rollout of GROW software to improve antenatal detection of growth restriction. New foetal heart rate monitoring teaching sessions will be implemented and an assessment tool will be introduced for key staff. Results of the postnatal audit will have identified areas for change that will be implemented within these quarters.

- **Quarter 4**—Re-audit will be undertaken on key areas: postnatal admissions, compliance with new CTG classification and monitoring tool, identification of growth restricted babies.
How will we track and report progress?

A quarterly report of progress towards completion of the action plans will be presented for review at the Maternity Services Meeting for progress.

We will also be contributing appropriate cases to the national review of babies born with brain injury to the Each Baby Counts database. This is a national project launched by the Royal College of Obstetricians to reduce the incidence of stillbirth, early neonatal death and brain injuries by 50% by 2020.

Priority 5: Friends and Family Test—inpatient responses

What is the context?

As part of the Trust Values, the Trust is committed to ensuring that all patients and their families receive consistent first class care and treatment in a timely manner and in a supportive environment. As part of ensuring and monitoring this commitment, the Trust has been engaging with the Friends and Family Test (FFT) during the financial year 2014/15. This is one important mechanism of measuring what we are doing and how our responses to patient and family feedback can ensure best care. The Trust Governors have chosen to focus on FFT as a priority measure of quality during 2015/16.

Patients who have been cared for in the Trust are asked to evaluate their care and treatment after they have been discharged from hospital. This is done in one of three ways; by responding to a text, completing a hard copy of the survey on discharge and some are contacted by an agency to rate the care they received. The feedback is shared with the Divisional teams and the clinical areas implement actions to ensure good practice and address any shortfalls.

The response rate to the FFT during the year (2014/15) has been variable both across different parts of the Trust and between months, ranging from 10% (Maternity, July 2014) to 40% (Inpatients, March 2015). The FFT report shows that some clinical areas continue to have a very low response rate. The percentage of people who would recommend the Trust ranges from an average of 88% for Inpatients and Outpatients, to 94% for Day Case. The Table below summarises our performance over the year.

| Table 2: Friends and Family Test results for 2014/15 by quarter |
|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| **Response Rate**         | Q1 14/15 | Q2 14/15 | Q3 14/15 | Q4 14/15 | **Average**** |
| Emergency Department      | 17%      | 23%      | 23%      | 24%      | 22%          |
| Inpatients                | 31%      | 30%      | 29%      | 34%      | 31%          |
| Maternity                 | 21%      | 18%      | 24%      | 22%      | 21%          |
| Outpatients               | N/A*     | N/A*     | 19%      | 17%      | 18%          |
| Day Case                  | N/A*     | N/A*     | 15%      | 14%      | 15%          |
| **Recommend**             | **Q1 14/15** | **Q2 14/15** | **Q3 14/15** | **Q4 14/15** | **Average**** |
| Emergency Department      | 91%      | 90%      | 88%      | 91%      | 90%          |
| Inpatients                | 91%      | 89%      | 85%      | 87%      | 88%          |
| Maternity                 | 90%      | 97%      | 95%      | 96%      | 95%          |
| Outpatients               | N/A*     | N/A*     | 87%      | 89%      | 88%          |
| Day Case                  | N/A*     | N/A*     | 93%      | 94%      | 94%          |

* Data availability for Day Case and Inpatients was partial year as rolled out 01 October 2014 (CWFT was an early adopter)
What is our plan for 2015/16?

The Trust recognises:

- The need to consistently improve our response rate to FFT across all the Divisions and clinical areas
- That there should be a variety of mechanisms for patients and families to respond to the survey
- The need to target clinical areas where there is a particularly low response rate
- That the number of people who would recommend the Trust needs to be improved and some clinical areas have been highlighted of concern
- That there is a need to raise the importance of FFT and to ensure that positive and negative feedback is acted on and remedial actions taken to address FFT feedback
- That some of the poorer qualitative results reflect the themes coming from complaints, ie poor communication, lack of or conflicting information and staff attitude/behaviour

During 2015/16 we will work to ensure that at least 95% of respondents will recommend the Trust. We will also seek to ensure at least a 30% response rate across all areas (Emergency Department, Inpatients, Maternity, Day Case, Outpatients and Paediatrics).

We will undertake the following actions, overseen by a re-established Patient Experience Committee:

- Focus on improving communication, accurate patient-centred information and staff attitudes and behaviours
- Improve our response rate to FFT consistently across all the Divisions and clinical areas
- Provide FFT training sessions for staff
- Support clinical areas where there is a particularly low response rate
- Ensure FFT results are sent to each Division to disseminate to all staff and to recognise achievements and shortfalls
- Ensure that positive and negative feedback is acted on and remedial actions taken to address FFT feedback
- Support clinical areas that have been highlighted by FFT as an area of concern
- Triangulate findings from complaints, PALS and FFT to identify trends, monitor and improve the patient experience

How we will track and report progress?

These metrics will be reviewed each quarter though the Divisional structure and reported to the Chief Nurse Cabinet, the Patient Experience Group and the Executive Board.
Progress made since the 2013/14 Quality Report

As part of the 2013/14 Quality Report the Trust identified four quality priorities to focus on during 2014/15. This section is a summary of what we said we would do and the progress we have made against each priority. As well as setting ourselves new priorities for 2015/16 as detailed in the previous section, we will continue to focus on ensuring that our 2013/14 priorities remain embedded as part of ‘business as usual’, with rigorous monitoring and continued improvement against the goals we set ourselves.

Priority 1 (Patient Safety): To have no hospital associated preventable venous thromboembolism (VTE)

VTE is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block the blood supply. This can be fatal.

The risk of developing VTE is increased after surgery and/or periods of immobility, and in certain situations such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one third of patients will develop VTE despite the best care but in the remaining two-thirds of patients a VTE can be avoided with preventive treatment.

What we said we would do in 2014/15 and what we actually did

Our goal is to have no hospital associated preventable VTEs by ensuring VTE risk assessments are completed, preventive treatment is prescribed, patients are educated and nurses and doctors are trained in VTE prevention.

We have continued to undertake a thorough review (root cause analysis) of cases where patients with a potentially preventable VTE associated with a hospital admission, defined as during or within 90 days of admission, did not receive appropriate preventive treatment.

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>We set ourselves a target of 25% fewer hospital associated VTEs than in the previous year—ie to have no more than 7 potentially preventable hospital associated VTEs</td>
<td>From April 2014 to March 2015, we have identified 8 potentially preventable hospital associated VTEs. We continue to focus on addressing the contributory factors eg management of patients in lower limb immobilisation, updating patient agreement to investigation or treatment consent form to include VTE risks, education on accurate completion of VTE risk assessments to identify those patients at risk of VTE requiring preventative medication if not contraindicated, weekly and monthly monitoring of VTE risk assessment completion rates and ensuring patients receive VTE information.</td>
</tr>
</tbody>
</table>

VTE risk assessments

All adult patients should have a VTE risk assessment completed on hospital admission to identify any risk factors that may be present.
<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to ensure that we meet our target of 95% adult patients admitted with completed VTE risk assessments.</td>
<td>This target has been achieved with weekly and monthly monitoring of completed VTE risk assessments, with feedback to departments.</td>
</tr>
</tbody>
</table>

### Preventive treatment

Adult patients at risk of VTE should receive appropriate preventive medication and the use of compression stockings, if indicated and no contraindications present, to help prevent blood clots developing during hospital admission.

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>We set a target of 90% of adult patients to receive appropriate medication and compression stockings.</td>
<td>During 2014/15, we performed monthly audits and on average 97% of adult patients received appropriate preventive medication, and approximately 87% of adult patients received compression stockings.</td>
</tr>
</tbody>
</table>

Our monthly delivery against this measure is illustrated in the figure below.

**Figure 1: Monthly audit on VTE prevention (medication and compression stockings)**

![Graph showing monthly audit results for VTE prevention](image)

**Patient information**

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>We recognised the importance of providing patients with information about the risks of VTE, its signs and symptoms, and when to seek urgent medical attention.</td>
<td>VTE patient information leaflets are available and visible on all adult wards, assessed by monthly audits. The patient information leaflet ‘Are you at risk of blood clots?’ is offered to all patients admitted to the hospital, all pregnant women and all patients attending A&amp;E who require a lower leg plaster cast. VTE patient information has been included on the admission and discharge checklist, and in admission packs to ensure patients receive written information.</td>
</tr>
</tbody>
</table>
VTE training

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>We said we would monitor completion rates and uptake of our online VTE training module on VTE prevention and treatment for all doctors with a target of 75% over 2 years. The aim is to ensure all frontline staff are aware of the preventive treatments we use in this hospital and standardise training.</td>
<td>From April 2014 to March 2015, 20% of new doctors have completed the online VTE training module. 79% of Foundation Year 1 and 2 doctors have completed the online VTE training module. As this has not met the quality initiative we set ourselves, a plan of action is in place to highlight training uptake at a divisional level, and significantly improve the percentage uptake of new doctor’s training around VTE in the coming year. Mandatory training reports are circulated monthly highlighting staff performance and for managers to follow up on incomplete training.</td>
</tr>
</tbody>
</table>

VTE ward rounds

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>We said we would roll out VTE ward rounds to medical and surgical wards, following the successful implementation on maternity wards, to assess VTE risk assessment completion and check patients are offered appropriate preventative treatment to help reduce their risk of developing blood clots.</td>
<td>We have performed regular VTE ward rounds on medical, surgical and maternity wards with education to ward staff and dissemination of findings and improvements to departments eg awareness on anti-embolism stockings, ensuring prescribed medication doses are given, documentation of management plans. The ward rounds have improved VTE prevention measures and increased VTE awareness with feedback to staff at ward level for medical, surgical and maternity inpatients ensuring optimum delivery of care and better outcomes eg no missed doses of thromboprophylaxis, patients at risk of VTE prescribed appropriate medication, appropriate use of anti-embolism stockings; thus delivering benefit to inpatients and staff.</td>
</tr>
</tbody>
</table>

Priority 2 (Patient Experience): To continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients

What we said we would do in 2014/15 and what we actually did

Communication

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce the Great Expectations project, a coaching programme to stimulate debate and challenge poor attitude. The project aims to give managers the tools and skills to deal with difficult situations within their teams effectively.</td>
<td>We teamed up with The Royal Central School of Speech and Drama who co-designed and delivered the innovative and interactive training to over 150 members of staff in the organisation.</td>
</tr>
<tr>
<td>Continue to run Schwartz rounds in the Trust.</td>
<td>In total, 678 people attended the first 11 rounds. The rounds aim to support staff in the more emotional aspects of their roles. The table below shows the feedback from these Schwartz Rounds.</td>
</tr>
</tbody>
</table>
Table 3: Feedback from Schwartz rounds

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>94% agreed that the case was relevant to their daily clinical work</td>
<td></td>
</tr>
<tr>
<td>82% gained knowledge that will help them care for patients</td>
<td></td>
</tr>
<tr>
<td>88% felt that the round will help them work with colleagues</td>
<td></td>
</tr>
<tr>
<td>95% found the overview and presentation helpful</td>
<td></td>
</tr>
<tr>
<td>95% found the open discussion helpful</td>
<td></td>
</tr>
<tr>
<td>96% gained an insight into how others think/feel in caring for patients</td>
<td></td>
</tr>
<tr>
<td>75% of attendees rated the round either ‘exceptional’ or ‘excellent’ and 21% rated it ‘good’</td>
<td></td>
</tr>
</tbody>
</table>

Discharge Projects

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and evaluate the discharge support tools we have implemented and develop training programmes for staff to support this.</td>
<td>The Nurse Delegated Discharge (NDD) project has been rolled out on David Evans Ward for elective surgical patients. Our experience here has meant that the model has moved towards an opt-out rather than opt-in model. The effect of this is being monitored by the ward staff for its efficacy and improved patient experience. The paperwork for patients on medical wards has been adapted and is being rolled out on a trial basis on Edgar Horne Ward during the Spring of 2015.</td>
</tr>
</tbody>
</table>

It is planned to continuing rolling out NDD across the Trust in both medical and surgical areas where appropriate, learning lessons and assessing additional efficiencies and improved patient experience as we go. The next area of focus is likely to be the Supported Discharge Suite (SDS) which is our Intermediate Care Ward.

Listening and Learning

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen the ways we listened to feedback from our Friends and Family Test (FFT) results.</td>
<td>The Nurse Delegated Discharge (NDD) project has been rolled out on David Evans Ward for elective surgical patients. Our experience here has meant that the model has moved towards an opt-out rather than opt-in model. The effect of this is being monitored by the ward staff for its efficacy and improved patient experience. The paperwork for patients on medical wards has been adapted and is being rolled out on a trial basis on Edgar Horne Ward during the Spring of 2015. Our overarching FFT results are reported on the performance dashboard to the Board, while at a divisional level, sisters and ward managers are responsible for reviewing the results within their areas and developing action plans from the feedback. We are currently undertaking some training to help our staff develop their knowledge and act on our patients’ feedback.</td>
</tr>
</tbody>
</table>

Details of our 2014/15 performance for FFT are set out above in ‘Our priorities for 2015/16’ on page 9.

Our analysis so far has shown high rates of satisfaction from the feedback we have received and next year we will be working with our FFT provider on finding new ways to encourage more patients to take an active part in this feedback.

The next roll out of the FFT is to our paediatric wards from April 2015 and this will mean that all our inpatient areas will be providing useful feedback on their experience while in our care.
Priority 3 (Patient Experience/Staff Engagement): To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals

We work against each of the seven staff pledges in the NHS Constitution to create and maintain a highly skilled and motivated workforce capable of improving the patient experience. Our progress against each pledge is set out in further detail on page 54.

What we said we would do in 2014/15 and what we actually did

Staff engagement and appraisals

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be in the top 20% of acute Trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey.</td>
<td>The results of the National Staff Survey 2014 show that Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment. Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role. NHS Staff Survey results also show that we are in the top 20% of Acute Trusts for the quality of our staff appraisals (with 44% of staff reporting having a well-structured appraisal). However, it is unlikely that we will achieve our target of 85% of staff having had an appraisal in the last 12 months and we will be working hard over the next year to improve on this. See page 54 for further details.</td>
</tr>
</tbody>
</table>

Friends and Family Test for staff

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure our agreed trust values inform everything that we do and include the staff FFT test to help measure this.</td>
<td>The National FFT for staff was launched in April 2014 and had a response rate of 20% (466 of 2,300 staff surveyed) in Quarter 1. Results showed 91% of staff were likely to recommend the trust as a place to receive care or treatment, and 75% would recommend this as a place to work. For Quarter 2 a total of 245 paper based surveys were distributed to a specific staff group—Support Workers/HCAs. 42 staff responded to the survey and it was positive to note that from the responses received 76% were likely or extremely likely to recommend the trust as a place to receive care or treatment and would also recommend the trust as a place to work.</td>
</tr>
</tbody>
</table>

Priority 4 (Clinical Effectiveness): To improve choice and quality in End of Life Care

What we said we would do in 2014/15 and what we actually did

A key priority for 2014/15 was to work together to implement the Trust End of Life Care Strategy. The ‘End of Life Care Committee’ was very pro-active in guiding, directing and monitoring progress during the year, with strong engagement from across the Trust and community services, including adult, paediatric, midwifery, clinical and non-clinical staff.

Following a successful funding bid to Macmillan and the Trust to increase the specialist palliative care nursing, the team are delivering a seven day face to face specialist palliative nursing care service. The service has been warmly received by patients, families and staff.
We have also responded to the Care Quality Commission (CQC) report on our end of life care by building on good practice and addressing limitations. Our progress against key components of this priority are set out below.

**Coordinate My Care (CMC)**

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll out offering the use of CMC database to help ensure patient’s preferences and choices are shared by people and services involved in the patient’s care, including the hospital, the GP, community nursing and care teams enabling patient’s choices to be managed and delivered.</td>
<td>Staff worked together and increased the number of patients identified as moving towards the end of life in order to plan care and to enable patients to die in their preferred place of care. This was supported by offering more patients and families the opportunity to have their wishes recorded on the CMC database, thereby ensuring their choices were met by the hospital, the GP and community services.</td>
</tr>
</tbody>
</table>

**Personalised care**

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that all people approaching end of life are sensitively offered the opportunity to talk about an advance care plan.</td>
<td>Staff were supported to sensitively offer patients and families the opportunity to talk about their needs and wishes.</td>
</tr>
<tr>
<td>Continue to support and address the needs of the family including partners, parents, children, friends and informal carers.</td>
<td>Staff continued to support and address the needs of the family including partners, parents, children, friends and informal carers.</td>
</tr>
<tr>
<td>Ensure staff will work together in a timely manner to identify when a patient may be moving towards the end of life in order to plan care and to enable them to die in their preferred place of care.</td>
<td>Personalised care during the last days of life was based on the patient and families’, physical, social, emotional, spiritual &amp; religious wishes and needs, overseen by their medical consultant and ward manager</td>
</tr>
</tbody>
</table>

**Working with partners**

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to enhance care, working with statutory, voluntary, community and charitable partners, to ensure that each patient and their family receive coordinated seamless care.</td>
<td>We continued to work collaboratively with statutory, voluntary, community and charitable (including Macmillan Charity, Trinity Hospice) partners.</td>
</tr>
</tbody>
</table>

**Education, research and innovation**

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver an educational programme to ensure support, education and training is provided to all clinical and non-clinical staff to support them in delivering high quality end of life care.</td>
<td>We have delivered educational and training programmes for staff including: ‘I can make a difference’—three rotational programmes for health care assistants and junior nurses, end of life care training for senior members of staff, CMC training for teams, end of life care training is now part of all non-medical staff induction programmes, medical staff are supported in end of life care needs and priorities. A training needs analysis in end of life care was undertaken and the findings are being used to develop a training programme for staff.</td>
</tr>
</tbody>
</table>
### What we said we would do vs. What we did

| Work creatively with our patients/families and partner organisations to deliver excellent care and participate in practice based projects and research in order to improve end of life care. | We have engaged in a CLAHRC (Collaboration for Leadership in Applied Health Research and Care) fellowship research programme, aimed at improving leadership of care at the end of life. Alex Mancini and the Neonatal Intensive Care Unit (NICU) published guidance to support staff caring for very young babies with life limiting conditions who require palliative or end of life care. The guidance now forms part of national guidance for all NICUs on the appropriate care to be provided to babies and families receiving end of life care. |

### Monitoring our progress

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>What we did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor ourselves through audit and benchmarking against quality agreed standards, this will also include learning from listening to bereaved relatives, and a regular review of good practice and complaints.</td>
<td>We were able to learn through meeting bereaved relatives, having bereaved families on our end of life care committee and regular reviews of good practice and complaints.</td>
</tr>
</tbody>
</table>
Statements of assurance from the Board

During 2014/15 the Chelsea and Westminster Hospital NHS Foundation Trust provided and or sub-contracted 87 relevant health services. The Chelsea and Westminster Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 100% of the total income generated from the provision of relevant health services by the Chelsea and Westminster hospital NHS Foundation Trust for 2014/15.

Participation in clinical audits

Clinical audits collect information on the treatment patients receive and its consequences in important areas of medicine. Participation in them enables healthcare professionals to evaluate their clinical practice against national standards and guidelines, so that they can continuously improve the quality of treatment and care they provide.

National confidential enquiries perform a similar role, but additionally include critical assessment by senior doctors of what actually happened to patients, with a view to driving up standards and enhancing patient safety.

During 2014/15, 46 national clinical audits and six national confidential enquiries covered relevant health services that the Trust provides.

During that period Chelsea and Westminster Healthcare NHS Foundation Trust participated in 91% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The tables below responds to the following assurance statements from the guidance:

- The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS Foundation Trust was eligible to participate in during 2014/15

- The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS Foundation Trust participated in during 2014/15

- The national clinical audits and national confidential enquiries that Chelsea and Westminster Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, with the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 4: National clinical audits for inclusion in the Quality Report 2014/15—including those in which the Trust was not eligible to participate due to the Trust not providing those services or procedures
## ACUTE CARE

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Mix Programme/Intensive Care National Audit &amp; Research Centre</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Application to participate in this audit from April 2015 submitted</td>
</tr>
<tr>
<td>National emergency laparotomy audit (NELA)</td>
<td>Yes</td>
<td>51</td>
<td>51</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
<td>412</td>
<td>412</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Cardiac Arrest (National Cardiac Arrest Audit)</td>
<td>Yes</td>
<td>44</td>
<td>44</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Severe Trauma (Trauma Audit &amp; Research Network, TARN)</td>
<td>Yes</td>
<td>72</td>
<td>27</td>
<td>36%</td>
<td>Trust is participating. Data to be submitted by 31/5/15</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>Yes</td>
<td>30</td>
<td>TBC</td>
<td>N/A</td>
<td>Audit not taking place in 2015. All eligible cases submitted.</td>
</tr>
<tr>
<td>Non-Invasive Ventilation</td>
<td>No/No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Audit not taking place in 2015. All eligible cases submitted.</td>
</tr>
<tr>
<td>Pleural Procedures</td>
<td>Yes</td>
<td>Min 8</td>
<td>31</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
</tbody>
</table>

## BLOOD

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 Audit of Patient Blood Management in Scheduled Surgery</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Data collection commences 1st April 2015.</td>
</tr>
<tr>
<td>2015 Audit of the use of blood in Lower GI bleeding</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Data collection starting date in January 2016</td>
</tr>
<tr>
<td>2016 Audit of the use of blood in Haematology (submitted for all)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

## CANCER

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Cancer Audit</td>
<td>Yes</td>
<td>*80</td>
<td>72</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>Bowel Cancer (National Bowel Cancer Audit Programme)</td>
<td>Yes</td>
<td>*82</td>
<td>82</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck Cancer (DAHNO)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible—the trust do not treat cancer of the head &amp; neck</td>
</tr>
<tr>
<td>Oesophago-Gastric Cancer (National O-G Cancer Audit)</td>
<td>Yes</td>
<td>&lt;50</td>
<td>28</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Yes</td>
<td>36</td>
<td>36</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
</tbody>
</table>

## HEART

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction &amp; other acute coronary syndrome (MINAP)</td>
<td>Yes</td>
<td>53</td>
<td>53</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Cardiac Arrhythmia (Cardiac Rhythm Management Audit)</td>
<td>Yes</td>
<td>46</td>
<td>33</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Heart Failure Audit</td>
<td>Yes</td>
<td>94</td>
<td>24</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Adult cardiac surgery audit</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric Cardiac Surgery)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
</tbody>
</table>

## LONG TERM CONDITIONS

(HEMS data do not provide a gold standard for comparison but can give an indication on major discrepancies between patients submitted and patients documented to be receiving care in HES)
<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes (National Adult Diabetes Audit)</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Participation requires compatible database/IT for submission⁴</td>
</tr>
<tr>
<td>Paediatric Diabetes (Royal College Paediatrics and Child Health)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Data submission commences 01 April 2015</td>
</tr>
<tr>
<td>Inflammatory bowel disease (IBD)—Biological Therapy audit</td>
<td>Yes</td>
<td>36</td>
<td>36</td>
<td>100%</td>
<td>All eligible cases</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Yes</td>
<td>25</td>
<td>23</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Rheumatoid &amp; early inflammatory arthritis</td>
<td>Yes</td>
<td>All eligible</td>
<td>8</td>
<td>100%</td>
<td>Data collection commenced 01 Feb’14 and closes early ’17. Next data submission 30.04.2015</td>
</tr>
<tr>
<td>Chronic Kidney disease in Primary Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Data collections for all hospitals will take place from April 2016</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health (Care in Emergency Departments) (CEM)</td>
<td>Yes</td>
<td>29</td>
<td>29</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Suicide &amp; homicide in mental health (NCISH)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td><strong>OLDER PEOPLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database</td>
<td>Yes</td>
<td>160</td>
<td>160</td>
<td>100%</td>
<td>Continuous data collection however audit requires hospitals to submit min. 100 cases per year</td>
</tr>
<tr>
<td>Sentinel Stroke (SSNAP)</td>
<td>Yes</td>
<td>188</td>
<td>188</td>
<td>100%</td>
<td>All eligible cases</td>
</tr>
<tr>
<td>Sentinel Stroke (SSNAP)—Organisational Audit</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A—organisational audit (questionnaire—non clinical)</td>
</tr>
<tr>
<td>Older People (Care in Emergency Departments) (CEM)</td>
<td>Yes</td>
<td>73</td>
<td>73</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Surgery: Hernia (National PROMs Programme)</td>
<td>Yes</td>
<td>126</td>
<td>43</td>
<td>34%</td>
<td>Using validated data only from April—Sep 14 as advised by PROMS</td>
</tr>
<tr>
<td>Elective Surgery: Hip Replacement (National PROMs Programme)</td>
<td>Yes</td>
<td>83</td>
<td>33</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Elective Surgery: Knee Replacement (National PROMs Programme)</td>
<td>Yes</td>
<td>77</td>
<td>27</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Elective Surgery: Varicose Veins (National PROMs Programme)</td>
<td>Yes</td>
<td>64</td>
<td>32</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>National Audit of Intermediate Care</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Data entry commences 04 May’15</td>
</tr>
</tbody>
</table>

⁴ The decision to move to a new Diabetes database is complex due to the need to maintain links with the community system. Participation in 15/16 is a divisional priority.
Table 5: National confidential enquiries for inclusion in the Quality Report 2014/15

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participated</th>
<th>Cases Indicated or Required</th>
<th>Cases Submitted</th>
<th>% Cases Submitted</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) &amp; ...</td>
<td>TBC</td>
<td>TBC</td>
<td>TBD</td>
<td>TBC</td>
<td>An individual workstream report was published 19 December ‘14. Status/details of audit to be confirmed.</td>
</tr>
<tr>
<td>WOMEN’S &amp; CHILDREN’s HEALTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy 12 audit (Childhood Epilepsy)</td>
<td>Yes</td>
<td>17</td>
<td>17</td>
<td>N/A</td>
<td>“Data submitted up to the 18th March 2014—Data collection closes on the 12th May 2014</td>
</tr>
<tr>
<td>Maternal, Newborn &amp; Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>Yes</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Neonatal Intensive &amp; Special Care Audit (NNAP)</td>
<td>Yes</td>
<td>All eligible</td>
<td>TBC</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Fitting Child (care in emergency departments)</td>
<td>Yes</td>
<td>50</td>
<td>50</td>
<td>100%</td>
<td>All eligible cases submitted</td>
</tr>
<tr>
<td>Child Health Review UK—Confidential Enquiry</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Participation dependent on occurrence of relevant episodes. Consultants contacted directly to report relevant occurrences. No input required from Trust</td>
</tr>
<tr>
<td>Tracheostomy related complications Insertion</td>
<td>Yes</td>
<td>4</td>
<td>3</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy related complications Critical Care</td>
<td>Yes</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy related complications Ward Care</td>
<td>Yes</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Lower limb amputations</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>No eligible cases identified</td>
</tr>
<tr>
<td>Gastrointestinal haemorrhage</td>
<td>Yes</td>
<td>5</td>
<td>1</td>
<td>20%</td>
<td>Eligible cases to be identified by NCEPOD</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Yes</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>This study is still open and figures have not yet been finalised.</td>
</tr>
</tbody>
</table>

National clinical audits and confidential enquiries—published reports

The reports of 13 national clinical audits were published in 2014/15. The reports of nine clinical audits were reviewed by the Chelsea and Westminster Hospital NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust intends to take the following actions to improve the quality of health care provided (as detailed below).

Clinical teams are routinely required to routinely review the results and recommendations from National Clinical Audits using a standardised ‘gap analysis/action plan’ tool, which is
a document designed to enable leads to identify gaps in service and to assess compliance levels and risks associated with non-compliance.

While 15 audits have been published in 2014/15 (set out in the table below), nine gap analysis documents have been completed. The remaining six were published toward the end of the year, are being considered by specialty multidisciplinary teams, and are scheduled for reporting back to the Trust Executive Safety and Effectiveness Group in line with the publication date of the relevant clinical audit report.

**Table 6: National Clinical Audits and Confidential Enquiries—Published reports**

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Actions Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Prostate CancerAudit</td>
<td>Urology Department</td>
<td>The lead Urology consultant reviewed the results from this audit. The trust was found to be compliant in 4 out of 5 areas. It was identified that complete and accurate data is submitted to the NPCA (National Prostate Cancer Audit) for every patient with newly diagnosed prostate cancer through an MDT (Multidisciplinary Team) Proforma, while a separate database is in place for patients to facilitate future audits. Multoparametrix MRI is also routinely used prior to biopsy to reduce unnecessary initial biopsies resulting in improved treatment decision making for patients with potential curable disease. There is support in place by personal support services ranging from the MacMillan Centre, dedicated erectile dysfunction service, continence MDT, psychosexual service, oncology specific counselling ensuring patients are provided the best available care. Two clinical nurse specialists have also been trained to allow patients to have access to specialists with a background in urology.</td>
</tr>
<tr>
<td>Aneurysmal Subarachnoid Haemorrhage</td>
<td>Emergency Department</td>
<td>The Emergency Department reviewed Aneurysmal Subarachnoid Haemorrhage and identified good areas of practice whereby pathways were in place for referrals to the neurosurgical registrar on call at Charing Cross Hospital. A thorough induction programme is also in place for new doctors, whereby handbooks are received outlining the management on SAH, with emphasis on red flags, referral pathways and the need for senior review of all patients presenting with acute onset headaches. The drug Nimodipine is regularly stocked within the Emergency Department in accordance with the National Clinical Guideline for Stroke; and policies are in place establishing pathways to ensure organ donation exists within the department. A department policy was created in September 2014, including a pathway based on the CEM (College of Emergency Medicine) guideline for the Management of Lone Acute Severe Headache 2009.</td>
</tr>
<tr>
<td>National Lung Cancer Audit</td>
<td>Cancer Services</td>
<td>The Trust participated in the National Lung Cancer Audit and has seen great improvements in the levels of data completeness over the past 12 months, and this has been formally recognised by the London Cancer Alliance. Furthermore, 100% of lung cancer patients with NHS numbers were successfully uploaded to LUCADA in the year in question. The trust has achieved joint highest compliance in the Cancer Network within two key areas: 1) Patients undergoing a bronchoscopy receive a CT (CAT) scan prior to procedure. 2) SCLC (Small Cell Lung Cancer) patients receiving chemotherapy.</td>
</tr>
<tr>
<td>Heart Failure National Audit</td>
<td>Respiratory Service</td>
<td>This audit was reviewed by The Respiratory Service and identified good practice in two areas. All Heart Failure admissions with a primary diagnosis of heart failure are recorded; and there are good prescribing rates for LVSD (Left Ventricular Systolic Dysfunction) patients, ensuring patients are offered treatment in line with the NICE clinical guideline.</td>
</tr>
<tr>
<td>Audit Title</td>
<td>Dept Leading Review</td>
<td>Actions Agreed</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>National Pain Audit</td>
<td>Pain Service</td>
<td>The Pain Service took part in the National Pain Audit and identified two areas of good practice. Whereby specialised pain services need to work in an integrated fashion across a wide geographical area. Musculoskeletal Services are offered at St. Charles Hospital, along with high level meetings with the Royal Marsden and Royal Brompton Hospital to offer clinical care network for complex pain. Similar arrangements are also being considered for spinal pain management with the Imperial Neuro Surgical and Spinal Orthopaedics. This is further strengthened with the knowledge that Information Governance and other consultants are members of the Specialist service clinical reference group.</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit</td>
<td>General Surgery</td>
<td>The General Surgery department reviewed this audit and identified 11 out of 12 areas of good practice. It was identified that the management of sepsis was incorporated into the routine care of all EGS (Emergency General Surgery) patients increasing the level of care received by patients. It was also identified that all consultants and juniors attended relevant Mortality and Morbidity meetings ensuring all relevant staff were aware of the progress of patients under their care. There is a structure handover of care in place in addition to daily handovers between members of the team. 24 hour theatre access is in place to ensure operating procedures can take place at any given time.</td>
</tr>
<tr>
<td>National Joint Registry Audit</td>
<td>Orthopaedics</td>
<td>The Orthopaedics Service reviewed the National Joint Registry Report and developed and implemented a protocol outlining a detailed process to improve the consent rate and data quality. Adherence to this process was initially piloted for three months, with the review of the data since reporting considerable improvement.</td>
</tr>
<tr>
<td>National Care of Dying Audit</td>
<td>Palliative Care Team</td>
<td>The Palliative Care Service reviewed this audit and identified 5 areas of care where the Trust has met its target. This ranged from continuing to offer clear, sensitive and timely, verbal and written information to the patient and family whereby the patient had passed away or was terminally ill. Education and training in care of the dying has also been made mandatory for all staff caring for dying patients. This includes communication skills training, skills for supporting families, and those close to dying patients. The Trust has a designated board member and a lay member with specific responsibility for care of the dying.</td>
</tr>
<tr>
<td>National Inpatient Diabetes Audit</td>
<td>Diabetes Service</td>
<td>The Diabetes Service participated in the National Inpatient Diabetes Audit. The service identified two areas of good practice. All Diabetes Specialist Nurses were found to have a dedicated inpatient care time in their job plans to provide referral service to patients in hospital. The department also has a clear referral pathway in place with integrated community and hospital based podiatry teams.</td>
</tr>
<tr>
<td>National Bowel Cancer Audit</td>
<td>Cancer Services</td>
<td>This audit was reviewed by the Cancer Services Team. Four areas of best practice were identified. Currently, staff ensure that patient cases are discussed at the General Surgery Mortality &amp; Morbidity and Clinical Governance meetings. In line with the current national (NICE) guidelines, Laparoscopic surgery is considered in all suitable cases, with suitable patients offered the opportunity laparoscopic resection. The team seeks to ensure accurate and complete data collection is submitted to the audit by ensuring that not only data is recorded on the relevant database, but that the lead clinician signs off on the data.</td>
</tr>
<tr>
<td>Audit Title</td>
<td>Dept Leading Review</td>
<td>Actions Agreed</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>National Oesophago Cancer Audit</td>
<td>Cancer Services</td>
<td>This audit was reviewed by Cancer Services and considered at the Trust Executive Quality Committee. All areas that were relevant to the Trust have been met. These include ensuring investigations are readily available at Chelsea and Westminster/Royal Marsden Hospital and used appropriately. Furthermore, all patients with SCC (Squamous-cell carcinoma) oesophagus are being seen and usually treated by medical/clinical oncolgists. All patients being considered for curative treatment undergo a EUS (endoscopic ultrasound scan) or staging laparoscopy; while all patients with oesophageal SCC (Squamous-cell carcinoma) being considered for curative treatment are discussed with a clinical oncologist and a surgeon.</td>
</tr>
<tr>
<td>National Dementia Audit</td>
<td>Elderly Medicine</td>
<td>The National Dementia Audit was reviewed and considered at the Trust Executive Quality Committee. On review of the results, it was recognised that the trust achieved compliance in 14 key areas. This included ensuring the 90% target set by CQUIN (Commissioning for Quality and Innovation). Furthermore, full day dementia training for trust staff commenced in September 2013, and have continued on a monthly basis offering training on both clinical and non-clinical staff, as well as volunteers. Protected mealtimes are enforced on all wards, with physical and verbal support provided to patients where appropriate. The trust ensures people with dementia admitted to hospital receive a standardised or structured assessment of functioning based on activities of daily living.</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care Audit (NNAP)</td>
<td>Neonatology</td>
<td>The nurse education team and medical team reviewed this Gap analysis and in regards to temperature a new ITU chart was introduced to improve time entry and information provided for temperature to be taken immediately on arrival in NICU with guidelines modification were done. Contemporaneous direct entry of ROP data on Badger Net neonatal database by the ophthalmologist are in good practice and further actions taken to improve the local standards by providing clarification of fields for “SEND” data extraction and internal record keeping for comparison/documentation where screening cannot be timely carried out for clinical indications. Breast milk at discharge home and continue to do extremely well in promotion of use of breast milk and this was discussed at network/NNAP feedback. There was a network issue identified and it was discussed at the network board meeting. A reminder was given at medical staff induction programme on blood stream infections on NNU due to central line b care.</td>
</tr>
<tr>
<td>Child Health Review Summary report</td>
<td>Paediatrics</td>
<td>The gap analysis was reviewed by divisional nurse and presented at the quality committee. Children, who access the shared care service, introduced a checklist for General Paediatric clinics. Children are discussed at monthly meeting who involve the Tertiary Neurology team and the Consultant Neurophysiologist. C&amp;W do not have the resources to develop ‘epilepsy passports’ for all our children but we do ensure that all clinic letters with relevant clinical information and advice are copied in to school nurses and head teachers. All inpatients are discussed with the local Consultant in charge of the child’s overall care.</td>
</tr>
<tr>
<td>UK Paediatric Inflammatory Bowel Disease Audit</td>
<td>Paediatrics</td>
<td>This gap analysis was reviewed by the clinician and nursing staff. A biological nurse was introduced to support IBD Clinic and data collection. The service has moved from 80% to 100% compliance following introduction of NICE guideline. However, sustainability will be confirmed in the long term, since there is a bed capacity pressure. Infliximab guideline to reflect screening requirements was updated.</td>
</tr>
</tbody>
</table>

**Local clinical audits**

The reports of 61 local clinical audits were reviewed by Chelsea and Westminster Hospital NHS Foundation Trust in 2014/15 and Chelsea and Westminster Hospital NHS Foundation
Trust intends to take the following actions to improve the quality of healthcare provided (as detailed below).

Please note rather than include details of all 61 audits a sample of 10 has been included below. Further details are available on request from Miss Zoë Penn, Trust Medical Director and Director of Quality at zoe.penn@chelwest.nhs.uk.

**Table 7: Details of local clinical audits**

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Audit Summary with Actions Agreed</th>
</tr>
</thead>
</table>
| An audit into appropriateness of CT pulmonary angiograms to investigate pulmonary embolisms in AAU | Acute and General Medicine | Further note—The original clinical audit project planner submitted reflected an intention to re-audit in 2 months’ time, the re-audit registration document which was submitted in April 2015 confirms that this re-audit will now take place during May 2015 with a projected end date of July 2015.  
- 48 patients in total were audited. Based on Trust ‘Suspected Pulmonary Embolism’ and Royal College of Radiology Guidelines, the CTPA indicated the following: 13 out of 48 (28%) of CTPAs were not indicated. Out of the 13 identified, none had a Wells score documented in the notes. In 6 cases patients with a Wells score <4, a D-dimer was not ordered. Had this been negative, these patients would not have required CTPA and notably, none of these patients actually had a PE. All 48 patients had a CXR prior to CTPA. Of those 48 patients, 20 were reported as abnormal with findings such as (i) Pleural Effusion; (ii) Consolidation; (iii) Interstitial Lung Disease; (iv) Pulmonary Oedema. 16 out of 47 patients had not had an ABG done prior to CTPA. Out of these 5 out of 16 had PEs. There were only 9 radiologically proven PEs during this period, meaning that less than half had an ABG to assess their degree of hypoxia.  
- The findings from this audit were presented at the AAU departmental meeting and actions taken as a result of the findings included placing a sticker in the notes to prompt better documentation and guide junior doctors to remind them to fill in the Wells score, and finally to re-audit in 2 months to measure if the actions taken has had the desired outcome. |
<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Audit Summary with Actions Agreed</th>
</tr>
</thead>
</table>
| Urgent Care Centre Minor Ailments Audit                                    | Emergency Department & Urgent Care Centre  | - 24 patients were audited in total and it was found that 2 patients should have been streamed into the minor injury stream rather than the minor illness stream. All presentations were found to be suitable for the Urgent Care Centre (UCC) and no cases should have been seen in the main Emergency Department.  
  - There were 2 episodes of prescribing differing from guidelines: (i) Penicillin used for 7 days not 10 days and (ii) co amoxiclav prescribed rather than amoxicillin. There was one episode of treatment in the streaming room by a nurse for a superficial wound with tissue glue which may have been more appropriate for review by an Emergency Nurse Practitioner or Doctor in order for them to document the findings of a neurovascular examination.  
  - There was no evidence of over investigation or incorrect treatment.  
  - Standard of compliance with the streaming and prescribing guidelines was found to be good and overall management in the minor illness stream of the UCC was also good.  
  - The results of the audit were reassuring and the actions taken following completion all revolved around feedback to individual members of staff regarding how their practice may be improved. |
| Analysis of disease activity and its management in patients with established rheumatoid arthritis attending a hospital based rheumatology service | Rheumatology                                | - DAS28 scores were recorded in 71 of 101 patients and disease activity was assessed informally in the majority of the remaining patients.  
  - Of those assessed, 67% were in remission/low disease activity and 26.5% had moderate disease activity and 6.5% had high disease activity. This should not be taken as an overall assessment of disease activity in the Callan patient cohort as patients in remission/low disease activity will tend to be seen less often within the medical clinics (reviews are offered monthly—annually depending on disease stage/activity).  
  - Where disease activity was moderate then patients were advised to increase DMARDS and/or provided with IM or intra-articular corticosteroid injections unless the clinician judged the disease to be inactive despite the high DAS28 score or the patient had just increased treatment or declined to do so. In line with national guidance patients were not offered oral prednisolone to manage established rheumatoid arthritis.  
  - Where disease activity was high and patients were not on a biologic agent then patients were advised to increase DMARDS and process was put in place to apply for biologic treatment. One patient declined treatment escalation as they were breastfeeding. As part of the learning from this audit staff have been asked to ensure that DAS 28 scores are recorded for all patients with RA attending Consultant clinics unless this has been done within the last month. If ESR and CRP are not available then the three other components of the score should be recorded. A re-audit will be undertaken in 2015/16 to assess the effectiveness of the measures implemented. |
### Audit Title
Audit of Intra Uterine Devices at West London Centre for Sexual Health

### Dept Leading Review
Sexual Health

### Audit Summary with Actions Agreed
- Further note—this audit is based on all data for the calendar year Jan-Dec 2013. The report itself was completed during FY 2014/15 based on this collected data.
- The aim of this audit was to assess the standard of clinical practice in IUD/IUS (intrauterine device/intrauterine system) insertions within West London Centre for Sexual Health from 1st Jan 2013—31st Dec 2013 against Faculty good practice points and recommendations to review the complication rates following IUD/IUS insertion and review the reasons why women had their device removed.
- The audit included all suitable women who opted for a Cu-IUD with higher efficacy as their first line choice. The Faculty suggests a follow-up visit 3-6 weeks post insertion, the Trust achieved this in 68% of all patients included in the audit. There were no known uterine perforations, and a 3% possible expulsion rate. 13% of devices were removed within 6 months.
- Staff now keep a diary of all women post IUD/IUS insertion to ensure improved follow up rates with an 8 and 10 week text reminder if not the patient has not attended for 3-6 week follow-up. In addition, measures have been put in place to ensure clearer documentation on thread length if sending patients for an ultrasound scan to ascertain if incorrectly inserted device or expulsion.
- Better counselling for patients pre-insertion on realistic changes in bleeding patterns to prevent early removal of device are also in place and all insertions to have clear documentation of device used in electronic patient record.
<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Audit Summary with Actions Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of the management of Febrile Neutropenia in paediatric oncology patients</td>
<td>Paediatrics</td>
<td></td>
</tr>
</tbody>
</table>
- Children with cancer are at increased risk of infection as a result of their disease and/or its treatment. Fever with neutropenia is the commonest manifestation of infection in children with cancer; such infection is potentially fatal.  
- Febrile neutropenia is a medical emergency requiring urgent investigation and the administration of intravenous empirical antibiotic therapy within 1 hour.  
- Aggressive use of inpatient intravenous antibiotic therapy has reduced morbidity and mortality rates and reduced the need for intensive care management. The purpose of this audit was to demonstrate whether we are following the national guidelines in management of febrile neutropenia in oncology patients and at the same time looking oncology patients who were admitted febrile but not neutropenic.  
- The results show that all febrile patients were admitted, assessed and managed as per guidelines none of the low risk stratifications forms were filled and followed. This would of prompt early discharge for those patients as per national guidelines. To further improve care for these patients regular teachings and presentations to medical and nursing staff regarding the importance of identifying low risk patients on admissions and the new changes to the definition of neutropenia, stickers will be attached to the notes of all patients who will have to be on standard risk protocol on admission and risk stratification forms are now available on wards. |
| Enoxaparin post regional anaesthesia in obstetric patients | Anaesthetics/Maternity |  
- The purpose of this audit was to assess whether the initial dose of low molecular weight heparin (LMWH) is being prescribed appropriately within 4-6hrs post-op and also to demonstrate whether or not subsequent doses of LMWH are prescribed at the agreed times of 07:00 and 18:00.  
- Following completion of the audit the following actions were implemented: All Specialist Trainee anaesthetic doctors working within labour ward were personally contacted to explain the optimal timing of LMWH prescribing, the optimal timing of LMWH prescribing information printed and attached to each anaesthetic machine on labour ward so clear for all anaesthetists to see and information has been produced for locum doctors including the standard prescription times for enoxaparin. |
<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Audit Summary with Actions Agreed</th>
</tr>
</thead>
</table>
| A review of patients referred with abnormal smear results—was a biopsy taken within 2 years? | Gynaecology | • The NHS Cervical Screening Programme published “Colposcopy and Programme Management” as part of ‘Publication 20’ in May 2010. The document states that women who are referred to colposcopy with a high grade abnormality on a smear test should have a biopsy taken at their first visit, target 90%. It also states that women referred with a low grade abnormality on a smear test should have a biopsy taken within 2 years, target >90%. The result of biopsies will help determine onward management including whether a patient should be offered treatment.  
• Patients who were kept under the care of the colposcopy department were adequately followed up. Those who were discharged to the GP would be adequately followed up by the National Cervical Screening Programme and reminded to attend for smear tests. 6 patients were not appropriately followed up due to appointments not being made. This may have been the patient choosing not to book an appointment, or an error on the clinic’s part by not booking an appointment.  
• As a result of the audit it was recommended that the patient is informed of whether they are due to be followed up before leaving the clinic. If an appointment is needed, the patient is advised to book this at reception before leaving the clinic. To limit the numbers of patients who are not seen again incorrectly, all colposcopy staff were reminded of the process of ensuring patient’s book their own appointment before leaving the department. ‘Publication 20’ was being updated by Public Health England at the time of this report due to the implementation of HPV triage for referral and management within colposcopy. Therefore, the need for a re-audit will be assessed once this document is published. |
| Audit of Patient Group Direction for Nurse Supervised Pharmacological Stress during Radionuclide Myocardial Perfusion Imaging | Radiology/Medicine | • To aim of the audit was to ensure that all patients have received appropriate care and all the records have been recorded in line with the Trust Medicine policy and the PGD (Patient Group Direction) and to improve its care delivery to patients.  
• The audit results revealed that patients had received appropriate care and the records had been recorded in line with the Trust Medicine policy and the current PGD. However, there were a few points in patient documentation that required improvement, therefore feedback was delivered to all relevant staff to ensure that any additional patient history is clearly documented in the appropriate section, to always document that the J&A has been checked and stressing the importance of always documenting the date/time of each drug given. |
### Audit Title

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Dept Leading Review</th>
<th>Audit Summary with Actions Agreed</th>
</tr>
</thead>
</table>
| Audit of follow up of patients treated for testicular cancer at Chelsea and Westminster Hospital between April '13 and April '14 | Urology | - All patients that attended the Tuesday morning (testicular only) or afternoon (uro-oncology clinic) clinics for follow-up of their testicular tumours were recorded in a paper database between January and March 2014. The database was updated each time the patient attended the clinic. The year of follow-up from their primary diagnosis was noted, together with their tumour type and whether they had received adjuvant therapy or chemotherapy for relapsed/stage II + disease.  
- The majority of patients are being followed up according to the agreed Cancer Network/Urology Supra-Network Testicular cancer surveillance protocols at Chelsea and Westminster Hospital.  
- The majority of CT scans were booked according to protocol however, breaches arose due to patient related events and a failure to arrange one scan by the clinical team.  
- Actions included the continued use of the oncology database to follow up patients with cancer and consider the use of a computer database as an add-on to the aria chemotherapy system to follow up patients with testicular cancer which is now being implemented. |
| Enhanced Recovery for Hips Surgery Patients | Trauma & Orthopaedics/Anaesthetics | - Enhanced recovery guidelines for all elective Hips and Knees were introduced Nov 2013. Aim was to reduce length of stay (LOS).  
- An assessment carried out in March 2014 confirmed low awareness and engagement amongst staff with the process put in place.  
- It was felt that additional education was required, and this was delivered via a presentation to Orthopaedic and Anaesthetic Department on referral guidelines and the recommendations from the audit project.  
- A further snap shot audit of elective Hip surgery was undertaken in September 2014 addressed gaps in compliance with guidelines, clinical pathways and complications that delayed discharge and highlighting the underlying issues that were resulting in increased length of stay, and complications associated with medication. |

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**Research approved by a research ethics committee**

The number of patients receiving relevant health services provided or sub-contracted by Chelsea and Westminster Healthcare NHS FT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 3377.

We recruited 3,377 patients to ethically approved, NIHR Portfolio adopted studies in FY 2014/15.

**Goals agreed with commissioners (CQUINs)**

A proportion of Chelsea and Westminster Hospital NHS Foundation Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Chelsea and Westminster Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS...
services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 months period are available electronically by contacting Leigh.Marsh@chelwest.nhs.uk.

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of the Trust’s income to the achievement of local quality improvement goals.

In 2014/15, income equal to 2.5% of the value of our main contract, which covers most of our NHS services, was conditional on achieving CQUIN goals agreed with our main commissioner, the North West London Clinical Commissioning Collaborative. Some of these schemes were nationally mandated, while the rest were developed locally. The schemes covered the following areas:

**Table 8: Coverage of CQUINS**

<table>
<thead>
<tr>
<th>National</th>
<th>Local</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expansion of Friends &amp; Family Test (FFT): timely feedback around patient experience.</td>
<td>• Improving timeliness of information given to GPs, shared patient records and information systems</td>
</tr>
<tr>
<td>• Ensure hospitals deliver high quality care to people with dementia</td>
<td>• Improving the effectiveness of emergency care and supporting care for patients outside hospital</td>
</tr>
<tr>
<td>• Improving collection of data for the NHS Safety Thermometer and reducing harm caused by Pressure Ulcers</td>
<td>• Improving the effectiveness of planned care and supporting improved pathways</td>
</tr>
<tr>
<td></td>
<td>• Planning and implementation of seven day services</td>
</tr>
<tr>
<td></td>
<td>• Improving access to services and advice for GPs and Patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialised services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improving clinical reporting of specialised services through dashboards</td>
</tr>
<tr>
<td>• Identification and improved reporting of specialised endocrinology</td>
</tr>
<tr>
<td>• Increase in retinopathy of prematurity screening</td>
</tr>
<tr>
<td>• Development of a specialised Orthopaedics Network</td>
</tr>
<tr>
<td>• Identification and improved reporting of burns and reducing the length of stay for burns patients</td>
</tr>
<tr>
<td>• Improving timeliness of obtaining a tertiary level fetal medicine opinion</td>
</tr>
<tr>
<td>• Planning and implementation of seven day services</td>
</tr>
<tr>
<td>• Increasing the availability of and recruitment of patients to clinical studies for HIV</td>
</tr>
<tr>
<td>• Improved pathway for stable HIV patients and the development of telemedicine.</td>
</tr>
</tbody>
</table>

We achieved 86% of our Local and National CQUIN-related goals in 2014/15, equating to a payment of £3.3m out of a maximum of £3.9m and we achieved 92% of our Specialist Commissioning CQUIN-related goals in 2014/15 equating to a payment of £1.4m out of a maximum of £1.5m.

Overall, we achieved 88% of our CQUIN-related goals in 2014/15 for which we received a payment of £4.7m out of a maximum of £5.4m.

This information is subject to final confirmation by the North West London and NHS England commissioners and is expected by June 2015.
Care Quality Commission

Chelsea and Westminster Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is complete.

Chelsea and Westminster Hospital NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Chelsea and Westminster Hospital NHS Foundation Trust during 2014/15.

Chelsea and Westminster Hospital NHS Foundation Trust has not participated in any special reviews or special investigations by the CQC during the reporting period.

Secondary Uses Service information (SUS)

Chelsea and Westminster Hospital NHS Foundation Trust submitted 787,916 records during April 2014 to January 2015 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

| The % of records in the published data which included the patient's valid NHS number was | 95.2% for admitted patient care  
90.3% for outpatient care and  
88.1% for accident and emergency care |
| --- | --- |
| The % of records in the published data which included the patient's valid NHS number was | 98.3% for admitted patient care;  
99.1% for outpatient care; and  
98.8% for accident and emergency care. |

Information Governance Assessment Report

The Chelsea and Westminster Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 85% and was graded Green—Satisfactory.

Clinical coding audit

Chelsea and Westminster Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 3.2% for the Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts HRG group and 1.0% for the Musculoskeletal disorders HRG group.

The results should not be extrapolated further than the actual sample audited. The sample was 190 Finished Consultant Episodes (FCEs)—94 FCEs from the Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare HRG group and 96 FCEs from the Musculoskeletal disorders HRG group.
Improving data quality

Chelsea and Westminster Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Introduce further improvements to the patient administration system to improve recording of the patient pathway. Those to be undertaken early in the financial year are relevant to 18 weeks, Cancer, Planned Procedures with a Threshold (PPwT) and outpatient bookings.

- Audit data quality of key quality and performance indicators early in the financial year as part of the internal audit programme. The areas to be covered are Cancer, A&E waiting times, 18 weeks, C.diff/MRSA and Learning Difficulties indicators.

- Standardise processes for routine local auditing of key indicators.

- Agree a mechanism for reporting to Trust Board on the data quality of each key indicator.

- Formalise the sign-off procedure for all reports issued externally; focusing on reports and KPIs issued to our regulators (Monitor and CQC), followed by other indicators or reports that the Board receive on a regular basis. The second phase will cover all other external reporting ie local contract KPIs. The review will include assessment of the sign off process to ensure this is both timely and appropriate.

- Formalise the sign-off procedure for internal reports by proposing roles to sign-off the relevant reports. Once this is agreed, it will be documented as part of the production process.
### Reporting against core indicators

The following data outlines the Trust performance on a selected core set of Indicators. Comparative data shown is sourced from the Health and Social Care Information Centre where available.

**Table 9: Performance against core indicators**

| Indicator                                                      | From local Trust data | From Health and Social Care Information Centre | Comments |
|                                                               |                       |                                           |          |
|                                                               | 2013/14               | 2014/15                                    |          |
| Summary hospital-level mortality indicator (“SHMI”)           | 0.813                 | 0.811                                      |          |
|                                                               | (3—‘lower than expected’) | (3—‘lower than expected’)                   |          |
|                                                               | N/A                   | Oct13–Sep14                                |          |
|                                                               | (Latest data is Oct13–Sep14) |                               |          |
| Most recent results for Trust                                 | 0.597                 | 1.198                                      |          |
|                                                               | (3—‘lower than expected’) | (1—‘higher than expected’)                  |          |
| Time period for most recent Trust results                     | Oct13–Sep14           |                                            |          |
| Best result nationally                                        | 1                     |                                            |          |
| Worst result nationally                                       | 1                     |                                            |          |
| National average                                              | 25.3%                 |                                            |          |
| Comments                                                      | • Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: the Trust has consistently shown good performance with regards to mortality  
• Chelsea and Westminster Hospital NHS FT intends to take the following action to improve this indicator and the quality of its services: reviewing this indicator for individual diagnosis groups, improving processes and further reducing deaths. |

| Patient deaths with palliative care coded                      | 26.8%                 | 33.2%                                      |          |
|                                                               | N/A                   | Oct13–Sep14                                |          |
|                                                               | (Latest data is Oct13–Sep14) |                               |          |
| Most recent results for Trust                                 | N/A                   |                                            |          |
| Time period for most recent Trust results                     | Oct13–Sep14           |                                            |          |
| Best result nationally                                        | N/A                   |                                            |          |
| Worst result nationally                                       | N/A                   |                                            |          |
| National average                                              | 25.3%                 |                                            |          |
| Comments                                                      | • Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: the trust has put in staff and processes to focus on providing excellent end of life care  
• Chelsea and Westminster Hospital NHS FT has taken the above steps to improve this indicator and the quality of its services. |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>From local Trust data</th>
<th>From Health and Social Care Information Centre</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2014/15</td>
<td>Most recent results for Trust</td>
</tr>
<tr>
<td>Patient reported outcome measures scores for groin hernia surgery: Adjusted Average Health Gain</td>
<td>EQ-5D index 0.051 EQ.VAS - 5.791</td>
<td>N/A (Latest data is Apr14-Sep14)</td>
<td>Not available because of low volumes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>EQ-VAS -5.791</td>
</tr>
<tr>
<td>Patient reported outcome measures scores for varicose vein surgery: Adjusted Average Health Gain</td>
<td>Not available because of low volumes</td>
<td>N/A (Latest data is Apr14-Sep14)</td>
<td>Not available because of low volumes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Chelsea and Westminster Hospitals NHS FT considers that this data is as described.
- Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve this indicator and the quality of its services: re-launching the Patient Reported Outcome Measure initiative during 2015/16 with a focus on improving previously low levels of questionnaires being completed by our patients compared to peers. Local and National results will be presented by clinical leads at Surgery Directorate meetings.

5 Apr14–Sep14 Includes ISTCs
<table>
<thead>
<tr>
<th>Indicator</th>
<th>From local Trust data</th>
<th>From Health and Social Care Information Centre</th>
<th>Time period for most recent Trust results</th>
<th>Best result nationally</th>
<th>Worst result nationally</th>
<th>National average</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reported outcome measures scores for hip replacement surgery:</td>
<td>EQ-SD index 0.483</td>
<td>EQ-SD index 0.501</td>
<td>Apr14–Sep14</td>
<td>EQ-SD index 0.501</td>
<td>EQ-SD index 0.350</td>
<td>EQ-SD index 0.442</td>
<td>• Chelsea and Westminster Hospitals NHS FT considers that this data is as described</td>
</tr>
<tr>
<td>Hip Replacement Primary Adjusted Average Health Gain</td>
<td>EQ VAS 15.927</td>
<td>EQ VAS 16.537</td>
<td></td>
<td>EQ VAS 5.380</td>
<td>Oxford Hip Score 18.537</td>
<td>Oxford Hip Score 21.922</td>
<td>• Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve this indicator and the quality of its services: re-launching the Patient Reported Outcome Measure initiative during 2015/16 with a focus on improving previously low levels of questionnaires being completed by our patients compared to peers. Local and National results will be presented by clinical leads at Surgery Directorate meetings.</td>
</tr>
<tr>
<td></td>
<td>Oxford Hip Score 23.227</td>
<td>Oxford Hip Score 25.418</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient reported outcome measures scores for knee replacement surgery:</td>
<td>N/A</td>
<td>EQ-SD index 0.394</td>
<td>Apr14–Sep14</td>
<td>EQ-SD index 0.350</td>
<td>EQ-SD index 0.283</td>
<td>EQ-SD index 0.328</td>
<td>• Chelsea and Westminster Hospitals NHS FT considers that this data is as described</td>
</tr>
<tr>
<td>Knee Replacement Primary Adjusted Average Health Gain</td>
<td>(Latest data is Apr14-Sep14)</td>
<td>EQ VAS 12.508</td>
<td></td>
<td>EQ VAS 5.380</td>
<td>EQ VAS 0.665</td>
<td>EQ VAS 6.369</td>
<td>• Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve this indicator and the quality of its services: re-launching the Patient Reported Outcome Measure initiative during 2015/16 with a focus on improving previously low levels of questionnaires being completed by our patients compared to peers. Local and National results will be presented by clinical leads at Surgery Directorate meetings.</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>EQ VAS 0.249</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Latest data is Apr14-Sep14)</td>
<td>EQ VAS -0.665</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8,9</td>
<td>8,9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 Hip Replacement Revision Adjusted Average Health Gain: Not available because of low volumes
7 Hip Replacement Revision Adjusted Average Health Gain
8 Apr14–Sep14 Includes ISTCs
9 Knee Replacement Revision Adjusted Average Health Gain: Not available because of low volumes
10 Knee Replacement Revision Adjusted Average Health Gain
<table>
<thead>
<tr>
<th>Indicator</th>
<th>From local Trust data</th>
<th>From Health and Social Care Information Centre</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2014/15</td>
<td>Most recent results for Trust</td>
</tr>
<tr>
<td>Readmitted to the trust within 28 days of being discharged from hospital (Age 0-15)</td>
<td>8.12% $^{11}$</td>
<td>8.26% $^{11}$</td>
<td>6.09% $^{12}$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmitted to the trust within 28 days of being discharged from hospital (Age 16+)</td>
<td>12.90% $^{11}$</td>
<td>9.99% $^{11}$</td>
<td>11.05% $^{12}$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^{11}$ Derived from Trust Qlikview Dashboard and Excludes: Non-PbR spells, Cancer, radiotherapy, chemotherapy, patients under 4 years, obstetric medicine, renal dialysis, gastro HIV, readmissions following self-discharge, A&E obs, rehab

$^{12}$ Apr11–Mar12 (next publication expected early 2016)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Most recent results for Trust</th>
<th>Time period for most recent Trust results</th>
<th>Best result nationally</th>
<th>Worst result nationally</th>
<th>National average</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Responsiveness to the personal needs of its patients                    | Not available | Not available | 66.1<sup>13</sup> | Jul12–Jun13<sup>13</sup> | 84.4<sup>14</sup> | 57.4<sup>14</sup> | 68.1<sup>14</sup> | • Chelsea and Westminster Hospitals NHS FT considers that this data is as described
  • Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve this indicator and the quality of its services: reviewing all areas around patient experience, PROMs (see above) and Friends and Family Tests to improve processes surrounding overall patient experience. |
| Staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends. | 85% | 76.9%<sup>14</sup> | 76.9%<sup>15</sup> | NHS National Staff Survey 2014 | 92.8%<sup>15</sup> | 38.2%<sup>15</sup> | 65.2%<sup>15</sup> | • Chelsea and Westminster Hospitals NHS FT considers that this data is as described
  • Chelsea and Westminster Hospital NHS FT intends to take the following actions to improve this indicator and the quality of its services: regularly reviewing staff and management training and appraisal data and their relationship to staff turnover, to improve staff management processes with a view to improve staff experience and staff turnover/stability. |
| Patients who were admitted to hospital and who were risk assessed for venous thromboembolism | 95.9% | 96.5% | Feb’15: 95.8% Q3 14-15: 96.9% | Feb’15 (Month) Q3 14/15 | Feb’15: 100% Q3 14-15: 100% | Feb’15: 75.0% Q3 14-15: 81.2% | Feb’15: 96.0% Q3 14-15: 96.0% | • Chelsea and Westminster Hospitals NHS FT considers that this data is as described for the following reasons: the trust has put in place systems and processes to support the VTE risk assessment process.
  • Chelsea and Westminster Hospital NHS FT has taken the above steps to improve this indicator and the quality of its services. |

<sup>13</sup> Jul12–Jun13 (data no longer available from Department of Health)
<sup>14</sup> National Survey Jan15–Mar15
<sup>15</sup> 2014 Staff Survey
<table>
<thead>
<tr>
<th>Indicator</th>
<th>From local Trust data</th>
<th>From Health and Social Care Information Centre</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2014/15</td>
<td>Most recent results for Trust</td>
</tr>
<tr>
<td>Rate per 100,000 bed days of cases of <em>C. difficile</em> infection reported within the trust amongst patients aged 2 or over</td>
<td>7.41</td>
<td>6.31</td>
<td>7.0</td>
</tr>
<tr>
<td>Rate of patient safety incidents reported within the trust and the number and percentage of such patient safety incidents that resulted in severe harm or death: <em>Incidents per 1000 days</em></td>
<td>35.02</td>
<td>35.07</td>
<td>50.77</td>
</tr>
<tr>
<td></td>
<td>0.08% resulted in severe harm or death</td>
<td>0.16% resulted in severe harm</td>
<td>0.03% resulted in death</td>
</tr>
</tbody>
</table>

16 Apr14–Sep14
Part 3: Other information

Our performance

Our performance on key national priorities in 2014/15

The Trust met most of the national priority targets tracked by Monitor, the independent regulator of Foundation Trusts.

Table 10: Performance on key national priorities in 2014/15

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Performance 2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of <em>Clostridium difficile</em></td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>All cancers: 31-day wait from diagnosis to first treatment</td>
<td>98.6%</td>
<td>96%</td>
<td>99.7%</td>
</tr>
<tr>
<td>All cancers: 31-day wait for second or subsequent treatment: surgery</td>
<td>100%</td>
<td>94%</td>
<td>93.3%</td>
</tr>
<tr>
<td>All cancers: 31-day wait for second or subsequent treatment: anti-cancer drug treatments</td>
<td>100%</td>
<td>98%</td>
<td>100.0%</td>
</tr>
<tr>
<td>All cancers: 62-day (urgent GP referral to treatment) wait for first treatment</td>
<td>92%</td>
<td>85%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Cancer: two week wait from referral to date first seen comprising all cancers</td>
<td>95.9%</td>
<td>93%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Referral to treatment waiting times &lt;18 weeks—admitted**</td>
<td>91.0%</td>
<td>90%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Before process improvements (Apr 2014—Nov 2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After process improvements (Dec 2014—Mar 2015)</td>
<td></td>
<td></td>
<td>91.6%</td>
</tr>
<tr>
<td>Referral to treatment waiting times &lt;18 weeks—non-admitted**</td>
<td>97.7%</td>
<td>95%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Referral to treatment waiting times &lt;18 weeks—Incompletes**</td>
<td>92.1%</td>
<td>92%</td>
<td>92.3%</td>
</tr>
<tr>
<td>A&amp;E: Total time in A&amp;E ≤4hrs</td>
<td>98.3%</td>
<td>95%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>Compliant</td>
<td>Compliant</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>

Notes

- All indicators in the above table are sourced from Trust’s Access Dashboard with the exception of Incidence of *Clostridium difficile* which is sourced from the Trust’s Patient Safety Dashboard; targets are national targets or have been set by DH
- For the Cancer indicators there may be a minimal variance with OpenExeter due to OpenExeter being updated in later months by other Trusts where patients have transferred to and or from this Trust

* All cancers: 31-day wait for second or subsequent treatment: surgery is showing lower than target but due to small numbers this is not reflected as a missed target nationally.

** Please see commentary directly below in relation to Referral to Treatment performance reporting.

Referral to Treatment performance reporting

The Trust assures the quality and accuracy of elective waiting time data through a combination of regular daily and weekly meetings to focus on elective waiting time data and review and sign-off procedures for performance data. The Trust has an advanced feed from the PAS system which is available throughout the Trust and updated daily. Divisional staff and the Information team regularly review a suite of reports including more advanced information for elective waiting times, including drill down to patient level information.

Patient pathways are validated to ensure that the quality of the data is accurate and the Trust has taken part in a national validation programme focusing on waiting lists during 2014/15. The sign-off and review process includes review at Senior Operational Group, Trust Executive, Quality Committee and Trust Board.
In agreement with its Commissioners, the Trust undertook a series of initiatives in Quarter 2 and 3 to reduce the waiting list, and in particular a backlog of long waiting patients. This resulted in a planned breach of the admitted 18 week RTT target during the first three quarters of the year, shown in an average admitted performance of 83.5% from April to November. Following completion of the initiative, our performance is again above the 90% target at an average of 91.6% for December to March.

During Quarter 2 and 3, we identified a number of issues with 18 week RTT data quality, and put in place an action plan to address issues identified. This included engaging additional external support from NHS Interim Management And Support (IMAS) and Intensive Support Team (IST) to assure that we are doing the right things in terms of our approach to RTT compliance, and ultimately patient care. The IST undertook a deep dive review into the outpatient booking processes, elective inpatient admissions processes and the reporting at the Trust, in order to review accuracy of data and support sustainable delivery of the Referral to Treatment Standard and the recommendations arising have formed part of an action plan to improve internal processes, as well as the quality and accuracy of data.

These findings, together with the assurance work undertaken by Deloitte LLP in respect of the Quality Report 2014/15, have resulted in qualified conclusion on the accuracy of the reported 18 week Referral to Treatment incomplete pathway indicator. Due to the nature of the three RTT indicators, these findings also indicate related issues with the admitted and non-admitted indicators.

Although we have made progress through the significant amount of work undertaken over the second half of 2014/15 to review and improve systems and processes to improve the quality and accuracy of data, improving data quality remains an area of focus, with ongoing actions including:

- Introduce further improvements to the patient administration system to improve recording of the patient pathway.
- Audit data quality of key quality and performance indicators as part of the internal audit programme and standardise processes for routine local auditing of key indicators.
- Remind staff of data entry procedures, provide update training and refresh of national RTT guidance and the Trust’s local access policy

In the medium term, the Trust plans to introduce a new Patient Administration System (PAS) which will provide an opportunity to embed data quality as we design policies and procedures for the new system, including greater use of automated data checks.
Our performance on local performance indicators

The table below sets out our performance on local quality indicators for 2014/15, grouped by the domains of Patient Safety, Clinical Effectiveness and Patient Experience. The data below reflects a data snapshot from the Trust’s Quality Dashboard as at week ending 24/04/2015 unless otherwise stated. Detail on key measures and the actions being taken are then explored in more detail in the Quality performance indicators section on page 54.

Where possible we have sought to reconcile to these figures throughout the document to give a consistent ‘point in time’ view wherever these measures are discussed. At the same time we recognise that in some cases these figures have been subject to further movement as year-end figures are confirmed and validated. Where there have been significant changes since the data snapshot we have updated the figure and provided the source.

Table 11: Performance on local performance indicators

<table>
<thead>
<tr>
<th>Subject</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
<th>Target 2015/16</th>
<th>Commentary and Notes on Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA bacteraemia cases</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>MRSA policy to ensure all newly MRSA positive patients receive decolonisation treatment, and old MRSA patients who remain MRSA positive will have MRSA suppression therapy for the duration of their hospitalisation. Target as set by DH.</td>
</tr>
<tr>
<td>C. difficile cases</td>
<td>73</td>
<td>17</td>
<td>15</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>These targets are those set by the Department of Health; 7 shown within NWL CCG Quality Schedule.</td>
</tr>
<tr>
<td>Hand hygiene audit—% completion rates</td>
<td>89</td>
<td>94</td>
<td>96</td>
<td>91.1</td>
<td>100</td>
<td>87</td>
<td>100</td>
<td>All clinical areas (In and Outpatient) are required to complete hand hygiene audits ie completion target of 100%. Data sourced from final year-end analysis by Infection Control Team, week commencing 11 May 2015. See Infection Control on page 54 for more information on performance this year and how this shortfall against target is being addressed.</td>
</tr>
<tr>
<td>Hand hygiene—% compliance rates</td>
<td>85</td>
<td>94</td>
<td>95</td>
<td>96.5</td>
<td>98</td>
<td>97.3</td>
<td>&gt;90</td>
<td>98% is an internal target.</td>
</tr>
<tr>
<td>Inpatient falls/occupied 1k bed days</td>
<td>-</td>
<td>3.19&lt;sup&gt;17&lt;/sup&gt;</td>
<td>2.62</td>
<td>3.20</td>
<td>3</td>
<td>3.31</td>
<td>&lt;3</td>
<td>This is an internal target.</td>
</tr>
</tbody>
</table>

<sup>17</sup> Cumulative rate reported at the end of 2011/12
### Performance 2014/15

<table>
<thead>
<tr>
<th>Subject</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
<th>Target 2015/16</th>
<th>Commentary and Notes on Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety incident reporting rate—incidents per 100 admissions</td>
<td>7.1</td>
<td>6.6</td>
<td>6.7</td>
<td>7.2</td>
<td>8.5</td>
<td>7.63</td>
<td>8.5</td>
<td>The target is an internal benchmark</td>
</tr>
<tr>
<td>Number and rate of patient safety incidents reported within Trust (number per 100 admissions)</td>
<td>-</td>
<td>Num=4,998</td>
<td>Num=5,162</td>
<td>Num=5,133</td>
<td>8.5</td>
<td>Num=5,777</td>
<td>Rate=7.57</td>
<td>&gt;8.5</td>
</tr>
<tr>
<td>Number of patient safety incidents resulting in severe harm or death and % of total incidents</td>
<td>-</td>
<td>2 (0.04% of total incidents)</td>
<td>3 (0.06% of total incidents)</td>
<td>1 (0.02% of total incidents)</td>
<td>0</td>
<td>1118 (0.16% of total incidents)</td>
<td>0</td>
<td>The target is an internal benchmark. See ‘Learning from mistakes to improve safety’ on page 60 for more information on 2014/15 performance and how this is being addressed</td>
</tr>
<tr>
<td>Never Events</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>% of adult inpatient (excluding maternity) observation charts scored accurately (CEWS/S)</td>
<td>81</td>
<td>89</td>
<td>Not measured</td>
<td>Not measured</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Resuscitation calls (cardiac arrest) due to failure to escalate</td>
<td>-</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>Sourced from Trust’s portal—individual KPI; The target is an internal benchmark</td>
</tr>
<tr>
<td>% patients with International Normalised Ratio (INR) less than 5</td>
<td>97</td>
<td>97</td>
<td>97</td>
<td>97</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Sourced from Trust’s portal—individual KPI</td>
</tr>
<tr>
<td>Hospital acquired preventable cases of venous thromboembolism (VTE)</td>
<td>-</td>
<td>1019</td>
<td>13</td>
<td>5</td>
<td>7</td>
<td>820</td>
<td>0</td>
<td>The target is an internal benchmark; Our ultimate target will remain as zero and we plan to reduce our number of cases by a further 25% in 2015/16 as part of our aim to have no hospital associated preventable VTE events</td>
</tr>
</tbody>
</table>

---

18 Updated to reflect final validated full-year position based on updates from Service Leads 22 May 2015 (initial end of year position per review draft of Quality Report was 9 incidents)
19 7 months data
20 Updated to reflect final validated full-year position based on updates from Service Leads 22 May 2015 (initial end of year position per review draft of Quality Report was 6 cases)
<table>
<thead>
<tr>
<th>Subject</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
<th>Target 2015/16</th>
<th>Commentary and Notes on Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality (Hospital Standardised Mortality Indicator—HSMR)</td>
<td>85</td>
<td>79</td>
<td>83</td>
<td>73%²¹</td>
<td>Top 10%²²</td>
<td>88.2</td>
<td>Top 10%²²</td>
<td>Sourced from Trust’s Patient Safety Dashboard; Target to remain in ‘Lower than expected banding’ and top 10% in England</td>
</tr>
<tr>
<td>% urgent surgery cases operated on within 24 hours of booking</td>
<td>99²³</td>
<td>95</td>
<td>98</td>
<td>96.2</td>
<td>100</td>
<td>94.8</td>
<td>95.0</td>
<td>While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator</td>
</tr>
<tr>
<td>% expedited surgery cases operated on within 4 days of booking</td>
<td>95²³</td>
<td>99</td>
<td>100</td>
<td>99.9</td>
<td>100</td>
<td>N/A</td>
<td>100</td>
<td>While we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%. There is no national definition for this indicator</td>
</tr>
<tr>
<td>Urinary catheters continuing care—% compliance with Care bundles</td>
<td>-</td>
<td>92</td>
<td>92</td>
<td>92.9</td>
<td>95</td>
<td>9624</td>
<td>95.0</td>
<td>We aim to reach 95%</td>
</tr>
<tr>
<td>Central line continuing care—% compliance with Care bundles</td>
<td>-</td>
<td>90</td>
<td>94</td>
<td>96.6</td>
<td>95</td>
<td>9825</td>
<td>95.0</td>
<td>We continue to work towards achieving 100% compliance having made much progress this year.</td>
</tr>
<tr>
<td>Peripheral line continuing care—% compliance with Care bundles</td>
<td>-</td>
<td>86</td>
<td>80</td>
<td>85.1</td>
<td>95</td>
<td>8726</td>
<td>95.0</td>
<td>We continue to aim high in line with the other continuing care indicators</td>
</tr>
<tr>
<td>Numbers of hospital pressure ulcers—grade 2</td>
<td>120</td>
<td>47</td>
<td>70</td>
<td>79</td>
<td>59</td>
<td>109</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

²¹ Dr Foster Jul 12 to Jun 13  
²² Of all non-specialist acute providers with the lowest HSMR  
²³ Average Nov 10 to Mar 11  
²⁴ Based on analysis of final year position by Infection Control Team, week ending 15 May 2015 (initial end of year position per review draft of Quality Report was 93.2%)  
²⁵ Based on analysis of final year position by Infection Control Team, week ending 15 May 2015 (initial end of year position per review draft of Quality Report was 99.1%)  
²⁶ Based on analysis of final year position by Infection Control Team, week ending 15 May 2015 (initial end of year position per review draft of Quality Report was 84.9%)
<table>
<thead>
<tr>
<th>Subject</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
<th>Target 2015/16</th>
<th>Commentary and Notes on Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers ulcers—grade 3</td>
<td>58 (grades 3 &amp; 4)</td>
<td>31 (grades 3 &amp; 4)</td>
<td>38 (grades 3 &amp; 4)</td>
<td>11</td>
<td>8</td>
<td>1827 (grades 3 &amp; 4)</td>
<td>&lt;3.6</td>
<td>Sourced from Trust’s Patient Safety Dashboard; Prior to 2013/14 Pressure ulcers grades 3 and 4 were reported together, so previous years’ figures reflect this. In 2013/14 we decided to monitor and report these separately; we have since reverted back Please see ‘Priorities for improvement’ on page 9 for more information on our 2014/15 performance and the actions we are taking to improve this as a Quality Report Priority for 2015/16</td>
</tr>
<tr>
<td>Numbers of hospital pressure ulcers—grade 4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>0</td>
<td>See above</td>
<td>See above</td>
<td>See above</td>
</tr>
<tr>
<td>Numbers of hospital pressure ulcers—unstageable</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26</td>
<td>20</td>
<td>29</td>
<td>20</td>
<td>The target is an internal benchmark</td>
</tr>
<tr>
<td>% patients nutritionally screened on admission</td>
<td>80</td>
<td>95</td>
<td>85</td>
<td>91.7</td>
<td>90</td>
<td>80.2</td>
<td>90.0</td>
<td>The target is an internal benchmark</td>
</tr>
<tr>
<td>% patients in longer than a week who are nutritionally rescreened</td>
<td>30</td>
<td>60</td>
<td>71</td>
<td>78.4</td>
<td>90</td>
<td>66.8</td>
<td>90.0</td>
<td>The target is an internal benchmark</td>
</tr>
</tbody>
</table>

**Patient Experience (INDICATORS SOURCED FROM THE TRUST’S PATIENT EXPERIENCE DASHBOARD, WITH THE EXCEPTION OF COMPLAINTS DATA)***28*

| % complaints reopened | 9 | 4 | 5 | 4 | N/A | 7 | <5% | There is no national definition for this indicator. These are consistently low numbers and we will report performance monthly; the target is an internal benchmark. |
| Complaints upheld by the Ombudsman (PHSO) | - | 0 | 0 | 3 | 1 | 4 partially upheld | 0 | All complaints upheld by the Ombudsmen will be monitored and reported. For 2013/14, we started monitoring the number of complaints referred to the Ombudsmen. In addition to 4 partially upheld, 3 were not upheld and 0 complaints were fully upheld. |
| No of complaints referred to Ombudsman | - | - | - | 10 | 7 | 8 | N/A | 1 complaint referred relates to FY 2014/15. Remaining 7 are for previous years, 2011-2014 inclusive. |

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27 Updated based on analysis of final year position by Tissue Viability Team, week ending 15 May 2015 (initial end of year position per review draft of Quality Report was 17)  
28 2014/15 Complaints Data is as provided by the Trust Complaints Team, and reflects year end position as calculated week ending 22 May 2015
### Subject

<table>
<thead>
<tr>
<th>Subject</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target 2014/15</th>
<th>Performance 2014/15</th>
<th>Target 2015/16</th>
<th>Commentary and Notes on Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Complaints responded to within target time (formal complaints responded to in 25 working days)</td>
<td>83</td>
<td>80</td>
<td>81</td>
<td>82.2</td>
<td>N/A</td>
<td>70</td>
<td>90</td>
<td>We will monitor the initial contact with complainants. We monitor performance every week and month and we will be relentless in our focus on experience and feedback.</td>
</tr>
<tr>
<td>Complaints (type 1 and type 2)—communication</td>
<td>260</td>
<td>198</td>
<td>179</td>
<td>227</td>
<td>Personal: 90 Comms Process: 9029</td>
<td>258</td>
<td>To be set via Patient Experience Group</td>
<td></td>
</tr>
<tr>
<td>Complaints (type 1 and type 2)—discharge</td>
<td>108</td>
<td>49</td>
<td>34</td>
<td>23</td>
<td>N/A</td>
<td>27</td>
<td>To be set via Patient Experience Group</td>
<td></td>
</tr>
<tr>
<td>Complaints (type 1 and type 2)—attitude and behaviour</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>176</td>
<td>120</td>
<td>243</td>
<td>To be set via Patient Experience Group</td>
<td></td>
</tr>
<tr>
<td>PLACE Scores—Cleanliness</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95.36%</td>
<td>97.25</td>
<td>98.96</td>
<td>-</td>
<td>Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments.</td>
</tr>
<tr>
<td>PLACE Scores—Food &amp; Hydration</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>82.92%</td>
<td>88.79</td>
<td>93.38</td>
<td>-</td>
<td>The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care—cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink. Changes in the forthcoming 2015 assessment: dementia elements will be scored and the final score will also be provided on a ward/departmental basis. (please note targets for 2014/15 are the national average figures)</td>
</tr>
<tr>
<td>PLACE Scores—Privacy, Dignity &amp; Wellbeing</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90.72%</td>
<td>87.73</td>
<td>95.43</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>PLACE Scores—Condition Appearance &amp; Maintenance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>88.27%</td>
<td>91.97</td>
<td>93.28</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

---

29 Target broken down into two individual areas
Review of quality performance

How the Trust identifies local improvement priorities

We are committed to understanding and responding to what our patients tell us about their experiences of care at the Trust and there are several ways in which we actively seek the views of our stakeholders to determine our priorities for quality improvement.

As a Foundation Trust, we have the benefit of a well-established and active Council of Governors. The Council represents the views of patients, public and staff to ensure that their views and experiences are heard. Governors hold frequent ‘Meet a Governor’ sessions for this purpose. Governors also take part in senior nurse and midwife clinical rounds to find out for themselves how care is delivered to patients. When things are not right they make a note of them and check to see what progress has been made to rectify them at subsequent visits. In their role as a critical friend the governors are consulted on many aspects of the hospital’s activities and may participate in the work of teams set up to carry forward particular projects. The perspective they bring is invaluable.

The Council of Governors Quality Sub-Committee is an important source of views and feedback and has a specific remit to help identify priorities for quality and members advise on the content and focus of the Quality Report and plans for quality improvement.

Governors on the Quality Sub Committee oversee our Quality Priorities and Quality Indicators and a governor member sits on both the Patient Experience Committee and the Staff Experience Committee.

Members of the Council of Governors Quality Sub Committee include patients, a representative from Healthwatch Central West London and our commissioners (CWHH). They not only feedback the experiences of those they represent in and outside meetings, but also their own, where relevant. They have also contributed to the discussions on our Quality Report priorities for 2015/16 and chosen their own quality indicator which will be audited by external auditors.

We seek clinicians’ and managers’ views via the Quality Committee of the Trust Board. And we take an inclusive approach to business planning, ensuring that all staff have the opportunity to be involved in the process. The feedback from open meetings with staff and governors during business planning is considered in the content of the Quality Report.

We actively look at complaints, incidents and feedback from service users to identify trends and areas where we can improve our services.

The various patient forums in the Trust influence how we design and deliver our services with an emphasis on quality. They represent specific areas and include the Patient Led Assessment of the Care Environment (PLACE) HIV Patient Forum, the Joint Research Committees, Bariatric Patient Support, the Stroke Forum, the Ex-Intensive Care Unit Patients Forum and the Learning Disabilities Steering Group.
Quality performance indicators

This section provides an explanation about some of our key quality performance indicators. So we have grouped some of the key indicators we measure into themes here and described how they contribute to quality.

Two groups of indicators are mandated by the Department of Health and our regulator Monitor—and one group we measure is local to our patient needs. We select our local indicators for monitoring to look at care that we consider important for us to measure in detail.

Care Quality Commission (CQC) visits and assessments

In July 2014 we had our CQC inspection, our first of the new style inspections, with 40 inspectors attending the Trust for 4 days. They visited all areas of the Trust to speak to staff and patients, as well as undertaking a robust interrogation of our data and policies. Listening events were held for staff and patient groups.

Our final report was received in October 2014 and the overall findings are shown in the table below.

Table 12: High level summary of CQC findings, October 2014

<table>
<thead>
<tr>
<th>Service</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Services</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Surgery</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity &amp; Gynaecology</td>
<td>Good</td>
</tr>
<tr>
<td>Services for Children and Young People</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Outpatients and Diagnostic Imaging</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>HIV and sexual health services</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Overall Finding</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

As a result of this, an action plan has been developed and implemented. Our aim has been to complete all the actions that can be completed at this stage, by the end of March 2015. There are a small number of exceptions to this—which need to be addressed over a longer period. These include:

- Emergency Department environment being addressed through the Trust’s current Emergency Department build, which has commenced and will conclude in 2016
- medical staffing for the Emergency Department, in line with the above
- addressing recommendations in relation to electronic medical record as part of the Electronic Patient record (EPR) being delivered as part of the WMUH integration
- integration with mental health services through placement of patients with Central North West London NHS Foundation Trust.

We subsequently held a peer review exercise in early April 2015, and are awaiting the results at the time of writing.

Infection control

Patients are more vulnerable to infection when they are in hospital and reducing the risk of this is a top priority for us. There are some healthcare associated infections that we have a
statutory responsibility to report on. These include *Methicillin Resistant Staphylococcus Aureus (MRSA)* bacteraemia and *Clostridium difficile (C.difficile or C.diff)*.

The Department of Health sets targets to reduce the number of new cases of these infections each year. Whenever a patient becomes infected, we complete a detailed review to find out how it happened and see what changes to our practice we may need to make.

Last year the Department of Health MRSA target was for zero hospital cases. We had zero cases and next year we aim to have zero. The equivalent target for *C.difficile* was for a maximum of eight hospital cases. We had eight cases and aim to achieve the Department of Health target of less than seven cases next year. We have shown that we can reduce the incidence of these infections by good infection prevention and control, making sure that everyone is involved in this.

**Table 13: Number of instances of MRSA and Clostridium difficile**

<table>
<thead>
<tr>
<th>Target Organisms</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>8</td>
</tr>
</tbody>
</table>

Thorough hand washing and good practice around the use of intravenous lines can help reduce the risk of infection. We train all our staff on hand hygiene and monitor compliance with this every month. Results are recorded in our online data management system, and all the information passed on to the Infection Prevention and Control Committee.

The completion rate for the monthly audit in 2014/15 was 87%. We want to achieve 100%. We will be looking to improve this compliance by making sure all areas have trained auditors around and by improving the timeliness of our reporting. We aim for 95% compliance with standards across all clinical areas. Our compliance rate for 2014/15 was 97%.

Another initiative that we have continued this year which has had an impact on improving practice is the Saving Lives Care ‘Bundles’ which were designed by the Department of Health (DH) in 2007. These are audit tools that are used to monitor the effective management of intravenous lines and urinary catheters. The use of each care bundle is checked regularly and the results are reported to the Infection Prevention and Control Committee and clinical divisions.

**Table 14: Compliance with Invasive device care bundles**

<table>
<thead>
<tr>
<th>Invasive Device Care Bundle</th>
<th>What is this?</th>
<th>Compliance for 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral venous catheters (PVC)</td>
<td>Tubes placed in smaller veins, and often referred to as a drip</td>
<td>87%</td>
</tr>
<tr>
<td>Central venous catheters (CVC)</td>
<td>Small tubes or catheters placed in large veins in the neck, chest, or groin</td>
<td>98%</td>
</tr>
<tr>
<td>Urinary catheters (UC)</td>
<td>Tubes inserted into the bladder to help a person to pass urine.</td>
<td>96%</td>
</tr>
<tr>
<td>Paediatric PVC</td>
<td>Tubes placed in smaller veins, and often referred to as a drip (for children)</td>
<td>81%</td>
</tr>
<tr>
<td>Paediatric CVC</td>
<td>Small tubes or catheters placed in large veins in the neck, chest, or groin (for children)</td>
<td>99%</td>
</tr>
</tbody>
</table>
Compliance with the PVC target is below target due to lapses in documentation, most commonly in the medical notes. An IV taskforce group has been set up in part to improve performance against this target.

**What has gone well this year?**

The Trust has invested in specialist software called ICNet designed to specifically help the Infection Control Team manage the infections around the hospital. This will be live from July 2015.

The Emergency Planning Officer has rolled out training for key staff including the Infection Control Team on how to safely put on and remove personal protective equipment (PPE) when suspected or confirmed cases of Ebola enter our hospital.

The Team have introduced ‘C. diff’ packs to improve ward staff compliance with the Trust *Clostridium difficile* policy. This ensures that patients with diarrhoea are medically assessed at an early stage. This also appears to have reduced the number of inappropriate specimens sent for testing in the lab and as such has contributed to reducing the number of *C. diff* cases helping us to achieve our target.

**Trips, slips and falls**

A fall is the main cause of death from injury among the over-75s in the UK and can lead to loss of confidence and social isolation. Falls cost the NHS £2.3 billion a year. Inpatient falls are measured per occupied 1,000 bed days. Our target against this measure was 3 and we achieved 3.31. It remains an ongoing priority for us to continue to reduce the number of falls, particularly those that cause harm.

**Figure 2: Patient Falls by Month by Degree of Harm, April 2014–March 2015**

Some of the risk factors for falls can be modified, and all patients who have had a fall are assessed for their risk of a subsequent fall and a care plan put in place. Both the risk assessment and care plan are electronic and readily available to patients, their carer’s and all staff caring for the patient at the bedside.
A Preventing Harm Group is in place and comprises of a multidisciplinary clinical and non-clinical team. This group regularly monitors falls, ensures audit and oversees the process that patients are assessed for their risk of falls.

The group have secured equipment such as low beds and falls alarms and made recommendations about changes in practice to reduce both the number and impact of falls.

Recognising and responding to clinical deterioration

The National Early Warning Score (NEWS) was introduced as a pilot in January 2013 on two wards. Following evaluation and adjustment it was rolled out across all adult inpatient areas with the exception of Maternity and Burns units later that year.

In line with NHS recommendations and to move towards a ‘common language’ the NEWS assists ward based staff to recognise deterioration in a patient’s condition, and to escalate and respond appropriately to deteriorating patients in a safe and consistent way. To improve the communication of deterioration between health care professionals the SBAR (Situation, Background, Assessment, Recommendations) communication tool was also introduced. This aims to promote a common language for communicating concerns, improve the transfer of clinical care by better handover of information.

An audit was undertaken was to measure the accuracy of the NEWS two months after the change from a previous system and assess adherence to the clinical escalation protocol. A second audit was conducted eight months post rollout by the Critical Care Outreach Team (CCOT). The table below shows the improvement of the accuracy of NEWS scoring from 77% to 90%.

### Table 15: Comparison of NEWS accuracy from 2013 and 2014 audits

<table>
<thead>
<tr>
<th>Comparison of news observations performed correctly</th>
<th>OVERALL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEPTEMBER 2013</strong> 2 months post roll out of NEWS</td>
<td></td>
</tr>
<tr>
<td>Number of patients episodes</td>
<td>All NEWS correct %</td>
</tr>
<tr>
<td>438</td>
<td>77</td>
</tr>
<tr>
<td><strong>MAY 2014</strong> 8 months post rollout</td>
<td></td>
</tr>
<tr>
<td>Overall 13% improvement in performing news observations with all elements performed correctly</td>
<td></td>
</tr>
</tbody>
</table>
Failure to calculate NEWS scores accurately and or failure to escalate promptly or to the appropriate teams

Over the last two years the number of adult inpatient cases where there has perceived to be a failure of either of the above criteria remains static at 18 cases per year excluding maternity and paediatrics. We are taking the following steps to improve this:

- Recognition training: Ongoing multi-professional training with the acute life threatening emergencies and recognition course (ALERT) and Bedside emergency assessment course (BEACH) for health care and maternity support workers
- Ongoing local NEWS training for ward areas
- Development of innovative acute care course using sequential simulation for ward-based nursing teams to address communication and confidence issues amongst nursing and health care support workers
- Development and trial of e-observation charting system

Improving tracheostomy care in adults

With the introduction of the NCEPOD report (2014) “On the Right Trach?” we have reviewed the recommendations of the report and have instigated the following:

- Reconvened a short life multi-professional tracheostomy working group to improve care of the adult with a tracheostomy.
- Reviewed all tracheostomy related incidents during 2014 and identified gaps and learning
- Updated and enhanced current core competencies for nurses managing tracheostomies for ward-based patients
- Critical care outreach team continue to deliver local ward based training for nurses as required
- Utilised the information and posters supplied by trachestomy.org.uk
- Reviewed and updated the adult tracheostomy guidelines
- Reinstated the tracheostomy study day for ward nurses
- The nurse consultant is reviewing the feasibility of training suitable health care assistants from the stroke ward to provide tracheostomy care and support to long term patients

Pressure ulcers

The Quality Targets for the Trust aim to support a reduction in the number of hospital acquired pressure ulcer (HAPU). The aim for the year was to have no more than 59 Grade 2 hospital HAPUs and only 8 Grade 3 HAPUs.

During 2014/15 there were 155 reported incidents of hospital acquired pressure ulcers. During the same period 491 incidents of admitted with pre-existing pressure ulcers were also reported.
Table 16: Pressure ulcers by grade 2014/15

<table>
<thead>
<tr>
<th></th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
<th>Unstageable/ Unclassified</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Acquired</td>
<td>304</td>
<td>84</td>
<td>26</td>
<td>77</td>
<td>491</td>
</tr>
<tr>
<td>Acquired during</td>
<td>109</td>
<td>17</td>
<td>1</td>
<td>29</td>
<td>156</td>
</tr>
<tr>
<td>hospital admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>413</td>
<td>101</td>
<td>27</td>
<td>106</td>
<td>647</td>
</tr>
</tbody>
</table>

We report all pressure ulcers, including those that are developed under a medical device.

All significant hospital acquired pressure ulcers (grade 3, 4 or ‘unstageable’) are investigated to try and establish and identify a root cause where there is one. We also review whether we think we did everything we could to avoid the pressure ulcer, and of the 47 incidents 18 were found to be unavoidable, 18 avoidable and the remaining 11 are still to be reviewed by the Trust's pressure ulcer standing panel.

Progress this year

We continue to work to reduce the incidents of harm for patients from pressure ulcers though we have some way to go to achieve our objective in significantly reducing pressure ulcer harm.

During 2014/15 the "Push off Pressure—POP" project was completed on our Acute Assessment Unit. This has seen an improvement in identifying pressure ulceration present on admission. In addition changes in equipment have been initiated as there had been a cluster of pressure ulcers as a consequence of facemasks and oxygen tubing, these changes have demonstrated positive results so far with no more incidents of mask/oxygen tubing pressure ulcers being reported.

We have now launched a further project on Lord Wigram ward to address the incidents of pressure ulcers associated with orthopaedic patients.

The Trust’s Preventing Harm Group is developing a newsletter to share learning and themes from completed reviews to ensure that staff are aware of good practice.

Good nutrition

The average estimated prevalence of malnutrition among patients admitted to hospital is 28%, and evidence shows this number increases by 5% once a patient has been an inpatient for seven days, or longer. Good nutrition is therefore important for patient safety, clinical effectiveness, and the patient experience. To make sure that patients are eating properly, we provide screening for malnutrition within 24 hours of admission, and weekly thereafter, and then put in place nutritional care for any who are already malnourished or at risk of being so.

Nutritional screening is completed on the Electronic patient record (EPR) and the nutritional data is linked to the EPR and bed census so the Nutritional Care Plan follows the patient and is visible to all medical, nursing and catering staff. Most adult wards now have electronic screens for ward kitchens to display an up-to-the-minute accurate nutritional score, status and nutritional requirements for each patient.

If the patient is moved to another area within the Trust, the Nutritional Care Plan follows the patient and is visible to all medical, nursing and catering staff. Once the ward clerk
updates the bed census, the screens update themselves every three minutes. These screens have allowed for a constant live communication system that is constantly updated to ensure the Nutritional Care Plan is clearly outlined for all at-risk patients. This is beneficial to all invested parties to improve not only patient safety (ensuring patients are receiving all aspects of the nutritional care pathway to prevent malnutrition) but also patient experience in receiving additional snacks, cooked breakfasts and nutritional supplements as promised by staff.

The nutritional care we provide is fully integrated; involving dieticians, ward and catering staff, and extends right through to discharge with various types of support provided. The number of patients who are screened within 24 hours of admission to within target, average for YTD 79.6%—range from 55.3% to 89.6%(our target is 90%), and those who are rescreened within a week, average 68.2%—range from 56.5% to 82.4% (target is 90%). These figures reflect a slight reduction on compliance from last year, so we will be working hard to improve these figures over the coming year, as we realise that good nutrition for patients is a fundamental element in providing excellent patient care.

**Learning from mistakes to improve safety**

**Our approach to reporting incidents or near misses**

When things go wrong, or incidents are narrowly avoided, we need to find out why it happened so that we can take steps to avoid a recurrence and make the Trust an even safer environment for patients and staff. But we can only do that if we know about the things that might cause problems. That’s why staff are constantly encouraged to report all mistakes (incidents) promptly, however minor they may seem. We believe it is just as important to know about the things that nearly happened as about those that did, and therefore we encourage the reporting of ‘near misses’ as well as ‘actual’ incidents.

The evidence shows that teams, departments, and organisations that report more safety incidents are more willing to learn from their mistakes and to promote a culture where patient and staff safety is a high priority. A reporting culture indicates an open and healthy organisation.

The number of patients treated at the hospital varies from day to day so rather than simply measuring the number of incidents reported we compare this figure with the proportion of patients treated to arrive at the incident reporting rate. This is a measure of the rates of patient safety incidents per 100 admissions at the hospital.

Experience in other industries shows that as an organisation’s reporting culture becomes established, staff become more likely to report incidents. But we know that not all incidents are reported, particularly those regarded as trivial, so we constantly remind staff about the importance of reporting anything that could or did go wrong and encourage them to tell us about it.

It should be second nature for staff to report incidents (including those that led to no harm or that were ‘near misses’) as they have confidence in the investigation process and understand the value of reporting and learning from incidents.

We look at trends in all incidents but investigate the more serious ones (or those that could have been serious) in more detail using Root Cause Analysis, a way of understanding
what went wrong. One of our objectives for 2015/16 is to continue to improve the speed at which we complete these investigations.

We make every effort to ensure that information relating to incidents reported is accessible, making sure that staff see how their incident reports are being used to improve patient safety and that patients and staff involved in incidents are treated fairly.

**Our performance during 2014/15**

Proportionately, the Chelsea and Westminster Hospital have more incidents leading to ‘no harm’ (81.3%) to patients that those within our cluster of acute trusts report (73.7%). Similarly, there are fewer incidents leading to severe harm or death at Chelsea and Westminster (0.2%) when compared to the same proportion in all Acute Trusts (0.5%).

Please see the table and chart below for the number and rate of patient safety incidents resulting in harm or death.

**Figure 4:** Percentage of patient safety incidents reported by degree of harm, comparing Chelsea and Westminster with acute non-specialist trusts based on NRLS comparison reporting, which was based on the 6 month period, 1st April–30th September 2014

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>Chelsea and Westminster</th>
<th>All Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>2,694</td>
<td>81.3%</td>
</tr>
<tr>
<td>Low Harm</td>
<td>549</td>
<td>16.6%</td>
</tr>
<tr>
<td>Moderate Harm</td>
<td>65</td>
<td>2%</td>
</tr>
<tr>
<td>Severe Harm</td>
<td>6</td>
<td>0.2%</td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Table 17:** Number & Percentage of Patient safety incidents reported by degree of harm based on NRLS comparison reporting, which was based on the 6 month period, 1st April–30th September 2014
Notwithstanding this, we are committed to reducing the number of serious incidents across the Trust. This includes reducing the number of incidents resulting in serious harm or death, for which our final year figure is 11 for 2014/15, an increase on the previous year. Our processes and the key actions we are taking are set out in the rest of this section.

**How we respond to incidents and near misses**

‘Evidence tells us that in complex healthcare systems things will, and do, go wrong, no matter how dedicated and professional the staff. When things go wrong, patients are at risk of harm and there can be devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be distressing, while members of their clinical teams can become demoralised and disaffected.’ (National Patient Safety Agency, 2004)

Reporting incidents is essential but even more important is how we respond to and learn from them and that includes ensuring that changes happen to improve services for patients.

All incidents reported as resulting in moderate or severe harm, or death, are fully investigated and final classification may later be altered, depending on the outcome of the investigation. It is rare that a death or severe harm incident is confirmed as avoidable and the outcome of an error.

The response to and learning from incidents is crucial. We feel that it is vital to both report and learn from incidents locally within teams, departments and divisions, and also across the organisation. Trends and themes are identified from reported incidents leading to, for example, the agreement of local changes in practice, provision of training or the strengthening of guidelines for safer practice. This helps teams to prevent the same type of incidents happening again locally or elsewhere.

Analysis of reported incidents in all departments relating to both safety and staff issues is shared via newsletters, reports and local action plans to ensure that lessons are learnt, solutions applied and we make changes.

Local action plans help our teams to develop a ‘memory’—or a record—of changes that have been introduced or recommended, and actions taken to implement or work towards implementing safer systems.

With respect to the timely reporting and investigation of serious incidents, during 2014/15 we reviewed and revised our serious incident escalation, reporting and investigation processes, and have taken account of the regulatory requirements of the Duty of Candour.

The multidisciplinary attendees at the Trust’s Risk Management Group, the Preventing Harm Group and the Health and Safety Group meets monthly and reviews incidents—those leading to actual harm and also no harm incidents.

These governance arrangements helps us to continue to protect our patients, staff and visitors from avoidable harm by ensuring that there are opportunities to review patterns and learn from incidents, particularly those where things go wrong. These groups use incidents reported by staff members to identify and take action to address emerging patterns and reduce the risk of harm. As a result, strategies are developed, which result in changes to practice, redesigned systems and processes to promote safety.
Duty of Candour

The Trust welcomed the Statutory Duty of Candour, which came into force in November 2014, and complimented our existing 'Being Open' policy and practices in relation to informing patients of mistakes which have led to significant harm or death.

This new duty emphasises the need for patient safety incidents to be investigated using a robust methodology; for investigation reports to be evidentially sound, accessible and focused on producing actionable and reasonable recommendations.

Candour is defined in Robert Francis’ report as: “The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.”

The Duty of Candour is a legal duty on all hospital, community and mental health trusts. It aims to help ensure that patients receive accurate, truthful information about incidents which may have led to harm. The facts and outcome of investigations related to any incident helps patients understand what has happened to them and also assists staff in continually improving care, effectiveness and service delivery.

Table 18: Duty of Candour—the key elements

<table>
<thead>
<tr>
<th>What is candour?</th>
<th>What triggers the statutory duty of candour</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognising when an incident occurs that impacts on a patient in terms of harm</td>
<td>• The death of a patient when due to treatment received or not received (not just an underlying condition)</td>
</tr>
<tr>
<td>• Notifying the patient something has occurred</td>
<td>• Severe harm—in essence permanent serious injury as a result of care provided</td>
</tr>
<tr>
<td>• Apologising to the patient</td>
<td>• Moderate harm—in essence non-permanent serious injury or prolonged psychological harm</td>
</tr>
<tr>
<td>• Supporting the patient further</td>
<td></td>
</tr>
<tr>
<td>• Following up with the patient as investigations evolve</td>
<td></td>
</tr>
<tr>
<td>• Documenting the above discussions and steps</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When might it arise?</th>
<th>What does candour look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• While the patient is an inpatient, ie at the “bedside”</td>
<td>• Open discussions between the patient and Trust staff when things go wrong</td>
</tr>
<tr>
<td>• When a patient is back at home following discharge or via community based care</td>
<td>• Recognition by staff that open conversations must take place at an early stage</td>
</tr>
<tr>
<td>• Following a patient's death</td>
<td>• Reduction in defensive approaches to information sharing about incidents in relation to the patient in question</td>
</tr>
<tr>
<td></td>
<td>• Engaging the patient with the outcome of investigations; and</td>
</tr>
<tr>
<td></td>
<td>• An apology in relation to the incident</td>
</tr>
</tbody>
</table>

Priorities for 2015/16 in relation to the Duty of Candour include ensuring that staff understand the incident reporting process and accurately and promptly report when an incident occurs, that staff understand what it means to be open and their role within the Trust’s Duty of Candour regulatory requirements, and that staff are trained and supported on how to share information with patients when things go wrong.

When something has gone wrong, this can be devastating to the staff involved, therefore the Trust will also be undertaking work in 2015/16 to ensure that adequate support is available for staff members and that this is proactively provided/available to them.
**Never Events**

Never Events are a subset of Serious Incidents and are defined as ‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers’.

The list of Never Events published by the NHS England in 2013/14 consists of 25 types of events or categories and includes incidents such as surgery on the wrong part of the body or surgical instruments or swabs being left in the body after a procedure.

There were no never events at Chelsea and Westminster in 2014/15 (two were reported in 2013/14).

Like other serious incidents, these events are always explained to patients along with an offer of appropriate support, a full apology is given and the incident is thoroughly investigated with a report back to the patient.

In all high-risk activities, variation—in processes, protocols, technical language, training and team member status—leads to uncertainty and increases opportunity for error.

We have therefore continued to focus on developing reliable and resilient systems in order to reduce variation, promote the development of safe and cohesive teams, and supporting the exercise of clinical leadership and responsibility.

We are using our clinical simulation suite to focus on the human factors element of changing behaviours and habits in relation to safe practice, looking at how things work and how we can be confident that they do, in order to ensure that Never Events cannot happen.

The Chelsea and Westminster’s response to incident reporting and investigation is open and inclusive. We value learning from staff, patients, carers, external stakeholders and respond to problems positively, encouraging questioning and challenge, to ensure that we continually learn from our mistakes.


**PALS and complaints**

The Patient Advice and Liaison Service (PALS) and complaints teams manage all comments, plaudits and complaints that come into the Trust.

**PALS**

This section highlights issues raised by service users who have contacted the PALS team either to raise a concern about a service, request information, advice, or to praise a service.

The total number of informal complaints (Type 1) for year 2014/15 was **1,034**. This compares to **761** for year 2013/14.
In 2014/15:

- We received 505 compliments—the majority of compliments were forwarded by the staff members for log
- 67% of PALS complaints were answered within 10 working days, 70% of complaints were acknowledged within two working days by the department investigating.

The top 3 complaints received in 2014/15 related to:

- Appointments, delay/cancellation (outpatient)—313; in 2013/14—176
- Attitude of staff—161; in 2013/14—93
- Communication/information to patients (written and oral)—189; in 2013/14—141

There was an increase in concerns throughout the Trust in 2014/15. The most frequent concerns related to staff attitude, communication along with appointments cancellation or long waiting times for outpatient appointment. These issues remain consistent each year with slow tracking on actual improvement. Many of our patients that report to us directly expressed their dissatisfaction with lack of the Appointments Office for patients’ access; it makes it harder to book/cancel an appointment. Patients also reported difficulties with calling the clinics as all phone calls are diverted to the Appointment Office.

Overall feedback demonstrates two main points.

- Patients felt that it was very difficult to call anyone within the hospital as the telephones were and currently are not answered or diverted to the answer machines.
- Patients were not happy with the long queues when calling the Appointments line.

In the last year there has been an overall increase in concerns related to staff attitude/behaviour. All concerns were sent to the appropriate managers for follow up with staffs involved ensuring cases were dealt with responsibly and to ensure the problem does not re-occur.

PALS has been working with Trust staff to highlight the need for local resolution, and re-skilling staff to take ownership of patient’s complaints before sending patients to PALS. PALS has distributed posters across the outpatient clinics with information about resolving concerns locally. This should raise (not only patients but also staff members) awareness of the correct process.

There is huge opportunity to improve and in particular in answering patients concerns in ‘real time’. PALS works with Divisions to encourage a reduction of length of time to respond to patients. Such example can be demonstrated where by large number of patients had to wait several weeks for a response to an informal issue that should have been resolved locally in a timely manner.

**Formal complaints**

The Complaints Team manages all formal complaints. These provide an important mechanism by which we can assess the quality of service we provide; Trust wide initiatives have incorporated the learning from complaints to inform service development. The total number of formal complaints for year 2014/15 is 299; 294 type 2 complaints, five
type 3 complaints. This is consistent with the number of formal complaints received in the previous two years, 356 for year 2013/14 and 377 for year 2012/13.

Figure 5: Type 2 Complaints Received between April 2012 and March 2014

Our performance target stipulates that complaints should be acknowledged in three working days and that a response should be provided within 25 working days or within a timescale agreed between the Trust and the complainant. While all the complaints have been acknowledged in three working days, the performance for response times has been very disappointing. Of the Type 2 concerns received 70% were responded to and resolved by the Directorates within 25 days.

A summary of the breaches relating to each division is sent to the Trust’s Executive Team every week for discussion with the Divisional Directors. The Divisional Directors are expected to account for the breaches and give assurance about when the response will be ready and any plans to improve performance.

During the year there have been a number of changes to senior staff in some of the divisions. This has meant that more junior staff have not always had the support they needed to investigate and complete more complex investigations. Some complaint investigations were not completed before the allocated investigating officer left; these had to be handed over to other staff to re-start the process.

In a number of cases the response from the medical teams has been delayed. This has been addressed directly with the clinical leads; our expectation is that complaints are dealt with in a sensitive and timely manner to prevent re-occurrence or escalation of incidents.

Going forward we will continue to monitor the response time frame and the complaints team will continue to work closely with the Divisions to achieve the required turnaround time for responses.

Last year Niche Patient Safety Consultancy undertook an external review of the complaints and concerns processes looking at the speed, appropriateness and quality of responses to complaints and concerns. The review identified some excellent practice. However, some areas required improvement including the timeliness of formal responses.
The Trust has refined the complaints policy, having a clearer process for sign off within the divisions.

Within the surgical division a senior service manager will now be concentrating on the more complex complaints that are received and will liaise directly with the clinicians. It is anticipated that this will improve the quality of the investigations and the timeliness of the responses. This member of staff will also provide support to more junior team members in responding to complaints and in ensuring early contact with complainants.

The newly appointed Divisional Directors of Nursing will work with the divisional teams to ensure appropriate level of senior personnel leads on investigation, response and action plan in response to clinical and non-clinical complaints and response

Reopening of complaints

At the point of reporting, of the 299 complaints received during the financial year 2014-2015, 20 complaints have been reopened. This represents 7% of the complaints received this year against a Trust target of 4%. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care.

All complainants received either a further written response or met with staff and issues have been resolved. Niche Patient Safety were asked to return to the Trust and work with staff to help to deliver improvements to help our response and handling of complaints. Niche Patient Safety delivered two training sessions for key staff involved in complaint handling. The training has been well received and there will be further training for Ward Sisters/Charge Nurses, Lead Nurse and Matrons and senior members each division. Amendments to the complaints policy will be made in response to the feedback from the teams. This will include more support and leadership from the divisional leads and clearer accountability.

Referral to the Parliamentary and Health Service Ombudsman

All complainants whose complaint relates to NHS funded care have the right to have their complaint reviewed by the Parliamentary and Health Service Ombudsman (PHSO). The Ombudsman is independent and is not part of government or the NHS. The Ombudsman considers the issues that each complaint raises, examines how the NHS trust responded, takes clinical advice if needed, and then reaches a decision on whether to uphold the complaint.

This year the Trust was informed that eight complaints have been referred to the PHSO. However only one of the complaints referred this year was received by the Trust during this financial year. Seven of the complaints referred to the PHSO were received in previous years between 2011 and 2014.

The Trust received seven reports in total this financial year from the PHSO, six of which were referred to the PHSO in the previous financial year. Three complaints were not upheld and four complaints were partially upheld. The PHSO noted that in each case
where the complaint had been partially upheld, the Trust had already acknowledged the service failing. The Trust was required to write to each complainant to apologise for the service failure. The Trust was required to write to the PHSO to describe what has been done to ensure that action had been taken to prevent a reoccurrence and to demonstrate how the learning has been shared with staff. This has been completed for all cases where the decision was to partially uphold the complaint; the PHSO has advised the Trust that no further action is required.

Learning and continuous improvement

As an organisation committed to improvement, it is important that lessons learned from complaints are shared across the Trust and used to enhance the quality of services for the future. The Trust ensures that complaints are used to learn lessons, and that this results in improved services. Below are some examples of service improvements that have been implemented during the reporting period as a result of complaints:

- A review of the dispensary staffing on the inpatient and outpatient late shift teams was undertaken to ensure more effective cross cover between the late shift teams in order to support discharge prescriptions.
- The Emergency Department has developed a consultant led hot clinic where patients who may not require admission, but would benefit from a surgical opinion, can be seen the next day.
- The Emergency Team are reviewing the process for escalation to ensure that decisions regarding appointments outside the requested time frame are made with the clinical teams.
- The Orthopaedic service has now set up 'Acute Knee Injury' clinics with a knee specialist available twice weekly. These clinics should ensure that patients with acute knee injuries are seen by the appropriate clinician or can be referred to be seen for expert advice.
- Maternity services have developed a tongue tie clinic with an agreed referral pathway between midwives, neonatal doctors, and paediatric surgeons.
- The Trust has recruited three nurses to the Palliative Care Team to enable the service to run seven days a week.

Valuing our workforce

The results of the national staff survey 2014 show that Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment.

Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role.

Our work against each of the seven staff pledges in the NHS Constitution (published in March 2013) helps to create and maintain a highly skilled and motivated workforce capable of improving the patient experience.
Pledge 1: To provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability

The Trust was in the top 20% of acute Trusts for the 2014 NHS staff survey in five out of 29 Key Findings. This related to: staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department, staff reporting good communication between senior management and staff, staff recommendation of the trust as a place to work or receive treatment, having well-structured appraisals, receiving support from their immediate managers.

Pledge 2: To provide all staff with clear roles and responsibilities and rewarding jobs that make a difference to patients, their families and carers and communities

The most recent NHS Staff Survey results show that we are in the top 20% of acute Trusts for the quality of our staff appraisals (with 44% of staff reporting having a well-structured appraisal). However, it is unlikely that we will achieve our target of 85% of staff having had an appraisal in the last 12 months and we will be working hard next year to improve on this. The appraisal forms and process will be reviewed in 2015/16 in order to simplify the process and ensure that managers and jib holders get the most out of it. Reports of overdue and due appraisals are issued to managers monthly and included within the Divisional Board reports to ensure action is taken to complete appraisals within 12 months.

Pledge 3: To provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential

The Trust offers a wide variety of training courses for professional and non-professional staff covering topics for basic administration to leadership and advanced clinical skills development.

Each year the Learning and Development (L&D) department consults with services and conducts a detailed training analysis to determine the priorities for the coming year.

The Trust is committed to its status as an outstanding teaching hospital, recognising the importance of investing in our future workforce to ensure quality and safety of care, and as a university teaching hospital we host over 150 medical students and 100 nursing and AHP students each year. The Trust also hosts in excess of 230 medical trainees as part of the pan London training rotation.

There is a well-established “Excellence of care” programme for developing the knowledge and skills of our Health Care Assistants (HCAs) and from April 2015 this programme will be replaced by the national care certificate. There are qualified staff, known as HCA leads in each ward/department who are responsible for overseeing their development in clinical areas, supported by the L&D team.

The Trust is also the host organisation for the HE NWL end of life care for the community Education Provider Network(CEPN) leading on a programme of development for HCAs across the HC community. This gives the staff the opportunity to rotate through acute, community and hospice placements gaining knowledge and a wider understanding of the services available.
Healthcare assistants are one of the largest staff groups within the Trust. However, there is high level of turnover in this group. To tackle this, a survey was sent out to all HCAs in the organisation to understand what the issues were and a short-life working group was set up to tackle these head on. The lack of differentiation between band 2 and 3 HCAs was outlined as a major reason for the turnover. The group looked at both job descriptions and ensured differentiation between the two. Band 3 HCAs were also renamed Senior Healthcare Assistants

**Pledge 4: To provide support and opportunities for staff to maintain their health, wellbeing and safety**

Staff ability to contribute towards improvements at work ranked above average compared with other acute trusts. Also scoring well in the survey was staff felt they were able to make valuable contributions to improve the work within their team and have frequent opportunities to show initiatives in their current role.

We continue to provide the following services and benefits to staff: occupational health; cycle to work scheme, fast track physiotherapy, subsidised on-site exercise classes, subsidised childcare during school holidays and Schwartz Rounds.

All of these initiatives aim to improve and sustain the mental and physical health of our employees. We also continue to run the Benefits and Wellbeing Newsletter ‘For Who You Are’ which promotes the wide range of benefits and support available for staff. This includes discounts with many local shops and restaurants.

This year we ran several wellbeing events promoting the importance of mental and physical health for staff. These included:

- **National Work Life Week.** Massages, mindfulness sessions, stress management sessions, and a benefits roadshow.

- **National Stress Day.** We held a roadshow in the cafeteria which showcased the stress resources available in the Trust and free ‘stress dots’ to boost awareness. Previous feedback from the maternity wards showed that staff felt high levels of stress and also unable to leave the wards throughout the day so often missed out on wellbeing events. As a result, a few members of the HR team also took the resources up to the maternity wards along with healthy snacks to boost morale, stress awareness and knowledge of what benefits and resources are available to staff.

- **Carers’ event.** Recent studies show 1/9 members of the workforce nationally have caring responsibilities. The Trust recognises that these members of the workforce may need extra support. As a result, the Trust has subscribed to Employers for Carers. As part of our membership we held a carers event for staff with caring responsibilities. The aim of this was to make staff feel supported, help staff to understand what they are entitled to, create a carers’ network and, help managers to support staff with caring responsibilities.

The Trust encourages staff to be active. As part of this, we have sourced and communicated discounted gym memberships, continued the cycle to work scheme, held lunch time Nordic walking classes, organised open weeks at Virgin Active Health Club, invited British Military Fitness into the Trust to discuss free classes and discounted membership with staff, and continued to subsidise exercise classes, including yoga classes, within the Trust.
As well as the cycle to work scheme, the Trust also offers staff the opportunity to take part in salary sacrifice schemes for electronic goods and cars.

The Trust has been named in the Top Employers for Working Families Awards from 2010 to 2014 inclusive.

**Pledge 5: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements—all staff will be empowered to put forward ways to deliver better and safer services for patients and their families**

We have well-established methods of involving staff, including joint consultative frameworks and strong lines of communication. The NHS staff survey results show that the Trust’s performance in both communication and staff engagement has improved every year for the past four years.

**Pledge 6: To have a process for staff to raise an internal grievance**

We have a Trust Grievance Policy and Procedure in place that is jointly reviewed and agreed with our staff side representatives on a regular basis.

**Pledge 7: To encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998**

All our policies and practices are focussed on early resolution to providing the right environment for staff to be able to raise and address concerns early on.

We have a Policy for Raising Concerns (Whistleblowing) and actively encourage and engage with staff to discuss issues in an open environment for the safety and welfare of our patients, their care and our staff.

**Listening to our staff**

**Friends and Family Test (FFT) staff surveys**

The National Friends and Family Test (FFT) for staff was launched in April 2014 and had a response rate of 20% (466 of 2,300 staff surveyed) in Quarter 1. Results showed 91% of staff were likely to recommend the trust as a place to receive care or treatment, and 75% would recommend this as a place to work.

For Quarter 2 a total of 245 paper-based surveys were distributed to a specific staff group—Support Workers/HCAs. 42 staff responded to the survey and it was positive to note that from the responses received 76% were likely or extremely likely to recommend the trust as a place to receive care or treatment and would also recommend the trust as a place to work.

The National Staff Survey was issued to trust staff during Quarter 3 and they were encouraged to complete. We look forward to receiving the results from this more in depth review of what our workforce thinks.
The Trust recognises that there are direct links between an engaged workforce and the quality of patient experience. We have continued to focus on staff engagement through a range of activities. These include:

- Participation in Work Life Week and National Stress Day in response to staff identifying high levels of stress at work. This aimed to boost awareness amongst staff and promote the resources available to staff.

- Staff communications: The Chief Executive hosts monthly team briefings which all staff are encouraged to attend; The Trust News staff magazine is published monthly; Daily Noticeboard email bulletins are sent to all staff as well as a weekly ‘For Who You Are’ benefits newsletter.

- Schwartz Rounds which continue to run in the Trust. In total, 678 people attended the first 11 rounds. 96% of attendees rated these rounds to be good, excellent or exceptional. The rounds aim to support staff in the more emotional aspects of their roles.

- The Chelsea and Westminster Star Awards. This recognises the work of both clinical and non-clinical staff in relation to our Trust values. The Quality Awards (see page 72) also recognise staff achievements.

- The Great Expectation training which took place last year was in response to feedback in the staff survey about perception of bullying and harassment. The training gave managers the tools to tackle difficult situations confidently and respectfully.

- Junior doctors in some specialities held patient experience sessions where they invited patients to reflect on their hospital experience and then undertook structured and supported reflective sessions following this. This was found to be helpful and enabled the doctors to reflect on the patients comments and actively think about their practice.

The Council of Governors Quality Awards

The Council of Governors Quality Awards aim to recognise and reward contributions to quality initiatives in the Trust by an individual or team under the three quality areas that are key to delivering high quality care: patient safety; patient experience; and clinical effectiveness.

Applicants have to prove that they also meet the Trust values of safe, kind, excellent and respectful, and show how their initiative could be applied elsewhere in the Trust to enhance the quality of patient care.

The awards, which have been running since January 2011 are open to all staff as every employee has the potential to improve quality either directly or indirectly. The awards were established by the Trust’s governors and are now led by a key group of governors from the Council of Governor’s Quality Sub Committee.

Award winners have the opportunity to meet directly with key Trust Directors and governors from the Council of Governors Quality Sub Committee to discuss their initiatives and highlight the value of their achievements that benefit the quality of patient services. The Quality Awards are awarded twice a year, in Spring and in Autumn.
Spring 2014 Quality Award winners
- Dr Alan McOwan and Mr Leigh Chislett and their team—For their Revolutionary Sexual Health Screen Service at Dean Street Express
- Alex Mancini and team—For their practical guidance document for palliative care on neonatal units
- Mars Paediatric Burns Dressing & Scar Management Team—For their Moving forwards for a Family Friendly Service initiative
- Kate Shaw Clinical Nurse Specialist in HIV associated haematological cancers
- Sandra Howard—For turning around Phototherapy
- Birth Centre Team—For several initiatives leading to continued quality of care improvements.

Plus two Highly Commended Awards:
- The Imaging Team—For the successful completion of the “Imaging Services Accreditation Scheme
- The One Stop Carpal Tunnel Clinic—Nominated by a patient for improved effectiveness leading to an excellent patient experience

Autumn 2014 Award winners
- Sarah Bryan and team—For their Dementia Care Initiative
- Miss Sheena Patel and team—For their Nuclear Medicine Department auditing of patient experience
- Emma Bartlett and Infant Feeding team—For two years of Maternity Baby Friendly UNICEF accreditation.
- Jane-Marie Hamill—For the Discharge booklet for ICU patients

Plus one Highly Commended Award:
- The Pain Clinic for their initiative in creating a Survivors of Torture project.

Our physical environment

Chelsea and Westminster is a modern, well-designed hospital, but the physical environment needs to be able to respond to changes in service provision. The Trust is continuing its multi-million pound investment programme to maintain and improve its facilities and meet rising demand for services.

Recent developments include:
- The annual PLACE (Patient Led Assessment of the Care Environment) assessment is due to take place during March 2015, and an action plan will be developed on its conclusion in order to make ongoing improvements to the patient environment, in addition a detailed score for each area will be provided. For the first time the dementia elements of the assessment will also be scored.
- Improvement to the current ‘wayfinding’ and signage to improve the patient experience is ongoing. The Wayfinding Steering Group identified areas for improvement in regards to general wayfinding and signage in particular for those who have learning difficulties...
and dementia. To this end, a trial on the third floor has been undertaken whereby colour is used to identify which floor you are on eg coloured lift buttons and on the glass balustrades (the colour used was agreed by the Learning Disability and Mental Health leads). Once funding is secured the wayfinding strategy will be implemented Trustwide.

- ‘Medicinema’, a small cinema in the Trust (sponsored the Hospital Charity) is currently under construction, due for completion this summer.

- Upgrade of the existing lights to LEDs within the Atria and wards was completed in 2014.

- Refurbishment of ward wet rooms and bathroom facilities are ongoing throughout the Trust.

- Replacement of the original flooring within the Trust is ongoing.

- Upgrade to the existing nurse call system throughout the Trust is ongoing.

There is a five-year development plan under way which will ensure that the Trust has state-of-the-art facilities to meet the needs of all its patients, and to accommodate Shaping a Healthier Future requirements. Plans include:

- An improved and expanded Emergency Department (A&E) for both adults and children is under construction—this is a £12 million project commencing July 2014 and with completion by May 2016.

- A new children’s outpatients department has been created on the first floor of the main hospital.

- The main outpatients department on the lower ground floor has been extended and there are ongoing improvements to outpatient areas.

- A new patient transport lounge is currently under construction, due for completion April 2015.

- A new immunology research laboratory has been completed.

- Retail pharmacy facilitating in pharmaceutical savings in outpatient dispensing facility both in the hospital and in 56 Dean Street.

**Health and safety**

The Trust is committed to providing and maintaining, so far as reasonably practicable, a safe and healthy environment for all employees, contractors, patients, visitors and those who may be affected by work related activities.

The Health, Safety and Fire Department in the hospital have been working hard to promote safe working arrangements and a safe environment for all. A programme of work is in place to support this continuous improvement.
This includes:

- **Training**—Health, Safety & Fire training is a mandatory requirement for all staff and is included in all of the Trust’s staff update programmes.
  
  - There are 246 identified fire marshals who have all received an enhanced level of fire safety training.
  - A network of health & safety leads for wards and departments are in place.
  - There is a Managing Safely course run for managers and their health & safety leads. The course includes developing local safe systems and risk assessment.
  - Controls of Substances Hazardous to Health (COSHH) Assessors have been identified and trained for all risk areas.

- **Inspections**—A programme of health & safety inspections is in place across the Trust. This identifies both good practice and shortfalls. The inspection supports managers in achieving satisfactory health & safety standards. The key themes/findings are reported to HSFC quarterly.

**Equality and diversity**

We continued to make good progress towards meeting actions in accordance with the Equality Act 2010 and against key objectives. A brief account of progress through the year is highlighted below.

**Objective 1: Improve equality data collection and usage across all protected characteristics**

- A breakdown of equality and diversity workforce related data shows that 44.14% of staff are identified as White British (excluding other white categories) while 50.05% of staff are identified as BME (including non-British white). The total from any white background made up 59.93% of the workforce. 74.16% of the workforce is female which is similar to the national picture with the Health and Social Care Information Centre (HSCIC) reporting that female staff comprise of 77% of the NHS workforce.

- The percentage of staff who indicated that they are disabled is 1.81%, while the percentages that have declared that they do not have a disability is 51.31%, and those not declaring a disability is 46.88%. The average age of Trust employees is 38.75 years.

- Only 42.32% of staff have disclosed their belief, and of these 27.25% have defined this as Christianity, which is the largest declared faith group.

- The records for sexual orientation indicate that the majority of staff at 52.31% are undefined. Heterosexuals account for 41.94% for the workforce.

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Objective 2: Continue to develop and promote an organisational culture that support the principles of equality

- We participated in the Stonewall’s ‘Diversity Champions Programme’ by undertaking a Workplace Equality Index questionnaire (2014/15). The results published in January 2015, showed that we had moved up a further 15 places in the rankings. We have also worked closely with our Stonewall representative to identify senior LGBT (Lesbian, gay, Bisexual and Trans) champions in the organisation with a view to re-launching our LGBT Network in 2015/16.

- The Faith network promoted the use of therapeutic meditation in the workplace and its success led to the trainer running meditation sessions in some departments for patients.

- We reviewed the equality and diversity training provided across the organisation and have adopted the online Core Learning Unit’s Equality and Diversity training module for corporate induction and refresher training for all staff.

- We participated in a roundtable discussion with NHS Employers and a number of other Trusts to share potential interventions and good practice on reducing bullying and harassment in the workplace.

- We participated in the Employers Network for Equality and Inclusion e-quality questionnaire for the first time in 2014. The tool is designed to benchmark organisational performance in equality and diversity across different sectors and we were awarded a bronze award. We will use the results to help inform our equality and diversity work plan for 2015/16.

Objective 3: Effectively communicate with, engage, and involve all of our stakeholders in equality

- We were successful in our application for the Stonewall ‘Health Champions Programme’. As a result we secured funding to help identify areas in our organisation that would benefit from tailored LGBT training to assist with delivering effective patient care and services to our LGBT community.

- The Wayfinding Steering Group has identified areas for improvement in regards to general way finding and signage in particular for those who have learning difficulties and dementia. To this end, a trial on the third floor of the hospital has been undertaken whereby colour is used to identify the floor eg colour lift buttons and on the glass balustrades (the colour utilised was agreed by the leads for Learning Disability and Mental Health). Once funding is secured the way finding strategy will be implemented Trust wide.

- We continued to focus on improving the experience of patients with learning disabilities through the Learning Disability Support Group. A Lead Nurse for Learning Disabilities and Transition was also appointed in November 2014 which will support the development of this agenda.

- The Trust’s Staff Faith Network, formed in 2013 has continued to meet and the main focus in the past few months has been on how to improve the ambiance of the multi-faith chaplaincy prayer spaces once the Tent is reinstated as the permanent Muslim
prayer space. The discussion continued in January at the Mica Gallery where Reedah El-Saie, the Director, facilitated an interactive session about the decoration of sacred spaces and the varied needs that can arise. Meanwhile the temporary removal of the Tent had led to a very practical example of sharing and hospitality as Friday Prayer has been taking place in the Chapel each week from late autumn 2014 until the Tent is reinstated in early May 2015.

**Objective 4: Strengthen equality and diversity communications and resources across the Trust**

- Following the success of the national stress awareness day in 2013, another event was organised in November 2014. This was in response to staff feedback through the 2013 Staff Survey. The day included promoting mental health wellbeing and a number of useful resources were made available from Mind and Occupational Health and received positive feedback from staff and manager.

- Learning Disability Training sessions were held in 2014-2015 for all staff groups, including ISS and volunteers. These sessions equip staff with basic communication skills to meet the needs of our patients and clients with a learning disability and how to support their carers. Understanding the Mental Capacity Act and ways of ‘making reasonable adjustments’ for this group of patients are key components of this useful training.

A work plan for 2015/16 will be prepared and we will continue to make further progress against our equality objectives, particularly around the staff survey results for equality and diversity and bullying and harassment.

**Good news stories from this year**

**Control and restraint training for Edgar Horne Ward (Staff Experience)**

Going by the Physical Assaults Statistics for 2013/14 Edgar Horne Ward surprisingly had the highest number. The Assaults were more Clinical Assaults, however staff got injured and we needed to do something different from Conflict Resolution Training. With the backing of the Chief Executive Officer we created a Training Pack for the staff who had suffered an assault, where we looked at how they were assaulted and with the help of the experts Maybo (Training Organisation) we showed them safer ways to do their tasks like: Putting a pair of slippers on a patient, change the sheets without being kicked or slapped, Controlling a Patient who is trying to abscond. This made a huge difference to the staff, they felt safer going about their tasks and we still get positive feedback who attended the course and we have seen a significant reduction in Assaults.

**Postage—Switch to Royal Mail (Patient Experience/Financial)**

In 2014 it became evident that some of our patients were not receiving their appointment letters in adequate time, or in some cases not at all. This led to missed appointments, and an associated approximate cost of £180.00 per patient. The Trust switched from using TNT to Royal Mail, purchased a new more advanced Franking Machine that marks the mail in such a way that we are guaranteed a First Class Service at a Second Class Rate. The Mail Service has subsequently improved 100%, with very little complaints from Patients or Departments.
Waste segregation and recycling (Financial/Environmental)

The Directorate has instigated significant changes to the Trusts Waste Segregation which includes bailing all cardboard and shredding of all confidential Waste; this is then sold back to the industry. This has meant that we are being kinder to the environment by being Greener as a Trust and improved our recycling figures. In addition the Trust has changed the disposal route for 60% of our clinical waste which now goes as offensive waste and has kept the directorate on track for a cost improvement.

Lone Working Devices for community staff (Staff Experience)

The Directorate has been supporting the Maternity Department (Community Midwifes) community Tuberculosis (TB) Nurses, HIV/GUM outreach teams and our onsite Chaplains by rolling out the MySOS Lone Working Devices to 50 members of staff, which is a safety measure for protecting our staff and making them Safe. This was highly commended by the Council of Governors.

Service Track—Electronic Patient Meal Service (Patient Experience)

Each ward now orders all patient meals through the Saffron Electronic Patient Meal Service device. For the patient this means that they will get the food they ordered, there is more interaction between the hostess and patient. The system is quicker for the staff and we have seen a significant reduction in food waste.

Scrubs vending machine (Scrubbex) (Staff Experience)

We now have six scrub suit vending machines (Scrubbex) based in all theatres, Emergency Department and maternity areas. This has been a huge success in terms of controlling scrubs across the Trust, complies with infection control stipulations, and ensures that our patients are kept safe from potential infections. In addition staff are assured that scrubs are readily available.

Interpreting services (Patient Experience)

In order to increase the accessibility of interpreting service for patients we have promoted the use of telephone interpreting services which are readily available, instantaneous and with 256 languages and dialects available. Nationally the utilisation rate of telephone interpreting is 19% and within London between 13–15%; the Trust is currently in the top 2 in the country for providing telephone interpreting and operates at 36%. This has had a beneficial effect of contributing to the patient experience and a secondary financial benefit to the Trust by reducing the face-to-face interpreting expenditure by approximately £50,000 per annum.
Annex 1: Statements from Commissioners, Healthwatch and Overview and Scrutiny Committees

Statement from our Governors

The year under review has been a very busy one. As made clear in last year’s Quality Report, the Trust had planned for a full year of improving the services it gives and this year's Account shows how those improvements are starting to come through. All this against a background of a substantial increase in patient numbers as shown in Table 1 in Part 1.3. In the Foreword to this Account, the Medical Director has characterised the Trust's approach to the improvement of quality as relentless, and the Governors can confirm that this is true. For their part, the Governors have kept themselves closely informed and offered encouragement, warning, and their outside experience in fulfilling their role as "critical friend" of the hospital. They have also kept abreast of the developing preparatory work on the strategic proposal to acquire a second hospital, the West Middlesex University Hospital in Isleworth. A decision on that will be made during 2015 and the Governors will contribute fully to that decision.

The Governors particularly welcome the development of a Quality Strategy and Plan for the next three years. They were consulted about its terms and look forward to keeping a close eye on it as time goes by, especially if the acquisition of a second hospital goes ahead.

In last year's commentary some matters were mentioned which were of particular concern to Governors. One of these was the incidence of pressure ulcers. The action taken during the year in respect of those acquired in the hospital has brought about an improvement in the figures which is welcome but we think we can do better—we will continue to monitor progress. Most pressure ulcers suffered by patients were acquired in the community—three times the number acquired in the hospital. We shall continue to encourage the Executive in initiatives to tackle this with the Trust's partners in primary and community care.

Another matter of concern was the failure to reach the Trust's target for staff appraisals (85%). It is disappointing that limited progress has been achieved towards the target. The Account records that 44% of the Trust's staff recorded that they had enjoyed a well structured appraisal and that this put the Trust in the top 20% of acute trusts (which was the target). This position must improve, notwithstanding that the area remains a challenge for NHS organisations across the country. The Account promises a review of the job appraisal form and process during 2015/16 and the Governors will wish to be closely involved with this. A well-structured, regular and well-conducted job appraisal review is essential to tackle the reported problems of communication and staff attitude in parts of the hospital. This also allows the Trust's core values to become fully embedded within all staff groups. The "Great Expectations" training which was given last year was a step in the right direction. It needs to be followed up with middle managers' training to ensure that they are applying it to their staff through job appraisal reviews. The training may need to be repeated, particularly for staff in areas where the Friends and Family Test indicate that there is a problem in communication and attitude.

The Friends and Family Test is helpful in giving an "across-the-board" view of a patient's hospital experience. It signals areas which need further investigation. It is essential that a
far greater percentage of patients complete the Test if it is to be effective. At the Governors’ request, this has been included as a Priority for 2015/16.

Alongside the pointers that come from the Friends and Family Test, areas needing focused attention can emerge from the complaints that are received. The Governors attach great importance to complaints, and agree that the speed of handling them needs to be improved. Governors will also wish to review with the Executive the revised method of dealing with complaints set out in the Account.

Our concern about Job Appraisal Reviews recorded above is one of several related to the management of the Trust's staff. A common problem for London hospitals is a high turnover rate and attrition. This is a complex area and includes the factors which make a job rewarding and fulfilling for the job-holder, opportunities for career development and advancement, and ways to recognise good performance. Exit interviews for staff who are leaving to find the reasons which resulted in their decision to leave are most important. The Governors intend to engage with the Executive to develop an overall view of this area. If the various elements of the problem could be improved so that the average length of service of staff in the hospital was increased by just one year the effect on patient care would be very worthwhile.
Statement from Commissioners

West London CCG Commissioners Statement—Chelsea and Westminster Quality Report

West London Clinical Commissioning Group (CCG) Quality, Patient Safety and Risk Committee has reviewed the Chelsea and Westminster Hospital NHS Foundation Trust’s Quality Report (QR).

The Trust presented its draft QR for formal comments and has sought the views of the CCGs and other commissioning stakeholders through conversation at the Clinical Quality Committee.

This statement has been signed off by the Chair of the West London CCG Quality, Patient Safety and Risk Committee and the West London CCG Managing Director. In our view, the QR complies with guidance as set out by both Monitor and the Department of Health (DoH).

Review of quality 2014/15

Implementation of the CQC action plan to address areas where services were identified as requiring improvement has been a key priority and concern for commissioners this year. The Trust’s action plan was felt to be ambitious and there were concerns regarding the Trust’s ability to achieve it in full within their specified timeline. The Commissioner/Trust Clinical Quality Group has discussed the Trust’s progress against the CQC action plan throughout the year.

The CCG is still waiting for presentation of the outcome of the peer review and independent table top review as the final evidence demonstrating assurance and completion of the action plan. However, gaining assurance has been and will continue to be an ongoing process, and we support the Trust’s intent to blend this into business as usual for the future.

Priorities for quality 2015/16

Considering the forthcoming acquisition with West Middlesex University Hospital Trust, the commissioners look forward to seeing both Trusts realise the opportunities the acquisition brings for patients, while remaining mindful of the risks. We will closely monitor and scrutinise the quality of care throughout this period of transition.

Further to the CQC inspection and subsequent findings, commissioners will continue to seek assurance that the areas identified as requiring improvement have fully implemented their plans, and are able to sustain the improvements. The commissioners welcome the Trust’s intention to undertake further peer reviews throughout the year (following their success as part of the CQC assurance process) and look forward to being part of that ongoing process.

The Trust has identified five new priorities for improvement for 2015/16. Although commissioners are keen to ensure that the efforts taken to establish improvements last year are sustainable, the refresh and refocus on current priorities a result of latest performance information is welcomed.
The Commissioners, having discussed each of the priorities, agree and support the choices made by the Trust, with the following specific comments:

In relation to the reduction of acquired pressure ulcers both in hospital and the community, we recognise that pressure ulcers remain one of the greatest burdens of harm in our health economy in North West London and welcome the Trusts commitment make significant improvements for patients. Appreciating the Trust has the greatest influence over hospital acquired ulcers, commissioners support the Trust’s aim to work collaboratively to reduce ulcers both in hospital and the community.

In relation to Priority 2: Embedding of the World Health Organisation (WHO) surgical checklist, the CQC’s identification of the need to improve consistent implementation of the WHO surgical checklist across the Trust did initially cause concern. Discussion has taken place regarding this priority -the implementation of a document that has been mandated and recommended since 2010. However, commissioners were assured to learn that this priority encompasses a wider ‘improving safety culture’ as a whole within the Trust’s theatre teams and departments, and plans are in place to focus on improving team dynamics, overall functioning, as well as compliance to the documentation. This we welcome.

In relation to the measure chosen by Trust Governors, Priority 5: Friends and Family Test (FFT), the focus on improving the FFT results is greatly welcomed, although commissioners are keen to ensure that work to improve this priority extends to encompass patient experience as a whole. It is disappointing to see current performance placing the Trust in the lower quartile of London Trusts, although we know the Trust is exploring mechanisms to support this. The Trust’s response rates in relation to investigating and responding to patient safety incidents and complaints in a timely manner needs to improve and we welcome the Trust’s commitment to do this.

Concluding statement

Commissioners would reflect that over the last twelve months improvements have been made in the relationship between the Trust and CCG, and West London CCG looks forward to continuing to work collaboratively with Chelsea and Westminster Hospital NHS Foundation Trust.

While we recognise improvements made over the last 12 months, we hope the Trust finds these comments helpful and we look forward to continuous improvements and productive collaborative working in 2015/16.
Statement from Healthwatch

Healthwatch Central West London statement on the Chelsea and Westminster Hospital NHS Foundation Trust’s Quality Report 2014/15

Healthwatch Central West London (Healthwatch CWL) welcomes the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) Quality Report (QR) 2014/15.

We have been quite pleased with the quality of our working relationship with the Trust in recent years and although there have been a number of changes in recent months, we seek to continue our engagement through Dignity Champions, PLACE visits, the Quality Sub-committee, the Membership Sub-committee and through our work on nutrition and on learning disability.

We would like to commend the improvements made by the Trust on its priorities for 2013-2014, particularly in relation to the quality of end of life care. We also want to praise the Trust for their excellent work in sexual health and on their improvements to A&E services.

We would like to commend the efforts made in providing simple explanations of the Quality Report, as well as of the Trust’s services and priorities. A one page summary of the quality report and a signposting of the main topics akin to the structure of last year’s account would help the reader greatly. It would also be useful to have data tables and lists of national audits removed from the main text and added in to the appendix.

We strongly feel the recent Care Quality Commission inspection report should inform the content of the Quality Report much more than in the current draft provides for. The CQC highlighted a number of areas that require improvements and we look forward to see the Quality Report highlighting these in the introduction, as well as providing greater details in line with the CQC action plan in parallel with priorities throughout the QR.

Overall, we:

- Would like further clarification on the way the impact of the various initiatives implemented to improve patient experience are being monitored

- Continue to be disappointed with the reported performance on staff appraisals. Staff experience and motivation at a time of much change in the health landscape is critical to quality care provision including patient experience.

- Would also welcome further detail on the different discharge projects, in particular the reasoning for restricting this work to elective surgery, whereas non elective surgery is more problematic, as well as on how impact is being monitored.

- Are worried Chelsea and Westminster Hospital maternity services are missing the target on 12 week assessments, homebirths, non-elective caesareans, 1:1 midwife care in labour, and the midwife to birth ratio for the majority of 2014-2015. An explanation on how the Trust plans to meet these targets seems particularly important considering the changes likely to happen in maternity services in the North West London area in the coming months.
• Are concerned about the quality of the paediatric dental services. While we recognise this is a North West London concern, Chelsea and Westminster Hospital is the only specialist provider for this area. To the best of our knowledge, we understand 4 of the 5 paediatric dental specialists have been lost within the last year and there has been a consequential loss of capacity. The service is currently operating to highly restrictive referral criteria and is not serving the majority of referrals in North West London.

• Are most disappointed and concerned that despite the provisions of the Health and Social Care Act, the Hospital has not responded to our numerous requests for an action plan on Nell Gwynne.

• Are not fully aware of the recent changes in governance at the Hospital and as a result, we are not as engaged as we were previously.

2015/16 Priorities

Priority 1: Reduction of acquired Pressure Ulcers both in Hospital and the Community

Pressure ulcers have been the main safety risk for a number of years now. Healthwatch is frustrated that more progress has not been made. While we recognise the need for this work to be prioritised, we suggest clearer specific targets and actions must be included leading to measurable change going forward.

Priority 2: Embedding of the WHO checklist

We welcome this innovative approach to improving patient safety. We would like to have further clarification on the way this priority will be measured and how the impact will be communicated to patients and the public.

Priority 5: Friends and Family Test (FFT)

We welcome the Trust’s efforts in taking the views of patients and families on board. However, our members feel that the FFT should not be seen as the only way to gather patient’s views as it is quite limited in terms of what can be expressed. We are happy to re-visit this discussion at the Trust’s convenience. In the interim, we would like to see greater emphasis on the way results are analysed and shared and actions plans are developed as a result.

Further issues:

Staffing

Is the high turnover of Healthcare Assistants still an issue? The number and percentage of agency and bank staff numbers should be reported in the final version of the QR.

Complaints

We commend the efforts to improve the way complaints are used for learning across the Trust. Our patient stories also flag concerns about the management of outpatient appointments and the quality of patient communication. We are aware that a lot has been
done about staff attitudes, and we are keen to know how the Trust will take that work forward and how it will be evaluated.

The frequency and time period for redress is a concern. While this is acknowledged by the draft QR, the data was not available at the time of writing.

We are disappointed the actions proposed for next year do not seem to map to the main concerns arising from the complaints. We would particularly welcome clarification on the way the Trust is planning to triangulate the findings from complaints, PALS and the Friends and Family Test to monitor and improve patient experience.

**Patient safety**

We welcome the change in organisational culture on the reporting of ‘never events’ and measures aimed at improving internal communication and openness. However and over the course of the last year, we have had concern about the speed and effectiveness of these processes.

In addition, we would welcome further detail on the level of safeguarding training provided to and completed by staff, including Mental Capacity Act compliance.

**Going forward**

In conclusion, we are keen to re-build our working relationship with the Trust and we hope progress can be made on the issues raised in the coming year including a number of outstanding issues raised in previous years as detailed above.

Contact:

Luul Balestra, Borough Manager, Kensington and Chelsea Healthwatch Central West London
Phone: 020 8964 1490
Email: luul.balestra@hestia.org

Date: 8 May 2015
Statements from Overview and Scrutiny Committees

Statement from Adult Services and Health Policy Scrutiny Committee, Westminster City Council

Chelsea and Westminster Hospital NHS Foundation Trust
Response to Quality Report 2014/15

Introduction

We welcome the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust’s Quality Report 2014/15.

Merger with West Middlesex University Hospital Trust

The Chelsea and Westminster Hospital NHS Foundation Trust has been an efficient and high performing trust.

There are a number of risks to Chelsea and Westminster NHS Foundation Trust in any merger with West Middlesex University Hospital Trust.

There are risks to finance associated with this merger. We do not believe the Chelsea and Westminster NHS Foundation Trust should take on the significant legacy debt that West Middlesex University Hospital Trust owes the Department of Health.

There are risks to performance due to management distraction from a challenging merger taking away focus from providing care for our residents and of maintaining Chelsea and Westminster Hospital as a centre of excellence.

- We note a decline in service, highlighted by the England’s Chief Inspector of Hospitals rating the services provided at the Chelsea and Westminster hospital as ‘requires Improvement overall’[^31], took place at the time this merger was being planned.

- We note a decline in service, highlighted by the England’s Chief Inspector of Hospitals rating the services provided at the West Middlesex University Hospital Trust as ‘requires Improvement overall’. The Care Quality Commission (CQC) report[^32] said the ‘protracted’ merger process had led to a high use of interim senior managers and ‘planning blight’. This had particularly affected surgery with an ‘unstable management support’.

A firm eye needs to be kept on the core business to minimise performance risks. The Foundation Trust will need to ensure that new work (ie to take forward the merger, bring the different bodies together and resolving the issues at West Middlesex University Hospital) does not distract from the core work at the Fulham Road site.

Performance in 2014/15

We recognise many improvements have taken place in many areas however issues in some areas still need to be addressed.

We are pleased:

Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care. For example, SHMI is 78.5 against a National Benchmark of 100—statistically significantly lower than expected risk

There were no ‘never events’ in 2014/15.

Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment.

The National Cancer Patient Survey 2013/14 has improved since the previous year, and the Trust recognised that there is still more that they can do to improve as identified in Dr Quinn’s Action Plan.

The Trust won two HSJ Value in Healthcare Awards 2014: (1) For ‘Value and Improvement in Acute Service Redesign’ Boundary less patient flow across acute and community emergency care pathway (2) For ‘Value and Improvement in the use of Diagnostics’ Dean Street Express. And then Dr Ann Sullivan, Consultant physician in HIV and genitourinary medicine was named an HSJ Innovator 2014.

We note:

- Compliance of peripheral venous catheters was at 84%.

- Over the last two years the number of adult inpatient cases where there has perceived to be a failure to calculate NEWs scores accurately and/or failure to escalate promptly or to the appropriate teams has remained static at 18 cases per year (excluding maternity and paediatrics).

We were disappointed this year:

- England’s Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as ‘requires Improvement overall’.

- There were 7 cases of Clostridium difficile.

- There were 3.2 inpatient falls per occupied 1,000 bed days (the target was 3)

- There were 140 pressure ulcers acquired during hospital admission this year. 98 grade 2 (target 59), 14 grade 3 (target 8). We agree the hospital should have the reduction of acquired pressure ulcers in next year’s priorities.

- From April 2014—January 2015, the Trust identified 6 hospital associated preventable venous thromboembolisms (VTEs). The Trust set a target of 90% of adult patients to receive appropriate medication and compression stockings. We note only 87% of adult patients received compression stockings. We note the % of patients who were admitted
to hospital and who were risk assessed for VTE during April 2014-February 2015 were 96.5% (not assessed 3.5%). To have no hospital associated preventable venous thromboembolism was a quality priority this year and it should remain a priority for next year.

Quality Report priorities 2015/16

The suggested priorities for 2015/16 will be:

- Reduction of acquired Pressure Ulcers both in Hospital and the Community
- Embedding of the WHO checklist
- Early Identifying of the Deteriorating Patient
- To Reduce Avoidable Admissions of Term Babies to the Neonatal Intensive Care Unit (NICU)
- Friends and Family Test—inpatient responses

Related to these new priorities, we are disappointed the Trust has dropped as Quality Priorities: (1) Hospital associated preventable venous thromboembolism; (2) Discharge.

The priorities for 2014/15 were:

- To have no hospital associated preventable venous thromboembolism (VTE)
- Continue to focus on communication, discharge, and delivering safe and compassionate care to all our patients
- Patient Experience (Staff Engagement) 2014/15
- To improve choice and quality in End of Life Care

National clinical audits

Diabetes Audit
We note participation in this audit ‘in 15/16 is a divisional priority.’

Child Health Review
We note the comment ‘C&W do not have the resources to develop ‘epilepsy passports’ for all our children but we do ensure that all clinic letters with relevant clinical information and advice are copied in to school nurses and head teachers.’

UK Paediatric Inflammatory Bowel Disease Audit
We note the comment ‘However, sustainability will be confirmed in the long term, since there is a bed capacity pressure.’

Local clinical audits

An audit into appropriateness of CT pulmonary angiograms to investigate pulmonary embolisms in AAU
Results from the 2 month re-audit should be presented in the Quality Report.

Urgent Care Centre Minor Ailments Audit
The statement ‘2 patients should have been streamed into the minor injury stream rather than the minor illness stream’ doesn’t make sense.
Audit of Intra Uterine Devices at West London Centre for Sexual Health
We note the data used relates to 2013.

A review of patients referred with abnormal smear results—was a biopsy taken within 2 years?
We note ‘6 patients were not appropriately followed up due to appointments not being made’ and the inconclusive statement ‘this may have been the patient choosing not to book an appointment, or an error on the clinic’s part by not booking an appointment’.

Conclusion

We are entirely supportive of the work that Chelsea and Westminster NHS Foundation Trust undertakes. The hospital on the Fulham Road has been an outstanding facility, but it is now in need of improvement.

We were disappointed that this year England’s Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as ‘requires Improvement overall’. We hope that progress can be made on all issues raised. Risks from the merger with West Middlesex University Hospital Trust will need to be kept to a minimum.

We are interested to find out how the priorities outlined in the Quality Report are implemented over the course of 2015/16.

We look forward to continuing our strong working relationship with Chelsea and Westminster Hospital NHS Foundation Trust in 2015/16.

Councillor David Harvey
Chairman, Adult Services and Health Policy Scrutiny Committee
Westminster City Council
Statement from Adult Services and Health Policy Scrutiny Committee, Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea

Chelsea and Westminster Hospital NHS Foundation Trust
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A firm eye needs to be kept on the core business to minimise performance risks. The Foundation Trust will need to ensure that new work (ie to take forward the merger, bring the different bodies together and resolving the issues at West Middlesex University Hospital) does not distract from the core work at the Fulham Road site.


\(^{34}\) CQC inspection report (7 Apr 15): West Middlesex available at: http://www.cqc.org.uk/provider/RFW
Performance in 2014/15

We recognise many improvements have taken place in many areas however issues in some areas still need to be addressed.

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- Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care. For example, SHMI is 78.5 against a National Benchmark of 100—statistically significantly lower than expected risk

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- Chelsea and Westminster remains in the top 20 per cent of acute trusts in the country as an organisation that staff would recommend as a place to work or to receive treatment.

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- Over the last two years the number of adult inpatient cases where there has perceived to be a failure to calculate NEWs scores accurately and/or failure to escalate promptly or to the appropriate teams has remained static at 18 cases per year (excluding maternity and paediatrics).

- We note the reference to ‘Understanding the Mental Capacity Act (MCA) and ways of ‘making reasonable adjustments’ for this group of patients [people with learning disabilities] are key components of this useful training.’ We would add that staff needs appropriate knowledge of the MCA and awareness of the requirements of Deprivation of Liberty Safeguards (DoLS). The processes for patients in need of DOLS assessment or MCA assessment should always be prompt and appropriate.

We were disappointed this year:

- England’s Chief Inspector of Hospitals rated the services provided at the Chelsea and Westminster hospital as ‘requires Improvement overall’.

- There were 7 cases of Clostridium difficile.

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There were 140 pressure ulcers acquired during hospital admission this year. 98 grade 2 (target 59), 14 grade 3 (tagret 8). We agree the hospital should have the reduction of acquired pressure ulcers in next year’s priorities.

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Related to these new priorities, we are disappointed the Trust has dropped as Quality Priorities: (1) Hospital associated preventable venous thromboembolism; (2) Discharge. The Trust needs to work to reduce all delayed transfers, both internal and external, and timeliness of discharge.

The priorities for 2014/15 were:

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We are interested to find out how the priorities outlined in the Quality Report are implemented over the course of 2015/16.

We look forward to continuing our strong working relationship with Chelsea and Westminster Hospital NHS Foundation Trust in 2015/16.

Councillor Robert Freeman
Chairman, Adult Social Care and Health Scrutiny Committee
Royal Borough of Kensington and Chelsea
Annex 2: Statement of Directors’ responsibilities for the Quality Report

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  
  - board minutes and papers for the period April 2014 to 26/05/2015
  - papers relating to Quality reported to the board over the period April 2014 to 26/05/2015
  - feedback from commissioners dated 22/05/2015
  - feedback from governors dated 21/05/2015
  - feedback from local Healthwatch organisations dated 08/05/2015
  - feedback from Overview and Scrutiny Committees dated 05/05/2015 and 08/05/2015
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/07/2014
  - the latest national patient surveys including the 2014 Accident and Emergency survey, dated 02/12/2014; and the 2014 Adult Inpatient Survey, dated 21/05/2015
  - the latest national staff survey 24/02/2015
  - the Head of Internal Audit’s annual opinion over the trust’s control environment dated 14/05/2015
  - CQC Intelligent Monitoring Report dated December 2014

- The Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Reports regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

[Signatures]

Sir Thomas Hughes-Hallett  
Chairman  
27 May 2015

Elizabeth McManus  
Chief Executive  
27 May 2015
Independent auditor’s report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Chelsea and Westminster Hospital NHS Foundation Trust’s quality report for the year ended 31 March 2015 (the ‘Quality Report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- maximum time of 18 weeks from point of referral to treatment in aggregate—patients on an incomplete pathway; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’.
We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2014 to 26 May 2015;
- papers relating to quality reported to the board over the period April 2014 to 26 May 2015;
- feedback from Commissioners, dated 22 May 2015;
- feedback from governors, dated 21 May 2015;
- feedback from local Healthwatch organisations, dated 8 May 2015;
- feedback from Overview and Scrutiny Committee, dated 5 May 2015 and 8 May 2015;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 July 2014;
- the latest national patient surveys including the 2014 Accident and Emergency survey, dated 2 December 2014; and the 2014 Adult Inpatient Survey, dated 21 May 2015;
- the latest national staff survey, dated 24 February 2015;
- Care Quality Commission Intelligent Monitoring Report dated 3 December 2014; and
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 14 May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised)—‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.
Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

As set out on page 46 in the Trust’s Quality Report, the Trust identified a number of issues in its 18 week Referral-to-Treatment reporting during the year and our testing identified additional issues including:

- The published indicator incorrectly includes records which should be excluded from the calculation of the indicator;
- In some cases, patients have been excluded from the calculation of the published indicator in circumstances where, per national guidelines or the Trust access policy, they should not have been;
- The underlying data includes records where one or both of the start and end date of treatment were not accurately recorded, affecting the calculation of the published indicator; and
- The calculation of the published indicator does not capture all relevant records within the Trust Patient Administration System records.

The Trust has received support from NHS England’s Intensive Support Team during the year, and is taking actions to resolve the issues identified in its processes, as detailed on page 46.

As a result of the issues identified, we have concluded that there are errors in the calculation of the “maximum time of 18 weeks from point of referral to treatment in aggregate—patients on an incomplete pathway” indicator for the year ended 31 March 2015. We are unable to quantify the effect of these errors on the reported indicator.

Qualified Conclusion

Based on the results of our procedures, except for the effect of matters set out in the basis for qualified conclusion paragraph, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
the quality report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports; and

the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom

28 May 2015

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust’s website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.
Chelsea and Westminster Hospital

NHS Foundation Trust

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