






Chelsea & Westminster Hospital NHS Foundation Trust
Council of Governors Meeting

20 October 2022 16:00 - 20 October 2022 18:00

AGENDA

#	Description	Owner	Time
1	GENERAL BUSINESS  1.0 COG Agenda 2022-10-20_SG_071022.doc 7		
1.1	Welcome & Apologies for Absence Verbal	Chair	16:00
1.2	Declarations of Interest Verbal	Chair	16:01
1.3	Minutes of previous meetings held on 21 July, 2022 and 1 August, 2022 Action Log Paper  1.3 Draft Cog Mins 21.07.22.doc 9  1.3a DRAFT Cog Mins 1.8.22.doc 15  1.3b COG action log v.2022-10-12.doc 19	Chair	16:02
1.4	Chair's Report Paper  1.4 Chair's report Chelsea and Westminster COG 2... 21	Chair	16:05
1.5	Chief Executive Officer's Report Verbal	Chief Executive Officer	16:10
2	FOR INFORMATION		
2.1	NWL Collaborative update Verbal	Chair & Chief Executive Officer	16:15
2.2	Performance & Quality: -Winter Preparedness -Workforce Performance Report Verbal	Chief Executive Officer	16:30

#	Description	Owner	Time
2.3	<p>Update on the External Auditors</p> <p>Paper</p> <p> 2.3 External Audit Contract Extension - COG Oct 2... 27</p>	Chief Finance Officer	16:45
2.4	<p>Governors Election 2022 - update</p> <p>Paper</p> <p> 2.4 Election update.doc 31</p>	Director of Corporate Governance	16:50
2.5	<p>Clinical Negligence Scheme for Trusts (CNST)</p> <p>Paper</p> <p> 2.5 B NWL LMNS CNST y4 Q2 position.pptx 35</p>	Chief Nursing Officer	16:55
2.6	<p>Membership</p> <p>Paper</p> <p> 2.6 CWFT Membership strategy - update October 2... 41</p>	Director of Corporate Governance / David, Phillips, Chair of MESC	17:05
3	FOR NOTING		
3.1	<p>Membership & Engagement Sub-Committee update</p> <p>Verbal</p>	David, Phillips, Chair of MESC	17:15
3.2	<p>Quality Sub-Committee update</p> <p>Verbal</p>	Laura Wareing, Chair of QSC	17:20
3.3	<p>Quality Committee Report to Council of Governors</p> <p>Paper</p> <p> 3.3 CWFT Board Quality Committee Chair's Report... 57</p>	Steve Gill, Vice Chair	17:25
3.4	<p>Accessibility Work Update</p> <p>Paper</p> <p> 3.4 Accessibility Audit of the Physical Environment... 85</p>	Steve Gill, Vice Chair	17:40
4	OTHER BUSINESS		17:50
4.1	<p>Questions from the governors and the public</p> <p>Verbal</p>	Chair / Chief Executive Officer	
4.2	Any other business, including:		

#	Description	Owner	Time
4.2.1	<p>Forward plan</p> <p>Paper</p> <p> 4.2.1 COG Forward Plan 2022.doc 89</p>	Chair	
4.2.2	<p>Schedule of meetings 2022/23</p> <p>Paper</p> <p> 4.2.2 Schedule of Council of Governors Meeting Da... 93</p>	Chair	
4.2.3	<p>Governor attendance register</p> <p>Paper</p> <p> 4.2.3 CoG Attendance Record 2022.doc 95</p>	Chair	
4.2.4	<p>Any other business</p> <p>Verbal</p>	Chair	
4.2.5	<p>NHS Acronyms</p> <p>Paper</p> <p> NHS Acronyms.docx 99</p>		
4.3.2	Date of next meeting: 26 January, 2023 16:00 – 18:00		18:00

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Council of Governors Meeting

Date: 20 October, 2022

Time: 16:00-18:00hrs

Location: Main Boardroom, Lower Ground Floor, Chelsea and Westminster Hospital NHS Foundation Trust, 369 Fulham Road, London SW10 9NH and/or Microsoft Teams

Agenda

	1.0	GENERAL BUSINESS			
16.00	1.1	Welcome & Apologies for Absence	Verbal		Chair
16.01	1.2	Declarations of Interest	Verbal		Chair
16.02	1.3	Minutes of previous meetings held on 21 July, 2022 and 1 August, 2022 Action Log	Paper	For Approval For Information	Chair
16.05	1.4	Chair's Report	Paper	For Information	Chair
16.10	1.5	Chief Executive Officer's Report	Verbal	For Information	Chief Executive Officer
	2.0	FOR INFORMATION			
16.15	2.1	NWL Collaborative update	Verbal	For Information	Chair & Chief Executive Officer
16.30	2.2	Performance & Quality: - Winter Preparedness - Workforce Performance Report	Verbal	For Information For Information	Chief Executive Officer
16.45	2.3	Update on the External Auditors	Paper	For Approval	Chief Finance Officer
16.50	2.4	Governors Election 2022 - update	Paper	For Information	Director of Corporate Governance
16.55	2.5	Clinical Negligence Scheme for Trusts (CNST)	Paper	For Information	Chief Nursing Officer
17.05	2.6	Membership	Paper	For Information	Director of Corporate Governance / David, Phillips, Chair of MESC
	3.0	FOR NOTING			
17.15	3.1	Membership & Engagement Sub-Committee update	Verbal	For Information	David, Phillips, Chair of MESC
17.20	3.2	Quality Sub-Committee update	Verbal	For Information	Laura Wareing, Chair of QSC
17.25	3.3	Quality Committee Report to Council of Governors	Papers	For Information	Steve Gill, Vice Chair
17.40	3.4	Accessibility Work Update	Paper	For Information	Steve Gill, Vice Chair
17.50	4.0	OTHER BUSINESS			
	4.1	Questions from the governors and the public	Verbal	For Information	Chair / Chief Executive Officer
	4.2	Any other business, including: *4.2.1 Forward plan *4.2.2 Schedule of meetings 2022/23 *4.2.3 Governor attendance register - 4.2.4 Any other business	Paper Paper Paper Verbal	For Information For Information For Information For Information	Chair
18.00	4.3	Date of next meeting: 26 January, 2023 16:00 – 18:00			

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*Items that have been starred will not be discussed, however, questions may be asked.

DRAFT



DRAFT MINUTES OF COUNCIL OF GOVERNORS (COG)
21 July 2022 10:00-11:00
Microsoft Teams Meeting

Present:	Matthew Swindells	North West London (NWL) Chair in Common	(MS)
	Stephen Gill	Vice Chair and Senior Independent Director	(SG)
	Lisa Addison	Patient Governor	(LA)
	Richard Ballerand	Public Governor	(RB)
	Caroline Boulliat	Public Governor	(CB)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Simon Dyer	Lead Governor/Patient Governor	(SD)
	Stuart Fleming	Public Governor	(SF)
	Dr Paul Kitchener	Public Governor	(PK)
	Anthony Levy	Public Governor	(AL)
	Rose Levy	Public Governor	(RL)
	Minna Korjonen	Patient Governor	(MK)
	Stella McCaskill	Patient Governor	(SM)
	Prof. Mark Nelson	Staff Governor	(MN)
	Will Pascal		(WP)
	David Phillips	Patient Governor	(DP)
	Jacquei Scott	Staff Governor	(JS)
	Laura Wareing	Public Governor	(LJW)
	Desmond Walsh	Appointed Governor	(DW)
In attendance:	Lesley Watts	Chief Executive Officer	(LW)
	Aman Dalvi	Non-Executive Director	(AD)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Peter Jenkinson	Joint Director of Corporate Governance	(PJ)
	Emer Delaney	Director of Communications	(ED)
	Sue Smith	Director of People	(SS)
	Virginian Massaro	Chief Financial Officer	(VM)
	Jessica Barnett	Corporate Governance Officer	(JB)
Apologies:	Jeremy Booth	Patient Governor	(JB)
	Cass J Cass-Horne	Public Governor	(CJCH)
	Julie Carter	Public Governor	(JC)
	Thewdros Leka	Staff Governor	(TL)
	Nicole Nunes	Staff Governor	(NN)
	Catherine Sands	Staff Governor	(CS)
	Trusha Yardley	Public Governor	(TY)
	Daryl Lutchmaya	Deputy Director of Corporate Governance	(DL)
	Parvinder Singh Garcha	Public Governor	(PSG)

1.0 STATUTORY/MANDATORY BUSINESS

1.1 Welcome and apologies for absence

MS welcomed the Governors and those in attendance to the meeting.

MS noted apologies as above and outlined the order of business for the meeting.

1.2 Declarations of interest

No declarations of interest were received.

1.3 Minutes of previous meeting held on 21 April 2022

The minutes of the previous meeting were approved as a true and accurate record of the meeting held on 21 April 2022 with the exception of a correction raised by SG to the timings of the AMM and COG at 4.6.

1.3.1 Action Log

The action log was reviewed and noted as complete.

1.4 Chair's Report

MS presented the Chair's report, highlighting the importance of the Board being visible to all staff.

1.5 Chief Executive Officer's Report

LW presented the Chairs report, highlighting the rise in patients with Covid, the prevalence of Monkeypox and the Trusts preparations for the Covid and Flu vaccinations in Autumn. LW praised the work of our colleagues in sexual health in response to Monkeypox.

CDB raised a concern as to how local authorities are responding to integrated care, highlighting his experience with one particular local authority and how governors can help local authorities become more receptive. LW responded that more work is needed to try and join up care with local authorities and that it is early days.

2.0 FOR INFORMATION

2.1 NWL Collaborative

MS presented the paper and opened to questions.

AL expressed the importance of highlighting that this is something that is evolving. He also asked how West Middlesex will be working with the South West London Collaborative as so many of their patients will be from that partnership. LW stated that we work very well with the SWL ICS and have been working with them for quite some time and there is very strong place based leadership at West Mid.

Resolution:-

The paper was formally noted and received by the Council of Governors.

3.0

FOR NOTING

3.1

Board Committees:

Finance & Investment Committee Report to Council of Governors; including Month 12

Financial Position

ND introduced himself and presented the report highlighting the following points; the broader remit of the Finance and Investment Committee covering both digital, data and estates in addition to finance and investment.

The Trust closed the year at £1.3 million surplus against a break even plan and met the cost improvement plan that had been set which is a notable achievement given the challenging year. ND extended thanks to VM and the Executive team for delivery this.

The Trust managed a healthy cash position and the capital spend for the year was to budget at £29 million. ND highlighted the completion of the neonatal intensive care unit in the ICU. The Trust has made a significant investment in our technology helping us guard against cyber security risks.

The Trust is progressing a major new estate development in the Ambulatory Diagnostic Centre at the West Middlesex site which is currently in its planning phase. The Committee has also approved a number of innovative clinical services including gender affirmation surgery and a new surgical robot.

In the spirit of collaborative working FIC supported the newly established show procurement service across NWL which enables us to pool resources and skills across the system rather than duplicate efforts. After looking at the cost of outsourcing our Pharmacy to Boots we came up with a number of options with the favoured one being a wholly owned subsidiary of Chelsea and Westminster now known as CW Medicines which went live on the 1st April at the Chelsea site with a plan to roll out at the West Mid site.

A number of estate and maintenance projects have been approved to ensure that our facilities and equipment are fit for purpose.

The year ahead will be challenging with the budget for the coming year to break even which is dependant on achieving a much larger cost improvement plan at £23 million. ND ended by saying that to build resilience the Trust needs to collaborate across the system and be patient centered rather than operating in silos and single organisations. He welcomes the ICS and as a system we have a shared responsibility to make it a success.

WP asked whether ND has had problems with regard to patient data and how that operates between the different partners in ICS. ND responded that there is data available but it is not at the level we need it and that it is not integrated. LW added that Cerner will help us as Imperial also use this and Hillingdon and LNW will soon be joining the system.

RB asked how the Trust has coped during the recent hot weather. LW responded that in recent refurbishments of certain wards at WM the Trust invested in air conditioning. We ensured we responded to any complaints from wards quickly. VM explained that when we do all of our ward refurbishments which are on a rolling programme we build in ventilation and make sure we are as energy efficient as possible. We have just signed off the business case for replacing the roof at Chelsea which will help with some of the heat issues.

CDB asked how we are currently performing in relation to projects being completed on time and to budget. VM referred to the projects listed in the report which were all delivered to budget and on time. In summary it has improved.

Audit and Risk Committee Report to Council of Governors

NG introduced himself and presented the report highlighting the following points; the main role of the audit committee is to give the assurance that the systems are in place in delivery to ensure proper financial control of the spending and with the support of our internal and external auditors and our counter fraud specialist to make sure that the money is looked after and properly accounted for and that we have systems in place to ensure that we are identifying and properly mitigating the risks to delivery of the plans that those committees will decide in terms of the strategy of the organisation.

NG reported that our external advisors have given the Trust a clean bill of health and have been very complimentary in the broadest sense about our systems and financial control which is a tribute to our teams who have been working in the background where frontline delivery through covid has been a major headline and priority for all the staff in the organisation. NG extended thanks to all teams involved.

It was noted that Audit Committee will have responsibility for the risk register and the board assurance framework. NG gave assurance that the internal audit report has an overall rating of moderate which is the second highest rating that can be given and have noted the areas where the Trust had limited assurance and those have now been addressed.

DP thanked NG for all his help as a NED.

LA asked whether we have experienced any risks with the increase in quality of technology. NG responded that the risks lay more with older equipment so the priority updating and replacing that. The other element is legacy systems and the renewal of those. NG went on to explain the importance of updating technology and that it is not a luxury but a necessity as there are huge risks in not updating and it is an absolute necessity that we get that right.

Resolution:-

Both papers were formally noted and received by the Council of Governors.

3.2 Performance Reports:

- **Performance and Quality Report**
- **People Performance Report**

LW took both reports as read and opened to questions.

Resolution:- There being no questions, the COG resolved to note the content of both reports.

3.3 COG Sub-Committees:

- **Quality Sub-Committee Report**
- **Membership & Engagement Sub-Committee Report**

LJW took the Quality Sub-Committee Report as read and opened to questions

DP took the Membership & Engagement Sub-Committee Report as read and opened to

questions.

At this point DP raised concerns regarding the number of Governors in attendance resulting in the following action: **add an item to next agenda around how we engage with our Members and Governors.**

PJ

LA asked ED how they may be able to help. ED responded that it is a priority that they are working on.

Resolution:- There being no questions, the COG resolved to note the content of both reports.

3.4 Accessibility Work Update

SG took the paper as read and opened to questions.

Resolution:- There being no questions, the COG resolved to note the content of the report.

4.0 OTHER BUSINESS

4.1 Questions from the governors and the public

There were no questions posed by the public.

4.2 Any other business, including:

4.2.1 Forward plan

4.2.2 Schedule of meetings 2022/23

4.2.3 Governor attendance register

All papers were taken as read with no questions

- a) SG extended his thanks on behalf of the Board and COG to NG for his time, commitment and expertise as the Chair of the Audit Committee as his term of office comes to end in October

4.6 Date and Time of the Next Meeting

Council of Governors Meeting, 20 October 2022 at 1600 hours.

Meeting closed at 10:56.



DRAFT MINUTES OF COUNCIL OF GOVERNORS (COG)
1 August 2022 17.30-18.30
MST Virtual Meeting

Present:	Matthew Swindells	Chair	(MS)
	Lisa Addison	Patient Governor	(LA)
	Richard Ballerand	Public Governor	(RB)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Julie Carter	Public Governor	(JC)
	Dr. Simon Dyer	Lead Governor/Patient Governor	(SD)
	Parvinder Singh Garcha	Public Governor	(PSG)
	Cass J Cass-Horne	Public Governor	(CJCH)
	Minna Korjonen	Patient Governor	(MK)
	Anthony Levy	Public Governor	(AL)
	Rose Levy	Public Governor	(RL)
	Prof. Mark Nelson	Staff Governor	(MN)
	Will Pascal	Appointed Governor	(WP)
	David Phillips	Patient Governor	(DP)
	Jacquei Scott	Staff Governor	(JS)
	Des Walsh	Appointed Governor	(DW)

In attendance:

Stephen Gill	Vice Chair and Senior Independent Director	(SG)
Lesley Watts	Chief Executive Officer	(LW)
Jessica Barnett	Corporate Governance Officer	(JBa)
Dawn Clift	NWL Collaborative Programme Director	(DC)
Emer Delaney	Director of Communications	(ED)
Daryl Lutchmaya	Interim Deputy Director of Corporate Governance	(DL)
Sue Smith	Director of People and Organisational Development	(SSm)

Apologies:

Caroline Boulliat	Public Governor	(CB)
Stuart Fleming (proxy)	Public Governor	(SF)
Dr. Paul Kitchener	Public Governor	(PK)
Stella McCaskill	Patient Governor	(SM)
Laura Wareing (proxy)	Public Governor	(LJW)
Jeremy Booth	Patient Governor	(JB)
Trusha Yardley	Public Governor	(TY)
Thewodros Leka	Staff Governor	(TL)
Nicole Nunes	Staff Governor	(NN)
Catherine Sands	Staff Governor	(CS)

<p>1.1</p>	<p>Welcome and apologies for absence</p> <p>MS welcomed members of the Committee to the meeting. Apologies for absence were noted as above.</p> <p>SD updated the meeting that he had received email confirmation that he could act as a proxy for LJW and SF who were unable to attend, the COG approved that SD could apply these 2 proxy votes at the meeting.</p> <p>The meeting was quorate with 15 Governors attending, plus 2 proxys, total of 17; with a majority of patient and public Governors (13 of 17).</p> <p>The CWFT Constitution specified that no business shall be transacted at a meeting of the COG unless there are at least 13 Governors present, and of that 13, at least eight must be public or patient Governors. For the avoidance of doubt, the number of public or patient Governors present at a meeting should be in the majority.</p>	
<p>1.2</p>	<p>Declarations of Interest</p> <p>There were no declarations of interest received.</p>	
<p>1.3</p>	<p>North West London (NWL) Acute Provider Collaborative Governance Model</p> <p>MS introduced the item saying that the purpose was to bring together a Board in Common for the four Acute Trusts in NWL. The four Acute Trusts would continue to have the same relationships with their local Borough Councils, the NHS , their patient groups and for the two Foundation Trusts, their relationships with their individual Council of Governors (COG) would be unchanged.</p> <p>The NWL Collaborative would through localism, ensure that focus would be on place and would help the needs of local people. But at the same time it would take the learning that came out of the COVID-19 pandemic, which was that organisations worked better and delivered better care and better value to the people of NWL when they worked together.</p> <p>The Collaborative would try to design the best possible local care whilst at the same time maintaining the values and personalities of the four individual Trusts.</p> <p>Chelsea and Westminster, Imperial, London North West and Hillingdon would continue to be individual Trusts, but by bringing them together into a single Board in Common, would set a single direction and hold all four of the Trusts to account for the same high standards. In order to achieve this, it would require a number of changes to be made to the structures.</p> <p>The Collaborative Committees would consider issues that would be cross cutting across all four of the Trusts and the single Board in Common would take delegated responsibility from the four Trust Boards to set the strategy.</p> <p><u>Resolution:-</u></p> <p>The Council of Governors resolved to note the new model.</p>	

1.4	<p>Amendments to the Constitution of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT)</p> <p>DC introduced the paper. CWFT had become a national innovator and provider of services in the fields of gender affirmation, sexual health and maternity services. In order to represent people from outside of NWL, it was proposed to establish a ‘Rest of England’ Public constituency with a minimum membership of 50 people. This would also align with the Hillingdon Hospital Foundation Trust (THHT) which also has a ‘Rest of England’ Public Constituency.</p> <p>In response to AL’s question, DC confirmed that the Annual Members Meeting (AMM) would be notified of the COGs approval to the changes to the Constitution. In response to AL’s second question regarding why the constituency was so geographically wide and not just based on London, it was explained that sometimes patients who moved outside of NWL still wanted to be involved in the Trust and therefore the Rest of England constituency would be more appropriate.</p> <p>PSG enquired about how much voluntary sector representation would be present at the Board in Common to aid the Collaborative to address inequalities. He also enquired whether the decision to form a Collaborative Board in Common could be reversed in the future if required.</p> <p>MS replied that a number of the NEDs did in fact have experience of senior roles in the voluntary sector. On the second point, he said that a review would be undertaken after 12 months to assess progress and that each statutory Board could take a view to unwind the Board in Common if it decided to.</p> <p>DW enquired whether it would be possible for the Collaborative to form alliances with local universities to engage with communities to conduct trials.</p> <p>MS replied that Imperial College currently had nominated an Academic NED onto the Imperial and London North West Trust Boards which provided linkage around training, quality and around research; in the new structure these Academic NEDs roles would be extended to CWFT and THHT (see 1.5 below).</p> <p>MS moved the meeting on to the following recommendations; to:</p> <ul style="list-style-type: none"> a) approve the establishment of a new ‘Rest of England’ public constituency as a modification to the CWFT constitution Annex 1 and Annex 4 b) approve the creation of an additional public Governor seat to represent this new constituency – Annex 4 c) approve a minimum membership of 50 for this new public constituency – Annex 4 d) approve an amendment to Annex 9 of the Constitution– Clause 3.2 – Amend to state that the Board of Directors will meet in public as part of the NWL Acute Provider Collaborative no less than four times a year and will hold an AMM in public once a year. <p><u>Resolution:-</u></p> <p>The Committee resolved to approve the recommendations.</p>	
1.5	<p>Report from the COG Nomination and Remuneration Committee held on 28 July 2022 – Non-</p>	

	<p>executive Director Appointments and Remuneration</p> <p>DC presented the item. The Nomination and Remuneration Committee of the COG recommended the approval of the following to the COG:</p> <ul style="list-style-type: none"> - approval of the five new Non-Executive Directors (details in Appendix 'B'), - approval of a 1-year term of office for 2 new NEDs, Professor Andy Bush and Peter Goldsborough, commencing 1 September 2022 until 30 August 2023, - approval to a second 3-year term of office for 2 existing NEDs, Aman Dalvi and Ajay Mehta, commencing 1 December 2022 until 30 November 2025, and - approval to the remuneration of voting NED positions (excluding the Chair and Vice Chair) in the sum of £13,000 per annum plus a £5,000 annual complexity allowance. - Approval of Aman Dalvi as the Chair of the Audit and Risk Committee (ARC) <p>MS provided a brief background to each of the 5 NEDs being proposed to serve on the CWFT Board.</p> <p><u>Resolution:-</u> The Committee resolved to approve the recommendations.</p>	
1.6	<p>Any Other Business</p> <p>There was no other business.</p>	



Council of Governors – 21 July, 2022 Action Log

Date	Minute number	Action	Current Status	Due/ Completion Date	Lead
21 Jul, 2022	3.3	Membership & Engagement Sub-Committee Add to next agenda around how we engage with our Members and Governors	See agenda item 2.6 of meeting of 20/10/2022	20/10/2022	PJ / DP
		COMPLETED ACTIONS TO BE REMOVED			
21 Apr, 2022	1.2	Declarations of Interest RB to write to Corp Governance team confirming interest and then publish on the Council of Governors register of Interests on the website	RB has written to Corp Governance team – Team has update register accordingly	June, 2022	RB / DL

1. Meeting Staff

2. As I have committed to since taking on the Chair in common role earlier this year, I have been on a number of visits and had the privilege to meet lots of staff across the breadth of our sites. My thanks as ever to the people who organised my visits and to the people who were so generous with their time in showing me their departments and services. Below is round up of some of the visits I have been on.
3. At **West Middlesex**, I had a tour of the maternity ward with Mark Murphy, Head of Facilities and his team, I went to see the Acute Medical Unit and Ambulatory Emergency Care service team with Sanjay Krishnamoorthy, Service Director for Acute Medicine giving me a tour. I also had the opportunity to attend the Junior Doctors induction session and answered questions.
4. At **Chelsea and Westminster** I have visited a number of services, I had a guided tour of the Intensive Care Unit, visited the Planned Care Division, specifically the Treatment Centre and the Burns Unit, thanks to Nicola Rose and her team. I also attended the ChelWest Innovation Expo to celebrate its three year anniversary, it was great to see such a range of people associated with Chelsea and Westminster coming together to share learning to improve patient care. I also last week attended a film screening at the medicinema of Below the Belt which was about endometriosis.
5. At **Hillingdon** I met with Kirsty Farrell, Clinical Services Manager & Trauma Service Lead to have a tour of the Emergency Department and I also met with members of the occupational therapy, pharmacy and integrated discharge teams. I accompanied Steve Barkley, then the Secretary of State for Health and Social Care when he visited for a tour at Hillingdon. I enjoyed being part of the Hillingdon Open Day last month where I got to meet staff (including staff from the Capitals Nepalese community) and members of the local community as well as receiving the gift from the Guild of Embroidery.
6. At **St Mary's** I had a tour of the Emergency Department and the Major Trauma service with Barbara Cleaver, Head of Specialty Emergency Medicine, joined a ward accreditation visit to the trauma Unit, and took part in a Schwartz round led by Alex King, Consultant Psychologist and was part of a Schwartz panel discussing being new at the trust.
7. At **Charing Cross** I visited the therapies and pharmacy departments, thanks to Ann Mounsey, Chief Pharmacist and Charlotte Allanby, Head of Adult Occupational Therapy for Physiotherapy for showing me around. I also attended the Summer Leadership Forum for staff at Imperial College Healthcare NHS Trust.
8. At **Northwick Park** I met with the Surgery Division and we walked around the operating theatres with Kevin Finlinson, Divisional Director of Operations, and Matthew Bartlett, Divisional Medical Director on the hottest day of the year. I also joined the senior leaders, as part of the Trust Board day, to have a tour of the Emergency Department and Same Day Emergency Care services.
9. At **Ealing Hospital** I met a number of the leadership team and had a tour of clinical areas, including Radiology and Endoscopy and I visited the planned site for the new Community Diagnostic Centre (CDC). I also attended a memorial tree planting funded by LNWH Charity. The hospital was the location for hit BBC drama 'This is going to hurt', written by former doctor Adam Kay. The tree has been planted in memory of NHS staff who have died by suicide.
10. At **Central Middlesex** I visited Gladstone 1 ward and the St Mark's Hospital. I also had the opportunity to talk meet with Mark Titcombe, Managing Director EOC, CMH & Ealing, Edgar Swart, Divisional Director of Nursing and Chloe Cox, Implementation Lead, Transformation Team to talk about the Elective Orthopaedic Centre and I also met with Evelyn Mensah, the clinical lead for ophthalmology to discuss outpatient plans.
11. I was also delighted to join the first part of the listening event for staff of **London North West University Healthcare NHS Trust** and attended the staff excellence awards ceremony.

12. I am still working on visiting every site and meeting as many staff across all departments as I can. So, please, if you would like me to visit your department, please contact my office.

13. The Acute Collaborative

14. The four acute NHS trusts in North West London have formally come together under a single board in common. A lot of work has happened over the summer to move from four to one board. In July all four trust boards as well as NHS England approved the plans to move to work as an acute collaborative across North West London. During August we ran an Non-Executive Director (NED) appointment process and have appointed the 19 NEDs that will sit on the board in common. The new structures will build on the close partnership working that offered so many advantages to patients during the Covid-19 pandemic and will support us as we strive to recover services.

15. I would also like to take this opportunity to thank the outgoing non-executives directors, Ayesha Akbar (The Hillingdon Hospitals NHS Foundation Trust), Kay Boycott (Imperial College Healthcare NHS Trust), Beverley Ejimofe (Imperial College Healthcare NHS Trust), Nick Gash (Chelsea and Westminster), Eliza Hermaan (Chelsea & Westminster NHS Foundation Trust), Ben Maruthappu (Imperial College Healthcare NHS Trust), Andreas Raffel (Imperial College Healthcare NHS Trust) and Andrew van Doorn (London North West University Healthcare Hospitals NHS Trust).

16. The Board in Common did have an Imperial (host Trust) and Hillingdon NED position which remained vacant after the summer. I am pleased to confirm, after a successful recruitment process Nick Gash has been appointed into this role. We are still waiting for NHS England to officially approve this role and will announce it formally once this has happened. Many of you will know Nick, as he has recently stood down as a Chelsea and Westminster NED, he will bring a breadth of knowledge to the Acute Collaborative going forward.

17. Our clear challenge now is to take best of what we do and spread it across North West London. Please see the North West London Acute Provider Collaborative Statement of Intent, below in Annex 1. During September we have had our first Collaborative Committees, each are led by one of the Vice Chairs and one of the four Trust Chief Executives; i) **Quality** (Stephen Gill and Tim Orchard), Chel/West membership - Roger Chinn, Rob Beasdale, Syed Mohinuddin and Peter Goldsbrough ii) **Finance and Performance** (Catherine Jervis and Lesley Watts), Chel/West membership Nilkunj Dodhia, Rob Hodgkiss, Virginia Massaro, iii) **People** (Janet Rubin and Pippa Nightingale) Chel/West membership – Ajay Mehta, Sue Smith and iv) **Infrastructure and Capital** (Patricia Wright and Bob Alexander), Chel/West membership – Neville Manuel, Aman Dalvi and Virginia Massaro.

18. The Collaborative Committees are in place to :

- i. Oversee and receive assurance that the Trust level Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- ii. Oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
- iii. Identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements

19. The Quality Collaborative Committee received assurance that all four trusts are on track to achieve full compliance against all 10 safety actions detailed in the CNST Maternity Scheme but acknowledged that there were operational risks which could occur during the winter which could potentially impact delivery. In addition, the Committee noted that during July, August and September all Trusts have had an assurance visit by the NHS London regional team to provide assurance against the 7 immediate and essential actions (IEAs) from the interim Ockenden report (December 2020). They reviewed progress against compliance with subsequent recommendations issued. The committee also agreed three pillars of our quality improvement approach -

- I. Transparent and comparable data across all four Trusts to inform quality improvement, risk identification and bench marking.

- II. The adoption of evidence based best practice across our services, apply GIRFT and other evidence sources across the collaborative, not just individual Trust level.
- III. Clinical Peer Review where senior clinicians from all 4 Trusts will walk the core pathways for a service at all the locations it is delivered within the collaborative to:
 - a) identify improvement changes that can be made immediately
 - b) identify staff and skills changes that are needed over time to enable best practice
 - c) identify capital changes that are needed over time to enable best practice

20. At the Finance and Performance Collaborative Committee the year to date deficit of £27.7M against a plan of £10M deficit was scrutinised with causal factors noted as ERF recovery, CIP delivery and in year cost pressures. Work continues to identify an appropriate forecasting and reporting approach plus the identification and deployment of appropriate affordable actions to improve delivery of the financial plan.

21. At the People Collaborative Committee, a number of workforce metrics are under considerable pressure including increasing levels of sickness absence. The past 12 months has seen an increase in the rolling sickness absence rate which is at 4.8%. This is a special cause concern.

22. At the Infrastructure and Capital Collaborative Committee, a review of the Strategic Collaborative Estate Context took place at the meeting, along with a review of the Collaborative's Digital Strategy.

23. Pleased that by working together the four acute hospitals in North West London have collectively recovered their acute activity post Covid faster than any other sector in London and the shortest ambulance handover times of any sector. There is still a large amount to do to get waiting times and finances back to where we would want them to be. The advantage of our brilliant staff working together on behalf of local people is already there to see.

24. Elective Orthopaedic Centre (EOC)

25. We have this week gone out to public consultation on the Elective Orthopaedic Centre which we are proposing will be based at Central Middlesex Hospital, as we emerge from the pandemic with long waiting lists and many other pressing challenges, we want to draw on best practice from other areas and go further with our improvements. We want to bring together much of the routine, inpatient orthopaedic surgery for the population of North West London in a purpose-designed centre of excellence, completely separated from emergency care services.

26. The public consultation will run between Monday 17 October 2022 and Friday 20 January 2023 to get feedback on our proposal. We want to connect with as many people as possible across North West London, ensuring everyone has the chance to find out more, share their views and possibly get involved in the project.

27. Our Staff

28. I wanted to finish my report with a thank you to all staff across the four trusts, we have had one of the toughest summers in NHS history as we work hard to recover services. An example of staff's outstanding efforts was during the heatwave in July, clinical and non-clinical staff did brilliantly in caring for and treating patients, and in keeping them and staff safe, through the unprecedented temperatures seen during the heatwave. Especially considering that many of our facilities need capital investment, such as Hillingdon, St Mary's and Northwick Park, the dedication to keep services running safely was magnificent.

29. I have had the privilege of attending staff award ceremonies at London North West, Chelsea and Westminster and Hillingdon. It was great to see so many staff coming together to celebrate the successes across the trusts after several challenging years. Congratulations to all the winners and nominees, it was very inspiring to hear all the work and services that are being delivered across North West London. Thank you also to the staff and patients for taking the time to nominate staff, I know it was greatly appreciated.

Annex 1

North west London acute provider collaborative

Statement of Intent

Purpose

The purpose of this document is to set out a joint statement of intent across the four acute trusts in North West London – Chelsea and Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust – regarding the development of our acute provider collaborative. It includes the principles which we propose to use to guide the development and management of the collaborative.

Background

All NHS and care organisations in the eight boroughs of North West London have come together as the [North West London Integrated Care System](#) to deliver four key objectives, to:

- improve outcomes in population health and health care
- prevent ill health and tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader economic and social development.

As part of the wider NHS changes that led to the development of integrated care systems, there is also an expectation for trusts providing acute health services [to come together to form provider collaboratives](#) by April 2022. They will be a key component of system working, providing opportunities to improve care by working together effectively at scale.

Our vision for collaboration

We have developed increasingly effective partnership working arrangements in response to Covid-19 and this collaborative approach is helping us now as we emerge from the pandemic with the urgent need to restore planned care capacity and reduce waits and delays.

Our vision is to expand our collaboration to support sustainable improvements in all aspects of our work, for the benefit of our patients, local communities and staff. We believe we have all the elements to help create one of the best health systems in the world - a committed and diverse workforce, world-leading research and innovation and deepening relationships with our communities and stakeholders. If we share and embed the best of what we see across our hospitals – in terms of ways of working, outcomes and experience – we have the potential to do something extraordinary.

In particular, we want our provider collaborative to:

- make the most of our collective resources, ensuring we provide high quality care as quickly as possible according to clinical need
- achieve continuous improvements in quality, efficiency and outcomes by supporting each other to identify, adopt and embed best practice
- proactively tackle unwarranted variations and inequalities in access and experience

- make better, collective use of our corporate and clinical support services
- promote the development of alliances and networks at all levels to support the development of more joined up care between and within specialties
- ensure our hospitals attract and retain excellent staff by fostering a supportive and inclusive working culture with a commitment to learning and development, health and wellbeing
- develop care models and care pathways that better meet the needs of our patients and communities, ensuring we understand and respond to views of all our users
- achieve more rapid and consistent spread of innovation, research and technology.

We want patients to be at the heart of everything we do and, further, to actively benefit the health and wellbeing of our local communities. We are committed to providing the best possible care to patients irrespective of age, disability, religion, race, gender or sexual orientation, ensuring that our services are accessible to all but tailored to the individual.

We will establish governance arrangements that enable us to reach joint decisions effectively and efficiently, which each partner is then committed to upholding. These arrangements will also enable us to hold each other to account, ensuring that decisions are implemented and benefits are realised.

Key principles of collaboration

In developing and managing the collaborative, we will draw on the following principles:

- a commitment to delivering a step change in quality and financial and operational performance across our system
- a commitment to treat everyone fairly and inclusively
- maximising the benefit of our collective resources by improving coordination and avoiding duplication
- collective decision-making for the benefit of our patients, communities and staff
- transparency of our data, information and decisions
- a commitment to join up our strategies and planning
- respect for the continuing statutory roles of our respective trust boards and councils of governors (in the case of foundation trusts).

Chelsea and Westminster NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

Imperial College Healthcare NHS Trust

London North West University Healthcare NHS Trust

CONFIDENTIAL

TITLE AND DATE (of meeting at which the report is to be presented)	Council of Governors, 20.10.22											
AGENDA ITEM NO.	XX5											
TITLE OF REPORT	External Audit Contract Extension											
AUTHOR NAME AND ROLE	Virginia Massaro – Chief Financial Officer											
ACCOUNTABLE EXECUTIVE DIRECTOR	Virginia Massaro – Chief Financial Officer											
THE PURPOSE OF THE REPORT <table border="1"> <tr> <td>Decision/Approval</td> <td>X</td> </tr> <tr> <td>Assurance</td> <td></td> </tr> <tr> <td>Info Only</td> <td></td> </tr> <tr> <td>Advice</td> <td></td> </tr> </table> Please tick below and then describe the requirement in the opposite column	Decision/Approval	X	Assurance		Info Only		Advice		The Council of Governors is asked to approve the 2 year extension to Deloitte LLP as the Trust’s external auditors, subject to Audit Committee approval on 27th October 2022.			
Decision/Approval	X											
Assurance												
Info Only												
Advice												
REPORT HISTORY Committees/Meetings where this item has been considered)	<table border="1"> <thead> <tr> <th>Name of Committee</th> <th>Date of Meeting</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>CEO Cabinet</td> <td>10/10/2022</td> <td>Approved</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name of Committee	Date of Meeting	Outcome	CEO Cabinet	10/10/2022	Approved					
Name of Committee	Date of Meeting	Outcome										
CEO Cabinet	10/10/2022	Approved										
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	This paper updates the Council of Governors on the progress to award a new contract for the provision of External Audit services. Following a failed tender process in early 2022, it is proposed to extend the current external audit contract with Deloitte for a further 2 years to September 2024. The intention is to retender the service to move to a new contract from October 2024.											
KEY RISKS ARISING FROM THIS REPORT	N/A											
STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)												
<table border="1"> <tr> <td>Deliver high quality patient centred care</td> <td>Y</td> </tr> <tr> <td>Be the employer of Choice</td> <td>N</td> </tr> </table>	Deliver high quality patient centred care	Y	Be the employer of Choice	N								
Deliver high quality patient centred care	Y											
Be the employer of Choice	N											



Deliver better care at lower cost	Y	
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<p>IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:</p> <table border="1"> <tr> <td>Equality And Diversity</td> <td>N</td> </tr> <tr> <td>Quality</td> <td>Y</td> </tr> <tr> <td>People (Workforce or Patients/ Families/Carers)</td> <td>N</td> </tr> <tr> <td>Operational Performance</td> <td>N</td> </tr> <tr> <td>Finance</td> <td>Y</td> </tr> <tr> <td>Public Consultation</td> <td>N</td> </tr> <tr> <td>Council of Governors</td> <td>Y</td> </tr> </table> <p>please mark Y/N – where Y is indicated please explain the implications in the opposite column</p>	Equality And Diversity	N	Quality	Y	People (Workforce or Patients/ Families/Carers)	N	Operational Performance	N	Finance	Y	Public Consultation	N	Council of Governors	Y	<p>As noted above.</p>
Equality And Diversity	N														
Quality	Y														
People (Workforce or Patients/ Families/Carers)	N														
Operational Performance	N														
Finance	Y														
Public Consultation	N														
Council of Governors	Y														

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT)	
Commercial Confidentiality	Y
Patient Confidentiality	N
Staff Confidentiality	N
Other Exceptional Circumstances (please describe)	

1. Introduction

This paper updates the Council of Governors on the progress to award a new contract for the provision of External Audit services. The external audit contract is currently with Deloitte LLP and was originally undertaken as a joint tender with the Royal Marsden Hospital NHS FT.

2. Current Status of Contracts

External Audit contract (Deloitte):

- Start date 01/10/2017
- Initial term 3 years
- End date of initial term 30/09/2020
- Length of extension within contracts 2 years, end date of extended term **30/09/2022**
- Annual (2021/22) contract value £155k

3. Tender Outcome

The Trust started the tender process for External Audit services in early 2022 which unfortunately failed as there were no bids received.

This is a similar tender outcome seen by other NHS organisations nationally, where there are known issues with the external audit market for NHS organisations. Other Trusts in NWL have also had failed tenders for external audit services and have had to extend existing contracts.

The Healthcare Financial Management Association (HFMA) published a report on the current issues with the external audit market in August 2022 and highlighted 3 key drivers:

- Audit risk - There is now significantly greater regulatory pressure from the Financial Reporting Council (FRC) on audit firms to deliver higher quality audits and to demonstrate much greater professional scepticism. Audit firms face an increase in both reputational risk and the potential for significant fines. They need to consider the risk of local audit to the firm overall, and its opportunity cost compared to delivering other services.
- Auditor capacity – shortage of supply of auditors due to a small pool of public sector auditors, requirement to separate external audit & non-audit services, independence considerations, tight and competing deadlines and recruitment and retention issues
- Fee levels - Fees relative to the corporate sector have been historically low.

4. Extension Proposal

Deloitte have agreed to extend the contract for 2 further years at a negotiated annual cost of £250k. This is based on the estimated number of hours for the 2022/23 year-end audit at the East of England procurement framework rates. While this represents a significant increase in the contract value, this increase is in line with other Trusts currently extending contracts due to the difficulties in the external audit market. It is intended to retender in 2 years' time.

5. Decision required

The Council of Governors is asked to approve the 2 year extension to Deloitte LLP as the Trust's external auditors, subject to Audit Committee approval on 27th October 2022.

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TITLE AND DATE (of meeting at which the report is to be presented)	Council of Governors, 20.10.22											
AGENDA ITEM NO.	2.4											
TITLE OF REPORT	Election Update											
AUTHOR NAME AND ROLE	Daryl Lutchmaya – Deputy Director of Corporate Governance											
ACCOUNTABLE EXECUTIVE DIRECTOR	Lesley Watts – Chief Executive Officer											
THE PURPOSE OF THE REPORT <table border="1"> <tr> <td>Decision/Approval</td> <td></td> </tr> <tr> <td>Assurance</td> <td></td> </tr> <tr> <td>Info Only</td> <td>X</td> </tr> <tr> <td>Advice</td> <td></td> </tr> </table> Please tick below and then describe the requirement in the opposite column	Decision/Approval		Assurance		Info Only	X	Advice		The Council of Governors is asked to note the seats that will be elected to at the end of 2022 / start of 2023.			
Decision/Approval												
Assurance												
Info Only	X											
Advice												
REPORT HISTORY Committees/Meetings where this item has been considered)	<table border="1"> <thead> <tr> <th>Name of Committee</th> <th>Date of Meeting</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name of Committee	Date of Meeting	Outcome								
Name of Committee	Date of Meeting	Outcome										
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	This report highlights those seats that will be elected to and those which will stand for re-election. <u>Public Constituency</u> Re-election of 5 seats Election of 2 seats <u>Patient Constituency</u> Election of 1 seat <u>Staff Constituency</u> Re-election of 1 seat Election of 1 seat <u>Rest of England Constituency</u> Election of 1 seat											
KEY RISKS ARISING FROM THIS REPORT	N/A											
STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)												
<table border="1"> <tr> <td>Deliver high quality patient centred</td> <td>Y</td> </tr> </table>	Deliver high quality patient centred	Y										
Deliver high quality patient centred	Y											



care		
Be the employer of Choice	N	
Deliver better care at lower cost	Y	

<p>IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:</p> <table border="1"> <tr> <td>Equality And Diversity</td> <td>Y</td> </tr> <tr> <td>Quality</td> <td>Y</td> </tr> <tr> <td>People (Workforce or Patients/Families/Carers)</td> <td>Y</td> </tr> <tr> <td>Operational Performance</td> <td>N</td> </tr> <tr> <td>Finance</td> <td>N</td> </tr> <tr> <td>Public Consultation</td> <td>Y</td> </tr> <tr> <td>Council of Governors</td> <td>Y</td> </tr> </table> <p>please mark Y/N – where Y is indicated please explain the implications in the opposite column</p>	Equality And Diversity	Y	Quality	Y	People (Workforce or Patients/Families/Carers)	Y	Operational Performance	N	Finance	N	Public Consultation	Y	Council of Governors	Y	
Equality And Diversity	Y														
Quality	Y														
People (Workforce or Patients/Families/Carers)	Y														
Operational Performance	N														
Finance	N														
Public Consultation	Y														
Council of Governors	Y														

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT)	
Commercial Confidentiality	Y
Patient Confidentiality	N
Staff Confidentiality	N
Other Exceptional Circumstances (please describe)	

1. Introduction

This paper updates the Council of Governors on those seats that are being elected to due to their being a vacancy and those which are being re-elected to.

2. Seats being elected

Please refer to the attached table

Public Constituency: Re-election

- 1 seat - Royal Borough of Kensington and Chelsea
- 1 seat - London Borough of Wandsworth
- 1 seat - London Borough of Hammersmith and Fulham
- 2 seats - City of Westminster

Public Constituency: Election

- 2 seats - London Borough of Richmond Upon Thames

Staff Constituency: Re-election

- 1 seat - Allied Health Professionals, Scientific and Technical

Staff Constituency: Election

- 1 seat - Support, Admin and Clerical

Patient Constituency – Election

- 1 seat – Patient Constituency

Rest of England Constituency - Election

- 1 seat – Rest of England

3. Process

A Governor may hold office for a period of up to three years. The returning officer will undertake the election of Governors in accordance with the Model Election Rules. An elected or an appointed Governor shall be eligible for re-election or re-appointment as appropriate at the end of his Term and may be re-elected or re-appointed for consecutive Terms provided that a Governor shall not hold office for longer than nine years. The full election results will be made available to the Council of Governors and to all election candidates.

4. Next steps

The Returning Officer, Civica Electoral Services has been notified of the forthcoming elections and will be providing a quotation to manage the process. The election timetable is being drawn up by Corporate Governance and the publications are being designed between Civica Electoral Services and the internal Communication Team.

NWL Maternity CNST yr4 Q2 position

September 2022




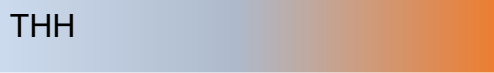
















Background / Context

- Year 4 of the scheme paused between Dec 21 and May 22 due to the impact of Covid 19 in maternity services in England.
- Publication on the 6th May set out revised timeframes to demonstrate compliance with all 10 safety actions
- Since inception, NW London LMNS have worked collaboratively to support units/trusts to achieve compliance
- Revised compliance deadline: 2nd February 2023

Q2 position against actions 1 - 5

Action 1	Are you using the PMRT to review perinatal deaths?			
Providers	CWHFT	ICHT	LNWUHT	THH
LMNS Status	In progress			
Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
Providers	CWHFT	ICHT	LNWUHT	THH
LMNS Status	At risk			
Action 3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
Providers	CWHFT	ICHT	LNWUHT	THH
LMNS Status	In progress			
Action 4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?			
Providers	CWHFT	ICHT	LNWUHT	THH
LMNS Status	In progress			
Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
Providers	CWHFT	ICHT	LNWUHT	THH
LMNS Status	At risk			

Q2 position against actions 5 - 10

Action 6	Can you demonstrate compliance with all five elements of the SBL care bundle v2?			
Providers	CWHFT 	ICHT 	LNWUHT 	THH 
LMNS Status	In progress			
Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?			
Providers	CWHFT 	ICHT 	LNWUHT 	THH 
LMNS Status	Compliant			
Action 8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?			
Providers	CWHFT 	ICHT 	LNWUHT 	THH 
LMNS Status	At risk			
Action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			
Providers	CWHFT 	ICHT 	LNWUHT 	THH 
LMNS Status	In progress			
Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?			
Providers	CWHFT 	ICHT 	LNWUHT 	THH 
LMNS Status	Compliant			

Summary / Next steps

- Progress against compliance monitored monthly through the LMNS
- Actions 2 – digital compliance is a risk across the system with support and investment required
- Action 3 – requires improved collaborative working with neonatology inc system level audit oversight
- Actions 4, 5 & 8 – all related to workforce planning and education identified level of risk noted.
- Delayed submission deadline welcomed by the LMNS
- Final CNST declaration to be signed of by trust/collaborative board January 2023

Membership Engagement and Communications Strategy - update

Council of Governors meeting
20 October 2022

Membership strategy - background

The Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) developed its initial Membership Strategy in 2006 as part of its work to become an NHS Foundation Trust. Following the acquisition of the West Middlesex University Hospital NHS Trust (WMUH) on 1 September 2015 a further plan had been developed (2015-2016) to ensure that the Trust's membership base was representative of the Trust's increased patient population base post-acquisition; reflecting the communities that the Trust serves with Governors actively representing the interest of members as a whole and the interests of public.

During 2018, the Membership and Engagement Committee (a sub-committee of the Council of Governors), reviewed the 2016 – 2018 strategy to ascertain what was working well and where further focus is required. In addition, a survey of all its patient and public members was conducted to determine how the Trust can increase the active engagement of its members.

The outputs of both of these activities have informed the latest version of the membership engagement and communications strategy for 2019-21.

The strategy is therefore due for review.

Membership strategy (2019-21)

The previous membership strategy was focused around two main objectives:

- Objective 1: Maintain and build membership numbers whilst ensuring the membership is representative of the population the Trust serves
- Objective 2: Effectively engage and communicate with members

Objective 1: Maintain and build membership numbers whilst ensuring the membership is representative of the population the Trust serves

The recruitment plan is to recruit at all levels of the community ensuring regardless of an individual's protected characteristic for example age (members must be 16+), gender, ethnicity, disability, sexual orientation or religion thereby providing a good balance of opinion and participation with the Trust.

The governors and the Trust will always strive to recruit members that are representative of their local community's profile.

The current position regarding membership profile is outlined in the following slides...

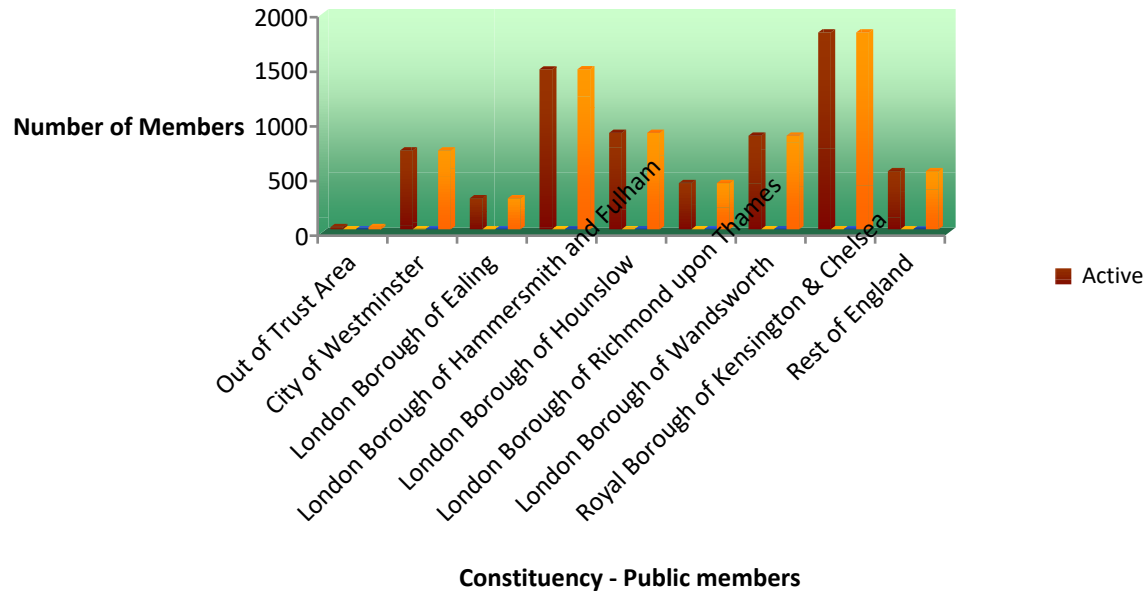
Objective 1 – current membership profile

The Trust currently has **18,289** members (2019 figures in brackets) in total broken down into:

- **6,988** public (7,122), **5,470** patients (5,687), and **5,831** staff (same).

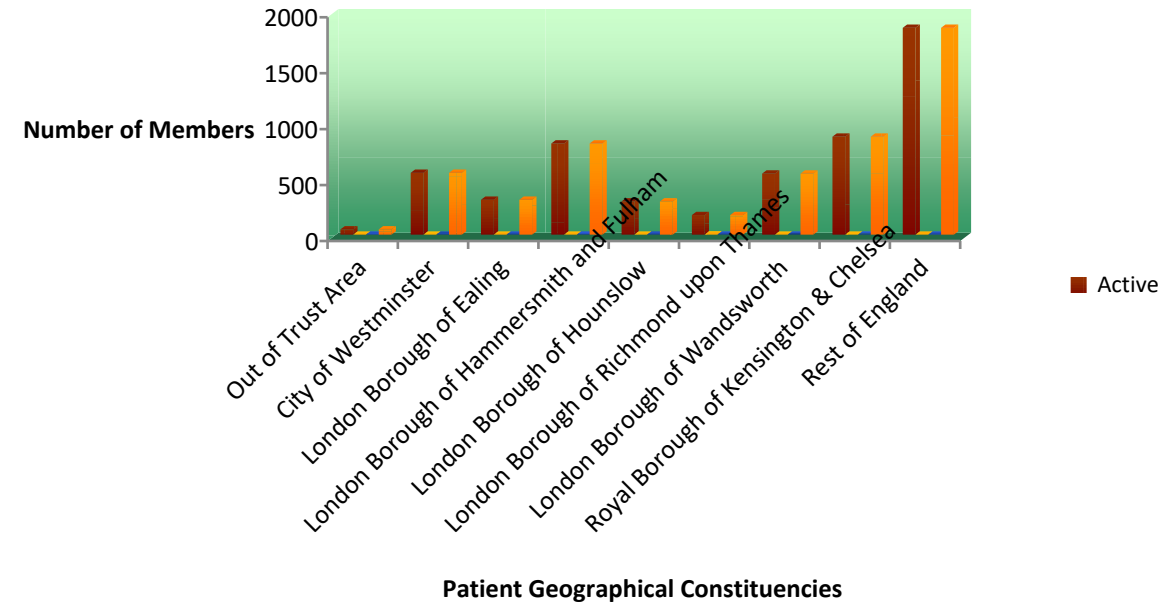
Constituency - Public members Chart

Filters:



Patient Geographical Constituencies Chart

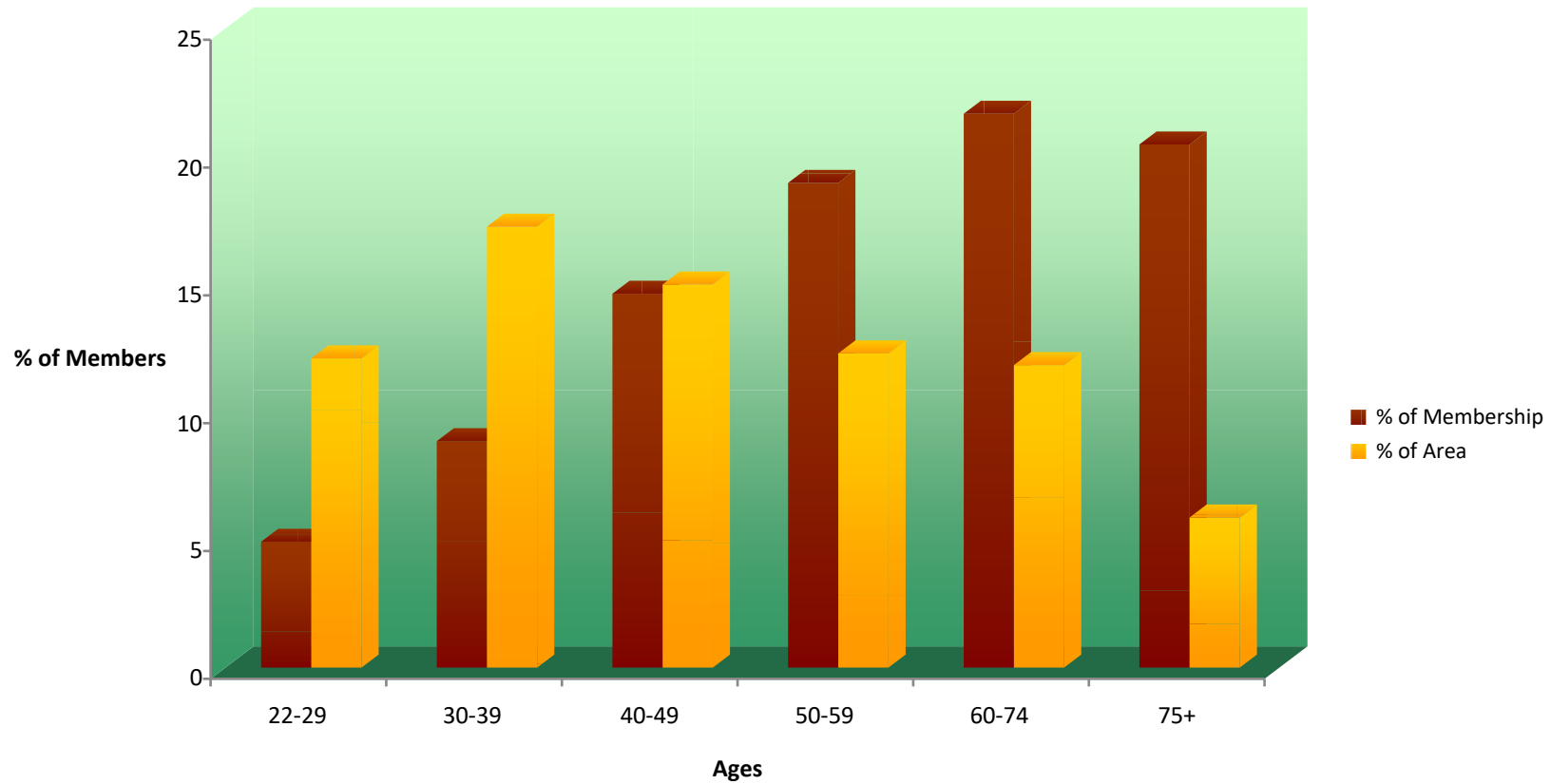
Filters:



[The RoE figure is 532 members within the public constituency. Out of Area is people with a non-English postcode or a postcode/address which is incomplete, meaning they can't accurately be placed in the correct constituency.]

Objective 1 – current age profile

Age Chart
Filters:

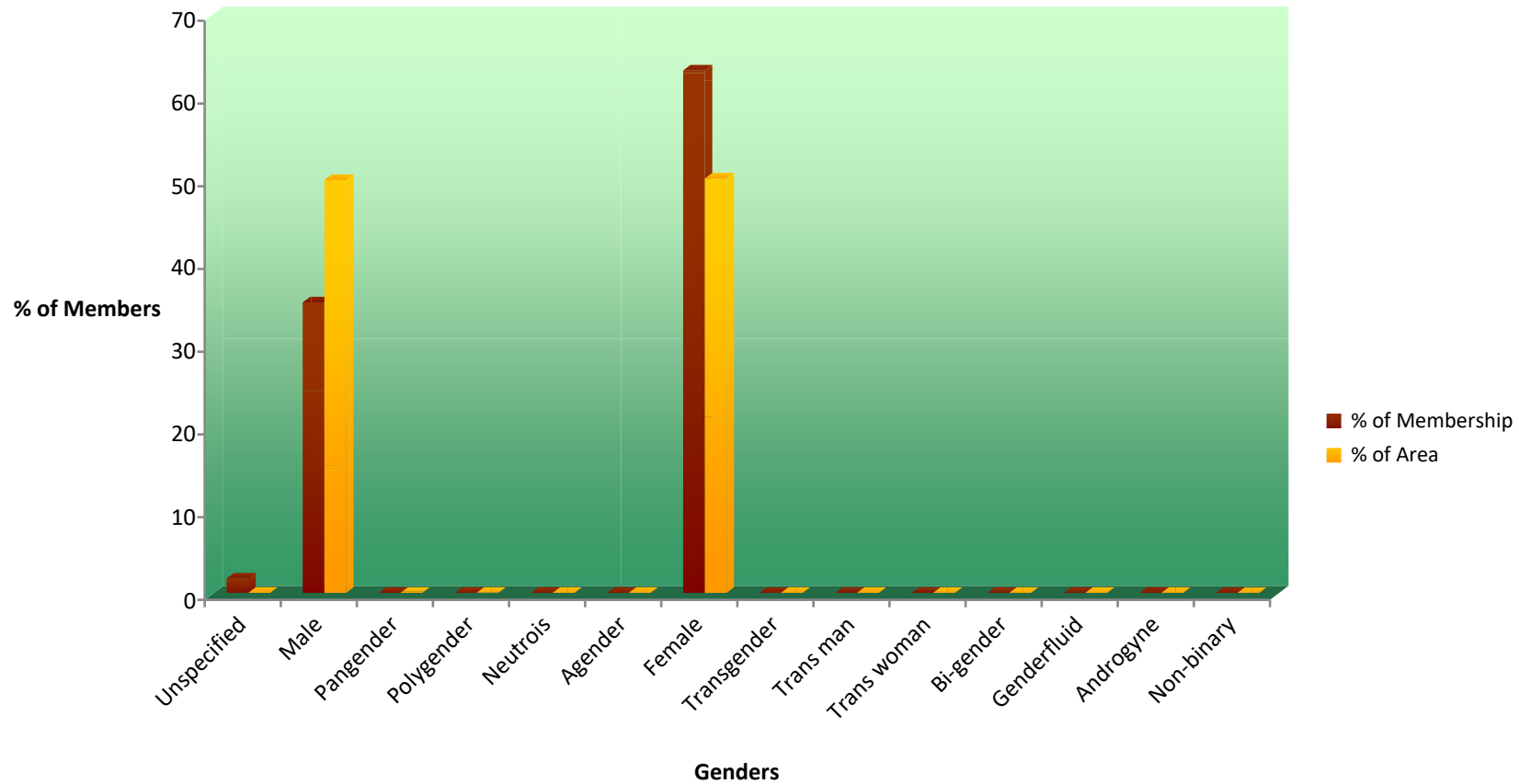


Source: 2014 Population Projections, CA

Younger population remains under represented compared with the local population

Objective 1 – current gender profile

Gender Chart
Filters:



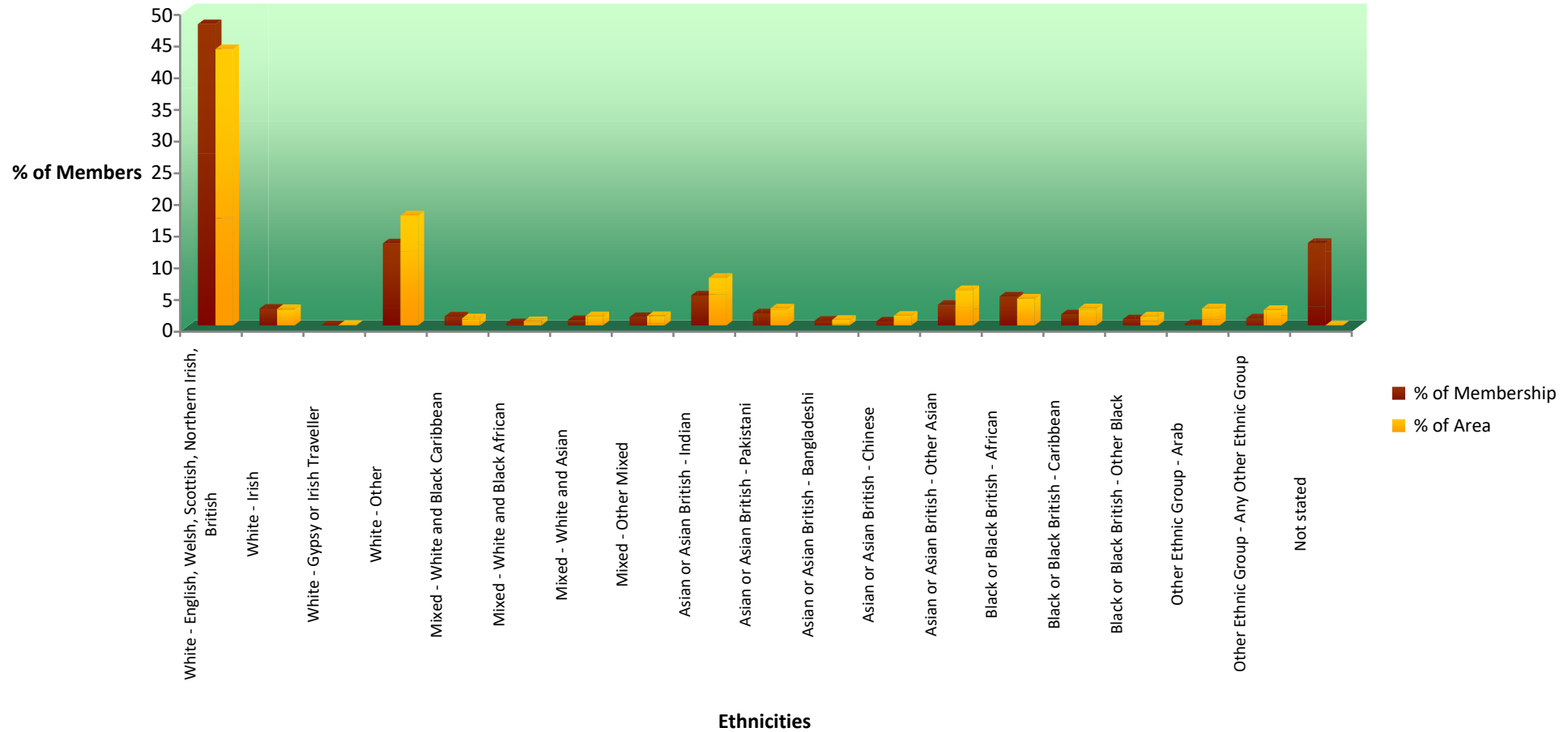
Source: 2014 Population Projections, CAI

Male population remains under represented compared with the local population

Objective 1 – current ethnicity profile

Ethnicity Chart

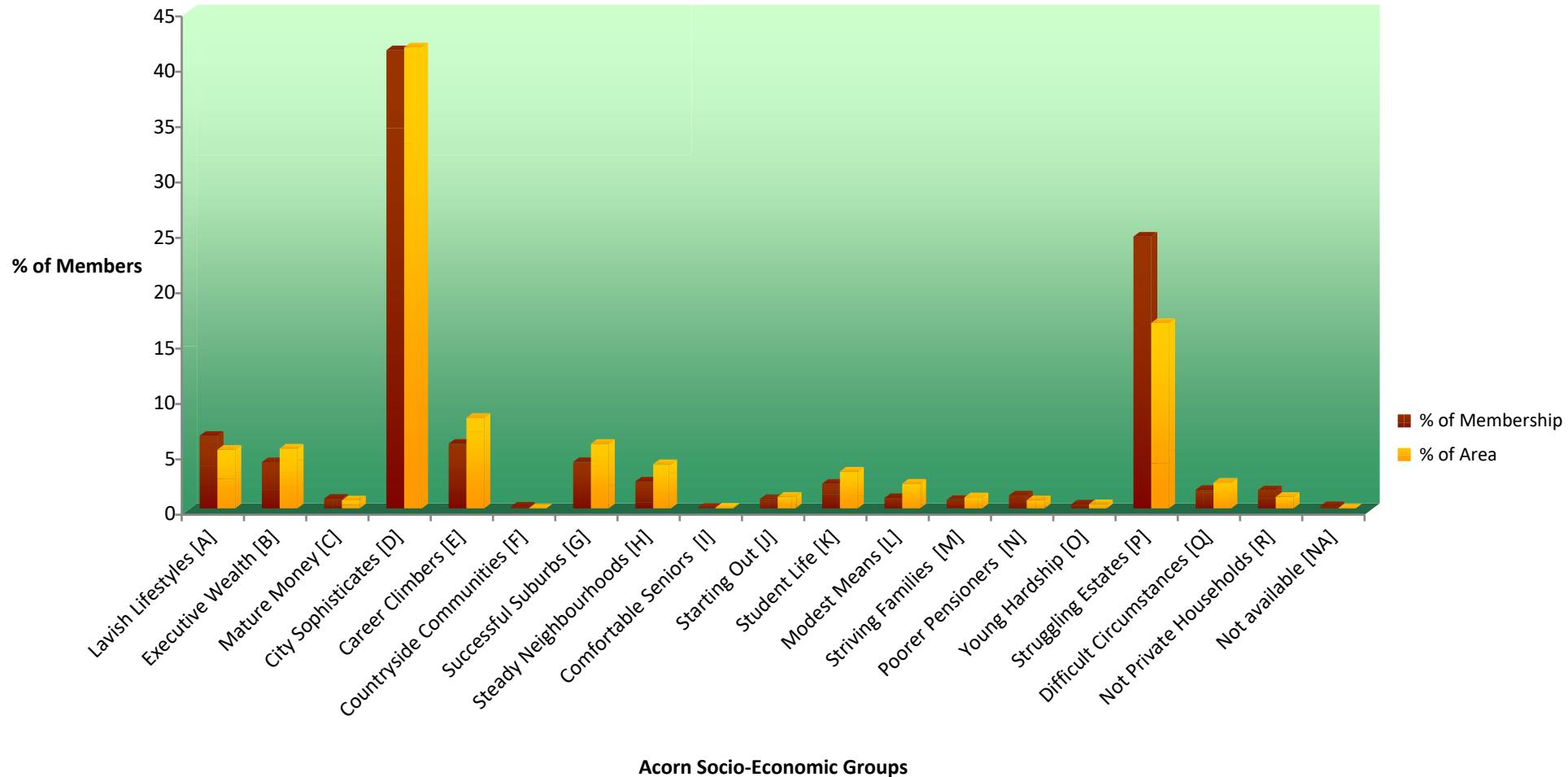
Filters:



Source: 2011 Census, Office of National Statistics

Objective 1 – current socio-economic profile

Acorn Socio-Economic Group Chart
Filters:



Objective 2: Effectively engage and communicate with members

The Trust is committed to maintaining a two-way dialogue with its membership by promoting work of the Trust and its Governors and identifying opportunities for communication between Members and Governors.

Objective 2: Effectively engage and communicate with members

Membership engagement and communication activities

- **Annual Members Meeting** – a statutory requirement the Trust is obliged to ensure happens on an annual basis, but also including presentations
- **Monthly e-newsletter (*Members' E-News*)** – currently sent out via the membership database to approximately 3,570 public and patient members who have provided us with their email addresses.
- **Printed Trust Magazine (*Going beyond*)** – the Trust currently produces half yearly editions of the magazine 'Going Beyond' which is available at all trust sites and on the website.
- **'Your Health' seminars** – educational sessions led by clinicians on specific medical topics, held quarterly.
- **Meet a Governor** – regular sessions designed to provide an opportunity for members, patients and the public to engage directly with Governors as independent representatives of the Trust.
- **Elections** – When a vacancy arises on the Council of Governors all members within the constituency are written to advise an election will be held and an invitation to them to stand and vote.
- **Website** – the existing website features information on member events and how to get involved, however we have developed a dedicated area of the website through which we can directly communicate with our membership and deliver targeted information.
- **Open Days** – both hospitals have held very popular and well attended Open Days in the past and the plan for the coming year will be to hold these again – traditionally the Chelsea and Westminster site Open Day takes place in the summer and at West Middlesex site in the autumn.
- **Focussed Community Meetings** - The West Middlesex hospital has a very different ethnic composition to that of the London Borough of Kensington & Chelsea. Hounslow has circa 56 different ethnic communities, the largest of these being Polish and people of Indian origin. Meetings with these communities through their religious organisations, schools and clubs, including Indian and Polish Community.

Implementation plan

- An implementation plan has been developed to ensure successful delivery of the strategy
- A progress report will be submitted to the membership sub-committee twice a year.

Objective 1: Maintain and build membership is representative of the population the Trust serves

#	Action	Success Criteria	Lead	Update
1	Conduct targeted recruitment campaigns in public constituencies: London Borough of Ealing, London Borough of Hounslow & London Borough of Richmond Upon Thames	Recruit new members and measure the diversity of new recruits	Membership and Comms	<p>Relevant leads to be contacted with membership material for the promotion of CWFT membership via:</p> <ul style="list-style-type: none"> • Local schools • Colleges • Youth Community Centre's • Voluntary Services • Councils • Healthwatch • PPG's
2	Recruit new members via Meet a Governor sessions	Recruit new members and continue to monitor the number of members recruited through this method	Membership / Governors	On-going membership recruitment through Meet a Governor Session.

Objective 1: Maintain and build membership is representative of the population the Trust serves

#	Action	Success Criteria	Lead	Update
3	Recruit new members via volunteers	Recruit new members and improve working relationship with volunteers manager	Membership	<p>The Volunteer Manager to be asked to support the following:</p> <ul style="list-style-type: none"> • Raise profile of FT members amongst volunteers to inspire greater collaboration between volunteers and members. • Membership information to be incorporated into the volunteer newsletter. • Volunteer information to be included in Membership E-Newsletter ‘
4	<p>Design and deliver targeted recruitment information and campaigns for young people to increase membership amongst 16-21 year olds via:</p> <ul style="list-style-type: none"> • volunteers • local schools / colleges • youth community centres/young peoples’ charities 	Recruit new young members	Membership and Comms	<p>Relevant leads to be contacted with membership material for the promotion of CWFT membership amongst 16-21 year olds via:</p> <ul style="list-style-type: none"> • Local schools • Colleges • Youth Community Centre’s • Voluntary Services • Councils • Healthwatch • PPG’s
5	<p>Work through existing networks to promote our membership, such as:</p> <ul style="list-style-type: none"> • Healthwatch • Patient participation groups in GP surgeries • Local Councils • Patients and families when they use Trust’s services • Meet a Governor Sessions • BAME Network • Membership advertising 		Membership and Comms	<p>Relevant leads to be contacted with membership material for the promotion of CWFT membership via:</p> <ul style="list-style-type: none"> • Local schools • Colleges • Youth Community Centre’s • Voluntary Services • Councils • Healthwatch • PPG’s

Objective 2: Effectively engage and communicate with members

#	Action	Success Criteria	Lead	Update
1	<p>Make opportunities for members to meet Governors:- Via Zoom</p> <ul style="list-style-type: none"> • Meet a Governor • Annual Members' Meeting • Open days • Christmas events 	<p>Stronger interactions between communities and governors to obtain meaningful feedback.</p> <ol style="list-style-type: none"> 1. Number of events attended by Governors 2. Approximate number of people reached 	Membership and Comms	<ul style="list-style-type: none"> • Opportunities for members to meet Governors on Zoom have been made through Meet a Governor sessions. • Annual Members Meeting
2	<p>Promote the work of the Trust and its Governors on the Trust's website through Members' E-Newsletter, and regular updates on the members' area of the Trust's website social media</p>	<p>Publicity of the Trust and membership to a wider audience. Interaction between Trust, members and the general public.</p>	Membership / Comms	<ul style="list-style-type: none"> • Monthly membership e-news is circulated to members; it is also published on the website for an easy access by the public. • FT Membership webpage has been refreshed and is regularly maintained. • Interaction between members, the general public and the Governors is supported by the Corporate Governance / Membership.
3	<p>Continue to operate a programme of talks and events for members.</p>	<p>Monitor attendance and evaluate feedback received from members.</p>	Membership / Comms	<ul style="list-style-type: none"> • A programme of talks and events for members through quarterly Health Seminars. • The presentations are regularly uploaded onto the Trust website.

Objective 2: Effectively engage and communicate with members

#	Action	Success Criteria	Lead	Update
4	Involvement in community meetings to include presentations about health conditions of particular interest for certain ethnic minority groups. As with all trust leaflets, translations will be made of FT membership leaflets and other documents, if requested.	Attend one meeting per quarter and strengthen links with the community.	Membership	<ul style="list-style-type: none"> Full potential could not be reached due to ongoing Covid pandemic; however when there is opportunity the Trust will be involved.
5	Continue asking members to supply or update their email address to ensure robust engagement.	Annual Members' Meeting Chairman's invite letter and notice of election	Membership / Board Governance Manager	<ul style="list-style-type: none"> Members are regularly asked to supply and/or update their email address to ensure an effective engagement via membership e-news.

Refreshing the strategy

Conclusion / recommendation:

- The two main objectives that were set in the previous strategy should remain the same:
 - To maintain and build membership numbers whilst ensuring the membership is representative of the population the Trust serves
 - To effectively engage and communicate with members
- The membership engagement plan remains appropriate so the focus will be on delivery

Discussion:

- Is there anything else we should be doing?

Chelsea & Westminster Hospital NHS Foundation Trust (CWFT) Board Quality Committee – Chair’s Report to the Council of Governors (CoG), October 2022.

This report summarises the work of the CWFT Board Quality Committee over the past 12 months (October 2021- September 2022) and introduces the updated Quality governance structure within the North West London (NWL) Acute Provider Collaborative, effective from September 2022.

1-Committee Chair:

Eliza Hermann was appointed a Non-Executive Director (NED) of CWFT in July 2014 and was Chair of the Quality Committee from October 2014 to June 2022.

I was appointed as Chair of the Quality Committee in July 2022 when Eliza reached the end of her term of office as a NED after 8 years, on behalf of the Trust Board and the CoG I would like to formally thank Eliza for her outstanding contribution to CWFT and to the Quality Committee in particular.

2-North West London (NWL) Acute Provider Collaborative Quality Committee in Common (CiC).

In September 2022, with approval from NHS England (NHSE) plus the CWFT and the Hillingdon Hospital NHS Foundation Trust (THHT) CoGs, the revised NED structure for the NWL Acute Provider Collaborative was implemented together with the establishment of four Collaborative Committees in Common including the NWL Collaborative Quality Committee in Common (CiC) which I also Chair.

The NWL Collaborative Quality CiC met for the first time on 29 September 2022 and will meet Quarterly (in September, December, March and June).

At the 29 September meeting the NWL Collaborative Quality CiC agreed on 5 priority workstreams:

- (i)-Improving the care of deteriorating patients and those at the end of their life.
- (ii)-Reporting from and learning from Getting It Right First Time (GIRFT) and the Clinical Reference Groups.
- (iii)-Implementing the National Patient Safety Strategy.
- (iv)-Standardising reporting and improvement of Maternity Standards (including responses to the interim and final Ockenden reports).
- (v)-Learning and improvement from Mortality & Clinical Harm Reviews.

Plus, additional programmes of work to set up a prioritised peer review process across the collaborative and a standardised, consistent approach to risk.

The NWL Collaborative Quality CiC also received assurance on action plans from each of the 4 Trusts re compliance with:

- (i)-the Interim Ockenden report plus subsequent recommendations.
- (ii)-the Clinical Negligence Scheme for Trusts (CNST) 10-point plan.

The NWL Collaborative Quality CiC and the 4 individual Trust local Quality Committee forward plans are in the process of being reviewed to ensure consistency and alignment across the Collaborative to allow triangulation and to identify opportunities for enhanced assurance and quality improvement.

Reports from the NWL Quality CiC will flow into the NWL Collaborative Board in Common (BiC), which will meet for the first time on 18 October 2022 and will meet Quarterly in October, January, April and July.

See Appendix 1 – NWL Collaborative Quality CiC Terms of Reference (ToR).

3-CWFT Board Quality Committee Purpose:

The Board Quality Committee provides assurance and oversight of the delivery of one of the Trust's three strategic priorities: 'To deliver high quality patient centred care'.

The purpose of the Board Quality Committee is to provide the Board with assurance that the quality of care is delivered to the highest possible standards and that appropriate processes are in place to identify and manage any gaps. The Committee's remit includes oversight of –

- (i)-the safety and effectiveness of treatment and care provided to patients, and
- (ii)-the experience that patients have of the treatment and care they receive.

The Quality Committee's work also relates directly to each of the Trust's 'PROUD' Values:

Putting patients first;

Responsive to and supportive of patients and staff;

Open, welcoming and honest;

Unfailingly kind, treating everyone with respect, compassion and dignity;

Determined to develop our skills and continuously improve the quality of care.

The CWFT Board Quality Committee has a broad scope illustrated by the Quality governance architecture (See Appendix 2).

The main Groups and their Chairs are:

- (i)-Patient Safety (Gary Davies, Medical Director, Chelsea & Westminster Hospital).
- (ii)-Clinical Effectiveness (Iain Beveridge, Medical Director, West Middlesex Hospital).
- (iii)-Patient & Public Experience (Lee Watson, Director of Nursing, Chelsea & Westminster Hospital).
- (iv)-Health, Safety & Environmental Risk (Rob Bleasdale, Chief Nursing Officer).
- (v)-Joint Safeguarding (Vanessa Sloane, Deputy Chief Nurse).

4-Board Quality Committee Membership and Attendance:

As noted above Eliza Hermann was Chair of the Quality Committee until June 2022; I became Chair from July onwards.

The other NED committee members until August 2022 were:

Nilkunj Dodhia (Finance Committee Chair) and Ajay Mehta (People Committee Chair).

With effect from September 2022 with the establishment of the NWL Acute Provide Collaborative Nilkunj and Ajay are no longer NED members of the Committee, the NED members are now:

Prof. Andy Bush and Neville Manuel, plus Associate NED Martin Lupton.

The Executive Directors on the Committee are:

Rob Hodgkiss (Deputy Chief Executive and Chief Operating Officer); Roger Chinn (Medical Director); Pippa Nightingale (Chief Nursing Officer) until March 2022 replaced by Rob Bleasdale (Chief Nursing Officer) from April 2022; plus, Alex Bolton (Associate Director of Quality Governance) together with regular attendance from the Group Chairs listed above.

Meeting attendance is excellent, everyone actively participates, with in-depth discussion, a high degree of candour, and robust challenge.

Over the last 12 months the Committee met every month except August 2022.

From September 2022 onwards meetings will be held 6 times per year linking into the quarterly meetings of the NWL Collaborative Quality CiC.

5-Significant Items Covered by the Board Quality Committee:

In the past 12 months the Committee has reviewed the following:

Note: many items cannot be categorised as neatly as the following list implies. For example, Getting It Right First Time (GIRFT) reviews into a particular clinical speciality are a means to improve clinical effectiveness and patient safety, thereby also improving patient experience and reducing cost.

(a)-Overall Quality and Improvement:

- Trust wide Quality & Performance Report, including over 100 metrics – every meeting.
- Elective Recovery Plan, including clinical pathways, Patient Tracking List, and backlog – every meeting.
- Quality Improvement (QI) - quarterly, including:
 - (i)-Quality Priorities - The four 2022/23 priorities are: Clinical handover; Reduce falls with severe harm; End of Life Care; Timelessness and quality of communication with patients & primary care.
 - (ii)-Quality Improvement, Innovation and organisational culture progress;
 - (iii)-Getting It Right First Time (GIRFT) reviews;
 - (iv)-Ward Accreditation programme.
- Quality Strategy progress – 6 monthly (See Appendix 3 – April-August 2022 update, reviewed at the September 2022 Quality Committee).
- Board Assurance Framework (Strategic) & Risk Assurance Framework (Operational) – quarterly.
- Serious Incidents, including learnings and actions – bi-monthly.

- Maternity Safety, including Ockenden; Clinical Negligence Scheme for Trusts (CNST) 10-Point Plan; - quarterly.
- Mortality Surveillance, including learnings – quarterly.
- Safeguarding Annual Report, including Adults; Children; Learning Disabilities; and Domestic Abuse.
- Sub-committee reports – 6 monthly (Patient Safety Group; Health, Safety & Environmental Risk Group; Clinical Effectiveness Group).
- Infection Prevention & Control, Annual Report plus quarterly updates.
- Learnings from Claims – 6 monthly.
- Medication Safety, including unlicensed medications audits.
- National Patient Safety Incident Response Framework (PSIRF) Clinical Effectiveness.
- West London Children’s Healthcare (WLCH) – 6 monthly.
- Annual Reports on: Quality; Safe Staffing; Medical Examiners; Regulatory Standards; Emergency Preparedness, Resilience & Response (EPRR) Assurance.

(b)-Patient Experience:

- Patient Experience & Engagement Group report – 6 monthly
- Patient communications including website
- Complaints Annual report
- Patient feedback including national patient surveys (E.g., Maternity) plus local surveys plus Trust wide Friends & Family Test (FFT) feedback.

6-What’s Working Well, What Needs Improvement:

In my opinion the CWFT Board Quality Committee is functioning well and fulfilling its purpose.

We are assured regarding the overall quality of care that the Trust provides to its patients. Data for August 2022 (latest available at the time of this report) showed the Trust was the 10th best performing acute hospital organisation in England, according to PublicView’s aggregation across all NHS metrics, and has consistently been in the top 10 throughout the last 12 months.

Patient safety is very good: the Trust’s mortality index (Summary Hospital Mortality Index - SHMI = 71) is among the lowest in the country, there has been 1 ‘never event’ in 2022/23, incidents with severe harm are infrequent and infection control is good.

The Quality Improvement ‘culture’ of the organisation is very much in evidence, with a number of QI projects underway throughout the Trust. There is emphasis on ensuring the learnings from incidents and complaints are truly learned, and changes in practice truly embedded, so that root causes are addressed and hopefully these issues will not recur.

However, context is important. Patient numbers at CWFT’s emergency departments are very high. GP referrals into acute care are very high. The backlog of elective care patients that accrued during

the pandemic is large and the overall Patient Tracking List (patients waiting for care) is still growing, despite elective care activity 'throughput' now at or above pre pandemic levels.

The Trust achieved zero – '104 week' wait patients at the end of March 2022 and has maintained that position; at the end of August 2022 the Trust has under 20 – '78 week' wait patients and just over 1000 – '52 week' wait patients, one of the lowest in England.

The Trust's close working relationships across the NWL Acute Collaborative and mutual aid with the other acute Trusts is benefiting patients by enabling more patients to be seen in a timely manner.

But the challenge of overall performance recovery remains enormous.

The 2 biggest risks to the quality of care that CWFT Quality Committee members consistently express are:

(i)-Volume of demand in urgent and emergency departments, including ambulance handovers and patient discharge.

(ii)-Workforce, the overall motivation remains good, and staffing levels are safe but, having worked at or above capacity through over 2 years of the Covid-19 pandemic and now heading into the additional 2022 'Winter' pressures the workforce is tired from the sheer relentless pressure of patient activity levels, and also sadly from the frequency of patients and their relatives being abusive towards our staff.

S. Gill

Chair of CWFT Board Quality Committee (July 2022) & Board NED for Maternity Safety (March 2021).

Chair of NWL Acute Provider Collaborative Quality CiC (September 2022).

11 October 2022.

NWL Acute Provider Collaborative Quality Committee

29/09/2022

Item number: 11

This report is: Public

North West London Collaborative Quality Committee Terms of Reference

Author: Shona Maxwell
Job title: Chief of staff – Imperial College Healthcare NHS Trust
Accountable director: Mr Stephen Gill
Job title: Non-Executive Director – Chelsea & Westminster NHS Foundation Trust

Purpose of report

Purpose: Approval

The terms of reference (TOR) for the NWL Acute Provider Collaborative Quality Committee are being presented for approval. These TOR have been shared with members of the committee, comments have been taken into consideration in this the final draft.

Report history

The TOR have not been reviewed at any committees in advance of approval at this committee.

Executive summary and key messages

On April 1, 2022 the first Chair in Common for the four acute Trusts in North West London was appointed. This was based upon an agreement between the London Region, the provisional North West London Integrated Care System (ICS), the four Acute Provider Trust Boards and the Governors of the two Foundation Trusts that the Trusts needed to formalise their collaborative working for the good of the people of North West London. The four Acute Provider Trusts that form the North West London Acute Provider Collaborative are:-

- Chelsea and Westminster Hospitals NHS Foundation Trust
- The Hillingdon Hospitals NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- London North West University Healthcare NHS Trust

As a Collaborative, we want to be demonstrably best in class in partnership working across health and care within the ICS with other parts of the NHS, Local Authorities, and the voluntary and private sectors; realising the benefits of mutual aid and working at scale for our populations and staff to deliver the highest quality of care efficiently, and supporting excellence in research and education.

Through this partnership work we will:

- Deliver recovery to our elective, emergency and diagnostic services that takes us not just back to where we were before the pandemic, but to waiting times that are appropriate to patients' needs.
- Support the ICS's mission to address the health inequalities that we see amongst our population and eliminate unfair inequalities in access to and experience of our services.
- Create an excellent environment for staff that attracts, retains and develops the best staff in the NHS, recognises and supports to exceptional efforts of our people and provides resilience to workforce pressures across North West London.
- Achieve continuous improvement in quality, efficiency and outcomes including pro-actively addressing unwarranted variation in clinical services and providing more effective and efficient corporate and clinical support services to better manage demand and capacity.
- Achieve a more rapid spread of innovation, research and transformation across our services

The Acute Provider Collaborative Quality Committee has a key role to enact to ensure we achieve these aims.

Terms of reference (TOR) have been produced and are attached here for approval. These TOR have been shared with members of the committee, comments have been taken into consideration in this the final draft.

Key points to note:

The committee's role is:

- To oversee and provide assurance that the Trust level Quality Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
- To oversee and assure collaborative-wide interventions for short and medium term improvements.
- To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements.

The committee is responsible for:-

- Reviewing the risks identified by the Trust Quality Committees and assuring themselves that they are being appropriately addressed.
- Identifying shared risks that would benefit from a collaborative-wide approach.
- Developing and applying quality metrics that facilitate the removal of unwarranted variation, levelling up of quality across the collaborative and indicate the existence or emergence of quality issues anywhere within the collaborative.
- Driving the collaborative towards evidence based best practice through collaborative-wide projects and the application of data and models of care from GIRFT, Model Hospital, Rightcare and other reliable sources.
- Oversee and assure the development of joint models of care that optimise the patient pathway across the collaborative

- Oversee and assure the development of improved patient and community engagement across the collaborative

The committee will enact its role and responsibilities through the use of a detailed forward planner.

Strategic priorities

- Achieve recovery of our elective care, emergency care, and diagnostic capacity
- Support the ICS's mission to address health inequalities
- Attract, retain, develop the best staff in the NHS
- Continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation
- Achieve a more rapid spread of innovation, research, and transformation

The Acute Provider Collaborative Quality Committee has a key role to enact to ensure we achieve these strategic priorities, in particular to support continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation. The terms of reference set out how this is to be achieved.

Impact assessment

- Equity
- Quality
- People (workforce, patients, families or carers)
- Operational performance
- Finance
- Communications and engagement
- Council of governors

The role and responsibilities of the committee are designed to drive collaborative-wide and ICS integrated improvements in quality, which will in turn have a positive impact on equity, our workforce, patients and communities, and support operational recovery.

Reason for private submission

- Commercial confidence
- Patient confidentiality
- Staff confidentiality
- Other exceptional circumstances

**North West London Acute Provider Collaborative
Collaborative Quality Committee
Terms of Reference**

1. Overarching Purpose

- 1.1 To support the discharge of each Board's respective duties and powers and their combined responsibilities by securing continuous improvement in the quality of services and outcomes in relation to the safety of services, effectiveness of services and the quality of the experience received by patients.
- 1.2 The overarching role of the Collaborative Quality Committee in Common is three fold:
- To oversee and receive assurance that the Trust level Quality Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - To oversee and receive assurance relating to the implementation of collaborative-wide interventions for short and medium term improvements
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
- 1.3 The Collaborative Quality Committee is responsible for to oversee and receive assurance regarding to:-
- Management of risks identified by the Trust Quality Committees.
 - Identification and management of shared risks that would benefit from a collaborative-wide approach.
 - Development and application of quality metrics that facilitate the removal of unwarranted variation, levelling up of quality across the collaborative and indicate the existence or emergence of quality issues anywhere within the collaborative.
 - Driving the collaborative towards evidence based best practice through collaborative-wide projects and the application of data and models of care from GIRFT, Model Hospital, Rightcare and other reliable sources.
 - Oversight and assurance on the development of joint models of care that optimise the patient pathway across the collaborative
 - Oversight and assurance on the development of improved patient and community engagement across the collaborative

2. Specific Duties and Responsibilities

- To oversee and provide assurance that the Trust level Quality Committees are functioning properly and identify areas of risk where collaborative-wide interventions would speed and improve the response.
 - Review the Integrated Quality Dashboard for the Collaborative and query any variation in provider outcomes to seek assurance or to give advice on

- remedial actions that can be taken to improve performance. Escalate any risks/concerns and successes to the Board in Common as appropriate.
- Receive regular updates on collaborative performance against National Patient Safety Improvement Programmes and, where appropriate, provide advice on how issues identified should be addressed.
 - Receive updates/assurance reports from each local provider Quality Committee on issues identified through the Patient Safety Incident Response Framework and seek assurance on how serious patient safety incidents are being addressed through this framework.
 - Review major patient safety incidents from local provider Quality Committees to identify any similarities, trends or areas for focussed and/or collaborative wide learning.
 - Review national inquiries for major safety concerns in the NHS to ensure learning is adopted and adhered to across the Collaborative including the Ockenden report.
 - Promote within the Collaborative a just culture of open and honest reporting of any situation that may threaten the quality of patient care
 - Review the relevant quality related risks within the Board Assurance Framework/Strategic Risk Register and report into the Board in Common on levels of assurance of mitigation
- To oversee and assure collaborative-wide interventions for short and medium term improvements
 - Nurture a quality improvement culture across the Collaborative by overseeing existing quality improvement programmes and expanding the use of effective quality improvement programmes more widely.
 - Oversee the approach to ‘lessons learnt’ across the Collaborative so that best practice can be shared and implemented
 - Consider themes and trends emerging from patient feedback across the Collaborative and oversee any actions to address any concerns that require a collaborative response/steer.
 - Consider themes and trends emerging from clinical audit, R&I and quality standards such as GIRFT across the Collaborative and oversee any actions to address any concerns that require a collaborative response/steer.
 - Ensure that the quality of care provided to patients is improving and developing to eradicate health inequalities across North West London.
 - To identify, prioritise, oversee and assure strategic change programmes to drive collaborative-wide and ICS integrated improvements
 - Review and monitor the implementation of the Patient Safety Strategy across the Collaborative and advise on areas of priority.
 - Ensure that strategies supporting Quality (Patient Safety, Clinical Effectiveness and Patient Experience) are continually meeting the needs of patients accessing services and determine whether the Collaborative is improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan.

3. Composition

Membership

3.1 The members of the Committee are appointed by the Boards and will be made up of:

- A Vice Chair from the Board in Common as the Collaborative Committee Chair
- Non-executive Director Chairs of the 4 Acute Provider Trust Quality Committees
- Lead CEO for Quality for the Collaborative

3.2 The lead CEO's Trust will provide secretariat and governance support to the Committee.

4. Meeting arrangements

Attendance

4.1 Members of the Committee are expected to attend meetings wherever possible. In exceptional circumstances and subject to prior approval from the Chair of the Committee, a deputy can attend.

4.2 Chief Medical Officers and Chief Nursing Officers from each of the 4 acute provider Trusts have a standing invitation to attend all meetings of the Collaborative Quality Committee.

4.3 The Collaborative Chair in Common may attend any meeting of the Committee (see para 3.6 re quoracy). At the invitation of the Committee Chair, other executive directors, senior managers or non-executive directors may also attend the Committee meetings.

4.4 The Committee Chair may ask any person in attendance who is not a member of the Committee to withdraw from a meeting to facilitate open and frank discussion of a particular matter.

Meetings

4.5 The Collaborative Committee will meet (including by telephone or video conferencing) at least four times a year, or more frequently as determined by the Committee Chair. Any member of the Committee can ask the Committee Chair for a meeting to be convened in person, by video conference or by telephone, or for a matter to be considered in correspondence/e governance.

4.6 The quorum for meetings is 3 members, including

- At least 2 Non-executive Directors, one of which will Chair the meeting
- Lead CEO for Quality for the Collaborative or Executive deputy agreed by the Chair

4.7 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be circulated to each member of the Committee and any other person required to attend, no later than four working days before the date of the meeting. Supporting papers (including a rolling 12-month forward plan) shall be sent to Committee members, and to other attendees as appropriate, no later than four working days before the date of the meeting.

4.8 The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

4.9 Draft minutes shall be sent to the Committee Chair within 1 week of the meeting and submitted for formal agreement at the next meeting.

5. Declarations of Interest

5.1 All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests where there is a conflict with an agenda item or matter under discussion, at the start of the meeting, or where there is a change to their published declaration of interests. The Chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required not to participate in a discussion or otherwise limit their involvement in the meeting.

6. Reporting Responsibilities

6.1 The Committee's Chair shall report formally to the Board in Common on its proceedings after each meeting.

6.2 The Committee will make whatever recommendations to the Board it deems appropriate in any area within its remit where action or improvement is needed.

6.3 The Committee will receive escalation reports from each of the 4 acute provider Quality Committees

7. Other Matters

The Committee will:

7.1 have access to sufficient resources to carry out its duties

7.2 consider any other matters where requested to do so by the Board in Common and the 4 acute Provider Quality Committees within the NWL Acute Provider Collaborative

7.3 review on an annual basis its own performance and terms of reference to ensure that it is operating effectively as part of the Board's effectiveness review.

8. Authority

The Committee is authorised:

8.1 to seek any information it requires, or request attendance at a meeting, from any employee or any other person in order to perform its duties

8.2 to obtain legal or other professional advice on any matter within its terms of reference, subject to Board in Common approval.

DRAFT

Quality Committee

Chair: Steve Gill
Frequency:

Clinical Effectiveness Group

Chair: Iain Beveridge
Hospital Medical Director WM
Frequency: Monthly

Patient Safety Group

Chair: Gary Davies
Medical Director CW
Frequency: Monthly

Patient and Public Experience Group

Chair: Lee Watson
Director of Nursing CW
Frequency: Monthly

Health, Safety and Environmental Risk Group

Chair: Robert Bleasdale
Chief Nursing Officer
Frequency: Monthly

Joint Safeguarding Group

Chair: Vanessa Sloane
Deputy Chief Nurse
Frequency: Quarterly

Critical Care Delivery Group

Chair: Sanjay Krishnamoorthy
CD Emergency & Acute Medicine
Frequency: Bi monthly

Nutrition & Hydration

Chair: Emer Delaney
Nutrition Specialist Practitioner
Frequency: Quarterly

Transfusion Group

Chair: Anastasia Chew
Consultant haematologist
Frequency: Quarterly

Thrombosis Group

Chair: N Wiles/S Patel
Thrombosis leads
Frequency: bi-monthly

PLACE Group

Chair: Matt Robinson
Head of Patient Experience
Frequency: Quarterly

Radiation Safety Group

Chair: Annelies Maenhout
Consultant Nuclear Physician
Frequency: Quarterly

Staff Safety Group

Chair: Nicola Rose
Divisional Director of Nursing PCD
Frequency: Monthly

Learning Disability Group

Chair: Kathryn Mangold
Lead Nurse for Learning Disability and
Transition
Frequency: Bi-Monthly

Organ Donation Group

Chair: Parvinder Garcha
Lay chair
Frequency: 6 monthly

Clinical Decision Support Group

Chair: Sarah Cox
Lead Consultant Palliative Care
Frequency: fortnightly / as need arises

Medical Devices Group

Chair: David Bushby
Deputy Director of Nursing WM
Frequency: Monthly

Falls Strategy Group

Chair: Stephanie Stevenson-Shad
Vaccination Lead
Frequency: Monthly

Learning Disability Group

Chair: Kathryn Mangold
Lead Nurse for Learning Disability and
Transition
Frequency: Bi-Monthly

Water Safety Group

Chair: David Butcher
Director of Estates & Facilities
Frequency: Monthly

Safer Sharps Group

Chair: Cathy Hill
Director of Nursing WM
Frequency: Monthly

Mental Health Group

Chair: Lee Watson/Cathy Hill
Director of Nursing CW/WM
Frequency: Bi-Monthly

End of Life Care

Chair: Iain Beveridge
Hospital Medical Director WM
Frequency: Monthly

Resuscitation Group

Chair: Kath Bonnici & Ruth Caulkin
Consultants
Frequency: Bi Monthly

Infection Prevention & Control

Chair: Nabeela Mughal
DIPC/ Consultant Microbiologist
Frequency: Monthly

Pressure Ulcer Group

Chair: Joanne Tillman
Deputy Director of Nursing CW
Frequency: Monthly

Research & Innovation P&P involvement

Chair: Chris Adamson
Lead Research Nurse & Delivery Manager
Frequency: Quarterly

Medical Gases Group

Chair: Deirdre Linnard
Chief Pharmacist and Head of
Professions
Frequency: Monthly

Bio-Safety Group

Chair: Damon Foster
Research Delivery and Operations
Manager
Frequency: Quarterly

Discharge Governance Group

Chair: Richard Turton
Frequency: Monthly
Meeting being established

New Interventional Procedures Group

Chair: Isabel Jones
DMD, Planned Care
Frequency: monthly

Medicines Safety Group

Chair: Hester Yorke/David Bushby
Consultant / Deputy Dir Nursing WM
Frequency: Monthly

IV access Group

Chair: Kim Watts
Resuscitation Lead Nurse
Frequency: Bi Monthly

Youth Forum

Chair: Melanie Guinan
Lead Nurse Paediatrics and Neonates
Frequency: Under review as part of
WLCH

Fire Safety Group

Chair: David Butcher
Director of Estates
Frequency: Monthly

Respiratory Protection Group

Chair: David Bushby
Deputy Director of Nursing (WM)
Frequency: Monthly

Mortality Surveillance Group

Chair: Iain Beveridge
Hospital Medical Director WM
Frequency: Monthly

Medico legal group

Chair: Roger Chinn
Chief Medical Officer
Frequency: Monthly

Patient & Public Involvement Group

Chair: Matt Robinson
Head of Patient experience
Frequency: Bi-Monthly



CONFIDENTIAL
Quality Committee Meeting, 06 Sept 22

AGENDA ITEM NO.	2.2
REPORT NAME	Quality Strategy progress update
AUTHOR	Sheriece Bracey, Associate Director of Improvement
LEAD	Robert Bleasdale, Chief Nursing Officer
PURPOSE	Assurance
REPORT HISTORY	Improvement Board
SUMMARY OF REPORT	<p>This report provides an update on the progress of the Quality Strategy (2019 -2025). Our aims are to :</p> <ul style="list-style-type: none"> • Ensure we meet the needs of our patients, carers and communities • Deliver outstanding care • Work in partnerships to improve the health of the population • Grow and strengthen our culture of continuous quality improvement and improve staff experience and well-being • Deliver quality and value to achieve sustainability for the health service <p>The report reviews our work streams & quality priorities.</p>
KEY RISKS ASSOCIATED	Failure to continue to deliver high quality patient care
FINANCIAL IMPLICATIONS	As above
QUALITY IMPLICATIONS	Equality and Diversity implications have been considered as part of the embedded Quality, Equality and Health Inequality Impact Assessment process of the Improvement Programme, which is led by the Chief Nursing officer and Chief Medical Officer
EQUALITY & DIVERSITY IMPLICATIONS	These are considered as part of the embedded Quality, Equality and Health Inequality Impact Assessment process of the Improvement Programme, which is led by the Chief Nursing Officer and Chief Medical Officer.
LINK TO OBJECTIVES	<ul style="list-style-type: none"> • Deliver high-quality patient-centred care • Deliver better care at lower cost
DECISION ACTION	For assurance.



Quality strategy

Progress update report
April to August 2022



RIQI

Research, Innovation and

Quality Committee

3.3 CWFT Board Quality Committee Chair's Report to the October COG.pdf



Chelsea and Westminster Hospital

NHS Foundation Trust

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Quality strategy – the next 5 years

This implementation plan and progress report should be read in conjunction with the 2019-24 Trust quality strategy, summarised below:

Provide outstanding high quality, safe and patient-centred care



Capability & Method

- Quality priorities delivered and supported by a systematic improvement method
- Develop improvement capabilities and capacity within the organisation

Culture & Mindset

- Sustain and strengthen a culture of continuous quality improvement
- Coproduction of quality improvements with our staff, service users, patient and communities

Wider System & Partnership

- Work in partnership to accelerate innovation and quality improvement



RIQI
Research, Innovation and
Quality Committee





Capability and Method: work stream 1

Quality priorities delivered and supported by a systematic improvement method

Capability and method	SRO	Improvement Lead
Quality priorities	Robert Bleasdale	Sheriece Bracey

	Aims	Plan	Evidence and measures
2022/23	<p>Deliver our annually set Trust and divisional quality priorities, aligned to our areas of greatest opportunity.</p> <p>Set an outcome measure for each quality priority to measure impact.</p>	<ul style="list-style-type: none"> Priorities are set following review and triangulation of data for areas of greatest opportunity Each priority includes an outcome measure Divisions focus on clinical pathway re design as quality priorities Progress regularly reported and assured through divisions, improvement board and quality committee 	<ul style="list-style-type: none"> Improvement is seen across the set quality priorities Both process and outcome measures are used to track improvements The Trust quality priority approach is mirrored at divisional level – selecting and prioritising a number of improvements that deliver The board are assured that the programmes of work are being delivered using data driven improvement methodology KPIs set in quality priorities

Details for each quality priority can be found in the appendix

Quality Priorities 22/23	SRO	
Reducing the risk of inpatient falls with harm	Jacqueline Sinclair	Yellow
Improve End of Life Care	Iain Beveridge	Yellow
Improve timeliness of communication	Peter Hyland	Yellow
Improve clinical Handover	Gary Davies	Red

Trustwide Improvement Programme 22/23	
The Trust also has a Trust wide programme that focuses on the below:	
Outpatient transformation	Yellow
Bed productivity	Yellow
Theatre productivity	Yellow
Workforce	Yellow
Sustainability	Red
Procurement	Yellow
Patient Transport (to commence September 22)	



Capability and Method: work stream 2

Develop improvement capabilities and capacity within the organisation

Capability and method		SRO	Improvement Lead
Improvement capability and capacity		Robert Bleasdale	Sheriece Bracey
Aims	Plan	Evidence and measures	
<p>Build improvement capability and capacity at all levels of the organisation</p> <p>Alignment of people with improvement priorities from ward to board.</p>	<ul style="list-style-type: none"> Expand and embed training delivery, with aim that each area has improvement support aligned to priorities (see appendix) Update governance so that priorities and projects are more visible through divisional governance structures Engage community of 'innovators' Adopt and build an innovation mentoring model 	<ul style="list-style-type: none"> A year on year increase in the number of staff who are trained in improvement skills Local quality improvement projects are aligned to divisional and strategic objectives for the organisation A consistent improvement method is demonstrable and understood across the organisation Launch of RIQI portal (see slide 6 and 7), number of projects submitted Delivery of training programme 	
Progress update Apr – Aug 22			Next steps
<p>Quality Improvement Training:</p> <ul style="list-style-type: none"> Quality improvement training is embedded within the Emerging Leaders programme, as well as continuous engagement throughout the participants training. Preceptorship programme quality improvement training re-established and led by the Improvement Team. Improvement apprenticeship is still ongoing since May 2021 and doing well. We are looking at who might be in the next cohort for the Trust March 2023. One day training established for for Junior Doctors on quality improvement methodology <p>Culture and Engagement:</p> <ul style="list-style-type: none"> There has been consistent engagement across the Trust registering projects on the portal. <p>RIQI Development:</p> <ul style="list-style-type: none"> There continues to be a joint RIQI presence on both the intranet and internet. RIQI was discussed at the All Staff webinar to refresh the support that is available to staff. <p>Collaborative Working</p> <ul style="list-style-type: none"> There is ongoing conversations with CW+; their grants process and how we can develop it further 			<ul style="list-style-type: none"> QI focused engagement across the wards teaching them about PDSA cycles in a simplistic way. Quarterly reports sent to triumvirates to ascertain any key projects that may need additional support Quality Improvement Training to be delivered within shared decision group training for MAGNET accreditation Evaluate effectiveness of horizon fellowship programme and improvement apprenticeship Opportunities to expand L&D offer with Enterprise division Develop QI training offer further at all levels. Exploring alignment between Improvement team and Health improvement /Public Health priorities



Capability and Method: work stream 3

Sustain and strengthen a culture of continuous quality improvement

- RIQI Portal

- RIQI is a collaboration across departments in Research, Innovation and Quality Improvement. The aim is to provide an integrated approach for implementing change ideas within the Trust.
- The Portal is a single point of access for staff who want to share a project or idea and access support, resources and guidance. It helps us to align ideas and projects against our areas of greatest opportunity and challenge, as well as ensure correct governance and oversight.
- We have had around 32 submissions, predominantly QI projects (since April 22), from W&C, EIC and Planned Care - and from both CW and WM sites. Our continuing challenge is to target the Corporate Division.

32 forms submitted

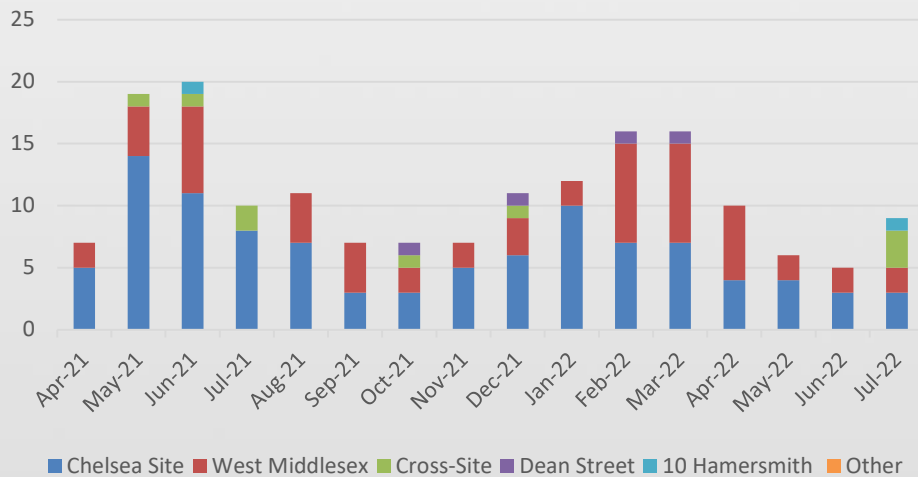


2 Innovation projects registered

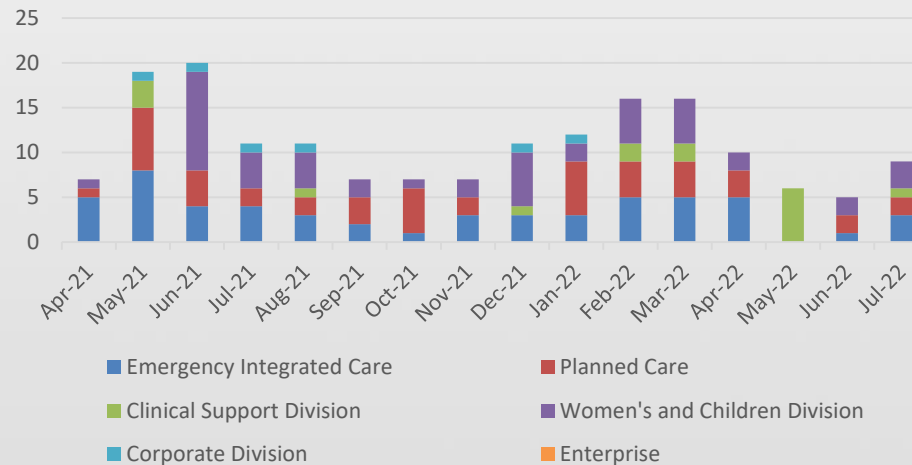
27 QI projects registered

3 registered TBC

Which site are you based at?



What division are you in?



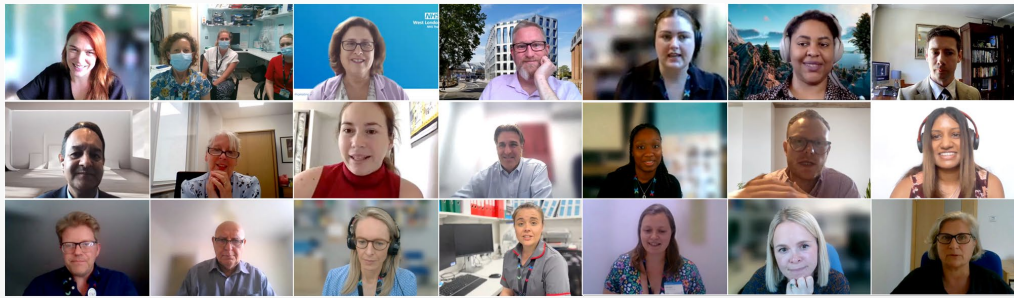
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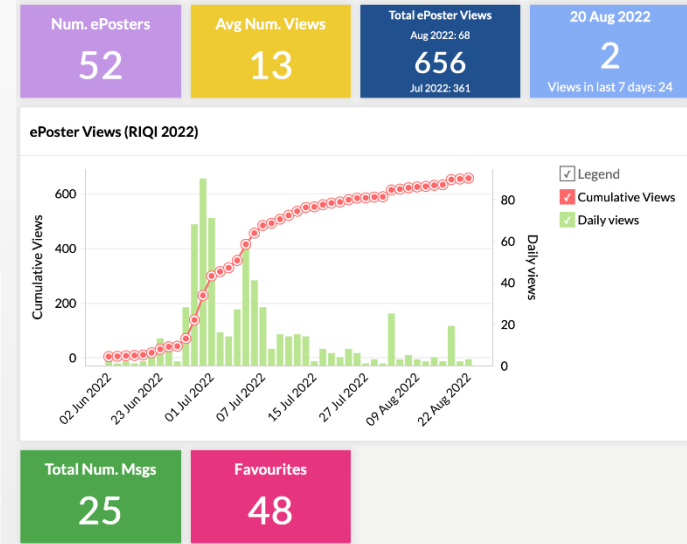
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RIQI event 2022

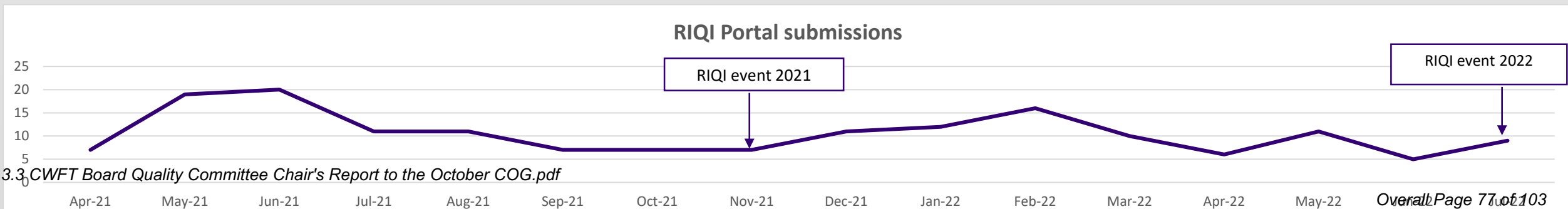
In 2022 we had a day virtual event which included **62 attendees in total** with **51 digital posters and 12 oral presentations and 3 key note speakers**; Carolyn Regan (CEO of West London) talking on Health Inequalities in NWL, Simon Klee (Head of Digital at London Borough Hounslow) discussing Making Hounslow.Digital and panel discussion chaired by Chris Chaney (Chief Exec of CW+). We invite feedback from attendees, presenters and organising team and keep a learning log, formal evaluation has been difficult with the flexible drop-in/drop out format.



The focus of this annual event is to:

- promote and publicise local initiatives to improve patient care or service delivery
- showcase and celebrate current projects and recent successes
- inspire future work to translate knowledge into impact and value
- raise awareness of the support available for those wishing to carry out research, innovation or quality improvement projects

Plans are currently under way on how we can do more focused RIQI events to engage staff. As well as how we can look to increase more projects that have patient and public involvement in them.





Culture and Mind-set: work stream 4

Coproduction of quality improvements with our staff, service users, patient and communities

Culture and mindset	SRO	Lead
Coproduction of quality improvements	Lee Watson	Matt Robinson and Sheriece Bracey

Aims	Plan	Evidence and measures
<ul style="list-style-type: none"> To improve equity of accessibility to CWFT services and reduce health inequalities. To ensure the profile of services offered, access/outcome/experience data broken down by demographics and meets the needs of the local population. To ensure CWFT services are coherently interlinked with the wider healthcare system from the patient perspective. To develop a culture of co-production by engaging and involving our patients, carers, families and our local community. 	<ul style="list-style-type: none"> To define clear principles for public/patient engagement which can be applied across the trust. To map existing engagement mechanisms to permit effective scoping of need, to build on with existing infrastructure and to embed lessons learned in future work. To develop tools to support individual departments to autonomously engage patients and the public to inform their decision making processes. To develop a framework for evaluation of engagement across the trust to permit monitoring and on-going learning. 	<ul style="list-style-type: none"> Meaningful patient and public engagement across our improvement priorities Improved patient experience Diverse feedback representative of our patient population FFT figures above national average Increase number of co-production case studies Reduced complaints

Progress 2022/23	Next steps
<ul style="list-style-type: none"> Patient and Public Involvement (PPI) Work Group set up to evaluate current PPI work to date and ongoing strategy. Development of a clear governance structure for PPI. Redesign plans of the PPI intranet and internet pages, with the inclusion of a patient representative page, PPI toolkit, visible list of focus groups and accessible platforms for user engagement. PPI Staff Culture Survey Benefit realisation with FFT provider to explore how we can capture more meaningful patient feedback data, which includes patient demographic data. Working groups set up with Healthwatch across the region Working groups and regular communication channels with other patient experience leads across the ICS to ensure shared learning of best practice and development of PPI pools of information/patient representatives. 	<ul style="list-style-type: none"> PPI working group ongoing with progress reports being produced to Board Once approved by the PPI working group, Patient and Public Engagement and Experience Group, and Board, PPI webpages to be redesigned. Patient representative recruitment campaign to be started. PPI staff Culture Survey to be disseminated to and completed by staff, to identify a baseline measure for PPI in the organisation and benchmark ourselves against progress made.



Wider system and partnership: work stream 5

Work in partnership to accelerate innovation and quality improvement

Wider system and partnership		SRO	Lead
Work in partnership to accelerate innovation		Bruno Botelho	Mike Wright
Aims	Plan	Evidence and measures	
Align the innovation and digital programme to enable delivery of the Trust wide and divisional improvement priorities	<ul style="list-style-type: none"> Use simple automation and AI to grip and improve 'repetitive' functions currently carried out by our staff Use existing Improvement resources and CW innovation partners to prioritise re-design of clinical pathways Grow and deepen partnerships with system partners Improve awareness of innovation support Align innovation activities with improvement and R&D to support a culture of 'above and beyond' Number of CW plus grants awarded for projects 	<ul style="list-style-type: none"> Increase the number of staff who are aware of the CW Innovation Programme and who are engaged in innovative activities and programmes. Increased number of innovation programmes supported by partners Launch at least one competition/ call for innovative ideas Deployment of AI/ automation in at least one pathway with clear performance measures and framework At least 50% of all new projects initiated will map onto agreed divisional and/or Trust priorities 	
Progress update 2022/23		Next steps	
<ul style="list-style-type: none"> Technical problems with AI assisted teledermatology service resolved, went live on 18th April, currently processing ~ 280 patients per month. Remote monitoring hub established with colleagues at ICHT. Managing COVID-19, COPD, HF, IBD and Monkey Pox virtual wards. Growing portfolio of virtual wards, deployed COVID, HFrEF, IBD and Monkey Pox VWs Blue Prism RPA Platform deployed – initial focus on HR processes. Staff turnover and reorganisation of innovation – recruitment of innovation business partners underway Partnered with Novartis Biome to launch international call for innovation from SMEs to address improved management of cardiovascular programmes at home. Horizon Fellowship programme live, 20 fellows recruited and 3 fellowship days delivered Recruited Nurse Innovation & Improvement Fellow to support improved engagement with nursing workforce 		<ul style="list-style-type: none"> Complete evaluation of AI telederm and business case Support the delivery of Horizon Fellowship programme Develop Phase II of Gilead partnership focusing on ageing HIV population with comorbidities Select winner of Novartis Biome challenge – work towards evaluation of technology Establish programme for developing and scaling up virtual wards at Trust Deploy RPA automation in HR and evaluate impact Support launch of Nursing and AHP call Complete recruitment of 2 innovation business partners 	
<p>3.3 CW Innovation Quality Improvement and R&D Call for Ideas</p> <ul style="list-style-type: none"> 3rd Anniversary of CW Innovation celebrated in September 22 			



Appendices

Capability and method: Workstream 1

1. Quality Priority: Falls
2. Quality Priority: End of Life Care
3. Quality Priority: Clinical Handover
4. Quality Priority: Improve timeliness and quality of communication with patients and primary care



RIQI

Research, Innovation and

Quality Committee



Improvement Programme Title	SRO	Lead	Improvement Support	RAG Status
Quality Priority: Falls	Jacqueline Sinclair	Sarah Bryan	Lynne O'Hanlon	Amber

Programme vision statement/aim: Reduce the number of severe falls across the trust through completion of risk assessments and implementation of subsequent care plans

Progress since last reported

- In July we had a fall with severe harm which has now been to panel. An audit is currently underway, reviewing all falls with severe harm from 2021, to establish from SI outcomes if they were preventable, this will be compared to this financial year.
- Met with Noel Palmer & Cerner team 09/08/22: discussed next steps with MFRA and care plan Cerner changes. Falls risk assessment and care plan are in the testing stage, no current time line but progressing.
- Staff training continues, continued good uptake. A recurring invite has been sent up to December.
- Collaboratively work with other trusts in NWL continues to develop a transferrable falls training package, SB is putting together a list of topics that must be included, before moving to the next step
- Falls QI projects continue, next meeting to review progress and consider any changes.
- Development of falls simulation experience for staff, will be ready to implement for national falls week in September
- Wards now receiving ward level data regarding falls incident reports, expectation that they will present at each Falls operational group meeting
- Giles Rolph aiming to have the falls dashboard live week ending the 20th August

Risks, challenges/issues and dependencies

- Changes within Cerner to be approved and actioned, currently on risk register with a score of 12, raised with Cerner team, no current time frame for completion – currently considering alternative narrative care plan as a Cerner short cut in the meantime.
- Falls dashboard completed, not live owing to IT issues
- Ability to adapt current online falls module, if not possible will require new module development
- Resource within older adult team- the Falls Lead, to implement, monitor and support project
- Medical staff are not routinely attending Falls Meetings to or owing to workload
- Staff vacancy rates impacting care delivery. Currently on the EIC divisional risk register, with a score of 9

Financial Benefits

The anticipated impact on average LOS was estimated at 3 days per month, this is unlikely to impact cost out or income. The scenario where the impact is material on both LOS and treatment is where a HIP replacement may be required. However as the Trust will for the majority of patients be reimbursed for this treatment in tariff it is unlikely to have a material financial impact to avoid it.

Currently nil were MFFD prior to fall for current year. This is based on the representative cost of a bed day and can be seen as a potential cost avoidance in the future and not an actual cost saving.

2021/22 Legal claims: 4 related to in-patient falls- the total paid on these claims was £40,815.40- however paid by NHS Resolution and not the Trust.

Clinical Negligence Schemes for Trusts (CNST) contributions are calculated & quite complex. Reducing falls-related claims will not necessarily reduce Trusts' CNST contributions.

2021/22 Inquests: 4 relating to in-patient falls. All cases were managed in-house including advocacy, therefore financial exposure calculated by taking an approximate amount of hours spent by legal services & clinicians with total of £2,511.55 + 8hrs of VSM time

CW	Ref	Detailed Initiatives	Baseline	Target	Apr-22	May-22	Jun-22	Jul-22
Falls	CW/WM	Reduce falls with severe harm (CUMULATIVE - WM & CW data)	16	50%	1	2	2	3
	1b	Patients to have documentation of lying and standing blood pressure	0%	90%	1%	7.7%	6.2%	11%
	1c	Patients over 65 to have falls risk assessment documented on admission	0%	90%	2.9%	59.4%	56.8%	63.5%
	1d	Patients over 65 to have a falls care plan documented		100%	TBC	TBC	TBC	
W M	Ref	Detailed Initiatives	Baseline	Target	Apr-22	May-22	Jun-22	Jul-22
Falls	1a							
	1b	Patients to have documentation of lying and standing blood pressure		90%	13.50%	29.7%	32%	39.1%
	1c	Patients over 65 to have falls risk assessment documented on admission		90%	34.30%	63.1%	61.9%	60.9%
	1d	Patients over 65 to have a falls care plan documented		100%	TBC	TBC	TBC	

Fractured NOFs 2021-2022

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Patient incurred #NOF & cost avoidance associated with LOS with average bed day surgical ward £217	0	6076 (28 days)	3,472 (16)	0	0	4340 (20)	4340 (20)	0	0	0	8897 (41)	3,038 (14)	30163
#NOF surgery cost £9985 (reimbursed in tariff)	0	19970 (2)	9985 (1)	0	0	0	19970 (2)	0	0	0	19970 (2)	9985 (1)	79880

2021-22 -Falls SI(Serious Incident) reviewed:

Between 2021 – 222 2 patients who were MFFD prior to their fall, resulted in a #NOF. This combined with LOS from date MFFD to actual discharge (38 days) cost the trust £8,246 (based on average cost of bed days at £217)

Improvement Programme Title	SRO	Lead	Improvement Support	RAG Status
Quality Priority: End of Life Care	Ian Beveridge	Louise Robinson	Lynne O'Hanlon	Amber

Programme vision statement/aim: Overall, identify and support patients, and those important to them, at the end of life through personalised care planning. Ensuring a timely and safe transfer to preferred place of care

Progress since last reported

- Weekly meetings of Trust wide Fast Track Task & Finish Group – first draft of New Fast Track process map completed and aiming to pilot mid September with appropriate staffing from SPCT & Discharge Hub. This focus on discharges is in line with NHSE 's 100 day discharge challenge.
- Membership of pan-London Fast Track steering group – design of new FT application from
- Meeting with Trust digital leads re: digital support for FT and UCP
- Scoping utilisation of 'Timely Care' dashboard to support FT process
- Discharge hubs now routinely collecting data on fast track applications to support monthly audits
- Comms plan for UCP – launch 27th July

Supportive projects: EOL education (including nursing EOL study days, EOL simulation courses), SPC placements for IMT3 doctors (with very positive evaluation), New EOL volunteers recruited and now on wards at WM, two EOL education quality improvement projects presented at Trust RIQI event (both selected for oral presentation), funding for two further butterfly rooms at WM site (Syon 2, Osterley 2).

Risks, challenges/issues and dependencies

- New FT process needs to be 'tested' on pilot wards
- Education across Trust re: new FT process - roles and responsibilities
- New FT application form - no digital option at present. If a Cerner form possible to develop ?Cerner format acceptable to 'CCGs'
- Limited opportunity to influence external delays with FT process (NH availability etc)
- Digital dashboard to enable 'visibility' of progress with FT discharges ?timely care
- Implementation of new UCP: resource to train staff and embed new system

Financial Benefits

- End of Life Care is an enabler for the current planned bed closures which have already been costed already in the Bed Productivity scheme
- There is potential for a saving arising from preventing unnecessary interventions; a piece of work being done to look at where unnecessary interventions occurred.
- The bed days listed in the table are an average cost and represent potential cost avoidance, however if these days were reduced, they would be counted in the Bed Productivity Scheme.

CW	Ref	Detailed Initiatives	Baseline	Target	Apr-22	May-22	Jun-22	Jul-22
EOLC	1a	Fast Track within 4 days (excluding SPCT rapid discharges)	6.8 (FT= 6)	4	4.7 (FT=3)	8 (FT=4)	9.5 (FT=2)	11 (FT=1)
	1b	Death during FT process (balancing measure)	NA	0	0	2	1	0
	-	Fast track average internal days	NA	-	2	2	4	4
	-	Fast track average external days	NA	-	2.7	6	5.5	7
	1c	Urgent Care Plans completed at A&E	0%	100%	n/a	n/a	n/a	

UCP Pan-London launch 27th July

WM	Ref	Detailed Initiatives	Baseline	Target	Apr-22	May-22	Jun-22	Jul-22
EOLC	1a	Fast Track within 4 days (excluding SPCT led discharges)	8.8 (FT=14)	4	16.5 (FT=8)	14.8 (FT=12)	9.5 (FT=13)	11.2 (FT=10)
	1b	Death during FT process (balancing measure)	NA	0	7	2	4	2
	-	Fast track average internal days	NA	-	5.4	6.1	3.6	4
	-	Fast track average external days	NA	-	10.6	8.7	5.5	7.2
	1c	Urgent Care Plans completed at A&E			n/a	n/a	n/a	n/a

The audit was adjusted to exclude at rapid discharges which will continue to be completed by SCPT (rapidly deteriorating and expected to die with 24-48hrs, paperwork completed same day as identified), while all other FTs will include those completed by wards and SPCT. Once we have completed the FT pilot & roll out, we expect SPCT led standard FT to decrease and wards to increase.

	Ref	Fast Track with LoS over 4 days (excluding SPCT led discharges and those died in hospital)	Mar-22	Target	Apr-22	May-22	Jun-22	Jul-22
EOLC	CW	Days	17	0	2	16	11	7
	CW	Average bed costs per day £240	£4080	0	£480	£3840	£2640	1680
	WM	Days	64	0	105	114	323	72
	WM	Average bed costs per day £200	£12800	0	£21000	£22800	£4600	14400



Improvement Programme Title	SRO	Lead	Improvement Support	RAG Status
Quality Priority: Clinical Handover	Gary Davies	Medical: Kathleen Bonnici (CW), TBC (WM) Nursing: Nicola Rose and Jacqueline Sinclair Surgical: Isobel Jones	Dhivya Kesavan	Amber

Programme vision statement/aim: To improvement timeliness and quality of communication with patients and primary care

Quality Priority Update

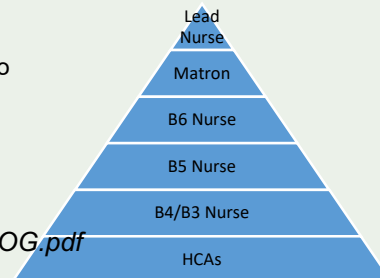
- An audit was conducted across WM and CW regarding the utilisation of CernerEPR tool for patient handover. Cerner EPR tool is currently being used at CW (for downstream handover and weekend handover), WM (for ward huddles where patient is reviewed and discussed) and within Nursing sporadically (for wards and best practice is being shared). The only places that Cerner is not being used within Nursing is ED, Theatres and Maternity – this will be an on going piece of work.
- Baseline of what is currently happening has been completed and principles to clinical handover has been reviewed by nursing and agreed – slides are currently being updated to be deliverable to nursing staff while remaining consistent with the medical training delivered. This will then be added to corporate induction (in October/November 22) – Team will look to record the training that can be delivered at clinical corporate induction (10-5mins in length).

Medical and Surgical Update

- The data for junior doctors trained as been adjusted to be reflected of the junior doctor rotation numbers. From August 21 – July 22 there was an expected 450 doctors expected. Data is now showing as a cumulative figure.
- An audit regarding handover quality is due to be completed, so that the standardisation can be implemented.

Nursing Update

- Standardisation of handover has been done for Wards and ICU which will be group handover then bedside handover. Standardisation for Theatres is also underway. This is still work to be done for ED and Maternity.
- An audit on the framework focus for nursing is also underway. As well as a Toolkit being developed.
- Regular training will be introduced to HCA essence of care, preceptorship, student nursing training.
- Nursing have also agreed to do a train the trainer method to get staff up to speak with best practice on clinical handover. Training to be agreed (by 30th August)
- Launch Train the Trainer on principles from 5th September
- An overview of handover models for nursing in different areas is also being developed to go into local and student induction



	Ref	Detailed Initiatives	Target	Apr-22	May-22	Jun-22	Jul-22
Trustwide	1a	Utilisation of CernerEPR tool to support patient handover.	70%	CernerEPR is in place across the Trust (expect ED, Theatres and Maternity)			
	1b	Hospital at night handover meetings to be attended by each specialty.	95%	88%	88%	58%	65%
	1c	Junior Doctors to be trained in the principles of safe and effective clinical handover.	50%	42.2%	42.2%	42.2%	42.2%
	1d	Clinical staff to be trained in the principles of safe and effective clinical handover.	50%				

CW	Ref	Detailed Initiatives	Target	Apr-22	May-22	Jun-22	Jul-22
	1e	Handovers to be attended by each medical downstream ward.	95%	95%	95%	74%	95%

WM	Ref	Detailed Initiatives	Target	Apr-22	May-22	Jun-22	Jul-22
	1e	Handovers to be attended by each medical downstream ward.	95%	-	-	-	-

Risks, challenges/issues and dependencies

- There was no WM attendance at the last Clinical Handover meeting.
- Data for Integrated Board report hasn't been agreed – it also only reports on junior doctor training and not all clinical staff.

Financial Benefits

- Currently this priority is mainly quality focused. A piece of work could be done looking at reducing the harm outcomes, which may avoid unnecessary interventions, delayed discharges, incidents and increased LoS.
- This quality priority also plays into bed productivity.

Improvement Programme Title	SRO	Lead	Improvement Support	RAG Status
Quality Priority: Experience	Peter Hyland	James McKean and Deirdre Linnard	Faizal Mohamed- Hossen	Amber

Programme vision statement/aim: To improvement timeliness and quality of communication with patients and primary care

Progress since last reported

- Cerner process for recording Accessible information requirements delivered : discussed at EPROG 08/06/22 to agree roll out and training for clinicians and admin staff, a further update has been requested for 17/08/2022

Areas	Target	Owners	Progress
Complaints	Formal - Reduce complaints by 25% (4 complaints per year) Informal - Reduce concerns by 25%	Deirdre Linnard James McKean	On target for complaints
Patient Experience (FFT)	Improve patient experience to 96%. The aspiration is to reach 100%	Deirdre Linnard James McKean	On target
DSums	Achieve 100% of Dsums	Rob Bleasdale/Gary Davies/Noel Palmer	Working towards trajectory. June performance was 98.2%
Outpatient letters	Maintain 95% of GP letter turn around.	James McKean/ Gary Davies	Working towards trajectory for OP letter . May performance was 85%.

Risks, challenges/issues and dependencies

- The 100% target for out-patient letters sent within 7 days of an appointment is an aspiration. The the Trust is working towards this but is unlikely to achieve the 100%. The aggregate data is provided in arrears, making real time monitoring challenging,
- There is a draft business case in progress to facilitate dictation into Cerner to improve GP letter performance. Moving the CW site (legacy) dictation process into line with the WM process will slightly increase consultant workload, however it will streamline the process and impact timeliness.
- Support from Patient Experience Team to upload feedback forms and analyse local survey data

	Ref	Detailed Initiatives	Baseline	Target	Apr-22	May-22	Jun-22	Jul-22
Timeliness of Comms	1a	Formal complaints (appt related cumulative)	17	12	1	2	3	4
	1b	Informal complaints (cumulative)	478	358	24	49	78	99
	1c	Patient Experience (FFT) (Very good & Good)	93.8%	96%	data not available	96.5%	97%	91.6%
	1d	DSums	97.5%	100%	98.5%	99.%	98.2%	97.5%
	1e	Outpatient Letters	86.0%	90%	86%	84%	85%	data not available

Forward Plan

- Cerner business case for digital dictation was delayed due to other IT priorities; now drafted by Bruno Botelho and to be reviewed by Peter Hyland.
- Clinical Leads/DDO/GM meeting regularly to review letter performance and progress
- EPROG continues to escalate DSUM performance to Divisions
- Await update of the accessible information standards work stream through EPROG
- Monitor and review progress at Monthly Divisional Board meeting

Financial Benefits

Cost avoidance:

- Reducing 1 formal complaint per quarter saves the Trust an estimated 20 hours of staff time, based on a Band 8b with on cost £800.
- It is difficult to estimate the **avoided cost of litigation** by reducing complaints and improving discharge summary performance.
- In 2020/21, NHS Resolution reported to the House of Lords that the cost of CNST clinical negligence claims incurred as a result of incidents in 2020/21 was £7.9 billion, down from £8.3 billion the previous year. 6,574 clinical claims received damages with [Total payments made to settle claims in 2020/21 was £2.26 billion](#), which is an average award of £40,000 per claim, costing £120k per claim including administration and consuming 1.5% of the overall NHS budget patient.
- Reducing formal complaints and informal concerns regarding appointment communications may also reduce the DNA rate and reduce wasted appointments.

Council of Governors Meeting

Lead: Stephen Gill, Vice Chair

Author: Andy Denton, Capital Project Manager

Accessibility Audit of the Physical Environment Briefing Paper / Update October 2022

Introduction

This paper has been written to update the Council of Governors on the progress of AccessAble and their audits of the Trust as previously reported.

Background

An accessibility audit was previously carried out on the Chelsea site by AccessAble and a report produced outlining the status in regards to accessing the main hospital and services. A secondary follow up visit /audit was undertaken in July 2022 to ascertain if there were any changes since their last visit and to audit the areas which were not covered in the initial audit. An initial brief update was received on the 29th August which outlined the areas visited. In conjunction with the re-audit of the Chelsea site, West Mid was also audited and detailed reports are expected week commencing 31 October 2022. In addition, the Trust's satellite sites (10 Hammersmith Broadway, 56 Dean Street and Dean Street Express) are also being audited late October/November.

As part of this project AccessAble produce "Access Guides" which are on-line virtual guides outlining what to expect when visiting the Trust from a physical environment perspective, which will be launched when all audits have been successfully completed.

Update

It was noted that certain areas on the Chelsea site still had not been audited (for example David Erskine – auditors were told they could not have access any of the ward due to Covid). To rectify this AccessAble have been instructed re-visits and these are currently in the process of being planned and co-ordinated in conjunction with the off-site audits.

The data and summary report which was produced has been challenged; the summary was very generalised and in many parts non-specific in regards to areas where improvements are required. The back-up data is difficult to interrogate and sometimes contradictory – these observations have been feedback and acknowledged by representatives from AccessAble. It has been requested that this is addressed by AccessAble and a revised specific report produced in order that positive action can be taken.

Actions Taken

On a positive note AccessAble's report highlighted a major area of concern which has been acknowledged by the Trust;

"Heavy manual doors with sprung closers can be extremely challenging not just to wheelchair users but also people with mobility aids, people with assistance dogs or those walking alongside a guide or carer. Doors that can be held open (which may be linked to the fire alarm system) are preferred. Where this is not appropriate, powered door opening devices are helpful"

I can report that as part of this year's capital programme the Trust are in the process of addressing this, and automating 24 door sets and these include all the main entrances to the wards – initial feedback from staff and patients have been positive. Works commenced on 10th October (starting on the 5th

Floor) and will be completed in December 2022. It is recommended that a further business case will be submitted outlining other doors that may also need to be addressed and not covered by these works hopefully in the next financial year.

The following was reported at the last meeting and updates are provided against each point;

- 1) Clear signage to Accessible Toilets to be added in departments – Further information has been requested from AccessAble to confirm the criteria / areas which are non-compliant– Detailed report to be completed by the end of the 3rd quarter of this financial year 1st December 2022
- 2) Signage to include ‘not every disability is visible’ - Further clarification has been requested from AccessAble. To be completed by December 2022.
- 3) Ensure all facilities have clear transfer space and correctly located grab rails – Further clarification/ details has been requested from AccessAble regarding the areas where the Trust is non-compliant and would potentially need to be addressed as part of the rolling ward refurbishments.
- 4) Ensure emergency pull cords are available, installed correctly and operational – operational team are monitoring as part of their audits – in addition – Further clarification has been requested from AccessAble on areas which have been identified as non-compliant. – Detailed report to be completed by the end of the 3rd quarter of this financial year 1st December 2022.
- 5) Ascertain facilities have correct levels of contrast i.e. between fittings, wall and door (if not, timeline to rectify) – specific areas which do not comply need to be extracted from report- AccessAble have instructed as part of the review to identify these areas – detailed report to be completed by the end of the 3rd quarter of this financial year.
- 6) Survey all Washrooms to ascertain suitability –AccessAble will assist with extracting this information as part of their revised / detailed report to be completed by the end of the 3rd quarter of this financial year.
- 7) Baby changing tables do not allow for wheelchair user parents – Further clarification has been requested from AccessAble regarding the locations which do not conform and provided in their updated report by the end of the 3rd quarter of this financial year.
- 8) Hospital entrance doors not easy to distinguish from the fixed glazing – review manifestations – these have been reviewed by the operational team and noted there are manifestations in place with exception of ED which will be addressed – to be completed by 30th November 2022.
- 9) Clear markings to be added to the head and foot of the escalators – A request has been raised with Trust’s maintenance contractor JCA to ascertain if feasible and quote accordingly by 31st October. Date to implement recommendation dependent on outcome of feasibility – No later than the 3rd quarter of this financial year..
- 10) St Stephens Centre Entrance to have handrails added to steps and step nosing’s to be clearly marked – A request has been raised with Trust’s maintenance contractor JCA to quote for these works so that this can be actioned. Quote expected by 1st November with an outline of programme to complete (dates to be confirmed).
- 11) Ensure Hearing Loops are fitted to at least one counter in each location including the Restaurant and Coffee Kiosk – this has been raised with ISS to confirm if hearing loops are in place by 31st October 2022 and action plan developed accordingly.

Audit and Summary Reports

For information, included in this paper are the original summary report and backing data reports.



Summary of
guidance reports - CI



CWNFT BPGs
Oct'21.xlsx



CWNFT LCIM
Oct'21.xlsx



CWNFT RAG
Oct'21.xlsx

Next Steps / Recommendations

AccessAble have been instructed to review the information / data submitted and the issues highlighted in this paper for the Chelsea site and provide a clear updated report outlining specific non-compliances in order for the Trust to develop appropriate and targeted action plans. These also include identifying areas where there are multiple issues / concerns that could potentially be addressed collectively and possibly form part of a capital project if appropriate. An updated report / detailed report to be completed by the end of the 3rd quarter of this financial year / December 2022 to address the issues highlighted in their report above.

In addition, AccessAble have been instructed to ensure that the audit reports for the West Mid Site and off site locations address all the issues raised prior to submission to the Trust – in line with the timescales above.



Council of Governors Forward Plan 2022

	27 January 2022 Council of Governors (Mandated) 1600 to 1800 hours	24 March 2022 Governor Briefing Session (Voluntary)	21 April 2022 Governor Away Day 1000 to 1400 hours
Statutory/Mandatory Business	<ul style="list-style-type: none"> Announcement of Election results Minutes of Previous Meeting, including Action Log Strategy: NWL Integrated Care System (ICS) developments – update Quality: People & OD Committee Report to the Council of Governors (SG) Quality Sub-Committee Report Membership Sub-Committee Report 	<ul style="list-style-type: none"> Understanding the Strategic Landscape and System Developments including Integrated Care Systems and Acute Provider Collaborative Models <p>Replaced with Performance and Quality Report Briefing Session</p>	<ul style="list-style-type: none"> Welcome and Networking/Introductions Governwell Training Programme for 2022-23 Introducing our Governor Sub Committees and refreshing membership Maximising our Effectiveness Introducing our Governor Guide for 2022-23
Papers for Information	<ul style="list-style-type: none"> Chairman’s Report Chief Executive Officer’s Report Performance & Quality Report; Workforce Performance Report Accessibility work update 		
Other Business	<ul style="list-style-type: none"> Questions from the governors and the public Forward plan Schedule of meetings Governor attendance register Any other business 		

	21 April 2022 Council of Governors Meeting 1400-1600 hours	19 May 2022 Governors Briefing Session 1600-1700 hours	21 July 2022 Council of Governors Meeting 1000-1100
Statutory/Mandatory Business	<ul style="list-style-type: none"> • Minutes of Previous Meeting, including Action Log • Strategy: NWL Integrated Care System (ICS) developments – update • Quality: CoG Quality Sub-Committee Report • Council of Governors Nomination and Remuneration Committee Report • Governor Commentary on the Quality Report sign-off • Quality Priorities 2022-23 • Business Planning 2022-23 Update • CoG Terms of Reference and Sub Committee Terms of Reference Approval • CoG Code of Conduct Refresh 	<p>Governor Quality Statement for 2021-22 – and briefing on performance against 2021-22 quality priorities</p>	<ul style="list-style-type: none"> • Minutes of Previous Meeting, including Action Log • Strategy: NWL Integrated Care System (ICS) developments – update • Quality: Finance & Investment Committee Report to Council of Governors; including Month 12 Financial Position (ND); Audit and Risk Committee Report to Council of Governors (NG) • COG Sub-Committees: Quality Sub-Committee Report; Membership Sub-Committee Report
Papers for Information	<ul style="list-style-type: none"> • Chairman’s Report • Chief Executive Officer’s Report • Performance & Quality Report; Workforce Performance Report • Accessibility work update 		<ul style="list-style-type: none"> • Chairman’s Report • Chief Executive Officer’s Report • Performance & Quality Report; Workforce Performance Report • Accessibility work update

Other Business	<ul style="list-style-type: none"> • Questions from the governors and the public • Forward plan • Schedule of meetings • Governor attendance register • Any other business 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Questions from the governors and the public • Forward plan • Schedule of meetings • Governor attendance register • Any other business
	29 September 2022 Briefing Session 1600-1700 hours	20 October 2022 Council of Governors 1600-1800 hours	8 December 2022 Briefing Session 1600-1700 hours
Statutory/Mandatory Business	<ul style="list-style-type: none"> • TBC 	<ul style="list-style-type: none"> • Minutes of Previous Meeting, including Action Log • Strategy: NWL Integrated Care System (ICS) developments – update • Quality: Quality Committee Report to Council of Governors (EH) • COG sub-committees: Membership & Engagement Sub-Committee Report; Quality Sub-Committee Report; 	TBC
Papers for Information		<ul style="list-style-type: none"> • Chairman’s Report • Chief Executive Officer’s Report • Governors Elections 2022 – update • Performance & Quality Report, including Winter Preparedness; Workforce Performance Report • Accessibility work update 	
Other Business		<ul style="list-style-type: none"> • Questions from the governors and the public • Governors Away Day January 2022 – plan • Forward plan • Schedule of meetings • Governor attendance register • Any other business 	<ul style="list-style-type: none"> •

January 2023 – Normal Hybrid meeting

April 2023 – Away Day

Topics to be presented at future meetings:

Klick for our HIV – Sexual Health London (Sara Day)

Council of Governors Meeting Dates 2022/23

The Council of Governors meetings take place in public every three months. All Governors are required to attend this meeting which will be chaired by the Vice Chair of the Council of Governors Steve Gill. Papers will be issued for this meeting approximately 1 week in advance.

Dates	Location	Time
27 January 2022	Virtual	16.00-18.00
21 April 2022	Virtual	16:15-18:00
28 June 2022	Away Day	09:30-12:30
21 July 2022	Virtual	10.00-11.00
20 October 2022		16.00-18.00
26 January 2023		16.00-18.00
19 April 2023	Away Day	10:00-17:00

Lead Governor & Council of Governors Informal Meeting Dates 2022/23

The purpose of this meeting is to provide a voluntary opportunity for Governors to meet with the Lead Governor Simon Dyer. These meetings have been scheduled to take place following your receipt of the main Council of Governor meeting papers (see above) so that you can discuss content, queries etc.

Dates	Location	Time
24 January 2022	Virtual	16.15-17.00
Date to be confirmed for April 2022		
18 July 2022		
17 October 2022		
23 January 2023		

Non-Executive Director (NEDs) & Council of Governors Informal Meeting Dates 2022

The purpose of this meeting is to provide a **voluntary** opportunity for Governors to meet with the Non-executive Directors in a non-public setting. The meetings are scheduled twice a year immediately following the main Council of Governors meeting.

Dates	Location	Time
21 April 2022	Virtual	18.00-19.00
19 October 2022		
TBC		

Council of Governor Briefing Session 2022

The Governor briefing sessions provide a voluntary opportunity for Governors to hear from a subject matter expert about a particular aspect of the work of the Trust.

Dates	Location	Time
24 March 2022	Virtual	1600-1700
19 May 2022		
29 September 2022		

23 March 2023		
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Corporate Governance Contact Detail

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Council of Governors – Attendance Record 2022

Governor	Category	Constituency	27.01.22	21.04.22	28.06.22 Away Day	21.07.22	01.08.22	20.10.22	TOTAL	TOTAL %
Richard Ballerand	Public	Royal Borough Kensington and Chelsea	✓	✓	Apologies	✓	✓			
Jeremy Booth	Patient		Apologies	Apologies	Apologies	Apologies	Apologies			
Caroline Boulliat	Public	London Borough of Wandsworth	✓	✓	✓	✓	Apologies			
Cass J. Cass-Horne	Public	City of Westminster	✓	Apologies	✓	Apologies	✓			
Christopher Digby-Bell	Patient		✓	✓	✓	✓	✓			
Simon Dyer	Patient		✓	✓	✓	✓	✓			
Richard Jackson	Staff	Support, Administrative and Clerical	✓	Apologies	Apologies	Apologies				
Paul Kitchener	Public	Royal Borough of Kensington and Chelsea	Apologies	✓	Apologies	✓	Apologies			
Minna Korjonen	Patient		✓	✓	✓	✓	✓			

Anthony Levy	Public	City of Westminster	✓	✓	✓	✓	✓			
Rose Levy	Public	London Borough of Hammersmith and Fulham	✓	✓	✓	✓	✓			
Mark Nelson	Staff	Medical and Dental	✓	✓	✓	✓	✓			
Nicole Nunes	Staff	Contracted	Apologies	Apologies	Apologies	Apologies	Apologies			
David Phillips	Patient		Apologies	✓	✓	✓	✓			
Catherine Sands	Staff	Management	✓	Apologies	✓	Apologies	Apologies			
Jacquei Scott	Staff	Nursing and Midwifery	✓	✓	✓	✓	✓			
Dr Desmond Walsh	Appointed	Imperial College	✓	Apologies	✓	✓	✓			
Laura Wareing	Public	London Borough of Hounslow	✓	✓	Apologies	✓	Apologies			
Trusha Yardley	Public	London Borough of Hammersmith and Fulham	Apologies	Apologies	Apologies	Apologies	Apologies			
Lisa Addison	Patient		✓	✓	✓	✓	✓			
Stella Macaskill	Patient		✓	✓	Apologies	✓	Apologies			

Julie Carter	Public	London Borough of Ealing	Apologies	Apologies	Apologies	Apologies	✓			
Parvinder Singh Garcha	Public	London Borough of Hounslow	Apologies	✓	✓	Apologies	✓			
Stuart Fleming	Public	London Borough of Wandsworth	✓	✓	Apologies	✓	Apologies			
Thewodros Leka	Staff	Allied Health Professionals , Scientific and Technical	Apologies	Apologies	Apologies	Apologies	Apologies			
CLlr Will Pascal							✓			



Acronyms

The following document explains some acronyms and terms which Staff and Governors may come across in their role.

A			
A&E	Accident & Emergency	AHSN	Academic Health Science Network
ARC	Audit & Governance Risk Committee	ALOS	Average Length of Stay
AGM	Annual General Meeting	AMM	Annual Members Meeting
AGS	Annual Governance Statement	AO	Accountable Officer
AHP	Allied Health Professionals	ALB(s)	Arms Length Bodies
AHSC	Academic Health Science Centre		
B			
BAF	Board Assurance Framework	BAME	Black Asian Minority Ethnic
BCF	Better Care Fund	BoD	Board of Directors
BMA	British Medical Association		
C			
CAMHS	Child and Adolescent Mental Health Services	CFO	Chief Financial Officer
CapEx		CMO	Chief Medical Officer
CBA	Cost Benefit Analysis	CNO	Chief Nursing Officer
CBT	Cognitive Behavioural Therapy	CoG	Council of Governors
CCG	Clinical Commissioning Group	COO	Chief Operating Officer
CDiff	Clostridium difficile	CPD	Continuing Professional Development
CE / CEO	Chief Executive Officer	CQC	Care Quality Commission
CF	Cash Flow	CQUIN	Commissioning for Quality and Innovation
CFR	Community First Responders	CSR	Corporate Social Responsibility
CHC	Continuing Healthcare	CT	Computed Tomography
CIP	Cost Improvement Plan		



D			
DBS	Disclosure and barring service	DoF	Director of Finance
DGH	District General Hospital	DPA	Data Protection Act
DHSC	Department of Health and Social Care	DPH	Director of Public Health
DNA	Did Not Attend	DTOC	Delayed Transfers of waiting Care
DNAR	Do Not Attempt Resuscitation	DTC	Diagnostic and Treatment Centre
E			
E&D	Equality and Diversity	EOLC	End of Life Care
ED(s)	Executive Directors or Emergency Department	EPR	Electronic Patient Record
EHR	Electronic Health Record	ESR	Electronic staff record
F			
FFT	Friends and Family Test	FT	Foundation Trust
FIC	Finance and Investment Committee	FTE	Full Time Equivalent
FOI	Freedom of Information	FTSU	Freedom to speak up
G			
GMC	General Medical Council	GDP	Gross Domestic Product
GDPR	General Data Protection Regulations		
H			
HCAI	Healthcare Associated Infection	HRA	Health Research Authority
HCA	Health Care Assistant	HSCA 2012	Health & Social Care Act 2012
HDU	High Dependency Unit	HSCIC	Health and Social Care Information Centre
HEE	Health Education England	HTA	Human Tissue Authority
HR	Human Resources	HWB / HWB B	Health & Wellbeing Board
I			
IG	Information Governance	ICU or ITU	Intensive Care Unit Intensive therapy unit
ICP	Integrated Care Pathway	IP	Inpatient
ICS	Integrated Care system	IT	Information Technology
ICT	Information Communications Technology	IV	Intravenous



K			
KLOE(s)	Key Line of Enquiries	KPIs	Key Performance Indicators
L			
LD	Learning Disability	LOS	Length of Stay
M			
M&A	Mergers & Acquisitions	MRI	Magnetic Resonance Imaging
MHPRA	Medicines and Healthcare Products Regulatory Agency	MRSA	Methicillin-Resistant Staphylococcus Aureus
MIU	Minor Injuries Unit	MSA	Mixed Sex Accommodation
MoU	Memorandum of Understanding		
N			
NAO	National Audit Office	NHSI	NHS Improvement
NED	Non Executive Director	NHSL A	NHS Leadership Academy
NHS	National Health Service	NHSP	NHS Professionals
NHS111	NHS nonemergency number	NHSX	
NHSBS A	NHS Business Services Authority	NICE	National Institute for Health and Care Excellence
NHSBT	NHS Blood and Transplant	NIHR	National Institution for Health Research
NHSE	NHS England	NMC	Nursing and Midwifery Council
O			
OD	Organisational Development or Outpatients Department	OSCs	Overview and Scrutiny Committees
OOH	Out of Hours	OT	Occupational Therapy
OP	Outpatients		
P			
PALS	Patient Advice & Liaison Service	PHSO	Parliamentary and Health Service Ombudsman
PAS	Patient Administration System	PICU	Psychiatric Intensive Care Unit or Paediatric Intensive Care Unit



PbR	Payment by Results or 'tariff'	PLAC E	Patient-Led Assessments of the Care Environment
PCN	Primary care network	POD	People and Organisational Development Committee
PDSA	Plan, do, study, act	PPI	Patient and Public Involvement
PFI	Private Finance Initiative	PTS	Patient Transport Services
PHE	Public Health England		
Q			
QA	Quality assurance	QIA	Quality Impact Assessment
QC	Quality Committee	QOF	Qualities and Outcomes Framework
QI	Quality improvement		
R			
R&D	Research & Development	RoI	Return on Investment
RAG	Red, Amber, Green classifications	RTT	Referral to Treatment Time
RGN	Registered General Nurse		
S			
SALT	Speech and Language Therapist	SLA	Service Level Agreement
SFI	Standing Financial Instructions	SoS	Secretary of State
SHMI	Summary Hospital Level Mortality Indicator	SRO	Senior Responsible officer
SID	Senior independent Director	STP	Sustainability and Transformation Partnership
SIRO	Senior Information Risk Officer	SUI	Series Untoward Incident / Serious Incident
SITREP	Situation Report	SWOT	Strengths, Weaknesses, Opportunities, Threats
T			
TTO	To Take Out		
V			
VTE	Venous Thromboembolism	VfM	Value for Money
W			
WLF	Well Led Framework	WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	WTE	Whole-time equivalent



Y

YTD

Year to Date