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

Zoom Conference: https://zoom.us/j/7812894174; Meeting ID 7812894174ORDial in: +441314601196; Meeting ID: 781 289 4174#

6 May 2021 11:00 - 6 May 2021 13:30

INDEX

Board of Directors Meeting (PUBLIC SESSION)

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Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence	Verbal	Interim Chairman
11.02	1.2	Declarations of Interest, including register of interests	Paper	Interim Chairman
11.05	1.3	Minutes of the previous meeting held on 4 March 2021	Paper	Interim Chairman
11.10	1.4	Matters arising and Board action log, including e-governance	Paper	Interim Chairman
11.15	1.5	Interim Chair's Report	Paper	Interim Chairman
11.20	1.6	Chief Executive's Report	Paper	Chief Executive Officer
11.30	1.7	Patient / Staff Experience Story	Verbal	Chief Nursing Officer
	2.0	**FOR DISCUSSION**		
11.45	2.1	Business planning 2021/22 update	Paper	Chief Financial Officer
11.55	2.2	Elective Care Recovery update	Paper	Deputy Chief Executive / Chief Operating Officer
12.05	2.3	Improvement Programme update and 2021/22 Quality Priorities	Paper	Chief Nursing Officer
12.15	2.4	NHSR 10 Point Maternity Plan	Paper	Chief Nursing Officer
12.25	2.5	Infection Prevention and Control Assurance update	Paper	Chief Nursing Officer
12.35	2.6	Equality, Diversity and Inclusion: Patient Equality Report 2020/21	Paper	Chief Nursing Officer
12.45	2.7	Integrated Performance and Quality Report – March 2021	Paper	Deputy Chief Executive / Chief Operating Officer
12.55	2.8	Responding to the National NHS Staff Survey 2020 results	Paper	Interim Director of HR & OD
13.00	2.9	Public Health at CWFT: priority-setting for 2021/22 including Applied Research Collaboration NWL annual update report	Paper	Chief Medical Officer
	3.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**		
13.10	3.1	Ockenden maternity review – for noting	Paper	Chief Nursing Officer
	3.2	Board Assurance Framework Q4 and year-end	Paper	Chief Nursing Officer

	3.3	Learning from Serious Incidents	Paper	Chief Nursing Officer
	3.4	People Performance Report – March 2021	Paper	Interim Director of HR & OD
	3.5	Mortality Surveillance Report Q4	Paper	Chief Medical Officer
	3.6	Guardian of Safe Working Report Q4	Paper	Chief Medical Officer
	3.7	Emergency Preparedness Resilience and Response (EPRR) 2020/21 Update	Paper	Deputy Chief Executive
	3.8	Digital Programme update	Paper	Chief Information Officer
	3.9	Year-end report on use of the Company Seal 2020/21	Paper	Director of Corporate Governance & Compliance
	4.0	**ITEMS FOR INFORMATION**		
13.15	4.1	Questions from members of the public	Verbal	Interim Chairman
13.25	4.2	Any other business	Verbal	Interim Chairman
13.30	4.3	Date of next meeting: 8 July 2021; 11.00 – 13.30.		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust
Register of Interests of Board of Directors

Name	Role	Description of interest	Relevant dates		Comments
			From	To	
Stephen Gill	Chair (Interim)	Owner of S&PG Consulting	May 2014	Ongoing	
		Chair of Trustees, Age Concern Windsor	Jan 2018	Ongoing	
		Shareholder in HP Inc	April 2002	Ongoing	
		Shareholder in HP Enterprise	Nov 2015	Ongoing	
		Shareholder in DXC Services	April 2017	Ongoing	
		Shareholder in Microfocus Plc	Sep 2017	Ongoing	
		Member of the Finance and Audit Committee (FAC), Phyllis Court Members Club	Aug 2019	Ongoing	
Sir Thomas Hughes-Hallett	Chairman (Former)	Chair of HelpForce Community CIC & Trustee of Helpforce Community Trust	April 2018	Ongoing	
		Chair of Advisory Council, Marshall Institute, LSE	June 2015	Ongoing	
		Trustee of Westminster Abbey Foundation	April 2018	Ongoing	
		Son and Daughter-in-law – NHS employees	April 2018	Ongoing	
		Adjunct Professor at the Institute of Global Health Innovation, part of Imperial College	April 2018	Ongoing	
		Trustee, Civic	Jan 2020	Ongoing	
Aman Dalvi	Non-executive Director	Aman Dalvi Ltd (Housing & Planning Consultancy)	2017	Ongoing	
		Non-Executive Director of Fairplace Homes	2018	Ongoing	
		Non-Executive Chair of Goram Homes (Bristol)	2019	Ongoing	
		Non-Executive Chair of Kensington & Chelsea TMO Residuary Body	2019	Ongoing	
		Non-Executive Chair of Aspire Housing (Staffordshire)	Jan 2021	Ongoign	
		Non-Executive Chair of Newlon HT	Jan 2021	Ongoing	
		Chair of Homes for Haringey	2017	Until Mar 2021	
Nilkunj Dodhia	Non-executive Director	Directorships held in the following:			
		Express Diagnostic Imaging Ltd	Feb 2012	Ongoing	
		Macusoft Ltd - DigitalHealth.London Accelerator company	May 2017	Ongoing	

		Turning Points Ltd	Nov 2008	Ongoing	
		Examiner of St. John the Baptist Parish Church, Old Malden	April 2016	Ongoing	
		Spouse – Assistant Chief Nurse at University College London Hospitals NHS FT	Jan 2019	Ongoing	
Nick Gash	Non-executive Director	Trustee of CW + Charity	Jan 2017	Ongoing	
		Lay Advisor to HEE London and South East for medical recruitment and trainee progression	Nov 2015	Ongoing	
		Chair North West London Advisory Panel for National Clinical Excellence Awards	Oct 2018	Ongoing	Lay Member of the Panel throughout my time as NED
		Spouse - Member of Parliament for the Brentford and Isleworth Constituency	Nov 2015	Ongoing	
		Associate, Westbrook Strategy	Feb 2020	Ongoing	
Eliza Hermann	Non-executive Director	Former Board Trustee and current Marketing Committee Chairman, Campaign to Protect Rural England, Hertfordshire Branch	2013	Ongoing	
		Committee Member, Friends of the Hertfordshire Way	2013	Ongoing	
		Close personal friend – Chairman of Central & North West London NHS Foundation Trust	Ongoing	Ongoing	
Ajay Mehta	Non-executive Director	Director and Co-Founder at em4 Ltd		Ongoing	Social Enterprise works with international funders and investors to build the capabilities of their grantees and partners in order to increase social impact
		Trustee, Watermans		Ongoing	The organisation showcases and delivers arts programmes to communities in West London
		Partner employee of Notting Hill Housing Trust		Ongoing	The Trust commissions the provision of care services to vulnerable people in LB Hammersmith and Fulham
		Head of Foundation, The Chalker Foundation for Africa		Ongoing	The Foundation invests in projects that build the capacity of health-related organisations, in particular healthcare workers, in sub-Saharan Africa.
		Volunteer with CWFT	01/03/2020	Ongoing	
Lesley Watts	Chief Executive Officer	Trustee of CW+ Charity	01/04/2018	Ongoing	
		Husband—consultant cardiology at Luton and Dunstable hospital	01/04/2018	Ongoing	

		Daughter—member of staff at Chelsea Westminster Hospital	01/04/2018	Ongoing	
		Son—Director of Travill construction	01/04/2018	Ongoing	
		ICS CEO NWL	Apr 2020	Ongoing	
		Special Advisor to THHT Board	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
Robert Hodgkiss	Chief Operating Officer / Deputy Chief Executive	Lead Chief Operating Officer for NWL ICS	Feb 2020	Ongoing	
		Senior Responsible Officer for NWL Elective Care	Feb 2020	Ongoing	
Pippa Nightingale	Chief Nursing Officer	Trustee in Rennie Grove Hospice	2017	Ongoing	No direct conflict of interest.
		NWL ICS chief nurse and executive quality	Feb 2020	Ongoing	No direct conflict of interest.
		Member of the Birth rate plus national maternity safe staffing board	Jan 2021	Ongoign	No direct conflict of interest.
Virginia Massaro	Chief Financial Officer	Director of Cafton Lodge Limited (Company holding the freehold of block of flats)	22/03/2014	Ongoing	
		Member of the Healthcare Financial Management Association London Branch Committee	Jun 2018	Ongoing	
		Director of Systems Powering Healthcare Limited	29/01/2020	Ongoing	
Dr Roger Chinn	Chief Medical Officer	Private consultant radiology practice is conducted in partnership with spouse. Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)	1996	Ongoing	
		Providing support to The Hillingdon Hospitals NHS Trust executive team	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
Kevin Jarrold	Chief Information Officer	CWHFT representative on the SPHERE Board	01/10/2016	31/03/2021	
		Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	01/10/2016	Ongoing	
		Joint CIO for the NW London Health and Care Partnership	01/01/2020	Ongoing	
Martin Lupton	Honorary NED, Imperial College London	Employee, Imperial College London	01/01/2016	Ongoing	
Chris Chaney	Chief Executive Officer CW+	Trustee of Newlife Charity	Jun 2017	Ongoing	
Susan Smith	Director of HR & OD	Joint Chief People Officer /Interim Director of HR & OD The Hillingdon Hospitals NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	13/10/2020	Ongoing	

Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to Board	Director, Women's Wellness Centre private healthcare facility	2005	Ongoing	
		Board of Governors, Latymer Upper School, London Audit and Risk Sub-Committee of Board	2015	Ongoing	
		Interim Medical Director, The Hillingdon Hospitals NHS Foundation Trust	14/10/2020	Ongoing	
Serena Stirling	Director of Corporate Governance and Compliance	Local Authority Governor at Special Educational Needs School (Birmingham)	2019	Ongoing	
		Mentor on University of Birmingham Healthcare Careers Programme	2018	Ongoing	
		Leadership Mentor for Council of Deans for Health	2017	Ongoing	
		Partner is Princess Royal University Hospital site CEO at King's College Hospital NHS Foundation Trust	Feb 2020	Ongoing	
		CW+ Fundraising Governance Committee Trust representative	Jul 2020	Ongoing	

DRAFT
Minutes of the Board of Directors (Public Session)
Held at 11.00am on 5 March 2021, Zoom

Present:	Sir Thomas Hughes-Hallett	Chair	(THH)
	Aman Dalvi	Non-Executive Director	(AD)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Deputy Chair/Senior Independent Director	(SG)
	Eliza Hermann	Non-Executive Director	(EH)
	Ajay Mehta	Non-Executive Director	(AM)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Chief Medical Officer	(RC)
	Rob Hodgkiss	Deputy Chief Executive/COO	(RH)
	Virginia Massaro	Chief Financial Officer	(VM)
	Pippa Nightingale	Chief Nursing Officer	(PN)
In attendance:	Kevin Jarrold	Chief Information Officer	(KJ)
	Serena Stirling	Director of Corporate Governance & Compliance	(SS)
	Sue Smith	Interim Director of HR & OD	(SSm)
	Chris Chaney	Chief Executive Officer CW+	(CC)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to Board	(GA)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Vida Djelic (Minutes)	Board Governance Manager	(VD)
Apologies	Nil		

1.0	**GENERAL BUSINESS**
1.1	**Welcome and apologies for absence** THH welcomed the Board members, Colleen Roach (CQC Inspector), and those in attendance and members of the Public to the Zoom Board public meeting. THH welcomed SS back to the Board from a period of recuperation and wished her well. THH noted ML advised he would join the meeting slightly later owing to prior commitment.
1.2	**Declarations of Interest** None.
1.3	**Minutes of the previous meeting held on 5 November 2020** The minutes of the previous meeting were approved as a true and accurate record of the meeting.
1.4	**Matters Arising and Board Action Log** The Board noted the action log.

	SG stated equality, diversity and inclusion is one of the key high priority areas and is regularly considered by the People and Organisational Development Committee.
1.5	**Chairman's Report** The Board noted the report. THH advised he was retiring and this was his last Board meeting as Chair of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT). He expressed how proud he was of the organisation and its performance and achievements. He highlighted Council of Governors' approval of the appointment of Steve Gill as Interim Chairman for one year, and one year extensions of Eliza Herman's and Nilkunj Dodhia's term of office as Non-Executive Directors. He further highlighted the substantive appointments of Virginia Massaro, Chief Financial Officer and Roger Chinn, Chief Medical Officer and offered his congratulations.
1.6	**Chief Executive's Report** The Board noted the report. LW stated since the last Board the Trust has experienced a significant second surge of COVID-19, predominantly in December 2020 and January 2021. February saw a significant reduction in COVID-19 admissions. As in the first surge of COVID-19, the Trust and its partners worked collaboratively across North West London ICS to provide a vital coordinated response to the pandemic and provide the best possible care to patients. Staff stepped up to work differently with the sector partners to deliver mutual aid and support to each other, share learning and work differently to deliver patient care. In recognition of their incredible dedication throughout the pandemic, LW congratulated staff on their outstanding efforts. Building on the successful NHS response to the pandemic, the government published a white paper proposing legislative change for health and social care aiming to improve how different parts of the health and care system collaborate and cooperate for the benefits of local people. The proposals will bring NHS, local government and key partners closer together to improve care, and address health inequalities and the needs of their communities as a whole. Four key elements that will underpin the future structure of the health and care system are ICSs, place-based partnerships, provider collaboratives and the national and regional bodies. The white paper will be considered by the Board and the Council of Governors in April. An update on this will be brought to a future Board meeting. While noting the biggest vaccination programme the NHS has ever undertaken, LW commended PN for her commitment to effectively leading the delivery of the COVID-19 vaccination programme in hospital hubs and mass vaccine centres in partnership with the NWL partners. LW noted the Trust's ongoing commitment to developing the health and wellbeing support for staff. Developments included enhanced counselling services, encouraging active commutes, and providing support for transport and accommodation where the pandemic has restricted staff. LW commended this was possible due to invaluable and on-going support from the CW+ charity, local communities and businesses to the Trust throughout this pandemic and acknowledged the hard work of the team, volunteers and donors during this challenging period. EH expressed her support of proceeding with the development of the ICS to improve health and care outcomes. She commended the CWFT CEO for successfully leading and shaping the strategic agenda and asked if the responsibility could be sustained in future. LW stated her primary role was to maintain stability of CWFT and then to the NWL and the wider system. She complimented the support she was getting from the Executive Directors and stated that the leadership structure and responsibilities will be reviewed by the

	CWFT Board and the NWL ICS in due course. THH noted that the Board Nominations and Remuneration Committee is charged with the responsibility of reviewing Executive Directors succession plans; he assured the Board he is comfortable with the performance of CWFT Executive Directors and acknowledged presence of strong senior management below the Executive level. Along with the recently agreed Interim Chair arrangements, this provides the Board continuity and thus stability to the Trust.
1.7	**Patient and Staff Experience Story – COVID-19** *Pippa Nightingale, Chief Nursing Officer* PN noted the Planned Care End of Life (EOL) video on 'What Matters to our Patients' was made available on the Trust website earlier in the week for Board, Governors and the public to view in advance of the meeting. The CW+ Charity funded the project through its 'Dragons Den' initiative. PN commended CW+ for their support. The video provides a real opportunity to reset the organisation, focusing on the positives and benefits of personalising EOL care. She acknowledged great and often outstandingly compassionate care has been delivered by CWFT staff, despite the COVID-19 challenges. EH commended the video and asked about plans for sharing this video widely. PN stated that the EOL team is considering how best to bring all palliative care training resources together online. THH congratulated PN on sharing such a great initiative with the Board and commended CW+ for their support.
2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**
2.1	**Integrated performance and Quality Report – January 2021** *Rob Hodgkiss, Deputy Chief Executive* The Board noted that the report. RH provided the key highlights: • The Trust's performance has been greatly impacted by predominantly caring for COVID-19 patients • In January 2021 Critical Care operated 300% over the usual capacity; • Performance metrics were not recorded in the usual way due to staff being redeployed to support COVID-19 inpatient areas; • A&E performance in January was not compliant at 83.47%; • RTT performance was validated at 78.06% which is an improvement of 1.27%; however due to the most recent closure of Elective Care for all except for priority 1 & 2 patients this position is expected to deteriorate ahead of a full restart; and • Diagnostic wait times performance was impacted by the second wave and is expected to improve in the coming months; and • In relative terms across pertinent Acute Trust metrics CWFT was the 14th highest ranked Trust nationally, reflecting the major impact COVID-19 has had on overall NHS performance. PN noted that performance and quality standards are closely linked to patient outcomes and this is expected to improve in the coming months. RC further noted that clinical effectiveness metrics were not as expected due to clinical staff being redeployed to critical care.
2.2	**COVID-19 Recovery Update** *Rob Hodgkiss, Deputy Chief Executive*

	The Board noted that the report. In response to THH's comment how difficult it might be to recover so soon after coming out of the pandemic, RH stated that there is a sense of relief amongst staff and feel they are eager to get to 'business as usual'(BAU). PN and RC echoed staff desire to get back to their clinical activities and aspiration to deliver excellent patient care. SG stated CWFT has delivered excellent performance historically and relative performance comparisons during the second wave of the pandemic were helpful. Although staff were excellent in their response to the pandemic, it is important to recognise the need to go through wellbeing recovery, to that end the Trust has established excellent on-going health and wellbeing initiatives to support them. In response to AM's query about Hillingdon recovery, LW stated that it was addressed at the Hillingdon Board earlier in the week. NG noted theatre productivity has been impacted and asked how many ITU beds may be required in future, potential for spare capacity, what good and best in class looks like. RH stated coming out of the second wave the system is in a much stronger position to plan and prepare for an event of similar size. Theatre efficiency and productivity, and bed size is to be considered by the Centre, London and the region. The amount of recovery activity is impacted by resources and finances. Efficiencies are created by consolidating surgical pathways in NWL. RC noted the introduction of fast track surgical hubs in NWL with dedicated facilities bringing skills and resources together in the sector in a COVID-19 free environment, with staff caring only for surgical patients to minimise the risk of infection which support recovery, clinical prioritisation and patient outcomes. VM noted although productivity decreased in 2020 due to the COVID-19 situation, there are vast opportunities in avoiding admissions to hospital with the development of digital and ambulatory care. RH added consideration will be given to utilising digital technology to help patient and health and care professionals communicate. EH emphasised the importance of effective communication with patients during the recovery period on accessing health and care and allocating the necessary resources.
2.3	**Modern Slavery and Human Trafficking Statement – for approval** *Pippa Nightingale, Chief Nursing Officer* The Board noted the report. PN advised that in accordance with the Modern Slavery Act 2015 the Trust is required to ensure that safeguards are in pace to prevent incidents of modern slavery, including through its supply chain and associated providers of services. The position statement for the financial year ending 31 March 2021 was presented for approval by the Board. **DECISION:** The Board approved the Modern Slavery and Human Trafficking Statement for publication on the website.
2.4	**BAME Network Lead update** *Gubby Ayida, Equality, Diversity and Inclusion Specialist Advisor to Board* To set the scene, GA noted that as the disproportionate effect of COVID-19 on BAME communities become evident and linked to the rise of the Black Lives Matter movement, the BAME network established itself as a voice and a path for staff engagement, communication and inclusion across the organisation having input to staff risk assessments, holding regular and extraordinary meetings and webinars and a series of executive led listening events for BAME staff, including a reciprocal mentoring for inclusion programme. Towards the

	end of 2020 the network undertook a review of the year and presented to the Trust Executive Management Board. Due to the ongoing pandemic situation BAME Network activities were paused in January 2021. The network is expected to resume its activities post the COVID-19 pandemic. The following points were highlighted: • The introduction of Diversity and Inclusion Champions programme on interview panels at band 8a and above; • An increased representation of BAME staff as Freedom to Speak Up Champions within the organization; • The Network contributed to the NHS People Plan and the Chelwest People Strategy; • The Network encouraged its members to become mental health first aiders and health and well-being champions ensuring representation in these areas and spreading awareness of the Trusts health and well-being message, including BAME specific offers; • CWFT BAME Network has representation at the North West London Inclusion Board and input into its four critical areas of delivery: Leadership, Action, Culture and COVID and sharing information to address vaccination hesitancy. • The Network is working with National Institute of Health Research and Imperial and newly formed Race and Ethnicity Research Unit to address the concern of COVID-19 vaccine hesitancy within BAME communities. • The Trust Equality Diversity and Inclusion (EDI) lead and communications team are exploring opportunities for joint initiatives and joint working with the staff network Leads (BAME, LGBTQ+ and Womens). Network chairs / vice or co- chairs will be members of the Trust's Workforce Development Committee contributing to workforce developments, initiatives and plans. In response to ND's question if BAME Network would assist the Trust with reducing patient inequalities, GA noted the importance of relationships between engagement, inclusion and patient satisfaction; it is well known that the patient satisfaction is significantly higher in NHS trusts with higher levels of employee engagement/inclusion. PN added some work has been recently undertaken on tackling health inequalities in the NWL sector and the outcome data will be shared at a future Board meeting. AD noted that the Board had increased BAME representation, but an embedded succession plan should be in place to ensure that it is reflected in the Executive. AD also noted that translation had been an issue in incidents and queried whether this was an emerging pattern. AD further stated that vaccine hesitancy may need to be linked to people's contracts in future, and asked if there were one to one conversations occurring with staff members, and if the Trust was making use of multifaith rooms. AM commended the report and excellent initiatives undertaken by the BAME Network. He suggested impact analysis of BAME Network initiatives be undertaken in future to monitor its effectiveness and inform future strategies. GA stated that monitoring is done as part of Trust's compliance with the WRES standards. ND referred to unconscious bias training and asked whether it was included into educational training session and available across different specialties. GA stated that this training is delivered as an interactive discussion on various issues related to unconscious bias which provides the opportunity to increase self-awareness. THH congratulated GA on the presentation to the Board.
2.5	**Business planning 2021/22** *Virginia Massaro, Chief Financial Officer* VM noted the paper setting out Trust's approach to 2021/22 business planning was provided in the meeting pack. She advised that NHS England and Improvement (NHSE/I) has not yet released its planning guidance or financial envelope for 2021/22, however some high level information regarding funding arrangements has been provided. Detailed planning guidance is expected to be published in April 2021 with Q2-Q4 plans due for submission in June 2021. The Trust has an underlying deficit and will need to continue to deliver savings in 2021/22 and beyond to improve financial sustainability. Overall capital budgets will be set at an ICS level.

	Due to COVID-19 this year's approach to business planning is intended to be light touch with many programs from 2020/21 to roll-over into the next financial year.
2.6	**Board Committee Terms of Reference approval: • Quality Committee; • Finance and Investment Committee; • People and Organisational Development Committee; and • Audit and Risk Committee** SS advised that the Board Committee Terms of Reference were presented as part of the annual review and were considered and approved by each Committee alongside their effectiveness review. NG stated, ordinarily the ARC would review its effectiveness, including the Terms of Reference at the January meeting. This year it was not possible due to the ongoing COVID-19 situation; however, it is scheduled for full review and scrutiny by the ARC at its 25 March meeting. He further stated, in his capacity as Chair of Audit and Risk Committee (ARC), he had reviewed the ARC effectiveness including the Terms of Reference, and assured the Board on its accuracy and relevance. THH advised the recent reduction in COVID-19 admissions allows the Trust proceed with resuming its corporate governance arrangements and the regular meeting format and cycle from February / March 2021.
3.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**
3.1	**Learning from Serious Incidents** The Board noted the paper. PN noted there were eight external serious incidents during December 2020 and January 2021 and highlighted that quality improvement projects commenced to embed the learning identified from the highest reported categories of serious incidents. EH stated that the Serious Incidents report has been thoroughly reviewed and scrutinised by Quality Committee at its recent meeting.
3.2	**People Performance Report – January 2021** SSm noted the January people performance report has been reviewed at the recent People and OD Committee. THH congratulated SSm and the HR team on low rates of sickness & absence and turnover. EH commended the report and drew attention to the dashboard detailing volunteer hours by site and queried the lower active volunteer hours on WM site compared with that of CW site. SSm undertook to look into this. **Action: SSm to look into active volunteer hours on WM site to establish reasons for having lower active volunteer hours on WM site compared with that of CW site.**
3.3	**Mortality Surveillance Report Q3** RC stated the Q3 report was taken as read and highlighted the following points: • The Trust-wide SHMI relative risk of mortality between October 2019 and September 2020 demonstrates the Trust outcomes are significantly below the expected range and is the 6th lowest value in the country; • Due to increasing clinical demand and impact on staffing as a result of the COVID-19 pandemic the organisation's mortality review process remains paused; assurance in the Trust learning from death approach and identification of potentially suboptimal care is supported by the Medical Examiner's Office who continue to scrutinise all in-hospital deaths;

	• Covid-19 has had a significant impact on crude mortality but current trends indicate the rate returning to 5 year mean average; • An improvement in the relative risk of mortality has been experienced since March 2017 and has continued within Q3 2020/21; this is an indicator of improving outcomes and safety; and • The outcome of mortality review has provided a rich source of learning; the resumption of the Trust wide review process will support the organisation's improvement objectives and improve assurance reporting to the Board. ML asked if there was an ambition to compare mortality rates with that of the European partners. RC stated that this piece of work is undertaken on the national level. The Board noted the Q3 report.
3.4	**Guardian of Safe Working Report Q3** The Board noted the Q3 report. RC advised that the Q3 report provides assurance of safe working hours and conditions for all junior doctors and dentists employed by the Trust. The emphasis of the report was to address the changes that had been put in place to support services, patient care and junior doctors as the Trust navigated through the second wave of the pandemic. This report had been scrutinised by the by the People and OD Committee at its recent meeting. It is understood from the outset that many junior doctors will have been impacted in different ways by the first wave. Many have lost training opportunities, the morale is somber and anxiety levels have been growing with the ongoing COVID-19 situation. In response to this, the junior doctor forum has now become a monthly meeting with ample support and guidance from the Medical Directors, HR and the Directors of Medical Education.
3.5	**Digital Programme update** The Board noted the report. KJ provided an update on digital and innovation activity, highlighting a list of projects in pipeline as detailed on the first slide of the paper. EH commended an ambitious digital agenda and asked more detail around patient benefit be included in future iteration of this report. KJ undertook to provide more detail on how patients can benefit from digitalisation. **Action: KJ to provide more detail on how patients can benefit from digitalisation in a future iteration of the report.** In response to SG's question about enabling transparent movement of patient records across the NWL sector, KJ stated that digitalisation of patient records and connecting digital technology aims to improve patient pathways. THH noted the use of digital technologies will support the empowerment of patients so that they may be involved in their own care and health improvement. He stated there are huge opportunities for volunteering to help this transformation and bring about real improvements for patients and undertook to discuss this outside the meeting with KJ.
4.0	**ITEMS FOR INFORMATION**
4.1	**Questions from members of the public**

	Barbara Benedek, public member and a former carer, asked about communication with carers in preparation for the discharge of patients without capacity. She commended the discharge hub and expressed there would be fewer failed discharges and better patient outcomes if family carers were involved in the discharge planning. She felt this should form part of recovery planning. Barbara Benedek, also raised an issue of poor communication with GPs following discharge she experienced and asked if hospital could help patients get input from their GP following discharge. Another point she felt should form part of recovery planning. LW stated staff invest considerable amount of time to get the patient discharge process right, which include sending a copy of patient discharge letter to the relevant GP, and offered to speak with the member outside the meeting. Rose Levy, Public Governor, asked what proportion of total mortality during the COVID-19 pandemic comes from underlying health conditions vs. COVID-19 related and how it is confirmed it is COVID-19 related. RC stated the range of clinical presentations of COVID-19 is varied, this is confirmed by testing. In terms of reporting, the Office of National Statistics data includes any death where COVID-19 is mentioned on the death certificate, either directly, as an underlying cause or as a contributory cause.
4.2	**Any other business** <u>Retirement of THH</u> LW announced it was THH's last Board meeting as Chair of Chelsea and Westminster Hospital NHS Foundation Trust as he was retiring at the end of March. She thanked him for his contribution to the work of the Trust Board and the Council of Governors, the outstanding service to the Trust and wished him every success for the future. SG, on behalf of the Non-Executive Directors, congratulated THH on leading the Trust Board for seven years and helping the Trust improve its CQC rating from 'Require improvement' in 2014 to 'Good' and 'Outstanding' in more recent years. He successfully held the Trust Board to account to deliver continued improvements. THH expressed his pride of the organisation, its staff and patients. He was delighted he supported the decision to always put patients first at the centre of every decision and making the staff top priority based on the maxim that 'Happy staff helps to support happy and safe patients'.
4.3	**Date of next meeting – 6 May 2021; 11.00 – 13.30.**

The meeting closed at 13.08.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Trust Board Public – 4 March 2021 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
Mar 2021	3.2	People Performance Report – January 2021	Action: SSm to look into active volunteer hours on WM site to establish reasons for having lower active volunteer hours on WM site compared with that of CW site.	SSm	Complete.
	3.5	Digital Programme update	Action: KJ to provide more detail on how patients can benefit from digitalisation in a future iteration of the report.	KJ	Complete.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	1.5/May/21
REPORT NAME	Interim Chair's Report
AUTHOR	Stephen Gill, Interim Chair
LEAD	Stephen Gill, Interim Chair
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
REPORT HISTORY	N/A
SUMMARY OF REPORT	As described within the paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Interim Chair's Report
April 2021

Trust Chair:

Having served as Trust Chair for 7 years, Sir Tom Hughes-Hallett retired in March 2021. On behalf of the Board and the Council of Governors (COG) I would like to express our thanks to Sir Tom for his outstanding leadership during that period and to wish him well for the future.

As approved by the January COG, I was appointed as Interim Chair with effect from 4th March 2021 for the period up to 31st March 2022, pending the appointment of a substantive Chair.

Interim Trust Deputy Chair and Senior Independent Director (SID):

The April COG Meeting approved Nick Gash as Interim Deputy Chair and Eliza Herman as Interim SID.

Interim Governance arrangements for Non-Executive Director (NED) membership of Board sub-Committees:

As Interim Chair I stepped down as Chair of the People & Organisational Development Committee (PODC) and as a member of the Finance & Investment Committee (FIC) at the end of March. I would like to congratulate Ajay Mehta on his appointment as Chair of PODC from 1st April.

Except as above, all Board sub-Committee NED membership will be unchanged. See attached Paper.

Simon Dyer - Lead Governor:

Congratulations to Simon Dyer on his re-election in March as Lead Governor.

Staff 'Thank You' Event - 23rd March:

In recognition of an extraordinary year, with extraordinary dedication, support, resilience and commitment from the Trust staff and volunteers, the Trust 'Thank You' Event was held virtually on 23rd March, marking the first anniversary of the National Lockdown.

The CEO announced that the Trust will plant 982 trees in the NHS Forest to remember the patients who died; will give staff 2 additional rest and recovery days; will continue to invest in Health & Well-being (H&WB) programmes to support staff; in addition, cakes and flowers were delivered to all Wards, the Sky Garden (Chelsea) and the Restaurant (West Mid) during 23rd.

Sir Tom, as outgoing Trust Chair, thanked the staff on behalf of the COG and the Board.

COG Briefing Sessions:

11th March - Virginia Massaro, CFO, presented the Finance and Annual Plan update.

1st April - Sue Smith, Interim Director of HR & OD, presented the Trust's People Strategy.

NHS Short / Medium Term Focus Areas:

The top 3 current NHS focus areas are – the Vaccination Programme; the Recovery Programme (return to 'business as usual'); Planning for potential COVID-19 Wave 3.

Department of Health & Social Care (DHSC) White Paper - establishment of ICSs:

DHSC's White Paper re the legislative proposals for a Health and Care Bill was published in February 2021. The Four key elements that will underpin the future structure of the health and care system are:

i. ICS's bringing together commissioners and providers of NHS services with local authorities and other partners to collectively plan and improve health and care.

ii. Place-based partnerships between local organisations that contribute to health and wellbeing in smaller areas within an ICS. For most areas (but not all), 'places' will be based on local authority boundaries.

iii. Provider collaboratives, bringing together NHS trusts and foundation trusts within places and across ICSs to work more closely with each other. The form these will take and their function remains to be seen, with further guidance expected in early 2021.

iv. The national and regional bodies, including NHS England and NHS Improvement, the Care Quality Commission (CQC) and the Department of Health and Social Care, which will increasingly work through systems rather than individual organisations.

Resulting in Integrated Care Systems (ICSs) having statutory authority and responsibility with effect from 1st April 2022 (based on the current legislative timetable).

Chair Meetings:

The London Region Chairs meetings and North West London (NWL) ICS Chairs / CEOs meetings during March and April discussed the following topics: COVID-19 wave 2 status; Vaccination status; Recovery plan status; NWL ICS outline strategic plan and 'road map'; NHS Anchor institutions - potential impact on the wider determinants of health.

I have had 1:1s with Tony Bourne (Chair CW+); Penny Dash (NWL ICS Chair); Bob Alexander (Interim Chair of Imperial College Healthcare Trust); Sir David Sloman (London Region Director); and Sir Amyas Morse (Chair of Hillingdon Hospital Foundation Trust & London North West University Healthcare Trust).

As the Trust NED lead re the Ockenden Maternity Safety programme I participated in the London Region 'kick-off' meeting in March.

Stephen Gill

Interim Chair

NED membership of Board Committees (1st April 2021):

Nominations and Remuneration Committee	Audit & Risk Committee (ARC)	Quality Committee	Finance & Investment Committee (FIC)	People and OD Committee (PODC)
Steve Gill (Chair) Aman Dalvi Nilkunj Dodhia Nick Gash Eliza Hermann Ajay Mehta	Nick Gash (Chair) Eliza Hermann Aman Dalvi	Eliza Hermann (Chair) Nilkunj Dodhia Ajay Mehta	Nilkunj Dodhia (Chair) Aman Dalvi	Ajay Mehta (Chair) Nick Gash Martin Lupton *(non-voting Board member*)

Strategy	Estates	IT	Ockenden - Maternity Safety	CW+	Raising Concerns (FTSU)	Mortality	Wellbeing Guardian
Nick Gash (NED Lead)	Aman Dalvi (NED Lead)	Nilkunj Dodhia (NED Lead)	Steve Gill (NED Lead)	Nick Gash (NED Lead and Trustee)	Nick Gash (NED Lead)	Ajay Mehta (NED Lead)	Ajay Mehta (NED Lead)

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	1.6/May/21
REPORT NAME	Chief Executive's Report
AUTHOR	Lesley Watts, Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
REPORT HISTORY	N/A
SUMMARY OF REPORT	As described within the paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chief Executive's Report
April 2021

Introduction

Since my last report to Public Board in March, the number of Covid-19 positive patients has fallen significantly and the vaccination programme has made excellent progress. We are determined to learn from the pandemic but the focus of the Trust is forward looking, to recovery and development of our services.

In this second surge we worked hard to ensure care – including urgent cancer care – remained in place and there was explicit partnership across the North West London Integrated Care System (ICS) to ensure the coordination of care across the sector. For example critical care resources were managed on a NWL basis with active collaboration between all of the units to ensure care on the basis of need rather than geography.

As we move into Recovery we know we need to meet the existing health challenges of our population and the additional challenges such as the reduction of longer waiting times, delivery of the vaccination programme, treatment of new issues such as Long Covid and the significant increased incidence of social anxiety and mental health.

Alongside our Recovery programme external business and services are also re-opening and we have made the decision to reflect this in revisions to our Visitor Policy. There is very strong evidence that shows the positive impact on patient experience and outcomes and while it will mean an increase in the numbers we see on our sites we continue to actively manage the risk of transmission through vigilance and compliance with our Infection Prevention & Control processes.

Learning from the pandemic

On the national day of reflection, 23 March, we shared our experiences, learning and thoughts for the future with staff through an online event. We are truly grateful for the work of our staff and volunteers, and this was echoed through the enormous outpouring of thanks and support we received from our communities. Here is the video we showed https://vimeo.com/526191358/6b75a7f42f

I am very proud that our response showed such strong team work, mutual support and innovation in how we deliver services. We will continue to build on all this learning into the future.

Staff health and wellbeing remains essential and we continue to invest in a three year programme. Staff have been granted a recovery day, to be taken by the end of June, and an extra day on or near their birthday.

The Trust will plant 982 trees or plants, one for every one of our patients that died, as part of the NHS Forest. Alongside the act of remembrance this aligns with our programme to make the Trust more sustainable.

Volunteers

Volunteers have been an essential and valued part of our response to Covid. There were obvious pressures on our existing volunteers and the team created a magnificent recruitment campaign which brought in new enthusiastic people throughout the pandemic. Over 400 volunteers contributed over 30,000 hours.

Our volunteers help in so many ways. They support everything from pharmacy runs to over 500,000 staff meals delivered to wards. They provide care and kindness to patients, whether helping with meals, passing on messages from families and loved ones, or helping them speak to family through various forms of technology. Volunteers have also provided crucial support to our vaccination programmes.

The team created a dynamic youth programme, for those aged 16+, which has brought nearly ninety lively young people into the Trust. The feedback I have had is that these young people bring a particular joy to many of our patients.

As a Trust we need to make their efforts worthwhile, a learning experience, and rewarding for those who do it. I was reminded about the breadth of what our volunteers do in our staff webinar and the feedback from their colleagues was heartfelt.

Developing facilities

In the summer we will be celebrating our new, world class NICU/ICU facilities on our Fulham Road site. This significantly expands our capacity to treat our sickest patients. We have been supported by CW+ and our donors to invest in and demonstrate the benefits of providing care in a healing environment. This project has garnered national interest. We are planning an Official Opening Day which will be digitally supported so we can showcase the new facilities and the efforts of our clinicians, estates and CW+ teams in translating our ambition into this world class facility, and what it might mean for future care in other parts of the organisation.

Our next major programme is planned for the West Middlesex site and we are well under way with ambitious plans for the new diagnostic centre at West Middlesex. This is aimed at providing enhanced services for the local community.

Vaccination

The Trust is playing a leading role in the North West London NHS vaccine programme including recruiting and deploying some of its staff. We lead in the management of the Science Museum and Fountain Leisure Centre Brentford centres. On 23 March, the national day of reflection, the Duke and Duchess of Cambridge visited the Westminster Abbey centre in support of the programme and spoke to staff and volunteers.

The Trust has been successful in vaccinating our staff: 91% of front-line staff and 93% of all staff have had at least their first Covid-19 vaccination. This makes us the fifth best performing Trust in London.

The vaccines in use are safe and effective, and help keep all of us, our colleagues, our friends and families safe. It is a concern that some eligible for the vaccine have not taken it up and we continue to promote the benefits of doing so.

Innovation news

Innovation is key to our thinking and the way to deliver outstanding care. Our staff have many good ideas on how to improve patient care and we support them to deliver them. CW Innovation is a joint venture between the Trust and our charity CW+ and recently they introduced the first nursing innovation fellow, Debbie Van Der Velden. She has already been active within the Trust identifying projects.

RADICAL was a recent chance for staff to bid for funding, specifically focused on digital solution, and for this award we also partnered with the Rosetrees Trust and Kusuma Trust.

In the final, shortlisted teams underwent a Dragons Den pitch, appropriately for a digital bid it was all held on Zoom. The winner was FibriCheck, a smartphone atrial fibrillation testing app proposed by Consultant Cardiologist Sadia Khan and Pavidra Sivanandarajah. The app will be used to measure pulse pressure signals in members of the local community who have recently suffered a stroke, and those at high risk of atrial fibrillation. Many many congratulations to the winners.

Brent Bartholomew was a very close runner up, with his proposal to use Microsoft's Hololens glasses across our hospitals, enabling medical students to remotely stream into clinics. Well done.

The quality of entries was so high that our partners have kindly agreed to fund all shortlisted projects. Thanks to them and congratulations to all the finalists:

- DBm-Health, a remote monitoring system developed by Daniel Morganstein, which allows patients with diabetes to manage their condition using an app.
- Kintsugi by Johan Redelinghuys, which aims to pilot an app to support children and young people presenting to A&E with mental health crises, enabling self-management
- Virtual Bodyworks from Harry Sarsah, which uses virtual reality to expand on equality, diversity and inclusion training for staff by replicating real-life situations

Equality and Diversity

On International Women's Day the theme was #ChooseToChallenge so I shared a few thoughts about values, leadership, and making a difference https://vimeo.com/519957235/cfcfa46fff. We should all be proud of what the women in our organisation achieve.

The Trust has a domestic violence team supporting staff and patients, and we also provide resources on feeling safe at work and away from it. Of course these issues do not only affect women.

Lesley Watts
Chief Executive

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.1/May/21
REPORT NAME	Business planning 2021/22 update
AUTHOR	Graham Henry, Deputy Director of Finance
LEAD	Virginia Massaro, Chief Financial Officer
PURPOSE	To provide an update to the 2021/22 business plan.
REPORT HISTORY	Executive Management Board, 14 April 2021 Council of Governors, 22 April 2021 Finance & Investment Committee, 27 April 2021
SUMMARY OF REPORT	• At the end of March NHS England & Improvement (NHSI/E) released its planning guidance for the first half of 2021/22 • The current block funding arrangements in 2020/21 will roll forward into the first half of 2021/22 (until the end of September 2021). • There will then be a separate planning process for the remaining 6 months of 2021/22. It is likely that Trusts will be funded on a blended payment mechanism which will have a fixed and variable element linked to activity. • Overall capital allocations/ budgets will be set at an ICS level and the overall ICS budget will be £232m. The Trust's capital plan is £29.3m. • An elective recovery fund has been set up to support acute elective recovery at 120% of tariff payment for activity above 85% of 19/20 levels at an ICS level • Additional funding has been allocated to support the implementation of the Ockenden Review for maternity • The Trust's CIP plan is £12.7m (2%)
FINANCIAL IMPLICATIONS	As stated above.
QUALITY IMPLICATIONS	None noted. Business plans will be reviewed by the Quality, Equality and Health Inequalities Analysis panel.
EQUALITY & DIVERSITY IMPLICATIONS	None noted. Business plans will be reviewed by the Quality, Equality and Health Inequalities Analysis panel.
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For information.

2021/22 Business planning update

1. Purpose

This paper provides an update on 2021/22 business planning.

2. 2021/22 Operational Plan Guidance and Priorities

At the end of March NHS England & Improvement (NHSI/E) released its planning guidance for the first half of 2021/22. The guidance sets out the following 6 priorities for the year:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

F. Working collaboratively across systems to deliver on these priorities.

Detailed planning guidance and funding allocations have been issued for the first half of 2021/22 (H1) and the financial settlement and arrangements for months 7-12 will be confirmed once there is greater certainty around the circumstances facing the NHS going into the second half of the year.

- The block funding arrangements in 2020/21 will roll forward into the first half of 2021/22 (until the end of September 2021). The funding is based on the last 6 months (H2) of 2020/21 envelopes adjusted for known pressures, policy priorities and efficiency requirements.
- Block payment arrangements will continue between NHS commissioners and providers will continue.
- An elective recovery fund has been set up to support acute elective recovery (see section 3)
- NHSE/I have announced c£80m of additional national funding to support maternity services and the implementation of the Ockenden Review. Funding allocations at ICS level have not yet been issued and implementation plans will be worked up by Local Maternity Systems (LMSs).
- Capital allocations/ budgets have been issued at an ICS level. The ICS capital budget for 2021/22 is £232m, which is in line with the 2020/21 allocation

There will then be a separate planning process for the remaining 6 months (H2) of 2021/22. It is likely that Trusts will be funded on a blended payment mechanism which will have a fixed and variable element linked to activity. Detailed planning guidance will be published later in the year and plans are likely to be due for submission in August/ September 2021.

3. Elective Recovery Fund (ERF)

Additional funding has been made available nationally to support the recovery of elective care. Systems will be paid through the ERF for activity delivered above set thresholds. The scheme will be applicable until the end of September 2021 and outlined as follows:

- Baseline thresholds will be set as a percentage of the 2019/20 activity – 70% for April, 75% for May, 80% for June and 85% for July to September.
- The ERF will apply to elective day case and inpatients, outpatient procedures and all outpatient attendances (excluding maternity and diagnostic imaging, but including virtual attendances). It will include activity undertaken by independent sector providers and be measured at an ICS level.
- Activity between the monthly threshold and 85% of 19/20 will be funded at 100% of national tariff. Activity above 85% of 19/20 levels will be funded at 120% of national tariff. There will be no financial penalty for activity below the activity threshold.

4. Impact on NWL ICS and CWFT

The impact on NWL and CWFT of the H1 financial arrangements is being worked through and will be updated at the next COG. However, it is expected that the H1 system envelope should allow the NWL ICS and the Trust to achieve a breakeven position for the first 6 months of 2021/22.

The Trust is planning on a CIP target of 2% for 2021/22, which is £12.7m.

The Trust has a capital plan of £29.3m, which is within the NWL ICS overall capital allocation and is broken down as follows:

Capital Type	**2021/22 Draft Plan (£000)**
Estates	19,149
ICT	5,000
Medical Equipment	4,952
Other	150
Grand Total	**29,251**

Key schemes include:

- NICU/ITU completion
- Ambulatory Diagnostics Centre
- Estates routine & backlog maintenance and PFI lifecycle costs
- IT schemes, including digital maternity solution
- Medical equipment replacement programme

5. Approach and timeline to business planning and budget setting

The approach to business planning for 2021/22 is intended to be light touch, with many programmes of work from 2020/21 to roll-over into the next financial year.

Clinical Divisions and Corporate departments have reviewed their 2020/21 business plan and presented their updated 2021/22 business plans to the Improvement Board on 18th March for approval. These set out strategic objectives, quality priorities, workforce priorities, pathway re-design and cost improvement schemes for the year.

Themes from the divisional priorities centred around 4 areas:

1. Productivity
2. Clinical Service Redesign
3. Covid-19 management & recovery
4. Digital/ Innovation

The draft milestone plan for the 2021/22 planning round is set out below:

Milestone	**Date**
2021/22 Budgets sign-off by Divisions	April 2021
Planning guidance/ financial envelopes to be published for H1 2021/22	25th March 2021
Provider capital and cash plan submission	12th April 2021
Submission of H1 2021/22 ICS Draft Operating Plans	6th May 2021
Submission of H1 Trust plans	24th May 2021
Submission of H1 2021/22 ICS Final Operating Plan	3rd June 2021

6. Key Risks

There are a number of financial risks to the financial plan for 2021/22, including:

- On-going impact of Covid-19
- Delivery of CIP target and financial plan
- Loss of non-NHS income
- Scale and pace of activity recovery
- Uncertainty over funding arrangements beyond H1 2021/22

7. Decision/action required

The COG is asked to note the update on 2021/22 Business Planning.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.2/May/21
REPORT NAME	Elective Care Recovery Update
AUTHOR	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
LEAD	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
PURPOSE	To provide the Quality Committee with an overview of elective care recovery and our current activity position across all aspects of the Elective Care Programme.
REPORT HISTORY	Elective care recovery has been regularly reviewed and discussed by the Executive Management Board, Quality Committee and Board.
SUMMARY OF REPORT	As attached.
KEY RISKS ASSOCIATED	As noted in the paper.
FINANCIAL IMPLICATIONS	As noted in the paper.
QUALITY IMPLICATIONS	As noted in the paper.
EQUALITY & DIVERSITY IMPLICATIONS	As noted in the paper.
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Delivering better care at lower cost
DECISION/ ACTION	For information and discussion.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Elective Care Recovery

Recovery Update - Summary 23 April 2021

Contents

P2 position

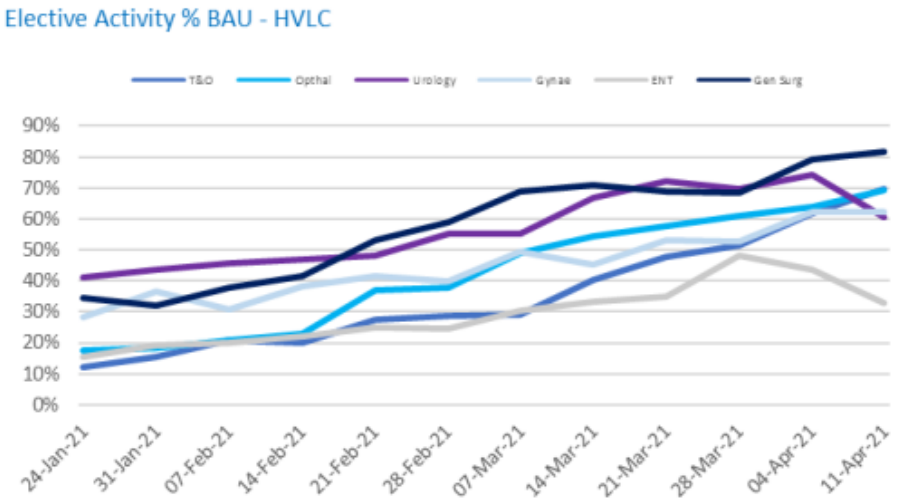
There are currently **3,462 patients on the P2 waiting list** and we have projected monthly capacity for **c. 2,775 patients**.

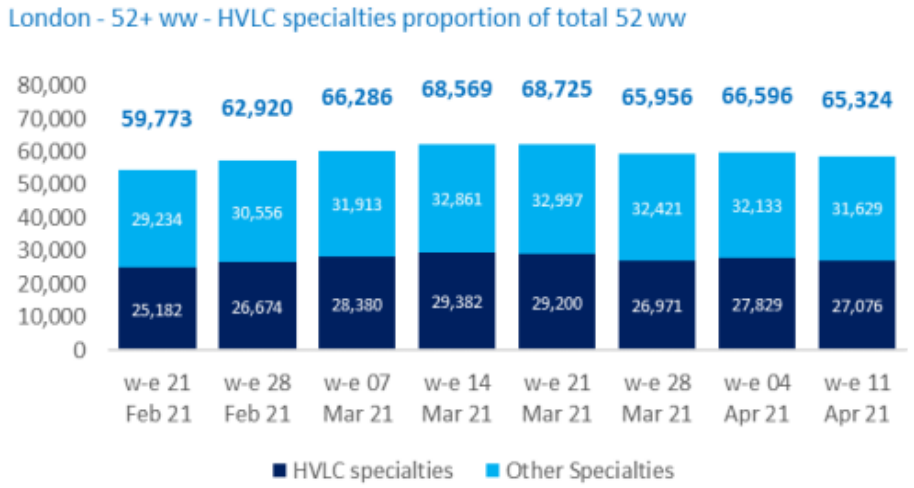
		P2 list & projected monthly capacity		
Date	**Weekly capacity for P2 patients**	**Number of P2 patients**	**Projected monthly capacity for P2 patients**	**Monthly P2 capacity shortfall**
03/03/2021	639	3,413	2,554	-859
10/03/2021	600	3,448	2,400	-1,048
17/03/2021	669	3,448	2,674	-774
24/03/2021	798	3,585	3,190	-395
31/03/2021	804	3,524	3,214	-310
07/04/2021	974	3,282	3,894	612
14/04/2021	988	3,435	3,952	517
21/04/2021	866	2,775	3,462	687

Trust	Comments and timeframes to achieve demand and capacity balance (4 week clearance)
CWHFT	**In balance as per Spring Plan**
Cancer	
Non Cancer	
Specialist	
ICHT	**In balance as per Spring Plan**
Cancer	
Non Cancer	
Specialist	
LNWUHT	**On trajectory as per Spring Plan** **CMH continue to provide DC capacity; P2 requiring ITU L2&3** – Some capacity by April 2021 – All capacity by end of May 2021
Cancer	
Non Cancer	
Specialist	
THHFT	**On trajectory as per Spring Plan - P2 Day Case – sufficient capacity** **P2 requiring ITU – Mid April 2021 – new ITU open**
Cancer	
Non Cancer	
Specialist	
RBHT	**In balance as per Spring Plan**
Cancer	
Non Cancer	
Specialist	

Source: NHSL P2 submission.
Figures represents unvalidated estimates.

London Elective – HVLC Specialties





*Note: The above views do not include Royal Free data so HVLC Specialty total will differ from those shown on slide 4

London - HVLC specialties Elective Activity					
Rank	Provider	Current Elective Activity	Prior week	Change	5 week Trend
1	Royal Marsden	186.5%	187.5%	θ	
2	RNOH	123.7%	86.1%	π	
3	Kingston	102.6%	87.1%	π	
4	Epsom	93.3%	69.8%	π	
5	Moorefields	87.5%	73.8%	π	
6	Kings	83.6%	76.1%	π	
7	ChelWest	81.5%	69.7%	π	
8	Homerton	78.1%	76.2%	π	
9	LNW	75.4%	72.7%	π	
10	Croydon	72.4%	122.8%	θ	
11	LGT	66.2%	78.3%	θ	
12	BHRUT	64.1%	58.6%	π	
13	RFL	62.6%	96.2%	()	
14	GSTT	61.6%	45.2%	π	
15	NMUH	58.0%	48.8%	π	
16	Hillingdon	56.6%	65.1%	()	
17	Imperial	53.6%	54.8%	()	
18	Barts	47.1%	41.7%	π	
19	St George's	46.6%	44.9%	π	
20	Whittington	44.2%	56.6%	()	
21	UCLH	0.0%	81.8%	()	
1	SWL	87.0%	82.0%	π	
2	SEL	74.6%	67.2%	π	
3	NWL	67.3%	65.0%	π	
4	NCL	64.7%	76.8%	()	
5	NEL	58.5%	54.0%	π	
	London	**69.9%**	**69.8%**	π	

Note: the specialties where HVLC opportunities have been identified are are T&O, Ophthalmology, Urology, Gynae, ENT and general surgery. The data on this page relates to all activity not just HVLC procedures in these specialties.

Key next steps

NW London ICS will take a balanced scorecard approach to HVLC specialties.

Focus will be on:

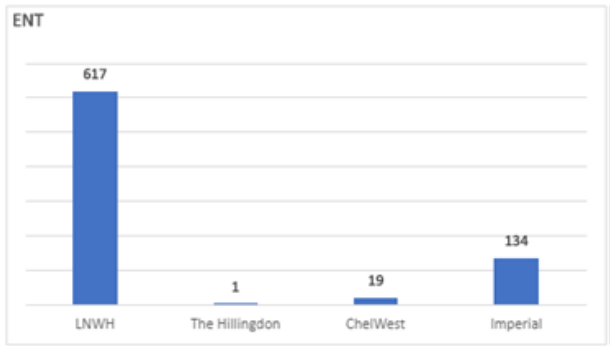
- clinical prioritisation
- 52 ww monitoring
- Clinical priority booking
- examine and support any patient cohorts not getting to surgery due to capacity constraints

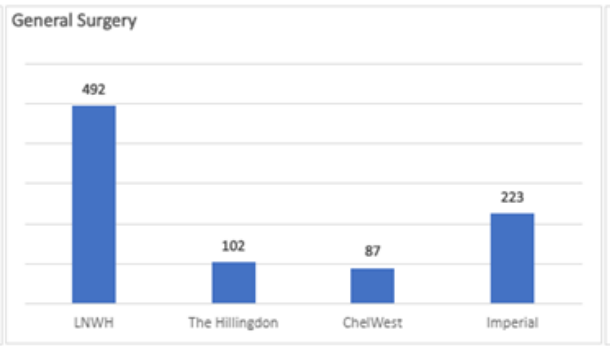
North West London

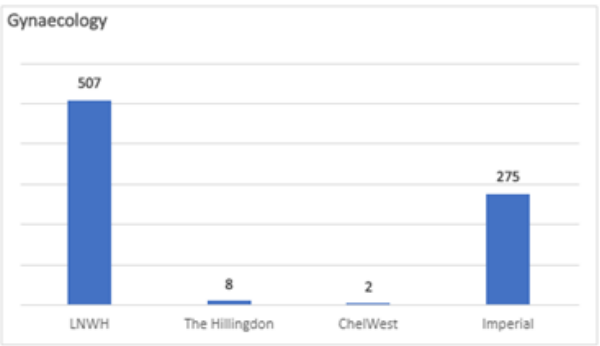
Outliers

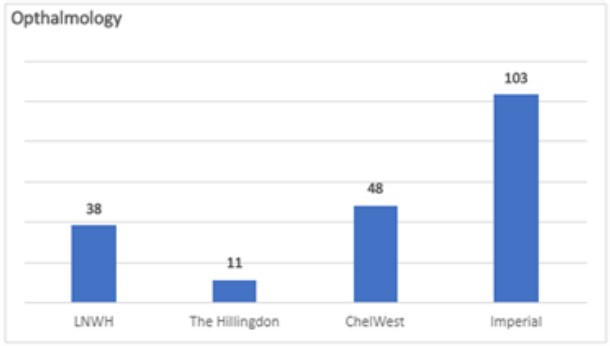
- LNWH are a consistent outlier across the HVLC services within North West London. The Trust 52+ week wait totals account for 80% (ENT), 54% (General Surgery), 61% (Gynae) of NWL's total respective backlogs
- **Trauma & Orthopaedics:** The Hillingdon are an outlier in T&O reporting 403 (down from 415) long waiting patients which is 52% of NWLs backlog.
- **Urology:** Imperial are an outlier in NWL for long waiting patients in this service, accounting for 75%; 354 (down from 349) patients in NWL's total service backlog.

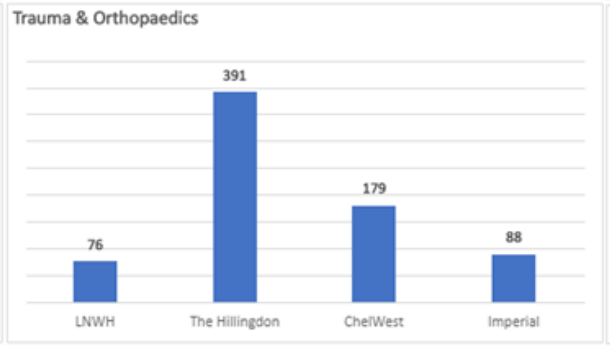
11 Apr	ENT	Proportion	Proportion of Total W/L	General Surgery	Proportion	Proportion of Total W/L	Gynaecology	Proportion	Proportion of Total W/L	Ophthalmology	Proportion	Proportion of Total W/L	Trauma & Orthopaedics	Proportion	Proportion of Total W/L	Urology	Proportion	Proportion of Total W/L
LNWH	617	80%	11.0%	492	54%	7%	507	64%	10%	38	19%	4%	76	10%	3%	2	0%	0%
The Hillingdon	1	0%	0.1%	102	11%	7%	8	1%	1%	11	6%	1%	391	53%	13%	49	11%	5%
ChelWest	19	2%	1.0%	87	10%	5%	2	0%	0%	48	24%	4%	179	24%	6%	63	14%	3%
Imperial	134	17%	2.3%	223	25%	8%	275	35%	4%	103	52%	2%	88	12%	4%	346	75%	9%
NWL		**771**			**904**			**792**			**200**			**734**			**460**	

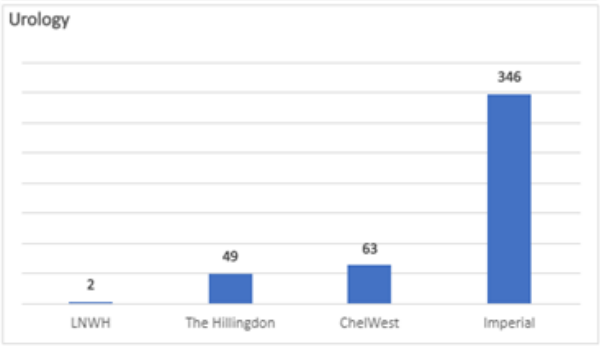












Phase 1: NHS Theatre throughput **NHS theatre activity in numbers**

W/E 18/04/2021

NHS activity / capacity
Rolling 8 weeks

1157 elective patients received surgery in NHS theatres **last week**

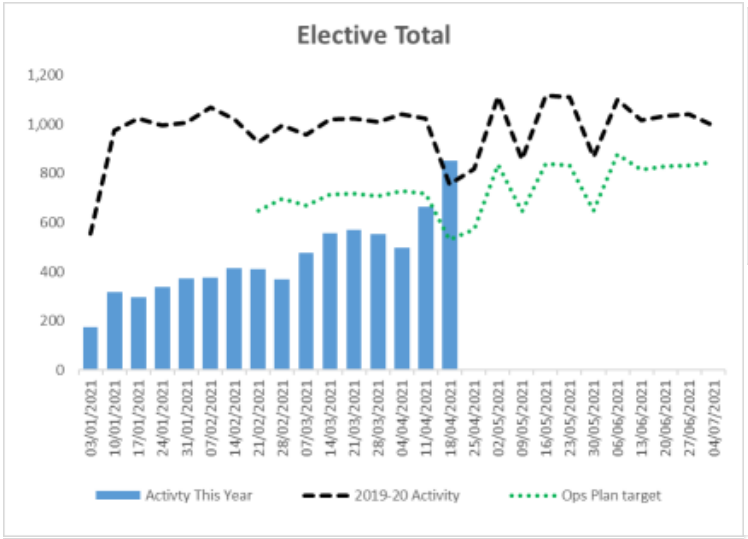
W/E	21/02/21	28/02/21	07/03/21	14/03/21	21/03/21	28/03/21	04/04/21	11/04/21	18/04/21
Trust	**Week 60**	**Week 61**	**Week 62**	**Week 63**	**Week 64**	**Week 65**	**Week 66**	**Week 67**	**Week 68**
CWHFT	130	104	164	166	202	196	274	279	356
ICHT	205	192	211	235	251	307	300	268	386
LNWUHT	174	201	204	211	249	251	194	216	299
THHFT	78	81	131	99	116	119	108	95	116
TOTAL	**587**	**578**	**710**	**711**	**818**	**873**	**876**	**858**	**1157**

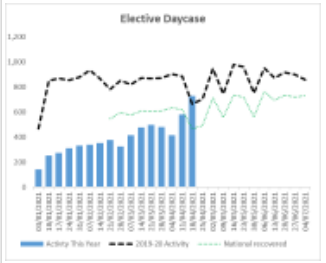
Sources:
Weekly theatre submission W/E 18/04/2021

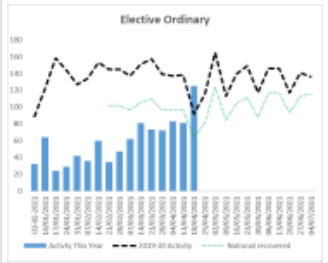
The North West London health and care partnership

Phase 2: Recovery Plan. Elective Weekly performance by Trust against Spring Recovery Plan

CWFT







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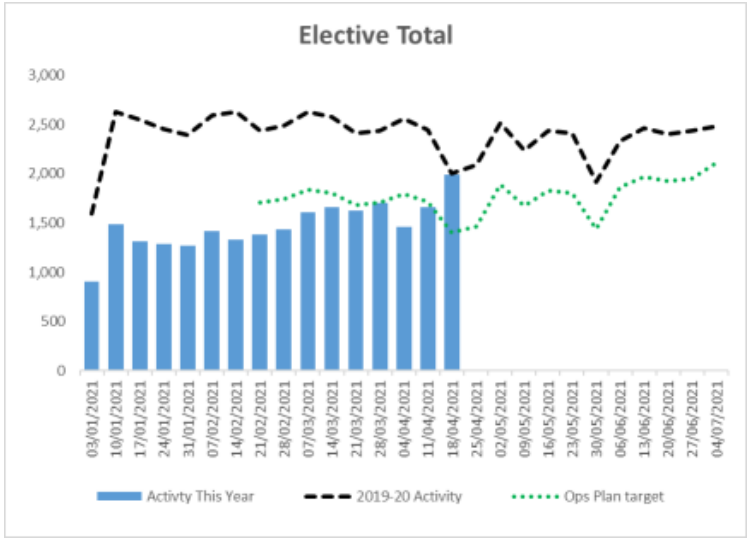
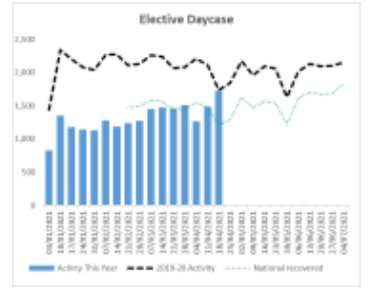
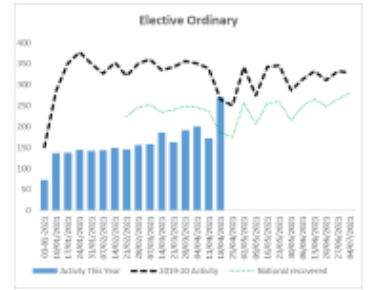
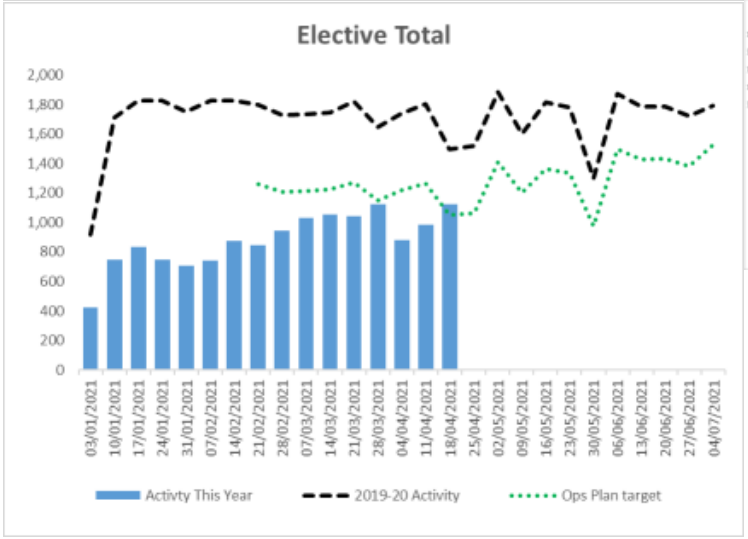
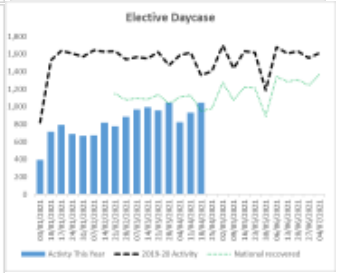


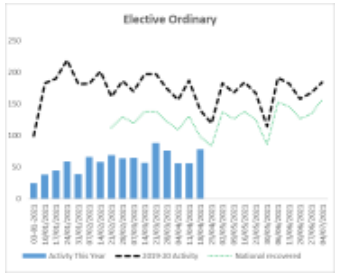




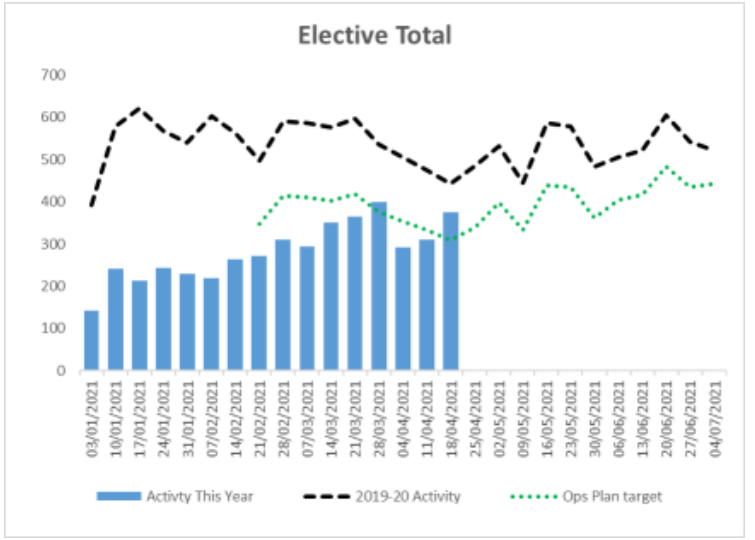
LNWUHT

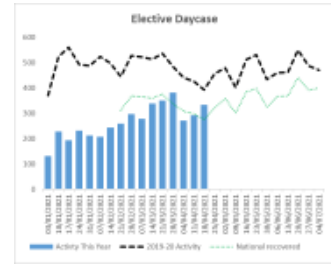


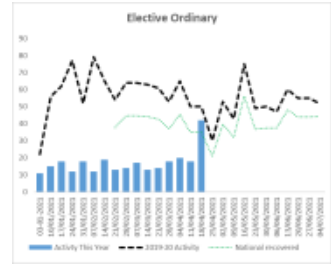




THHFT



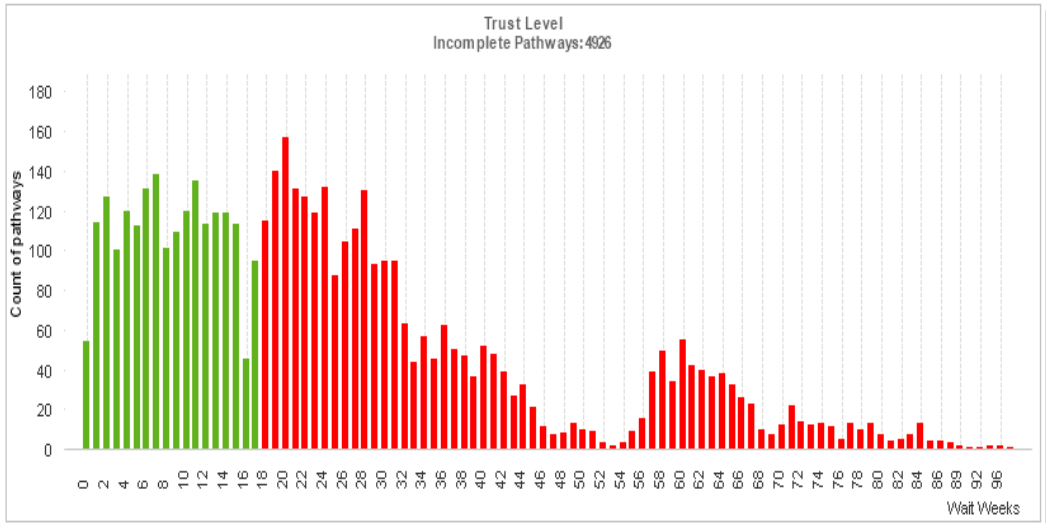


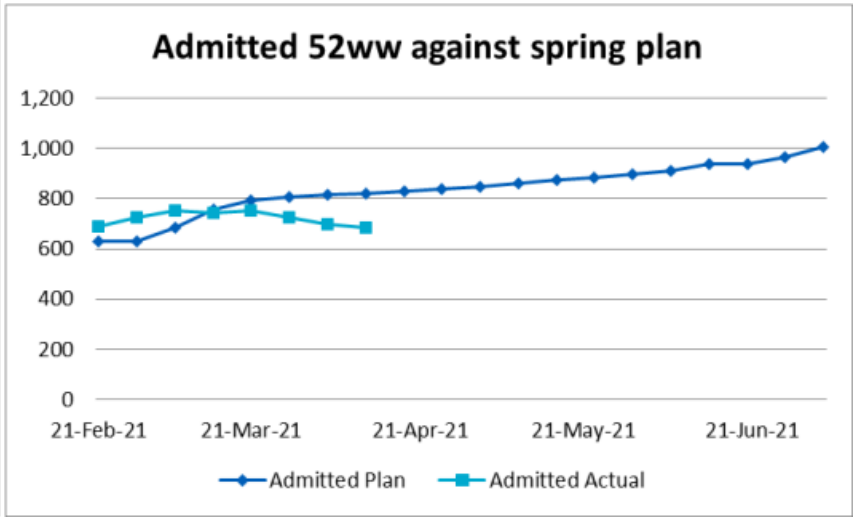


Source: COVID-19 NHS Weekly Phase 3 Activity Report

Current PTL Position

Admitted

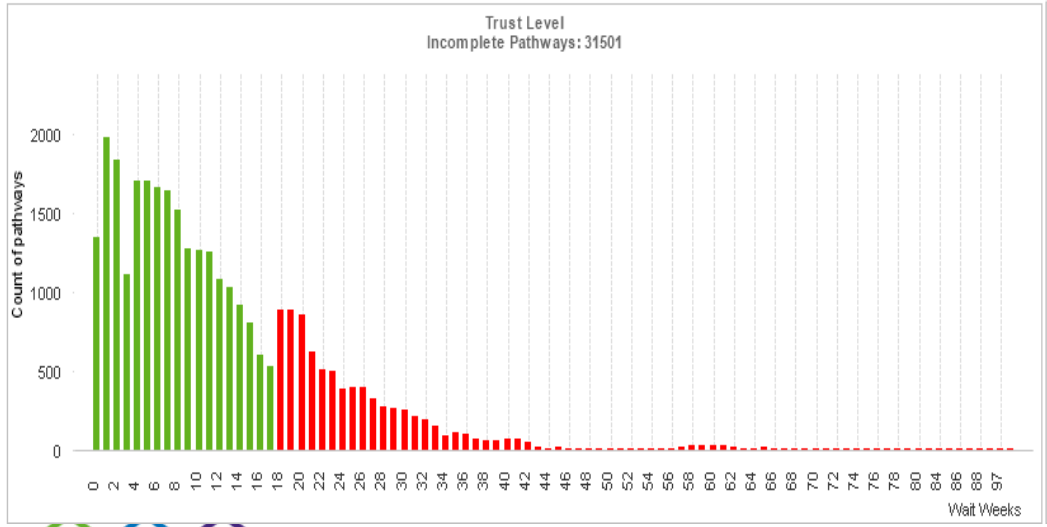


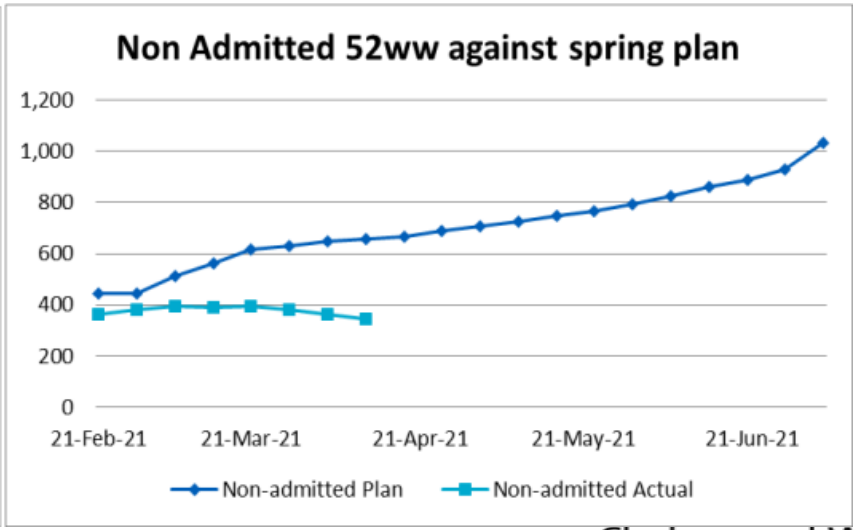


Admitted Summary (previous data)

- **52ww - ↓644** (682)
- **Dated – ↓818** (1,346)
- **Undated – ↑4,106** (3,837)

Non-Admitted

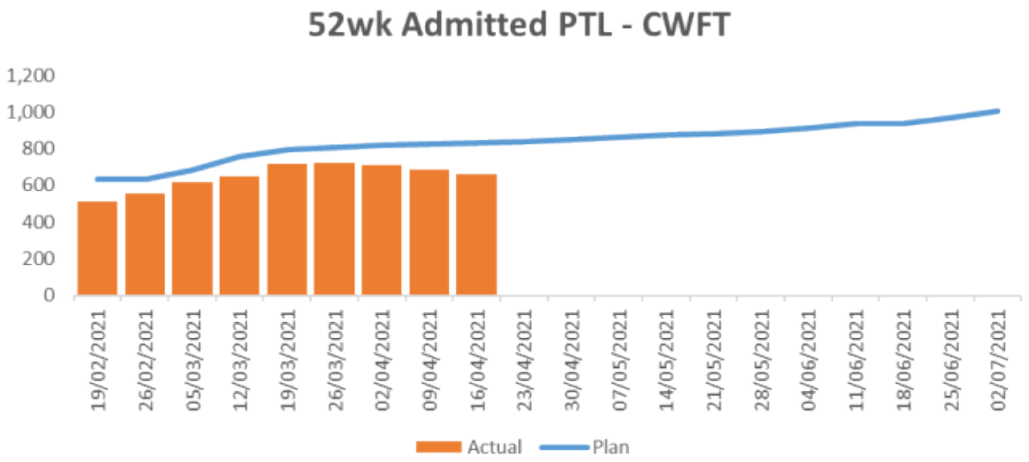


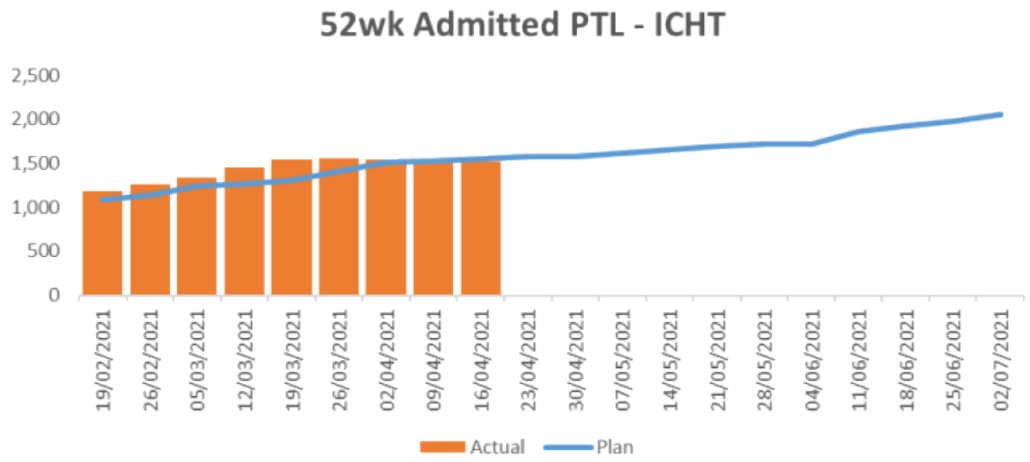


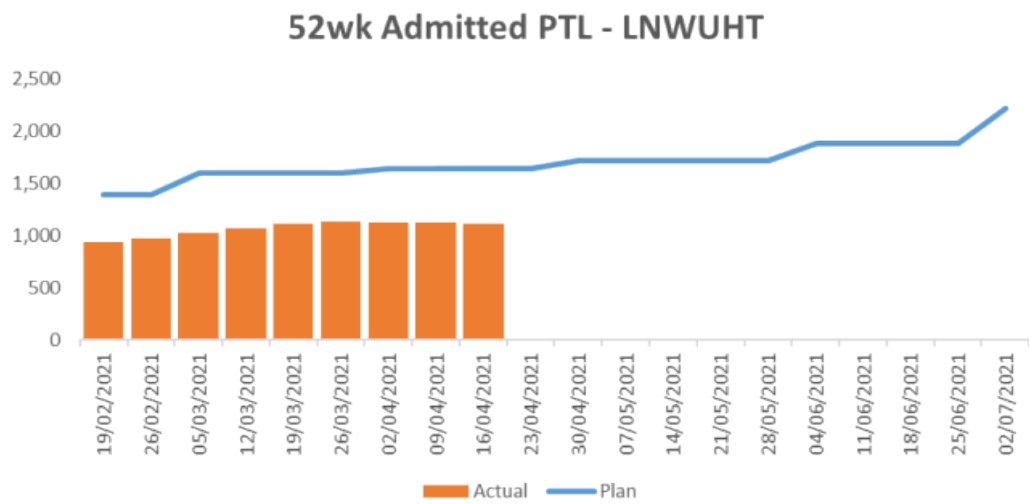
Non-Admitted Summary (previous data)

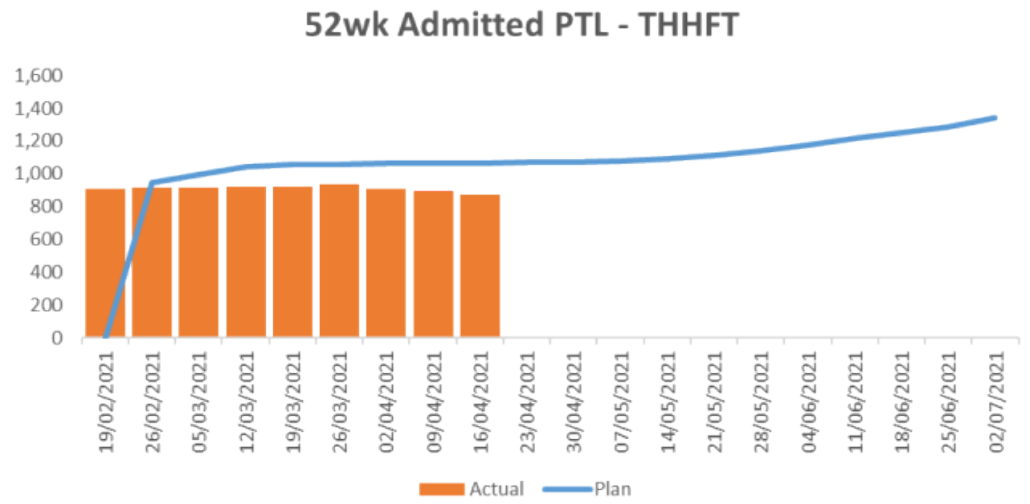
- **52ww – ↓313** (343)
- **Dated – ↑21,296** (21,015)
- **Undated – ↓10,205** (10,275)

All trusts are on or exceeding Spring Plan admitted 52ww reduction trajectories







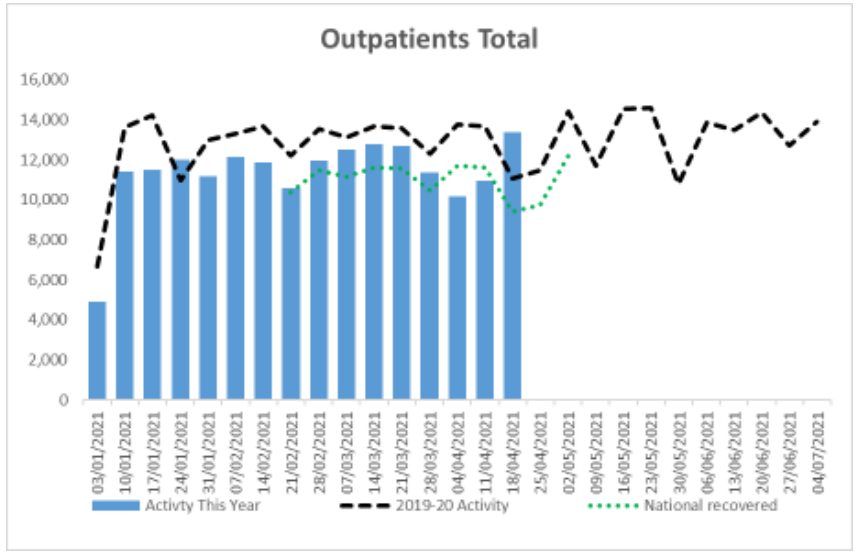


Sources:
NW London OnePTL W/E 18/04/2021
Unvalidated operational data

The North West London health and care partnership

Phase 2: Recovery plan Outpatients Weekly performance by Trust against Spring Recovery Plan

CWFT



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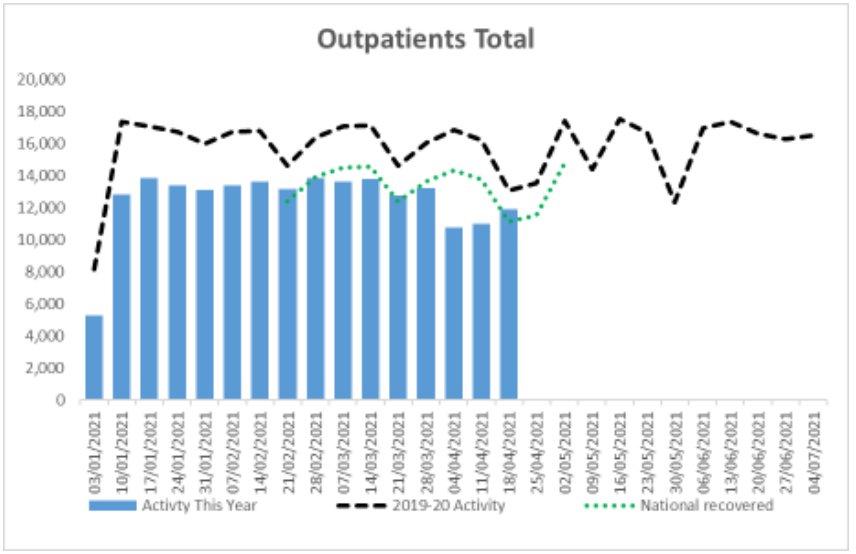

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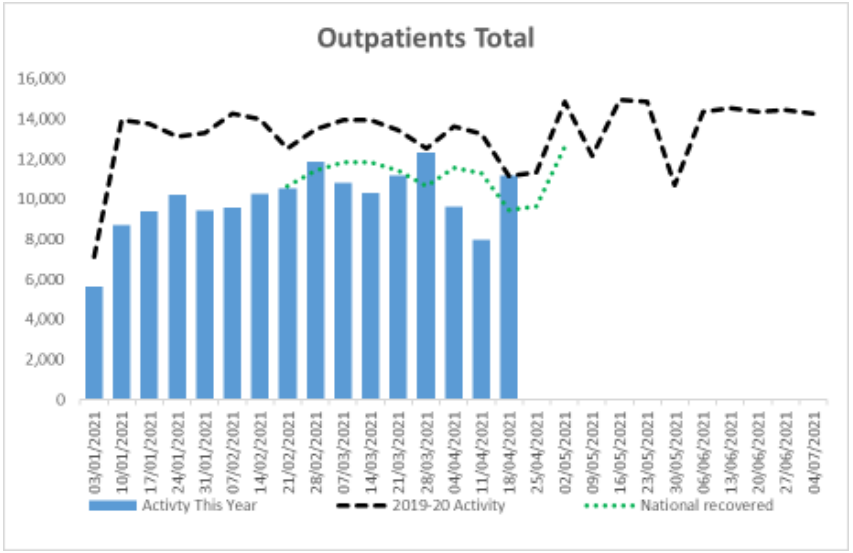

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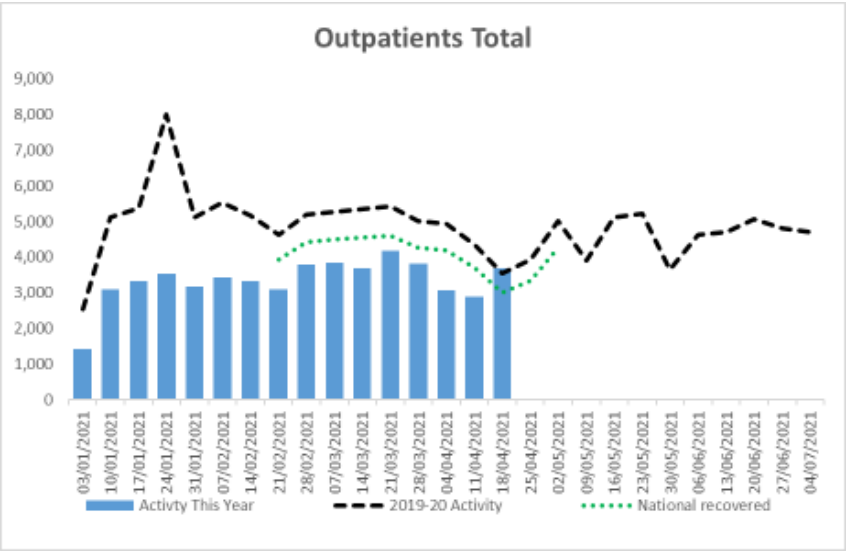
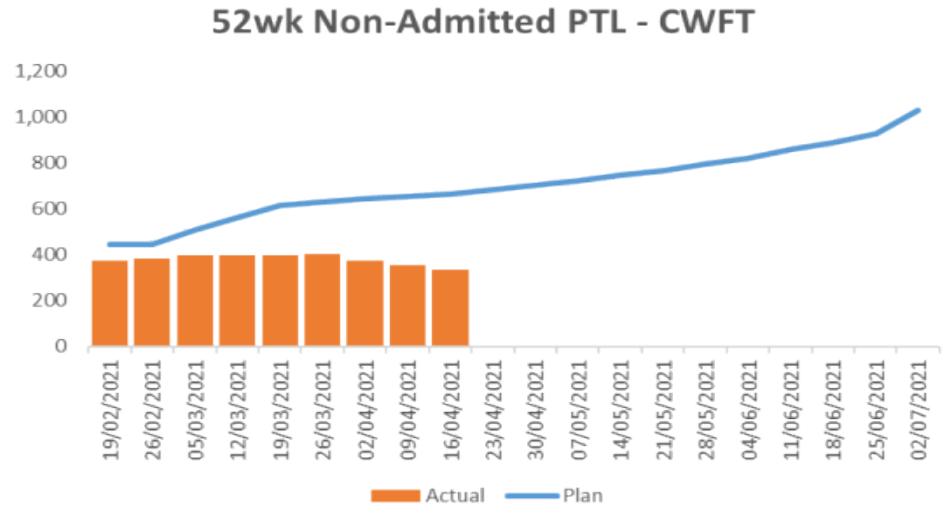
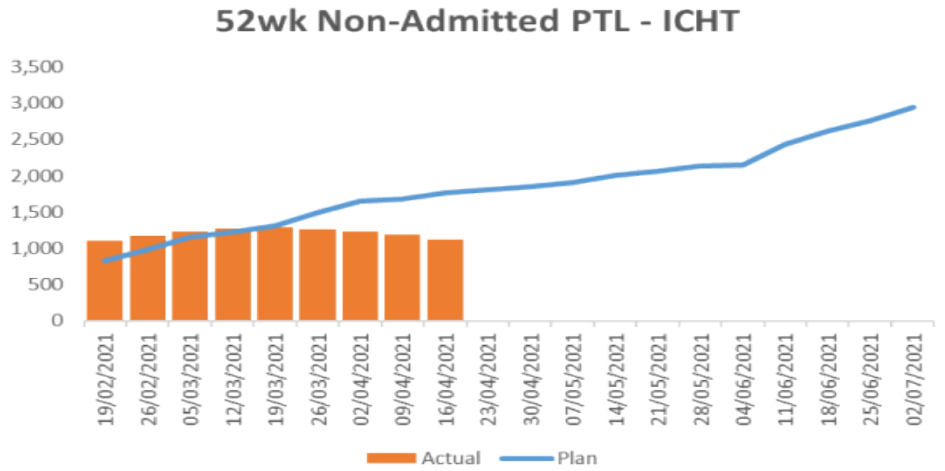


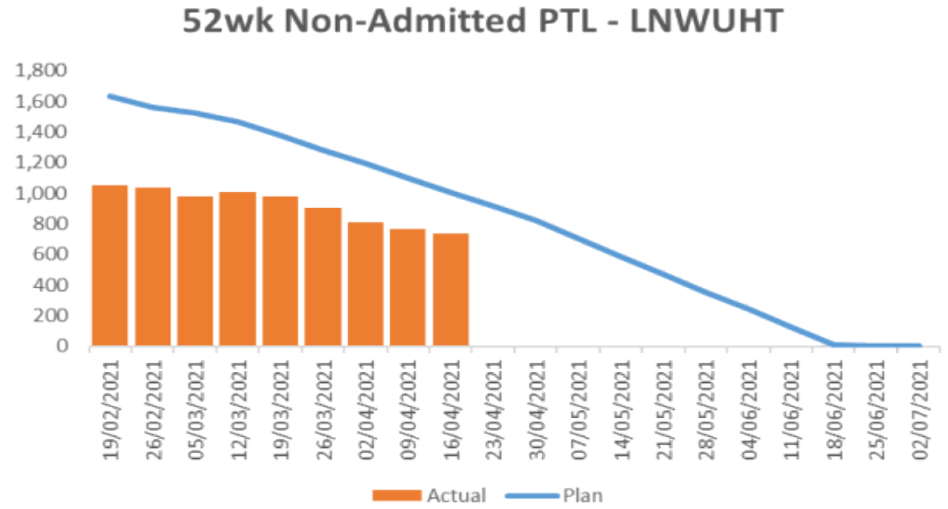
Source: COVID-19 NHS Weekly Phase 3 Activity Report

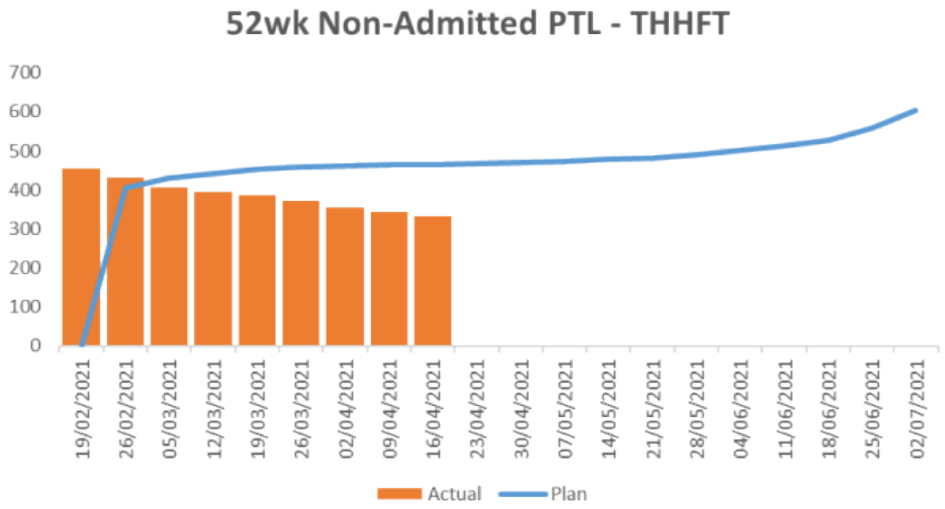
The North West London health and care partnership

All trusts are exceeding Spring Plan non-admitted 52ww reduction trajectories



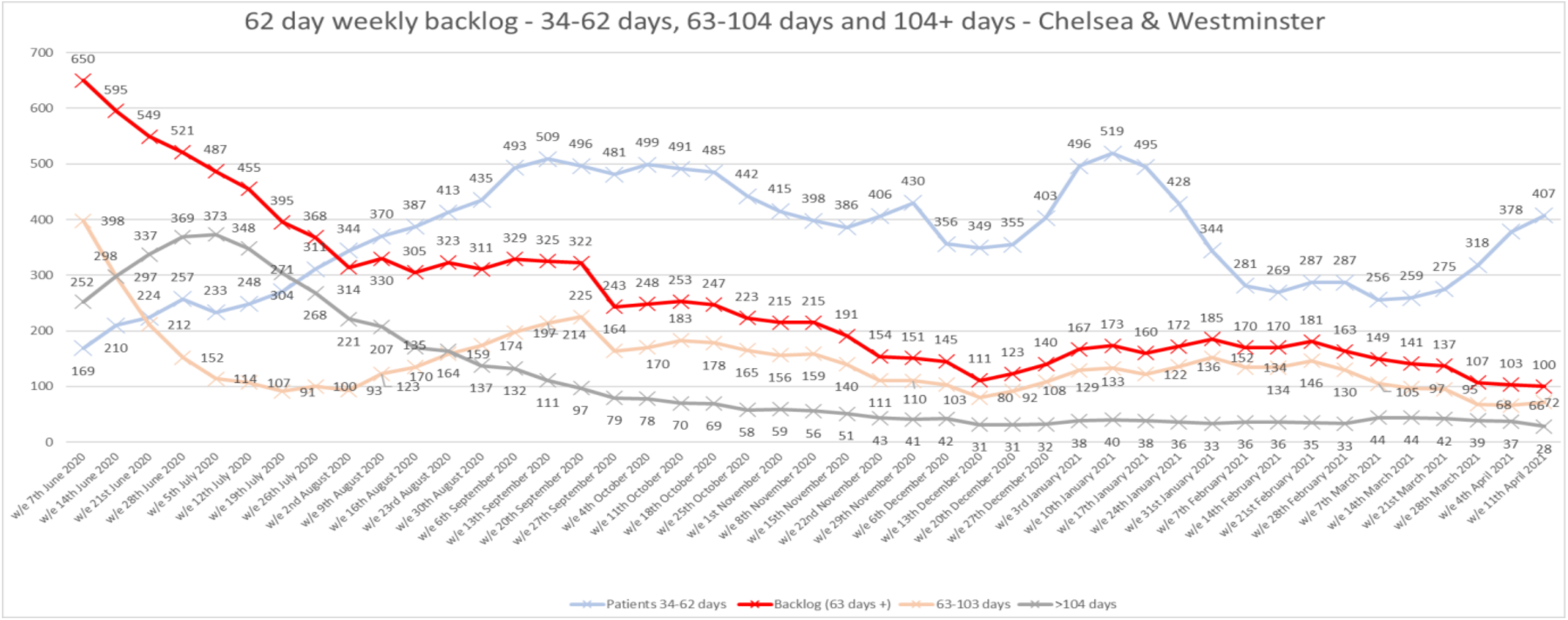






Sources:
NW London OnePTL W/E 18/04/2021
Unvalidated operational data

Chelsea and Westminster Hospital NHS Foundation Trust – w/e 11th April 2021



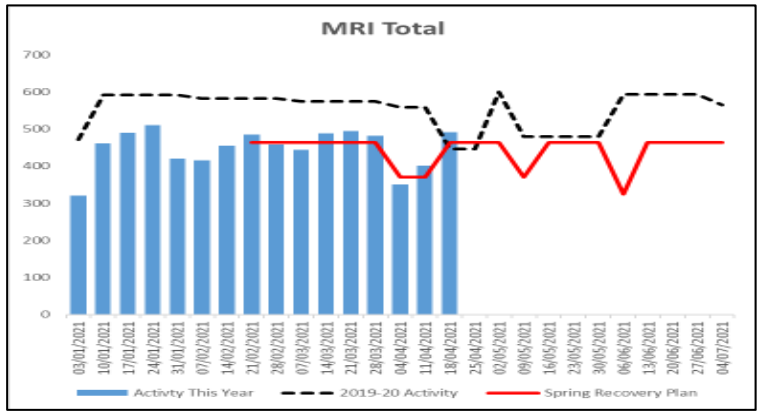
Change in last week:

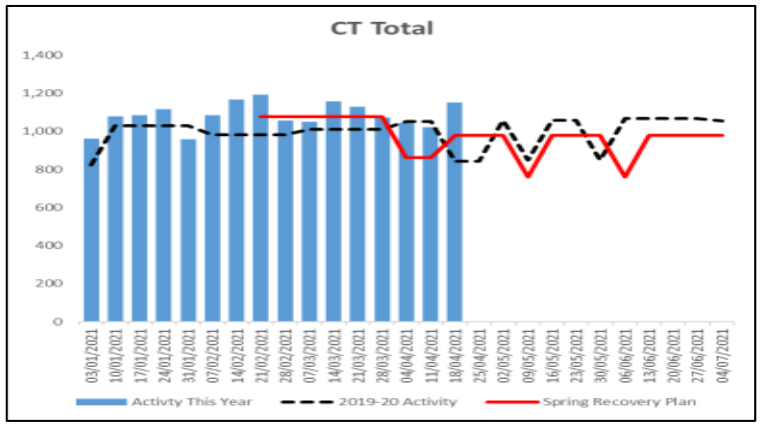
C&W	34-62 days	63-103 days	104+ days	63 days +
% change	7.7%	9.1%	-24.3%	-2.9%
Number of patients	+29	+6	-9	-3

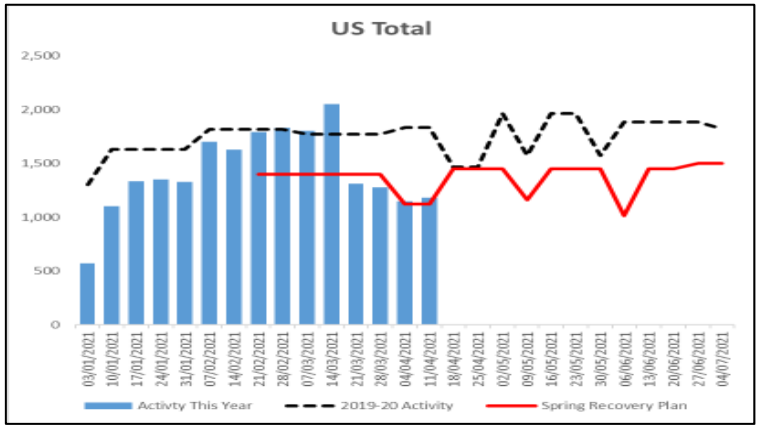
Totals:

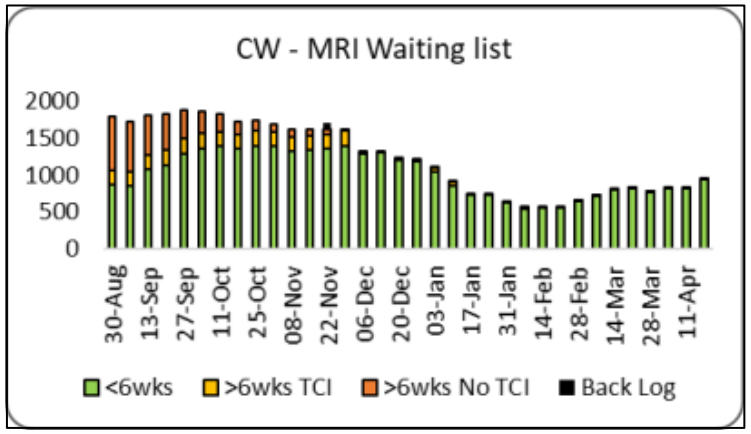
C&W	34-62 days	63-103 days	104+ days	63 days +
RMP w/e 11.04.2021	407	72	28	100
Baseline (w/e 01.03.20)	493	189	63	252
Difference to baseline	-86	-117	-35	-152

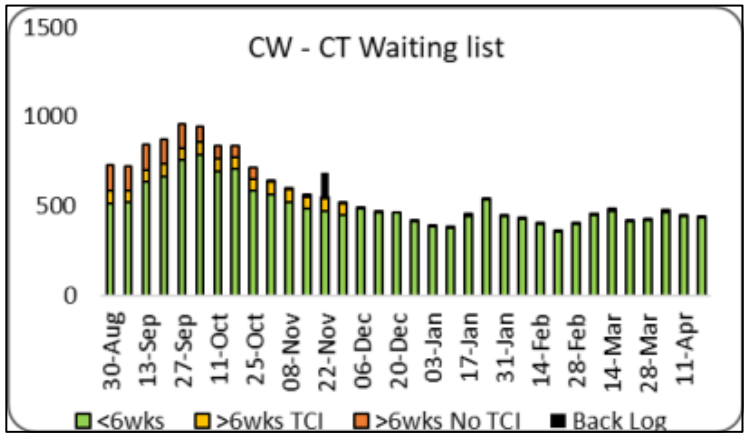
Imaging – C&W performance

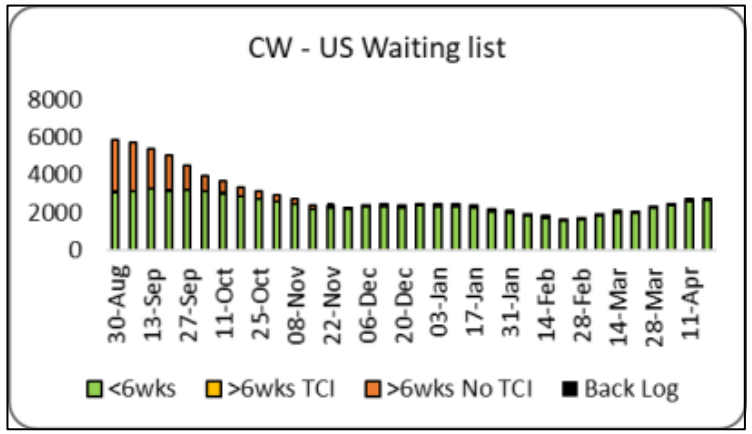








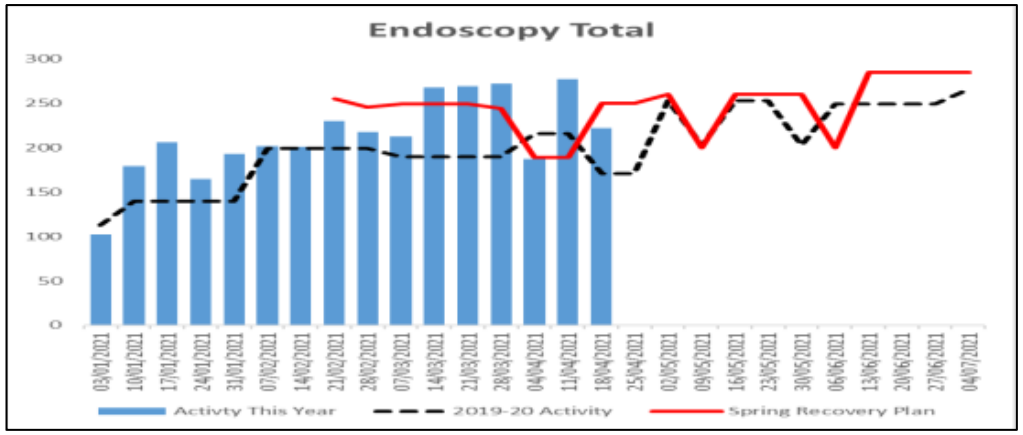


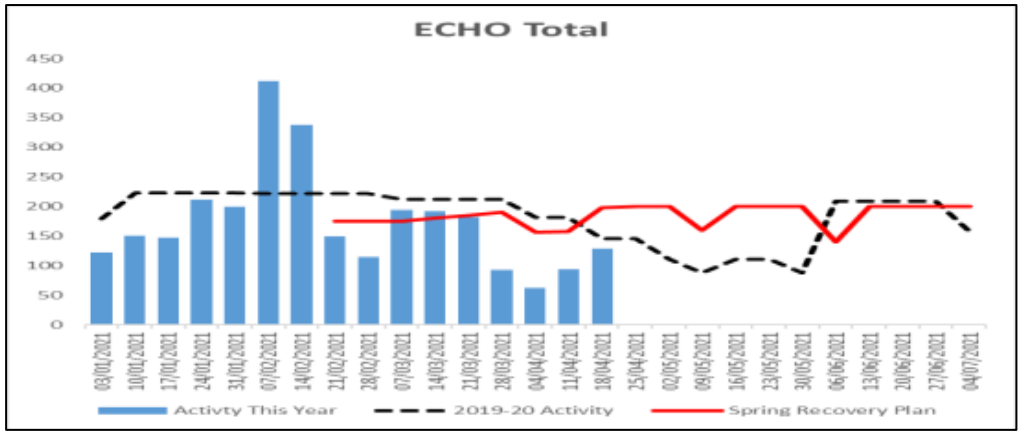


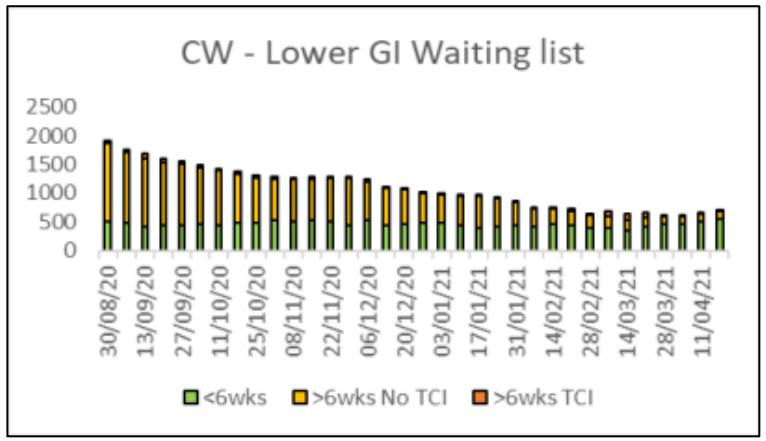
Source: DMO1, COVID-19 NHS Weekly sitrep

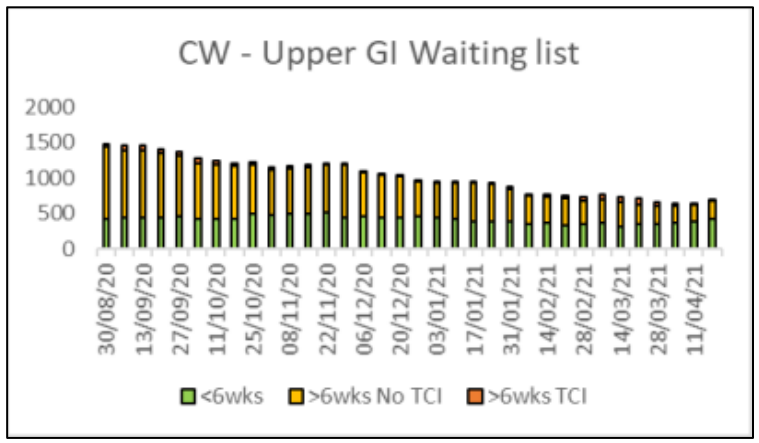
The North West London health and care partnership

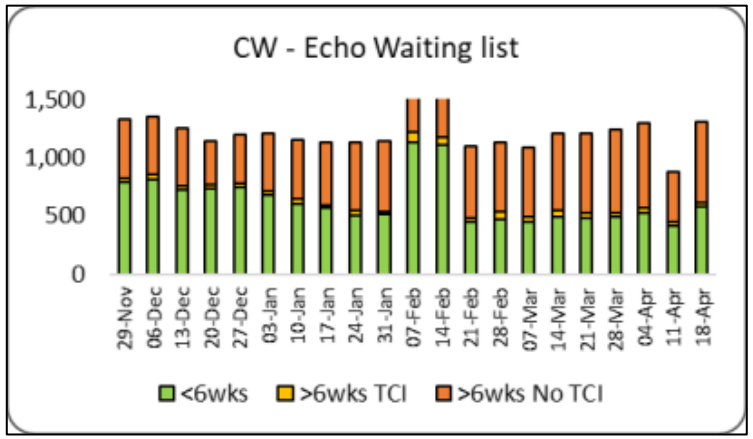
Endoscopy and Echo – C&W Performance











- Additional Echo waiting list initiatives are being run with substantive staff to reduce long waits
- Validation of the waiting list is planned

Source: DMO1, COVID-19 NHS Daily and Weekly sitreps

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.3/May/21
REPORT NAME	Improvement Programme Update and 2021/22 Quality Priorities
AUTHOR	Victoria de La Morinière, Head of Improvement
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	Assurance
REPORT HISTORY	Executive Management Board, 17 March 2021
SUMMARY OF REPORT	This report provides an update on the progress of the Improvement Programme: • Quality priorities for 2020/21- YTD • Patient experience for 2020/21- YTD • Quality Priorities for 2021/22 • Continuous improvement; 2021/22 deep dives schedule, GIRFT
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	• Deliver high-quality patient-centred care • Deliver better care at lower cost
DECISION/ ACTION	For assurance.

Quality priorities 2020/21

The quality priorities for 2020/21 are:

1. Improving dementia care
2. Improving cancer care
3. Improving sepsis care
4. Improving impact of volunteers

A summary of baseline position and year end achievement is outlined in Table 1 below. The final Q4 figures will be signed off in April 2021 and included in the quality account.

Priority	Key Indicator	Baseline	EOY target	Progress	Next Steps / Commentary
1. Improving dementia care	No of patients >75 years screened at admission	81%	90%	91% Feb	*Moving into business as usual:* Further discussion with wider multidisciplinary team regarding shared responsibility of abbreviated mental test score completion. Due to movement within the older adult nursing team there is an opportunity for service redesign to maximise support for patients. Developed a new slide pack with script so that material can be delivered by the wider multidisciplinary team. Reviewing current online content for tier 2 dementia training, to minimise impact on staff time off the ward Work completed with learning and development team, to identify individual staff members that have not yet undertaken Tier 2 training, so that we can engage with ward managers to send identified staff members on the training.
2. Improving cancer care	% of newly diagnosed patients with a HNA appointment and personal care plan	61%	70%	Q3: 67% of newly diagnosed patients with a HNA and 62% had care plan. Q4 – *data being finalised*	*Steady progress through Q1-Q3 – not consistently at 70% due to;* • Impact of covid pandemic. • A significant proportion of patients included in diagnosis totals are not accessible due to going to other organizations for treatment. Forward plan: • Increase upward trend. • New staff trained in completion • Increase completed care plans to match HNA completion
3. Improving sepsis care	% of patients screened for sepsis within 1 hour	81%*	90%	73% patients meeting the relevant criteria were screened for	*Continuing sepsis programme into 2021/22* Wards should continue to encourage the "sepsis nurse" role and lead ward level improvement projects to maintain and

Priority	Key Indicator	Baseline	EOY target	Progress	Next Steps / Commentary
	% of patient receiving IV antibiotics within 1hr	72%*	90%	sepsis in ED with 1 hour (against target of 90%) 74% of patients had a clinical review within 1 hour, and a further 45% of patient with suspected sepsis (red flag) received antimicrobial therapy within 1 hour (against target of 90%).	improve on results The qliksense dashboard should be continue to be monitored for any changes in clinical practice Communications should continue to encourage good behaviour in terms of sepsis management through awareness days and communication materials EDs should continue to monitor effectiveness of early antibiotic pilot and any risks related to antibiotic administration
4. Improve the impact of volunteers	Number of volunteers April>March	600	900	354 volunteers active within the Trust since Apr 2020. In addition, approximately 180 "partner" volunteers who are largely paused due to covid. They may or may not return	*Moving to business as usual* • Using the volunteering hubs as a platform to scale up the volunteering programme; devolving more of the operational running onto volunteers, freeing up the team to focus more on development • Ensuring safe deployment of volunteers – assessing risk of new roles and adapting processes/deployment to reflect changing Covid risk • Returning volunteers who have been inactive during Covid • Supporting partners to restart their volunteering services and deploy safely • Formalising training programme • Expand palliative care support (in a pilot volunteers are supporting patients to face time loved ones) • Keeping the service focussed despite wide ranging requests for support (and managing expectations of what volunteers can and can't do)
	Volunteer recruit to commence time	101 days	56 days	Average recruitment time reduced to 34 days	
	Number of bleep volunteer bleeps, calculated in clinical hours saved	188h CW 10 h WM	400 hours per month	Total of 25,496 hours have been logged since April 2020.	

2. Improving patient experience

The patient experience priority projects agreed for 2020-21 are:

1. FFT improvement
2. PALS improvement program
3. Patient information leaflets
4. Discharge Project

A summary of year end baseline and progress is outlined in Table 1 below.

Priority	Key Indicator	Baseline	EOY target	YTD progress	Next Steps / Commentary
1 FFT Improvement	All departments achieving a response rate and satisfaction scores above the national average	Satisfaction Score ED-88>90, GUM-95>96, Maternity-91>97 Inpatients-94 >96, Paeds-91>96, OPD-92>94	Satisfaction Score ED - 85 GUM- 96 Maternity - 97 Inpatients - 96 Paeds - 96 OPD - 94	12 month average : **ED –** Response rate: 20%, Satisfaction rate: 90% **GUM –** Response: 21%, Satisfaction rate: 95% **Maternity –** Response: 16%, Satisfaction: 91% **Inpatients –** Response: 21%, Satisfaction: 96% **Paediatrics –** Response: 15%, Satisfaction: 93% **Outpatients –** Response: 3%, Satisfaction: 92%	All departments have seen fluctuations over the past 12 months and have been affected by the Covid-19 pandemic, either through uptake of responses or due to teams being displaced or redeployed to other areas of work FFT remains an area of improvement focus and work will continue to ensure areas exceed baseline KPIs
2 PALS improvement program	To achieve a 90% 5 day response rate for all PALS concerns (baseline 67%)	67%	90%	91%	The PALS and Complaints team have been working with Divisional colleagues to improve the experience of patients using the PALS service and the team have consistently maintained an increased rate of resolving logged concerns within 5 working days at an average of 91% over the past 12 months In addition to this, the majority of concerns received by the PALS team each month are resolved on the spot and not included in the percentage above

Priority	Key Indicator	Baseline	EOY target	YTD progress	Next Steps / Commentary
					Changes in the service provision have increased 5 day response rates and in addition demonstrated that 70% of PALS work is completed through immediate resolution and so is not logged on Datix Due to Covid restrictions the PALS team have not been able to implement their schedule of ward link visits, however intend to commence this when appropriate to do so as part of the Trust recovery plan
3 Patient information leaflets	100% of departments to have all patient information leaflets available digitally through the Trust website	0%	100%	96%	58% of departments (63/108) identified have their patient information available on the Trust website 81% of pieces of information (805/1000) have been uploaded to the Trust website and are available as QR codes in every area It is envisaged that the remainder of this project will be delivered by end of March This project has been affected by the Covid-19 pandemic due to teams being displaced or redeployed to other areas of work
4 Discharge projects	Improve experience of discharge process to be better than the national average	Not delayed 56% Home situation considered 74% Who to contact 70% Additional equipment 68%	Not delayed 60% Home situation considered 82% Who to contact 76% Additional equipment 79%	See comments	The discharge improvement project has been difficult to start due to the staff involved being committed to supporting Covid-19 An SRO was appointed and initial discovery phase commenced to identify areas for improvement in the process and to define what 'good looks like' as a benchmark The programme will be monitored locally throughout the year and updates against the KPI's are taken directly from the national survey which reports annually This project has been halted due to the Covid-19 pandemic due to teams being displaced or redeployed to other areas of work

3. 2021/22 Quality Priorities

Priority	Aims	Key indicator	Baseline	Target	SRO	Clinical lead + Improvement support
Improve sepsis screening and timely management	Improve early recognition of deteriorating patient in ED and inpatients so that at least 90% patients who meet the relevant criteria are screened for sepsis within 1 hour Improve the timely commencement of appropriate antimicrobial therapy for patients found with suspected red flag sepsis so that at least 90% of patients receive IV antibiotics within 1 hour	% of patients screened in emergency department and wards within 1hour % of patients who receive IV antibiotics within 1 hour	73% Screened <60mins in ED 45% IV antibiotics in ED 12% wards	90%	Dr Iain Beveridge, West Middlesex Medical Director	Dr Sanjay Krishnamoorthy, Trust lead for Sepsis and deteriorating patient Lucie Wellington, Clinical Improvement Fellow
Improve personalised cancer care at diagnosis	Ensure >75% of patients whose treatment is managed by our Trust have a Holistic Needs Nurse Assessment (HNA) appointment after a diagnosis of cancer and a personalised cancer care plan 10% increase per quarter in the number of patients who have end of treatment summaries	% patients receive a holistic needs assessment (HNA) and personalised care plan Number of patients with end of treatment summary	62%*	>75%	Vanessa Sloane, Deputy chief nurse	Eamon O'Reilly, Lead Nurse Burns Musanu, Macmillan Project Manager
Improving outcomes for inpatient diabetes patients	Improve the identification and management of diabetes Set up an inpatient diabetes team – this would be a 7 day service with an	Number of patients identified as having diabetes per month	885 per month 131 staff trained LOS for elective patients	Targets to be agreed at working group	Dr Roger Chinn, Medical Director	Dr Daniel Morganstein, Trust diabetes lead Mandy Trinh, Assistant

Priority	Aims	Key indicator	Baseline	Target	SRO	Clinical lead + Improvement support
	appropriately staffed MDT consultant led team Ensure that patients with diabetes are optimised before surgery/elective care Up-skilling of non-diabetes staff	Nurses/HCA staff in inpatient wards who have received 10-point training Reduce elective surgery LOS	with recorded diabetes – 4.3 *Data from 2019/20			Improvement Manager
Improve clinical handover	Embed a shared appreciation of the principles underpinning good clinical handover through the delivery of a training package Introduce a standardised handover process based on national best practice Introduce a standardised handover proforma / documentation within the Trust electronic medical records system (Cerner)	% staff trained on the principles of safe and effective handover % utilisation of handover tool within Cerner	Tools and training need to be developed, not in place currently (0%).	Year 1: 50% staff trained Year 2: 70% utilisation of Cerner tool	Dr Gary Davies, Chelsea Medical Director	Debbie van der Velden, Clinical improvement fellow

4. Continuous Improvement

4.1. Getting It Right First Time

In 2020/21, the following GIRFT review visits were completed:

- Plastic Surgery, Burns and Hand Surgery
- Lung Cancer
- Rheumatology
- Gastroenterology
- Neurology

Due to COVID, a scheduled paediatric trauma and orthopaedic review was cancelled, we are currently awaiting further dates from GIRFT for this visit. Also, the implementation meetings for the above visits were cancelled, we are currently reorganising the meetings to ensure that actions are agreed and implemented.

4.2. Deep dive programme

The Deep Dive Programme is a fluid programme to meet emerging risks in a timely manner. These explore specific challenges that are affecting the delivery of high quality care in line with the Trust's strategic objectives, which may focus on a range of quality, workforce, performance, and/or finance issues.

The programme is restarting from April 2021 and the below table indicates the scheduled topics:

	Planned Care	W&C	EIC	CSS	Corporate
Apr 2021	Surgical Wards WM/CW and Assessment Unit (20 Apr)	Early Pregnancy (27 Apr)	Discharge (6 Apr)	-	Research and Development (13 Apr)
May 2021	-	GUM (4 May)	Clinical Hub 6 month review (11 May)	Phlebotomy (18 May)	Estates and Facilities (25 May)
Jun 2021	General Surgery (1 Jun)	-	Delirium/Dementia (8 Jun)	Decontamination Services (15 Jun)	Finance Topic TBC (22 Jun) HR; Learning and Development (29 Jun)
Jul 2021	ITU – incl. Medical Workforce Focus (6 Jul)	Obs and Gynae incl. 10 Point Plan (13 Jul)	-	Diagnostics Demand/Radiology (20 Jul)	Digital/IT Topic TBC (27 Jul)
Aug 2021	Trauma and Orthopaedics (3 Aug)	-	Syncope (10 Aug)	Outpatients Letter Turnaround (17 Aug)	Command Centre and Clinical Site Teams (24 Aug)
Sep 2021	Colorectal (7 Sept)	Paeds Surgery (14 Sept)	Sepsis (21 Sept)	Endoscopy (28 Sept)	-
Oct 2021	ENT/Audiology (5 Oct)	Dermatology (12 Oct)	Diabetes (19 Oct)	Pharmacy (26 Oct)	-
Nov 2021	Anaesthetics (2 Nov)	ACU/Fertility (9 Nov)	-	Cancer Services (16 Nov)	Procurement (23 Nov) Research, Innovation and Improvement (30 Nov)
Dec 2021	Urology (7 Dec)	Private Patients (14 Dec)	VTE (21 Dec)	-	-
Jan 2022	-	HIV (4 Jan)	Acute Medicine incl. AEC (11 Jan)	Interventional Radiology (18 Jan)	Corporate Nursing; Patient Experience (25 Jan)
Feb 2022	Pain (1 Feb)	-	Frailty (8 Feb)		HR; Staff Health and Wellbeing (22 Feb)
Mar 2022	Podiatry (1 Mar)	Paeds Nursing (8 Mar)	AHP Services (29 Mar)	Patient Access – Appointments (15 Mar)	Fire Safety (22 Mar)

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.4/May/21
REPORT NAME	Maternity safety improvement plan
AUTHOR	Victoria Cochrane, Director of Midwifery & Gynaecology
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	To provide the Trust Quality Committee and Board with assurance on the progression in maternity in achieving compliance with national and local recommendations that will have the greatest impact on quality, safety and patient experience.
REPORT HISTORY	Executive Management Board, 14 April 2021 Quality Committee, 4 May 2021
SUMMARY OF REPORT	The maternity department is working to achieve recommendations outlined in multiple national and local reports. The aim of this paper is to summarise these recommendations into a single comprehensive improvement plan for the directorate. The following 11 priority workstreams are included: • Increase continuity of care • MMBRACE-UK • NHSR 10 point safety plan • Ockenden • Saving babies lives care bundle V2 • Improving staff well-being • Grip • Improving flow & reducing length of stay • NWL Maternity helpline project • Maternity digital solution This report provides assurance to Quality Committee and Board on the progress of the recommendations that will have the greatest impact of quality, safety and patient experience and includes a focus topic on the NHSR 10 point safety plan.
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Maternity improvement plan

2021/22

Maternity improvement programme: 2021/22

The maternity department is working to achieve recommendations outlined in multiple national and local reports.

The aim of this paper is summarise these recommendations into a single comprehensive improvement plan for the directorate.

This report provides assurance to quality committee on how we are progressing the recommendations that will make the greatest impact on quality, safety and patient experience.

This paper includes a focus topic on the 10 point safety plan.

Drivers of the maternity improvement programme

Focus areas	Key drivers
Quality & Safety	• Ockenden report • 10 point maternity safety plan • MBBRACE recommendations • Better Births continuity of carer
Patient Experience	• Family and friends test feedback • Healthwatch reports • Survey of BAME women's experience • Picker survey
Staff experience & wellbeing	• Staff survey
Effective & efficient	• Covid-19 recovery • CIP target

In addition, a programme of locally owned research, innovation and QI projects

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Maternity improvement programme

Delivering high-quality, patient-centred care

Be the employer of choice

Deliver better care at lower cost

Workstream 1 Quality, safety and patient experience

Priority 1:
Increase continuity of carer
Aim: increase no. of women booked onto a Continuity of carer (CoC) pathway to >50% by March 2023
***KPIs*:** No of women booked onto CoC pathway
Lead: Vicki Cochrane / Natalie Carter
***Reports to*:** WIG, Improvement Board, LMS

Priority 2:
MMBRACE-UK
Aim: Ensure compliance with published reports
-Implement recommendations on MBRRACE: Stillbirths and neonatal deaths in twin pregnancies
- delivery against 8 themes
Lead: Vicki Cochrane & MQAS
KPIs: *GAP analysis against recommendations*
Reports to: Cross-site MQAS, WIG, Divisional Quality Committee

Other work :
- Achieving BFI gold standard
- Picker survey
- QA assurance – screening, CQC
- Guideline
- PMRT (M & M)
- VTE compliance
- Consultant leads/ coc

Priority 3:
Compliance with the 10 measures of the NHSR incentive scheme for CNST
***Aim*:** Achieve 10 requirements of the incentive scheme by August
KPIs: delivery against 10 safety action
Lead: HOM, DOM, CD
Reports to: WIG, Women's services Directorate Board

Priority 4:
Ockenden
Aim: To improve the safety and outcomes of maternal and neonatal care
KPIs: delivery of 8 themes
Lead: HOM, DOM, CD, MQAS
Reports to: WIG, Women's services Directorate Board

Priority 5..
Saving babies lives care bundle v2
Aim: To improve the safety and outcomes of maternal and neonatal care
KPI: 5 Elements with specific measures
Lead: HOM, DOM, Service Leads
Reports to: WIG, Maternity Forum, Service Quality Meeting CW

Workstream 2 Workforce

Priority 6:
Improving staff retention & staff survey results
Aim: Create Staff development opportunities and cultural safety
KPIs: % mandatory training. Maternity staff survey

Leads: HOMs, PDMs and PMA's
Reports to: WIG

Priority 7:
Improve staff wellbeing
- Health and wellbeing
- Diversity and inclusion
- Recovery post-Covid

Leads: HoMs, SDs
KPIs: Staff survey metrics, sickness
Reports to: Divisional Board, POD

Priority 8:
Grip
- Skill mix
- Roster management
- Recruitment/Vacancy/ turnover
- Temporary staffing
- Job planning
- Leave management

Reports to: P&I
Leads: DOM, HR Partners, service leads
KPIs: turnover, vacancy, safer staffing

Workstream 3 Efficient and effective

Priority 9:
Improving flow and reducing LOS, focused on three pathways
- IOL
- Elective section
- Postnatal

Aim: CW: reduce average LOS to 2.6
WM: maintain LOS at 1.9 days
KPIs*:* LOS, numbers of readmissions
***Leads*:** HOM, DOM, Matrons, Clinical Lead
Reports to: MCIG, Bed Productivity

Priority 10:
NWL Maternity helpline project
Aim: Implementation of sector-wide maternity helpline
***Lead*:** Tina Cotzias, LMS chair
Reports to: Local Maternity System

Priority 11:
Maternity digital solution (K2)
Aim: Implementation of electronic patient record
***Lead*:** Clare Baker, Lyndsey Smith, Francesca Hanks
Reports to: Maternity planning meeting: WIG, Directorate Board
KPIs: : MSDS , coding, tarif

Other work:
Demand and capacity planning

Progress update: Workstream 1. Quality, safety and patient experience

Priority	Clinical Lead	Key activities/ recommendations	Delivery status update	Rating
1. Continuity of carer	Vicki Cochrane, (DoM) Natalie Carter (Consultant Midwife)	Increase continuity of carer to reach >50% of women by 2023	• 30% CoC, target 2021/22 35% • Major disruption to programme due to Covid19, roll-out of CoC restarted • Require outcome of Birth rate + (end of April) • NHSI guidance published on 25/03/21 states that: building blocks should be in place to ensure continuity of carer is the default model of care offered to all women by March 2023	
2. MBRRACE & HSIB	MQAS Sunita Sharma (CW) Susan Barnes (WM)	MBRRACE-UK / HSIB reports & recommendations - Delivery 8 recommendations from findings of the fourth perinatal confidential enquiry carried out as part of the MBRRACE-UK Focused improvements to reduce stillbirths and neonatal deaths in twin pregnancies.	• 2 of 8 recommendations met, 6 in progress • Focus area is implementing specialist teams for twin pregnancies and dedicated multiple pregnancy midwife, and multiple pregnancy clinics at West Mid site.	
3. 10 point safety plan	Natasha Singh (CD) Vicki Cochrane (DOM)	Implement 10 safety improvements as part of CNST maternity incentive scheme	• 5 on track / delivered, 1 red, remaining amber • Focus/ risk areas are midwifery workforce planning, obstetric workforce planning and SBL care bundle 2 • Parameters for submission have changed favourably in the last week and are subject to local review and benchmarking currently	
4. Ockenden	Natasha Singh (CD) Vicki Cochrane (DOM)	Implement 8 recommendations from Ockenden Report: Emerging findings from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust	• Investment announced from NHS England and details shared 08/04/21, submission to achieve gaps by 6th May for funding • Peer review concluded 19/03/21 with RAG rating, all immediate actions partially completed have plans behind them • Workforce investment: 20 PA Consultant at CW in April	

Progress update: Workstream 2. Workforce

Priority	Clinical Lead	Key activities/ recommendations	Delivery status update	Rating
6. Staff development and training	Education team Natalie Carter (Consultant Midwife) RCOG tutors	Staff development; • Culture/ behaviours • Training and development	• Women's services compliance is as 85% for mandatory training (90% target). This is an area of focus and has been impacted by covid restrictions on face to face training • HEE funding available for every registered nurse and midwife, £1k over 3 years – plans in place to encourage staff to take this offer up and secure training places • Focus on MDT training from Ockenden recommendation and 10 point plan MDT emergencies training	
7. Staff health and wellbeing	Lyndsey Smith (WM) Clare Baker (CW) Tina Cotzias (WM) Natasha Singh (CW)	Responding to staff survey and pulse checks to address improvement areas in: • Health and wellbeing • Diversity and inclusion • Rest & recovery post-Covid	• Directorate report due to be presented at next divisional team meeting 19/04/21 relating to staff survey • Pledge of commitment to be made by each directorate and measurable outcomes set and launched • Trust have provided 2 thank you days per WTE staff member for R and R which are being mapped into rosters • Cultural safety champions appointed for maternity, boards in areas to identify these staff. Anti Racism and Cultural Safety training planning underway – pilot undertaken with senior team for maternity	
8. Grip	Lyndsey Smith (WM) Clare Baker (CW) Tina Cotzias (WM) Natasha Singh (CW)	Robust planning and grip around workforce resourcing; including • Skill mix • Roster management • Vacancy/ turnover • Recruitment • Temporary staffing • Job planning • Leave management	• 88% PDRs, 3,88% vacancy, 7.86% turnover (Feb 21) • Focus on birth rate plus as part of 10 point safety plan. Recruitment and posted frozen waiting outcome of Birthrate plus (lower births 2020/21). • Focus on obstetric business case for CW site as part of 10 point safety plan clinical workforce review	

Progress update: Workstream 3. Efficient and effective

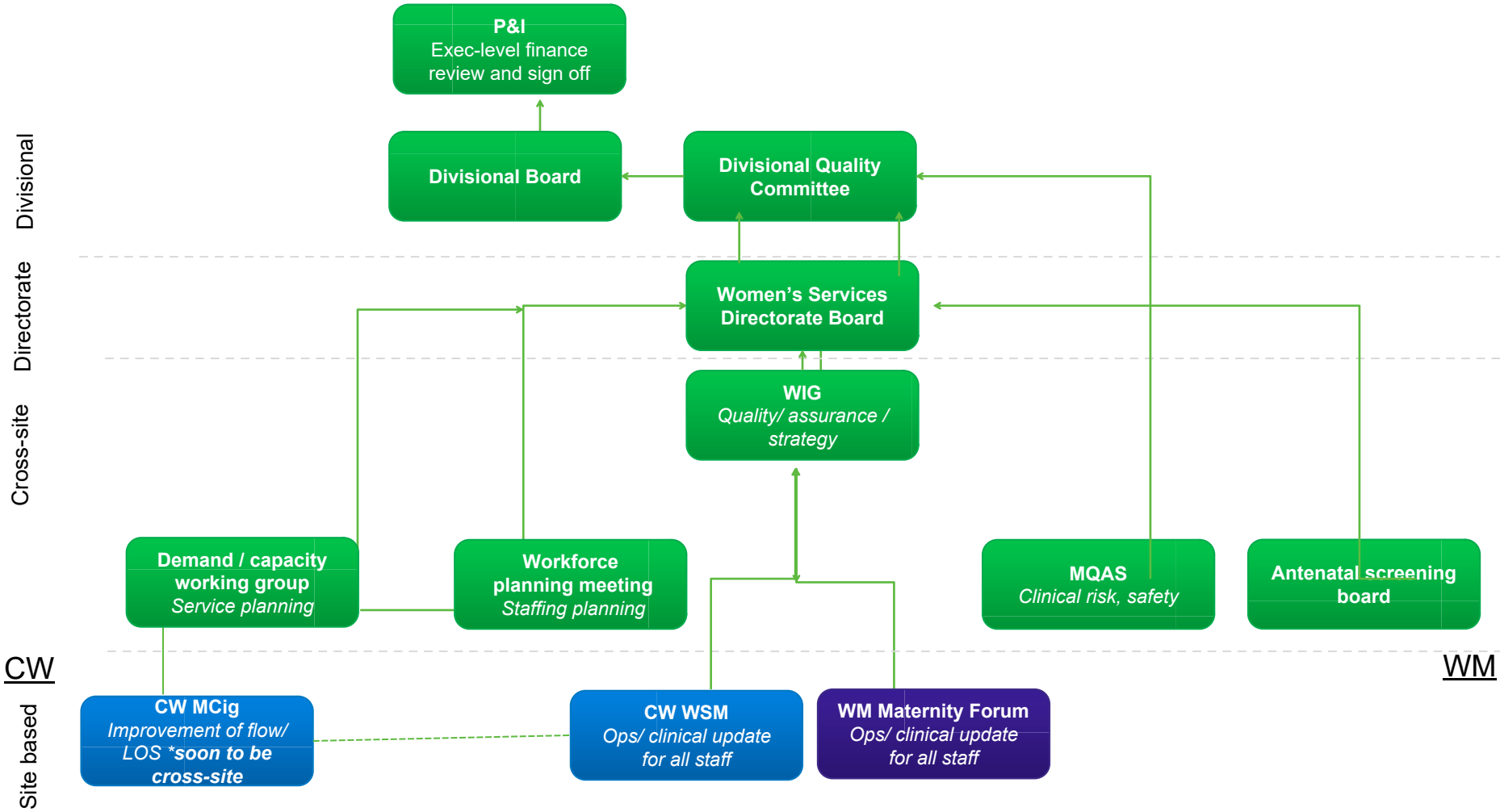
Priority	Clinical Lead	Key activities/ recommendations	Delivery status update	Rating
9: Improving flow	Natasha Singh (CD)	MCIG focused on improving flow and reducing LOS across three pathways • IOL • Elective section • Postnatal	• New clinical director appointed with vision to make this meeting cross site • LOS in a positive position currently but may be due to Covid restrictions • Changes to pathways due to covid have positively influenced LOS such as increase in uptake of outpatient IOL alongside safe outcomes	
10. North West London Maternity helpline project	Tina Cotzias (Chair of NWL Local Maternity System)	Implementation of sector-wide maternity helpline. Aims to: • Protect clinical time in NWL maternity units • Provide timely advice and support for women in NWL.	• Leads appointed to drive quality improvement project. Currently in process mapping stage and gathering baseline data • Next steps to work up as full programme with expected benefits	
11. Maternity digital solution (K2)	Obstetric Consultant lead Francesca Hanks (Digital Midwife) HOMs	Implementation of electronic patient record in maternity aligned to other North West London units and integrated with Cerner	• Funding for posts required secured, jobs added to Trac and interview dates set • Weekly review meeting underway to ensure project is moving forward • Commitment from the team to drive this forward	

Focus topic: 10-point safety plan

Priority	Clinical Lead	Key activities/ recommendations	Delivery status update	Rating
Review perinatal deaths using NPMRT	Sunita Sharma & Alex Shushard Susan Barnes & Sally Kelly	• At least 50% of all deaths of babies reviewed • Quarterly reports have been submitted to Trust board	• On track	
Submit to MSDS	Francesca Hanks	• Submit all 13 criteria • NHS digital issue monthly scorecards to data submitters	• January 2021 submission 10 criteria met, December 11 criteria met	
Transitional care services to avoid term admissions into neonatal units	Shu Ling Elanor Hulse Matrons	• Data recording for transitional care is established • Progress on covid19 related requirements	• CW compliant • WM plan to be compliant June 21	
Demonstrate effective system of clinical workforce planning	Natasha Singh Amir Raza Elspeth Pickering Ruchira Patel Shu Ling	• Demonstrate workforce planning and board level oversight for obstetrics, anaesthetic and neonatal	• Neonatal component at risk • Business case for obstetric staffing	
Demonstrate effective system of midwifery workforce planning	Vicki Cochrane	• Systematic process to calculate midwifery staffing	• Birth rate plus in progress (report due end April 21) • Business case approved by board Oct 20 and implemented to increase staffing numbers to 1.28 WM & 1:27 CW	
Compliance with savings babies lives care bundle	MQAS, clinical leads	• Compliance and evidence of each element of saving babies lives • 5 elements • Quarterly survey	• Element 1 – Reintroduction of CO monitoring May 21 • Element 2 – Booking RA implemented March • Element 3 – April launch of cCTG • Element 4 – compliant • Element 5 - compliant	
Mechanism for gathering service user feedback and coproduce services	HOMs, Consultant Midwife	• Engaged maternity voices partnership with evidence of coproduction. FFT/ compliments & complaints. PMA/ PACs	• Evidence with ToR, minutes of meeting • Survey of BAME service users in 2021 • Survey of service users experience of covid	
90% of each maternity unit staff group have attended MDT emergencies training	PDM	• *Significant compliance* of maternity unit staff who have attended in house maternity emergencies training day	• At risk due to NLS compliance of neonatal nurses	
Trust board level safety champions	Vicki Cochrane	• Visibility of champions; walk around and virtual communication sessions (monthly on each site • Development of pathway	• Attendance at bi-monthly MQAS meeting • Commenced Feb 21 • Pathway being developed	
Report 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?	MQAS	• Reporting outstanding qualifying cases to NHSR for 19/20 • Reporting qualifying cases to HSIB for 2020/21	• On track	

Appendix

Maternity quality governance



CW | Cross site | WM

Key Provider Board Metrics – suggested by NHS England (for discussion)

Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: • The number of incidents logged graded as moderate or above and what actions are being taken • Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training • Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.5/May/21
REPORT NAME	Infection Prevention and Control assurance: update
AUTHOR	Pippa Nightingale, Chief Nursing Officer
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	To provide assurance to Quality Committee around the Infection Prevention and Control (IPC) strategies employed by the Trust.
REPORT HISTORY	Executive Management Board, 17 February 2021 Quality Committee, 2 March 2021
SUMMARY OF REPORT	This paper sets out the IPC strategies that the Trust has employed in order to maintain healthcare services and manage capacity whilst providing safe services for staff, visitors and patients/individuals until public health strategies such as mass vaccination are complete. The application of these strategies is in line with national and local Infection Prevention and Control guidance developed by DH, PHE, NWL sector and Pan London.
KEY RISKS ASSOCIATED	Failure to deliver safe effective IOC standards
FINANCIAL IMPLICATIONS	nil
QUALITY IMPLICATIONS	Not meeting national IPC standards would result in direct patient and safe harm.
EQUALITY & DIVERSITY IMPLICATIONS	nil
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For information.

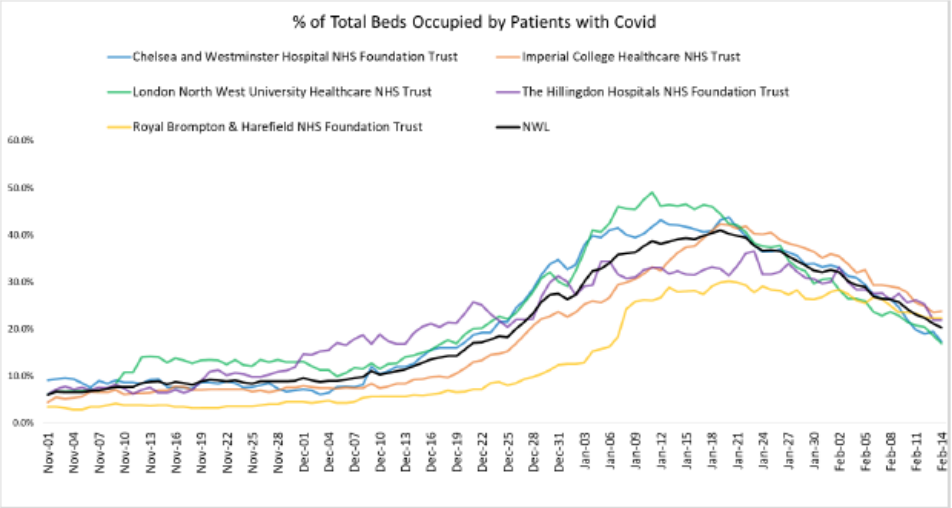
Infection Prevention and Control (IPC): update

This report sets out the IPC strategies that the Trust has employed in order to maintain healthcare services and manage capacity whilst providing safe services for staff, visitors and patients/individuals until public health strategies such as mass vaccination are complete. The application of these strategies is in line with national and local Infection Prevention and Control guidance developed by DH, PHE, NWL sector and Pan London.

Since the beginning of November 2020 the percentage of patients in the Trust testing positive for coronavirus (COVID-19) started to increase, reaching a peak during the week commencing 18th January 2021. The increased prevalence of COVID-19 and the introduction of variants of concern has correlated with a rise in hospital outbreaks of which there have been 15 in total over the past 3 months, see table below. The greatest number of outbreaks was reported over the Christmas and New Year period where 4 outbreaks occurred simultaneously on the West Middlesex site, see table below.

The decrease in prevalence in the community towards the end of January has been mirrored in the Trust and by the week ending the 31st January, CWFT was one of the few London trusts with zero hospital onset definite healthcare associated cases per 100,000 bed days.

COVID bed occupancy in NWL Trend



The percentage of the total available beds that are occupied by patients with covid.

Number of COVID-19 outbreaks per site

Number of Outbreaks			
Site	**November 2020**	**December 2020**	**January 2021**
Chelsea and Westminster hospital	2	2	2
West Middlesex hospital	3	6	0

London Hospital Onset healthcare associated COVID transmissions as of the 12th of February 2021

Region	Organisation	Type of Trust	Definite Hospital Onset		Includes Hospital Onset Probable Healthcare Associated and Definite Hospital Onset	
			Cases => 15 days 7 Feb	Cases => 15 days per 100,000 bed days w/e 7 Feb	Cases => 8 days 7 Feb	Cases => 8 days per 100,000 bed days w/e 7 Feb
London	Oxleas NHS Foundation Trust	MHLDA	13	555	16	683
London	St George's University Hospitals NHS Foundation Trust	Acute	15	266	28	496
London	Epsom and St Helier University Hospitals NHS Trust	Acute	10	232	21	487
London	West London NHS Trust	MHLDA	8	181	8	181
London	South London and Maudsley NHS Foundation Trust	MHLDA	6	160	10	266
London	Croydon Health Services NHS Trust	Acute	4	122	8	245
London	The Hillingdon Hospitals NHS Foundation Trust	Acute	3	110	4	146
London	Central and North West London NHS Foundation Trust	MHLDA	5	106	5	106
London	King's College Hospital NHS Foundation Trust	Acute	9	94	14	146
London	South West London and St George's Mental Health NHS Trust	MHLDA	2	92	2	92
London	Barking, Havering and Redbridge University Hospitals NHS Trust	Acute	5	83	23	383
London	The Royal Marsden NHS Foundation Trust	Acute	1	81	1	81
London	London North West University Healthcare NHS Trust	Acute	4	64	9	145
London	Great Ormond Street Hospital For Children NHS Foundation Trust	Acute/MHLDA	1	58	3	175
London	Guy's and St Thomas' NHS Foundation Trust	Acute	4	53	10	133
London	Imperial College Healthcare NHS Trust	Acute	3	46	6	92
London	Kingston Hospital NHS Foundation Trust	Acute	1	44	5	218
London	North East London NHS Foundation Trust	MHLDA	1	40	1	40
London	East London NHS Foundation Trust	MHLDA	2	40	2	40
London	North Middlesex University Hospital NHS Trust	Acute	1	31	1	31
London	University College London Hospitals NHS Foundation Trust	Acute/MHLDA	1	25	4	99
London	Lewisham and Greenwich NHS Trust	Acute	1	17	11	185
London	Barts Health NHS Trust	Acute	1	10	6	59
London	Royal Free London NHS Foundation Trust	Acute	0	0	3	46
London	Royal National Orthopaedic Hospital NHS Trust	Acute	0	0	0	0
London	Moorfields Eye Hospital NHS Foundation Trust	Acute	0	0	0	0
London	Chelsea and Westminster Hospital NHS Foundation Trust	Acute	0	0	8	181
London	Homerton University Hospital NHS Foundation Trust	Acute	0	0	0	0
London	Whittington Health NHS Trust	Acute/MHLDA	0	0	0	0
London	Your Healthcare	MHLDA	0	0	0	0
London	Bromley Healthcare	MHLDA	0	0	0	0
London	Barnet, Enfield and Haringey Mental Health NHS Trust	MHLDA	0	0	0	0
London	Hounslow and Richmond Community Healthcare NHS Trust	MHLDA	0	0	0	0
London	Central London Community Healthcare NHS Trust	MHLDA	0	0	0	0
London	Camden and Islington NHS Foundation Trust	MHLDA	0	0	0	0
London	Tavistock and Portman NHS Foundation Trust	MHLDA	0	#DIV/0!	0	#DIV/0!

Outbreak meetings were arranged by the Infection Prevention and Control (IPC) Team for all outbreaks to ensure good, safe practice, consistency and clarity in the process of providing clinical care and the following control and containment measures were employed:

- Closure of wards or bays dependent on risk factors for transmission such as symptoms of index case.
- Transfer of COVID-19 positive patients to COVID-19 positive wards.
- Patient contacts were isolated or cohorted for 14 days from last the contact with a COVID-19 positive patient.
- Patient contacts were closely monitored for the development of symptoms and had samples taken for PCR testing at days 0, 3, 5 and 10 post exposure.
- Reiteration of compliance for routine patient screening on admission and days 3 and 7 and weekly thereafter.
- Information leaflets advising on self-isolation was given to patients on discharge.
- Patients who were discharged before their swab results were reported were contacted by the clinical team if the result was positive.
- PCR swabbing of staff that had significant contact with the outbreak ward from 48 hours prior to commencement of an outbreak in addition to staff lateral flow tests.
- Reinforcement of personal protective equipment and hand hygiene best practice.
- Reinforcement of social distancing and PPE requirements when in non-clinical area.
- Only essential visitors allowed entry to outbreak wards which is in line with PHE (2020) guidance for the management of high risk patients.

- Commencement of enhanced cleaning of the ward environment with chlorine.
- PHE informed of all outbreaks and outbreak data reported externally.

A number of lessons were learnt during the management of COVID-19 outbreaks which resulted in changes to Trust policies and these lessons listed below also helped to inform the management of further outbreaks.

- The requirement for staff to wear FFP3 respirators for aerosol generating procedures on any patient pathway except patients admitted for elective procedures on the low risk pathway. All staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit and where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker should be moved to an area where FFP3 respirators are not required, see table 2 for an overview of healthcare worker fit testing compliance per Division.
- AGPs performed on patients across all pathways must be carried out in an isolation room requiring cleaning of the area and where necessary emergency equipment.
- Glove misuse observed and education given.
- Only essential visitors were not allowed whilst the outbreak was being managed.
- Processes were developed to ensure compliance with routine patient testing, this was implemented through Cerner.
- Instigation of staff PCR testing in outbreak situations in addition to lateral flow testing.
- Isolation of patient contacts in single patient isolation rooms rather than cohorting in bays where possible as this reduces the risk of viral transmission from person to person.
- Testing all patients on the ward once a cluster of COVID-19 is identified to determine if there has been onward spread of the virus.

Divisional overview of healthcare worker fit testing compliance

Fit Testing Compliance up to 10th February 2021				
Division	**Denominator (RED)**	**OLM Fit mask completion (PASS)**	**To be Tested (FAILED/ NEED TEST)**	**% of OLM Fit mask PASS**
Clinical Support Division	269	246	23	91.00%
Emergency & Integrated Care Division	713	606	107	85.00%
Planned Care Division	585	476	109	81.00%
Womens, Childrens and Sexual Health Division	964	772	192	80.00%
Total	**2531**	**2100**	**431**	**83.00%**

Communication

A strong communications strategy has been maintained to keep staff informed of changes to COVID-19 guidance. The IPC nursing team have led on three Quality Rounds since November and Grand Rounds have been held by the IPC Drs, all specific to COVID-19. IPC information bulletins are disseminated to all staff via Trust email which include the current status of COVID-19 activity within the sector and nationally, any significant amendments to local practices/protocols, and any other specific issues that are relevant to include. These key messages are reinforced when the IPC team visit wards, through fortnightly IPC Q&A webinars and the use of information posters on wards.

Audit

Hand hygiene compliance and the appropriate use of gloves has remained a key initiative to further reduce the risk of COVID-19 transmission. Trust wide average hand hygiene compliance from November 2020 – January 2021 was 90%. Compliance below the local 95% target was principally due to non-submission of audits. The introduction of Survey Monkey for audit data collection at the CW site and the reconfiguration of wards and redeployment of staff in response to the COVID-19 surge are likely contributing factors.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.6/May/21
REPORT NAME	Equality, Diversity and Inclusion: Patient Equality Report 2020/21
AUTHOR	Lee Watson, Director of Nursing
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	The Trust is required to annually compile and present an annual report on the profile of patients using the organisations services.
REPORT HISTORY	Executive Management Board, 3 March 2021 Quality Committee, via e-governance
SUMMARY OF REPORT	As attached.
KEY RISKS ASSOCIATED	There is a requirement of the Trust to produce this report in the prescribed style, there is therefore a reputational risk if this is not completed.
FINANCIAL IMPLICATIONS	None associated to this paper.
QUALITY IMPLICATIONS	None associated to this paper.
EQUALITY & DIVERSITY IMPLICATIONS	None associated to this paper.
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital
NHS Foundation Trust

Patient Equality Report

2020/21

Contents

1.0 Introduction

Chelsea and Westminster Hospital NHS Foundation Trust (the Trust), which encompasses our two main hospital sites, Chelsea and Westminster Hospital and West Middlesex University Hospital, and our 12 community-based services.

2020/21 has been an incredibly busy year for the Trust and the NHS as a whole, as we responded to the COVID-19 incident.

Reflecting on our achievements against our strategic priorities, highlighted are a few of which we are particularly proud:

Our quality
Strategic priority 1: **Deliver high-quality, patient-centred care**
Our values and strategic priorities drive us to continually improve and ensure that we put the quality and safety of care at the centre of everything we do.

Our people
Strategic priority 2: Be the employer of choice
As a Trust, we employ more than approx. 6,400 staff. Over the past year, our focus on our people has, through a series of local, national and international work-streams, seen us achieve a marked reduction in our vacancy rates. The Trust's commitment to equality, diversity and inclusion was strengthened this year by the introduction of staff networks.

Our sustainability
Strategic priority 3: Delivering better care at lower cost
Our excellent financial and operational performance continues to be of great pride to us, seeing us simultaneously achieving our financial plan while continuing to be one of the best performers against the national access standards.

The following sections provide an overview of the demographic profiles of our patients who have used the Trust services during 2020/21.

The sections have been divided into 4 services.

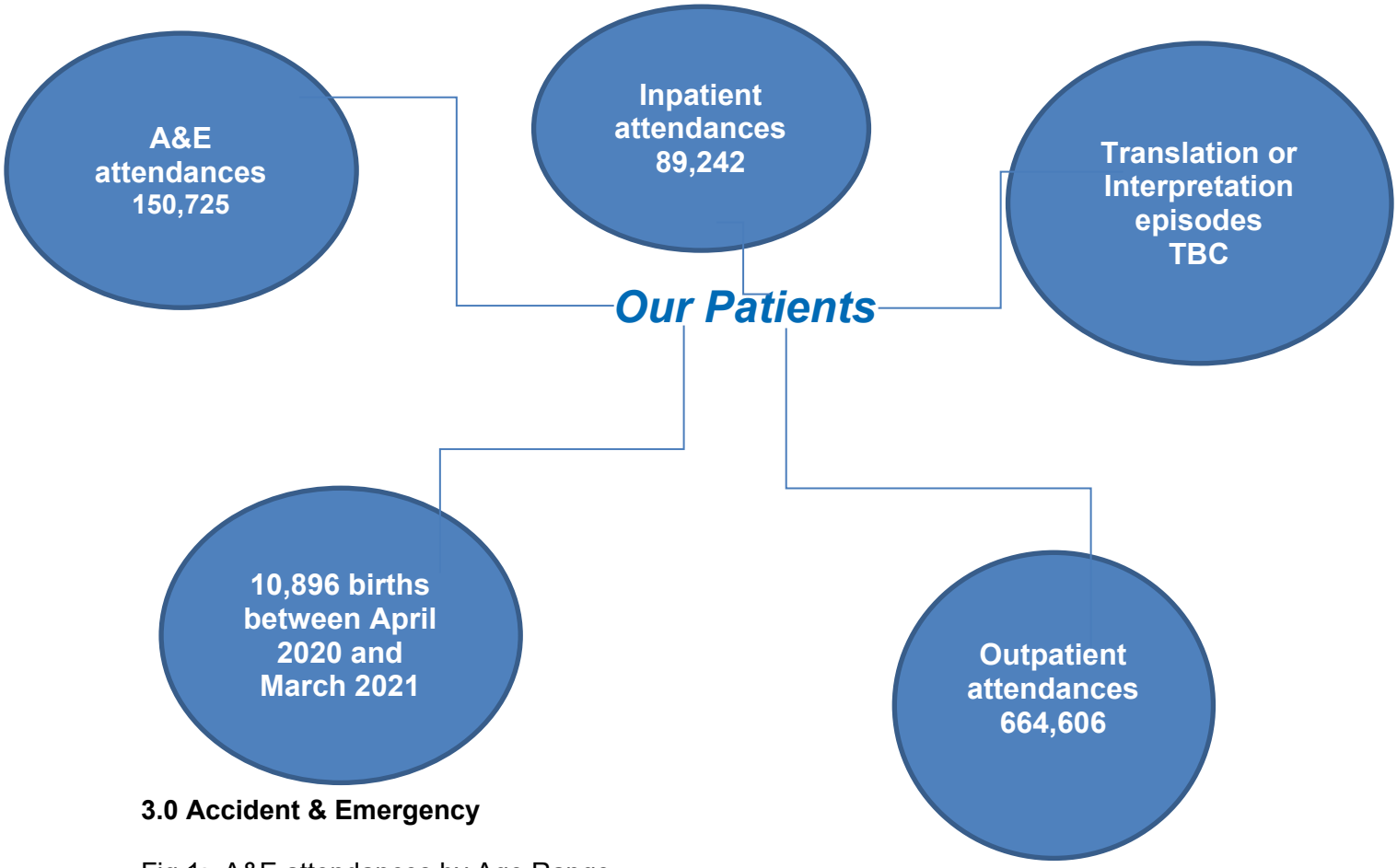
A&E, Maternity, Inpatients, Outpatients

For the purposes of this report, the following breakdown of ethnicity has been used. Non BAME incorporates patients that identify as White British, White Irish and Any Other White background.

BAME includes patients who identify as Asian (Indian, Pakistani, Bangladeshi), Mixed (White Black/Asian), Black (Caribbean, African) and Other (Chinese and Any Other). These are in line with the Office of National Statistics' Census categories.

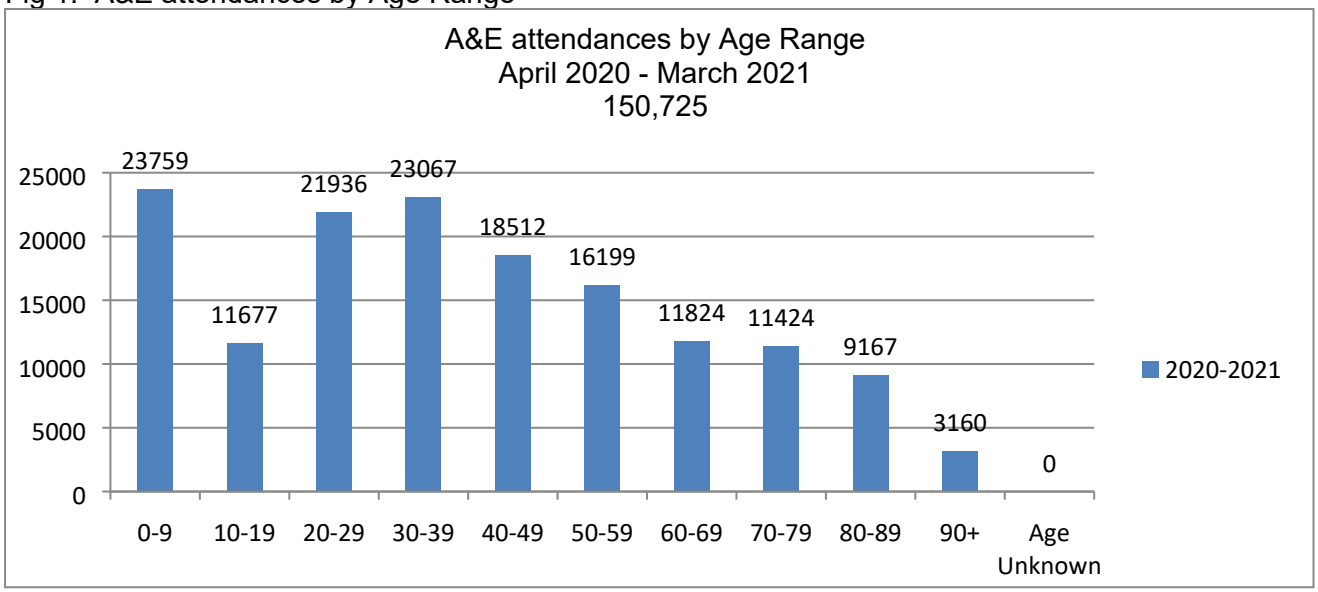
The Not Stated category also includes those who have chosen not to disclose their ethnic background.

2.0 Key Highlights April 2020 – March 2021



3.0 Accident & Emergency

Fig 1: A&E attendances by Age Range



*The A&E data does not include patients who left the department without being treated

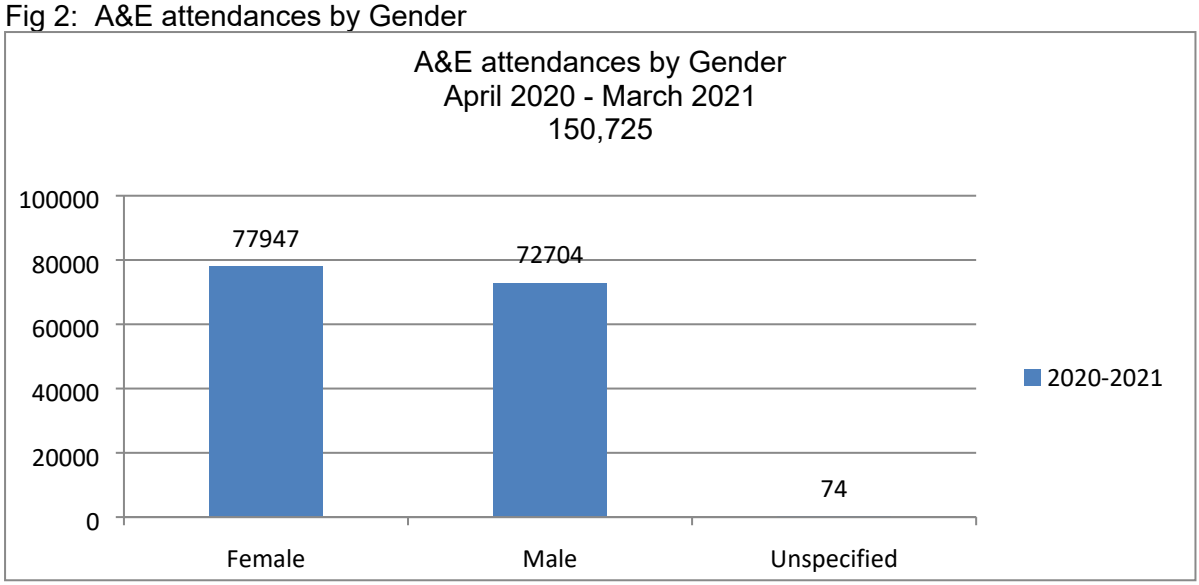
150,725 patients attended one the two Trusts A&E departments in the financial year April 2020 to March 2021. From April 2019 to March 2020 the number of patients who attended was 224,091 a 32.7% decrease in attendances in comparison of the two years.

There were decreases in attendances across all age ranges. As in previous years the paediatric A&E department is consistently the most attended service and still remains so,

however whilst it did see a decreases in numbers the 20–29 and in particular the 30–39 age ranges were almost at comparable levels. This data excludes births that occurred over the same period. Births are detailed in Figure 4.

The under 60's account for 76.3% of overall attendances whilst the over 60's accounted for 23.6% of overall attendances in April 2020 to March 2021

Fig 2: A&E attendances by Gender



A&E attendances by gender for April 2020 to March 2021 shows that females still account for the slight majority at 51.7% with males at 48.2%. Females' making up the slight majority of A&E attendances has remained consistent with the percentage differences having remained largely unchanged over the past two years.

For April 2020 to March 2021 attendances were either not recorded or unspecified is less than 1%.

Fig 3: A&E attendances by Ethnicity

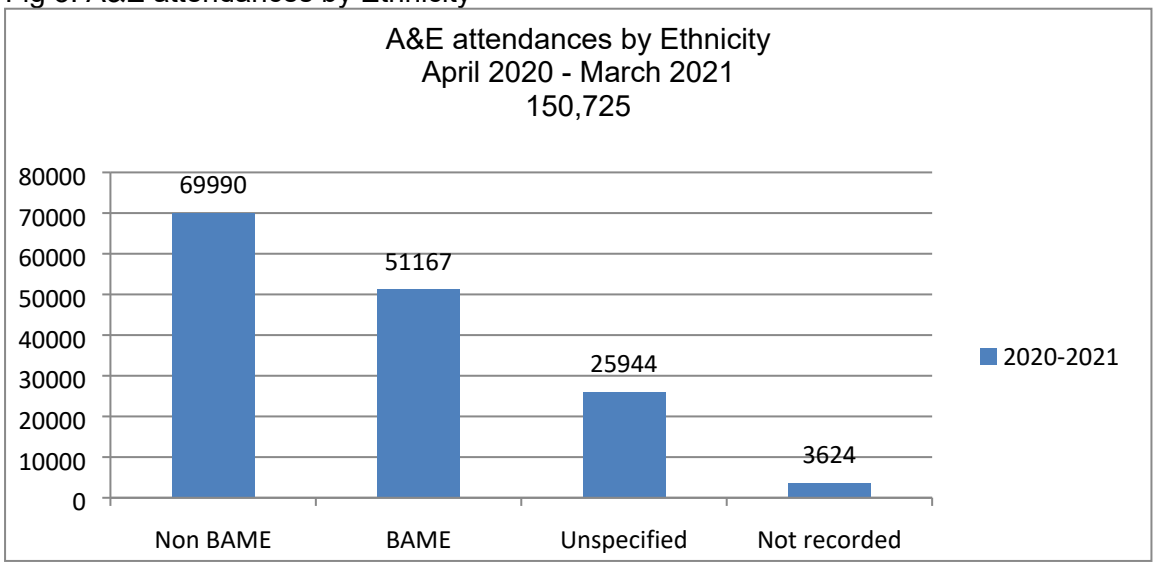
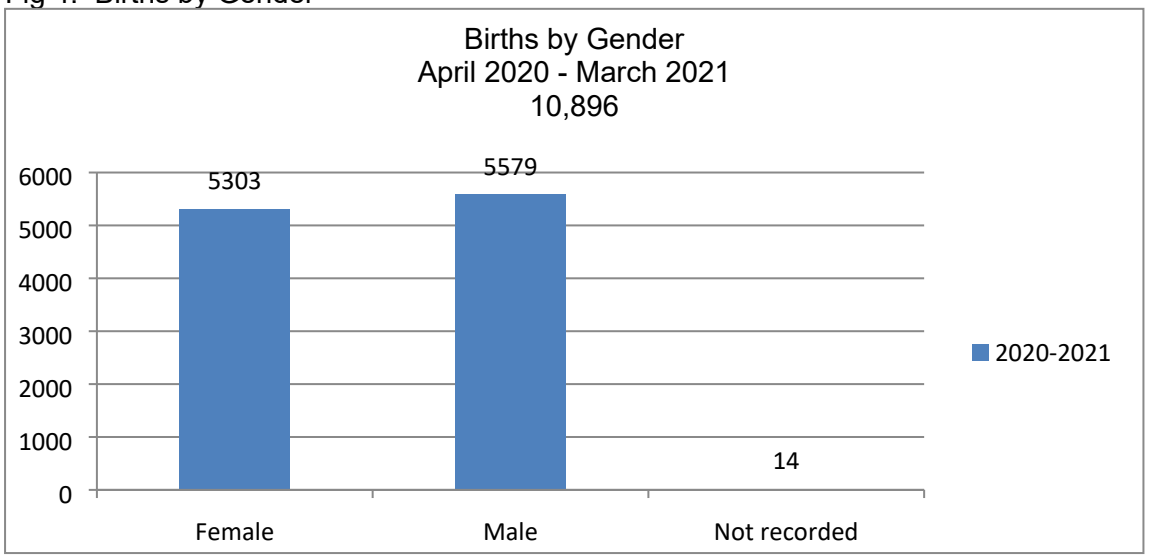


Figure 3 above shows that Non BAME patients accounted for 46.4% of service users and remains higher than BAME service users which at 33.9% for April 2020 to March 2021.

In April 2019 to March 2020 Non BAME patients accounted for 43.9% of attendances and BAME accounted for 32.5%. The number of attendances where ethnicity was either unspecified or not recorded has for April 2020 – March 2021 was 13.1%.

4.0 Maternity

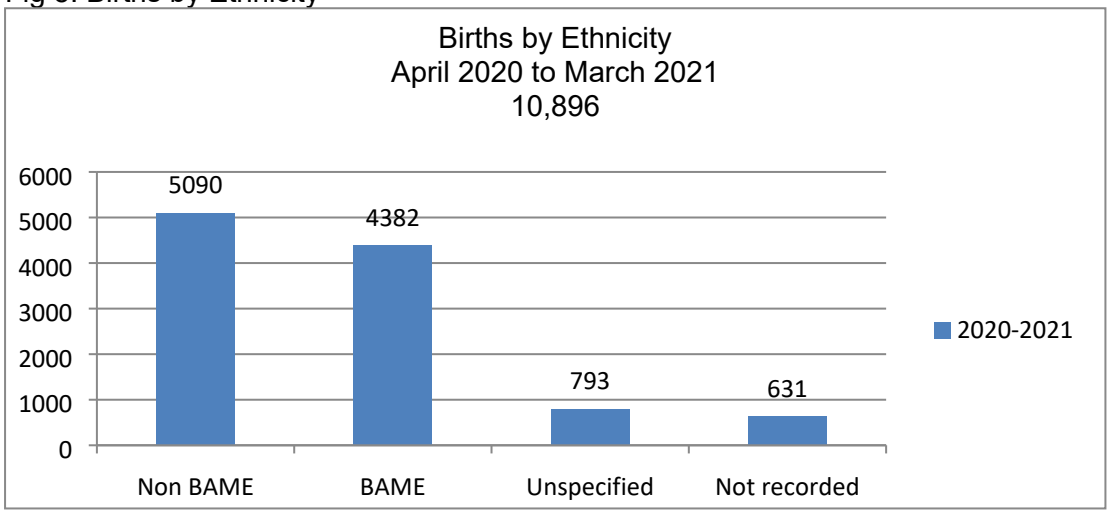
Fig 4: Births by Gender



There number of births across maternity services from April 2020 to March 2021 was 10,896; this is a decrease of 5.2% compared to April 2019 to March 2020 where the number was 11,470.

The average monthly birth rate for April 2020 to March 2021 was 908 per month down from 955 for the previous year. More male babies were born in both years April 2019 to March 2020 and April 2020 to March 2021 accounting for 51% of all births. The number of not recorded or unspecified is below 1%.

Fig 5: Births by Ethnicity

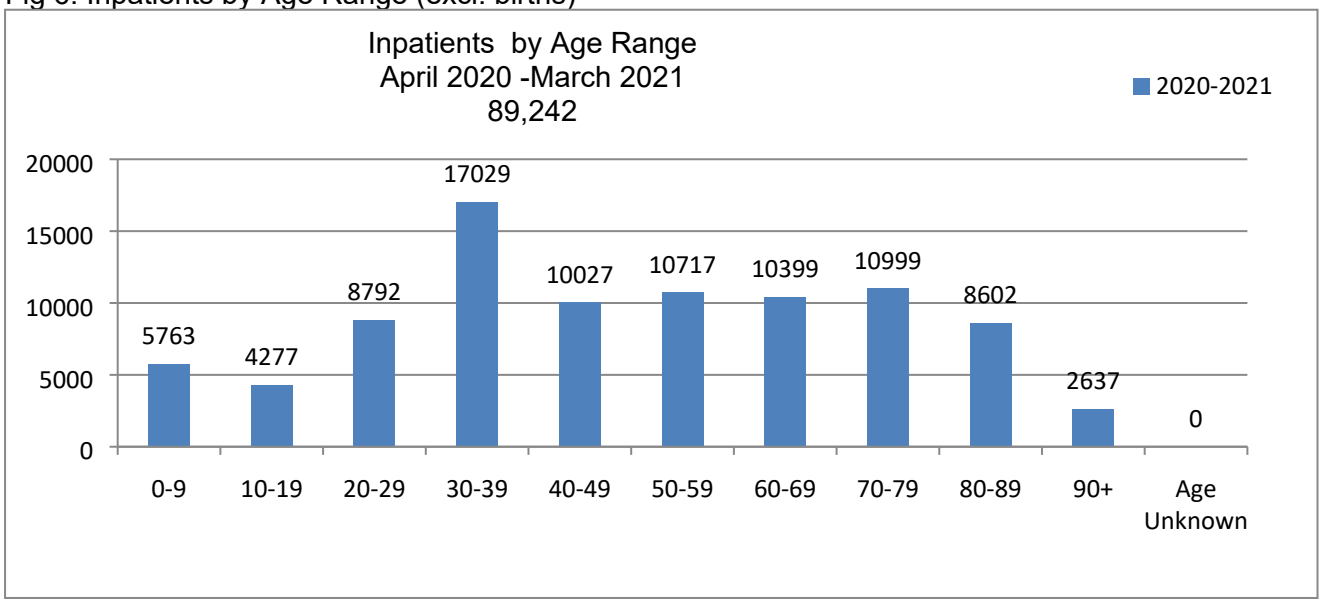


Of all births in April 2020 to March 2021 Non BAME accounted for 46.7% and BAME accounted for 40.2%. In the previous year April 2019 to March 2020 Non BAME accounted for 47.3% of births and BAME 38.5%.

Unspecified or Not Recorded for April 2020 to March 2021 was 13% and 14% for April 2019 to March 2020.

5.0 Inpatients

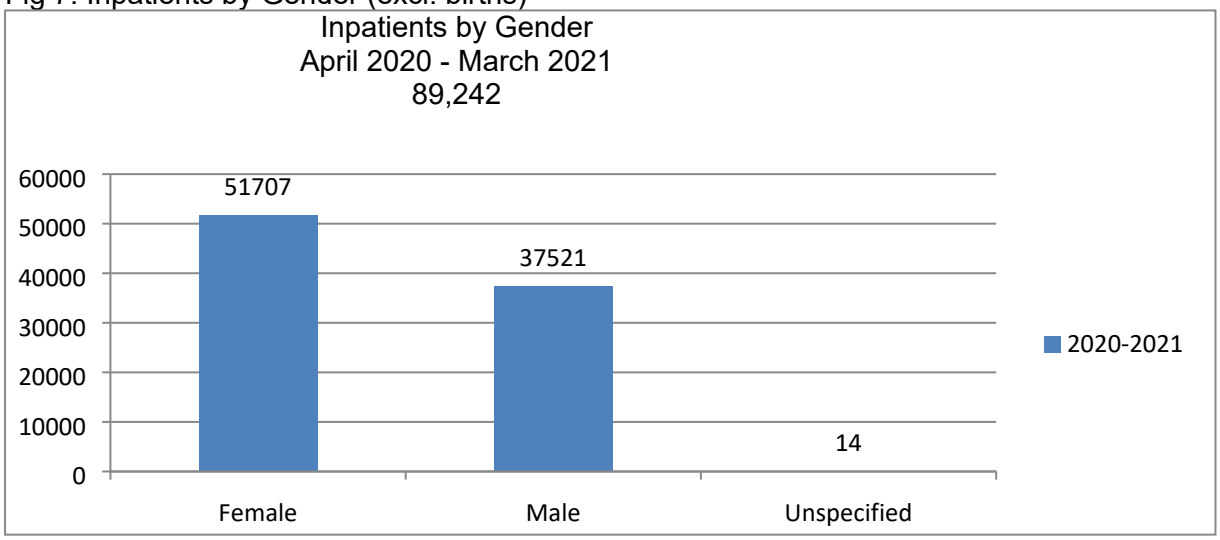
Fig 6: Inpatients by Age Range (excl. births)



The number of inpatient admissions for April 2020 to March 2021 was 89,242. In comparison the number of admissions for April 2019 to March 2020 was 134,588 a reduction of 33.6% on the previous year, and in keeping with this there were falls in numbers across all age ranges

The 30–39 age range were most frequent users of this service as they have been over previous years being 19.0% of service users.

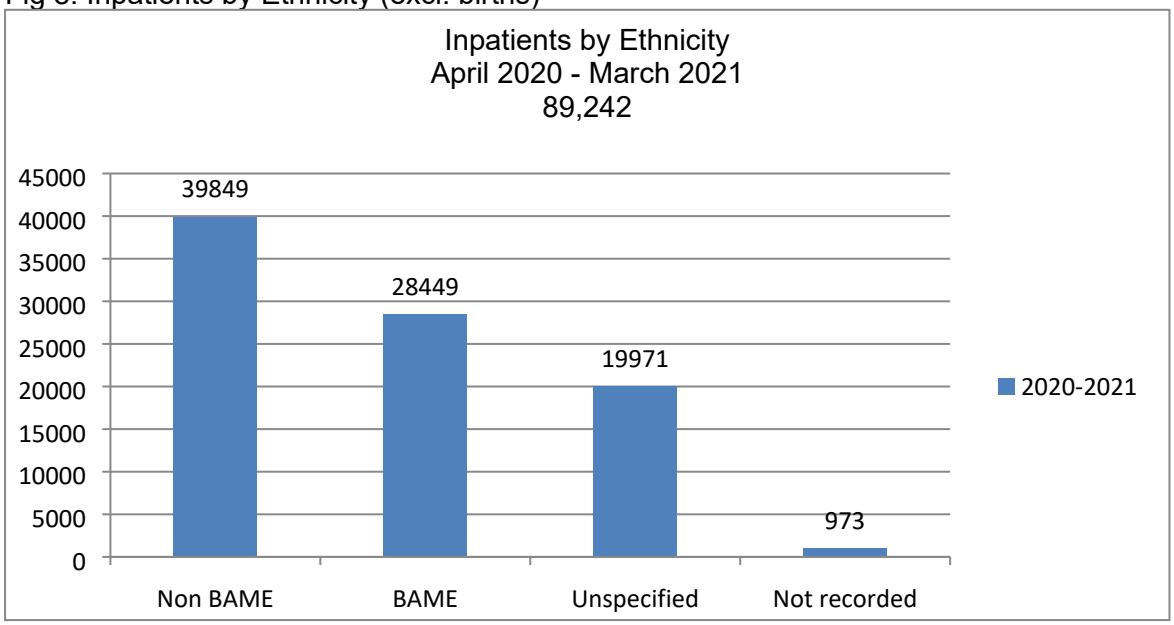
Fig 7: Inpatients by Gender (excl. births)



Inpatient attendances by gender show that females make up of 57.9% of service users in April 2020 to March 2021; this figure was 56.8% for April 2019 to March 2020. Males accounted for 42% in April 2020 to March 2021 and 43.1% for April 2019 to March 2021.

Not recorded and unspecified by gender is less than 1% in both years.

Fig 8: Inpatients by Ethnicity (excl. births)

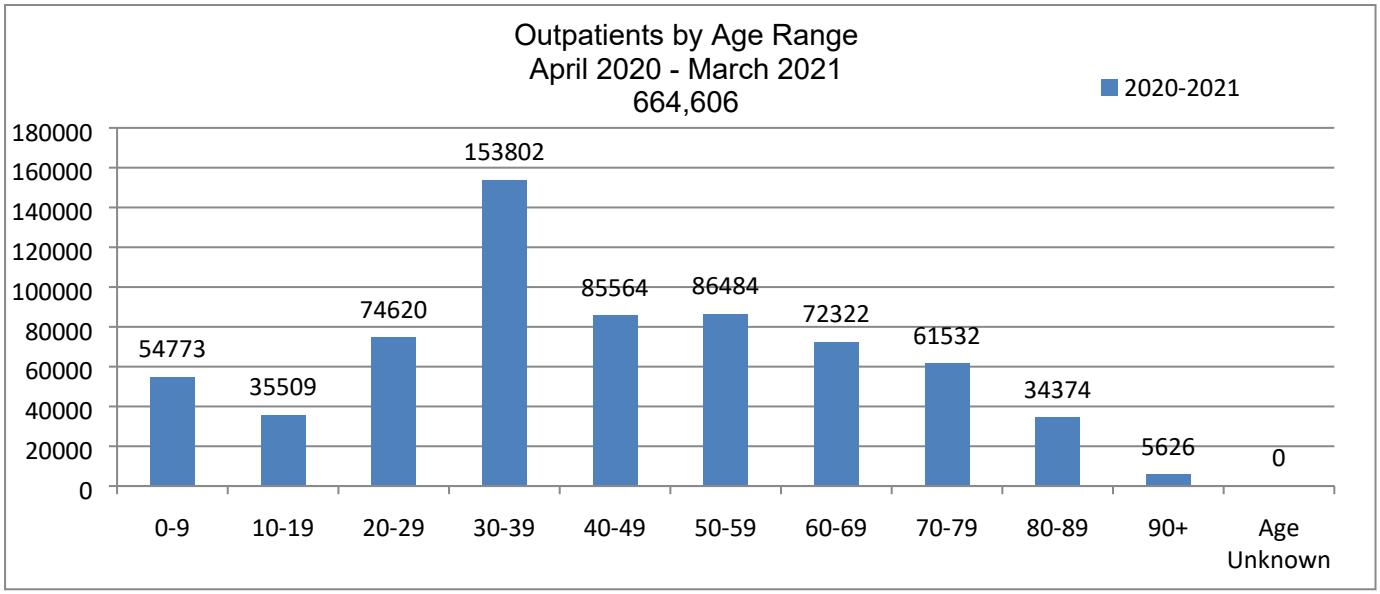


In April 2020 to March 2021Non BAME patients accounted for 44.6% of inpatients and 44.1% in April 2019 to March 2020. BAME patients accounted for 31.8% of inpatients in April 2020 to March 2021 and 31.3% in April 2019 to March 2020

The percentage of unspecified or not recorded has decreased by 44% from an increase of 25% of attendances the previous year.

6.0 Outpatients

Fig 9: Outpatients by Age Range



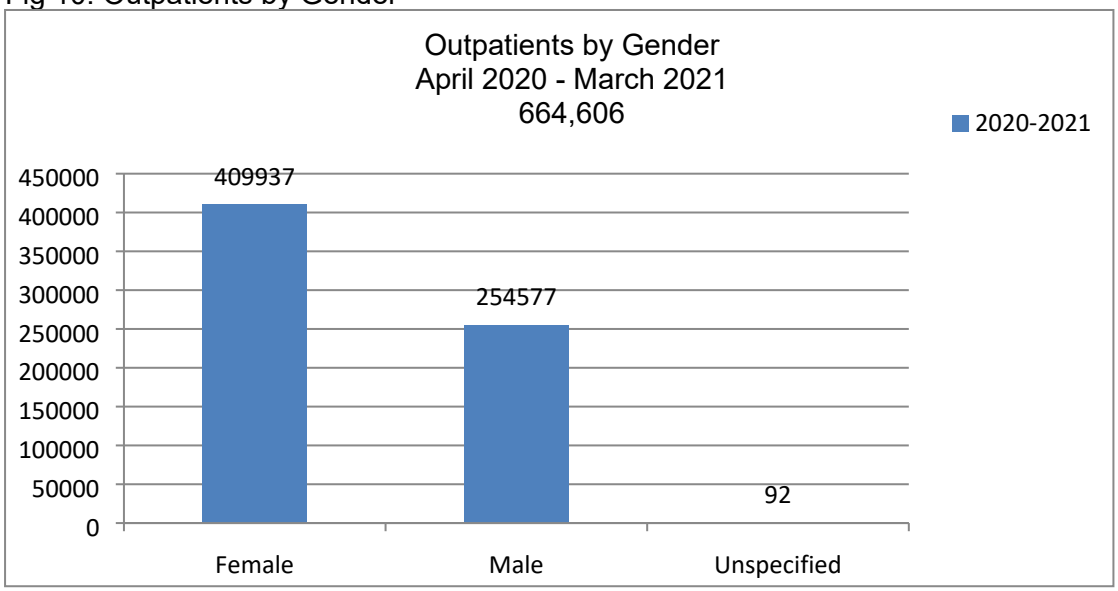
* The outpatient data only shows patients who attended an appointment and excludes cancellations or those who did not attend.

There were 664,606 outpatient attendances in April 2020 – March 2021. In the same period April 2019 to March 2020 there were 811,124 a reduction of 18%.

The 30-39 age range makes up the most frequent service users.

The under 60's as a whole account for 73% of users in April 2020 to March 2021with the over 60's at 26.1% of the total.

Fig 10: Outpatients by Gender

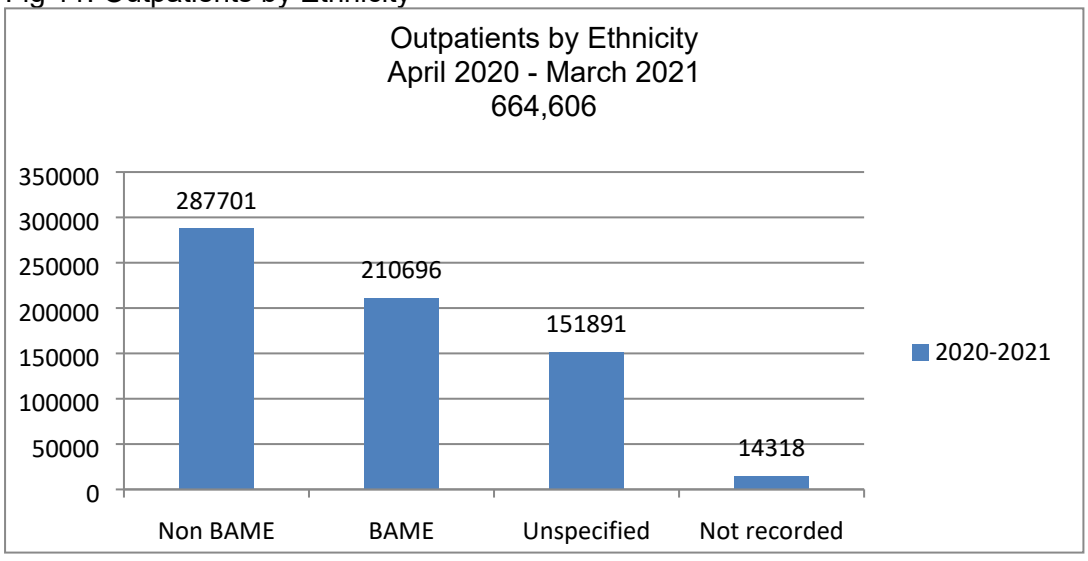


Females make up the majority of attendances at 61.6% with males at 38.3% in April 2020 to March 2021. Females also make up the majority of attendances for April 2019 to March 2020 at 61.2% with males at 38.6%.

In both of these years this will be the first time females have been the majority service users.

The number of unspecified has increased in April 2020 to March 2021 was 92 which is less than 1%.

Fig 11: Outpatients by Ethnicity



Data for outpatient attendances by ethnicity for April 2020 to March 2021 shows that 43.2% of attendees were Non BAME, for April 2019 to March 2020 this was 43.7%. BAME attendees accounted for 31.7% in April 2020 to March 2021 and 30.2% in April 2019 to March 2021

9.0 Religion by Service

Fig 12: Top Religions By Service (April 2020 – March 2021)

Religion	Inpatients	A&E	Outpatients
All other religions	69244	123748	538260
Buddhist	82	93	718
Christian (all other denominations)	8671	11073	53271
Hindu	1023	1036	6602
Jewish	98	121	595
Muslim	3054	5116	19526
No religion	2778	3522	18180
Not Declared	241	342	4637
Patient Religion Unknown	3072	4523	16732
Roman Catholic	17	2	148
Sikh	962	1149	5937
Total of all denominations	**89242**	**150725**	**664606**

The Trust collects data on the religious beliefs of patients of all denominations. The top most recorded individual religious beliefs by service are shown in the above. Only a very small number of patients would appear to refuse to declare their religious belief when asked (Not Declared). More accurate recording of patients' religious belief is addressed through the Trust patient equality objectives.

Learning Disabilities, Autism or Both

The Trust has continued to make progress in improving services for patients with a learning disability, autism or both by developing its approach to inclusion, information sharing, access to services, by providing support and partnership working with their families/carers. We continue to enhance the experience of our patients by working towards recommendations from NHSE/I and the Learning Disability Mortality Programme (LeDeR).

The Trust's Learning Disability Steering group met virtually during the second wave of the pandemic. The group includes departmental representatives, a Trust Governor, parents of patients a learning disability, the Assistant Head of Queensmill School and representatives from local charities and services.

The monthly Level 2 training session for all levels of Trust staff continued virtually during the lockdowns with the support of Richmond Mencap. They made two videos for us with their service users, talking about their experiences of being a patient and also the with a service user demonstrating Makaton signing.

In September, 2020 we welcomed our third intake of Project SEARCH interns at the West Middlesex Hospital site. This project focusses on providing on the job training for young people with a learning disability, autism or both. During the lockdowns, the team continued to provide twice weekly virtual training/learning and a weekly team meeting to socialise by and sharing their experiences of the pandemic with each other and the Project SEARCH team. In March, 2021 the interns and the Project SEARCH team returned to the hospital, having been fully briefed on Covid-19 safety measures, were individually risk-assessed and had had at least one vaccination.

Accessible Information Standard (AIS)

The Trust continues to work towards full compliance with the AIS identifying patients with a communication need and raising awareness to all staff.

A working group has been established to oversee this project which will be a long term on-going commitment.

The below table identifies the Trust level of compliance as at July 2020

Fig:13: AIS Compliance at December 2020

Domain	Description	Actions required	Compliance
1. Identify	Identify communication needs (as opposed to disability) as part of an individual's first or next interaction with the Trust	Development of the Accessible Information Policy	Completed November 2017 **Green**
2. Record and flag	Communication needs to be clearly visible in records.	Cerner change request to be instigated to add flags for written communication needs and communication needs during care	**Amber**
3. Share	Information needs to be shared between departments in the Trust and with other providers, as appropriate.		Dependent on 2, above **Amber**
4. Meet the need – patient information leaflets	Information provided in in the appropriate accessible format	Patient information leaflets to be migrated to the hospital website, which has extensive accessibility features	In Implementation, migration from patient leaflets to Trust website to utilise RectieMe software **Green**
5. Meet the need – letters	Information provided in in the appropriate accessible format	Appointment and other patient letters to be provided in the appropriate format	There will be partial compliance when the Care Information Exchange is running **Amber**
6. Meet the need – use of interpreters during care	Information provided in in the appropriate accessible format	Face-to-face or remote interpreters to be available during care	**Green**

As part of the action from the Accessible Working Group a physical audit of the Trust IT infrastructure and Trust estate has been commissioned.

AccesAble has been commissioned and is due to start a week long physical inspection and audit of the Trust site in May and will generate an action plan for the Trust to consider – this covers all aspects of the building, the wards/depts. and the facilities provided to patients and members of the public

Interpretation & Translation

Continuing effective patient care depends upon the accurate exchange of information. It is therefore the aim of the Trust to ensure that a range of interpreter and translator services are provided for people whose first language is not English and also those who communicate via sign language.

These services are provided by accessing the use of telephone interpreters and where required face to face interpreters within the permitted specialities.

Interpreting; relates to the spoken word.

Translation; relates to the written word (transferring ideas expressed in writing from one language to another).

It has not been possible to provide the data of access to interpretation services at the point of writing this report as the Interpretation Provider has not been submitted them to the Trust.

The Trust does not have direct access to the system to review the data and is reliant on the Provider supplying it. Due to the Covid-19 pandemic the Provider has been unable to do this

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

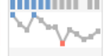
AGENDA ITEM NO.	2.7/May/21
REPORT NAME	Integrated Performance & Quality Report – March 2021
AUTHOR	Robert Hodgkiss, Chief Operating Officer & Deputy CEO
LEAD	Robert Hodgkiss, Chief Operating Officer & Deputy CEO
PURPOSE	To report the combined Trust's performance for March 2021 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for March 2021. **A&E** 4hr A&E performance for the month of March, while remaining non-compliant, saw an improvement by almost 2% from 89.14% in February to 90.90% in March. A&E attends increased between February (11,088) to March (14,484). **RTT** 18 Weeks RTT Incomplete performance has seen a decline from 77.03% in February to 75.45% in March 20201. This is primarily being driven by post Wave one new referrals now waiting over 18 weeks. The RTT PTL has seen an increase in month. Again this will be driven by an increased level of demand post Wave 2. Elective activity has however seen an increase in late march and across April which will start to mitigate the challenges. RTT Incompletes 52 week patients at month end There has been an increase in patients waiting over 52 weeks between February and March 2021. However across March and in to April a reversal of this trend and is now reducing **Cancer** Performance has seen a decline from 78.15% in February to 70.10% in March 2021. Robust management of pathways continues to ensure timely management of patient pathways. This along with a significantly reduced backlog and a fuller restart of elective work will drive recovery. There were 109 patients treated in March (102 pathways in total) which is the highest number recorded for the Trust. **Diagnostics** DM01 performance has again improved, at 92.7% for March 2021, and is significantly outperforming most national, London-based and other ICS providers. Imaging remains compliant at 99.5% for March 2021. Now that the elective programme has resumed across the Trust, we expect to see further improvements going forward across diagnostics in other divisions

KEY RISKS ASSOCIATED:	There are significant risks to the achievement of all of the main performance indicators, including A&E, RTT, Cancer & Diagnostics.
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience
DECISION / ACTION	For noting.

TRUST PERFORMANCE & QUALITY REPORT

March 2021

NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	84.05%	87.38%	90.41%	90.98%	82.98%	90.41%	91.26%	92.14%	83.42%	89.14%	90.90%	88.09%	91.64%		!
RTT	18 weeks RTT - Incomplete (Target: >92%)	78.79%	76.99%	76.09%	68.60%	76.99%	77.08%	74.58%	70.80%	78.06%	77.03%	75.45%	76.81%	69.44%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	97.61%	97.77%	97.22%	97.70%	95.16%	98.77%	99.08%	96.43%	96.13%	98.35%	98.32%	97.26%	96.57%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	93.10%	98.85%	97.60%	98.54%	93.10%	98.85%	97.60%	96.55%	98.54%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-21) in this report	31 days diagnosis to first treatment (Target: >96%)	84.00%	91.67%	96.08%	87.21%	94.44%	91.23%	92.22%	94.22%	90.16%	91.40%	93.62%	90.70%	93.32%		!
	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	n/a	n/a	100%	n/a	n/a	n/a	81.82%	n/a	n/a	n/a	n/a	83.33%		-
	62 days GP referral to first treatment (Target: >85%)	78.26%	82.22%	69.33%	67.23%	70.00%	75.68%	70.54%	73.05%	72.60%	78.15%	70.10%	75.09%	70.95%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	100%	n/a	0.00%	100%	100%	20.00%	54.55%	57.58%	100%	20.00%	50.00%	46.67%	58.82%		-
Patient Safety	Clostridium difficile infections (Year End Target: 26)	1	1	1	13	1	0	0	12	2	1	1	4	25		!
Learning Difficulties	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-

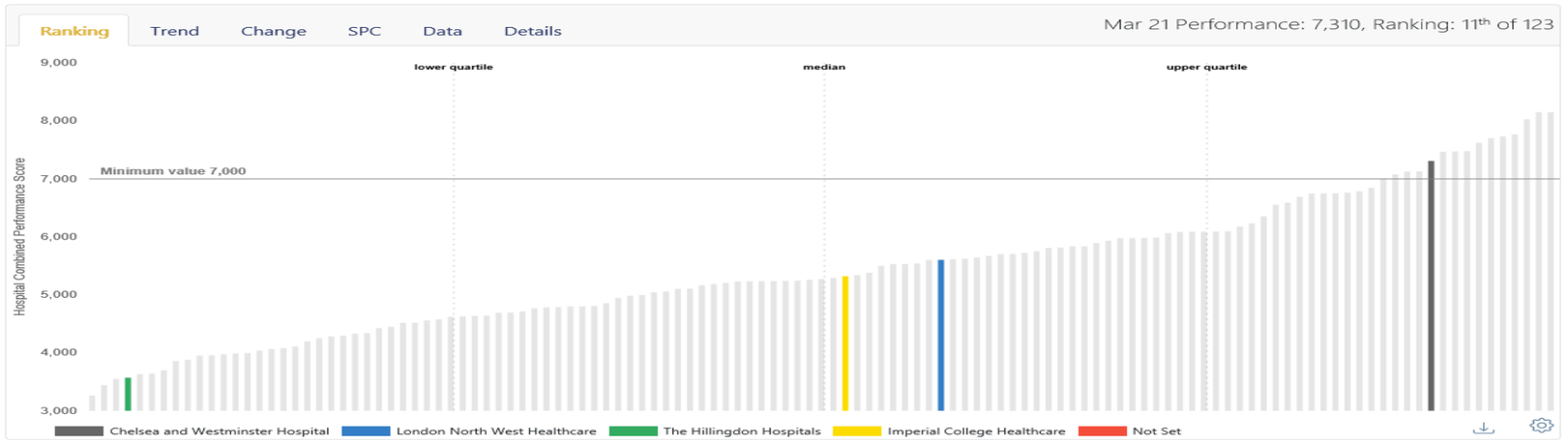
Please note the following three items	n/a	Can refer to those indicators not applicable (eg Radiotherapy) or indicators where there is no available data. Such months will not appear in the trend graphs.
	RTT Admitted & Non-Admitted are no longer Monitor Compliance Indicators	! Either Site or Trust overall performance red in each of the past three months
	Note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-21) and are not included in quarterly or yearly totals	

A&E
4hr A&E performance for the month of March, while remaining non-compliant, saw an improvement by almost 2% from 89.14% in February to 90.90% in March. A&E attends increased between February (11,088) to March (14,484).

RTT
18 Weeks RTT Incomplete performance has seen a decline from 77.03% in February to 75.45% in March 20201. This is primarily being driven by post Wave one new referrals now waiting over 18 weeks. The RTT PTL has seen an increase in month. Again this will be driven by an increased level of demand post Wave 2. Elective activity has however seen an increase in late march and across April which will start to mitigate the challenges.

Cancer
Performance has seen a decline from 78.15% in February to 70.10% in March 2021. Robust management of pathways continues to ensure timely management of patient pathways. This along with a significantly reduced backlog and a fuller restart of elective work will drive recovery. There were 109 patients treated in March (102 pathways in total) which is the highest number recorded for the trust.

CDiFF
There was 1 Trust attributed cases of CDI in March 2021 at the West Middlesex site.

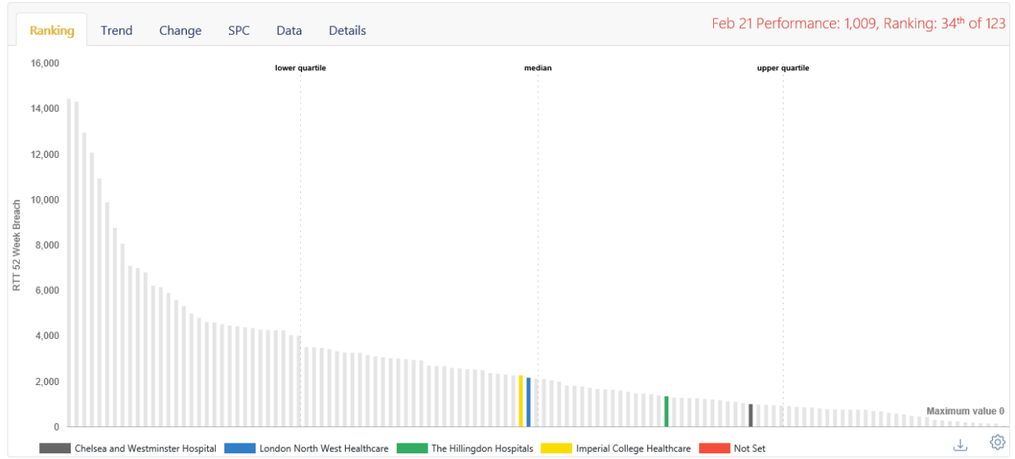


Hospital Combined Performance Score:
The trust has maintained its position between February and March 2021, remaining one of the best performing trust in the country and 11th across all AcuteTrusts.

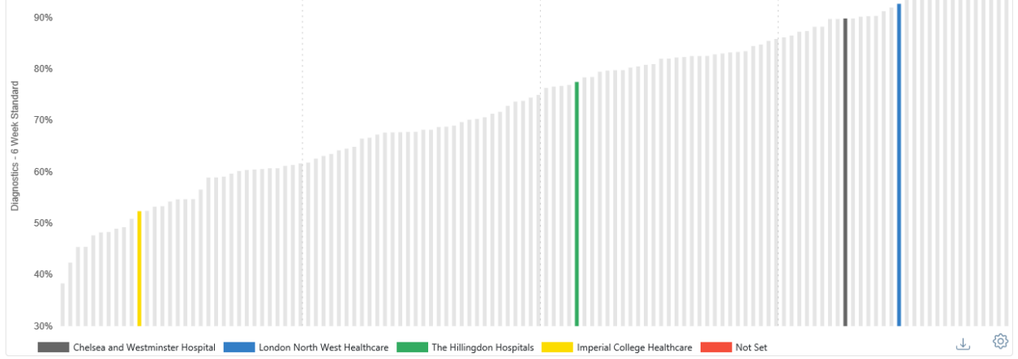
Please note, the below charts are for comparative purposes only and are 1 month retrospective – February 2021

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

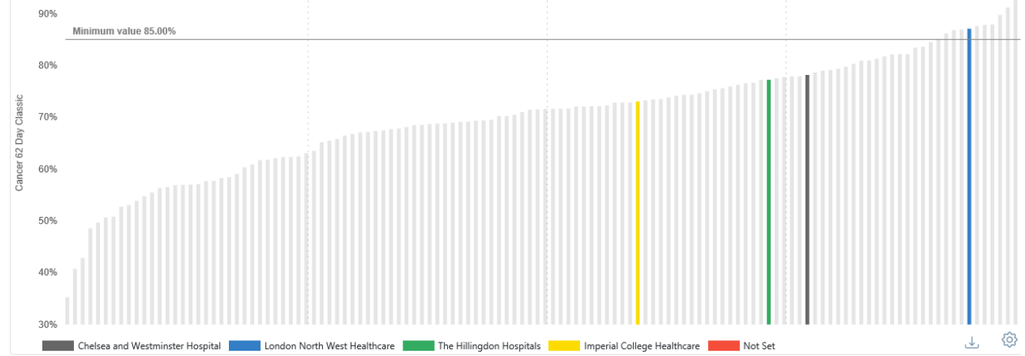
The chart above shows the relative ranking against the RTT 18 week standard. The Trust is currently ranked 13th of 124 Trusts nationally which is a positive improvement from 15th the previous month. The chart also demonstrates the position across the ICS.



The chart above shows the relative ranking against the RTT 52ww standard. The Trust is currently ranked 34rd of 124 Trusts nationally. The chart also demonstrates the position across the ICS.



The chart above shows the relative ranking against the 6 Week Diagnostic Standard. The Trust is currently ranked 22nd of 125 Trusts nationally which is a movement from 17th the previous month. The chart also demonstrates the position across the ICS.



The chart above shows the relative ranking against the 62 Day Cancer Standard. The Trust is currently ranked 28th of 125 Trusts nationally which is an improved position from 57th. The chart also demonstrates the position across the ICS.

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	2	1	0	4	0	0	0	0	2	1	0	3	4		-
	Hand hygiene compliance (Target: >90%)	82.1%	82.7%	95.2%	91.5%	88.0%	88.7%	96.3%	93.8%	84.5%	85.4%	95.6%	88.7%	92.5%		-
Incidents	Number of serious incidents	2	4	4	43	1	5	5	33	3	9	9	21	76		-
	Incident reporting rate per 100 admissions (Target: >8.5)	12.8	11.5	10.1	11.5	12.9	10.4	10.4	11.9	12.9	10.9	10.2	11.3	11.7		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.03	0.03	0.05	0.03	0.02	0.05	0.06	0.03	0.03	0.04	0.05	0.04	0.03		!
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	5.64	6.21	6.20	5.74	2.39	2.32	3.22	3.22	3.95	4.28	4.64	4.28	4.49		-
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.5%		-
Harm	Never Events (Target: 0)	0	0	0	1	0	0	0	1	0	0	0	0	2		-
	NEWS compliance %															-
	Safeguarding adults - number of referrals	27	25	18	298	28	27	49	354	55	52	67	174	652		-
	Safeguarding children - number of referrals	37	35	54	418	115	115	143	1319	152	150	197	499	1737		-
	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.78	0.76	0.77	0.77	0.78	0.76	0.77	0.77	0.78	0.76	0.77	0.77	0.77		-
Mortality	Number of hospital deaths - Adult	112	58	29	554	231	98	65	1028	343	156	94	593	1582		-
	Number of hospital deaths - Paediatric	1	1	0	8	0	0	0	0	1	1	0	2	8		-
	Number of hospital deaths - Neonatal	3	1	2	17	1	2	3	12	4	3	5	12	29		-
	Number of deaths in A&E - Adult	2	3	4	28	17	2	4	74	19	5	8	32	102		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	0	3	0	0	0	0	3		-

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

Medication-related safety incidents
A total of 149 medication-related incidents were reported in March 2021. CW site reported 83 incidents, WM site reported 56 incidents and there were 10 incidents reported in community. The number of incidents reported in March has increased from the number of incidents reported in February (110 incidents).

Medication-related (NRLS reportable) safety incidents per 1000 FCE bed days
The Trust position of medication-related incidents involving patients (NRLS reportable) for March 2021 was 4.64 per 1,000 FCE bed days which is above the Trust target of 4.2 per 1,000 FCE bed days. There has been an increase in the reporting of medication related incidents across all sites within the Trust. The trend in reporting medication-related incidents will be continued to be encouraged and monitored by the MSG.

Medication-related (NRLS reportable) safety incidents % with harm
The Trust had 0% of medication-related safety incidents with moderate harm and above in March 2021, which is in line with the Trust target of ≤2%.

Incidents resulting severe harm or death
In March 2021, there were four incidents reported that potentially caused severe harm to patients and two incidents that potentially caused the death of the patients. The four severe harm incidents have been declared SIs and relate to two patient falls, a Venous thromboembolism (VTE) event and a treatment delay. The two incidents potentially resulting in death relate to a unexpected stillbirth (declared an SI) and Hospital Acquired Covid-19 (nosocomial) related death which is being reviewed via the Trusts mortality review process.
The circumstances of these events and the degree of harm associated will be confirmed following completion of these investigations.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts	
Complaints	FFT: Inpatient satisfaction % (Target: >90%)	95.4%	95.3%	92.4%	95.1%	96.1%	96.6%	93.4%	95.7%	95.9%	96.2%	92.9%	94.4%	95.5%		-
	FFT: Inpatient not satisfaction % (Target: <10%)	3.5%	2.1%	4.1%	2.0%	2.1%	1.4%	3.9%	1.4%	2.5%	1.6%	4.0%	3.0%	1.7%		-
	FFT: Inpatient response rate (Target: >30%)	21.5%	24.1%	40.5%	21.3%	50.4%	50.5%	60.3%	28.9%	36.5%	38.1%	49.2%	42.8%	25.0%		-
	FFT: A&E satisfaction % (Target: >90%)	92.9%	91.7%	87.6%	89.6%	88.2%	86.6%	83.0%	90.7%	91.5%	90.3%	86.3%	87.8%	89.9%		!
	FFT: A&E not satisfaction % (Target: <10%)	4.8%	4.4%	7.1%	5.9%	9.1%	8.1%	9.3%	5.9%	6.1%	5.4%	7.7%	7.1%	5.9%		-
	FFT: A&E response rate (Target: >30%)	13.1%	7.2%	16.2%	18.4%	11.0%	7.0%	15.9%	19.7%	12.4%	7.2%	16.1%	13.1%	18.7%		!
	FFT: Maternity satisfaction % (Target: >90%)	93.9%	97.0%	92.7%	87.4%	100.0%	100.0%	100.0%	95.2%	94.4%	97.5%	93.2%	94.7%	88.8%		-
	FFT: Maternity not satisfaction % (Target: <10%)	4.0%	3.0%	4.1%	8.0%	0.0%	0.0%	0.0%	4.0%	3.7%	2.5%	3.8%	3.4%	7.3%		-
	FFT: Maternity response rate (Target: >30%)	26.0%	16.9%	39.3%	20.2%	33.3%	68.2%	100.0%	11.2%	26.5%	19.6%	41.2%	28.1%	17.7%		-
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Complaints	Complaints (informal) through PALS	16	40	32	225	16	16	21	191	30	28	46	104	416		-
	Complaints formal: Number of complaints received	14	12	25	168	11	12	7	129	22	24	15	61	297		-
	Complaints formal: Number responded to < 25 days	11	12	8	460	15	31	34	444	31	71	66	168	904		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	1	1	0	0	1	1	1		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	2	3	0	0	2	2	3		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months
Regarding Friends and Family Tests:	These metrics are currently suspended and will be re-instated it this report when brought back on line			

PALS & Complaints

- The number of complaints received and investigated has increased by 15 during March 2021 to 42. Our performance with responding to complaints within the 25 day KPI (95%) exceeded the target at 100%.
- The number of PALS concerns logged during March has remained steady and our performance with responding to the 5-day KPI (90%) during March was met at 91%.
- We aim to resolve as many concerns instantly and for March 2021 this was 59% (96) of the concerns received for that month.
- We have five complaints with the PHSO. Two are for EIC and there is one each for PC, CSS and WCH Divisions. We have received the outcome on two complaints (EIC and PC) where both have been partly upheld.

FFT

- Inpatient satisfaction scores remain above Trust targets for the month of March. Inpatient response rates have risen in the March due to additional SMS's being sent to that patient group. Our live FFT data warehouse reports that March inpatient scores at West Middlesex University Hospital are: Response rate: 67%, Satisfaction rate: 93%, Not satisfied: 4%.
- A&E response rates have increased in March after a system failure relating to SMS's was rectified. The reduction in satisfaction scores is attributed to the number of patients for the service increasing with a self-selecting patient cohort giving negative feedback.
- Data quality issues present in Maternity's response rates in March. The number of patients discharged is not accurate, affecting the response percentage. This has been raised with the FFT provider and resolution supported by the information team.
- All key senior staff has super user access, and can monitor their scores in real time.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.29	3.59	2.09	4.49	44.41	3.38	1.22	7.50	7.41	3.57	2.02	3.62	4.73		-
	Average length of stay - non-elective (Target: <3.95)	5.17	4.55	4.52	4.06	3.86	3.08	3.26	3.25	4.41	3.66	3.76	3.95	3.59		!
	Emergency care pathway - average LoS (Target: <4.5)	7.20	6.26	5.60	5.06	4.58	3.48	3.70	3.79	5.46	4.33	4.27	4.70	4.23		!
	Emergency care pathway - discharges	171	140	152	2016	342	320	358	3768	513	460	510	1484	5784		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	5.66%	5.61%	4.67%	5.72%	11.61%	12.70%	12.03%	11.58%	8.92%	9.55%	8.64%	9.01%	8.77%		!
	Non-elective long-stayers	291	265	349	3901	208	227	291	3329	499	492	640	1631	7230		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	100.0%	86.1%	79.1%	80.4%	100.0%	96.3%	93.9%	95.4%	100.0%	90.5%	81.8%	85.7%	85.4%		-
	Operations canc on the day for non-clinical reasons: actuals	0	0	0	15	0	0	0	22	0	0	0	0	37		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.00%	0.00%	0.00%	0.08%	0.00%	0.00%	0.00%	0.27%	0.00%	0.00%	0.00%	0.00%	0.14%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	0	17	0	0	0	5	0	0	0	0	22		-
	Theatre Utilisation (Target >85%)	35.4%	56.4%	67.9%	61.8%		40.6%	74.1%	67.8%	35.4%	55.8%	68.6%	63.7%	63.4%		!
Outpatients	First to follow-up ratio (Target: <1.5)	2.50	2.52	2.39	2.44	2.33	2.19	1.91	2.20	2.43	2.38	2.18	2.31	2.34		!
	Average wait to first outpatient attendance (Target: <6 wks)	11.5	13.1	10.6	10.7	8.6	8.1	7.6	8.7	10.2	10.8	9.2	10.0	9.8		!
	DNA rate: first appointment	8.4%	6.8%	6.9%	7.9%	7.1%	6.6%	6.8%	7.1%	7.9%	6.7%	6.9%	7.1%	7.6%		-
	DNA rate: follow-up appointment	8.2%	7.7%	7.1%	7.9%	7.5%	7.1%	7.0%	6.3%	7.9%	7.5%	7.0%	7.4%	7.3%		-

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Theatre Metrics

There has been an improvement in figures from 55.8% in February to 68.6% in March. These indicators have been impacted by the cessation of activity over the period and are not comparable with recent months.

Outpatient

There has been an improvement from 10.8 weeks wait in February to 9.2 in March. These indicators would have been impacted by the cessation of activity over the period and are not comparable with recent months however have slowly increased through the month.

New – Follow up Ratio

There has been an improvement from 2.38 in February to 2.18 in March. These indicators would have been impacted by the cessation of activity over the period and are not comparable with recent months however have slowly increased through the month.

Elective ALoS

Has been delivered across both sites in March, this will be down to the increase in Elective activity and the stabilisation of pathways post Wave 2.

Clinical Effectiveness Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts
Best Practice	Dementia screening case finding (Target: >90%)	7.1%	70.4%	92.9%	76.4%	24.0%	84.6%	95.4%	72.6%	16.4%	78.6%	94.4%	57.7%	74.3%	-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	100.0%	92.3%	84.6%	94.0%	58.8%	75.0%	95.7%	87.9%	78.1%	81.8%	91.7%	84.2%	90.4%	!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	91.7%	94.7%	85.7%	83.4%	100.0%	63.6%	88.0%	90.3%	92.9%	83.3%	87.2%	86.7%	87.2%	-
VTE	VTE: Hospital acquired	0	0	0	3	1	0	1	13	1	0	1	2	16	-
	VTE risk assessment (Target: >95%)	78.2%	91.1%	89.1%	83.9%	72.2%	93.5%	95.9%	88.4%	75.2%	92.4%	92.5%	86.5%	86.2%	!
TB Care	TB: Number of active cases identified and notified	1	3	1	27	9	2	5	88	10	5	6	21	115	-
Sepsis	% Sepsis screening <1 hour - Emergency Department (Target >=90%)	77.6%	76.6%	80.3%	71.7%	68.6%	70.1%	69.5%	64.7%	72.4%	73.1%	74.5%	73.1%	67.8%	!
	% Sepsis screening <1 hour - Wards	4.7%	6.8%	12.9%	6.5%	9.7%	12.1%	13.8%	11.3%	7.3%	9.6%	13.4%	9.1%	9.0%	-
	% Sepsis patients receiving IV antibiotics within 1 hour - Emergency Department	42.7%	37.8%	52.2%	38.4%	53.5%	59.1%	43.1%	53.9%	48.8%	51.5%	45.9%	49.0%	46.2%	-
	% Sepsis patients receiving IV antibiotics within 1 hour - Wards	13.8%	37.5%	26.2%	23.6%	29.1%	29.6%	31.4%	29.4%	21.4%	32.6%	29.0%	26.1%	27.0%	-
Improving outcomes for Inpatient diabetes patients	% of patients identified and triaged as having diabetes														
	% of non-diabetes staff who have received 10-point training														
	% of patients with diabetes with a reduced LoS due to improved diabetes control before elective surgery														

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

#NoF Time to Theatre <36hrs for medically fit patients
There has been a reported improvement in performance against this metric from 81.8% in February to 91.7% in March against a 100% target.

VTE
Performance has improved from last month from 81.8% to 91.7%

Sepsis Screening
Performance has seen an improvement from 73.1% in February to 74.5% in March 2021.

Dementia Screening
In March we achieved 93% at Chelsea site and 95% at West Middlesex, attaining our target of 90% and above for dementia screening case finding.

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site Jan-21	Chelsea & Westminster Hospital Site Feb-21	Chelsea & Westminster Hospital Site Mar-21	Chelsea & Westminster Hospital Site 2020-2021	West Middlesex University Hospital Site Jan-21	West Middlesex University Hospital Site Feb-21	West Middlesex University Hospital Site Mar-21	West Middlesex University Hospital Site 2020-2021	Combined Trust Performance Jan-21	Combined Trust Performance Feb-21	Combined Trust Performance Mar-21	Combined Trust Performance 2020-2021 Q4	Combined Trust Performance 2020-2021	Trust data 13 months Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	469	646	667	3731	300	363	387	2303	769	1009	1054	2832	6034		!
	Diagnostic waiting times <6 weeks: % (Target: >99%)	86.86%	90.56%	91.98%	65.01%	89.61%	89.13%	93.22%	64.13%	88.41%	89.79%	92.70%	90.43%	64.53%		!
	Diagnostic waiting times >6 weeks: breach actuals	310	198	203	16685	318	266	240	20230	628	464	443	1535	36915		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.4%	9.5%	9.0%	9.5%	9.0%	8.0%	8.1%	8.3%	9.3%	8.9%	8.7%	8.9%	9.0%		!
	A&E time to treatment - Median (Target: <60')	00:43	00:36	00:28	00:34	00:56	00:52	00:58	00:50	00:51	00:45	00:43	00:46	00:44		-
	London Ambulance Service - patient handover 30' breaches	8	0	2	70	258	54	58	809	266	54	60	380	879		-
	London Ambulance Service - patient handover 60' breaches	0	0	0	0	61	1	1	96	61	1	1	63	96		!

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

RTT Incompletes 52 week patients at month end
There has been an increase in patients waiting over 52 weeks between February and March 2021. However across March and in to April a reversal of this trend and is now reducing

Diagnostics
DM01 performance has again improved, at 92.7% for March 2021, and is significantly outperforming most national, London-based and other ICS providers.
Imaging remains compliant at 99.5% for March 2021.
Now that the elective programme has resumed across the Trust, we expect to see further improvements going forward across diagnostics in other divisions

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021	Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	Trend charts	
Birth indicators	Total number of NHS births	448	417	363	5320	374	345	298	4476	822	762	661	2245	9796		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	35.8%	37.0%	35.9%	37.2%	33.8%	34.2%	33.3%	33.6%	34.9%	35.8%	34.8%	35.1%	35.6%		!
	Midwife to birth ratio (Target: 1:30)	1:27	1:27	1:27	1:29.5	1:28	1:28	1:28	1:29	1:27.5	1:27.5	1:27.5	1:27.50	1:28.60		-
	Maternity 1:1 care in established labour (Target: >95%)	97.7%	98.3%	98.8%	97.7%	98.1%	98.5%	96.7%	97.7%	97.9%	98.4%	97.8%	98.0%	97.7%		-
Safety	Admissions of full-term babies to NICU	8	15	19	188	n/a	n/a	n/a	n/a	8	15	19	42	188		-

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

Caesarean Birth

The number of caesarean sections performed in March: West Middlesex: total 132 a reduction of 0.9% on February, split by 51 women (13%) had an elective CS, 81 women (20.7%) had an emergency CS. West Middlesex supported 11 elective caesareans sections for uncomplicated women booked at CW The main indication for caesarean section was lack of progress followed by other (work needs to be undertaken with the clinical teams to ensure accurate data entry)

Chelsea: total 164a reduction of 1.1%, split by 98 women (14%) had an elective CS, 66 women (20.8%) had an emergency CS. The main indication for caesarean section was lack of progress followed by fetal distress.

Combined CS rate across the sites for February 35.6%

Midwife to birth ratio

The midwifery to birth ratio on both sites has been enhanced following investment in October 2020. At WM it is now 1:28 and a CW it is 1:27. We are currently undertaking a full Birth Rate plus midwifery workforce assessment. This will be completed by May.

Maternity 1:1 care

The 1:1 care in labour on both sites remains stable and above the recommended target

62 day Cancer referrals by tumour site Dashboard

Target of 85%

Domain	Tumour site	Chelsea & Westminster Hospital Site Jan-21	Feb-21	Mar-21	2020-2021	YTD breaches	West Middlesex University Hospital Site Jan-21	Feb-21	Mar-21	2020-2021	YTD breaches	Combined Trust Performance Jan-21	Feb-21	Mar-21	2020-2021 Q4	2020-2021	YTD breaches	Trust data 13 months Trend charts	
62 day Cancer referrals by site of tumou	Breast	n/a	n/a	n/a	n/a		100%	90.0%	100%	80.4%	19.5	100%	90.0%	100%	94.1%	80.4%	19.5		-
	Colorectal / Lower GI	83.3%	100%	70.0%	64.1%	20	50.0%	62.5%	60.6%	71.0%	21	60.0%	73.9%	62.8%	67.4%	67.5%	41		!
	Gynaecological	n/a	100%	75.0%	72.7%	3.5	63.6%	100%	50.0%	73.7%	10.5	63.6%	100%	66.7%	80.0%	73.5%	14		-
	Haematological	n/a	100%	100%	72.0%	3.5	50.0%	100%	100%	72.7%	6	50.0%	100%	100%	66.7%	72.5%	9.5		-
	Head and neck	n/a	n/a	n/a	60.0%	2	80.0%	100%	100%	52.4%	5	80.0%	100%	100%	87.5%	54.8%	7		-
	Lung	60.0%	0.0%	75.0%	70.4%	4.5	75.0%	80.0%	50.0%	68.8%	5.5	66.7%	66.7%	66.7%	66.7%	69.5%	10		!
	Sarcoma	n/a	n/a	n/a	n/a		100%	n/a	n/a	40.0%	1.5	100%	n/a	n/a	100%	40.0%	1.5		-
	Skin	84.2%	66.7%	77.8%	87.4%	14.5	57.1%	100%	85.2%	93.5%	6	76.9%	75.0%	81.5%	76.2%	89.9%	20.5		!
	Upper gastrointestinal	100%	100%	100%	61.5%	5	0.0%	75.0%	50.0%	64.0%	5	50.0%	85.7%	66.7%	72.7%	62.7%	10		!
	Urological	71.4%	85.7%	55.6%	33.9%	42	77.8%	40.0%	57.1%	59.3%	62.5	75.6%	62.1%	56.5%	70.0%	51.9%	104.5		!
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a	100%	0	100%	n/a	n/a	100%	100%	0		-
	Site not stated	n/a	n/a	n/a	n/a		n/a	n/a	n/a	88.2%	1	n/a	n/a	n/a	n/a	88.2%	1		-

Improving personalised cancer care at diagnosis

Note that this is currently a place-holder whilst the reporting methodology of the metrics are under review

% patients receiving an (HNA) & care plan	
Patients with an end of treatment summary	

Please note the following	n/a	Refers to those indicators where there is no data to report. Such months will not appear in the trend graphs	! Either Site or Trust overall performance red in each of the past three months
		Please note that all indicators show interim, unvalidated positions for the latest month (Mar-21) and are not included in quarterly or yearly totals	

Trust commentary

No commentary available yet

Split by Tumour site the breaches and treatment numbers for February 2021 were as follows:

Tumour Site	Chelsea & Westminster		West Middlesex	
	Breaches	Treatments	Breaches	Treatments
Breast			1	10
Gynaecology		2.5	0	2
Haematology		1.5	0	1.5
Head and Neck			0	1.5
Colorectal		3.5	3	8
Lung	1	0.5	0	2.5
Skin	2	6	0	2
Upper GI		1.5	0.5	2
Urology	1	7	4.5	7.5
Total:	**4**	**22.5**	**9**	**37**

Safe Staffing & Patient Quality Indicator Report – Chelsea Site

March 2021

Ward	Day		Night		CHPPD	CHPPD	CHPPD	National Benchmark		February Vacancy Rate	February Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents (moderate and severe)		FT
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA	Total				Qualified	Un-qualified	No harm and mild		Moderate and severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Maternity	100%	82%	98%	101%	12.3	4.5	16.8	15.3		4%	9%	14%									94.70%
Annie Zunz	147%	73%	100%	95%	9.4	2.9	12.3	7.8		0%	O%	0%		12							100.00%
Apollo	74%	-	69%	-	13.2	0	14	10.9		12%	24%	31%	1	1							100.00%
Jupiter	0.54	-	0.61	-	13.2	0	13.2	10.9		53%	53%	0%		1							100.00%
Mercury	146%	110%	137%	-	7.9	0.6	8.5	9.3		9%	3%	33%									94.74%
Neptune	0.87	-	0.99	-	20.9	0	20.9	10.9		18%	14%	67%		1							100.00%
NICU	109%	-	110%	-	15.1	0	15.1	26		6%	11%	13%								2	100.00%
AAU	105%	67%	103%	80%	8.1	1.8	10.1	7.8		11%	11%	42%		66		3				1	86.05%
Nell Gwynne	95%	75%	132%	87%	4.6	3.7	8.5	7.3		7%	0%	37%	1	31							87.50%
David Erskine	93%	95%	97%	101%	8	6.8	15	7		-3%	13%	4%									71.43%
Edgar Horne	89%	80%	100%	98%	3.2	2.8	6.1	6.9		18%	6%	27%	2	19							88.06%
Lord Wigram	90%	84%	101%	100%	5	3.3	8.4	7		3%	3%	5%	1	25							96.30%
St Mary Abbots	94%	51%	80%	109%	3.8	2.2	6.4	7.2		13%	9%	0%		4							94.34%
David Evans	78%	77%	76%	141%	9.7	4.5	14.2	7.2		4%	10%	12%		27		1		1			96.64%
Chelsea Wing	-	-	-	-	-	-	-	7.2		0.345	14%	0.1842		2							
Burns Unit	0.85	0.92	1	0.98	9.9	4.9	14.8	N/A		9%	15%	15%		11							95.45%
Ron Johnson	-	-	-	-	-	-	-	7.4		6%	10%	20%									
ICU	188%	101%	212%	-	38.4	0.4	39.6	26		4%	16%	133%	1	6							
Rainsford Mowlem	94%	43%	98%	64%	4.9	3	8	7.3		11%	8%	14%	3	88		1					82.35%

Safe Staffing & Patient Quality Indicator Report – West Middlesex Site

March 2021

Ward	Day		Night		CHPPD	CHPPD	Total	National Benchmark		Vacancy Rate	February Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents		FFT
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA					Qualified	Un-Qualified	Moderate		Severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Lampton	60%	61%	74%	74%	4.8	4.5	9.3	7.3		4.10%	0.00%	6.42%		35					2	22	96.43%
Richmond	-	-	-	-	-	-	-	7.2		0.025	3.69%	0.00%									
Syon 1 cardiology	97%	84%	99%	127%	4.2	2.1	6.3	8		9.40%	0.00%	16.67%	5	67					5	30	95.56%
Syon 2	100%	98%	106%	107%	3.6	3.1	6.9	7.3		11.60%	7.18%	6.25%	6	61					1	31	96.94%
Starlight	109%	-	129%	-	8.5	0	8.5	10.9		4.40%	22.73%	0.00%							3	26	92.68%
Kew	95%	73%	100%	98%	3.6	2.7	6.6	6.9		-4.20%	4.65%	17.73%	6	63					1	19	100.00%
Crane	82%	63%	87%	82%	4.5	3.4	8.2	6.9		12.00%	3.35%	0.00%	7	58	1	3			3	15	94.44%
Osterley 1	82%	81%	84%	102%	3.7	3.1	7.1	7		-3.70%	15.40%	0.00%	2	47		1	1			20	85.71%
Osterley 2	55%	84%	80%	109%	3.2	2.8	6.2	7.2		16.40%	2.78%	18.34%	4	39		1			3	18	88.89%
MAU	106%	125%	109%	131%	7.7	3.2	11	7.8		9.60%	8.75%	27.27%	3	101					13	76	100.00%
Maternity	102%	77%	108%	90%	8.3	2.5	10.8	15.3		2.50%	4.70%	1.20%	2	3					4	26	100.00%
Special Care Baby Unit	97%	100%	82%	100%	8.1	2.6	10.8	10.9		8.30%	3.84%	0.00%								13	100.00%
Marble Hill 1	105%	95%	99%	123%	3.8	2.7	6.6	7.3		20.70%	20.74%	14.93%	3	64					3	39	86.49%
Marble Hill 2	88%	79%	104%	129%	3.8	2.9	6.8	6.5		6.00%	10.36%	25.94%	2	72	1	1			2	31	100.00%
ITU	243%	-	276%	-	43.9	0	44.9	26		-13.80%	11.28%	0.00%	1				1		3	37	100.00%

Safe Staffing & Patient Quality Indicator Report

March 2021

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours per Patient Day (CHPPD). This is then benchmarked against the national benchmark and triangulated with associated quality indicators, staffing vacancy/turnover and patient experience for the same month. Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Wards at the Chelsea Site such as Ron Johnson, David Erskine, Edgar Horne, David Evans and Saint Marys Abbots are referred to by their roster name rather than their present physical location.

During March hospital admissions due to the pandemic decreased. There were low fill rates of HCA's mainly in the Chelsea site but an additional 30 new recruits commenced in March.
Jupiter and Neptune returned to their paediatric speciality on the 17th March and opened to 8-12 beds and staff were redistributed across paediatrics. Apollo was an admissions ward and Neptune staff were moved there to open additional capacity. Mercury had high acuity during early March and extra beds were opened as needed when Neptune and Jupiter were under adult speciality. PSSU staff were moved to Starlight as PSSU has been closed to enable safe flow of patients.
Annie Zunz returned to their home ward on 10th March and the high day rate for RN's was due to the requirement of an extra RN to cover patients admitted through the Surgical Admissions Lounge. Ron Johnson ward moved to Rainsford Mowlem in early March having been allocated 15 beds. The low fill rates for HCA's on Rainsford Mowlem was due to a mixture of both short and low term sickness. Historically HCA fill rates have been low and this is currently being reviewed. Nell Gwynne had low HCA fill rates due to 2 HCA's on long term sickness and an increased requirement for HCA specials. High fill rates for RN's was due to additional requirement for tracheostomy patients. Saint Mary Abbotts had low fill HCA rates as there were bed closures throughout March so low fill rates presented no risk. Over fill on the night shifts for David Evans was due to the low HCA establishment at night which is currently being reviewed. AAU low HCA fill rate was due to vacancies.
Lampton had low fill rates as 14 beds were closed for the duration of March. Kew and Crane also reduced HCA fill rates as beds were closed when possible.Syon 1 and Marble Hill 2 required extra HCAs on nights for patients with high risk of falls and absconding. Osterley I had low day RN fill rates due to bed closures. The high RN fill rate on WM ICU and CW ICU was due to the numbers of both COVID19 patients and other acutely unwell patients

During March there were two falls with severe harm on Crane and Marble Hill 2 and one with moderate harm on David Evans. Osterley 1 had a patient with an unstageable pressure ulcer. The Friends and Family test showed 6 wards at WM and 5 wards at CW wards scored 100% with David Erskine scoring 71.43% and all other wards scoring above 80%. The turnover and vacancy figures refer to February as Workforce has high sickness levels.

Safe Staffing & Patient Quality Indicator Report – Improving Clinical Handover

March 2021

CQUIN Dashboard

2020/21 CQUIN Schemes

As contracting with NHS commissioning organisations has been suspended during the period of the COVID-19 response, the position relating to CQUIN remains unclear. Whilst national CQUIN schemes have been published, delivery of them has been postponed. The Trust is currently receiving block funding which includes CQUIN payments in full.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.8/May/21
REPORT NAME	Responding to the National NHS Staff Survey 2020 results
AUTHOR	Sue Smith, Interim Director of People & OD
LEAD	Sue Smith, Interim Director of People & OD
PURPOSE	The purpose of this paper is to provide a detailed analysis of the 2020 NHS Staff Survey results and outline our proposed response to the issues raised.
REPORT HISTORY	People & OD Committee, 27 April 2021
SUMMARY OF REPORT	Culture in an organisation is often described as 'the way we do things round here' and this fundamentally affects the way staff treat each other and patients. The purpose of this report is to provide a detailed analysis to the People & OD Committee regarding the results of the 2020 NHS Staff Survey – 59% of the workforce (3,674 members of staff) took part in the survey and their responses provide a wealth of information about the culture at Chelwest. Whilst there is much to be proud of within this report, the senior leadership team recognises that it is our responsibility to listen and engage further with the workforce to address the issues that have been raised about working in the Trust, in particular feedback around Equality, Diversity & Inclusion, Health & Wellbeing, Morale, and Safe Environment. One of the biggest influences on culture is the style of leadership in an organisation and collective leadership is recognised as the key to creating a culture that will give staff the freedom and confidence to act in the interests of patients and support sustainable improvements. An existing programme of work is already in place at Trust level that will support how we address the key themes identified within the report as below average when compared to our benchmark group – acute / acute community trusts. Work is also ongoing within the divisions to develop a bottom-up action planning process through the development of pledges of commitment to address local themes and issues. An organisational priority, the first draft of the "*You said … We did*" action plan encompassing these actions will be in place by the end of May. The People & OD Committee will oversee the further development and delivery of the staff survey action plan, with monthly updates to Board and the wider workforce, underpinned by a very clear ongoing programme of staff engagement and listening, which will be supported by a refreshed People Strategy.

KEY RISKS ASSOCIATED	Board Assurance Framework Risk 3 - Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Quality of Care is a key theme within the NHS Staff Survey.
EQUALITY & DIVERSITY IMPLICATIONS	Equality, Diversity & Inclusion is a key theme within the NHS Staff Survey.
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For discussion.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Responding to the National NHS Staff Survey 2020 results

Contents

2020 Chelwest results briefing

Themes

Next steps

1. Executive Summary

Culture in an organisation is often described as 'the way we do things round here' and this fundamentally affects the way staff treat each other and patients. The purpose of this report is to provide a detailed analysis to the People & OD Committee regarding the results of the 2020 NHS Staff Survey – 59% of the workforce (3,674 members of staff) took part in the survey and their responses provide a wealth of information about the culture at Chelwest.

Whilst there is much to be proud of within this report, the senior leadership team recognises that it is our responsibility to listen and engage further with the workforce to address the issues that have been raised about working in the Trust, in particular feedback around Equality, Diversity & Inclusion, Health & Wellbeing, Morale, and Safe Environment.

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2. Introduction

Participation

3,674
ChelWest staff responded

100% online survey mode

59%
response rate
(median response rate 45%)

- The survey was nationally administered by the Survey Coordination Centre, based at Picker, on behalf of NHS England and NHS Improvement.
- 280 NHS organisations took part, including all 220 trusts in England.
- Despite the outbreak of the Covid-19 pandemic in 2020, the survey used the same methodology and timings as in previous years with the majority of questions asked in the same way in order to maintain comparability of the trend data and thus provide an indication of the impact of the pandemic on NHS staff.
- In 2020 some specific questions were added on staff experience during the Covid-19 pandemic.
- Ten summary indicators referred to as 'themes' have been created from the responses to certain individual survey questions. These have been calculated for previous years where possible.
- All themes are scored on a scale that ranges from 0 (worst) to 10 (best). Sections 4-13 of this report are focused on ChelWest results relating to each of these themes.

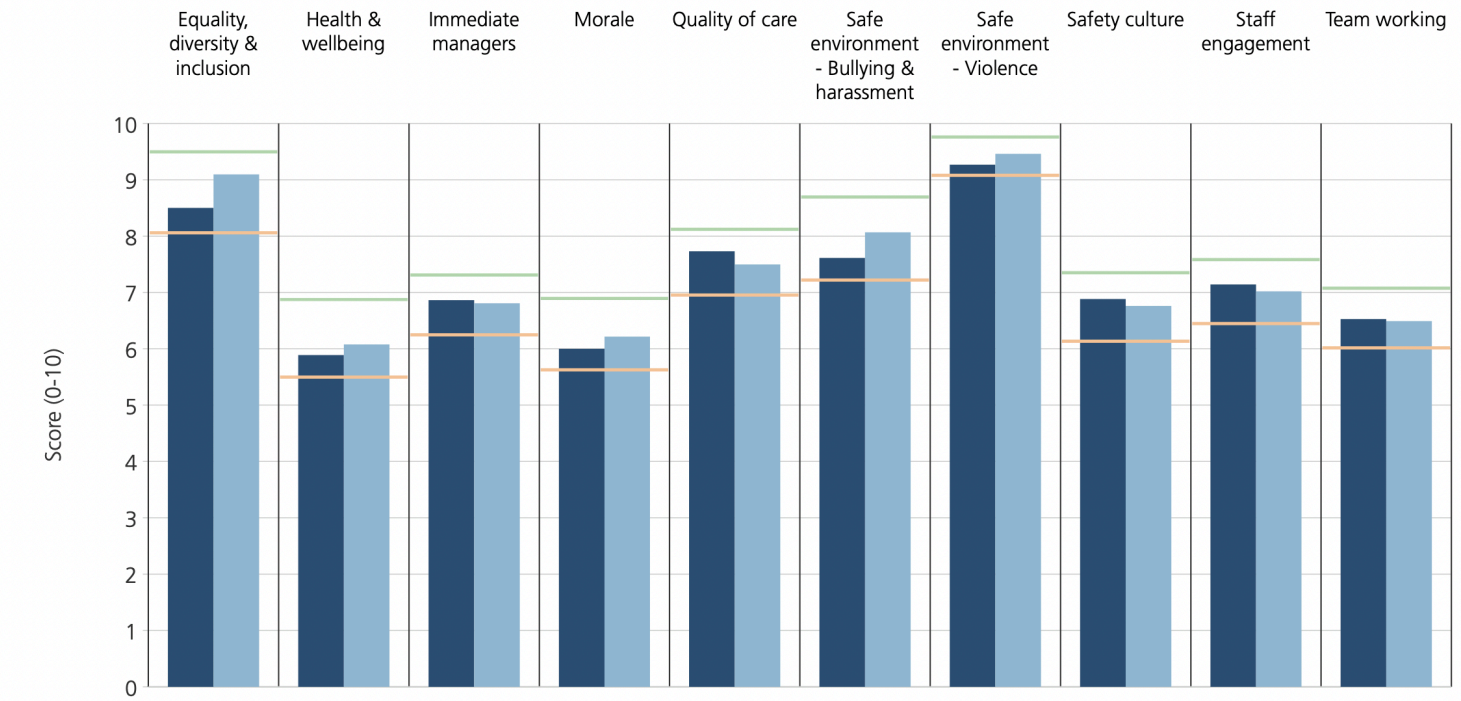
3. Overview of Theme Results

- Above average:
  - Immediate managers
  - Quality of care
  - Safety culture
  - Staff engagement
  - Team working
- Below average:
  - EDI
  - H&W
  - Morale
  - Safe environment

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	8.5	5.9	6.9	6.0	7.7	7.6	9.3	6.9	7.1	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	3,553	3,582	3,587	3,539	3,399	3,468	3,573	3,562	3,615	3,558

2019 v 2020 Theme Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.6**	2688	**8.5**	3553	Not significant
Health & wellbeing	**5.8**	2721	**5.9**	3582	Not significant
Immediate managers †	**6.9**	2725	**6.9**	3587	Not significant
Morale	**6.0**	2687	**6.0**	3539	Not significant
Quality of care	**7.8**	2532	**7.7**	3399	Not significant
Safe environment - Bullying & harassment	**7.7**	2687	**7.6**	3468	Not significant
Safe environment - Violence	**9.3**	2693	**9.3**	3573	Not significant
Safety culture	**6.9**	2710	**6.9**	3562	Not significant
Staff engagement	**7.3**	2742	**7.1**	3615	↓
Team working	**6.9**	2694	**6.5**	3558	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

London - Ranked by Theme

		2020 Results										2019 Results									
	Rank	Equality. Diversity and Inclusion	Safety Culture	Health and Wellbeing	Immediate Managers	Quality of Care	Morale	Staff Engagement	Bullying and Harrassment	Violence	Team Working	Equality. Diversity and Inclusion	Safety Culture	Health and Wellbeing	Immediate Managers	Quality of Care	Morale	Staff Engagement	Bullying and Harrassment	Violence	Team Working
Rank	Barking, Havering and Redbridge University Hospitals NHS Trust	16	17	17	16	12	17	17	15	16	15	13	10	10	9	6	12	10	11	16	7
	Barts Health NHS Trust	15	9	16	15	11	13	14	12	10	14	16	9	17	17	16	15	13	17	13	16
	Chelsea and Westminster Hospital NHS Foundation Trust	6	5	9	5	6	8	5	11	17	10	6	4	6	4	5	7	2	7	14	2
	Croydon Health Services NHS Trust	5	16	5	7	7	11	11	8	8	3	9	16	4	8	7	10	14	5	7	14
	Epsom and St Helier University Hospitals NHS Trust	1	8	4	17	16	7	9	2	2	17	2	11	3	13	13	5	11	2	3	12
	Guy's and St Thomas' NHS Foundation Trust	3	1	2	1	3	1	1	1	1	1	3	1	1	1	2	1	1	1	1	1
	Homerton University Hospital NHS Foundation Trust	11	3	12	4	1	6	7	4	3	4	10	3	14	7	4	9	7	3	2	8
	Imperial College Healthcare NHS Trust	12	7	8	11	4	4	4	6	7	7	4	6	9	3	3	3	5	8	8	5
	King's College Hospital NHS Foundation Trust	17	15	18	13	17	15	16	17	14	16	15	15	18	14	18	16	18	16	17	17
	Kingston Hospital NHS Foundation Trust	2	2	3	6	5	3	3	3	11	8	1	2	5	2	8	2	3	6	9	3
	Lewisham and Greenwich NHS Trust	10	11	13	8	14	12	15	13	9	6	5	12	8	6	10	4	12	10	12	4
	London North West University Healthcare NHS Trust	14	12	10	14	8	14	12	14	15	13	17	13	11	15	11	18	16	13	15	15
	North Middlesex University Hospital NHS Trust	18	13	15	10	2	16	13	18	18	9	18	8	15	11	1	14	8	18	18	6
	Royal Free London NHS Foundation Trust	9	10	7	9	9	5	6	16	5	11	11	14	13	10	14	11	9	15	11	11
	St George's University Hospitals NHS Foundation Trust	8	14	6	12	15	9	10	5	13	12	12	17	16	18	17	17	17	9	10	18
	The Hillingdon Hospitals NHS Foundation Trust	13	18	11	18	18	18	18	9	12	18	8	18	2	16	15	13	15	4	5	13
	University College London Hospitals NHS Foundation Trust	4	4	1	3	10	2	2	10	6	2	14	7	7	12	12	6	4	14	6	10
	Whittington Health NHS Trust	7	6	14	2	13	10	8	7	4	5	7	5	12	5	9	8	6	12	4	9

Areas for Improvement - Learning across London

		2020 Results										2019 Results									
	Score	Equality. Diversity and Inclusion	Safety Culture	Health and Wellbeing	Immediate Managers	Quality of Care	Morale	Staff Engagement	Bullying and Harrassment	Violence	Team Working	Equality. Diversity and Inclusion	Safety Culture	Health and Wellbeing	Immediate Managers	Quality of Care	Morale	Staff Engagement	Bullying and Harrassment	Violence	Team Working
Score	Barking, Havering and Redbridge University Hospitals NHS Trust	8.20	6.51	5.64	6.54	7.60	5.71	6.79	7.54	9.28	6.32	8.46	6.70	5.67	6.82	7.71	5.90	7.02	7.59	9.32	6.64
	Barts Health NHS Trust	8.29	6.71	5.68	6.58	7.61	5.82	6.92	7.61	9.34	6.34	8.32	6.71	5.45	6.56	7.53	5.76	6.95	7.40	9.36	6.43
	Chelsea and Westminster Hospital NHS Foundation Trust	8.50	6.89	5.89	6.86	7.73	6.00	7.14	7.61	9.27	6.53	8.59	6.93	5.78	6.90	7.78	5.98	7.29	7.65	9.34	6.86
	Croydon Health Services NHS Trust	8.51	6.52	5.98	6.82	7.70	5.95	6.99	7.71	9.40	6.63	8.55	6.52	5.83	6.83	7.66	5.91	6.94	7.72	9.43	6.48
	Epsom and St Helier University Hospitals NHS Trust	8.77	6.72	6.01	6.54	7.56	6.02	7.01	7.84	9.50	6.27	8.71	6.65	5.86	6.69	7.59	6.01	7.02	7.84	9.48	6.51
	Guy's and St Thomas' NHS Foundation Trust	8.56	7.16	6.18	6.95	7.81	6.31	7.46	7.88	9.53	6.78	8.69	7.17	5.99	6.95	7.85	6.32	7.51	7.91	9.56	6.88
	Homerton University Hospital NHS Foundation Trust	8.38	6.99	5.82	6.87	7.85	6.03	7.13	7.78	9.47	6.60	8.50	6.96	5.54	6.87	7.78	5.93	7.08	7.76	9.52	6.64
	Imperial College Healthcare NHS Trust	8.38	6.80	5.89	6.69	7.80	6.08	7.16	7.74	9.41	6.55	8.61	6.81	5.69	6.92	7.82	6.04	7.21	7.65	9.42	6.67
	King's College Hospital NHS Foundation Trust	8.18	6.54	5.50	6.63	7.45	5.77	6.85	7.51	9.30	6.29	8.40	6.53	5.26	6.68	7.37	5.71	6.79	7.45	9.25	6.38
	Kingston Hospital NHS Foundation Trust	8.70	7.03	6.04	6.84	7.73	6.17	7.25	7.82	9.33	6.54	8.71	7.02	5.82	6.93	7.64	6.13	7.26	7.69	9.42	6.79
	Lewisham and Greenwich NHS Trust	8.43	6.68	5.77	6.81	7.59	5.91	6.87	7.60	9.39	6.57	8.60	6.65	5.69	6.87	7.61	6.02	7.01	7.60	9.38	6.73
	London North West University Healthcare NHS Trust	8.30	6.65	5.88	6.60	7.70	5.80	6.97	7.59	9.29	6.41	8.31	6.63	5.65	6.61	7.61	5.66	6.89	7.50	9.34	6.45
	North Middlesex University Hospital NHS Trust	8.06	6.63	5.73	6.71	7.83	5.73	6.96	7.22	9.08	6.54	8.30	6.73	5.53	6.77	7.89	5.87	7.08	7.34	9.18	6.67
	Royal Free London NHS Foundation Trust	8.43	6.70	5.89	6.74	7.70	6.05	7.14	7.51	9.43	6.43	8.48	6.62	5.56	6.78	7.59	5.90	7.04	7.45	9.39	6.53
	St George's University Hospitals NHS Foundation Trust	8.45	6.62	5.94	6.64	7.56	5.97	7.00	7.75	9.31	6.41	8.46	6.51	5.51	6.50	7.49	5.71	6.86	7.61	9.40	6.37
	The Hillingdon Hospitals NHS Foundation Trust	8.33	6.25	5.83	6.46	7.35	5.65	6.61	7.70	9.32	6.26	8.56	6.47	5.86	6.60	7.57	5.87	6.89	7.74	9.46	6.50
	University College London Hospitals NHS Foundation Trust	8.54	6.99	6.19	6.88	7.69	6.21	7.35	7.69	9.42	6.70	8.45	6.78	5.70	6.76	7.61	5.98	7.21	7.48	9.44	6.60
	Whittington Health NHS Trust	8.50	6.82	5.77	6.88	7.60	5.96	7.10	7.73	9.46	6.59	8.57	6.82	5.57	6.88	7.62	5.93	7.10	7.51	9.47	6.62

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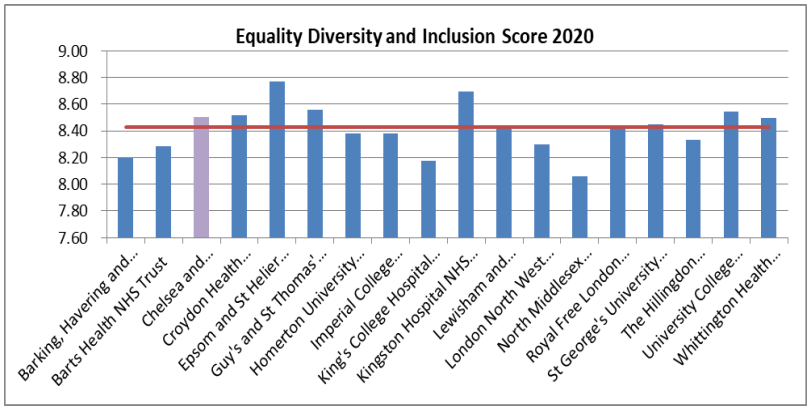
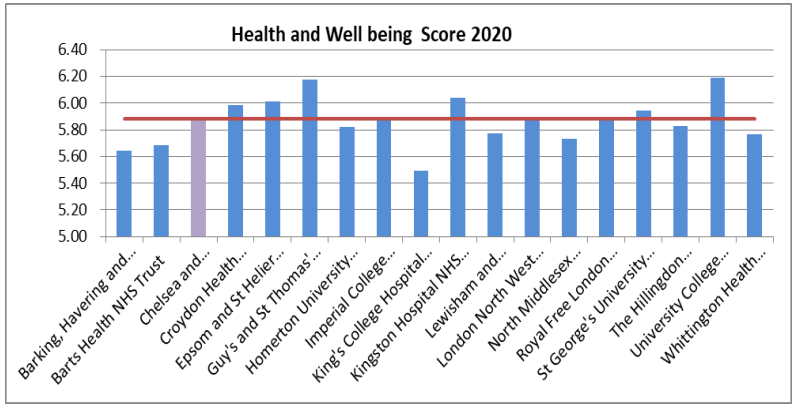
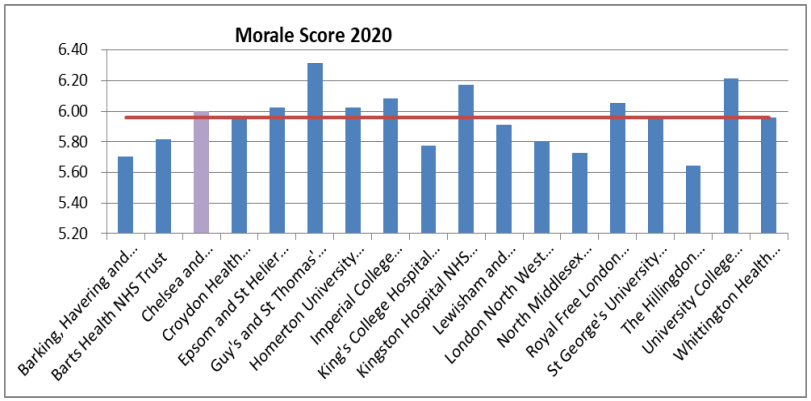
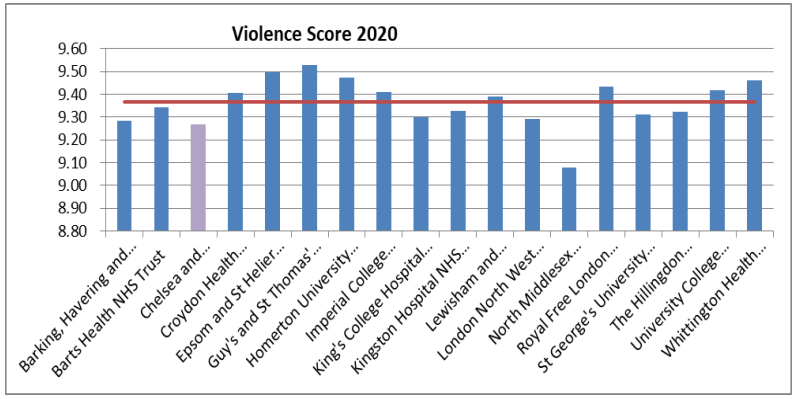
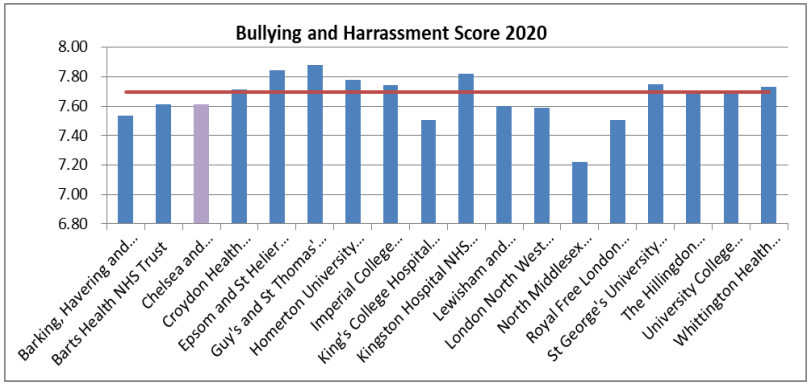
Our Key Areas for Improvement











- What can we learn from high scoring London Trusts in areas we are below average?
- What resources are in place in these organisations?

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4. The Covid-19 pandemic: Changes to working life @ Chelwest

Working in Covid-19 specific areas

56.6%

of staff had worked on a Covid-19 specific ward or area at any time (q20a) – considerably higher than the **Acute/Acute & Community Trusts average (39.3%)**

Shielding

13.0%

of staff had been shielding, either for themselves and/or for a member of their household (q20d) – **Acute/Acute & Community Trusts (10.1%)**

- 8.9% shielding for themselves
- 4.1% shielding for a member of their household

Redeployment

31.8%

of staff had been redeployed due to the Covid-19 pandemic (q20b) – considerably higher than the **Acute/Acute & Community Trusts average (20.6%**

Working remotely / from home

20.4%

of staff had been required to work remotely / from home (q20c) – considerably higher than the **Acute/Acute & Community Trusts average (26.2%)**

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5. Health & wellbeing: theme score & contributing questions

Theme score: 5.9, lower than the Acute/Acute & Community Trusts average (6.1)

Organisational work on health & wellbeing

55.5%

of staff were satisfied with the opportunities for flexible working (q5h)

- This measure has steadily improved since 2016 (53.5%) and matches the **Acute/Acute & Community Trusts average (55.5%)**

28.8%

said ChelWest had definitely takes positive action on health & wellbeing (q11a)

- This measure has slightly improved since 2019 (28.4%) but remains lower than the **Acute/Acute & Community Trusts average (31.7%).**

Staff health

46.2%

reported feeling unwell as a result of work related stress in the last 12 months (q11c)

- This measure has seen a marked increase this year (41.4% in 2019) and has increased steadily since 2016 (38.5%)
- Overall, increases were sharpest in **Acute/Acute & Community Trusts (46.6%)**

32.4%

experienced musculoskeletal problems (MSK) as a result of work activities in the last 12 months (q11b)

- This is slightly higher than last year (31.4% in 2019) and has increased steadily since 2016 (27.5%) and is higher than the **Acute/Acute & Community Trusts (28.8%)**

Working when ill

47.7%

said they have gone to work in the last three months, despite not feeling well enough to perform their duties (q11d). This is notably fewer than in previous years (59.2% in 2019) but higher than the **Acute/Acute & Community Trusts (average 46.6%)**

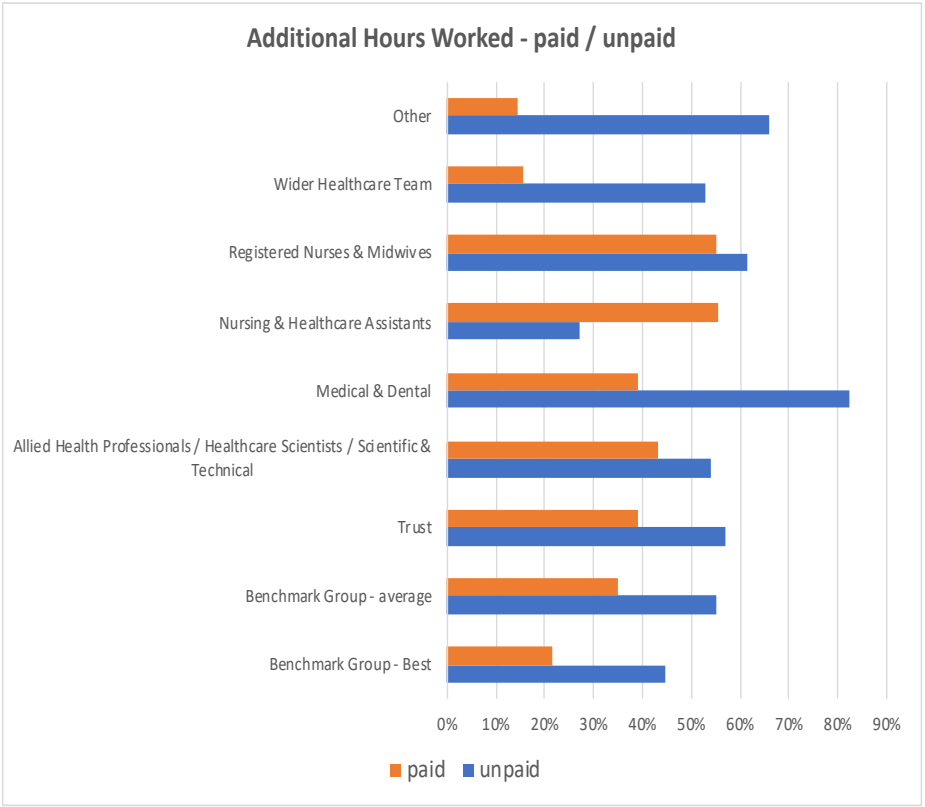
Working additional hours

What proportion of NHS staff work additional unpaid hours (q10c)?

Over half of staff continue to work additional unpaid hours on a weekly basis (57.0%); this proportion declined between 2018 (61.6%) and 2019 (60.0%) and has continued to decline this year – but remains higher than the **Acute/Acute & Community Trusts average (54.9%)**

Nationally there has been a steady year on year decline in this measure over several years, with the proportion falling from 59.4% in 2016.

In contrast 39.2% of staff reported that they had worked additional paid, higher in comparison that the benchmark group – **Acute/Acute & Community Trusts (35.0%).**



6. Morale: theme score & contributing questions

Theme score: 6.0, lower than the Acute/Acute & Community Trusts average (6.2)

Stress factors

Relationships

70.2% said they receive the respect they deserve from their colleagues (q4j) - **Acute/Acute & Community Trusts average 70.4%)**

71.1% said their immediate manager encourages them at work (q8a) - **Acute/Acute & Community Trusts average 69.2%)**

45.2% said relationships at work are strained (q6c) - **Acute/Acute & Community Trusts average 45.5%)**

Ways of working

50.4% are involved in deciding on changes introduced that affect their work (q4c) - **Acute/Acute & Community Trusts average 50.3%)**

51.2% often or always have a choice in deciding how to do their work (q6b) - **Acute/Acute & Community Trusts average 54.3%)**

22.8% never or rarely have unrealistic time pressures (q6a) - **Acute/Acute & Community Trusts average 24.4%)**

Thinking about leaving

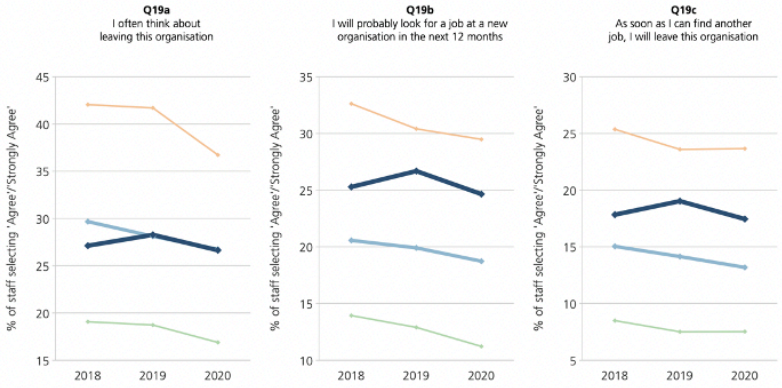
The following percentage of staff said they…

26.6% …often think about leaving their organisation (q19a)

24.9% …will probably look for a job at a new organisation in the next 12 months (q19b)

17.5% …will leave their organisation as soon as they can find another job (q19c)

All three measures have **improved year on year since 2018**:



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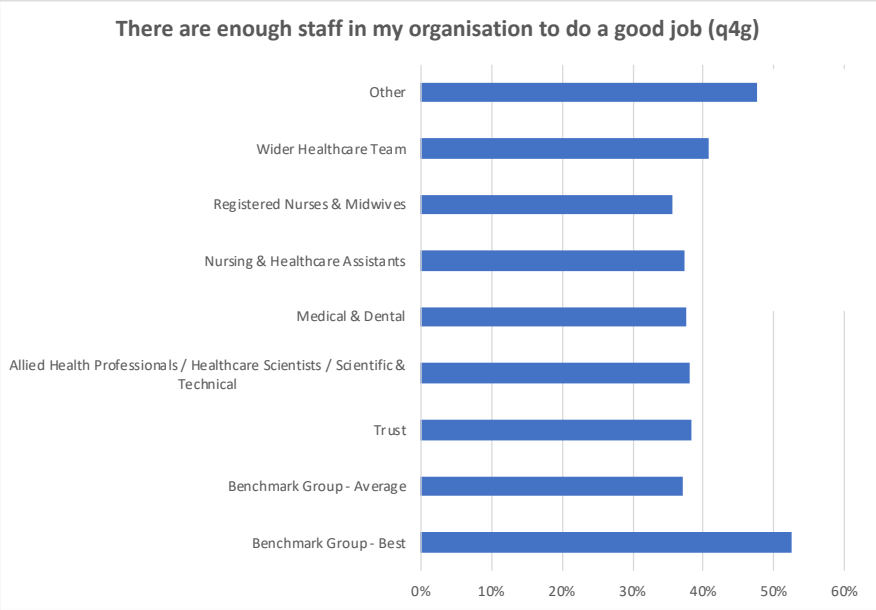
Workloads and resources

Of all staff:

38.2% agree that there are enough staff at the Trust for them to do their job properly, very similar relatively static since 2019 (38.1) (q4g) - **Acute/Acute & Community Trusts average (37.0%)**



52.8% agree that they are able to meet all the conflicting demands on their time at work, down from 54.2% in 2019 (q4e) - **Acute/Acute & Community Trusts average (47.6%)**

61.7% feel they have adequate materials, supplies and equipment to do their work, above average when compared to the Acute/Acute & Community Trusts benchmark group (58.5%) (q4f) **Acute/Acute & Community Trusts benchmark group (58.5%)**

7. Staff engagement: theme score & contributing questions

Theme score: 7.1, higher than the Acute/Acute & Community Trusts average (7.0)

Ability to contribute to improvements

60.0% said they often or always look forward to going to work (q2a) - **Acute/Acute & Community Trusts average (58.5%)**

73.0% said they are often or always enthusiastic about their job (q2b) - 2.9% down on 2019 (75.9%) – slightly lower than the **Acute/Acute & Community Trusts average (73.1%)**

75.8% said time often or always passes quickly when they are working (q2c) (2019: 79.2%) - **Acute/Acute & Community Trusts average (76.0%)**

Motivation

72.1% said they have frequent opportunities to show initiative in their role (q4a) - **Acute/Acute & Community Trusts average (71.9%)**

71.8% said they are able to make suggestions to improve the work of their team / department (q4b) - **Acute/Acute & Community Trusts average (73%)**

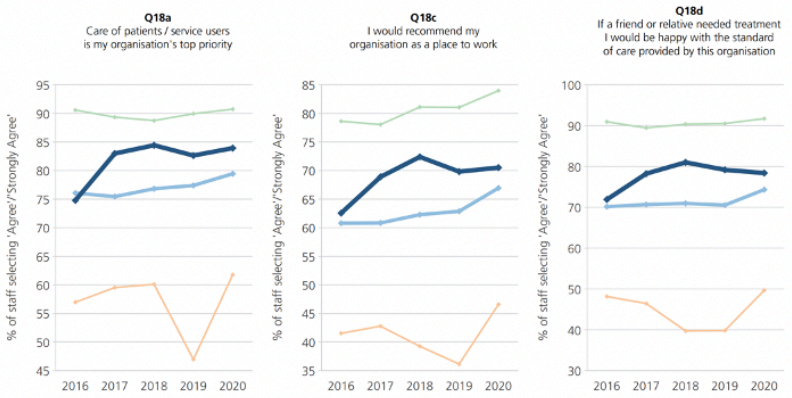
56.5% said they are able to make improvements happen in their area of work (q4d) - **Acute/Acute & Community Trusts average (55.4%)**

Recommendation of their organisation

70.7% said they would recommend their organisation as a place to work (q18c) - **Acute/Acute & Community Trusts (66.9%)**

78.4% said they would be happy with the standard of care provided by their organisation for a friend or relative needing treatment (q18d) - **Acute/Acute & Community Trusts (74.3%)**

83.9% said that care of patients / service users is their organisation's top priority (q18a) - **Acute/Acute & Community Trusts (79.4%)**



8. Immediate managers: theme score & contributing questions

Theme score: 6.9, slightly higher than the Acute/Acute & Community Trusts average (6.8)

Support & feedback

69.9% of staff were satisfied with the support they got from their immediate manager (q5b) – higher than the **Acute/Acute & Community Trusts average (69.1%)**

62.4% of staff said that their immediate manager gave them clear feedback on their work (q8c) – higher than the **Acute/Acute & Community Trusts average (60.6%)**

Inclusion & motivation

The following percentage of staff said that their manager:

69.1% …takes a positive interest in their health and well-being (q8f) – slightly lower than the **Acute/Acute & Community Trusts average (69.2%)**

56.7% …asks for their opinion before making decisions that affect their work (q8d) – higher than the **Acute/Acute & Community Trusts average (54.5%)**

73.6% …values their work (q8g) – higher than the **Acute/Acute & Community Trusts average (71.8%)**

9. Team working: theme score & contributing questions

Theme score: **6.5**, matching the Acute/Acute & Community Trusts average (6.5)

Team objectives and effectiveness

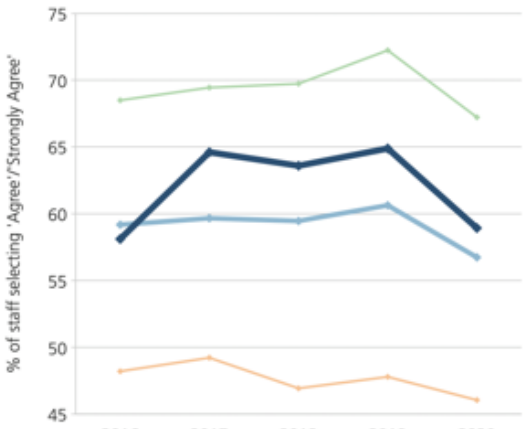
The following percentage of staff said that the team they work in…

70.2% …has a set of shared objectives (q4h) (2019: 74.3%) – slightly higher than the **Acute/Acute & Community Trusts average (69.1%)**

58.9% …often meets to discuss the team's effectiveness (q4i) (2019: 64.9%) – lower than the the **Acute/Acute & Community Trusts average (60.6%)**

It is worth noting that across the NHS both these measures declined amongst staff working in Acute/Acute & Community Trusts this year.

Q4i
The team I work in often meets to discuss the team's effectiveness



	2016	2017	2018	2019	2020
Best	68.5%	69.4%	69.7%	72.2%	67.2%
Your org	58.1%	64.6%	63.6%	64.9%	58.9%
Average	59.2%	59.7%	59.5%	60.6%	56.7%
Worst	48.2%	49.2%	46.9%	47.8%	46.1%

10. Equality, diversity & inclusion: theme score & contributing questions

Theme score: 8.5, lower than the Acute/Acute & Community Trusts average (9.1)

Equal opportunities

76.6%

of staff felt their organisation acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (q14)

- Below average again this year (84.9%) and significantly lower than the **Acute/Acute & Community Trusts average (84.9%)** again this year, there has been a. 3.3% drop in this score since 2019 (79.9%) with a downward trend since 2016

74.6%

of staff with a long term physical or mental health condition or illness* said their employer had made adequate adjustments to enable them to carry out their work (q26b), a very similar score to 2019 (74.7%) and slightly lower than the **Acute/Acute & Community Trusts average (75.6%)**

* Defined as staff 'with a disability or long term condition' prior to 2020

Discrimination

The following percentage of staff reported personally experiencing discrimination at work in the last 12 months:

14.1%

...from patients / service users, their relatives or other members of the public (q15a)

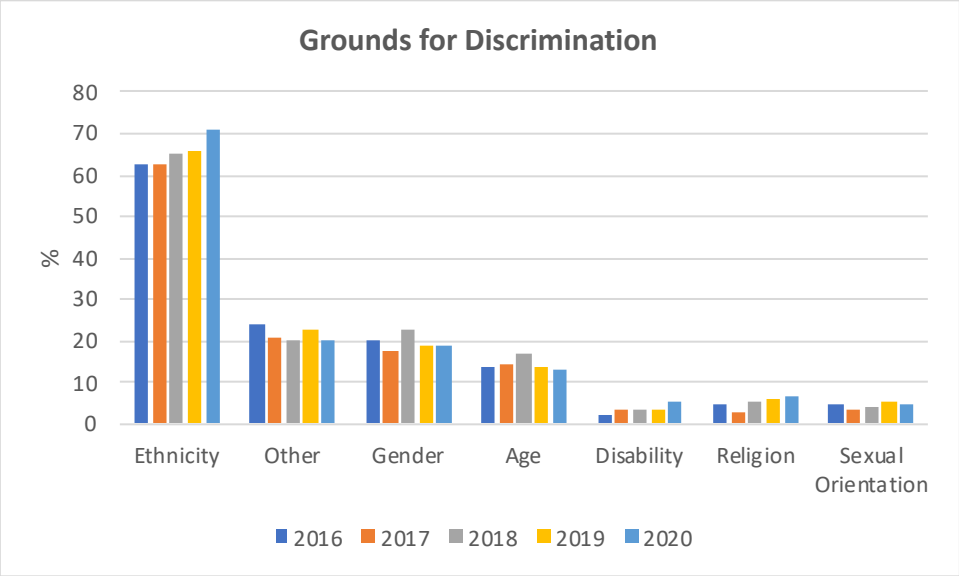
- This is a slight increase since 2019 (13.9%) and higher than the **Acute/Acute & Community Trusts average (6.2%)**

11.0%

...from managers or colleagues (q15b) – an increase since 2019 (10.4%) and is now at its highest level since 2016 (8.8%), and higher than the **Acute/Acute & Community Trusts average (7.9%)**,

On what grounds is discrimination experienced?

In the 2020 survey **25%** of staff reported experiencing discrimination at work (q15a & b). The graph below shows on what basis staff claimed to have experienced discrimination.

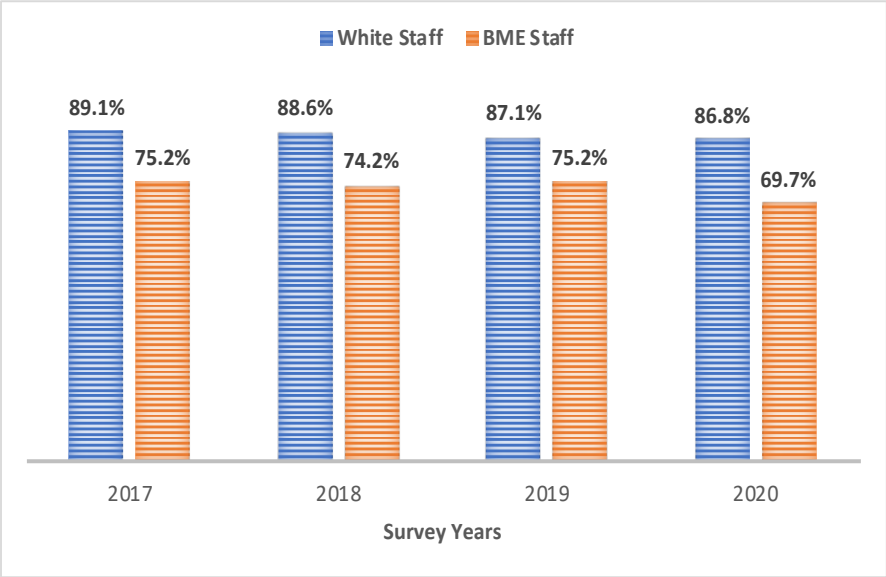


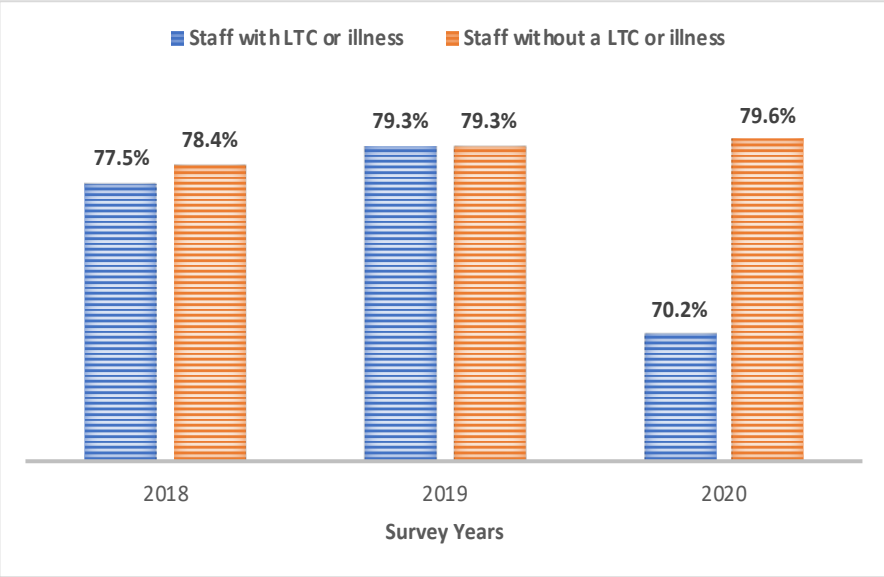
Ethnic background continues to be the most common reason cited and was mentioned by **71.1%** of staff who claimed to have experienced discrimination at work.

Staff views on whether Chelwest provides equal opportunities for career progression / promotion have this year been comparable when viewed in the context of both ethnicity and whether staff had long-lasting health conditions or illnesses (q14) – both remain below average:

69.7% of **BME staff** said their organisation provides equal opportunities in contrast with **86.8%** of **white staff** - 87.7% and 72.5% respectively in **Acute/Acute & Community Trusts**.

70.2% of **staff with a long-lasting health condition or illness** said their organisation provides equal opportunities, compared to **78.5%** of **staff without a long last health condition or illness** – 79.6% and 86.3% respectively in **Acute/Acute & Community Trusts**.





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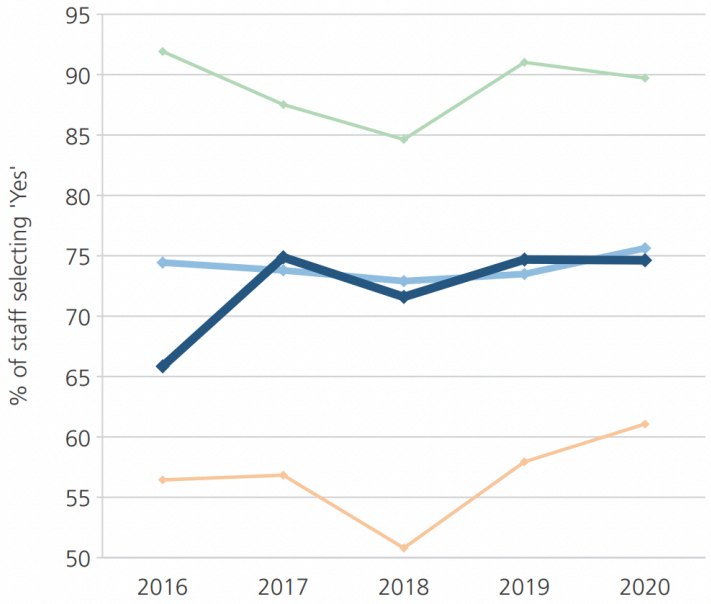
Has your employer made adequate adjustments to enable you to carry out your work? (q26b)

74.6% of staff with long term physical or mental health conditions or illnesses felt that their employer made adequate adjustments to enable them to carry out their work - lower than the **Acute/Acute & Community Trusts average (75.6%)**

Q26b
Has your employer made adequate adjustment(s) to enable you to carry out your work?



	2016	2017	2018	2019	2020
Best	91.9%	87.5%	84.6%	91.0%	89.7%
Your org	65.8%	74.9%	71.6%	74.7%	74.6%
Average	74.4%	73.8%	72.9%	73.5%	75.6%
Worst	56.4%	56.8%	50.8%	57.9%	61.1%

11. Quality of care: theme score & contributing questions

Theme score: 7.7, slightly higher than the Acute/Acute & Community Trusts average (7.5)

Quality of care

85.3% of staff were satisfied with the quality of care they give to patients / service users (q7a)

- This is a slight increase since 2019 (84.5%) and above **Acute/Acute & Community Trusts average (82.0%)**

91.3% felt their role makes a difference to patients / service users (q7b) (2019: 91.2%) – higher than the **Acute/Acute & Community Trusts average (89.7%)**

75.3% said they are able to deliver the care they aspire to (q7c)

- This is **5%** above the **Acute/Acute & Community Trusts average (70.0%)**

12. Safety Culture: theme score & contributing questions

Theme score: 6.9, slightly higher than the Acute/Acute & Community Trusts average (6.8)

Action on reported incidents

The following percentage of staff said that their organisation…

61.9% …treats staff who are involved in an error, near miss or incident fairly (q16a) slightly higher than the **Acute/Acute & Community Trusts average (61.4%)**

74.5% …takes action to ensure that reported errors, near misses or incidents do not happen again (q16c) higher than the **Acute/Acute & Community Trusts average (72.7%)**

79.0% …acts on concerns raised by patients / service users (q18b) – higher than the **Acute/Acute & Community Trusts average (74.0%)**

65.8% …gives them feedback about changes made in response to reported errors, near misses and incidents (q16d) - higher than the **Acute/Acute & Community Trusts average (61.9%)**

Reporting incidents

The following percentage of staff said they …

73.5% …would feel secure raising concerns about unsafe clinical practice (q17b) – higher than the **Acute/Acute & Community Trusts average (71.8%)**

61.6% …were confident that their organisation would address their concern (q17c) – higher than the **Acute/Acute & Community Trusts average (59.1%)**

Safety of staff

New questions for 2020 asked whether staff feel **safe in their work** (Q18e) and **safe to speak up about anything that concerns them in their organisation** (Q18f).

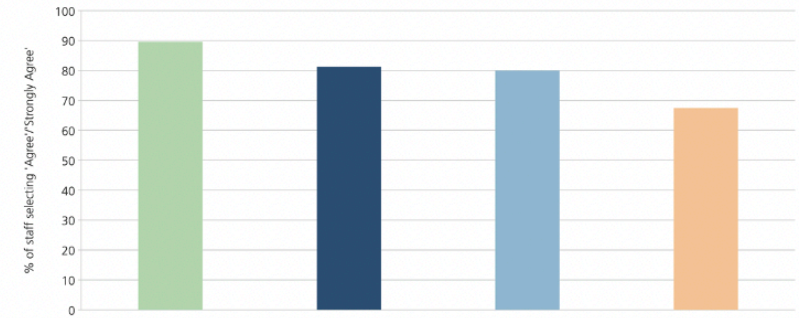
Feeling safe in my work

81.2% of staff agreed that they feel safe in their work (q18e) – higher than the **Acute/Acute & Community Trusts average (80.0%)**

Survey Coordination Centre

2020 NHS Staff Survey Results > Question results > Your organisation > Q18e > I feel safe in my work

NHS England



Best	89.6%
Your org	81.2%
Average	80.0%
Worst	67.5%
Responses	3,534

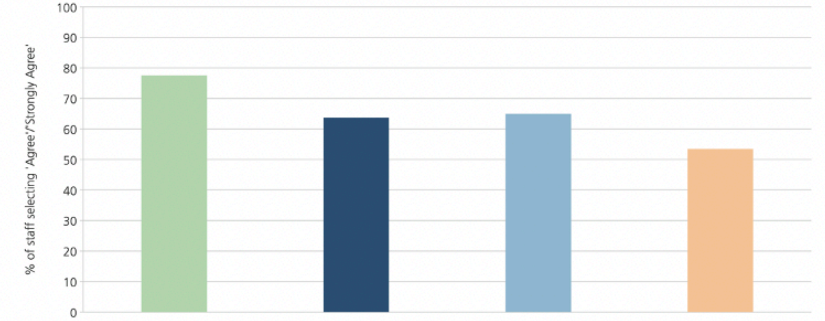
Feeling safe to speak up

63.7% of staff agreed that they **feel safe to speak up** about anything that concerns them in their organisation (q18f) – lower than the **Acute/Acute & Community Trusts average (65%)**

Survey Coordination Centre

2020 NHS Staff Survey Results > Question results > Your organisation > Q18f > I feel safe to speak up about anything that concerns me in this organisation

NHS England



Best	77.6%
Your org	63.7%
Average	65.0%
Worst	53.4%
Responses	3,538

13. Safe environment – Bullying & harassment: theme score & contributing questions

Theme score: 7.6, lower than the Acute/Acute & Community Trusts average (8.1)

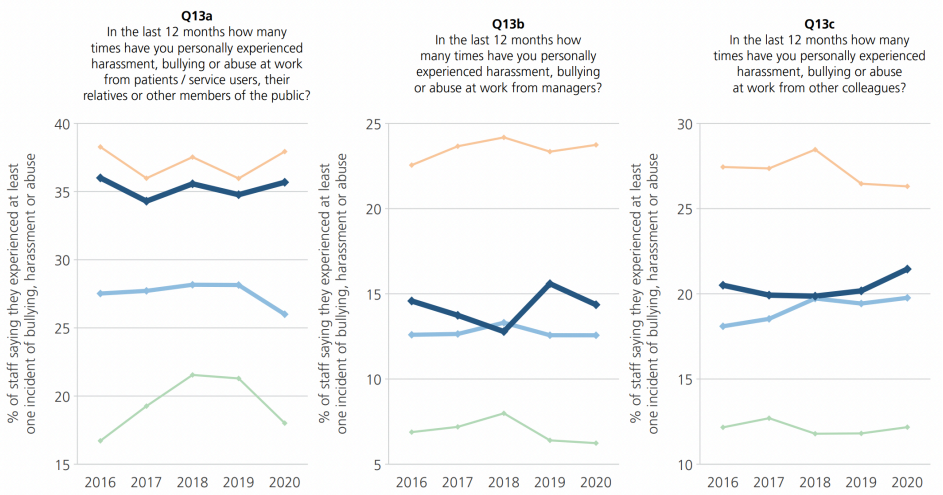
Staff experiencing bullying & harassment

The following percentages of staff experienced at least one incident of bullying, harassment or abuse in the last 12 months:

35.7% ...from patients / service users, their relatives or other members of the public (q13a) – higher the **Acute/Acute & Community Trusts average (26.0%),**

14.4% ...from managers (q13b) – higher than the **Acute/Acute & Community Trusts average (12.6%)**

21.5% ...from other colleagues (q13c) – higher than the **Acute/Acute & Community Trusts average (19.8%)**



Q13a	2016	2017	2018	2019	2020
Worst	38.3%	36.0%	37.5%	36.0%	37.9%
Your org	36.0%	34.3%	35.6%	34.8%	35.7%
Average	27.5%	27.7%	28.2%	28.1%	26.0%
Best	16.7%	19.3%	21.5%	21.3%	18.0%

Q13b	2016	2017	2018	2019	2020
Worst	22.6%	23.7%	24.2%	23.3%	23.7%
Your org	14.6%	13.7%	12.8%	15.6%	14.4%
Average	12.6%	12.6%	13.3%	12.6%	12.6%
Best	6.9%	7.2%	8.0%	6.4%	6.2%

Q13c	2016	2017	2018	2019	2020
Worst	27.4%	27.4%	28.5%	26.5%	26.3%
Your org	20.5%	19.9%	19.9%	20.2%	21.5%
Average	18.1%	18.5%	19.7%	19.4%	19.8%
Best	12.2%	12.7%	11.8%	11.8%	12.2%

14. Safe environment – **Violence:** theme score & contributing questions

Theme score: **9.3**, lower than the Acute/Acute & Community Trusts average (9.5)

Staff experiencing physical violence

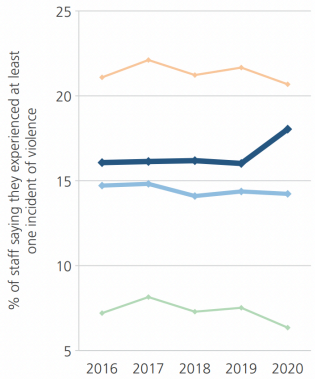
The following percentage of staff experienced at least one incident of physical violence in the last 12 months:

18.0% ...from patients / service users, their relatives or other members of the public (q12a) - higher than the **Acute/Acute & Community Trusts average (14.2%)**

1.0% ... from managers (q12b) (2019: 1.1%) - higher than the **Acute/Acute & Community Trusts average (0.5%)**

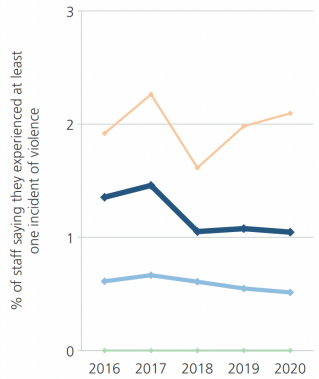
3.0% ...from other colleagues (q12c), higher than the **Acute/Acute & Community Trusts average (1.4%)**

Q12a
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



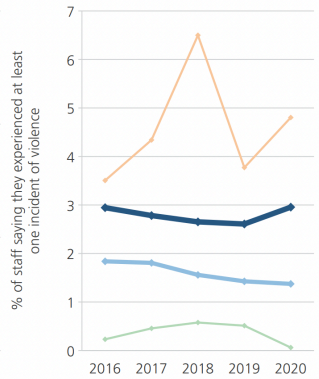
	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your org	16.1%	16.1%	16.2%	16.0%	18.0%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

Q12b
In the last 12 months how many times have you personally experienced physical violence at work from managers?



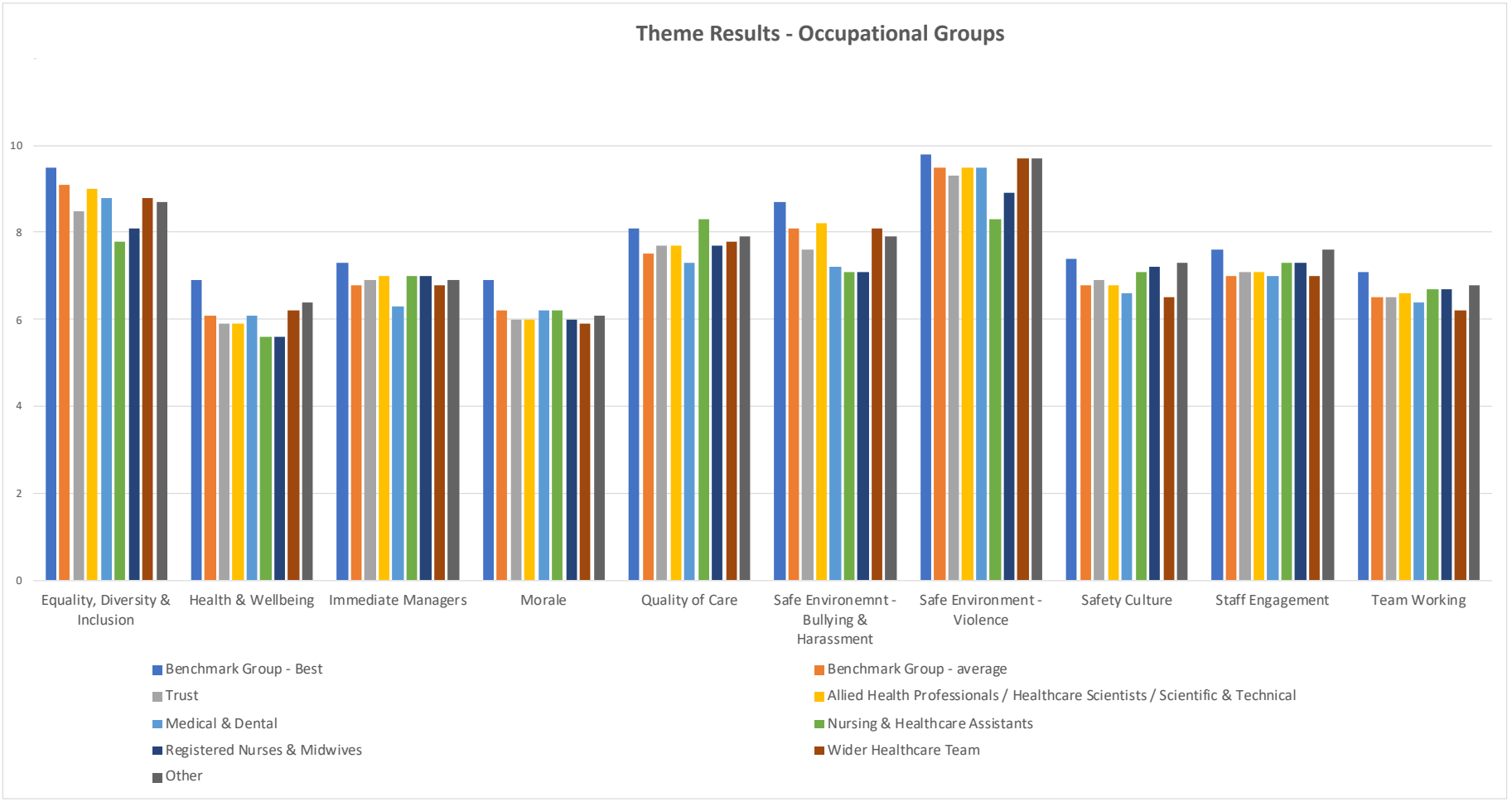
	2016	2017	2018	2019	2020
Worst	1.9%	2.3%	1.6%	2.0%	2.1%
Your org	1.4%	1.5%	1.1%	1.1%	1.0%
Average	0.6%	0.7%	0.6%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

Q12c
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?

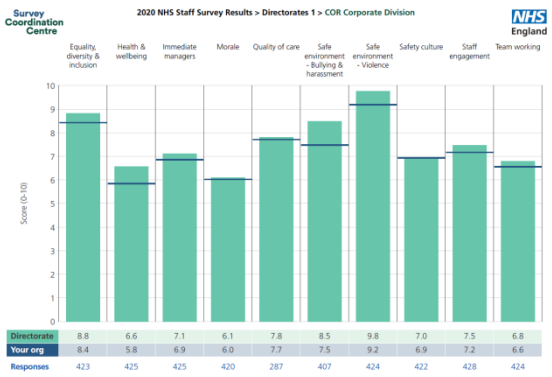


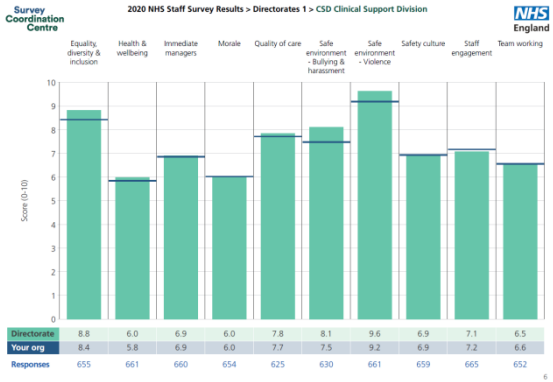
	2016	2017	2018	2019	2020
Worst	3.5%	4.3%	6.5%	3.8%	4.8%
Your org	2.9%	2.8%	2.7%	2.6%	3.0%
Average	1.8%	1.8%	1.6%	1.4%	1.4%
Best	0.2%	0.5%	0.6%	0.5%	0.1%

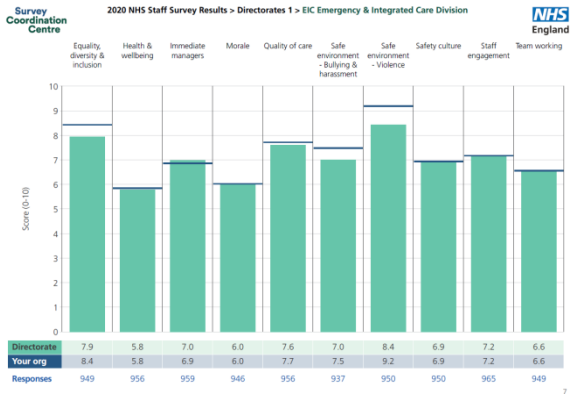
15. Themes by Occupational Group

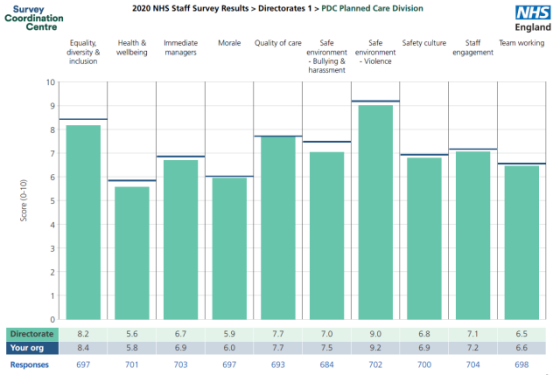


16. Themes by Division









Chelsea and Westminster Hospital NHS
NHS Foundation Trust

17. Trust Response – 4 key priorities

Equality, Diversity & Inclusion

- 3 year plan – Year 2 actions focused on embedding managers commitment to EDI, developing influential staff networks with a voice, fairness and disciplinary, grievance, performance management processes, fairness of recruitment and progression opportunities, addressing the negative experiences of staff from under presented groups of B&H, embedding a culture of compassion and inclusion.

Health & Wellbeing

- 3 year business case – Year 1 focused on practical wellbeing offers and now rest and recovery and establishing new programmes and evaluating uptake and feedback to plan year 2.

Safe Environment

- Safety Group re-focused and led by DDN Planned Care and newly published Violence Standards for all Trusts to embed.
- Bullying & Harassment actions featured across EDI and leadership development plans focused on behavioural framework, just culture and civility and respect.

Morale

- Staff Thank-you event in response to Covid
- Current reward and recognition schemes, Monthly PROUD Awards, Long Service Awards, staff thank-you cards, annual awards ceremonies, external awards and recognition, to be bought together under one programme, listening to what staff value

17. Divisional Response – pledges of commitment

- During April, clinical divisions and corporate services are in the process of developing **pledges of commitment** at service response to the Staff Survey 2020 results.
- This includes reviewing the Staff Survey results but also other existing intelligence on employee experience, such as compliments and Datix`, local exit data or holding dedicated listening events
- Each pledge will articulate the service`s commitment **to improving the employee experience** in their teams **over the next 12 months** with **SMART actions and measurable outcomes** to review progress over the course of the year
- Each division selects the team with the **best pledge of commitment** in **May** once all pledges have been submitted
- Each division selects the team with the best progress on **delivery on their pledge of commitment** in **September**
- All pledges will be triangulated centrally by the HR business partnering team to facilitate collaboration and learning between difference services
- In addition to tracking progress on divisional pledges, the Trust will also be able to review performance by triangulating data from workforce performance data and the employee experience surveys (joiners, leavers and pulse)

18. Timeline for action

1	Communicate results with staff and key stakeholders	Mar 21
2	Develop pledges of commitment at divisional level	Apr 21
3	Staff engagement sessions	May 21
4	“You said … We did” action plan at Trust level	Jun 21
5	“You said … We did” communicate key themes + quick wins	Jul 21
6	“You said … We did” communicate key themes + quick wins	Aug 21
7	“You said … We did” communicate key themes + quick wins	Sep 21
8	2021 Staff Survey	Oct 21

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	2.9/May/21
REPORT NAME	Public Health at CWFT: priority-setting for 2021/22 including Applied Research Collaboration NWL annual update report
AUTHOR	Sophie Coronini-Cronberg, Public Health Consultant
LEAD	Roger Chinn, Chief Medical Officer
PURPOSE	The intended outcomes of this paper are for the Board to note: 1. Summarise high-level outcomes achieved by the Public Health Team in 2020; 2. The Trust's Public Health priorities for 2021/22.
REPORT HISTORY	Executive Management Board, 14 April 2021
SUMMARY OF REPORT	The public health team has had a very successful year (2020/21), including: delivery of commissioned health improvement programmes; generating significant income; supporting the COVID-19 response; delivering innovation and research outputs; as well as raising the visibility of CWFT's as an organisation committed to population health improvement, including peer-reviewed research outputs. Meanwhile, the national population health agenda – through the development of integrated Care Systems, COVID recovery and delivery of the NHS Long-Term plan as well as public consultations such as "Working Together to Improve Health and Social Care for all" all call for a population health approach. Bringing together the system priorities and public health team's expertise, the Executive Management Board has agreed four public health priorities be adopted for 2021/22.
KEY RISKS ASSOCIATED	As above/below.
FINANCIAL IMPLICATIONS	The Public Health Programme is supported by a number of external funding streams for projects such as the oral health and the Health Inequalities Research Fellow. In addition, some activity is supported by NIHR Applied Research Collaboration North West London which is hosted by the Trust.
QUALITY IMPLICATIONS	COVID-19 has renewed the national focus on reducing inequalities – both among patients and staff. Narrowing the inequality gap is linked with improved service quality. All NHS Organisations must now have a nominated

	Executive-Level lead for Inequalities. Public health generally is well-placed to lead this agenda, and the team at CWFT specifically has recently received national recognition for some if its work particularly around health inequalities.
EQUALITY & DIVERSITY IMPLICATIONS	A Public Health approach supports the reduction of health inequalities – whether of access, outcomes or experience. The anticipated reduction in public health resources will have a knock-on effect on the range and level of health and wellbeing inequalities that can be mitigated, both for patients and staff.
LINK TO OBJECTIVES	Public health work programmes particularly supported following corporate objectives (2020/21): • Deliver high quality patient centred care [e.g. Equitable COVID-Recovery planning; Oral health programme] • Be the employer of choice [e.g. building the public health knowledge and skills of the Trust's workforce; Public Health specialty training location] • Effective use of resources [eg directing our use of resource to those in need]
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Public Health at CWFT: Review of 2020/21, and priority-setting for 2021/22

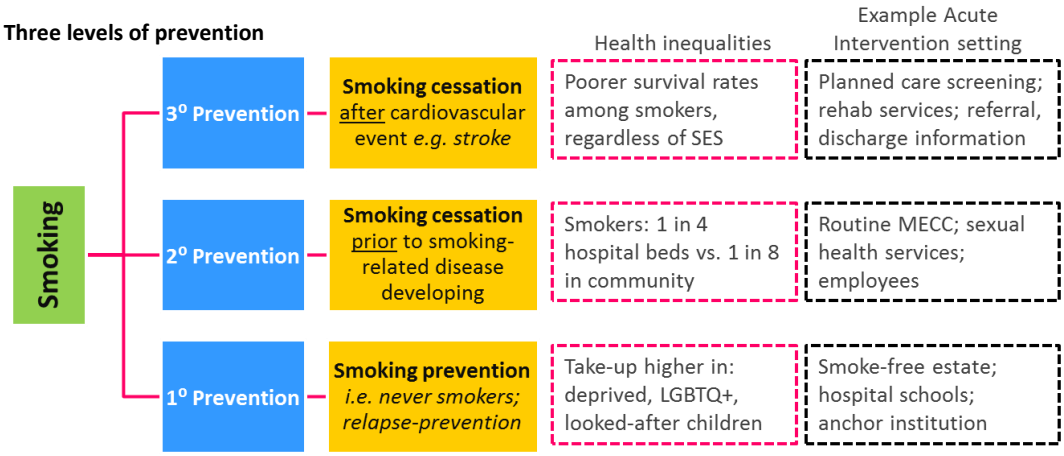
Appendix: Applied Research Collaboration North West London (ARC NWL): update paper

Public Health overview

- Traditionally, the medical thinking has been largely concerned with the needs of sick individuals. By contrast, public health is concerned with the achievement of equitable health of the community as a whole. Unlike traditional, clinical medicine, public health medicine focusses on:
  1. **defined populations and communities**, not individuals;
  2. **preventing ill-health**, rather than treating people when they are unwell;
  3. the **social, economic and cultural factors which influence health and wellbeing;**
  4. seeks **equitable health outcomes** across all population sub-groups.

- Prevention is mainly concerned with avoiding disease or inequity from developing (see Figure 1). A public health approach can conflict with traditional medicine as an intervention that greatly benefits an individual may only have a small population-level impact. As a result **reducing risk factors of many people at small risk may be more effective in reducing injury and illness and inequity than interventions addressing small numbers at high risk.** This is the so-called 'Prevention Paradox'.

Figure 1: Three levels of prevention



n.b. usually there is an inverse relationship between level of prevention and size of target population

- Health inequalities are preventable differences in health outcomes between different population groups. **Public health is particularly focussed on reduction of health inequalities, aligning strongly with national policy including the NHS Long-Term Plan.** This is usually through measures that have a greater effect on sub-groups with higher prevalence of risk factors. In practice, this means both prioritising population-level interventions and targeting interventions on these smokers.

- **Health inequality and quality of care are intrinsically linked: care outcomes and experiences are worse for those living in the most deprived areas.** Where an indicator (e.g. A&E waiting times) shows declining quality, the difference in quality of care between those living in the most and least deprived areas tends to widen. This is of particular concern as the NHS looks towards COVID-recovery, with waiting times at record levels, services at capacity, and patient experience declining.

- If the quality of access, outcomes and experience of care continues to deteriorate, the inequality gap between the most and least deprived groups is likely to widen further. It is recognised nationally that cross-sector action, most likely-coordinated through Integrated Care Systems and driven by public health teams, is needed to reduce the inequality gap.

- It is also important to recognise inequalities in the experience of staff too. Nationally, for example, **inequalities are reflected in clinical excellence awards**, where black and minority ethnic doctors are underrepresented, while **inflexible NHS employment terms or expectations can create issues for those with caring responsibilities**, forcing them to leave their chosen roles.

- The NHS has a statutory duty to reduce health inequalities, and this agenda has received renewed focus in the wake of COVID-19, particularly its disproportionate effect on some of the most marginalised groups. **The Phase 3 letter sets out eight urgent actions for the NHS to reduce inequalities in both provision and outcomes of care, and requires each Trust to have a named Executive Lead for Health Inequalities. CWFT as nominated its Chief Medical Officer.**

- Further, in December, **NHSE/I launched a consultation on a draft framework to support NHS organisations deliver against these actions and address health inequalities**. The proposed framework integrates urgent actions into the established elements of the CQC's Well-Led assessment, which is central to Board governance and Assurance mechanisms.

Public Health at CWFT

- Building on historical success, CWFT remains committed to improving outcomes and experience for the patients. 2019 saw it revise its strategic priorities to extend and complement its traditional hospital responsibilities and to **embrace provision of wider health and wellbeing support for our local population. The Trust explicitly identified contributing to improvements in health outcomes and reductions in health inequalities in the population as a priority**.

- Fundamental to this is the appointment of a public health specialist to lead the strategic development, facilitation and implementation of population health programmes. The responsibility for many public health services moved from the NHS to local government in 2013 and it remains **unusual for a hospital to appoint a public health consultant. Even fewer NHS trusts are GMC-accredited training placements for public health registrars, making CWFT quite unique in this regard.**

- The team fluctuates in size and level of specialist knowledge. It currently has two permanent staff roles: a Consultant in Public Health (CPH), and a Public Health Programme Manager. The remainder of the team consists of various fixed-term posts, almost all of which are externally-funded through partnership agreements. For example, **in January 2020 the public health team had 5.0WTE persons, three of whom had some level of specialty training. This halved to 2.8 WTE in September and is projected to be 1.6WTE by August 2021.**

Public Health Work Programme 2020/21

- The team delivered an active and varied work programme with almost all workstreams directly contributing to reducing the health inequalities and inequities. **The work has received national recognition, including by NHS Providers, and separately the HSJ Value Awards 2021** (see below).

- Notable 2020/21 successes include, but are not limited to:
  1. **Securing a conservatively-estimated £300k of income** through a combination of direct grants, match-funding or resources-in-kind. The CPH is seconded to the NW London NIHR Applied Research Collaboration (ARC) for 4 PAs/week as Implementation Lead, time for which the trust is remunerated.

2. **Being awarded an £80k grant by the West London Cancer Alliance, RM Partners, to fund a one-year Fellowship to support the development of equitable COVID recovery strategies in planned care.** Recruitment is underway and will be supported in a partnership arrangement with ARC NW London.

3. Securing a **Health Foundation grant to develop a catchment population model for the trust, and applying open-access data to produce and CWFT's first population health needs assessment,** A Picture of Health**.** This has been cited as a best practice case study by NHS Providers for how hospitals should be tackling inequalities, and has been shortlisted as HSJ's Value Pilot Project of the Year.

4. The Bi-Borough-funded Oral health Programme (OHP) is in its second and final year. Despite significant COVID-related disruption, **>1000 children – many of them particularly vulnerable to dental decay - have been impacted to date.** The majority are >5 years, identify as BAME with 1 in 4 living with a long-term condition, or in areas associated with the highest areas of child poverty[1]. We anticipate impacting about 140 families/week through maternity booking, antenatal classes, postnatal bedside and discharge information. The programme has been shortlisted for HSJ's inaugural Public and Preventive Health Service Redesign Award.

5. **Contributing significant public health and health protection support during the first COVID-19 surge, including**: developing decision-support tools outlining community self-isolation and infection control protocols for patients and discharge teams; drafting hospital-to-care home discharge guidance for COVID-19 patients (at request of local Director of Public Health); issuing Vitamin D supplementation guidance; establishing a discharge food parcel pilot for vulnerable patients.

6. **Leveraging the NIHR ARC relationship to develop CWFT's public health research reputation, with an emphasis on public health policy including inequalities.** Recent examples peer-reviewed research includes: health inequalities in acute trusts (*Journal of the Royal Society of Medicine*); the digital divide (*BMJ Open)*; evidence review of smoking and SARS-CoV-2/COVID-19 outcomes *(Tobacco Induced Diseases.* There have also been locally, national and international presentations of our work.

7. The NIHR ARC is supporting the trust with **income, training and development opportunities, evaluation and research support to measure impact and outcomes for programmes,** such as: Staff Health and Wellbeing; Oral Health Programme; 'Best for You' integrated emergency mental health support for young people (see Appendix)**.**

Priority-setting for 2021/22

- Particularly given the renewed national mandate around reducing health inequalities as set out in policy documents and consultations (including, but not limited to: Working Together to Improve Health and Social Care for all (2021); Transforming the Public Health System (2021); a Well-Led Approach to Health Inequalities (2020)), and building on the Public Health Team's progress to date, the Executive Management Board agreed the following four public health priorities be adopted for 2021/22:
  1. Support the Office of the Chief Medical Officer and Trust Quality Improvement agenda by **leading the delivery of an Equitable Health strategy** for the Trust, alongside providing specialist input to the NW London Integrated Care System as requested;

[1] *n.b. COVID has reduced community dentistry provision by >75% (BDA, 2020), making OHP even more important as it may be the only oral health advice families will receive for the foreseeable future*

2. Further leverage the successful collaboration with ARC NW London to further **grow the reputation of the Trust as a public health research organisation**, with a particular focus on health inequalities thereby also attracting additional resource;

3. Prioritising **maintaining GMC-accreditation for public health specialty training** to continue to attract specialist public health expertise in form of senior Registrar rotations;

4. **Any future externally-funded health improvement programmes** should be underpinned by quality improvement methodology and be co-produced with and embedded into relevant Trust Divisions.

- The detailed implementation plan to delivery on this is currently being developed, and is expected to be ratified by the Executive Management Board this month (May 2021).

Imperial College London

NIHR | Applied Research Collaboration Northwest London

ARC NWL: update paper

PURPOSE

- To introduce and update progress of the NIHR Applied Research Collaboration Northwest London that is hosted by CWFT for the year 2020/21.

BACKGROUND AND INTRODUCTION

- NIHR Applied Research Collaboration (ARC) Programme is a 5-year £135 million national research programme launched by the NIHR in October 2019. The ARC's remit is to work in partnership across academic and local health and care systems to support efficient, accelerated and sustainable uptake of clinically innovative and cost-effective research interventions into patient care.

- **The NIHR ARC for Northwest London (ARC NWL)** is hosted by the Trust, with Imperial College London the lead academic partner. The consortium is one of 15 nationally, and was provisionally awarded **£9 million over five years** to support the NHS in NWL to deliver improvements in health care and outcomes. This builds on the successful NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) NWL which CWFT hosted between 2008 to 2019.

> **The overarching ARC NWL goal:** *To build sustainable infrastructure for a continual improvement in health behaviours and population health, and a reduction in health inequalities for the people of Northwest London.*

- The programme is conducted via seven research themes. 1. Child population health; 2. Multimorbidity, including mental health; 3. Digital Health; 4. Innovation and Evaluation; 5. Information and Intelligence; 6. Patient, Public and Community Engagement; 7. Collaborative Learning and Capacity Building (see: Appendix 1, p4).

- As programme host, CWFT enjoys specific benefits, including: research and evaluation support for CWFT improvement projects, bespoke QI and evaluation training, attendance at biannual Collaborative Learning Events (biannual events), and health economics support (see: Appendix 2, p5).
  - NWL ARC offers the eLearning platform **QI4U** which hosts 10 quality improvement modules informed by cutting edge applied healthcare research, and is free to all CWFT staff.
  - CWFT currently funds 6 NHS contracts for ARC NWL staff and the Trust's Consultant in Public Health is seconded to ARC for 2 days/week.
  - A match-funding arrangement includes staff time working on improvement and service redesign initiatives and service delivery.

PROGRESS AND IMPACT TO DATE

Impact on CWFT

1) **Catchment Population Project:** Supported by a Health Foundation grant, a model was developed to identify CWFT's core catchment population. Once established, the Trust's first-ever Health Needs Assessment ('A Picture of Health') was developed, and its utility in supporting service design and delivery assessed. This project has been nominated for the HSJ Value Award 2021 in the category, 'Pilot Project of the Year' and has been included as a best-practice example in the NHS Providers framework for reducing COVID-related health inequalities.

2) ARC is supporting the evaluation of several CWFT improvement programmes, including:
   - ***Oral Health Programme:*** Exploring the impact of the C&W oral health programme which aims to improve access to dental services and increase staff awareness, education and training to improve oral health of patients admitted to CWFT.

   - **'Best for You':** In collaboration with CW+, 'Best for You' seeks to improve care quality for young people presenting at Emergency Departments in NWL who need integrated physical and mental health crisis support . The objective is to demonstrate tangible impact on key performance indicators, and extend this model to similar NHS settings across the UK.

   - **At the request of maternity services, an evidence review on the impact of smoking on Covid-19 was undertaken and published** (TID, 2020). Findings were shared for incorporation into the Trust's maternity smoking policy and pathways with relevant and accurate messaging for pregnant women and their partners.

3) One of 12 **ARC NWL Improvement Leader Fellowships** has been awarded to an advanced research nurse at the Trust who is developing learning for assessing the severity of COPD. The fellow cohort includes: 8 clinicians, 2 academics, a service-user, an industry partner.

4) In partnership with CWFT, ARC's Implementation Theme will be hosting a one-year fixed-term (1.0WTE) Health Inequalities Research Fellowship following an £80,000 grant from the West London Cancer Alliance, RM Partners. The fellow will support equitable planned acute care clinical service recovery post-COVID-19, as well delivery of an equitable health outcomes framework.

Impact on NHS in NW London

- Despite the advent of the COVID-19 pandemic, ARC NWL has nonetheless delivered research and training impacts for both for NW London, and CWFT specifically. ARC NWL also doubled the number of research projects planned for the first year. This work has directly contributed into NHS decision-making, and supporting improved patient care with examples including:
  1) A risk assessment framework jointly produced and published by NWL and East Midlands ARCs for NHS employers regarding the high Covid-19 mortality among BAME NHS staff (Faculty of Occupational Medicine, 2020).

2) The programme has delivered 2 **Collaborative Learning Events** with a third planned for April 2021, and will continue biannual events for the rest of the funded period. The most recent event (November 2020), was attended by 98 participants including members of the public, patients and carers, academics, NHS and social care colleagues and commissioners.

3) Contribution to the Royal College of Physicians repository of examples of how acute trusts are mitigating the impact of Covid-19 on health inequalities, and published an peer-reviewed paper on this topic (JRSM, 2020).

4) ARC COVID Volunteer Response: To directly provide support and relief for the NHS, 7 ARC NWL staff volunteered for redeployment to frontline services. Three staff returned to clinical work in both acute and primary settings, and four colleagues actively supported the vaccination programme in North West London (including two at the West Middlesex University Hospital vaccination centre).

RISKS AND ISSUES

- In October 2020, ARC NWL hosted the NIHR for a virtual site visit and submitted the first annual progress report. A planned gateway review will be submitted on April 1st 2021. The outcome of this review is expected in July 2021 and will decide the funding for the remaining three years of the programme (i.e. to Autumn 2024).

NEXT STEPS

- We will continue to support our local ARC partners and national bodies such as NHS England and PHE in their response to Covid-19. This includes using local and national NHS data sets to assess the impact of Covid-19 on health outcomes and support programmes that aim to suppress the spread of Covid-19 in the population.

- Future work includes partnering with the NW London Diabetes Transformation Group to develop new care pathways patients, and separately working with local NHS providers and commissioners, to investigate how the NHS can minimise the "Digital Divide" so that all sectors of the population can benefit from a shift to remote methods of clinical working.

- The ARC NWL team will actively seek to secure NIHR funding until Autumn 2024.

CONTACTS

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Appendix 1: ARC NWL Themes

Research Themes	Theme Aim
Multi-Morbidities	To improve the quality and coordination of care, experience and health outcomes for people with multimorbidity and frailty.
Child Population Health:	To promote health and wellbeing for children and young people and their families in NW London, to mitigate health inequalities by minimising unwarranted variation in health care, and minimise health costs to the NHS and families.
Digital Health	To understand how digital technology can be harnessed to improve the health and wellbeing of the population in NW London.
Innovation and evaluation:	To improve translation of innovation into practice in complex systems through the design, uptake, evaluation and spread of improvement practices across NWL and beyond and build capacity for innovation evaluation
Cross Cutting Themes	**Theme Aim**
Information Intelligence:	To empower the NW London health and care system through innovative, rigorous and reproducible analytics; making use of new integrated care datasets, capable of providing new insights and understanding; driving health improvement and evaluation; and supporting applied health research.
Patient, public and community engagement:	To improve the engagement and involvement of patients, carers and diverse communities; understand how to co-design and implement meaningful engagement and involvement strategies with them in health improvement, evidence translation and applied health research.
Collaborative Learning and Partnerships	To understand the mechanisms through which people – including academics, healthcare professionals and patients – learn and work together to translate evidence and achieve improvements in health behaviours and population health.

APPENDIX 2: ARC NWL PARTNERSHIP BENEFITS

Included	Description/Benefits
Free places for attendance at quarterly Collaborative Learning Events	- Learn about quality improvement approaches, tools and methods - Peer to peer learning between improvement initiatives - Expert review and advice on improvement initiatives - Networking and relationship building to strength collaboration between NHS organisations, patient and community groups, industry and academics
Bespoke QI and Evaluation training sessions	-Ad hoc sessions on QI methods, improvement science methodology, research methods, and improvement evaluation -Mentorship and support for improvement projects and evaluation
Health Economic support	-Online Health economic training course -Health economic support and guidance for improvement projects -Supervision of doctoral researchers
Unlimited QI4U licences	- Unlimited access to e-learning for quality improvement informed by cutting edge research - 10 modules already established and new modules in development
Opportunity to apply for fellowship places	- Fellows participate in unique cross system Northwest London fellowship working on an organisational priority
Membership of Exchange Network	- Connects patients, carers, clinicians, NHS managers and researchers for collaborative learning - Meets 4 times a year (52 members) - Uses facilitation and action learning to foster constructive dialogue to support engagement, involvement and improvement - Inclusive approach recognises diverse experiences - Moves away from traditional committee and advisory group approaches
Discounted Improvement Science MSc rates	- Innovative MSc programme in partnership with the University of West London - Gain an academic qualification through a practical work based improvement project
Support with measurement for improvement through Access to Impala and the CLAHRC's automated A&E Tracker	- Impala: an interactive online resource to support measurement planning for improvement work. https://impalaqi.com - A&E Tracker: Control chart analysis of A&E attendance data, to support and inform improvements in urgent and unscheduled care provision. https://clahrcnwl.shinyapps.io/ae-app/

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.1/May/21
REPORT NAME	Ockenden maternity review
AUTHOR	Victoria Cochrane, Director of Midwifery & Gynaecology
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	To provide the Board with the gap analysis of maternity's compliance with the 7 immediate and essential actions.
REPORT HISTORY	Executive Management Board, 3 February 2021 Quality Committee, 2 March 2021 Board Closed, 4 March 2021
SUMMARY OF REPORT	**Background** In recent years maternity services across England have been under increased scrutiny regarding the safety and quality of the care provided to women and their babies. Ineffective maternity care can lead to life changing consequences for women, their babies and family. In 2015 the Morecambe Bay report was published following an independent investigation established by the Secretary of State for Health that examined the concerns raised by the occurrence of serious incidents at University Hospitals of Morecambe Bay NHS Foundation Trust, including the deaths of mothers and babies. The findings we serious and highlighted a series of failures at almost every level and included the dysfunctional nature of the maternity service, clinical competence being sub-standard, deficient knowledge and skills, poor multi-disciplinary team working, a growing aim to pursue normal birth 'at any cost', failures in risk assessment and care planning and the response to adverse incidents was deficient, with repeated failures to investigate properly and learn lessons. At the time of the Morecambe publication, the maternity services at the Trust undertook a full gas analysis and this has been reviewed and updated as per the Ockenden recommendation and is included below. In 2017 following a letter from bereaved families, raising concerns where babies and mothers had died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health, instructed NHS Improvement to commission the Ockenden review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. Initially the review comprised of 23 families, however the number of families

	wishing to raise concerns has continued to grow and now encompasses 1,862 and the majority of the cases are from 2000-2019. It will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry in the history of the NHS. It is anticipated that the second and final report will be published in 2021, however as the review team had already identified emerging themes that should be addressed by the Trust and the wider maternity community across England the decision was made to publish the first report in December 2020 of important emerging themes and findings, **Local Actions for Learning** and **Immediate and Essential Actions** for the Trust and the wider maternity system in advance of the completion of the final report. For this first report 250 cases were investigated which are drawn from the entire period of the review and include the original cohort of 23 families. **Findings** • Turnover of Executive leadership at the Trust impacting organisational knowledge and memory <u>Midwifery and obstetric issues identified</u> • Lack of kindness and compassion • Formal risk assessment for place of birth • Clinical care and competency management of complex women • Escalation of concerns • Management of labour: monitoring of fetal wellbeing, use of oxytocin • Traumatic birth • Caesarean section rate below the national average • Bereavement care <u>Anaesthetic issues identified</u> • Poor obstetric anaesthesia practice • Lack of escalation to, and involvement of, senior anaesthetists • Limited consultant anaesthetic representation in incident investigation and multidisciplinary team meetings after significant incidents These findings form the recommendations of 7 immediate and essential actions (within the 12 urgent clinical priorities) and the 10 safety actions that all Trusts in England have to assess their compliance against. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. It is strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2. **Chelsea and Westminster Hospital NHS Foundation Trust current compliance with the 7 Immediate and Essential Actions (within this 12 urgent clinical priorities)** 1. Enhanced safety - x2 points green/x1 point - Amber 2. Listening to women and their families - Green 3. Staff training and working together - Green WM. Amber CW- not compliant with weekend labour ward rounds 4. Managing complex pregnancy - Green 5. Risk assessment throughout pregnancy – Amber cross-site- working group to strengthen formal risk assessment at every appointment & increased

	length of antenatal appointments 6. Monitoring fetal wellbeing- Amber- advert out to appoint fetal monitoring leads 7. Informed consent - Green **Additional compliance components** • Maternity workforce planning- Action 4&5 Amber/Birth rate plus assessment- Red (commenced 8.2.20) • Midwifery leadership - Green • NICE guidelines - Green • Updated gap analysis of Morecambe Bay findings - Green Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe. Full details of the Morecambe Bay and Ockenden assessment and assurance document are appended to this paper.
DECISION/ ACTION	The Board is asked to note this report.

	CWHFT - Chelsea			CWHFT - WM		
	Chelsea site RAG	**Processes in place**	**Plan to implement if not already in place and resources required / additional information**	**West Mid site RAG**	**Processes in place**	**Plan to implement if not already in place and resources required / additional information**
1) Enhanced Safety						
a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	Green	Awaiting further guidance		Green	Awaiting further guidance	
External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	Amber	This currently takes place when requested	Need to work together as a regional to ensure this takes place for all cases	This currently takes place when requested	Need to work together as a regional to ensure this takes place for all cases	
b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Green	An overview, findings, recommendations and actions shared at Quality committee, executive board and trust board shared with Trust board.	Standardise to share all from the next meeting- 2nd Friday of every month. Working towards standardisation of reporting of All Sis are discussed at the regional SI meeting	Green	An overview, findings, recommendations and actions shared at Quality committee, executive board and trust board shared with Trust board.	Standardise to share all from the next meeting- 2nd Friday of every month. Working towards standardisation of reporting of All Sis are discussed at the regional SI meeting
2) Listening to Women and their Families						
Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	Green	Awaiting further guidance on role description	N/A	Green	Awaiting further guidance on role description	N/A

The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	Green	Awaiting further guidance on role description	N/A	Green	Awaiting further guidance on role description	N/A
a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Green	The maternity service has a robust service user partnership through the MVP which is cross site. The MVP also feedback to the LMS and is represented regionally. This year the MVP have supported us with x3 survey's gathering feedback and they have a full work plan that supports co-production of the maternity service. x2 of co-chairs have national MVP positions	N/A	Green	The maternity service has a robust service user partnership through the MVP which is cross site. The MVP also feedback to the LMS and is represented regionally. This year the MVP have supported us with x3 survey's gathering feedback and they have a full work plan that supports co-production of the maternity service. x2 of co-chairs have national MVP positions	N/A
b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and	Green	Non- Executive director in place for 1 year.	Strengthen our relationship with the NED to inform the wider Executive team of clinical scenarios identified through SI's and lower level incidents	Green	Strengthen our relationship with the NED to inform the wider Executive team of clinical scenarios identified through SI's and lower level incidents	

neonatal services and ensuring that the voices of service users and staff are heard.						
3) Staff Training and working together						
2. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	Amber	There is a consultant led ward round 0800 and 2000hrs Monday - Friday. Saturday and Sunday ward rounds at 0800 hrs only	The unit is working towards 98hrs to increase the consultant presence on LW and in particular over the weekend. This will facilitate a second ward rounds on Saturday and Sunday.	Green	There is a consultant led ward round 0800 and 2000hrs 7 days a week	N/A
1. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	Green	Our MOMs training is MDT and in place involving all health care professional in maternity on a rolling programme with monitoring of attendance. We will implement any further recommendations. Validated through the LMS every month	N/A	Green	Our MOMs training is MDT and in place involving all health care professional in maternity on a rolling programme with monitoring of attendance. We will implement any further recommendations. Validated through the LMS every month	N/A
3. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	Green	Fully compliant	N/A	Green	Fully compliant	N/A
4) Managing complex pregnancy						

2.Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Green	Early specialist involvement and MDT plans	N/A	Green	Early specialist involvement and MDT plans	N/A
a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Green	Women with complex pregnancy have a named consultant but there is no present audit in place for compliance	Audit will be initiated as part of our annual audit plan- planned for March	Green	Women with a complex pregnancy have a names consultant but there is no present audit in place for compliance. Collaborative MDT working relationships facilitate communication regarding women and care planning	Audit will be initiated as part of our annual audit plan- planned for March
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres (Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.)	Green	We are fully engaged in supporting the development of maternal medicine specialist centres and we currently have a maternal medicine service and have endocrinologist and Professor of obstetrics	We are working closely with our medical colleagues to create a post for an obstetric physician	Green	We are fully engaged in supporting the development of maternal medicine specialist centres and continue to provide exemplary maternal medicine services on site.	
5) Risk Assessment throughout pregnancy						

A risk assessment must be completed and recorded at every contact so that they have continued access to care provision by the most appropriately trained professional. The risk assessment must include ongoing review of the intended lace of birth, based on the developing clinical picture. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Amber	Risk identification at booking, during pregnancy but not formally documented and then formally in labour	Strengthen recording via updated handheld notes for each AN contact & admission, discharge and triage. Strengthen risk assessment as part of fresh eyes review, admission to the PN ward and discharge to community. Increased length of AN Appointments needed- RV and likely investment needed	Amber	Risk identification at booking, during pregnancy but not formally documented and then formally in labour	Strengthen recording via updated handheld notes for each AN contact & admission, discharge and triage. Strengthen risk assessment as part of fresh eyes review, admission to the PN ward and discharge to community. RV and likely investment needed
6) Monitoring Fetal Wellbeing						
a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Amber	(1)We do not have an obstetric or midwifery lead for CTG monitoring (2) We have weekly MDT Intrapartum sessions focusing on CTG physiology, human factors and comprehensive risk assessment. (3) We have K2 training package which have to be completed by members of the clinical team working on labour ward. They complete the	Funding in place for a lead MW and lead obstetrician for CTG training. This will be recruited to by February 2021. Out to advert currently	Amber	(1)We do not have an obstetric or midwifery lead for CTG monitoring (2) We have a monthly MDT Intrapartum sessions focusing on CTG physiology, human factors and comprehensive risk assessment. (3) We have K2 training package which have to be completed by members of the clinical team working on labour ward. They complete the	Funding in place for a lead MW and lead obstetrician for CTG training. This will be recruited to February 2021. Out to advert currently

		assessment at the end of the training. (4) We have a CTG update once a month via our MOMS training. (5) central monitoring to teach and train as part of the clinical care and fresh eyes			assessment at the end of the training. (4) We have a CTG update once a month via our MOMS training. (5) central monitoring to teach and train as part of the clinical care and fresh eyes	
7) Informed Consent						
a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Green	We have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website (identified in the recommendations). We have birth choices pathway and MRCS pathway for women who need additional time and support	Review and update of our website	Green	We have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website (identified in the recommendations) We have a birth choices and MRCS pathway for women who need additional time and support	Review and update of our website
ADDITIONAL COMPLIANCE						
Maternity Workforce Planning						
Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard	Amber	No current BR + for obstetric workforce planning	Investment required to achieve weekend evening consultant ward round	Amber	No current BR + for obstetric workforce planning	Support need for locum posts to become substantive

Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard	Amber	Yearly tabletop exercise for workforce planning. Investment in Oct 2020 to achieve MW ratio 1:27	Plan to undertake full BR+ assessment	Yearly tabletop exercise for workforce planning. Investment in Oct 2020 to achieve MW ratio 1:28	Plan to undertake full BR+ assessment	
Providers need to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate plus standard by 31.1.21 and to confirm timescales for implementation	Red	Trust has not undertaken full BR+ since 2017	Plan to commence BR+ in Feb. Assessment agreed & funding and resource secured	Trust has not undertaken full BR+ since 2017	Plan to commence BR+ in Feb. Assessment agreed & funding and resource secured	
Midwifery Leadership						
Confirmation that your DOM/HOM is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements in Strengthening midwifery leadership: a manifesto for better maternity care	Green	DOM directly accountable to the Chief nurse, HOM on each site, x3 Consultant midwives and senior clinical lecturer. Specialist midwives on each site. Access to internal and external leadership programmes	N/A	DOM directly accountable to the Chief nurse, HOM on each site, x3 Consultant midwives and senior clinical lecturer. Specialist midwives on each site. Access to internal and external leadership programmes	N/A	
NICE guidelines related to maternity						

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	Green	Ensures a reliable and robust system is in place so that all guidelines trust wide are in line with current research and development within maternity services nationally. All newly published NICE Guidelines are distributed by the Clinical Governance Manager cross site to the relevant clinical leads and a completed compliance request form is received within two weeks.	x1 guidelines needs to be reviewed by the clinical leads	Green	Ensures a reliable and robust system is in place so that all guidelines trust wide are in line with current research and development within maternity services nationally. All newly published NICE Guidelines are distributed by the Clinical Governance Manager cross site to the relevant clinical leads and a completed compliance request form is received within two weeks.	x1 guideline needs to be reviewed by the clinical leads

GAP ANALYSIS – IN RESPONSE TO MORCAMBE BAY INVESTIGATION REPORT (January 2021)

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should have a process in place so that where harm has occurred patients and their loved ones are being informed and an apology given	Duty of candour policy in place and monitored through the divisional quality board where compliance is recorded. Recognised as exemplar nationally and a study site for NIHR 'DISCERN' study. Ongoing listening service facilitated by PMA's for concerns not relating to serious incidents but more so for when lower level harm may have occurred. Trust fully engages in the HSIB and Each Baby Counts Processes.	Datix system is used to audit the compliance of duty of candour when a moderate harm incident is reported Appointments to and learning from the listening service EBC monitors the involvement of women and loved ones when higher level of harm has occurred	None	Assured

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should have a process of regular review of the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies and have a training and development plan in place.	Training needs analysis in place for all staff groups based on the national and professional recommendations. All internal staff rotations occur with the support of the PDM team to ensure upskills in the area. Long standing preceptorship program in place for newly qualified midwives. PDR's undertaken yearly to review progress against objectives and identify any additional training needs as well as outstanding mandatory training elements	Training needs analysis Training logs – face to face (MoMS) – OLM Qlikview – mandatory training reports Junior doctors competencies assessed by their educational supervisors and there is a formal appraisal process in place. Training portfolios are completed when competencies are achieved. Annual appraisals for consultants and completion of personal development plans. PDR compliance	None	Assured
Trust should have a continuing professional development programme for all staff linked explicitly with professional requirements including revalidation.	PDR, appraisal and revalidation in place for clinical staff. Appraisal compliance is monitored. Concerns with individuals will be identified through complaints, risk management and supervision pathways and would be addressed through the performance management processes.	PDR logs QAS meeting minutes Revalidation logs	None	Assured

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should have effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff.	MOMs multidisciplinary training is in place yearly, and adhoc multidisciplinary training also includes- impromptu simulation and skills and drills Regular multidisciplinary meetings include: Wednesday morning Meeting CW/ Forum WM/ Women's Services Meeting CW Weekly joint obstetric and neonatal MDT Weekly fetal medicine meeting Weekly Intrapartum MDT Perinatal morbidity and mortality MDT Policy/guidelines MDT Q&S committee Management meetings Risk management meetings Obstetric medicine MDTs	Meeting minutes Training logs	None	Assured
Trust should be able to evidence the risk assessment process in maternity services, setting out clearly the delivery options and the process for ensuring this is documented in the care plan (including triggers for escalation of care).	Formal risk assessment currently in place at booking and risk assessment for BAME women during covid and at the start of labour. Recently introduced risk assessment at each contact- plan to have formal risk assessment at each appointment Personalised care plans via the mum & Baby app for all women Birth planning appointment undertaken at 36 weeks with the midwife or obstetrician as per schedule of care Care plans individually developed with consultant midwives/obstetricians for complex women	CERNER review Notes audits	Embedding of risk assessment at each contact	On-going

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.	Standard inclusion criteria for birthplace including home births, birth centres and obstetric unit. Any woman requesting care outside of these guidelines receive a thorough consultation and specific care plan by the consultant midwife team. All inutero transfers are discussed with the consultant neonatologist and consultant obstetrician. Dashboard metrics monitor the birth rates of premature births to include magnesium sulphate administration; this is to ensure that babies requiring level 3 NICU are birthed in the most appropriate place with the correct trained staff available. ATAIN MDT to discuss term avoidable admission to nicu	Birth choices plans and clinic schedules Notes audits Birth choices guideline Audit of in utero transfers Dashboard with preterm birth rates and magnesium administration ATAIN MDT meeting minutes	None	Assured
Trust should have a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience.	Clear recruitment and retention strategy in place, with regular recruitment drives. Commenced BR + assessment	Current vacancy rate is <5% on each site for midwifery/nursing staff combined Obstetric. Workforce at CW needs investment to achieve 98 hour cover and weekend evening ward round	None	Assured

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should describe how joint working is in place between its main hospital sites, including the development and operation of common policies, systems and standards.	Amalgamation of policies and guidelines since West Middlesex site joined the trust in 2015 is complete, with guidelines centrally located on trust intranet. While some differences occur (because of structural differences such as different level neonatal services) these are clearly highlighted in the guidelines. Regular cross site meetings with the senior team ensure a shared ethos, with many of the senior team working on both sites. Women's service vision and strategy cross-site	Intranet guidelines sites Senior Midwives meeting Minutes MQAS cross-site meeting minutes Vision and Strategy	None	Assured
Trust should set out how they ensure incidents are reported and investigated in an open and honest way including requirements, benefits and processes. This should include a review of the structure, training, reporting and support for staff involved in SIs.	Incident reporting, via the DATIX reporting system is encouraged and utilised by all staff and monitored daily by the risk and senior teams. Investigation process, including training, reporting and feeding back to relevant staff, set out in policy trust policy derived from NHS England guidance	DATIX reports	None	Assured
Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints.	MQAS specific newsletter ('Risky Business') sent to all staff so recurrent themes and actions can be observed and specific messages included within 'messages of the week'. PMA system used for midwifery staff and educational supervision system for medical staff to ensure that investigations are not seen as punitive, nor a blame culture MVP meets regularly and is given access to Risky Business and discuss other DATIX themes.	Risky business newsletters PMA newsletters	None	Assured
Trust should evidence that clinical leadership arrangements in obstetrics, paediatrics and midwifery appropriate and training and development is in place for the clinical leaders.	Internal leadership courses are available for staff at all grades including senior management. There is a clear senior and middle grade level of management. The clinical leadership structure is replicated in the PDR and line management cascade.	PDR reviews	None	Assured

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should evidence that the Board has adequate assurance of the quality of care provided by the Trust's services. This should include assurance that roles and responsibilities are clear in relation to quality from board to middle managers (including training).	Trust board are aware of the divisional quality agenda through the quality and safety governance reporting structure and are sighted on risk registers, patient experience complaints and serious incidents.	Trust board minutes	None	Assured
Trust should evidence that the facilities in the delivery suites are fit for purpose	Chelsea site: recent refurbishment has ensured the facilities are fit for purpose with all equipment fit for purpose West Middlesex site: facilities on the delivery suite are fit for purpose. Work to the birth pool room on LW took place in 2020. Planned estates work to ensure better access to birth centre. Continuous procurement of necessary equipment needed take place	Estate plans	None	Assured
Trust should have clear guidance for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths.	Incident and SI reporting in line with national guidelines	Risk meeting minutes	None	Assured
Trust should evidence that they report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor.	Fully compliant with all requirements and requests	Risk meeting minutes	None	Assured
Trust should evidence their whistleblowing policy and its impact.	The trust has clear whistleblowing policies and guardians, and the impact is measured at board level	Whistleblowing policy	None	Assured

Recommendation	Assessment of Chelsea and Westminster	Evidence	Actions needed	Status
Trust should evidence the process for managing inquests to avoid this process reducing the incident review process and a reliance on the coronial process	Each maternal inquest would have a full panel with external review and all learnings and actions identified cascaded	Panel minutes	None	Assured
Trust should evidence the supervision process for midwives to provide assurance that where issues are found they are dealt with	While statutory supervision has been discontinued, the trust is fully compliant with the new PMS process, with active PMAs alongside annual appraisals and revalidation processes	PMA minutes/newsletters	None	Assured
Trust should evidence the links made between complaints, incident reviews, system issues, inquests and the actions taken as a consequence.	All trends within and across complaints, incident reports, system issues and inquests are reviewed both internally (via senior team) and externally (via the LMS)	Senior team minutes	None	Assured
Trust should evidence accurate recording of perinatal mortality, a process for review of all cases and recording systems that are adequate. This should include the use and actions taken in response to national audits such as MBRRACE-UK, and include analysis of comparison with other trusts.	Mortality reporting in place including process for reviewing all cases and recording systems that are appropriate and robust. Dashboard for LMS makes constant comparisons with local organisations alongside London-wide and national data.	Dashboards LMS meeting minutes	None	Assured
Trust should evidence the mechanism to scrutinise perinatal deaths or maternal deaths to identify patient safety concerns and to provide early warning of adverse trends. This should also include still birth and neonatal death.	The Perinatal Mortality tool is used to report all of the perinatal deaths. A monthly perinatal mortality meeting attended by the neonatal and obstetric team scrutinises all of the Intrapartum and neonatal deaths. Clear processes in place, as detailed above	Risk meeting minutes PMRT minutes	None	Assured
Trust should evidence the process for managing and learning from external reviews.	Clear processes in place	Risk meeting minutes – local and regional Senior team meeting minutes Trust board meeting minutes	None	Assured

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their **internal audit function** to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider **including maternity audit activity in their plans for 2020/21.**

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

1.Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

2.External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

3.All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	**IEA 1:** 1.Themes and trends from low level incidents (Datix) and internal/external SI's are reviewed and actions plans put in place to enable clinical change to take place. Regional LMS workstream that currently meets monthly to review SI's from each Trust this will be strengthened over the next 2 months to ensure full regional oversight of incidents. We are continually responding to women's feedback/ incidents and staff feedback and practice is adapted based on the best available evidence. The perinatal mortality tool is used and there is a lead obstetrician, neonatologist and midwife. All cases are presented in the monthly perinatal mortality and morbidity meeting and action plans are formulated to impact clinical change aimed at further reducing our perinatal mortality and morbidity. Dashboard information gathered and is reviewed and interrogated internally by the leadership/MQAS team and shared with the wider internal teams monthly at Women's Services Meeting (C&W) / Maternity Forum (WM) and via a monthly infographic. The dashboard is shared regionally at the LMS on a monthly basis and deviations from benchmarked targets are considered. (Example- fully dilated caesarean section/ assisted vaginal birth with double instrument). **Evidence** Messages of the week from MQAS with actions and learning disseminated to staff (MQAS minutes/ Safety messages/emails to staff). Minutes of regional SI' meeting/ LMS minutes with summary from SI meeting. Bigger projects of change: IOL labour pathway improving (based on women's experiences / central fetal monitoring (full review by MDT and incidents via risk)/Continuity of care/ Wrong blood in tube (in conjunction with HBIB)/Sepsis work on both sites/Choice for women- MRCS pathway/Birth choices pathway. TOR and minutes from 12 months of the region SI meetings/mortality and morbidity minutes/ Internal dashboard 12 months/ LMS dashboard/ minutes of LMS dashboard meeting/minutes of LMS meeting/minutes of LMS safety meeting/ copies of the infographic 2. Compliant with full external investigation for those cases that meet the HSIB criteria and where families agree and progress to a full investigation. The regional team at HSIB feedback quarterly to the cross-site leadership/MQAS and board safety champion to share local themes and trends and national learning. SI panels for each site will have representation from the opposite site but from within the Trust. Occasionally it will be from an external Trust within the region. We will work to strengthen the external representation on all panels. **Evidence**: HSIB slide deck/HSIB investigations/HSIB LMS slide deck/monthly DOM update meeting/email evidence of tri-partite meetings with families and HSIB, details of panels member available. 3. An overview of all SI reports (findings/recommendations/actions) are shared at Patient safety group, Quality committee, executive board and Trust board. Currently HSIB regional reports are presented quarterly at the LMS SI workstream and the CCG have presented their perspective of SI's reported to identify trends and themes for all units to learn from. Next steps to review the process whereby all SI reports are shared at an LMS level **Evidence**: Copies of the paper for Trust board in the last 12 months

Describe how we are using this measurement and reporting to drive improvement?	1.Close monthly monitoring of dashboard with RAG rating parameters set to highlight outliers to identify where areas of change may be needed. 2.Record of all cases that have proceeded to HSIB investigation. Register of those who have attended panel for non-HSIB cases. External representation should provide an extra dimension of impartial scrutiny to action planning in response to incidents and drive improvement. 3. Improvement projects; Triage cross site helpline review of staffing model and implementation of BSOTs at CW site.(pre-implementation),Significant QI in the IOL pathway and most recently mechanical induction with balloon to enable more women to have out-patient IOL during covid, Reduced fetal movements QI, implementation of Computerised CTG, education package and the implementation of new guidance to standardise pathway, ensure appropriate intervention and USS where indicated(implementation phase). Postnatal project – lumeon. Improved communication with other agencies on discharge to community and Beyond Birth Living Library programme (postnatal peer support group, created with Maternity Voices Partnership and now available through website)(complete) Management of MOH following NMPA alert-Rotem, shock packs MDT training, QI projects driven by audit and dashboard outcomes(complete) Implementation of an electronic tool for assessment of VTE on admission, within 24 hours, post-delivery and when VTE changes (complete,)Implementation of the GAP protocol, to reduce the number of fetal growth restricted babies unidentified at term. Swab counting QI following never event. Fetal monitoring buddies to ensure fresh eyes carried out hourly following lower levels of compliance identified (recently implemented) PRECEPT – reducing Intrapartum brain injury by administration of magnesium sulphate timely and optimising birth of preterm baby. Home blood pressure monitoring pathway for women at risk of PET using Patient Know Best as a platform for the PET care plan. This pathway is also continued postnatally. Feed back to NICE on behalf of region via LMS because of learning from PN Sis (standardised postnatal checklist documentation)

How do we know that our improvement actions are effective and that we are learning at system and trust level?	The dashboard is used to monitor trends in the RAG rating, leading to review of current clinical practice and quality improvement work. IE fully dilated CS/assisted birth with double instrument. Dashboard is reviewed and changes implemented locally and regionally. We use the themes from complaints to inform change in clinical care and communication We monitor our stillbirths, HIE and preterm birth rates via our dashboard locally and regionally via the LMS. Perinatal mortality rate
What further action do we need to take?	1.Reduction of data entry as currently 5 systems on the CW site and 6 system on the WM site. Business case approved by Executive board to use end to end K2 for clinical documentation supported by CERNER for EPMA & PAS. As part of the project work to enhance data entry and therefore reporting and enhanced data trend analysis. Improving the digital pathways will alleviate midwifery time and allow more direct clinical care to be achieved and enhance women's experiences. Support from the Trust wide data team. 2.Currently developing a process across the LMS to ensure that specialist clinical opinion is sought in all other cases of preterm birth, intrapartum fetal death, maternal death, neonatal brain injury and neonatal death and any others that do not proceed to an HSIB investigation**.** At present investigations have clinicians from the opposite maternity unit in attendance to enable some level of external scrutiny. 3.Currently some of the Si's reports shared and discussed in detail at the LMS safety meeting. Next steps are to ensure all SI's are reviewed at LMS at least every 3 months. Maternity safety is a continuous process of review, quality improvement and evaluation that we are committed to in order to provide sustainable improvement to care and requires on-going investment. National support and work to align all our reporting processes nationally would be better eg CNST / SBCB2/ NHSR / PNMRT/ HSIB etc would make the case review smoother and less repetitive to focus on clinical improvement not just reporting

Who and by when?	1.Maternity leadership team- December 2021 2 & 3.LMS co-chairs – February 2021
What resource or support do we need?	1.Trust funding approval through business case to support better data entry and output. Change in the metrics reported to the Trust board on a monthly basis 2. Agreement from the LMS 3. Investment to release clinicians to be able to undertake the regional attendance at SI panels
How will mitigate risk in the short term?	As explained above

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

1.Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

2.The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

3.Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions: **Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** **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 to coproduce local maternity services?** **Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**
Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	**IEA 2.** **Evidence** Independent senior advocate not in place currently, new role. Awaiting clarity from the national team and chief nurse on this role and its specifications. In the meantime families are offered support by a number of clinicians – the governance team, consultant obstetric lead for the postnatal debrief clinic, bereavement midwife, listening service, professional midwifery advocate and consultant midwives. Families are also invited to share their experiences of maternity services at board level at regular intervals. NED in place with oversight for maternity, plan to strengthen this role. **Safety Action 1.** **Evidence:** Evidence of PMRT being used to review perinatal deaths to the required standard **Safety Action 7.** **Evidence: Mechanisms for gathering feedback –** On-going collection through email and social media which the MVP chairs collate and forward to the senior team. The contact details for the MVP are located in women's handheld notes and on the website and social media. At the quarterly MVP meeting there is an agenda item for lay members to report back any direct feedback received or heard through active listening. Outside of Covid-19 the MVP conduct 'walk the patch' feedback sessions face to face with women and also organise focus groups in community settings. Specific co-produced surveys provide a great deal of feedback, the most recent two being an on-going survey regarding ethnicity in maternity services and a survey conducted in collaboration with Healthwatch about women's experiences of maternity care during the pandemic. Friends and family used for collecting feedback Fortnightly service updates- MVP co-chair & Consultant Midwife **Co-production –** Information leaflets for women and families, the most recent being the Covid-19 information for women and other birthing people, Surveys for women and families collecting feedback about maternity services. Maternity Transformation Workstreams which have led to the co-production of code of conduct policies for the attendance of support people, noise posters for ward areas and a heatmap to support future planning for continuity teams. Since May 2020 an MVP chair has joined the maternity service Covid-19 response call weekly. Development of Covid-19 information for women – leaflet/facebook live/website/social media posts. Recruitment of x2 co-chairs to the MVP. Collaboration on a postnatal working group on the back of feedback from surveys. We have directly called them for advice and support related to how women will feel and experience care related to changes due to Covid-19. Beyond birth living library co-produced with MVP from the beginning. Lumeon CW postnatal digital suite c-produced, Mum & Baby app co-produced. Where available we signpost women to multilingual patient information. **Safety Action 9:** **Evidence:** This take place by monthly at the cross-site MQAS meeting and monthly at the divisional performance and improvement meeting

How will we evidence that we are meeting the requirements?	Minutes from (MVP/ co-produced work meetings) will demonstrate attendance and actions in response. Project work- posters/package/policy/guideline Survey Reports and action plans arising for them. Examples of feedback received from MVP directly. Co-produced work available to view on website Minutes and presentations from cross-site Maternity Quality and safety meetings & performance and improvement meeting. Access to the mum & Baby dashboard via LMS
How do we know that these roles are effective?	Actions are being implemented or evidenced. Surveys repeated can demonstrate change. Review of themes from feedback and complaints.
What further action do we need to take?	Continue listening and implementing change using the above tools and evidencing changes made. Continue to broaden membership of MVP for equality and diversity Include more MVP involvement in review of clinical guidelines
Who and by when?	NED role: DOM to liaise with Chief Nurse re. JD clarity MVP year working plan supported by consultant midwife yearly work plan actions and report at end Dec 2021
What resource or support do we need?	Continue to support MVPs / departmental investment into PMRT teams and ensure learning is shared appropriately / appropriate resources in order to put meaningful changes in place in response safety recommendations Additional resource to support NED role
How will we mitigate risk in the short term?	No risk currently to be mitigated

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

1. Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

2. Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

3. Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	**IEA 3** 1.A Maternity Training Needs Analysis document is reviewed by the multi professional team on a yearly basis. An annual multi-disciplinary team (MDT) programme of teaching and assessment is co-produced and delivered to participants by an MDT (participants include midwives, maternity support workers, ODPs, Anaesthetists and Obstetricians) The practice development team hold a central register of attendance and competency assessment (where applicable) for all staff groups, this tool is used to evidence annual compliance. There is a standardised approach to ensure compliance, including a DNA process, and clear pathway and actions where individuals do not meet the required competency or attend training. Compliance is presented at the MQAS maternity service meeting, LW forum, Women's improvement group, Women's Divisional meeting. During the Covid 19 pandemic, MDT training has continued face to face where appropriate, however with reduced numbers of participants. During this period we have extended the compliance timeframe to 18 months in line with the Maternity incentive scheme technical guidance. Simulation/ skills in the clinical areas occur on a quarterly basis and a register of attendance is saved by the practice development team. **Evidence**: training statistics/ LMS dashboard/Training agendas/ MDT attendance lists/ Yearly TNA meeting minutes 2.WMUH – achieved, Consultant led ward rounds 8am / 8pm, 7 days a week C&W – not achieved: robust investment in Chelsea site required to meet the needs. Currently Consultant led ward rounds 8am / 8pm, Monday – Friday. Weekend cover: Saturday and Sunday cover us 0800-1400hrs. During the weekend an 8am ward rounds occurs. There is no evening consultant led ward round on weekend. **Evidence**: LMS dashboard/ medical workforce metrics/Job plans 3.Maternity transformation funds are ring-fenced and used for maternity transformation and safety workstreams. Evidence: MTP project plan and spending
What are our monitoring mechanisms?	A) Multi-disciplinary training programme reviewed yearly to include local and national learning. Programme agenda, Locally held database of Compliance with the TNA, for each staff group, reviewed within division monthly. B) Via LMS monthly reporting C) Monthly finance meeting

Where will compliance with these requirements be reported?	A) Dashboard / LMS / Women's Directorate Board / Maternity Forum (WMUH) / Executive Board once per quarter (as part of NHSR 10 point plan). Submission of compliance for Maternity Incentive Scheme year 1, 2 3 B) Dashboard & LMS C) Finance meetings
What further action do we need to take?	A) Review further opportunities to work collaboratively across the LMS to offer MDT education and training. Ensure the challenges that COVID 19 have imposed on robust F2F MDT training are continually minimised and that a recovery plan is adequately supported so staff have time to 'catch up' from remote learning. B) Secure investment to adequately achieve the require number of Consultants to cover these hours. Support for the required investment from the Trust increase from 77hrs to 98hrs and achieve evening weekend ward rounds (night) C) Piece of work needs to be done to understand the external funding coming in for training of maternity staff, and education funds to support student midwives in clinical practice
Who and by when?	A) Educational and leadership teams – continuously monitored, and re-reviewed when pressures of pandemic ease / are resolved B) Executive team / ASAP C) During the month of March
What resource or support do we need?	A) Ensure maternity education and training programme meets the needs of the service and has appropriate backfill to release staff from clinical areas and training requirement increase year on year- recent investment received from the Trust – especially in light of covid recovery need. Increase opportunities for shop floor education and learning B) CW - Current labour ward Consultant presence is 77hrs and a business case has been submitted to increase the hours to provide 98 hrs as well as ward rounds twice a day over the weekend. WM- Support to continue the consultant model of working and substantiate locum maternity posts. C) Confirmation that training money will always be ring-fenced for maternity staff

How will we mitigate risk in the short term?	A) Half day model developed by Maternity Incentive Scheme for staff unable to complete the usual training during the pandemic to be implemented MDT training above and beyond requirements of NHSR 10 point plan during covid. B) CW site: Consultant on-call from home and able to attend as required

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

1.Women with complex pregnancies must have a named consultant lead

2.Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	**1.Women with complex pregnancies must have a named consultant lead** – **CW**: all women with complex pregnancies have a named Consultant and have continuity antenatally with the consultant and in certain cases (complex cardiac, abnormally invasive, complex diabetic) consultant is present for the birth. We have well established dedicated MDT clinics for women with complex medical pregnancies. We are a tertiary centre for referral of women in complex cardiac disorders in pregnancy and cystic fibrosis. The obstetric medicine team consists of a Professor of Obstetrics/obstetric physician, 1 subspec trained feto-maternal medicine consultant, 3 consultants ATSM trained in maternal medicine, endocrine consultant, obstetric physician trainee. There is well established MDT with the cardiac, heamatology, gastroenterology, respiratory, cancer services, renal and neurology. We have an obstetric medicine continuity of carer midwifery team led by a Band 7. Quality improvement work continues across the antenatal clinic to improve the continuity for women who are on a low or intermediate pathway **WM**: all women are booked under a named consultant. Depending on the complexity identified they will remain their geographical consultant or transfer care to the specialist diabetes or maternal medicine team who then become the lead named consultant for all care **2.Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team** **WM** - this is met via the Obstetric medical team who have regular cardiology / neurology /haematology MDT and weekly Mat medicine Acute med meetings – we have evidence based spread sheets of all women through obstetric medicine and all women discussed at WM MDTs – there is a very big dataset **CW**: Well defined referral pathway for women identified with a complex pregnancy with specialist MDT clinics established for women with maternal medical disorders, diabetes, cardiac, respiratory, endocrine, complex mental health and vulnerable women, women with invasive placenta, women with multiple pregnancies and women high risk of preterm birth (Additional information in appendix) To support our pathways, we have well established weekly MDTs (Cardiac, endocrine) and monthly (respiratory, heamatoloy, gastrointestinal, infectious diseases). Well established NWL perinatal mental network that feeds into the pan London and national networks with established MDT clinical governance between maternity and mental health services. **Overview of SBLCv2**

	Element 1 CO monitoring to be re-introduced by April 21 at booking, and 36 weeks (and as appropriate), captured in the hand held paper maternity records and MIS (CMiS). VBA training being rolled out to community and ANC midwives (paused due to Covid-19) Smoking Cessation services and signposting, with feedback to services currently in place. Service and outcomes compared with local trust via the smoking in pregnancy collaborative (Matneo QI) **Element 2** Assessment of pregnancies at risk of FGR completed at booking – risk assessment updated and in line with SBLCv2, and new pathway to be embedded in practice from March 21. This assessment is not currently captured in MIS, and required a manual documentation audit. Indication for aspirin assessed at booking GAP protocol in place using customised growth charts and birth centiles. Data is inputted and analysed utilising the perinatal institute tools, (audit monthly and presented quarterly at maternity forum). All clinicians involved in antenatal care are expected to be compliant with online training on SFH measurement and recording on customised growth charts. Audit and presentation of FGR/SGA detection rates presented at forum and women's services. This data will be presented at the LMS for sector wide comparison and overview. PMRT used to identify cases and calculate the percentage of missed FGR/SGA could have contributed to the outcome. Mechanism to be put in place to ensure the trust board has oversight of SGA/FGR detection rates and percentage of babies born <3rd centile >37+6 weeks' gestation and >39+6 and <10th centile to provide an indication of detection rates and management of SGA babies, and action to improve these rates. **Element 3** All women are provided with the Tommys information leaflet regarding fetal movements, and the updated hand held records will capture that this is revisited at each antenatal appointment. The presence of normal fetal movements is documented at all appointments. **Element 4** Midwives and Obstetricians undertake MDT education and training on CTG interpretation with the inclusion of human factors. Case study based training is accessible weekly trust wide on a weekly basis virtually at CW and to be implemented bi weekly on labour ward at WM. Competency assessment is undertaken using the K2 system, and compliance with monitored by the Education team monthly, this is presented data is available on the LMS dashboard, and is reported to the Women's improvement group. The fetal surveillance lead midwife has been advertised externally for 1WTE trust wide. There will be the appointment of 1PA Obstetric lead on each site. Fresh Eyes hourly review of all intrapartum CTG is embedded in practice and is audited monthly. Risk assessment at the onset of labour and on-going throughout labour captured via K2 MIS, and monthly audit in place.

	Element 5 Detection of pregnancies at risk of preterm birth identified at booking and referral mechanism in place for triage and review by pre term birth lead obstetrician on both site. SBLCv2 recommendations regarding management of pregnancies with risk factors in place Local and LMS dashboard captures preterm birth rate, using MIS (CMiS), and compared across the network Local and LMS dashboard identifies use of MGSO4, and steroids administration within 7 days of birth (babies born before 34 weeks). – data captured manually at present. Management of multiple pregnancy – non compliant with standard regarding specialist MDT team being responsible for care of women with multiple pregnancy. Currently care lead by named geographical obstetrician. Optimisation of place of birth – national guidance implemented and use of EBS to ensure in utero transfer of women at risk of preterm birth Training delivered via LMS to MDT in prediction, prevention and preparation in Nov 20, Jan 21
What are our monitoring mechanisms?	A).NWL meeting minutes of the maternal medicine meetings/ regular audit of compliance. B).As the Maternal medicine network is established in NWL the governance overview will be established
Where is this reported?	Safety action 6: reported through directorate meetings/quality committee/quarterly executive board
What further action do we need to take?	A). Implementation of the national for the maternal medicine network with hubs and spokes within the NWL ICS to streamline the pathways in practice in NWL with a robust governance process B). CW: Appointment of another obstetric physician to continue to support the MMC and integrate MDTs cross site as well as regionally. C). Local audit needs to take place on each site of 20 cases to ensure they have followed a specialist pathway, had the correct management plans from the beginning of pregnancy- plan to undertake this in February. Review the notes of 25 women on each site with different complexities to ensure documentation and compliance of management plans (low platelets/ cardiac/epilepsy/birth outside of guidance)
Who and by when?	1.Roshni Patel – CW/Joanna Girling – WMUH 2.Development of a business case for an Obstetric physician appointment

What resources or support do we need?	Appropriate funding to resource and grow service on both site
How will we mitigate risk in the short term?	Datix and SI reporting of any adverse event or outcome.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

1. All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

2. Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	**IEA 5** Maternity hand held records have a standardised risk assessment which is completed at booking including a COVID-19 at risk assessment, this is also documented on CMIS booking summary. A formal discussion of a PCP is documented within CMIS, with supporting documentation. Guidance recommends continuous risk assessment at each antenatal encounter. There is further work to be undertaken to ensure the PCP is full fit for purpose for all women and embedded into practice. Documentation within the hand held records when referral is required and rationale. At the onset of labour/ on admission guidance recommends review of place of birth and risk assessment. This is documented within the maternity triage proforma and within k2 electronic records at onset of labour/ one to one care. Not current guidance to formally document that the risk assessment has been completed and reassessment of place of birth. Updated hand held records will include a prompt, at each antenatal contact, to risk assess; for midwife led care and place of birth. Medium term plan to implement a new MIS (K2 EPR) that will prompt and re risk assess the pregnancy at each contact and when new complexities are identified.
What are our monitoring mechanisms and where are they reported?	No formal monitoring mechanism in place apart from Datix/SI where full records are reviewed, learning identified and action plans formulated even in the event of coincidental learning Plan to undertake a baseline audit prior to commencing the workstream and implementation of EPMA
Where is this reported?	N/A

What further action do we need to take?	A and B) Workstream to be set up with Midwifery and Obstetric representation to map out current and future process of risk assessment: a need for on-going education / documentation / digital solution to help support process / funding K2 electronic documentation for antenatal care, will include formal risk assessment at each antenatal contact, and documentation of referral and re assessment of recommendation regarding place of birth. Regular quarterly audit to be undertaken- risk assessment and documentation Review the length of antenatal appointments as 20mins is no longer adequate to cover the information that needs to be shared, allow for meaningful personalised discussion, risk assessment and recommendations Review the use of personalised decision-making tools as part of this work Resource support from the trust QI team.
Who and by when?	A&B: task & finish group led by consultant midwife & consultant obstetrician and QI team.
What resources or support do we need?	Increased resource to enable increased times for antenatal contacts during the antenatal pathway. Strengthened communication and pathway with primary care (GP's providing AN care)
How will we mitigate risk in the short term?	Communication to all staff to ensure a risk assessment takes place at each appointment

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	**IEA 6** Funding secured for full time cross site fetal monitoring lead midwife and post going out to advert week of 2.2.20 and lead Consultant Obstetrician for each site with dedicated PA. The practice development team and wider education team (including lead obstetrician for education/ fetal monitoring) currently delivery face to face fetal monitoring training within the MDT training, fetal monitoring case studies are presented weekly within the clinical environment (currently virtually). Case studies and learning from internal and external SI/ HSIB presented at maternity forum WM and the Wednesday morning meeting CW. There is a well-established ATAIN MDT group who meet weekly to comprehensively review all of the term admissions to NICU and review the CTG tracing of the Intrapartum cases. These cases are used for learning and presented at the weekly Wednesday 0800-0900 meeting or the Friday Intrapartum teaching session. The Friday MDT intrapartum teaching occurs weekly and is aimed at human factors and fetal monitoring as main components. The Maternity Quality and Safety team currently review all cases where CTG misinterpretation has been identified as a theme. At WM these cases are shared at the Perinatal M&M and teaching undertaken and the cases are then integrated into the MDT teaching days. An electronic training tool (K2) is used to compliment face to face training, and to assess competency in fetal monitoring. NWL LMS has developed a MDT working group with a remit for developing a regional approach to education/ training and assessment of competence of fetal wellbeing. **Evidence**: JD for leads/agenda for MDT/attendance sheet from weekly/monthly learning events/working group minutes **Action 8**: See previous IEA 3
How will we evidence that our leads are undertaking the role in full?	IEA 6: The evidence should be demonstrated in a reduction in the number of cases where CTG misinterpretation is a factor. A reduction in term admissions to the neonatal unit where the root cause was CTG misinterpretation Action 6: Elements within SBLC2 will be audited and presented to MQAS and forums.
What outcomes will we use to demonstrate that our processes are effective?	Successful appointment to the lead fetal monitoring posts, with clear objectives for the role in place and monitored Culture where there is continuous learning in relation to managing obstetric emergencies, assessment of fetal wellbeing and escalation. – staff survey/ feedback from MDT training Compliance with MDT training and CTG competency

What further action do we need to take?	Appointment of clinicians to the advertised posts. Identify existing networks where expertise can be shared and ensure collaboratively working across the LMS and other regions Senior leadership team and education team to work on strategy for embedding the role and the continuous development of high quality intrapartum fetal monitoring training and teaching
Who and by when?	Senior leadership team – advertise and appoint to the posts Set objectives of the postholder and outcome measures-Within 3 months
What resources or support do we need?	N/A
How will we mitigate risk in the short term?	On-going education and training, Clinical governance and risk management processes. Ensuring on-going review of cases where CTG misinterpretation has been identified
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	
Link to Maternity Safety actions: **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 to coproduce local maternity services?**	

Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	
What do we have in place currently to meet all requirements of IEA 7?	**IEA 7** As per highlighted we are the Trust that has been recognised for having this in place. Website up to date with detailed information for all components of the maternity pathway/ videos/ links and birth choices email address for women who require further care planning on choices for place and mode of birth, including maternal request for caesarean section. Information in place via a number of platforms (via appointments / mum & baby app / website / leaflets/guidelines). The maternal records have a decision-making tree to support women making informed choices regarding place of birth. The maternity service continues to face challenges ensuring women who need translating services have access to the correct information especially out of hours. **Evidence**: Website/ mum & baby app/guidelines - (MRCS/birth choices/ specialist care guidelines (IE diabetes)), leaflets **Safety Action 7:** Evidence as per IEA 2 evidence A clinical priority: we have been highlighted as an example of good practice
Where and how often do we report this?	Birth choices audit and feedback Minutes of MVP meeting Patient experience group
How do we know that our processes are effective?	Feedback / complaints / FFT
What further action do we need to take?	Need to establish database, education programme, digital solution in different languages Continual review and update of website/digital tools/guidelines and patient information leaflet

Who and by when?	Senior Clinical Lecturer evidenced based midwifery – review of all patient information to ensure unbiased/evidence based information available Learning from Risk study on optimum way to express chance Multilingual population
What resources or support do we need?	Scoping and potential investment into improved translation services to support women during the whole maternity pathway- in and out of hours
How will we mitigate risk in the short term?	Big word/ face-to-face interpreter

Section 2
MATERNITY WORKFORCE PLANNING
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	**Action 4: Demonstrating an effective system of clinical workforce planning to the required standard** **Obstetric medical workforce (CW**): Labour ward: There is 77 hrs of dedicated consultant presence on labour ward. 0800-2100hrs. The consultant covers labour ward and the maternity triage/MDAU and the inpatient areas. Formal job planning currently supports ward rounds is currently twice a day Monday – Friday and once AM on Saturday and Sunday. Antenatal ward rounds: dedicated consultant hot week, 2 hrs per day for 5 days. Caesarean section: There are 7 elective caesarean lists. 5 out of 7 caesarean lists have consultant presence and prospective cover. Two of the lists have consultant cover but not prospective. A weekly Education and Service planning meeting attended by the clinical director, workforce planning consultant and junior doctor, general managers, college tutor and service directors identifies rota gaps and ensures proactive recruitment to fill gaps as soon as possible. Last GMC survey for CW site for O&G had red flags and actions required to increase training opportunities. Action plan developed and continually reviewed. Monthly Education Faculty meeting reviews the junior doctor's rotas and pattern of working to ensure safe working hours and standards. This meeting also oversees delivery of educational and training opportunities. Recent review of the consultant workforce and development of business case to support safe staffing levels undertaken. **Obstetric Medical workforce (WM):** Robust consultant presence on LW adapting the provision to be focused on clinical need of service. Meets all standards for consultant presence (for 12hours per 24 hours) - WR at 0800 and 2000 and for review of all readmissions and supervision support and can join teaching and training on the LW. Last GMC survey for WM site for O&G positive with no red flags or immediate mandatory actions. Continuing to improve educational experience for trainees. **Evidence**: rota's/ Minutes of meetings/GMC survey/ HEE action for CW/Trust board minutes where GMC survey highlighted **Anaesthetic medical workforce**: CW: Current consultant presence in maternity is from 0800-1800. We have 24 hour anaesthetic presence on labour ward and 5 CS lists with dedicated consultant anaesthetist WM: Current consultant presence in maternity is from 0800-1800. We have 24 hour anaesthetic presence on labour ward and 5 CS lists with dedicated consultant anaesthetist. Plan to review additional cover required once we have a clear understanding regarding the need for consultant anaesthetic presence/attendance at ward rounds 7 days a week **Evidence**: Rota's **Neonatal medical workforce**: WM: Some staffing gaps have been identified with the aim of have clear action in the near future. CW: During the hours of 5-9pm Mon to Friday the standard is not met through BMA requirements but the department has an action plan in place to address this and currently this is mitigated as the consultant body are present to cover these gaps. Active workforce recruitment strategy in place **Evidence:** Action plan for neonatal medical workforce at both to achieve the new BMA requirements **Neonatal nursing workforce**: CW: as a neonatal intensive care unit we are currently undertaking a nursing workforce calculation using the CRG workforce staffing (Dinning) tool. Current ratio is 1:1.5 and a business case to support 1:1 care for intensive care cots is being developed WM: level 1 unit- regional review of neonatal services has recognised the need for a level 2 unit and appropriate staffing. **Evidence:** Business case **Safety Action 5:** We have undertaken a table top exercise in 2019 & 2020 to map the midwifery workforce and improve the midwifery ratios. From a business approved by the executive committee we secured funding to improve the midwifery ratio's to CW 1:27 and WM 1:28. We have been waiting for BR+ to be modelled appropriately to account for continuity of carer before undertaking a full BR+ assessment. We have now started the process of

How have we assured that our plans are robust and realistic?	Safety Action 4: Business case planning with the executive team to ensure safe obstetric staffing levels in line with growth of the service. Safety Action 5: yearly review of midwifery ratio's via table top exercise- comparing establishment to birth rate & acuity and making appropriate establishment changes.
How will ensure oversight of progress against our plans going forwards?	Safety Action 4:Via women's improvement group, Directorate board and performance and improvement Safety Action 5: Via women's improvement group, Directorate board and performance and improvement
What further action do we need to take?	Safety Action 4: Business case to support achievement of the 98hrs of consultant presence on the labour ward and achieve ward rounds twice a day 7 days a week. Safety Action 5: complete full BR+ assessment and then then implement recommended midwifery ratio's.
Who and by when?	Safety Action 4: Executive team to support business planning Safety Action 5: Senior Midwifery leadership team, currently on-going
What resources or support do we need?	Safety Action 4: Investment from the Trust into the Obstetric workforce on the Chelsea site Safety Action 5: funding for the BR+ assessment- secured, staff released to undertake the data collection- secured. Investment from the Trust to achieve the required ratio's
How will we mitigate risk in the short term?	Safety Action: Monitor SIs linked to lack of consultant presence as contributory factor. Potential to use locum consultant posts to increase hours to 98 and twice a day ward rounds during the weekend. Safety Action 5: Use of bank and agency to ensure safe staffing levels as required

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

We can confirm that the Director of Midwifery (Band 8D) is responsible and accountable to the Chief Nurse who is also a midwife. Each of Trusts 2 sites also has a Head of Midwifery (Band 8C). There are 3 cross-site consultant midwives (Band 8C)- x1 with a remit for Public Health & Safeguarding, x1 with a remit for supporting physiological birth on the alongside midwifery units & community and x1 with a remit for supporting physiological birth on the obstetric units. The maternity service also has a recently appointed senior clinical lecturer in evidenced based midwifery with a remit for midwifery and wider maternity research
Evidence: Job descriptions/details of those in post/Trust organogram

There are specialist midwives on each site with the following remit:

Chelsea: Infant feeding, safeguarding, perineal/FGM, Antenatal screening, fetal medicine, Breech, birth after caesarean section, perinatal mental health, diabetes, examination of the newborn, bereavement, guidelines &quality improvement, professional midwifery advocates and digital midwife

West Middlesex: Infant feeding, safeguarding, perineal/FGM, antenatal screening, fetal medicine, professional midwifery advisors, examination of the newborn, perinatal mental health, bereavement midwife, guideline & quality improvement midwife and digital midwife.

Evidence: Birth rate plus table top exercise demonstrates all specialists in post

Senior midwifery leaders have access to Trust leadership programmes and external management and Leadership MSc's & MBA's through the apprentiship levi.

Evidence: outline of courses available to leadership team

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	The Guidelines and Quality Improvement Midwife ensures a reliable and robust system is in place so that all maternity guidelines trust wide are in line with current evidence and best practice. New and updated NICE Guidelines are reviewed by the clinical leads and compliance and mitigation is submitted to the central governance team within two weeks of publication. A GAP analysis is performed by the Clinical lead and the recommendations are reviewed at the Maternity Quality and Safety meeting cross site on a weekly basis. The Guidelines and Quality Improvement Midwife and the two lead consultants in guidelines meet on a fortnightly basis to review the status of guideline development and the introduction of the new NICE Guidance. The guideline development team take an active role in supporting the development / updating of guidelines alongside the clinical lead in this area, the practice development team and the pharmaceutical team, and other stakeholders. The final version is circulated to all maternity staff via email, and the updated guideline is presented with all key changes to the Maternity collective and ratified via the Maternity Forum and Women's Services monthly Meeting. Oversight of guideline compliance is reviewed at Divisional quality and safety committee. A monthly Guideline newsletter is circulated by the guidelines and QI Midwife to all staff highlighting updates and amendments to guidelines and practice to ensure an effective communications pathway for all staff. This encourages staff engagement and input into clinical guideline development and cultivates a culture of ownership for best practice standards within the maternity team. Updates are also circulated to staff via email, whatts app groups, presented at forum and highlighted on posters within the unit. The implementation of new guidance will be planned in collaboration with multi-disciplinary team trust wide, with the aim of adopting a quality improvement methodology where appropriate.

Where and how often do we report this?	• The Guidelines and Quality Improvement lead takes responsibility for a data base which supports a cycle of updating all clinical guidelines, ensuring there is an even distribution of work to support reasonable review of emerging evidence and incorporating it in practice. This is reviewed on a daily basis (37.5 hours a week). • The Clinical governance team review the maternity guideline status on a monthly basis and send the status report to the relevant maternity leads. This is presented by the Guidelines and Quality Improvement Midwife and reviewed cross site at the weekly Maternity Quality and Safety meeting. • The Guidelines and Quality Improvement Midwife and the two lead consultants in guidelines meet on a monthly basis to review the status of guideline development and the introduction of new NICE Guidance and ensure clinical sign off of new and amended guidelines. The Clinical Director and the trust clinical governance team supports the Guidelines Development midwife in ensuring an appropriate escalation plan is initiated should there be significant delays in achieving guideline completion.
What assurance do we have that all of our guidelines are clinically appropriate?	All NICE Guidelines have been reviewed against the Trust's existing guidelines and a GAP Analysis has been performed to highlight any outstanding areas which require review and updating. **four** NICE guideline has been highlighted as requiring review. The Guidelines and Quality Improvement Midwife has liaised with the Clinical leads responsible for this and the existing Trust guideline has been distributed accordingly for review. Audit and review of the standards within the guideline Review of serious incidents and compliance with guidance
What further action do we need to take?	Good assurance of guideline compliance, on-going work required to harmonize all maternity guidelines trust wide. Resource to enable timely implementation of quality improvements linked to new and emerging guideline would enable more rapid implementation in clinical practice and the enable the QI to be monitored and further improved over time
Who and by when?	Short term project leads identified for saving babies lives care bundle, require lead midwives to have non clinical time to support implementation of projects within their clinical areas.

What resources or support do we need?	Funding to support clinical lead midwives to be non-clinical
How will we mitigate risk in the short term?	Accept there will be delays in full implementation of all guidance, however prioritisation of resource to high risk areas

Appendix IEA 4

CW is a tertiary centre for referral of women with complex cardiac disorders, working closely with a team of cardiologists from the Royal Brompton Hospital (100 women with complex cardiac disorders and 150-175 women with lower risk cardiac conditions). The cardiac team provides continuity for the women and have a well-established integrated pathway to ensure continuity of care through to birth and postnatal period for those women who are extremely at risk. There is well established cross site working among the team between the Royal Brompton Hospital and the Chelsea and Westminster site to facilitate a safe birth and at times this may be planning the birth a the Royal Brompton Hospital. We are also a tertiary referral centre for women with cystic fibrosis and complex respiratory disorders and work closely with the team of physicians from the Royal Brompton Hospital to provide care for the women. We have a well-established endocrine service for women with complex endocrine disorders and this service with a consultant endocrinologist and consultant obstetrician. We have a fetal medicine team of 5 consultants and 1 subspec trainee who provides continuity for women with complex fetal conditions, growth restriction and previous pregnancy with adverse outcomes.

The consultant obstetricians do a hot week ward rounds to ensure continuity for the women with complex pregnancies. There is a weekly MDT meeting attended by the consultant obstetricians, neonatologist and midwifery team in which all of the inpatient women with complex pregnancies are discussed and there is a handover between consultants with a clear plan for the inpatient management of the woman.

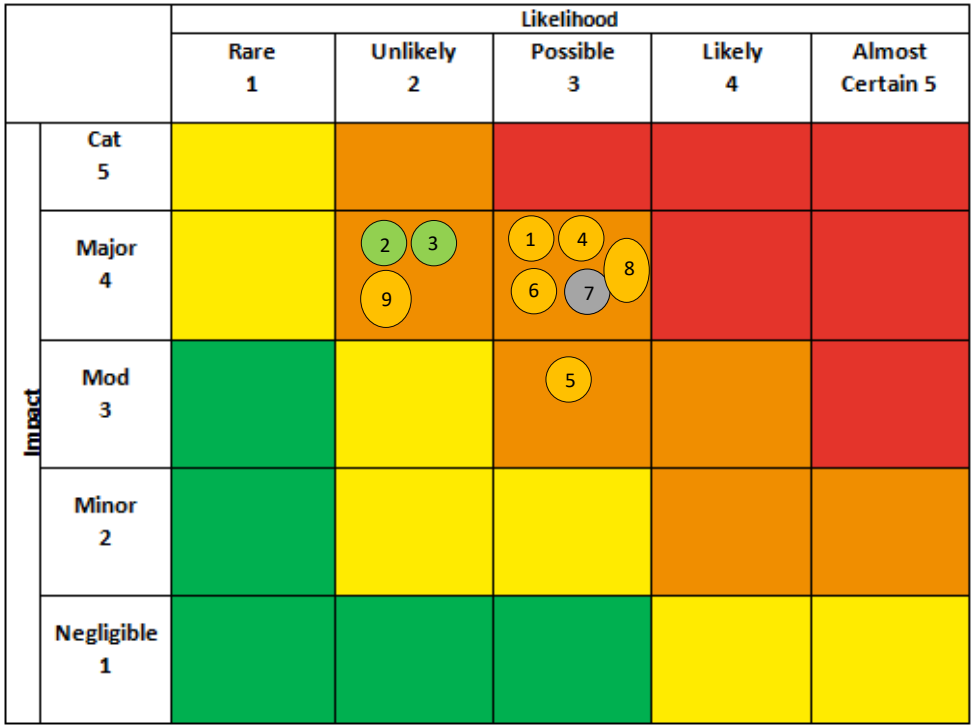
Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.2/May/21
REPORT NAME	Board Assurance Framework: Q4 and year-end review
AUTHOR	Alex Bolton, Associate Director of Quality Governance
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	To present the Q4 and year-end review of the Board Assurance Framework.
REPORT HISTORY	Executive Management Board, 17 March 2021 Audit and Risk Committee, 25 March 2021 Finance and Investment Committee, 31 March 2021 People and OD Committee, 31 March 2021 Quality Committee, 6 April 2021
SUMMARY OF REPORT	The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks, and also enable the Board to gain assurance about the effectiveness of these controls. The BAF is monitored through the Board sub-committees on a quarterly basis, and the full Board on a bi-annual basis. All of the individual risks and controls, means of assurance and any actions required have been reviewed to address any gaps in the controls, aimed at ensuring a consistent approach to the articulation of risks, controls and lines of assurance. The risks are set out at two levels of increasing detail in the following sections of the report: • *Section 1* sets out the summary matrix of all seven BAF risks, providing a single page overview; and • *Section 2* provides a one page overview of each risk including the individual controls, sources of assurance and any actions required to address gaps in the controls. The progress with a managing a number of strategic risks on the BAF in 2020/21 has been impacted by the prevalence of the Covid-19 pandemic. Key work programmes and personnel were diverted to deliver the organisational response during a number of pandemic surges.

	In summary: • One risk was closed in September 2020 following the successful implementation of the Electronic Patient Record. Following on from that, a new risk was identified with respect to the transformation capability and sustainability of the Digital Programme. • The Covid-19 pandemic impacted financial management and planning across the year, which has resulted in modifications to the national financial planning timetables and financial regime for 2021/22. The impact of this has been considered in the quality risk (Risk 2) and financial sustainability risk (Risk 4). • February 2021 saw the publication of the government's white paper: 'Integration and innovation: working together to improve health and social care for all'. In line with this, the North West London Integrated Care System will be taking a sector approach to performance management, and capital planning and expenditure. The system working risk (Risk 1) and financial risk (Risk 4) has been updated to acknowledge this potential impact on the Trust's position. Next steps: The prevalence of the Covid-19 pandemic has evolved across the year, and shows no signs of subsiding. Whilst, at the time of writing, the national alert level has been downgraded, the Trust is still managing the recovery from recent surges, and planning for further waves of the virus in line with national directives. It is for this reason that a new risk has been added to the BAF to reflect wider impact to the Trust from Covid-19 (Risk 9). This has been scored 'high risk' and will be regularly reviewed by the Board.
KEY RISKS ASSOCIATED	The document sets out the key strategic risks facing the organisation including the financial and quality implications
FINANCIAL IMPLICATIONS	
QUALITY IMPLICATIONS	
EQUALITY & DIVERSITY IMPLICATIONS	
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For review.

Board Assurance Framework – Summary Matrix (Q4 2021)



Key Risks

No.	Title	Assurance
1	Sustainability	Amber
2	Quality	Green
3	Culture Values and Leadership	Green
4	Use of Resources	Amber
5	Innovation & Improvement	Amber
6	Estates & Environment	Amber
7	EPR Programme – Closed September 2020	Green
8	Digital Programme	Amber
9	Covid-19	Amber

Key: Control Assurance levels

Green - Controls are effective, no additional assurance required

Amber - Controls are partially effective, further monitoring by management is required

Red - Controls are ineffective, may require immediate action to remediate

Board Assurance Framework – Controls and Assurance (Q4 2021)

BAF Risk 1: Failure to deliver the NWL Health & Care Partnership (HCP) System Recovery Plan and build a sustainable portfolio of outstanding acute and specialised services; consolidated across NWL (and beyond); leading to improved care and patient experience. **Cause(s):** • **No/partial delivery in NWL Provider Board back office support programmes** • **No/partial delivery in NWL Provider Board clinical standardisation programmes** • **Insufficient progress with ICHT Joint Transformation Programme** • **Failure of CCG consolidation and fragmentation of Commissioning Intentions** • **The system does not have appropriate management or governance arrangements in place to support the delivery of joined up, effective and efficient services across NWL.** **Impacting on:** • **The Trust's ability to support growth in activity, with the impact on performance and quality of care** • **The Trust's ability to implement new models of care and the resulting impact on the availability and quality of services** • **The Trust's freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance** • **The pace of the Trust's Recovery Programme with a collaborative system approach to recovery of elective care during Covid-19 pandemic** ***NB Extreme risk on Trust Risk Register is the continued growth in Non Elective activity impacting quality, safety and performance.***			**Executive Owner:** **Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Quality and Use of Resources	4 x 4 = 16 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver better care at lower cost	Well-Led	Trust Board / Finance & Investment Committee	Board – 05/11/20 Finance and Investment Committee – 31/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1.1 A NWL Integrated Care System (ICS) Chair and Chief Financial Officer have been appointed. Delivery against NWL System Recovery Plan is overseen by NWL Provider Board. Progress is also monitored through the weekly ICS Executive meeting and the NWL CEO Group forum. Both are chaired by the CWFT CEO as the SRO for the NWL ICS. The CWFT Deputy CEO and CNO are members of the ICS Executive Team	Programme Reports Deep Dive Reports NWL ICS System Recovery programmes 1) Programme of Care 2) Contract and Operating Plan		CEO	September 2021
1.2 Revised ICS Governance Structure now in place to support delivery of the key the NWL Health & Care Partnership programmes and strategy. CW Directors have lead operational and relational roles for many of these programmes.	NWL Clinical and Care Strategy Programme Reports Deep Dive Reports	Ensure resources deployed to support CW Executive Directors leadership on major work programmes and aligned with Divisional business plans	CEO	September 2021
1.3 Joint programme of work with Imperial College Healthcare Trust in place underpinned by Memorandum of Understanding and overseen by Joint Executive Board.	Joint Service Transformation Plan (high level) Joint Programme update reports NWL Clinical Reference Groups	Ensure trust recovery plans build on NWL CRG Leadership Ensure ICHT and CWFT lead on deploying full capacity to support NWL recovery	CEO	September 2021
1.4 A comprehensive series of Provider Oversight meetings have been re-introduced as a result of the Covid pandemic, to ensure system-wide oversight and ownership of provider performance in workforce, quality and use of resources.	Provider Oversight meetings reports		CEO	September 2021

BAF Risk 2: Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards **Cause(s):** • **Governance structures not in place or ineffective** • **Lack of alignment on priorities and plans across the organisation** • **Poor adherence to policies and guidelines** • **Quality of information does not support effective decision making** • **Emergence of Covid-19 pandemic** **Impacting on:** • **The ability to deliver the best patient experience and clinical outcomes** • **The Trust is subject to regulatory action and possible fines because it is not able to demonstrate compliance with relevant standards e.g. CQC, Health & Safety, GDPR** • **The Trust is unable to demonstrate compliance with Single Operating Framework and falls below the standards set by our commissioners, regulators and those we set for ourselves including 4h A&E access, 18w RTT and Cancer standards** • **The Trust does not make the most effective use of its resources** • **The loss of reputation as a result of the above** • **The ability to deliver safe elective and non-elective care due to Covid-19 virus**			**Executive Owner:** **Deputy Chief Executive / Chief Nurse**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Quality	3 x 5 = 15 (Extreme)	2x4= 8 (Moderate)	1x4 = 4 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centred care	Well-Led	Quality Committee / Audit & Risk Committee	Audit & Risk Committee – 25/03/2021 Quality Committee – 02/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
2.1 Establish Covid-19 Risk Register which includes infection control, PPE and FIT testing	Covid-19 Risk Register Report to Quality Committee and Trust Board	Full up to date risk register in place	Chief Nurse	July 2021
2.2 Embedded top down and bottom up annual business planning process ensures alignment across strategic objectives and quality, financial and operational plans. Plans are signed off through Executive Management Board, the relevant Board Committee and Trust Board.	Annual Quality Priorities and Plans Annual Operating and Financial Plans	Bottom up 2021/22 business planning process is underway. There are modifications to the national financial planning timetables due to the Covid-19 pandemic, so top down planning will be 2 parts - Q1 plan in March 2021 and Q2-4 planning in June 2021	Chief Financial Officer	April 2021
2.3 Maintain Quality Impact Assessment (QIA) process to ensure any quality risks associated with proposed service changes and financial improvement plans are effectively mitigated, and a Equality Impact Assessment is integral to this.	Risk matrix and mitigation output	QIA process applied to all Improvement opportunities and approved by Chief nursing Officer and Chief Medical Officer	Chief Nurse/ Chief Medical Officer	July 2021
2.4 Maintain and monitor medical staff appraisal and revalidation process	Annual Medical revalidation report and annual NMC revalidation reports to POD	Quarterly meeting with GMC and NMC Liaison officer, and quarterly GMC returns completed. Annual report on NMC and GMC revalidations made POD.	Chief Medical Officer/Chief Nurse	August 2021

2.5 Completion of CQC Board Assurance Framework for Covid-19 Infection Control	Assurance report to Quality Committee and Trust Board	Reviewed and updated in February 2021. Engagement meeting with the CQC to review document has been completed.	Chief Nurse	Complete – March 2021
2.6 Re-established Recovery Board for the Trust, and lead and engage with NWL Recovery Groups to ensure partnership working	Monthly Recovery Board reports to Executive Management Board, sub committees and Trust Board. NWL Recovery reports to Trust Board		Deputy CEO	September 2021
2.7 Established Board Governance structures and processed in place to monitor all relevant national and local quality, performance and regulatory standards including: • Integrated Quality &Performance report incorporating national quality, performance and financial standards monitored through Quality Committee and Trust Board • CQC registration requirements monitored through Clinical Effectiveness Committee. CQC action plan monitored through Quality Committee • Legal function, compliance and outcomes monitored at Executive Management Board and reported to Quality Committee including evidence of learning • Annual internal audit programme agreed and monitored through Audit and Risk Committee • National patient experience surveys and in house PREMS patient feedback.	Patient experience, serious Incident , complaints and mortality surveillance reports Integrated Quality &Performance report National survey reports and action plans Annual legal report Clinical audit reports Internal and external audit reports NHSE/I Provider Oversight Meetings CQC self-assessment and Inspection reports Embedded quality assurance system Ward accreditation Deep Dives Benchmarking information	CQC inspection due in Q3 2019/20 Annual self-evaluation of Board Committee effectiveness National patient survey results	Chief Nurse Director of Corporate Governance Chief Nurse	Complete - February 2020 Complete – January 2020 July 2021
2.8 Divisional oversight and governance structures in place to monitor all relevant national and local quality, performance and regulatory standards reporting to the Trust's Executive Management Board (EMB)	Divisional Update Reports to EMB Divisional Performance and Improvement Reports Divisional Finance Reports	Ensure Integrated Performance report is kept relevant and aligned to internal and national reporting requirements	Deputy CEO	Complete - March 2020
2.9 Mandatory training programme in place and compliance monitored through Divisional Performance & Improvement meetings, Executive Management Board, People & OD Committee and Quality Committee and Workforce Development Committee	Divisional Performance Reports Integrated Quality & Performance Report Workforce Report	Process in place	Interim Director of Human Resources & Organisational Development	Complete – January 2020
2.10 Harm Reviews introduced for all long waiting patients to be completed regularly to ensure appropriate clinical prioritisation is in place.	Cerner System has in-built Harm Review	Cancer Board Elective Access Board Weekly 'P2' clinical prioritisation meetings	Deputy CEO and Chief Medical Officer	June 2021

BAF Risk 3: Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market. **Cause(s):** • **Requirement to re-deploy large numbers of staff at pace to expand key service provisions. e.g. ICU during Covid-19 pandemic** • **Failure to manage and mitigate the impact of COVID virus on our workforce and specific 'at risk' groups** • **Psychological impact of dealing with the COVID incident across our key services** • **Communication with our workforce may not sufficient to ensure understanding and commitment to our future outcomes** • **Failure to respond to the staff survey (and other indicators)** • **Failure to build an engaged, responsive, and inclusive workforce** • **Staff do not feel valued, listened to and supported** **Impacting on:** • **The health and wellbeing of our people. e.g. absence rates** • **Expectations of staff around the 'give and get' between staff and the trust** • **Retention of 'hard to recruit' staff across key services** • **The approach to training our staff to increase their versatility to be deployed** • **Where staff will work, the way in which they deliver care to our patients and in some cases the role they undertake** • **The extension of our culture and values outside of the organization and for the benefit of the wider population** • **The Trust's reputation with partners, commissioners, regulators, the NHS and the public**			**Executive Owner: Interim Director of Human Resources and Organisation Development**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Human Resources	4 x 4 = 16 (Extreme)	2x4= 8 (High)	2 x 3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Be the employer of choice	Well-Led	People & OD Committee	21/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
3.1 People programme in place and delivery monitored through Workforce Development Committee and People and OD committee	People programme Staff survey report HR KPI dashboard (incl. voluntary turnover rate) People reset and recovery programme Establishment of Retention Steering Group to consolidate plans and identify further actions to retain staff particularly after a period of intense work and flight risk of those close to retirement and younger workforce to travel etc.	People reset and recovery programme actions (including mandatory training recovery plan)	Interim Director of Human Resources & Organisational Development	April 2021
3.2 EDI plan in place and delivery monitored through Workforce Development Committee and People & OD Committee	New EDI 3 year plan agreed with key actions including harassment and bullying action plan. Staff survey report Staff networks updates quarterly to committees Listening events with executive team NWL Inclusion Board and 4 associated workstreams NWL BAME Network EDI metrics in section 3.6	Bringing together the work of the Networks and more formal establishment of the role of the Executive Sponsor to champion and support the growing staff networks, BAME, LGTBQ+, Women's and Disability. Delivery of the NWL Leadership Ladder programme and agreed deliverables across the sector	Interim Director of Human Resources & Organisational Development	July 2021 onwards

		Evaluation of the reverse mentoring programme		
3.3 Health and Wellbeing plan in place and delivery monitored through Workforce Development Committee, People & OD Committee and Health and Wellbeing Steering Committee	Health and Wellbeing business case and associated two year work programme – approved at EMB, PODC, FIC in July 2020 Staff survey report COVID related work-streams for workplace risk assessments, individual risk assessments, support to clinically extremely vulnerable staff, psychological support offers, welfare check ins, support of staff with Long-Covid and stress, burnout, vaccination uptake and testing.	Consolidation of OH services across NWL, to give greater stability and service breadth. Re-set and recovery programme in place including supporting staff to take annual leave, re-set with teams and team building, approach to PDRs for 2021-22 to change to focus on health and wellbeing conversations.	Interim Director of Human Resources & Organisational Development	April 2021 onwards
3.4 Systems in place to listen to and respond to staff feedback including listening events, staff networks, team brief, senior link leads and perfect day	Trust and Divisional Staff Survey Action Plans Senior link survey report Twice weekly briefing to staff Weekly CEO Webinar Monthly Talk to HR webinars Monthly Starter and leaver feedback Quarterly FTSU report to People and OD Committee Monthly Staff Network meetings	Staff survey engagement events to discuss and agree results of the 2020 staff survey results Monthly national Pulse survey to be launched from April 2021 to ensure more regular feedback from staff which will be incorporated into the heatmaps.	Interim Director of Human Resources & Organisational Development	May 2021 May 2021
3.5 External systems in place for staff feedback monitored through Divisional Boards, Executive Management Board and People & OD Committee	National staff survey report GMC survey Staff Friends and Family test Freedom to Speak Up report Senior Link Partner Programme	No further actions identified over and above current plans	Interim Director of Human Resources & Organisational Development	April 2021 onwards
3.6 Systems in place to monitor key workforce metrics including Divisional Boards, Executive Management Board, Workforce Development Committee and the People & OD Committee	Workforce KPI dashboard (incl. voluntary turnover rate) HR Transactional Services KPI dashboard Annual review of WRES, WDES, Gender Pay Gap reporting, Model Employer Targets	Workforce information improvement plan to develop reporting arrangements including introduction of workforce heatmap to review at committees quarterly	Interim Director of Human Resources & Organisational Development	May 2021 onwards
3.7 Partnership Forum and LNC reviews formal and informal staff feedback	Internal and National staff survey scores Quarterly FFT scores Leaver surveys Union feedback GOSW Staff Networks	Formal Partnership and LNC meetings to restart from March 2021.	Interim Director of Human Resources & Organisational Development	August 2021
3.8 Development of a full people strategy for CW with alignment with ICS and national people plan (released July 2020).	People programme NWL People programme with NWL People Board Agreed CW people strategy Review of the 4 key themes of the People Plan at People and OD Committee each quarter: Looking After Our People – April 21	Execution of final draft of CW People Strategy for exec cabinet, EMB, WDC and PODC.	Interim Director of Human Resources & Organisational Development	May 2021

	Belonging in the NHS – July 21 New Ways of Working & Delivering Care – October 21 Growing for our Future – January 2022			

BAF Risk 4: Failure to maintain the financial sustainability of the Trust and the services it provides **Cause(s):** • **NWL Sector affordability impacting on Trust income** • **Uncertainty over NHS financial arrangements beyond 2020/21 due to covid-19** • **Impact of inflationary costs and price changes, including CNST premium costs** • **Loss of transaction funding not fully mitigated** • **Lack of robust financial management across operational and corporate teams to ensure the cumulative impact of all decisions is understood** • **Non-Delivery of financial efficiency targets and impact of reduced efficiency due to infection control requirements during covid-19 and back-log of elective patients** • **Pathway changes and service redesign across the sector** • **Digital and other innovations are not fully exploited** **Impacting on:** • **Capacity to support growth in activity, with the impact on performance** • **Ability to continue to invest in the workforce and infrastructure required to maintain and improve the quality of services** • **Loss of freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance**	**Executive Owner:** **Chief Financial Officer**

Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Use of Resources	4 x 5 = 20 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	21/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
4.1 Long term financial strategy and position is reviewed quarterly by the Finance and Investment Committee	LTFM report	Detailed planning and budget setting underway for the 2021/22 financial plan.	Chief Financial Officer	June 2021
4.2 Delivery against the Trust's financial improvement plan (CIP) is monitored through Divisional Finance Review meetings, the Improvement Board, and Finance and Investment Committee	Improvement Programme Reports Monthly CIP Delivery Report Divisional and Financial Performance Reports	Divisional CIP plans for 2021/22 are in development.	Chief Financial Officer	June 2021
4.3 The effectiveness of the Trust's financial control systems are monitored through the Audit and Risk Committee as part of the internal audit programme	Internal Audit Reports	Ongoing process in place	Chief Financial Officer	October 2021
4.4 Capital plans are reviewed regularly and monitored through Capital Programme Board, Executive Management Board and Finance & Investment Committee. Large capital projects (e.g. NICU/ICU, EPR) have separate programme boards where progress is monitored and reported through to Capital Programme Board and Finance & Investment Committee	Capital programme report NICU/ICU programme update report EPR programme update report	Ongoing process in place	Chief Financial Officer	October 2021
4.5 NWL sector financial recovery plan and financial governance for sector decisions are reviewed and monitored through the NWL CFO group, then to NWL CEOs & Partnership Group.	NWL CFOs group NWL Partnership group	Ongoing process in place	Chief Financial Officer	October 2021
4.6 Changes in commissioner contract terms are reviewed and signed off by the Executive Management Board, Finance and Investment Committee and Trust Board. Performance against the contract is monitored as part of the delivery against the Trust's overall financial plan.	Annual Financial Plan Divisional and Trust level monthly Financial Performance Reports	Process in place	Chief Financial Officer	October 2021
4.7 Annual financial plan signed off through Executive Management Board, Finance and Investment Committee and Trust Board	Annual Financial Plan	Process in place	Chief Financial Officer	June 2021
4.8 Annual financial improvement plan (CIP) signed off through Improvement Board, Executive Management Board and Finance and Investment Committee	Cost Improvement Plan Improvement Programme Plans Project Initiation Documents	Process in place	Chief Financial Officer	June 2021
4.9 Delivery against the Trust's overall financial plan is monitored on a monthly basis through Divisional Finance Review meetings, the Executive Management Board, Finance and Investment Committee and Trust Board	Divisional and Trust level monthly Financial Performance Reports	Process in place	Chief Financial Officer	October 2021
4.10 The effective use of resources is monitored against external benchmarks through the Improvement Board and individual programme boards (e.g. theatre productivity, bed productivity, outpatient transformation, diagnostic demand management), as well as external visits and assessments (GIRFT, NHSI)	Programme Board Reports Reference Costs & Model Hospital GIRFT Reports Use or Resources Assessment	Process in place	Chief Financial Officer	October 2021

BAF Risk 5: Failure to embed innovation and improvement in our culture and deliver innovative, patient centered services at scale **Cause(s):** • **Staff not encouraged and enabled to drive innovation and improvement** • **Lack of capability and capacity to support idea generation, testing and scaling** • **Failure to build partnerships to access innovative ideas and technology** • **Failure to spread innovative practice** • **Lack of funding to support innovation programme** • **Capital limits and capital prioritisation set at NWL ICS level may limit ability to invest in innovation** **Impacting on:** • **Transformative models of care, required to deliver wide ranging service improvement, are not adopted** • **Research & Development agenda fails to grow and deliver** • **Lost revenue opportunities from failure to commercialise innovations** • **Ability to deliver world class care aspiration**	**Executive Owner:** **Chief Nurse/Deputy CEO**

• **Profile and reputation for innovation is negatively impacted**				
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Innovation	4 x 4 = 12 (Extreme)	3x3 = 9 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	31/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
5.1 Innovation Strategy Group in place to oversee the implementation of the Trust's Innovation Strategy	Innovation strategy Research Strategy Improvement and Innovation Framework Innovation Project tracker Media footprint for innovation Staff survey results	Formalise approach to and oversight of commercialisation and partnership agenda. Consider opportunities for an NWL approach	Deputy CEO	Sept 2021
5.2 Improvement and Innovation Framework in place setting out clear approach to developing the Trust's improvement and innovation culture, and building the Trust's capability and capacity to support this		Innovation and Improvement Champions in place across all departments. Support with case studies inc ROI Build capacity in business intelligence to support digital maturity	Deputy CEO	Sept 2021
5.3 CW Innovation Programme in place as vehicle for attracting new partners and funding. • Overseen by an Innovation Advisory Board that brings together a broad set of third party skill sets and experience to provide guidance, challenge and support • Supported by dedicated Innovation Business Partners	Feedback from Advisory Board members Innovation project tracker Innovation fund growth Media footprint for innovation	Explore the creation of an innovation fund with corporate funders and partners	Deputy CEO	Sept 2021
5.4 Innovation Operations Group in place to oversee delivery of Trust's portfolio of innovation projects and support diffusion of innovative practice	Innovation Project tracker Projects plan and update reports against agreed project milestones and KPIs.	Incorporate innovation in to Improvement Board monitoring and reporting structure	Deputy CEO	Complete – January 2020
5.5 Strict alignment of innovation grant awards with Trust strategy supported through Improvement and Innovation Team and overseen by Executive Management Board and CW Grants Committee	Innovation Project tracker Grant applications CW+ Impact Report	New process supported by Improvement and Innovation team will support improved capture and tracking of the full end to end process	Deputy CEO	Complete – January 2020
5.6 Agreed capital prioritization criteria across NWL, with regular review through NWL CFOs group and reviewed through Capital Programme Board	Annual and 5 year capital programme Review through Capital Programme Board	Process in place	Chief Finance Officer	October 2021
5.7 Development of a new division which encompasses Research, Innovation and Digital teams to provide a streamlined and coordinated infrastructure and approach.	Governance and reporting structures will be established for this new division in line with current divisional structures. Executive Management Board monthly reports		Dep CEO	September 2021

BAF Risk 6: Failure to develop our estate in a sustainable way to support the delivery of high quality, effective and efficient care **Cause(s):** • **Commercial and cost improvement plans not delivered** • **Capital development programme not delivered (including ITU/NICU development)** • **Long term development plan for WMUH is not realised** **Impacting on:** • **Capacity to support growth in activity, with the impact on performance** • **Ability to transform models of care and improve the quality of services** • **Environmental impact of how we deliver services**			**Executive Owner:** **Deputy Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Estate & Environment	4 x 4 = 16 (Extreme)	3x4 =12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	31/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
6.1 Capital Development Programme, aligned to Estates Strategy, signed off and regularly reviewed through Capital Programme Board, Finance and Investment Committee and Trust Board	Capital Development Programme Report ERIC report Targeted Deep Dive – Estates Capital Strategy Senior Link Partner Programme Ward Accreditation	Establish rolling ward refurbishment programme led by the Hospital Directors Consider impact of London ICP guidelines and establish 'Silver Site' status and COVID-19 protected pathways to support all priority services	Deputy Chief Executive	September 2021
6.2 Annual Operating Plan and budgets aligned with Capital Development Programme with clear scheme of delegation with regular updates to Executive Management Board	Estates and Facilities Monthly Report	Review Capital requirements in light of NWL ICS development programmes; Critical Care expansion, Endoscopy, SDEC	Deputy Chief Executive	September 2021
6.3 ITU/NICU development overseen by dedicated Programme Board reporting to Finance and Investment Committee	ITU/NICU Programme Report Internal Audit	Apply learning from the NICU/ICU project and ensure that the contingency for unknown risks in future major developments is adequate	Deputy Chief Executive	September 2021
6.4 Estates Strategy approved by Trust Board and reviewed through Finance and Investment Committee and Trust Board Strategy sessions	Estates Strategy WMUH Site Master Plan	Site Master Plan for WMUH and supporting arrangements in development. Procurement process to be established.	Deputy Chief Executive	Complete – January 2020
6.5 Rolling maintenance programme in place aligned to Annual Operating Plan	Estates and Facilities Monthly Report Targeted Deep Dive – Estates Capital Strategy	Establish a sub-group to regularly review capital expenditure on each site	Deputy Chief Executive	Complete - February 2020
6.6 Establishment of a new sub-group of Finance and Investment Committee to oversee capital developments			Deputy Chief Executive/Chief Finance Officer	September 2021

BAF Risk 8 (opened September 2020): Risk that the implementation of work programmes within Digital and Innovation Strategy may not be delivered due to costs associated with purchase of software and hardware, costs of transformation, and sustainability of resources. **Cause(s):** • **Workforce capability** • **Clinician, Executive and other staff engagement (including training)** • **Risks associated with system collaboration across NWL and decision making processes potentially delaying CWFT progress** • **Budget constraints due to the need for recurrent investment in to both hardware and software** • **Change management does not ensure adoption of best practice and / or benefits realization** **Impacting on:** • **The running of the hospitals to deliver normal services and contractual responsibilities during periods of significant disruption** • **The need to maintain and improve cyber security** • **Adequately respond to the digital requirements of local communities** • **The need to modernize and upskill the workforce** • **Ability to respond to major incidents as well as the current global pandemic**	**Executive Owner:** **Deputy Chief Executive**

Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Digital and Innovation Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	31/03/2021	
Current controls and assurance	Actions to further enhance risk management			
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
8.1 Review of IT Infrastructure upgrade costs in preparation of 2021/22 capital spend	Deep Dive to schedule for October 2020	None at present	Chief Financial Officer	Completed - December 2020
8.2 Review current Digital and Innovation projects and align with Trust / ICS objectives	Monthly Digital and Innovation Programme Board	None at present	Deputy Chief Executive	September 2021
8.3 Joint EPR change board governance process with Imperial College Healthcare Trust in place	Monthly EPR Board Report	Continued monthly EPR/Digital Steering Group	Deputy Chief Executive	September 2021 (transferred from Risk 7)
8.4 Development of Digital Strategy in concert with NWL partners	EPR Board Report	First meeting of the NWL Digital Transformation Board on 9th March 2021 which will oversee the development of the NWL Digital and Data Strategy.	Chief Information Officer	September 2021 (transferred from Risk 7)

BAF Risk 9: Failure to ensure systems are in place to effectively manage, monitoring, and reduce COVID-19 infections within the Trust. **Potential Cause(s):** • **Weak infection prevention and control arrangements** • **Inability to provide clean and appropriate clinical environment** • **Lack of appropriate guidance to patients and staff** • **Delayed identification of people at risk of developing infection** • **Sub-optimal isolation facilities** • **Insufficient laboratory support** **Impacting on:** • **The ability to deliver safe care to patients** • **The ability to reduce risk for staff**			**Executive Owner:** **Deputy Chief Executive / Chief Nurse**	
Risk Domain	**Gross (uncontrolled) risk score**	**Net (Current) risk score:**	**Target risk score**	
Quality and Safety	5 x 3= 15 (Extreme Risk)	4 x 2= 8 (High Risk)	4 x 1= 4 (Moderate Risk)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centred care	Safe	Quality Committee / People Committee	**31/03/2021**	
Current controls and assurance		Actions to further enhance risk management		
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
9.1 **Systems to manage prevention and control of infection.**				
Gold and EMB updated on changes to national guidance Patients, visitors and staff temperature checked at front door IPC practices monitored by local management teams and site inspections Staff testing and self-isolation strategies are in place IPC policy and procedure embedded Infection status included in handover (when suspected or confirmed COVID-19 patient moved) Rapid and continued response through ongoing surveillance of rates of infection transmission within the local population Outbreak process in place	Staff testing results Patient testing results Trust incident management (Gold) Sector situation reporting (Gold)	Handover procedure to be updated and strengthened (Quality Priority) Outbreak procedure to be reviewed and published on intranet Evidence of contractor training arrangements Outcome of outbreak investigations to be escalated via PSG and QC	Deputy Chief Executive / Chief Nurse	June 2021
9.2 **Systems to provide a clean and appropriate environment**				
Increased cleaning schedule introduced – at least twice daily for areas with higher contamination rates Enhanced training provided for cleaning teams in COVID-19 areas Enhanced linen cleaning arrangements for covid patients Decontamination and terminal decontamination of isolation rooms & covid areas Regular communication regarding need to clean frequently touched surfaces and electrical equipment Ventilation monitored to ensure appropriate air changes All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Ventilation verification reporting Incident reporting (covid related) Risk register (covid related) Inspection reporting	Evidence of contractor training arrangements Compliance with cleaning schedule monitoring and reporting up Clinical waste management assurance reporting	Deputy Chief Executive / Chief Nurse	June 2021
9.3 **Providing information and guidance to patients and visitors**				

Signs on all areas with suspected or confirmed COVID-19 patients	Inspection reporting	Update internet guidance for visitors	Chief Nurse	June 2021
Signs on infection control for patient and visitors clearly displayed				
Information and guidance on COVID-19 published on internet				
Clear guidance on face masks provided to all patients and visitors				
9.4 **Providing information and guidance to staff, contractors and volunteers**				
COVID-19 intranet site established	Training compliance Inspection reporting Hand hygiene audits		Chief Nurse	June 2021
Programme of all staff webinars				
Signage in all areas outlining PPE requirements				
Fit testing service operating 5 days per week				
IPC mandatory training				
PPE training guidance circulated to all staff (including donning and doffing)				
All staff (clinical and non-clinical) instructed on COVID-19 symptoms				
9.5 **Identification of patients who are at risk of, or have, developed an infection**				
Screening and triaging of all patients as per IPC and NICE Guidance	Daily return to NHSE on Covid-19 admissions and bed occupancy Nosocomial infection rates Inspection reporting		Chief Nurse	June 2021
Triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases				
Standard template for triage questions to ask introduced				
A&E patients isolated and tested				
Programme of re-testing admitted patients				
9.6 **Systems of estate management to reduce risk of infection**				
Mask stations available at entrances and in all clinical areas	Inspection reporting		Deputy Chief Executive / Chief Nurse	June 2021
One way systems introduced				
Social distancing introduced				
Workplace risk assessments undertaken for all areas				
Increased hand sanitizer station introduced				
Separation of patient pathways and staff flow to minimise contact between pathways.				
9.7 **Systems to meet occupational health needs of staff**				
Staff in 'at-risk' groups are identified using an appropriate risk assessment tool	Sickness reporting rate		Interim Director of HR and OD	April 2021 onwards
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing				
Staff who test positive have adequate information and support to aid their recovery and return to work				
Health and Well-being package promoted to all staff				

Closed September 2020. New risk opened – Digital Programme.				
BAF Risk 7: **Short Term: Risk that the EPR programme will not be delivered on time or within budget and that any associated risks, including business continuity, are not effectively managed and mitigated** **Cause(s):** • **Capability/ resource risks** • **Clinician, Executive and other staff engagement (including training)** • **Risks associated with multiple clinical systems and legacy impact** • **The data migration issues or operation of system causes data quality issues post go live impacting on reporting and quality of care** • **Change management does not ensure adoption of best practice and / or benefits realization** **Impacting on:** **The running of the hospitals. The Trust is unable to deliver normal services and contractual responsibilities during periods of significant disruption. Key risks include:** • **Cyber security** • **EPR migration or operational systems** • **Other Major Incidents** **Medium to Long Term: Failure to maximize the benefits from the EPR programme and develop and implement a wider Digital Strategy to support:** • **Modern workforce and requirements of future care** • **Innovation & improvement programmes** • **Needs and convenience of patients and population** • **Wider requirements of London and NWL Strategies**			**Executive Owner:** **Deputy Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
EPR and Digital Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	30/07/20	
Current controls and assurance		Actions to further enhance risk management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
7.1 Joint EPR change board governance process with Imperial College Healthcare Trust in place	Monthly EPR Board Report	Continued monthly EPR/Digital Steering Group	Deputy Chief Executive	January 2021 – transferred to Risk 8 (Digital Programme)
7.2 Development of Digital Strategy in concert with NWL partners	EPR Board Report		Chief Information Officer	January 2021 (transferred to Risk 8 Digital Programme)
7.3 Significant investment programme to address known cyber security weaknesses.	Cyber Security updates to Audit and Risk Committee		Chief Information Officer	Complete - May 2020
7.4 Established series of external Gateway Reviews for Key Stages Go/No Go decisions. External audit assurance and actions monitored at EPR Board and	Monthly EPR Programme Report External Audit gateway reports	Final gateway report due to be reviewed at Finance and Investment Committee ahead of final go live decision	Deputy Chief Executive	Complete – January 2020

Finance and Investment Committee.				
7.5 Data cleaning and optimization embedded process in place to ensure data correction and preparedness for EPR migration. Monitored at EPR board and by external auditor	Monthly EPR Programme Report External Audit gateway reports	N/A	Deputy Chief Executive	Complete for Phase 2 – November 2019
7.6 SOP's in place and refreshed for all IT down time processes	EPR annual audit	N/A	Deputy Chief Executive	Complete – October 2019
7.6 Establishment of Director of Digital Operations post to align operational with technical programme	Monthly EPR Programme Report External Audit gateway reports Established 1:1 meetings with Deputy CEO and Director of Digital Operations	N/A	Deputy Chief Executive	Complete – 2018/19

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.3/May/2021
REPORT NAME	Learning from Serious Incidents (March 2021 data)
AUTHOR	Stacey Humphries, Quality and Clinical Governance Assurance Manager
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	This paper provides an update on the process compliance, key metrics and learning opportunities arising from Serious Incident investigations.
REPORT HISTORY	Executive Management Board, 14 April 2021 Patient Safety Group, 28 April 2021 Quality Committee, 4 May 2021
SUMMARY OF REPORT	During March 2021 the Trust declared 9 External Serious Incidents: • Maternal, fetal, neonatal (2) • Diagnosis/Observations (2) • Patient falls (2) • Provision of care / treatment (1) • Venous thromboembolism (VTE) (1) • Access to care / admissions (1) There were 11 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the NWL Collaborative (Commissioners). A précis of each SI is detailed in the appendices. Quality improvements projects are being undertaken to embed the learning identified from the Trusts highest reported SI categories relating to maternity safety and patient falls. Serious Incident investigations explore problem in care, the contributing factors to such problems, and the root cause(s)/fundamental issues. To support understanding a process of theming across these areas has been undertaken to identify commonalities across Serious Incidents. Key themes arising from investigation relate to; incomplete documentation, sub-optimal processes, adherence to guidance/process/policy. Key themes will be submitted to the Patient Safety Group and the Executive Management Group for consideration of requirement for further Quality Improvement Projects, deep-dives, or targeted action.
KEY RISKS ASSOCIATED	• Critical external findings linked patient harm • Reputational risk associated with Never Events.
FINANCIAL IMPLICATIONS	Penalties and potential cost of litigation relating to serious incidents and never events

QUALITY IMPLICATIONS	Serious Incident investigation provides clinical teams with a structured approach to care and service delivery evaluation and supports the identification of learning opportunities designed to reduce the risk of harm to patients, staff and the public.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Delivering high quality patient centred care
DECISION/ ACTION	This paper is for information/discussion.

1. Introduction

The Chelsea and Westminster NHS Foundation Trust is committed to the provision of high quality, patient centred care. Responding appropriately when things go wrong is one of the ways the Trust demonstrates its commitment to continually improve the safety of the services it provides.

Serious Incidents are adverse events where the consequences to patients, families, staff or the organisations are so significant or the potential for learning so great, that a heightened level of response is justified. When events of this kind occur the organisation undertakes comprehensive investigations using root cause analysis techniques to identify any sub-optimal systems or processes that contributed to the occurrence. The Trust is mandated to report these events on the Strategic Executive Information System (StEIS) and share investigation reports with our commissioners; for this reason these events are referred to as External Serious Incidents within the organisation.

Outcomes from Serious Incident Investigations are considered at Divisional Quality Boards, Patient Safety Group, Executive Management Board, and the Quality Committee so that learning can be shared and improvements enacted.

2. Serious Incidents declared March 2021

The Trust started 9 External Serious Incident Investigations:

Site	Specialty	Ref	Sub category
CW	Emergency Department	INC77424	Delayed or Missed Diagnosis
CW	Rheumatology	INC70249	Delay or failure to monitor
CW	Ophthalmology	INC77118	Delay / failure in access to hospital / care
CW	Cancer Performance	INC76997	Delayed or missed diagnosis of cancer
WM	Stroke	INC77683	Hospital-associated VTE event (during or within 90 days of recent admission)
WM	Maternity / Obstetrics	INC76352	Maternal - Undiagnosed breech in labour **(Case referred to HSIB)**
WM	Care Of Elderly	INC76735	Fall whilst walking/standing
WM	Maternity / Obstetrics	INC77721	Neonatal - Unexpected Neonatal Death **(Case referred to HSIB)**
WM	Care Of Elderly	INC77760	Fall whilst walking/standing

Table 1: External SIs declared in March 2021

The investigations into these events will seek to identify any care or service delivery problems that impacted the outcome and establish actions to reduce the risk or consequence of the event recurring.

3. External Serious Incident completed March 2021

Following review and agreement by the Divisional Serious Incident Panel and the Chief Nurse / Medical Director 11 Serious Incident reports were submitted to the NWL Collaborative (Commissioners).

StEIS Category	Site	Specialty	StEIS reference No.	Degree of harm
Diagnostic incident including delay	CW	Rheumatology	2021/6124	Severe
Diagnostic incident including delay	CW	Paediatric Surgery	2020/21582	Moderate
Diagnostic incident including delay	WM	Clinical Administration	2021/4464	Severe
Diagnostic incident including delay	WM	Imaging	2020/23243	Severe
Slips/trips/falls	WM	Acute Medicine	2020/21159	Death
Slips/trips/falls	CW	Diabetes/Endocrine	2020/21788	Severe
Treatment delay	WM	NICU / SCBU	2020/20968	Low
Maternity/Obstetric incident: mother and baby	WM	Maternity / Obstetrics	2020/23322	Moderate
Maternity/Obstetric incident: baby only	WM	Maternity / Obstetrics	2020/21977	No harm
Maternity/Obstetric incident: baby only **(HSIB case)**	CW	Maternity / Obstetrics	2020/20969	Moderate
Maternity/Obstetric incident: baby only **(HSIB case)**	CW	Maternity / Obstetrics	2020/15933	Moderate

Table 2: External SI reports submitted to the Commissioners in March 2021

4. Learning from Serious Incidents

The Serious Incident investigations are designed to identify weaknesses in our systems and processes that could lead to harm occurring. It is incumbent on the Trust to continually strive to reduce the occurrence of avoidable harm by embedding learning from these events into our improvement plans.

4.1. Individual action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan it developed to address these factors. At the time of writing there are 19 SI actions that have passed their expected due date. Action plan completion is monitored by the Patient Safety Group and the Executive Management Board to ensure barriers to completion are addressed and change is introduced across the organisation (when required).

4.2. Quality Improvement projects

Action plans arising from individual incidents do support organisation wide improvement, however, to offer enhanced assurance that the outcome from serious incidents is leading to change the themes identified are linked to Quality Improvement Programmes.

Quality improvements projects have been commenced to embed the learning identified from the Trusts highest reported SI categories including; Maternity Safety and Patient falls. Outcomes from QI and deep dives will be reported up through the Patient Safety Group and Executive Management Board.

4.2.1. QI Project: Maternity Safety

Computerised CTG provides an objective CTG interpretation and allows the communication of robust, numeric facts instead of opinion. The Dawes/Redman analysis has a database of 100,000 traces; by using this vast numeric data and relating it to outcomes, it acts as an expert assistant for CTG interpretation and accurate interpretation criteria. Whilst final clinical judgement will be based on the entire clinical assessment the introduction of cCTG will support decision making, reduce risk of human error, and address a key theme identified through maternity SIs.

Clinical Leads
Vicki Cochrane, Director of Midwifery & Gynaecology & Tina Cotzias, Service Director WM
Theme
Reduce the risk of human error through the use of computerised antepartum cardiotocogram (CTG) for women who present with reduced fetal movements after 28 weeks
Aims/ key indicators
Objective 1: 95% of women who present with reduced fetal movements have a computerised CTG [cCTG] undertaken by August 2021 Objective 2: 95% of women given the reduced fetal movement information leaflets by 28 weeks & documented that this has been given in the notes by August 2021 Objective 3: 95% of women who present for the 1st time with reduced fetal movements and no other risks factor to have a computerised CTG undertaken and no growth ultrasound scan by August 2021 Objective 4: If a cCTG does not meet the Dawes-Redman criteria escalation is followed 95% of the time in line with local cCTG guidance by August 2021 Objective 5: Balancing measure - Monitor the % of induction of labour when reduced fetal movements is the only indication before 39+0

Project plan / milestones	Progress update
Oct 2020: Set up cross-site maternity working group Jan 2021: Procure Dawes-Redman cCTGs - Feb 2021: Develop education package for staff Feb 2021: Develop guideline March 2021: Implement training package	March 2021 : • The guideline was ratified in December 2020 • Completed procurement of equipment January 2021 • Education package roll-out commenced February 2021 • Data collection proforma developed and plan for prospective audit February 2021 • Launch date planned for April 2021

4.2.2. QI Project: Patient Falls

Reducing in-patient falls was set as a two-year quality priority in 2018/19 and formed part of the Trust's overall frailty improvement plan; the trust achieved its aim to reduce fall rate through successful educational programmes and the introduction of standardised falls assessment care plans. The falls steering group indent to continue this trajectory through quality improvement project designed to address key themes identified within serious incidents.

Clinical Lead	
Helen Kelsall, Divisional Director of Nursing EIC	
Theme	
Reduction of Patient Falls from beds	
Aims/ key indicators	
• Improvement objective 1: Reduce the no. of falls from beds by 30% by April 2021 (Compared to falls occurring 2019/20) • Improvement objective 2: Reduce the use of bed rails • Improvement objective 3: Increase Hi-Lo bed usage	
Project plan / milestones	**Progress update**
The QI project will include the following wards: 1. Rainsford Mowlem (CW) 2. Crane (WM) 3. Acute Assessment Unit (CW) Plan: • Set up a Task group which will include senior nursing membership from all three wards • Identify measures • Design the baseline assessment to audit current usage of bed rails and Hi-Lo beds • Review the availability of Hi-Lo beds to support the proposed increased usage • Develop a list for keys changes required to embed learning	March 2021: This project was delayed due to the impact of Covid. The team are in the process of identifying baseline figures for floor line bed usage over the last 2 yrs. A bed rail audit tool has been designed and will be launching at a falls quality round in May 2021 to establish baseline information on Bed rail use appropriateness. AAU have undertaken some initial improvement work including a falls safety huddle at the start of the shift to ensure patients' needs can be care planned as effectively as possible. There was a reduction in falls for the 3 subsequent months. These then increased and so are planning the addition of a new intervention to support a further sustained reduction.

4.3. Thematic review

Serious Incident investigations explore problem in care (what?), the contributing factors to such problems (how?) and the root cause(s)/fundamental issues (why?). To support understanding a process of theming across these areas has been undertaken to identify commonalities across External Serious Incidents submitted to commissioners since 1st April 2020 (excluding HSIB maternity SIs).

The review did not seek to weight the themes according to their influence on an event but merely to identify their occurrence; this provided increased insight into the more common factors associated with serious incident investigation and increased the opportunity to identify overarching improvement actions.

A review of the 43 reports submitted to the CCG between 1st April 2020 and 31st March 2021 identified 232 themes. Key themes contributing to the serious incident were:

- Documentation: Incomplete/missing – 18 SIs
- Process - Non-adherence to guidance/process/policy – 17 SIs
- People: Patient factors – 17 SIs
- Process – Sub-optimal guideline/ process/ policy – 15 SIs
- Staff: Knowledge/awareness – 14 SIs
- Communication Internal – Communication failure between different specialties or teams – 13 SIs
- Treatment/Care: Observations/patient reviews (Delayed/inadequate/missed) – 11 SIs

18 (42%) of the Serious Incidents reviewed identified issues with incomplete or missing documentation; the identification of this theme does not mean missing documentation led to the event occurring but highlights the issue of poor documentation standards identified by the investigation process.

17 (40%) of the Serious Incidents reviewed identified issues with non-adherence to guidance/process/policy. This theme frequently appeared in incidents relating to patient falls and diagnostic incidents.

A codified theming list has now been added to the Datix incident system; following submission of all external SIs (excluding HSIB maternity cases) themes will be identified.

Key themes will be submitted to the Patient Safety Group and the Executive Management Group for consideration of requirement for further Quality Improvement Projects, deep-dives, or targeted action. Updates on these programmes of work will be reported to the Quality Committee.

5. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Correctable causes and themes are tracked by the Patient Safety Group and the Executive Management Board to ensure change is embedded in practice.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.4/May/21
REPORT NAME	People Performance Report
AUTHOR	Karen Adewoyin, Deputy Director of People and OD
LEAD	Sue Smith, Interim Director of HR & OD
PURPOSE	The People and OD Committee KPI Dashboard highlight's current KPIs and trends in workforce related metrics at the Trust.
REPORT HISTORY	Workforce Development Committee have reviewed a more in-depth, detailed version of the KPI's. Executive Management Board – via e-governance People and OD Committee, 27 April 2021
SUMMARY OF REPORT	The dashboard is to provide assurance of workforce activity across eight key performance indicator domains; • Workforce information – establishment and staff numbers • HR Indicators – Sickness and turnover • Employee relations – levels of employee relations activity • Temporary staffing usage – number of bank and agency shifts filled • Vacancy – number of vacant post and use of budgeted WTE • Recruitment Activity – volume of activity, statutory checks and time taken • PDRs – appraisals completed • Core Training Compliance • Volunteering It also includes an update on the key work streams for Workforce and progress made during the month up to end February 2021.
KEY RISKS ASSOCIATED	The majority of KPI's have started to return to pre-COVID-19 levels
FINANCIAL IMPLICATIONS	Costs associated with turnover and sickness and the impact on staff of COVID-19
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability and the impact on staff of the pandemic.

EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.
LINK TO OBJECTIVES	• Be the employer of choice
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the People and Organisational Development Committee

Month 12 – March 2021

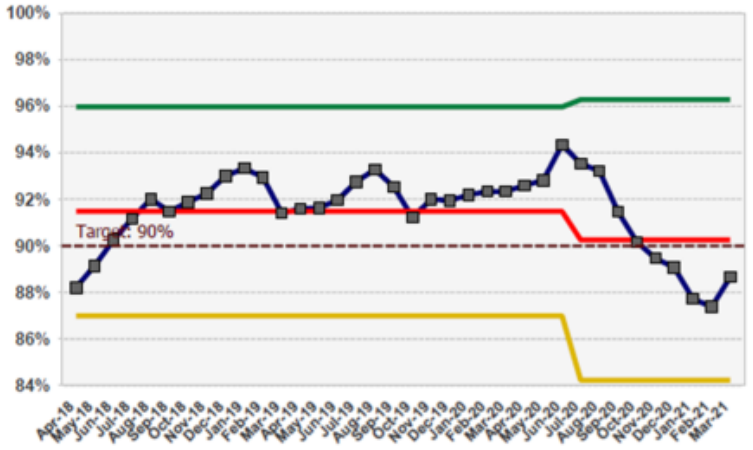
Statistical Process Control – Apr2018 to Mar2021

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

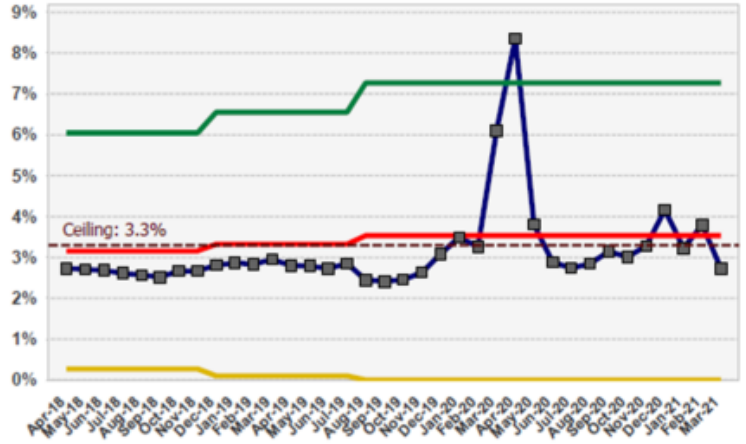
WORKFORCE INDICATORS

Statistical Process Control Charts for the last 36 months

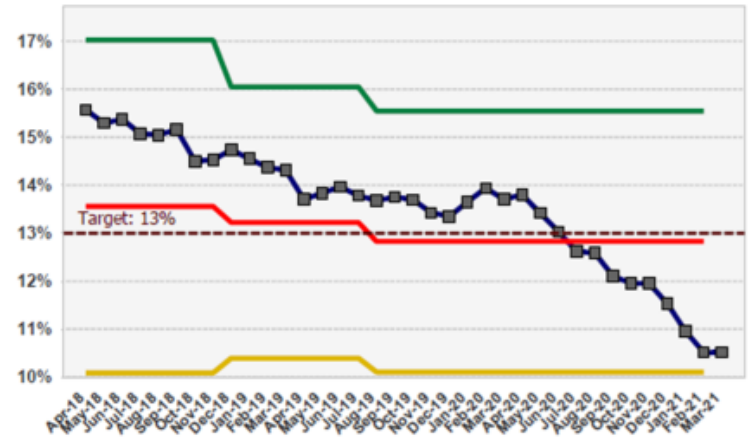
Mandatory Training compliance



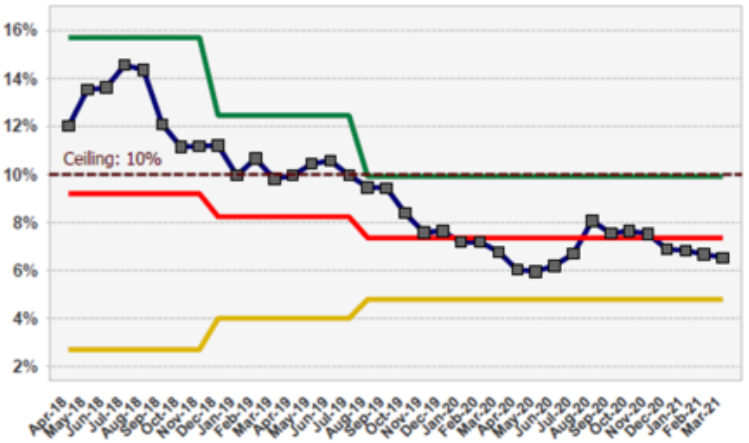
Sickness absence



Staff voluntary turnover rate



Vacancy rate



People and Organisational Development Workforce Performance Report March 2021
Key Performance Indicators

NHS Chelsea and Westminster Hospital NHS Foundation Trust

Item	Units	This Month Last Year	Last Month	This Month	Target / Ceiling	RAG Status			Trend
						Red	Amber	Green	
1. Workforce Information									
1.1 Establishment	No.	6333.84	6,419.62	6,440.76					↑
1.2 Whole time equivalent	No.	5952.07	5991.44	6019.80					↑
1.3 Headcount	No.	6436	6472	6495					↑
1.5 Overpayments (Number)	No.	62	32	40					↑
1.4 Overpayments (Costs)	£	132,526.93	173,292.66	190,726.21					↑
2. HR Indicators									
2.1 Sickness absence	%	8.31%	3.79%	2.73%	<3.3%				↓
2.2 Long Term Sickness absence	%	2.08%	1.83%	1.54%					↓
2.3 Short Term Sickness absence	%	6.23%	1.96%	1.19%					↓
2.4 Gross Turnover	%	17.93%	16.16%	16.21%	<17%				↑
2.5 Voluntary Turnover	%	13.80%	10.51%	10.52%	<13%				↑
3. Employee Relations									
3.1 Live Employment Relations Cases	No.	118	112	112					↔
3.2 Formal Warnings	No.	0	1	1					↔
3.3 Dismissals	No.	1	2	2					↔
4. Temporary Staffing Usage									
4.1 Total Temporary Staff Shifts Filled	No.	10882	15173	16418					↑
4.2 Bank Shifts Filled	No.	9640	13176	15414					↑
4.3 Agency Shifts Filled	No.	1242	1997	1004					↓
5. Vacancy									
5.1 Trust Vacancy Rate	%	6.01%	6.67%	6.54%	<10%				↓
5.2 Corporate	%	-9.06%	-0.09%	2.94%	<10%				↑
5.3 Clinical Support Services	%	8.94%	9.24%	9.11%	<10%				↓
5.4 Emergency & Integrated Care	%	8.29%	8.05%	7.76%	<10%				↓
5.5 Planned Care	%	8.57%	5.77%	4.30%	<10%				↓
5.6 Women's, Children and Sexual Health	%	3.44%	6.59%	6.41%	<10%				↓
6. Recruitment (Non-medical)									
6.1 Offers Made	No.	73	112	103					↓
6.2 Pre-employment checks (days)	No.	29.9	25.9	20.4	<20				↓
6.3 Time to recruit (weeks)	No.	10.96	9.52	8.66	<9				↓
7. PDRs Undertaken (AfC Staff over 12 months)									
7.1 Trust PDRs Rate (AfC Staff)	%	84.42%	89.62%	89.19%	≥90%				↓
7.2 Corporate	%	82.66%	84.94%	80.99%	≥90%				↓
7.3 Clinical Support Services	%	79.08%	90.38%	89.97%	≥90%				↓
7.4 Emergency & Integrated Care	%	90.77%	91.92%	92.79%	≥90%				↑
7.5 Planned Care	%	89.43%	91.02%	91.12%	≥90%				↑
7.6 Women's, Children and Sexual Health	%	80.22%	88.23%	88.03%	≥90%				↓

People and Organisational Development Workforce Performance Report March 2021
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

March 2021 SICKNESS

Division	Sickness Abs.	RAG Status Ceiling <3.30%	Available WTE hours	Absence WTE hours	Episodes	Long Term (WTE hours)	% Long Term	Prev. Month	% +/-
Corporate	1.55%		19218.47	298.68	34	124.68	0.65%	1.73%	-0.18%
Clinical Support	3.65%		31046.08	1134.17	143	845.60	2.72%	5.27%	-1.62%
Emergency & Integrated Care	2.10%		50465.25	1062.17	208	498.53	0.99%	3.05%	-0.95%
Planned Care	2.69%		32649.57	879.18	176	385.55	1.18%	4.20%	-1.51%
Women's, Children and Sexual Health	3.25%		52803.60	1713.51	261	1016.72	1.93%	4.13%	-0.88%
Trust	**2.73%**		**186182.97**	**5087.71**	**822**	**2871.08**	**1.54%**	**3.79%**	**-1.06%**

March 2021 Core Training

Course	Last Month	This Month	Target	RAG Status	Trend
Core Training Compliance Overall	87%	89%	<90%		↑
Theory Adult BLS	70%	71%	<90%		↑
Practical Adult BLS	70%	74%	<90%		↑
Conflict Resolution - Level 1	96%	96%	<90%		↔
Equality & Diversity	94%	94%	<90%		↔
Fire	86%	88%	<90%		↑
Health & Safety	94%	94%	<90%		↔
Infection Control (Hand Hygiene)	92%	92%	<90%		↔
Infection Control - Level 2	90%	91%	<95%		↑
Information Governance	86%	90%	<95%		↑
Moving & Handling - Level 1	91%	91%	<90%		↔
Moving & Handling - Level 2 Theory	78%	84%	<90%		↑
Moving & Handling - Level 2 Patient	65%	70%	<90%		↑
Safeguarding Adults Level 1	94%	93%	<90%		↓
Safeguarding Adults Level 2	91%	91%	<90%		↔
Safeguarding Adults Level 3	84%	85%	<90%		↑
Safeguarding Children Level 1	94%	94%	<90%		↔
Safeguarding Children Level 2	91%	92%	<90%		↑
Safeguarding Children Level 3	76%	90%	<90%		↑

March 2021 Employee Relations

Category	Metric	Number / %
No of Disciplinary cases opened in month	Number	2
No of current, live disciplinary cases	Number	5
Length of Disciplinary cases	Days <60	34.6
Total Disciplinary cases in year (from April 2(	Number	19
% BAME Disciplinary Cases in year	%	68%
% BAME Disciplinary Cases in month	%	50%
Exclusions - No. of live in month	Number	0
Grievance - No. of live cases in month	Number	9
Grievance – Average length of case	Days	75.6
B&H cases - included in grievance numbers	Number	9
Sickness - No. of cases in month	Number	90
Long Term - sickness cases in month	Number	62
Short Team - sickness cases in month	Number	28
No. of Employment Tribunals (ET)	Number	10
Managers having ER training (from April 20)	Number	20
No. of informal queries (disciplinary process	Number	5
MHPS cases	Number	9

March 2021 Vacancy / Bank and Agency Ratio on "Fill Rate"

Division	Budgeted WTE	Staff in Post (WTE)	Vacancy (WTE)	Bank Usage (WTE)	Agency Usage (WTE)	**Total WTE Used	Budget minus Used WTE	RAG Status
Corporate	641.42	622.56	18.86			647.75	-6.33	
Clinical Support	1105.35	1004.65	100.70			1097.22	8.13	
Emergency & Integrated Care	1770.06	1632.78	137.28			1773.04	-2.98	
Planned Care	1102.16	1054.78	47.38			1111.25	-9.09	
Women's, Children and Sexual Health	1821.77	1705.03	116.74			1785.27	36.50	
TRUST	**6440.76**	**6019.80**	**420.96**			**6414.53**	**26.23**	

March 2021 Voluntary Turnover

Division	Turnover	Prev Month	% + / -
Corporate	12.10%	11.27%	0.83%
Clinical Support	9.83%	9.93%	-0.10%
Emergency & Integrated Care	12.84%	12.88%	-0.04%
Planned Care	8.33%	8.50%	-0.17%
Women's, Children and Sexual Health	9.50%	9.60%	-0.10%
TRUST	**10.52%**	**10.51%**	**0.01%**

Key to Sickness Figures

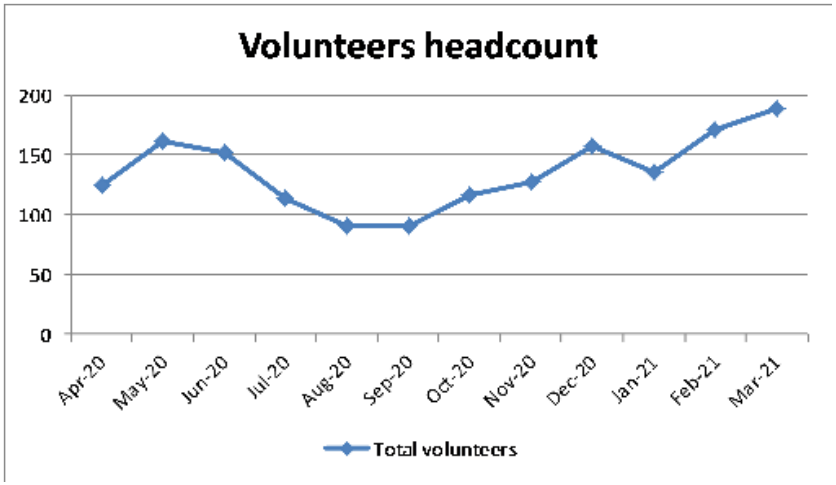
Sickness Absence = Calendar days sickness as percentage of total available working days for past 3 months (days x ave FTE)

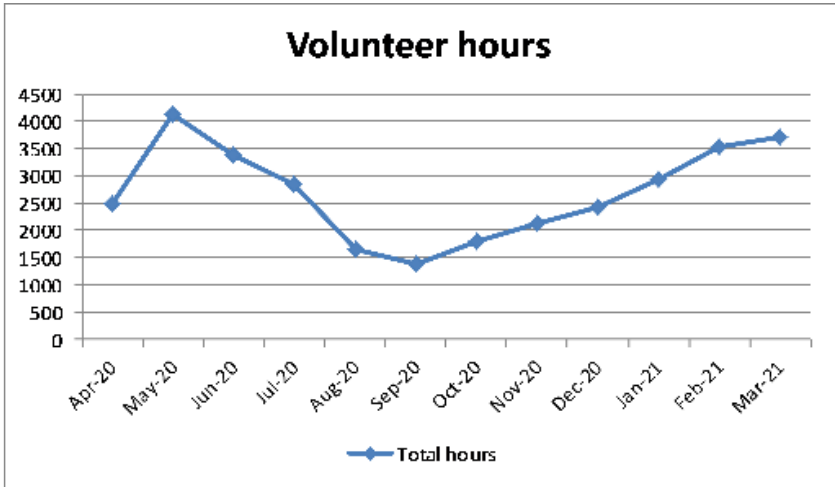
Episodes = number of incidences of reported sickness

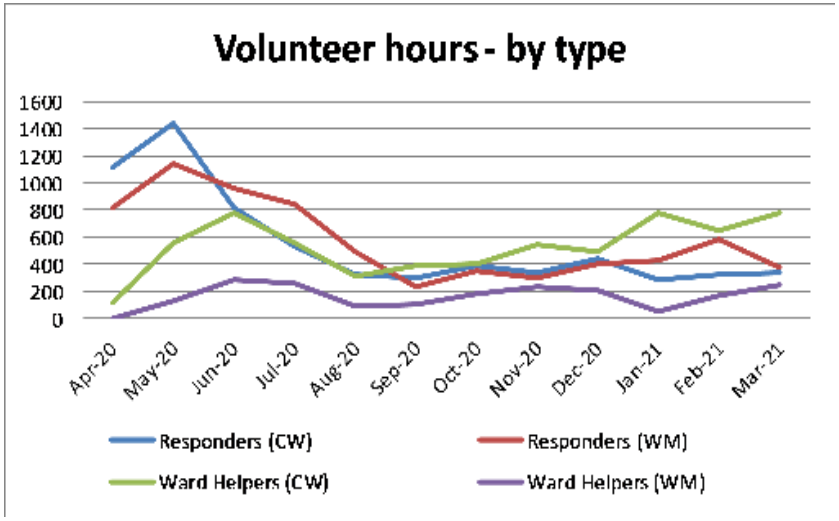
A Long Term Episode is greater than 27 days

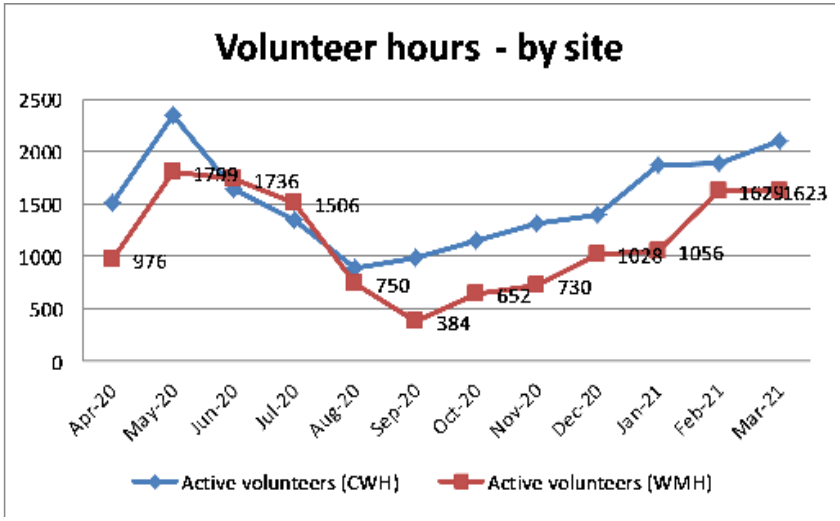
**Total WTE Used Adjusted to account for staff currently on maternity leave & establishment adjustments

People and Organisation Development Workforce Performance Report
Volunteer Staff Activity Profile – March 2021

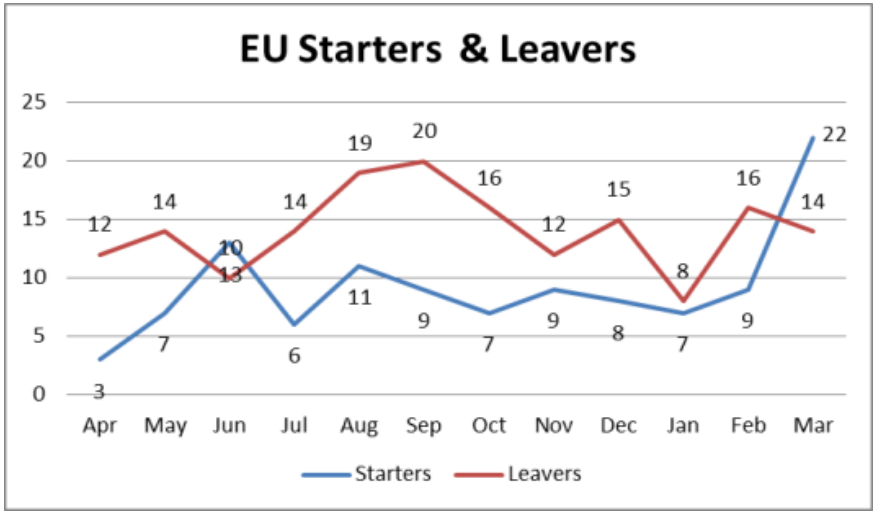








People and Organisation Development Workforce Performance Report
EU Staff Profile – March 2021



Area	Settled Status / Headcount Yes	No	Total	Yes %
Bank	**88**	**413**	**501**	**18%**
BNK Staffbank Temporary Staffing Division	88	413	501	18%
Medical	**13**	**43**	**56**	**23%**
COR Corporate Division		1	1	0%
CSD Clinical Support Division	3	1	4	75%
EIC Emergency & Integrated Care Division	1	12	13	8%
PDC Planned Care Division	3	9	12	25%
WCH Womens, Childrens and Sexual Health Division	6	20	26	23%
Non-Medical	**145**	**177**	**322**	**45%**
COR Corporate Division	32	22	54	59%
CSD Clinical Support Division	29	22	51	57%
EIC Emergency & Integrated Care Division	25	58	83	30%
PDC Planned Care Division	22	25	47	47%
WCH Womens, Childrens and Sexual Health Division	37	50	87	43%
Grand Total	**246**	**633**	**879**	**28%**

EU Staff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Starters	3	7	13	6	11	9	7	9	8	7	9	22	111
Leavers	12	14	10	14	19	20	16	12	15	8	16	14	170

Narrative:

The Trust continues to send out regular communications to EU staff to ensure that they apply for settled status by the deadline of 30 June 2021. Staff are asked to notify the Trust once they have successfully applied, so that this can be recorded on ESR, although there is no requirement for staff to provide this prior to 30 June 2021. The staff who have provided this information is captured in the above table. This information also includes bank members of staff – which has increased significantly in 2021 due to the vaccination programme. The number of EU leavers was 14 in March and the number of EU starters increased from 9 to 22 between February and March 2021.

People and Organisation Development Workforce Performance Report March 2021

Establishment, Staff in Post and Vacancies:

The Trust currently employs 6495 people working a whole time equivalent of 6020 which is 28.36 WTE higher than February. This equates to 112 wte more permanent members of staff than this time last year. There has been a decrease in the vacancy rate for March, 6.54% against the Trust ceiling of 10% and a small improvement since the same time last year which was 6.77% The qualified nursing vacancy rate is 4.93% and remains one of the lowest in the country with a national median of 12.75%. The medical vacancy rate has increased to 0.84% and is in quartile 2 in Model Hospital with a national median of 7.43%. Further work is continuing to review historical gaps and establishment of trainee doctors so pro-active recruitment can be taken at an early stage. AHP (5.04%) S&T (10.06%) are also in line with the national median but AHP at this level sits in quartile 3.

Temporary Staffing:

Demand for temporary staff rose again in March, but we saw fill rates recover as staffing levels improved and the second COVID19 surge subsided. Overall, demand was down 5.3% compared to March 2020, but by the same comparison bank fill rates improved by 15%. Agency usage approximately halved compared to February, and was at its lowest point since September last year. However we have seen an increase in Agency used for the Medical and Dental staff group, with the number of shifts booked 200% higher than in February, albeit we remained 25% down year on year. Retrospective bookings were at 10.5% which is the lowest figure the Trust has recorded to date.

Core Training Compliance:

Overall compliance has risen to 89% this month, having fallen to 87% last month and work is on-going to continue this rise in the compliance on all topics. Ten topics have risen this month and seven have remained the same. The work put in has started to pay dividend with Theory M&H rising 6% and Practical M&H rising 5% and multiple additional sessions planned to allow staff to book on. BLS has also risen 4% to 74% and funding has been granted for 6 months additional Resus officer to provide further sessions and increase compliance. IG saw a 4% increase this month and sits at 90%. (National target for IG is 95%). The IG team have resumed contacting all non compliant staff to remind them to undertake their training. The same approach has been taken in respect of Fire training which has also see a 2% increase but this was only commenced mid-month. The biggest improvement has been for safeguarding level 3 , 14%, due to a change in recording processes linked to the MUMs training. The only topic to have gone down this month is Safeguarding Adults level 1 by 1%(to 93%) but this remains above the 90% compliance rate expected

Sickness Absence:

The Trust's sickness rate is 2.73%, which is lower compared to last month and lower than this time last years due to COVID19 related challenges. Our sickness target of 3.3% has been breached six times during the last 31 months peaking in April '20 due to Covid-19 . This compares favorably with peers and the Trust remains in the lower quartile on Model Hospital. The three most common reasons for sickness were Anxiety/depression/other, Chest & respiratory problems which include Covid-19 related absence and back problems. The top sickness reason for the number of days lost were anxiety and depression and Covid-19 related absence making up the highest reason for both number of episodes and days lost. The ER team have agreed a targeted approach with the division to review this and plan accordingly.

Staff Turnover Rate: Voluntary:

Voluntary turnover has increased to 10.52% and is below the Trust target for the ninth consecutive time and lowest it's been in recent years. The third highest reason for leaving (preceded by promotion and relocation) is work/life balance. The recently approved health and well-being strategy has a key focus on solutions to help all our staff enjoy a good work-life balance, such as a better availability of flexible working options, offering a backup care service for staff who have children or care for elderly or vulnerable adults, as well as a nursery partnership to enable staff to afford childcare in London. The recent staff survey results have highlighted that 26.6% of respondents often think about leaving the Trust, and 24.6% will probably look for a new job, and clearly there has been reduced turnover due to COVID. The staff survey results also give an indication of where staff are thinking of moving to, and 12% would be looking to move to a different role in our organisation, 23.5% another NHS Trust, 4.1% healthcare but outside of the NHS, 4.5% leaving healthcare altogether and 6.8% looking to retire. The last 3 have all reduced since 2019. Therefore a focus for the retention group is to review hotspot areas of specific risks of higher turnover and wider Trust promotion of secondment and career breaks.

PDRs:

The PDR rate for March was 89.19%, decreased by 0.43% from the previous month however this is now a focus for managers to ensure all staff have their PDR's.

People and Organisation Development Workforce Performance Report March 2021

Diversity & Inclusion:

Key highlights in the last month included celebration of International Women's Day in early March with #Choose To Challenge as the theme. The rescheduled BAME staff network went ahead and was dedicated to vaccine hesitancy. The staff network leads and special advisor to the executive management board held a scheduled quarterly meeting in March with representatives from HR and communications. A number of topics were discussed including staff survey results, themes and trends, network specific health and wellbeing champions, dates for network presentations to POD for the coming year, adding inclusion objectives into senior manager's appraisals and funding for staff networks and activities. A draft outline for the staff network executive sponsor role was agreed and was to be sent to current sponsors for comment. Head of Inclusion and Wellbeing Staff Engagement post has been advertised. A grant application was put forward to CW+ to pilot virtual reality EDI training work with a company Virtual Bodyworks, to reduce unconscious bias which was successful.

Leadership and Development:

Management Fundaments programme was launched in January 2019. Since its launched over 200 staff have a attended a variety of the courses offered. The course with the highest number of attendance are Management vs Leadership, PDR and Time Management. To support the Trust EDI agenda we have updated the programme to include a session on Equality, Diversity and Inclusion. The management fundamentals programme has been mapped to ILM standards to convert the programme to an apprenticeship at level 3 or 4. This will enable the Trust to be paid for the delivery of the programme and for staff participating to have a recognised qualification. Emerging Leaders programme have restarted with Cohort 15 and 16. There are 18 delegates participating. The programme has revised and expanded to have additional sessions to meet the demand required from leaders that is highlighted by the pandemic. Stakeholder engagement for Talent and Succession Planning have commenced. In total there are more than 20 people across various levels of the organisation that have participated.

Health and Wellbeing:

During the last month there has been a focus on the rest, recovery and recuperation of staff and included the offer of two additional days across NWL for staff to take a rest and recovery day before the end of June and also to take their birthday off to spend time with their families and friends in recognition of the work undertaken over the last year. The Health and Wellbeing Committee meets monthly and during April the group met to review the staff survey results specifically looking at the health and wellbeing questions and hotspot areas, across particular departments, staff groups to ensure that there is a focus in these areas, and also where there are particularly high scores to understand good practice to share. The group also focused on the support needed to have good wellbeing conversations with staff to ensure that these are handled well and staff have a good experience. Across NWL the leads meet weekly to discuss areas of collaboration and whilst the focus has been on the rest and recuperation medium term plans, the group are starting to focus on longer term collaborative work across NWL in the health and wellbeing space. The new programmes of activity such as the back up care, cycle servicing, counselling provision are going well with increasing uptake and very positive feedback from staff who have been using the services. The health and wellbeing champions and mental health first aiders forum is proving a useful forum to support staff undertaking these roles and also to gather feedback. At present the team are working on starting the RESET health programme and a number of staff through the risk assessment process have been identified as suitable, the procurement process for a nursery partnership, re-starting on-site exercise classes and potentially partnering with Harlequins to deliver outdoor rugby, walking clubs, outdoor exercises. The new wage stream service to support financial wellbeing has had 474 staff sign up, 58 have used the streaming of wages and there have been 313 separate wage streams. The team are also preparing for a number of upcoming wellbeing days and events such as stress awareness month, Get on Your Feet Britain day, and mental health awareness week.

People and Organisation Development Workforce Performance Report March 2021

Transactional Plan:

As focus shifts to the recovery of recruitment lead times following the second wave of the pandemic, time to hire has reduced to an average of 8.6 weeks and is now within Trust target. There will be continued focus around reducing recruitment lead times over the upcoming months whilst also engaging with the corporate nursing team and NHSE/I to further reduce vacancy rates through programmes such as the Health Care Worker Support Programme and international recruitment. Following the launch of the diversity and inclusion champions (D&I Champions) programme for roles at band 8a and above in Q1 last year, consideration will now be given to extending the programme to band 6 and 7 roles across the Trust, with increased training sessions for DIC champions and refreshed guidance for hiring managers and interview panels on inclusive recruitment practices.

Mass Vaccination Recruitment Programme

The Trust has been selected as the lead employer for recruitment to the North West London mass vaccination sites. The recruitment and staff bank teams are currently processing over 4300 candidates for deployment to various hubs across the sector. The first mass vaccination centre was opened in mid-January and so far the teams have successfully cleared over 2300 candidates for deployment including volunteers from the Imperial Medical School. We currently have 9 mass vaccination sites open across North West London with another opening in May. Activity in the mass vaccination sites has been heavily reliant on vaccine delivery. In order to support the update on the vaccine, a number of call centres have been temporarily set up in the CCGs and we have utilised the available Admin bank workers to staff these and drive increased vaccination uptake across NWL.

Employee Relations

During January and February 2021 some ER activity was paused due to covid-19 and the need to redeploy some of the team to other roles to support with sickness reporting and welfare calls to staff. Support for complex disciplinary, grievance and MHPS cases did however continue. All ER casework resumed in March 2021; however the pause has impacted on some timeframes, particularly for grievance cases where the average length of case was 75 days. There were two new disciplinary cases opened in March, bringing the total for the financial year to 19 cases. The average length of cases for March was 34.6 days

Organisational Change

The HR team continue to support an increasing number of organisational change programmes. Currently, there are 2 live consultations affecting just over 30 staff members.

Volunteers:

Since 1st April 2020 the Trust has benefited from the support of 400 active volunteers contributing 32,738 hours of volunteering in total. There were 188 active volunteers in March, contributing 3718 hours of volunteering across both sites. Volunteer responders have superseded the bleep role and contributed 726 hours across both sites in March. Volunteers continue to play a key part in supporting the vaccine roll-out although the service is increasingly reorienting towards business as usual. It is anticipated that some volunteers will choose to leave or pause their volunteering as lockdown eases, people return to work from furlough, and young people take their exams. The service is actively recruiting volunteers..

Apprenticeships:

In the Trust we have nearly 200 staff currently completing a variety of Clinical and Non -Clinical apprenticeship programmes. We currently have 76 staff on Non-Clinical apprenticeships including the Senior Leadership programme as well 13 programmes which includes five additional programmes that have been added for a variety of staff in different roles including within Finance, Learning & Development. Across Clinical Apprenticeships we have 113 staff on a variety of programmes including the Nursing Associate, Diagnostic Radiographer and Healthcare Support Worker as well as a few others. Our numbers have enabled us to utilise the levy of which our current usage is 40%. Throughout the pandemic we have managed to recruit new Healthcare Support Workers with an expected 24 due to start in the coming weeks. From the launch of National Apprenticeship Week on the week commencing 8th of February and the promotion of the internal and external webpage on Apprenticeships, we raised awareness of apprenticeships and the benefits they offer for staff looking to further their career development and progression. In total we have 27 staff members who have successfully completed apprenticeships over Clinical and Non-Clinical programmes with more planned completions later in the year.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.5/May/21
REPORT NAME	Learning from deaths: Q4 Mortality Report
AUTHOR	Alex Bolton, Associate Director of Quality Governance
LEAD	Roger Chinn, Chief Medical Officer
PURPOSE	This paper updates the Board on key metrics relating to the Trust's learning from death approach.
REPORT HISTORY	Executive Management Board, 14 April 2021 Quality Committee, 4 May 2021
SUMMARY OF REPORT	The Trust-wide SHMI relative risk of mortality between January 2020 and December 2020 demonstrates that both sites have outcomes significantly below the expected range; the CWH site has a SHMI value of 75.06, the WHUH site 79.85. Overall the Trust SHMI is 77.97 and is one of the best performing Trust's within NHS England. Following consultation a revised mortality review process has now been reinstated; the revised process includes a new screening step (see appendix A for process flow). The Divisional Mortality Review Groups are charged with providing scrutiny of aligned mortality cases, to identify themes, and to escalate any issues of concern. Outcomes from the revised processes will be submitted to the committee within subsequent reports. Covid-19 has had a significant impact on crude mortality but current trends indicate the rate returning to 5 year mean average. A step change (improvement) in the relative risk of mortality has been experienced since March 2017 and has continued within Q3 2020/21; this is an indicator of improving outcomes and safety. The outcome of mortality review has provided a rich source of learning; the resumption of the Trust wide review process will support the organisation's improvement objectives and improve assurance reporting to the committee.
KEY RISKS ASSOCIATED	The paused mortality review process impacting the recognition and response to learning from death.
FINANCIAL IMPLICATIONS	Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
QUALITY IMPLICATIONS	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Deliver high quality patient centred care
DECISION/ ACTION	For noting.

Mortality Surveillance

1. Background

In response to increasing clinical demand and impact on staffing as a result of Covid-19 the organisations mortality review process was paused. The following arrangements were introduced to provide assurance that the Trust continues to learn from deaths and has processes in place to recognise and respond to sub-optimal care.

- All in-hospital deaths logged to the mortality module by the Medical Examiner's Officers
- Medical Examiners (MEs) commissioned to scrutinise in-hospital deaths and provide an opportunity for the bereaved to raise concerns
- Where ME scrutiny identifies the potential for Trust learning specialty case review or clinical governance input to be sought; this process is overseen by the Clinical Governance Department
- Potential learning opportunities identified via Medical Examiner scrutiny are reported to the Mortality Surveillance Group
- Weekly monitoring of crude mortality relating to covid reported to gold command

Following consultation a revised mortality review process has now been reinstated; the revised process now includes a new screening step (see appendix A for process flow). The Divisional Mortality Review Groups are charged with providing scrutiny of aligned mortality cases, to identify themes, and to escalate any issues of concern.

The objectives of the Divisional Mortality Review Groups include:

- To oversee the Specialty and Divisional Mortality Review processes
- To monitor the timeliness of review of all deaths (within 45 days for completion of specialty mortality review)
- To review all deaths with identified suboptimal care (CESDI >0), agreeing any that require escalation as a possible SI
- To identify the trends, actions and learning from mortality reviews
- To escalate issues, themes or notable learning to the Trustwide Mortality Surveillance Group
- To ensure at least 30% of in-hospital deaths are given full mortality review

2. Relative risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) to monitor the relative risk of mortality within our hospitals. This tool was developed by NHS Digital to calculate the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 is lower than expected mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI is designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between our sites and peer organisations and seek to identify improvement areas where there is variance.

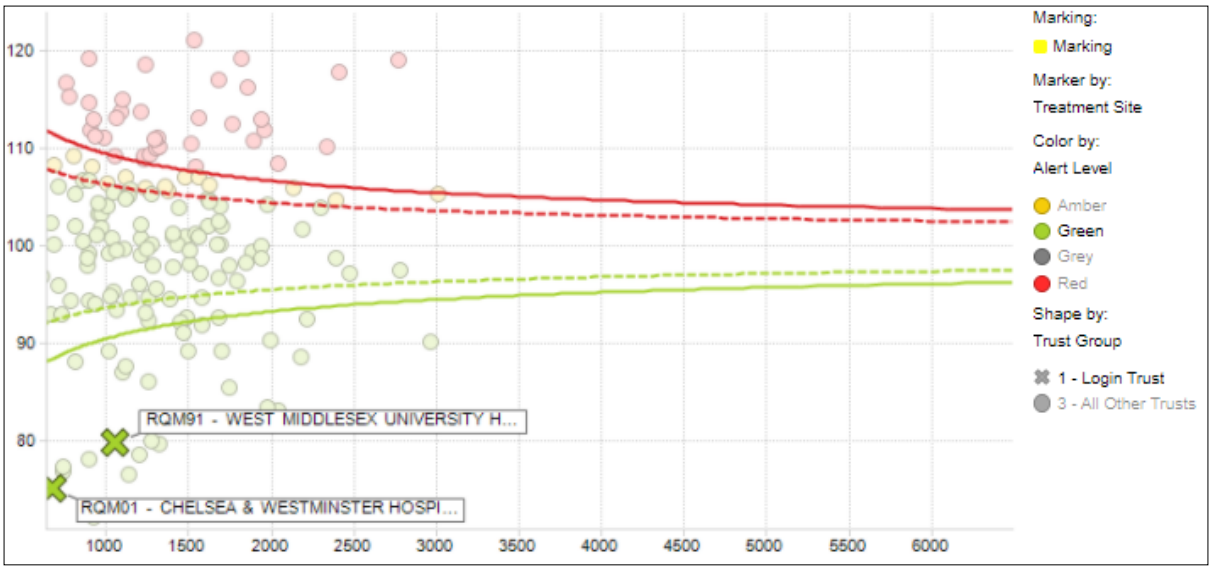


Fig 1 – SHMI comparison of England acute hospital sites based on outcomes between Jan 2020 and Dec 2020

The Trust remained one of the best performing in terms of relative risk of mortality with a Trustwide SHMI of 77.98 recorded for this period. This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- WestMid, expected 1049 deaths, observed 838, SHMI value 79.85
- ChelWest, expected 745 deaths, observed 540, SHMI value 75.06

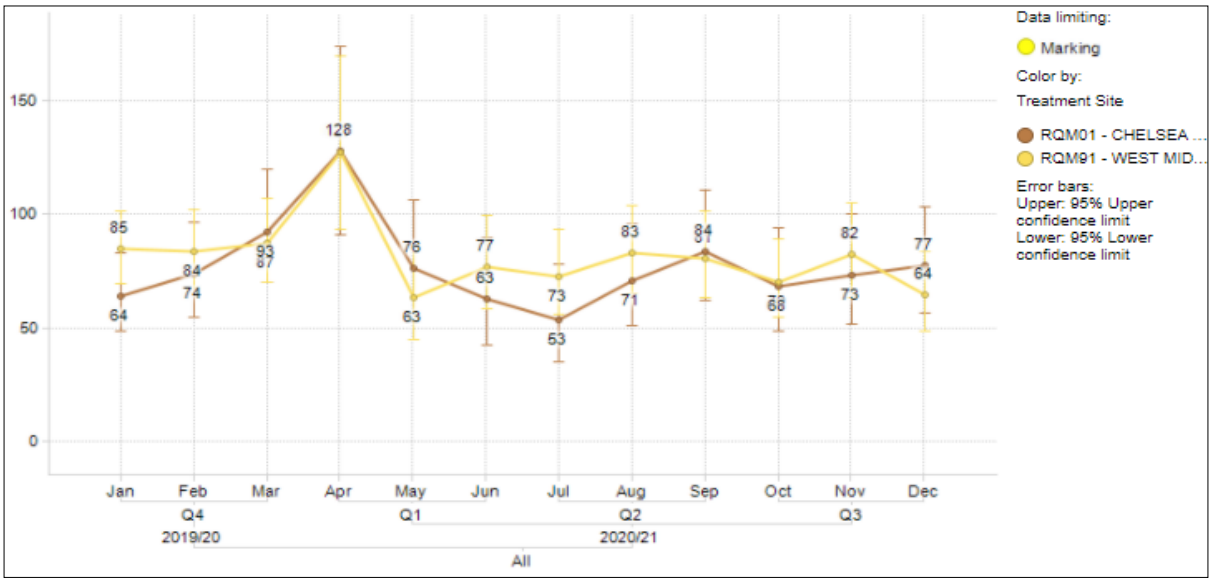


Figure 2: Monthly SHMI trend comparison of the WMUH and CWH sites

Covid-19 activity is excluded from the SHMI as the tool was not designed for this type of pandemic activity. Significant national data modelling is taking place regarding the relative risk of mortality associated with Covid-19; outcomes from these publications will be monitored by MSG and CEG.

3. Diagnostic & procedure groups

The overall relative risk of mortality on both sites is within the expected range, however, the Mortality Surveillance Group seeks further assurance by examining increases in relative risk associated with procedure and diagnostics groups. Where higher than expected relative risk linked to a diagnostic or procedure group is identified a further review of those patients within the cohort is undertaken. Following consideration no patient safety concerns have been raised with individual procedure or diagnostic groups during this reporting period.

4. Crude mortality

Emergency spells (activity) and the deaths associated with those spells (crude number) can be used to calculate the rate of in-hospital deaths per 1000 patient spells (this calculation excludes elective and obstetric activity).

Crude mortality rates must not be used to make comparisons between sites due to the effect that population demographics, services offered by different hospitals, and services offered by intermediate / community care has on health outcomes (e.g. crude mortality does not take into account the external factors that significantly influence the relative risk of mortality at each site). Crude mortality is useful to inform resource allocation and strategic planning.

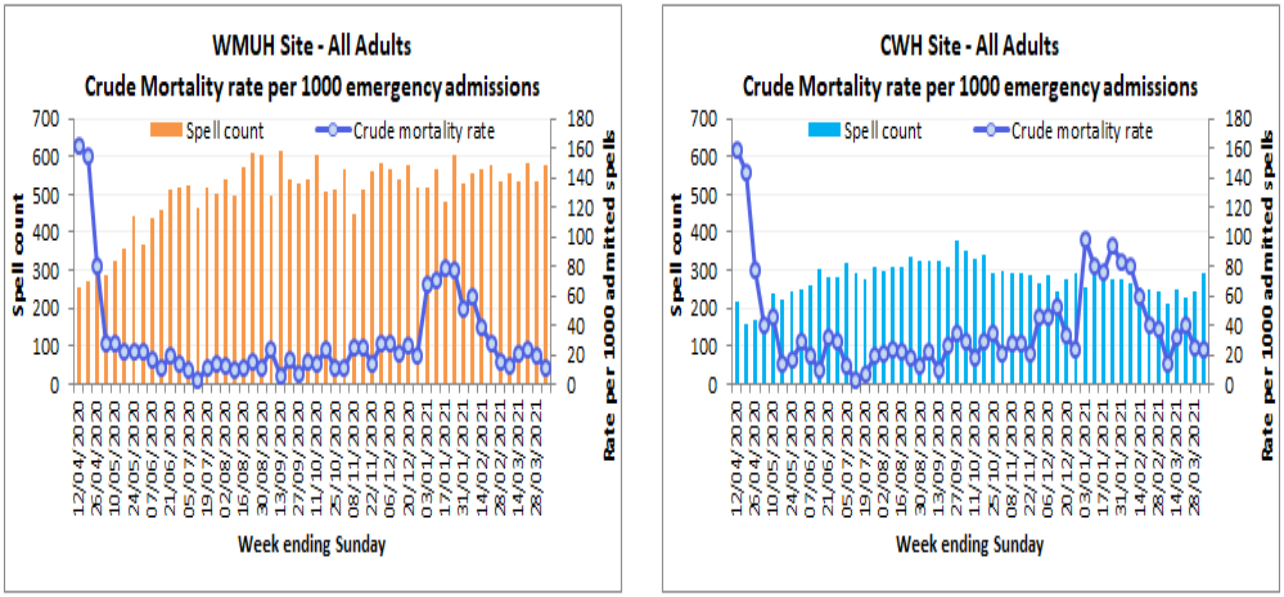


Fig 2: Crude Mortality– Trust Level. Period WE 23/02/2020 to WE 14/02/2020

Significant variation in weekly crude mortality rates have been experienced during this 52 week period; during the first covid-19 surge in March / April 2020 activity dropped sharply and the crude mortality rate rose. A second sharp increase in crude rate was experienced in January, activity was maintained but the crude rate peaked on the 17th January before rapidly reducing in February.

The count of in-hospital deaths demonstrates that the highest single week for mortality of the last 52 weeks was experienced week ending 24 January 2021 where the raw number of deaths that week was 93 (Trust wide). Overall numbers of deaths reduced sharply in week ending 31 January 2021 and the trend is now near the 5 year mean value.

5. Conclusion

Improving relative risk of mortality has been experienced across both sites since March 2017. The SHMI provides an indicator of improving outcomes and safety that is evidenced at both sites; this position is monitored by the Mortality Surveillance Group.

Clinical case review is being undertaken following all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss). Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups (operating within EIC) and the trust wide Mortality Surveillance Group (MSG) where all cases of sub-optimal care are now being presented. Progress with the mortality review restart will be reported within subsequent submissions of this paper.

Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.6/May/21
REPORT NAME	Guardian of Safe Working Q4 2020/21 Report
AUTHOR	Shamima Chowdhury, Head of Medical Workforce
LEAD	Dr Roger Chinn, Chief Medical Officer & Sue Smith, Interim Chief People Officer
PURPOSE	Provide assurance of the safe working hours and working conditions for all junior doctors and dentists employed by the Trust.
REPORT HISTORY	Executive Management Board – 14 April 2021 People and OD Committee, 27 April 2021
SUMMARY OF REPORT	A total of 88 Exception reports have been submitted for this quarter with the majority submitted in January 2021. The majority of these were due to working hours and workload. The majority of reports were submitted by Foundation Year (FY1) doctors reflecting the national picture. The Chelsea Hospital site had the majority of reports submitted.
KEY RISKS ASSOCIATED	Financially, all 88 exception reports submitted were resolved by additional payment to the junior doctors concerned in accordance with the 2016 Junior Doctors TCS. No fines were levied on services.
FINANCIAL IMPLICATIONS	Please see previous point.
QUALITY IMPLICATIONS	NA
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For noting.

Guardian of Safe Working Hours Q4 2020/21

1. Executive Summary

This report is presented to the Executive Board with the aim of providing context and assurance of safe working hours and conditions for all junior doctors employed by the Trust.

As was confirmed in the Q3 report a number of changes were put in place to support services, patient care and junior doctors as the Trust navigates through the second wave of the pandemic.

The senior management has focused on robust preparation to support the junior doctor workforce at this time. Senior clinical leads from all relevant specialties have been consulted to identify factors that will be different from the first wave whilst highlighting levels of support that are required to ensure safe working for junior doctors at all times.

Additional measures have included bi weekly lateral flow tests for all frontline staff. Stringent compliance to track and trace for exposure to infected persons outside of the ward and hospital setting. COVID19 vaccination made available to all frontline staff on both sites from December 23 2020.

A total of 225 junior doctors saw their rota patterns change to support the Trust's response to the second pandemic. This meant that the Medical Workforce Team assessed the working patterns and pay of each of the 225 junior doctors to ensure they were paid correctly.

In addition Health Education England redeployed 12 external junior doctors into the Trust to provide additional support from 1 February 2021 to 31 March 2021. The majority of these doctors came from GPVTS Community training programmes or research posts at the Royal Marsden. The doctors were allocated to ITU, General Medicine or AMU at both sites.

The majority of the Emergency COVID-19 rotas were stepped down by services in March 2021 which meant that junior doctors returned to their BAU rotas.

In order to support NHS Trusts in their response to the second pandemic, HEE also postponed the February 2021 core training rotations between 2 February 2021 to 2 March 2021. This meant that all Core Trainees (CT1-3) remained in their posts and rotated on 3 March 2021. This allowed for a continuity of service cover.

A total of 88 Exception Reports have been submitted for this quarter.

The majority of these (81) were due to working hours and work load.

There are no Red Flag areas.

There are no Amber Flag areas.

There have been no fines levied for this quarter.

Shamima Chowdhury, Head of Medical Workforce, 09.04.21

2. The Junior Doctor Forum

The Junior Doctor forum has evolved since becoming a virtual meeting to become a cross site virtual event. There has been active attendance by senior management who has willingly shown dedication to provide support, direction and counsel during this time.

Meetings are hosted by each site on alternate months and take place on the third Wednesday of each month from 1-2pm. The Education fellows at both sites have kindly agreed to take meetings for these meetings and circulate them to relevant members of the forum.

The Forum has been considered to be the most successful JDF in the UK based on the BMA Junior doctor survey and this feedback is a reflection of the wider Trust working as a unified team to support our juniors.

For this quarter, the junior doctor body has requested an open agenda to ensure that all their questions are answered. The emphasis has remained on the pandemic and safe working conditions.

Junior doctors have been sign posted to safety through risk assessments and fit testing

<u>In Q4 there has been very well received question and answer sessions with:</u>

Robert Hodgkiss Deputy CEO

Dr Gary Davies Medical Director has provided monthly updates for planning and preparation for the second surge of the pandemic.

Dr Tina Cotzias and Dr Orhan Orhan, DME's have actively contributed to provide further support for ongoing training and education at this time.

Shamima Chowdhury, Head of Medical Workforce also regularly attends to provide updates on HR issues and to answer any employment related questions.

Other issues dealt with:

Concerns about travelling on public transport after finishing on call shift

Claiming for travel expenses.

3. Exception Reporting

A total of 88 reports were submitted for the quarter. This represents a reduction of 119 reports in comparison to 207 reports submitted in Q4.

Out of the 88 reports submitted 74 were at C&W site and 14 at WM site.

The Exception Reporting data has been broken down to demonstrate a monthly analysis.

The outcome for all exception reports was payment to the junior doctor who had submitted the exception report.

Shamima Chowdhury, Head of Medical Workforce, 09.04.21

January 2021: A total of 60 reports were submitted. No Fines Levied.

Division	**C&W: 48**	**WMUH: 12**
W&C	Paeds Surgery SPR (4),	
EIC	FY1 General Medicine (9), General Medicine CT2 (3), General Medicine FY2 (11), FY1 AAU CW (14), Neurology SPR (2)	FY1 General Medicine (5)
Planned Care	General Surgery FY1 (5)	FY1 & FY2 General Surgery (7)

February 2021: A total of 15 reports were submitted. No Fines Levied.

Division	**C&W: 14**	**WMUH: 1**
W&C	Paeds Surgery SPR (3)	
EIC	FY1 General Medicine (1), FY1 AAU (2)	FY2 A&E (1),
Planned Care	General Surgery FY1 (8),	

March 2021: A total of 13 reports were submitted

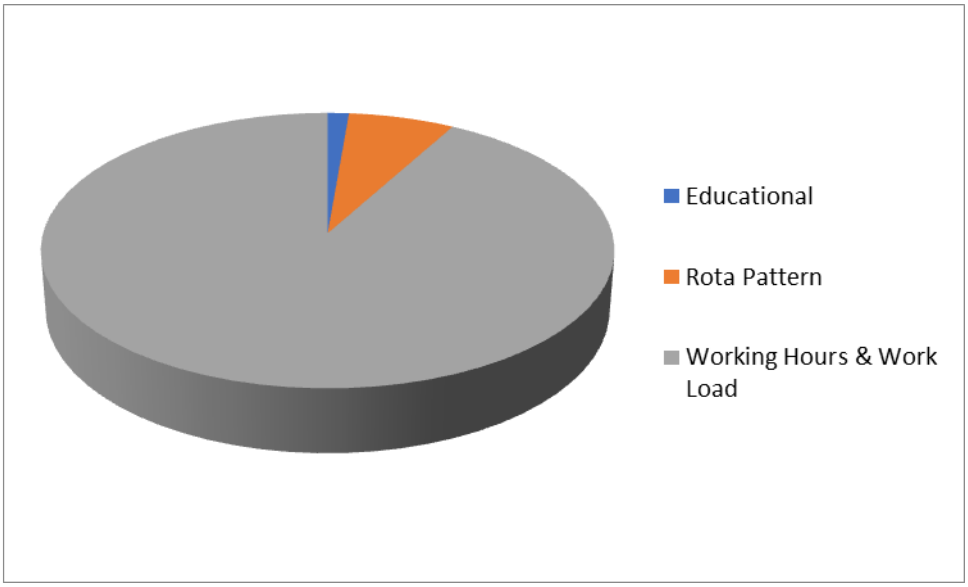
Division	**C&W: 12**	**WMUH: 1**
EIC	FY1 General Medicine (4), FY1 AAU (2)	FY1 General Medicine (1)
Planned Care	General Surgery FY1 (6),	

This breakdown shows that in Q4, the majority of reports were submitted for the Chelsea Hospital site. The majority of reports for both sites came from FY1 Doctors. This reflects the national picture where the majority of reports are submitted by Foundation Doctors. The busiest months for reports was January 2021 which may be due to the second pandemic still having a considerable impact on the Trust at this point.

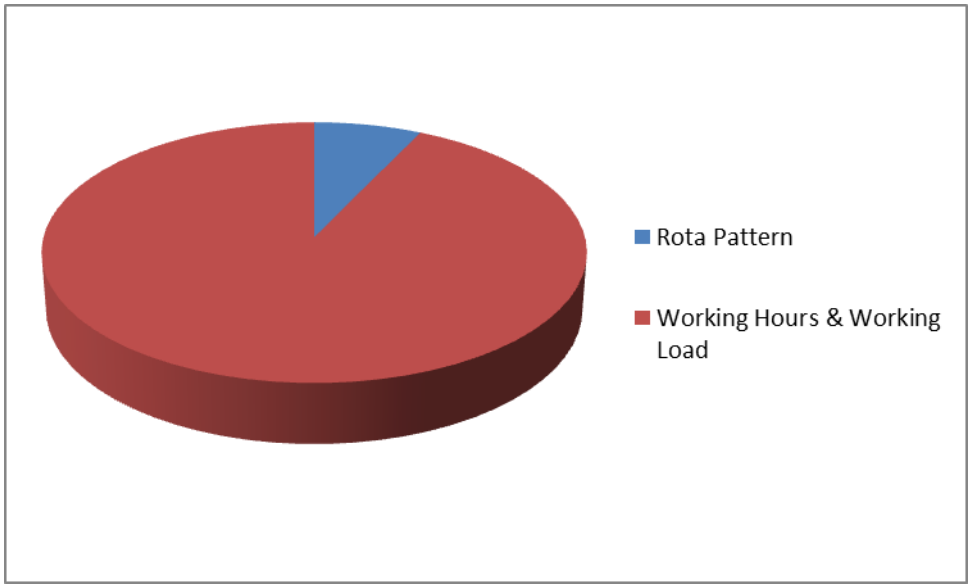
The fact that the majority of the reports relate to the General Medicine rota at Chelsea Hospital reflects the size of the rota in terms of the number of doctors allocated to the rota. The numbers also reflect that between January 2021 and the beginning of March 2021, General Medicine at Chelsea Hospital ran an emergency COVID-19 rota.

In terms of the reasons listed by junior doctors for their exception reports in Q4, as illustrated in the pie chart below, the main reason for both sites and all rotas was working longer hours due to workload.
Shamima Chowdhury, Head of Medical Workforce, 09.04.21

CW Site: Exception Reports by Submission Reason



WM Site: Exception Reports by Submission Reason



Shamima Chowdhury, Head of Medical Workforce, 09.04.21

Shamima Chowdhury, Head of Medical Workforce, 09.04.21

PUBLIC SESSION

Board of Directors Meeting, 6 May 2021

AGENDA ITEM NO.	3.7/May/21
REPORT NAME	Emergency Preparedness Resilience and Response (EPRR) Update
AUTHOR	Catherine Sands, Head of Emergency Preparedness Resilience and Response and Business Continuity
LEAD	Rob Hodgkiss, Deputy Chief Executive, Accountable Emergency Officer
PURPOSE	Emergency Preparedness Resilience and Response (EPRR) Annual NHSE Core Standards update including EPRR work streams
REPORT HISTORY	EPRR Working and Strategic Group Executive Management Board, 3 March 2021 Quality Committee, via e-governance
SUMMARY OF REPORT	Maintaining EPRR key priorities during COVID
KEY RISKS ASSOCIATED	Inability to ensure NHSE EPRR Core Standards full compliance at the August submission if progress with Business Continuity plans isn't progressed
FINANCIAL IMPLICATIONS	None known
QUALITY IMPLICATIONS	None known
EQUALITY & DIVERSITY IMPLICATIONS	None known
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	React to requests for Business Continuity and Incident Response Plans progression

1. **Annual NHSE EPRR Core Standards Assurance (November)**
   A light touch exercise requesting assurance that a thorough and systematic review of our response to the first wave of the COVID-19 pandemic has taken place with a plan to embed learning which informed the wider winter preparedness activities. The Trust was rated as fully compliant.

2. **EPRR Team**
   MD has been working back in the team since Feb 2020 filling the EPRR Resilience Admin Officer (Band 5 training role into DipHEP) MD retired last week but will return to support the vaccination hub. Post will be reviewed before going out to advert.

3. **Covid Response Second Wave**
   During the First wave, the EPRR team supported EU Exit planning, Heathrow hotel, ICC inboxes, mortality deaths and mortuary capacity, continuing to support during second wave, also working in Gold control and taking on clinical roles e.g. vaccination and ICU shifts whilst ensuring EPRR priorities maintained.

4. **Incident Response Plans / Business Continuity**
   EPRR Dashboard maintained - Incident Response Plans (IRP) progressed within timelines, Business Continuity (BC) progress slow pre COVID in key areas, need divisions to support when COVID demand reduces to ensure alignment to ISO22301 as currently not compliant.

5. **Equipment**
   All CBRNE/HAZMAT annual inspections are on target. The significant delay in the annual inspections of the decontamination shelter has been raised with the NHSE Regional lead who picked up with company, borrowed a bladder bag from London Fire Brigade as lead order time 12/52. Noting 34/45 decon suits are due inspection this year cost of £7,200+, NWL NHSE team made aware as suits are due 3 inspections over 10 years.

6. **Training**
   - ED CBRNE/HAZMAT training continues to be provided in small groups, and difficulties with WMUH ED medics not attending need to be addressed, which the Division have now rostered
   - Currently working with Learning Industries to produce eLearning programmes for BC, on-call and CBRNE training
   - 2021 PHE Loggist Courses booked, only 10 active loggists, need to increase numbers to ensure all command areas have trained loggists

7. **Exercises**
   - Nessun Accordo – Oct 2020, third EU Exit exercise, first virtual EPRR table top exercise, to raise awareness of the NHS response arrangements during the EU Exit period and post EU exit, capture key learning that should be shared with teams and be reflective in Service Continuity Plans with knowledge to provide support, guidance and communication to staff to promote settled status
   - Cyber Attack – postponed multi-agency exercise rearranged May 13th 1300-1400
   - Commex – two commexs took place in May and November, working with Thamesnet to move to an online directory for both sites by ensuring emergency cascades are accurate

8. **Planned synchronised and black building start tests**
   Annual programme of works being worked through so key areas know in advance to aid planning.

9. **Incidents**
   Business continuity meetings held to capture learning where appropriate, reports shared.

10. **NHSE EPRR London Acute and Specialist Group**
    As per TOR, Catherine Sands stood down in February having chaired this group for two years.

    The Trust remains in a good position for sustaining its fully compliant rating for a fourth year; priority is to sustain this highest level of compliance. EPRR team have benefitted and appreciated the level of support from senior directors and the Accountable Emergency Officer in raising awareness and embedding EPRR into the organisation.

Board of Directors Meeting, 6 May 2021

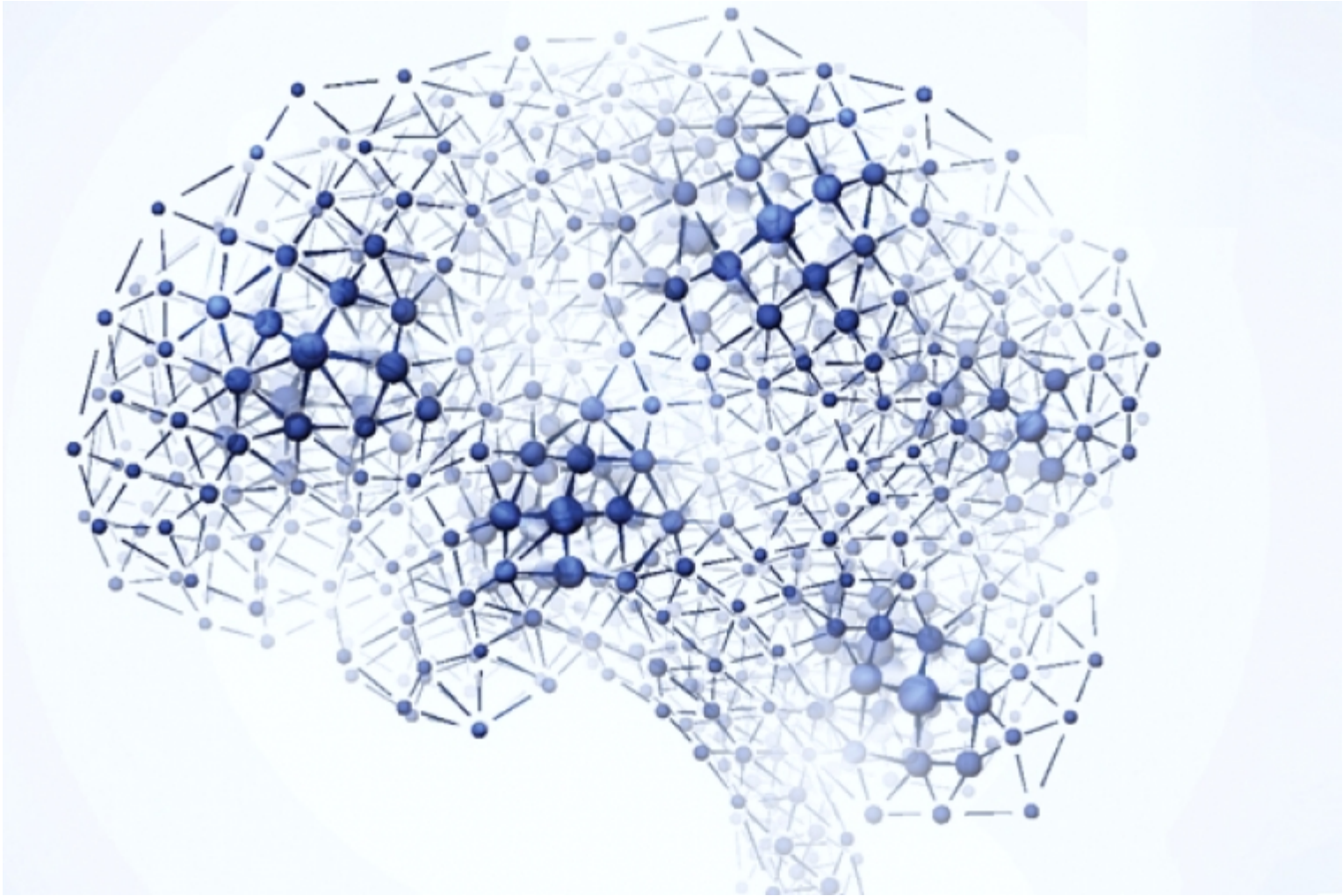
PUBLIC SESSION

AGENDA ITEM NO.	3.8/May/21
REPORT NAME	Digital Programme Update
AUTHOR	Bruno Botelho, Director of Digital Operations
LEAD	Rob Hodgkiss, Deputy Chief Executive/Chief Operating Officer Kevin Jarrold, Chief Information Officer
PURPOSE	The purpose of the paper is to provide the Trust Board with an update on digital and innovations programmes.
REPORT HISTORY	Executive Management Board, 28 April 2021
SUMMARY OF REPORT	As attached.
KEY RISKS ASSOCIATED	The main risks associated with the implementation of a complex EPR solution have been addressed or mitigated.
FINANCIAL IMPLICATIONS	
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Digital & Innovation Update

Public Board May 2021



1. End to End pathway Project
2. ISLA Visual records
3. New Staff app

1. End to End Proof of Concept

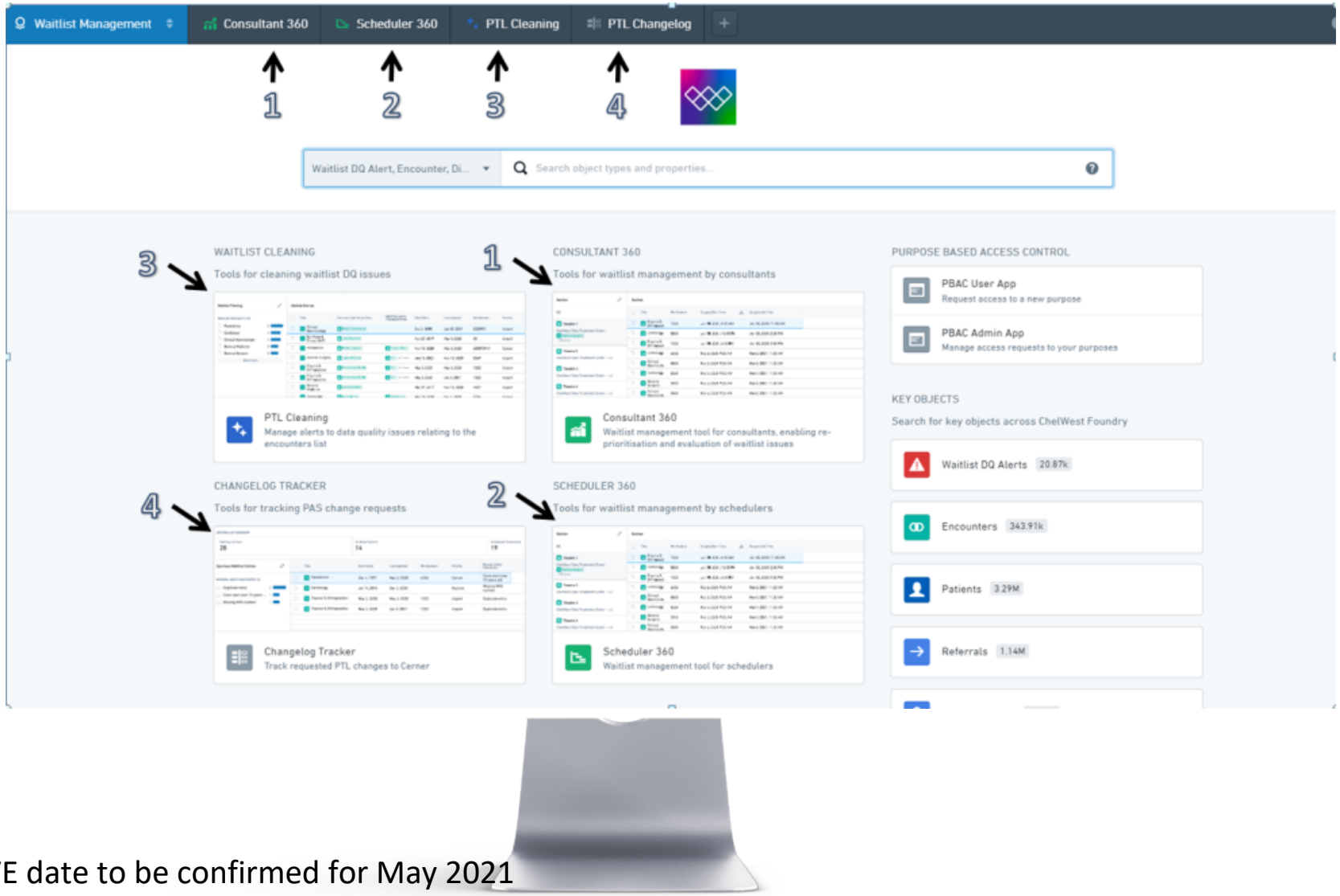
- Data-driven tools **to enable clinicians** to reduce their waiting lists.
- **Streamlining the patient pathway management** process, by enabling clinical and non-clinical users to collaboratively make patient-level decisions based on live, accurate information;
- **Engagement of patients with their care**, by keeping patients informed and involved throughout the their whole journey;
- **Optimising the allocation of resources** by providing visibility into supply and demand; and
- **Strengthen remote monitoring** and integration of this new technology/ data in to pathways

Project being sponsored by NHSD as part of a national pilot

End to End Proof of Concept (cont.)

Designed by users for users **and currently being tested***. A collaborative platform to access and manage patient pathways for:

1. Consultants.
2. Theatre Schedulers
3. Administrators / Operational teams
4. And with the ability to monitor any outstanding action and provide good governance



*Testing/ development to continue with GO LIVE date to be confirmed for May 2021

2. Video Photo Pathway

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Background:

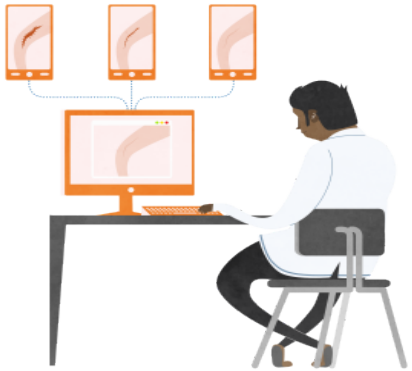
Isla is building the “visual component” to the medical record, aiming to improve the completeness of information available at the point of making a clinical decision.

This is an essential part of supporting the shift to a more flexible, remote first model of healthcare delivery.

In June 2020, a free pilot with Chelsea and Westminster was launched within **Dermatology, Burns and Podiatric Surgery.**

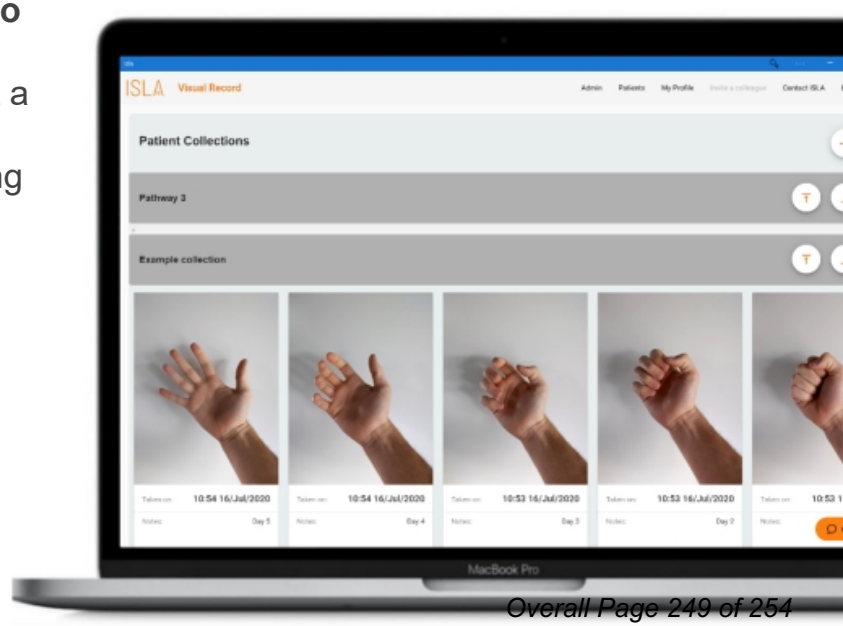
The pilot officially end in January 2021 and the Trust has been in a free extension period until the end of March 2021 and is now beyond this extension.

The pilot has provided an opportunity to assess the operational and financial impact of deployment, develop the platform further, monitor uptake by clinicians and gather feedback from all groups.



Platform Summary

- **Supports patients/family members/carers** to securely share photos, videos and forms in under a minute
- Market beating patient response rates of 65-90% varying by patient demographic
- **Avoids patients returning to hospital unnecessarily** for follow up appointments
- **Reduces administrative time and risk in handling images** through email, whatsapp etc
- **Allows clinicians to automatically monitor** and see at a glance how a condition is changing over time
- **Fully encrypted**, scalable cloud architecture
- **Integrated** with Cerner



Activity and Feedback

Adoption through pilot

Adoption has been rapid throughout the pilot with clinicians driving adoption through word of mouth

14,257
images, videos and forms submitted for clinical review

4.75
average submissions made per patient

2.5 miles
average travel distance avoided

There has been significant demand to adopt the platform outside of the initial pilot areas and the platform is now is use or in the scoping stage for:

Paediatric Burns
Paediatric Dermatology
Neurology
Paediatric Surgery
Trauma and Orthopaedics
Pain Management
Maternity
Sexual Health (10HB)

Feedback

A short video has been produced in collaboration with CW+ to celebrate the work that has been done so far and show the Trust to be at the forefront of digital innovation even throughout the Covid pandemic. This is available below:

Chelwest Innovation Video

92% of Chelwest patients (from over 300 responses) would use the service again and **95%** would recommend to friends and family.

> *We love the platform and have been thinking about creating an app for ages for the acne service and we just haven't been able to.*
>
> *You have come at the perfect time! It is really really exciting.*
>
> **Marie Claire Wilmot**
> **Consultant Dermatologist**

> *If we start using Isla more, we will have empty Wednesdays.*
>
> *This will be a change to the way we work!*
>
> **Kate Elworthy**
> **Therapies Matron**

Impact and Further Opportunities

Impact

As part of the pilot, clinical teams have provided feedback on the time saved through using the visual record to deliver remote consultations.

The calculations so far are based on the specialties which have been piloting the platform for a sufficient time to be able to give feedback on the change to clinical practice made, these are Dermatology, Burns and Burns Therapy. The full calculations are available in the business case however the highlights are below:

Within Burns and Burns Therapies, the estimated time to complete a photo review follow up is **33%** to **50%** of the time required for a traditional follow up.

Within relevant Dermatology clinics, the estimated time to complete a photo review New or Follow up is **50%** to **57%** of the time required for a remote consultation without Isla.

Across the 3 services modeled, this change once embedded frees up clinical capacity equivalent to over 9000 FU appointments and over 1000 New appointments/year.

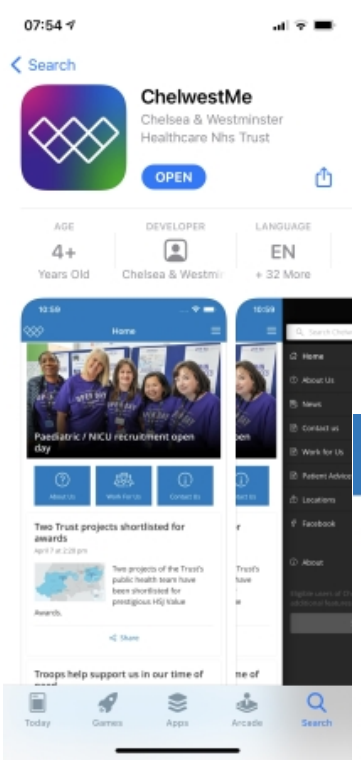
This provides an additional income opportunity (where supported by commissioning) or an opportunity to reduce clinical overtime.

Further Opportunities

With the completion of the pilot, there is an opportunity to purchase the solution and implement the visual record to support remote consultations at scale.

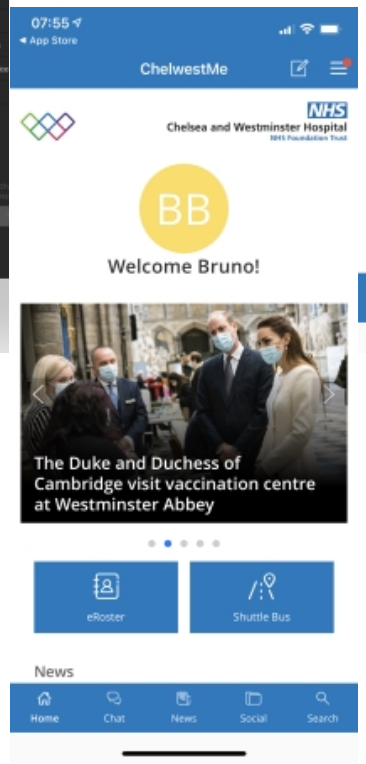
Across other partner centres, the Isla platform has been deployed in a wide range of services, from Infection control to monitor patients for SSI post discharge to Therapy services to Breast Surgery and Private patients.

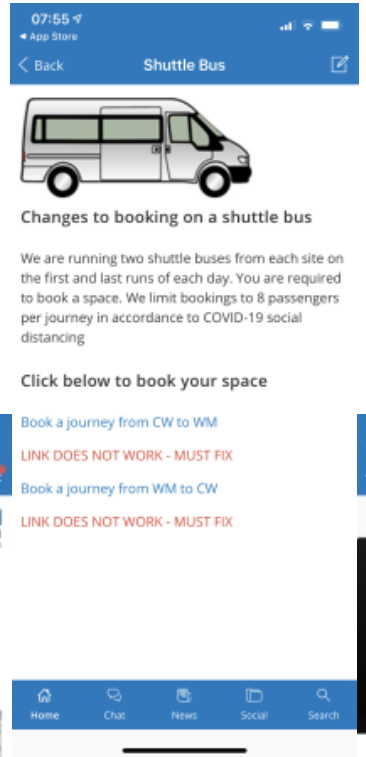
ChelwestMe- release date to be confirmed



Available on both IOs and Android online stores

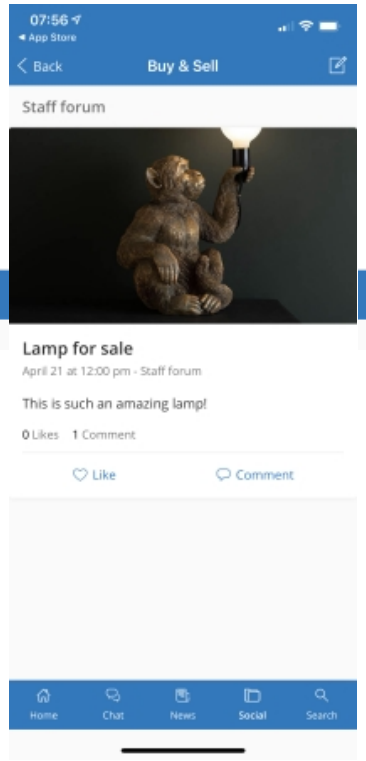
Available with public and private (CWFT only) contents

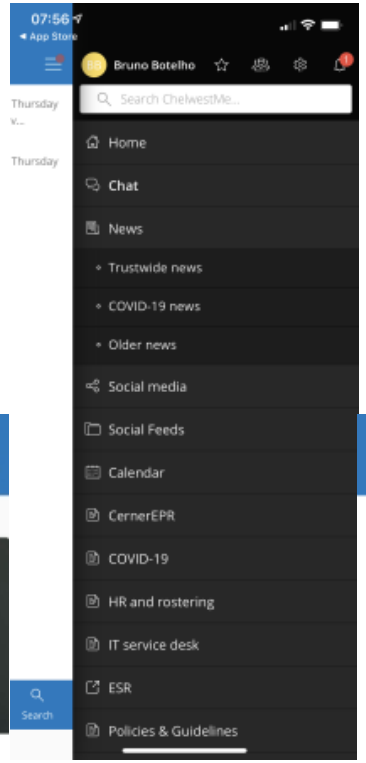




Relevant and up to date content

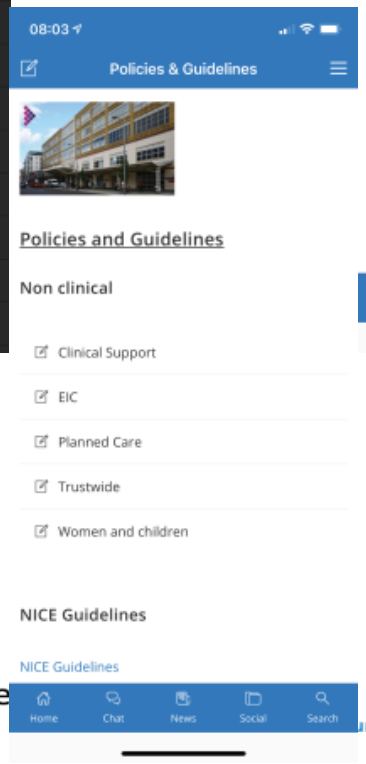
Opportunity to socialise and support each other requirements

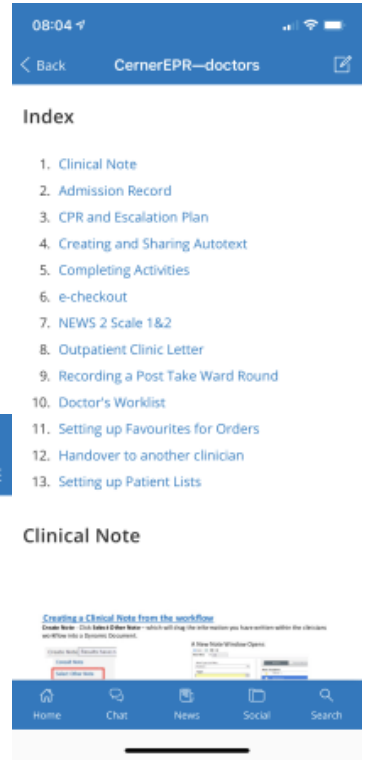




A significantly improved usability

Easy access to information and training materials





Board of Directors Meeting, 6 May 2021

PUBLIC SESSION

AGENDA ITEM NO.	3.9/May/21
REPORT NAME	Year-end report on use of the Company Seal 2020/21
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Serena Stirling, Director of Corporate Governance and Compliance
PURPOSE	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
REPORT HISTORY	N/A
SUMMARY OF REPORT	As enclosed.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	All.
DECISION/ ACTION	For noting.

Report on use of the Company Seal 2020/21

1. The Constitution, at Annex 7 (Standing Orders), Section 11 refers to the sealing of documents. This section states:

Custody of Seal and Sealing of Documents

11.1. **Custody of Seal** – the common seal of the Trust shall be kept by the Company Secretary in a secure place.

11.2. **Sealing of documents** - where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.

11.3. **Register of sealing** - an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.

11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

2. During the period 1 October 2020 – 31 March 2021, the seal was affixed to the following documents:

Seal Number	Description of the document	Date of sealing	Affixed and attested by
208	Variation to the Trust's lease of premises at 56 Dean Street (1 copy)	05.01.2021	Lesley Watts Chief Executive Officer Virginia Massaro Chief Financial Officer
209	Variation to the telecommunications lease relating to part of the roof at West Middlesex University Hospital (1 copy)	05.01.2021	Lesley Watts Chief Executive Officer Virginia Massaro Chief Financial Officer