Chelsea & Westminster Hospital NHS Foundation Trust Council of Governors Meeting

Zoom Conference https://chelwest-nhs-uk.zoom.us/j/781289174OR Dial in: +441314601196; Meeting ID: 781 289 4174# United Kingdom
22 July 2021 09:30 - 22 July 2021 11:00

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Council of Governors Meeting

Date: 22 July 2021 **Time:** 09:30 - 11:00

Location: Zoom Conference https://chelwest-nhs-uk.zoom.us/j/781289174 OR

Dial in: +441314601196; Meeting ID: 781 289 4174# United Kingdom

Agenda

	1.0	STATUTORY/MANDATORY BUSINESS			
09:30	1.1	Welcome & Apologies for Absence	Verbal		Chair (Interim)
09:31	1.2	Declarations of Interest	Verbal		Chair (Interim)
09:32	1.3	Minutes of previous meeting held on 22 April 2021 1.3.1 Action Log	Paper Paper	For Approval For Information	Chair (Interim)
09:35	1.4	Interim Chair's Report	Paper	For Information	Chair (Interim)
09:40	1.5	Chief Executive Officer's Report	Paper	For Information	Chief Executive Officer
09:45	1.6	Board Committee Chairs – top priorities	Verbal	For Information	Board Committee Chairs
09:55	1.7	Coronavirus (COVID-19) update, including 1.7.1 Elective care recovery 1.7.2 Vaccination program update	Verbal/ Paper	For Information	Chief Executive Officer
10:05	1.8	NWL Integrated Care System (ICS) developments – update PRE-READING MATERIAL: ICS Design Framework https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf	Verbal	For Information	Chief Executive Officer
10:15	1.9	Substantive Chair recruitment update	Paper	For Noting / Discussion	Chair (Interim)
		QUALITY			
10:30	1.10	Board Committees: 1.10.1 Finance & Investment Committee Report to Council of Governors; including Month 12 Financial Position 1.10.2 Audit and Risk Committee Report to Council of Governors	Papers	For Information	Nilkunj Dodhia, NED / Virginia Massaro, CFO Nick Gash, NED
10:40	1.11	COG Sub-Committees: 1.11.1 Quality Sub-Committee Report 1.11.2 Membership & Engagement Sub-Committee Report	Paper Paper	For Information For Information	Laura Wareing, Chair of QSC David, Phillips, Chair of MESC
10:45	2.0	FOR INFORMATION			
	2.1	Performance Reports: *2.1.1 Performance and Quality Report *2.1.2 People Performance Report	Papers	For Information	Chief Executive Officer
	2.2	Accessibility work update	Verbal	For Information	Chair (Interim)
10:50	3.0	OTHER BUSINESS			
	3.1	Questions from the governors and the public	Verbal	For Information	Chair (Interim) / Chief Executive Officer
	3.2	Any other business, including: *3.2.1 Forward plan *3.2.2 Schedule of meetings 2021/22 *3.2.3 Governor attendance register	Paper Paper Paper	For Information For Information For Information	Chair (Interim)
11:00	3.3	Date of next meeting: 21 October 2021, 16:00 – 18:00			
				I	

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



NHS Foundation Trust

DRAFT MINUTES OF COUNCIL OF GOVERNORS (COG) 22 April 2021, 16.00-18.00 **Zoom Conference**

Present:	Stephen Gill	Chair (Interim)	(SG)
	Nowell Anderson	Public Governor	(NA)
	Richard Ballerand	Public Governor	(RB)
	Juliet Bauer	Patient Governor	(JBa)
	Jeremy Booth	Patient Governor	(JBa)
	Caroline Boulliat	Public Governor	(CB)
	Cass J. Cass-Horne	Public Governor	
			(CJCH)
	Tom Church	Patient Governor	(TC)
	Nigel Davies	Public Governor	(NDa)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Dr Simon Dyer	Lead Governor/Patient Governor	(SD)
	Elaine Hutton	Public Governor	(EHu)
	Richard Jackson	Staff Governor	(RJ)
	Paul Kitchener	Public Governor	(PK)
	Minna Korjonen	Patient Governor	(MK)
	Thewodros Leka	Staff Governor	(TL)
	Anthony Levy	Public Governor	(AL)
	Rose Levy	Public Governor	(RL)
	Johanna Mayerhofer	Public Governor	(JM)
	Professor Mark Nelson	Staff Governor	(MN)
	Fiona O'Farrell	Public Governor	(FOF)
	David Phillips	Patient Governor	(DP)
	Cllr Patricia Quigley	Local Authority Governor	(PQ)
	Dr Desmond Walsh	Appointed Governor	(DW)
	Laura Wareing	Public Governor	(LJW)
	Trusha Yardley	Public Governor	(TY)
In attendance:	Lesley Watts	Chief Executive Officer	(LW)
	Aman Dalvi	Non-Executive Director	(AD)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Eliza Hermann	Non-Executive Director	(EHe)
	Ajay Mehta	Non-Executive Director	(AM)
	Rob Hodgkiss (in part)	Deputy Chief Executive/Chief	(RH)
		Operating Officer	
	Virginia Massaro (in part)	Chief Financial Officer	(VM)
	Vida Djelic (minutes)	Board Governance Manager	(VD)
Apologies:	Martin Lupton	Honorary Non-Executive Director	(ML)
	Nicole Nunes	Staff Governor	(NN)
	Catherine Sands	Staff Governor	(CS)
	Jacquei Scott	Staff Governor	(JS)
	Serena Stirling	Director of Corporate Governance	(SS)
		& Compliance	

1.0	STATUTORY/MANDATORY BUSINESS
1.1	Welcome and apologies for absence
	SG welcomed the Governors and those in attendance to the Zoom video conference meeting.
	SG noted apologies as above and outlined the order of business for the meeting.
1.2	Declarations of interest
	None declared.
1.3	Minutes of previous meeting held on 28 January 2021
	Minutes of previous meeting were approved as a true and accurate record of the meeting.
1.3.1	Action Log
	The action log paper was noted.
	1.3.2 Lead Governor Election outcome
	SG reminded the Council of Governors of an earlier email communication advising of the
	outcome of the Lead Governors election held in March 2021 and offered his congratulations to
	Simon Dyer on his re-election as Lead Governor.
	SG offered his thanks to the other three excellent candidates who stood for election and to all
	Governors for their participation in the 'virtual' election process.
	1.3.3 Governor Advisory Committee (GAC) Election outcome
	SD updated the Council of Governors on the recent publication of the outcome of the (GAC)
	election. He asked for clarification of the role of GAC members, including how they represent
	trusts which do not have a governor representative on the Committee, to be provided to all governors.
	governors.
	Action: Council of Governors to be provided with information regarding the role of GAC members, including how they represent trusts which do not have a governor representative
	on the Committee.
1.4	Interim Chair's Report
1.7	Stephen Gill, Chair (Interim)
	The report was noted.
	SG reflected on the January Council of Governors meeting at which his appointment as Interim
	Chair was ratified, with effect from 4 March 2021 for the period to 31 March 2022, pending the
	appointment of a substantive Chair. He expressed his thanks to Governors for their support.
	He advised a Staff 'Thank You' Event (virtual) was held on 23 March 2021 in recognition of an
	extraordinary year, with extraordinary dedication, support, resilience and commitment from the Trust staff and volunteers, marking the first anniversary of the National Lockdown.
	SG reported on his recent call with Sir David Sloman, the NHS Regional Director for London, and
	passed on congratulations from the London Region Team to CWFT for excellent acute hospital performance.
	The Department of Health and Social Care White Paper was discussed in detail at the COG Away

Day, held earlier in the day on Zoom.

SG advised that he has participated in a number of London Region Chairs meetings and NWL ICS Chairs / CEOs meetings during March and April. Topics covered include: 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.

1.5 Chief Executive Officer's Report

Lesley Watts, Chief Executive Officer The report was noted.

LW highlighted the following points:

- The NICU/ITU redevelopment project is approaching completion; it will provide world class facilities on the Fulham Road site, expanding the Trust's capacity to treat the sickest patients; The Board would like to thank the Trust's clinicians, estates and CW+ teams for their work on this essential development for our patients.
- The Trust has worked in partnership with our North West London (NWL) colleagues to deliver an extensive vaccination programme; Pippa Nightingale, Chief Nursing Officer, was commended for her commitment to leading the roll out of the NWL programme in hospital hubs and mass vaccine centres.
- In support of staff health and wellbeing and as a one off thank you in 2021/22, the Trust
 is offering every staff member one day of protected time to focus on their own recovery
 in addition to their annual leave; staff are also offered an additional day's leave on or
 near their birthday.

LW updated the Council of Governors in relation to a leaked document which was a draft for discussion relating to potential mandatory COVID-19 vaccinations for NHS staff. It is not current NHS policy for COVID-19 vaccinations to be mandatory which recognises that the vast majority of staff have welcomed the opportunity to be vaccinated against COVID-19, but that there is a small minority who are reluctant or decline to have the vaccine for varied reasons; individual staff conversations are ongoing to understand their reasons and to clarify the benefits of the vaccination.

1.6 Coronavirus (COVID-19) update

Lesley Watts, Chief Executive Officer

This item was discussed as part of above item 1.5.

1.6.1 | Elective care recovery

Rob Hodgkiss, Deputy Chief Executive Officer

RH provided an overview of elective care recovery and the current position across all aspects of the Elective Care Programme. He advised the report was covered in detail at the recent all staff webinar and highlighted the following:

- Planning assumptions for the first half of 2021/22:
 - Non-elective demand from COVID and non-COVID returns to pre-pandemic (2019/20) levels from the beginning of 2021/22, subject to the impact of any planned service developments.
 - b) For April, systems that carry out more than 70% of their pre-Covid elective activity levels will be paid at tariff prices for the above-threshold activity, in addition to their

- core funding. The threshold will rise to 75% in May and 80% in June, before being set at 85% from July to September 2021. Any additional activity above 85% will be paid at 120% of tariff rates.
- c) To operate dedicated fast track hubs for high volume, low complexity care with standardised clinical pathways; dedicated elective service pathways within acute sites; elective activity coordination hubs for booking and scheduling across sites to tackle backlogs at system level.
- d) Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation.
- Spring 2021 recovery plan has been submitted;
- Elective and outpatient activity: monitored weekly;
- Cancer and imaging backlog: good position maintained;
- Endoscopy: CWFT ahead of trajectory;
- All 4 divisions working on elective recovery;
- The outpatient and elective trajectory is on target to reach 85% of 2019/20 activity by July. To receive above-tariff payments for activity over 85%, there will also be checks on the impact of recovery work on health inequalities.

In noting that CWFT is at the top of the NWL elective league table, MN commended the recovery work. He reflected on the Trust's comprehensive support to staff health and wellbeing and asked whether staff would be able to fully support the elective recovery considering the scale of the task. RH stated that the Trust recognises that recovery of the elective backlog is the most significant challenge the NHS has ever faced and can only be dealt with through collaboration across the ICS.

In response to RL's question, RH explained that non-elective emergency service is available 24/7; although elective services operate the standard working hours Monday to Friday, together with our NWL partners we are considering extending the service to weekends and evenings in order to reduce waiting lists.

1.7 Governor Commentary on the draft Quality Report 2020/21 sign-off

Laura Wareing, Chair of COG Quality Sub-Committee

LJW presented the Governor commentary and explained she had prepared it having read the draft Quality Report 2020/21. The commentary was endorsed by the COG Quality Sub-Committee and was presented to the Council of Governors for ratification. The ratified commentary will be included in the final Quality Report.

JBo stated some time ago CWFT introduced the Early Warning Score to aid the recognition of acutely unwell patients; this study was recommended for implementation across the NHS as National Early Warning Score (NEWS). He praised the study and suggested it could be used in patients with sepsis in the emergency department which would allow earlier identification of physiological deterioration.

DECISION: The Council of Governors approved the Governor Commentary on the 2020/21 Quality Report.

1.7.1 Council of Governors' Quality Sub-Committee report, including Sub-Committee Terms of Reference

Laura Wareing, Chair of COG Quality Sub-Committee

The Council of Governors noted the minutes of the COG Quality Sub-Committee meeting held on 26 March 2021.

DECISION: The Council of Governors approved the COG Quality Sub-Committee Terms of Reference.

1.8 Quality Priorities 2021/22

Eliza Hermann, NED Board Chair of Quality Committee

EHe advised the quality priority and patient experience work was disrupted during 2020/21. Two of the four priorities (dementia and volunteering) were achieved while sepsis and cancer are carried over to 2021/22.

The four Quality Priorities for 2021/22 have been agreed with the Quality Committee and the Trust Board.

The first quality priority: Improve sepsis screeing and timely management; Sepsis has been a quality and safety focus for the Trust for a number of years and will carry over for another year as the work of the previous year was interrupted by the pandemic. Early identification and treatment of sepsis is key to improving patient outcomes. The sepsis data is regularly scrutinised by the Quality Committee and EHe noted that a deep dive will be undertaken (as part of the deep dive programme), and the outcome will be included in a robust action plan to be developed as required and presented to the Quality Committee.

The second quality priority: Improve personalised cancer care at diagnosis will also carry over from the previous year, given the extensive changes to cancer services due to the pandemic.

The third quality priority: Improving outcomes for inpatients with diabetes is a proposed new quality priority for 2021/22. The inpatient diabetes metrics are to be agreed and an update will be provided to Governors.

The fourth quality priority: Effective clinical handover and communication between teams and/or shifts is an essential element of patient safety.

AL commended the four quality priorities and asked about the selection process. EH stated that the final quality priorities were discussed and agreed by the Executive Team and the Quality Committee.

In response to SD's comment about the priorities, EH explained that sepsis has been a priority for a number of years and the work on this priority was paused in 2020/21 due the Covid pandemic. However, the sepsis management action plan will be embedded across all clinical areas to ensure early identification and treatment of sepsis. Dr lain Beveridge, Medical Director, WM site, leads a group which monitors progress on improving the work in this area.

1.9 People and OD Committee Report to Council of Governors

Stephen Gill, NED Board Chair of People and Organisational Development Committee (PODC) SG noted the report was postponed from January to April 2021 owing to wave two of COVID-19 and therefore covers the 15-month period, January 2021 to March 2021.

SG took the report as read and provided the following highlights:

- Non-Executive Director Ajay Mehta was appointed as Chair of PODC on 1 April 2021;
- Sue Smith was appointed as Interim Director of Human Resources and Organisational Development in October 2020 and is also the Chief People Officer at the Hillingdon Hospitals NHS Foundation Trust;

- Strong investment in staff health and wellbeing initiatives during the period;
- CWFT has been selected as the lead employer for recruitment of volunteers for the North West London mass vaccination programme;
- CWFT has benefited from the support of active volunteers contributing to patient and staff health and well-being and providing crucial support to our vaccination programmes; and
- The Committee contributes to the work in developing the CWFT people strategy within the NWL ICS people plan and the NHS People Plan framework.

SG congratulated NED Ajay Mehta on his appointment as Chair of People and OD Committee.

1.10 Business planning 2021/22 update

Virginia Massaro, Chief Financial Officer

VM provided an overview of the business planning and highlighted the following:

- The current block funding arrangements in 2020/21 will roll forward into the first half (H1) of 2021/22;
- There will be separate planning process for the remaining 6 months (H2) of 2021/22.
- It is expected that the H1 system envelope will allow the NWL ICS and the Trust to achieve a breakeven position for the first 6 months of 2021/22;
- Overall capital allocations / budgets will be set at an ICS level; the Trust's capital plan is £29.3m;
- Any additional investment or cost pressures would be funded by Cost Improvement Programmes (CIPs);
- An elective recovery fund has been set up to support acute elective recovery at 120% of tariff payment for activity above 85% of 2019/20 levels at an ICS level; and
- Additional funding has been allocated at the ICS level to support the implementation of the Ockenden Review for maternity safety.

In response to AL's question regarding capital allocations, VM stated that the Trust capital plan of £29.3m is within the NWL ICS overall capital allocation.

1.11 Nominations and Remuneration Committee update

Substantive Chair recruitment update

SG advised that he presented a verbal proposal to the NED Nominations and Remuneration Committee regarding the substantive Chair recruitment and that views were sought from the committee members. Following the discussion, the NED Nominations and Remuneration Committee unanimously approved the proposed approach subject to the provision of further detailed information, as and when this is available.

LW noted that there is a general sense of the benefits from working closer together, and the direction of travel in the White Paper is one of provider collaboration.

LW stated the ambition set out in the Department of Health and Social Care White Paper is to reduce inequalities and support people to live longer, healthier and more independent lives. This will be achieved by creating an enabling flexible and permissive framework for local partners to build upon existing partnerships at place and system levels, aligning services and decision making in the interests of the local community. Focused work on a number of areas will be required; as part of this system-wide leadership arrangements joint strategies will be developed including: the acute trusts with common strategic interests working closely together,

mutual support, building strong relationships across the trusts and helping to stabilise leadership teams, more joined-up care, support for system working and a potential decrease in competition in the interests of improving care outcomes for patients, etc.

The Council of Governors discussed the proposal put forward to them and expressed the following points:

- Appreciated the candid verbal update and discussion at this early stage.
- A clear requirement for a written proposal to be circulated in advance to allow sufficient time for governors to read prior to future discussion on the proposal with reasonable time in the meeting for Q&A.
- Draft Chair Job Description to be shared with the Council of Governors when it becomes available; and
- The Council of Governors to be advised and involved in every stage of the process.

Following the discussion, the Council of Governors voted on the proposal. A majority of governors supported the proposal.

SG concluded the item by thanking governors for the helpful discussion and for their support to proceed to the next stage.

He further stated he would arrange individual follow up calls with each of the six governors who opposed the proposal in order to understand their concerns, and that he would update the COG at each stage of the process.

DECISION: The Council of Governors approved (by majority) to proceed to the next stage of the substantive Chair recruitment process, subject to a follow up Council of Governors meeting being held as and when a detailed Paper, a draft job description and inputs from all the relevant stakeholders are available.

NED configuration and succession plan, including appointment of Non-Executive Directors NHSE/I letter

SG advised that due to his appointment as Interim Chair he has stepped down from PODC (both as Chair and as a member) and from the Finance and Investment Committee (FIC) with effect from 1 April 2021. He reminded the governors that the NED configuration update was circulated to them in early March and was included for reference as an attachment to the Interim Chair's report in the April COG Papers.

On advice from Sir David Sloman, NHS London Regional Director, the recruitment of new NEDs within the London Region should be put on hold and consideration be given to the possibility of making joint appointments of NEDs between connected trusts within provider collaboratives, thereby strengthening joint working on independent boards.

Interim Chair remuneration

SG, Interim Chair, left the meeting for the discussion of this item.

SD noted that a proposal to keep the salary level of Interim Chair consistent with the prior Chair was discussed and approved by the NED Nominations and Remuneration Committee. The proposal took account of the NHSE/I publication 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts', which sets out an expectation that decisions on remuneration and expenses for chairs and NEDs are in line with the structure.

SD put forward the Committee's recommendation to retain the salary level of Interim Chair consistent with the prior Chair (£60k per annum).

DECISION: The Council of Governors ratified the NED Nominations and Remuneration Committee's recommendation to retain the salary level of Interim Chair consistent with the prior Chair (£60k per annum)

Non-Executive Director remuneration

SG noted a proposal regarding the remuneration of Non-Executive Directors was discussed and approved by the NED Nominations and Remuneration Committee. The took account of the NHSE/I publication 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts', which sets out an expectation that decisions on remuneration and expenses for chairs and NEDs are in line with the structure.

SG put forward the Committee's recommendation that each of the five NEDs (excluding the Interim Chair) receives an increase of £1k per annum taking the remuneration to £13k per annum; plus an additional payment of £1k per annum for each of the four chairs of Board Committees; and an additional £1k per annum in recognition of designated extra responsibilities for each of the Deputy Chair and the Senior Independent Director (SID).

He advised that the Trust Board is currently running at least one NED below the usual number of NEDs and the additional expenditure of £11k in total, as noted above, will therefore be absorbed within the current budget.

DECISION: The Council of Governors ratified the Nominations and Remuneration Committee's recommendation that each NED receives a payment of £13k per annum; and an additional payment of £1k per annum for the four chairs of Board Committees; and an additional £1k per annum each in recognition of designated extra responsibilities to the Deputy Chair and the SID.

Interim Senior Independent Director and Deputy Chair appointments

SG noted a proposal to appoint Nick Gash as Deputy Chair and Eliza Hermann as Senior Independent Director was discussed and approved by the NED Nominations and Remuneration Committee and requested ratification by the COG.

DECISION: The Council of Governors ratified the NED Nominations and Remuneration Committee's recommendation to appoint Nick Gash as Deputy Chair and Eliza Hermann as Senior Independent Director.

Extension of the term of office of the Non-Executive Director Nick Gash

SG noted a proposal to extend the term of office for NED Nick Gash for a further year, until end October 2022 was discussed and approved by the NED Nominations and Remuneration Committee and requested ratification by the COG.

DECISION: The Council of Governors ratified the NED Nominations and Remuneration Committee's recommendation to extend the term of office for NED Nick Gash for a further year, until end October 2022.

Committee Terms of Reference

	SG advised that the Terms of Reference review was undertaken by the NED Nominations and Remuneration Committee. The Committee proposed an additional word 'Chair' be added to the aims section, second bullet point.
	DECISION: Subject to the above change, the Council of Governors ratified the NED Nominations and Remuneration Committee's Terms of Reference.
1.12	Council of Governors' Membership and Engagement Sub-Committee Terms of Reference The paper was noted.
	DP noted that the Sub-Committee reviewed the Terms of Reference in early April 2021.
	DECISION: The Council of Governors approved the Membership and Engagement Sub-Committee Terms of Reference.
2.0	FOR INFORMATION
2.1	*Performance and Quality Report, including
	2.1.1 People Performance Report
	This report was noted.
2.2	'Thank You' to all Staff, including the Executive Directors
	SD noted a message of appreciation to all staff has been sent from the Trust Governors.
2.3	Accessibility work update
	SG advised that the Trust has engaged with AbilityNet and is moving forward with the virtual audit work.
	The physical audit with AccessAble has progressed well; the surveys are expected to commence
	in May 2021 and the outcome of the audit and recommendations are expected to be produced
	in July 2021.
	The Trust intends to implement the access recommendations from both the virtual and physical
	audits in August 2021.
3.0	OTHER BUSINESS
3.1	Questions from the governors and the public
	None noted.
3.2	Any other business
	3.2.1 Forward plan – Noted
	3.2.1 Schedule of meetings 2020/21 – Noted
	3.2.3 Governor attendance register – Noted
3.3	Date of next meeting : 22 July 2021, 10.00 – 11.00, followed by Annual Members' Meeting, 15.00 – 16.00
1	

Meeting closed at 18.15.





Council of Governors Meeting & Away Day – 22 April 2021 Action Log

Meeting Date	Subject	Action	Current status	Lead
COG 22 Apr 2021	Governor Advisory Committee (GAC)	Council of Governors to be provided with information regarding the role of GAC members, including how they represent trusts which do not have a governor representative on the Committee.	Appended to this paper is NHS Providers (the membership organisation for NHS trusts in England) document detailing Governor Advisory Committee (GAC) general description. The membership of the GAC reflects the different foundation trust sectors (acute, mental health, ambulance, community) with each sector having at least one member as well as governor sub types (patient/service user/carer, staff, public, appointed) rather than representing the individual Trusts. GAC members frequently attend NHS Providers events so there is also an opportunity to make contact with them there (albeit virtually for now) as well as by contacting governors@nhsproviders.org.	VD
COG AD 22 Apr 2021	Council of Governors effectiveness	Circulate paper on best practice key points on 'how to be a Governor'.	With reference to best practice guide, please see here for an induction toolkit for governors provided by NHS Providers.	VD
		Investigate potential Governor training opportunities.	NHS Providers GovernWell provides the national training programme for Foundation Trust governors; the GovernWell programme covers a variety of topics to equip governors with the skills required to fulfil their responsibilities, as set out in the Health and Social Care Act 2012. Governors can choose which parts of the programme best meet their development needs depending on their experience, interest, responsibilities and current level of understanding. The training programme includes a range of teaching and learning methods including face to face and on-line learning, supplemented by workbooks and other resources, where appropriate. GovernWell is a four step programme which offers: Core skills module is for those in the first year of their first term of office, and for those governors who require a refresher. These build on a trust's induction when governors are ready to learn in more detail and discuss issues from a position of insight and initial experience.	VD age 13 of 12

		the role Specialist skills training courses - these focus on specific aspects of the role and enable governors to explore them in a practical, interactive way to help form the basis for a deeper understanding of their duties. Visit the course page to see upcoming training modules and dates. https://nhsproviders.org/training-events/governor-support/governwell-course-dates If you are interested in attending any of the upcoming training courses, please email Vida Djelic (vida.djelic1@nhs.net) who will make the necessary booking for you.	
	Confirm Informal Governor meetings (4 per year, run by Chair and Lead Governor).	Complete. The high level meetings schedule circulated to all governors on 20 May.	SG/SD/VD
Governor involvement in Strategy	Republicise dates of Governor Strategy briefings.	Complete.	VD
	Set up informal NED / Governor Strategy discussions (2 per year) with topics / paper circulated in advance.	This is being arranged. A paper will be will submitted in due course.	SG/NG/VD
Governor engagement with constituents / public	The Chair of the Membership & Engagement Sub-Committee to explore with the sub-committee members various options for governor engagement with the FT members, in particular options for engagement with the public members.	This has been discussed at the 4 th June Membership & Engagement Sub-Committee. David will provide a verbal update at the meeting.	David Phillips / MESC
COG Agenda	Board sub-committee chairs list their top 3 points (opportunities / issues); to be put on COG agenda as a standing item.	Complete.	VD



Governor advisory committee (GAC) general description

What is GAC?

The governor advisory committee (GAC) is part of the NHS Providers organisation and consists of eight elected governors and one foundation trust chair appointed by the NHS Providers board.

To be eligible for election a governor must be a serving governor, nominated by their own FT's council of governors. A FT's council of governors may not nominate more than one candidate.

What does GAC do?

The primary role of the GAC is to guide the work programme of those employees of NHS Providers working on the delivery of the governor support work programme. The role of the committee is to provide guidance and advice to oversee the work of NHS Providers in support of councils of governors. Along with fellow GAC members you will be expected to read and assimilate reports, actively contribute to discussions and work as a team. You will have excellent communication skills within and beyond the committee as you represent NHS Providers and the GAC. All GAC members are expected to work to the Standards of Public Life (Nolan Principles).

How has the previous GAC added value?

Over the past three years GAC members identified areas of positive working or concerns that facilitated debate and action e.g. new articles for our governor e-newsletter and presentations at regional workshops/conferences. Members also provide feedback on our resources e.g. website navigation and content and contribute to guidance documents so we can continuously improve our offer.

Member updates are very useful to understand what is happening in practice e.g. mergers, hospital redevelopments and to triangulate this with our own intelligence. It has also been very helpful to understand the processes and systems foundation trusts are required to go through e.g. links with the regulators in service redesign, improvements to internal processes being made e.g. simplifying the process for governors appraising NEDs, areas of concern e.g. A&E pressures, areas of varying practice e.g. governors observing audit committees and issues that are new or hot topics in national policy or in the news e.g. Sustainability and Transformation Partnerships/Integrated Care Systems.

Is there training involved?

NHS Providers provides induction training and support for elected candidates. Members will need to work effectively as a team. They will need to attend meetings, contribute to discussions, assimilate information and feedback from their experiences.

Who do GAC members represent?

Whilst members of the committee are nominated by their FTs, they are only expected to bring an informed view to the committee based on their NHS and governor experiences. They are not expected to specifically represent the interests of their trusts or their councils in this capacity.

What is the time commitment?

The GAC meets formally four times a year and meetings typically take place at the NHS Providers offices in London. During the COVID-19 emergency these meetings have been happening virtually. In addition, there is often informal discussion with GAC members between meetings on a range of issues. NHS Providers is keen to develop a strong and active committee and potential members should consider carefully whether they can make the commitment alongside other priorities.





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.4/Jul/21	
REPORT NAME	Interim Chair's Report	
AUTHOR	Stephen Gill, Interim Chair	
LEAD	Stephen Gill, Interim Chair	
PURPOSE	To provide an update to the Council of Governors on high-level Trust affairs.	
REPORT HISTORY	Board Public, 8 July 2021	
SUMMARY OF REPORT	OF REPORT As described within the appended paper. Governors 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	For information.	





Interim Chair's Report July 2021

NHS short / medium term priorities - Thank you to our staff and Executive Team

The top 3 current NHS focus areas are: the Vaccination Programme; the Elective Recovery Programme; COVID-19 Wave 3.

On behalf of the Board, I want to express our gratitude to the Trust staff for their hard work and resilience throughout the pandemic to maintain a high standard of GRIP and achievement against the NHS performance metrics. The entire organisation has now been operating at or above capacity for almost two years since the start of the winter pressures in October 2019.

The Trust continues to invest in staff health and wellbeing programmes covering both physical and mental health together with working through the action plans from the Staff Survey. The Executive team are working with staff groups to balance patient priorities and to enable staff to take much needed planned time for personal rest and recovery.

I also want to thank the Executive Team for their extraordinary commitment and leadership. As a Trust we have a highly experienced, dedicated and stable Executive team which has ensured the Trust continues to deliver high standards of patient care within the Trust and to enable the Trust to take a leadership role across North West London (NWL) on the 3 focus areas, for example:

Our Chief Nurse, Pippa, is leading the NWL Vaccination programme, including the set-up of the mass-vaccination centres at Twickenham stadium on 31st May where over 15,000 people were vaccinated and at Stamford Bridge, Chelsea on 19th June where over 5,000 people were vaccinated, other high profile 'pop up' mass vaccination events are planned for July;

Our Deputy CEO & COO, Rob, is coordinating the NWL Elective Recovery programme.

Critical Care – Chelsea site Official Opening – 29th June

The new Critical care ICU / NICU provide world class facilities for patient care at the Chelsea site on Fulham Road. The official opening on 29th June was a 'Virtual' Event in compliance with current COVID-19 guidelines. The ICU / NICU opening received extensive media coverage, a link to the opening event video was published in the July Public Board pack. A big 'thank you' to the Clinical and Estates teams for the work on this project, to CW+ for their fundraising and to all of the Trust supporters who generously donated.

Trust Annual General Meeting (AGM) – 22nd July

The Trust Financial Report and Accounts plus the External Auditors Report for 2020/21 were approved by the Trust Board in June, I am delighted to report the Trust received a 'clean' audit opinion with no significant issues. The Report and Accounts will be presented at the AGM at 16:00-17:00 on the 22nd July, preceded by the Council of Governors Meeting at 09:30-11:00 on the 22nd July.

North West London Integrated Care System (ICS)

The Department of Health & Social Care (DHSC) published a White Paper in February 2021 outlining the legislative proposals for the establishment of ICSs with effect from 1st April 2022. NHSE/I published guidance

on the ICS Design Framework and Oversight in June 2021. The Government published the Health and Care Bill on 6th July which provided further details. The following is a very high-level summary:

ICSs will be made up of two parts: the ICS partnership, and the ICS NHS body.

The ICS NHS body will be a statutory body, whose functions will include planning to meet population health needs, allocating resources, and overseeing delivery.

ICS NHS bodies will have a unitary board. The statutory minimum membership of the board will be confirmed in forthcoming legislation but is expected to be comprised of: a chair and at least two independent non-executive directors (NEDs); a chief executive and three executive directors; plus, a minimum of three further members, representing Trusts, Primary Care and Local Authorities.

All Trusts providing acute and mental health services are expected to be part of one (or more) provider collaborative. The NHSE/I guidance sets out three potential models for provider collaboration (Provider leadership board; Lead provider board; Shared leadership board).

Chelsea & Westminster Hospital Foundation Trust will be part of the NWL Acute Provider collaborative together with Imperial College Healthcare Trust; London NW University Healthcare Trust; and The Hillingdon Hospital Foundation Trust.

The Chairs and CEOs of the four NWL Acute Providers are working with the NWL ICS to develop the provider collaborative agreement, to agree the proposed collaborative model and related governance arrangements.

Providers will continue to be accountable for quality, safety, use of resources and compliance with standards, as well as the delivery of services and functions delegated to them by the ICS NHS body. Executives of providers will remain accountable to their boards for the performance of services and functions for which their organisation is responsible.

Council of Governors (COG) Briefing Sessions:

20th May – James Eaton (Operational Services Manager), on behalf of Rob Hodgkiss (Deputy CEO & COO), presented an update on the Elective Recovery programme.

The next COG briefing session is scheduled for 23rd September.

Chair Meetings:

The London Region Chairs meetings and North West London (NWL) ICS Chairs / CEOs meetings during May and June discussed the following topics: COVID-19 wave 3; Vaccination programme; Elective Recovery programme; NWL ICS Development plan and 'road map'; NHSE/I guidance on Provider collaboratives.

As part of the work on the NWL Acute Provider collaborative, noted above, I have had weekly meetings in June and July with Bob Alexander (Imperial College Healthcare Trust) and Lord Morse (Chair of Hillingdon Hospital Foundation Trust & London North West University Healthcare Trust).

Substantive Chair recruitment update:

This is covered in a separate paper for the July COG.

Stephen Gill

Interim Chair - July 2021





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.5/Jul/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 Governors on high-level Trust affairs.	
REPORT HISTORY	Board Public, 8 July 2021	
SUMMARY OF REPORT	As described within the paper. Governors 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	For information.	

Chief Executive's Report June 2021

Elective Recovery

Alongside the vaccination programme, and preparing for any future surges our key priority has been the restoration of the elective work programme.

In the past two months as the number of Covid patients in hospital has remained at a relatively low level and we have seen the resumption of all or our planned care services. We, together with the other Trusts in our sector, have continued with the collaborative effort to ensure that we both stabilise and begin to address the expanded waiting lists.

This effort has been reinforced by the establishment of the Joint Acute Care Board. This will co-ordinate the work of all operational areas including planned surgery, out-patients, diagnostics, cancer and emergency and urgent care. Its membership includes all chief executives, chief medical officers, chief nurses and chief operating officers. The focus is on ensuring patients are prioritised according to clinical need, then by waiting time. Ensuring equity of access and outcome underpins this work.

Covid-19 and Vaccinations

Although the easing of Covid-19 restrictions is welcome, we know that the pandemic continues to pose a threat to our communities, patients and staff. Currently, stringent infection control measures remain in place to ensure we are protecting everyone as much as possible.

Trust staff come from all over the world, and many have relatives or friends in other countries. The impact of Covid-19 in some of these countries has been truly distressing. We have heard particularly from staff with relatives in India, Nepal and the Philippines. We have both provided support for staff affected and discussed ways in which we can help support communities across the world. We have worked with national colleagues led by Prerana Issar, Chief People Officer, to support the response mounted for these countries.

Pippa Nightingale, Chief Nursing Officer has led the vaccination programme across North West London. The rate of uptake amongst our own staff is 94%.

In North West London 2.3 million vaccine doses have been administered and we continue to work hard to ensure our communities in every borough have access to the vaccine. Mass vaccinations e.g. at the Twickenham and Stamford Bridge Stadiums have proved popular. One off campaigns such as 'Let's take Covid down' and 'Grab a Jab' together with more bespoke pop-up clinics, touring buses, pharmacies and importantly the work of our primary care networks have ensured we have been able to support all of our communities to access the vaccine. It is clear this work needs to continue and will remain a priority for us.

Visit of His Royal Highness, The Prince of Wales

We were delighted to receive a visit from HRH The Prince of Wales. His Royal Highness met apprentices and volunteers, supported to work by the Prince's Trust. The Trust has over 200 apprentices, many of them from local communities and underpins our ambition to be an anchor institution sitting at the heart of our community. The Prince officially opened our wellbeing garden which has been magnificently supported by the work of Jamie Butterfield of Butterworth Horticulture and provides a place of respite in the open air for our staff.

World class critical care facilities

Our fantastic adult and neonatal intensive care facilities at Chelsea and Westminster Hospital were formally opened this month, enabling the treatment of more than 2,000 patients every year.

With support from our charity CW+ and underpinned by contributions from many generous donors we have created world-class units which demonstrate how clinically led innovations supported by great design, an understanding of the therapeutic importance of the environment can significantly improve the care and recovery of our most seriously unwell adults and babies. We hope to set a benchmark for Critical Care services improving clinical outcomes, reducing costs, improving efficiency and reducing risks for our patients.

We are so grateful for the contributions of so many people, including our amazing staff who, absolutely, love the new facilities.

Grip on quality

We have resumed our ward accreditation scheme. This is a systematic approach to examining the environment and delivery of care in each ward and department by a multi-disciplinary peer-review. These provide invaluable opportunities to challenge ourselves and share learning as the exercise mirrors the CQC domains. Since relaunching on 23 April, 30 clinical areas – 16 at Chelsea and 14 at West Mid – have been accredited. I know you would want to join me in congratulating Children's outpatients, Josephine Barnes Ward, Kensington Wing, Kew Ward and Plastics outpatients who achieved Gold, the highest rating.

Continued commitment to learning and development

I am pleased that our Year 3 OSCE and Year 5 PACES examinations for the Imperial Medical School Students have been successfully completed despite the restrictions created by Covid-19

We have received outstanding feedback from the Medical School's External examiners and Head of Assessments that the Exams ran effectively and were coordinated extremely well given the current circumstances.

We have continued to run our leadership development courses internally and supported our senior staff to continue with their studies to ensure we maintain our commitment to continuous improvement.

Project Search is one of my favourite programmes at West Middlesex, and we are proud of how it puts our compassionate values into action. It gives students with learning disabilities and autism supported work experience internships, which in some cases have led to paid employment in the Trust. The students enjoy the experience but provide very valuable learning experience for all our staff. From September we will expand this to the Chelsea site as well.

We are a research active Trust, always looking for better ways to improve the care to our patients. During the pandemic, 3000 patients were recruited in the Trust to 23 Covid-19 trials, including 730 to vaccine trials. These included trials which have validated better treatments for Covid-19 and proved that Covid-19 vaccines are safe and effective.

Innovations such as remote monitoring of patients, apps to deliver training to the pocket, and risk-assessment to help our teams better treat Covid-19 patients have been developed.

Our People-Equality Diversity and Inclusion

We are committed to this being a Trust where everyone feels welcome, where everyone is treated fairly, and where everyone has the same opportunities to learn and progress.

Gubby Ayida who chairs the BAME network remains the advisor to the Trust Board. We have increased representation of our ethnic minority staff in leadership roles and we have seen significant increases on our leadership development/MSc programmes. We have also appointed cultural safety advisers in maternity and increased the diversity of our Freedom to Speak Up champions, health and wellbeing champions and mental first aiders – all areas where it is important that all voices are heard.

We became a Stonewall Diversity Champion, and maintained our Disabled Confident Employer status at level two, whilst we work towards level three. Four EDI networks are now in place – Women's, BAME, LGBTQ+ and Disability.

Our latest figures show improvements in narrowing the gender pay gap, and I am determined we continue to make progress across all these important areas of inequality and inequity.

Our staff wellbeing remains both a concern and a priority. During the past year and in line with our staff health and wellbeing programme we have sought to understand the general and specific needs of our staff and our committed to investing in programmes that will provide sustainable support now and in the future.

The Trust and the ICS

The Trust continues to be part of national, regional and sector discussions. NWL Integrated care system submitted its Development Plan on the 30th June and I have attached the summary slides to provide an update to our Board. We continue to operate as one system whilst legislative changes continue to be progressed.

Briefing meetings have been held with:

- All NHS provider Chairs
- NWL CCG Chairs
- All LA Council Leaders and Chief Executives
- All Provider CEOs
- Primary Care Network Directors
- Partnership Board
- Local MPs
- Scrutiny committees
- Local partnership and patient representatives

The Trust continues to support Hillingdon Hospital in its work to improve quality, operational delivery and use of resources.

Lesley Watts

Chief Executive Officer





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.7.1/Jul/21		
REPORT NAME	Elective Care Recovery		
AUTHOR	Robert Hodgkiss, Chief Operating Officer & Deputy CEO		
LEAD	Robert Hodgkiss, Chief Operating Officer & Deputy CEO		
PURPOSE	To provide the Governors 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 NWL Elective Care Board, Executive Management Board, Quality Committee and the Trust Board.		
SUMMARY OF REPORT	 Priority 2 waiters have increased across NWL this week, specifically at ICHT a LNWHT. Chelsea & Westminster and Hillingdon have seen a reduction for the consecutive week. 		
	• Elective IP/DC is at 86.6% of BAU volumes, up 0.3% across the previous four war and above plan		
	 Elective high volume low complexity (HVLC) specialities is at 106.7% of volumes, up 3.1% across the previous four weeks and above plan 		
	Elective outpatient activity is at 107.1% of BAU volumes, down 4% across the previous four weeks but above plan		
	CWFT is ahead of its 52 week waiters (ww) trajectory but behind on its 78 w trajectory, the trend has however reversed with improvement in the positio There were no over 104 ww reported in the latest period.		
	Cancer Backlog continues to improve with a reported position of 92 patients.		
	 Imaging activity is at 82.5% of BAU volumes, down 4.7% across the previous four weeks and reporting minimal patients over 6 weeks 		
	Endoscopy activity is at 107.3% of BAU volumes, up 3.1% across the previous four weeks		
	• Echocardiography activity is at 74.8% of BAU volumes, up 11.4% across the previous four weeks and reporting minimal patients over 6 weeks.		
KEY RISKS ASSOCIATED	There are on-going risks to the achievement of Elective recovery		
FINANCIAL IMPLICATIONS	Attainment of the Elective Recovery Fund		
QUALITY IMPLICATIONS	There are on-going risks to the achievement of Elective recovery		

EQUALITY & DIVERSITY IMPLICATIONS	None	
LINK TO OBJECTIVES	 Deliver high quality patient centred care Delivering better care at lower cost 	
DECISION/ ACTION	For information.	





Chelsea and Westminster Elective Care Recovery

Recovery Update - Summary 12th July 2021



P2 waiting list size across NWL Trusts

Trusts	11.06.21	18.06.21	25.06.21	02.07.21	Trends
CWFT	468	471	464	449	
ICHT	1,167	1,174	1,174	1,206	/
LNWUHT	511	572	591	601	
THHT	60	53	44	43	
NWL Total	2,206	2,270	2,273	2,299	

Source: OnePTL

Number of P2 patients waiting 6 weeks or more

Trusts	18.06.21 2	5.06.21	02.07.21
CWFT	3	5	TBC
ICHT	247	273	182
LNWUHT	184	178	162
THHT	31	19	17
NWL Total	465	475	361

Headlines:

ICHT:

The latest ICHT OnePTL submission (census date 27 Jun 21) shows 1042 NHS P2 patients on an active RTT admitted pathway. C.150 non-surgical patients on found on PTL when audited last week

LNWHT:

Colorectal is the main specialty not at p2 equilibrium. Trust is work through options to develop a range of solutions and mitigate the risk of reducing overall volume of EL and DC activity.

THHFT:

Null priority records will decrease to 37% next reporting period.

Data collation update:

ICS team is collating the number of P2 patients waiting 6 weeks or more, and is working with Trusts to understand the variation in numbers – in particular the inclusion and exclusion criteria for reporting.



Prioritisation of admitted patients: Data source and quality

'Null' data across NWL

Dates	Total number of patients on the PTL	Nulls (n)	Nulls (%)
11.06.21	23,218	5,482	24%
18.06.21	23,261	5,371	23%
25.06.21	23,376	5,302	23%
02.07.21	23,281	5,217	22%

'Null' % by Trust

Trusts	11.06.21	18.06.21	25.06.21	02.07.21
CWFT	21%	22%	23%	23%
ICHT	13%	14%	14%	14%
LNWUHT	24%	20%	17%	16%
THHFT	55%	56%	56%	54%

Source: OnePTL

Headlines

1. THHFT null improvement project has commenced, latest week figures indicate 37% null. Improvements should be visible in extract next week.



Executive summary



	Lat	Latest Freeze Position (w/e 27-Jun)					Latest Freeze Position - % BAU by ICS				
	Activity	Var	% BAU ⁽¹⁾	London Regional Rank ⁽²⁾	4 Week Change in Activity	Jun-21	NWL	NCL	NEL	SEL	SWL
Elective	23,362	•	87.4%	7	-0.6%	103,029	84.2%	92.0%	84.6%	86.3%	88.4%
Outpatients	257,525	•	95.9%	5	0.8%	1,417,761	101.7%	98.0%	96.4%	89.8%	93.7%
Endoscopy	4,739	•	98.6%	2	2.9%	19,370	91.1%	89.5%	117.6%	105.3%	91.8%
Imaging	60,419	•	97.6%	4	-1.2%	239,990	85.1%	108.6%	97.4%	103.8%	96.3%
Echocardiography	6,445	A	95.9%	1	-3.7%	23,982	74.7%	121.3%	90.8%	102.4%	93.7%

- (1) Prior year baselines from March are based on unadjusted data submitted to SUS by providers for 2019/20
- (2) Regional Rank is based on % BAU

Headlines

- ► Activity levels increased in 1 (Echocardiography) of the 5 key pods in the week ending 27th June 2021
 - There have been slight reductions in activity across the other 4 pods
 - % BAU across all pods seems to have reached a plateau, and future changes to activity are likely to be marginal
- ▶ When compared to baseline relative to other regions, London now ranks 7th for Elective activity and has maintained 5th position for Outpatient activity
- ► Of the diagnostic modalities, London ranks 1st for Echocardiography, and 2nd and 4th for Endoscopy and Imaging respectively
- ▶ 52ww has maintained its week on week reductions however, similarly to all other regions, 104ww has risen
- ► Admitted PTL continues its reduction whilst non-admitted PTL has increased at a lower rate compared to recent weeks
- ► Endoscopy and Imaging have both seen an increase in waiting lists, however the latter expects to see future reductions following the implementation of Community Diagnostic Hubs

		27-Jun	04-Jul	Var
	NWL	4,229	4,054	-175
	NCL	16,182	15,636	-546
W	NEL	12,809	12,576	-233
25	SWL	1,758	1,676	-82
	SEL	7,335	6,961	-374
	London	42,313	40,903	-1,410
	NWL	110	112	2
Ţ	NCL	568	590	22
W	NEL	311	326	15
104	SWL	12	13	1
	SEL	123	136	13
	London	1,124	1,177	53
	Admitted PTL	127,407	127,128	-279
	N on-Admitted PTL	768,569	771,443	2,874
st	Cancer DTT Backlog	235	206	-29
Waitlist	Cancer No DTT Backlog	2,158	2,215	57
Š	Cancer 104 Day Waits	537	558	21
	Endoscopy Waitlist (3)	21,748	-	187
	Imaging Waitlist (3)	139,636	_	2,246

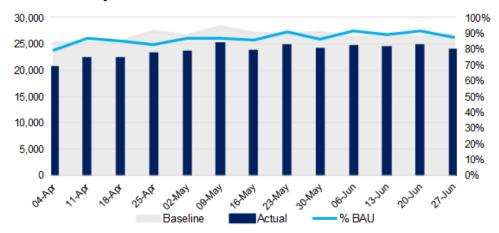
(3) Diagnostic waitlists showlatest freeze position and variance on prior week

Official Sensitive – Not for Publication 09 July

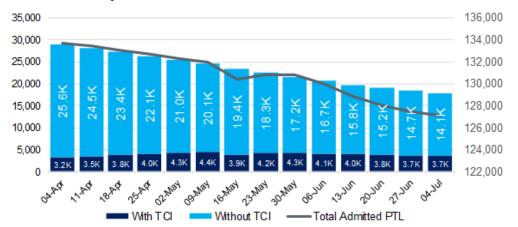
Elective Activity



Elective Activity Volumes and % of Baseline



Admitted Pathway: 52 www and Total PTL



Total Electives (Latest Freeze Data: w/e 27-Jun)

Provider	% BAU	Actual	4 Week	Jun-21
		Activity	Change	Plan
NEL	84.6%	3,246	3.5%	13,519
BHRUT	92.1%	1,090	13.9%	
Homerton	90.6%	509	6.9%	
Barts	78.8%	1,647	-3.3%	
NCL	92.0%	6,389	-1.2%	30,323
GOSH	100.3%	771	5.3%	
UCLH	97.8%	2,318	1.3%	
Whittington	93.6%	436	-12.4%	
Moorfields	89.7%	682	8.8%	
NMUH	88.0%	596	2.8%	
RFL	84.5%	1,343	-6.4%	
RNOH	77.4%	243	-20.3%	
NWL	84.2%	4,836	1.5%	19,909
Imperial	89.7%	2,186	1.5%	
ChelWest	86.6%	902	0.3%	
LNW	77.7%	1,339	4.6%	
Hillingdon	75.3%	409	-5.1%	
SEL	86.3%	5,485	-3.2%	23,832
LGT	90.1%	872	0.7%	
Kings	88.0%	2,197	-3.2%	
GSTT	83.5%	2,416	-4.5%	
SWL	88.4%	3,406	-2.1%	15,446
Royal Marsden	96.2%	359	-6.0%	
Kingston	93.4%	513	1.0%	
St George's	89.4%	1,196	-1.9%	
Epsom	87.8%	889	2.8%	1
Croydon	77.0%	449	-11.3%	†
LONDON	87.4%	23,362	-0.6%	103,029

Admitted PTL (w/e 04-Jul)

Admitted PTL (w/e 04-Jul)						
PTL Size	4 Week Change	52ww				
22,988	-2.1%	5,272				
4,082	-6.3%	482				
3,193	-0.8%	91				
15,713	-1.3%	4,699				
31,320	-3.2%	4,802				
1,939	-1.8%	189				
8,407	-1.6%	1,315				
2,109	0.7%	303				
5,623	-3.8%	6				
1,168	-6.5%	91				
9,723	-5.4%	2,724				
2,351	-0.7%	174				
23,365	0.7%	2,742				
9,154	1.3%	958				
5,204	0.2%	377				
5,627	1.7%	727				
3,380	-1.9%	680				
32,369	-1.9%	3,963				
6,286	-0.2%	1,326				
11,276	1.1%	1,093				
14,807	-4.8%	1,544				
17,086	-4.8%	1,009				
202	-14.8%	3				
2,675	-11.6%	31				
6,512	-4.6%	870				
5,647	-1.9%	85				
2,050	-2.4%	20				
127,128	-2.2%	17,788				
Source: RTT V	Veekly PTI					

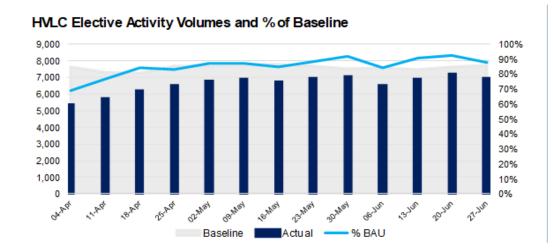
Source: Weekly Activity Return

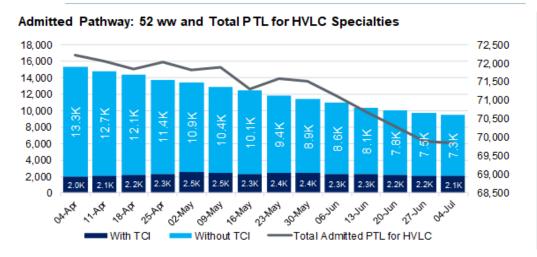
Source: RTT Weekly PTL

London elective activity in the equivalent baseline period: 26,735.

Elective – high volume low complexity specialties







HVLC Elective Activity (Latest Freeze Data: w/e 27-Jun) HVLC Admitted PTL (w/e 04-Jul)

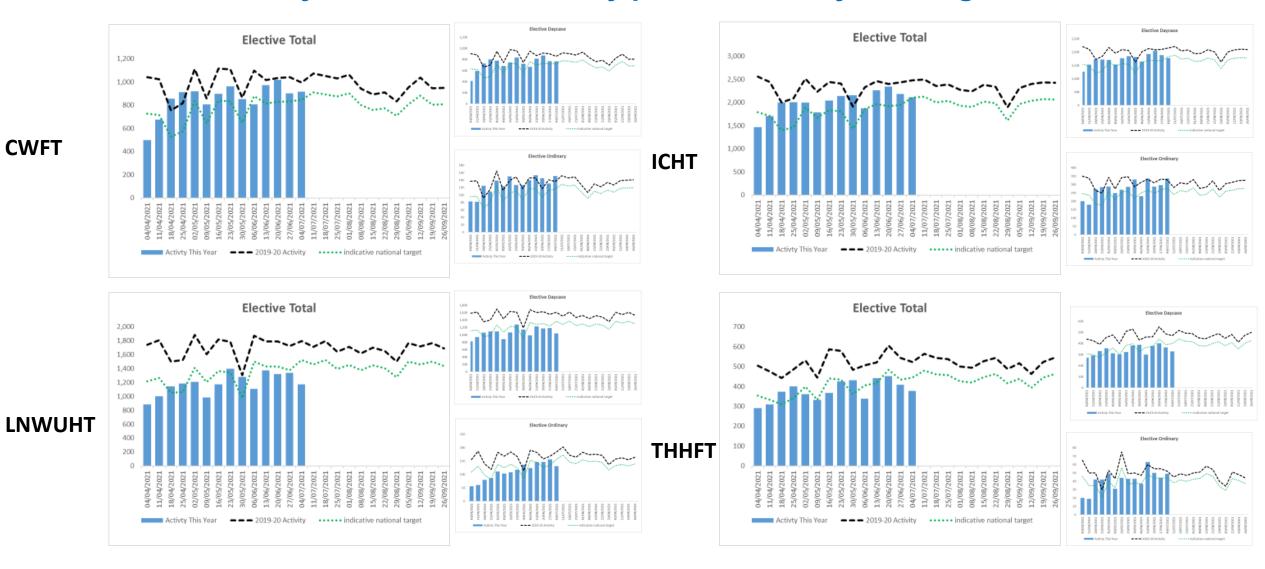
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Provider	% BAU	Actual Activity	4 Week Change	PTL Size	4 Week Change	52w w	
NEL	88.5%	1,120	19.8%	10,742	-1.7%	2,426	
Homerton	111.4%	234	16.4%	2,121	4.2%	62	
BHRUT	105.7%	483	31.3%	2,456	-6.2%	272	
Barts	67.3%	403	10.1%	6,165	-1.7%	2,092	
NCL	86.6%	1,861	-4.4%	19,172	-3.3%	2,655	
RNOH	101.0%	208	-18.8%	2,172	-1.0%	169	
Moorfields	90.1%	682	8.8%	5,623	-3.8%	6	
RFL	87.7%	363	-20.0%	4,395	-6.9%	1,096	
UCLH	83.2%	347	-2.3%	4,326	-2.3%	1,003	
NMUH	80.3%	191	7.9%	831	-4.3%	83	
Whittington	59.3%	70	-10.3%	1,825	2.9%	298	
NWL	89.0%	1,340	-1.8%	13,649	0.7%	1,531	
ChelWest	106.7%	303	3.1%	2,453	-0.9%	144	
LNW	90.0%	440	-16.7%	4,919	1.8%	671	
Hillingdon	86.4%	172	11.7%	1,962	-2.3%	254	
Imperial	79.7%	425	9.3%	4,315	1.7%	462	
SEL	81.7%	1,182	-10.9%	16,213	-0.8%	2,391	
Kings	85.0%	651	-9.0%	5,741	-0.1%	474	
GSTT	84.6%	352	-11.3%	5,421	-3.4%	618	
LGT	67.5%	179	-16.7%	5,051	1.2%	1,299	
SWL	93.0%	1,283	-4.4%	10,063	-3.7%	456	
Royal Marsden	167.6%	119	-3.3%	71	-11.3%	0	
Croydon	100.0%	202	-9.4%	1,381	-2.9%	10	
St George's	93.9%	200	-1.5%	2,196	-5.8%	350	
Epsom	85.6%	557	1.6%	4,744	0.4%	68	
Kingston	84.4%	205	-16.3%	1,671	-11.9%	28	
LONDON	87.6%	6,786	-1.9%	69,839	-1.8%	9,459	
Source: Weekly Activ	ity Return			Source: RTT	Meekly PTI		

Source: Weekly Activity Return

Source: RTT Weekly PTL

London HVLC activity in the equivalent baseline period: 7,748.

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





Phase 1: NHS Theatre throughput NHS theatre activity in numbers

represents bank holiday week

NHS activity / capacity

Rolling 8 weeks

1,622 elective patients received surgery in NHS theatres **last week**

W/E	Peak Recovery 06/12/2020	16/05/21	23/05/21	30/05/21	07/06/21	14/06/21	21/06/21	28/06/21	04/07/21
Trust	Week 49	Week 06	Week 07	Week 08	Week 09	Week 09	Week 10	Week 11	Week 12
CWHFT	540	447	426	436	302	512	496	448	460
ICHT	521	483	545	539	382	555	564	544	576
LNWUHT	484	366	347	384	285	371	365	402	358
THHFT	168	148	172	167	155	163	197	177	152
TOTAL	1,713	1,444	1,490	1,526	1,124	1,601	1,616	1571	1546

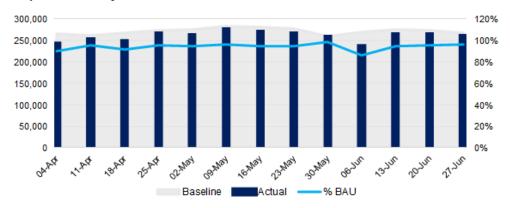


Outpatient activity

Note: Epsom has been removed whilst baselines are updated in national dataset (see page 4). We are also investigating a potential discrepancy in the way radiology is captured (see page 4).



Outpatient Activity Volumes and % of Baseline



Non-Admitted Pathway: 52 ww and Total PTL



Outpatients (Latest Freeze Data: w/e 27-Jun)

Provider	% BAU	A ctual	4 Week	Jun-21
FIOVILLEI	/8 DAG	A ctivity	Change	Plan
NEL	96.4%	35,783	3.2%	213,769
Homerton	118.6%	6,133	2.2%	
Barts	94.0%	21,621	2.9%	
BHRUT	89.6%	8,029	4.6%	
NCL	98.0%	76,301	-0.5%	418,588
NMUH	117.5%	8,833	3.7%	
UCLH	109.3%	26,738	-1.8%	
GOSH	101.9%	3,588	-1.8%	
Whittington	91.8%	5,782	-5.8%	
Moorfields	90.2%	11,175	4.3%	
RNOH	89.4%	1,883	-13.5%	
RFL	85.0%	18,302	0.3%	
NWL	101.7%	48,796	1.4%	240,322
ChelWest	107.1%	13,601	-4.0%	
LNW	104.6%	15,107	11.2%	
Imperial	98.6%	15,801	-2.7%	
Hillingdon	89.3%	4,287	3.5%	
SEL	89.8%	56,316	1.9%	313,056
LGT	114.8%	11,538	20.7%	
GSTT	87.1%	26,330	-1.8%	
Kings	82.4%	18,448	-2.3%	
SWL	93.7%	40,329	-0.7%	232,026
Croydon	128.0%	9,150	-3.8%	
Kingston	98.6%	7,238	5.9%	
Royal Marsden	95.5%	4,735	-4.3%	
St George's	85.0%	12,876	-2.3%	
LONDON	95.9%	257,525	0.8%	1,417,761

Non-Admitted PTL (w/e 04-Jul)

Non-Admitted PTL (w/e 04-Jul)						
PTL Size	4 Week Change	52ww				
150,652	2.5%	7,304				
19,767	2.9%	20				
84,056	3.3%	6,405				
46,829	1.0%	879				
191,354	2.4%	10,834				
13,249	3.6%	7				
41,973	3.8%	1,105				
4,960	2.6%	113				
14,689	-1.2%	487				
28,325	3.8%	8				
3,844	-2.6%	37				
84,314	2.0%	9,077				
158,157	4.1%	1,312				
35,546	3.9%	225				
38,846	2.8%	189				
66,200	5.6%	659				
17,565	1.9%	239				
161,687	0.9%	2,998				
46,840	-3.6%	1,114				
61,421	5.6%	646				
53,426	-0.2%	1,238				
109,593	2.4%	667				
19,724	4.9%	16				
19,958	0.2%	36				
1,064	5.3%	0				
38,913	1.0%	401				
771,443	2.4%	23,115				

Source: RTT Weekly PTL

London outpatient activity in equivalent baseline period: 268,667.

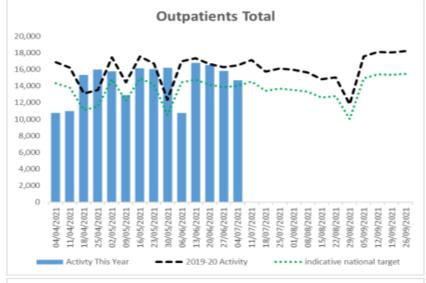
Phase 2: Recovery plan Outpatients Weekly performance by Trust against Spring Recovery Plan

Outpatients Total 16,000 10,000 8,000 6,000 4,000 2,000 **Outpatients Total** 16,000 12,000 10,000 8,000 6,000 4,000 2,000

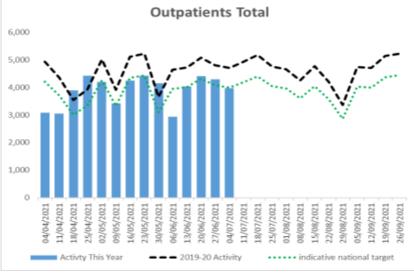
CWFT

LNWUHT

ICHT



THHFT



N.b. This report includes unvalidated operational data which needs to be viewed in conjunction with exception reports from trust teams.

Confidential information - not for further distribution

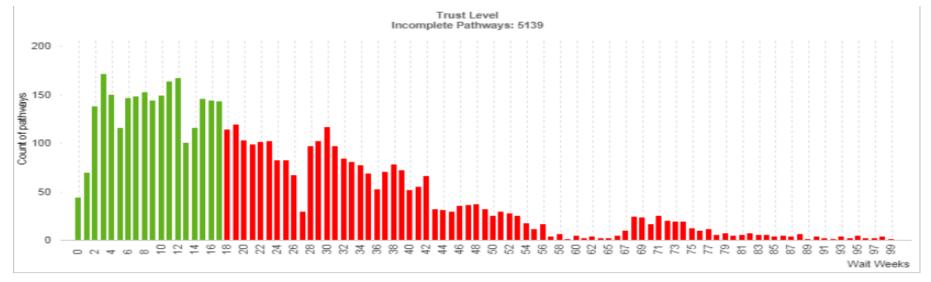
Source: COVID-19 NHS Weekly Phase 3 Activity Report



Current PTL Position

Admitted



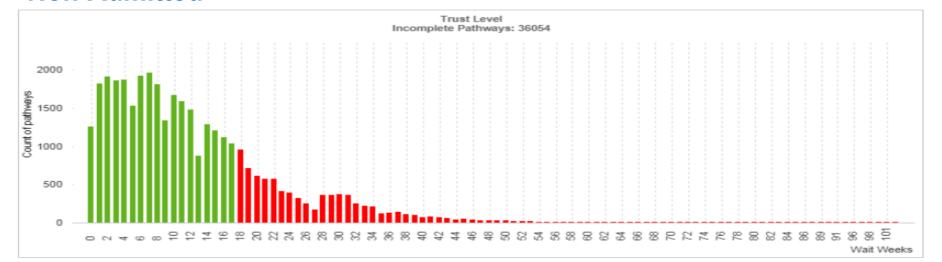


Admitted Summary

(previous data)

- **52ww ↓384** (431)
- **Dated -** ↑**1,360** (1,308)
- Undated **J3,779** (3,845)

Non-Admitted

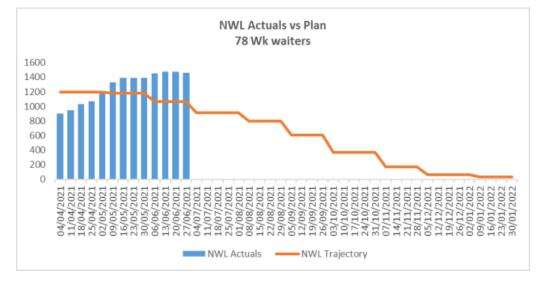


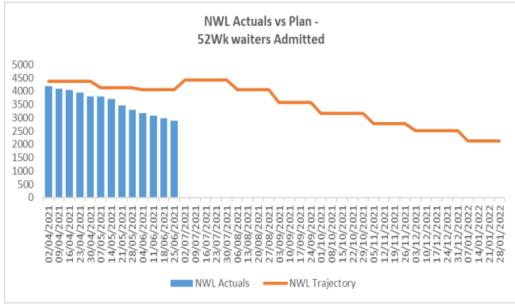
Non-Admitted Summary (previous data)

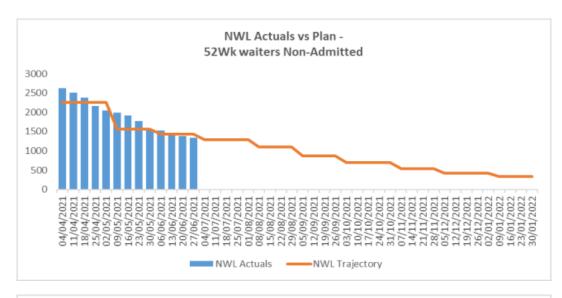
- **52ww -** ↑**232** (218)
- **Dated -** ↑24,524 (23,947)
- Undated ↑11,530 (11,393)

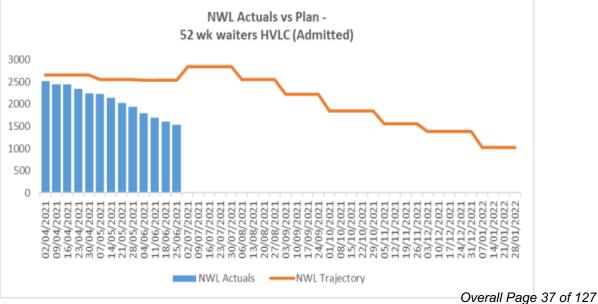
NWL Actuals vs Trajectories

Actual activity: Un-validated data



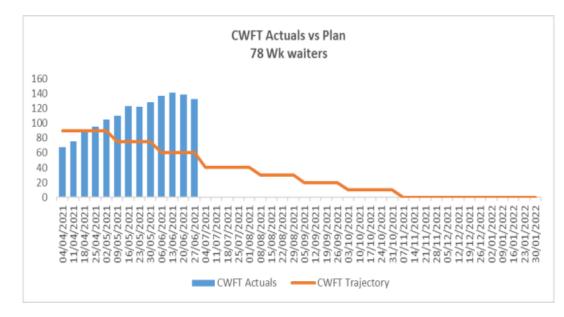


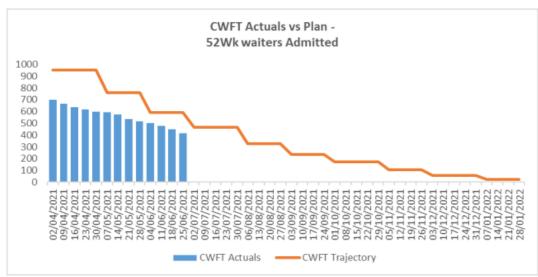


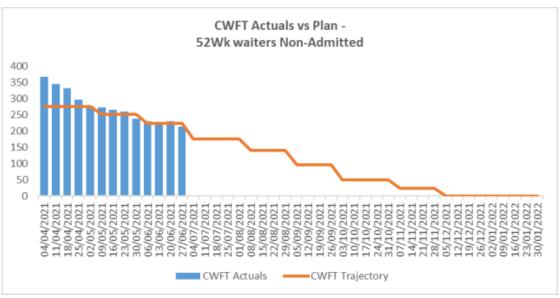


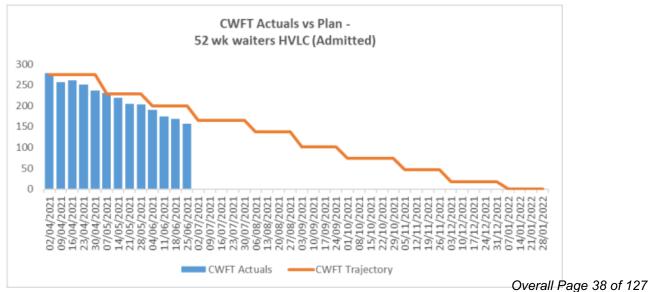
Trajectories

Actual activity: Un-validated data

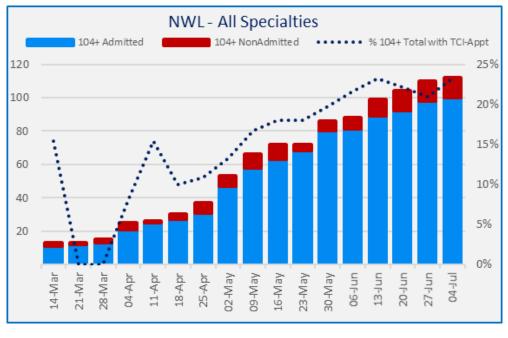


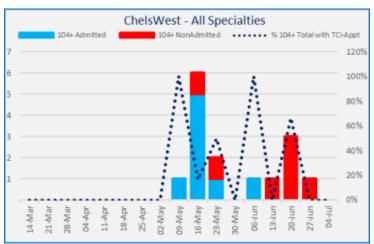


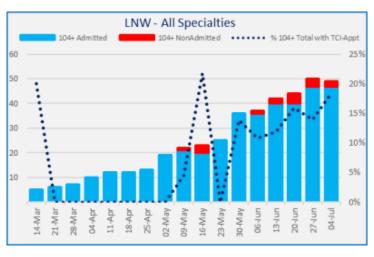




NW London 104ww – there are 112 patients as of 4th July



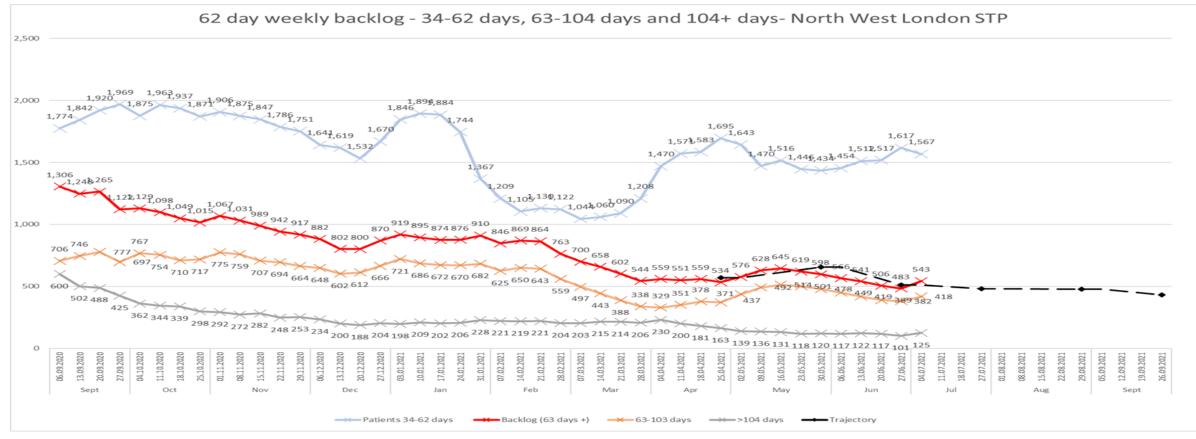








North West London – w/e 4th July 2021



Change in last week by patients:

Provider	34-62 days	63-103 days	104+ days	63 days +	Total 63+ day backlog
Chelsea & Westminster	-53	-4	+3	-1	92
Imperial	+33	+23	+17	+40	245
London North West	-20	+14	+3	+17	172
Hillingdon Hospitals	-10	+3	+1	+4	34
Royal Brompton & Harefield					
North West London	-50	+36	+24	+60	543

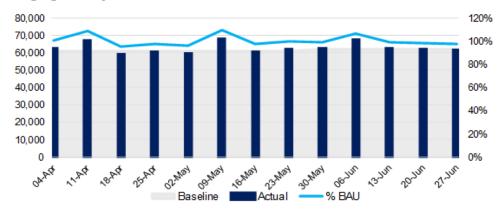
Totals:

NWL	34-62 days	63-103 days	104+ days	63 days +
RMP w/e 04.07.2021	1567	418	125	543
Baseline (w/e 01.03.20)	1,644	725	158	883
Difference to baseline	-77	-307	-33	-340

Imaging activity



Imaging Activity Volumes and % of Baseline



Imaging: Total Wait List



Imaging (Latest Freeze Data: w/e 27-Jun)

Provider	% BAU	Actual	4 Week	Jun-21
	27.40/	Activity	Change	Plan
NEL	97.4%	12,923	1.8%	52,961
Barts	103.6%	6,698	-0.2%	
Homerton	97.6%	1,921	-2.1%	
BHRUT	88.8%	4,304	7.0%	
NCL	108.6%	11,911	-5.6%	48,307
NMUH	158.6%	1,521	-14.0%	
Whittington	133.7%	1,537	-2.0%	
UCLH	133.6%	3,552	-0.8%	
Moorfields	126.1%	163	17.3%	
RNOH	104.2%	524	-1.5%	
GOSH	96.9%	383	-24.5%	
RFL	81.8%	4,231	-6.5%	
NWL	85.1%	12,292	-3.2%	48,561
Imperial	97.4%	4,787	-0.2%	
ChelWest	82.5%	2,923	-4.7%	
LNW	79.1%	3,338	-6.7%	
Hillingdon	70.3%	1,244	-1.2%	
SEL	103.8%	12,585	1.7%	48,199
Kings	112.8%	5,039	2.0%	
LGT	105.0%	3,461	3.7%	
GSTT	93.7%	4,085	-0.2%	
SWL	96.3%	10,708	-0.4%	41,962
Epsom	113.8%	2,621	5.4%	
Croydon	108.3%	2,213	-2.1%	
Royal Marsden	96.9%	1,554	-9.9%	
Kingston	86.6%	1,563	-1.1%	
St George's	81.9%	2,757	2.3%	
LONDON	97.6%	60,419	-1.2%	239,990

Waitlist (w/e 27-Jun)

vvaiuisi (w/c Z1-Juii)				
Waitlist	4 Week Change	>6 Weeks		
47,868	4.0%	12,574		
32,063	0.7%	10,654		
5,396	4.8%	61		
10,409	15.1%	1,859		
21,587	-4.1%	1,271		
1,314	-41.7%	47		
3,037	4.3%	6		
7,252	-7.1%	674		
146	-5.2%	2		
1,946	-11.5%	163		
1,119	-10.7%	214		
6,773	14.0%	165		
24,839	3.0%	1,536		
7,808	-7.4%	139		
4,747	9.4%	13		
6,935	5.7%	50		
5,349	11.9%	1,334		
21,729	-2.2%	1,792		
7,609	6.2%	413		
5,194	-12.0%	442		
8,926	-2.4%	937		
23,613	1.8%	1,059		
7,518	5.4%	528		
7,143	4.7%	338		
0	-	0		
3,348	12.9%	9		
5,604	-10.8%	184		
139,636	1.1%	18,232		
Source: Week	dv Activity Retu	ırn		

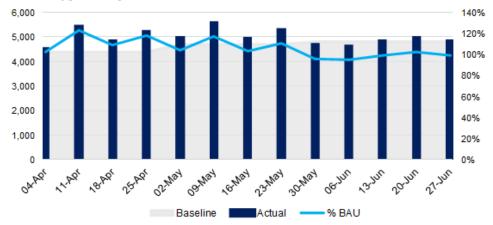
Source: Weekly Activity Return

London Imaging Activity in the equivalent baseline period: 61,936.

Endoscopy activity







Endoscopy: Total Wait List



Endoscopy (Latest Freeze Data: w/e 27-Jun)

Endoscopy (Edito	3t 1 10020 Du		u.,	
Provider	% BAU	Actual Activity	4 Week Change	Jun-21 Plan
NEL	117.6%	998	10.9%	3,778
BHRUT	168.8%	235	0.9%	
Barts	121.5%	605	22.2%	
Homerton	74.6%	158	-8.1%	
NCL	89.5%	780	-10.3%	4,038
UCLH	178.7%	471	-6.5%	
Whittington	95.6%	137	-4.2%	
NMUH	41.6%	55	-30.4%	
RFL	35.4%	114	-8.8%	
GOSH	30.0%	3	-84.2%	
NWL	91.1%	1,004	29.4%	4,257
Hillingdon	297.6%	125	-10.7%	
ChelWest	107.3%	265	3.1%	
Imperial	106.4%	335	5.0%	
LNW	56.0%	279	365.0%	
SEL	105.3%	1,053	-8.8%	3,812
GSTT	168.6%	290	-16.2%	
LGT	110.0%	348	3.3%	
Kings	81.2%	415	-11.9%	
SWL	91.8%	904	0.0%	3,485
Croydon	112.6%	156	-11.4%	
Epsom	105.5%	286	19.2%	
Kingston	94.4%	169	-13.8%	
St George's	74.0%	268	5.5%	
Royal Marsden	71.9%	25	-34.2%	
LONDON	98.6%	4,739	2.9%	19,370

Source: Weekly Activity Return

Waitlist (w/e 27-Jun)

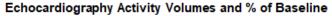
VVaitilist (VV/C		
Waitlist	4 Week Change	>6 Weeks
5,211	-6.6%	2,384
677	2.1%	19
3,762	-11.4%	2,309
772	15.1%	56
5,106	-0.4%	1,879
2,029	2.5%	982
458	4.8%	111
1,012	-5.9%	354
1,501	-0.9%	385
106	-12.4%	47
5,528	-15.3%	1,708
868	-11.2%	329
1,098	-13.5%	183
2,241	-21.4%	1,034
1,321	-7.6%	162
3,359	-8.4%	994
1,071	-7.0%	243
909	-14.8%	287
1,379	-4.8%	464
2,544	-2.8%	216
563	-2.6%	44
695	-6.6%	70
579	16.0%	12
707	-11.2%	90
0	-	0
21,748	-7.5%	7,181

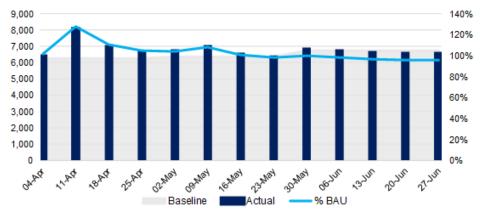
Source: Weekly Activity Return

London Endoscopy Activity in equivalent baseline period: 4,807.

Echocardiography activity







Echocardiography: Total Wait List



Echocardiography (Latest Freeze Data: w/e 27-Jun)

Provider	% BAU	Actual	4 Week	Jun-21
riovidei	/8 DAG	Activity	Change	Plan
NEL	90.8%	1,248	0.7%	4,429
Barts	105.0%	967	1.4%	
Homerton	87.6%	145	10.7%	
BHRUT	47.2%	136	-11.7%	
NCL	121.3%	1,130	-6.6%	4,182
GOSH	173.3%	286	-20.3%	
UCLH	172.7%	430	-5.5%	
Whittington	107.9%	113	2.7%	
RFL	85.2%	186	-8.8%	
NMUH	59.2%	115	40.2%	
NWL	74.7%	960	-6.2%	4,104
Hillingdon	121.1%	195	20.4%	
LNW	114.9%	303	-23.5%	
ChelWest	74.8%	156	11.4%	
Imperial	46.9%	306	-5.8%	
SEL	102.4%	2,089	-3.2%	7,301
GSTT	107.9%	1,197	-1.2%	
Kings	98.2%	698	-4.0%	
LGT	88.1%	194	-11.8%	
SWL	93.7%	1,018	-4.2%	3,966
Croydon	108.7%	218	-14.5%	
Epsom	91.3%	173	-3.4%	
Kingston	87.5%	117	7.3%	
St George's	82.4%	464	-1.1%	
LONDON	95.9%	6,445	-3.7%	23,982

Source: Weekly Activity Return

London Echo Activity in the equivalent baseline period: 6,719.

Waitlist (w/e 27-Jun)

vvaitiist (w/e .		
Waitlist	4 Week	>6 Weeks
9,504	Change 1.0%	5,697
8,290	1.1%	5,558
732	5.0%	61
482	-6.2%	78
2,409	-10.5%	328
172	-13.6%	44
651	2.5%	39
391	-26.4%	35
758	-0.9%	197
437	-22.4%	13
2,578	-5.2%	275
562	8.1%	170
999	10.3%	8
663	-24.2%	0
354	-15.3%	97
4,468	-4.8%	1,314
1,094	-4.1%	353
2,419	-15.3%	954
955	37.6%	7
3,608	-3.8%	925
759	15.3%	1
668	-10.6%	31
920	-24.8%	762
1,261	12.2%	131
22,567	-3.0%	8,539
22,567		-

Source: Weekly Activity Return





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.9/Jul/21
REPORT NAME	Substantive Chair recruitment update
AUTHOR	Stephen Gill, Interim Chair
LEAD	Stephen Gill, Interim Chair
PURPOSE	The purpose of this Paper is to update the Council of Governors (COG) on the Substantive Chair recruitment, the next stage of which is to appoint an Executive Search firm.
REPORT HISTORY	N/A
SUMMARY OF REPORT	The Paper comprises three documents: 1. Paper setting out the background and rationale supporting the recruitment of a Joint Chair for the four North West London (NWL) Acute Trusts as recommended by the NWL Acute Trust Chairs & CEOs; the NWL ICS Chair & Interim CEO; and the NHS London Region Director. 2. Draft Joint Chair job description. 3. PowerPoint slide deck setting out the NHSE/I national guidance on Provider Collaboratives. The Council of Governors (COG) is asked to note the documents. The Trust Nominations & Remunerations Committee (Board Chair, Lead Governor plus 5 Governors) working with the other relevant stakeholders (NWL Acute Trust Chairs; NHSE/I; The Hillingdon Hospital Foundation Trust COG) will take the next steps to: - Review and approve the appointment of an Executive Search firm. - Review and agree the Interview & Selection Panel process and membership. Notes: - The Hillingdon Hospital Foundation Trust COG meeting will be held on 22nd July and will review the identical set of papers as listed above.
KEY RISKS ASSOCIATED	None arising from this paper.

FINANCIAL IMPLICATIONS	None arising from this paper.
QUALITY IMPLICATIONS	None arising from this paper.
EQUALITY & DIVERSITY IMPLICATIONS	None arising from this paper.
LINK TO OBJECTIVES	All
DECISION/ ACTION	For noting and discussion.

Moving toward greater collaboration across the acute sector in North West London (NWL)

Executive Summary

This paper sets out proposals for changing the configuration of Chairs of acute sector organisations in NWL in order to improve quality, reduce inequality and improve productivity across the acute sector for benefit of the whole population of NWL. In parallel to initiating arrangements for the recruitment of a new Chair, the NWL ICS and the four acute trusts will put in place an interim *Collaboration Agreement* that will include a commitment to collaborate to improve population health, quality of care and the use of resources, along with measures to strengthen leadership and ensure sustained grip and control. This *Collaboration Agreement* will be a precursor to the proposed System Collaboration and Financial Management Agreement (SCFMA)

The benefits of greater collaboration have been clearly demonstrated over the last year and are expected to continue. The last year has seen significant additional challenges for the NHS in NWL in responding to the impact of COVID-19. Acute providers across NWL have risen to this by working effectively together to keep patients and staff safe. The four acute trusts successfully collaborated to begin to address long-standing issues of inequality of access, variation in quality outcomes and financial deficits across the acute sector. Building on this successful collaboration will require decisions based on a culture of continual improved outcomes for the whole population, of tackling inequality and of enhancing productivity collectively rather than a culture of 'organisation first'.

Revisiting the Chair arrangements across the acute sector is seen as a necessary step in this collaboration. There is currently an opportunity to move in this direction as there are two interim Chairs and the remaining Chair, who covers two Trusts, is due to stand down in September 2021.

A number of alternative options have been considered by the Chairs and CEOs of acute Trusts in NWL. There is no support from the Chairs and CEOs to maintain the existing model of three Chairs across four Trusts nor to revert to four Chairs. Combinations of one Chair across two Trusts have been considered but these carry serious risks of perpetuating inequalities and of not sufficiently securing the benefits to quality and productivity which are required.

The option recommended by the four NWL Acute Provider Chairs & CEOs, the NWL ICS Chair & CEO and the NHS London Region Director is to move to a single Chair.

It is proposed that, on behalf of the stakeholders at the four acute Trusts, the NWL Integrated Care System (ICS) will coordinate the process to appoint a single Chair, working closely with the Governors, the current Chairs and CEOs, NHSE/I and in consultation with the Trust boards. The next steps are to select an Executive Search firm, agree a job description and agree the members of the Appointment Panel.

In parallel, we will build on our successes to date to develop proposals to ensure there is robust grip and control within each acute Trust, and across the sector, to deliver the required improvements and to ensure that structures and processes are secured to make the role of the single Chair feasible and attractive. We will put in place a framework that allows the delivery

of collaborative benefits, including setting out details of governance arrangements, alignment with statutory responsibilities and the emerging NWL ICS, and the day to day operating model.

The CEOs and their executive teams will continue to drive improvements to patient care through both a relentless focus within their own Trusts and through collaboration; and the ICS will continue to develop the acute sector strategy (in conjunction with clinical and managerial leaders from across NWL) to inform future demand/capacity/site/service/capex decisions (as well as implications for finance, workforce etc).

a) Background and introduction

There are currently 12 acute hospitals in NWL, organised into four Trusts. In addition there are two specialist trusts – the Royal Brompton and Harefield and the Royal Marsden – which provide specialist services but are outwith the discussion/remit of this paper.

In spite of many previous attempts to create greater alignment of services and improve the quality of care across the acute sector in NWL, there remain variations in quality and operational performance which increases the inequity of access and outcomes for the population of NWL.

In NWL \sim 51% of the healthcare budget is spent on acute care services¹. This compares to 50% across the NHS. Despite this higher level of spend on the acute sector, there is an underlying 21/22 financial deficit of 9% of income. Deficits are not evenly distributed between Trusts, which, in past years, have had differential success in delivering improved performance in part due to differing infrastructure.

At the same time, there are considerable opportunities for the acute sector to play a significant role in the development of place (Borough/PCN) based systems focusing on greater collaboration between health and care partners, the voluntary sector and volunteers, leveraging their role as anchor organisations to create employment opportunities and reduce inequalities. This will require new ways of operating between organisations that have traditionally not shared resources and a much greater understanding about resource allocation that aligns with population need.

The wider health and care system also has the opportunity to capitalise on partnerships with academic organisations and the wider economy to further research and innovation which can be tested and evaluated in 'real life' situations. These relationships are already in place, but there is scope for greater innovation through greater shared learning and sharing of resources.

b) Rationale for moving towards an acute provider collaborative in NW London

The NHS Long Term Plan signalled a move to greater integration of care and this was strengthened by the Government Bill published on 6th July 2021. The draft proposals suggest that there should be greater collaboration at place (PCN/Borough) level and between

¹ Source: Trusts' response to financial plan April 2021

acute care providers. NHSE/I published guidance in June 2021 on how Trust collaboration models may be arranged. Group and Chain models of care were proposed in the Dalton Review² and have been established with some success in other parts of England.

The last year has seen significant additional challenges for the NHS in NWL in responding to the impact of COVID-19. Acute providers across NWL have risen to this by working effectively together to address these significant challenges to keep patients and staff safe. Examples include:

- ensuring more consistent, equitable high-quality care across NWL through shared leadership teams/proactive clinical support
- operating services in more efficient and effective ways to improve throughput e.g., joint waiting lists, establishing surgical hubs, working together to share staff and resources to respond to the pandemic
- putting in place management and governance systems to support more collaborative working e.g. daily clinical and CEO calls

Local care providers, including community, mental health, primary care and social care, have similarly worked together and with acute providers to address significant challenges.

At the same time, the acute sector continues to face considerable challenges, not least a significant financial deficit. Addressing a deficit of this magnitude while increasing quality requires mature collaboration and different ways of working.

The learning from the last 12 months is that greater collaboration across acute providers would enable a continued focus on improving quality, efficiency and equality of care delivery. Specifically, closer collaboration would:

1. Enable decision making for the benefit of the whole population of NWL.

- Ensure all strategic options are appraised against the criteria of delivery of the greatest value to the population of NW London and of reducing inequalities rather than delivery of the greatest benefit to any single acute Trust and to their patients
- Facilitate one common NWL patient tracking list (PTL) supported by one system of clinical governance, one standard operating model and one financial model
- Facilitate the reallocation of resources (money and people) between Trusts

2. Accelerate the pace of change.

- Enable more rapid learning and adoption of best practice by pooling knowledge management, business intelligence, transformation expertise, clinical leadership and clinical governance
- Result in more rapid service change across the sector to ensure more equitable access to high quality care, in particular the development of specialist centres of excellence for low

² Dalton review: options for providers of NHS care, December 2014

volume/high complexity care and the development of high throughput elective centres for high volume/low complexity work

- Improve standards in each Trust by sharing comparative data to spotlight areas to improve
- Reduce competition and facilitate peer support between Trusts
- Allow for faster and better decisions, in the interests of the whole population of NWL, facilitated by shared governance

3. Enable more efficient use of resources (staff, equipment, estate)

- Pooling use of, and access to, diagnostic equipment, leading to improved utilisation and a reduction in waiting times
- Improve recruitment and retention of talent into NWL
- Facilitate more effective capacity planning specifically ensuring optimal deployment of new capital across NWL
- Ensure greater sharing of resources, for example in responding to emergency situations such as pandemics or other major incidents

4. Strengthen research, education and innovation across NWL

Support greater collaboration across the ICS, enabling access to a larger population group

c) Proposal for future Chair arrangements

At the moment closer collaboration takes the form of regular dialogues and decisions between Chairs, CEOs and executive directors, joint programme management leadership and a number of clinical working groups drawn from across organisations to review specific services. Individual Trusts maintain their own governance arrangements with a Chair, Non-Executive Directors and, in the case of Foundation Trusts, Councils of Governors. And each Trust is a statutory organisation with clear responsibility and accountability for quality of care and financial performance.

In order to facilitate greater collaboration and deliver on the aspirations set out above, the CEOs and Chairs of the acute sector organisations across NW London believe there needs to be closer working across the non-executive bodies. This is in line with the national direction of travel, the London region of NHSE/I and the NWL ICS vision. There is an opportunity to begin this closer collaboration by revisiting the Chair arrangements across the acute sector.

There are currently three Chairs in the acute sector in NW London – one in each of Imperial College Healthcare NHS Trust and Chelsea and Westminster NHS Foundation Trust, and one covering both Hillingdon NHS Foundation Trust and London NW University Healthcare NHS Trust. The substantive Chairs at Imperial and Chelsea & Westminster left their posts at the end of March 2021; the Chair at Hillingdon/LNW is due to leave in September 2021.

Rather than appointing new Chairs to each organisation, the CEOs and Chairs of the acute Trusts in NWL, along with the leadership of the ICS, believe it is opportune to instead begin to move towards greater collaboration by appointing a single Chair across all four acute Trusts. This will encourage and support collaboration across organisations rather than embed a culture of "organisation first". For example, and as described above, we know that to recover elective care while improving quality of care/outcomes, increasing productivity and equality of access will require one common NWL patient tracking list (PTL) supported by one system of

clinical governance, one standard operating model and one financial model. Despite a great deal of goodwill, four separate Chairs, encumbered by their institutional requirements, will struggle to facilitate this necessary collaboration in a timely way.

More collaborative working would be facilitated by a single Chair, together with committees in common with delegated decision making and collective oversight of quality, finance and performance. It should be emphasised that while formalising collaboration and mutual aid across trusts, each trust will simultaneously be held to account, through the ICS oversight mechanism, for their delivery, for example for their contribution to the recovery plan and for the delivery of safe services.

The current opportunity of having two vacant Chair posts will be less disruptive than appointing a single Chair at a later date. We appreciate that Steve Gill and Bob Alexander have agreed to take on the roles of interim Chair at Chelsea & Westminster NHSFT and at Imperial College Hospitals NHS Trust respectively to enable consideration of the one Chair option.

A draft job description and person specification is attached. At a high level the single Chair will be responsible for:

- Chairing and developing the acute collaborative, supported by dedicated resource
- Inputting into the development of the wider ICS vision, strategy and plans
- Building alignment across the acute sector to the wider ICS vision, strategy and plans
- Ensuring the optimal deployment of services (and estate/resources/staff) across the whole acute sector to ensure consistently high quality and equitable services and optimum recovery
- Driving improvements in quality of care, productivity of care and financial sustainability across all sites
- Working closely with colleagues working at Borough (place) to ensure high quality, evidence based, responsive care, provided as close to home as possible, for the local population
- Ensuring continued innovation of service delivery robust evaluation of those changes underpinned by a vibrant, world leading research capability and strong relationships with partners across academia and industry

d) Proposals for non-executive/governor arrangements

We have the luxury in NWL of having a committed group of Non-Executive Directors, Governors and Local Champions. Individually, and collectively, the group brings a set of distinctive skills and capabilities, a passion and commitment to the NHS and its associated bodies e.g. Universities, and an ability to provide critical challenge to ensure good governance. We need to retain this crucial resource within the patch.

While the move towards closer collaboration across the acute sector does not necessarily imply changes to the Non-Executive and Governor bodies, there is a risk that maintaining each individual board would result in a continued focus on individual organisations rather than the collective whole.

It is therefore proposed that, over time, the individual boards increasingly work together deploying committees in common to cover the whole acute sector. The brief will span quality, operational and financial performance, support to borough-based care, research, education

and innovation. This could be organised in a number of ways, for example with individuals taking lead responsibility for ensuring high quality/productive care in each acute site through to audit/quality leads working across the sector.

This proposal is aligned with a letter from Sir David Sloman (28th January 2021) which specifies that new non-executives should not be appointed to Trust Boards in order to consider carefully the roadmap to a provider collaborative model.

e) Proposals for executive teams

In order to drive the benefits of collaboration, we will, over time, need to consider how to align the executive function with the collaborative, supporting optimal delivery across NWL and on each site.

f) Implications for statutory requirements

It is recognised that current statute requires individual Trusts to account for their own financial and quality performance. This system is currently evolving with new guidance from NHSE/I suggesting a move towards more system level oversight. We will need to work through this, as an ICS, to set out how we collectively work together to meet the new system wide performance requirements.

g) Risks and mitigations

Moving towards an acute sector collaborative in NW London is not without risks. These will need to be carefully considered with due attention given to how they can be mitigated. These include:

- **Size and complexity**: 12 acute sites employing ~ 30,000 people, providing a wide range of care/services is not straightforward to manage, particularly given the scale of change required, the very high levels of exhaustion and stress felt by many front line staff, and local politics. The Chair, non-executives and executives will need to be outstanding and experienced leaders, committed to leading change, supporting the workforce and meaningfully engaging stakeholders.
- Lack of focus on place/borough based care: there is a risk that greater collaboration across
 acute sites could result in less collaboration locally. The ICS will be paying particular attention
 to ensuring good outcomes from borough based care as it develops its borough based strategy
 with all stakeholders, including the acute sector.
- Loss of local expertise in executives and non-executives: a group model could result in
 less focus on individual hospital sites. The deployment of NEDs and execs will be carefully
 considered to ensure clear responsibility and accountability for performance at each site. At
 the same time, the group model offers many benefits to each and every site, including
 opportunities to focus on areas of special interest, career development, improved recruitment
 and increased autonomy which will come with improved quality and efficiency in all Trusts.
- Loss of local buy in/commitment from executives and non-executives. While consistent and high standards will be set across the acute collaborative, implementation will continue to be local with a strong executive presence focused on each site.
- Focus on structural change will divert from improving care. Any structural change can be time consuming and detract from the significant challenges facing the NHS at the moment. The collaboration to date has, though, demonstrated that collaborative working can deliver

significant benefits. Our view, based on evidence, is that continued collaboration will accelerate the pace of improving quality and efficiency. The proposals to move towards an acute collaborative represents the minimum amount of structural change required to ensure continued improvement of patient care. The option of merger is not being considered as this would require significant structural change which could be at the expense of focussing on improved care.

h) Next steps/moving forward

- 1. We will immediately build on our successes to date and develop proposals to ensure there is robust grip and control within each acute Trust to deliver the required improvements, underpinned by compassionate leadership behaviours:
 - a. Through the Managed Service Agreement between Chelsea and Westminster Hospital NHS FT and Hillingdon Hospitals NHS FT, continue to support improved quality and performance.
 - b. Implement a Managed Service Agreement between the ICS and London North West University Healthcare NHS Trust to ensure the provision of safe maternity services, alongside the continued support to improve performance.
 - c. Continue the System Oversight meetings to review integrated performance (quality, operational, people, finance). We will match accountability for results with system improvement support, as appropriate.
- 2. We will continue to collaborate day to day across all acute Trusts in NWL where collaboration drives further improvements to patient care and delivers both the recovery and the financial plan.
 - a. Set ambitious milestones for the recovery plan based on comparative quality and performance data, monitor and take remedial action, including mutual support, through current collaborative structures (ICHT CEO as the SRO supported by Chelsea and Westminster COO and Medical Director).
 - b. NWL ICS Partnership Board to make decisions on movement of resource or services to enhance recovery.
- 3. We will ensure that structures and processes are secured to make the role of the single Chair feasible and attractive:
 - a. The NWL ICS and the four acute Trusts will immediately put in place an interim *Collaboration Agreement* that will include a commitment to collaborate to improve population health, quality of care and the use of resources, along with measures to strengthen leadership and ensure sustained grip and control. This *Collaboration Agreement* will be a precursor to the proposed System Collaboration and Financial Management Agreement (SCFMA).
 - b. Develop more detailed proposals for the future collaboration, drawing on lessons learnt from other parts of the country, along with proposals for future governance structures and the operating model. This will also need to include proposals for how the acute provider collaborative could/should work effectively with local ICPs and include a timescale for action as well as an opportunity for the assessment of progress/impact. This work should start immediately. The ICS will identify resource to support this work.

- c. Develop a financial strategy for collectively managing and distributing resources so they can be used to address the greatest need and tackle inequalities in line with the NHS system development plan.
- 4. It is proposed that, on behalf of the stakeholders at the four acute Trusts, the NWL Integrated Care System (ICS) will coordinate the process to appoint a single Chair, working closely with the Governors, the current Chairs and CEOs, and NHSE/I and in consultation with the Boards. The immediate next steps are to select an Executive Search firm, agree a job description and agree the members of the Appointment Panel.
- 5. Agree a communications plan both key messages and key constituencies to communicate with/engage with.
- 6. Begin to consider more joint NED appointments, accelerating post the appointment of the Chair with a view to no new single Trust NEDs being appointed.
- 7. In parallel, move forward on the acute sector strategy to inform future site/service/capex decisions (as well as implications for finance, workforce etc).

Bob Alexander, interim Chair, Imperial College Healthcare NHS Trust

Lord Morse KCB, Chair Hillingdon Hospitals FT and

Chair, London North West University Healthcare NHS Trust

Steve Gill, interim Chair, Chelsea and Westminster Hospital FT

Penny Dash, Chair, NW London ICS

Lesley Watts interim CEO, NWL ICS and CEO, Chelsea and Westminster Hospital FT

16th July 2021

JOB DESCRIPTION

Background

NW London's health and care partners share an ambition to significantly improve quality and productivity across all health and care services, improve health and life expectancy of the population of NW London, address long standing inequalities in access to and quality of care, as well as in quality of life and life expectancy, and support wider economic development.

The four acute Trusts in NW London believe that greater collaboration will enable them to better deliver on the aspirations set out above, and that this needs to be underpinned by closer working across the non-executive bodies. This is in line with the national direction of travel, the London region of NHSE/I and the NWL ICS vision.

The Role

The single Chair will be responsible for:

- Chairing and developing the acute collaborative, supported by dedicated resource
- Inputting into the development of the wider ICS vision, strategy and plans
- Building alignment across the acute sector to the wider ICS vision, strategy and plans
- Ensuring the optimal deployment of services (and estate/resources/staff) across the whole acute sector to ensure consistently high quality and equitable services and optimum recovery
- Driving improvements in quality of care, productivity of care and financial sustainability across all sites
- Working closely with colleagues working at Borough (place) to ensure high quality, evidence based, responsive care, provided as close to home as possible, for the local population
- Ensuring continued innovation of service delivery robust evaluation of those changes underpinned by a vibrant, world leading research capability and strong relationships with partners across academia and industry

Key relationships

ICP leads (include Local Authorities, primary care, mental health care, community care, wider voluntary sector)

Health and Well Being Boards; local MPs; local (Borough) political leaders

ICS leadership (Chair, Executives)

London region of NHSE/I

Key responsibilities of the role

Leadership

 Support executive colleagues across the acute collaborative to deliver a step change improvement in quality of care and productivity of care delivery, with a balanced financial position

- Ensure an appropriate balance and delivery of Strategy and Operational performance (maintaining GRIP plus continuation of journey to well performing/outstanding ratings across all Trusts and sites)
- Support and work closely with the ICS leadership to contribute to, advocate for and deliver against the wider ICS strategic agenda to improve health, life expectancy, quality and productivity of care as well as reduce inequalities in access, quality and outcomes
- Collaborate with colleagues from academia and wider industry to explore opportunities for innovation, put in place robust evaluation processes and provide an unrivalled training and educational environment
- Ensure all Trusts provide an exceptional work environment, opportunities for development and the highest standards of transparency and support for the whole workforce.
- Work with colleagues across the ICS to ensure a more diverse workforce along with greater equality of opportunity for all colleagues
- Develop and extensively communicate (along with other members of the Board) a single shared narrative to the public, and internally within organisations.
- Promote the values and role model the behaviours of healthcare system leaders in London.

Governance

- Chair the individual Trust Board meetings
- Develop and implement proposals for new governance arrangements across the acute collaborative
- Ensure that the Trust Boards are effective and well governed
- Promote a culture of openness and transparency across Trust Boards, with constituent members "acting as one organisation".
- Require a high standard of discussion and decision making across Boards.
- Ensure that the patient voice and stakeholder engagement is clearly embedded in all components of development and delivery
- Ensure the Board acts in accordance with the highest ethical standards of public service and that any conflicts are appropriately resolved.
- Ensure that the Board addresses and incorporates best practice regarding relevant legislation and guidance, including equality and diversity in its functioning.

PERSON SPECIFICATION

- Experience of leading and transforming organisations to deliver a step change in performance
- Ability to work closely and in a supportive way with a highly diverse workforce
- Comfortable working across organisations
- Outstanding chairing skills and capabilities with significant experience in how boards of large, complex organisations, operating in a highly regulated environment, work.
- Highly developed influencing skills and political awareness
- High level of personal credibility along with an openness to engage with a wide range of other stakeholders.
- The presence and interpersonal skills to build and enhance relationships with the leaders of statutory NHS organisations and Local Authorities.

Criteria	Essential	Desirable	Assessment method
Educated to degree level or equivalent.	Yes		Application
Can demonstrate extensive senior leadership role at board or equivalent senior level.	Yes		Application
Highly developed interpersonal and influencing skills, commensurate with a very senior public appointment.	Yes		Panel interview
A capacity to thrive in a complex and politically charged environment of change and uncertainty.	Yes		Application / Panel Interview
Demonstrable experience of Chairing complex professional meetings at a senior level and an ability to chair in an efficient manner.	Yes		Application / Panel Interview
A strong commitment to public sector values and the Leadership Values of the NHS in London	Yes		Panel Interview
Exceptional communication skills, comfortable presenting in a variety of contexts and able to deal with the media.	Yes		Presentation [?]
A track record delivering improved performance.	Yes		Application /

Criteria	Essential	Desirable	Assessment method
			Panel Interview
Experience of leading change at a very senior level in the public sector, bringing together Local Authority and other stakeholder interests.		Yes	Application
Knowledge of establishing corporate / organisational structures and governance frameworks across multiple organisations.		Yes	Application
Experience in resolving transactional conflicts to deliver both high quality services and the highest value for money for stakeholders.		Yes	Application
Working across agency and professional boundaries and collaborative and stakeholder working.		Yes	Application

Provider Collaboratives: Building and strengthening collaboratives to achieve benefits of scale

June 2021

Source: Draft national guidance

What are Provider Collaboratives and why do we need them?

A Provider Collaborative is an arrangement whereby providers work together across multiple places, to achieve the benefits of scale, in the best interests of patients and the local population. This is achieved by bringing together leadership teams through agreed governance and decision-making arrangements, to make effective and efficient decisions on behalf of the collaborative.

Required capabilities

- Enact mutual aid and support arrangements between partners
- Make collective decisions that speed up service changes/transformation
- Challenge and hold each other to account through agreed systems, processes and ways of working, for example open-book approaches to finance and planning
- Agree a common purpose supported by a set of programmes that are delivered on behalf of all collaborative partners and the system
- Work with clinical networks and clinical leaders to agree proposals and implement resulting changes
- Drive shared definitions of best practice and the application of a common quality improvement methodology

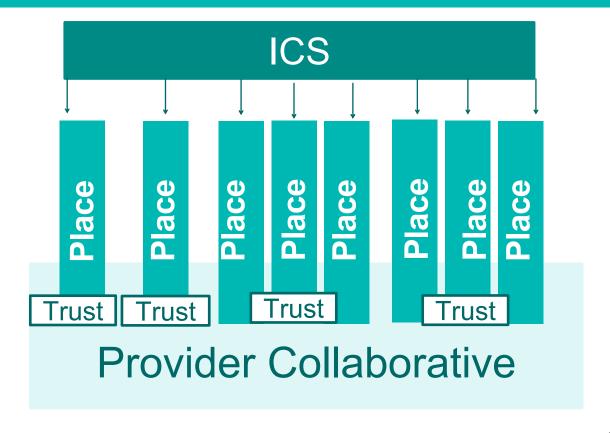
Benefits of scale

- Reductions in unwarranted variation in clinical practice and outcomes to improve quality
- Reductions in health inequalities, including fairer and more equitable access to services across the footprint
- More efficient and effective corporate and clinical support services providing better services and better able to manage demand and capacity
- Alleviation of workforce pressures and better development of staff and leadership talent enabling improved staff experience and retention
- Greater resilience, for example in ensuring patient safety through improved access, new ways of working and better deployment of staff in hard-to-recruit specialities
- Transformation at scale across care pathways through rapid spread of successful innovation

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Working as part of Integrated Care Systems

Trusts will typically be involved in both Place-based Partnerships and Provider Collaboratives. All trusts providing acute and mental health services will be expected to be part of one or more Provider Collaborative by April 2022



Accountability and financial flows

- Accountability will continue to rest with statutory organisations.
- Provider Collaboratives will, though, increase the mutual accountability felt between providers as transparency and peer-to-peer challenge increases.
- Provider Collaboratives will help streamline ways of working within systems.

NHSE/I will revise:

- The Foundation Trust (FT) Code of Governance
- An addendum to the reference guide for FT governors
- Memorandums for accounting officers of FTs and accountable officers of NHS trusts.
- New guidance under the NHS provider licence that good governance includes a requirement to collaborate.

Three main models of collaboration







Provider Leadership Board Model



A provider leadership board involves CEOs from participating trusts coming together, with common delegated responsibilities from their respective boards such that they are able to tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners.

Partners would either become members of or subscribe to the collaborative. Members of the collaborative typically draw up a vision to encourage and incentivise collaboration that set outs minimum requirements (for example, networked care) and further options for stronger collaboration.

- At a minimum, each trust board delegates decision-making responsibility for certain (agreed and common) areas to the trust CEO (and optionally additional members of the leadership team) so that decisions agreed by that person(s) do not need to return to the board for approval.
- CEOs (and optionally others) from each trust meet in common sometimes referred to as Committees in Common to discuss issues of shared concern.

Decision making

- Locked gateways: Provider trusts agree that at each stage once a decision is made it will not be reopened.
- Majority versus consensus decision- making.
- Strong dispute resolution processes are necessary

Lead Provider Board Model



A Lead Provider model involves a single trust taking contractual responsibility for an agreed set of services, on behalf of the whole Provider Collaborative, and then sub-contracting to other providers/members as required. Whilst there is a contractual basis, the lead provider enters into a partnership with other trusts/providers in the geographic footprint similar to the provider leadership board.

- A single trust is nominated to be the lead provider. Funding flows to the lead provider who then subcontracts, as appropriate, with the other providers.
- The lead provider arrangement is not solely provider-initiated. The commissioner, in this case the ICS as the contract awarding body, has a role in determining who the lead provider is.
- The lead provider takes responsibility for designing pathways and delivery models.
- A partnership agreement exists between providers in the collaborative to set out ways of working, how decisions will be made.
- Providers will need to agree on the voting and decision-making structure of the collaborative, and consider questions such as:
 - do all the providers have equal voting rights, or does the lead provider get more of a say?
 - must the majority vote also include the lead provider, or can the lead provider be bound by a decision it disagrees with?
 - in the event of deadlock, does the lead provider get the casting vote?
 - what are the processes for existing providers to leave or new providers to join the collaborative?

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Shared Leadership Board Model



A Shared Leadership model involves a defined leadership structure whereby the same person or people lead each of the providers involved.

Trust boards appoint the same person to multiple posts and/or operate under an agreement whereby the board of one trust (must be an NHS Trust) outsources the leadership of its organisation to a different trust's leadership team.

- Leadership (in particular the CEO, but potentially the full leadership team) are the same for each of the providers involved.
- Shared Leadership can be achieved through a management support agreement, joint venture, memorandum
 of understanding, terms of reference or through joint posts.
- Providers may choose to combine this approach with a form of shared governance (for example a leadership board or through Committees in Common to support decision-making).
- Each provider's board remains accountable for all decisions. Each provider retains the power to change or revoke the authority delegated to its Committee in Common if this is established.

Decision making

A single leadership team operating across multiple sites should consider a group operating model, involving a
dual-tier leadership structure. The group leadership makes strategic decisions that need to be made once for
the whole group. Operating unit leadership focuses on operational activities and developing partnerships to
integrate care

When this model is most suitable

Typically used:

- To share leadership talent where there is a strong leader/ leadership team with the capacity to act across multiple sites
- To strengthen previous loose decision-making arrangements

Strengthening Shared Leadership model: the Group operating model

The Group operating model has emerged as a way to work at scale that can be adapted to different contexts, but is particularly helpful for those

operating a Shared Leadership model or those operating large organisations across multiple sites.

- At its core, a Group is a way of organising a trust or trusts with multiple operating units (typically site or 'place' based), involving a dual-tier leadership structure.
- The Group leadership (or headquarters (HQ)) makes strategic decisions and decisions that need to be made once for the whole Group.
- Operating unit leadership focuses on operational activities and developing partnerships to integrate care within their locality or place.
- This arrangement enables quick, robust decision-making across larger geographies, while ensuring that the
 important relationships with staff and partners are maintained and developed.
- Core to this arrangement working effectively is that: roles and responsibilities are clear; that do-once activities
 are performed by the Group headquarters; and that site leadership has the autonomy to act effectively on
 operational matters, with the Group headquarters providing oversight monitoring of performance with
 focused support and intervention where required, rather than active day-to-day management.
- This arrangement creates a diversity of leadership roles and potentially enables available talent to add maximum value. The broader range of roles within the leadership team also allows the Group to develop a talent pipeline, nurturing future leaders within a lower-risk environment, supported by more experienced executives.
- The split in responsibilities also lowers some of the risk inherent in operating a large organisation as
 potentially high-risk decisions, such as on the use of capital, are taken once by the Group headquarters, and
 lower risk decisions are made by operating units, freeing up Group headquarters time and capacity.

Strengthening Shared Leadership model: the Group operating model

Consolidated corporate and clinical support functions. To maximise scale benefits, Groups typically consolidate corporate and clinical support functions.

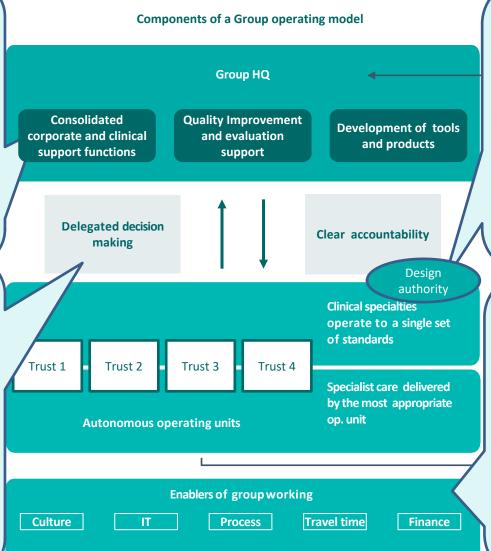
Quality Improvement and evaluation support. Groups benefit from a common framework for improvement that drivex clinical consistency across member organisations.

Development of tools and products. Scale supports the Group's ability to invest in tools that improve staff productivity – for instance IT systems

Delegated decision making. To support effective operation, Groups typically have a scheme of delegation setting out clear accountabilities and responsibilities at all levels. It will articulate the types of decisions and circumstances under which they are delegated, giving operating unit leaders autonomy over day-to-day

Clear accountability. Groups typically have an accountability framework which sets out the measures that the Group HQ will monitor and how and when they would act.

management.



Design Authority. Typically an advisory board with a small team tasked with approving the 'operating models' that each service/function will follow to ensure that clinical specialties operate to a single set of standards. The Design Authority chooses which services/ functions to tackle; creates and approves the operating model they follow; determines how to implement changes; and monitors standards

Specialist care delivered by the most appropriate operating unit. Groups may arrange and run clinical specialties to operate to a single set of standards to reduce unwarranted clinical variation, increase reliability, and benefit sites through networked access to excellence.

Enablers of group working:

A **shared culture** among the workforce ensures staff feel like they are working for a single organisation

A common/interoperable IT/digital platform ensures that patient information can flow between sites and that site-to-site comparisons use consistent, coherent data.

Process means staff do not need to relearn how to carry out the functions they require when moving between sites Workable travel times between sites ensures that staff and patients are able to move between sites

Shared finances mean that the collaboration can ensure that money is spent where it WAP and Pass 6 July 127





Finance and Investment Committee (FIC) - Chairman's Report to Council of Governors, 22 July 2021

The purpose of this report is to provide governors with information about the activities and effectiveness of the Finance and Investment Committee (FIC). This report covers the committee's meetings during the period from April 2020 to March 2021.

About the Committee Chairman

Nilkunj was appointed a Non-Executive Director (NED) of the Trust in July 2014 and has chaired the Finance and Investment Committee (FIC) since July 2020 when Jeremy Jenson stood down as chair. Jeremy attended the July 2020 and September 2020 meetings by way of handover and to support the Board during the pandemic. Nilkunj is a member of the Quality Committee and is the NED lead for the Trust's technology and digital agenda.

Committee Background and Terms of Reference

The aim of the FIC is to bring the finances of the hospital under scrutiny on behalf of the Trust Board.

There are three objectives:

- 1) Oversight of Financial Planning and Performance
 - a. Review budgets, annual and medium term targets.
 - b. Maintain an oversight as to the robustness of the Trusts income streams and contractual safeguards.
- 2) Investment Policy
 - a. Approve and keep under review the Trusts investment and treasury policy and ensure compliance by reviewing the Trusts' balance sheet and cash flows.
- 3) Other
 - a. Review proposals for major business cases before submission to the board (>£1m in budget >£200k out of budget).
 - b. Commercial and Private Patient growth strategy and business cases.
 - c. All Capital Expenditure and business cases >£1m.
 - d. Monitor and keep major projects under review.
 - e. To consider the performance and effectiveness of Joint Ventures and Joint Operations (change to FIC Terms of Reference in 19/20).

Committee Membership and Attendance (April 2020 – March 2021)

The current Committees members are Aman Dalvi (NED), Rob Hodgkiss (COO) and Virginia Massaro (CFO). Steve Gill (NED) was a member until March 2021 when he stepped up to the Interim Chair role upon Sir Tom Hughes-Hallet's departure. Due to NHS restrictions on hiring new NEDs during the transition to Integrated Care Systems, the Board agreed to continue with two NEDs, the minimum required to be quorate.

Virginia Massaro, Acting CFO, was appointed substantively as the Trust's CFO from December 2020.

The Committee met virtually (by video conference) at its scheduled times during the period until the COVID emergency necessitated a different approach. From March 2020 to May 2020, and between December 2020 to January 2021, the committee moved to a weekly call attended by Virginia Massaro and me. Other members of the committee and the Board were kept informed by weekly minutes that were circulated after each call. Any major items of expenditure requiring FIC approval were subject to e-governance processes with input from the other committee members.

The discussions are constructive, robust and challenging for both the Executives and NEDs. The committee has a packed agenda with participation from all members and those attending meetings for specific items. The attendance record was 100% over the period.

Significant Items Covered Since July 2020

At every meeting, the committee reviews:

- Monthly financial results
- Improvement Programme (including Cost Improvement Programmes CIP) status
- Business cases as they arise
- Deep dive into aspects of service and/or divisional performance (paused during COVID emergency; recommenced July 2021)
- Capital expenditure forecast and plan (In detail at least twice yearly)
- Annual budget and plan preparation
- Long Term Financial Plan (Quarterly)
- Forward diary of the committee's agenda

In the past year the committee has reviewed the following major items:

- Business Cases
 - Low voltage switchgear replacement (CW site) approved (£1.3m capital)
 - Marjory Warren wards refurbishment (WM site) approved (£1.2 capital)
 - O Pharmacy Wholly Owned Subsidiary business case approved (£1.2m pa revenue)
 - o Interventional Radiology business case (CW site) approved (£1.25m capital)
 - CT Scanner replacement business case (CW site) approved (£1.8m capital)
 - Staff Health & Wellbeing business case approved (£0.7m pa revenue)
 - o IT Server & Storage replacement business case approved (£3.6m revenue)
 - o Richmond Ward & ICU surge business case (WM site) approved (£4.8m capital)
 - Ambulatory Diagnostic Centre outline business case (WM site) approved to progress to next stage (£55m overall project, £2m approved to undertake preparatory work)
 - Endoscopy replacement programme approved (£3.7m capital)
 - Emergency Department Resus Expansion (WM site) approved (£1.5m capital)
 - Maternity digital solution business case approved (£1.0m capital)

Other

- o Electronic Patient Record (EPR) Gateway Reviews & project monitoring
- NICU/ICU project monitoring
- o Digital Programme
- Borrowing capacity and benchmarking
- Cash forecasting
- o COVID financial arrangements
- Approval of urgent COVID PPE and equipment purchases >£1m via e-governance
- Reference costs index
- Insourcing IT Joint Venture (SPHERE)
- Review of financial risk register including Risk Assurance Framework and Business Assurance Framework.
- Benchmarking with Getting it Right First Time (GIRFT), Model hospital and other productivity
 metrics
- Review of joint ventures & partnerships, including Sensyne Health and North West London
 Pathology
- NWL ICS shared service proposals for procurement and payroll

What's Working Well, What Needs Improvement, Future Challenges

The committee members conducted a committee evaluation process in November 2020 and the overall evaluation was positive. The committee has maintained meetings to 9 per annum.

The impact of FIC is felt beyond the committee as teams are often asked to attend and present in their given area. The Chair and other members would periodically attend deep-dive meetings which are held to review elements of the improvement plan (to avoid duplication and to increase members understanding of a particular area). However, these were paused during the COVID emergency while access to the hospital has been restricted.

June 2020 saw the successful conclusion of the 3-year Cerner Electronic Patient Record (EPR) implementation across both West Middlesex and Chelsea sites, the largest Cerner implementation carried out in the UK. FIC oversaw the Gateway Reviews conducted by Ernst and Young to monitor implementation progress and project costs before they were presented to the Board. FIC has undertaken a post-implementation review and continues to review IT risks and benefits.

Future Challenges

Rapidly increasing non-elective demand, coupled with a health system that is tackling a significant patient backlog and rising costs, presents a challenge that is likely to represent the norm over the coming years. Low hanging cost improvements and productivity gains have been achieved at 4% consistently year-on-year, and further gains are becoming harder to realise.

The Trust has made a significant investment in its technology and digital estate with Cerner EPR and IT infrastructure. Future productivity improvements will be made through EPR and pathway/service redesign, virtual models of care, data intelligence, process automation, and back-office rationalisation.

The Board must continue with the principle that it will not agree on a budget that it is not confident in achieving, a challenge with pandemic induced uncertainly. Overall the Trust continues to have an underlying

deficit even though the Trust's reference cost index is one of the lowest in the country, implying services are reimbursed at unsustainable levels.

The Trust is currently funded until September 2021 on a break-even basis. The plan for the rest of this financial year has yet to be announced by NHS England, upon which the Trust will submit its budget for the second half of the year.

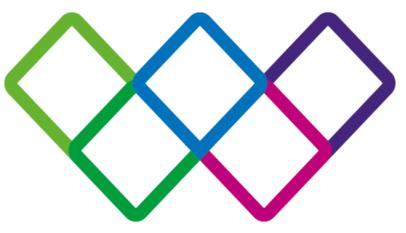
Integrated Care System that become statutory bodies from April 2022 will bring further change as NHS financial systems align organisations across health and care work together and centre care on patients needs. A control process over service and pathway changes and the impact of any financial changes will be set out.

Nilkunj Dodhia

22 July 2021



Chelsea and Westminster Hospital 2020/21 Financial Performance





Summary Financial Performance in 2020/21

- Adjusted position was £1.6m surplus, which was £6.8m better than the plan for the year due to additional funding to offset a reduction in non-NHS income due to the covid pandemic.
- Overall reported deficit of £19.8m, due to an accounting adjustment for an impairment of the Trust's property and buildings of £24.7m
- Capital expenditure was £46.3m. Included NICU/ICU project, ICU surge capacity at both sites, Marjory Warren refurbishment at WM site, medical equipment replacement, ED Resus expansion at WM, IT equipment replacement and covid equipment and estates work.





Chelsea and Westminster Hospital NHS Foundation Trust Annual Financial Statements 2020/21

_	2020/21	2019/20
•	£000	£000
Operating income from patient care activities	631,632	603,795
Other operating income	120,902	106,115
Operating expenses	(755,818)	(665,596
Operating surplus/(deficit) from continuing operations	(3,284)	44,314
Finance income	-	927
Finance expenses	(5,759)	(5,712
PDC dividends payable	(9,674)	(10,456
Net finance costs	(15,433)	(15,241
Other gains / (losses)	8	(444
Profit on assets and liabilities transferred in respect of the discontinued		
operations of the investment in Joint Ventures	(1,480)	
Share of profit / (losses) of associates / joint arrangements	357	909
Surplus / (deficit) for the year from continuing operations	(19,832)	29,538
Surplus / (deficit) for the year	(19,832)	29,538
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(19,832)	29,538
Remove net impairments not scoring to the Departmental expenditure limit	24,702	(11,352
Remove I&E impact of capital grants and donations	(2,482)	(6,868
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(910
Remove net impact of inventories received from DHSC group bodies for		,
COVID response	(798)	
Adjusted financial performance surplus	1,590	10,408









Finance Dashboard Month 12 2020-21

	Combined Trust		
£'000	Plan to Date	Actual to Date	Variance to Date
Income Expenditure	671,166	752,534	81,368
Pay	(377,416)	(424,569)	(47,153)
Non-Pay	(259,382)	(285,073)	(25,690)
EBITDA	34,367	42,892	8,524
EBITDA %	5.12%	5.70%	0.6%
Depreciation	(21,309)	(21,309)	О
Non-Operational Exp-Inc	(15,741)	(41,412)	(25,671)
Surplus/Deficit	(2,683)	(19,830)	(17,147)
Control total Adj - Donated asset, Impairment & Other	(2,482)	22,217	24,699
Donated PPE Stock	0	(798)	(798)
Adjusted Surplus/Deficit	(5,165)	1,590	6,755

The Trust is reporting a year end surplus of £1.59m which is £6.76m ahead of the control total. The favourable position is driven by £10.45m funding received from NHS England for lost income between M7-12.

1031 INCLUME DETWEEN MY-12.

Page: £47.15m overspend, the position includes £17.2m spend against Covid and £18.1m unidentified CIPs. At month 12 the position further deteriorated with the inclusion of; 6.3% Pension contribution £15.16m (a notional figure), £4.8m movement in holiday accruals (including additional two day accrual for R&R and birthday); however, these are all matched this homelands in contribution £15.16m (a notional figure), £4.8m movement in holiday accruals (including additional two day accrual for R&R and birthday); however, these are all matched with equivalent income.

with equivalent income.

Non-Pay -£25.69m overspent and includes £15.42m against Covid. At M12 £5.9m donated PPE was included in the figures, however, this is matched by equivalent income.

Income: Contractual income from CCG and NHS England continued on a block at the same level as M1-6. A&E and Emergency activity remained low and at the levels seen in February.

Elective, Outpatient and diagnostic imaging have shown signs of recovery in March. Maternity deliveries were up but booking reduced significantly across both sites. Adult critical care remains high compared to pre-pandemic levels, including maternity HDU beds. Local authority income has reduced considerably in December and January as expected, following clinic closures and staff redeployment. NHS Non-contracted activity income has been added to the sector baseline and added to the top up now received from CCGs (M7-12), but sexual health is being billed as normal.



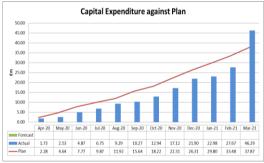
Comment: Month 12 payroll figures include additional spend for 6.3% Pension contribution £15.16m (a notional figure) and £4.8m movement in holiday accrual and additional two day accrual; these are all matched with equivalent income.



Comment: The favourable cash variance to plan in M12 of £70.16m is favourable cash variance Comment: The Tavourable cash variance to plan in M12 of £70.15m is travourable cash variance bifwd from M11 of E58.98m, Higher cash receipts to plan of £22m (Extra CCG (£3.68m) + Extra NHS England (£10.29m) + Extra Donations/Grant (107K) + Extra PDC (£6.12m) + Higher Health Education (£92k), Higher FT's and Trust (£240k), Higher Mon NHS Income (£4.05m) offset by lower PP Income £-1m, lower PSF £-1.6M) offset by Higher cash outflows to plan-£10.86m (Higher Creditor Payments).



Comment
The Trust submitted a revised plan for M7-12, this included a change to the agency plan which is more reflective of Q1/Q2 trends. Between M9 & M11 the Trust overspent due to the covid -19 2nd wave. However, in M12 there was a reduction in Covid spend which meant that the Trust is below the internal target.



Comment
The Trust has spent £46.29m in 2020/21 against the 2020/21 plan of £37.89m, resulting in an overspend of £8.43m - at the gross capital expenditure level. The overspend mainly related to two areas; the Trust received £2.08m of donated assets at the end of the financial year in relation to COVID, and following the dissolving of the Sphere IV, the Trust transferred £7.62m of I.T. assets from Sphere as part of the accounting treatment of closing down Sphere's accounts; neither of these transactions were included in the original plan.



Audit and Risk Committee (ARC) - Chairman's Report to Council of Governors, 22 July 2021

The Committee Chairman - Nick Gash

I am delighted to present my annual report of the work of the Audit and Risk Committee to the Council of Governors.

When I last reported to the Council I wrote of us coming out of Covid and hoped for gradual return to some semblance of normality. As we all know Covid reasserted itself with a vengeance and as I write this, despite the lifting of restrictions, cases continue to rise. We can only hope that the success of the vaccine programme and the clear impact on the acuity of symptoms and consequent hospital admissions is sustained.

This has meant continued use of virtual meetings but I have maintained close contact with relevant executive directors, external auditors, internal auditors and the counter fraud team as well as keeping myself up to date with the latest guidance for NHS audit as it is published. Covid has impacted on national and local networks but I have maintained as much contact as I can.

Committee role and membership

ARC is directly accountable to the Board and provides assurance that probity and professional judgement is exercised in all financial and operational areas of governance. It is the only Board Committee which is made up solely of NEDs (executive directors attend but are not members)

The overall role is well described by the Healthcare Financial Management Association (HFMA):

"it is the 'lens' through which the Board examines the assurances it requires to discharge its duties."

To fulfil this role, we are supported by independent advisors who attend all ARC meetings:

External auditors - Deloitte

Internal auditors - KPMG

Counter fraud specialists – **KPMG**

After a joint North West London procurement, in which I participated, we have moved to a shared Internal Audit and Counter Fraud Service from 1st July 2021. **BDO** will provide internal audit services and **RSM** counter fraud. We will continue to have our own direct contract with the firms, but the shared tender does give us an opportunity not only to benefit from lower fees but also to look at system wide issues and share learning across providers.

The other NEDs who sit on the committee are **Eliza Herman** and **Aman Dalvi** who replaced **Andrew Jones** in July 2020. I would like to thank them all for their hard work and the insight and wisdom they bring to the committee.

Executive support to ARC is provided by Virginia Massaro (Acting CFO) and Serena Stirling (Director of Corporate Governance and Compliance). Lesley Watts (CEO) also attends the committee with other members of the executive team. As you are aware Serena has been on extended sickness absence and I am immensely grateful for the additional work that Vida Djelic has done to support the work of the committee.

Committee activities

The committee meets on a cycle geared to the Trusts external reporting timetable - standing items on the ARC agenda include:

- External audit most importantly the Annual Report and Accounts including the Quality Account but also
 our External Auditors maintain a watching brief and keep the committee abreast of regulatory
 requirements and any changes in reporting standards.
- Internal audit (annual workplan and in-year reporting) The non-statutory and discretionary work of the
 Audit and Risk Committee is agreed by the committee each year and forms the basis of the Internal Audit
 Plan carried out by KPMG.
- Scrutinising the Risk Register and Board Assurance Framework. It is worth noting here that ARC's role is
 not managing all of the risks, it is about providing assurance to Board that the governance processes are in
 place to ensure there is effective management of risk across the organisation. Specific risks are scrutinised
 by the relevant operational board committees.
- Counter fraud agreeing the annual work plan and receiving progress reports at every meeting.
- Oversight of losses and special payments including the writing off of any bad debts.
- Cyber Security the committee receives an update including a performance dashboard at every meeting.
- Information Governance the committee reviews a full report on this on a half yearly basis.

Review of Committee Activity

As with all committees, our normal activity has been disrupted by the Covid pandemic and only briefly returned to business as usual before reverting to emergency protocols for the first part of 2021 During the peaks of the outbreak I had weekly calls with Virginia, and I would like to take this opportunity to pay tribute to her and her team for their outstanding work over this time in maintaining the trust's financial systems and controls while also supporting a range of frontline activity across the Trust. Again, the pandemic added a particular challenge in finalising the year end and preparing with Vida and her colleagues the Annual Report and Accounts. Our last meeting was taken up with the review of these documents alongside the report from our external auditors. In the light of Covid this year there was again no requirement for an audited Quality Account. The committee was pleased to recommend the Report and Accounts for approval by the Trust Board. The Governors and members will have the opportunity to formally review the Annual Report and Accounts and to question the External Auditors at the annual meeting later today. I would note however that it was pleasing

not only to meet our financial targets but also to receive very positive assurance from Deloittes on the sound financial management and governance of the Trust.

The annual reports from Internal Audit and Counter Fraud were also reviewed at that meeting. The table attached to this report from KPMG's annual report on the Trust shows all the internal audits that were undertaken in 2020/21 and the level of assurance given (Appendix 1).

The protocol whereby the chairs of Board Committees are not only consulted about the content of the annual internal audit plan but also the terms of reference of individual audits has continued and has been beneficial in ensuring that audits focus on the operational areas that are of concern to the NEDs.

You will note that there were four areas where the level of assurance was "partial" This is in part because we consciously ask the team to audit areas where we think there may be issues of concern. The audit reports provided helpful additional insight and key recommendations were passed to relevant committees for review and monitoring of implementation. This year there were 6 high priority recommendations. You will note that there are more outstanding recommendations than in previous years. This is in part because there was considerable interruption to the audit programme with 5 reports coming to the June meeting and also the understandable pressures on the teams in this extraordinary year. However, ARC receives an update on the implementation of recommendations at every meeting and will ensure that progress is made to address all outstanding recommendations.

The overall Internal Audit rating for 2020/21 was "significant assurance with minor improvements required".

Because the new internal audit and counter fraud teams only started work on 1st July the committee has not yet signed off the work plans for 2021/22. This will be done at our meeting on 27th July. We will again ensure that we gain assurance that the Trust's control environment has not been compromised during the extraordinary circumstances of the epidemic and also that there is appropriate audit focus on the systems in place to ensure the best recovery of services to our patients.

ARC again oversaw the annual review of the Board Committees. A systematic review of their effectiveness and terms of reference was undertaken which included a review of our own work as a committee. The review drew on self-assessment and external comment and provided excellent overall assurance as well as offering helpful insight and ideas for improvement for committee chairs.

Looking Forward

I am confident that the committee is working effectively but there are significant challenges ahead.

The coming year will be one of great change as the ICS gains a statutory footing and we move towards a more formal collaboration with fellow acute providers. This will bring challenges in balancing provider organisations' autonomy and accountability with the powers and accountability of new integrated systems. I look forward to playing my full part along side Board colleagues to support these developments and to ensure that they deliver

the best possible services for our patients. One of the first step towards that is a meeting of Audit Chairs in the next few weeks to take an overview of risk management across the system.

Nick Gash

14 July 2021

Coverage and recommendations raised

We have completed the following reviews during the year:

ш	Parities	A		Recommendations Accep		
#	Review	Assurance	Н	M	L	Total
1	Working from Home Infrastructure	Significant Assurance with m improvement opportunities	-	2	1	3
2	Research Governance	Significant Assurance with m improvement opportunities	-	4	3	7
3	Financial Controls, including Financial Governance and Control during Covid-19 (Phase One and Phase Two)	Significant assurance with mi improvement opportunities	-	2	3	5
4	Management of Joint Ventures	Partial assurance with improvements required	1	4	-	5
5	Corporate Records Management	Partial assurance with improvements required	3	6	-	9
6	Employee Relations: Disciplinary	Partial assurance with improvements required	1	4	2	7
7	Workforce Data	Significant assurance with mi improvement opportunities	-	1	4	5
8	Serious Incidents	Significant assurance with mi improvement opportunities	-	-	7	7
9	Estates Project Management	Significant assurance with mi improvement opportunities	-	2	-	2
10	DSP Toolkit	Significant assurance with mi improvement opportunities	-	4	2	6
11	Pharmacy	Significant assurance with mi improvement opportunities	-	-	9	9
12	Cerner Projects Review	Partial assurance with improvements required	1	3	-	4
Tota	al		6	32	31	69

The recommendation from the current and prior years work have progressed as follows:

December detions	Recon	Recommendations Accepted			
Recommendations	Н	M	L	Total	
Total carried forward from previous periods	-	15	6	21	
Add: New recommendations raised during the period	6	32	31	69	
Remove: Recommendations implemented by 2 June 2021	(1)	(11)	(11)	(23)	
Total current outstanding internal audit recommendations	5	36	26	67	
Of which are considered over due:	1	8	5	14	

We have raised six high priority recommendations during the year, five of which are outstanding with one overdue as at 2 June 2021.





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.11.1/Jul/21
REPORT NAME	Draft minutes of the Council of Governors Quality Sub-Committee meeting held on 2 July 2021
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Laura Wareing, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Quality Sub-Committee meeting held on 2 July 2021.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.



DRAFT

Minutes of a meeting of the Council of Governors Quality Sub-Committee Held at 10am on 2 July 2021 (Zoom)

Attendees	Laura Wareing (Chair)	Chair / Public Governor	IJW
	Nowell Anderson (in part)	Public Governor	NAn
	Nigel Davies	Public Governor	ND
	Minna Korjonen	Patient Governor	MK
	Anthony Levy	Public Governor	AL
In attendance	David Bushby	Director of Nursing	DB
	Alex Bolton	Associate Director of Quality Governance	AB
	Vicky Cochrane	Director of Maternity	VC
	Jessica Wood (in part)	Associate Nurse Specialist, Palliative Care	JW
	Vida Djelic (Minutes)	Board Governance Manager	VD
Apologies	Caroline Boulliat	Public Governor	СВ
	Simon Dyer	Patient Governor, Lead Governor/Deputy Chair	SD
	Richard Jackson	Staff Governor	RJ
	Lee Watson	Director of Nursing	LW
	Trusha Yardley	Public Governor (Hammersmith & Fulham)	TY

1.	GENERAL BUSINESS		
1.1	Welcome and Apologies		
	LJW welcomed all to the meeting. Apologies were noted as above.		
1.2	Declarations of interest		
	Nil of note.		
4.2	Minutes of anniana marking held on 20 March 2024		
1.3	Minutes of previous meeting held on 26 March 2021		
	The minutes of the previous meeting held on 26 March 2021 were accepted as a true and accurate record.		
	The minutes of the previous fried on 20 March 2021 were accepted as a true and accurate record.		
1.4	Matters Arising & Action Log		
	The Sub-Committee noted that there were no actions/matters arising from the previous meeting.		
2.	REGULAR REPORTS		
2.1	Learning from Serious Incidents		
	Alex Bolton, Associate Director of Quality Governance		
	AB presented an overview of this report which provides an update on process compliance, key metrics and		
	learning opportunities arising from Serious Incident investigations.		
	AP highlighted the following:		
	AB highlighted the following:		
	The Trust started 9 external Serious Incidents investigations in March; 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.		
	11 investigations completed in the month of March and submitted to the NWL Commissioners.		
	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.
- The Trust recognises the impact of patient safety incidents 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. Action plans arising from individual incidents 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. Correctable causes and themes are tracked by the Patient Safety Group and the Executive Management Board to ensure change is embedded in practice.

VC assured the sub-committee on the work progressing in maternity with achieving compliance with national and local recommendations that will have the greatest impact on quality, safety and patient experience. As a result of Ockenden maternity recommendations, all recommendations have been put together into a single comprehensive improvement plan for the directorate.

VC added that achieving equity in outcomes in maternity is a priority for the work of the Maternity Transformation programme. Improved communication and outreach with Black, Asian and minority ethnic communities will reduce maternal inequalities. To deliver safer, more personalised care local maternity groups reach out and engage local pregnant BAME women in co-production with their maternity voice's partnerships and relevant community organisations.

MK stated she is working closely with local communities and has developed good relationships with her constituents in Kensington and Chelsea; it came to her knowledge that some of pregnant woman/mothers in her constituency need practical support with essential items. VC offered to link in with MK and put her in touch with community midwives who provide women with pre and post natal care.

In response to ND's comment regarding homebirth, VS stated that pre-Covid-19 homebirth facility was available to private maternity patients; however, as part of reducing inequalities in women's use of maternal health-care services, improving maternity services and providing high quality care to all patients in NWL, this option in terms of place of birth is now available to all service users. All maternity patients now have a choice of giving birth at home or in hospital. At CWFT the options are the midwife-led birth centre or the labour ward depending on the level of support required.

ND commended the work in maternity services.

The sub-committee noted the report.

2.2 Performance & Quality Report – March 2021

Alex Bolton, Associate Director of Quality Governance David Bushby, Director of Nursing

The sub-committee noted the following highlights:

- A&E performance improved in April, although still non-compliant; there has been an exponential increase in attendances;
- Although RTT has seen a further decline to 73.71%, it is expected will take some time to recover to pre-pandemic levels.
- Cancer 62 day performance is improving and a huge number of patients were treated on the pathway in April in efforts to reduce the backlog.

In response to AL's comment regarding Cancer 62 Days GP referral to first treatment, AB sated that the highest number of patients treated on the pathway reflect treatment of longest waiting patients. The April position stands at 79.20% and is expected to further improve.

In response to a further question from AL regarding cancer referrals and capacity, AB stated that resources are shared and optimised across the NWL sector in efforts to reduce the backlog.

In response to NA's question regarding low reporting of medication incidents on WM site, AB stated that

significant work has been put in trying to capture all medication incidents, near misses and no harm incidents, with opportunities for learning which can result in improved safety and quality of both clinical and non-clinical services and prevent recurrence. The Chelsea and Westminster Hospital supports a culture of fairness, openness and learning and actively encourages all staff to report incidents and never events, including near misses, and to speak up when things go wrong.

AL referred to RTT 52 weeks waiters speciality dashboard, paediatric dentistry having the highest number of waiting patients, and asked if there is a sector solution to address this matter.

Action: VD to seek advice from Rob Hodgkiss, Deputy CEO/COO on the sector wide solution to address RTT 52 weeks paediatric dentistry waiting patients.

The sub-committee noted the report.

2.3 Group reports

2.3.1 | Falls Steering Group

LJW advised that there was no report available from the Falls Steering Group at present and noted that an update will be presented at the September Sub-Committee meeting.

2.3.2 End of Life Care Group

Jessica Wood, Associate Nurse Specialist, Palliative Care

There is an in house and national End of Life Care education and training programme tailored to the needs of staff, and, importantly, led by the voices of patients and their families, with a view to improve the delivery of care for, and experiences of, patients and their families.

Education examples include recognising the transition from active to palliative care, improving communication skills and providing emotional support to patients and families, other approaches will be needed such as role modelling, interactive role play or simulation, and practice-based learning. Including patient, public and carer involvement in the design, delivery and evaluation of education will ensure the reality of our knowledge and that the actions are rooted in every day experiences.

The Planned Care End of Life (EOL) video on 'What Matters to our Patients' was made available to the Trust in early March for Board, Governors and the public to view in advance of the meeting. The CW+ Charity funded the project through its 'Dragons Den' initiative.

The video provided a real opportunity to reset the organisation, focusing on the positives and benefits of personalising EOL care, with great and often outstandingly compassionate care having been delivered by CWFT staff, despite the COVID-19 challenges.

AL commended the Palliative Care Team and the work undertaken in this area to support patients and families and improve their experience.

2.3.3 Disability Steering Group Report

Minna Korjonen, Patient Governor

MK noted an update from the Disability Steering Group was provided at the March Sub-Committee and noted progress with the Project Search. The project has been extended and the current cohort of interns will stay with CWFT until the autumn. The Trust is now in the third year of Project Search with learning disability interns placed within the Trust until the autumn to gain work experience and future employment within the organisation. There are six learning disability intern places at the Trust to be filled.

Further update on progress with the Project Search will be provided at the September Sub-Committee meeting.

2.3.4 Dementia Steering Group Report

LJW advised that this Dementia Steering Group's report has been deferred to September Sub-Committee

due to Simon Dyer's absence.

2.5 Governor's patient story and feedback on patient contacts

NA commended work of the Trust's cancer services booking appointment system on WM site.

VD reported on a patient who contacted her to share positive patient experience of CWFT A & E department.

3. AD HOC REPORTS

3.1 Improvement programme and 2021/22 quality priorities – progress update

Alex Bolton, Associate Director of Quality Governance

AB noted the report provides a comprehensive update on the progress of the Improvement Programme and highlighted the following:

- 2021/22 Quality Priorities agreed with the Quality Committee and Board: Sepsis; Cancer care;
 Diabetes; Clinical handover;
- Patient experience 2020/21: a summary of year end baseline and progress outlined in table 1;
- 2021/22 Quality Priorities agreed with the Quality Committee and Board: Sepsis; Cancer care; Diabetes; Clinical handover; and
- To drive continuous improvement 2020/21 GIRFT reviews were conducted and the 2021/22 deep dive programme developed.

The sub-committee noted the report.

3.2 Patient Experience Strategy – update

The sub-committee noted the following highlights from the paper:

- Due to the Covid-19 pandemic there have not been any meetings of the Patient and Public Experience & Engagement Group (PPEEG).
- The PPEEG meetings restarted in April; the group is meeting monthly through Zoom/MS Teams.
- A re-set and scope of the annual workplan was agreed.
- The PPEEG forward plan was included in the meeting pack for information.

3.3 Complaints Annual Report 2020/21

The sub-committee noted the highlights from the Annual Report.

There has been a general decrease in the number of complaints received, but this is not a true reflection, having been skewed by the pandemic, and is expected to rise. The themes remain unchanged, with communication being one of the most common causes for complaint. This will be built into a patient experience quality improvement project for the team; communication with patients also links in with the digital agenda.

The number of complaints received by the Trust and investigated during 2020/21 has reduced to 390 from 840 the previous financial year. Similarly the number of PALS concerns has also reduced to 896 from 2,870. The COVID-19 Pandemic is thought to be the primary reason for the reduction.

PALS resolution is achieving an average of 67% of all concerns received immediately at source.

The most frequently complained about theme in 2020/21 is communication with patients and their families. The COVID-19 pandemic is thought to be the primary reason for this and the Corporate Nursing team have identified this as a quality priority theme for the team.

The new PALS model was halted due to the 2nd wave COVID-19 surge, however the model of PALS team

visiting wards and departments is now up and running and is being well received by inpatients and ward staff

In response to AL's comment about complaints themes and if a breakdown of the themes of complaints received across the Trust could be provided, AB stated that the complaints categories are set nationally. We have reviewed our systems and processes to ensure that learning and improvements from complaints and concerns is captured and implemented.

The NHS Complaint Standards are being tested in pilot sites in 2021 and will be refined and introduced across the NHS in 2022.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff with emphasis on learning from complaints.

4. OTHER BUSINESS

4.1 COG Quality Sub-Committee forward plan

The sub-committee noted the forward plan.

Action: Simon Dyer to provide an update from the Dementia Steering Group.

Action: LJW to follow up with Trusha Yardley and Caroline Boulliat regarding non-attendance at the subcommittee.

4.2 Any other business

Nil of note.

4.3 Date of next meeting – 24 September 2021; 10.00-12.00.





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	1.11.2/Jul/21
REPORT NAME	Draft minutes of the Council of Governors Membership & Engagement Sub-Committee meeting held on 4 June 2021
AUTHOR	Anne McCarville, Corporate Governance Support
LEAD	David Phillips, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Membership & Engagement Sub-Committee meeting held on 4 June 2021.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.





DRAFT Minutes of the Council of Governors Membership & Engagement Sub-Committee meeting Held at 10.30am on 4 June 2021 on Zoom

Attendees	David Phillips Nowell Anderson Cass Cass-Horne Minna Korjonen Rose Levy	Chair Public Governor Public Governor Patient Governor Public Governor	DP NA CCH MK RL
In attendance	Stephen Cox Vida Djelic Anne McCarville (minutes)	Head of Communications Board Governance Manager Corporate Governance Support	SC VD AMcC
Apologies	Serena Stirling Simon Dyer	Director of Corporate Governance & Compliance Lead Governor	SS SD

1.1	Welcome & Apologies
	The Chair welcomed all to the meeting.
	Apologies for absence were noted as above.
1.2	Declarations of interest
	Nil of note.
1.3	Minutes of previous meeting held on 19 November 2020
	Minutes of the previous meeting were approved as a true and accurate record.
1.4	Matters Arising & Action Log
	The sub-committee reviewed the list of actions and noted that all actions have been completed or on track to be completed.
	To support membership recruitment, DP suggested patients are approached to become members and provided with a membership form at the point of discharge from hospital. VD undertook to follow up on this action from the November meeting.
	DP reminded sub-committee members that Governors talk to the FT members, patients and the public, and listen to their views and suggestions about the health services provided by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) and its future plans as part of their role. He emphasised that governors cannot solve any questions in relation to patient complaints and any complaints received be forwarded to PALS / Complaints team in line with the Trust's complaints management process.
2.1	Membership Report – June 2021
	This report was taken as read. VD acknowledged NA's recent membership recruitment efforts which
	resulted in 12 new members being recruited, bolstering membership numbers in the Hounslow area. NA
	reiterated that he finds the virtual Meet A Governor (MAG) sessions more convenient than face to face,

however, he finds engagement much more effective in face to face sessions.

2.2 2019/22 Strategy Action Plan update

The sub-committee noted the updated action plan. VD confirmed that the action plan has been extended to March 2022 due to the COVID-19 pandemic.

Virtual Meet A Governor (MAG) sessions replaced in person meetings over the last year in line with government guidance, however, it has been noted that these have proved less popular with members. Following some discussion, it was agreed that a reduced number of virtual MAG sessions would be promoted over the coming weeks, pending the lifting of restrictions around onsite meetings.

DP emphasised the need for Governors representing constituencies to be more engaged in promoting membership within in their communities. DP sought guidance on ways in which this could be achieved, and how the Trust could support the Governor group in achieving this goal. NA reported recruiting members at the local supermarket and post church services. RL advised of her involvement with GPs in her local area, however, of less involvement in the Community itself. CCH offered to collect membership forms when next at the hospital for distribution to local apartments.

2.3 Health Seminar Topics, including membership engagement and communication events

Stephen Cox joined the meeting to provide an update on engagement and communication events over the coming months.

SC advised that the Trust has reviewed arrangements for the Annual Members' Meeting on 22 July and recommends that the event be run virtually this year to allow as many people as possible to be involved.

While no hard decisions have been made the Trust is cautious in these uncertain times about going live with events over the coming months. SC provided the following update on the Trust's event calendar:

- 100th Anniversary celebrations for West Middlesex have been deferred to March 2022;
- Christmas events, these are uncertain particularly at scale, and will be considered nearer the time;
- On Staff Awards, SC advised that there is some discussion as to whether the traditional Black Tie events would continue, other options are under discussion; and
- The thank you film to which the Governor Group contributed was well received by the staff, other options are being explored for 2021.

DP advised that the Governor Group would be delighted to offer their support to any future Trust events and communications.

RL raised the idea of recruiting a young Governor to help attract a younger membership. VD advised that setting up a new Governor group would require a change to the constitution, however, a young person's champion could be considered alongside next Governor elections.

SC advised that young people are much less interested in membership, however, more likely to align with a programme for change. SC suggested that setting up a forum to address e.g. teenage issues across the Trust might be a more effective route. Working through our volunteer group could also drive young membership numbers. It was suggested that the Governor group consider working with Further Education institutions. DP asked if this is something the Communications team could possibly offer support with.

The Governor Group were also encouraged to continue engaging with staff and volunteers and tracking Trust communications via social media.

DP pointed out the Trust's obligation to developing FT membership and questioned its commitment to truly delivering on this. VD reassured Governors of the Trust's commitment to recruiting and engaging

with its membership, and recognised that activities had been somewhat constrained due to the covid-19 pandemic.

Action: VD/AMcC/SC to discuss how the communication team could support implementation of membership engagement and recruitment activities.

2.4 Feedback from 'Your Health' seminar

It was reported that the Frailty, Covid-19 and Health Ageing seminar, held on 13 April 2021 proved very popular with 59 expressions of interest from the FT members.

DP sought input on suggested topics for future seminars and below is a note of the proposed topics:

- The impact of climate change e.g. sun damage and the rise of respiratory illness;
- Cardiology/Endocarditis to possibly form part of a wider topic;
- Early identification of particular conditions that might be on the rise;
- Illnesses where a lifestyle change could provide significant improvement;
- Prostate cancer (covered in a previous seminar 18/20 months ago);
- The impact of COVID-19 on Mental Health;
- Getting healthy again post COVID, including diet; and
- The rise in sexually transmitted infections (STIs); NA commended a recent presentation at Hammersmith that was well received.

VD undertook to speak with colleagues to identify one specialist who could talk broadly on Mental Health.

The prevalence of conditions at West Middlesex site was also briefly explored. VD stated Dr Sadia Khan has recently presented to Board a very interesting piece of work on best staff idea for a digital solution – SMARTS – a smartphone atrial fibrillation testing app. 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.

Action: VD to speak with colleagues to identify one specialist who could talk broadly on Mental Health.

2.6 Meet a Governor Schedule

AMcC advised that a request for availability is due to be sent to the Governor Group for Meet A Governor sessions throughout July and August.

Following some discussion, it was agreed that due to current restrictions these would continue as virtual sessions for the moment, and on the basis two per month would be scheduled. The Trust is happy to accommodate additional sessions as requested by the Governor group.

DP proposed that moving forward Meet A Governor sessions be scheduled on the first Tuesday and Thursday of every month. The idea of one being live onsite and the second being via Zoom was also proposed to offer greater flexibility to our membership.

2.7 Feedback from members

The group noted that there had been limited contact from members due to the ongoing Covid-19 situation.

3.1 Membership and Engagement Sub-Committee Forward plan

The sub-committee noted the forward plan.

3.2 Any other business

Nil of note.

3.3	Date of next meeting
	18 November 2021; 10.30 - 12.30.



Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	2.1.1/Jul/21
REPORT NAME	Integrated Performance Report – May 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 May 2021 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
REPORT HISTORY	Executive Management Board, 23 June 2021 Quality Committee, 6 July 2021 Board of Directors, 8 July 2021
SUMMARY OF REPORT	A&E Waiting Times Performance against this indicator has declined for the month of May 2021 to 90.74% from 91.85% in April 2021. The Trust is experiencing a significant surge in activity and is reflective of the regional and national demand profile. Work is underway to better understand what is driving the volumes attending the departments
	18 Weeks RTT – Incomplete Performance has seen an improvement from 73.31% in April to 75.81% in May 2021. Both Inpatient and Outpatient activity continues to increase across sites mitigating any growth in the longer waiting patients. Despite this referral rates continue to rise which will drive an increase in the overall waiting list. The Trust waiting list has grown by 2,276 patients during the month to 39,369.
	Cancer – 62 days GP Referral to first treatment The Trust achieved the Cancer – 62 days GP Referral to first treatment standard for the first time at both sites since August 2019 with a performance of 85.93%. Maintaining this performance and reduction of the backlog further remains the focus to ensure timely care for our cancer patients
	RTT Incompletes 52 week Patients at month end Numbers of patients waiting over 52 weeks has continued to reduce for the third month in a row. As at the end of May there were 766 patients waiting over 52 weeks. This number looks to continue to reduce as activity increases.
	Diagnostic waiting times The final May performance figure 95.55%, up again from last month at 94.78% and at the highest post-Covid level. Diagnostic Imaging is compliant at 99.9%, Audiology compliant at 100%. Physiology on track to be compliant from July 2021. Plans are in place to achieve remaining specialties by August 2021.

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	 Deliver high quality patient centred care Be the employer of choice Delivering better care at lower cost
DECISION / ACTION	For noting.



TRUST PERFORMANCE & QUALITY REPORT May 2021





		C		Westmins ital Site	ter	u		liddlesex Hospital S	iite		Combin	ed Trust F	erformance	9	Trust data 13 months
Domain	Indicator \(\triangle \)	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	90.41%	92.46%	90.29%	91.30%	91.26%	91.37%	91.09%	91.22%	90.90%	91.85%	90.74%	91.26%	91.26%	-
RTT	18 weeks RTT - Incomplete (Target: >92%)	76.09%	75.04%	77.00%	76.05%	74.58%	71.87%	74.13%	73.03%	75.45%	73.71%	75.81%	74.79%	74.79%	Andrew Company
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	97.34%	95.99%	95.07%	95.99%	99.00%	98.95%	97.85%	98.95%	98.32%	97.73%	96.65%	97.73%	97.73%	M
- Carlot	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n√a	97.60%	100%	98.43%	100%	97.60%	100%	98.43%	100%	100%	IIII idi
Please note that all Cancer	31 days diagnosis to first treatment (Target: >96%)	98.18%	97.56%	100%	97.56%	94.32%	96.00%	93.44%	96.00%	95.80%	96.70%	96.19%	96.70%	96.70%	MAN
ndicators show interim.	31 days subsequent cancer treatment - Drug (Target: >98 %)	n/a	n/a	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	*************
unvalidated ositions for the	31 days subsequent cancer treatment - Surgery (Target > 94%)	n/a	n/a	n/a	n√a	n√a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
latest month May-21) in this	62 days GP referral to first treatment (Target: >85%)	69.86%	80.39%	85.71%	80.39%	69.29%	80.77%	86.08%	80.77%	69.50%	80.62%	85.93%	80.62%	80.62%	Mary
report	62 days NHS screening service referral to first treatment (Target: >90%)	0.00%	0.00%	n/a	0.00%	53.85%	66.67%	50.00%	66.67%	53.85%	66.67%	50.00%	50.00%	50.00%	M
Patient Safety	Clostridium difficile infections (Year End Target: 26)	1	1	1	2	0	2	2	4	1	3	3	6	6	.dha.ar
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	65.25%	65.25%	
	Please note the following three items	n/a	Can refer	to those inc	dicators not a	pplicable (eg	j Radiother	apy) or indic	ators where t	there is no a	vailable da	ta. Such mo	onths will not a	appear in the	trend graphs.
			RTT Adm	itted & Non-	-Admitted are	no longer N	Monitor Con	pliance Indi	icators	Eithe	r Site or Tr	ust overall p	erformance r	ed in each of	the past three mo

A&E Waiting Times

Performance against this indicator has declined for the month of May 2021 to 90.74% from 91.85% in April 2021. The Trust is experiencing a significant surge in activity and is reflective of the regional and national demand profile. Work is underway to better understand what is driving the volumes attending the departments

Note that all Cancer indicators show interim, unvalidated positions for the latest month (May-21) and are not included in quarterly or yearly totals

18 Weeks RTT – Incomplete

Performance has seen an improvement from 73.31% in April to 75.81% in May 2021. Both Inpatient and Outpatient activity continues to increase across sites mitigating any growth in the longer waiting patients. Despite this referral rates continue to rise which will drive an increase in the overall waiting list. The Trust waiting list has grown by 2,276 patients during the month to 39,369.

Cancer – 62 days GP Referral to first treatment

The Trust achieved the Cancer – 62 days GP Referral to first treatment standard for the first time at both sites since August 2019 with a performance of 85.93%. Maintaining this performance and reduction of the backlog further remains the focus to ensure timely care for our cancer patients

Patient Safety – C.diff infections

There were 3 Clostridium difficile nosocomial infections in May, 2 at WMH and 1 at CWH. RCA meetings were held and it was established that no lapses in care contributed to the development of each C. diff case. Each clinical area did identify areas for improvement e.g.

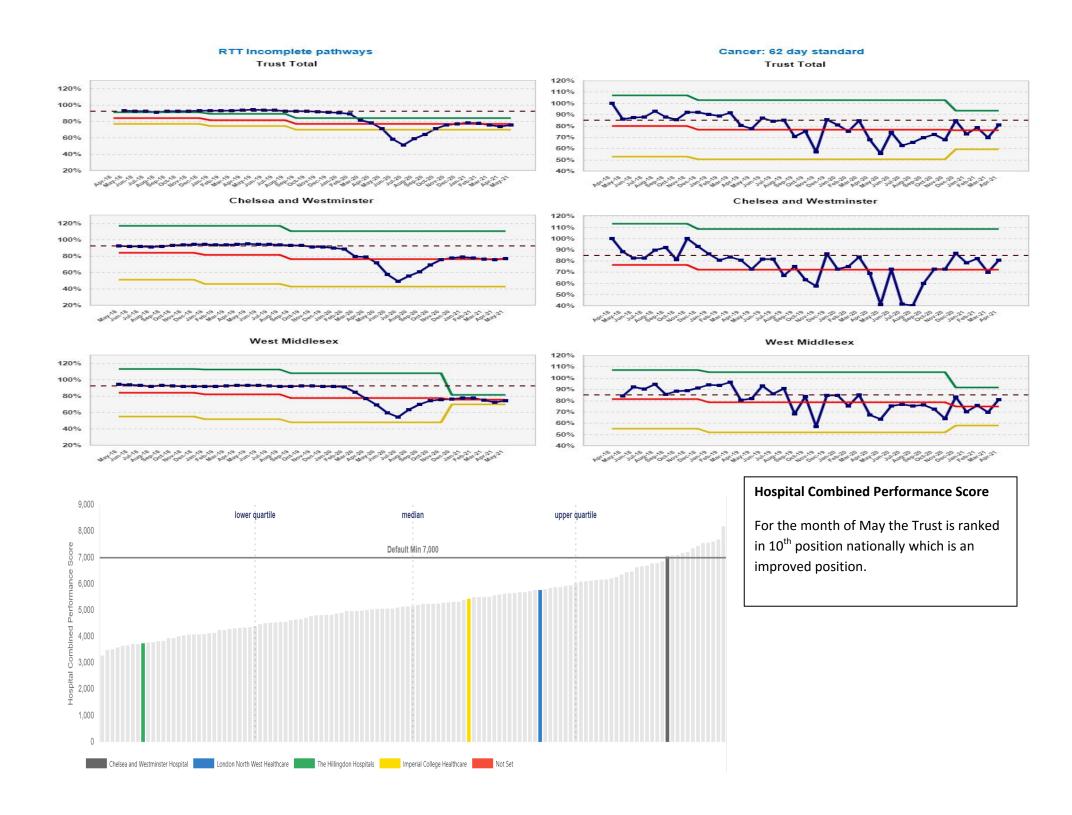
- Staff training on the process for requesting a *C.diff* test
- Documentation of stool charts on Cerner
- Delay in isolation of patient with suspected C. diff
- Inappropriate antibiotic prescription
- Inappropriate PPI prescription once patient stepped down from ITU





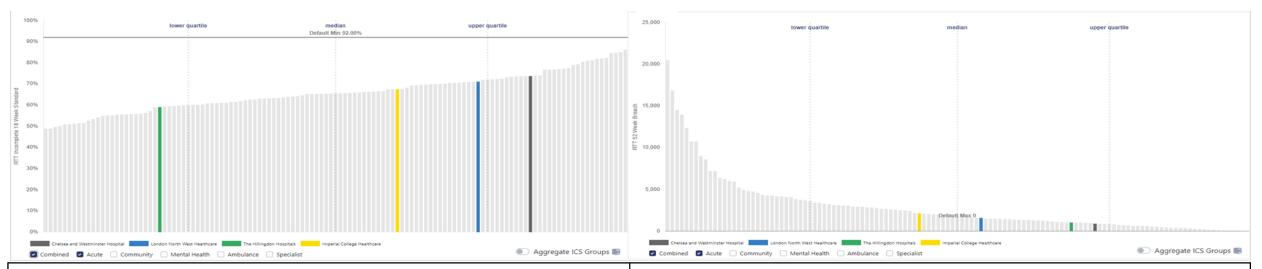
SELECTED BOARD REPORT NHSI INDICATORS

Statistical Process Control Charts for the last 37 months April 2018 to May 2021



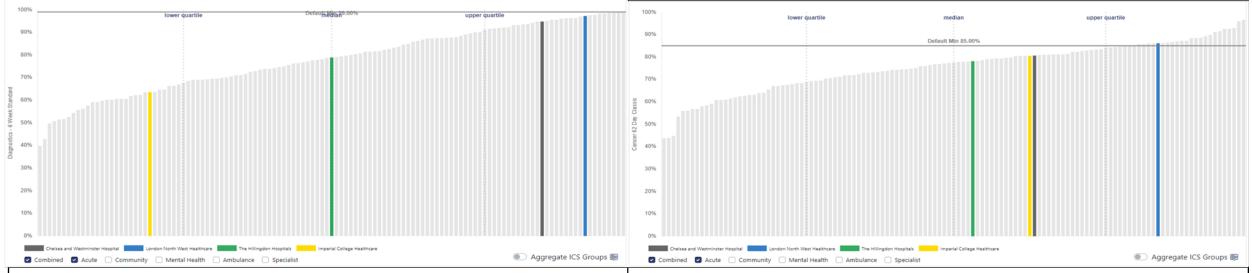
Please note, the below charts are for comparative purposes only and are 1 month retrospective – April 21. There have been an additional 14 trusts added to the national reporting so some positions may differ from last month's report.





The chart above shows the relative ranking against the RTT 18 week standard. The Trust is currently ranked 21st of 123 Trusts nationally which is a positive improvement. 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 33rd of 123 Trusts nationally which is an improved position from March 2020. 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 18th of 123 Trusts nationally which is an improvement. 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 45th of 123 Trusts nationally which is an improved position. The chart also demonstrates the position across the ICS.



Either Site or Trust overall performance red in each of the past three months

Safety Dashboard

				Westmins oital Site	ster	u		Middlesex Hospital S	Site		е	Trust data 13 months			
Domain	Indicator \(\triangle \)	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
lospital-acquired	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	- 1	0	1	0	1	0	1	1	1
infections	Hand hygiene compliance (Target >90%)	95.2%	96.7%	88.0%	91.2%	96.3%	84.9%	89.6%	86.7%	95.6%	89.4%	88.6%	89.0%	89.0%	an II do
	Number of serious incidents	4	4	4	8	5	1	7	8	9	5	11	16	16	la tadadh
	Incident reporting rate per 100 admissions (Target: >8.5)	10.3	8.5	9.0	8.8	10.5	9.7	10.2	10.0	10.4	9.1	9.6	9.4	9.4	handa .
Incidents	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.02	0.06	0.05	0.04	0.02	0.02	0.02	0.02	0.02	0.04	0.04	0.04	0.04	Marie
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	6.16	5.67	4.42	5.01	3.44	2.77	4.34	3.59	4.80	4.18	4.38	4.29	4.29	him
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	0.0%	1.6%	0.0%	0.9%	0.0%	3.1%	0.0%	1.2%	0.0%	2.1%	0.0%	1.0%	1.0%	~
	Never Events (Target: 0)		0	0	0	0	0	0	0	0	0	0	0	0	
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)		0	0	0	0	0	1	1	0	0		1	1	1
Harm	Safeguarding adults - number of referrals	18	16	21	37	49	42	52	94	67	58	73	131	131	minimi
	Safeguarding children - number of referrals	54	34	44	78	169	130	153	283	223	164	197	361	361	andilin d
	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.77	0.78	0.77	0.77	0.77	0.78	0.77	0.77	0.77	0.78	0.77	0.77	0.77	and the
	Number of hospital deaths - Adult	29	24	28	52	65	53	49	102	94	77	77	154	154	
	Number of hospital deaths - Paediatric	0	0	0	0	0	0	0	0	0	0	0	0	0	
Mortality	Number of hospital deaths - Neonatal	2	0	2	2	3	0	1	1	5	0	3	3	3	.111
	Number of deaths in A&E - Adult	4	1	0	1	4	4	1	5	8	5	1	6	6	alatalata.
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	1	1	0	0	1	1	1	

blank cell An empty cell denotes those indicators currently under development

Hand Hygiene

Performance has seen a second month of decline from 89.4% in April to 88.6% in May against the >90% target.

Medication-related safety incidents

A total of 129 medication-related incidents were reported in May 2021. CW site reported 62 incidents, WM site reported 65 incidents and there were 2 incidents reported in community. The number of incidents reported in May has increased for WM site since April (44) and has remained consistent at CW site.

Medication-related (NRLS reportable) safety incidents per 1000 FCE bed days

The Trust position of medication-related incidents involving patients (NRLS reportable) for May 2021 was 4.38 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 reporting of medication related incidents across the Trust since April, and this will continue to be monitored and encouraged by the MSG.

Medication-related (NRLS reportable) safety incidents % with harm

Please note the following

The Trust had 0% of medication-related safety incidents with moderate harm and above in May 2021, which is within the Trust target of ≤2%.

Incidents

In May 2021 there were two incidents reported that potentially caused severe harm to patients and one incident that potentially caused death out of the 11 reported in total. All incidents have been declared external serious incidents; the two severe harms relate to a delayed cancer diagnosis and patient fall #NOF. The incident potentially resulting in death relates to treatment delay. The circumstances of these events and the degree of harm associated will be confirmed following completion of these investigations.





Patient Experience Dashboard

		C		Westmins ital Site	ster	U		liddlesex Hospital	Site		Combin	ed Trust F	erformanc	e	Trust data 13 months
Domain	Indicator	△ Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
	FFT: Inpatient satisfaction % (Target: >90%)	92.4%	95.0%	94.5%	94.8%	93.4%	93.5%	93.3%	93.4%	92.9%	94.2%	93.8%	94.0%	94.0%	MY
	FFT: Inpatient not satisfaction % (Target: <10%)	4.1%	2.7%	2.4%	2.6%	3.9%	3.4%	3.4%	3.4%	4.0%	3.1%	3.0%	3.0%	3.0%	
	FFT: Inpatient response rate (Target: >30%)	40.5%	56.0%	47.9%	51.7%	60.3%	65.3%	65.9%	65.6%	49.2%	60.6%	57.0%	58.7%	58.7%	man have
	FFT: A&E satisfaction % (Target: >90%)	87.6%	87.2%	85.3%	86.2%	83.0%	84.0%	89.0%	87.2%	86.3%	86.4%	86.6%	86.5%	86.5%	M
Complaints	FFT: A&E not satisfaction % (Target: <10%)	7.1%	7.0%	9.2%	8.1%	9.3%	10.2%	5.9%	7.5%	7.7%	7.8%	8.0%	7.9%	7.9%	hand of he
	FFT: A&E response rate (Target: >30%)	16.2%	22.3%	21.4%	21.8%	15.9%	20.0%	30.3%	25.6%	16.1%	21.7%	23.8%	22.8%	22.8%	A STATE OF THE PARTY OF THE PAR
	FFT: Maternity satisfaction % (Target: >90%)	92.7%	89.6%	87.1%	88.0%	100.0%	91.7%	100.0%	95.5%	93.2%	89.7%	87.6%	88.4%	88.4%	III
	FFT: Maternity not satisfaction % (Target: <10%)	4.1%	6.3%	10.0%	8.6%	0.0%	8.3%	0.0%	4.5%	3.8%	6.4%	9.6%	8.4%	8.4%	Inhi. al
	FFT: Maternity response rate (Target: >30%)	39.3%	26.3%	24.6%	25.2%	100.0%	17.6%	100.0%	28.2%	41.2%	25.4%	25.4%	25.4%	25.4%	mark on
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints (informal) through PALS	32	59	53	32	21	26	13	39	45	41	30	71	71	dullille
	Complaints formal: Number of complaints received	24	15	17	13	9	10	4	14	19	16	11	27	27	all litation
Complaints	Complaints formal: Number responded to < 25 days	10	6	7	112	34	31	19	50	66	90	72	162	162	dd llaad
	Complaints sent through to the Ombudsman	0	0	0	0	1	0	0	0	1	0	0	0	0	
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	2	0	0	0	2	0	0	0	0	1

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

PALS & C

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complex and required longer to resolve.

We aim to resolve as many concerns instantly and for May 2021 this was 59% (102) of the concerns received for that month.

We have three complaints for investigation with the PHSO - one each for EIC, CSS and WCH Divisions.

Friends and family test

A&E satisfaction rates continue to be below the target for both sites. The matrons are aware.

A&E Response rate at the Chelsea site continues to be below the target. At West Middlesex, response rate met the 30% target in May. The department has been actively encouraging patients to participate with paper surveys, in addition to the text message surveys that are sent

Maternity at West Middlesex have been very actively encouraging participation in FFT with the iPads that were acquired this year. This has resulted in high response and satisfaction rates for May 2021. At Chelsea, both the response and satisfaction rates are below the targets. The matrons at this site are aware.



Efficiency & Productivity Dashboard

				Westmin	ster	i		Viiddlesex Hospital			,	Trust data 13 months			
Domain	Indicator	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
	Average length of stay - elective (Target: <2.9)	2.06	1.75	2.79	2.27	1.04	0.98	1.60	1.43	1.98	1.67	2.53	2.14	2.14	
	Average length of stay - non-elective (Target: <3.95)	4.63	3.57	3.44	3.50	2.97	3.00	3.05	3.03	3.62	3.25	3.22	3.23	3.23	and be seen a
dmitted Patient	Emergency care pathway - average LoS (Target: <4.5)	5.62	3.45	3.52	3.49	3.27	3.28	3.42	3.35	3.97	3.34	3.46	3.40	3.40	and the same
Care	Emergency care pathway - discharges	151	236	252	488	358	385	410	796	510	621	662	1284	1284	dilitidi
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	4.54%	5.45%	7.10%	6.30%	11.85%	9.87%	10.59%	10.24%	8.45%	7.74%	8.86%	8.31%	8.31%	Mary
	Non-elective long-stayers	352	339	310	649	307	321	319	640	659	660	629	1289	1289	
	Daycase rate (basket of 25 procedures) (Target: >85%)	80.0%	71.1%	80.7%	75.4%	95.0%	95.4%	81.3%	89.9%	83.2%	80.1%	80.9%	80.5%	80.5%	The
	Operations canc on the day for non-clinical reasons: actuals	0	0	0	0	0	1	1	2	0	1	1	2	2	ulla a
Theatres	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.08%	0.09%	0.08%	0.00%	0.03%	0.03%	0.03%	0.03%	1
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	0	0	0	1	1	2	0	1	1	2	2	.lla
	Theatre Utilisation (Target >85%)	66.9%	68.1%	66.3%	67.2%	73.6%	70.4%	73.7%	72.0%	67.6%	68.8%	68.5%	68.7%	68.7%	/ V
	First to follow-up ratio (Target: <1.5)	2.41	2.57	2.54	2.55	1.91	1.91	2.00	1.95	2.19	2.27	2.30	2.28	2.28	lide di a
Outpatients	Average wait to first outpatient attendance (Target: <6 wks)	10.6	9.6	9.0	9.3	7.6	9.9	10.3	10.1	9.2	9.8	9.6	9.7	9.7	W/V
Outpatients	DNA rate: first appointment	7.4%	8.3%	7.4%	7.9%	7.3%	8.4%	8.0%	8.2%	7.4%	8.4%	7.7%	8.0%	8.0%	1
	DNA rate: follow-up appointment	7.3%	7.2%	7.6%	7.4%	7.1%	7.2%	7.3%	7.3%	7.2%	7.2%	7.5%	7.3%	7.3%	por

Emergency Readmissions

Performance against this target has increased from 7.74% in April to 8.86% in May.

Daycase Rate

Performance has increased to 80.1% in May against the 80.9% target.

Operations cancelled on the same day and not rebooked within 28days

There was 1 recorded operation that was cancelled on the same day and not booked within 28days. Much effort is being put in place to ensure robust management of the inpatient waiting list and communication between theatres and scheduling teams to ensure patients are sighted for rebooking as soon as possible

Theatre Utilisation

Performance has remained relatively stable over the last three months. May performance was 68.5% against the >85% target.

Outpatients

Firs to follow-up ratio has seen a second month of increase against the <1.5 target to 2.30 in May 2021. Average wait to first outpatient appointments has seen a declined from 9.8 weeks in April 2021 to 9.6 weeks in May against the <6 week target. DNA rates for first appointment has seen a decline to 7.7% in May 2021 while there has been an increase in DNA rates for follow up to 7.5% in May 2021 from 7.2% in April.



Clinical Effectiveness Dashboard

		(Westmins oital Site	ster	u		liddlesex Hospital S	iite		Trust data 13 months				
Domain	Indicator \(\triangle \)	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
	Dementia screening case finding (Target: >90%)	92.9%	92.6%	97.2%	94.9%	95.4%	96.0%	98.7%	97.3%	94.4%	94.6%	98.1%	96.3%	96.3%	A Variable
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	84.6%	83.3%	100.0%	92.0%	95.7%	76.5%	82.6%	80.0%	91.7%	79.3%	88.9%	84.6%	84.6%	WW
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	85.7%	83.3%	100.0%	90.9%	88.0%	94.1%	100.0%	97.5%	87.2%	89.7%	100.0%	95.2%	95.2%	My
	VTE: Hospital acquired	0	0	0	0	1	0	1	1	1	0	1	1	1	M
VTE	VTE risk assessment (Target: >95%)	89.1%	90.1%	91.3%	90.7%	95.9%	95.1%	95.3%	95.2%	92.5%	92.8%	93.4%	93.1%	93.1%	1
TB Care	TB: Number of active cases identified and notified	1	2	3	5	5	6	2	8	6	8	5	13	13	Hall Hale
	ED % of patients with high NEWS score screened for Sepsis	93.6%	93.3%	89.8%	91.6%	89.9%	90.0%	91.2%	90.6%	91.6%	91.7%	90.5%	91.1%	91.1%	1111111111
	ED % of patients at risk of developing sepsis receiving antibiotics	75.7%	71.9%	68.4%	70.3%	89.3%	88.7%	87.1%	87.9%	84.8%	81.9%	79.7%	80.9%	80.9%	1111111111
	ED % of patients at risk of developing sepsis receiving antibiotics within 1 hour	42.9%	34.4%	34.2%	34.3%	57.9%	61.7%	63.8%	62.6%	52.9%	50.6%	52.1%	51.3%	51.3%	
	AAU/AMU % of patients with high NEWS score screened for Sepsis	55.5%	85.9%	87.5%	86.8%	50.7%	86.4%	94.9%	90.8%	53.2%	86.1%	90.1%	88.4%	88.4%	mill
	AAU/AMU % of patients at risk of developing sepsis receiving antibiotics	76.9%	72.4%	70.3%	71.2%	66.7%	78.3%	58.1%	65.2%	71.4%	75.0%	63.7%	68.2%	68.2%	
	Inpatient Wards % of patients with high NEWS score screened for Sepsis	59.3%	85.5%	84.3%	84.8%	58.2%	84.4%	92.0%	88.4%	58.8%	85.0%	87.9%	86.5%	86.5%	nillinilli
Improving	% of patients identified and triaged as having diabetes														
outcomes for	Number of inpatient nurses/HCAs that have received 10- point training	0	7	7	14	0	0	0	0	0	7	7	14	14	
	Length of stay for elective (surgical specialties only) patients with recorded diabetes	2.2	1.9	2.6	2.3	1.0	1.2	2.1	1.9	2.1	1.7	2.3	2.1	2.1	
	% staff trained on the principles of safe and effective handover (Target >=50%)				Theres				to months						
	% utilisation of handover tool within Cerner (Target >=70%)				rnese indi	cators are	currently	unavailat	ole - awaitin	g services	to provid	e data			

#NoF Time to Theatres

CW Site May 2021 NOFF data update: 100% of medically fit patients achieved theatre within 36 hours. At the WMUH site performance improved from 76.5% in April to 82.6% in May 2021. WMUH performance was 82.6%, resulting in a trust performance of 88.9% against the >90% target.

VTE Risk Assessments

WMUH site achieved the ≥ 95% target. CW site performance shows improvement (91.3%) but remains below target. VTE performance is tracked weekly through the TW3 performance meetings to ensure improved compliance.

Hospital Associated thrombosis (HATs)

In May, 0 HAT reported for CW site; and 1 HAT reported for WMUH site. VTE root cause analysis is performed for HATs to ensure appropriate VTE prevention management with shared learning.

Sepsis

Sepsis: Consistent compliance with screening (>90%) across ED and AMU. Significant improvement in Medical and Surgical wards. Improved timely administration of antibiotics (though not compliant at >90%).

Actions required; Improve timelines of screening and Improve clinical review of patients - KPI 3 (Abx administration) is dependent on clinical review

Dementia Screening

For May 2021 West Middlesex university Hospital achieved 98.7% and Chelsea and Westminster hospital achieved 97.2%. We achieved our target of 90% as a trust.

Improving outcomes for Inpatient Diabetic Patients

We are rolling out 10 point diabetes training online and via zoom, this will also be disseminated via the nursing program and we have a slot in July on the quality rounds. We hope that through these means we can continue to increase the number of nurses undergoing and completing training over the next 12 months. Length of stay of elective patients with diabetes is being addressed with a review of the current surgical pathway. Currently there is no dedicated pathway for patients undergoing non-urgent surgery with diabetes, and we hope by introducing care pathways and guidelines, we can improve length of stay, reduce complications, and improve patient experience. Additionally we are actively seeking patient engagement, through the diabetes CRG, and benchmarking against neighbouring trusts



Access Dashboard

		C		Westmins ital Site	ster	u		liddlesex Hospital S	iite		Trust data 13 months				
Domain	Indicator	∆ Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts
	RTT Incompletes 52 week Patients at month end	667	555	460	1015	387	362	306	668	1054	917	766	1683	1683	dillinis.
RTT waits	Diagnostic waiting times <6 weeks: % (Target: >99%)	91.98%	93.55%	95.49%	94.53%	93.22%	95.70%	95.60%	95.65%	92.70%	94.77%	95.55%	95.15%	95.15%	- Janear
	Diagnostic waiting times >6 weeks: breach actuals	203	202	143	345	240	175	168	343	443	377	311	688	688	A
	A&E unplanned re-attendances (Target: <5%)	9.0%	8.4%	8.0%	8.2%	8.1%	8.1%	7.6%	7.8%	8.7%	8.3%	7.9%	8.1%	8.1%	None of
	A&E time to treatment - Median (Target: <60')	00:28	00:28	00:28	00:28	00:58	00:57	00:58	00:58	00:43	00:43	00:41	00:42	00:42	MAN
A&E and LAS	London Ambulance Service - patient handover 30' breaches	2	3	3	6	58	47	53	100	60	50	56	106	106	
	London Ambulance Service - patient handover 60' breaches	0	0	101	(0)	1	0	0	0	-1	0:	0	0	0	ı
	Please note the following	blank cell	An emnty	cell denote	s those indica	tore current	v under de	velonment	•	Fither Site	or Truet o	verall nerfor	mance red in	each of the n	ast three months

RTT Incompletes 52 week Patients at month end

Numbers of patients waiting over 52 weeks has continued to reduce for the third month in a row. As at the end of May there were 766 patients waiting over 52 weeks. This number looks to continue to reduce as activity increases.

Diagnostic waiting times

The final May performance figure 95.55%, up again from last month at 94.78% and at the highest post-Covid level. Diagnostic Imaging is compliant at 99.9%, Audiology compliant at 100%. Physiology on track to be compliant from July 2021. Plans are in place to achieve remaining specialties by August 2021.



RTT Positions Dashboard

			Chelsea & Westminster Hospital Site	ι	West Middlesex Iniversity Hospital Site	Coi	Combined Trust Performan			
Domain	Indicator	Apr-21	May-21	Apr-21	May-21	Apr-21	May-21			
	Total RTT waiting list	21899	23080	15395	16290	37294	39370			
	Total Non-Admitted waiting list	18537	19451	13555	14313	32092	33764			
	Non-Admitted with a date	10834	11426	9644	10375	20478	21801			
	Non-Admitted without a date	7703	8025	3911	3938	11614	11963			
RTT waiting list	Total Admitted waiting list	3362	3629	1840	1977	5202	5606			
positions	Admitted with a date	1132	874	712	576	1844	1450			
	Admitted without a date	2230	2755	1128	1401	3358	4156			
	Patients waiting >78 weeks	40	59	51	56	91	115			
	Patients waiting >104 weeks	0	0	1	ĩ	1	1			

	Chelsea & Westminster Hospital Site							
Local Specialty	Apr-21	May-21	Jun-21					
Total	557	460						
Burns Care	1	1						
Colorectal Surgery	3	3						
Community Paediatrics	1	2						
Dermatology		1						
ENT								
Gastroenterology								
General Surgery	37	31						
Gynae Colposcopy								
Interventional Radiology								
Maxillo-Facial Surgery	2	1						
Ophthalmology	35	24						
Oral Surgery								
Paediatric Cardiology	1	1						
Paediatric Clinical Immunology and Allergy	16	17						
Paediatric Dentistry	161	132						
Paediatric Dermatology	4	2						
Paediatric ENT	27	27						
Paediatric Gastroenterology								
Paediatric Maxillo-Facial Surgery	17	16						
Paediatric Plastic Surgery	13	14						
Paediatric Surgery	32	28						
Paediatric Trauma and Orthopaedics	2	2						
Paediatric Urology	10	8						
Paediatrics	1	1						
Pain Management	1							
Plastic Surgery	78	64						
Podiatric Surgery								
Podiatry								
Trauma and Orthopaedics	87	60						
Urology	12	13						
Vascular Surgery	16	12						

	lospital Sit	
Apr-21	May-21	Jun-21
344	306	
6	2	
	1	
16	12	
2		
45	32	
	1	
1	1	
11	23	
26	22	
	1	
11	10	
4	10	
8	6	
2	3	
27	21	
	1	
18	11	
81	66	
43	47	
43	46	

Combined Trust Position										
Apr-21	May-21	Jun-21								
901	766									
1	1									
9	5									
1	2									
	2									
16	12									
2										
82	63									
	1									
1	1									
2	1									
35	24									
11	23									
1	1									
16	17									
161	132									
4	2									
53	49									
	1									
17	16									
13	14									
43	38									
6	2									
18	14									
3	4									
1										
105	85									
	1									
18	11									
168	126									
55	60									
59	58									



Maternity Dashboard

		C		Westmins ital Site	ster	ι		liddlesex Hospital	Site		Combin	ed Trust F	erformance	e	Trust data 13 months	
Domain	Indicator	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022	Mar-21	Apr-21	May-21	2021-2022 Q1	2021-2022	Trend charts	8
	Midwife to birth ratio (Target: 1:30)	1:27	1:27	1:27	1:27	1:28	1:28	1:28	1:28	1:27.5	1:27.5	1:27.5	1:27.50	1:27.5		
Workforce	Hours dedicated consultant presence on labour ward (Target 1:98)	1:77	1:77	1:77	1:77	1:98	1:98	1:98	1:98	1:87.5	1:87.5	1:87.5	1:87.50	1:87.50		
	Total number of NHS births	478	434	483	917	398	367	371	738	876	801	854	1655	1655		
Birth indicators	Total number of bookings	672	613	565	1178	502	478	461	939	1174	1091	1026	2117	2117	MM	
	Maternity 1:1 care in established labour (Target: >95%)	98.8%	99.3%	98.5%	98.9%	96.5%	97.9%	95.5%	96.7%	97.7%	98.6%	97.1%	97.8%	97.8%	Money	
	Admissions >37/40 to NICU/SCBU	25	13	22	35	n/a	n/a	n/a	n/a	25	13	22	35	35	dati lista	
	Number of reported Serious Incidents	0	1	0	1	2	1	1	2	2	2	1	3	3	Lhlln.	
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	0	0	0	0	0	0	0	0	0		
Safety	Pre-term (gestation <37 weeks) as % of mothers delivered	5.3%	8.3%	7.2%	7.7%	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Hitalda li									
	Number of stillbirths	0	3	0	3	0	3	1	4	0	6	1	7	7	draille.	
	Number of Infant deaths	3	0	2	2	3	0	1	1	6	0	3	3	3	.111.11	
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	Trend charts Trend charts	
	% of women on a continuity of care pathway	19.8%	16.6%	17.4%	17.0%	15.4%	8.0%	11.0%	9.5%	17.6%	12.3%	14.2%	13.3%	13.3%	1 1	
	Spontaneous unassisted vaginal births	30.4%	25.1%	31.8%	28.6%	38.8%	33.6%	34.8%	34.2%	34.2%	29.0%	33.1%	31.1%	31.1%	ha blat r	
	Vaginal Births - spontaneous & induced	65.0%	60.3%	64.4%	62.4%	66.3%	62.8%	63.3%	63.0%	65.6%	61.4%	63.9%	62.7%	62.7%	Idd Itda	
Outcomes	Instrumental deliveries	19.1%	16.5%	13.6%	15.0%	13.0%	15.0%	10.4%	12.7%	16.3%	15.8%	12.2%	14.0%	14.0%		
	Pre-labour elective caesarean sections	65	69	66	135	50	45	47	92	115	114	113	227	227		
	Emergency caesarean sections in labour	56	52	55	107	54	61	56	117	110	113	111	224	224	Hillian	

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	e months
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The above dashboard has been updated since last report to include metrics for workforce, birth indicators, safety and clinical outcomes.

Workforce: The current midwifery ratio's on each site are 1:27 at Chelsea and 1:28 at West Middlesex. The recently commissioned birth rate plus analysis of the midwifery workforce recommends that the ratio's are 1:24.9 for the Chelsea site and 1:21.7 West Middlesex site. The metric for 98 hours dedicated consultant presence is achieved at West Middlesex, however at the Chelsea site this is currently 77 hours. Two obstetric jobs were approved to increase the hours of consultant presence at the Chelsea site to 88hrs. Furthermore, a national submission has been put forward to achieve both the enhanced ratio's and 98 hours dedicated labour ward cover at the Chelsea site.

Birth indicators: The last 12 months has seen a slight drop in the birth rate particularly at Chelsea (on average 25-40 births per month), this is being monitored closely and in May the births were on plan. We remain achieving the target for one to one care in labour.

Safety: SIs there was one SI for the month of May at West Mid and none for Chelsea. There were no cases of HIE on both sites. All SIs are reviewed both locally and at the regional Sis meetings.

The preterm birth rate at the Chelsea site is currently at 7.2% and the national ambition is to reduce rate to <6%. The West Mid site had a preterm birth rate of 5.5% for May. Both sites had a higher than expected preterm birth rate for April. We are currently undertaking a cross site preterm birth audit to (i) determine our own local population rate rather than that associated with in utero transfers and (ii) review the April cases to determine if there were any trends or care/service delivery issues. Both sites have established preterm birth prevention services and pathways are in place for prediction, prevention and preparation of preterm birth. We are currently implementing the BAPM toolkit for optimisation of preterm infants <34weeks.

Both sites had similar and expected fluctuations with respect to the stillbirth and infant death. We are compliant across both sites with SBLV2 and aiming to reduce by 50% our stillbirths by 2025. There were no never events for month of May.

Outcomes indicators: Our proportion of women experiencing instrumental and caesarean births show similar trends across both sites and also with our regional neighbouring units. The caesarean section activity is higher on the Chelsea site due to increased complexity and also higher demand for maternal choice caesarean birth.





62 day Cancer referrals by tumour site Dashboard Target of 85%

				sea & West Hospital S			1		est Middle rsity Hosp				Trust data 13 months					
)omain	Tumour site $ ag{}$	Mar-21	Apr-21	May-21	2021-2022	YTD breaches	Mar-21	Apr-21	May-21	2021-2022	YTD breaches	Mar-21	Apr-21	May-21	2021- 2022 Q1	2021-2022	YTD breaches	Trend charts
	Breast	n/a	n/a	n/a	n√a	2. Olionolio	100%	100%	100%	100%	0	100%	100%	100%	100%	100%	0	
	Colorectal / Lower GI	61.5%	76.9%	66.7%	76.9%	2	56.3%	66.7%	100%	66.7%	0.5	57.8%	75.0%	85.7%	75.0%	75.0%	2.5	
	Gynaecological	100%	100%	50.0%	100%	0.5	33.3%	100%	100%	100%	0	66.7%	100%	66.7%	100%	100%	0.5	MM
	Haematological	100%	100%	100%	100%	0	100%	100%	71.4%	100%	1	100%	100%	77.8%	100%	100%	1	M
	Head and neck	n/a	100%	n/a	100%	0	n/a	n/a	100%	T 65	0	n/a	100%	100%	100%	100%	0	1
	Lung	50.0%	100%	100%	100%	0	100%	n/a	66.7%		- 31	66.7%	100%	71.4%	100%	100%	1	l Illitanlı
	Sarcoma	n/a	n/a	n/a	n/a		n/a	n/a	n/a	i (28		n/a	n/a	n/a	n/a	n/a		
	Skin	78.8%	87.5%	92.3%	87.5%	1.5	87.0%	62.5%	100%	62.5%	1.5	82.1%	75.0%	94.7%	75.0%	75.0%	3	Man M
	Upper gastrointestinal	n/a	n√a	100%	n/a	0	100%	75.0%	50.0%	75.0%	2.5	100%	75.0%	70.0%	75.0%	75.0%	2.5	1
62 day ncer referrals ite of tumou	Urological	52.9%	64.7%	77.8%	64.7%	5	48.7%	64.0%	81.0%	64.0%	6.5	50.0%	64.3%	79.5%	64.3%	64.3%	11.5	and and and a
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a			100%	n/a	n/a	n/a	n/a		
	Site not stated	n/a	n/a	n/a	n/a		n/a	100%	n/a	100%	0	n/a	100%	n/a	100%	100%	0	. 1 1

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

Tumour Site	Chelsea &	Westminster	West Middlesex						
	Breaches	Treatments	Breaches	Treatments					
Breast			0	12					
Gynaecology		2	0	2					
Haematology	0	0.5	0	1.5					
Head and Neck		2.5	0	0					
Colorectal	1.5	6.5	0.5	1.5					
Lung		1.5	0	0					
Other			0	1.5					
Skin	0.5	4	1.5	4					
Upper GI			1	4					
Urology	3	8.5	4.5	12.5					
Total:	5	25.5	7.5	39					





Safe Staffing & Patient Quality Indicator Report – Chelsea Site

May 2021

Ward	Day		Night		СНРРО	CHPPD	CHPPD	National Benchmark	Vacancy Rate	Turi	Turnover		patient fa	all with har	m	Trust acquired pressure ulcer 3,4,unstageable		Medication incidents (moderate and severe)		FET
	Average	Average	Average	Average							Un-									FFT
	fill rate - registered	fill rate - care staff	fill rate - registered	fill rate - care staff	Reg	HCA	Total			Qualified	qualified	No har mi		Modera sev						
												Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Maternity	102%	87%	100%	92%	7.8	2.7	10.5	15.3	4.6%	8.3%	12.3%									89.23.%
Annie Zunz	137%	74%	100%	104%	10	3.5	13.4	7.6	0.0%	0.0%	0.0%								1	97.59%
Apollo	99%	-	91%	-	16.6	0	17.4	10.9	16.6%	20.9%	31.3%	1	1							100.00%
Jupiter	-	-	-	-	-	-	-	10.9	56.4%	63.6%	0.0%									
Mercury	104%	90%	102%	-	7.5	0.6	8.1	9.3	20.9%	15.8%	40.0%									95.83%
Neptune	1.3	1.81	1.38	-	21.9	6.4	28.3	10.9	18.3%	13.9%	66.7%									88.89%
NICU	98%	-	98%	-	14.9	0	14.9	26	3.7%	14.5%	12.9%									100.00%
AAU	102%	62%	100%	69%	8.2	1.9	10.1	7.8	13.9%	13.6%	47.1%	6	14							88.66%
Nell Gwynne	108%	52%	155%	65%	5.3	2.7	8.4	7.3	5.8%	5.0%	26.4%	5	10							83.33%
David Erskine	93%	64%	96%	72%	7.2	4.1	11.6	7	11.3%	14.0%	13.1%									
Edgar Horne	110%	74%	122%	86%	4	2.4	6.6	6.9	9.9%	0.0%	25.8%	6	15							100.00%
Lord Wigram	90%	82%	100%	100%	4.6	2.9	7.6	7	12.0%	0.0%	0.0%	2	5							94.05%
St Mary Abbots	103%	69%	86%	99%	4.3	2.8	7.4	7.2	10.3%	9.3%	0.0%	5	5							94.90%
David Evans	73%	111%	94%	100%	7.2	3.7	10.9	7.2	0.9%	9.9%	10.9%	3	8							97.09%
Chelsea Wing	0.99	1.13	1.02	0.89	7.8	6.4	14.2	7.2	29.4%	14.9%	31.0%	1	1							80.00%
Burns Unit	0.91	0.92	0.98	0.98	15.7	4.2	19.8	N/A	9.9%	21.2%	15.5%		2							89.47%
Ron Johnson	-	-	-	-	-	-	-	7.4	13.5%	11.4%	23.8%									94.44%
ICU	110%	60%	114%	-	28.9	0.4	30.2	26	4.0%	13.6%	0.0%									
Rainsford Mowlem	77%	53%	80%	57%	4.9	3	7.9	7.3	13.4%	12.9%	10.5%	1	10							875%





Safe Staffing & Patient Quality Indicator Report – West Middlesex Site

May 2021

Ward	Day		Night		CHPPD	CHPPD	Total	National Benchmark	Vacancy Rate	Turnover		In	patient fa	all with har	m	Trust acquired pressure ulcer 3,4,unstageable		Medication incidents (moderate & severe)		FFT	
	Average fill rate -	Average fill rate -		Average fill rate -	Average fill rate -	Reg	HCA				Qualified	Un-	Mod	orato	Sov	oro.					
	registered	care staff	registered	care staff							Qualified	Moderate		Severe							
												Month	YTD	Month	YTD	Month	YTD	Month	YTD		
Lampton	94%	74%	102%	97%	3.8	3.1	6.8	7.3	6.90%	0.00%	0.00%	3	3							93.22%	
Richmond	-	-	-	-	-	-	-	7.2	0	0.00%	0.00%	1	1							100.00%	
Syon 1 cardiology	99%	101%	101%	106%	4.2	2.1	6.3	8	10.10%	0.00%	16.67%	3	6							94.44%	
Syon 2	110%	102%	102%	106%	3.9	3.3	7.3	7.3	9.40%	8.63%	6.45%	5	8			1				94.44%	
Starlight	112%	-	123%	-	9.5	0	9.5	10.9	5.20%	16.80%	0.00%									84.85%	
Kew	102%	107%	100%	137%	3.6	3.8	7.5	6.9	-4.20%	4.44%	19.59%	12	19						1	80.00%	
Crane	78%	48%	78%	72%	4	2.6	6.7	6.9	10.20%	3.35%	6.13%	2	3							93.62%	
Osterley 1	99%	99%	97%	118%	3.9	3.1	7.2	7	5.30%	18.49%	0.00%	10	17							89.39%	
Osterley 2	88%	93%	98%	126%	3.8	2.9	6.7	7.2	3.40%	0.00%	20.42%	5	7							85.53%	
MAU	117%	119%	120%	118%	8.3	3	11.4	7.8	8.70%	10.76%	16.35%	2	10	1	1					100.00%	
Maternity	105%	86%	107%	93%	4.9	1.5	6.4	15.3	3.60%	3.80%	2.27%	1	1							90.20%	
Special C are Baby Unit	92%	109%	93%	107%	11.5	1.6	13.2	10.9	12.70%	0.00%	11.05%									100.00%	
Marble Hill 1	105%	101%	102%	143%	4	3	7.2	7.3	22.90%	7.93%	14.69%	7	14							88.24%	
Marble Hill 2	96%	109%	100%	172%	3.3	3.4	6.7	6.5	9.10%	15.57%	17.52%	1	5		1					89.80%	
ITU	120%	-	117%	-	29.5	0	30.9	26	-1.00%	7.14%	0.00%					1				100.00%	





Safe Staffing & Patient Quality Indicator Report

May 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 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.

SMA and David Evans had lower activity during May, hence staffing levels were reduced. The establishment for SMA is currently under review. On David Evans staffing was titrated to accommodate elective lists including the 2 Bank Holidays and staff were redeployed to other wards or moved to days when theatre activity was higher. The high fill rate for Neptune was due to the number of CAMHS patients and resulting requirement for 1:1 care.

Some beds were closed on Lampton, Crane, Rainsford Mowlem and David Erskine during May which accounts for lower staff fill rates. In all these instances this did not negatively impact on CHPPD. Ron Johnson is currently hosted on Rainsford Mowlem therefore staff fill rates are not completed for this ward but are included in Rainsford Mowlem figures.

Following the required change to include number of babies as well as mothers on maternity units, this data submission is still being refined for the West Mid Site. For now, the number of WM maternity cots has been based on the number of bed days on the top floor of QMMU. Benchmarking data for CHPPD will be updated once this is updated on Model Hospital.

Kew and Osterley 2 had high fill rates for HCAs at night which was to care for confused patients at high risk of falls and Marble Hill 1 and 2 was due to a requirement for enhanced monitoring. Nell Gwynne has 2 HCASs on long term sickness and had a number of patients who were confused and wandering at risk of falls and absconding and therefore needed additional HCAs. This was partially mitigated by additional Registered Nurses to care for patient with tracheostomies. Increased RN fill rates on Edgar Horne was due to patients requiring 2 RMNs per shift and low HCA fill rate due to long term sickness which were not replaced but mitigated by RMNs on shift. Annie Zunz had high day fill rate for RNs due to the requirement of an extra RN to cover patients admitted through the Surgical Admissions Lounge. AAU had a number of HCAs vacancies which are currently being recruited hence the low fill rate but this did not compromise CHPPD when compared to the national benchmark.

During May there was one fall on Acute Medical Unit with severe harm. There were two unstageable pressure ulcers this month on WM ICU and Syon 2 and a category 3 full thickness pressure ulcer on WM ICU. All mechanisms are in place to minimise pressure with involvement of the tissue viability team.

The Friends and Family test showed 3 wards at WM and 3 wards at CW wards scored 100% and all other wards scoring above 80%.



Finance Dashboard M1 2021/22

	Co	mbined Trust		
£'000	Plan to Date	Actual to Date	Variance to Date	
Income Expenditure	123,791	125,294	1,504	
Pay	(64,596)	(69,200)	(4,605)	
Non-Pay	(52,723)	(48,332)	4,390	
EBITDA	6,472	7,761	1,289	
EBITDA %	5.23%	6.19%	1.0%	
Depreciation	(3,850)	(3,850)	0	
Non-Operational Exp-Inc	(2,895)	(2,990)	(95)	
Surplus/Deficit	(273)	921	1,195	
Control total Adj - Donated asset, Impairment & Other	(161)	(161)	(0)	
Adjusted Surplus/Deficit	(434)	760	1,195	



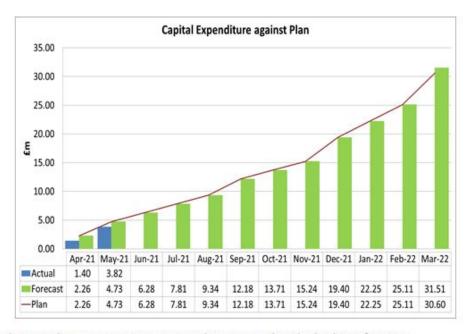
Month 12 payroll figures include additional spend for 6.3% Pension contribution - £15.16m (a notional figure) and £4.8m movement in holiday accrual and additional two day accrual; these are all matched with equivalent income.

At month 2 the Trust is reporting a YTD surplus of £0.76m, when adjusted for the financial impact of donated assets. This is £1.2m favourable against plan year to date.

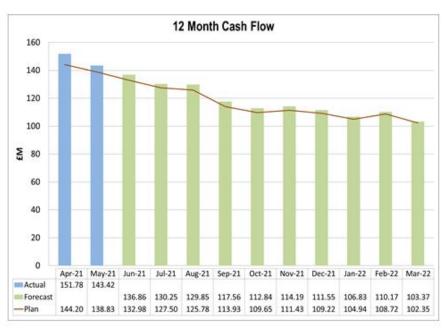
Pay: Pay is overspent by £2.8m in month and by £4.6m YTD. The position includes £1.9m COVID-19 spend in month (including costs of the vaccination programme) and £2.9m YTD; and unidentified CIP targets of £0.8m in month and £1.6m YTD (this includes prior year CIPs).

Non-Pay excluding pass through drugs, is £2.6m favourable in month and £4.4m YTD. The position in month and YTD includes adjustment of the non-clinical budget to match the NHSI plan.

Income: Contractual income from CCG and NHS England continues on a block at the same level as 2020/21. NHS Non-contracted activity income has been added to the sector baseline and added to the top-up now received from CCGs. There has been an increase in the sector block (NWL CCG) for drugs & devices, CNST and complex knees procedures. Sexual health contracted activity is back to cost and volume in 21/22 and PreP has been included on the baseline. This is the first month wehave included the Elective Recovery Framework (ERF) performance, which showed an over performance for M1 & M2.



The Trust has spent £2.42m in period 2 compared to the budget of £2.46m, resulting in an underspend of £0.04m. The YTD variance against plan is an underspend of £0.90m, actual spend of £3.82m compared to budget of £4.72m. The underspend mainly relates to timing differences, with a number of schemes yet to be worked up and business cases prepared. It is envisaged that the capital spend will be incurred in later months as seen in previous years



The favourable cash variance to plan in M2 of £4.59m is favourable cash variance b/fwd from M1 of £7.58m, lower receipts to plan of £3.19m (Lower LA Income -£1.74m, Lower FT's income -£1.1m, Lower Donations -£328K, Lower AR -£427k, Lower NHS England -£325K, offset by CCG £760k higher, PP Income £122k higher) offset by lower cash outflows to plan £194k (lower Direct Debit payments).





CQUIN Dashboard

2021/22 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.





Council of Governors Meeting, 22 July 2021

AGENDA ITEM NO.	2.1.2/Jul/21
REPORT NAME	People Performance Report – May 2021
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 and People and OD Committee were not held in June; therefore the documents have been circulated via e-governance. Board of Directors, 8 July 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 May 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	The performance report highlights some specific concerns in relation to equality,

IMPLICATIONS	specifically the disproportionate impact of BAME staff in the disciplinary process and also the low numbers of BAME staff raising concerns of B&H given the staff survey results.
LINK TO OBJECTIVES	Be the employer of choice
DECISION/ ACTION	For information.





Workforce Performance Report to the People and Organisational Development Committee

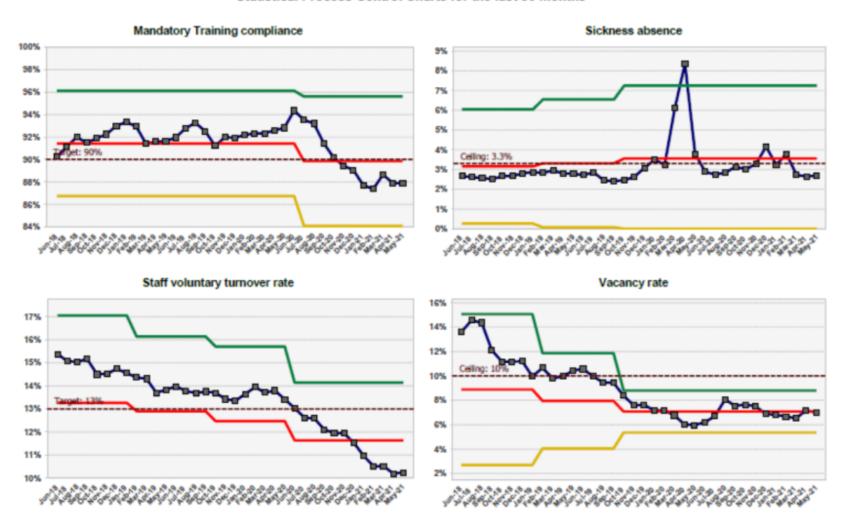
Month 02 – May 2021

Statistical Process Control – Jun 2018 to May 2021





WORKFORCE INDICATORS Statistical Process Control Charts for the last 36 months



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



ttem	Units	This Month	Last M onth	This Month	Target /	RAG Status Red Amber Green		Trend	
		Last Year			Ceiling				
1. Workforce Information									
1.1 Establishment	No.	6333.84	6,474.38	6,465.28					↓
1.2 Whole time equivalent	No.	5952.07	6011.07	6011.42					↑
1.3 Headcount	No.	6436	6490	6499					↑
1.5 Overpayments (Number)	No.	27	26	31					↑
1.4 Overpayments (Costs)	£	69,544.74	43,273.43	81,714.36					^
2. HR Indicators									
2.1 Sickness absence	%	8.31%	2.64%	2.69%	<3.3%				Α
2.2 Long Term Sickness absence	%	2.08%	1.28%	1.36%					•
2.3 Short Term Sickness absence	%	6.23%	1.37%	1.33%					→
2.4 Gross Turnover	%	17.93%	15.95%	15.66%	<17%				Ψ
2.5 Voluntary Turnover	%	13.80%	10.19%	10.24%	<13%				•
3. Employee Relations									
3.1 Live Employment Relations Cases	No.	118	100	92					↓
3.2 Formal Warnings	No.	D	2	1					. ↓
3.3 Dismissals	No.	1	٥	a					← →
4. Temporary Staffing Usage									
4.1 Total Temporary Staff Shifts Filled	No.	10882	14737	17780					↑
4.2 Bank Shifts Filled	No.	9640	14085	16780					^
4.3 Agency Shifts Filled	No.	1242	652	1000					↑
5. Vacancy									
5.1 Trust Vacancy Rate	%	6.01%	7.16%	7.02%	<10%				Ψ
5.2 Corporate	%	-2.60%	1.02%	2.39%	<10%				•
5.3 Clinical Support Services	%	8.94%	10.38%	10.35%	<10%				₩
5.4 Emergency & Integrated Care	%	8.29%	8.18%	8.42%	<10%				•
5.5 Planned Care	%	8.57%	4.41%	3.30%	<10%				₩
5.6 Women's, Children and Sexual Health	%	3.44%	8.05%	7.50%	<10%				. ↓
6. Recruitment (Non-medical)									
6.1 Offers Made	No.	73	113	156					↑
6.2 Pre-employment checks (days)	No.	29.9	16.8	18.9	<20				•
6.3 Time to recruit (weeks)	No.	10.96	7.70	8.30	جه ح				*
7. PDRs Undertaken (AfC Staff over 12 months)									
7.1 Trust PDRs Rate (AFC Staff)	%	84.42%	89.91%	85.90%	≥90%				→
7.2 Corporate	%	82.66%	86.00%	83.30%	≥90%				₩
7.3 Clinical Support Services	%	79.08%	90.95%	84.46%	≥90%				₩
7.4 Emergency & Integrated Care	%	90.77%	92.99%	89.06%	≥90%				₩
7.5 Planned Care	%	89.43%	90.67%	88.64%	≥90%				Ψ
7.6 Women's, Children and Sexual Health	%	80.22%	87.65%	83.67%	≥90%	1			₩







May 2021 SICKNESS									
Division	Sickness Abs.	RAG Status Ceilling <3.30%	Available WTE hours	Absence WTE hours	Episodes	Long Term (WTE hours)	% Long Term	Prev. Month	%+/-
Corporate	1.89%		19438.52	367.89	35	251.08	1.29%	1.66%	0.23%
Clinical Support	3.96%		30994.27	1226.47	174	745.07	2.40%	3.96%	0.00%
Emergency & Integrated Care	2.58%		50590.41	1305.82	254	555.77	1.10%	2.35%	0.24%
Planned Care	1.96%		33161.45	649.12	150	239.82	0.72%	1.93%	0.03%
Women's, Children and Sexual Health	2.82%		52144.88	1469.11	248	744.25	1.43%	2.97%	-0.15%
Trust	2.69%		186329.54	5018.40	861	2535.98	1.36%	2.64%	0.05%

May 2021 Core Training							
Course	Last Month	This Month	Target	RAG Status	Trend		
Core Training Compliance Overall	88%	88%	<90%		←→		
Theory Adult BLS	72%	71%	<90%		+		
Practical Adult BLS	73%	74%	<90%		^		
Conflict Resolution - Level 1	96%	96%	<90%		←→		
Equality & Diversity	93%	93%	<90%		←→		
Fire	87%	88%	<90%		↑		
Health & Safety	93%	93%	<90%		←→		
Infection Control (Hand Hygiene)	91%	92%	<90%		•		
Infection Control - Level 2	91%	91%	<95%		←→		
Information Governance	89%	89%	<95%		←→		
Moving & Handling - Level 1	89%	90%	<90%		↑		
Moving & Handling - Level 2 Theory	84%	85%	<90%		↑		
Moving & Handling - Level 2 Patient	72%	75%	<90%		↑		
Safeguarding Adults Level 1	91%	91%	<90%		←→		
Safeguarding Adults Level 2	89%	88%	<90%		+		
Safeguarding Adults Level 3	86%	86%	<90%		€→		
Safeguarding Children Level 1	93%	93%	<90%		←→		
Safeguarding Children Level 2	91%	91%	<90%		←→		
Safeguarding Children Level 3	86%	84%	<90%		+		

Category	Metric	Number / 5
No of Disciplinary cases opened in month	Number	1
No of current, live disciplinary cases	Number	6
Average length of current disciplinary cases	Days <60	45
Average length of disciplinary Investigation	Days<30	39
Total Disciplinary cases opened in year (from April 21)	Number	3
% BAME Disciplinary Cases in year	%	66%
% BAME Disciplinary Cases in month	%	0%
No of current, live MHPS cases	Number	2
Average length of current MHPS cases	Days<60	148
Average length of MHPS investigation	Days<30	106
% BAME – current MHPS Cases	%	66%
Exclusions - No. of live in month	Number	0
Grievance - No. of live cases in month	Number	4
Grievance – Average length of case	Days <60	58
Grievances - % that are BAME	%	0%
B&H cases - included in grievance numbers	Number	4
Sickness - No. of cases in month	Number	70
Long Term - sickness cases in month	Number	49
Short Term - sickness cases in month	Number	21
No. of Employment Tribunals (ET)	Number	8
Staff attending ER training sessions	Number	22
Staff attending ER training sessions	Number	22

May 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	643.37	628.02	15.35			653.21	-9.84	
Clinical Support	1117.45	1001.84	115.61			1094.41	23.04	
Emergency & Integrated Care	1777.28	1627.57	149.71			1767.83	9.45	
Planned Care	1105.35	1068.87	36.48			1125.34	-19.99	
Women's, Children and Sexual Health	1821.83	1685.12	136.71			1765.36	56.47	
TRUST	6465.28	6011.42	453.86			6406.14	59.14	

May 2021 Voluntary Turnover						
Division	Turnover	Prev Month	%+/-			
Corporate	10.57%	11.67%	-1.10%			
Clinical Support	10.44%	9.87%	0.57%			
Emergency & Integrated Care	13.20%	12.81%	0.38%			
Planned Care	7.46%	7.25%	0.21%			
Women's, Children and Sexual Health	8.90%	9.10%	-0.20%			
TRU <u>S</u> T	10.24%	10.19%	0.05%			

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					

Chelsea and Westminster Hospital MHS

People and Organisation Development Workforce Performance Report May 2021

Establishment, Staff in Post and Vacancies:

The Trust currently employs 6499 people working a whole time equivalent of 6011. This equates to 63 wte more permanent members of staff than this time last year. There has been an reduction in the vacancy rate for May, 7.02% against the Trust ceiling of 10%.

Temporary Staffing:

Our temporary staffing demand increased again in May, although it should be noted that this was impacted by the COVID19 vaccination programme's use of bank staff. Bank fill performance remains strong with a fill rate of 84% compared to just 5% agency (although agency did increase 1% compared from April). Our agency usage in the Medical and Dental staff group remains high, however at time of reporting, spend had fallen compared to April by 11%. The majority of agency spend was used to cover vacancy (45%) followed by additional demand (21%) and shifts booked to cover 'on call' (18%). Additionally, we have reached agreement to continue our relationship with Patchwork Health who provide the booking app and technology for our Doctors Bank shifts. This enables us to continue our partnership working across North West London on a number of collaborative projects, including the shared bank initiative.

Core Training Compliance:

Overall compliance remained at 88% this month. The work undertaken to date has had a great impact, Practical M&H rising 3% since the end of last month and Adult BLS has seen a 1% increase. The L&D team are continuing with campaigns sending out email reminders and booking people on to sessions when spaces become available. Fire continues to be below 90% due to no longer being able to have drop in sessions. IG maintained at 89% (National Target 95%) the team will continue to send email reminders from the Head of IG, as the team found this has a great impact on staff completions. The Resus team are piloting a new method of training in the next months and hopefully this will allow the team to run more sessions and improve compliance. We have also been able to increase capacity by two in some rooms, 20 in the conference room at the West Mid site. This will allow us to start running Conflict Resolution Training that had to be suspended due to the pandemic.

Sickness Absence:

The Trust's sickness rate is 2.69%, which is marginally higher than last month and lower than this time last year. Our sickness target of 3.3% has been breached six times during the last 32 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 gastrointestinal. 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 remains low at 10.24% and is below the Trust target for the eleventh 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 retention group has been focused on implementing the pulse survey monthly and the April results have been collated and will be presented through meetings during July along with feedback from the new joiner and leaver surveys and working on the Timewise accreditation programme to become a flexible employer. This has included holding a series of focus groups with key stakeholders to discuss flexible working in the Trust and development of a draft action plan which is to be agreed by the Trust for implementation.

PDRs:

The PDR rate for May was 86% and July is the first month where all members of staff will only progress through the pay steps based on the PDR policy, which includes a positive PDR rating, all of mandatory training completed.





People and Organisation Development Workforce Performance Report May 2021

Diversity & Inclusion:

Key highlights in the last month included joining the Calibre leadership programme, a new programme for staff with a disability across the ICS, hosted by Imperial where the Trust has 2 places. The Disability Network has appointed its new Co-Chairs. The Trust has also been interviewing staff for the Leadership Ladder programme for our 2 places across the ICS. The Reciprocal Mentoring for Inclusion participants participated in the final celebratory event, and we are now working through continuation of the programme given successful feedback to take place in the Autumn. The Virtual Reality programme is being finalised, to agree the roll-out across the Trust. 4 Trust participants have started the Compassionate and Inclusive Leadership pilot programme.

Leadership and Development:

The Management Fundamentals programme was launched in January 2019. Since it launched over 250 staff have a attended a variety of the courses offered. The course with the highest attendance are Management vs Leadership, PDR and Time Management. To support the Health and Wellbeing agenda we have updated the programme to include a session on how to have a 'Wellbeing Conversation'. There have been various leadership and development support delivered locally, with many of the requests plugging the gap from the unavailability of the management fundamental programme during COVID. The Emerging Leaders programme cohort 17 have now commenced. The program has expanded to include a session from Public Health England, with a focus on health inequalities and how delegates could play a positive role in this. Stakeholder engagement for Talent and Succession Planning have concluded and a final report is being written. The report will formalise the organisation's trajectory for Talent Management and Succession Planning.

Health and Wellbeing:

In June the Trust launched the Virgin Go Challenge (VP Go) and had continued promoting it in order to get staff involved in improving their physical wellbeing. The Trust offered free cycle events at WMUH in partnership with the London Cycling Campaign, providing free bicycle repairs and cycling advice. In June the H&W team continued to proactively support the health and wellbeing through the provision of counselling services, Vivup EAP support, PTS psychological support and the substantial national and regional offer. The H&W team hosted information stalls at both sites to promote the H&W offer to staff. During June a further 3 H&W Champions were trained; the monthly support sessions are continuing for MHFA's and H&W Champions with MHFA training planned for July. The Trust were also successful in winning CW+funding to support a new menopause application to support women going through the menopause, Peppy, following feedback from the Women's Network and are actively involved in the London task and finish group to provide more support in this area.

Apprenticeships:

The Trust Ofsted report is now published on the Ofsted website. The Prince of Wales and Secretary of State visited the Chelsea site to meet the Apprentices (both admin and clinical) recruited through the Prince's Trust. A Head of Apprenticeships working across Chelsea and Westminster, and Hillingdon, Trusts, has been appointed. The invitation to apply for the Register of Apprenticeship Training Provider (RoATP) is not expected until February 2022, at the earliest. The Trust will be applying to become a main provider once its invitation is received in order to deliver Apprenticeship Programmes to other organisations, primarily to NHS-Northwest London organisations, including Hillingdon Hospital. The Trust currently has 214 Apprentices; delivering 18 Non-Clinical Apprenticeship programmes to 90 staff members and 20 Clinical Apprenticeship programmes to 124 staff members. We have one apprentice who completed a business admin programme in June. We are currently conducting interviews with the University for the new Academic Year. We will be having 2 candidates in the pilot programme for Occupational Therapy Degree Apprenticeship at University of East Iondon.





People and Organisation Development Workforce Performance Report May 2021

Transactional Plan:

The Time to Hire increased in May but is still below the Trust target. There will be continued focus around reducing recruitment lead times over the upcoming months whilst also exploring further automation of recruitment services and specifically improving candidate experience, following feedback from the new joiner surveys.

Mass Vaccination Recruitment Programme

The mass vaccination programme continues at pace and the Trust now employs over 2000 additional staff to support the vaccination effort across NWL. The focus will now be on the Attracting Talent programme for which the HR Director for Chelsea is the SRO, to ensure that these staff plus the additional 1,500 staff in the pipeline are transitioned to employment across NWL where vacancies exist in the sector.

Volunteers:

There were 171 active volunteers in May, contributing 2175 hours of volunteering across both sites. We are experiencing a decline in volunteering hours as volunteers return to their "normal" lives. This includes many young volunteers taking exams. Chelsea benefits from a population of older pre-Covid volunteers to make up for this decline. West Middlesex does not. The service is therefore recruiting across both sites over the coming weeks with around 50 new volunteers due to start over the summer. The roles are also changing away from Covid-response and towards recovery. The service is focusing on supplying volunteers to wards, growing the youth pathway, and engaging in new projects such as patient discharge.

Organisational Change

The HR team continue to support an increasing number of organisational change programmes. Currently, there are 6 live consultations affecting just over 50 staff members

Employee Relations:

Disciplinary cases: The average length of investigation shows the time from when the investigation is started to when concluded (measured from when the report is sent to the commissioning manager). The target for this is 30 days and in May 2021 the average timeframe was just over target at 39 days. The second line shows an average length for the entire disciplinary process - the target for this is 60 days and in May 21 the average length of time for this process was 45 days. The KPI figures also include data on medical cases (those managed under MHPS). For these cases the same target timeframes have been applied; although it is noted that MHPS cases and investigations may take longer due to their complexity and staff group involved. The average timeframe for live MHPS cases in May 2021 was higher in comparison to non-medical cases at 106 days for the investigation process and 148 days for the overall process. These 2 cases have been impacted through delays due to absence. The KPIs also show the % of staff from a BAME background entering into a disciplinary process. This data is now provided for both non-medical and medical (MHPS) cases. The one new disciplinary case opened in May 21 involved a member of staff from a non-BAME background. A project to work with the RCN, paused due to Covid in 2020, will resume to support measures to reduce this figure. The ER team has recommenced the Employee Relations training for managers – running remote 'bite-size' sessions on key employee relations topics. In addition a session for clinical leaders on the MHPS process took place in June 21. Grievance cases were paused during the second Covid surge and subsequently the average timeframes did increase during this period. The ER team are supporting managers in concluding these cases and the average length of case has decreased from 75 days in March to 58 days in May 2021 (this is for the entire process). The ER team meets on a monthly basis with the FTSU guardian and the Divisional HRBPs to triangulate the data with concerns raised and with the staff survey data.





NHS Foundation Trust

Council of Governors Forward Plan 2021-22

	28 January 2021 Council of Governors	11 March 2021 Briefing Session – performance, quality workforce & finance	1 April 2021 NED / Governor Strategy and Representation Group)
Statutory/Mandatory Business	 Announcement of Election results Minutes of Previous Meeting, including Action Log External Auditor appointment (VM) Lead Governor election – update COG Effectiveness evaluation Coronavirus (COVID-19) update Extension of the term of office of the Non-Executive Directors Eliza Hermann and Nilkunj Dodhia Strategy: NWL Integrated Care System (ICS) developments – update Support arrangements: The Hillingdon Hospital NHS Foundation Trust Chairman's recruitment – update Election for the Governor Advisory Committee 	Finance, including Annual Plan	People Strategy (SSm)
Papers for Information	 Chairman's Report Chief Executive Officer's Report Quality Sub-Committee Report Membership Sub-Committee Report Accessibility Working Group – update 		
Other Business	 Questions from the governors and the public Froward plan Schedule of meetings Governor attendance register Any other business 	•	•

	22 April 2021 AWAY DAY	22 April 2021 Council of Governors	20 May 2021 Briefing Session – performance, quality workforce & finance
Statutory/Mandatory Business	North West London Integrated Care System (NWL ICS) White Paper Acute provider collaboration update How does the ICS affect our Trust strategy and what is the role of the governor COG Effectiveness evaluation Role of the Governor Review of survey results COG to share experiences of being governors in other organisations and sharing learning/best practice Effectiveness of COG Sub- committees	 Minutes of Previous Meeting, including Action Log & Lead Governor election results; Governor Advisory Committee Election outcome; Coronavirus (COVID-19) update, including Elective care recovery Governor Commentary on the Quality Report 2020/21 sign-off Quality Priorities 2021-22 People and OD Committee Report to Council of Governors Business planning 2021/22 update Nominations and Remuneration Committee update, including - Substantive Chair recruitment update - NED configuration and succession plan review, including appointment of Non- Executive Directors NHSE/I letter - Interim Senior Independent Director and Deputy Chair appointments -Extension of the term of office of the Non- Executive Director Nick Gash - Committee Terms of Reference approval COG sub-committees: - Membership and Engagement Sub- Committee Terms of Reference approval - Quality Sub-Committee report, including Sub-Committee Terms of Reference approval 	• Elective recovery (RH)
Papers for Information	•	 Chairman's Report Chief Executive Officer's Report Quality Sub-Committee Report Membership Sub-Committee Report 'Thank You' to all Staff, including the Executive Directors Accessibility work update 	•

Other Business	• 22 July 2021 Council of Governors	 Questions from the governors and the public Froward plan Schedule of meetings Governor attendance register Any other business 23 September 2021 Briefing Session – performance, quality workforce & finance 	• 21 October 2021 Council of Governors
Statutory/Mandatory Business	 Minutes of Previous Meeting, including Action Log Strategy: NWL Integrated Care System (ICS) developments – update Quality: Finance & Investment Committee Report to Council of Governors; including Month 12 Financial Position (ND); Audit and Risk Committee Report to Council of Governors (NG) COG Sub-Committees: Quality Sub-Committee Report; Membership Sub-Committee Report 	• Complaints	 Minutes of Previous Meeting, including Action Log Strategy: NWL Integrated Care System (ICS) developments – update Quality: Quality Committee Report to Council of Governors (EH) COG sub-committees: Membership & Engagement Sub-Committee Report; Quality Sub-Committee Report;
Papers for Information	 Chairman's Report Chief Executive Officer's Report Performance & Quality Report; Workforce Performance Report Accessibility work update 		 Chairman's Report Chief Executive Officer's Report Governors Elections 2021 – update Performance & Quality Report, including Winter Preparedness; Workforce Performance Report Accessibility work update
Other Business	 Questions from the governors and the public Froward plan Schedule of meetings Governor attendance register Any other business 	•	 Questions from the governors and the public Governors Away Day January 2022 – plan Froward plan Schedule of meetings Governor attendance register Any other business

	9 December 2021 Briefing Session – performance, quality workforce & finance	27 January 2022 AWAY DAY NED/Governor Strategy and Representation Group	27 January 2022 Council of Governors
Statutory/Mandatory Business Papers for Information	• People •	 Strategy Finance Responsibilities and Accountability COG Effectiveness evaluation COG Engagement 	 Announcement of Election results Minutes of Previous Meeting, including Action Log Strategy: NWL Integrated Care System (ICS) developments – update Quality: People & OD Committee Report to the Council of Governors (SG) Quality Sub-Committee Report Membership Sub-Committee Report Chairman's Report
			 Chief Executive Officer's Report Performance & Quality Report; Workforce Performance Report Accessibility work update
Other Business	•	•	 Questions from the governors and the public Froward plan Schedule of meetings Governor attendance register Any other business

High Level Meetings 21/22

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Board PUBLIC	07-Jan Cancelled		04-Mar		06-May		08-Jul		09-Sept		04-Nov		06-Jan		03-Mar
	11.00-13.30		11.00-13.30		11.00-13.30		11.00-13.30		11.00-13.30		11.00-13.30		11.00-13.30		11.00-13.30
	Zoom		Zoom		Virtual		Virtual		Virtual/WMA		Virtual/CWHB		Virtual/WMA		Virtual/CWHB
Lead Governor, Chair & COG				09-Apr			08-Jul			07-Oct			13-Jan		
Informal Meeting				16.00-17.00			16.00-17.00			16.00-17.00			16.00-17.00		
				Zoom			Virtual			Virtual/CWHB			Virtual/CWHB		
Council of Governors	28-Jan			22-Apr			22-Jul			21-Oct			27-Jan		
1	16.00-17.30			16.00-18.00			10.00-11.00			16.00-18.00			16.00-17.00		
	Zoom	_		Zoom			Virtual			Virtual/CWHB			External Venue		
COG Away Day 2020/21				22-Apr											
				14.30-15.55											
		_		Zoom											
													27-Jan		
COG Away Day 2021/22													09.30-15.30		
Americal Billions beautiful Billions in a		-					22-Jul						External Venue		
Annual Members' Meeting															
							15.00-16.00 Virtual								
NED/COG Informal Meeting		-		22-Apr			VII Luai	_		21-Oct		+			
NED/COG Informat Meeting				18.00-19.00						18.00-19.00					
				Zoom						Virtual/CWHB					
COG Agenda Sub-Committee		-	25-Mar	200111		24-Jun			16-Sep	Vii taai, CVVIIB		16-Dec			25-Mar
COO / Igeniaa oub committee			16.00-17.00			16.00-17.00			16.00-17.00			16.00-17.00			16.00-17.00
			Zoom			Virtual			Virtual/CWHB			Virtual/CWHB			Virtual/CWHB
COG Quality Sub-Committee		1	26-Mar			25-Jun			24-Sep			10-Dec			25-Mar
, , , , , , , , , , , , , , , , , , , ,			10.00-12.00			10.00-12.00			10.00-12.00			10.00-12.00			10.00-12.00
			Zoom			Virtual			Virtual/WMA			Virtual/CWHB			Virtual/WMA
COG Membership & Engagement		1			19-May						18-Nov				
Sub-Committee					10.30-12.30						10.30-12.30				
					Virtual						WM Room A				
NED Nominations and				22-Apr						21-Oct					
Remuneration Committee				11.30-12.30						14.00-15.00					
				Zoom						Zoom					
NED/Governor Strategy Group				01-Apr									27-Jan		
				16.00-17.00									Part of Away Day		
				Zoom											
Briefing sessions – performance,			11-Mar		20-May				23-Sep			09-Dec			24-Mar
workforce, finance & quality			16.00-17.00		16.00-17.00				16.00-17.00			16.00-17.00			16.00-17.00
			Zoom		Virtual				Virtual/CWHB			Virtual/CWHB			Virtual/CWHB

Bank Holidays 2021/22: 01-Jan, 02-Apr, 05-Apr, 03-May, 31-May, 30-Aug, 27-Dec, 28-Dec; 3 Jan;





Council of Governors – Attendance Record 2021/22

Governor	Category	Constituency	22.04.21	22.07.21	21.10.21	27.01.22	TOTAL	27.01.22 Away Day
Nowell Anderson	Public	Hounslow	1					
Richard Ballerand	Public	Kensington and Chelsea	✓					
Juliet Bauer	Patient		✓					
Jeremy Booth	Patient		/					
Caroline Boulliat	Public	London Borough of Wandsworth	/					
Cass J. Cass-Horne	Public	City of Westminster	/					
Tom Church	Patient		/					
Nigel Davies	Public	Ealing	/					
Christopher Digby-Bell	Patient		/					
Simon Dyer	Patient		✓					
Anna Hodson-Pressinger	Patient		✓					
Elaine Hutton	Public	Wandsworth	✓					
Richard Jackson	Staff	Support, Administrative and Clerical	/					
Jodeine Grinham	Staff	Contracted	/					

Kush Kanodia	Patient		✓		
Paul Kitchener	Public	Kensington and Chelsea	1		
Minna Korjonen	Patient		1		
Thewodros Leka	Staff	Allied Health Professionals, Scientific and Technical	✓		
Anthony Levy	Public	City of Westminster	✓		
Rose Levy	Public	London Borough of Hammersmith and Fulham	✓		
Johanna Mayerhofer	Public	London Borough of Richmond upon Thames	1		
Mark Nelson	Staff	Medical and Dental	✓		
Nicole Nunes	Staff	Contracted	Х		
Fiona O'Farrell	Public	London Borough of Richmond upon Thames	✓		
David Phillips	Patient		1		
Cllr Patricia Quigley	Appointed	London Borough of Hammersmith and Fulham	✓		
Catherine Sands	Staff	Management	Х		
Jacquei Scott	Staff	Nursing and Midwifery	Х		
Dr Desmond Walsh	Appointed	Imperial College	✓		
Laura Wareing	Public	Hounslow	√		

Trusha Yardley	Public	London Borough of Hammersmith and	✓			
		Fulham				