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

Main Boardroom, Chelsea Site

5 March 2020 11:00 - 5 March 2020 13:30

INDEX

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)

Location: Main Boardroom, Chelsea site
Date: 5 March 2020
Time: 11.00 – 13.30

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence	Verbal	Chairman
11.01	1.2	Declarations of Interest, including register of interests	Report	Chairman
11.02	1.3	Minutes of the previous meeting held on 9 January 2020	Report	Chairman
11.05	1.4	Matters arising and Board action log	Report	Chairman
11.10	1.5	Chairman's Report	Report	Chairman
11.15	1.6	Chief Executive's Report	Report	Chief Executive Officer
11.20	1.7	Coronavirus update	Verbal	Chief Nursing Officer
	2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**		
11.30	2.1	Staff Experience Story	Verbal	Deputy Medical Director
11.45	2.2	Improvement programme update, including: - sepsis and e-coli deep dive	Report	Chief Nursing Officer
11.55	2.3	Learning from Serious Incidents	Report	Chief Nursing Officer
12.05	2.4	Mortality Surveillance Q3 Report	Report	Deputy Medical Director
12.15	2.5	Integrated Performance and Quality Report	Report	Deputy Chief Executive
12.25	2.6	NHSR Maternity 10 Point Plan	Report	Chief Nursing Officer
	3.0	**PEOPLE**		
12.30	3.1	People performance report	Report	Director of Human Resources & Organisational Development
	4.0	**STRATEGY**		
12.40	4.1	Draft 2020/21 Operating Plan	Report	Acting Chief Financial Officer
12.50	4.2	Digital Programme update	Report	Chief Information Officer

13.00	4.3	Estate Strategy update	Report	Deputy Chief Executive
	5.0	**GOVERNANCE**		
13.05	5.1	Guardian of Safe Working Report Q3	Report	Deputy Medical Director
13.10	5.2	Equality, Diversity and Inclusion: • Human Trafficking and Modern Slavery Act Statement • Patient Equality Report 2019-20	Report	Chief Nursing Officer
13.15	5.3	Board Assurance Framework	Report	Director of Corporate Governance and Compliance
13.20	5.4	Sub-committee Terms of Reference approval: • Quality Committee • Finance and Investment Committee • People and Organisational Development Committee • Audit and Risk Committee	Report	Director of Corporate Governance and Compliance
	6.0	**ITEMS FOR INFORMATION**		
13.23	6.1	Questions from members of the public	Verbal	Chairman
13.27	6.2	Any other business	Verbal	Chairman
13.30	6.3	Date of next meeting – 7 May 2020, Main Boardroom, Chelsea and Westminster Hospital		

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

Name	Role	Description of interest	Relevant dates		Comments
			From	To	
Sir Thomas Hughes-Hallett	Chairman	Director of HelpForce Community CIC & Trustee of Helpforce Community Trust	April 2018	Ongoing	
		Chair of Advisory Council, Marshall Institute	June 2015	Ongoing	
		Trustee of Westminster Abbey Foundation	April 2018	Ongoing	
		Chair & Founder HelpForce	April 2018	Ongoing	
		Son and Daughter-in-law – NHS employees	April 2018	Ongoing	
		Visiting Professor at the Institute of Global Health Innovation, part of Imperial College	April 2018	Ongoing	
		Partner- Nala Ventures Investments	March 2019	Ongoing	
Aman Dalvi	Non-executive Director	Director of Aman Dalvi Ltd		Ongoing	
		Owner of Aman Dalvi Ltd		Ongoing	
		Employed two days a week with Canary Wharf Group via my company advising in Planning and Regeneration		Ongoing	
		Chair of Goram Homes in Bristol	2019	Ongoing	
		Chair of Homes for Haringey - since 2017	2017	Ongoing	
		Chair of Kensington & Chelsea TMO Residuary Body	2019	Ongoing	
Nilkunj Dodhia	Non-executive Director	Directorships held in the following:			
		Express Diagnostic Imaging Ltd	Feb 2012	Ongoing	
		Macusoft Ltd - DigitalHealth.London Accelerator company	May 2017	Ongoing	
		Turning Points Ltd	Nov 2008	Ongoing	
		Examiner of St. John the Baptist Parish Church, Old Malden	April 2016	Ongoing	
		Spouse – Assistant Chief Nurse at University College London Hospitals NHS FT	Jan 2019	Ongoing	
Nick Gash	Non-executive Director	Trustee of CW + Charity	Jan 2017	Ongoing	
		Associate Director Interel (Public Affairs Company)	Nov 2015	Ongoing	
		Lay Advisor to HEE London and South East for medical recruitment and trainee progression	Nov 2015	Ongoing	
		Chair North West London Advisory Panel for National Clinical Excellence Awards	Oct 2018	Ongoing	Lay Member of the Panel throughout my time as NED

		Spouse - Member of Parliament for the Brentford and Isleworth Constituency	Nov 2015	Ongoing	
Stephen Gill	Non-executive Director	Owner of S&PG Consulting	May 2014	Ongoing	
		Chair of Trustees, Age Concern Windsor	Jan 2018	Ongoing	
		Shareholder in HP Inc	April 2002	Ongoing	
		Shareholder in HP Enterprise	Nov 2015	Ongoing	
		Shareholder in DXC Services	April 2017	Ongoing	
		Shareholder in Microfocus Plc	Sep 2017	Ongoing	
		Member of the Finance and Audit Committee (FAC), Phyllis Court Members Club	Aug 2019	Ongoing	
Eliza Hermann	Non-executive Director	Board Trustee: Campaign to Protect Rural England – Hertfordshire Branch (2013 – present)	2013	Ongoing	
		Committee Member, Friends of the Hertfordshire Way (2013 – present)	2013	Ongoing	
		Close personal friend – Chairman of Central & North West London NHS Foundation Trust	Ongoing	Ongoing	
Jeremy Jensen	Non-executive Director	Directorships held in the following:			
		Stemcor Global Holding Limited;	Oct 2015	Ongoing	
		Frigoglass S.A.I.C;	Dec 2017	Ongoing	
		Hospital Topco Limited (Holding Company of BMI Healthcare Group)	Jan 2019	Jan 2020	Ceased
		Owner of JMJM Jensen Consulting	Jan 2002	Ongoing	
		Connections with a voluntary or other organisation contracting for or commissioning NHS services: Member of Marie Curie (Care and Support Through Terminal Illness)	April 2009	Ongoing	
Dr Andrew Jones	Non-executive Director	Directorships held in the following:			
		Ramsay Health Care (UK) Limited (6043039)	01/01/2018	Ongoing	
		Ramsay Health Care Holdings UK Limited (4162803)	01/01/2018	Ongoing	
		Ramsay Health Care UK Finance Limited (07740824)	01/01/2018	Ongoing	
		Ramsay Health Care UK Operations Limited (1532937)	01/01/2018	Ongoing	
		Ramsay Diagnostics UK Limited (4464225)	01/01/2018	Ongoing	
		Independent British Healthcare (Doncaster) Limited (3043168)	01/01/2018	Ongoing	
		Ramsay UK Properties Limited (6480419)	01/01/2018	Ongoing	
		Linear Healthcare UK Limited (9299681)	01/01/2018	Ongoing	
		Ramsay Health Care Leasing UK Limited (Guernsey) Guernsey	01/01/2018	Ongoing	

		(39556)			
		Ramsay Health Care (UK) N0.1 Limited (11316318)	01/01/2018	Ongoing	
		Clifton Park Hospital Limited (11140716)	01/07/2018	Ongoing	
		Ownership or part-ownership of private companies, businesses or consultancies:			
		A & T Property Management Limited (04907113)	01/07/2014	Ongoing	
		Exeter Medical Limited (05802095)	01/12/2018	Ongoing	
		Independent Medical (Group) Limited (07314631)	01/01/2018	Ongoing	
		Board member NHS Partners Network (NHS Confederation)	01/01/2018	Ongoing	
Ajay Mehta	Non-executive Director	Director and Co-Founder at em4 Ltd - Company works with international funders and investors to build the capabilities of their grantees and partners in order to increase social impact		Ongoing	
		Owner of Ki-Rin consultancy - The agency works with leaders of non-profit organisations globally to build their capabilities		Ongoing	
		Trustee, Watermans - The organisation showcases and delivers arts programmes to communities in West London		Ongoing	
		Partner employee of Notting Hill Housing Trust - The Trust commissions the provision of care services to vulnerable people in LB Hammersmith and Fulham		Ongoing	
		Head of Foundation, The Chalker Foundation for Africa - The Foundation invests in projects that build the capacity of health-related organisations, in particular healthcare workers, in sub-Saharan Africa.		Ongoing	
Lesley Watts	Chief Executive Officer	Trustee of CW+ Charity	01/04/2018	Ongoing	
		Husband—consultant cardiology at Luton and Dunstable hospital	01/04/2018	Ongoing	
		Daughter—member of staff at Chelsea Westminster Hospital	01/04/2018	Ongoing	
		Son—Director of Travill construction	01/04/2018	Ongoing	
Robert Hodgkiss	Chief Operating Officer / Deputy Chief Executive	No interests to declare.			
Pippa Nightingale	Chief Nursing Officer	Trustee in Rennie Grove Hospice	2017	Ongoing	
		CQC specialist advisor	2016	Ongoing	
		Specialist advisor PSO	2017	Ongoing	
Dr Zoe Penn	Chief Medical Officer	Trustee of CW + Charity	01/04/2018	Ongoing	
		Daughter – employed by the Trust	01/04/2018	Ongoing	
		Member of the Independent Reconfiguration Panel, Department of Health (examines and makes recommendations to the Secretary of State for Health on proposed reconfiguration of	01/04/2018	Ongoing	

		NHS services in England, Wales and Northern Ireland)			
		Son – employed by the Trust	June 2018	Ongoing	
Thomas Simons	Director of HR & OD	Nothing to declare			
Virginia Massaro	Acting Chief Financial Officer	Cafton Lodge Limited (Company holding the freehold)	March 2014	Ongoing	
		Member of the Healthcare Financial Management Association London Branch Committee	June 2018	Ongoing	
Chris Chaney	Chief Executive Officer CW+	Trustee of Newlife Charity	June 2017	Ongoing	
Dr Roger Chinn	Deputy Medical Director	Private consultant radiology practice is conducted in partnership with spouse.	1996	Ongoing	
		Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)	01/04/2018	Ongoing	
Kevin Jarrold	Chief information Officer	CWHFT representative on the SPHERE board	01/04/2018	Ongoing	
		Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	01/10/2016	Ongoing	
Martin Lupton	Honorary NED, Imperial College London	Employee, Imperial College London	01/01/2016	Ongoing	
Serena Stirling	Director of Corporate Governance and Compliance	Local Authority Governor at Special Educational Needs School (Birmingham)	2019	Ongoing	
		Mentor on University of Birmingham Healthcare Careers Programme	2018	Ongoing	
		Leadership Mentor for Council of Deans for Health	2017	Ongoing	
		Partner is Princess Royal University Hospital site CEO at King's College Hospital NHS Foundation Trust	February 2020	Ongoing	

Minutes of the Board of Directors (Public Session)
Held at 11.00am on 09 January 2020, Room A, West Middlesex

Present:	Sir Thomas Hughes-Hallett	Chair	(THH)
	Jeremy Jensen	Deputy Chair	(JJ)
	Roger Chinn	Deputy Medical Director	(RC)
	Aman Dalvi	Non-Executive Director	(AD)
	Nilkunj Dhodia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Non-Executive Director	(SG)
	Eliza Hermann	Non-Executive Director	(EH)
	Rob Hodgkiss	Deputy Chief Executive/COO	(RH)
	Andy Jones	Non-Executive Director	(AJ)
	Virginia Massaro	Acting Chief Financial Officer	(VM)
	Ajay Mehta	Non-Executive Director	(AM)
	Pippa Nightingale	Chief Nursing Officer	(PN)
	Thomas Simons	Director of HR and OD	(TS)
	Lesley Watts	Chief Executive Officer	(LW)
	Martin Lupton	Honorary Non-Executive Director	(ML)
In attendance:	Kevin Jarrold	Chief Information Officer	(KJ)
	Sheila M Murphy	Interim Company Secretary	(SM)
	Serena Stirling	Director of Corporate Governance & Compliance	(SS)
	Karen Adewoyin	Deputy Director of HR	(KA)
	Vida Djelic (minutes)	Board Governance Manager	(VD)
	Bruno Botelho (in part)	Director of Digital Operations	(BB)
	Felix Vaal (in part)	ICT Project Manager	(FV)
	Rebecca Taylor (in part)	Hospital Youth Worker	(RT)
Apologies:	Chris Chaney	Chief Executive Officer, CW+	(CC)
	Zoe Penn	Chief Medical Officer	(ZP)

2.1	**Staff Experience Story** *Pippa Nightingale, Chief Nursing Officer* PN introduced Rebecca Taylor, the Trust's Youth Worker and 'Buddy Bags' Project Lead. Her team was awarded funding from the CW+ charity following a successful Dragons' Den-style pitch to provide 'buddy bags' for children and young people who come to our hospitals with little or no possessions. RT's story demonstrated an example of staff driving improvements in patient care and experience. EH asked how many play specialists are employed by the Trust. RT replied that there are three play specialists and two play workers; the team supports patient care by using therapeutic play techniques to meet children's individual needs, help them cope with pain, anxiety or fear during their stay in hospital; play is also used to prepare children for treatment and distract them during procedures such as injections or operations. In response to a comment from AJ about the project funding, RT confirmed that the project is sustained through charitable donations and that each 'buddy bag' is tailored to the individual patient needs e.g. age appropriate bags. AM asked if the Trust would be working in partnership with other health providers for this initiative to

	become a system-wide approach. LW replied that this can be addressed through the Provider Board. The Board recognised the opportunity for communicating and advertising this project to the wider health economy. JJ thanked RT for presenting her excellent initiative to the Board. The Board noted the report.
	A video clip of the Chelsea site Emergency Department Team Christmas dance was played, which highlighted clinical staff enthusiasm whilst working on Christmas Day. The video had been very popular on social media and was viewed 80,000 times.
1.0	**GENERAL BUSINESS**
1.1	**Welcome and apologies for absence** JJ welcomed the Board members and those in attendance to the meeting. Apologies were noted as above. JJ noted that the Chair was attending a meeting of the London Leaders and was expected to join the meeting slightly later in the morning. JJ introduced and welcomed the newly elected Public Governor Caroline Boulliat. JJ introduced and welcomed to the Board the newly appointed Director of Corporate Governance & Compliance, Serena Stirling and the Deputy Director of Human Resources, Karen Adewoyin.
1.2	**Declarations of Interest** JJ declared that he had stepped down from Hospital Topco Limited (Holding Company of BMI Healthcare Group). AD noted that he has submitted his new interests to the Board Governance Manager, which will be reflected on the next iteration of the Register of Board of Directors Interests. **Action: VD to update JJ's and AD's interests on the Register.**
1.3	**Minutes of the previous meeting held on 05 September 2019** The minutes of the previous meeting were approved as a true and accurate record of the meeting, subject to minor typographical errors that would be sent to the Director of Corporate Affairs & Compliance.
1.4	**Matters Arising and Board Action Log** **<u>Matters Arising</u>** JJ noted that all actions were marked as complete.
1.5	**Chairman's Report** *Sir Thomas Hughes-Hallett, Chair* The paper was taken as read and no questions were raised.
1.6	**Chief Executive's Report** *Lesley Watts, Chief Executive Officer*

	LW opened her report by wishing all staff, patients and friends a very happy, healthy and successful New Year. LW drew the Board's attention to the following matters: • Progress with the Strategic Partnership work; • The financial and operational performance; • The names of staff who had been recognised during the past two months; • The December Team Brief and the CEO bulletin; and • A summary of the meeting with the Regulatory bodies. LW highlighted that the past year was successful for the Trust and paid tribute to the hard work and commitment of the Trust's staff. In commending the CEO's report EH queried if the Board will be sighted on a proposal for participating in Genomics England in due course. LW stated that the Trust had previously been involved in the work of genomics along with other health partners and this programme is now led by Genomics England. RC confirmed that the programme has been subsumed by Genomics England, a company wholly funded and owned by the Department of Health and confirmed that the Board will be kept informed in due course. EH expressed that she found it disheartening to see ISS staff staging protests so soon after the Trust signed up to the London Living Wage Charter. LW confirmed that the Trust has signed up to the London Living Wage Charter and explained that it had received a notice from activists with a small number of signatories that it would hold a protest in December. However, ISS staff at Chelsea and Westminster and West Middlesex Hospitals are satisfied with the support and arrangements, in addition to UNISON members. In response to ND's question about progress with the Cultural Ambassador Programme to improve the fairness of recruitment processes for all staff, TS said that it would be covered in the People Report on the agenda later in the meeting. JJ referred to the recent news about a number of people who died last year after suffering possible side-effects of the flu jab and the need to educate staff and patients. LW noted that the signage on flu jab is available in the hospital and that currently 76% of front line staff have been vaccinated against a target of 80%. PN agreed to circulate a briefing note on flu to Board members. **Action: PN to circulate a briefing note on flu to Board members.**
2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**
2.2	**Improvement Update including Quality Improvement, Deep Dives and reducing inpatient falls** *Pippa Nightingale, Chief Nursing Officer* PN reported that the Trust is making good progress against its four quality priorities in building the culture of innovation and improvement, with a growing portfolio of quality improvement projects. The work plan to reduce inpatient falls is on track. Although 4.2% rate is well below the national average, this is expected to improve further next year as a result of Trust-wide falls prevention initiatives. JJ observed that many falls which classify as a Serious Incident (SI) occurs to patients who have been an inpatient for a prolonged period of time, due to delays in discharge as a result of insufficient community and social care support in the system. He queried if it would be possible to restrict more vulnerable patients in order to prevent falls. PN stated that due to the lack of the system support some patients stay in hospital longer than necessary, however whilst in hospital, they cannot be restrained from moving. LW noted that falls are a common health concern among older adults and have a significant impact on both the individual and the healthcare system. The importance of hospitals working together with care homes to avoid unnecessary hospital admissions plays an important part; however this requires redesign of the healthcare system.

	PN noted that the summary of quality priorities is detailed on p.39 of the meeting pack. In response to a question from AD if a risk map will be developed to monitor progress and track any risks of non- delivery, LW said that the Quality Committee oversee the delivery of the quality priorities, with granular data being discussed in Improvement Board, and high level summary presented to Board for assurance. PN also noted the following points: • The Trust continues to promote an improvement and innovation culture. • The Research, Innovation and Quality Improvement (RIQI) 2019 event, which took place on 27 November, builds on the strategy to develop a culture and environment where all staff can put forward ideas and explore how to do things better, whilst becoming more efficient, to benefit patient care. • Improving efficiency and reducing costs will also be driven through Getting It Right First Time (GIRFT). EH congratulated the Trust on the celebratory RIQI event and asked how frequently it will be arranged. LW replied that it will be an annual event and clarified that it is a refresh of the Trust's established annual research event which this year has been enriched with the innovation and quality improvement. EH noted that at January's Quality Committee meeting, the Committee learnt that the November 2019 Care Quality Commission report is expected at the end of January 2020. PN added that the initial feedback the Trust received was positive. The Board noted the report.
2.3	**Learning from Serious Incidents (SIs)** *Pippa Nightingale, Chief Nursing Officer* PN introduced the report and drew the Board's attention to the following matters: • The report provided two month's worth of data and themes were identified. • The learning aspect of the process works well, with all internal actions being completed and well embedded, with only a few external actions outstanding. SG commented that Healthcare Safety Investigation Branch (HSIB) actions should be extracted from the report and be reported on separately. PN confirmed that this would be actioned. **Action: HSIB actions to be reported separately in report. (PN)** In response to NG's query about the reporting of SIs, PN confirmed that the Trust's commissioners have formally indicated that the Trust is over-reporting on SIs, and stated that this should be perceived as having a good learning culture embedded in the Trust. In response to EH's question if there are any areas in which the Trust is under-reporting, RC confirmed that there are and education sessions were being delivered to those teams PN highlighted the importance of learning from SIs and helping the health-care system prevent similar incidents from happening again. The Board noted the report.
2.4	**Mortality Surveillance Q2** *Pippa Nightingale, Chief Nursing Officer* RC presented the report and noted that Mortality Case Review is undertaken following all in-hospital deaths and the outcome of the review process, including review completion rates and sub-optimal care

	trends/themes, are overseen by the Mortality Surveillance Group. The group also reviews mortality data drawn from a range of sources to support understanding, and to steer improvement work plans. This is further scrutinised by the Quality Committee. The Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHMI) are used by the Mortality Surveillance Group to compare relative mortality risk. The Trust-wide HSMR relative risk of mortality for the Q2 is below the expected range. In the Q2, 14 cases of sub-optimal care had been identified and the cases were discussed at local specialty Mortality and Morbidity meetings and themes identified at Mortality Surveillance Group. Sub-optimal care linked to incident investigations are reviewed by the Mortality Surveillance Group to ensure learning from both mortality review and incident investigation are identified, triangulated and cascaded. JJ asked if there is an external assurance that the Trust's process is adequate. RC confirmed that assurances are taken from neighbouring Trusts and CQC peer review. EH commented that feedback from external sources should provide adequate assurance. NG commended the report and asked if all of open cases are most complex and if learning is most likely to be taken from those cases. RC stated that some of most complex cases are open but not all, and they might be subject to other process review. He assured the Board that the Trust is picking up cases it is most likely to learn from. EH assured the Board that the Quality Committee has oversight of Mortality and Morbidity, and monitors Trust performance in these areas. The report is presented to Board for assurance. She emphasised that although the statistical data is satisfactory there is a room for improvement. THH expressed how satisfied he was that the Trust is constantly working on improving in this area and that Board members are not complacent. He suggested that an overview of the Mortality Review Process and a case study are presented at a future Board. **Action: Board to receive an overview of the Mortality Review Process and walkthrough of a case study. (RC)** The Board noted the report.
2.5	**Integrated Performance and Quality Report** *Rob Hodgkiss, Deputy Chief Executive / Chief Operating Officer* In presenting the report RH noted that no single Trust is compliant with all performance standards and drew the Board's attention to the dashboard with the following highlighted: • The Trust remains part of the Urgent and Emergency Care (UEC) test pilot and review of standards, and continues to deliver a high level of performance. • Growth in attendances to the Emergency Departments were noted, with a 5.8% increase at CW, 6.4% at WM, and a Trust wide increase of 6% in attendances compared to November 2018. • Following the roll out of Cerner on the Chelsea site, RTT performance for the Trust dropped below the national standard delivering 91.51% for November; recovery plans are in place. • Cancer 62 day performance is below the national standard; this is driven in part by the Trust addressing the backlog of patients needing treatment; there is an agreed recovery plan to deliver a compliant position for December 2019 and sustainably going forward. This involves urology and colorectal pathway reviews and how the supporting services are structured to maintain compliance. This is monitored weekly at the Cancer Access meeting. JJ commented on page 17 of the report and drew attention to the CQC Insights Report indicating the Trust was rated as 'much worse' in three performance areas. RH explained that the data and report were

	prepared by CQC, and currently there is not sufficient information made available to the Trust to be able to understand the report. LW requested that CQC insights data are accompanied by commentary where performance is identified as substandard. **Action: Commentary should be provided alongside CQC Insights data where performance is identified as substandard in future reports. (RH)** THH referred to the stability of nursing and midwifery staffing, and noted that the Trust has outstanding performance in safe staffing of clinical areas. SG drew attention to p.75/76 Safe Staffing & Patient Quality Indicator Report and queried data which appear to be below the national benchmark. PN stated that our data cannot always benchmark to the national standards and that clinical professional judgment is taken on safe staffing to accommodate the Trust's needs. **Action: Commentary should be included where the Trust is under the benchmark for Safe Staffing of clinical areas. (RH/PN)** NG queried whether the UEC test pilot data will be reviewed alongside the Trust's contribution to the pilot to determine the learning and benefits of the Trust supporting and participating in this project. RH stated that the Trust will undertake a deep dive in this area, however, the reporting process remains the same. He added that LW will confirm with the Centre how the pilot will be reported on. **Action: The Board to receive an end of UEC test pilot evaluation. (RH)** THH reported on his recent visit to another acute provider and his observation of dedicated and caring staff committed to delivering good patient care. However, he noted the estate condition was not optimal and that reminded him of how fortunate Chelsea and Westminster Hospital is with respect to capital investment and the positive impact on patient and staff experience. The Board noted the report.
3.0	**PEOPLE**
3.1	**People Performance Report** *Thomas Simons, Director of HR & OD* TS presented the report and highlighted the following: • There has been a continued decrease in the vacancy rate of all staff in November at 7.58% against the Trust ceiling of 10% and a significant improvement since the same time last year. The qualified nursing vacancy rate is at 4.66%. • Mandatory training compliance rate remains at 92%. • Sickness rate is currently 2.63% which is an increase from October although this is an improvement on November 2018 rates. • The 12 month rolling PDR rate increased in November to 92%, exceeding the 90% target. • Voluntary turnover decreased to 13.42% which is the lowest rate for over 18 months. • Work plans continue on the Equality, Diversity and Inclusion agenda, with the launch of the Cultural Ambassador Programme to improve the fairness of recruitment processes for all staff. Staff will be trained to participate in recruitment panels and add external challenge where necessary. EH thanked TS for a comprehensive report and encouraging trend in the vacancy rate, however, she said this should not be confused with the high turnover rate. AM asked if breakdown of BAME staff could accompany the report to provide an insight into equality and diversity. LW stated that 48% of our workforce identify with BAME group. The Trust plans to address this in future reports and to demonstrate that we are an inclusive organisation and reports should detail inclusivity, protected characteristics, equality and diversity. AD suggested the reporting remains as is and that breakdown of BAME staff is included in future reports. **Action: TS to provide breakdown of BAME staff in future people reports.**

	THH noted that volunteer data is not included in the report and asked TS to consider including volunteer data in future people reports. **Action: TS to consider including volunteer data in future people reports.** The Board noted the report.
4.0	**STRATEGY**
4.1	**Digital Programme update, including update on DrDoctor** *Kevin Jarrold, Chief Information Officer* KJ introduced Bruno Botelho and Felix Vaal to the Board. BB took the Board through the report and explained that following the successful implementation of Cerner EPR, the Trust is proceeding to the next phase of delivering the Digital Strategy which will enable the Trust to deliver greater quality patient care. SG asked if there are any concerns with the schedule for delivering Phase 3 of the programme during Q4. BB stated that the Trust is in a strong position to deliver during the Q4, however, there are some challenges with staff training. RH confirmed that all issues will be resolved in advance of proceeding with Phase 3. ND congratulated the team on the successful implementation and asked how it will resolve any technical issues around incompatibility with some Imperial systems. RC stated that the new system is much better than the previous and there are mitigations plans to address any clinical issues. ML stated that as a new user of Cerner it is a challenging experience having to use new language and it should be recognised that staff should be supported. LW stated that this had been discussed with individual staff and acknowledged that the previous system was inadequate. She was positive that the robust mitigations plans will address the issues. In response to THH's question about feedback from staff on the use of the new system, BB stated that younger people feel comfortable with the new technology and further support is provided to more senior staff. KJ commented that overall, staff feel very positive and enthusiastic about the new system. In response to NG's question about continued Cerner programme assurance, KJ explained that post-implementation phase risks are mitigated by the Trust. The programme is making use of internal gateway reviews in the transition phase and will provide the Board with these updates. **Action: Board to receive internal gateway updates for Cerner Programme, similar to the format used by Ernst Young for external assurance, whilst the programme transitions following the Go Live phase. (KJ)** VF, ICT Project Manager, took the Board through an update on DrDoctor and explained that it is a web based appointment and letter management system, which is integrated with Cerner. Chelsea and Westminster Hospital is the first organisation to have integrated DrDoctor to Cerner. The following points were highlighted: • DrDoctor enables patients to manage their hospital care digitally, giving them greater flexibility and control • Benefits include: reduced follow up activity; improved clinical utilisation; improved patient experience; reduced workload; reduced printing costs; ; DNA rates reduced by 25-30%; clinic utilisation increased by 5-10%; booking administration time down by 20-30%; and postage expenditure reduced by 40-50%. • Challenges: Delivering full capacity of the technology through building capacity & capability in primary care, responsive service may increase the number of referrals received and redeveloping dermatology care pathways to fully realise the benefits of artificial intelligence. **Action: DrDoctor project timelines and progress to be monitored by Executive Management Board.**

	Action: Governors Away Day to receive an update on DrDoctor, including the role of technology in facilitating a patient's journey through clinical pathways. (KJ/BB) The Board noted the report.
5.0	**GOVERNANCE**
5.1	**Guardian of Safe Working** *Roger Chinn, Deputy Medical Director* In presenting the report RC noted that it provided an overview of all exception reports and themes including work on current and anticipated rota gaps. He highlighted that the Trust has been proactive in recruiting additional Junior Clinical Fellow posts to departments where work load is perceived to be most demanding. The Trust is at the forefront of delivering the BMA's Fatigue and Facilities Charter and received funding for improving rest facilities on both hospital sites. THH commended the report and suggested that a staff story from two Junior Doctors about their experience of working in the organisation be presented at a future Board. **Action: RC to arrange for a staff story from two Junior Doctors to present their experience of working in the organisation at a future Board.** The Board noted the report.
6.0	**ITEMS FOR INFORMATION**
6.1	**Questions from members of the public** None.
6.2	**Any other business** THH reported that he had been asked to lead on a volunteering programme, namely, London Health Companions, to support the delivery of the London Vision. This programme will focus on five keys areas: Chelsea and Westminster Hospital has been selected as a hub for the volunteering vision. He stated that a proof of concept is expected to be delivered within the six months. In response to SG's question relating to KPIs, THH stated that a project plan will be developed in February and KPIs will be established.
6.3	**Date of next meeting – 5 March, Boardroom, Chelsea and Westminster**

The meeting closed at 13.30.

Trust Board Public – 9 January 2020 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
Jan 2020	1.2	Declarations of Interest	Action: VD to update JJ's and AD's interests on the Register.	VD	Complete.
	1.6	Flu	Action: PN to circulate a briefing note on flu to Board members.	PN	Complete.
	2.3	Learning from Serious Incidents/Healthcare Safety Investigation Branch	Action: HSIB actions to be reported separately in report.	PN	Complete.
	2.4	Mortality Review Process	Action: Board to receive an overview of the Mortality Review Process and walkthrough of a case study.	RC	Complete.
	2.5	Integrated Performance and Quality Report/CQC Insights Report	Action: Commentary should be provided alongside CQC Insights data where performance is identified as substandard in future reports.	RH	Complete – to be included in future reports
			Action: Commentary should be included where the Trust is under the benchmark for Safe Staffing of clinical areas.	RH/PN	Complete – to be included in future reports
		UEC test	Action: The Board to receive an end of UEC test pilot evaluation.	RH	Scheduled – May 2020 Public Board
	3.1	People Performance Report	Action: TS to provide breakdown of BAME staff in future people reports.	TS	Complete - All protected characteristics will be included in the next iteration of the disciplinary reporting and where appropriate, for indicators.
			Action: TS to consider including volunteer data in future people reports.	TS	This is under consideration and time line for inclusion will be confirmed shortly – remain open for conclusion by end of Q4.
	4.1	Digital Programme update, including update on DrDoctor	Action: Board to receive internal gateway updates for Cerner Programme, similar to the format used by Ernst Young for external assurance, whilst the	KJ	Complete - EPR Programme Board is continuing to review progress and will present to Board when developed.

			programme transitions following the Go Live phase. Action: DrDoctor project timelines and progress to be monitored by Executive Management Board Action: Governors Away Day to receive an update on DrDoctor, including the role of technology in facilitating a patient's journey through clinical pathways.		
				KJ/BB	Complete - Bruno Botelho to include in regular Digital updates to Executive Management Board.
				KJ/BB	Complete – 30 January 2020.
	5.1	Guardian of Safe Working	Action: RC to arrange for a staff story from two Junior Doctors to present their experience of working in the organisation at a future Board.	RC	Scheduled – March 2020 Public Board

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Chairman's Report
AUTHOR	Sir Thomas Hughes-Hallett, Chairman
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chairman's Report
March 2020

Coronavirus

The Trust is working closely with NHS England and Public Health England to support the national response to the Coronavirus outbreak, which includes resourcing community screening hubs, community screening cars, and 'pods' in our Emergency Departments. Containment of the virus remains a key focus.

Performance

There are continued high levels of activity across the Trust's services, specifically in non-elective demand.

Referral to Treatment performance for the trust dropped in January, but despite this drop, the trust has maintained a high level of performance.

National Apprenticeship Week

Our Trust promoted the recent 'National Apprentice Week'. Many of our current apprentices provided an inspiring glimpse into how the programme opens up a career pathway and allows them to fulfil their work ambitions.

Council of Governors

The Council of Governors hosted an Away Day on 30 January which included the newly elected Governors. This provided an opportunity for discussions on strategy, digital work programmes and quality of care. The Council also spent a period time reviewing the effectiveness of the group, and opportunities for further engagement with Trust business.

Communications and Engagement

The Trust hosts '*Your Health'* seminars, throughout the year on topics that our members tell us they want to hear about. They are open to members of the public and local communities, are free to attend and are presented by experts in their field. The next event is on 31st March, and will focus on Dementia. This will be led by one of our Consultants, Dr Ruth Mizoguchi, and take place 5–6pm, in the Main Boardroom, Lower Ground Floor, Chelsea and Westminster Hospital

Strategic Partnerships Update

The Trust continues its focus on how to lead and support the development of an Integrated Care System for North West London with two main programmes namely, the Joint Transformation Programme with Imperial Healthcare Hospitals NHS Trust, and the Hounslow Integrated Care Partnership.

Sir Thomas Hughes-Hallett
Chairman

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Chief Executive's Report
AUTHOR	Rob Hodgkiss, Deputy Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chief Executive's Report
February 2020

1.0 Introduction

The start to 2020 has been a busy one. Our hospitals have experienced increasing demand for our services through the winter months, whilst trying to ensure the change to our new Cerner system is successful, and also supporting the NHS national response to coronavirus.

We have also received our reports from the Care Quality Commission, and from the NHS Annual Staff survey, giving us much to celebrate.

2.0 Quality

It has been a wonderful thing to be able to share and celebrate with so many of our staff the results of our CQC report. To be rated 'outstanding' in our maternity service at the West–Middlesex site and our Critical Care unit on the Chelsea site, with 'good' in our other inspected services is truly exceptional and a credit to the staff involved.

We received an 'outstanding' for our use of resources, and 'outstanding' for being 'well-led'. On behalf of the Executive, I would say a huge thank you for the loyalty and commitment to patients and each other that has resulted in this fantastic achievement.

I mentioned in my previous report that the Trust has re-designed its external patient feedback pages on the website to ensure patients are correctly directed to the right team if they want to provide formal and informal feedback. I am pleased to say that we continue to see a reduction in the number of formal complaints, with more patients using the early resolution process. Performance with the formal complaints time target continues to exceed the target.

3.0 People

There has been a decrease in the vacancy rate for January, 7.17% against the Trust target of 10%, and a significant improvement since the same time last year, with both sites now having more aligned vacancy rates. This rate compares favourably with other Trusts and is in Quartile 2 on Model Hospital. We received the results of the 2019 staff survey and I'm pleased to say that 2,758 of our staff (46%) participated in the survey (an improvement from last year's response rate of 41%). This sits just below National Median Response Rate of 47%.

Where we improved since last year

Out of the 11 topics reviewed in the survey, the Quality of Appraisals section scored 6.3 (out of 10) this year, compared to the 2018 score of 6.0. All questions in this topic area were above the national average, two of which were close to meeting the Best National Score.

Improvements to *Quality of Care* and *Team Working sections* now place the Trust above the national average for all questions in both of these topic areas. Specific to *Quality of Care*, 76.5% of respondents agreed/strongly agreed with the statement 'I am able to deliver the care I aspire to' (compared to the 2018 score of 72.7%).

It is also important to note that there has been a decrease in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. For disabled staff this has reduced from 46.7% in 2018 to 42.3% in 2019. For non-disabled staff this has reduced from

40.8% in 2018 to 36.3% in 2019. Despite this being an improvement, the results still sit below the national average, so we must continue to improve these areas.

Our results around the four Workforce Race Equality Standards were mixed, with *violence from the patients, relatives and public* reducing, and *opportunities for promotion* improving. We still have work to do as the experience of BAME staff in terms discrimination from colleagues and managers has slightly worsened.

Areas we need to improve:

The areas in need of improvement are consistent with the 2018 survey. The topic of *Health and Wellbeing* maintained the same score as in 2018. The Trust is above the National Average for the questions relating to *The opportunities for flexible working patterns* and Does *your organisation take positive action on health and wellbeing?* which are positive.

Overall

The areas of focus remain broadly the same as last year and plans are in place for the following areas:

- *Health & Wellbeing*
- *Equality & Diversity & Inclusion*
- *Safety Culture*

Once again, I would thank all staff who completed the survey and I am pleased to see an increase in responses given how busy everyone was with Cerner and CQC preparations at the same time.
The full staff survey report is published at http://www.nhsstaffsurveyresults.com/

4.0 Finance and Operational Performance

The 4hr A&E standard was not achieved in January with performance of 92.16% which is an improvement on December. At a national level this standard was not met by any acute Trust, with only 6 organisations reporting performance >90%, and had we been reporting, the trust would have been 5th nationally and 2nd highest performing organisation in London. Increasing attendances year to date continue to be a challenge to performance with a 6.15% growth in attendances year to date.

RTT performance for the trust dropped in January delivering 90.31% for January at trust level. This is driven by a 0.80% drop on the Chelsea site and 0.51% on the West Middlesex site. Despite this drop the trust has maintained a high level of performance. Recovery plans are in place covering challenged specialties and issues relating to wait for first outpatient, surgical waits and the increase in data quality issues post go live. On-going training continues with teams to support recovery. Despite these challenges the trust remains in the top quartile nationally and has not reported any 52 week long waiters.

The 62 day standard is compliant for December following a backlog clearance in November; specific focus has been put into the start of the pathway ensuring that all patients are booked within 7 days of referral. Validation continues on the January position as this is not yet due. All other Cancer standards were met for the reported month.

The Trust is reporting a year to date surplus of £8.99m on a control total basis with an adverse variance of £0.03m against the YTD plan. The Trust is forecasting to achieve its year-end control total of £11.8m. Pay costs are overspent by £10.1m for the year to date, of which £5.7m relates to unidentified and slippage in cost improvement plans and £6.1m relates to overspends in medical pay, offset by underspends in nursing and other pay. The main areas of focus for the last 2 months of 2019/20 and

going into the next financial year is medical pay, particularly recruiting to vacant and hard to fill posts and reducing reliance on locums and mitigating the extended use of 'winter pressure' escalation capacity.

5.0 Strategic Partnerships

The main focus of our Strategic Partnerships work continues to be focussed on how the Trust leads and supports the development of an Integrated Care System in North West London:

- The Joint Transformation Programme with Imperial College Healthcare NHS Trust and the wider development of a Clinical Academic strategy between the two Trusts and Imperial College Medical School. Our initial programmes of HIV, Dermatology, Ophthalmology and Children's services are progressing through their 100 day challenge stages and we are now considering a second wave of joint developments.

- Hounslow Integrated Care Partnership: Alongside London Borough of Hounslow, GP Federation, Hounslow & Richmond Community Health Services Trust and West London NHS Trust we are putting in place an Alliance Agreement for 2020/21 to support our first generation Integrated Care Partnership. Activity and finance sits within our main NWL contract. NWL CCGs have specified that they see Borough based partnerships as the delivery arm of our Integrated Care System.

- CW+ continues to support us in a range of partnerships under the *CW Innovation* banner. Our most recent development Community Bridge, was launched in collaboration with the Mayor of Royal Borough of Kensington & Chelsea and work has started on site. We expect to formally open the facility in Spring 2020.

6.0 Communications and Engagement

Past and present staff from Chelsea and Westminster Hospital attended a special unveiling ceremony today of a new Westminster Green Plaque on the previous site of Westminster Hospital which celebrated its 300th anniversary last year. We were delighted to welcome both The Lord Mayor of Westminster and The Mayor of Royal Borough of Kensington and Chelsea for the unveiling. The Westminster Green Plaque Scheme marks buildings of historical interest that form a significant part of the heritage of the city.

The plaque was unveiled by Rennie and Audrey Hoare, descendants of Mr Henry Hoare who was one of the four founding donors who established the first Westminster Hospital back in 1719, making it the first hospital in the world funded by charitable giving, which continued to grow and become Chelsea and Westminster Hospital in 1993.

We are incredibly proud of our long and impressive history and it is wonderful to have this new plaque as a permanent reminder of our old hospital site where so many staff proudly cared for hundreds of thousands of Londoners over many years. The legacy of this remarkable hospital and its pioneering forefathers continues at our hospitals today.

7.0 Staff Awards

Our December PROUD Award winners are listed below:

- Emergency and Integrated Care: Rainsford Mowlem Ward, CW
- Planned Care: Dariana Murphy, Interim Clinical Facilitator for Theatre Services, CW
- Women and Children: Sally Kelly, Bereavement Midwife, WM
- Clinical Support: Sowntharya Sachchithananthasivam, HCA–Interventional Radiology, CW
- Corporate: Federica Guerra, Volunteering Administrator, CW
- Volunteers: Breastfeeding Peer Supporters, CW

Lesley Watts
Chief Executive Officer
February 2020

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	2.2/Mar/20
REPORT NAME	Improvement Programme Update
AUTHOR	Victoria Lyon, Head of Improvement
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	To report on the progress of the Trust Improvement Programme
SUMMARY OF REPORT	The Trust continues to make progress against the four quality priorities for the year and in sustaining and strengthening our culture of innovation and improvement. The paper provides a deep dive into one of the 4 trust wide quality priorities; reducing hospital acquired e-coli bloodstream infections.
KEY RISKS ASSOCIATED	Failure to continue to deliver high quality patient care
FINANCIAL IMPLICATIONS	By improving care and patient outcomes, e.g. through GIRFT, we expect to also drive improved efficiency and reduce costs.
QUALITY IMPLICATIONS	These are considered as part of the embedded Quality Impact Assessment process of the Improvement Programme.
EQUALITY & DIVERSITY IMPLICATIONS	Equality and Diversity implications have been considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
LINK TO OBJECTIVES	Deliver high-quality patient-centred care Deliver better care at lower cost
DECISION/ ACTION	For assurance.

1. Quality priorities

Quality priorities 2019/20

The quality priorities for 2019/20 are:

1. Reducing inpatient falls
2. Improving continuity of care within maternity services
3. Improving sepsis care
4. Reducing hospital acquired E.Coli bloodstream infection

In summary at the end of January headline performance is:

- Ahead or at trajectory for three priorities (1, 2 & 4)
- Behind trajectory for one priority (3) with an action plan in place to mitigate the slippage in delivery. Sepsis will be continued as quality priority in 2020/21 to maintain focus.

Performance against the key indicators is summarised in table 1 below.

Table 1: Summary of quality priorities 2019/20

Priority	Key Indicator	Baseline	End of year target	Progress	Next Steps / Commentary
1. Reducing inpatient falls	Rate of falls per 1,000 bed days	3.8	3.6	The average falls rate YTD is 3.6 (Q3)	Bitesize training on lying and standing blood pressure in progress is being rolled out from Dec-March. Falls Cerner dashboard in development and alignment with Imperial.
2. Improving continuity of carer within maternity services	% of women on a continuity of carer pathway	9%	35%	Trust performance is 30.4%	Continuity teams launched in January to improving continuity to 30.4%. Final continuity team to launch at West Middlesex site to bring % to reach 35% target.
3. Improving sepsis care	% of patients screened for sepsis	84%	90%	88% average across Q3*	Significant issues with Cerner Sepsis tool and calculation of screening results. Refinement work is priority and underway. Action plan in place to increase screening to target rates at West Middlesex. Progress seen in data since interventions put in place in Nov/ Dec.
	% of patient receiving IV antibiotics within 1hr	80%	90%	65% average across Q3*	
4. Reducing hospital acquired E.Coli BSI	Number of hospital onset E.Coli BSI cases	57	51	There were 35 hospital onset cases YTD (April 19 to January 20)	The small number of cases means that there is significant variation on a month by month basis.

Quality priorities 2020/21

Each year we set quality priorities in partnership with our patients and stakeholders, to help to deliver the Trust's quality strategy. The priorities align with one or more of the Trust's three strategic objectives and triangulate with areas of the greatest opportunities for improvement.

The proposed quality priorities for 2020/21 are:

- Improving the dementia care pathway
- Improving sepsis care
- Improving cancer care
- Improving the experience and impact of volunteers

The quality priorities are monitored through Improvement Board and assured through Quality Committee.

2. Building a culture of innovation and improvement

Our systematic approach to quality improvement has grown over a number of years and we continue to build our culture of innovation and improvement under three key streams of work;

- Building improvement and innovation capability and capacity
- Alignment of improvement priorities and opportunities
- Communications plan for awareness building and engagement.

The Trust was recognised in the well-led CQC inspection as 'Outstanding' for its use of a systematic approach to continually improving the quality of its services. The report highlighted our 'fully embedded and systematic approach to improvement and innovation', and the commitment to improving services with an extensive programme of research and innovation.

Our culture of continuous improvement and innovation was well-noted throughout the report, and we were commended on celebrating projects through Trust publicity, our improvement and innovation hub and regular events throughout the year, including the Research, Innovation and Quality Improvement (RIQI) event which took place in November 2019.

An example improvement / research project highlighted as 'outstanding' by the CQC report from critical care is outlined in Appendix 1.

3. CQC Improvement Plan

In January 2020 the Trust received the outcome of the November 2019 unannounced inspection of two core services; Maternity and Critical Care, and the outcome of the planned inspection for 'use of resources' and 'well-led' by the Care Quality Commission (CQC).

The Trust received a rating of 'Good' overall, with 'Outstanding' in 'Use of Resources' and 'Well-Led'.

Figure 1. Chelsea and Westminster Healthcare NHS Foundation Trust overall CQC rating

For the core services inspection, Maternity received a rating of 'Outstanding' at West Middlesex and 'Good' at Chelsea site. Critical Care received a rating of 'Outstanding' at Chelsea site and 'Good' at West Middlesex.

Figure 2 and 3. CQC rating split by hospital, core service and CQC domain.

Ratings for Chelsea and Westminster Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Mar 2018	Good Mar 2018	Outstanding Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Medical care (including older people's care)	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Critical care	Good → ← Jan 2020	Good → ← Jan 2020	Outstanding ↑ Jan 2020	Good → ← Jan 2020	Outstanding ↑ Jan 2020	Outstanding ↑ Jan 2020
Maternity	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Good Jan 2020
Services for children and young people	Good Mar 2018	Good Mar 2018	Outstanding Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
End of life care	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
HIV and Sexual Health Services	Good Jul 2014	N/A	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014	Outstanding Jul 2014
Overall*	Good → ← Jan 2020	Good → ← Jan 2020	Outstanding → ← Jan 2020	Outstanding ↑ Jan 2020	Good → ← Jan 2020	Outstanding ↑ Jan 2020

Ratings for West Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Medical care (including older people's care)	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Surgery	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Critical care	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Maternity	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Outstanding Jan 2020	Good Jan 2020	Outstanding Jan 2020
Services for children and young people	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
End of life care	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Outpatients	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018
Overall*	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020

The report recommended 18 'should do' actions. There were no 'must do' actions. Themes included improving workforce cover and vacancies, compliance to training and appraisals, and FFT scores.

The report also highlighted 31 examples of 'Outstanding' practice', including themes such as excellent research, training programmes for staff, use of innovation and effective leadership. The 'Outstanding' examples have been shared through each division to ensure best practice learning is implemented.

The actions from the 2019/20 CQC report will be monitored through Improvement Board and assured through Quality Committee.

4. Deep Dive – Reducing hospital acquired E.Coli bloodstream infection

E. coli bacteraemia is a potentially life-threatening bloodstream infection caused by common bacteria, also associated with less dangerous urinary tract infections, and poses a significant public health threat and is a healthcare safety issue.

What we aim to achieve during 2019/20
We will reduce the number of hospital onset *E.coli* BSIs by:

- Reducing use of urinary catheters which increase the risk of infection
- Improving adherence to best practice with respect to the use of devices; and
- Standardisation around products that are associated with a lower risk of infection

Progress against plan

There have been 35 cases of hospital onset E.coli blood stream infections from the 10 month period April 2019 to January 2020, the equivalent rate of 42 per annum. This is an improvement from 2018/19.

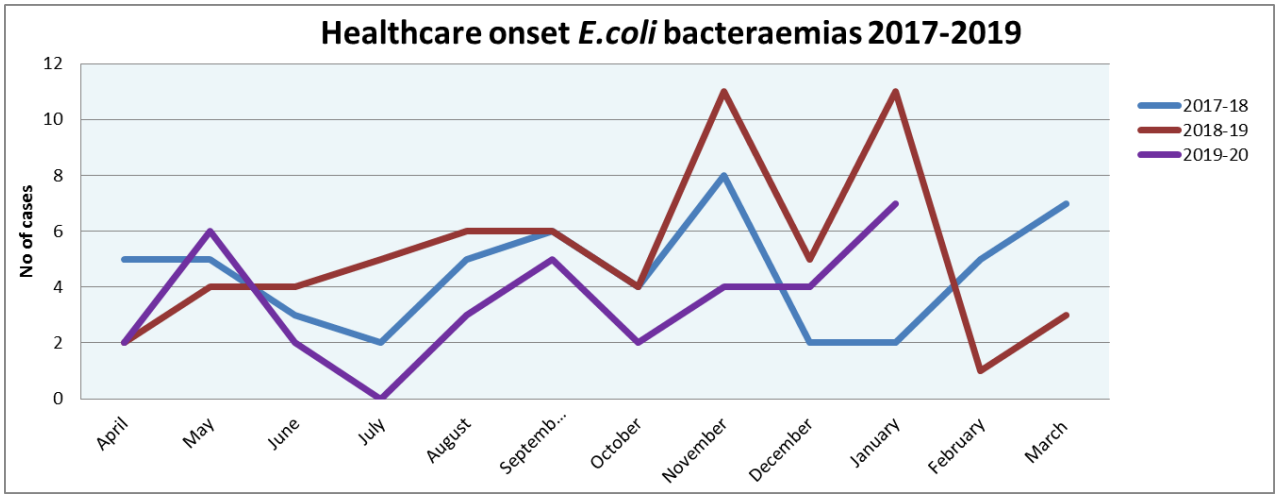
There have been no specific changes in practice driving the lower number of infections observed, compared to the previous period last year. There are limited addressable risk factors; the improvement plan has focused on UTIs and reducing use of urinary catheters as these account for the largest proportion of cases (c.50%).

Table 2: Reducing hospital acquired E.Coli bloodstream infections

	Baseline	Target	Year-to-date progress
Annual cases of hospital onset *E.coli* BSIs	57*	≤51	There have been 35 cases year-to-date (April – January 2019).

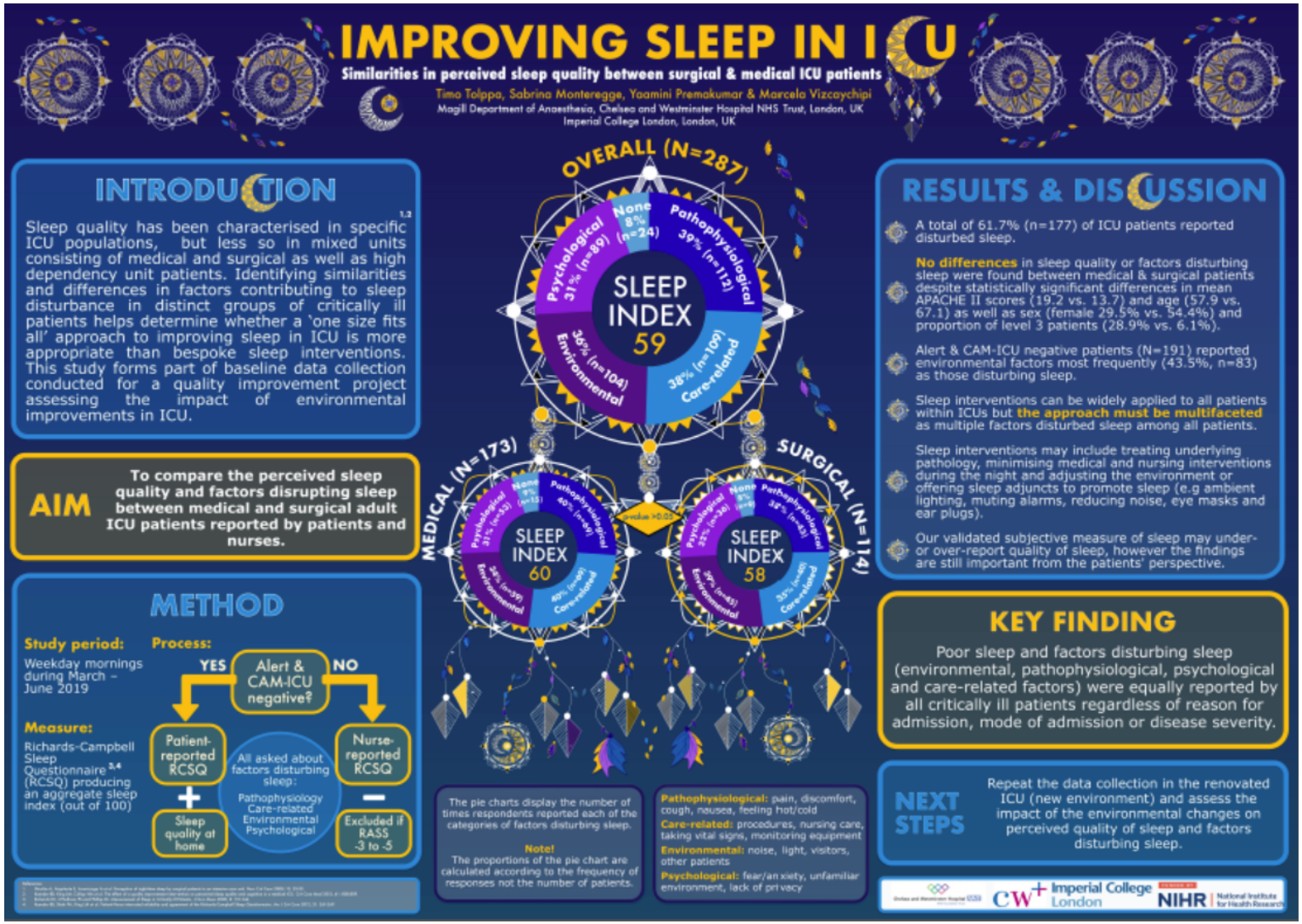
Based on a mean rate of 19.3 per 100,000 bed days between August 2018 and January 2019

Figure 4: Hospital acquired E.Coli bloodstream infections – Trust vs National Rate 2017 -2020



5. **Appendix 1**

Example research improvement project: Critical care, as highlighted in CQC outstanding



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	2.3/March/2020
REPORT NAME	Learning from Serious Incidents – Incidents reported/investigated (January 2020)
AUTHOR	Stacey Humphries – Quality and Clinical Governance Assurance Manager
LEADS	Pippa Nightingale – Chief Nursing Officer
PURPOSE	This paper updates the Board on the process compliance, key metrics and learning opportunities arising from Serious Incident investigation process.
SUMMARY OF REPORT	During the 12 month period to January 2020 the Trust reported 77 serious incidents on StEIS; of these 41 were associated with Chelsea and Westminster Hospital (CWH) and 36 with West Middlesex Hospital (WMUH). In January 2020, 6 SI reports were submitted to the Trust's commissioners: • 3 x Slips/trips/falls • 1 x Adverse media coverage or public concern about the organisation or the wider NHS • 1 x Surgical/invasive procedure incident • 1 x Blood product/ transfusion incident Root and contributory causes are identified as part of the serious incident investigation process. The following primary themes were identified during this reporting period: • Lack of adherence to Trust polices/procedures • Lack of risk assessment • Patient factors
KEY RISKS ASSOCIATED	• Reputational risk associated with Never Events. • Delayed delivery of action plans associated with serious incident investigations reduces risk reduction assurance offered by the SI investigation process.
FINANCIAL IMPLICATIONS	Penalties and potential cost of litigation relating to serious incidents and never events.
QUALITY IMPLICATIONS	Serious Incident investigation provides clinical teams with a structured approach to care and service delivery evaluation and supports the identification of learning opportunities designed to reduce the risk of harm to patients, staff and the public.
EQUALITY & DIVERSITY IMPLICATIONS	• None
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	• The Board is asked to comment on the report

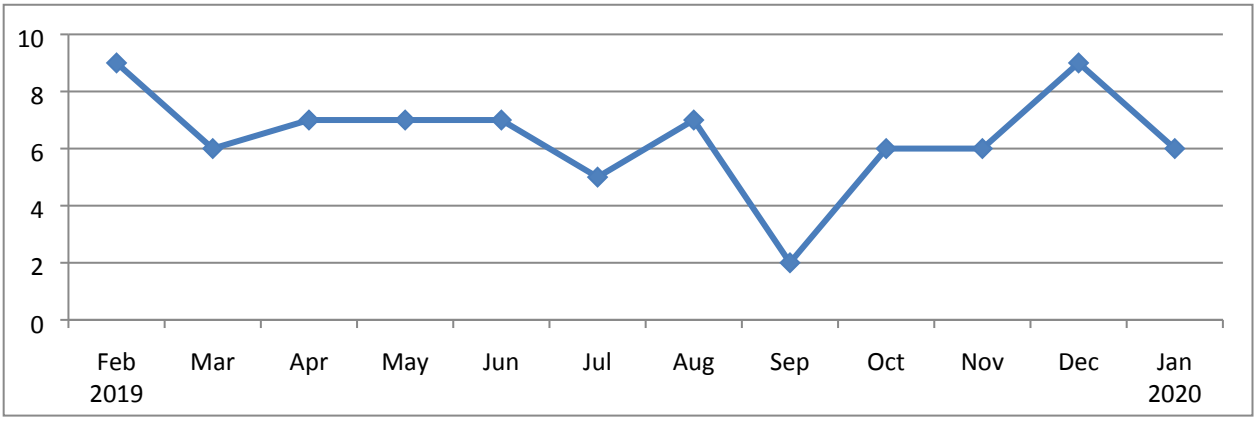
1. Introduction

This report provides an update on Serious Incidents (SIs), including Never Events, reported on the Strategic Executive Information System (StEIS) by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT). Serious incidents are reported in accordance with NHS England's Serious Incident Framework. Following investigation the reports are submitted to the Trust's commissioners for review and closure.

2. Serious Incident activity – 12 month period

2.1. Incidents reported

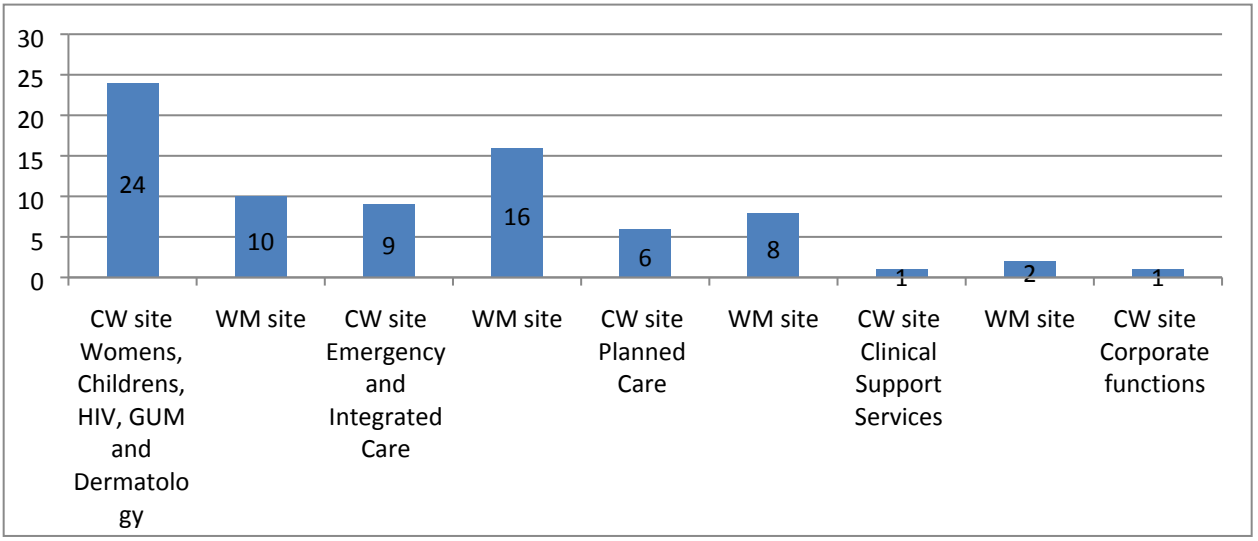
During the 12 month period to January 2020 the Trust reported 77 serious incidents on StEIS; of these 41 were associated with Chelsea and Westminster Hospital (CWH) and 36 with West Middlesex Hospital (WMUH).



Graph 1: No. of SIs reported on StEIS, February 2019 – January 2020

2.2. Division comparison

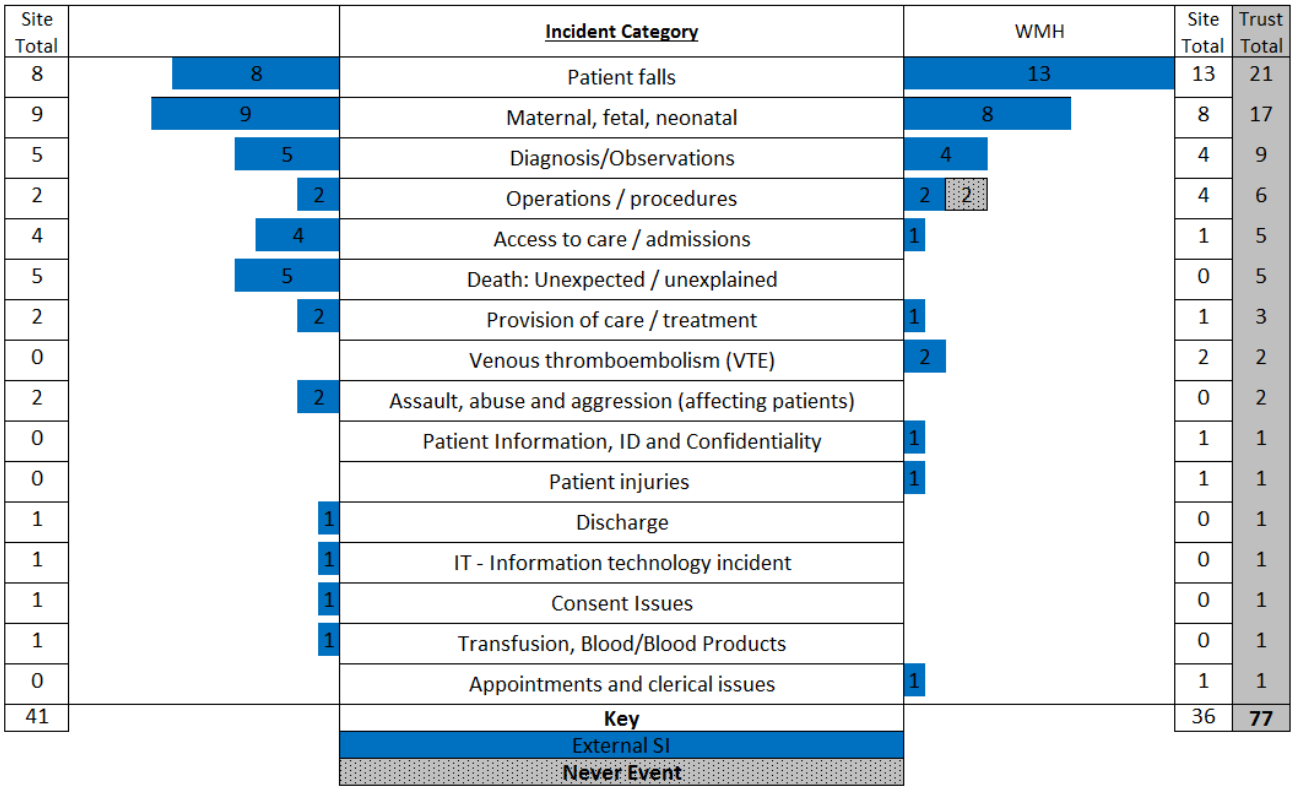
The Womens, Childrens, HIV, GUM and Dermatology division has declared 34 SIs, the Emergency and Integrated Care division has declared 25 SIs, the Planned Care division has declared 14 SIs, Clinical Support division has declared 3 SIs and the Corporate division has declared 1 SI.



Graph 2: No. of SIs reported on StEIS by division and site, February 2019 – January 2020

2.3. Categorisation

The figure below highlights the incident categories of the incidents reported by each site in the last 12 months (February 2019 – January 2020). WMUH most reported category is patient falls, whilst CWH most reported category is 'Maternal, fetal, neonatal'.



Site Total	Incident Category	WMH	Site Total	Trust Total
8	Patient falls	13	13	21
9	Maternal, fetal, neonatal	8	8	17
5	Diagnosis/Observations	4	4	9
2	Operations / procedures	2 2	4	6
4	Access to care / admissions	1	1	5
5	Death: Unexpected / unexplained		0	5
2	Provision of care / treatment	1	1	3
0	Venous thromboembolism (VTE)	2	2	2
2	Assault, abuse and aggression (affecting patients)		0	2
0	Patient Information, ID and Confidentiality	1	1	1
0	Patient injuries	1	1	1
1	Discharge		0	1
1	IT - Information technology incident		0	1
1	Consent Issues		0	1
1	Transfusion, Blood/Blood Products		0	1
0	Appointments and clerical issues	1	1	1
41	**Key**		36	**77**
	External SI			
	Never Event			

3. Serious Incidents reported in January 2020

During January 2020, 6 SIs were reported on StEIS.

Site/ Incident Category	No. of SIs reported on StEIS in January 2020
Chelsea and Westminster Hospital	3
Maternal, fetal, neonatal	1
Operations / procedures	1
Death: Unexpected / unexplained	1
West Middlesex University Hospital	3
Diagnosis/Observations	2
Maternal, fetal, neonatal	1
Total	**6**

Table 1: No. of serious incidents reported onStEIS in January 2020 by incident category and site

4. Serious Incident Action Plans

Serious Incident action plans are recorded within the Trusts incident reporting system. This increases visibility of the actions arising from incidents and offers assurance that improvement actions are being delivered to reduce the risk of recurrence. At the time of writing this report, there are 6 SI actions that have passed their expected due date as outlined within the SI investigation. Non-delivery or lack of documentation / evidence of delivery of SI action limits the assurance offered by the serious incident investigation process.

	Total
Emergency and Integrated Care	**1**
Planned Care	**3**
Women's, Children's, HIV, GUM and Dermatology	**2**
Total	**6**

Table 2: Overdue serious incidents actions by owning division

5. Serious Incident Reports submitted to Commissioners in January 2020

Site	Division	Directorate	StEIS ref	StEIS Category
CW	EIC	Specialist Medicine	2019/23069	Slips/trips/falls
CW	EIC	Specialist Medicine	2019/24470	Slips/trips/falls
WM	EIC	Specialist Medicine	2019/22990	Slips/trips/falls
WM	CSS	Patient Access	2019/23604	Adverse media coverage/ public concern about the organisation
WM	PC	Surgery	2019/26657	Surgical/invasive procedure incident
CW	W&C,HGD	Paediatrics	2019/24057	Blood product/ transfusion incident

Table 3: SI reports submitted in January 2020

Root and contributory causes are identified as part of the serious incident investigation process. The following primary themes were identified during this reporting period:

- Suboptimal Trust policies/procedures
- Lack of adherence to Trust polices/procedures
- Lack of risk assessment
- Patient factors

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Mortality Surveillance – Q3 2019/20
AUTHOR	Alex Bolton, Head of Health Safety and Risk
LEAD	Roger Chinn, Deputy Medical Director
PURPOSE	This paper updates the Board on the process compliance and key metrics from mortality review.
SUMMARY OF REPORT	The Trust wide Hospital Standardised Mortality Ratio (HSMR) relative risk of mortality, as calculated by the Dr Fosters 'Healthcare Intelligence indicator', between October 2018 and September 2019 was 70.9; this is below the expected range. Ten months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced during the twelve month period to end of September 2019. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust. Mortality case review is undertaken following all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss). The outcome of the Trust's mortality review process, review completion rates and sub-optimal care trends / themes are overseen by the Mortality Surveillance Group (MSG). The group also scrutinises mortality analysis drawn from a range of sources to support understanding and to steer improvement action. The Trust aims to review 80% of all mortality cases within 2 months of death. 341 cases for review were identified within Q2 2019/20, of these 53% have been reviewed and closed to date. In the twelve month period to end of December 2019 1300 cases were identified; 75% of which have been reviewed. 16 cases of suboptimal care have been identified within Q2 to date. Identified sub-optimal care cases have been discussed at local specialty Morbidity and Mortality (M&M) meetings and themes have been identified at MSG. Key themes arising over the last 12 months include; handover between clinical teams, delays in assessment, investigations or diagnosis, Establishing and sharing ceilings of care discussions, management of MDTs / Pathways that include external organisations, and medication errors.
KEY RISKS ASSOCIATED	Delayed review closure could lead to missed opportunities to addresses weakness in service delivery.
FINANCIAL IMPLICATIONS	Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
QUALITY IMPLICATIONS	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care

	• Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	The Board is asked to note and comment on this report

Mortality Surveillance – Q3 2019/20

1. Background

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

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

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

2. Relative risk of mortality

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

The Trust wide HSMR relative risk of mortality, as calculated by the Dr Fosters 'Healthcare Intelligence indicator', between October 2018 and September 2019 was 70.9; this is below the expected range.

Ten months of low relative risk, where the upper confidence limit fell below the national benchmark, were experienced during the twelve month period to end of September 2019. This indicates a continuing trend for improving patient outcomes and reducing relative risk of mortality within the Trust.

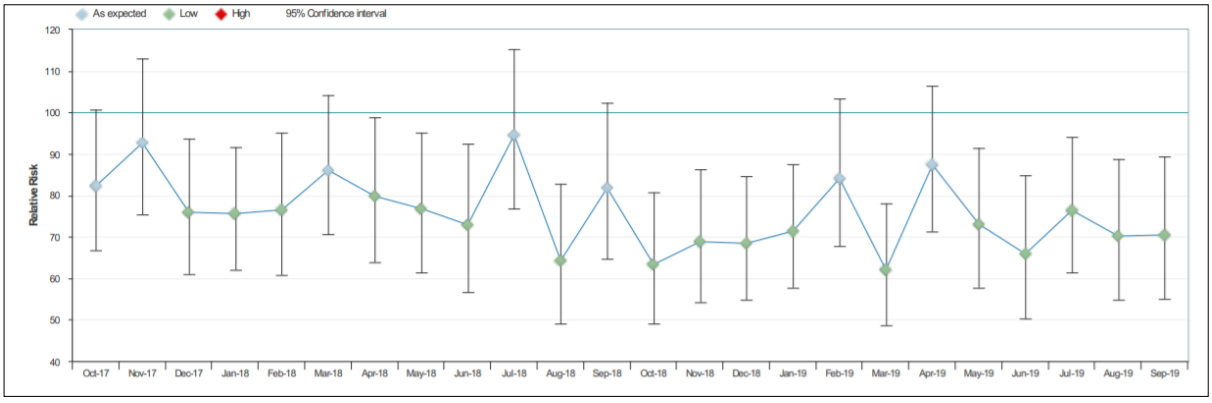


Fig 1: Trust HSMR 24-month trend (October 2017 – September 2019)

Improving relative risk of mortality has been experienced across both sites since March 2017. During the 12 month period to September 2019 the HSMR relative risk of mortality at ChelWest was 67.8 and at WestMid it was 73.1. Both sites performed below the expected range and overall the Trust compares favourably to local peer organisations.

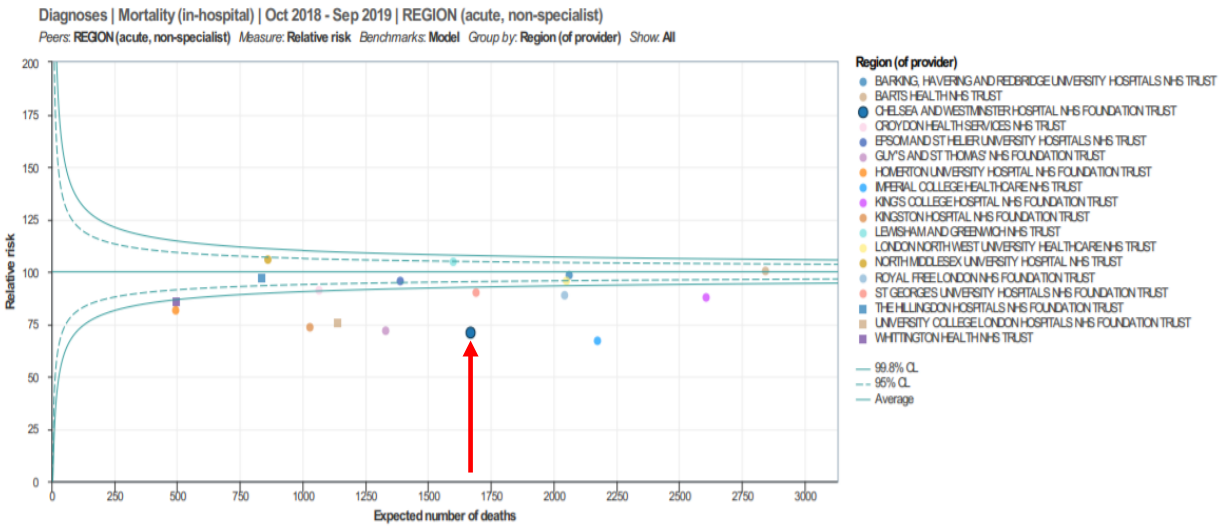


Fig 2 – Relative Risk, regional acute provider comparison (October 2018 to September 2019)

3. Diagnostic & procedure groups

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

4. Crude rate

1300 cases for review (in-hospital deaths: adult, child, neonatal, stillbirth, and late fetal loss) have been identified between January 2019 and December 2019.

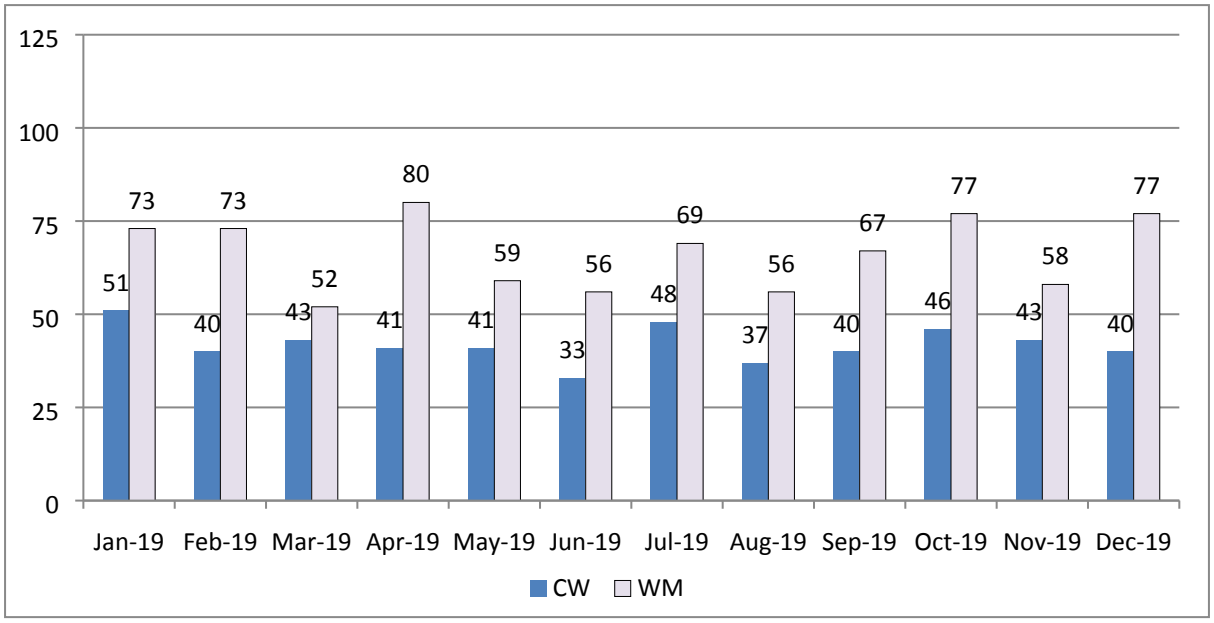


Fig 3: Total mortality cases logged to Datix by site and month, January 2019 – December 2019

5. Review completion rates

5.1. Closure target

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

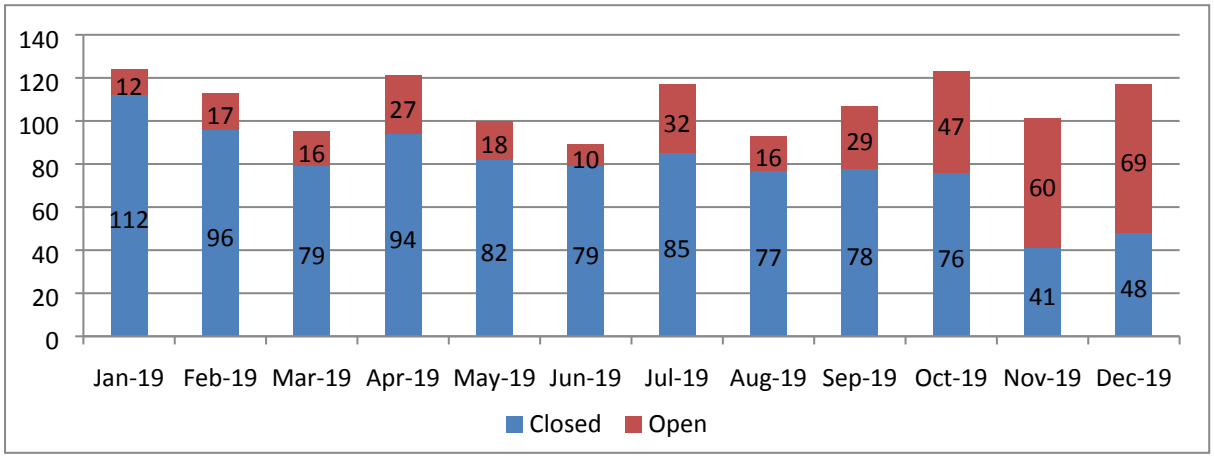


Fig 4: Open and Closed mortality cases by month, January 2019 – December 2019

1300 mortality cases (adult/ child/ neonatal deaths, stillbirths, late fetal losses) were identified for review during this 12 month period. Within Q3 there are 32 cases that are within the 2 month target to review; these cases have not been included in when calculating the percentage closed for this period.

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Total
Closed	287	255	240	165	**947**
Open	45	55	77	176	**353**
Total	332	310	317	341	**1300**
% Closed	**86%**	**82%**	**76%**	**53%**	**75%**

Table 1: Cases by financial quarter, January 2019 – December 2019

	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Total
EIC	87%	84%	80%	56%	**77%**
PCD	84%	71%	62%	43%	**65%**
WCHGD	87%	80%	63%	38%	**70%**
CSD	N/A	N/A	N/A	N/A	**N/A**
Total	**86%**	**82%**	**76%**	**53%**	**75%**

Table 2: Percentage of closed cases by division and fin. quarter, January 2019 – December 2019

The Mortality Surveillance Group has overseen the following actions to promote the review and closure of mortality cases required to achieve the 80% review within 2 months of death target:

- Mortality Surveillance Group monitoring and promoting review process
- Effectiveness of review arrangements in specialties with low review closure assessed by clinical teams / service directors
- Guidance to specialty teams regarding establishment of effective M&Ms/MDTs
- Guidance for and support for Divisional / Specialty mortality review practice provided by the Heads of Quality and Clinical Governance

6. Sub-optimal care

Cases are graded using the Confidential Enquiry into Stillbirth and Deaths in Infancy scoring system:

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

CESDI grades are initially scored by the reviewing consultant and are then agreed at Specialty MDT/M&M. All cases of suboptimal care are considered by the mortality surveillance group. Where cases are graded as CESDI 2 or 3 they are considered for Serious Incident investigation.

75 cases of suboptimal care were identified via the mortality review process between January 2019 and December 2019:

- **67 CESDI grade 1**: Unavoidable death, suboptimal care, but different management would not have made a difference to the outcome
- **6 CESDI grade 2**: Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- **2 CESDI grade 3:** Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death)

CESDI grades for closed cases occurring in Q3 2019/20

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3	Total
EIC	132	9	1	0	142
PCD	14	3	0	0	17
WCHGD	3	3	0	0	6
Total	**149**	**15**	**1**	**0**	**165**

CESDI grades for closed cases occurring in Q1 2019/20

	CESDI grade 0	CESDI grade 1	CESDI grade 2	CESDI grade 3	Total
EIC	183	7	1	0	191
PCD	34	3	0	0	37
WCHGD	6	5	1	0	12
Total	**223**	**15**	**2**	**0**	**240**

When reviewing deaths the aligned specialty considers the patient's full episode of care e.g. the mortality review aims to identify sub-optimal care that occurs prior to admission or the reviewing specialty taking on the management of that patient. This ensures that opportunities to improve the services offered by the organisation are identified across the full pathway rather than being limited to learning solely from the care provided by the specialty that was responsible for the patient at the time of death.

Maternity /Obstetrics, NICU/SCBU, and the intensive care unit have identified the most opportunities for improvement via the mortality review process; the sub-optimal care identified may have occurred within previous specialties involved in that patient's care rather than the

specialty undertaking the review therefore this should not be considered a measure of specialty safety. The identification of sub-optimal care provides assurance to the committee that specialties are engaging in the mortality review process.

7. Sub-optimal care linked to Incidents

During the 12 month period to December 2019 eight deaths were identified within the Mortality module that have been reviewed and closed with a CESDI grade 2 or 3; these cases have been considered by the Mortality Surveillance Group. When reviewing deaths the patient's full episode of care is considered e.g. the mortality review may identify issues in care occurring before admission to Trust or the reviewing specialty.

During this period the Trust identified two cases with CESDI grade 3 (probable avoidable death); both cases relate to intrauterine death/still births and were investigated as serious incidents (SIs). Following the investigation the degree of harm experienced as a direct result of the incident was confirmed as moderate (the CESDI grades were re-confirmed as grade 3). The précises for these incidents (ref. 2019/2408 and ref. 2019/3247) were considered by the Quality Committee in July 2019.

The Trust reported six cases with CESDI grade 2 (possibly avoidable death); four cases have been investigated as serious incidents and the degrees of harm following the SI investigations included one death and three moderate harms:

1. VTE incident– Death (ref. 2019/12100 précised in September 2019 SI paper)
2. Provision of care / treatment - Moderate harm (ref. 2019/12081 précised in November 2019 SI paper)
3. Patient injury – Moderate harm (ref. 2019/26657 to be précised in March 2020 SI paper)
4. Patient fall – Moderate harm (ref. 2019/25077 to be précised in May 2020 SI paper)

The other two cases graded as CESDI 2 at mortality review are associated with incidents; however, following MSG consideration two of these were confirmed as not requiring serious incident investigation.

5. Maternal - IUD/Still birth (Incident ref. INC43489, no harm) - Cause of death; placental ischemic event affecting the blood flow to the fetus. Case MM3518 submitted to the mortality surveillance group in June 2019.
6. Maternal - IUD/Still birth (ref. INC48074, low harm) - Cause of death; inflammation of the fetal membranes due to a bacterial infection (Chorioamnionitis). Case MM3924 submitted to the Mortality Surveillance Group in September 2019.

Serious Incident investigations are reviewed by the mortality Surveillance Group to ensure learning from both mortality review and incident investigation is identified, triangulated and cascaded. Robust arrangements are in place to identify potential suboptimal care from these sources of learning.

7.1. Overarching themes / issues linked to sub-optimal care

Review groups discuss the provision of care / treatment; where element of suboptimal care are identified recommendations for further action are recorded. Review themes are considered by the Mortality Surveillance Group.

The key sub-optimal care themes across both sites during this reporting period relate to:

- Handover between clinical teams
- Delays in assessment, investigations or diagnosis
- Issues establishing and sharing ceilings of care discussions
- Issues tracking patients following multidisciplinary team review / pathways that include external organisations
- Medication errors

The MSG, in coordination with other governance and operational groups, utilises learning from review to develop high level actions designed to improve outcomes, reduce suboptimal care and gather further assurance evidence. Key improvement actions tracked by the mortality surveillance are:

- Review of hospital transfer policy
- Review of approach to major haemorrhage process
- Review of handover guidance
- Management / tracking of VTE risk assessment and prophylaxis

8. Conclusion

The outcome of mortality review is providing a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality has been experienced since March 2017 and has continued within Q3 2019/20; this is an indicator of improving outcomes and safety.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Integrated Performance Report – January 2020
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 January 2020 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for January 2020. **Regulatory performance** The Trust continued to deliver a high level of performance in its UEC standards. During January the trust achieved 92.16%. The trust remains part of the UEC test pilot in to the review of standards which is set to continue in to 2020. RTT performance for the trust dropped in January delivering 90.31% for January at trust level. This is driven by a 0.80% drop on the Chelsea site and 0.51% on the West Middlesex site. Despite this drop the trust has maintained a high level of performance. Recovery plans are in place covering challenged specialties and issues relating to wait for first outpatient, surgical waits and the increase in data quality issues post go live. On-going training continues with teams to support recover. Despite these challenges the trust remains in the top quartile nationally and has not reported any 52 week long waiters. Cancer 62 day performance for December delivered a compliant position of 85.26%. All other Cancer Standards were delivered. Validation is on-going for January ahead of the final submission. DM01 Performance was sustained for the reported position in January delivering 99.14% There were 6 cases of community onset health care associated Clostridium Difficile in January. There have been 28 identified cases against a Trust tolerance of 26 for 2019/20.
KEY RISKS ASSOCIATED:	There are continued risks to the achievement of a number of compliance indicators, including A&E performance & RTT incomplete waiting times, whilst Cancer 2 week, 31 and 62 day waits remain a high priority.
QUALITY	As outlined above.

IMPLICATIONS	
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION / ACTION	The Board is asked to note the performance for January 2020 and to note that whilst some indicators were not delivered in the month, the overall YTD compliance remained good.

TRUST PERFORMANCE & QUALITY REPORT

January 2020

NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	87.96%	89.18%	90.06%	93.06%	92.15%	91.92%	93.89%	93.83%	90.31%	90.77%	92.2%	92.16%	93.49%		!
RTT	18 weeks RTT - Incomplete (Target: >92%)	90.79%	90.50%	89.70%	92.49%	92.32%	91.63%	91.12%	91.94%	91.51%	91.01%	90.31%	90.31%	92.23%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	88.25%	90.10%	86.27%	93.70%	96.72%	96.46%	96.44%	97.08%	93.61%	94.18%	92.58%	n/a	95.78%		!
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	100%	97.22%	97.30%	98.22%	100%	97.22%	97.30%	n/a	98.22%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jan-20) in this report	31 days diagnosis to first treatment (Target: >96%)	92.68%	100%	95.24%	97.08%	100%	97.44%	94.55%	98.63%	96.84%	98.63%	94.74%	n/a	97.98%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	n/a	100%	100%	n/a	n/a	100%	100%	n/a	n/a	n/a	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	100%	n/a	97.14%	100%	100%	100%	96.97%	100%	100%	100%	n/a	97.06%		-
	62 days GP referral to first treatment (Target: >85%)	57.45%	86.05%	79.31%	74.17%	56.63%	84.62%	80.65%	79.97%	56.92%	85.26%	80.22%	n/a	77.58%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	0.00%	n/a	n/a	0.00%	100%	100%	100%	77.42%	50.00%	100%	100%	n/a	72.73%		-
Patient Safety	Clostridium difficile infections (Year End Target: 26)	2	1	2	13	2	1	4	15	4	2	6	6	28		!
Learning Difficulties	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-

Please note the following three items	n/a	Can refer to those indicators not applicable (eg Radiotherapy) or indicators where there is no available data. Such months will not appear in the trend graphs.	
		RTT Admitted & Non-Admitted are no longer Monitor Compliance Indicators	! Either Site or Trust overall performance red in each of the past three months
		Note that all Cancer indicators show interim, unvalidated positions for the latest month (Jan-20) and are not included in quarterly or yearly totals	

A&E Waiting Times
The 4hr A&E standard was not achieved in January with performance of 92.16% which is an improvement on December. At a national level this standard was not met by any acute Trust, with only 6 organisations reporting performance >90%. Had we been reporting the trust would have been 5th nationally and 2nd highest performing organisation in London. Increasing attendances Year to date continue to be a challenge to performance with a 6.15% growth in attendances year to date.

RTT Waiting Times
RTT performance for the trust dropped in January delivering 90.31% for January at trust level. This is driven by a 0.80% drop on the Chelsea site and 0.51% on the West Middlesex site. Despite this drop the trust has maintained a high level of performance. Recovery plans are in place covering challenged specialties and issues relating to wait for first outpatient, surgical waits and the increase in data quality issues post go live. On-going training continues with teams to support recover. Despite these challenges the trust remains in the top quartile nationally and has not reported any 52 week long waiters.

Cancer 62 Day
The 62 day standard is compliant for December following a backlog clearance in November; specific focus has been put into the start of the pathway ensuring that all patients are booked within 7 days of referral. Validation continues on the January position as this is not yet due. All other Cancer standards were met for the reported month.

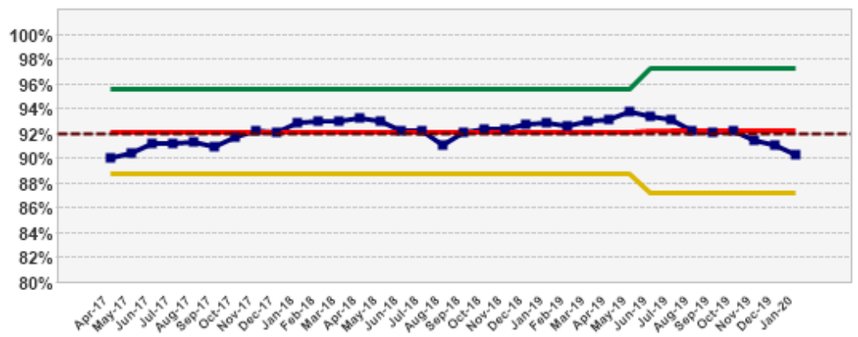
Clostridium Difficile infections
There were 6 cases of community onset health care associated Clostridium Difficile in January 2020. There have been 28 identified cases against a Trust tolerance of 26 for 2019/20 to date.

SELECTED BOARD REPORT NHSI INDICATORS

Statistical Process Control Charts for the 33 months April 2017 to January 2020

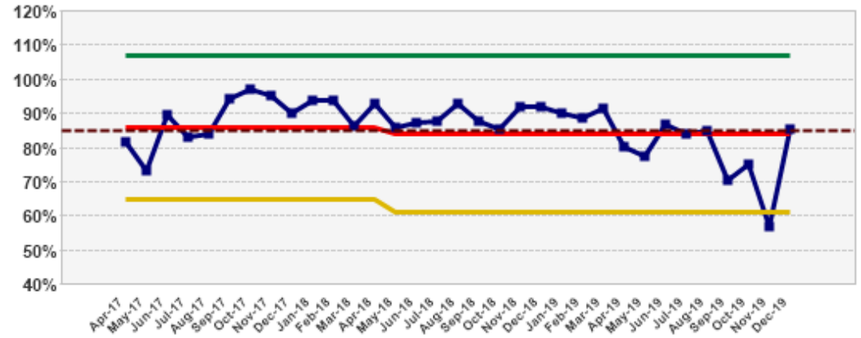
RTT Incomplete pathways

Trust Total

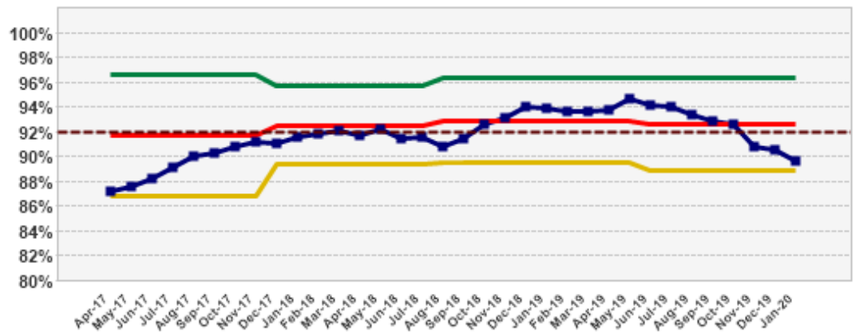


Cancer: 62 day standard

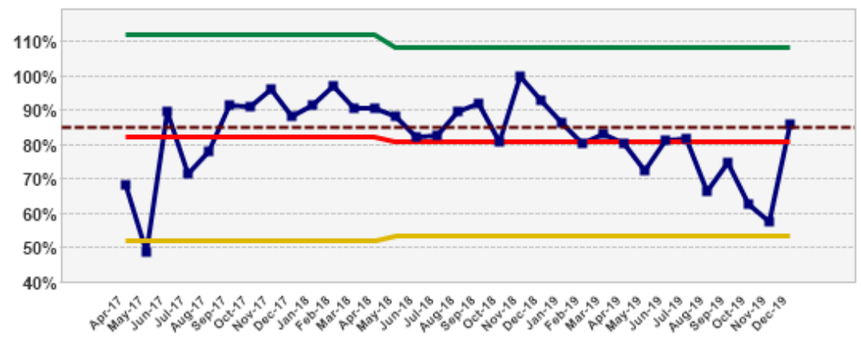
Trust Total



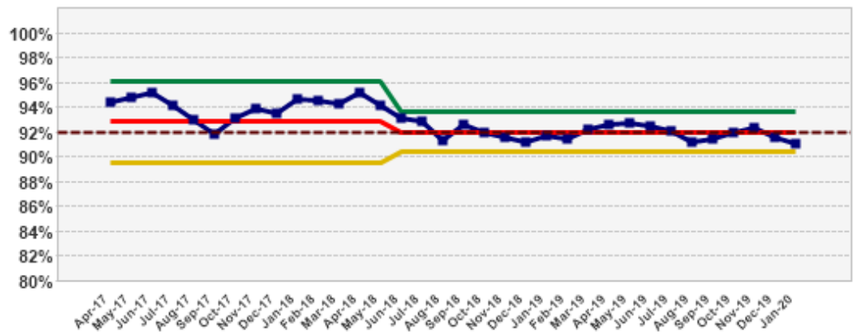
Chelsea and Westminster



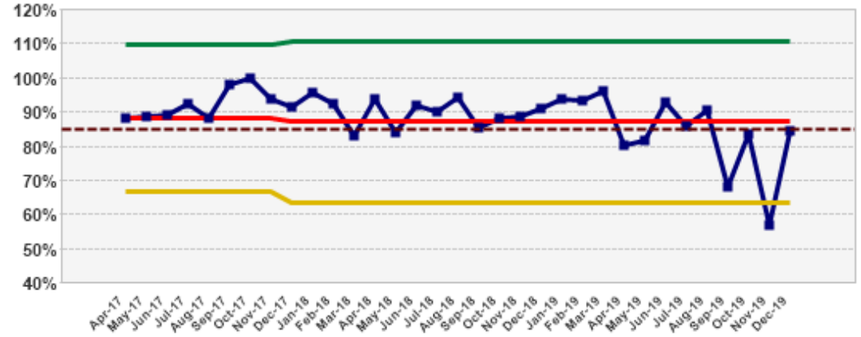
Chelsea and Westminster



West Middlesex



West Middlesex



Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	1	0	0	0	0	0	0	0	0	1		-
	Hand hygiene compliance (Target: >90%)	85.7%	94.1%	88.7%	93.7%	93.2%	86.9%	83.9%	90.4%	89.1%	90.8%	86.5%	86.5%	92.2%		-
Incidents	Number of serious incidents	3	4	3	31	3	5	3	31	6	9	6	6	62		-
	Incident reporting rate per 100 admissions (Target: >8.5)	9.4	9.2	10.7	8.4	9.5	10.0	8.7	9.0	9.5	9.6	9.7	9.7	8.7		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.03	0.09	0.03	0.02	0.00	0.04	0.03	0.01	0.02	0.06	0.03	0.03	0.02		!
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	5.34	4.68	5.62	5.42	3.83	4.58	3.58	4.11	4.60	4.63	4.63	4.63	4.76		-
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	1.3%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.8%	0.0%	0.0%	0.0%	0.2%		-
Harm	Never Events (Target: 0)	0	0	0	0	0	0	0	1	0	0	0	0	1		-
	Safety Thermometer - Harm Score (Target: >90%)	95.9%	90.2%	96.4%	93.2%	98.3%	92.7%	96.5%	95.8%	97.6%	92.0%	96.5%	96.5%	95.0%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	NEWS compliance %	97.9%	95.8%	98.6%	96.9%	93.1%	95.4%	92.7%	96.5%	95.7%	95.6%	95.9%	95.9%	96.7%		-
	Safeguarding adults - number of referrals	49	18	26	317	13	18	27	298	62	36	53	53	615		-
	Safeguarding children - number of referrals	30	35	43	470	83	77	122	934	113	112	165	165	1404		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.76	0.75	0.75	0.75	0.76	0.75	0.75	0.75	0.76	0.75	0.75	0.75	0.75		-
	Number of hospital deaths - Adult	33	30	40	328	52	64	83	608	85	94	123	123	936		-
	Number of hospital deaths - Paediatric	1	1	0	8	0	0	0	0	1	1	0	0	8		-
	Number of hospital deaths - Neonatal	0	2	1	11	4	2	2	17	4	4	3	3	28		-
	Number of deaths in A&E - Adult	4	4	2	23	5	6	5	43	9	10	7	7	66		-
	Number of deaths in A&E - Paediatric	0	0	0	2	0	1	0	5	0	1	0	0	7		-
	Number of deaths in A&E - Neonatal	0	0	0	1	0	0	0	0	0	0	0	0	1		-

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

Hand Hygiene compliance
The Trusts Hand Hygiene compliance fell below the standard in January delivering 86.5%

This was driven by a decline at both sites. An action plan led by the Division but supported by the IPCT is currently in progress to recover compliance.

Rate of patient safety incidents resulting in severe harm or death per 100 admissions

During January 2020, four incidents were reported as resulting in severe harm or death. The ChelWest site reported one incident of severe harm relating to a potential delayed diagnosis of testicular torsion. The WestMid site reported two incidents of death relating to an out of hospital maternal death and a potential delayed diagnosis and one incident of severe harm relating to a potential delayed diagnosis of cancer.

All cases have been declared serious incidents and the degrees of harm will be confirmed following SI investigations.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	93.4%	87.6%	92.7%	94.1%	94.4%	95.2%	97.2%	95.4%	94.1%	92.8%	95.3%	95.3%	94.9%		-
	FFT: Inpatient not recommend % (Target: <10%)	2.8%	4.0%	2.1%	2.1%	2.2%	1.8%	0.3%	1.4%	2.4%	2.5%	1.1%	1.1%	1.6%		-
	FFT: Inpatient response rate (Target: >30%)	14.8%	9.8%	19.1%	24.8%	21.5%	17.7%	24.7%	21.3%	18.9%	14.1%	21.9%	21.9%	22.5%		!
	FFT: A&E recommend % (Target: >90%)	87.6%	88.6%	88.6%	90.1%	85.6%	88.4%	91.6%	89.5%	86.8%	88.5%	89.4%	89.4%	89.9%		!
	FFT: A&E not recommend % (Target: <10%)	7.6%	8.0%	7.4%	6.4%	10.1%	8.1%	5.7%	7.1%	8.6%	8.0%	6.9%	6.9%	6.6%		-
	FFT: A&E response rate (Target: >30%)	17.2%	15.5%	19.2%	18.5%	17.2%	18.1%	19.2%	18.3%	17.2%	16.4%	19.2%	19.2%	18.4%		!
	FFT: Maternity recommend % (Target: >90%)	77.9%	88.9%	92.6%	92.0%	100.0%	100.0%	88.5%	94.6%	79.0%	91.5%	92.4%	92.4%	92.3%		-
	FFT: Maternity not recommend % (Target: <10%)	16.1%	10.3%	4.3%	5.3%	0.0%	0.0%	11.5%	4.0%	15.3%	7.9%	4.6%	4.6%	5.2%		-
	FFT: Maternity response rate (Target: >30%)	11.5%	12.5%	16.3%	18.7%	2.4%	10.1%	6.9%	13.0%	9.6%	11.9%	15.3%	15.3%	17.9%		!
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Complaints	Complaints formal: Number of complaints received	51	45	35	492	34	25	33	311	85	70	68	68	803		-
	Complaints formal: Number responded to < 25 days	39	20	17	337	22	16	17	211	61	36	34	34	548		-
	Complaints (informal) through PALS	229	207	234	1912	54	40	56	555	283	247	290	290	2467		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	1	10	0	0	1	1	10		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	1	0	1	2	1	0	1	1	2		-

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

Friends and family test

FFT surveys have seen an improvement in January in responses rates across all 3 domains IP and Maternity have also delivered over 90% recommend rate at the WM site which is an improvement from December. The implementation of EPR system has had an impact on the collection of FFT responses but this trend looks to be reversing. The newly appointed Patient Experience Manager is currently working closely with the ward staff to support them in addressing this in specific areas where there has been a reduction in response rate and this is having an impact.

The Emergency Department recommendation rates in January were stable from the previous month but improved by 1% with the West Middlesex site achieving over 90%.

Complaints

The number of formal complaints has decreased again this month, the Trust continue to meet the 2 working day acknowledgement target and exceed the 25 working day response rate target. The PHSO have partially upheld a complaint, the Trust are working to implement the associated action plan resulting from the complainant taking account of its recommendations.

Same Sex Accommodation

There have been no same sex accommodation breaches

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.12	5.36	2.85	3.14	2.19	4.22	1.95	2.71	2.14	5.08	2.61	2.61	3.04		-
	Average length of stay - non-elective (Target: <3.95)	3.51	3.92	3.86	3.80	3.07	3.41	3.19	3.03	3.27	3.64	3.49	3.49	3.36		-
	Emergency care pathway - average LoS (Target: <4.5)	3.99	4.54	4.60	4.24	3.56	3.92	3.59	3.41	3.72	4.16	3.99	3.99	3.71		-
	Emergency care pathway - discharges	271	258	279	2389	429	415	433	4232	700	673	713	713	6622		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	6.28%	6.06%	6.38%	4.52%	11.09%	11.22%	10.26%	11.03%	8.82%	8.69%	8.42%	8.42%	7.75%		!
	Non-elective long-stayers	494	490	514	4448	404	392	405	3942	898	882	919	919	8390		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	85.1%	82.7%	81.5%	83.8%	87.8%	90.0%	90.2%	90.4%	86.3%	85.3%	84.3%	84.3%	86.3%		-
	Operations canc on the day for non-clinical reasons: actuals	23	19	23	149	8	8	12	112	31	27	35	35	261		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	1.12%	0.95%	1.03%	0.54%	0.58%	0.69%	0.86%	0.81%	0.90%	0.85%	0.96%	0.96%	0.63%		!
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	4	6	7	34	0	1	0	21	4	7	7	7	55		!
	Theatre Utilisation (Target >85%)	62.2%	65.1%	67.3%	67.0%	73.6%	72.6%	72.8%	74.0%	65.5%	67.3%	68.9%	68.9%	69.2%		!
Outpatients	First to follow-up ratio (Target: <1.5)	2.34	2.43	2.26	2.45	1.52	1.55	1.46	1.54	1.91	1.99	1.87	1.87	2.02		!
	Average wait to first outpatient attendance (Target: <6 wks)	9.4	8.3	9.1	7.6	7.2	6.8	7.7	7.5	8.2	7.6	8.4	8.4	7.5		!
	DNA rate: first appointment	14.3%	15.3%	14.7%	11.6%	9.1%	9.3%	8.8%	10.6%	11.6%	12.4%	11.9%	11.9%	11.1%		-
	DNA rate: follow-up appointment	13.0%	11.6%	10.7%	10.2%	8.4%	8.7%	8.1%	9.1%	11.1%	10.5%	9.7%	9.7%	9.8%		-

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

Emergency re-admissions within 30 days of discharge
Emergency readmissions continue to be monitored through the Emergency Department governance processes. It is recognised that the position at West Middlesex includes patients who have planned attendances to Ambulatory Emergency Care or admission to the Emergency Department Clinical Decisions Unit, which drives performance above the expected target.

Average Los
Upon investigation, there are a small number of patients who have not been administered on Cerner correctly, following resolution of these patients the Los is within the standard and <2.9.

Daycase rate (basket of 25 procedures)
The Trust reported a combined position of 84.3% against the 85.0% standard. This is being reviewed by the service. There are a number of cases in the month that due to clinical reasons were admitted as an overnight stay.

Operations cancelled on the day for non-clinical reasons: % of total elective admissions
Indicator is being redeveloped due to data capture issues post go live. Historically the trust has used a manual process for recording cancellations and migration to the Cerner theatre module has created data anomalies that require resolution..

Theatre Utilisation
Theatre Utilisation continues to pose a challenge across both sites with 68.9% delivered, Trust-wide, during January, which is the 2nd month of improvement however, the Improvement programme continues to work through key challenges identified.

First to follow up rates
The position across the Trust has improved during January and is reflective of improvement on both sites. West Middlesex has delivered the ambition for the period. Work continues through the Out Patient productivity board to understand and improve this position ahead of ambitious plans in 20/21.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	59.0%	68.1%	81.1%	83.8%	97.4%	98.6%	95.0%	94.6%	75.4%	81.4%	87.4%	87.4%	88.8%		!
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	78.6%	94.1%		91.9%	100.0%	100.0%		90.2%	88.9%	97.1%			91.0%		-
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	86.7%	87.5%	90.9%	91.7%	92.9%	88.9%	92.3%	91.3%	89.7%	88.0%	91.7%	91.7%	91.5%		-
VTE	VTE: Hospital acquired	0	0	0	4	1	0	1	10	1	0	1	1	14		-
	VTE risk assessment (Target: >95%)	65.8%	69.2%	65.9%	86.8%	89.4%	87.2%	87.6%	77.5%	77.8%	77.6%	76.2%	76.2%	82.6%		!
TB Care	TB: Number of active cases identified and notified	2	4	3	32	7	6	8	70	9	10	11	11	102		-

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

Dementia screening case finding

CWH

Although screening improved for January we continued to have issues with the creation of a live list. This issue has now resolved and a daily list is generated for patients awaiting screening. We are currently on target to achieve above 90% for those screened in February.

WMUH

Continues to achieve 95% and above.

#NoF Time to Theatre

Data is not currently available for this indicator for January.

VTE Risk Assessment

C&W site:

Following Cerner roll out, performance has declined compared to previous months to 65.9%. There is on-going work to accuracy check performance by division and speciality. Inclusion and exclusion criteria for VTE risk assessment was applied in December 2019. Cerner VTE risk assessment alert trigger for ward locations under current review – awaiting Cerner EPR team to implement so relevant wards have Cerner VTE alert appearing.

A paper VTE risk assessment form for maternity patients was introduced as the Cerner form was not appropriate and would have led to inaccurate VTE risk assessment and inappropriate thromboprophylaxis management – currently awaiting build of the new Cerner form (ETD unknown). The APEX online tool was introduced at Chelsea site to allow midwifery staff to document if a VTE risk assessment was completed or not for electronic data capture on completion rates. The APEX tool is now being used by midwifery staff to record VTE risk assessment outcome and performance is expected to improve

WMUH site:

Performance remained stable in January 2020 (87.6%) compared to the previous months. Paper VTE risk assessment form has been implemented in all clinical areas until Cerner implementation. The APEX tool to electronically record completion rates is embedded in clinical areas. The data on APEX now refreshes every hour (between 6am and 6pm) to support staff with timely completion. VTE magnets in use on non-electronic patient noticeboards to identify patients with outstanding VTE risk assessments to prompt completion, with action at board rounds/ward visits/handovers. On-going VTE education and awareness continues.

Access Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Diagnostic waiting times <6 weeks: % (Target: >99%)	98.05%	97.62%	97.01%	97.64%	99.62%	99.71%	99.72%	99.34%	99.09%	99.09%	99.14%	99.14%	98.86%		!
	Diagnostic waiting times >6 weeks: breach actuals	49	45	52	546	19	13	18	381	68	58	70	70	927		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	8.5%	9.6%	9.1%	9.0%	8.5%	8.5%	8.7%	8.4%	8.5%	9.2%	9.0%	9.0%	8.8%		!
	A&E time to treatment - Median (Target: <60')	00:36	00:41	00:35	01:09	00:56	00:58	00:55	01:02	00:44	00:49	00:45	00:45	01:07		-
	London Ambulance Service - patient handover 30' breaches	44	46	54	287	80	60	43	436	124	106	97	97	723		-
	London Ambulance Service - patient handover 60' breaches	3	1	2	10	0	1	0	1	3	2	2	2	11		!

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

LAS Handovers

The Emergency Departments continue to perform well on ambulance handover targets with 97.5% of handovers within 30 minutes at West Middlesex and 96.9% at Chelsea site.

There were 2 x 60 minute ambulance breach at Chelsea during the month.

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	Trend charts	
Birth indicators	Total number of NHS births	481	465	506	4919	400	396	381	4006	881	861	887	887	8925		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	35.2%	38.7%	39.0%	36.2%	28.9%	29.4%	29.3%	30.0%	32.3%	34.4%	34.8%	34.8%	33.4%		!
	Midwife to birth ratio (Target: 1:30)	1:29.5	1:29.5	1:29.5	1:29.5	1:29	1:29	1:29	1:29	1:29.25	1:29.25	1:29.25	1:29.25	1:29.43		-
	Maternity 1:1 care in established labour (Target: >95%)	95.9%	91.9%	94.1%	96.1%	98.5%	97.3%	97.2%	97.3%	97.1%	94.4%	95.5%	95.5%	96.6%		-
Safety	Admissions of full-term babies to NICU	14	9	14	182	n/a	n/a	n/a	n/a	14	9	14	14	182		-

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

Caesarean Births
CW site - (39%) Caesarean births. Year to date 36.2% - increase on last month of 0.3%
WM site - (29.3%) Caesarean births. Year to date 30.0%- decrease on last month of 0.1%

The services continue to support women who choose to have an ELCS provided they follow the maternal request for Caesarean section pathway. This clinic is run by experienced consultant midwives who counsel the women and where appropriate encourage them to aim for a vaginal birth. The Chelsea Site is now running a maternal request workshop that is facilitated by a consultant midwife and consultant obstetrician. There is a current review of 'Birth after Caesarean section' guideline and pathway in order to support increased uptake of vaginal birth after Caesarean at the Chelsea site by increasing the support for women opting for an induction of labour.

1:1 care in labour
This has been recovered in the month of January

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	Nov-19	Dec-19	Jan-20	2019-2020	YTD breaches	Nov-19	Dec-19	Jan-20	2019-2020	YTD breaches	Nov-19	Dec-19	Jan-20	2019-2020 Q4	2019-2020	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Breast	n/a	n/a	n/a	n/a		66.7%	100%	77.8%	92.6%	7.5	66.7%	100%	77.8%	n/a	92.6%	7.5		-
	Colorectal / Lower GI	54.5%	100%	100%	77.0%	8.5	37.5%	100%	100%	82.3%	7	47.4%	100%	100%	n/a	79.7%	15.5		-
	Gynaecological	66.7%	n/a	50.0%	51.9%	7.5	66.7%	80.0%	66.7%	80.0%	4.5	66.7%	80.0%	60.0%	n/a	67.7%	12		!
	Haematological	50.0%	100%	0.0%	83.3%	3.5	100%	100%	100%	87.5%	1.5	71.4%	100%	50.0%	n/a	85.2%	5		-
	Head and neck	n/a	100%	100%	71.4%	2	100%	n/a	50.0%	80.0%	1.5	100%	100%	75.0%	n/a	75.0%	3.5		-
	Lung	100%	100%	100%	91.7%	0.5	100%	100%	40.0%	92.3%	2	100%	100%	57.1%	n/a	92.0%	2.5		-
	Sarcoma	n/a	n/a	n/a	n/a		n/a	0.0%	n/a	75.0%	1	n/a	0.0%	n/a	n/a	75.0%	1		-
	Skin	100%	100%	100%	95.1%	3.5	100%	100%	75.0%	98.3%	1.5	100%	100%	83.3%	n/a	96.1%	5		-
	Upper gastrointestinal	n/a	100%	100%	54.5%	5	n/a	100%	100%	69.6%	3.5	n/a	100%	100%	n/a	62.2%	8.5		-
	Urological	42.9%	60.0%	81.8%	55.3%	35	34.3%	64.3%	90.9%	64.4%	45	37.5%	62.1%	87.9%	n/a	60.9%	80		!
	Urological (Testicular)	n/a	n/a	n/a	100%	0	n/a	100%	n/a	100%	0	n/a	100%	n/a	n/a	100%	0		-
	Site not stated	n/a	n/a	n/a	100%	0	n/a	n/a	n/a	100%	0	n/a	n/a	n/a	n/a	100%	0		-

Please note the following	n/a	Refers to those indicators where there is no data to report. Such months will not appear in the trend graphs	!	Either Site or Trust overall performance red in each of the past three months
	Please note that all indicators show interim, unvalidated positions for the latest month (Jan-20) and are not included in quarterly or yearly totals			

Trust commentary

January performance continues to be validated ahead of submission

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CQUIN Dashboard

January 2020

National CQUINs (CCG commissioning)

No.	Description of Indicator	Responsible Executive (role)	Forecast RAG Rating
CCG1a	Antimicrobial Resistance - lower urinary tract infections in older people	Chief Medical Officer	
CCG1b	Antimicrobial Resistance - antibiotic prophylaxis in colorectal surgery	Chief Medical Officer	
CCG2	Staff Flu Vaccinations	Chief Nursing Officer	
CCG3a	Alcohol and Tobacco - Screening	Chief Medical Officer	
CCG3b	Alcohol and Tobacco - Tobacco Brief Advice	Chief Medical Officer	
CCG3c	Alcohol and Tobacco - Alcohol Brief Advice	Chief Medical Officer	
CCG7	Three high impact actions to prevent hospital falls	Chief Nursing Officer	
CCG11a	Same Day Emergency Care (SDEC) - Pulmonary Embolus	Chief Operating Officer	
CCG11b	Same Day Emergency Care (SDEC) - Tachycardia with Atrial Fibrillation	Chief Operating Officer	
CCG11c	Same Day Emergency Care (SDEC) - Community Acquired Pneumonia	Chief Operating Officer	

National CQUINs (NHSE Specialised Commissioning)

No.	Description of Indicator	Responsible Executive (role)	Forecast RAG Rating
PSS1	Medicines Optimisation and Stewardship	Chief Medical Officer	
SDS1	Secondary Dental Services	Chief Operating Officer	

2019/20 CQUIN Schemes Overview

Nationally, CQUIN scheme content has been reduced in comparison with 2018/19, as has the associated funding. It has been agreed with Specialised Commissioning that the 'Medicines Optimisation and Stewardship' indicator will be our sole focus in 19/20. Our agreement with CCG Commissioners is that payment will reflect 100% achievement for the year, but with our commitment that each indicator will be delivered on a 'reasonable endeavours' basis and, where possible, quarterly evidence submitted in the normal way. This is the same as the approach agreed for 18/19.

2019/20 National Indicators (CCG commissioning)

The key change to note from 18/19 is that CQUIN funding has been reduced from 2.5% of contract value, to 1.25%. The number of indicators has been limited to 5 accordingly. The forecast RAG rating for each indicator relates only to expected delivery of the specified milestones, not financial achievement (which is guaranteed).

2019/20 National Indicators (NHSE Specialised Commissioning)

The key change to note from 18/19 is that CQUIN funding has been reduced from 2% of contract value, to 0.75%. The number of indicators has been reduced accordingly. The forecast RAG rating for each scheme reflects both expected delivery of the milestones and the associated financial performance.

2019/20 CQUIN Outcomes

NHSE Specialised Commissioning has confirmed that the Trust achieved 100% for the Medicines Optimisation indicator for both Q1 and Q2. The outcome of the Q1 assessment from NWL CCGs was 34% for all indicators combined. Delivery RAG ratings have been updated accordingly.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Safe Staffing & Patient Quality Indicator Report – Chelsea Site

January 2020

Ward	Day		Night		CHPPD	CHPPD	CHPPD	National Benchmark	Vacancy	Voluntary Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents		FF scores 2018/19 Q4
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA	Total			Qualified	Un-qualified	Moderate		Severe						
												month	YTD	month	YTD	month	YTD	month	YTD	
Maternity	95.8%	83.1%	96.1%	87.6%	10.8	3.9	14.7	14.9	-3.0%	14.5%	10.2%							9	67	
Annie Zunz	110.7%	80.6%	100.0%	96.8%	5.9	2.3	8.2	8	21.6%	48.4%	0.0%							1	15	100.0%
Apollo	102.0%	93.5%	100.0%	-	8.5	1.1	9.6	12.1	-13.3%	25.5%	57.1%							2	21	100.0%
Jupiter	129.7%	63.6%	131.5%	-	11.6	1.7	13.3	12.1	14.1%	23.9%	80.0%							2	18	100.0%
Mercury	101.2%	92.9%	101.5%	-	7.6	1	8.6	9.4	20.0%	22.5%	57.5%							2	19	94%
Neptune	106.7%	67.7%	108.4%	-	8.2	0.7	8.9	12.1	7.8%	25.4%	66.7%							5	19	100.0%
NICU	95.7%	59.5%	97.2%	-	19	0.7	19.7	27	9.1%	10.4%	0.0%							8	79	
AAU	104.8%	67.9%	105.9%	81.0%	10.6	2.2	12.8	8.5	15.9%	8.6%	64.7%		1				1	7	86	89.4%
Nell Gwynne	124.1%	62.1%	171.0%	88.5%	5.5	2.9	8.4	7.3	-4.9%	18.5%	0.0%							1	24	100.0%
David Erskine	95.3%	90.7%	97.6%	111.0%	3.5	3	6.5	7.3	4.9%	34.5%	11.9%		2					3	30	83.3%
Edgar Horne	121.2%	66.3%	135.5%	100.0%	4.1	2.5	6.6	6.7	6.7%	10.9%	19.8%		1					9	39	85.7%
Lord Wigram	97.1%	97.7%	100.0%	101.1%	4.2	2.8	7	7	13.5%	22.8%	0.0%		2					1	27	100.0%
St Mary Abbots	96.0%	64.3%	93.1%	94.3%	4.4	2.5	6.9	7.3	21.2%	35.0%	11.1%							3	28	100.0%
David Evans	101.9%	93.5%	100.0%	152.2%	6	2.6	8.6	7.3	0.9%	21.9%	0.0%		1					1	4	95.2%
Chelsea Wing	77.8%	99.1%	100.2%	88.0%	42.8	27.5	70.3	7.3	13.8%	19.1%	25.3%							2	16	100.0%
Burns Unit	97.6%	96.7%	103.1%	100.0%	23.6	3.3	26.9	N/A	4.1%	11.1%	30.0%							2	7	
Ron Johnson	98.0%	103.3%	102.2%	103.2%	5	2.8	7.8	7.6	-0.7%	17.1%	10.5%							1	51	85.7%
ICU	100.0%	-	101.2%	-	23.6	0.1	23.7	27	10.9%	19.2%	0.0%						1	5	48	
Rainsford Mowlem	91.6%	81.3%	97.6%	92.9%	3.1	2.7	5.8	7.3	6.7%	17.0%	0.0%							5	29	67.6%
Nightingale	94.6%	58.8%	97.6%	92.9%	4.3	3.1	7.4	6.7	N/A	N/A								7	18	43.5%

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Safe Staffing & Patient Quality Indicator Report – West Middlesex Site

January 2020

Ward	Day		Night		CHPPD	CHPPD	CHPPD	National Benchmark	Vacancy	Voluntary Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents		FF scores 2018/19 Q4
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA	Total			Qualified	Un-qualified	Moderate		Severe						
												month	YTD	month	YTD	month	YTD	month	YTD	
Maternity	95.5%	79.6%	102.5%	95.7%	6.7	2.2	9.9	14.9	-1.3%	4.0%	9.4%							2	22	
Lampton	99.8%	118.5%	100.0%	138.3%	3	3	6	7.3	5.8%	541.5%	10.1%		3					0	9	100.0%
Richmond	103.9%	94.8%	132.2%	118.7%	7.3	3.1	10.4	7.3	15.3%	18.0%	0.0%							0	8	95.8%
Syon 1	102.8%	94.0%	130.8%	103.4%	4.6	2.7	7.3	7.3	17.9%	4.6%	1091.0%							4	26	75.0%
Syon 2	96.9%	80.6%	100.2%	101.3%	3.4	2.5	5.9	7	23.5%	13.7%	9.6%		2					1	30	95.3%
Starlight	105.8%	-	126.3%	-	9.5	0	9.5	12.1	-5.0%	1414.5%	0.0%							3	30	100.0%
Kew	107.2%	97.2%	114.0%	168.0%	3.5	3	6.5	7.3	9.2%	18.6%	7.4%				1			5	26	100.0%
Crane	100.0%	109.5%	100.0%	108.0%	3.2	3.2	6.4	6.7	19.4%	5.5%	0.0%		1					1	19	90.0%
Osterley 1	105.8%	149.9%	102.4%	212.2%	3.5	3.8	7.3	7.3	13.6%	10.4%	15.5%		1		1			9	67	91.8%
Osterley 2	106.5%	104.7%	116.1%	101.6%	4	3.3	7.3	7.3	7.0%	6.6%	12.5%							1	27	97.8%
MAU	103.9%	74.5%	99.4%	86.2%	6.8	2.4	9.2	8.5	9.2%	5.9%	24.4%		2				1	3	112	98.4%
CCU	100.0%	113.0%	100.0%	-	5.7	1.3	7	8	8.2%	0.0%	0.0%							2	14	94.9%
Special Care Baby Unit	78.3%	80.6%	73.8%	41.9%	9.3	1.1	10.4		16.3%	0.0%	0.0%							0	20	100.0%
Marble Hill 1	100.3%	94.9%	101.6%	182.0%	3.9	3.8	7.7	7.3	20.6%	19.7%	29.0%		2				1	0	30	83.6%
Marble Hill 2	98.6%	97.9%	103.3%	100.0%	2.6	2.1	4.7	7.3	9.2%	10.5%	0.0%							4	21	100.0%
ITU	100.9%	-	100.4%	-	25.7	0	25.7	27	6.6%	20.4%	0.0%							5	39	

Safe Staffing & Patient Quality Indicator Report

January 2020

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 from the same month and staffing vacancy/turnover and patient experience for the previous month. Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on outcomes. Please note that CHPPD scores are inclusive of Apprentice Nursing Associates which are now required to be reported separately to NHSI. The Trust is compliant with this request.

AAU, AMU, Nightingale, Edgar Horne & Nell Gwynne had difficulties filling day bank shifts for HCAs throughout January and the risk was mitigated by daily review, moving staff when required and nursing staff assisting HCAs. A number of staff are progressing through the recruitment process. Nell Gwynne had high fill rates for RNs due to the number of tracheostomy patients requiring enhanced care. Edgar Horne, Juniper and Lampton required RMNs for the care of mental health patients. Juniper reduced the HCAs they used to compensate for this extra support. Kew, Marble Hill 1 and Osterley 1 had high fill rates for HCAs on nights due to additional staffing being required to care for confused mobile patients at risk of falls and absconding.

The CHHPD ratio for Chelsea Wing was extremely high due to extremely low activity. An additional 76 day case patients were cared for on the unit but these patients are not accounted for in the midnight census. CHPPD is high on Richmond due to Day Surgery patients not being counted, as the patient census is taken at midnight. There are high fill rates on Richmond at night due to high acuity and recovering day surgery patients into the evening.

In January there were no falls with moderate or severe harm at either site and no level 3, 4 or unstageable pressures sores for the month

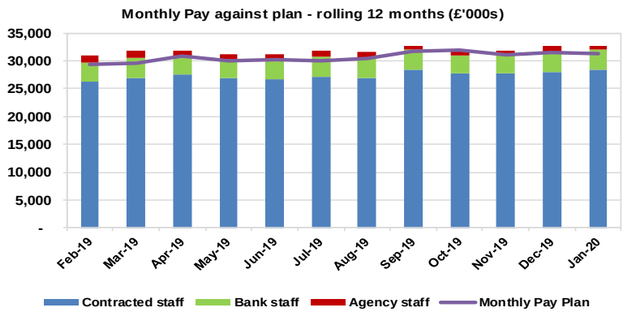
Family and friends test scores relate to December 2019. Lampton, Starlight, Kew, SCBU and Marble Hill 2 at West Middlesex Site and Annie Zunz, Apollo, Jupiter, Neptune, Nell Gwynne, Lord Wigram, SMA and Chelsea Wing at the Chelsea Site scored 100% of patients being likely to recommend the ward to their friends or family if they needed similar care or treatment. The lowest score was for Nightingale ward with 43% of patients likely to recommend the ward to their friends or family if they needed similar care or treatment. The winter pressure beds had been staffed with a number of temporary staff during December and fill rates for HCAs was low. Since then recruitment of more permanent staff to the unit has occurred and the recommendation rates for January 2020 are suggestive of an improvement to over 80%. Turnover and vacancy rates also relate to December 2019.

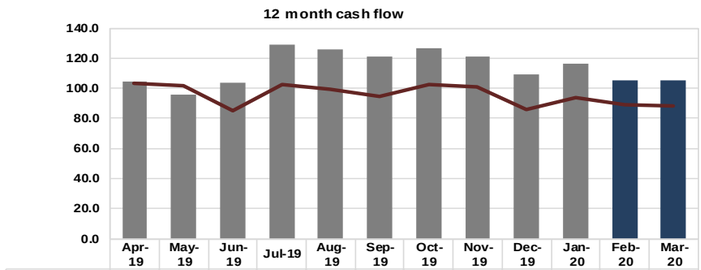
In line with recommendations by the National Quality Board (2016) and the Developing Workforce Safeguards (2018) guidance, actual staffing levels have been compared with staffing levels required according to the bi-annual patient's acuity and dependency assessments utilising the Shelford Safer Nursing Care tool. In early July 2019 this data was presented to Trust Board in line with other staffing and quality metrics. As part of this safe staffing review, the Chief Nurse & Medical Director confirmed in a statement to the Board that they were satisfied with the assessment that staffing is safe effective and sustainable.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance Dashboard
Month 10 2019-20 Integrated Position

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	561,731	574,594	12,863
Expenditure			
Pay	(309,025)	(319,154)	(10,129)
Non-Pay	(215,898)	(212,418)	3,480
EBITDA	36,809	43,022	6,213
EBITDA %	6.55%	7.49%	0.93%
Depreciation	(14,417)	(14,753)	(336)
Non-Operational Exp-Inc	(13,375)	(1,335)	12,041
Surplus/Deficit	9,016	26,934	17,918
Control total Adj - Donated asset, Impairment & Other		(17,945) 0	
Surplus/Deficit on Control Total basis	9,016	8,990	(26)





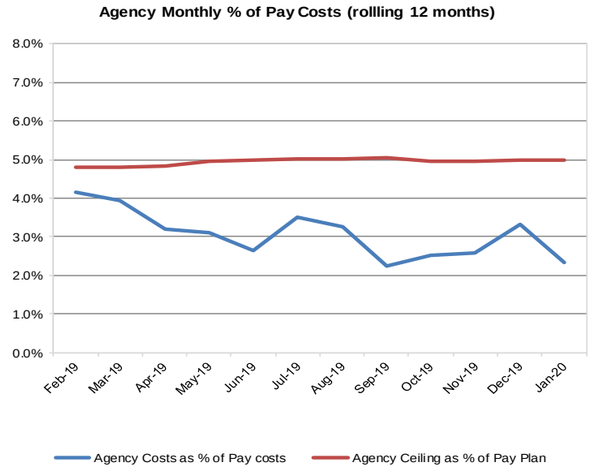
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Forecast			0.0								105.6	105.4
Actual	104.1	95.9	103.7	128.7	125.8	121.3	126.7	120.7	108.8	116.6		
Plan	103.1	101.5	85.3	102.8	99.3	94.3	102.2	100.9	85.9	93.4	89.2	88.4

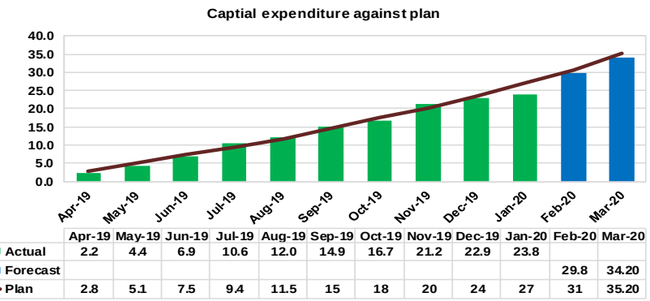
The favourable cash variance to plan in M10 of £23.2m is favourable cash variance b/fwd from M9 of £22.9m, higher cash receipts to plan of £5.1m (settlement of Local Authority debt, PDC Drawdown and Grant receipt for the Wave 2 Test Beds and receipt of Q4 MRET) offset by higher cash outflows to plan £4.8m (higher payroll, higher creditor payments and lower VAT refund).

The Trust is reporting a YTD surplus of £8.99m on a control total basis with an adverse variance of £0.25m against the YTD plan.

Income: Income was just below plan, considering a very high monthly phasing. Maternity deliveries, emergency admissions and GUM activity were the main over performing areas, since outpatients are blocked for NWL CCGs. Uncoded activity was unusually high in month and some activity still missing from January's data due to Cerner capture issues which are being dealt with.

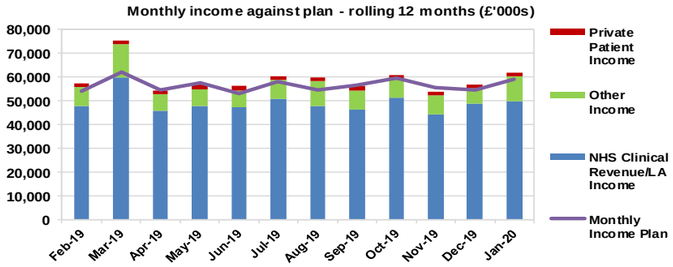
Pay is adverse by £10.13m YTD. The Trust continues to use bank and agency staff to cover vacancies, sickness and additional activity. However, the main contributor to this position are unidenifiied CIPs and idenified red and amber CIP schemes.

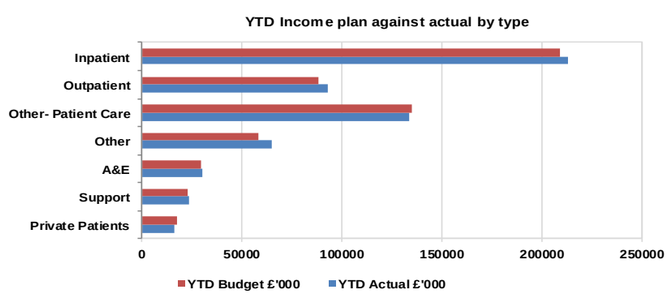


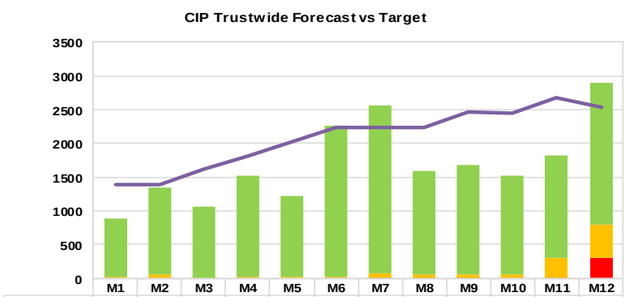


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Actual	2.2	4.4	6.9	10.6	12.0	14.9	16.7	21.2	22.9	23.8		
Forecast											29.8	34.20
Plan	2.8	5.1	7.5	9.4	11.5	15	18	20	24	27	31	35.20

The Trust has spent £23.83m at the end of month 10. This is £3.08m less the planned year to date spend of of £26.91m. The major variance is against NICU which is £2.42m overspent against its planned profiled year to date spend of £8.74m, less the underspends on medical equipment replacement £1.67m, Treatment Centre £1.36m, maintenance projects £1.23m, Majorie Ward Air Conditioning £0.46m and RIS project £0.59. It is envisaged that these projects will be fully spent by 31.3.2020.







	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Green	862	1299	1047	1496	1193	2245	2497	1542	1625	1452	1514	2098
Amber	18	52	10	21	26	20	70	47	55	66	296	496
Red	0	0	0	0	0	0	4	4	4	0	10	310
Target	1396	1396	1622	1816	2029	2242	2245	2246	2459	2446	2674	2529

Use of Resources Rating	Jun 19 (YTD) Plan	Jun 19 (YTD) Actual
Capital Service rating	2	2
Liquidity rating	1	1
I&E Margin rating	1	1
I&E Margin Distance from Financial Plan		1
Agency rating	1	1
UORR before override M3		1
UORR after override M3		1

BPPC % of bills paid in target	Year to date		
	Current Month %	Previous Month (%)	Movement %
By number	93.8%	95.1%	-1.4%
By value	84.6%	84.6%	0.0%
Creditor days	120	116	3
Debtor days	36	38	(2)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March / 2020
REPORT NAME	Maternity CNST 10 point safety plan
AUTHOR	Victoria Cochrane Director of Midwifery
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	To report on the progress against the CNST safety 10 point plan
SUMMARY OF REPORT	This report provides a summary of the purpose of the CNST maternity 10 point plan with the organisation's achievement of the 2019/20 year two plan, and the plan to deliver year 3.
KEY RISKS ASSOCIATED	• Failure to continue to deliver high quality patient care • Failure to deliver 2019/20 financial improvement and efficiency targets
FINANCIAL IMPLICATIONS	Lack of achieving the 10% CNST premium reduction
QUALITY IMPLICATIONS	The national plan sets clear expectations that trust that achieve the 10 point plan will achieve safer quality outcomes.
EQUALITY & DIVERSITY IMPLICATIONS	The plan identifies that women from a BAME background should be provided with continuity of care, the trust has plans to achieve this.
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For assurance

NHSR Incentive scheme year two & year 3 – maternity

This paper is to provide assurance and a progress update on the NHSR maternity incentive scheme for year two and plans in place to achieve year 3 to the Trust Public Board.

Background

The Maternity safety CNST scheme was implemented in 2018/19 as a financial incentive to drive quality improvements and safer outcomes in maternity care nationally. Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Of clinical negligence claims nationally in 2018/19, obstetrics claims represented ten per cent (1,068) of clinical claims by number, but accounted for 50% of the total value of new claims, £2,465.5 million of the total £4,931.8 million.

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety, with each provider receiving a 10% reduction in their CNST maternity premium if all 10 safety steps were achieved.

Maternity services across Chelsea and Westminster Healthcare NHS Foundation Trust were successful in their compliance in both year one and two of the scheme, meeting all 10 safety standards. As a result of this received the monetary incentive of £1.4 million in 2019-20. As the majority of trusts did not meet the 10 safety standards further money was distributed to the trusts that were complaint therefore Chelsea and Westminster received a further £400,000 incentive.

Year 3 of the scheme 2020/21

The year 3 standards for 2020/21 have just been published and the Division have created a gap analysis and work plan to achieve the standards by March 2021. The progress of this work is monitored through the divisional quality board and executive board.

Below outlines the full achievement for 2019-20 against the safety standards.

Safety Standard	CW Compliance
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
Are you submitting data to the Maternity Services Data Set to the required standard?	
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	
Can you demonstrate an effective system of medical workforce planning to the required standard? Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	
Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	

Year 3 of the NHSR Incentive Scheme

The overarching standards are the same but have been stretched to include additional areas of compliance. Achieving the 10 standards in full in 20/21 will result in the Trust receiving a £2.2 million reduction. Achieving this may also result in an additional incentive as in 19/20. The Scheme is also working with NHSE to implement an assurance process of the compliance in 20/21 as year's 1 and 2 have just been made on self-declaration.

A high level action plan has been developed as tabled below that outlines the changes in the standards, our current compliance with the safety standards. The service is confident that the work plan will ensure that full completion of the standards are achieved in year 3

Safety Action	Changes for 20-21 compliance	Current compliance for new 20-21 standards
1, Perinatal mortality review tool	No changes to requirement	
2, Maternity Services Data Set	MSDS v2.0	
3, Demonstrate that you have transitional care services to support the recommendations made in the ATAIN programme	Pathways of care for admission into TC have been jointly approved by maternity and neonatal teams	
4, Can you demonstrate an effective system of clinical workforce planning to the required standards	No changes	
5, Can you demonstrate an effective system of midwifery workforce planning to the required standard	• A clear breakdown of BirthRate+ or equivalent calculation to demonstrate how the required establishment has been calculated	
6, Can you demonstrate compliance with all five elements of the saving babies lives care bundle version 2	• A new element to reduce preterm birth • Recording of CO measurement at 36 weeks • Women who attend with reduced fetal movements should have a computerised CTG • New posts for midwifery obstetric fetal monitoring leads	
7, Demonstrate a mechanism for gathering service user feedback, and work with service users with the MVP to coproduce local maternity services	• No change	
8, Can you evidence that at least 90% of each maternity unit staff group have attended an 'in house' multi professional maternity emergencies training session within the last training year?	• Staff group increased to include neonatal staff • Twice yearly in situ training • Neonatal resuscitation training should also be included	
9, Can you demonstrate that the trust safety champions (obstetric and midwifery) are meeting bimonthly with board level safety champions to escalate locally identified issues?	• The executive sponsor for the MNHSC is actively engaging with supporting quality and safety improvement within the trust and Local learning system (LLS) • The champion have taken steps to address named safety concerns and that progress with actioning these are visible to staff. • A clear plan for achieving 51% of women receiving continuity of carer	
10, Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification Scheme?	• No changes	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

PUBLIC SESSION

Board of Directors Meeting, Thursday 5th March 2020

AGENDA ITEM NO.	March/2020
REPORT NAME	People and OD Committee KPI Dashboard
AUTHOR	Karen Adewoyin, Deputy Director of People and OD
LEAD	Thomas Simons, Director of Human Resources & Organisational Development
PURPOSE	The People and OD Committee KPI Dashboard highlights current KPIs and trends in workforce related metrics at the Trust. There is not a scheduled People and OD Committee in February, however there has been a review of performance at the Workforce Development Committee in February.
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
KEY RISKS ASSOCIATED	The need to continue to focus on staff engagement and retention to reduce turnover rates further.
FINANCIAL IMPLICATIONS	Costs associated with high turnover rates and reliance on temporary workers.
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability.
EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the People and Organisational Development Committee

Month 10 – January 2020

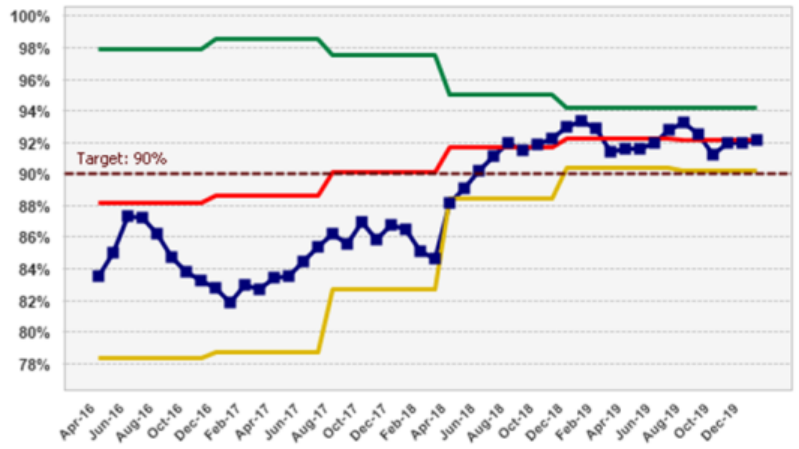
Statistical Process Control – April 2016 to Jan 2020

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

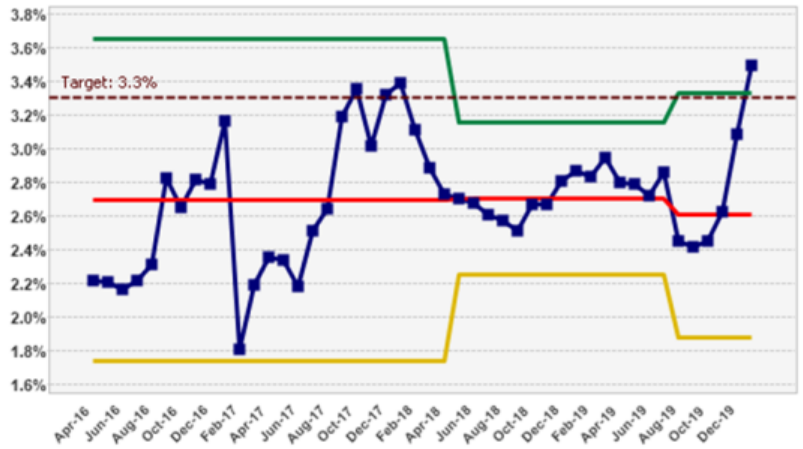
WORKFORCE INDICATORS

Statistical Process Control Charts for the 46 months April 2016 to January 2020

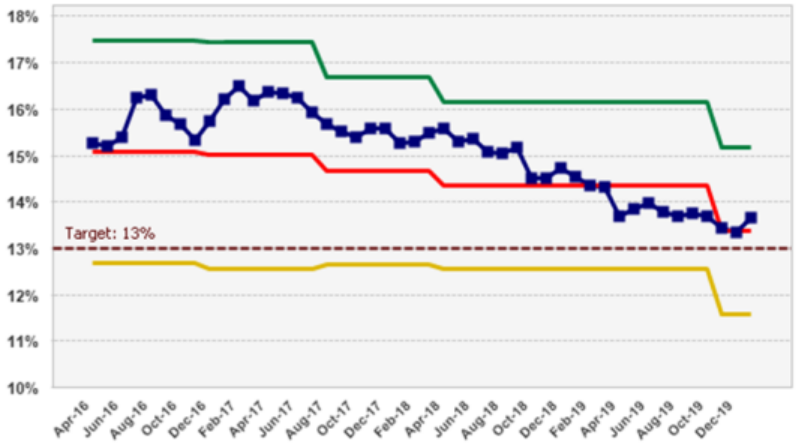
Mandatory Training compliance



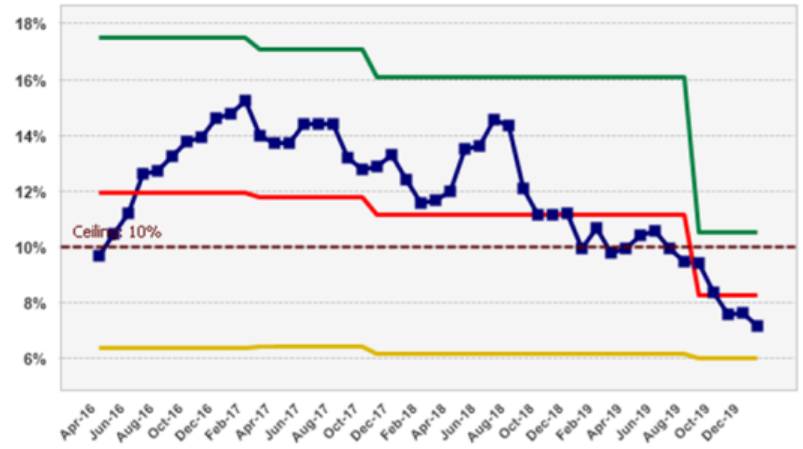
Sickness absence



Staff voluntary turnover rate



Vacancy rate



People and Organisational Development Workforce Performance Report January 2020
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

Item	Units	This Month Last Year	Last Month	This Month	Target / Ceiling	RAG Status			Trend
						Red	Amber	Green	
1. Workforce Information									
1.1 Establishment	No.	6226.51	6,357.33	6,358.28					↑
1.2 Whole time equivalent	No.	5611.73	5871.76	5902.18					↑
1.3 Headcount	No.	6115	6365	6397					↑
1.5 Overpayments (Number)	No.		32						↓
1.4 Overpayments (Costs)	£		145,461						↓
2. HR Indicators									
2.1 Sickness absence	%	2.87%	3.08%	3.50%	<3.3%				↑
2.2 Long Term Sickness absence	%	1.17%	1.41%	1.65%					↑
2.3 Short Term Sickness absence	%	1.70%	1.67%	1.85%					↑
2.4 Gross Turnover	%	19.00%	17.86%	18.16%	<17%				↑
2.5 Voluntary Turnover	%	14.55%	13.35%	13.65%	<13%				↑
3. Employee Relations									
3.1 Live Employment Relations Cases	No.		141	132					↓
3.2 Formal Warnings	No.		1	1					↔
3.3 Dismissals	No.		1	1					↔
4. Temporary Staffing Usage									
4.1 Total Temporary Staff Shifts Filled	No.	14775	13691	15022					↑
4.2 Bank Shifts Filled	No.	12593	11944	13207					↑
4.3 Agency Shifts Filled	No.	2182	1747	1815					↑
5. Vacancy									
5.1 Trust Vacancy Rate	%	9.87%	7.64%	7.17%	<10%				↓
5.2 Corporate	%	9.07%	1.98%	3.69%	<10%				↑
5.3 Clinical Support Services	%		10.64%	10.91%	<10%				↑
5.4 Emergency & Integrated Care	%	8.85%	9.12%	7.91%	<10%				↓
5.5 Planned Care	%	12.63%	9.72%	10.09%	<10%				↑
5.6 Women's, Children and Sexual Health	%	8.00%	5.02%	3.56%	<10%				↓
6. Recruitment (Non-medical)									
6.1 Offers Made	No.		104	143					↑
6.2 Pre-employment checks (days)	No.		25.0	19.1	<20				↓
6.3 Time to recruit (weeks)	No.		8.60	7.64	<9				↓
7. PDRs Undertaken (AfC Staff over 12 months)									
7.1 Trust PDRs Rate (AfC Staff)	%	85.20%	89.95%	87.70%	≥90%				↓
7.2 Corporate	%	70.78%	95.33%	92.06%	≥90%				↓
7.3 Clinical Support Services	%		87.04%	81.68%	≥90%				↓
7.4 Emergency & Integrated Care	%	89.88%	92.73%	92.66%	≥90%				↓
7.5 Planned Care	%	85.74%	93.54%	93.36%	≥90%				↓
7.6 Women's, Children and Sexual Health	%	85.93%	85.21%	82.23%	≥90%				↓
8. Mandatory Training									
8.1 See Appendix 1 for details on Mandatory Training									

People and Organisational Development Workforce Performance Report January 2020
Key Performance Indicators

Chelsea and Westminster Hospital NHS Foundation Trust

December 19 SICKNESS

Division	Sickness Abs.	RAG Status Ceiling <3.30%	Available WTE	Abs. WTE	Episodes	Long Term (WTE Lost)	% Long Term	Prev. Month	% +/-
Corporate	1.91%		18218.51	348.63	76	178.00	0.98%	2.40%	-0.49%
Clinical Support	3.92%		29401.89	1151.31	271	479.60	1.63%	3.72%	0.20%
Emergency & Integrated Care	2.76%		49728.87	1374.34	355	594.11	1.19%	2.36%	0.40%
Planned Care	3.83%		31703.94	1212.77	218	612.46	1.93%	3.49%	0.34%
Women's, Children and Sexual Health	4.29%		53337.54	2288.75	419	1141.89	2.14%	3.39%	0.90%
Trust	**3.50%**		**182390.75**	**6375.80**	**1339**	**3006.06**	**1.65%**	**3.08%**	**0.42%**

January 20 Core Training

Course	Last Month	This Month	Target	RAG Status	Trend
Core Training Compliance Overall	92%	92%	<90%		↔
Theory Adult BLS	84%	83%	<90%		↓
Practical Adult BLS	88%	87%	<90%		↓
Conflict Resolution	96%	96%	<90%		↔
Equality, Diversity and Human Rights	94%	94%	<90%		↔
Fire	89%	89%	<90%		↔
Health & Safety	95%	95%	<90%		↔
Infection Control (Hand Hygiene)	95%	96%	<90%		↑
Infection Control - Level 2	93%	93%	<95%		↔
Information Governance	92%	92%	<95%		↔
Moving & Handling - Inanimate Loads	92%	92%	<90%		↔
Moving & Handling - Patient Handling	89%	88%	<90%		↓
Safeguarding Adults Level 1	94%	94%	<90%		↔
Safeguarding Adults Level 2	91%	92%	<90%		↑
Safeguarding Adults Level 3	68%	67%	<90%		↓
Safeguarding Children Level 1	95%	95%	<90%		↔
Safeguarding Children Level 2	93%	94%	<90%		↑
Safeguarding Children Level 3	92%	91%	<90%		↓

January 20 Employee Relations

Category	Metric	Number / %
No of Disciplinary cases in month	Number	3
Length of Disciplinary cases	Days <60	67
Total Discplinary cases in year (April 19)	Number	41
% BAME Disciplinary Cases in year	%	59%
% BAME Disciplinary Cases in month	%	100%
Exclusions - No. of live in month	Number	3
Grievance - No. of live cases in month	Number	7
Grievance – Average length of case	Days	42
B&H cases - included in grievance numbers	Number	1
Sickness - No. of cases in month	Number	93
Long Term - sickness cases in month	Number	52
Short Team - sickness cases in month	Number	41
No. of Employment Tribunals (ET)	Number	8
Managers having ER training (from April 19)	Number	80
No. of informal queries (disciplinary process	Number	2

January 20 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	615.07	592.39	22.68	24.35	4.00	605.70	9.37	
Clinical Support	1064.93	948.78	116.15	135.01	10.09	1071.09	-6.16	
Emergency & Integrated Care	1764.97	1625.30	139.67	281.75	32.74	1842.77	-77.80	
Planned Care	1130.72	1016.66	114.06	124.25	21.16	1132.15	-1.43	
Women's, Children and Sexual Health	1782.59	1719.06	63.53	165.86	14.72	1818.76	-36.17	
TRUST	**6358.28**	**5902.19**	**456.09**	**731.22**	**82.71**	**6470.47**	**-112.19**	

January 20 Voluntary Turnover

Division	Turnover	Prev Month	% + / -
Corporate	14.05%	13.70%	0.35%
Clinical Support	16.02%	15.10%	0.92%
Emergency & Integrated Care	15.71%	15.70%	0.01%
Planned Care	11.52%	11.00%	0.52%
Women's, Children and Sexual Health	11.49%	11.50%	-0.01%
TRUST	**13.65%**	**13.40%**	**0.25%**

Key to Sickness Figures

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

Episodes = number of incidences of reported sickness

A Long Term Episode is greater than 27 days

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

People and Organisation Development Workforce Performance Report
PDRs Windows January 2020

PDR's Completed Since 1st April 2019 (19/20 Financial Year)					
Division	**Band Group**	**%**	**Division**	**Band Group**	**%**
COR	Band 2-5	87.50%	**CSD**	Band 2-5	66.54%
	Band 6-8a	83.86%		Band 6-8a	86.47%
	Band 8b +	86.75%		Band 8b +	89.19%
Corporate		**85.62%**	**Clinical Support**		**72.19%**
PDC	Band 2-5	88.16%	**EIC**	Band 2-5	93.49%
	Band 6-8a	93.75%		Band 6-8a	88.68%
	Band 8b +	100.00%		Band 8b +	94.74%
Planed Care		**90.86%**	**EIC Emergency & Integrated Care**		**91.44%**
WCH	Band 2-5	72.07%			
	Band 6-8a	78.30%			
	Band 8b +	95.24%			
WCH Women's, Children's & SH		**75.96%**			

Band 2-5	Band 6-8a	Band 8b +		
79.97%	84.81%	89.94%	**Trust Total**	**82.52%**

People and Organisation Development Workforce Performance Report January 2020

Establishment, Staff in Post and Vacancies:

The Trust currently employs 6397 people working a whole time equivalent of 5902 which is 30 WTE lower than December. This equates to 261 more permanent members of staff than this time last year. There has been an decrease in the vacancy rate for January, 7.17% against the Trust ceiling of 10% and a significant improvement since the same time last year which was 9.87% The qualified nursing vacancy rate is 4.78%, remains one of the lowest in the country with a national median of 12.75%. Medical staff has reduced to 3.64% which is quartile 2 in Model Hospital and national median of 7.43%. AHP (7.32%) S&T (81.32%) are also in line with the national median but AHP at this level sits in quartile 3. Across the Divisions Women's and Children's and Sexual Health have the lowest vacancy rate of 3.56% which has reduced from significantly over a 12 month period.

Staff Turnover Rate: Voluntary

Voluntary turnover has increased to 13.65%. The data by staff group shows that AHP's (22.4%) and Scientific and Technical (17.5%) have the highest turnover. The results of the quarter 3 joiner and leaver surveys show a slightly increased response rate for joiners of 17% with an overall 88% positive feedback score, with key strengths being staff feeling managers were approachable, proud to work for the Trust and feeling their department made them feel welcome. There had also been an improvement in the scores for new joiners feeling that they were kept informed during the recruitment process following new touch points introduced by the recruitment which saw a 12% increase. The response rate for leavers was 16% and overall 75% were positive and key strengths related to enjoying working for the Trust and that people behaved in accordance with Trust values. Key areas for ongoing improvement include managers giving regular feedback, praise and ensuring staff are valued and recognised. Progress is also being made against the key actions to improve response rates.

Mandatory Training Compliance :

The Trust's mandatory training compliance rates are 92% in January, staff are continued to be reminded to undertake their training as required. Our current rate has remained above our ceiling rate of 90% for 19 consecutive months. Infection Control (Hand Hygiene) increased by 1% due to the additional sessions run by the Resus team. All other topics either rose or dropped by 1% or remained the same. Dates for face to face sessions have been advertised and staff are booking on.

Sickness Absence: (December)

The trust's sickness rate is currently 3.50%. Our sickness target (3.3%) has been breached for the first time during the last 19 months peaking in April '18 . This compares favourably with peers and the Trust remains in the lower quartile on Model Hospital.

Long-term sickness increased to 1.65%. The three most common reasons for sickness were gastrointestinal problems, anxiety and depression and musculoskeletal problems with depression and anxiety remaining the top reason for the number of days lost. The ER team continue to work with managers to support staff through sickness absence and are currently managing 52 long term sickness cases and 41 short term cases. The Workforce Development Committee heard from Maternity where sickness has been high on the West Middlesex site with clear plans to support staff and reduce sickness.

Temporary Staffing:

As vacancy rates have reduced there has not been a corresponding reduction in temporary staffing usage with 15,022 temporary staffing requests filled in comparison to 13,691 in December. This was notably in Admin & Clerical (bank shifts up 20.2%) which is largely the result of approximately 30 Cerner floorwalkers who were recruited and started working shifts in October. Nursing & Midwifery also increased (total demand up 4.9%) but this is in line with normal trends during autumn/winter months. In addition, temporary staffing fill rate has increased by 1.80% to 88.7% this month . The trust is currently reporting 12 breaches on the NHSI capped rate of £100 per hour, all of which are medical consultant posts and weekly challenge sessions are continuing to reduce pay spend.

PDR:

The 12 month rolling PDR rate decreased in January to 87.7%. Divisions continue to be provided with monthly management reports detailing completion rates and plans have been established to support managers and staff to complete their outstanding PDRs. Work is on going to review the process for introduction in April 2020 of the new PDR process moving away from the window process and returning to anniversary of joining.

People and Organisation Development Workforce Performance Report

January 2020

Race Equality Plan & Inclusion:

The Diversity and Inclusion Champions supporting 8a interview panels and above has been implemented within the organisation with the training being well received and a number of panels have been run with champions on board. Feedback is regularly being collated from champions in terms of their experience and more champions were trained during February.

A refreshed Race Equality through promoting fairness plan is being developed to ensure work continues on this as a priority area of the Trust. The Trust has also been awarded funding to support improvements in WRES indicator score 3, in relation to reducing the disproportionate numbers of BAME staff going through the disciplinary process. This will focus on up skilling managers in informal resolution and set up an internal mediation service, as well as supporting managers develop the skills to undertake fair and robust investigations.

The Women's Network has been reviewing the results from the survey to women working in the Trust in order to develop a plan of work for the year, this group will also review the outputs of the Trusts gender pay gap report which is due for publication in March but shows a gender pay gap still exists and has reduced marginally in year.

Health and Wellbeing:

Work is continuing across the five key objectives in the Health and Wellbeing High Level Action Plan. There remains a continued focus on raising awareness of health and wellbeing benefits and to date there are 1353 registered users which has increased to 21% our workforce. Work continues as part of the health and wellbeing work group reviewing the sickness data and what key interventions are most effective liaising with the public health team. This will determine what approach the Trust takes to investments in key areas such as mental health first aid training, fast track physiotherapy services, face to face counselling provision. 11 staff have currently accessed the Employee Assistance Programme for advice and support since the launch in July and the workforce team continue to promote this at key opportunities and 4 staff have received structured telephone counselling sessions. The face to face counselling service has seen 45 staff over the last 6 months with 200 sessions being accessed for a variety of reasons including work-related stress.

Leadership and Development:

The AHSC programme is approaching its conclusion with the final project presentations taking place on 1st July 2020.

Management Fundamentals launched in January with the "New Managers Induction" and the first (optional) sessions commencing in February. Detailed evaluation and quality assurance taking place to ensure that lessons learned can inform programme improvements / development, and identifying gaps. In the offerings available

The tender process for the senior leadership programme (replacing the Trust's Established Leaders programme) has completed and meetings were held in January with Ashridge and Henley Business Schools to look at a new programme commencing before the end of the financial year.

Talent Management & Succession Planning:

Work has started on a process for talent management and succession planning and an agreement is being sort on who to pilot this work with. Alongside this, an e-solution is being sought to enable the Trust to capture outputs from the PDR/Appraisal process to facilitate the Talent Management information gathering Trust-wide.

People and Organisation Development Workforce Performance Report

January 2020

Transactional Plan:

There is a continued focus on the delivery of the detailed transaction plan, and the pilot of Amelia has entered Sprint 4, and the four test cases will be piloted with users during March, which enable staff and managers to ask Amelia key HR queries and receive a response 24/7 and 7 days per week. There has been on-going work to review 371 cost centres and ensure reconciliation to the ledger which has been a time intensive piece of work and will be concluded in February. Work to create Divisional dashboards is due for completion at the end March and will include a heat map of workforce indicators. A new process has been successfully implemented to reduce overpayments in the Trust and in the first month this has placed a number of leavers on suspend no pay, awaiting termination forms. On going progress can also be seen with time to recruit which has reduced to 7.64 weeks and feedback on the recruitment process itself from the Q3 joiner surveys.

Employee Relations:

This has increased from 61 days in December to 67 days in January 2020 which is above the target of 60 days. Three cases have taken longer than anticipated to investigate (due to changes in the case investigator, sickness absence); however these have or will have concluded in February 2020, and we therefore anticipate a reduction in the length of disciplinary cases next month. The team will be running training sessions for managers on the new disciplinary process in March and May. This will include implementation of Just Culture principles and investigation training. We will also be training a cohort of independent mediators and running additional training for managers on facilitated conversations to support early resolution strategies.

The data now shows both the number of new disciplinary cases opened in month and the total disciplinary cases opened in year. 3 new formal disciplinary cases were opened in January 2020, using the new authorisation process. This brings the total number of disciplinary cases opened in this year (from April 2019) to 41. The target was to reduce the number of disciplinary cases from 50% from the previous year (79 cases in total). As the new process started at month 6, we are on target to achieve this reduction for the last 6 months of the year. 100% of the 3 cases opened in January involved a BAME member of staff.

Apprenticeships:

Clinical and Non-Clinical Apprenticeships continue to be used in the Trust to support and develop staff in their roles. Over 2.3% of Trust staff are currently completing an Apprenticeship, which meets the National Target. The Trust is now working across the NW London STP, and recently procured for L3&5 HR Apprenticeships and a Master's Degree Level Senior Leaders Programme, due to start in the late Spring. We have maintained our position as a RoATP employer provider for the HCA Apprenticeship. National Apprenticeship Week was an opportunity to celebrate existing Apprentices in the Trust whilst also speaking to over 100 members of staff about the opportunities available to those that work in the Trust.

The beginning of February was National Apprenticeship week and we had several events planned to raise the profile for Trust staff of the opportunity to develop their careers and skills through utilising apprenticeships. It was the opportunity to acknowledge and celebrate the current apprentices in the Trust who have either completed their programme or are on their journey to complete an apprenticeship. 149 staff have commenced clinical and non-clinical apprenticeship programmes with 6 successful apprenticeship completions so far. Nursing Associates commenced their training in December as well as Degree Nurse Students to add to the existing cohorts who have already commenced on Nursing programmes. 25 % of our monthly levy payment is utilised each month however this continues to rise each month by a minimum of 3%.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Draft Operational Plan 2020/21
AUTHOR	Virginia Massaro, Chief Financial Officer
LEAD	Virginia Massaro, Chief Financial Officer
PURPOSE	Our approach to 2020/21 business planning.
SUMMARY OF REPORT	• The draft Trust plan is due for submission on 5th March and final plan on 29th April. • The operating plan includes quality, workforce and financial plans, as well as activity, performance and alignment to STP. • The Trust will also input into an STP wide plan for 2020/21. • The Trust's approach to cost improvement for 2020/21 is focussing on clinical pathway redesign within clinical divisions, as well as building on existing Trust-wide improvement work-streams
KEY RISKS ASSOCIATED	• Commissioner affordability and NWL STP financial challenges • Delivery of CIP target and financial plan . Continuing increase in demand for loss-making emergency care
FINANCIAL IMPLICATIONS	See above
QUALITY IMPLICATIONS	None noted
EQUALITY & DIVERSITY IMPLICATIONS	None noted
LINK TO OBJECTIVES	• Excel in providing high quality clinical services • Deliver financial sustainability
DECISION/ ACTION	The Board is asked to note the approach to business planning for 2020/21.

1.0 Introduction

1.1 This paper provides an update on the 2020/21 business planning process.

2.0 2020/21 Operational Plan Process

2.1 Sustainability & Transformation Partnerships (STPs) have been asked to submit sector medium term plans, with draft plans submitted in September and final plans in November.

2.2 Trusts are also required to submit a Trust-specific operational plan for 2020/21. The draft operational plan is due to be submitted on 5th March and the final plan is due to be submitted on 29th April. There will also be a further STP plan submission in early May incorporating individual Trusts' final plan submission. The planning timetable is included in appendix 2.

2.3 The operational plan submission to NHSI/E include 5 separate returns:

- *Financial Plan template* – covers the financial income & expenditure plan, capital plans, cost improvement programme, cash and balance sheet
- *Activity Plan template* – includes activity planning assumptions on growth, demand management and alignment with commissioners
- *Workforce Plan template* – covers expected staff numbers by staff group and key workforce performance indicators
- *Triangulation template* – to ensure that the financial, activity and workforce plans are aligned.
- *Operational plan narrative* – which covers:
  - Strategic priorities
  - Activity planning
  - Operational performance
  - Quality priorities
  - Workforce
  - Financial plan
  - STP Alignment

2.4 The final operational plan will be reported to the May Trust Public Board.

3.0 Approach to the Trust's Cost Improvement Plans

3.1 The Trust's draft financial plan for 2020/21 is based on a cost improvement programme (CIP) of £21.2m, or 3.3% of relevant turnover. This is in line with the projected CIP delivery for 2019/20 and represents a considerable challenge given the wider system context and the fact that the Trust already benchmarks in the top quartile in terms of the Model Hospital Weighted Activity Unit (WAU) measure.

3.2 As a result, whilst the proposed approach for 2020/21 builds on key elements of the 2019/20 Improvement Programme (including Trust-wide work-streams on bed productivity, theatre utilisation and outpatient productivity); it also recognises that a more significant, clinically led redesign of key pathways will be required to deliver the level of financial improvement required, while improving quality of care. These pathways extend beyond the walls of our two hospitals and realising the full benefit of this approach will involve increasing partnership working.

3.3 Each clinical division had their divisional away days in January and agreed their 3 areas of focus for clinical pathway redesign for 2020/21, which are being worked up in more detail in workshops in February and March.

4.0 Key Risks

4.1 There are a number of financial risks to the financial plan for 2020/21, including:

- Commissioner affordability and NWL STP financial challenges
- Delivery of CIP target and financial plan
- Continuing increase in demand for loss-making emergency care

5.0 Summary and next steps

- The draft Trust plan is due for submission on 5th March and final plan on 29th April.
- The operating plan includes quality, workforce and financial plans, as well as activity, performance and alignment to STP.
- The Trust will also input into an STP wide plan for 2020/21.
- The Trust's approach to cost improvement for 2020/21 is focussing on clinical pathway redesign within clinical divisions, as well as building on existing Trust-wide improvement work-streams

6.0 Decision/action required

6.1 The Board is asked to note the approach to business planning for 2020/21.

Appendix 1 – Glossary of acronyms

CIP	Cost Improvement Programme
CQUIN	Commissioning for Quality and Innovation
CNST	Clinical Negligence Scheme for Trusts
CWFT	Chelsea & Westminster Hospital Foundation Trust
FIT	Financial Improvement Trajectory
FRF	Financial Recovery Fund
NHSI/E	NHS Improvement & England
NWL	North West London
PSF	Provider Sustainability Funding
STP	Sustainability & Transformation Partnership

Appendix 2 – 2020/21 planning timetable

Milestone	Lead	Report to	Date
Clinical Divisions report on Clinical Pathway Redesign and away days	Divisional Triumvirates	Executive Management Board	05/02/2020
Draft operational plan to be reviewed at EMB	Deputy Director Of Finance	Executive Management Board	19/02/2020
First cut of CIP identified schemes	Clinical & Corporate Divisions	Improvement Board	20/02/2020
First review of Divisional existing cost pressures	FBPs	Cost Pressure meeting	21/02/2020
Draft activity plan shared with Divisions	Finance		21/02/2020
FIC sign-off draft plan	Deputy Director Of Finance	FIC	26/02/2020
Draft capital plan to be reviewed and signed off	Finance	Capital Programme Board	27/02/2020
Workshop 2 per clincical pathway redesign pathway	Clinical Divisions		Feb
Final PIDs for CIP schemes	Project leads with support of SI&E leads	Approval by SRO	End of Feb
Second review & sign-off of Divisional existing cost pressures	Clinical & Corporate Divisions	Cost Pressure meeting	02/03/2020
1st QIA Panel for projects commencing in Q1	Improvement team, Project Leads	Executive Management Board, Improvement Board	04/03/2020
Final Divisional Business Plans, including workforce, quality priorities, clinical pathway update	Clinical & Corporate Divisions	Executive Management Board	04/03/2020
Draft Operational Plan to be submitted to NHSI/E	Deputy Director Of Finance	CFO	05/03/2020
Board sign-off operational plan	CFO	Board	05/03/2020
Responses on activity plan	Clinical Divisions		06/03/2020
Report on progress on clinical pathway redesign schemes	Clinical Divisions	Improvement Board	17/03/2020
Cost pressures signed off at EMB	Clinical & Corporate Divisions	Executive Management Board	18/03/2020
Final capital plan to be reviewed and signed off	Finance	Capital Programme Board	25/03/2020
Detailed 2020/21 budgets, activity plans & capital programme sign-off by Divisions	Divisional Triumvirates	CFO	31/03/2020
Workshop 3 per clincical pathway redesign pathway	Clinical Divisions		March
Board sign-off final operational plan	CFO	Board	02/04/2020
Final operational plan to be reviewed at EMB	Deputy Director Of Finance	Executive Management Board	15/04/2020
Final Operational Plan - sign off by COG	CFO	COG	23/04/2020
Final Operational Plan to be submitted to NHSI/E	Deputy Director Of Finance	CFO	29/04/2020
Final Operational Plan - sign off by FIC	Deputy Director Of Finance	FIC	29/04/2020

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Digital Programme Update
AUTHOR	Bruno Botelho – Director of Digital Operations (DODO)
LEAD	Kevin Jarrold – Chief Information Officer
PURPOSE	The purpose of the paper is to update the Board on progress with the Digital Programme.
SUMMARY OF REPORT	The paper provides an update on: - Progress with Test bed project - Implementation of Cerner Phase 2 and stabilisation progress - CW Innovation Projects.
KEY RISKS ASSOCIATED	n/a
FINANCIAL IMPLICATIONS	n/a
QUALITY IMPLICATIONS	Failure to successfully embed some of the digital solutions (including the EPR) would have significant implications for patient experience and may compromise clinical outcomes
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	The Board is asked to note the progress being made

Digital Update

05 March 2020

Test Bed Update - Developing a Schedule for Unscheduled Care

Positives:

- **All three services live on all core functionality including DrDoctor direct hot clinic booking**
- **Care Information Exchange (CIE) and Medopad sign up continues for all services**, over 1000 Test Bed patients registered.
- **SystmOne into CIE interface** regional approach confirmed and in progress

Challenges:

- **Parallel DrDoctor WM pilot and roll out**
- **Continued patient engagement and pathway utilisation**; targeted communications and training material in progress to address
- HIV safeguarding with CIE GP access in combination with Avegen Project

Action Plan:

- **Post Cerner integration deliverables** e.g. additional CIE feeds, issue resolution and CIE kiosk sign up (March), and Cerner to CIE single sign on launch button in progress
- **Plan Trust wide CIE sign up and DrDoctor deployment** during 2020 with robust communications plan
- **Imperial College Healthcare Trust** data to be added to Waitless
- Final NHSE review of exploitation plan in progress

Areas to flag to the Board:

- **Q7 and Q8 extension forecasts submitted ,** included full integration support until July
- **Evaluation extension confirmed by NHSE** for existing evaluation and Trust funding to support is available until 09/2020
- **CIE demos** arranged for COPD, Diabetes and Oncology
- **Governor representation** now Simon Dyer and Laura-Jan Wareing

Cerner Update March 2020

Positives:

- **Clinical engagement continues to be positive** despite recent events related to downtime requirement
- **New Check-out process agreed** and to be tested at Chelsea Site on behalf of Chelwest & Imperial shared domain
- **NHSX visited Critical Care on 21/02/2020** with excellent feedback on overall staff engagement and overall adoption of the Electronic Patient Record system

Challenges:

- **Data Quality indicators** mainly related to clinical outputs in Outpatients.
- **Network/ IT Infrastructure** stability and impact on the clinical & operational teams
- **Patient Correspondence** post Cerner deployment at Chelsea site.
- **Chelsea Site Phase 2 Project Closure**

Action Plan:

- Continue to **establish business as usual (BAU) teams** , including staff and processes (support running of the business & embed new workflows)
- **Re-focus**:
  - DQ, mainly clinical outcome of patients in clinic;
  - Cerner Adoption Coaches (4 WTEs) to arrive on 03/03/2020 and spend 3 weeks supporting clinicians
  - Correspondence & letters- change in process from 05/02/2020)
- **Trial new Outpatient Checkout at Chelsea site** and in line with consultant feedback

Areas to flag to the Board:

- **On-going impact of the Network/ IT Infrastructure** stability. Currently finalising the migration to new infrastructure – **completion date 01/04/2020**

Update on stability of our IT infrastructure

Communication sent out to all staff 31/01/2020

Key issues	Cause(s)	Remediation plans	Timescale
a. Intermittent loss of internet connectivity across Trust sites	1. On-going work in the Trust Network/ Infrastructure to achieve compliance with national Requirements (HSCN), the replacement of N3	Compliance achieved.	Completed
	2. Faulty hardware	Parts have been replaced	Completed
b. Trust email has seemed slow	1. Bulk distribution of emails (15,000 + emails sent in one go)	Bulk emails being reviewed with distribution lists to be validated	Mar-20
	2. Insufficient memory and processor allocated to email server	a. Processors and memory upgrade have been purchased and installed	a. Completed
		b. Move to new NHS Mail and O365 later in the year	b. July 20
c. Sexual Health system slow and poor performance	1.Technical issues with the core application post-September '19 Sexual Health System upgrade	System supplier is currently developing technical fixes	Apr-20
d. Internal network stability and poor performance	1. Age of legacy equipment	a. Continue the upgrade of the network. There will be more planned outages to complete this work	Mar-20
		b. Prioritise resources and complete work- currently 50% completed	
	2. Cyber security patching having unintended consequences on other systems	PC/system upgrades to be monitored and planned	Completed
e. There is a lot of change going on to IT infrastructure and not enough notice or co-ordination with the operational teams	1. We have not been able to schedule works and align/prioritise with senior Ops and Clinical Teams	a. Improve coordination and communication with Hospital site leads	Completed
		b. Sphere to share schedule of works	
f. Cerner is slow	1. Due to connectivity, infrastructure speed or workflow issues	Transformation team will work with clinical teams to identify the cause of problems in order to focus on effective solutions	Completed

Innovation Update March 2020

Allocation per Division- work in progress

Partnerships

- Sensyne Health (Data and Analytics)
- Sensium Vitals (Remote patient monitoring)
- DH. London Accelerator (pipeline of digital health SME's)
- GE Healthcare (Command centres, theatres, remote monitoring)
- Samsung Health (wearables)
- NOVA Digital Health (innovation support and training)

Corporate

- Robotic process automation – automation of repetitive tasks
- IPSoft cognitive virtual assistants – delivering always on services
- Patchwork – improving management of temporary staffing
- Wayfinding app – improving navigation around trust (WiP)
- Infinity.Health – emergency preparedness app (WiP)
- Patient experience platform – sentiment analysis
- Xim – measurement of vital signs using a mobile phone (WiP)

Women and Children's

- TestBed (PKB, DrDr, Medopad, Waitless) – Pre-eclampsia pathway
- Sexual health - nurse led annual review clinic for stable Hiv patients
- Gestational Diabetes App
- Skin Analytics Ltd – evaluating the potential of AI to support triage of referrals to dermatology on 2 week pathway
- VisualDx – improving diagnosis of 'rashes' in dermatology
- Lumeon - post natal dashboard, reducing discharge times
- Trusted Doctor – improving uptake of maternity services in PPU
- Verseone, maternity remote consultation platform (WiP)
- Long acting reversible contraception service for women in north west London (WiP)
- Early Pregnancy Unit – remote monitoring of high risk pregnancies
- Neonatal palliative care app
- Mum and Baby app – scaling across NWL
- Mira rehab – rehabilitation for children

EiC

- TestBed (PKB, DrDr, Medopad, Waitless) - Heart failure and chest pain pathway's
- Working with Dell AI to improve Sepsis detection
- MedApp – providing junior doctors with ready access to trust guidelines and advice
- Bronchoscopy 'biosim' – improving training
- Butterfly handheld ultrasound device (ED)
- Hand therapy app
- Evaluation of smoke free app in cardiology
- GE Healthcare – evaluating digital ambulatory monitoring solution
- Sensium vitals – evaluating potential of wireless vital signs monitors to identify early deterioration on AMU/AAU at WMUH
- Analysis of Sensium Vitals remote monitoring data using AI
- Partnering with BMS to evaluate potential of AI to improve early detection of Atrial Fibrillation in West London
- Motilent – improving management of Crohn's disease
- Ampersand – improving management of patients with inflammatory conditions
- Burns scar management laser

Planned Care

- Theatres - E-consent / Informed consenting platform
- Edge Health – optimising theatres utilisation
- Myclinicaloutcomes - PROMs in Colorectal Services
- Relax app – improving experience of anesthesia for children
- Craniofacial planning software – improving surgical planning
- Monitoring environment in ICU using novel Kronos and Sensyne technology
- Eye tracking technology in ICU

Clinical Support Services

- Exploring the potential of AI in Radiology - Icometrix, Zebra medical, Feedback PLC, Cosmonio
- Robotic process automation in patient administration
- Evaluation of BD software to improve performance of robotic dispensing in pharmacy
- Rolling out DrDoctor

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

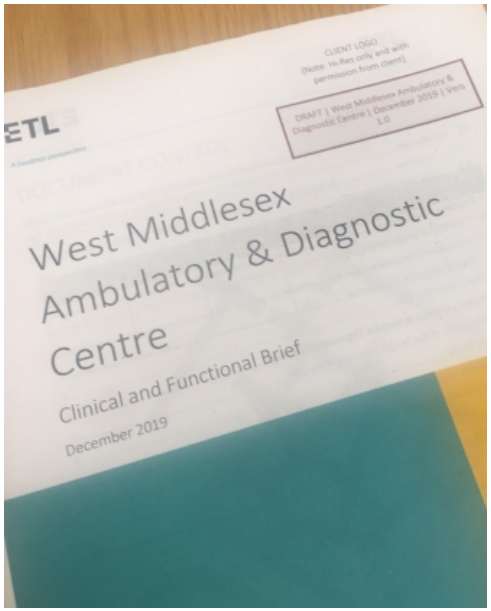
PUBLIC SESSION

AGENDA ITEM NO.	March 2020
REPORT NAME	Estates Strategy: West Middlesex Hospital – Site Update
AUTHOR	Mark Titcomb, Hospital Director
LEAD	Robert Hodgkiss, Deputy CEO & COO
PURPOSE	To provide an update and proposed timelines re: West Mid site development, and in particular Phase 1A which is the proposed new Diagnostic Centre
KEY RISKS ASSOCIATED	Continued growth in non-elective demand continues to place pressure on the WMUH site, both in terms of A&E, resus capacity and also ward space. The case allows for the future proofing of the site and acts as mitigation to current space constraints.
FINANCIAL IMPLICATIONS	Capital and Revenue implications to be defined
QUALITY IMPLICATIONS	Improved patient and staff experience. Expanded Chemotherapy provision will for repatriation of local patients back to West Middlesex Hospital, in addition to significant improvements in our teaching and educational facilities.
EQUALITY & DIVERSITY IMPLICATIONS	EDI impact assessment to be developed as part of detailed business case.
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For information

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

WM Hospital - Future Health Campus

Phase 1A - Diagnostic Centre



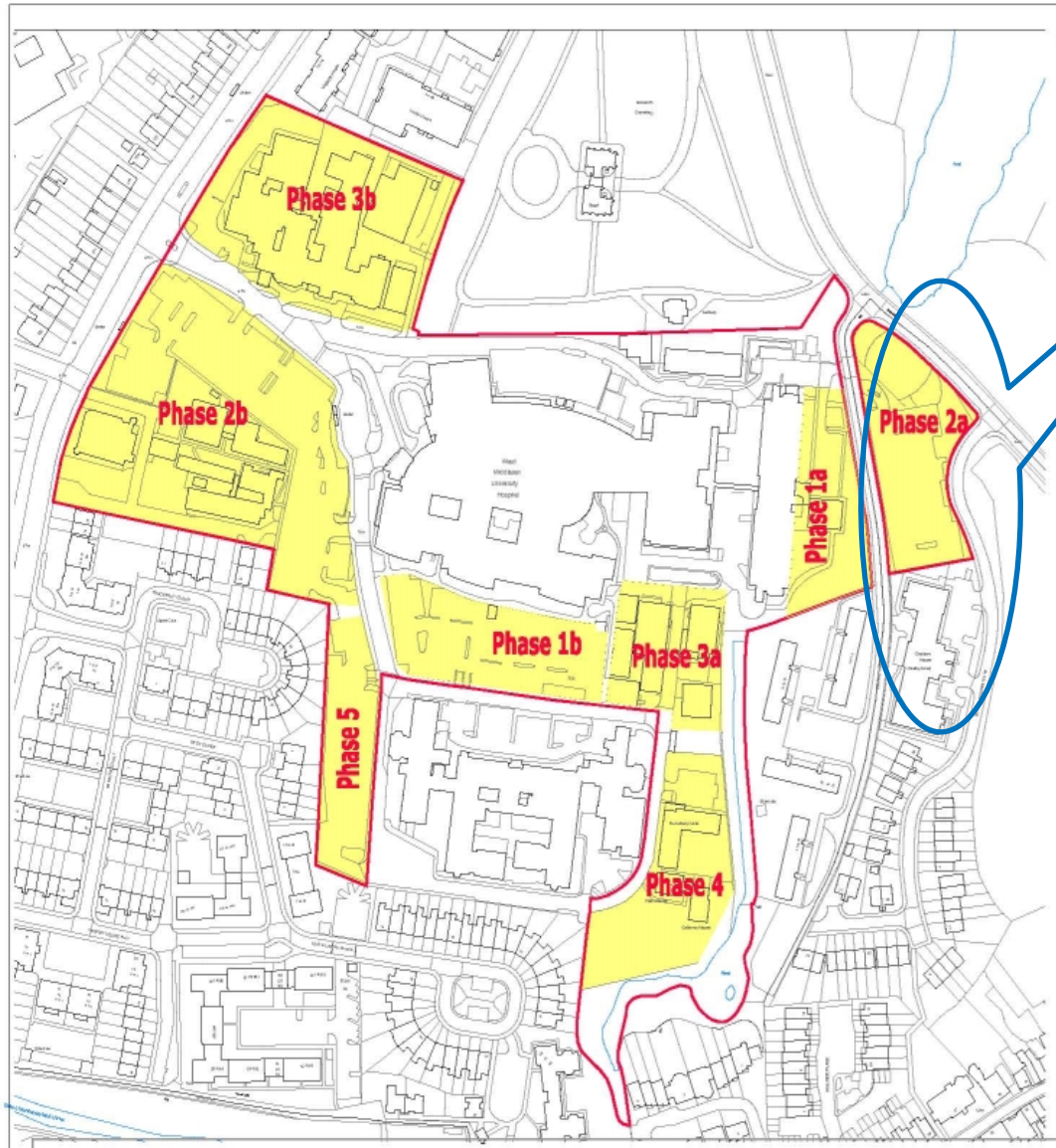
Date: February 2020

West Mid site expansion - where are we now ?

- **Some 'front door integrated services' are a reality:**
  - SDEC/AEC expansion, UTC, HOT clinics, Community cardiology etc.

- **Demonstrable record of recent investment to support local patients & residents**
  - Cath Lab, EPAU, Phlebotomy, workforce investments at WM, improved ED, early Cerner roll out
  - Smaller but important developments planned in 2020: Dr's Mess, ED resus, future proofed re-provision of MRI,

- **West Mid future site plans – a 'phased' Health campus approach**
  - Anchor institution, volunteering strategy, engagement with borough/MPs etc.
  - Increasingly a key role/voice in Hounslow ICP & member of Richmond ICP
  - Space and capital allocation to fund phase 1 (diagnostic treatment centre)



0 50 100

Proposed Phasing plan

Phase 1a, site area 2815m²
- New oncology centre, internal space requirements to be confirmed. Enables decant of office accommodation currently in East Wing.

Phase 1b, site area 3800m²
- 50% of surface parking consolidated in new multi-storey parking, connected to main hospital building.This phase will also include necessary improvements around main hospital entrance.

Phase 2a, site area 2700m²
- Residential family units opposite the new oncology unit

Phase 2b, site area 12740m²
- Mix-use scheme, incorporating integrated care, new residential quarter (affordable housing), office building and commercial ground floor uses along primary route to hospital.

Phase 2c,site area 3960m²
- Residential scheme at the rear of the hospital and adjacent with the new oncology unit.

Phase 3a, site area 3023m²
- Relocated maternity centre with direct link to main hospital and extension to multi-storey car parking.

Phase 3b, site area 8324m²
- New residential quarter at the site of the former maternity unit.

Phase 4, site area 4153m²
- Site for Key hospital workers accommodation. 55 residential units.

Phase 5, site area 2700m²
- Residential family units for key workers. 18 units

WEST MIDDLESEX UNIVERSITY HOSPITAL
ISLEWORTH, TW7 6AF

Drawing Title: PHASING DRAWING - REV B
Scale: 1:2000 @ A3
Date: 03.04.2019
Drawing Number: 4D_1819_PHASING

4D STUDIO

PROPOSED ONCOLOGY CENTRE & RESIDENTIAL QUARTER ALONG HEPPLE CLOSE

MASTERPLAN - PROPOSED ONCOLOGY CENTRE (PHASE 1A) & RESIDENTIAL QUARTER ALONG HEPPLE CLOSE (PHASE 2A)

3D11 - MODEL VIEW, FROM SYON PARK

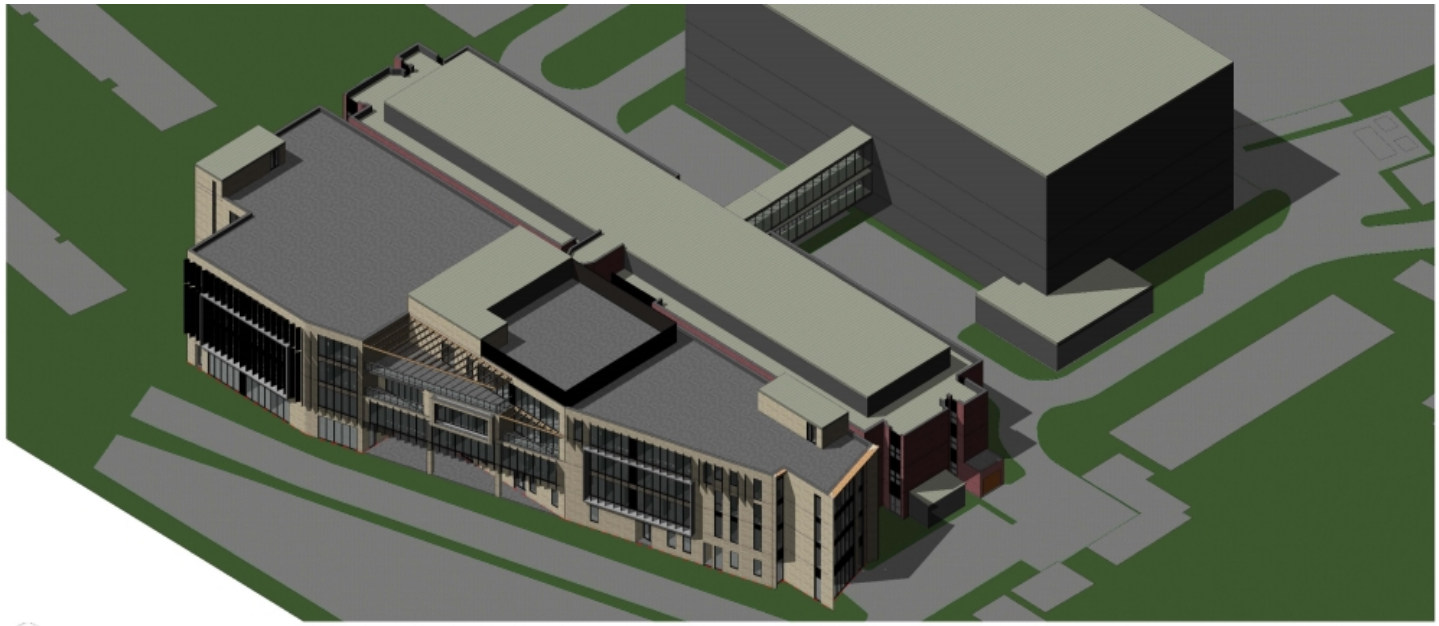
3D12 - MODEL VIEW, FROM PARK RD

WEST MIDDLESEX UNIVERSITY HOSPITAL

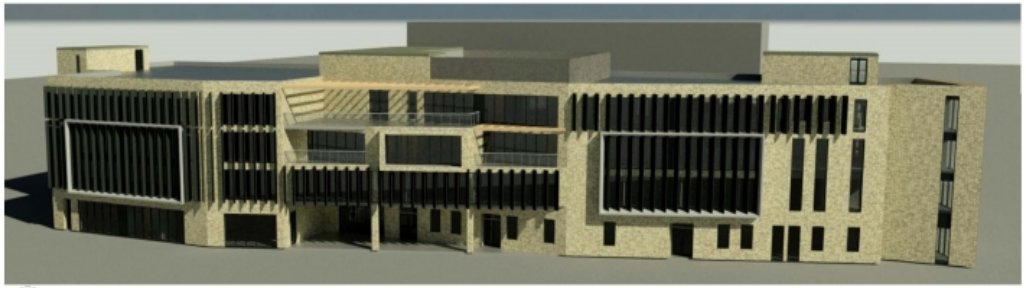
Drawing Title:	MASTERPLAN, PROPOSED ONCOLOGY CENTRE & RESIDENTIAL QUARTER ALONG HEPPLE CLOSE
Scale:	1:1000 @ A3
Date:	03 MARCH 2019
Drawing Number:	4D_1819_SK_223 revA

4D STUDIO

WEST MIDDLESEX HOSPITAL – PROPOSED ONCOLOGY CENTRE



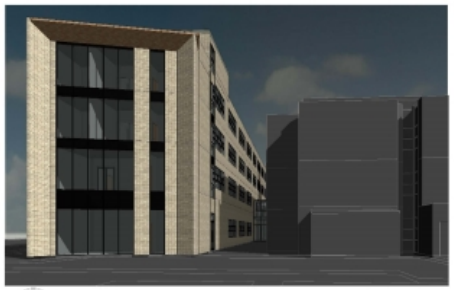
1 Proposed Building 3D



2 Proposed 3D View 1 - East

3 Proposed 3D View 2 - North-East

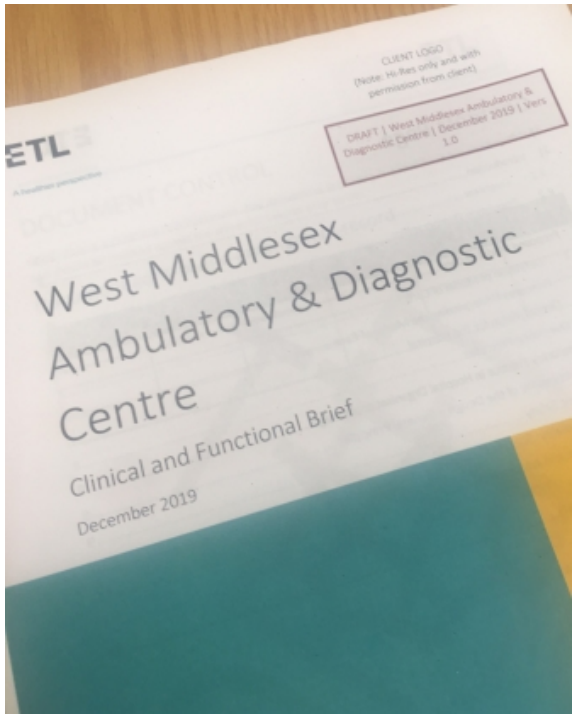
4 Proposed 3D View 3 - North-East



5 Proposed 3D View 4 - North

Scope

The clinical & functional briefing document was completed in December 2019 has been circulated to specialties for their input and feedback.



Comprises 5 components (“future proofed” for capacity for 5-10 year timeframe):

- Oncology Day unit (c100% increase in current capacity to repatriate activity from Imp)
- Renal Dialysis unit (c80% increase in capacity)
- Imaging and diagnostic radiology (includes option to include IR suite)
- Education and training/L&D (renew/replace current facilities)
- Executive offices (free up 2nd floor for clinical/ward space) & public amenities

Outline timeline

- Functional clinical brief **– complete January 2020**
- Options paper/Final Business Case (full design) **– April 2020**
- Planning request submitted **- April/May 2020**
- Planning consent received **– Sep/Oct 2020 (tbc)**
- Tender process & downselection - **tbc**
- Contract Award/start work -**tbc**

- **Proposed capital expenditure timeline as per capital plan: 2020-2022**

Summary of Benefits and Opportunities

- Extends Trust Ambulatory & Diagnostic strategy & capability with focus on Cancer which echoes Long Term Plan and aligns with NWL/RM Partners strategy

- Delivers the Acquisition case benefits of repatriation and care closer to home for Hounslow Haem-Oncology and other cancer patients

- Enables provision of non clinical service office which:
  - Supports next steps on IP capacity at WMUH
  - Supports relocation of staff from HY (and potential release of c£1.5m rental)

- Supports attractive offer to staff re: additional accommodation London Borough Hounslow Housing Strategy

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Guardian of Safe Working Hours Report: Quarter 3 of 2019
AUTHOR	Dr Rashmi Kaushal, Guardian of Safe Working
LEAD	Dr Roger Chinn, Deputy Medical director
PURPOSE	To update the Board on the progress of reducing the number of rota gaps on both sites, and also implementation of the new Junior Doctor contract.
SUMMARY OF REPORT	The number of Exception Reports submitted has increased from 206 in Q3 2018, to 337 for Q3 2019. The reports have reflected an exceptionally busy winter, as well as the transition to Cerner which impacted IT activity at C&W site in December 2019. Most Exceptions submitted were as a result of increased work load and reduced staffing levels, impacted by a combination of unfilled bank shifts and staff sickness. The number of rota gaps has been significantly reduced from 42 (Q2) to 25 (Q3). Junior and Senior Clinical Fellow rotations have become successfully embedded into the clinical task force. The DME's and Educational leads have worked to ensure robust and quality training to enable appropriate career progression. The Trust is compliant with the contractual increment in Junior Doctor Salaries which has been implemented across the Trust. All 137 rotas have been reviewed. 71 rotas were identified to be non-compliant with the revised terms and conditions. We are on track to achieve absolute compliance by August 2020. There are no Red or Amber flag areas, No fines have been levied by the GOSW for this quarter
KEY RISKS ASSOCIATED	Patient safety
FINANCIAL IMPLICATIONS	Where working conditions are breached and doctors work extra hours, they will be remunerated either as a payment or time off in lieu. Where there is failure of the Educational/Clinical supervisor to respond to exception reports submitted to them, Fines shall be levied and collected from the relevant department and division. Rota Gaps need to be filled and this will have financial

	implications.
QUALITY IMPLICATIONS	Safe working, clinical supervision and on- going education are all an integral part of a doctors training and patient safety
EQUALITY & DIVERSITY IMPLICATIONS	N/A.
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For assurance

Guardian of Safe Working Hours Report: Quarter 3 of 2019

1. Executive Summary

The main objectives of this quarter have been to reduce the number of rota gaps on both sites and also to implement the new changes to the terms from July 2019.

- This Trust has led nationally in terms of delivering the contractual agreement and on this occasion, the hard work and commitment by senior members of HR led by Shamina Choudhury, divisional leads and rota coordinators has paid off ensuring most rota's will be fully compliant by February 2020.

- The number of Exception Reports submitted has increased from 206 in Q3 2018 to 337 for Q3 2019. The reports have reflected an exceptionally busy winter with many Black Alert days as well as the transition to Cerner which impacted IT activity at C&W site in December 2019.

- Most Exceptions submitted were as a result of increased work load and reduced staffing levels impacted by a combination of unfilled bank shifts and staff sickness. Organisational factors have included a very short term delay created by the transition to Cerner which has now been resolved.

- The number of rota gaps has been significantly reduced from 42 (Q2) to 25 (Q3). The senior management and divisional leads have worked hard to fill most anticipated gaps in good time to ensure that high standards of clinical care are maintained. Junior and Senior Clinical Fellow rotations have become successfully embedded into the clinical task force. The DME's and Educational leads have worked to ensure robust and quality training to enable appropriate career progression.

- The Trust is compliant with the contractual increment in Junior Doctor Salaries which has been implemented across the Trust. The additional funding of £54,000 has come from central government and distributed by Finance to the divisions to cover 2019-20. The current funding has been allocated on the basis of the number of training posts employed by the Trust in August 2019. The number of these posts has remained unchanged. A further income of £200,000 is expected for 2020-21.

- All 137 rotas have been reviewed. 71 rotas were identified to be non- compliant with the revised terms and conditions. We are on track to achieve absolute compliance by August 2020. In total, 50 rotas at C&W site and 21 at WM site required significant changes to reach compliance. At the time of reporting, only 24 require further action for absolute compliance.

- There are no Red or Amber flag areas, No fines have been levied by the GOSW for this quarter

- Payment Calculations for Exception Reports has been deployed to the Medical Workforce. This process will be reviewed at PODC to ensure efficiency continues.

2. Rota Gaps: Table 1

- Rota Gaps continue to be a national problem. The Trust has responded by ensuring that existing gaps have been filled promptly to ensure patient safety and maintain desired standards of clinical care. Our Rota gap status has come down from 42 in Q2 to 25 in Q3.
- The rota gap status for GOSW report is based on information gathered from clinical leads, rota coordinators, the medical workforce and college tutors. At present, there is no real time application that provides rota gap visibility on a day to day basis.
- Most gaps have been filled by Junior Clinical Fellow Posts. There has been active succession planning of such posts to ensure quality training with designated Educational Supervisors and engagement in the Trust Appraisal process.

Site	Department	Gaps for Quarter 3 of 2019	Anticipated Quarter 4 2019/20	Solutions
C&W	Paediatrics	2.6 SHO and 1 SPR		Gaps remain unfilled
C&W	General Surgery	1.7 SPR gap from October 2019 in general surgery rota.	.	RSO posts will be covering until posts can be filled.
C&W	COTE	1 CMT1		Intermittent locum cover only
WM	Respiratory	1 CT1 (Post shifted by the Deanery to COTE)		Work load absorbed by existing team
WM	COTE	2 SPR Gaps	Until Jan 2020	Work load absorbed by existing team
WM	Anaesthetics	10 gaps (4 rotas designed for 8 people each and have 22 WTE people on them).	Dr Chiara Pieretti (Anaesthetics service lead) or Kerry Foley (GM for anaesthesia are working with HR to resolve this.	Locum cover by existing staff
WM	General Surgery	SHO grade: 5 vacant posts SHO/JCF/CT1/CT2/F2)		Filled by long term locums and 2 SHO, filled with short term locum
WM	Paediatrics	2.4 SHO 1.8 SPRs	From March 2020 3.3 SPR gaps	Measures in place to recruit 2 senior clinical fellows.

3.

4. Rota design process for implementation of revised terms and conditions.

    - All training post rotas are complaint for 72 hour working week. This was established from the outset of the initial contract in August 2016. New Changes to the agreed terms and conditions are shown below. Table 2

Effective Date	Implementation	Additional Information	Trust Status
August 7th 2019	Additional 30 minute break when working a night shift of 12 or more hours.	All divisions informed and engaged	Compliant
December 2019	Maximum of 72 hours worked in any consecutive 168 hour period.	All training post rotas are complaint for 72 hour working week.	Compliant
February 2020	Rest after night shifts; 46 hours rest after any number of nights worked (reduced from 3 nights worked) Maximum 1:3 weekend frequency	137 rotas reviewed. 50 rota changes required at C&W 21 rota changes required at WM Information per division in Table 3	C&W 35/50 complaint Jan 2020 WM 12/21 complaint Jan 2020
August 2020	The maximum number of consecutive shifts worked to be reduced from 8 to 7. The maximum number of consecutive long day shifts reduced from 5 to 4	Information per division in Table 3 (C&W) and Table 4 (WM).	Rota review completed. HR & GOSW liaising with individual departments

This will enable the GOSW and Medical work force teams to ensure that compliance is achieved uniformly across all divisions.

With regards to the maximum 1:3 weekend frequency, this will impact many front line rotas in the emergency setting. The TCS has the provision that where the Clinical Director has confirmed that there is a clinical reason to maintain a weekend frequency of more than 1:3, the Guardian of safe working will confirm that it is appropriate in the interest of patient safety.

Table 3: Table 3 shows the breakdown of rota changes required to achieve compliance by division at C&W site. 35 out of the 50 rotas are now compliant.

Site	Division	Department	Rota	Breach	Outcome
C&W	Women and Children	HIV/GUM	2 XFY2	Both: Breach of maximum 7 shifts rostered over 7 consecutive days rule One post: Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	HIV/GUM	CT2	Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	HIV/GUM	ST3-8	Breach on minimum period off after consecutive shifts	Compliant
C&W	Women and Children	NICU	ST1-3	Breach Max of 1:3 weekend frequency Breach on minimum period off after consecutive shifts. Weekend 1:3 frequency approved by GOSW. Review needed within 6 months	Complaint
C&W	Women and Children	NICU	ST4-8	Fail on minimum period off after consecutive shifts. Changes approved by GOSW	Compliant
C&W	Women and Children	Paediatrics	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
C&W	Women and Children	Paediatric Surgery	ST4-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Department engaged with making rota adjustments. Zero day option possible.
C&W	Women and Children	ED Paediatrics	CT3 ST1-3	Breach Max of 1:3 weekend frequency Weekend 1:3 frequency approved by GOSW. Review needed within 6 months	Compliant.
C&W	Women and Children	Obs & Gynae	2XFY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	Obs & Gynae	St1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after	Compliant

				consecutive shifts.	
C&W	Women and Children	Infectious Diseases	2 X ST3-8	Breach on minimum period off after consecutive shifts.	Department engaged with making rota adjustments.
C&W	Planned Care	General Surgery/T&O	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Department engaged with making rota adjustments.
C&W	Planned Care	General Surgery/T&O	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Department engaged with making adjustments.
C&W	Planned Care	Plastic Surgery	SHO CT1-2 ST1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Department engaged with making rota adjustments. Zero day option possible.
C&W	Planned Care	Plastic Surgery	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts	Department engaged with making adjustments.
C&W	Planned Care	ICU	SPR	Breach of 46hrs rest rule for night shift between 23.00-06.00 Breach of maximum 4 long shifts rostered on 4 consecutive day rule Fail on minimum rest requirement after long shifts.	Department engaged with making rota adjustments.
C&W	Planned Care	General Surgery	SPR	Breach of 46hrs rest rule for night shift between 23.00-06.00 Breach of maximum 7 shifts rostered over 7 consecutive days rule	Department engaged with making rota adjustments. Zero or half day option.
C&W	EIC	AAU	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts. Breach of maximum 4 long shifts rostered on 4 consecutive day rule	Department engaged with making rota adjustments. Zero day option possible.
C&W	EIC	AAU	SHO	Breach on minimum period off after consecutive shifts. Includes the ST1-2, CT1-2 & ACCS	Need the creation of one standard work schedule.

C&W	EIC	AAU	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts. Breach of maximum 4 long shifts rostered on 4 consecutive day rule	Department engaged with making rota adjustments. Zero or half day option.
C&W	EIC	Endocrinology/GIM	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Endocrinology/GIM	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Neurology/GIM	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Neurology/GIM	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Gastroenterology/GIM	3 XFY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	COTE/GIM	2 XFY1	One post: Breach of maximum 7 shifts rostered over 7 consecutive days rule. Both posts: Breach on minimum period off after consecutive shifts	Compliant
C&W	EIC	COTE/GIM	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Respiratory/GIM	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts.	Compliant
C&W	EIC	Haematology/GIM	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant

				Breach on minimum period off after consecutive shifts	
C&W	EIC	Oncology	2X FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant
C&W	EIC	A&E	FY2	Breach Max of 1:3 weekend frequency Weekend 1:3 frequency: not compliant but CD confirmation of clinical reason to maintain current frequency. Approved by GOSW	Compliant
C&W	EIC	A&E	ST1-3	Breach Max of 1:3 weekend frequency Weekend 1:3 frequency: not compliant but CD confirmation of clinical reason to maintain current frequency. Approved by GOSW	Compliant
C&W	EIC	GIM	CT1-2 ST1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant
C&W	EIC	GIM	SPR ST3-8 CT3	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant
C&W	EIC	Cardiology	ST3	Weekly hours are 49.5, needs to be reduced to 48 hours.	Compliant
C&W	EIC	CXH Medical Oncology	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant

Table 4: Table 3 shows the breakdown of rota changes required to achieve compliance by division at

Site	Division	Department	Grade	Breach	Outcome
WM	Women and Children	Obs & Gynae	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant
WM	Women and Children	Obs & Gynae	ST1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Compliant
WM	Women and Children	Obs & Gynae	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Department engaged with making rota adjustments. Zero day option possible.
WM	Women and Children	Paediatrics	FY2	Breach Max of 1:3 weekend frequency Breach on minimum period off after GOSW approved. Robust Business plan needed within 6 months.	Compliant
WM	Women and Children	Paediatrics	ST1-3	Breach Max of 1:3 weekend frequency Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts Weekend 1:3 frequency GOSW approved. Review August	Compliant
WM	Planned Care	Anaesthetics	CT1-2 ST1-8	Breach Max of 1:3 weekend frequency	Department engaged with making rota adjustments.
WM	Planned Care	Anaesthetics	CT1-2	Breach Max of 1:3 weekend frequency	Department engaged with making rota adjustments.
WM	Planned Care	General Surgery	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Department engaged with making rota adjustments. Zero day option possible.

WM	Planned Care	General Surgery	ST1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Department engaged with making rota adjustments. Zero day option possible.
WM	Planned Care	General Surgery	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Fail on EWTD max hours & fail on minimum period off after consecutive shifts.	Department engaged with making rota adjustments. Zero day option possible.
WM	Planned Care	T&O	CT1-2 ST1-2	Breach on minimum period off after consecutive shifts	Department engaged with making rota adjustments.
WM	Planned Care	ENT (joint rota with NPH)	ST3-8	Breach Max of 1:3 weekend frequency Fail on minimum period off after consecutive shifts.	Department engaged with making rota adjustments. Zero day option possible.
WM	EIC	A&E	FY2	Breach Max of 1:3 weekend frequency Breach of maximum 4 long shifts rostered on 4 consecutive day rule Breach on minimum period off after consecutive shifts Guardian for approval. CD confirmation of clinical need in high risk area.	Complaint
WM	EIC	A&E: Urgent Care	GPVTS ST1-2	Breach Max of 1:3 weekend frequency Guardian for approval. CD confirmation of clinical need in high risk area.	Complaint
WM	EIC	GIM	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach of maximum 4 long shifts rostered on 4 consecutive day rule Breach on minimum period off after consecutive shifts	Department engaged with making rota adjustments

WM	EIC	GIM	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Department engaged with making rota adjustments. Zero day option possible.
WM	EIC	GIM Haematology	ST3	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Department engaged with making rota adjustments. Zero day option possible.
WM	CSD	Microbiology	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule. Breach on minimum period off after consecutive shifts	Medical Workforce meeting with Nupur Goel to review on 20.01.20.

5. Junior Doctor Forum

- The Junior Doctor Forum at this Trust is very well attended and has evolved to become a place where doctors can develop a better understanding of the Trust Vision and goals.
- The forum is regarded to be a safe space where juniors can express concerns or anxieties about working patterns with the GOSW, members of HR or the DME's in the form of one to one confidential exchanges.
- The third quarter has focussed on Quality Improvement Projects and Guidelines to improve patient care.

Wednesday 16th October C&W: Dr Sheharyar Qureshi BMA Rep: Quality improvement Projects

Wednesday October 30th WM: GOSW: Exception Reporting

Wednesday 20th November C&W: Dr Peta Longstaff: NEWS2 or the early Detection, Management and Escalation of Deteriorating Adult Patients

Wednesday November 27th WM: Changes to working conditions: Shamina Chowdhury HR

- Rest and Facilities: C&W is fully compliant with completion of work for rest facilities. There remains an operational delay at West Middlesex Site where the DME and Medical Director are fully engaged in ensuring that structural work to doctors mess area is completed as soon as possible.

Exception Reporting

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

October 2019: A total of 97 reports were submitted. No Fines Levied.

Division	C&W: 27	WMUH: 70
Emergency & Integrated Care	Neurology: 6 Gastroenterology :1 COTE:1	Cardiology: 11 COTE: 1 Ortho-geriatrics: 21 Diabetes & Endocrinology: 5 Respiraory:13
Planned Care	General surgery: 3 Urology:1, Plastic Surgery: 13	General surgery: 17
Women and Children	Paediatrics: 1, Obs & Gynae:1	Paediatrics: 2

November 2018: A total of 133 reports were submitted. No Fines Levied

Division	C&W: 71	WMUH: 62
Emergency & Integrated Care	AMU: 23 Gastroenterology: 11 COTE: 15 Diabetes &Endocrinology: 2 Neurology: 3	AMU: 4 Diabetes & Endocrinology: 5 Cardiology: 6 COTE: 19 Ortho-geriatrics: 3 Gastroenterology: 10 Respiratory 13
Planned Care	General surgery: 15	General surgery: 2
Women and Children	Paediatrics: 2 Obs & Gynea: 2	

December 2018: A total of 105 reports were submitted. No Fines Levied

Division	C&W: 31	WMUH: 74
Emergency & Integrated Care	Gastro: 3 AAU: 1	Cardiology: 9 Gastroenterology: 24 Respiratory: 4
Planned Care	General surgery: 24	General surgery: 30 Urology: 3
Women & Children	Paediatrics: 1 Obs & Gynea: 2	

Appendix 1-Exception Reporting Analysis:

Table # 1 outlines the reports for each speciality and also the on- going efforts to resolve the issues. It is RAG rated for convenience.

.

Graph and Table #2 presents the variation of exception reports throughout the week. Nearly all additional hours have been reimbursed with financial payment. Short staffing levels and busy wards have not enabled many juniors to secure TOIL.

Graph and Table #3 presents the split of themes at the C&W site. The dominant themes remain "Work load", "staffing levels" and "ward rounds". We can also deduce that the average number of hours of individual exceptions is similar across the themes.

Graph # 4 presents the split of themes at the WMUH site.

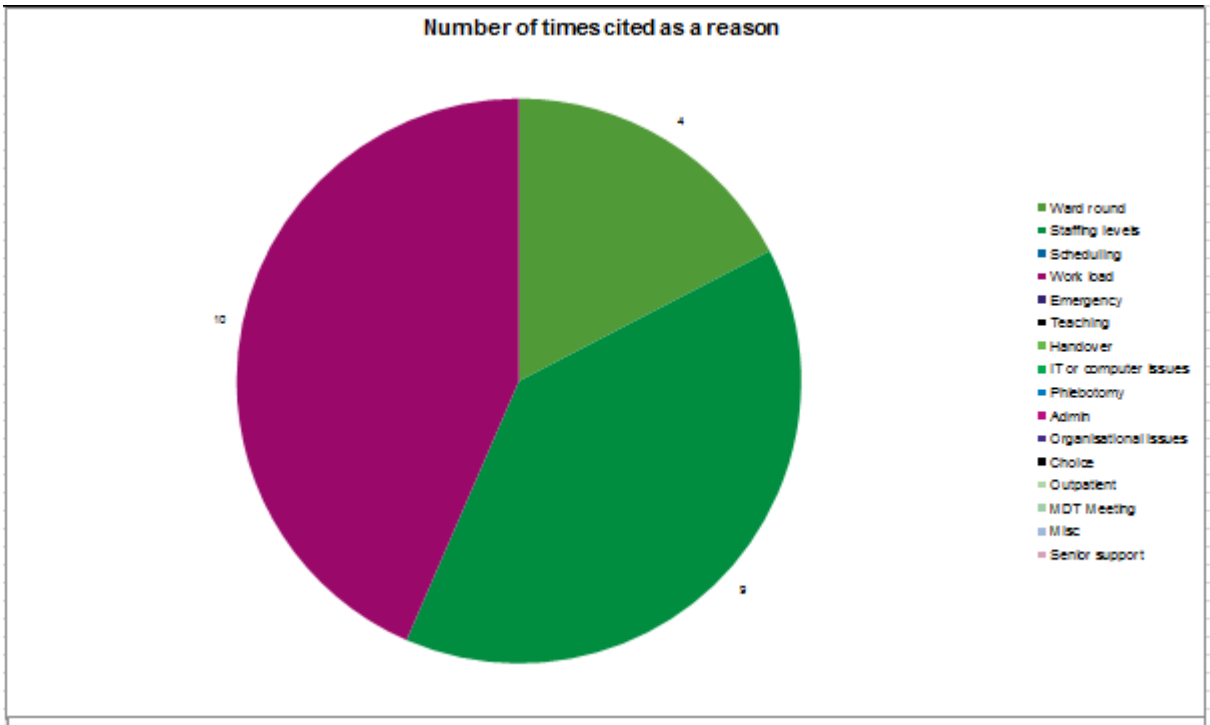
Graph and Table # 5 compares each speciality across both sites.

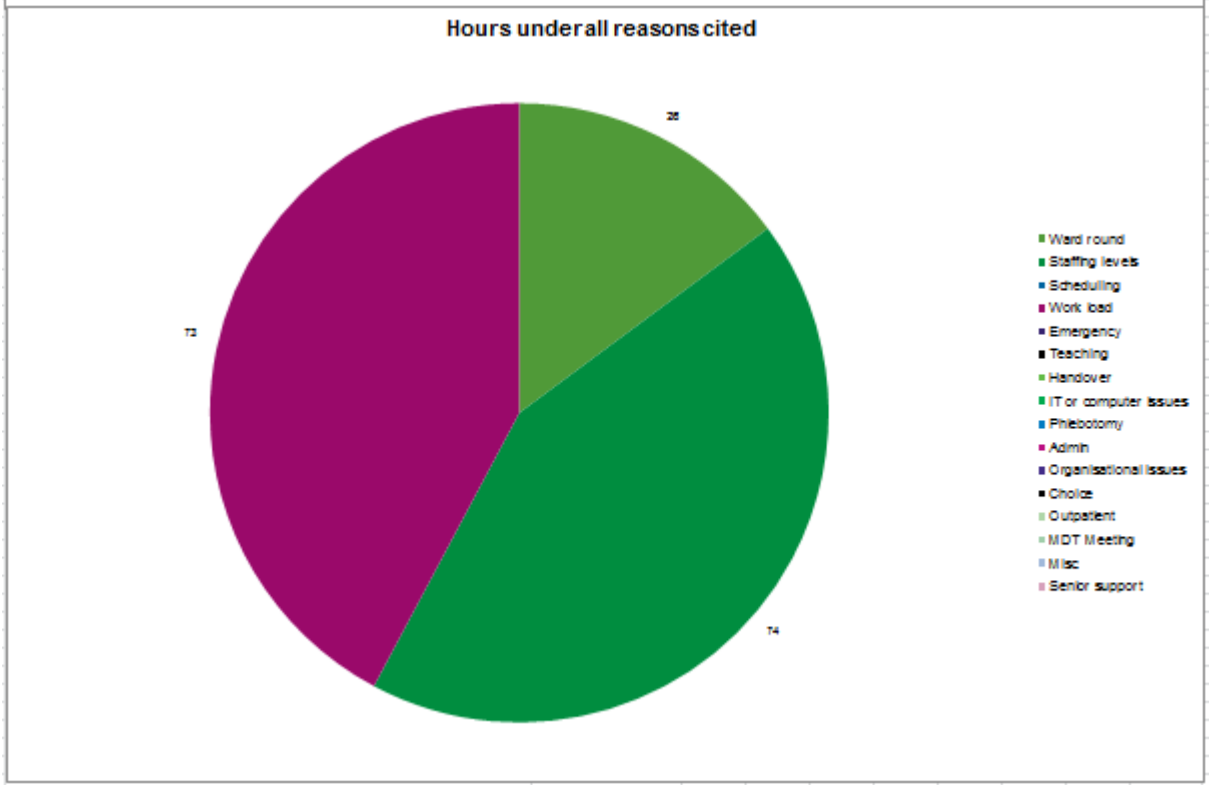
Table 1:

Department	No of reports	*Grade*	Themes	Trends
WMUH: Orthogeriatrics	24	*FY1*	Rota Gaps of 2 SPR's Failure of engagemnet in Exception Reporting process	Deanery Visit Jan 2020
WMUH: General Surgery	49	*FY1*	Increased Work load due to winter Pressures on beds	Seasonal
C&W: General Surgery	43	*FY1*	Increased Work load due to winter Pressures on beds	Seasonal
WMUH: Gastroenterology	34	*FY1*	Increased Work load due to winter Pressures on beds	Seasonal
WMUH: Respiratory	30	*FY1*	Increased Work load due to winter Pressures on beds	Seasonal
C&W: AMU	23	*FY1*	Increased Work load due to winter Pressures on beds	Seasonal
WMUH: Cardiology	21	*FY1, CT1*		Improving Trends
C&W: COTE	16	*FY1*		Improving Trends
C&W: Gastroenterology	15	*FY1*		Improving Trends
C&W: Plastic Surgery	11	*ST1*		
WMUH: Diabetes & Endo	10	*FY1, CT1*		Improving Trends
C&W: General Surgery	13	*FY1*		Improving Trends
C&W:Neurology	9	*FY2, ST5, ST7*		Resolved
C&W: Endocrinology	2	*FY1*		Resolved
WMUH: AMU	4	*FY1, FY2*		Resolved
WMUH: Urology	3	*FY1*		Resolved
C&W: Obs & Gynae	3	*ST1, ST2*		Resolved
WMUH: A&E	1	*FY2*		Resolved
WMUH: Paediatrics	2	*ST1*		Resolved
C&W: Paediatrics	4	*ST2,ST4* *ST7*		Resolved
All other daeparments	0		No reports	

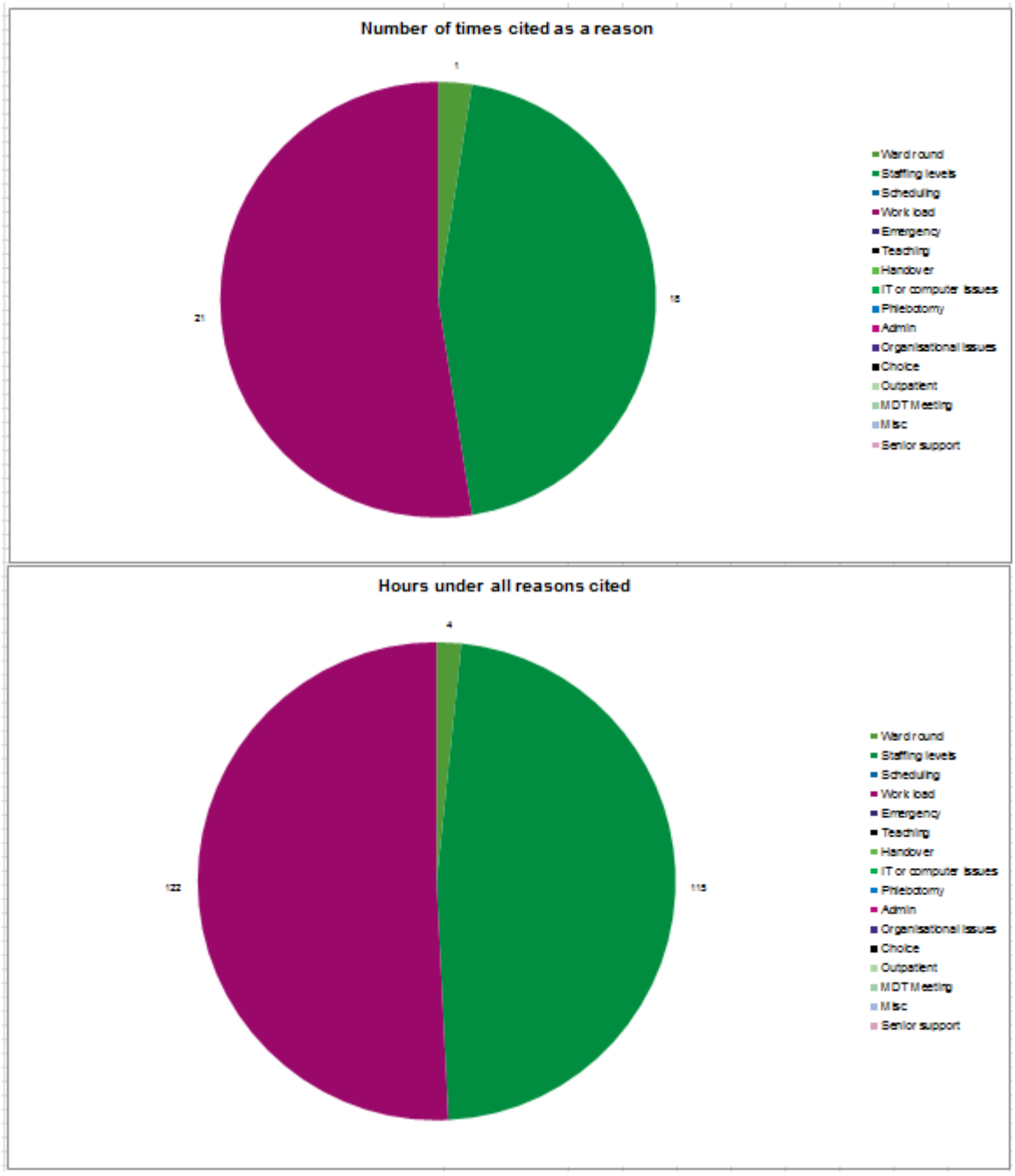
Graph 2: Exception reports throughout the week and observed themes.

Graph and Table #3 - Overview of Exception Themes – CW

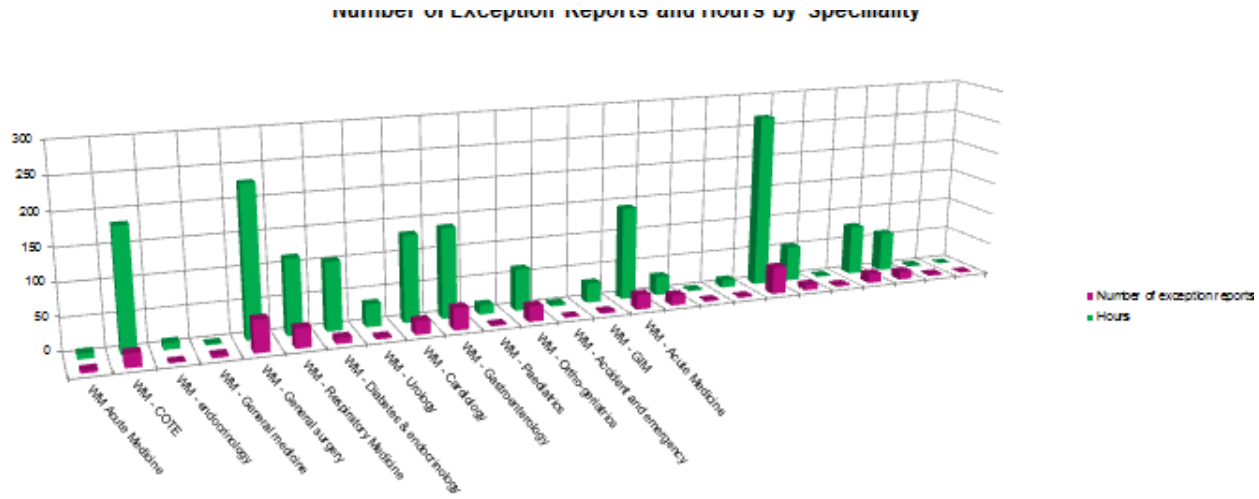


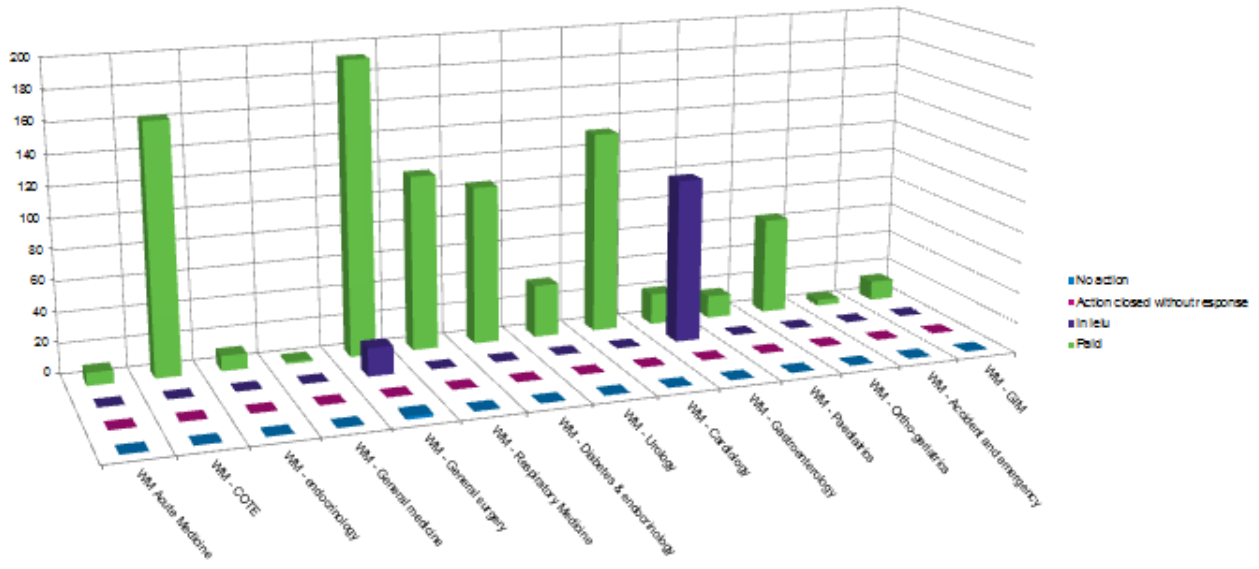


Graph and Table #4 - Overview of Exception Themes WMUH



Graph 5 - Overview of Exceptions per Site and Speciality





Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL

PUBLIC SESSION

Board of Directors Meeting, 5 March 2020

AGENDA ITEM NO.	March/2020
REPORT NAME	Human trafficking and modern slavery Act statement and Patient equality report 2019-20
AUTHOR	Nathan Askew, Director of Nursing
LEAD	Pippa Nightingale, Chief Nurse
PURPOSE	The Trust are required to annually review and publish the Modern Slavery Act Statement and also compile and present an annual report on the profile of patients using the organisations services. This report presents both to the Trust board for approval and publication.
SUMMARY OF REPORT	**Modern Slavery Act** The Trust are required to ensure that safeguards are in place to prevent incidents of modern slavery, including through its supply chain and associated providers of services. The position statement has been updated for approval by the board and publication on the website. **Patient Equality Report** The report provides information on the patients and service users of the Trust by a range of characteristics. Of note, other than ethnicity, the Trust continue to be challenged in the recording of patient demographics. Gender remains as male / female and data is currently not collected on the broader range of recognised genders. The same can be said for religion and communication issues / disability are largely not recorded. This provides a challenge for the analysis of the data and will be addressed through a working group led by the E&D lead during the coming year.
KEY RISKS ASSOCIATED	There is a requirement of the Trust to produce and publish these reports in the prescribed style, there is therefore a reputational risk if this is not completed.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None

LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	The Trust Board are asked to approve the attached for publication.

MODERN SLAVERY ACT STATEMENT

Slavery and Human Trafficking Policy Statement

1. Introduction

At Chelsea and Westminster Hospital NHS Foundation Trust ('the Trust') we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by the Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

2. Organisational structure

The Trust delivers specialist and general hospital care at Chelsea and Westminster Hospital and West Middlesex University Hospital. Both hospitals have major A&E departments and the Trust also provides the second largest maternity service in England.

Our specialist hospital care includes the burns service for London and the South East, children's inpatient and outpatient services, cardiology intervention services and specialist HIV care. We also manage a range of community-based services, including our award-winning sexual health clinics which extend to outer London areas.

The Trust serves a catchment area in excess of one million people. The Trust's main health commissioning and social care partnerships cover two Sustainability and Transformation Partnership (STP) footprints and the following areas:

- West London CCG
- Hounslow CCG
- Hammersmith and Fulham CCG
- Central London CCG
- Ealing CCG
- Richmond CCG
- Wandsworth CCG
- NHS England (NHSE) for Specialised Services Commissioning

The Trust values are firmly embedded. They demonstrate the standard of care and experience our patients and members of the public should expect from any of our services. They are:

- **P**utting patients first
- **R**esponsive to patients and staff
- **O**pen and honest
- **U**nfailingly kind
- **D**etermined to develop

We are a leading Trust for teaching, training and research, with close links to Imperial College London and Imperial College Health Partners, as well as other Higher Education Institutions (HEIs).

Our supply chains enable the procurement of a wide range of goods and services on behalf of our clients and service users.

3. Our policy on slavery and human trafficking

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (ie all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures.

4. Due diligence

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Undertake appropriate pre-employment checks on directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff
- Implement a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations—these include provision of fair pay rates, fair terms of conditions of employment, and access to training and development opportunities
- Consult and negotiate with trade unions on proposed changes to employment, work organisation and contractual relations
- Purchase most of our products from UK- or EU-based firms which may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states
- Purchase a significant number of products through the NHS Supply Chain, whose 'supplier code of conduct' includes a provision around forced labour
- Since January 2017, require all suppliers to comply with the provisions of the UK Modern Slavery Act (2015) through our purchase orders and tender specifications, which set out our commitment to ensuring no modern slavery or human trafficking in relation to our business
- Uphold professional codes of conduct and practice relating to procurement and supply, including through our procurement team's membership of the Chartered Institute of Procurement and Supply
- When possible and consistent with public contracts regulations, build long standing relationships with suppliers

5. Training

Advice and training about modern slavery and human trafficking is available to staff through our safeguarding children and adults training, our safeguarding policies and procedures and our safeguarding leads.

6. Board of Directors' approval

This statement has been approved by the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust, who will review and update it on an annual basis.

Further information about the Trust can be found at www.chelwest.nhs.uk.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Equality Report

December 2019

Contents

1.0 Introduction

Chelsea and Westminster Hospital NHS Foundation Trust covers two main hospital sites, Chelsea and Westminster Hospital (C&W) and West Middlesex University Hospital (WMUH) and 12 community-based clinics.

NHS West London Clinical Commissioning Group is the Lead Commissioner for Chelsea and Westminster Hospital NHS Foundation Trust. This function is jointly delivered with NHS Hounslow CCG on behalf of a number of Clinical Commissioning Groups (CCGs) across London. Both CCGs monitor the quality and performance of services across the Trust's two hospital sites and the other sites from which the Trust delivers its services.

During this busy year the Trust has continued to experience high demand for our emergency and urgent care services and we have been proud to see our staff demonstrate their outstanding commitment to patient care and experience.

Our Values
The Trust values are firmly embedded. They demonstrate the standard of care and experience our patients and members of the public should expect from any of our staff and services. They are:

- **P**utting patients first
- **R**esponsive to patients and staff
- **O**pen and honest
- **U**nfailingly kind
- **D**etermined to develop

Our values and strategic priorities drive us to make our performance better today than it was yesterday and to ensure that we put the quality of care that we offer at the centre of everything we do. In response to an increased level of demand we have worked innovatively and actively to provide a comprehensive approach, notably:

- Created a state-of-the-art ambulatory emergency care (AEC) service at both hospital sites

- Redesigned patient pathways to provide virtual clinics and allow patients to be monitored at home

- Made much better use of digital technology

The following sections provide an overview of the demographic profiles of our patients who have used the Trust services during 2018/2019. The sections have been divided into 4 services.

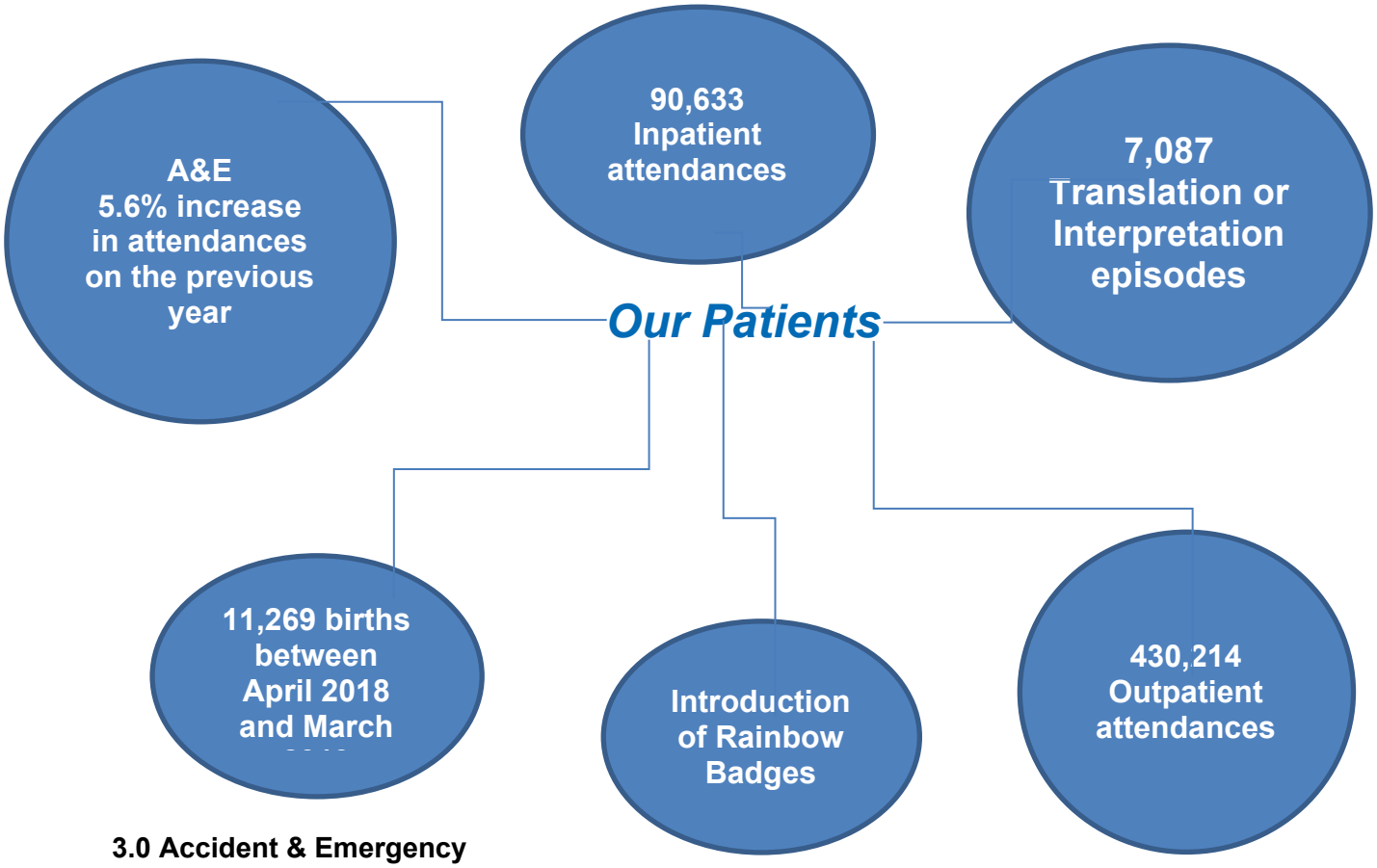
A&E, Maternity, Inpatients, Outpatients

For the purposes of this report, the following breakdown of ethnicity has been used.

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

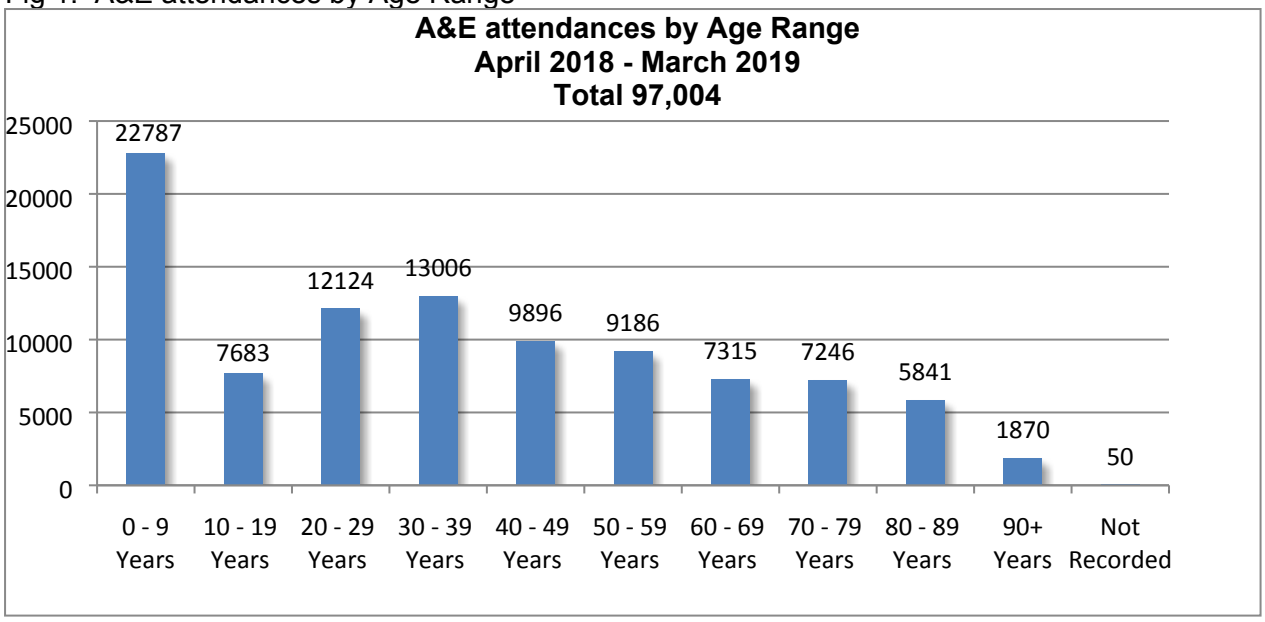
Non BAME incorporates patients that identify as White British, White Irish and Any Other White background. The Not Stated category also includes those who have chosen not to disclose their ethnic background.

2.0 Key Highlights April 2018 – March 2019



3.0 Accident & Emergency

Fig 1: A&E attendances by Age Range



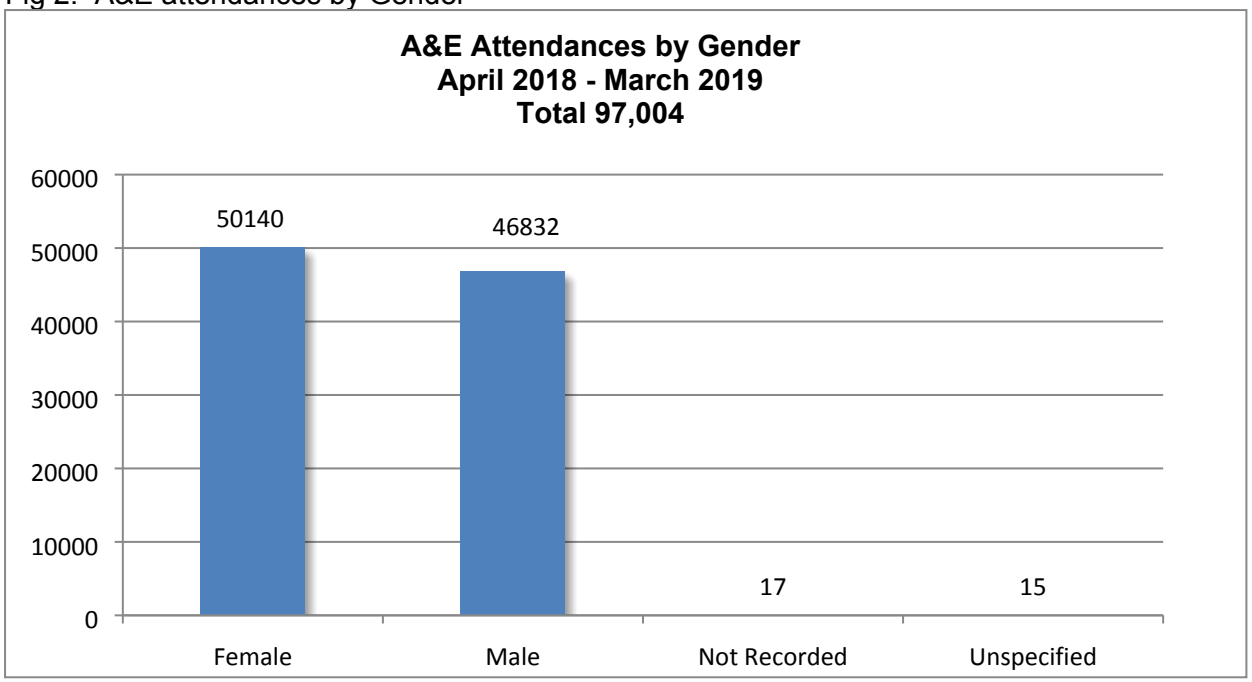
*The A&E data does not include patients who left the department without being treated

The data shows that there were 97,004 patients who attended one of the Trusts two A&E departments in the financial year April 2018 to March 2019. This is a 5.6% increase on the previous year.

The Trusts paediatric A&E departments remains the most attended of these emergency services specifically by the 0-9 age range. This data excludes births that occurred over the

same period. The under 60's account for 77% of overall attendances, with the over 60's for 23% which has remained unchanged from last year.

Fig 2: A&E attendances by Gender



A& E attendances by gender show that females at 51% with males at 48% make up the service users. This remains the same as the previous year.

Fig 3: A&E attendances by Ethnicity

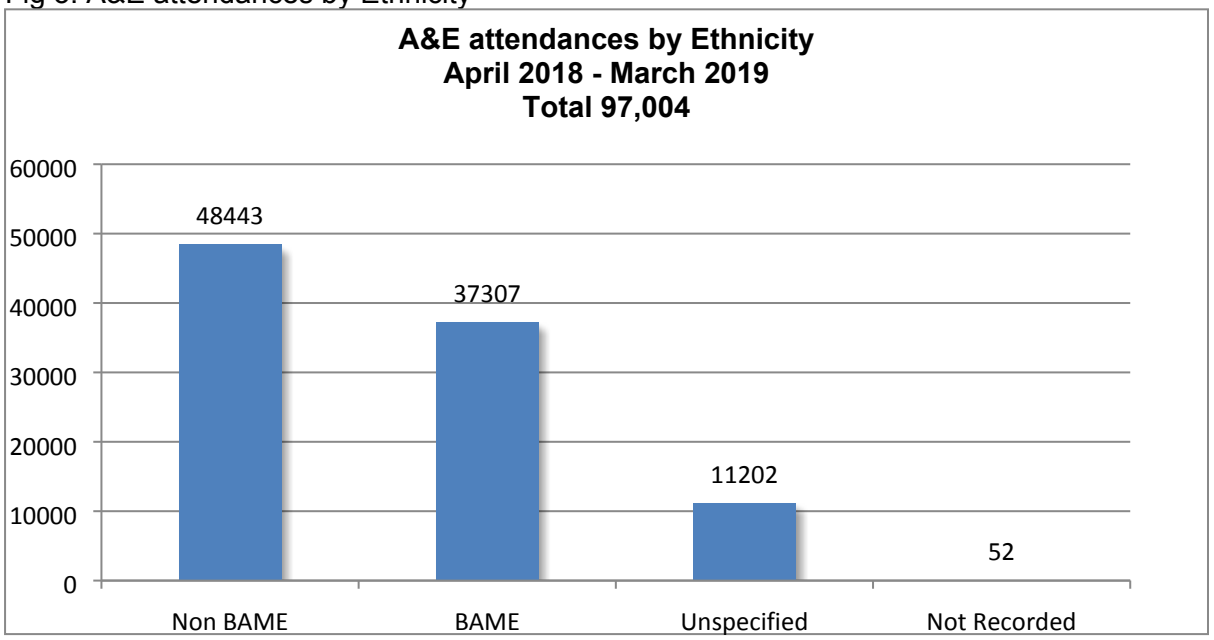
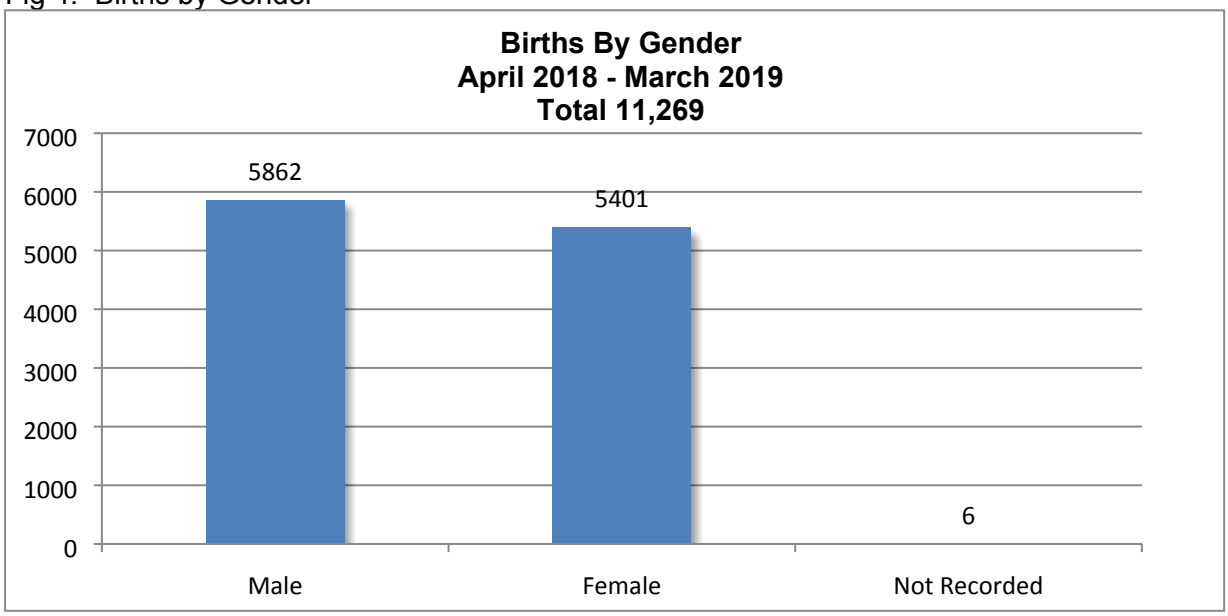


Figure 3 above shows that Non BAME patients account for 50% of service users, slightly down on the previous year which was 52%. BAME service users remained unchanged at 38% with unspecified or not recorded accounting for 12%, an increase from 10% on the previous year.

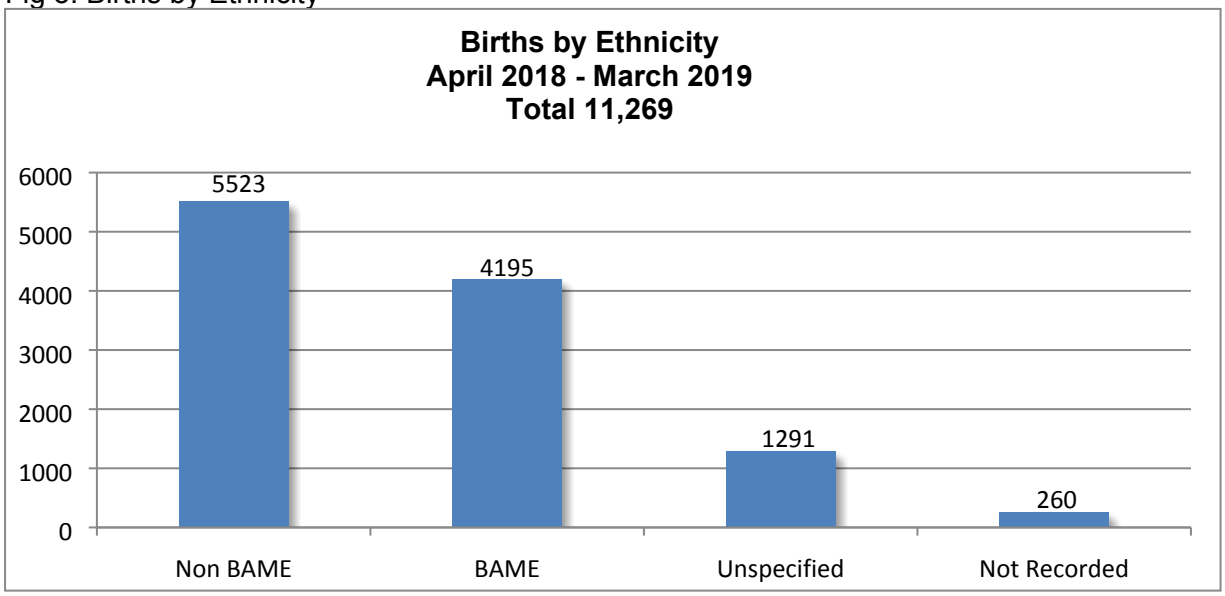
4.0 Maternity

Fig 4: Births by Gender



There was a slight fall 1.9% in the number of births across the maternity services compared to the same period last year. The average monthly birth rate was 939. More male babies were born accounting for 52% of the total and females at 47% a slight change from 51% and 48% respectively last year.

Fig 5: Births by Ethnicity



Of all births Non BAME accounted for 49% of the total with BAME at 37%. The percentage of births recorded as BAME has fallen from 43% the previous year. Unspecified or Not Recorded accounted for 14% of the total which has increased from 8% the previous year.

5.0 Maternity Services National Survey 2018 – Appendix 1

As part of the Patient Experience Programme Chelsea and Westminster Hospital NHS Foundation Trust undertook the national maternity services survey 2018. The survey was undertaken by Picker and data collection took place in February 2018.

As part of the equality and diversity programme an interest arose as to how the feedback on the service may have difference between those from a Black and Asian Minority Ethnicity (BAME) and those for ethnicities outside of these (non-BAME).

Over all there are many areas within the survey where the BAME service users report higher levels of satisfaction that the non-BAME service users.

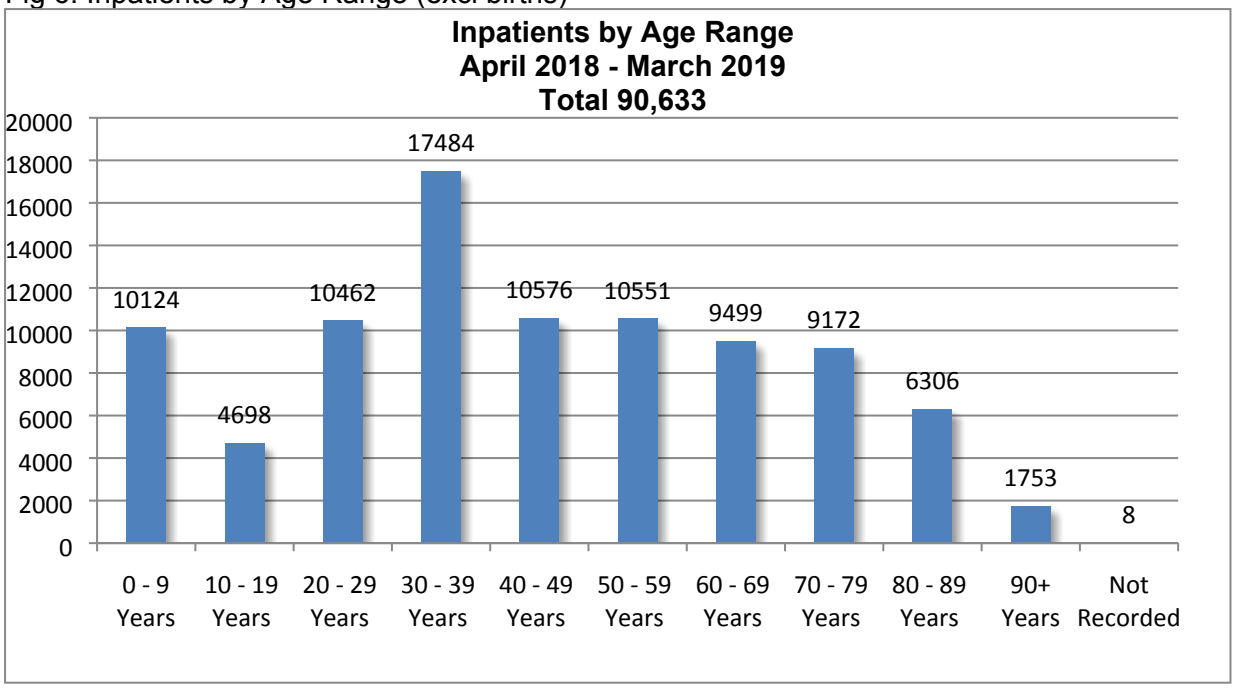
Three areas where BAME service users reported lower levels of satisfaction were:

- amount of choice of where to have their baby
- having telephone numbers of the midwives
- seeing the midwife as much as they would have liked

The three areas identified as being reported less favourably provide a focus for the department of where they could target their efforts to improve the experience of the BAME service users. There remain areas of the survey where satisfaction with the service could be improved for both groups; these should also be addressed in the local action plan.

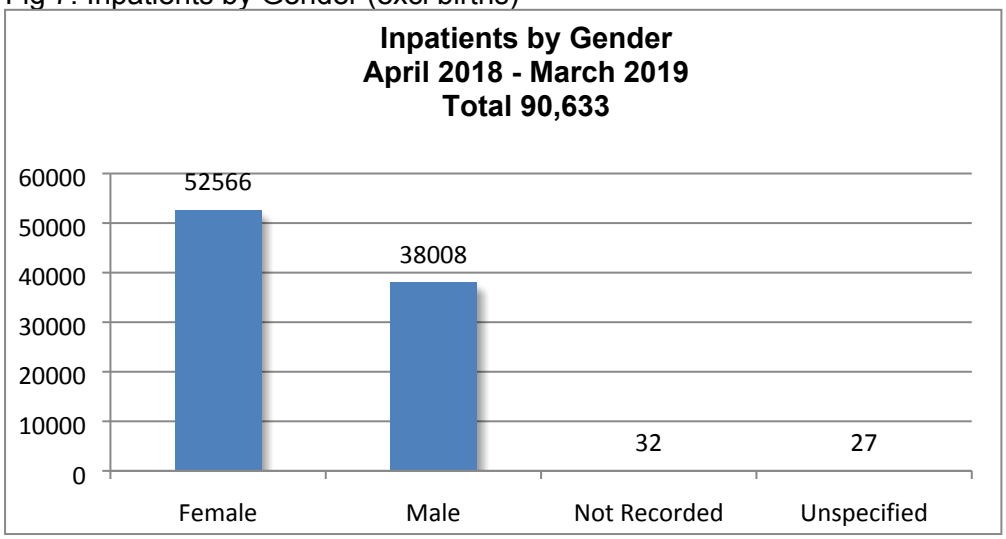
6.0 Inpatients

Fig 6: Inpatients by Age Range (excl births)



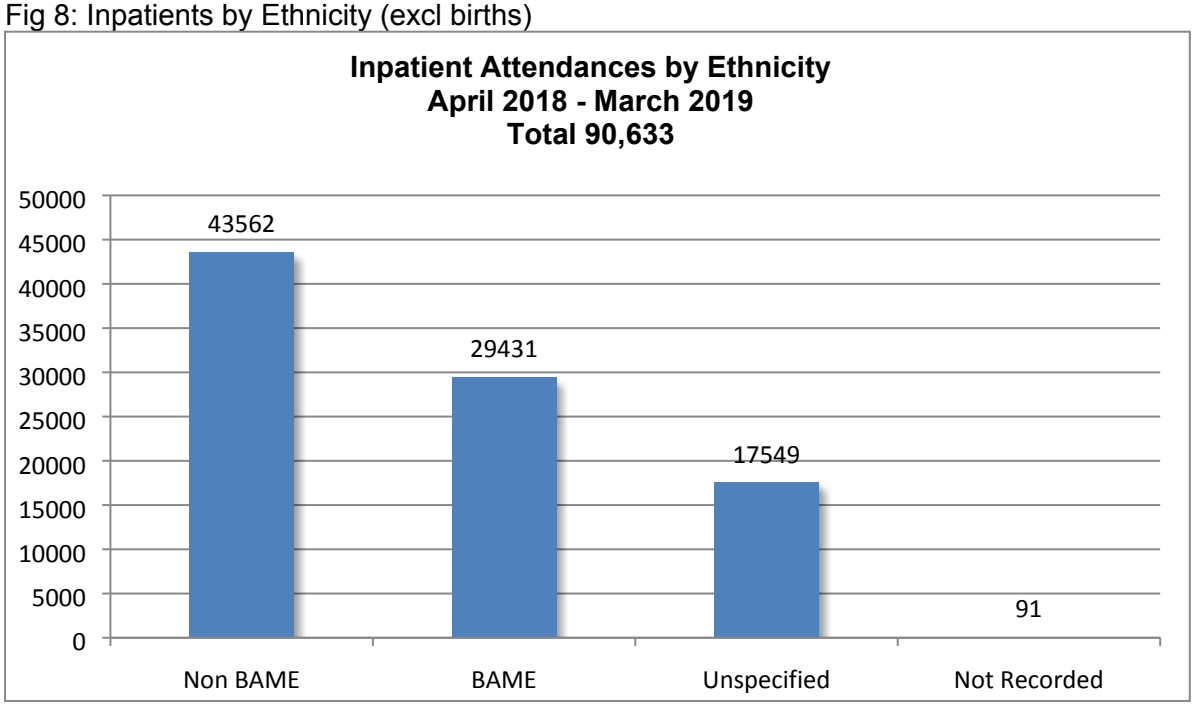
There were a total of 90,633 attendances in April 2018 – March 2019 a 6.1% increase on the year before with the 30 – 39 age range again being the most frequent users of this service the same as the previous year.

Fig 7: Inpatients by Gender (excl births)



Inpatient attendances by gender show that females make up 57% of service users with males at 41%.

Fig 8: Inpatients by Ethnicity (excl births)



Non BAME patients accounted for 48% of inpatients with BAME at 32%. Unspecified or Not Recorded accounted for 20% of attendances.

7.0 Inpatient Survey by Protected Characteristics – Appendix 2

Following the release of the national inpatient survey the Trust have undertaken further analysis of the data in relation to feedback from patients identified by protected characteristics. The data was split to enable comparison based on ethnicity, age, sexual orientation and disability.

Comparison was made between the protected characteristic group and patients not included in that group to identify areas of positive or negative experience.

Whilst there are some common themes within the inpatient survey which are applicable to all patient groups, the analysis by protected characteristic has revealed some specific issues for certain patient groups.

These messages will be shared with staff across the organisation to raise awareness and to highlight the needs of specific patient groups**.** The Key Messages were:

BAME patients

- Report higher levels of being discussed by nurses and doctors as if they were not there
- Report not being given enough information at discharge and not feeling fully involved in the process
- Report being given high levels of conflicting advice relating to clinical care and treatment

Patients with disabilities

- Report not being given enough privacy when discussing care or having the right level of emotional support
- Report not having access to staff within a reasonable time when help was needed and low satisfaction with pain control.
- Several issues relation to the discharge process were also highlighted, specifically about information and medication.

Age

- Older patients report less satisfaction with the availability of staff to help when needed and less satisfaction with level of involvement in decisions about their care.
- Older patients report less opportunity to discuss their concerns with staff and they find the advice they are given by staff contradicts each other
- Older patients also feel they would like more involvement in decisions relating to their discharge.

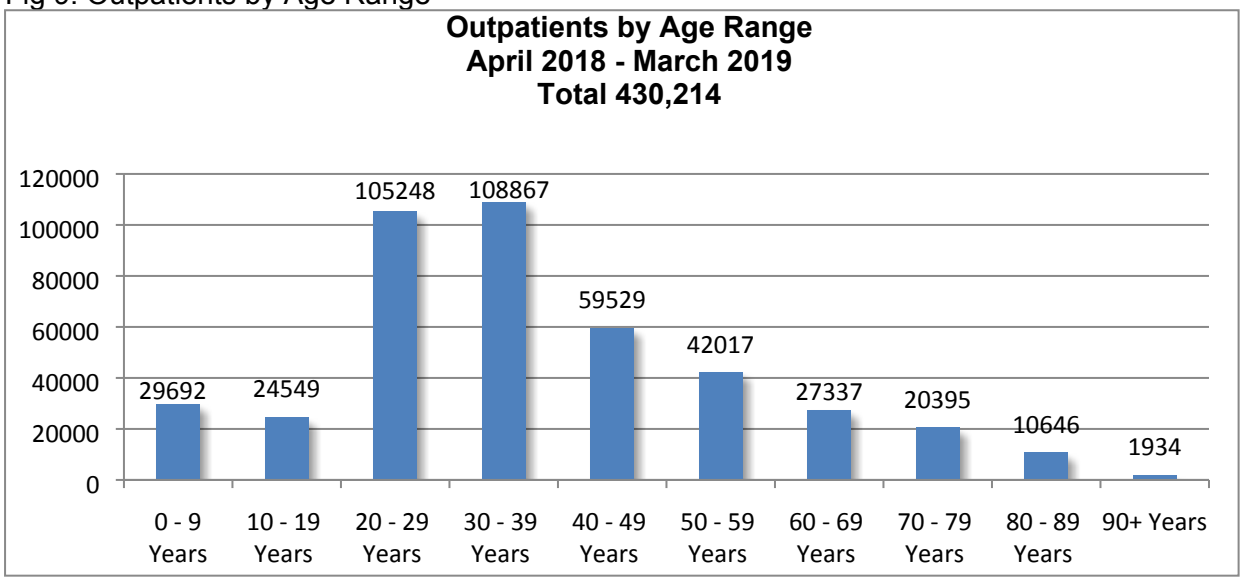
The above key messages have been used to educate staff in the in-patient adult areas about where they could provide a better experience for people of protected characteristics.

It should be noted that although the data was requested in relation to sexuality and sexual orientation the number of respondents in each category was to low that this characteristics was unable to be analysed with any meaningful results.

This poses a question for the organisation and wider NHS how they get people of a non-heterosexual background to divulge their sexual orientation and the reason this may be important in addressing inequalities in their care experience.

8.0 Outpatients

Fig 9: Outpatients by Age Range

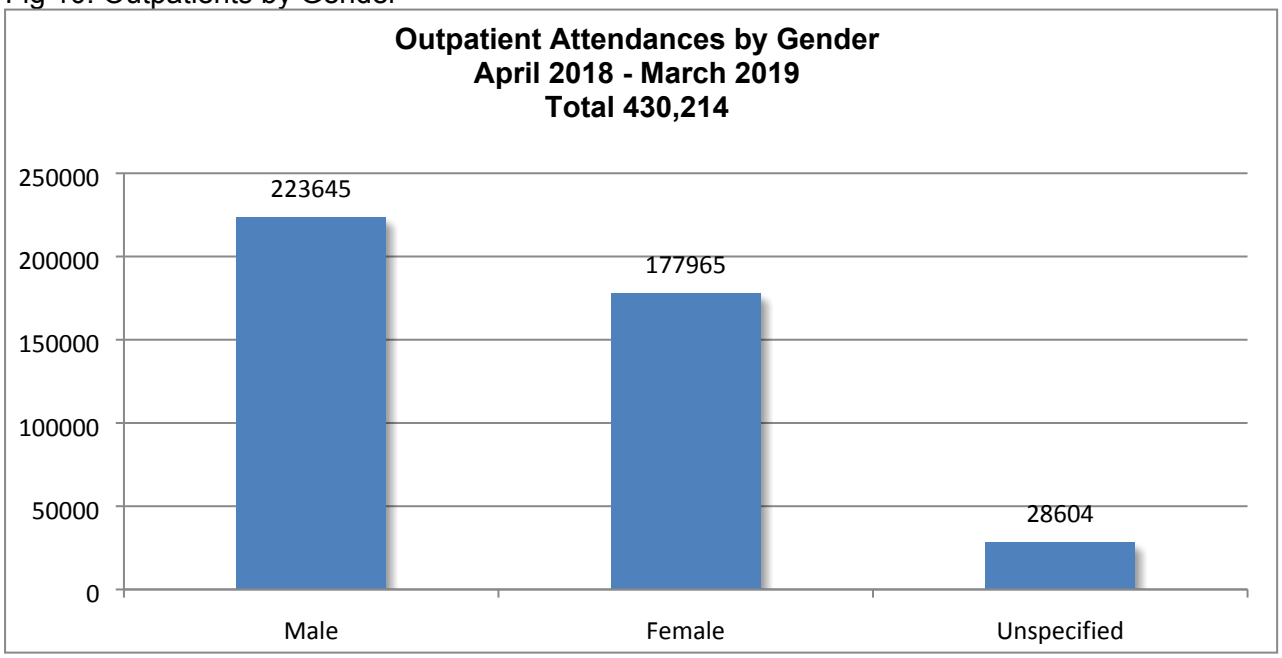


* The outpatient data only shows patients who attended an appointment and excludes cancellations or those who Did Not Attend.

430, 214 outpatients attendances in April 2018 – March 2019 is a reduction of 5.3% on the previous year. The 30-39 age range makes up the most frequent service users.

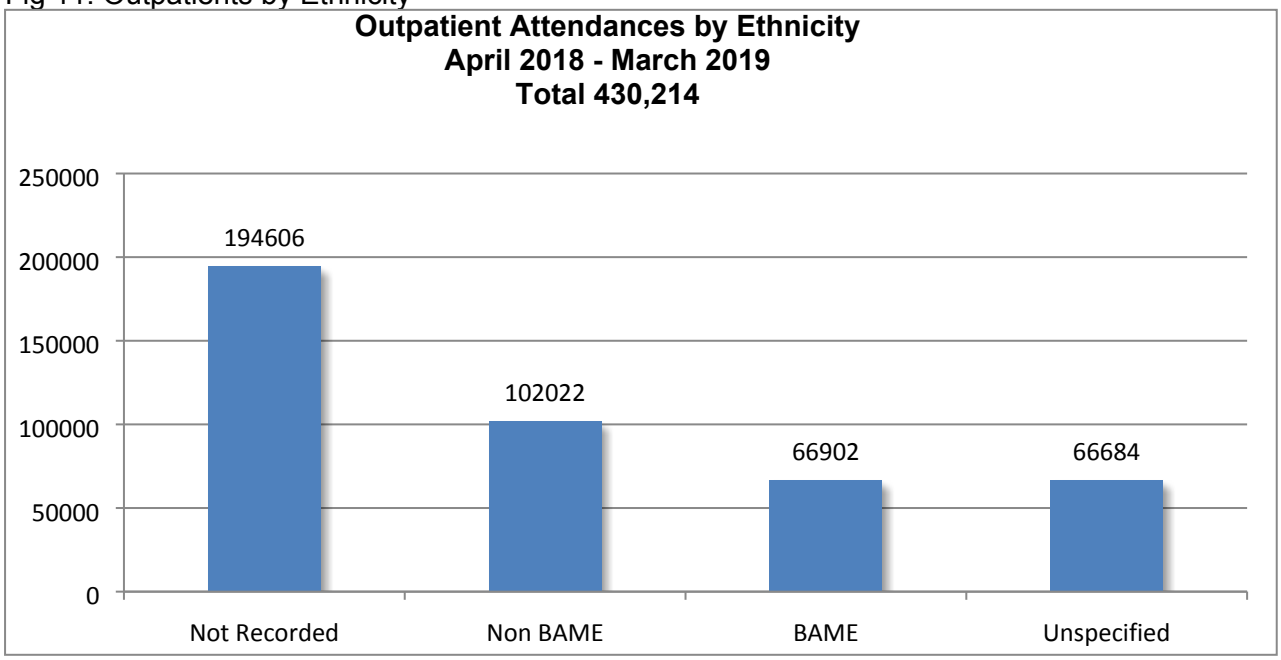
The under 60's as a whole account for 85% of users with the over 60's at 14% of the total.

Fig 10: Outpatients by Gender



Males make up the majority of attendances at 53%, females at 42%. The number of unspecified has increased to 55 from less than 1% in the previous year.

Fig 11: Outpatients by Ethnicity



Data for outpatient attendances by ethnicity from April 2018 to March 2019 shows that 60% has either not been recorded or recorded as unspecified. Of those that have been recorded 23% have been recorded as Non BAME and 15% as BAME.

9.0 Religion by Service

Fig 12: Top Religions By Service

Religion	Inpatients		A&E		Outpatients	
Christian (all other denominations)	5454	(6.0%)	6246	(6.4%)	15597	(3.6%)
Church of England	1559	(1.7%)	1221	(1.2%)	2675	(0.6%)
Hindu	1193	(1.3%)	1161	(1.1%)	2470	(0.5%)
Muslim	2740	(3.0%)	3639	(3.7%)	6049	(1.4%)
Sikh	920	(1.0%)	1241	(1.2%)	1922	(0.4%)
Roman Catholic	1625	(1.8%)	1285	(1.3%)	2788	(0.6%)
Jehovah's Witness	32	(0.1%)	21	(0.1%)	42	(0.1%)
Jewish	114	(0.2%)	95	(0.1%)	317	(0.1%)
Buddhist	160	(0.2%)	154	(0.2%)	325	(0.1%)
All other religions	81825	(90.2%)	83287	(85.8%)	207747	(48.2%)
Patient Religion Unknown	71300	(78.6%)	77093	(79.4%)	195979	(45.5%)
Not Declared	32	(0.03%)	17	(0.1%)	49	(0.1%)
Total of all denominations	**90633**		**97004**		**430214**	

The Trust collects data on the religious beliefs of patients 33 different denominations were recorded this year. The top most recorded individual religious beliefs by service are shown in the above. There remains a high percentage ranging from (45% to 79%) across the services were the patient religious beliefs are unknown. This is where the patient has not been asked. Only are very small number of patients would appear to refuse to declare their religious belief when asked (Not Declared). More accurate recording of patients' religious belief is addressed through the Trust patient equality objectives.

10.0 Learning Disabilities

The Trust continues to focus on improving the experience of patients with learning disabilities and/or autism together with their families and carers. The Trusts Learning Disability Support Group meets bi-monthly with representatives from all areas and departments of the Trust. In 2018 the Trust employed a part time Deputy Lead Nurse for Learning Disabilities and Transition who is based at the WMUH site.

Learning Disability Level 2 Training sessions continue to be held monthly for all levels of Trust staff with over 5,300 staff trained since 2014 as well as providing Learning Disability awareness sessions at Trust Induction for new clinical staff and training for all new junior doctors at every new intake.

In September 2018 the first Project SEARCH programme was started at the WMUH site with a particular focus on providing on the job training for young people with autism. In July 2019 this project was short-listed for the Health Service Journal learning disability award. Of the original 8 students from the pilot programme 7 have been placed within a substantive work placement in the organisation. The second cohort of young people have started at both sites with a view to using this as an on-going method of supporting their development from students to the work place.

11.0 Accessible Information Standard (AIS)

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

A working group has been established to oversee this project which will be a long term on-going commitment. The below table identifies the Trust level of compliance as at August 2019.

Fig:13: AIS Compliance at August 2019

Domain	Description	Actions required	Compliance
1. Identify	Identify communication needs (as opposed to disability) as part of an individual's first or next interaction with the Trust	Development of the Accessible Information Policy	Completed November 2017 **Green**
2. Record and flag	Communication needs to be clearly visible in records.	Cerner change request to be instigated to add flags for written communication needs and communication needs during care	**Amber**
3. Share	Information needs to be shared between departments in the Trust and with other providers, as appropriate.		Dependent on 2, above **Amber**
4. Meet the need – patient information leaflets	Information provided in in the appropriate accessible format	Patient information leaflets to be migrated to the hospital website, which has extensive accessibility features	In pilot phase **Amber**

Domain	Description	Actions required	Compliance
5. Meet the need – letters	Information provided in in the appropriate accessible format	Appointment and other patient letters to be provided in the appropriate format	There will be partial compliance when the Care Information Exchange is running **Amber**
6. Meet the need – use of interpreters during care	Information provided in in the appropriate accessible format	Face-to-face or remote interpreters to be available during care	**Green**

12.0 Accessibility Working Group

In September 2019 the Trust has set up an Accessibility Working Group with the aim to identify the accessibility needs for disabled staff, patients and members of the public using our services and to prioritise these against evidence based framework. The purpose of the group is to:

• Identify an agreed accessibility framework

•To identify evidence of initiatives that improve access in both the physical and virtual environments and objectively assess the merits and applicability for CWFT

• To be compliant with relevant regulations and standards and identify best practice that could be applicable to CWFT

• To review a gap analysis against the accessibility framework

• To bring a recommendation to the Trust Board as to how to:
Prioritise actions that the Trust can undertake to improve accessibility standards.
Prioritise these actions for the next 3 years, taking into account impact, risk, cost and CWFT values.
Recognising the opportunity for CWFT to work towards a leadership position in accessibility

13.0 Rainbow Badges

In March 2019 the Trust joined the national NHS Rainbow Badge initiative. The initiative originated at Evelina London Children's Hospital part of Guy's and St Thomas' NHS Foundation Trust.

Rainbow Badges is an initiative that gives staff a way to show that Chelsea and Westminster Hospital NHS Foundation Trust offers open, non-judgemental and inclusive care for patients and their families, who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means that we are inclusive of all identities, regardless of how people define themselves). Within six weeks of the launch of the initiative over 1000 staff applied for and were wearing a rainbow badge. A rainbow badge is now a recognisable symbol of inclusion worn by staff around the Trust.

14.0 Interpretation & Translation

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

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

Interpreting; relates to the spoken word.

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

The tables below indicate the usage of Interpretation and Translation Services between April2018– March 2019 across Trust services and sites.

The top 10 Face to face languages

Language	Total Serviceable 2019	2018 Usage Total Serviceable Jobs	Position in 2018
Arabic	450	543	1
British Sign Language	364	214	5
Polish	250	239	3
Spanish	249	284	2
Arabic (Middle Eastern)	183	N/A	n/a
Farsi	175	218	4
Portuguese	162	192	6
Farsi (Persian)	104	218	n/a
Russian	99	102	7
Somali	96	85	8

Top 10 Telephone languages

Language	Total Serviceable 2019	2018 Usage Total Serviceable Jobs	Position in 2018
Arabic	390	288	1
Spanish	159	136	3
Romanian	146	112	5
Portuguese	144	148	2
Polish	122	129	4
Farsi (Persian)	99	77	9
Albanian	61	n/a	n/a
Somali	60	101	6
Mandarin	58	n/a	n/a
Amharic	57	80	7

Top 5 users of Telephone Interpreting by Department

Account Name	Serviceable	2018 Usage Total Serviceable Jobs
Antenatal Clinic / Ultrasound	376	250
Dean Street	197	161
Medicine Outpatients	139	155
Paediatric Outpatients	116	98
Accident & Emergency	104	n/a

Face to Face Bookings by Department

Client Name	Serviceable	Serviced
Chelsea and Westminster Hospital NHS Foundation Trust	2455	2361
Pain Clinic	119	117
Endoscopy Unit	56	55
Physiotherapy	54	51
Women's Services and Sexual Health	43	42

Appendix 1

Maternity Services National Survey 2018

Introduction

As part of the Patient Experience Programme Chelsea and Westminster Healthcare NHS Foundation Trust undertook the national maternity services survey 2018. The survey was undertaken by Picker and data collection took place in February 2018.
As part of the equality and diversity programme an interest arose as to how the feedback on the service may have different between those from a Black and Asian Minority Ethnicity (BAME) and those for ethnicities outside of these (non-BAME).

Methodology

Picker was able to pull the data set sorted by ethnicity, and provide a comparisons between the BAME, non-BAME and trust aggregate score. The data were sorted and categorised. Where there was a discrepancy greater than 2% between the BAME and non-BAME group this was considered to demonstrate a difference in experience which may require further attention.

Results

Areas where BAME service users reported a higher level of satisfaction were as follows:

Question	Trust Score	Non BAME Respondents	BAME Respondents
B7+ Given a choice about where to have check-ups	42%	36%	56%
B9+ Felt midwives aware of medical history	81%	78%	92%
B14+ Given the help needed by midwives	94%	93%	96%
C15+ Felt concerns were taken seriously	81%	80%	87%
C18+ Involved enough in decisions about their care	93%	91%	98%
D3 Discharged without delay	52%	51%	56%
D5+ Received attention within a reasonable time	89%	88%	95%
D6+ Given enough information	93%	92%	97%
D9+ Found hospital ward very or fairly clean	96%	95%	98%

E3+ Felt midwives gave consistent advice	**82%**	81%	85%
E4+ Felt midwives gave active support and encouragement about feeding their baby	**90%**	90%	94%
F1+ Given a choice about where to have check-ups	**42%**	37%	56%
F8+ Felt midwives aware of medical history	**74%**	69%	94%
F10+ Found that midwives took personal circumstances into account	**97%**	96%	99%
F14+ Given enough information about their own physical recovery	**86%**	83%	94%
F16+ Received support or advice about feeding their baby during evenings, nights or weekends	**69%**	69%	73%

Areas where BAME service users reported lower levels of satisfaction compared to non-BAME service users were:

Question	Trust Score	Non BAME Respondents	BAME Respondents
B4+ Offered a choice of where to have baby	**92%**	95%	89%
F2+ Had a telephone number for midwives	**94%**	95%	92%
F7 Saw the midwife as much as they wanted	**69%**	71%	62%

Discussion

It's interesting to note that for several of the categories BAME service users reported higher levels of satisfaction than the non-BAME service users. This included choice about where t have appointments and the midwives knowledge of past medical history. Higher levels of satisfaction with knowledge about their care and that concerns were taken seriously also was reported.

BAME service users also reported that they felt they were discharged in the right time, received enough information, consistent advice given by midwives and the cleanliness of the environment.

Whilst many areas received positive feedback from our BAME group three areas were identified where BAME service users reported a lower level of positive experience. BAME service users reported that they were less satisfied with the amount of choice of where to have their baby, lower levels of having telephone numbers of the midwives and saw the midwife as much as they would have liked. These are all area of improvement that could be addressed by the maternity services.

Conclusion

Over all there are many areas within the survey where the BAME service users report higher levels of satisfaction that the non-BAME service users. The three areas identified as being reported less favourably provide a focus for the department of where they could target their efforts to improve the experience of the BAME service users. There remain areas of the survey where satisfaction with the service could be improved for both groups; these should also be addressed in the local action plan.

Full Survey Results

Question	Trust Score	Non BAME Respondents	BAME Respondents
B4+ Offered a choice of where to have baby	**92%**	95%	89%
B6+ Given enough information about where to have baby	**89%**	89%	89%
B7+ Given a choice about where to have check-ups	**42%**	36%	56%
B9+ Felt midwives aware of medical history	**81%**	78%	92%
B10+ Had enough time to ask questions during check-ups	**97%**	97%	97%
B11+ Felt midwives listened	**99%**	98%	100%
B12+ Found midwives asked how mother was feeling emotionally	**93%**	94%	92%
B13+ Had a telephone number for midwives	**97%**	96%	97%
B14+ Given the help needed by midwives	**94%**	93%	96%
B15+ Spoken to in a way they could understand	**99%**	99%	98%
B16+ Involved enough in decisions about their care	**97%**	96%	100%
B17+ Provided with relevant information about feeding their baby	**86%**	86%	87%
C1+ Felt they they were given appropriate advice and support at the start of labour	**87%**	86%	88%
C3+ Able to move around and choose own position	**90%**	91%	88%
C10+ Had skin to skin contact with baby shortly after birth	**95%**	96%	94%
C11+ Partner / companion involved	**97%**	98%	98%
C12+ Found staff introduced themselves	**99%**	99%	99%
C14 Not left alone when worried	**79%**	79%	77%
C15+ Felt concerns were taken seriously	**81%**	80%	87%
C16+ Received attention within a reasonable time	**93%**	94%	94%

C17+ Spoken to in a way they could understand	**99%**	99%	99%
C18+ Involved enough in decisions about their care	**93%**	91%	98%
C19+ Treated with respect and dignity	**97%**	97%	98%
C20+ Had confidence and trust in staff	**96%**	97%	98%
D2+ Felt length of stay in hospital was about right	**73%**	73%	73%
D3 Discharged without delay	**52%**	51%	56%
D5+ Received attention within a reasonable time	**89%**	88%	95%
D6+ Given enough information	**93%**	92%	97%
D7+ Treated with kindness and understanding	**96%**	95%	97%
D8+ Found partner was able to stay with them as long as they wanted	**70%**	69%	69%
D9+ Found hospital ward very or fairly clean	**96%**	95%	98%
E2+ Found decisions as to how to feed their baby were respected by midwives	**96%**	96%	97%
E3+ Felt midwives gave consistent advice	**82%**	81%	85%
E4+ Felt midwives gave active support and encouragement about feeding their baby	**90%**	90%	94%
F1+ Given a choice about where to have check-ups	**42%**	37%	56%
F2+ Had a telephone number for midwives	**94%**	95%	92%
F3+ Given the help needed by midwives	**91%**	92%	91%
F7 Saw the midwife as much as they wanted	**69%**	71%	62%
F8+ Felt midwives aware of medical history	**74%**	69%	94%
F9+ Felt midwives listened	**99%**	99%	99%
F10+ Found that midwives took personal circumstances into account	**97%**	96%	99%
F11+ Had confidence and trust in midwives	**97%**	97%	99%
F13+ Found midwives asked how mother was feeling emotionally	**98%**	99%	97%
F14+ Given enough information about their own physical recovery	**86%**	83%	94%
F15+ Received help and advice about feeding their baby	**89%**	90%	88%
F16+ Received support or advice about feeding their baby during evenings, nights or weekends	**69%**	69%	73%

Appendix 2

National Inpatient survey - Protected characteristic analysis

Introduction

Following the release of the national inpatient survey the Trust have undertaken further analysis of the data in relation to feedback from patients identified by protected characteristics. The data was split to enable comparison based on ethnicity, age, sexual orientation and disability.

Comparison was made between the protected characteristic group and patients not included in that group to identify areas of positive or negative experience.

Ethnicity

The data was split by those identifying as Black and Asian (BAME) and non-BAME. All but one question received adequate response rates to allow comparison. Patients who identified as from a BAME background reported a more positive experience than non-BAME patients in the following areas:

Accident & Emergency - Waiting list or planned admission - All types of admission	Non BAME	BAME	Total
Q7. Planned admission: admission date not changed by hospital	67.74	80.00	70.87
The hospital & ward (part 1 of 2)			
Q14. Hospital: not bothered by noise at night from other patients	54.89	63.49	56.54
Q15. Hospital: not bothered by noise at night from staff	79.35	83.87	78.72
The hospital & ward (part 2 of 2)			
Q17+. Hospital: got enough help from staff to wash or keep clean	87.27	92.11	89.71
Doctors			
Q24. Doctors: had confidence and trust	97.86	100.00	97.89
Your care & treatment (part 2 of 2)			
Q38+. Care: enough emotional support from hospital staff	79.00	82.22	79.17
Q42. Care: staff helped control pain	90.18	95.83	91.89
Leaving hospital (part 1 of 2)			
Q49. Discharge: given enough notice about when discharge would be	84.57	90.48	86.71
Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital	62.78	70.31	66.55
Leaving hospital (part 2 of 2)			
Q63. Discharge: told who to contact if worried	75.45	80.70	76.08

Particular areas of positive feedback or this group related to confidence in doctors, adequate pain control and increased satisfaction with the discharge process.

Patients who identified as BAME reported negative experiences in relation to the following

Accident & Emergency - Waiting list or planned admission - All types of admission	Non BAME	BAME	Total
Q9. Admission: did not have to wait long time to get to bed on ward	72.38	53.85	64.89
The hospital & ward (part 1 of 2)			
Q11. Hospital: did not share sleeping area with opposite sex	91.53	85.94	91.00
The hospital & ward (part 2 of 2)			
Q18+. Hospital: able to take own medication when needed to	84.54	76.92	80.13
Doctors			
Q25. Doctors: not talked in front of patients as if they were not there	75.79	57.81	71.68
Nurses			
Q28. Nurses: not talked in front of patients as if they weren't there	80.95	52.38	73.94
Q29. Nurses: always or nearly always enough on duty	63.49	39.06	59.09
Your care & treatment (part 1 of 2)			
Q33. Care: staff did not contradict each other	71.05	50.00	65.26
Leaving hospital (part 1 of 2)			
Q48+. Discharge: felt involved in decisions about discharge from hospital	85.08	75.41	81.09
Leaving hospital (part 2 of 2)			
Q59+. Discharge: given clear written/printed information about medicines	91.67	83.33	88.41
Q61+. Discharge: family or home situation considered	76.85	71.74	74.03
Q65+. Discharge: staff discussed need for further health or social care services	81.82	75.68	79.17

areas compared to non-BAME patients:

Particular areas of reduced satisfaction focussed on doctors and nurses talking in front of patients as if they were not there, the number of nurses on duty, contradictions in advice relating to care and being sufficiently involved in decisions about discharge. Despite high levels of satisfaction with the discharge process several areas relating to discharge have been identified as poorer patient experience.

The Trust has had no same sex accommodation breaches in a long period of time and as such the satisfaction with sharing accommodation with people of the opposite sex is not fully understood.

Disability

Patients are asked to indicate if they suffer from a disability. The data was complete with sufficient responses in all areas to provide an analysis. The survey does not ask for indication of type of disability and so all patients who identify as having any disability are represented in this data set.

Accident & Emergency - Waiting list or planned admission - All types of admission	Disability	No Disability	total
Q4. A&E Department: given enough privacy when being examined or treated	98.91	95.31	96.83
Q6. Planned admission: was admitted as soon as necessary	78.57	66.67	73.20
Q7. Planned admission: admission date not changed by hospital	80.95	55.56	70.87
The hospital & ward (part 1 of 2)			
Q11. Hospital: did not share sleeping area with opposite sex	95.00	82.11	91.00
Leaving hospital (part 1 of 2)			
Q48+. Discharge: felt involved in decisions about discharge from hospital	85.40	82.22	81.09

High levels of satisfaction are reported in relation to the privacy and dignity offered in the ED and the waiting time for admission where this was required. There was high incidence of satisfaction with the level of involvement in discharge plans.

The hospital & ward (part 2 of 2)	Disability	No Disability	total
Q17+. Hospital: got enough help from staff to wash or keep clean	86.67	92.45	89.71
Q19+. Hospital: food was very good or good	51.82	60.92	54.65
Doctors			
Q23+. Doctors: got clear answers to questions	89.31	95.51	93.16
Nurses			
Q28. Nurses: not talked in front of patients as if they weren't there	71.22	79.79	73.94
Your care & treatment (part 2 of 2)			
Q38+. Care: enough emotional support from hospital staff	74.68	85.71	79.17
Q39. Care: enough privacy when discussing condition or treatment	90.00	97.89	93.71
Q42. Care: staff helped control pain	87.80	96.83	91.89
Q43+. Care: staff helped within reasonable time when needed attention	89.47	95.45	92.11
Leaving hospital (part 1 of 2)			
Q50. Discharge: was not delayed	54.35	62.11	56.89
Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital	60.00	73.40	66.55
Q57+. Discharge: told purpose of medications	86.73	98.68	91.67
Q58+. Discharge: told side-effects of medications	58.82	72.73	62.89
Overall			
Q70. Overall: asked to give views on quality of care	18.64	25.32	21.65

Lower levels of satisfaction were reported in relation to the quality of the food, the satisfaction with explanations and the issue of nurses talking about the patient as if they

were not there. Issues were raised in relation to privacy when discussing care, the level of emotional support offered, the availability of staff within a reasonable time when help was needed and the level of pain control. Several issues relation to the discharge process were also highlighted, specifically about information and medication.

Sexual orientation

Other than for patents that identify as heterosexual / straight there were insufficient sample sizes to allow for comparison of patients experience based on sexual orientation. Even when groups not identifying as heterosexual were aggregated there was still insufficient sample size for comparison.

Age

Age demographics are aggregated into ten year age bands below. There were insufficient responses in all ranges with the exception of 50 – 89 years old.

The hospital & ward (part 2 of 2)	50-59	60-69	70-79	80-89	Total
Q17+. Hospital: got enough help from staff to wash or keep clean	*	91.67	93.33	86.27	89.71
Q18+. Hospital: able to take own medication when needed to	*	93.33	82.86	77.50	80.13
Nurses					
Q26+. Nurses: got clear answers to questions	96.77	95.45	92.00	90.32	93.63
Q28. Nurses: not talked in front of patients as if they weren't there	81.25	75.00	75.00	69.44	73.94
Q30. Nurses: knew which nurse was in charge of care	90.32	88.00	72.13	75.00	78.32
Your care & treatment (part 1 of 2)					
Q32. Care: staff worked well together	90.32	95.74	98.31	95.52	95.54
Q33. Care: staff did not contradict each other	78.13	62.00	67.80	68.06	65.26
Q34. Care: was involved as much as wanted in decisions	90.63	90.20	81.97	82.43	86.11
Your care & treatment (part 2 of 2)					
Q37+. Care: found staff member to discuss concerns with	*	82.86	60.61	56.10	70.88
Operations & procedures					
Q47. Procedure: explained how it had gone in an understandable way	*	93.33	97.37	87.50	93.59
Leaving hospital (part 1 of 2)					
Q48+. Discharge: felt involved in decisions about discharge from hospital	84.38	88.24	85.00	68.75	81.09
Q49. Discharge: given enough notice about when discharge would be	81.25	96.15	88.33	85.71	86.71
Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital	75.00	57.69	70.69	65.22	66.55
Overall					
Q67. Overall: treated with respect or dignity	93.75	97.96	100.00	97.26	97.55

Satisfaction declines with age in relation to gaining assistance from staff and access to own medication in addition to a range of factors relating to nursing staff. Older patients also reported less satisfaction with the level of involvement with decisions and they reported more often that staff contradicted each other.

Older patients reported they were less opportunity to discuss their concerns with staff and hey felt that staff were less clear in their explanations of what would happen. Satisfaction with involvement regarding decisions about discharge fell sharply with patients ages over 80.

Conclusion

Whilst there are some common themes within the inpatient survey which are applicable to all patient groups, the analysis by protected characteristic has revealed some specific issues for certain patient groups.

These messages will be shared with staff across the organisation to raise awareness and to highlight the needs of specific patient groups.

Key Messages

BAME patients

- Report high levels of being discussed by nurses and doctors as if they were not there
- Report not being given enough information at discharge and not feeling fully involved in the process
- Report being given high levels of conflicting advice relating to clinical care and treatment

Patients with disabilities

- Report not being given enough privacy when discussing care or having the right level of emotional support
- Report not having access to staff within a reasonable time when help was needed and low satisfaction with pain control.
- Several issues relation to the discharge process were also highlighted, specifically about information and medication.

Age

- Older patients report less satisfaction with the availability of staff to help when needed and less satisfaction with level of involvement in decisions about their care.
- Older patients report less opportunity to discuss their concerns with staff and they find the advice they are given by staff contradicts each other
- Older patients also feel they would like more involvement in decisions relating to their discharge

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 March 2020

PUBLIC SESSION

AGENDA ITEM NO.	March/2020
REPORT NAME	Board Assurance Framework
AUTHOR	Serena Stirling, Director of Corporate Governance and Compliance
LEAD	Serena Stirling, Director of Corporate Governance and Compliance
PURPOSE	To present the latest iteration of the Board Assurance Framework (BAF) for review and discussion.
SUMMARY OF REPORT	The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks, and also enable the Board to gain assurance about the effectiveness of these controls. All BAF risks have been reviewed by the Risk Owners, Executive Management Board and Board sub-committees since the previous version of the BAF was presented to Trust Board in November 2019.
KEY RISKS ASSOCIATED	The document sets out the key strategic risks facing the organisation including the financial and quality implications
FINANCIAL IMPLICATIONS	As above
QUALITY IMPLICATIONS	As above
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	This report presents an opportunity to demonstrate how we perform against our corporate objectives in 2019/20: • Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For review and discussion

Overview

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and also enable the Board to gain assurance about the effectiveness of these controls.

Each BAF risk is monitored through one of the Board sub committees.

All BAF risks have been reviewed by the Risk Owners, Executive Management Board and Board sub-committees since the previous version of the BAF was presented to Trust Board in November 2019.

This has resulted in a number of updates aimed at ensuring a consistent approach to the articulation of risks, controls and lines of assurance.

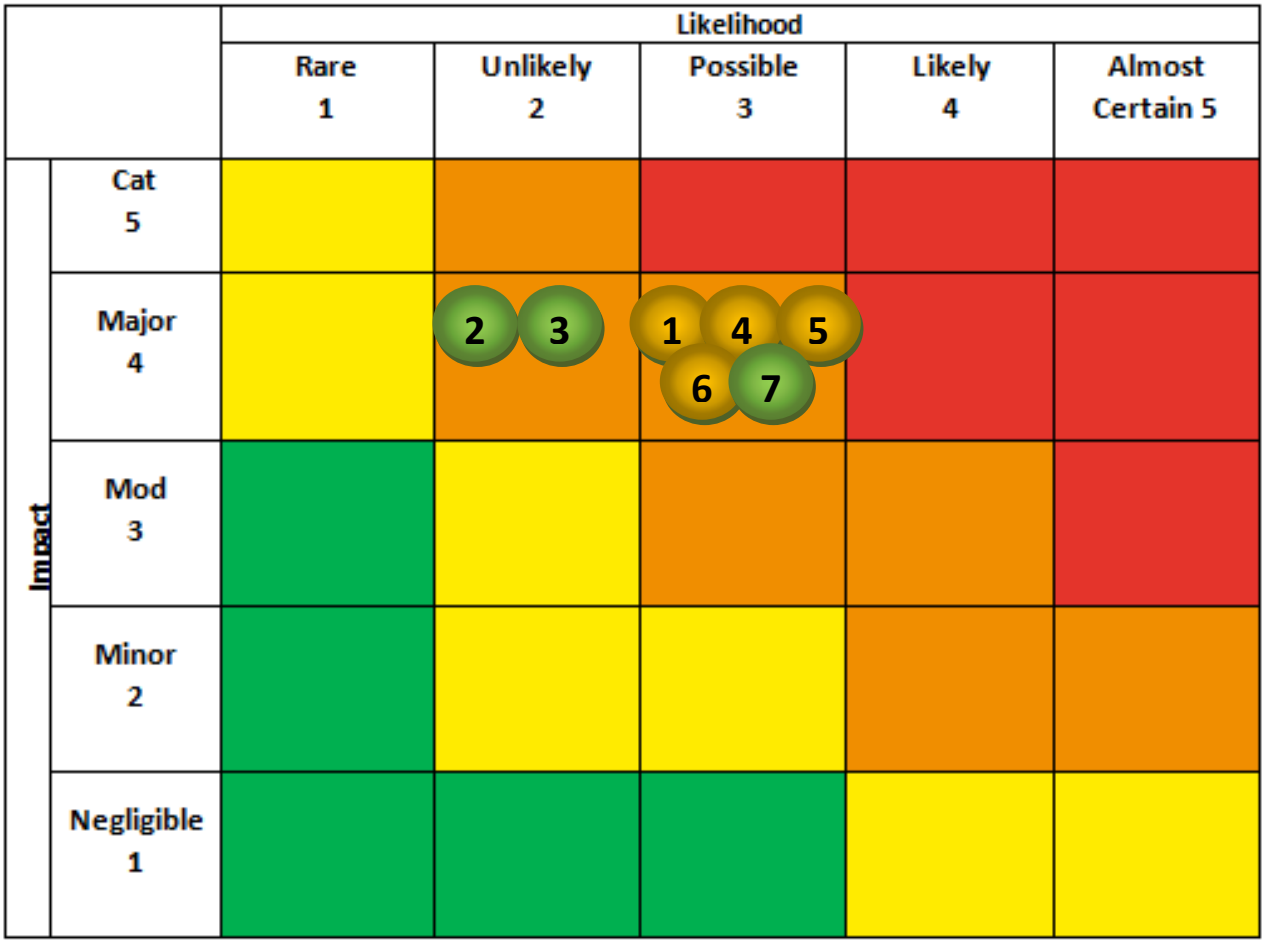
The key updates are:

- All of the individual risks have been reviewed and the controls, means of assurance and any actions required to address gaps in the controls have been updated.
- Risk scores have been reviewed by individual Risk Owners. Risk 5 'Innovation and Improvement' had a previous 'current' risk rating of 9 in the detailed risk section of the BAF, and scored 12 in the Risk summary section of the BAF. This has been reviewed by the Executive Risk Owner and confirmed as 9 and the change has been reflected in the document.

The BAF comprises seven risks which are set out at three levels of increasing detail in the following sections of the report:

- *Section 1* sets out the summary matrix of all seven BAF risks, providing a single page overview.
- *Section 2* sets out the individual risks in one table and includes the detailed individual risk statements and risk scores.
- *Section 3* provides a one page overview of each risk including the individual controls, sources of assurance and any actions required to address gaps in the controls.

1. Board Assurance Framework – Summary Matrix (February 2020)



Key: Control Assurance levels

Green - Controls are effective, no additional assurance required
Amber - Controls are partially effective, further monitoring by management is required
Red - Controls are ineffective, may require immediate action to remediate

Key: Risks

No.	Title	Assurance
1	Sustainability	Amber
2	Quality	Green
3	Culture Values and Leadership	Green
4	Use of Resources	Amber
5	Innovation & Improvement	Amber
6	Estates & Environment	Amber
7	EPR & Digital Programme	Green

2. Board Assurance Framework - Risk Summary (February 2020)

No	Short Title	Risk type and description		Gross Risk		Current Risk		Time horizon	Executive Lead / Risk Owner	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x I	T	L x I	T					
1	Sustainability	Strategic & Operational	Failure to deliver the NWL Health & Care Partnership System Recovery Plan and build a sustainable portfolio of outstanding acute and specialised services; consolidated across NWL (and beyond); leading to improved care and patient experience. Cause(s): • No/partial delivery in NWL Provider Board back office support programmes • No/partial delivery in NWL Provider Board clinical standardisation programmes • Insufficient progress with ICHT Joint Transformation Programme • Failure of CCG consolidation and fragmentation of Commissioning Intentions • The system does not have appropriate management or governance arrangements in place to support the delivery of joined up, effective and efficient services across NWL Impacting on: • The Trust's ability to support growth in activity, with the impact on performance and quality of care • The Trust's ability to implement new models of care and the resulting impact on the availability and quality of services • The Trust's freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance	4 x 4	16	3 x 4	12	1-3 years	Chief Executive	February 2020	Trust Board / Finance & Investment Committee	FIC (29/01/20)
2	Quality	Operational	Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards Cause(s): • Governance structures not in place or ineffective • Lack of alignment on priorities and plans across the organisation • Poor adherence to policies and guidelines • Cerner EPR not implemented effectively (see Risk 8) Impacting on: • The ability to deliver the best patient experience and clinical	3x5	15	2x4	8	1-12 months	Deputy Chief Executive/ Chief Nurse	January 2020	Quality Committee / Audit and Risk Committee	ARC (23/01/20) QC (03/03/2020)

			outcomes • The Trust is subject to regulatory action and possible fines because it is not able to demonstrate compliance with relevant standards e.g. CQC, Health & Safety, GDPR • The Trust is unable to demonstrate compliance with Single Operating Framework and falls below the standards set by our commissioners, regulators and those we set for ourselves including 4h A&E access, 18w RTT and Cancer standards • The Trust does not make the most effective use of its resources • The loss of reputation as a result of the above									
3	Culture, Values & Leadership	Strategic & Operational	Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market. Cause(s): • Failure to respond to the staff survey (and other indicators) • Failure to build an engaged, responsive, and inclusive workforce • Staff do not feel valued, listened to and supported Impacting on: • The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience • The ability of the Trust to attract or develop competent credible leaders and promote the Trust as a place to work and provide excellent care • The health & welling and wider resilience of our people • The extension of our culture and values outside of the organization and for the benefit of the wider population • The Trust's reputation with partners, commissioners, regulators, the NHS and the public	4 x 4	16	2 x 4	8	1-2 years	Director of HR & OD	January 2020	Trust Board/ People & Organisational Development Committee	POD (29/01/20)
4	Use of Resources	Strategic & Operational	Failure to maintain the financial sustainability of the Trust and the services it provides Cause(s): • Impact of 2019/20 contract (including reduction in MFF) and commissioner demand management schemes in 20/21 • Impact of inflationary costs and price changes, including CNST premium costs • Loss of transaction funding not fully mitigated • Lack of robust financial management across operational and corporate teams to ensure the cumulative impact of all decisions is understood	4 x 5	20	3x 4	12	1-12 months	Chief Financial Officer	February 2020	Finance & Investment Committee	FIC (29/01/20)

			• Non-Delivery of financial efficiency targets • Digital and other innovations are not fully exploited (see Risk 5) Impacting on: • The Trust's capacity to support growth in activity, with the impact on performance reducing any linked incentive funding • The ability to continue to invest in the workforce and infrastructure required to maintain and improve the quality of services • Loss of freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance									
5	Innovation & Improvement	Strategic & Operational	Failure to embed innovation and improvement in our culture and deliver innovative, patient centered services at scale Cause(s): • Staff not encouraged and enabled to drive innovation and improvement • Lack of capability and capacity to support idea generation, testing and scaling • Failure to build partnerships to access innovative ideas and technology • Failure to spread innovative practice • Lack of funding to support innovation programme Impacting on: • Transformative models of care, required to deliver wide ranging service improvement, are not adopted • Development agenda fails to grow and deliver • Lost revenue opportunities from failure to commercialise innovations • The Trust's world class care aspiration is not delivered • The Trust's s profile and reputation for innovation doesn't develop	4 x 4	16	3 x 3	9	1 -3 years	Chief Nurse/Deputy CEO	February 2020	Trust Board/ Finance & Investment Committee/ Quality Committee	FIC (29/01/20)
6	Estate & Environment	Strategic & Operational	Failure to develop our estate to support the delivery of high quality, effective and efficient care Cause(s): • Commercial and cost improvement plans not delivered • Capital constraints • Capital development programme not delivered (including ITU/NICU development) • Long term development plan for WMUH is not realised Impacting on: • Capacity to support growth in activity, with the impact on performance	4 x 4	16	3 x 4	12	1-5 years	Deputy Chief Executive	February 2020	Finance & Investment Committee	FIC (29/01/20)

			• Ability to transform models of care and improve the quality of services									
7	EPR and Digital Programme	Operational	**Short Term:** Risk that the EPR programme will not be delivered on time or within budget and that any associated risks are not effectively managed and mitigated: **Cause(s):** • Capability/ resource risks • Clinician, Executive and other staff engagement (including training) • Risks associated with multiple clinical systems and legacy impact • Data migration issues or operation of system causes data quality issues post go live impacting on reporting and quality of care • Change management does not ensure adoption of best practice and /or benefits realisation. **Impacting on:** The running of the hospitals. The Trust is unable to deliver normal services and contractual responsibilities during periods of significant disruption. Key risks include: • Cyber security • EPR migration or operational systems • Other Major Incidents **Medium to Long Term:** Failure to develop and implement Digital Strategy to support: • Modern workforce and requirements of future care • Innovation & improvement programmes • Needs and convenience of patients and population • Wider requirements of London and NWL Strategies	4 x 4	16	3 x 4	12	1-3 years	Deputy Chief Executive	January 2020	Finance & Investment Committee	FIC (29/01/20)

3. Board Assurance Framework – Controls and Assurance (February 2020)

BAF Risk 1: Failure to deliver the NWL Health & Care Partnership (HCP) System Recovery Plan and build a sustainable portfolio of outstanding acute and specialised services; consolidated across NWL (and beyond); leading to improved care and patient experience. **Cause(s):** • **No/partial delivery in NWL Provider Board back office support programmes** • **No/partial delivery in NWL Provider Board clinical standardisation programmes** • **Insufficient progress with ICHT Joint Transformation Programme** • **Failure of CCG consolidation and fragmentation of Commissioning Intentions** • **The system does not have appropriate management or governance arrangements in place to support the delivery of joined up, effective and efficient services across NWL.** **Impacting on:** • **The Trust's ability to support growth in activity, with the impact on performance and quality of care** • **The Trust's ability to implement new models of care and the resulting impact on the availability and quality of services** • **The Trust's freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance** ***NB Extreme risk on Trust Risk Register is the continued growth in Non Elective activity impacting quality, safety and performance.***	**Executive Owner:** **Chief Executive**

Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
Quality and Use of Resources	4 x 4 = 16 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Deliver better care at lower cost	Well-Led	Trust Board / Finance & Investment Committee	29/01/20

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
A NWL STP Chair has been appointed. Delivery against NWL System Recovery Plan is overseen by NWL System Recovery Board. Progress is also monitored through the NWL Provider Board. Both are chaired by the CWFT CEO as the SRO for the NWL HCP and delivery is supported by a Turnaround Director. The CWFT Deputy CEO attends Provider Board as the Trust's' representative.	NWL System Recovery Plan Update Report Programme Reports Deep Dive Reports	Impact assessment on CWFT of: 1)System recovery programmes 2) Contract and operating plan	CEO	May 2020
Transformation Boards in place to support delivery of the key the NWL Health & Care Partnership programmes and strategy. CW Directors have lead operational and relational roles for many of these programmes.	NWL H&CP Clinical and Care Strategy Programme Reports Deep Dive Reports	Ensure CW Executive Directors lead on major work programmes	CEO	March 2020
Joint programme of work with Imperial College Healthcare Trust in place underpinned by Memorandum of understanding and overseen by Joint Executive Board.	Joint Service Transformation Plan (high level) Joint Programme update reports	Detailed programme plans to be developed and integrated into Trust Draft Operating Plan 2020/21	CEO	March 2020

BAF Risk 2: Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards **Cause(s):** • **Governance structures not in place or ineffective** • **Lack of alignment on priorities and plans across the organisation** • **Poor adherence to policies and guidelines** • **Quality of information does not support effective decision making** • **Cerner EPR not implemented effectively (see Risk 8)** **Impacting on:** • **The ability to deliver the best patient experience and clinical outcomes** • **The Trust is subject to regulatory action and possible fines because it is not able to demonstrate compliance with relevant standards e.g. CQC, Health & Safety, GDPR** • **The Trust is unable to demonstrate compliance with Single Operating Framework and falls below the standards set by our commissioners, regulators and those we set for ourselves including 4h A&E access, 18w RTT and Cancer standards** • **The Trust does not make the most effective use of its resources** • **The loss of reputation as a result of the above**			**Executive Owner:** **Deputy Chief Executive / Chief Nurse**
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
Quality	3 x 5 = 15 (Extreme)	2x4= 8 (Moderate)	1x4 = 4 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Deliver high quality patient centred care	Well-Led	Quality Committee / Audit & Risk Committee	Audit & Risk Committee – 23/01/20 Quality Committee – 03/03/20

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
Established Board Governance structures and processed in place to monitor all relevant national and local quality, performance and regulatory standards including: • Integrated Quality &Performance report incorporating national quality, performance and financial standards monitored through Quality Committee and Trust Board • CQC registration requirements monitored through Clinical Effectiveness Committee. CQC action plan monitored through Quality Committee • Legal function, compliance and outcomes monitored at Executive Management Board and reported to Quality Committee including evidence of learning • Annual internal audit programme agreed and monitored through Audit and Risk Committee	Patient experience, serious Incident , complaints and mortality surveillance reports Integrated Quality &Performance report National survey reports and action plans Annual legal report Clinical audit reports Internal and external audit reports NHSE/I Provider Oversight Meetings CQC self-assessment and Inspection reports Embedded quality assurance system Ward accreditation Deep Dives Benchmarking information	CQC inspection due in Q3 2019/20 Annual self-evaluation of Board Committee effectiveness	Chief Nurse Company Secretary	Complete - February 2020 Complete – January 2020
Divisional oversight and governance structures in place to monitor all relevant national and local quality, performance and regulatory standards reporting to the Trust's Executive Management Board (EMB)	Divisional Update Reports to EMB Divisional Performance and Improvement Reports Divisional Finance Reports	Ensure Integrated Performance report is kept relevant and aligned to internal and national reporting requirements	Deputy CEO	March 2020

Embedded top down and bottom up annual business planning process ensures alignment across strategic objectives and quality, financial and operational plans. Plans are signed off through Executive Management Board, the relevant Board Committee and Trust Board.	Annual Quality Priorities and Plans Annual Operating and Financial Plans	2020/21 business planning process due to complete in Q4 2019/20	Chief Financial Officer	March 2020
Quality Impact Assessment (QIA) process in place to ensure any quality risks associated with proposed service changes and financial improvement plans are effectively mitigated	Project Initiation Documentation Risk matrix and mitigation plans	Process in place	Chief Nurse/Medical Director	Complete – January 2020
Mandatory training programme in place and compliance monitored through Divisional Performance & Improvement meetings, Executive Management Board, People & OD Committee and Quality Committee and Workforce Development Committee	Divisional Performance Reports Integrated Quality & Performance Report Workforce Report	Process in place	Director of Human Resources & Organisational Development	Complete – January 2020
Medical revalidation process in place and monitored through People &OD committee. Quarterly meeting with GMC Liaison officer and quarterly GMC returns made	Medical revalidation report GMC survey report	Process in place	Deputy Medical Director	Complete – January 2020

BAF Risk 3: Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market. **Cause(s):** • **Failure to respond to the staff survey (and other indicators)** • **Failure to build an engaged, responsive, and inclusive workforce** • **Staff do not feel valued, listened to and supported** **Impacting on:** • **The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience** • **The ability of the Trust to attract or develop competent credible leaders and promote the Trust as a place to work and provide excellent care** • **The health & welling and wider resilience of our people** • **The extension of our culture and values outside of the organization and for the benefit of the wider population** • **The Trust's reputation with partners, commissioners, regulators, the NHS and the public**			**Executive Owner: Director of Human Resources and Organisation Development**
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
Human Resources	4 x 4 = 16 (Extreme)	2x4= 8 (High)	2 x 3 = 6 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Be the employer of choice	Well-Led	People & OD Committee	29/01/20

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
People programme in place and delivery monitored through Workforce Development Committee and People and OD committee	People programme Staff survey report HR KPI dashboard (incl. voluntary turnover rate)	Establishment of Retention Steering Group to consolidate plans and identify further actions.	Director of Human Resources & Organisational Development	February 2020
EDI plan in place and delivery monitored through Workforce Development Committee and People & OD Committee	EDI action plan report Staff survey report	No further actions identified over and above current plans	Director of Human Resources & Organisational Development	February 2020
Health and Wellbeing plan in place and delivery monitored through Workforce Development Committee, People & OD Committee and Health and Wellbeing Steering Committee	Health and Wellbeing action plan report Staff survey report	Consolidation of OH services with alternative provider to give greater stability and service breath. Interim arrangements with Imperial to cover clinical management elements of Occupational Health service.	Deputy Director of Human Resources & Organisational Development	February 2020
Systems in place to monitor key workforce metrics including Divisional Boards, Executive Management Board, Workforce Development Committee and the People & OD Committee	Workforce KPI dashboard (incl. voluntary turnover rate) HR Transactional Services KPI dashboard	Workforce information improvement plan to develop reporting arrangements	Director of Human Resources & Organisational Development	March 2020

Systems in place to listen to and respond to staff feedback including listening events, staff networks, team brief, senior link leads and perfect day	Trust and Divisional Staff Survey Action Plans Senior link survey report Hotspot reporting New Starter 3 monthly drop in sessions	Review starter and leaver survey process to ensure action is taken on feedback. Review onboarding process to ensure optimum experience	Deputy Director of Human Resources & Organisational Development	March 2020
External systems in place for staff feedback monitored through Divisional Boards, Executive Management Board and People & OD Committee	National staff survey report GMC survey Staff Friends and Family test Freedom to Speak Up report Senior Link Partner Programme Perfect Day	No further actions identified over and above current plans	Director of Human Resources & Organisational Development	March 2020
Partnership Forum and LNC reviews formal and informal staff feedback	Internal and National staff survey scores Quarterly FFT scores Leaver surveys Union feedback	No further actions identified over and above current plans	Director of Human Resources & Organisational Development	March 2021

BAF Risk 4: Failure to maintain the financial sustainability of the Trust and the services it provides **Cause(s):** • **Impact of 2019/20 contract (including reduction in MFF) and commissioner demand management schemes in 20/21** • **Impact of inflationary costs and price changes, including CNST premium costs** • **Loss of transaction funding not fully mitigated** • **Lack of robust financial management across operational and corporate teams to ensure the cumulative impact of all decisions is understood** • **Non-Delivery of financial efficiency targets** • **Digital and other innovations are not fully exploited** **Impacting on:** • **Capacity to support growth in activity, with the impact on performance reducing any linked incentive funding** • **Ability to continue to invest in the workforce and infrastructure required to maintain and improve the quality of services** • **Loss of freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance**			**Executive Owner:** **Chief Financial Officer**
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
Use of Resources	4 x 5 = 20 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	29/01/20

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
Long term financial strategy and position is reviewed quarterly by the Finance and Investment Committee	LTFM report	Detailed planning and budget setting underway for the 2020/21 financial plan.	Chief Financial Officer	March 2020
Changes in commissioner contract terms are reviewed and signed off by the Executive Management Board, Finance and Investment Committee and Trust Board. Performance against the contract is monitored as part of the delivery against the Trust's overall financial plan.	Annual Financial Plan Divisional and Trust level monthly Financial Performance Reports	Process in place	Chief Financial Officer	Complete - January 2020
Annual financial plan signed off through Executive Management Board, Finance and Investment Committee and Trust Board	Annual Financial Plan	Process in place	Chief Financial Officer	Complete - January 2020
Annual financial improvement plan (CIP) signed off through Improvement Board, Executive Management Board and Finance and Investment Committee	Cost Improvement Plan Improvement Programme Plans Project Initiation Documents	Process in place	Chief Financial Officer	Complete - January 2020
Delivery against the Trust's overall financial plan is monitored on a monthly basis through Divisional Finance Review meetings, the Executive Management Board, Finance and Investment Committee and Trust Board	Divisional and Trust level monthly Financial Performance Reports	Process in place	Chief Financial Officer	Complete - January 2020
Delivery against the Trust's financial improvement plan (CIP) is monitored through Divisional Finance Review meetings, the Improvement Board, and Finance and Investment Committee	Improvement Programme Reports Monthly CIP Delivery Report Divisional and Financial Performance Reports	The trust is projecting a recurrent shortfall against the 2019/20 financial improvement target. Plans are in development to mitigate the gap.	Chief Financial Officer	March 2020

The effective use of resources is monitored against external benchmarks through the Improvement Board and individual programme boards (e.g. theatre productivity, bed productivity, outpatient transformation, diagnostic demand management), as well as external visits and assessments (GIRFT, NHSI)	Programme Board Reports Reference Costs & Model Hospital GIRFT Reports Use or Resources Assessment	Process in place	Chief Financial Officer	Complete - January 2020
The effectiveness of the Trust's financial control systems are monitored through the Audit and Risk Committee as part of the internal audit programme	Internal Audit Reports	Recommendations from the 2019/20 financial controls to be implemented.	Chief Financial Officer	March 2020

BAF Risk 5: Failure to embed innovation and improvement in our culture and deliver innovative, patient centered services at scale **Cause(s):** • **Staff not encouraged and enabled to drive innovation and improvement** • **Lack of capability and capacity to support idea generation, testing and scaling** • **Failure to build partnerships to access innovative ideas and technology** • **Failure to spread innovative practice** • **Lack of funding to support innovation programme** **Impacting on:** • **Transformative models of care, required to deliver wide ranging service improvement, are not adopted** • **Research & Development agenda fails to grow and deliver** • **Lost revenue opportunities from failure to commercialise innovations** • **Ability to deliver world class care aspiration** • **Profile and reputation for innovation is negatively impacted**			**Executive Owner:** **Chief Nurse/Deputy CEO**
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
Innovation	4 x 4 = 12 (Extreme)	3x3 = 9 (High)	2x3 = 6 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	29/01/20

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
Innovation Strategy Group in place to oversee the implementation of the Trust's Innovation Strategy	Innovation strategy Improvement and Innovation Framework Innovation Project tracker Media footprint for innovation Staff survey results	Formalise approach to and oversight of commercialisation and partnership agenda.	Deputy CEO	March 2020
Improvement and Innovation Framework in place setting out clear approach to developing the Trust's improvement and innovation culture, and building the Trust's capability and capacity to support this		Innovation and Improvement Champions in place across all departments	Deputy CEO	March 2020
CW Innovation Programme in place as vehicle for attracting new partners and funding. • Overseen by an Innovation Advisory Board that brings together a broad set of third party skill sets and experience to provide guidance, challenge and support • Supported by dedicated Innovation Business Partners	Feedback from Advisory Board members Innovation project tracker Innovation fund growth Media footprint for innovation	Explored the creation of an innovation fund with corporate funders and partners	Deputy CEO	March 2020
Innovation Operations Group in place to oversee delivery of Trust's portfolio of innovation projects and support diffusion of innovative practice	Innovation Project tracker Projects plan and update reports against agreed project milestones and KPIs.	Incorporate innovation in to Improvement Board monitoring and reporting structure	Deputy CEO	Complete – January 2020
Strict alignment of innovation grant awards with Trust strategy supported through Improvement and Innovation Team and overseen by Executive Management Board and CW Grants Committee	Innovation Project tracker Grant applications CW+ Impact Report	New process supported by Improvement and Innovation team will support improved capture and tracking of the full end to end process	Deputy CEO	Complete – January 2020

BAF Risk 6: Failure to develop our estate in a sustainable way to support the delivery of high quality, effective and efficient care **Cause(s):** • **Commercial and cost improvement plans not delivered** • **Capital development programme not delivered (including ITU/NICU development)** • **Long term development plan for WMUH is not realised** **Impacting on:** • **Capacity to support growth in activity, with the impact on performance** • **Ability to transform models of care and improve the quality of services** • **Environmental impact of how we deliver services**			**Executive Owner:** **Deputy Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Estate & Environment	4 x 4 = 16 (Extreme)	3x4 =12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	29/01/20	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
Estates Strategy approved by Trust Board and reviewed through Finance and Investment Committee and Trust Board Strategy sessions	Estates Strategy WMUH Site Master Plan	Site Master Plan for WMUH and supporting arrangements in development. Procurement process to be established.	Deputy Chief Executive	Complete – January 2020
Capital Development Programme, aligned to Estates Strategy, signed off and regularly reviewed through Capital Programme Board, Finance and Investment Committee and Trust Board	Capital Development Programme Report ERIC report Targeted Deep Dive – Estates Capital Strategy Senior Link Partner Programme Ward Accreditation		Deputy Chief Executive	March 2020
Annual Operating Plan and budgets aligned with Capital Development Programme with clear scheme of delegation with regular updates to Executive Management Board	Estates and Facilities Monthly Report		Deputy Chief Executive	March 2020
ITU/NICU development overseen by dedicated Programme Board reporting to Finance and Investment Committee	ITU/NICU Programme Report Internal Audit	Apply learning from the NICU/ICU project and ensure that the contingency for unknown risks in future major developments is adequate	Deputy Chief Executive	March 2020
Rolling maintenance programme in place aligned to Annual Operating Plan	Estates and Facilities Monthly Report Targeted Deep Dive – Estates Capital Strategy	Establish a sub-group to regularly review capital expenditure on each site	Deputy Chief Executive	Complete - February 2020

BAF Risk 7: Short Term: Risk that the EPR programme will not be delivered on time or within budget and that any associated risks, including business continuity, are not effectively managed and mitigated Cause(s): • Capability/ resource risks • Clinician, Executive and other staff engagement (including training) • Risks associated with multiple clinical systems and legacy impact • The of data migration issues or operation of system causes data quality issues post go live impacting on reporting and quality of care • Change management does not ensure adoption of best practice and / or benefits realization Impacting on: The running of the hospitals. The Trust is unable to deliver normal services and contractual responsibilities during periods of significant disruption. Key risks include: • Cyber security • EPR migration or operational systems • Other Major Incidents Medium to Long Term: Failure to maximize the benefits from the EPR programme and develop and implement a wider Digital Strategy to support: • Modern workforce and requirements of future care • Innovation & improvement programmes • Needs and convenience of patients and population • Wider requirements of London and NWL Strategies			Executive Owner: Deputy Chief Executive
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**
EPR and Digital Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate)
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	29/01/20

Current controls and assurance	Actions to further enhance risk management			
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
Established series of external Gateway Reviews for Key Stages Go/No Go decisions. External auditors assurance and actions monitored at EPR Board and Finance and Investment Committee.	Monthly EPR Programme Report External Audit gateway reports	Final gateway report due to be reviewed at Finance and Investment Committee ahead of final go live decision	Deputy Chief Executive	Complete – January 2020
Joint EPR change board governance process with Imperial College Healthcare Trust in place and supported by joint programme resource	Monthly EPR Programme Report	Establishment of monthly EPR/Digital Steering Group	Deputy Chief Executive	Complete – January 2020
Data cleaning and optimization embedded process in place to ensure data correction and preparedness for EPR migration. Monitored at EPR board and by external auditor	Monthly EPR Programme Report External Audit gateway reports	N/A	Deputy Chief Executive	Complete for Phase 2 – November 2019
SOP's in place and refreshed for all IT down time processes	EPR annual audit	N/A	Deputy Chief Executive	Complete – October 2019

Establishment of Director of Digital Operations post to align operational with technical programme	Monthly EPR Programme Report External Audit gateway reports Established 1:1 meetings with Deputy CEO and Director of Digital Operations	N/A	Deputy Chief Executive	Complete – 2018/19
Significant investment programme to address known cyber security weaknesses.	Cyber Security updates to Audit and Risk Committee		Chief Information Officer	May 2020

Quality Committee
Terms of Reference

1. Constitution

The Quality Committee is established as a sub-committee of the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

All members of staff are directed to co-operate with any request made by the Quality Committee.

The Quality Committee will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any changes recommended to the Terms of Reference will require Trust Board approval.

2. Authority

The Quality Committee is directly accountable to the Trust's Board.

The Quality Committee is authorised by the Board of Directors to act within these terms of reference. In doing so, the Committee may instruct professional advisors and request the attendance of individuals and authorities from outside its membership, and the Trust, with relevant experience and expertise if it considers this necessary for or expedient to the fulfilment of its functions.

3. Aim

3.1 The Quality Committee provides the Trust's Board with assurance that quality within the organisation is being delivered to the highest possible standards and that there are appropriate policies, processes and governance in place to continuously improve care quality, and to identify gaps and manage them accordingly. This aim applies to all forms of delivery of care equally, whether face to face, remotely or by using a digital pathway, and these Terms of Reference should be read accordingly.

4. Objectives

4.1 This Committee oversees the three themes that define quality:

- **The EFFECTIVENESS of the treatment and care provided to patients** – measured by both clinical outcomes and patient-related outcomes
- **The SAFETY of treatment and care provided to patients** – safety is of paramount importance to patients and is the bottom line when it comes to what services must be delivering
- **The EXPERIENCE patients have of the treatment and care they receive** – how positive an experience people have on their journey through the organisation can be even more important to the individual than how clinically effective care has been.

4.2 The Committee's objectives are:

- To have oversight of the Trust's Quality Strategy and Plan including to agree the annual quality priorities and monitor progress against them;
- To monitor the impact on quality of any strategic change programme such as reconfiguration of clinical pathways, national initiatives such as Getting it Right First Time, and Sustainability and Transformation Partnership (STP) led changes in clinical services.

- To approve the Trust's annual quality account before submission to the Board;
- To monitor the Trust's Quality and Performance Dashboard;
- To consider matters referred to the Quality Committee by its sub-groups as shown below;
- To monitor Trust compliance with statutory Health and Safety requirements
- To monitor the extent to which the Trust meets the requirements of commissioners and regulators.

In relation to **EFFECTIVENESS**

- To have oversight of the annual clinical audit programme
- To make recommendations to the Audit and Risk Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;
- To have oversight of Trust-wide compliance with clinical regulations and Central Alert System requirements;
- To ensure the review of patient safety incidents (including near-misses, complaints, claims and Coroner Prevention of Future Deaths reports) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;
- To monitor the impact on the Trust's quality of care of the Improvement Programme and any other significant reorganisations;
- To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

In relation to **SAFETY**

- To have oversight of the Trust's Mortality and Morbidity Surveillance Group, and to monitor Trust performance in these areas;
- To have oversight of and review quality related risks on the Trust's Risk Assurance Framework;
- To review and monitor the Quality Committee elements of the Trust's Board Assurance Framework.
- To scrutinise serious incidents, analyse patterns and monitor trends and to ensure appropriate follow up within the Trust;
- To monitor progress and approve the Trust quality priorities such as the Trust work plan on sepsis and deteriorating patients;
- To provide the Board with assurance regarding Adult and Child Safeguarding requirements and processes;
- To monitor nurse staffing levels in accordance with safe staffing benchmarks;
- To have oversight of infection protection and control and to scrutinise the annual Infection Protection and Control report on behalf of the Board;
- To have oversight of health and safety and environmental risk and monitor progress;

- To promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy;

- To ensure compliance with standards set by statutory and regulatory bodies;

- To ensure that where practice is of high quality, that practice is recognised and propagated across the Trust.

In relation to **EXPERIENCE**:

- To have oversight of the Trust's performance against the 5 key areas as described by the Care Quality Commission: Safe, Effective, Caring, Responsive and Well Led.

- To monitor the Trust's compliance with the national standards of quality and safety of the Care Quality Commission, and NHS Improvement's licence conditions that are relevant to the Quality Committee's area of responsibility, in order to provide relevant assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement;

- To monitor the Trust's Friends and Family Test response rates and recommendation rates;

- To provide the Board with assurance that complaints are handled both a timely and effective manner;

- To scrutinise patterns and trends in patient survey results, Friends and Family results, complaints and PALs data, and ensure appropriate actions are put into place;

- To oversee the Trust's work progress on Patient Experience.

5. Method of Working

5.1 All Committee Members will:

- Be open in making their contributions
- Be honest and transparent with comments, criticism and compliments
- Listen to advice and comments
- Make their contributions concisely and keep focused on the desired outcomes
- Ensure that every decision or question should be viewed from the perspective of the service-user.

5.2 The Quality Committee will have a standard agenda. At every meeting, the following item headings will be on the agenda:

1. Apologies for absence
2. Declarations of interests
3. Minutes of the previous meeting
4. Business to be transacted by the Committee
5. Any other business
6. Date of next meeting

5.3 All Minutes of the Quality Committee will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

6.1 The membership of the Quality Committee shall consist of:

- One Non-Executive Director who will Chair the meeting
- A minimum of two other Non-Executive Directors
- Medical Director
- Chief Executive
- Chief Nurse
- Chief Operating Officer
- Director of Quality Governance
- Deputy Medical Director
- Director of Corporate Governance and Compliance

6.2 The Chief Nurse, Medical Director and Chief Operating Officer need to have a deputy in their absence.

6.3 The Director of Nursing (Chelsea site), Director of Nursing (West Middlesex site), Director of Communications and Director of Human Resources each have a standing invitation to attend meetings of the Committee.

7. Quorum

7.1 The Quality Committee will be deemed quorate to the extent that the following members are present:

- Two Non-Executive Directors, one of whom should Chair the meeting
- Medical Director or deputy
- Chief Nurse or deputy
- Chief Operating Officer or deputy
- Director of Quality Governance or deputy

7.2 For the avoidance of doubt, Trust employees who serve as members of the Quality Committee do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

7.3 If a meeting is not quorate it may still proceed, however any decisions taken in principle at a non-quorate meeting must be ratified subsequently by a quorum of members.

8. Frequency of Meetings

8.1 The Committee will meet at least six times each year at suitable intervals.

8.2 Additional meetings may be held on an exceptional basis at the request of any three members of the Quality Committee.

8.3 Urgent items may be handled by email or conference call.

8.4 Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

9.1 Meeting minutes, agendas and forward work plans to be maintained by the Director of Corporate Governance and Compliance.

10. Reporting Lines

10.1 The Quality Committee will report to the Trust Board after each meeting. The minutes of all meetings of the Quality Committee shall be formally recorded and submitted to the next Board. Matters of material significance in respect of quality will be escalated to the following meeting of the Board of Directors. However, any items that require urgent attention will be escalated to the Chief Executive and Chairman at the earliest opportunity and formally recorded in the Quality Committee minutes.

10.2 The following groups shall report to the Quality Committee:

- Patient Safety Group
- Patient Experience Group
- Clinical Effectiveness Group
- Health and Safety and Environmental Risk Group

10.3 The above groups will report as per the Quality Committee Work plan, and also at times when requested by the Quality Committee. The reports provided by the groups should be in written format unless agreed by the chair.

10.4 The above groups' Terms of Reference will be reviewed by the Quality Committee annually.

10.5 The Quality Committee has key relationships with all other Board committees via its membership. In addition, there are links to Commissioners and other providers through the Medical Director and Chief Nurse.

11. Openness

11.1 The agenda, papers and minutes of the Quality Committee are considered to be confidential.

Reviewed by:	Quality Committee
Date:	7 January 2020
Approved by:	Board of Directors
Date:	March 2020
Review date:	December 2020

Finance and Investment Committee
Terms of Reference

1. Constitution

The Finance and Investment Committee (FIC) is established as a sub-committee of the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

All members of staff are directed to co-operate with any request made by the FIC.

The FIC will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any changes recommended to the Terms of Reference will require Trust Board approval.

2. Authority

The FIC is directly accountable to the Board of Directors.

The FIC is authorised by the Board of Directors to act within these terms of reference. In doing so, the Committee may instruct professional advisors and request the attendance of individuals and authorities from outside its membership, and the Trust, with relevant experience and expertise if it considers this necessary for or expedient to the fulfilment of its functions.

3. Aim

The Finance and Investment Committee shall conduct objective review of financial and investment policy, estates, IM&T and commercial development issues on behalf of the Board.

4. Objectives

4.1 In relation to: Oversight of **financial planning and performance**

- To consider the Trust's medium-term financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial targets and performance against them.
- To review the annual budget, before submission to the Trust Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- To review proposals for business cases over £200,000 revenue funding or costs and/or over £200,000 capital investment, where no budget has been previously approved by Trust Board and their respective funding sources prior to submission to the Board and any business cases greater than £1m within budget.
- Maintain an oversight of the robustness of the Trust's key income sources and contractual safeguards, including oversight of major income streams.
- Conduct post investment reviews of major investment's and/ or business cases

4.2 In relation to: **Investment Policy, Management and Reporting**

- To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy (including the Trust's treasury policy)
- To maintain on oversight of the Trust's investments, ensuring compliance with the Trust's policy and regulatory requirements.

4.3 **Other**

- To consider business cases, in line with the medium term strategy agreed at the Board
- To make arrangements to inform the Board on the undertakings of the Finance and Investment Committee and minutes.
- To examine any other matter referred to the Committee by the Board of Directors.
- To consider every capital expenditure for the business case where the proposed capital expenditure is > £1m
- In line with NHSI requirements, review all business cases for wholly owned subsidiaries (and joint ventures and partly-owned subsidiaries that will operate as separate and distinct legal entities) to inform Board approval for submission to NHSI.
- To consider the performance and effectiveness of Joint Ventures and Joint Operations.

5. Method of working

5.1 The Finance and Investment Committee will have a standard agenda. At every meeting, the following item headings will be on the agenda:

- Apologies for absence
- Declarations of Interest
- Minutes of the previous meeting
- Business to be transacted by the Committee (under the item headings: Strategy and Performance)
- Any Other Business
- Date of next meeting

5.2 All Minutes of the Finance and Investment Committee will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

6.1 The membership of the Finance and Investment Committee shall consist of:

- One Non-Executive Director who will Chair the meeting
- Two other Non-Executive Directors
- Chief Executive Officer
- Chief Operating Officer
- Chief Financial Officer

6.2 The Committee may invite other Trust staff to attend its meetings as appropriate.

6.3 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

6.4 Members are expected to attend a minimum of 75% of all meetings.

7. Quorum

7.1 The Finance and Investment Committee will be deemed to be quorate to the extent that the following members are present:

- Non-Executive Chair; if the Chair unavailable a second Non-Executive Director must be present
- One other Non-Executive Director
- The Chief Executive Officer or the Chief Operating Officer deputing for CEO, providing the Chief

Financial Officer present

8. Frequency of meetings

8.1 Meetings shall be held monthly (except for June, August and December), with additional formal meetings as deemed necessary.

8.2 Urgent items may be handled by email or conference call.

9. Secretariat

9.1 Minutes and agenda to be circulated by the Trust Secretary.

10. Reporting Lines

10.1 The Finance and Investment Committee will report to the Board of Directors after each meeting. The minutes of all meetings of the Finance and Investment Committee shall be formally recorded and submitted to the next Board. Oral reports will be made to the Board as appropriate as part of the monthly finance report.

10.2 Matters of material significance in respect of finance issues will be escalated to the following meeting of the Board of Directors. However, any items that require urgent attention will be escalated to the Chief Executive and Chairman at the earliest opportunity and formally recorded in the Finance and Investment Committee minutes.

10.3 The Capital Programme Board will routinely report to the Finance and Investment Committee.

11. Openness

11.1 The agenda, papers and minutes of the Finance and Invest Committee are considered to be confidential.

Reviewed by: Finance and Investment Committee
Date: 29 November 2018
Approved by: Board of Directors
Date: January 2019
Reviewed by: Finance and Investment Committee
Date: 25 November 2019
Approved by: Board of Directors
Date: March 2020

People and Organisational Development Committee
Terms of Reference

1. Constitution

The People and Organisational Development Committee (PODC) is established as a sub-committee of the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

All members of staff are directed to co-operate with any request made by the PODC.

The PODC will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any changes recommended to the Terms of Reference will require Trust Board approval.

2. Authority

The PODC is directly accountable to the Board of Directors**.**

The PODC is authorised by the Board of Directors to act within these terms of reference. In doing so, the Committee may instruct professional advisors and request the attendance of individuals and authorities from outside its membership, and the Trust, with relevant experience and expertise if it considers this necessary for or expedient to the fulfilment of its functions.

3. Aim

3.1 Strategic Aims

The vision for the Trust is to deliver excellent experience and outcomes for our patients and be the employer of choice. Supporting this are a number of strategies including quality and clinical services. The People and Organisational Development Strategy is as follows;

"We aim to have a workforce that puts patients first, is responsive and supportive to our patients and each other, is open, welcoming and honest, is unfailingly kind, respectful and compassionate, treating our patients with dignity. We are also determined to develop the skills of our people. This will ensure we achieve our objectives of providing the best quality care and become an employer of choice."

3.2 Specific Aims

To provide the Trust Board of Directors with assurance on matters related to its staff, and the development thereof to the highest standards and that there are appropriate processes in place to identify any risks and issues and manage them accordingly. It is also there to ensure opportunities are not missed and are capitalised upon for the benefit of patients, our people and the organisation.

In particular, the Committee will consider the following work areas:

- People and Organisational Development Strategy and planning (including recruitment and retention)
- Leadership development and talent management
- Education, skills and capability (clinical and non-clinical, statutory and mandatory)

- Performance, reward and recognition
- Culture, values and engagement
- Health and well-being

4. Objectives

4.1 To ensure the Trust's People and Organisational Development Strategy and plans link into the Trust's overall objectives and reflect the culture and values of the organisation we aspire to be.

4.2 To have oversight of the Trust's People and Organisational Development Strategy and plan.

4.3 To consider matters referred to the PODC by its sub-groups and by other Trust Committees; in particular, matters raised by the Improvement Board relating to the management of people through the Cost Improvement Programme (CIP) and transformation agendas.

4.4 To ensure the Trust's Employee Value Proposition is fit for purpose.

4.3.1 In relation to: **PEOPLE STRATEGY AND PLANNING**

- To ensure that the Trust has a robust People Strategy and that it, and the associated plans, are aligned and focused on meeting the needs of the Trust's strategic priorities including the Clinical Strategy.

- To ensure that the organisation has a grip on critical workforce issues such as people in posts, time to fill, retention and essential training.

- To set and monitor the Key Performance Indicators (KPIs) relating to staff.

- To ensure that appropriate recruitment and retention strategies are in place.

4.3.2 In relation to: **LEADERSHIP DEVELOPMENT AND TALENT MANAGEMENT**

- To oversee the identification, nurturing and development of leaders within the organisation; to establish and monitor the strategy for leadership development in the Trust.

- To ensure that the Trust is developing an appropriate process to manage its succession planning and talent management.

4.3.3 In relation to: **EDUCATION, SKILLS AND CAPABILITY**

- Have oversight of the education agenda in the context of the future strategy.

- Have oversight of the annual training needs analysis including rationalisation of requirements to fit the funding allocation.

- Have an overview of the process to identify skills and competency development required for staff to meet the changing needs of the organisation providing appropriate training as required within national and local budgets.

- To keep under review the Trust's general skill mix/balance and workforce capacity/capability, identifying key strengths as well as 'skills gaps', taking action to address such gaps, as appropriate.

- To receive the annual educational cost collection report and note its contents.

- To receive reports on apprenticeships and progress to meeting national standards.

- To receive reports on educational quality performance and national trainees surveys and associated action plans.

- Review the objectives for the Education Strategy Board and receive regular progress reports.

4.3.4 In relation to: **PERFORMANCE, REWARD AND RECOGNITION**

- To ensure that performance, reward and recognition policies support the Trust's overarching people (recruitment, development and retention) strategy.

- To receive and review reports to give assurance that key workforce policies are being appropriately applied and to make recommendations to change policy as appropriate.

- To review and scrutinise the effectiveness of risk mitigation plans, based upon the people risks detailed within the Risk Assurance Framework.

- To ensure the Trust acts with speed where inappropriate behaviour or performance is identified.

4.3.5 In relation to: **CULTURE, VALUES AND ENGAGEMENT**

- To ensure strategies are in place that engage the Trust's people in understanding the vision for the organisations future.

- To oversee the embedding of the Trust's organisational values within all aspects of the Trust's people strategies, policies and procedures, ensuring a 'golden thread' and ensure they are embedded across the organisation.

- To ensure the review of the annual NHS staff survey results and monitor the associated action plans.

- To receive and review reports to provide assurance that appropriate and effective policies and practices are in place to meet the Trust's obligations to encourage, support and protect its staff in raising concerns about the safe and proper running of the Trust.

- To receive reports to provide assurance that the Trust is delivering its commitment to diversity and inclusion including by meeting its legal duty to promote workforce equality and combat unlawful discrimination.

- To receive reports on progress towards the Trust's commitment to support the health and wellbeing of its staff. To ensure the review of the staff Friends and Family Test and monitor associated action plans.

4.3.6 **Other**

- To scrutinise and provide assurance to the Board of Directors on the Trust's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and The Care Quality Commission (Registration) Regulations 2009 (as amended) in so far as they relate to the aims and objectives of the Committee.

- To scrutinise and provide assurance on the self-certification to NHS Improvement of: Continuity of services condition 7 - Availability of Resources; and the Corporate Governance Statement in so far as they relate to the aims and objectives of the Committee.

5. Method of working

5.1 The PODC will have a standard agenda, but on occasion, the meetings will address a strategic issue so will not conform to the standard agenda. At every meeting, the following item headings will be on the agenda:

1. Apologies for absence
2. Declarations of Interest
3. Minutes of the previous meeting
4. Business to be transacted by the Committee
5. Key Performance Indicators/Performance report
6. Review of organisational P&OD priorities
7. Any Other Business
8. Date of next meeting

5.2 All minutes of the PODC will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

6.1 The membership of the PODC shall consist of:

- One Non-Executive Director who will Chair the meeting
- Two other Non-Executive Directors
- Chief Executive or suitable deputy
- Executive Director responsible for HR or suitable deputy
- Medical Director or suitable deputy
- Chief Nurse or suitable deputy
- Chief Operating Officer or suitable deputy
- Director of Nursing (WM)
- Director of Corporate Governance and Compliance or suitable deputy
- Deputy Director of HR

6.2 The CEO, Executive Director with responsibility for HR, Medical Director and Chief Operating Officer must send a deputy in their absence.

7. Quorum

7.1 The Committee will be deemed quorate to the extent that the following members are present:

- Two Non-Executive Directors (one of whom may be the Chair of the Committee)
- Two Executive Directors or suitable deputies
- Either the Executive Director with responsibility for HR or Chief Nurse

8. Frequency of meetings

8.1 Meetings shall be held monthly (except for August and December), with additional formal meetings as deemed necessary.

8.2 Urgent items may be handled by email or via conference call.

8.3 Members are expected to attend a minimum of 75% of all meetings within one year.

9. Secretariat

9.1 Minutes and agenda to be circulated by the Board Governance Manager.

10. Reporting Lines

10.1 The PODC will report to the Board of Directors after each meeting. The minutes of all meetings of the PODC shall be formally recorded and submitted as a draft to the next Board.

10.2 Matters of material significance in respect of people issues will be escalated to the following meeting of the Board of Directors. However, any items that require urgent attention will be escalated to the Chief Executive and Chairman at the earliest opportunity and formally recorded in the PODC minutes.

10.3 The following groups shall report to the People and Organisational Development Committee:

- Education Strategy Board
- Workforce Development Committee
- Health and Well-being Committee
- Partnership Forum (for the purposes of policy approval only)

Other groups may be invited to report into or attend the meeting on an ad hoc basis.

10.4 The above groups will report as per the PODC forward plan, and also at times when requested by the Committee. The reports provided by the groups should be in written format unless agreed by the Chair.

10.5 The above groups' Terms of Reference and the Committee's effectiveness will be reviewed by the Committee annually. .

10.6 The Committee has key relationships with other committees and groups via its membership.

- Members will facilitate information gathering and sharing with other key committees such as the Quality Committee and the Trust Executive Team.
- In addition, there will also be links to Health Education England and the "HR for London" network in relation to London-wide streamlining initiatives.

11. Openness

11.1 The agenda, papers and minutes of the PODC are considered to be confidential.

Reviewed by: People and OD Committee
Date: 19 November 2019
Approved by: Board of Directors
Date: TBC
Review date: December 2020

Annex A

Audit and Risk Committee
Terms of Reference

1. Constitution

The Audit and Risk Committee (ARC) is established as a sub-committee of the Board of Directors of Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

The ARC will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any changes recommended to the Terms of Reference will require Trust Board approval.

2. Authority

The ARC is directly accountable to the Board of Directors.

The ARC is authorised by the Board of Directors to act within these terms of reference. In doing so, the Committee may instruct professional advisors and request the attendance of individuals and authorities from outside its membership, and the Trust, with relevant experience and expertise if it considers this necessary for or expedient to the fulfilment of its functions.

3. Aim

This Committee provides the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the foundation trust's activities (clinical and non-clinical), both generally and in support of the annual governance statement.

4. Objectives

4.1 Support the Trust's Values and objectives.

4.2 Review the establishment and maintenance of effective systems of internal control, establishment of value for money and risk management including fraud and corruption.

4.3 Assure the Board on completeness and compliance of required disclosure statements and policies.

4.4 Review the Trust's Annual Report, including Quality Report and financial statements, Annual Governance Statement and Head of Internal Audit Opinion and the External Assurance on the Trust's Quality Report and assure the Board on compliance.

4.5 Assure the Board on judgements and adjustments relating to annual financial statements.

4.6 Review the Trust's self-certification as required by NHS Improvement or its successors to comply with any conditions of its foundation trust licence

4.7 Assure the Board on the appropriateness and effectiveness of the internal audit service its fees, findings and co-ordination with external audit.

4.8 Assure the Board on the appropriateness, effectiveness and co-ordination of external auditors, and the Trust's management response and outcomes.

4.9 Assure the Board on the appropriateness and effectiveness of the local counter fraud specialist service, their fees, findings and co-ordination with internal audit and management.

4.10 Make recommendations to the Council of Governors on the appointment, re-appointment and remuneration and terms of engagement of the external auditors.

4.11 Assure the Board on the appropriateness and effectiveness of the Trust's Risk Assurance Framework and of the processes for its implementation.

4.12 Ensure that arrangements are in place for investigation of matters raised, in confidence, by staff relating to matters of financial reporting and control, clinical quality, patient safety or other matters.

4.13 Assure the Board on the appropriateness and effectiveness of the Trust's approach to mitigate and manage cyber security related risks.

4.14 Undertake such other tasks as shall be delegated to it by the Board in order to provide the level of assurance the Board requires.

4.15 Report to the Council of Governors on significant matters where these matters are not notified to the Council of Governors via other means.

5. Method of working

5.1 The Committee will have a standard agenda. At every meeting, the following item headings will be on the agenda:

1. Apologies for absence
2. Declarations of Interests
3. Minutes of the previous meeting
4. Business to be transacted by the Committee
5. Any Other Business
6. Date of next meeting

5.2 All Minutes of the Committee will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

5.3 In carrying out its duties, the Committee may take account of the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work.

6. Membership

6.1 The membership of the Committee shall consist of:

- Non-Executive Chair
- 2 other Non-Executive Directors

6.2 In Attendance: Chief Executive Officer, Chief Financial Officer, Medical Director, Deputy Medical Director, Company Secretary or equivalent, Head of Internal Audit, External Audit representatives and a Counter Fraud representative. Other Directors only when required. Deputies have to attend if the Chief Executive or Chief Financial Officer cannot.

7. Quorum

7.1 The Committee will be deemed quorate to the extent that the following members are present:

- 2 Non-Executive Directors one of whom will chair the meeting

8. Frequency of meetings

8.1 Meetings shall be held quarterly, aligned with Trust Board and Quality Committee and additionally if requested by auditors.

8.2 Urgent items may be handled by email or conference call.

8.3 Members are expected to attend a minimum of 75% of Committee meetings throughout the year.

9. Secretariat

9.1 Minutes and agenda to be circulated by the Company Secretary or equivalent.

10. Reporting Lines

10.1 The Committee will report to the Board of Directors after each meeting. The minutes of all meetings of the Committee shall be formally recorded and submitted to the next Board.

10.2 Matters of material significance in respect of audit issues will be escalated to the following meeting of the Board of Directors. However, any items that require urgent attention will be escalated to the Chief Executive and Chairman at the earliest opportunity and formally recorded in the Committee minutes.

10.3 The Committee shares some items with the Quality Committee.

10.4 Internal and External Auditors and Counter Fraud representatives report to each meeting of the Committee.

11. Openness

11.1 The agenda, papers and minutes of the ARC are considered to be confidential.

Reviewed by: Audit Committee
Date: 23 January 2020
Approved by: Board of Directors
Date: TBC
Review date: January 2021