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

5 May 2022 11:00 - 5 May 2022 13:30

AGENDA

#	Description	Owner	Time
1	General Business 1.0. Board Public Agenda.doc 9		
1.1	Welcome and apologies for absence Verbal	Chair	11:00
1.2	Declarations of Interest, including register of interests Paper 1.2. Board Register of Interests.doc 11 1.2a BOARD REGISTER OF INTERESTS.docx 15	Chair	11:01
1.3	Minutes of the previous meeting held on 3 March 2022 Paper 1.3 Draft Board Minutes 03.03.22.docx 21	Chair	11:02
1.4	Matters arising and Board action log Paper 1.4 Board Action Log PUBLIC.doc 35	Chair	11:05
1.5	Patient/Staff Story: BAME Network Presentation	Board Inclusion Advisor and Chief Nursing Officer	11:10
1.6	Chairman's Report Paper 1.6 Joint Chair Report.docx 37	Chair	11:25
1.7	Chief Executive's Report Paper 1.7. Chief Executive Report.docx 43	Chief Executive	11:35
2	For Discussion		

#	Description	Owner	Time
2.1	Trust Elective Recovery Plan update Paper 2.1 Elective Recovery Programme.docx 49 2.1a. Elective Recovery Programme.pdf 51	Deputy Chief Executive / Chief Operating Officer	11:45
2.2	Integrated Performance and Quality Report Paper 2.2. Integrated Performance and Quality Report.doc... 65 2.2a. Integrated Performance and Quality Report.d... 69	Deputy Chief Executive / Chief Operating Officer	11:55
2.3	Maternity Services Improvement Programme Report Paper 2.3. Maternity Improvement Programme.doc 85 2.3. Maternity Services Improvement Programme R... 91 2.3b. Ockenden Update (Maternity Safety).pptx 99 2.3c. Ockenden-Report.pdf 115	Chief Nursing Officer	12:05
2.4	Staff Survey Results and Improvement Plan Paper 2.4. Staff Survey.docx 365 2.4a. Staff Survey 2022 Board 5th May 2022 FINAL... 369	Interim Director of People and Organisational Development	12:15
3	For Approval		
3.1	Board Assurance Framework 2022/23 Paper 3.1. Board Assurance Framework.docx 417 3.1a. Board Assurance Framework.docx 419	Interim Director of Corporate Governance and Compliance	12:35
3.2	Board and Committee Governance inc Terms of Reference 2022/23 Paper 3.2. Board and Committee Governance inc Terms o... 439 3.2a Board and Committee Governance inc Terms... 441	Interim Director of Corporate Governance and Compliance	12:45

#	Description	Owner	Time
3.3	Board Business Cycle 2022/23 Paper 3.3 Board Business Cycle 22-23.docx 487 3.3a. BoD Business Cycle 22-23.docx 489	Interim Director of Corporate Governance and Compliance	12:55
3.4	Standing financial Instructions and Scheme of Delegation Paper 3.4 Standing Financial Instructions and Scheme of... 495 3.4a. Standing Financial Instructions - March 2022 -... 497 3.4b Reservation of Power and Scheme of Delegati... 559	Chief Financial Officer	13:05
4	For Noting - Highlights by Exception		
4.1	Annual EPRR Assurance Report 2021/22 Paper 4.1. EPRR Assurance Report.docx 591 4.1a.EPRR Annual Assurance.pdf 593	Deputy Chief Executive/Chief Operating Officer	13:10
4.2	Learning from Serious Incidents Paper 4.2. Learning from Serious Incidents _February 22_... 611	Chief Nursing Officer	13:10
4.3	People Performance Report and Quarterly Heatmap Paper 4.3. Workforce Performance Report and Heatmap.d... 619 4.3.a. Workforce Heatmap Q4 Board.pptx 623 4.3.a. Workforce Performance Report Board FINAL.... 635	Director of Human Resources & Organisational Development	13:10
4.4	Learning from Deaths Report Q4 2021/22 Paper 4.4. Learning from deaths.docx 657	Chief Medical Officer	13:10

#	Description	Owner	Time
4.5	Use of the Company Seal Paper 4.5. Use of Company Seal Cover.docx 667 4.5a.Use of the Company Seal 202122.doc 669	Interim Director of Corporate Governance and Compliance	13:10
5	Items for Information		
5.1	Questions from members of the public Verbal	Chair	13:20
5.2	Any other business Vetbal	Chair	13:25
5.3	Date of next meeting – 7 July 2022 11.00am – 13.30pm		13:30

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Date: 5 May 2022
Time: 11.00 – 13.30
Location: Via Zoom (https://zoom.us/j/7812894174)

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	Paper	Chairman
11.02	1.3	Minutes of the previous meeting held on 3 March 2022	Paper	Chairman
11.05	1.4	Matters arising and Board action log	Paper	Chairman
11.10	1.5	Patient/Staff Story: BAME Network	Presentation	Board Inclusion Advisor and Chief Nursing Officer
11.25	1.6	Chairman's Report	Paper	Chairman
11.35	1.7	Chief Executive's Report	Paper	Chief Executive Officer
	2.0	**FOR DISCUSSION**		
11.45	2.1	Trust Elective Recovery Plan update	Paper	Deputy Chief Executive / Chief Operating Officer
11.55	2.2	Integrated Performance and Quality Report	Paper	Deputy Chief Executive / Chief Operating Officer
12.05	2.3	Maternity Services Improvement Programme Report	Paper	Chief Nursing Officer
12.15	2.4	Staff Survey Results and Improvement Plan	Paper	Interim Director of People and Organisational Development
	3.0	**FOR APPROVAL**		
12.35	3.1	Board Assurance Framework 2022/23	Paper	Interim Director of Corporate Governance and Compliance
12.45	3.2	Board and Committee Governance inc Terms of Reference 2022/23	Paper	Interim Director of Corporate Governance and Compliance
12.55	3.3	Board Business Cycle 2022/23	Paper	Interim Director of Corporate Governance and Compliance
13:05	3.4	Standing financial Instructions and Scheme of Delegation	Paper	Chief Financial Officer
	4.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**		
13.10	4.1	Annual EPRR Assurance Report 2021/22	Paper	Deputy Chief Executive/Chief

				Operating Officer
	4.2	Learning from Serious Incidents	Paper	Chief Nursing Officer
	4.3	People Performance Report and Quarterly Heatmap	Paper	Director of Human Resources & Organisational Development
	4.4	Learning from Deaths Report Q4 2021/22	Paper	Chief Medical Officer
	4.5	Use of the Company Seal	Paper	Interim Director of Corporate Governance and Compliance
	5.0	**ITEMS FOR INFORMATION**		
13.20	5.1	Questions from members of the public	Verbal	Chairman
13.25	5.2	Any other business	Verbal	Chairman
13.30	5.3	Date of next meeting – 7 July 2022, 11.00am – 13.30pm		

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting XX May 2022

AGENDA ITEM NO.	1.2
TITLE OF REPORT	Board Register of Interests April 2022
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To approve the updated Board of Directors Register of Interests as of April 2022 in readiness for publication on the Trust Website
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Board of Directors; Date of Meeting: September 2021; Outcome: Approved Name of Committee: Board of Directors; Date of Meeting: March 2022; Outcome: Aprroved
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Board of Directors Register of Interests was last updated in March 2022 and published on our website. Amendments have now been made to the Register to reflect the following:- • Appointment of Matthew Swindells as NWL Chair in Common from 1 April 2022 • Appointment of Robert Bleasdale as Chief Nursing Officer from 4 April 2022 • Closure of the appointment of Vanessa Sloane as interim Chief Nursing Officer from February 2022 – 3 April 2022

	• Additional interest of Aman Dalvi as Board member of Old Oak Development Corporation from 24 March 2022
KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y	
Be the employer of Choice	Y	
Deliver better care at lower cost	Y	

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		
Equality And Diversity	N	
Quality	N	
People (Workforce or Patients/ Families/Carers)	N	
Operational Performance	N	
Finance	N	
Public Consultation	N	
Council of Governors	N	

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust
Register of Interests of Board of Directors - 1 APRIL 2022

Name	Role	Description of interest	Relevant dates		Comments
			From	To	
Matthew Swindells	Chair	MJS Healthcare Consulting (Founder / Owner) Clients: - Senior Advisor to Global Council Policy and Strategy Consultancy whose clients include a number of pharma companies and Palantir, whose Health Advisory Panel I chair - Internal Advisor to Accenture Global consultancy firm - Internal Advisor to Carnall-Farrar Healthcare strategy consultancy Board Member for Prism Improvement Limited - Small healthcare improvement consultancy	Aug 2019 Sept 2019 Sept 2019 Feb 2022 Apr 2022	Present Present Present Present Present	To be excluded from any decision making in relation to Palantir with whom Chelwest work.
		Shareholder of Written Medicine			Written Medicine are a supplier to LNW Trust. MS is in the process of transferring his shares to the LNW Charitable Trustees as a gift.
Stephen Gill	Vice Chair and Senior Independent 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	
		Member of the Board , Phyllis Court Members Club	September 2021	Ongoing	
Aman Dalvi	Non-executive Director	Aman Dalvi Ltd (Housing & Planning Consultancy)	2017	Ongoing	
		Non-Executive Director of Fairplace Homes	2018	Ongoing	
		Non-Executive Chair of Goram Homes (Bristol)	2019	Ongoing	
		Non-Executive Chair of Kensington & Chelsea TMO Residuary Body	2019	Ongoing	
		Non-Executive Chair of Aspire Housing (Staffordshire)	Jan 2021	Ongoing	
		Non-Executive Chair of Newlon HT	Jan 2021	Ongoing	
		Board Member of Old Oak Development Corporation	March 2022	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	
		Cerner Limited as Director and GM for London	27 September 2021	Ongoing	To be excluded from any decision making relating to Cerner Limited with whom Chelwest work
		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	
		Chair North West London Advisory Panel for National Clinical Excellence Awards	Oct 2018	Ongoing	Lay Member of the Panel throughout my time as NED
		Spouse - Member of Parliament for the Brentford and Isleworth Constituency	Nov 2015	Ongoing	
		Associate, Westbrook Strategy	Feb 2020	Ongoing	
		Chair of the Audit and Risk Committee for the Royal Society of Medicine.	October 2021	Ongoing	
Eliza Hermann	Non-executive Director	Former Board Trustee and current Marketing Committee Chairman, Campaign to Protect Rural England, Hertfordshire Branch	2013	Ongoing	
		Committee Member, Friends of the Hertfordshire Way	2013	Ongoing	
		Close personal friend – Chairman of Central & North West London NHS Foundation Trust	Ongoing	Ongoing	
Ajay Mehta	Non-executive Director	Director and Co-Founder at em4 Ltd	2019	Ongoing	Social Enterprise works with international funders and

					investors to build the capabilities of their grantees and partners in order to increase social impact
		Trustee, Watermans	2014	Ongoing	The organisation showcases and delivers arts programmes to communities in West London
		Partner employee of Notting Hill Housing Trust	2013	Ongoing	The Trust commissions the provision of care services to vulnerable people in LB Hammersmith and Fulham
		Head of Foundation, The Chalker Foundation for Africa	2015	Ongoing	The Foundation invests in projects that build the capacity of health-related organisations, in particular healthcare workers, in sub-Saharan Africa.
		Volunteer with CWFT	01/03/2020	Ongoing	

Lesley Watts	Chief Executive Officer	Trustee of CW+ Charity	01/04/2018	Ongoing	
		Director of Imperial College Health Partners	14/09/2015	Ongoing	
		Husband—consultant cardiologist 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	
		NWL ICS Interim Chief Executive Officer	Apr 2020	January 2022	Will be removed from the register in June 2022
		Special Advisor to THHT Board	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
Robert Hodgkiss	Chief Operating Officer / Deputy Chief Executive	Interim Lead Chief Operating Officer for NWL ICS	Feb 2020	Ongoing	
		Senior Responsible Officer for NWL Elective Care	Feb 2021	Ongoing	
Pippa Nightingale	Chief Nursing Officer – left the organisation February 2022	Trustee of Rennie Grove Hospice	2017	Ongoing	No direct conflict of interest.

		NWL ICS Interim Chief Nurse and Executive Quality	Feb 2020	Ongoing	No direct conflict of interest.
		Member of the Birth rate plus national maternity safe staffing board	Jan 2021	Ongoing	No direct conflict of interest.
Vanessa Sloane	Interim Chief Nurse – Feb 2022 to April 2022	Nothing to declare			
Robert Bleasdale	Chief Nursing Officer April 2022 onwards				
Virginia Massaro	Chief Financial Officer	Director of Cafton Lodge Limited (Company holding the freehold of block of flats)	22/03/2014	Ongoing	
		Member of the Healthcare Financial Management Association London Branch Committee	Jun 2018	Ongoing	
		Director of Systems Powering Healthcare Limited	29/01/2020	Ongoing	
		Sister works for the Trust	13/04/2021	Ongoing	No actual or potential conflict of interest.
		Managing Director of CW Medicines Limited	16 September 21	Ongoing	CW Medicines Limited is a wholly owned subsidiary out patient pharmacy which will be operational from 1 April 2022
Dr Roger Chinn	Chief Medical Officer	Private consultant radiology practice is conducted in partnership with spouse. Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)	1996	Ongoing	
		Providing support to The Hillingdon Hospitals NHS Trust executive team	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
		Trustee of CW+	16/03/2021	Ongoing	4 year term with option to stand for re-election for further 4 years.

Non-Voting Directors

Kevin Jarrold	Chief Information Officer	CWHFT representative on the SPHERE Board	01/10/2016	31/03/2021	
		Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	01/10/2016	Ongoing	
		Joint CIO for the NW London Health and Care Partnership	01/01/2020	Ongoing	

Martin Lupton	Honorary NED, Imperial College London	Employee, Imperial College London	01/01/2016	Ongoing	
Chris Chaney	Chief Executive Officer CW+	Trustee of Newlife Charity	Jun 2017	Ongoing	
Susan Smith	Interim Director of HR & OD	Joint Chief People Officer /Interim Director of HR & OD The Hillingdon Hospitals NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	13/10/2020	Ongoing	
Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to Board	Director, Women's Wellness Centre private healthcare facility	2005	Ongoing	
		Board of Governors, Latymer Upper School, London Audit and Risk Sub-Committee of Board	2015	Ongoing	
		Interim Medical Director, The Hillingdon Hospitals NHS Foundation Trust	14/10/2020	Ongoing	
Serena Stirling	Director of Corporate Governance and Compliance	Local Authority Governor at Special Educational Needs School (Birmingham)	2019	Ongoing	
		Mentor on University of Birmingham Healthcare Careers Programme	2018	Ongoing	
		Leadership Mentor for Council of Deans for Health	2017	Ongoing	
		Partner is Princess Royal University Hospital site CEO at King's College Hospital NHS Foundation Trust	Feb 2020	Ongoing	
		CW+ Fundraising Governance Committee Trust representative	Jul 2020	Ongoing	
Dawn Clift	Interim Director of Corporate Governance and Compliance (August 2021)	Panel member of the Serious Incident Accreditation Panel of the Royal College of Psychiatrists	2020	Ongoing	No actual or potential conflict

Minutes of the Board of Directors (Public Session)

Held at 11.00am on 3 March 2022 via Zoom

Present	Stephen Gill	Chair (Interim)	(SG)
	Aman Dalvi	Non-executive Director	(AD)
	Nilkunj Dodhia	Non-executive Director	(ND)
	Nick Gash	Deputy Chair (Interim)	(NG)
	Eliza Hermann	Senior Independent Director (Interim)	(EH)
	Ajay Mehta	Non-executive Director	(AM)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Chief Medical Officer	(RC)
	Rob Hodgkiss	Deputy Chief Executive and Chief Operating Officer	(RH)
	Virginia Massaro	Chief Financial Officer	(VM)
	Vanessa Sloane	Interim Chief Nursing Officer	(VS)
In Attendance	Dawn Clift	Interim Director of Corporate Governance and Compliance	(DC)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Sue Smith	Interim Director of Human Resources and Organisational Development	(SSm)
	Emer Delaney	Director of Communications	(ED)
	Chris Chaney	Chief Executive Officer CW+	(CC)
	Victoria Cochrane	Director of Midwifery (item 2.3)	(VC)
	Alex Bolton	Associate Director of Quality Governance (item 4.1)	(AB)
	Joe Crook	Head of Volunteering (item 1.5)	(JC)
	Nina Littler	Youth Volunteering Manager (item 1.5)	(NL)
Members of the Public/Observers	Anthony Levy	Governor	(AL)
	Dr Paul Kitchener	Governor	(PK)
	Richard Ballerand	Governor	(RB)
	Dr Des Walsh	Governor	(DW)
	Prof Mark Nelson	Staff Governor	(MN)
	Lisa Addison	Governor	(LA)
	Minna Korjonen	Governor	(MK)
	Jacqui Scott	Staff Governor	(JS)
	Matthew Swindells	NWL Acute Trusts Joint Chair designate	(MS)
	Nicole Nunes	Governor	(NN)
	Janet Adeyemi	Interim Board Governance Manager Chelwest	(JA)

Apologies for Absence	Serena Stirling	Director of Corporate Governance and Compliance	(SS)
	Vida Djelic	Board Governance Manager	(VD)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to the Board	(GA)

Minute Reference		Action
1.0	**GENERAL BUSINESS**	
1.1	**Welcome and Apologies for Absence**	
	SG welcomed the Board members, those in attendance, Governors, members of the public and the media to the Trust Board Meeting held in public on Zoom. He welcomed Matthew Swindells (MS) incoming North West London (NWL) Acute Trusts Joint Chair as an observer to the meeting and advised that he would be asking MS to introduce himself under item 5.1 on the agenda. SG requested that members of the meeting, those in attendance and those observing remain on mute unless they are presenting a paper or asking / responding to a question. It was noted that the majority of the papers to be presented at the meeting had been subject to prior scrutiny at Board sub-Committees. Apologies received as above were noted.	
1.2	**Declarations of Interest including the Board Register of Interest**	
	SG presented the updated Board Register of Interest and highlighted a typing error within the cover note to the report which should read September 2021 (not September 2022). <u>Resolution:-</u> The Board resolved to approve the Board Register of Interests.	
1.3	**Minutes of the Previous Meeting held on 6 January 2022**	
	The minutes of the previous Board meeting held in public on 6 January 2022 were approved as a correct and accurate record of proceedings.	
1.4	**Matters Arising and Board Action Log**	
	The action log was reviewed and noted. SSm advised that action 3.4 was now nearing completion and confirmed that regular diarised meetings are now in place between the Deputy Director of HR and NG. It was agreed that this action could now be closed.	
1.5	**Presentation from the Youth Volunteering Service**	

SG welcomed JC (Head of Volunteering) to the meeting along with NL (Youth Volunteering Manager) and Salman, Yoonis and Emily (Youth Volunteers).

JC spoke to a PowerPoint presentation that had been circulated with the papers for the meeting highlighting:-

- A high influx of individuals participating in the Youth Volunteering Programme
- A recruitment timeframe for the programme of approximately one month inclusive of training and induction
- A six month commitment to Youth Volunteering from each individual on the programme
- The development of reflective logs over an 8 week period for all participants to aid their development and learning
- Deployment of Youth Volunteers across a range of areas and integration into the overall volunteering model operating across the Trust
- The high level of enthusiasm, passion and dedication provided by the Youth Volunteers

NL advised that 158 Youth Volunteers were currently operating across the Trust contributing 10,000 hours of volunteering time (approximately 25% of all volunteering hours). She spoke of the ethnic diversity that had been created within the Youth Programme advising that further work was to take place to develop gender balance which was currently 85% female and 15% male or undisclosed. Recruitment had taken place from over 70 local institutions.

NL spoke with passion about the huge energy that the Youth Volunteers bring to the Trust including their commitment to volunteering at weekends and the positive profile that they demonstrate to the local community. In return it was noted that the Trust offer a volunteering experience in a hospital that includes the development of skills that can support individuals in their further education and employment.

Salman (aged 18 years) spoke about the youth volunteering work that he was undertaking during his gap year before starting University in September 2022. He spoke of his experience of helping as a responder volunteer at the hospital and how this had helped him to increase his skills in different environments such as communication, listening and teamwork. Salman spoke with pride about his role and how he now also helps to train new volunteers to the scheme. He stated that he found the role very rewarding.

Yoonis was introduced to the Board. Yoonis joined the youth volunteering scheme through Project Search which has a specific focus to support young people with Learning Disabilities and Autism. He had been volunteering since June 2021. He reflected on how much he liked helping people and enjoys guiding people around the hospital. This was helping to improve communication skills, team-working skills and problem solving

	skills. Yoonis hoped that these skills would help him to gain employment in the future. Emily introduced herself to the Board. She spoke of her role as a responder volunteer contributing to pharmacy runs and the movement of patients from wards to the discharge suite. She advised the Board that she was now a ward helper in AAU and that she enjoyed this role as every day was busy and different. Emily reflected on how much her role had helped patients and staff during the Covid pandemic, by releasing pressure on staff and also providing a listening ear and comfort for patients. She advised that volunteering had helped her to use her own initiative and was very much hoping to develop a career as a nurse in the hospital in the future. LW expressed her enormous thanks to the Youth Volunteering Service stating that they make the Trust a better place. She recognised the empathy, self-giving commitment and support that they give to staff, patients and each other and stated that the Youth Volunteering Programme was helping to transform the lives of young people, the experience of patients and the experience of staff. AD stated his thanks to JC and the Youth Volunteering Team for the fantastic work that they deliver and the positive difference that volunteering makes to patient care and experience. He asked what type of outreach work was being undertaken with state schools to increase their representation within the scheme. NL advised that strategic work had now commenced to reach out to local comprehensive schools and colleges to promote the scheme and encourage application. It was noted that a new Volunteering Strategy would be launched later in the year which had a strong focus on representation. CC thanked the Youth Volunteering Team for all of their hard work and was delighted to see how the programme had grown. CC thanked the Pears Foundation who were major donors to the Programme. SG concluded the discussion by expressing the sincere thanks, gratitude and recognition of the Board to the Youth Volunteering Programme and reiterated the value that this brings to the Trust.	
1.6	**Interim Chairs Report**	
	SG introduced his report and highlighted the following aspects:- • The appointment of Matthew Swindells as the NWL Acute Trust Joint Chair. Noting that Matthew would take up his role on 1 April 2022 • The away day for the Council of Governors had been scheduled for April 2022 and it was anticipated that this would be an in-person meeting subject to no further changes to Covid restrictions. The away day would be immediately followed by the public meeting of the Council of Governors	

	• His thanks to the Executive Team and all staff at the Trust for their extraordinary resilience and continued hard work over the past 2 years SG advised that his report had been written on 23 February the day before the Russian conflict with Ukraine and therefore asked LW to appraise the Board of the recent all staff webinar that she had hosted to offer support to staff affected by this conflict. <u>Resolution:-</u> With there being no questions, the Board resolved to note the content of the report.	
1.7	**Chief Executive's Report**	
	In advance of presenting the written report, LW spoke to the terrible unfolding of events in Ukraine. She advised the Board that the Trust employed staff from Ukraine, Russia and the Baltics and that much work was taking place to ensure that these staff have psychological and practical support from a range of networks. An all-staff webinar had taken place earlier in the week to engage with staff and ensure that they were well informed of support available and had the opportunity to inform the type of support that would be helpful. LW confirmed that she had spoken to the NHS national team about the logistics of sending supplies to Ukraine and that the Trust would be contributing to a centrally coordinated approach by the NHS. It was noted that some supplies had already been delivered. LW then presented her written report and highlighted the following aspects:- • All Trust sites would be retaining Infection Prevention and Control measures to mitigate the spread of Covid despite the removal of national restrictions – the purpose of this was to protect each other and to protect vulnerable patients whilst in our care • System working continues to take place across North West London to ensure we can meet emerging demands for care and maximise our capacity and ability to treat patients. Opportunities continue to be explored for further collaborative working where appropriate • There is a need to restore grip around productivity and to live within the resources available to us as we work to deliver the NHS operating plan for 2022/23 • Quality of care and patient experience must receive appropriate attention and as such we are restoring controls such as ward accreditation visits NG asked whether we are 'asking' or 'requiring' members of the public to adhere to the Infection Prevention and Control measures to mitigate Covid. LW advised that we are requiring members of the public to adhere to these controls unless they are deemed exempt.	

	EH sought assurance that the system meetings referred to in the report are meaningful as well as plentiful. LW gave assurance that this wide level of engagement was leading to positive change for patients. ML asked how the system was supporting changes within primary care. LW advised that care outside acute units is a piece of work to be developed and that some exploratory work had already commenced which was demonstrating productivity opportunities. LW appraised the Board of her contribution in leading a national piece of work aimed at ensuring that patients are only in an acute hospital if they need to be and that patients are treated in the right therapeutic environment for their needs. It was noted that this would enable the whole patient pathway to be as effective and streamlined as possible.	
	Resolution:- The Board resolved to note the content of the report.	
2.0	**FOR DISCUSSION**	
2.1	**Elective Recovery Plan Update**	
	RH presented the progress in delivering the elective recovery plan. It was noted that this report had been considered in detail at the Quality Committee the previous week. He highlighted the following:- • The Trust was operating above activity levels experienced pre-Covid in 2019/20 for outpatient care and elective inpatient activity • Priority 2 waiters had remained stable across North West London in recent weeks • The cancer backlog of 62 days+ had remained relatively static during January 2022, however this had reduced to 100 from 788 in May 2020 • The Trust had 10 patients waiting for more than 104 weeks for treatment (out of 64 across Acute Provider Trusts in North West London) • The Trust had 552 patients waiting for more than 52 weeks for treatment (out of 4,200 across Acute Provider Trusts in North West London) • The Trust continued to be one of the best performing Trusts in London SG asked for details associated with the timeframes for eradicating over 104 week waits and over 52 weeks waits. RH confirmed that the National Target for eradicating over 104 week waits was end June 2022, however the Trust plan to achieve this by the end of March 2022. With regard to over 52 week waits, the national target was confirmed as March 2024. RH assured the Board that this was deliverable for the Trust. SG asked how we had been able to 'overachieve' pre-pandemic activity levels and whether this was sustainable. RH stated that in his opinion this	

	was sustainable due to system and pathway developments that had enabled greater productivity. He gave examples of digital developments, pathway reviews and the use of Quality Improvement methodology. AM asked where the recovery work was happening to understand health inequalities associated with deprivation. RH made reference to the NWL system plan and the approach to seeing patients in clinical priority order, along with those who had been waiting the longest. RC spoke to the mutual aid approach in NWL which is helping to drive equality and continues to be a key focus through the Operating Plan. He confirmed that PLACE based equality had a strong clinical focus. SG invited EH to make any comments following scrutiny of the report at the Quality Committee. EH advised that there were no further matters for escalation from the discussion at the Quality Committee.	
	Resolution: - The Board resolved to take assurance of the status of the Elective Recovery plan against planned trajectory.	
2.2	**Integrated Performance and Quality Report**	
	RH presented the Integrated Performance Report which had been subject to scrutiny at the Quality Committee during the previous week and highlighted the main constitutional standards:- A&E was non-compliant on both sites with a performance of just below 82% which was noted to be in the upper decile nationally. RH advised that challenges associated was the swabbing and testing of patients requiring admission was contributing to delays in attaining the 4 hour standard. It was noted that a protocol of covid testing for respiratory only patients would be introduced from 22 March 2022 which should aid flow. 18 week referral to treatment times continued to be non-compliant with the focus being to treat long waiting patients first and the delivery of mutual aid to support system wide equality of access to services. Positive performance was noted in relation to cancer standards including the 2 week waiting time standard. RH advised that the Faster Diagnosis Standard was unvalidated and that colleagues should expect some challenge around this standard due to the effects of Omicron. It was noted that these challenges would then impact on the 62 day standard in March 2022. The 31 day standard has also been challenged due to referral levels of 190% for suspect skin cancers compared to 2 years ago. RH referred to the performance associated with screening services and confirmed that this reflected very small numbers and that a pathway review was being undertaken to improve performance. RH highlighted two areas of the report that required amendment – the first related to SHMI where the actual reported position needed amending to read 71. The second amendment related to the number of patients waiting over 104 weeks which would be adjusted to read 10.	RH

EH confirmed that the report had been scrutinised at the Quality Committee and that assurance had been sought in relation to the Referral to Treatment Time standard for Vascular which appeared to be consistently challenging. This service was provided by Imperial College Healthcare NHS Trust through a Service level Agreement (SLA) which would be the focus of an Executive to Executive discussion scheduled for later in the month.

EH provided assurance that the Committee had also discussed the emergence of safe staffing red flags contained with the report and had sought further intelligence around these flags. This was noted to be a new metric added to the report that was critical in determining the correlation between safe staffing and safe care which would now be reported and tracked through trend analysis. VS advised that staffing levels had been compromised during the month due to vacancy rates of 20% for Health Care Assistants. It was noted that meetings were ongoing with NHS Improvement at a national level to develop recruitment plans and associated career development opportunities for Health Care Assistants. Healthcare Assistants were noted to be on the national shortage occupation list which now gives an opportunity for overseas recruitment.

AD referred to the patient experience dashboard contained in the report and questioned why only 50% of complaints were being responded to within 25 days. VS confirmed that this is a constant area of focus and recognised that further improvement was required. She provided assurance that all complainants do receive a written acknowledgement letter and telephone to confirm that their complaint has been received and is under investigation.

NG asked whether colleagues had experienced any impact following the launch of the 'MyPlannedCare App'. RH stated that very little impact had been experienced at this stage. ED advised that this could be due to the phased approach being taken nationally whereby MyPlannedCare is currently a platform on a website rather than a fully functioning app.

LW thanked RH for his report and commended RH on his grip of operational delivery and his commitment to innovation and improvement.

SG invited VM to present on the financial performance aspects of the report. VM confirmed that the Trust was reporting £3.1M surplus at the end of January 2022 and was on track to achieve a £5M surplus at the year-end.

Challenges were noted in relation to the capital programme and VM gave assurance that all opportunities to maximise appropriate spend were being taken forward.

With regard to bank and agency spend, it was noted that costs had increased during December and January directly aligned to increased staff sickness associated with Omicron and Winter pressures. She confirmed that levels had reduced in February 2022.

	The cash position of the Trust was noted to be comfortable and VM confirmed that income from the Elective Recovery Fund in the sum of £800K had been received during the quarter. ML asked if the Trust would still have a surplus if all vacancies were filed. VM confirmed that this would be the case.	
	Resolution: As there were no further questions, the Board resolved to take assurance from the report on the current performance of the organisation.	
2.3	**Maternity Services Improvement Programme Report**	
	VS introduced Victoria Cochrane, Director of Midwifery for this item. She highlighted three key aspects to the report:- •A progress update with the implementation of the 7 Immediate and Essential Actions as outlined in the Ockenden report and the plan to ensure full compliance, •Presentation of maternity services workforce plans, and sought approval to share with the Local Maternity and Neonatal System (LMNS) and the NWL Integrated Care System (ICS) •A progress update on the maternity unit's action plan status from the recommendations of the Morecambe Bay report (Kirkup 2015). VC advised that since submission of the Ockenden Compliance report to the Board last year, compliance levels had now increased from 90% to 95%. The non-compliant aspects related to two particular standards surrounding risk assessment; the first being to ensure that a risk assessment for every pregnant woman is undertaken and documented at every ante-natal contact, the second being to ensure risk assessments of women take place to ensure their planned place of birth remains appropriate. VC confirmed that the maternal handheld notes were now being updated to include these aspects. The revised notes would be introduced in clinical areas during mid March 2022. A subsequent audit would then take place to demonstrate compliance levels and any barriers to completion. VC anticipated that the Trust would be able to demonstrate 100% compliance with all standards within the original Ockenden Report by June 2022. VC notified the Committee that version 2 of the Ockenden Report was anticipated to be published on 22 March 2022 and that this was likely to include additional standards for Maternity Care. VC delivered an overview of the status and progress of the maternity service workforce plans. It was noted that the Trust was now fully compliant with Consultant Labour Ward cover following the appointment of 2.7WTE Consultant Obstetricians. VC advised that in order to achieve the recommendations of Birthrate plus (via the Maternity Incentive Scheme & Ockenden) a gap of 71.43 Whole	

	Time Equivalent (WTE) had needed to be addressed through a mix of clinical midwives, midwifery support workers, specialist and management posts. The Ockenden investment in September 2021 of 21.2 WTE Midwives has reduced the overall gap to 50.23 WTE (27.95 Midwives (MW)/ 4 Midwifery support workers (MSW) & 18.28 specialist & management posts). It was noted that an announcement of further funding had been made to invest in maternity workforce nationally and that a meeting was planned with the executive team on 9th March to discuss the business case to support the service to achieve the recommendations of Birthrate plus. EH confirmed that discussions had taken place at the Quality Committee during the previous week about the risk associated with the national shortage of midwives and how this could impact of recruitment opportunity and compliance with nationally defined midwifery workforce standards. VC had been able to advise the Committee that a range of opportunities to explore alternative roles to support safe midwifery care were underway including options such as international recruitment. ML asked what the measures are to assure safe and effective delivery of care versus investment. VC advised that birthrate plus and the 98 hours of labour ward cover were two measures and that a new perinatal surveillance model was under development. With regard to the Morecambe Bay report, VC advised of one outstanding recommendation which is yet to be embedded. It was noted that this was linked to the risk assessment work being taken forward as part of the Ockenden recommendations and as such would be addressed by June 2022.	
	Resolution: The Board resolved to take assurance of the progress being made in relation to:- • Ockenden compliance • Maternity workforce plans • The maternity unit's action plan status from the recommendations of the Morecambe Bay report (Kirkup 2015).	
3.0	**FOR APPROVAL**	
3.1	**Guardian of Safe Working Q2 Report 2021-22**	
	RC presented the report and provided assurance that this had been discussed at the People and Organisational Development Committee. RC highlighted the increasing trend in reporting with 294 exception reports raised during Quarter 3 of 2021/22. He advised that this was in part reflective of working conditions linked to Omicron associated sickness during the Winter period. It was noted that most exception reporting was generated from Junior Doctors during the first two years of their placement. RC assured the Board that this was being taken very seriously and that ongoing work was taking place with the Medical School to support improvement.	

	AM confirmed that the report had been discussed at the People and Organisational Development Committee at the end of February 2022. He stated that the Committee had been pleased to note that the Finance and Investment Committee had approved additional investment for Junior Doctor rota compliance in Paediatrics and the Emergency Department, which should help to reduce pressure on the existing Junior Doctor workforce. EH noted that attendance at the Junior Doctor Forum had reduced and asked if this was indicative of a morale issue. RC stated that soft intelligence was very important and that he thought this was probably more reflective of a capacity issue rather than a morale issue. NG asked if future reports could include the impact of the national reduction in training numbers so that we can consider the strategic approach to the medical workforce. RC advised that he would take this through the People and Organisational Development Committee in the first instance as a stand-alone report.	
	Resolution / Action**:** The Board resolved to:- • Receive and approve the content of the report • Request the People and OD Committee to receive and consider a report on the impact of the national reduction in training numbers	AM/RC
3.2	**Mortality Report**	
	RC presented the Mortality Report providing assurance that the Trust has some of the lowest levels of mortality in the Country. He confirmed that 12 incidents of sub-optimal care had been evident through the mortality surveillance process however this had not impacted on the outcome for the patient. They did however demonstrate opportunities to improve care and these opportunities were now being taken forward. EH confirmed that the report had been scrutinised at the Quality Committee during February 2022 and that the Committee were reassured by the Mortality Surveillance Process, the outcomes of Mortality Reviews and the associated learning.	
	Resolution: The Board resolved to receive and approve the content of the report.	
3.3	**Feedback from the Board Committee Effectiveness Review 2021/22**	
	DC presented the findings of the Board Committee Effectiveness Review process which had been approved at Board in November 2021. The review process had attracted over 600 responses to questions designed to measure the effectiveness of the five Board Committees:- • Audit and Risk Committee • Quality Committee	

	• People and Organisational Development Committee • Finance and Investment Committee • Board Nomination and Remuneration Committee It was noted that over 92% of all responses either strongly agreed or agreed that the Committee was effective. Where disagreement with effectiveness measures was noted, improvement actions had been taken. These had largely been associated with administrative arrangements, the need for more focussed report writing and the need to refresh the Board Assurance Framework. DC provided assurance that the individual reports had been presented at each of the respective Committee meetings. NG highlighted that the totality of survey results had not been able to be presented at the Audit and Risk Committee as it would have impeded timings for the Trust Board. Resolution:- The Board resolved to approve the report.	
4.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**	
4.1	**Learning from Serious Incidents**	
	VS introduced AB who presented this report. AB highlighted the declining number of overdue actions associated with serious incident investigations. EH provided assurance that the Quality Committee had considered this report in detail and were assured that a robust process was in place for incident investigation and associated learning. She commented that she was pleased to see the focus being applied to effectiveness of actions arising from serious incident investigations.	
	Resolution:- The Board resolved to receive and note the content of the report.	
4.2	**People Performance Report**	
	SSm presented the report and confirmed that this had been considered in detail at the People and Organisational Development Committee (PODC). She highlighted the following:- • The report was in a new format linked to the 4 key pillars of the People Strategy • A quarterly heatmap was included to identify trends and support improvement opportunities and associated learning • The Trust had been nominated for a Health Service Journal award for the back up care initiative • The Trust had attained Timewise Accreditation AM advised that the People and Organisational Development Committee had raised concerns relating to sickness absence levels and turnover in	

	some part of the organisation and confirmed that the Committee would continue to govern this matter.	
	Resolution: The Board resolved to note the content of the report.	
4.3	**Escalation Reports from the Board Sub-Committee Meetings held in January 2022**	
4.3.1	Audit and Risk Committee – NG presented the report and provided assurance that the Committee is continually focussing on cyber security	
4.3.2	Quality Committee – EH presented the report and gave assurance that the Committee continues to give a good balance of scrutiny and overview of clinical effectiveness, patient experience and patient safety.	
4.3.3	People and Organisational Development Committee – AM presented the report with nothing further to add.	
4.3.4	Finance and Investment Committee – ND presented the report and highlighted the challenging impact that the following aspects would have on the 2022/23 financial year:- • The business planning approach for the coming fiscal year • A reduction in covid funding for 2022/23 • Increasing inflation and rising energy costs	
5.0	**ITEMS FOR INFORMATION**	
5.1	**Questions from Members of the Public**	
	SG invited MS to introduce himself to the meeting. MS thanked the Board for the very generous welcome that he had received following his appointment as North West London Acute Trusts Joint Chair and he confirmed that he would be starting in post on 1 April 2022. MS delivered an overview of his career history including his former position as Deputy CEO and Chief Operating Officer for NHS England. MS stated that the Board meeting has been a good example of Chelsea and Westminster NHS Foundation Trust and that he had been impressed with the papers, performance of the Trust and its leadership. He stated that his aim was to ensure that the acute provider collaborative across North West London was the best collaborative in the Country by reducing health inequalities and improving access to services at the right place at the right time. AL public governor welcomed MS on behalf of the Council of Governors and stated that the Council were keen to explore the focus of the Council of Governors within a provider collaborative. MS thanked AL and looked forward to meeting with the Governors and Non-executive Directors in early April 2022. NL referenced the recent announcement from Amanda Pritchard on the reservist model. SSm advised that the Trust is currently exploring what this would look like within a system approach.	
5.2	**Any Other Business**	
5.2.1	Term of Office of the Interim Chair	

	SG stated that this was his last Public Board meeting as Interim Chair of the Trust and confirmed that from 1 April 2022 he would be reverting to the role of Vice Chair of the Board and Senior Independent Director. He stated that it had been a privilege to hold the position of interim Chair over the past 12 months. He thanked all of the Board members and all staff for their support, commenting that they have demonstrated courage, hard work and resilience during the most challenging period ever experienced by the NHS. Governors MK and LA thanked SG for his leadership as Interim Chair of the Council of Governors as well as Interim Chair of the Board of Directors.	
4.3	**Date of the Next Meeting**	
	The next meeting will take place on 5 May 2022 at 11.00am until 1.30pm. The meeting closed at 1300 hours.	

Glossary of Terms

NHS	National Health Service
NHSE/I	NHS England / Improvement
FDS	Faster Diagnosis Standard (Cancer Care)
GIRFT	Getting It Right First Time (An evidence based quality standard)
MPs	Members of Parliament
ICS	Integrated Care System
NWL	North West London
ITU	Intensive Treatment Unit
P2	Priority 2 Patients (Elective Patients)
IP	In-Patient
DC	Day Case
HVLC	High Volume, Low Complexity
OP	Out Patient
WW	Week wait
BAU	Business as Usual
A&E	Accident and Emergency
RTT	Referral to Treatment Time

Trust Board Public –Action Log 5 May 2022

Meeting Date	Minute number	Subject	Action	Current status	Lead
06.01.22	3.4	People Performance Report	Arrange a meeting between NG and SSM regarding the Maintaining High Professional Standards (MHPS) Service.	Complete	SSM
03.03.22	2.2	Integrated Performance and Quality Report	Make two amendments to the report – the first related to SHMI where the actual reported position needed amending to read 71. The second amendment related to the number of patients waiting over 104 weeks which would be adjusted to read 10.	Complete	RH
03.03.22	3.1	Guardian of Safe Working Report	Request that the People and OD Committee receive and consider a report on the impact of the national reduction in training numbers	Formally referred to POD Chair and Exec Lead via email on 22 April 2022. To be scheduled for POD in May 2022	RC/AM

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting 5 May 2022

AGENDA ITEM NO.	1.6
TITLE OF REPORT	North West London Acute Chair's Report (Chair in Common)
AUTHOR NAME AND ROLE	Matthew Swindells, Chair in Common
ACCOUNTABLE EXECUTIVE DIRECTOR	Matthew Swindells, Chair in Common
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To introduce and provide a background and context to the role of Chair in Common and a personal background to Matthew Swindells To assure the Board of discussions that have progressed since coming into post on 1 April 2022 in relation to the development of the acute provider collaborative To assure the Board of the range of internal and stakeholder discussions that have taken place to ensure recognition and understanding of a range of perspectives on our organisation and to get to know our organisation in depth.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• The benefits of working in collaboration across North West London • The experience that Matthew Swindells brings to the position of NWL Chair in Common • The development and aims of the North West London Integrated Care System • Next Steps

KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)	
Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	X
Quality	X
People (Workforce or Patients/ Families/Carers)	X
Operational Performance	X
Finance	X
Public Consultation	
Council of Governors	
please mark Y/N – where Y is indicated please explain the implications in the opposite column	

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

North West London Acute Trusts Chair's Report – May Public Board

(1) Firstly, Thanks

Before I do anything else, let me express my thanks to Steve Gill who has done a fabulous job as Chair of Chelsea and Westminster Foundation Trust in the hiatus between Sir Thomas Hughes-Hallatt retiring and my arrival as Chair of the four Trusts in the NW London acute collaborative. Steve has now returned to his role as Vice Chair and Senior Independent Director where he continues to provide outstanding service to the Trust and the local community, provide wise counsel to me.

(2) Introduction to the Chair of the Acute Collaboration for the four trusts in North West London

(A) Background

The Joint Chair / Chair in Common position was created to facilitate closer working between the four NWL Acute trusts: Chelsea and Westminster Hospital NHS Foundation Trust; The Hillingdon Hospitals NHS Foundation Trust; Imperial College Healthcare NHS Trust; and London North West University Healthcare NHS Trust, building on the increased collaboration over the past two years that has helped the NHS in NWL respond to the pandemic. At the heart of our objective is the ambition to improve the health and care for individuals and communities by making the best that is available in NWL available to everyone in NWL, working with our partners in other parts of the NHS, in local government and the voluntary sector to help people stay well and improve their experience of care, and sweep aside the bureaucratic blockages to good decision making that occur when institutions are placed before patients.

I formally started as Chair in Common for the four Acute trusts in NWL on 1 April, although I attended three of the four Trusts' Board meetings (including ChelWest) as a member of the public in March and also joined the weekly calls of the four trust Chairs during March to start to get up to speed.

(B) A Bit About Me

I have had a long career in healthcare, as hospital Chief Executive, as Deputy Chief Executive and Chief Operating Officer for the NHS in England, in the Cabinet Office and as a Senior Vice President for the world's largest dedicated healthcare IT company, Cerner Corporation, where I ran their global business across 21 countries, whilst living in the US. Through these roles, I have had the opportunity to see some of the best healthcare delivery in England and the rest of the world. We have an exciting opportunity to turn North West London into the best health system in England and a place that is admired around the world, I hope to bring my experience to bear in helping that to happen.

(C) – First Steps

Over the next couple of months I shall be taking the opportunity to speak to as many people as possible and get to know our organisations in more depth. I am not walking into the chair role with a manifesto. I want to find out what really matters to communities, staff and patients. I am looking forward to working with the excellent leadership teams at each trust to understand how I can best support them and their goals. I plan to be a very visible chair and to get out and about though I will most definitely not be getting involved in any day-to-day management!

If you step back and take the perspective of our population, there are some obvious priorities. We have to reduce waiting times for care and ensure access to care is fair to everyone in our population. Working ever closer with other NHS and care partners will also be key—if care can be better provided at home or by a GP, social worker or community nurse, then we must support that. And, finally, we have some big sustainability issues to get to grips with, not least improving much of our estate and getting on top of our finances for the long term.

(3) - Our Staff

As everyone will be aware, the NHS has a major workforce challenge. As we emerge from the extraordinary experience of the pandemic and into the pressures it has compounded, we have to create working environments than are so much better than what we accepted before. It's vital that we are organisations which represent the communities that we serve, where people feel passionately about their work and are truly valued and included, whatever their background, role or place of work. It is our staff who will make or break collaboration—they will need the right space and support to work with our partners, patients and communities to change the way healthcare is provided.

Significant investment has been made in Health and Well-being (H&WB) programmes to support staff through this unprecedented period.

On behalf of the Trust Board and the Council of Governors (COG), we would like to express our gratitude to the Trust staff and Executive Team for their hard work and resilience throughout the pandemic to maintain a high standard of GRIP and achievement against the NHS performance metrics.

The entire organisation has now been operating at or above capacity for two and a half years since the start of the winter pressures in October 2019 and is continuing to face major ongoing challenges dealing with the current Covid wave.

(4) - NWL Acute Collaborative / NWL Integrated Care System (ICS)

The NWL ICS and the NWL Acute Collaborative cannot individually succeed without both succeeding.

ICSs have a huge agenda across multiple settings and will be key in helping us all to navigate the massive complexity of health and care. They have great potential to transform health and reduce health inequalities but it will require all partners to work together to ensure that potential is delivered. Although the legislation that formally brings ICSs into being has only just been passed by parliament, the North West London ICS has already made a great start in defining its priorities. All four Acute Trust Boards across North West London have had a chance to meet with the new ICS Chair, Penny Dash, and the new ICS Chief Executive, Rob Hurd, to discuss these priorities:

- Improving outcomes in population health and health care
- Preventing ill health and tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Supporting broader economic and social development

As part of delivering this agenda the ICS will be working closely with, and relying on, the Acute Collaborative to play our part, which we are wholly committed to doing.

(5) – Update

As I said in my interview for the hospital websites, which can be seen here: https://www.imperial.nhs.uk/about-us/blog/meet-matthew-swindells-the-first-joint-chair-for-all-four-acute-trusts-in-north-west-london, my first few weeks have bee mostly about getting to know people. I have spend time at all four Trusts, met the NEDs and am starting to get to know the executive leadership. I hope that in the next few weeks I will be able to spend more time walking about the hospitals talking to staff on the front-line.

During February and March, Steve Gill continued to do a fantastic job as the interim Chair of the Foundation Trust participating in meetings with the Chief Executive and the other Trust Chairs that discussed: COVID-19 Omicron variant; the ongoing Elective Recovery programme; the NWL ICS Development plan and 'road map'; NHS England/Improvement (NHSE/I) guidance on Provider collaboratives; Urgent & Emergency Care, with a focus on Ambulance response & handover times plus Hospital discharge pathways.

Since I joined in April, there has been a particular focus agreeing our operational and financial plans for the coming year to address the challenge of reducing waiting times, whilst dealing with the ongoing pressures of emergency demand and the impact of Covid.

During February and March as part of the work on the NWL Acute Provider collaborative, the NWL Acute Trust Chairs continued to have weekly meetings, from mid-February I joined these meetings as the NWL Acute Joint Chair designate. From April onwards these meetings have continued with myself and the 4 NWL Acute Vice Chairs.

I have met with the lead governors for both of our Foundation Trusts and have had an informal introductory meeting with a number of the Chelsea and Westminster Governors. I look forward to working closely with with our sets of Governors over the coming months to support them in holding the NEDs to account and bringing an effective patient voice to the development of the individual Trusts and the Collaborative.

I am starting the process of speaking to the patient voice representatives at the non-FT hospitals to ensure that we have a strong patient and public engagement across all of North West London.

I also have had my first meetings with the leaders of our local authorities and look forward to meeting with them all over the next few weeks. And, I have met with Rt Hon Jacqui Smith, the Chair of the North East London Acute Collaborative, incorporating Barts and the London Trust and Barking, Havering and Redbridge Trust, to ensure that we learn from each other's experiences of developing an Acute Collaborative.

Matthew Swindells

Chair – North West London Acute Trusts

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors (Pubic) 5 May 2022

AGENDA ITEM NO.	1.7
TITLE OF REPORT	Chief Executive's Report
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Lesley Watts, Chief Executive Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To assure the Board of high level affairs pertinent to April 2022.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: N/A Date of Meeting: Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• Welcome to two new members of the senior Leadership Team – Matthew Swindells, Chair in Common of North West London and Robert Bleasdale Chief Nursing Officer • Our elective recovery programme continues to deliver activity levels above those seen before the Covid pandemic. Demand for services is however increasing and we have a challenging operating plan to deliver in 2022/23 • We are making good progress in achieving all of the Ockenden recommendations from the original report and are now reviewing the learning from the March 2022 report • Our staff continue to be the fundamental core of our Trust and we thank them for their continued hard work, resilience and commitment to patient care

KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	X
Be the employer of Choice	X
Deliver better care at lower cost	X

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	

Equality And Diversity	
Quality	Y
People (Workforce or Patients/ Families/Carers)	Y
Operational Performance	Y
Finance	
Public Consultation	
Council of Governors	Y

please mark Y/N – where Y is indicated please explain the implications in the opposite column

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

Chief Executive's Report to the Council of Governors meeting, 21 April 2022

1. Keeping Each Other Safe – Infection Control and Covid 19

Despite it no longer being mandatory, we continue to encourage our staff to have the Covid vaccination as it is safe, saves lives and protects staff and patients. Like everyone else we are adjusting to the ending of Covid restrictions and assessing what this will mean for how we operate. At the time of writing my report, we are asking people to wear masks at our sites, use hand sanitiser and we continue to limit the number of people who can visit our wards. It is important to remember that COVID-19 has not gone away. Though cases have fallen significantly in recent weeks, and the work everyone has supported on the vaccination campaign has made a massive difference to the numbers of seriously ill patients, the number of people testing positive for COVID-19 remains high, especially in the boroughs we serve.

2. System Wide Working

2.1 Appointment of Matthew Swindells as the North West London Chair in Common

Following a strong and rigorous recruitment process, Matthew Swindells was appointed as North West London Chair in Common and started in post on 1 April 2022. I am sure you will join me in offering Matthew a very warm welcome to his first public Board meeting as Chair of the Trust.

2.2 Thank you to Interim Chair, Steve Gill

On behalf of all of us, I would like thank our former Interim Chair, Steve Gill for his expertise, leadership and commitment to our Trust. Steve has led us through one of the most challenging periods in the history of the health service. He has been an excellent Interim Chair to our Board of Directors and Council of Governors. Since Matthews appointment, Steve has now assumed the role of Vice Chair of the Board and Senior Independent Director.

2.3 First medical director and director of nursing appointed to lead integrated acute and specialist services for children and young people across West London

Over the past two years or so, we've been working in partnership with Imperial College Healthcare NHS Trust—and with colleagues at Imperial College—to develop more integrated care for children and young people with a stronger focus on health and wellbeing, disease prevention and research.

We're delighted to announce formally that we have now reached an important milestone with the appointment of Dr Simon Nadel as the first joint medical director and Herdip Sidhu-Bevan as the first joint director of nursing for children's services across our two trusts. This follows an external recruitment process. Huge congratulations to both—we know they will be excellent in these roles.

2.4 Continued System Working

Chelwest continues to be part of national, regional and sector discussions and the North West London Integrated Care System continues to operate as one system whilst legislative changes continue to be progressed.

Meetings continue to be held with:

- All NHS provider Chairs

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

3. The Ockenden Review – Improving Maternity Services

I am sure many of our staff, patients and governors are concerned following the publication of the final Ockenden report of the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. My thoughts are with all the parents and families affected.

Since the publication of the first Ockenden Report we have worked hard to ensure that we are meeting all of the recommendations of the national review and today our Director of Midwifery Vicki Cochrane presents our achievements to date.

In March 2022, Donna Ockenden released her second report and we are already reviewing all of these recommendations to determine how we can ensure that our maternity service meets the very best standards in care. In the last year, we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing attrition of maternity staff, and providing the required funding for a sustainable and safe maternity workforce is essential as we move forward so that we can ensure the safety of mothers and their babies.

4. A New Out Patient Pharmacy at Chelsea and Dean Street

After nearly seven years, the Trust's contract for outpatient dispensing services provided by Boots UK has come to an end. Outpatient pharmacy services are now provided by CW Medicines Ltd, a wholly owned subsidiary of the Trust, at our Chelsea site and at 56 Dean Street.

The new CW Medicines contract means we can continue to improve the services to patients through innovation—including a redesign of the premises, improved prescription tracking displays for patients, and an automated prescription collection machine, enabling patients at Chelsea to collect their medicines at any time, even when the pharmacy is closed.

5. Optimising Patient Flow

Whilst we are proud of the achievements we have made in sustaining the delivery of our elective recovery programme, it is fair to say that the NHS is under considerable pressure to meet the ongoing demands for care. We are working incredibly hard both within Chelwest and across the Acute Provider Collaborative and Integrated Care System to explore all opportunities to streamline our ways of working, remove barriers and reduce health inequalities. Ensuring that patients receive the right care in the right place at the right time is critical to the clinical effectiveness and safety of care we provide. We have submitted our Operating and Business Plan for 2022-23 confirming that

we will deliver at least 107% of elective activity (compared to pre-covid levels) and at least 120% of diagnostic modalities (compared to pre-covid levels).

6. Valuing and Recognising our Staff

We continue to be extremely busy across all of our sites, and I know how incredibly hard everyone is working right now despite this pressure. Nationally, the NHS is experiencing increased pressures due to staff shortages from sickness, and I along with the rest of the Trust Board continue to be incredibly grateful for the extraordinary efforts that each and every colleague is making—our organisation is outstanding because of our people.

Our staff continued to be our most precious resource and as ever I am sure that Board members would like to join me in thanking them for their continued hard work, commitment, kindness and loyalty to each other, patients and their families/carers.

6.1 Welcome to Robert Bleasdale, Chief Nursing Officer

I am delighted to introduce you to Robert Bleasdale who joined the Trust in April 2022 as our Chief Nursing Officer. Robert was previously Chief Nurse and Director of Infection Prevention and Control at St George's University Hospital, and has held a number of senior nursing leadership roles in the NHS. He has been instrumental to the Covid-19 response, leading on the vaccination programme to establish one of the first vaccination clinics in the country. He has led on a number of quality improvement programmes, including the development of accreditation systems, which helped raise standards of care and was involved in St George's exiting CQC special measures. He has proactively promoted partnership working and is passionate on the role of staff and patient involvement in key service decisions.

Robert became Deputy Chief Nurse at St George's in 2017, having previously held a number of other senior nursing roles at St George's since 2014. He started his nursing career in acute medicine, before moving into emergency care. He is an advanced trauma nursing course instructor, and completed his nursing degree at Oxford Brookes University. He also has a Masters in Senior Healthcare Leadership from Birmingham University.

I am sure you will all join me in welcoming Robert to Chelwest.

6.2 Consultant midwives awarded prestigious silver Chief Midwifery Officer award

Congratulations to our consultant midwives Natalie Carter, Louise Nunn and Claire Davidson for their silver Chief Midwifery Officer award for excellent services to maternity care during the pandemic. This prestigious award was presented to the three midwives by Prof Jacqueline Dunkley-Bent, Chief Midwifery Officer, and Kate Brintworth, Regional Chief Midwifery Officer for London.

6.3 Kindness campaign – steps up

The second phase of our kindness to staff poster campaign will be launched soon, after the success of the first phase. This campaign will now be part of a wider London initiative. Staff safety is a priority to our Trust – we want people to feel safe, welcomed and valued at our organisation so they in turn can focus on providing high-quality care for our patients. Our staff feeling safe enables us to live our proud values, and is a key part of our strategic aim to be the employer of choice. We are delighted to hear that the Royal College of Nursing are supporting us in our campaign. Last week, our kindness to staff campaign was shortlisted in the Public Sector Campaign category at the

Chartered Institute of Public Relations Excellence Awards. Being unfailingly kind is one of our Trust values, and I am so pleased this campaign is getting the recognition it deserves. A personal and heartfelt thank you to all involved in this project, including those who have chosen to share their lived experiences. Despite our best efforts there are times when our staff experience behaviours from patients which do not live up to the values that we hold. Today we hear from Olivia, a loyal and longstanding member of our administrative team who sadly experienced racial abuse from a patient. She speaks of the impact this had on her and how the organisation responded to this incident.

6.4 Ramadan Mubarak

I would like to take this opportunity to wish all our Muslim colleagues a Ramadan Mubarak. Ramadan ended on the evening of Sun 1 May, followed by the celebration of Eid Al-Fitr.

7. Concluding Remarks

In concluding this report I would like to say how very proud I am of our Trust and how we would not be able to achieve the results described above without the fabulous team that is Chelwest.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Trust Board of Directors (Public) 5th May 2022

AGENDA ITEM NO.	2.1
TITLE OF REPORT	Elective Recovery Programme Update
AUTHOR NAME AND ROLE	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: √ Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To provide the Board with assurance relating to our progress in delivering our Elective Recovery Programme.

REPORT HISTORY
Committees/Meetings where this item has been considered)

Name of Committee	Date of Meeting	Outcome
NWL ECB	11/04/2022	Noted
EMB	April 2022	Noted
Quality Committee	3 May 2022	Noted

SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND

Data relates to w/e 27th March 2022 apart from High Volume and Low Complexity (HVLC) activity and Cancer which is 3rd April

- The Priority 2 waiting list across North West London (NWL) has remained stable with this week's variation remaining within statistical control limits. With Chelwest positively below the average.
- Elective Inpatient Activity and Day Case Activity is at 94.9%
- HVLC – 85.7% an improvement on the previous week.
- Elective Out Patient (OP) First Appointments – is 123.1% whilst OP Follow-up is at 103.3%
- As at the 3rd April the trust Patient Tracking List has seen a significant decrease in a week from 47,412 to 47,534. There has been a marginal increase in the number of patients waiting over 52 weeks from 557 to 567 patients, however sustained performance is noted for patients waiting more than 104 weeks which has been at zero for two consecutive weeks.

	• Cancer Backlog 63 days+ is reported at 93 patients as at week ending 03/04 • Endoscopy Activity – 159.1% • Imaging Activity – 87.1% • Echocardiograph Activity – 99.4%
KEY RISKS ARISING FROM THIS REPORT	There are on-going risks to the achievement of Elective recovery

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	
Deliver better care at lower cost	

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR: Equality And Diversity Quality People (Workforce or Patients/ Families/Carers) Operational Performance Finance Public Consultation Council of Governors please mark Y/N – where Y is indicated please explain the implications in the opposite column	Quality - There are on-going risks to the achievement of Elective recovery Finance - Attainment of the Elective Recovery Fund. Validation work of RTT Applicable specialties is being completed to ensure all applicable activity is being accounted for.

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

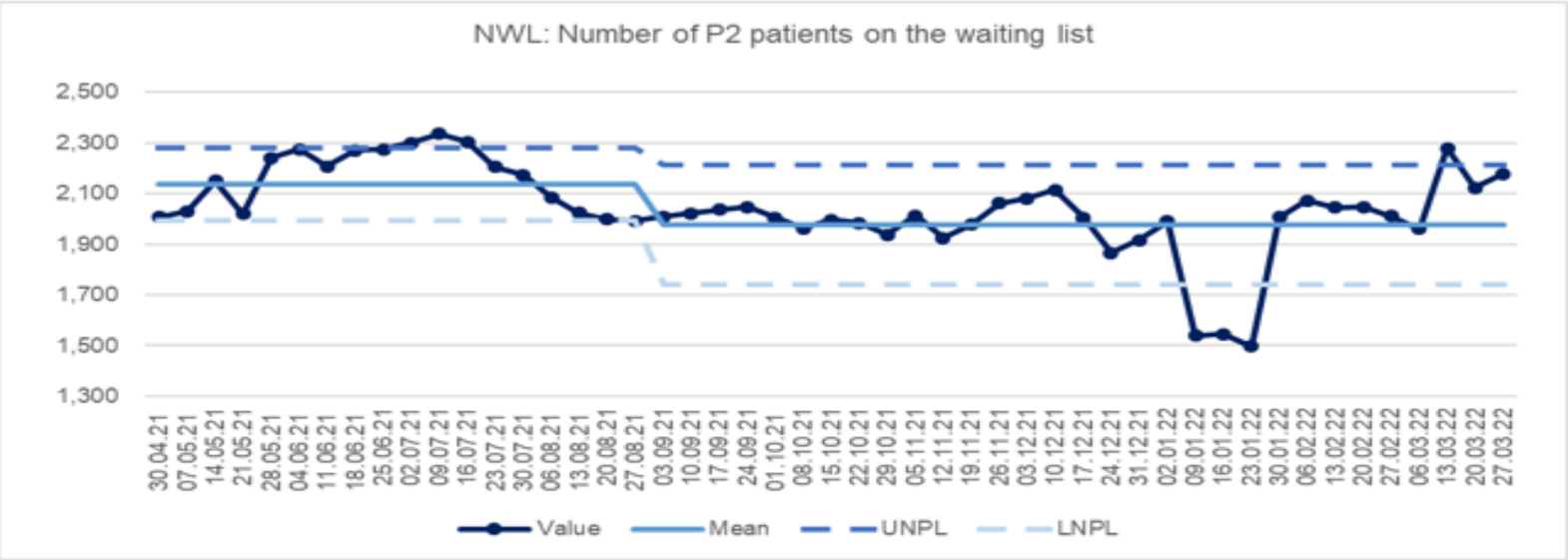
Chelsea and Westminster Elective Care Recovery

Recovery Update - Summary

11th April 2022

P2 waiting list size across NWL Trusts

Trusts	06.03.22	13.03.22	20.03.22	27.03.22
CWFT	518	594	436	444
ICHT	803	1,036	1,045	1,061
LNWUHT	516	519	501	530
THHT	130	128	141	142
NWL Total	**1,967**	**2,277**	**2,123**	**2,177**



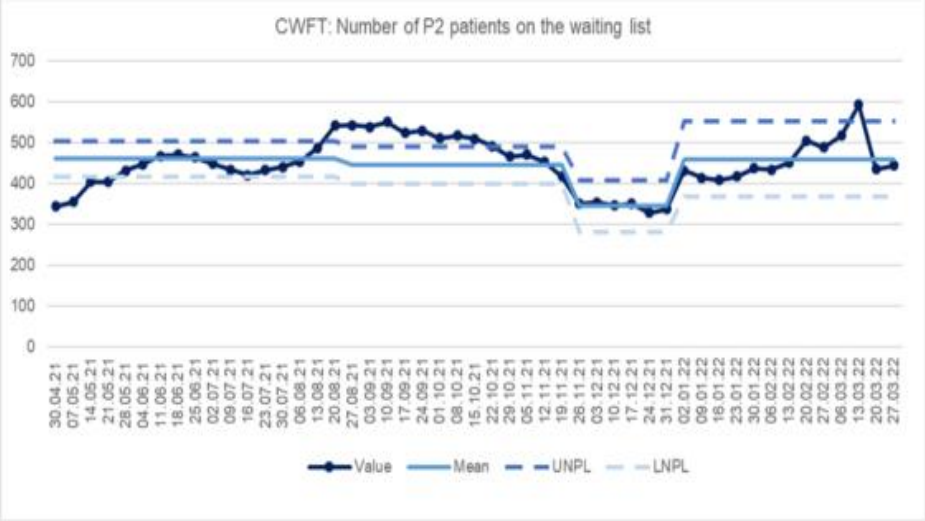
Source: OnePTL prior to 02.01.22 and WLMDs from 02.01.22
Note: Upper natural process limit (UNPL) and Lower natural process limit (LNPL)
Note: ICHT in January 2022 utilised a new supplier for PTL extraction which impacted on reporting of PTL numbers.

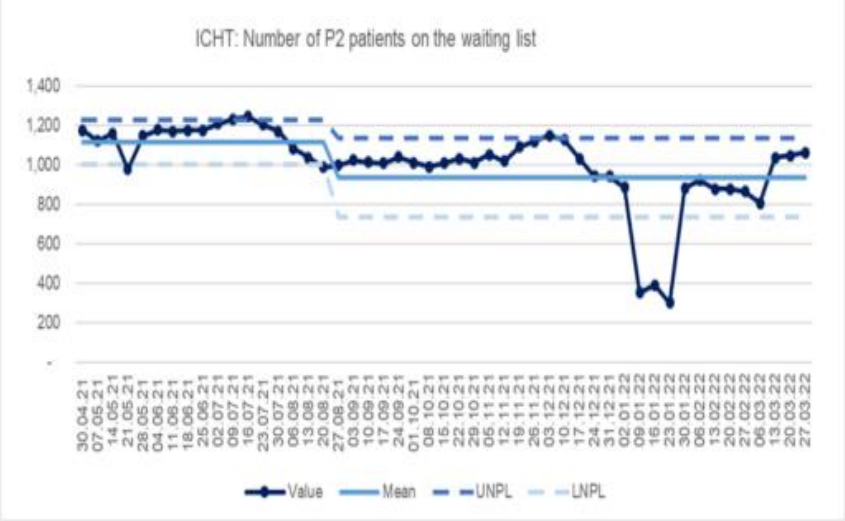
Statistical Process Control charts demonstrate trend of P2 numbers over the last 49 wks.

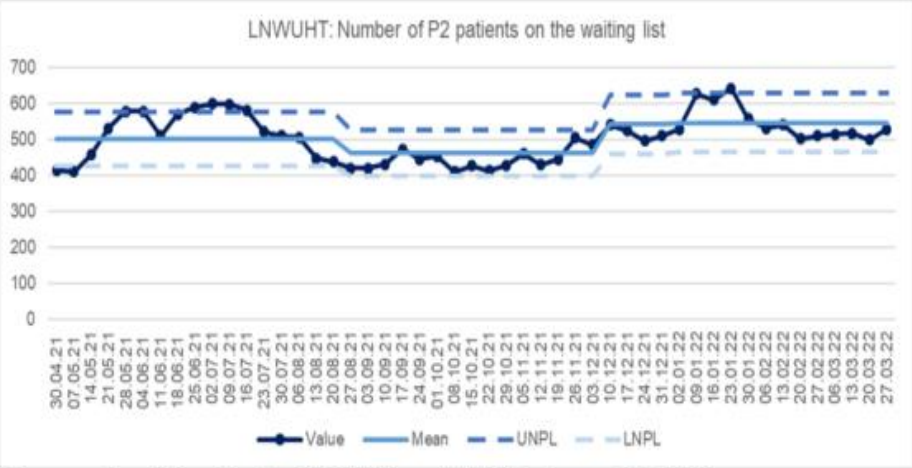
Aggregated NWL position shows variation over time of P2 patients on waiting lists. This week, variation remains within statistical control limits.

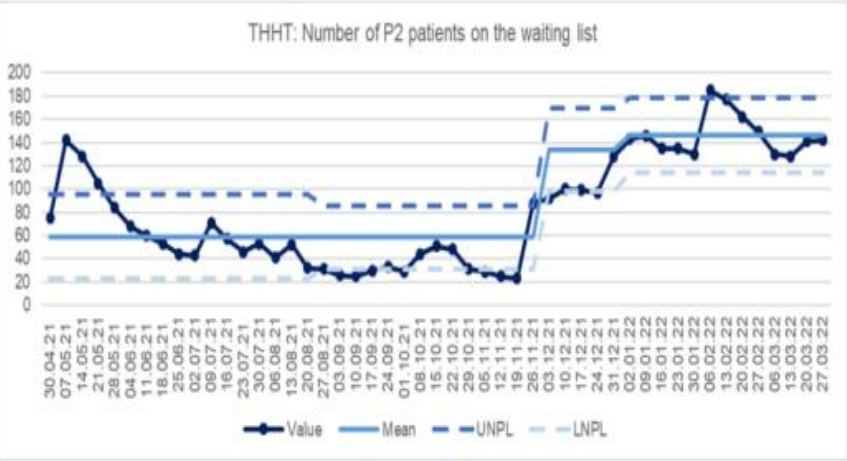
Trust level SPC charts can be found on the next slide.

P2 waiting list size at each Trust: SPC charts









Statistical Process Control charts demonstrate variation of P2 numbers over the last 49 wks and any trends.

All the Trusts show variation over time of P2 patients on waiting lists.

Source: OnePTL prior to 02.01.22 and WLMDs from 02.01.22

Note: Upper natural process limit (UNPL) and Lower natural process limit (LNPL)

Note: ICHT in January 2022 utilised a new supplier for PTL extraction which impacted on reporting of PTL numbers.
actual numbers as the previous dataset was using different counting rules. This also impacted Imperial as noted in the report

P2 Patients Waiting 6 Weeks Or More

Number of P2 patients waiting 6 weeks or more

Trusts	06.03.22	13.03.22	20.03.22	27.03.22
CWFT	19	21	20	23
ICHT	64	83	80	89
LNWUHT	181	204	202	191
THHT	55	53	40	43
NWL Total	**319**	**361**	**342**	**346**

Undated P2 patients waiting 6 weeks or more

Trust	06.03.22		13.03.22		20.03.22		27.03.22	
	N	% of total P2 WL	N	% of total P2	N	% of total P2	N	% of total P2
CWFT	7	1%	7	1%	5	1%	8	2%
ICHT	26	3%	30	3%	33	3%	44	4%
LNWUHT	113	22%	129	25%	130	26%	131	25%
THHT	23	18%	26	20%	21	15%	24	17%
NWL Total	**169**	**9%**	**192**	**8%**	**189**	**9%**	**207**	**10%**

Source: Exception reporting from Trusts

Note: Timeframe for manual reporting of P2s waiting 6 wks or more had changed from 06 March 22 with the transition from OnePTL to WLMDS.

Executive summary

- **PTL:** The total PTL (admitted and non-admitted) stands at **1,035,879** - an increase of c.3,500 (0.3%) from the previous week.
- **104ww:** A significant decrease of 182 pathways.
- **52ww:** After two weeks of increases, 52ww have seen a decrease of 604 pathways to a total position of 26,634.
- **Cancer**: Total back log increased by 2.6% from 2,854 to 2,929. 104+ day waits have again decreased, down 32 to 901 from 933.
- **Diagnostics:** All three diagnostic areas experienced waitlist declines: Echo down 132 (-0.7%), Imaging decreased by 3,069 (-2.1%) and Echo decreased 1.9% down 454 to 23,283. >6 week positions decreased significantly in Endo (6.1%), with slight increases in Imaging (0.4%) and Echo (0.3%). Endo (2.7%) saw a slight increase in activity; with Imaging and Echo showing slight decreases but either remaining above or at BAU.
- **Activity:** Overall activity positions decreased slightly. (Outpatients c. 101% and Electives c. 87% of BAU). Elective positions are challenged at NEL, NWL and SEL.
- **OPA First:** 102% of BAU with a slight decrease in activity (-1.6%) from the prior week.
- **OPA Follow Up:** Activity decreased slightly in week (-0.5%) but remains around c. 100% against BAU.
- **OP Transformation:** The PIFU rate for Jan-22 is 0.5%, well below the national target of 5%. A&G utilisation sits at 11%, below the national target of 16%. The cancellation rate is currently 19% and DNA's at 10%.

	Latest Week (w/e 03-Apr)		
	Volume	% Change	Volume Change
Total PTL	**1,035,879**	**0.3%**	**3,539**
52ww	26,634	-2.2%	-604
78ww	3,893	-2.6%	-104
104ww	642	-22.1%	-182
Cancer Backlog	**2,929**	**2.6%**	**75**

Latest Week by ICS				
NCL	NEL	NWL	SEL	SWL
250,598	**188,687**	**215,312**	**232,435**	**148,847**
9,274	7,469	4,347	4,425	1,119
1,441	1,407	374	594	77
231	296	10	99	6
710	**605**	**611**	**683**	**320**

	Freeze Week (w/e 27-Mar)		
	Volume	% Change	Volume Change
Endoscopy Waitlist	18,163	-0.7%	-132
Imaging Waitlist	140,256	-2.1%	-3,069
Echo Waitlist	23,283	-1.9%	-454

Latest Freeze Position by ICS				
NCL	NEL	NWL	SEL	SWL
4,426	2,549	4,916	3,515	2,757
27,667	42,728	25,792	17,420	26,649
2,476	9,229	3,286	3,866	4,426

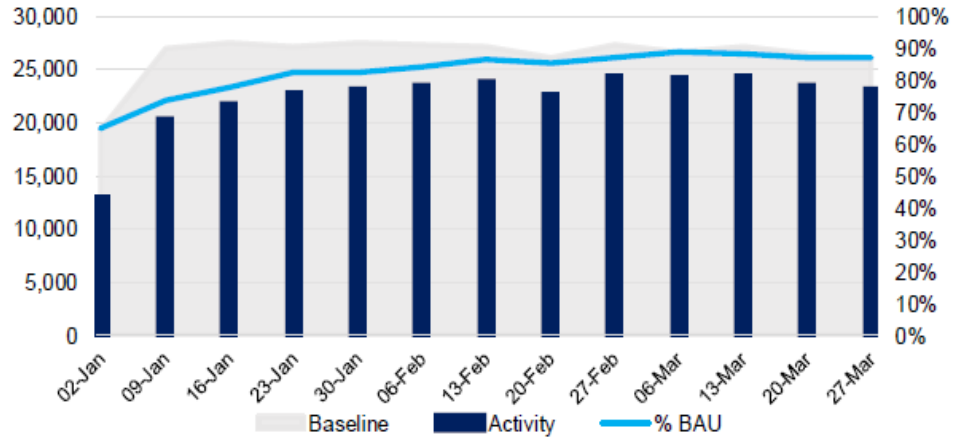
	Latest Freeze Position (w/e 27-Mar)			
	Activity	Weekly Change	% BAU (1)	Regional Rank (2) (4)
Total Electives	**22,703**	**-1.3%**	**87.2%**	**3**
Elective Day Case	18,954	-1.3%	88.1%	4
Elective Ordinary	3,749	-1.4%	82.9%	3
Total Outpatients	**261,511**	**-0.9%**	**101.2%**	**1**
Outpatients - First	82,911	-1.6%	102.0%	1
Outpatients - Follow-Up (3)	178,600	-0.5%	100.9%	6
Diagnostics				
Endoscopy	4,048	2.7%	91.0%	3
Imaging	61,848	-2.7%	102.0%	3
Echocardiography	6,380	-0.2%	100.7%	1

Latest Freeze Position - % BAU by ICS				
NCL	NEL	NWL	SEL	SWL
93.4%	**78.8%**	**82.8%**	**85.0%**	**94.9%**
93.0%	78.7%	83.8%	87.4%	97.1%
95.6%	79.3%	75.8%	76.2%	85.8%
106.9%	**95.6%**	**107.9%**	**99.5%**	**91.5%**
104.4%	90.1%	109.2%	105.7%	96.5%
108.0%	98.2%	107.3%	97.2%	88.6%
88.6%	102.4%	84.0%	97.2%	82.8%
110.7%	98.7%	91.0%	108.2%	103.9%
118.0%	86.2%	94.2%	100.3%	113.3%

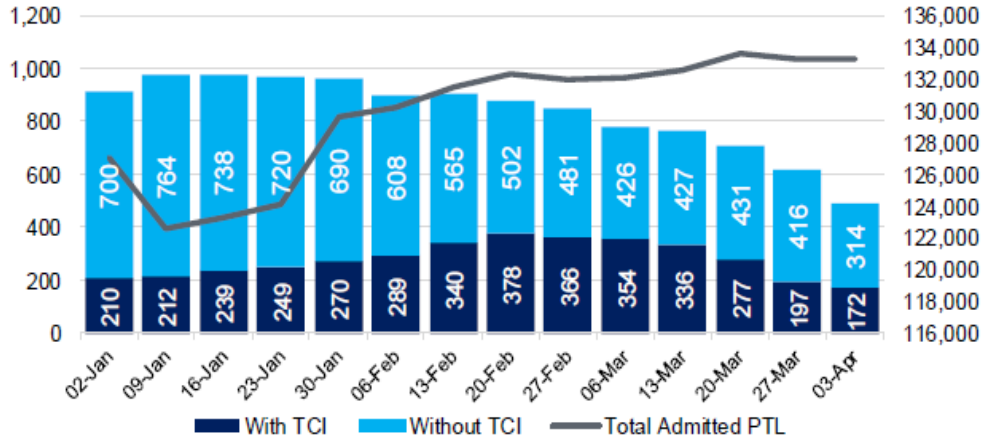
(1) Prior year baselines from March are based on unadjusted data submitted to SUS by providers for 2019/20
(2) Regional Rank is based on % BAU
(3) Colour coding modified to reflect reduction as positive, due to National target of reducing follow-ups by 25%
(4) London Regional Ranking for Outpatient Follow-ups is in the reverse order

Elective Activity

Elective Activity Volumes and % of Baseline



Admitted Pathway: 104 ww and Total PTL

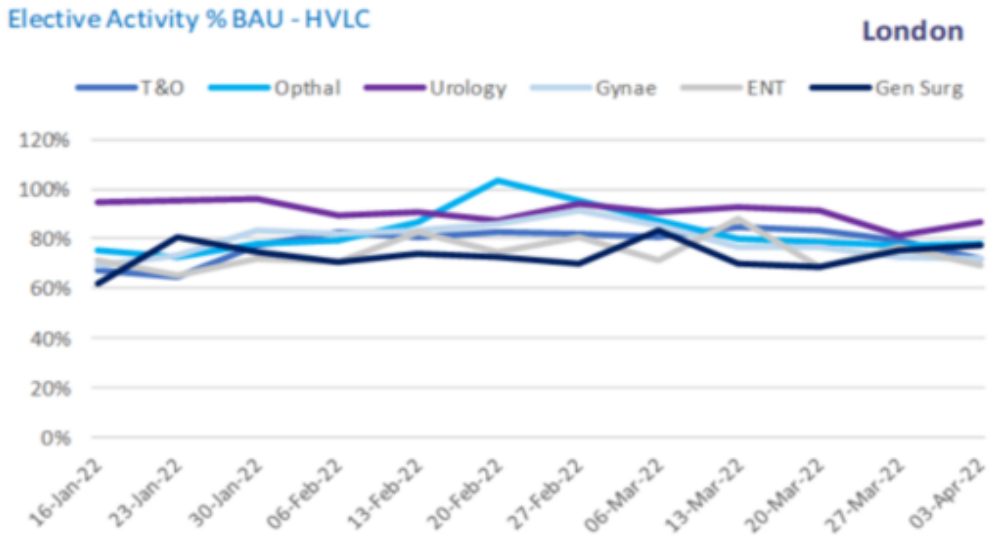


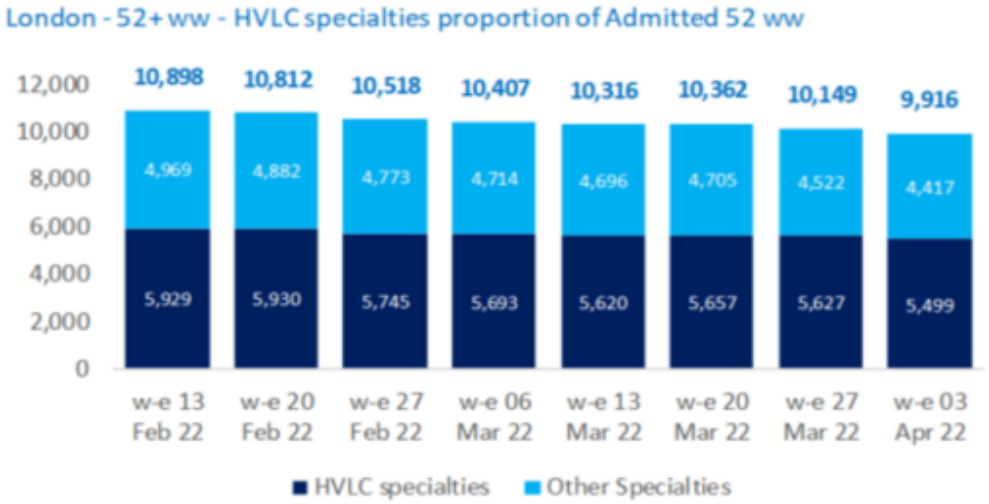
Total Electives (Latest Freeze Data: w/e 27-Mar) | Latest Data: w/e 03-Apr

Provider	% BAU	Activity Volume	Weekly Var (%)	Admitted PTL Size	Weekly Var (%)	Admitted 104ww	Weekly Var (%)
LONDON	**87.2%**	**22,703**	**-1.3%**	**133,269**	**0.0%**	**486**	**-20.7%**
NCL	**93.4%**	**6,299**	**-6.3%**	**33,445**	**-0.4%**	**174**	**-21.3%**
RFL	94.0%	1,423	-18.7%	8,322	-1.2%	84	-13.4%
UCLH	101.2%	2,300	-0.5%	10,040	-0.7%	76	-29.0%
NMUH	93.6%	644	5.2%	1,434	1.2%	7	-12.5%
GOSH	100.6%	730	-4.2%	1,877	1.0%	5	-28.6%
RNOH	63.7%	205	-28.8%	2,200	-1.9%	2	-
Moorfields	83.0%	623	8.5%	7,040	0.0%	-	-
Whittington	79.7%	374	-11.4%	2,532	1.6%	-	-
NEL	**78.8%**	**2,968**	**1.8%**	**20,305**	**-0.3%**	**237**	**-17.1%**
Barts	81.5%	1,686	4.2%	12,719	-0.5%	234	-16.4%
BHRUT	73.0%	821	1.4%	4,207	0.1%	3	-25.0%
Homerton	80.2%	461	-5.3%	3,379	0.0%	-	-100.0%
NWL	**82.8%**	**4,657**	**-3.1%**	**25,064**	**0.3%**	**10**	**-44.4%**
LNW	80.4%	1,323	-3.8%	4,918	0.1%	8	-11.1%
Imperial	79.3%	1,931	-3.2%	10,709	0.7%	2	-66.7%
ChelWest	94.9%	958	-2.6%	6,346	0.0%	-	-100.0%
Hillingdon	83.0%	445	-1.8%	3,091	-0.1%	-	-100.0%
SEL	**85.0%**	**5,348**	**3.0%**	**35,962**	**-0.2%**	**61**	**-27.4%**
GSTT	84.8%	2,448	3.7%	15,809	-0.1%	29	-3.3%
LGT	79.8%	825	-1.9%	6,569	-0.4%	28	-39.1%
Kings	87.6%	2,075	4.2%	13,584	-0.2%	4	-50.0%
SWL	**94.9%**	**3,431**	**1.7%**	**18,493**	**1.1%**	**4**	**-**
Epsom	88.2%	856	4.5%	5,295	-0.4%	2	-
Kingston	84.4%	469	-2.7%	3,953	0.8%	1	-
St George's	90.9%	1,125	0.0%	6,555	0.6%	1	-
Croydon	108.1%	588	7.5%	2,428	7.1%	-	-
Royal Marsden	128.4%	393	-1.8%	262	-2.6%	-	-

Source: Weekly Activity Return | Source: RTT Weekly PTL

Elective – high volume low complexity specialties

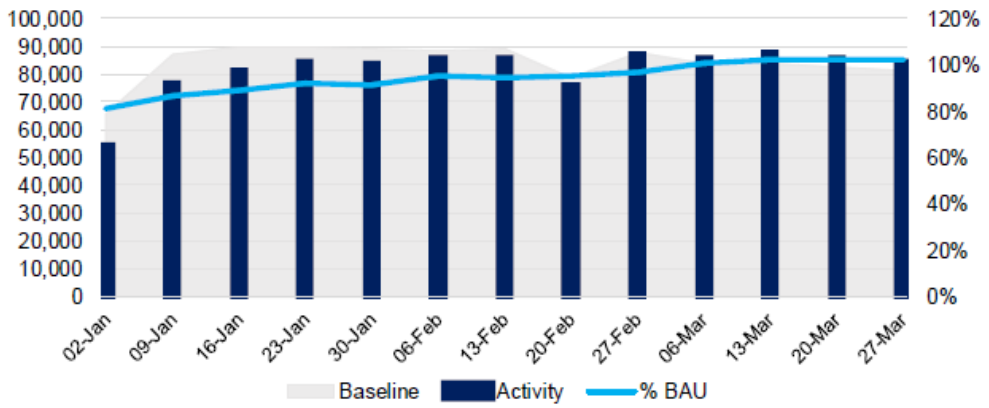




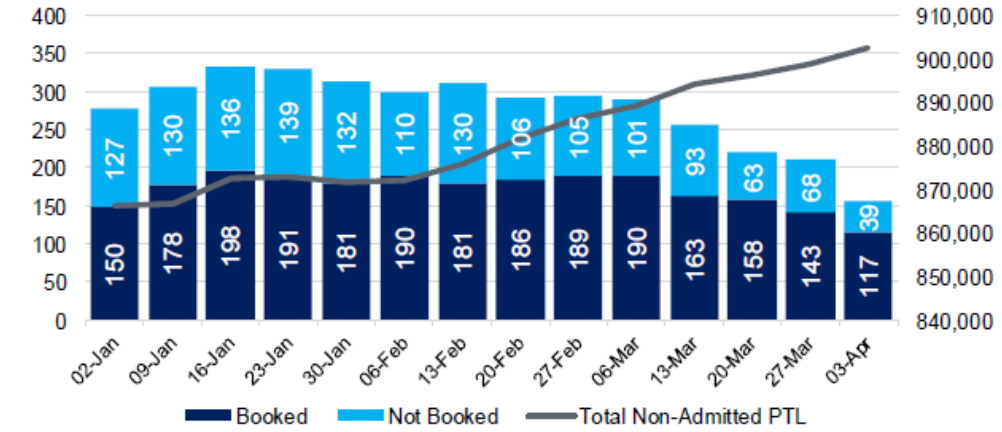
London - HVLC specialties Elective Activity							
Rank	Provider	Flex Week (Current)	Freeze Week (Last)	Freeze Week (Previous)	Change between Freeze Weeks	Current Elective Activity volume	5 week Trend
1	Croydon	122.8%	122.8%	97.1%	▲	210	
2	Royal Marsden	100.0%	104.1%	84.9%	▲	70	
3	BHRUT	95.3%	94.2%	96.7%	▼	384	
4	RNOH	88.9%	73.8%	95.3%	▼	200	
5	UCLH	87.3%	75.9%	68.6%	▲	262	
6	Moorfields	87.0%	83.3%	80.3%	▲	642	
7	ChelWest	85.7%	69.3%	92.7%	▼	246	
8	Epsom	83.4%	83.4%	85.6%	▼	502	
9	Hillingdon	83.3%	75.9%	65.5%	▲	179	
10	Homerton	82.8%	81.7%	101.7%	▼	193	
11	GSTT	81.4%	80.2%	78.9%	▲	351	
12	Kings	75.0%	81.9%	72.6%	▲	604	
13	Kingston	73.6%	83.2%	85.7%	▼	170	
14	St George's	72.7%	78.8%	78.8%	▼	160	
15	RFL	71.5%	67.0%	97.5%	▼	313	
16	LNW	64.8%	76.8%	73.8%	▲	350	
17	Barts	64.5%	73.6%	66.4%	▲	369	
18	LGT	63.6%	66.9%	59.1%	▲	136	
19	NMUH	59.8%	59.7%	63.8%	▼	158	
20	Imperial	57.3%	57.7%	61.5%	▼	310	
21	Whittington	34.4%	40.6%	63.3%	▼	44	
1	SWL	85.9%	88.5%	85.9%	▲	1,112	
2	NEL	78.3%	82.1%	82.7%	▼	946	
3	NCL	77.4%	72.6%	80.1%	▼	1,619	
4	SEL	75.2%	78.8%	71.8%	▲	1,091	
5	NWL	68.5%	68.6%	71.8%	▼	1,085	
	London	**76.7%**	**77.3%**	**78.2%**	▼	**5,853**	

Outpatient Activity: 1st Appointment

OP - 1st Appt Activity Volumes and % of Baseline



Non-Admitted Pathway: 104 ww and Total PTL



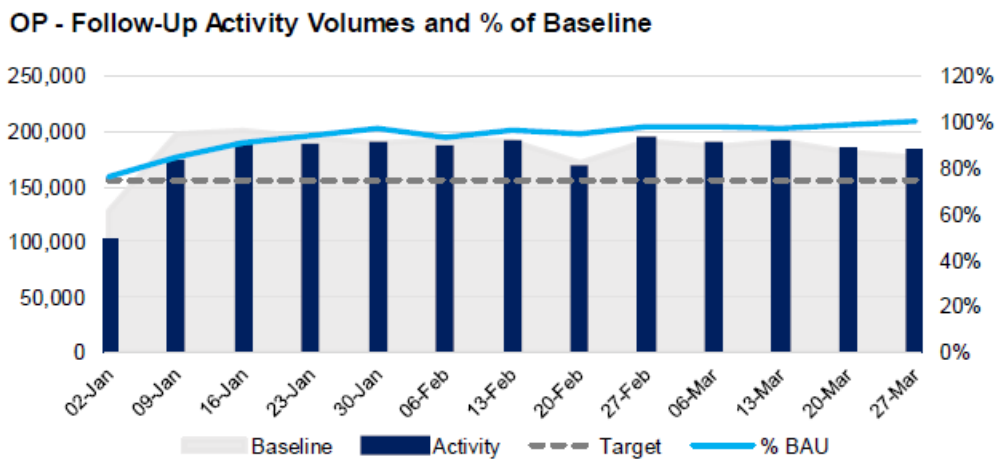
OP - 1st Appt (Latest Freeze Data: w/e 27-Mar)

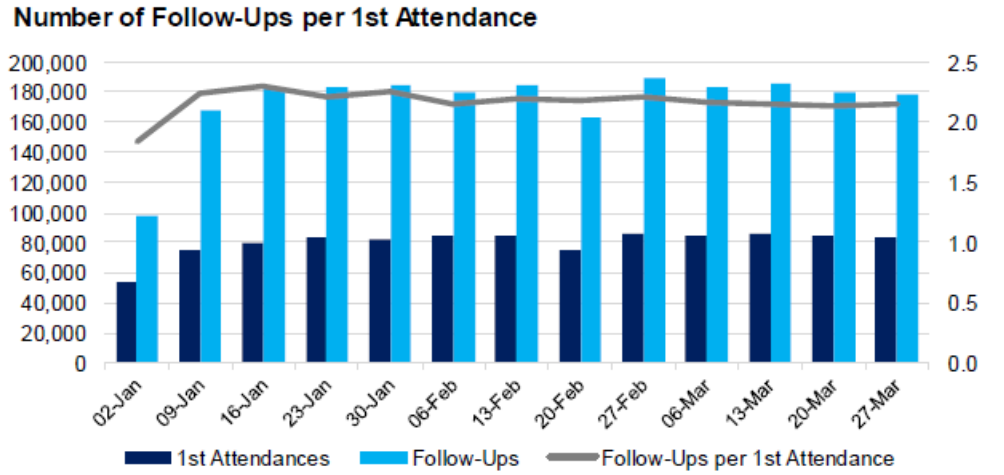
Provider	% BAU	Activity Volume	Weekly Var (%)	Latest Data: w/e 03-Apr Non-Adm. PTL Size	Weekly Var (%)	Non-Adm. 104ww	Weekly Var (%)
LONDON	**102.0%**	**82,911**	**-1.6%**	**902,610**	**0.4%**	**156**	**-26.1%**
NCL	**104.4%**	**22,187**	**-5.6%**	**217,153**	**0.1%**	**57**	**-27.8%**
RFL	103.5%	8,019	-7.7%	86,385	-0.7%	41	-28.1%
UCLH	105.5%	5,208	-10.5%	52,332	1.0%	13	-38.1%
GOSH	89.5%	651	5.3%	5,126	0.0%	3	-
Moorfields	90.0%	2,285	0.6%	33,056	1.2%	-	-100.0%
NMUH	131.2%	2,495	-2.4%	16,796	-0.6%	-	-
RNOH	92.6%	389	-24.2%	4,888	-0.1%	-	-
Whittington	105.0%	3,140	3.1%	18,570	0.1%	-	-
NEL	**90.1%**	**10,529**	**3.0%**	**168,382**	**1.3%**	**59**	**-28.0%**
Barts	80.0%	5,595	1.3%	90,108	0.8%	50	-33.3%
BHRUT	95.3%	2,832	1.1%	55,925	0.8%	9	28.6%
Homerton	123.0%	2,102	10.6%	22,349	4.7%	-	-
NWL	**109.2%**	**17,409**	**-0.8%**	**190,248**	**0.1%**	**0**	**-100.0%**
ChelWest	123.1%	4,921	-0.9%	41,162	0.3%	-	-100.0%
Hillingdon	78.6%	1,561	-3.5%	22,370	-1.0%	-	-
Imperial	115.5%	6,268	3.3%	75,185	0.3%	-	-100.0%
LNW	102.8%	4,659	-4.8%	51,531	0.1%	-	-100.0%
SEL	**105.7%**	**17,882**	**-0.6%**	**196,473**	**0.3%**	**38**	**-5.0%**
GSTT	86.2%	6,305	-0.4%	76,256	0.5%	27	22.7%
LGT	117.7%	5,549	-1.2%	55,552	0.0%	11	-35.3%
Kings	123.1%	6,028	-0.3%	64,665	0.2%	-	-100.0%
SWL	**96.5%**	**14,904**	**-0.5%**	**130,354**	**0.2%**	**2**	**-**
Kingston	82.6%	3,395	-1.1%	22,451	0.9%	1	-
St George's	84.1%	5,753	-3.8%	43,412	-0.1%	1	-
Croydon	151.3%	3,095	4.7%	24,125	0.4%	-	-
Epsom	108.2%	2,244	2.0%	39,259	0.1%	-	-100.0%
Royal Marsden	111.8%	417	0.5%	1,107	-3.9%	-	-

Source: Weekly Activity Return

Source: RTT Weekly PTL

Outpatient Activity: Follow-Ups





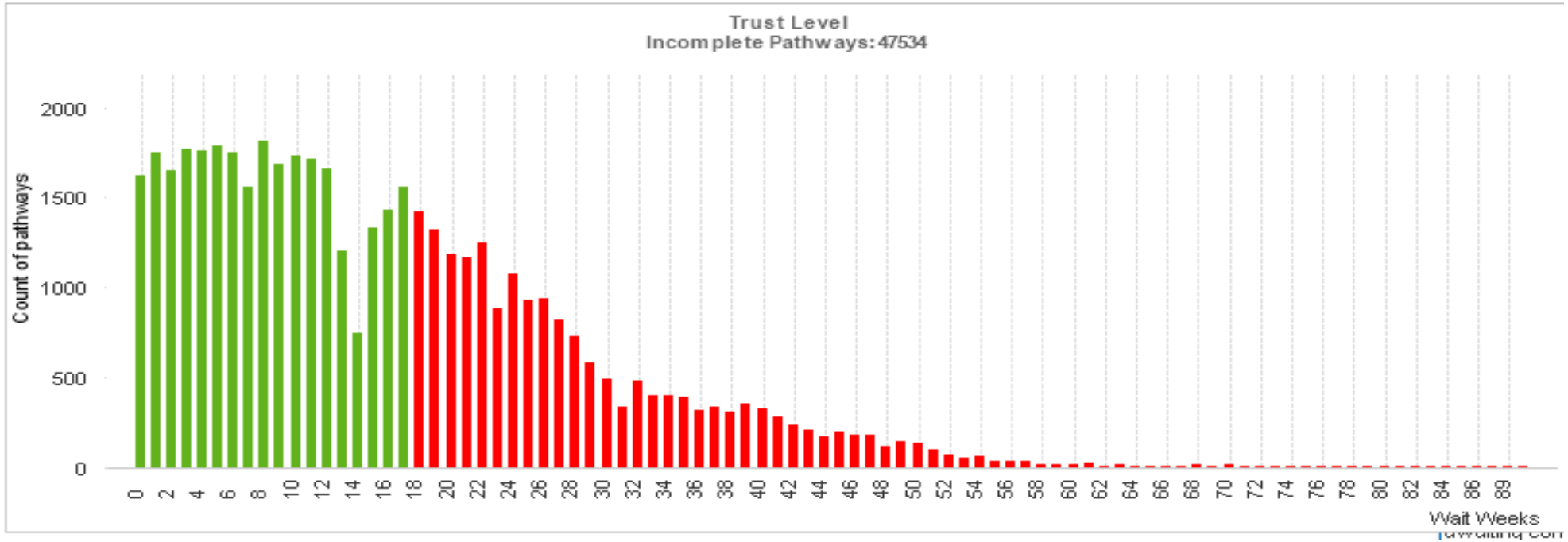
OP - Follow-Up (Latest Freeze Data: w/e 27-Mar)

Provider	% BAU	Activity Volume	Weekly Var (%)	Ratio of 1st to FUP
LONDON	**100.9%**	**178,600**	**-0.5%**	**1: 2.2**
NCL	**108.0%**	**55,638**	**-2.5%**	**1: 2.5**
RFL	98.0%	12,805	-2.3%	1: 1.6
UCLH	133.9%	21,786	-3.0%	1: 4.2
GOSH	88.4%	2,985	-4.1%	1: 4.6
Moorfields	95.8%	8,456	1.3%	1: 3.7
NMUH	108.8%	5,649	0.0%	1: 2.3
RNOH	77.4%	1,174	-24.3%	1: 3.0
Whittington	85.0%	2,783	-1.2%	1: 0.9
NEL	**98.2%**	**23,838**	**1.5%**	**1: 2.3**
Barts	95.5%	15,228	1.4%	1: 2.7
BHRUT	86.0%	4,427	6.6%	1: 1.6
Homerton	131.2%	4,183	-3.2%	1: 2.0
NWL	**107.3%**	**31,804**	**3.1%**	**1: 1.8**
ChelWest	103.3%	8,585	-6.4%	1: 1.7
Hillingdon	97.0%	2,944	11.6%	1: 1.9
Imperial	107.0%	11,062	1.3%	1: 1.8
LNW	115.6%	9,213	13.7%	1: 2.0
SEL	**97.2%**	**43,795**	**-0.4%**	**1: 2.4**
GSTT	81.6%	19,944	2.8%	1: 3.2
LGT	119.8%	5,334	-0.8%	1: 1.0
Kings	114.5%	18,517	-3.5%	1: 3.1
SWL	**88.6%**	**23,525**	**-2.6%**	**1: 1.6**
Kingston	102.6%	3,449	-2.2%	1: 1.0
St George's	98.5%	7,515	-1.2%	1: 1.3
Croydon	88.7%	4,550	4.3%	1: 1.5
Epsom	64.5%	3,847	-4.9%	1: 1.7
Royal Marsden	93.3%	4,164	-9.7%	1: 10.0

Source: Weekly Activity Return

Current PTL Position

Trust PTL Total: ↑ 47,534 (47,412)
52w+ ↑ 567 (557)
104w+ ↓ 0 (11)

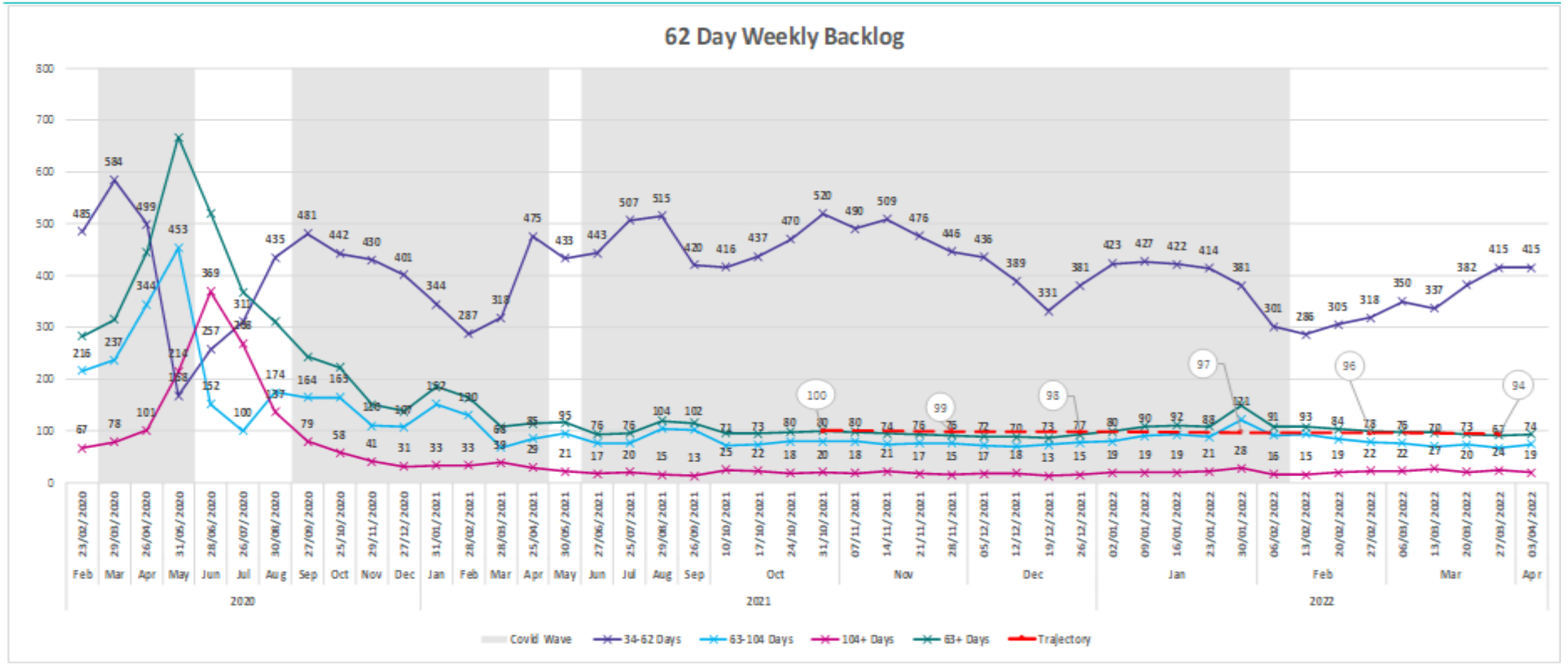


Specialty Name	14 to 18 Weeks	<18 Weeks	>18 Weeks	>26 Weeks	>40 Weeks	>52 Weeks	>78 Weeks	>104 Weeks	Total Waiters
Total	5101	28571	18963	9740	2854	567	34	0	47534

Chelsea and Westminster Hospital NHS Foundation Trust

W/E 03/04/2022

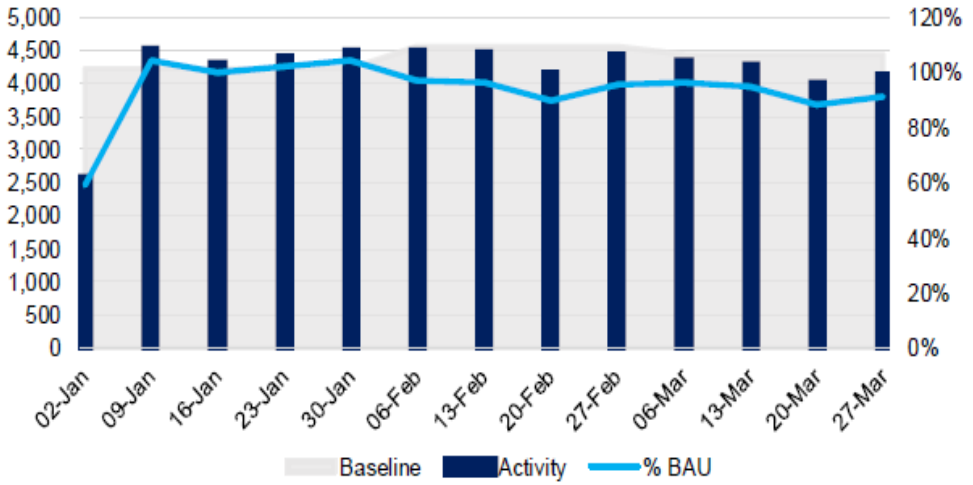
RM Partners
West London Cancer Alliance



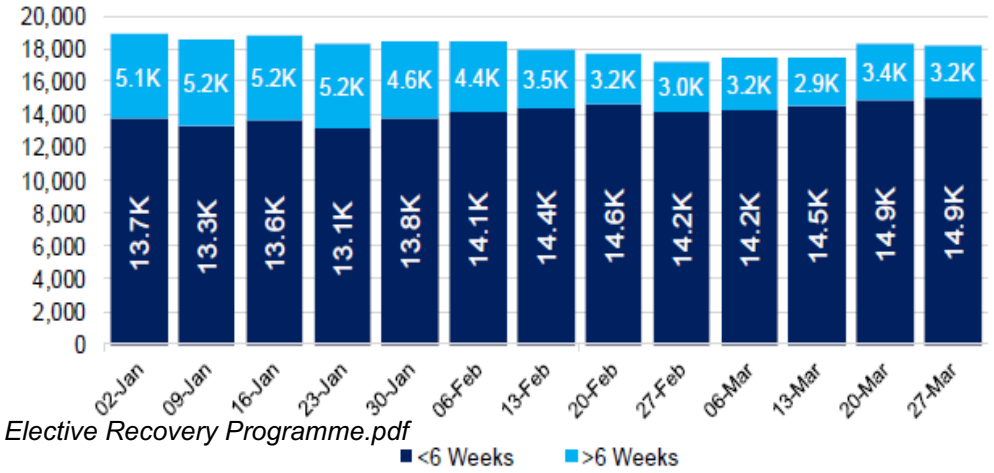
Endoscopy Activity

Below table note: Royal Free current year and baseline activity has been removed from Endoscopy calculations.

Endoscopy Activity Volumes and % of Baseline



Endoscopy: Total Wait List



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

Provider	% BAU	Activity Volume	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
LONDON	**91.0%**	**4,048**	**2.7%**	**18,163**	**-0.7%**	**3,220**	**-6.1%**
NCL	**88.6%**	**486**	**-4.5%**	**4,426**	**-7.6%**	**1,383**	**-2.4%**
RFL	-	-	-	2,070	-5.6%	693	0.0%
UCLH	95.9%	246	13.4%	1,162	-2.9%	353	-8.5%
NMUH	119.4%	158	3.3%	765	-1.9%	197	1.0%
Whittington	55.1%	78	-43.9%	311	-36.9%	94	-5.1%
GOSH	22.4%	4		118	-7.8%	46	4.5%
NEL	**102.4%**	**907**	**12.0%**	**2,549**	**6.1%**	**95**	**11.8%**
Homerton	87.7%	168	-2.9%	691	9.7%	85	21.4%
Barts	103.4%	505	14.0%	1,354	6.8%	9	-35.7%
BHRUT	113.8%	234	20.6%	504	0.0%	1	0.0%
NWL	**84.0%**	**854**	**-2.4%**	**4,916**	**1.0%**	**724**	**-19.6%**
Hillingdon	690.3%	143	2.1%	939	2.0%	310	2.6%
Imperial	72.7%	228	8.1%	1,848	-2.7%	203	-50.2%
ChelWest	159.1%	302	11.0%	1,299	1.2%	143	10.9%
LNW	36.7%	181	-28.2%	830	8.4%	68	9.7%
SEL	**97.2%**	**990**	**-0.2%**	**3,515**	**5.2%**	**858**	**-2.4%**
GSTT	184.5%	351	4.8%	1,307	4.1%	478	-1.2%
Kings	78.5%	392	14.0%	1,240	1.3%	326	-4.7%
LGT	75.0%	247	-21.1%	968	12.2%	54	1.9%
SWL	**82.8%**	**811**	**7.1%**	**2,757**	**-4.7%**	**160**	**8.8%**
Epsom	114.5%	297	2.1%	866	-9.9%	69	-6.8%
Croydon	143.8%	175	0.6%	741	4.2%	63	61.5%
St George's	39.9%	159	30.3%	552	-11.7%	19	-32.1%
Royal Marsden	89.0%	25	0.0%	82	-8.9%	9	50.0%
Kingston	89.7%	155	6.9%	516	2.2%	0	-

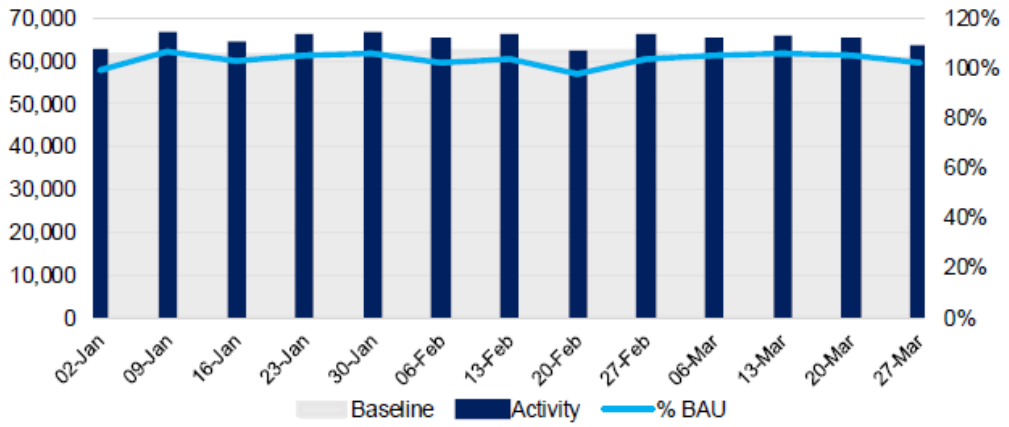
Source: Weekly Activity Return

Latest Data: w/e 27-Mar

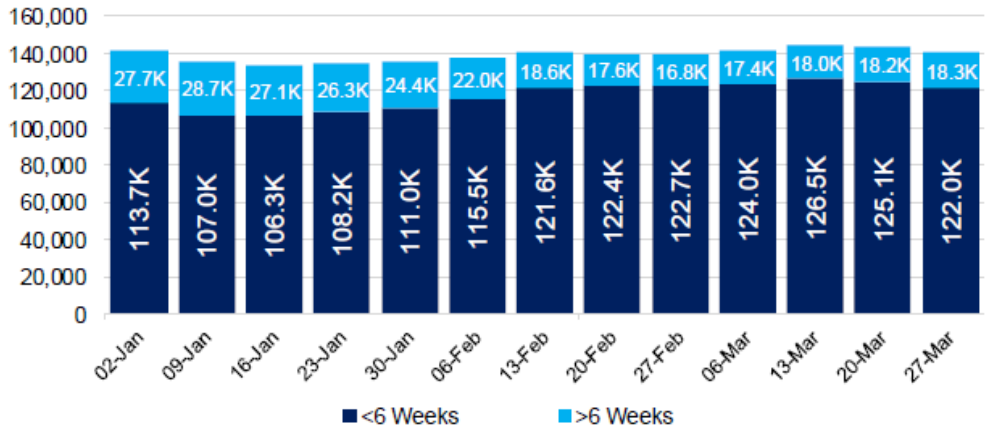
Source: Weekly Activity Return

Imaging Activity

Imaging Activity Volumes and % of Baseline



Imaging: Total Wait List



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

Provider	% BAU	Activity Volume	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
LONDON	**102.0%**	**61,848**	**-2.7%**	**140,256**	**-2.1%**	**18,258**	**0.4%**
NCL	**110.7%**	**12,774**	**-3.0%**	**27,667**	**2.8%**	**2,860**	**6.0%**
UCLH	120.0%	3,676	0.4%	7,821	-1.4%	1,479	2.4%
RFL	91.1%	4,736	-9.5%	10,384	11.0%	941	14.8%
NMUH	166.6%	1,634	-1.0%	3,148	-3.5%	143	-1.4%
GOSH	83.2%	415	4.0%	1,041	-1.8%	129	-11.0%
RNOH	82.3%	420	-18.9%	1,792	0.0%	99	11.2%
Whittington	146.6%	1,714	13.1%	3,300	-0.6%	69	25.5%
Moorfields	144.9%	179	-4.3%	181	-3.7%	0	-
NEL	**98.7%**	**12,688**	**-1.9%**	**42,728**	**-0.4%**	**11,519**	**-1.7%**
Barts	110.8%	6,905	-0.1%	28,276	-1.4%	9,157	-2.6%
BHRUT	83.4%	3,885	-4.6%	8,141	0.0%	2,240	0.0%
Homerton	96.5%	1,898	-2.4%	6,311	3.6%	122	76.8%
NWL	**91.0%**	**12,294**	**-5.5%**	**25,792**	**0.7%**	**1,211**	**25.5%**
Imperial	104.2%	4,843	-6.0%	9,983	-0.4%	566	47.4%
Hillingdon	68.4%	1,256	-10.0%	3,384	4.5%	361	8.1%
LNW	89.1%	3,273	2.7%	7,032	-1.1%	266	12.2%
ChelWest	87.1%	2,922	-10.8%	5,393	3.1%	18	80.0%
SEL	**108.2%**	**13,071**	**-1.7%**	**17,420**	**-19.3%**	**853**	**-23.8%**
GSTT	103.3%	4,526	3.5%	4,006	-49.2%	427	-39.1%
Kings	119.5%	5,345	-2.7%	7,610	-0.9%	358	0.6%
LGT	99.1%	3,200	-6.8%	5,804	-3.3%	68	7.9%
SWL	**103.9%**	**11,021**	**-1.3%**	**26,649**	**1.2%**	**1,815**	**7.5%**
Kingston	90.7%	1,580	1.8%	4,586	-0.3%	931	5.9%
Epsom	113.8%	2,468	-3.5%	7,799	4.4%	562	21.6%
Croydon	127.8%	2,447	1.7%	7,057	-3.1%	195	-15.2%
St George's	87.6%	2,833	-0.7%	6,606	4.1%	124	6.0%
Royal Marsden	109.2%	1,693	-5.8%	601	-4.9%	3	-

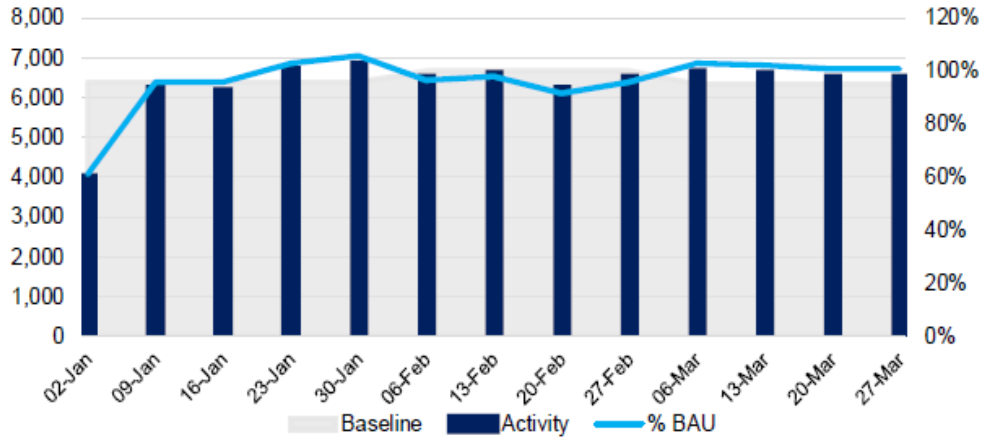
Source: Weekly Activity Return

Latest Data: w/e 27-Mar

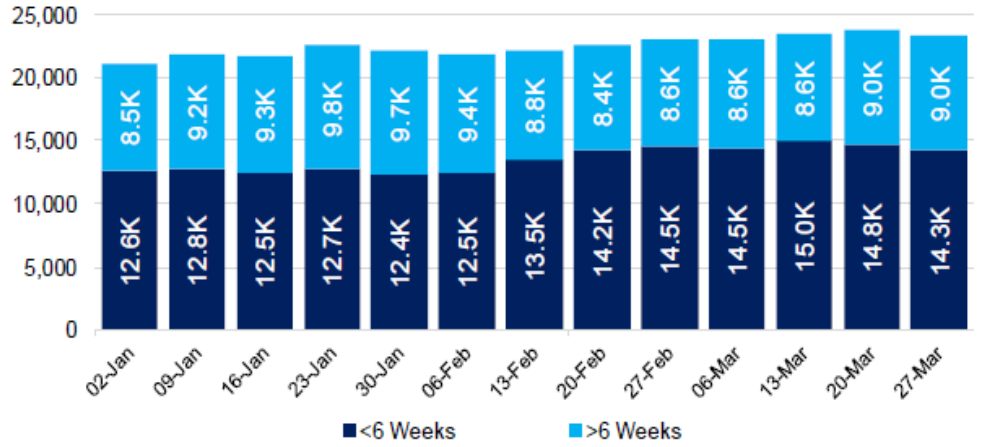
Source: Weekly Activity Return

Echocardiography Activity

Echocardiography Activity Volumes and % of Baseline



Echocardiography: Total Wait List



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

Provider	% BAU	Activity Volume	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
LONDON	**100.7%**	**6,380**	**-0.2%**	**23,283**	**-1.9%**	**9,000**	**0.3%**
NCL	**118.0%**	**1,085**	**-0.5%**	**2,476**	**-1.6%**	**296**	**-2.3%**
RFL	131.7%	255	-4.1%	940	-3.0%	168	6.3%
Whittington	106.2%	112	-7.4%	522	-2.2%	61	-12.9%
UCLH	227.7%	296	2.4%	561	2.0%	41	-16.3%
GOSH	104.4%	313	-2.5%	116	-6.5%	16	-23.8%
NMUH	57.1%	109	16.0%	337	-0.9%	10	100.0%
NEL	**86.2%**	**1,168**	**-1.6%**	**9,229**	**-2.0%**	**5,399**	**-1.6%**
Barts	92.5%	871	1.6%	7,971	-1.3%	5,310	-1.4%
Homerton	106.5%	156	-2.5%	787	-9.7%	86	-15.7%
BHRUT	53.0%	141	-17.1%	471	0.0%	3	0.0%
NWL	**94.2%**	**1,126**	**-1.2%**	**3,286**	**3.0%**	**1,229**	**12.4%**
Hillingdon	76.9%	133	-11.9%	1,404	1.4%	807	14.6%
LNW	98.9%	239	-1.6%	1,352	12.3%	204	7.9%
Imperial	95.6%	544	-0.4%	345	1.8%	175	12.9%
ChelWest	99.4%	210	5.0%	185	-29.1%	43	-4.4%
SEL	**100.3%**	**1,899**	**1.2%**	**3,866**	**-9.1%**	**516**	**-6.7%**
GSTT	109.9%	1,163	9.9%	1,283	-14.6%	345	-5.2%
Kings	87.2%	547	-7.3%	2,155	2.2%	160	-7.5%
LGT	90.8%	189	-17.5%	428	-33.4%	11	-31.3%
SWL	**113.3%**	**1,102**	**0.4%**	**4,426**	**1.7%**	**1,560**	**1.5%**
Kingston	61.5%	80	-36.0%	1,117	-0.9%	809	2.7%
Croydon	110.0%	218	-1.8%	1,771	-0.9%	709	0.4%
Epsom	198.8%	249	0.0%	721	28.8%	41	-2.4%
St George's	99.2%	515	13.9%	814	-7.3%	1	0.0%
Royal Marsden	-	40	-20.0%	3	50.0%	0	-

Source: Weekly Activity Return

Latest Data: w/e 27-Mar

Source: Weekly Activity Return

London Echo Activity in the equivalent baseline period: 6,334.

TITLE AND DATE (of meeting at which the report is to be presented)	Trust Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	2.2
TITLE OF REPORT	Integrated Performance Report – March 2022
AUTHOR NAME AND ROLE	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: √ Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To report the combined Trust's performance for March 2022, highlighting risk to achievement, issues and identifying key actions going forward.
REPORT HISTORY Committees/Meetings where this item has been considered)	Executive Management board, April 2022 Quality Committee, May 2022
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	In Month 12 (March 2022), across both inpatient and outpatient areas, an increased prevalence of COVID19 affected our capacity as staff absences continued to affect overall delivery. One of the key focus areas in M12 for the RTT pathway was to ensure elimination of 104 waiters by the end of the month, which we achieved. In addition, the overall waiting list (PTL) has seen a reduction in M12 following the previous months' increase. The Trust continuing to achieve its OP Plan activity plans and is currently working through speciality plans to ensure to ensure the delivery of 22/23 Operating Plan ambitions. The Cancer 2-week Urgent Referrals, 2-week Breast Symptomatic, 31-Day (Drug) standards and 62-Day (NHS Screening Service) Referral to First Treatment are all reporting compliance in March. The 6-Week Diagnostic standards is marginally below the 99% target in M12, however it is noted that Nationally the Trust continues to retain its position as one of the best performing Trusts.

	A&E March saw 30,214 urgent and emergency care attendances; higher than pre-pandemic levels of activity. This level of activity, coupled with the staffing challenges saw our compliance against the 4-hour standard deliver 78%. Although this was a non-compliant position, CWHFT remains as one of the top performing organisations in the country in a very challenging urgent and emergency care environment. Reduced performance was driven by a number of factors including COVID-19 staff absences and a further deterioration in performance at the West Middlesex UTC. Work continues to ensure there is sufficient staffing to cope with additional demand, as well as to redirect patients to community partners where possible. **Cancer** ***14-Day (All Urgent)****:* The 2-Week wait target continues to be compliant, with 95% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received ***14-Day (Breast Symptomatic)****:* The 2-Week wait target continues to be compliant, with 99.08% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received ***28-Day FDS***: The 28-Day Faster Diagnostic Standard has returned to compliance in February 2022, it is forecast that this measure will remain compliant in March 2022 once full validation is compelted. **62-Day GP Referral to First Treatment**: 62-Day target is non-compliant, currently showing an unvalidated position of 78.84%. This is largely due to impact of COVID on the diagnostic part of the pathway and increased patient initiated delays. **31 day:** 31-Day target is non-compliant at 92% in Mar 2022, however this is forecast to improve following final validation. The target was met in Feb 2022 reflecting the focused work on the skin pathway to improve the overall performance **18 Week RTT Incomplete** Focus continues on delivery of RTT and reducing the number of long waiting patients. The Trust achieved its trajectory of zero 104 week waiter at the end of March 2022 and focus is now placed on those waiting over 52 weeks **Diagnostic Waits <6 weeks** There has been a marginal decrease in performance as the Trust is reporting non-compliance against the 99% diagnostic standard in M12 due to underperformance on the West Middlesex site. The Trust retains it standing as the best performing Nationally in this area and expects to be so throughout 2022/23.
KEY RISKS ARISING FROM THIS REPORT	Key areas of risk to delivery continue to be: RTT, Cancer Services, A&E

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:

Equality And Diversity	
Quality	Y
People (Workforce or Patients/ Families/Carers)	Y
Operational Performance	Y
Finance	
Public Consultation	
Council of Governors	

please mark Y/N – where Y is indicated please explain the implications in the opposite column

- Excel in providing high quality, efficient clinical services
- Improve population health outcomes and integrated care
- Deliver financial sustainability

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

TRUST PERFORMANCE & QUALITY REPORT

March 2022

NHSI Reporting

NHSI Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	80.41%	79.15%	78.07%	83.55%	82.68%	82.87%	78.60%	85.02%	81.70%	81.24%	78.37%	80.32%	84.38%		!
RTT	18 weeks RTT - Incomplete (Target: >92%)	75.03%	69.90%	65.72%	74.37%	67.25%	64.90%	60.96%	69.91%	71.76%	67.82%	63.66%	67.71%	72.50%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	91.82%	94.79%	90.21%	93.41%	94.89%	95.89%	97.97%	96.23%	93.67%	95.45%	94.79%	94.60%	95.05%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	100%	n/a	n/a	100%	82.65%	100%	99.08%	97.98%	82.83%	100%	99.08%	92.51%	97.98%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-22) in this report	31 days diagnosis to first treatment (Target: >96%)	84.00%	97.87%	93.65%	92.40%	95.65%	95.29%	90.28%	94.57%	90.76%	96.21%	91.85%	93.63%	93.67%		!
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	n/a	n/a	80.00%	100%	100%	n/a	92.31%	100%	100%	n/a	100%	88.89%		-
	62 days GP referral to first treatment (Target: >85%)	90.91%	67.80%	84.09%	82.66%	84.52%	72.90%	74.26%	79.05%	87.05%	71.08%	78.84%	78.36%	80.41%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	0.00%	n/a	33.33%	42.86%	45.45%	100%	64.29%	42.86%	41.67%	100%	52.17%	61.29%		-
Cancer - FDS	Faster Diagnosis Standard (Target: >= 75%)	64.59%	79.74%	76.42%	78.19%	62.02%	75.70%	69.95%	67.15%	63.05%	77.16%	72.45%	70.87%	71.47%		-
Patient Safety	Clostridium difficile infections (Year End Target: 26)	0	0	0	11	0	0	0	11	0	0	0	0	22		-

Please note the following three items	n/a	Can refer to those indicators not applicable (eg Radiotherapy) or indicators where there is no available data. Such months will not appear in the trend graphs.
		RTT Admitted & Non-Admitted are no longer Monitor Compliance Indicators
	!	Either Site or Trust overall performance red in each of the past three months
		Note that all Cancer indicators show interim, unvalidated positions for the latest month (Mar-22) and are not included in quarterly or yearly totals

A&E

March saw 30,214 urgent and emergency care attendances; higher than pre-pandemic levels of activity. This level of activity, coupled with the staffing challenges saw our compliance against the 4-hour standard deliver 78%. Although this was a non-compliant position, CWHFT remains as one of the top performing organisations in the country in a very challenging urgent and emergency care environment. Reduced performance was driven by a number of factors including COVID-19 staff absences and a further deterioration in performance at the West Middlesex UTC. Work continues to ensure there is sufficient staffing to cope with additional demand, as well as to redirect patients to community partners where possible.

RTT 18 Week Incomplete: Focus continues on delivery of RTT and reducing the number of long waiting patients. The Trust achieved its trajectory of zero 104 week waiter at the end of March 2022 and focus is now placed on those waiting over 52 weeks. A focused piece of data quality work has helped n reducing the size of the PTL over the last month.

Cancer (*Unvalidated)*

14-Day (All Urgent)*:* The 2-Week wait target continues to be compliant, with 95% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received
14-Day (Breast Symptomatic)*:* The 2-Week wait target continues to be compliant, with 99.08% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received
28-Day FDS: The 28-Day Faster Diagnostic Standard returned to compliance in February 2022 and it is forecast that this measure will remain compliant in March 2022 once full validation has concluded.
62-Day Referral to First Treatment: 62-Day target is non-compliant with an unvalidated position of 78.84%. This is largely due to impact of COVID on the diagnostic part of the pathway and increased patient initiated delays.
31 day: 31-Day target is non-compliant at 92% in Mar 2022, however this is forecast to improve following final validation. The target was met in Feb 2022 reflecting the focused work on the skin pathway to improve the overall performance.

Patient Safety

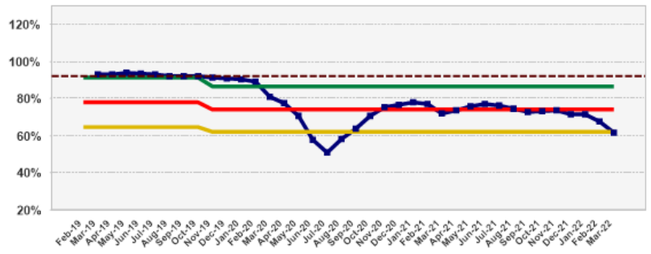
There were 5 Trust attributed cases of CDI in March 2022, 2 occurred at the WM site and 3 at the CW site. 2 RCA meetings have been conducted and no lapses in care were identified, 3 further RCAs have been scheduled. This takes the yearly total of Trust attributed cases to 36 against a target of 23.
The IPC team continues to work with the Cerner team to improve compliance with stool chart and 'C-diff checklist' completion and Cerner floorwalkers continue to educate staff as to the set-up/ access to stool charts and the C. diff checklist on Cerner.

SELECTED BOARD REPORT NHSI INDICATORS

Statistical Process Control Charts from Mar 2019 to Feb 2022

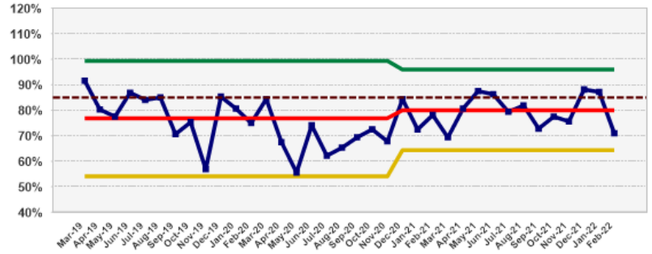
RTT Incomplete pathways

Trust Total

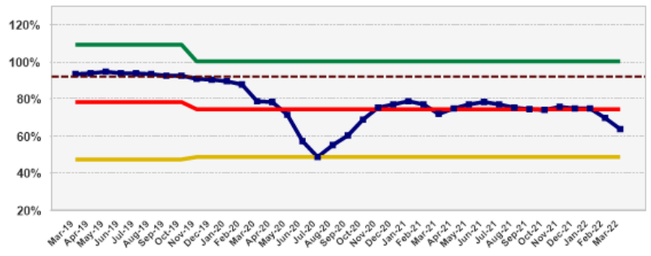


Cancer: 62 day standard

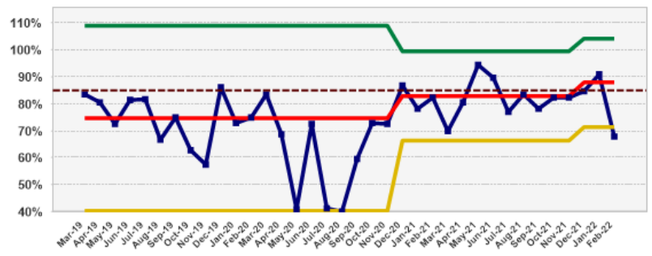
Trust Total



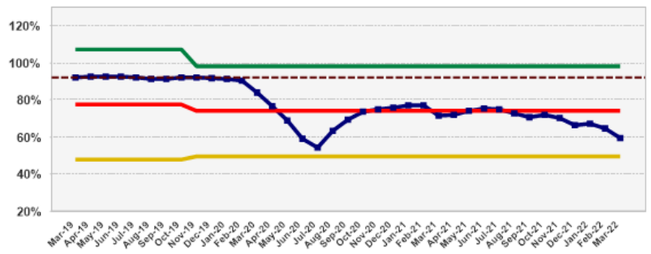
Chelsea and Westminster



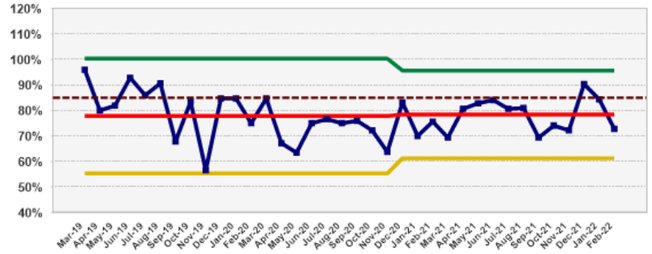
Chelsea and Westminster



West Middlesex



West Middlesex



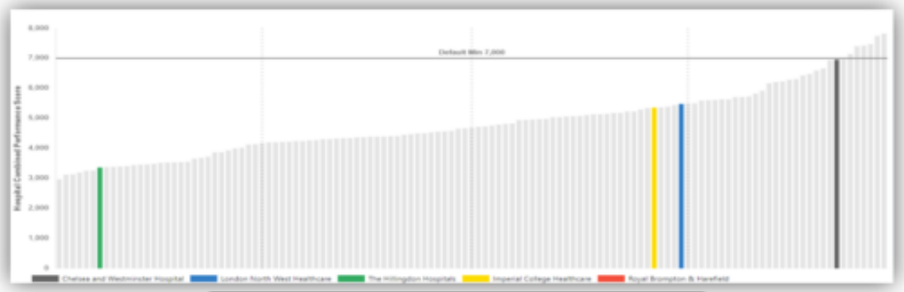
Cancer 62-Day Standard: *Cancer Performance is noted to show the unvalidated position for the current month on the NHSE dashboard. Cancer is one month in arrears. The final validated performance is represented in the SPC charts above and is a month in arrears.*

National Benchmarking Against Select Indicators

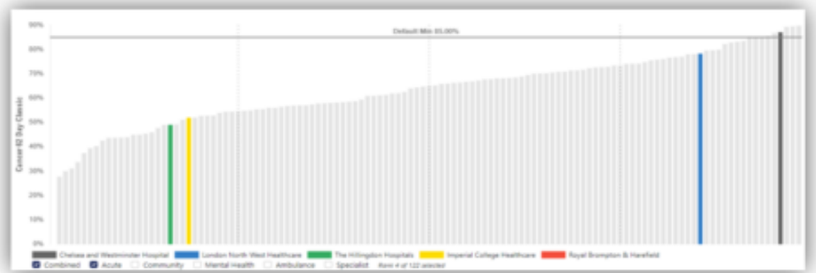
The below has been sourced from PublicView and represents the Trust Performance for Jan 22, except for the ***Hospital Combined Score (HCS)*** which is displaying Feb 22 data. The Ranking is based on peers in the same group as the Trust

The Trust ranked 8th nationally on the HCS in Feb 2022

Hospital Combined Score -8TH *Nationally*



Cancer 62 Days 4th OF *122*



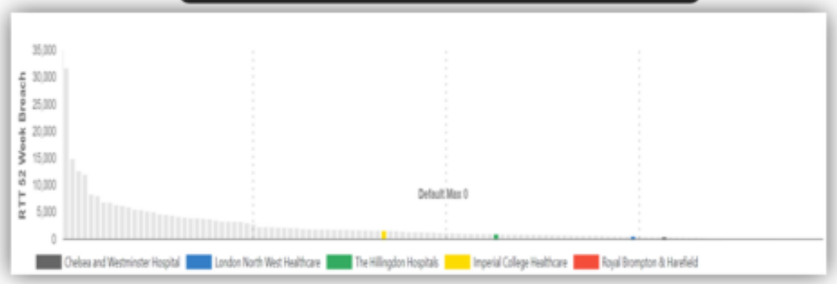
62 Day Cancer Standard: The Trust is currently ranked 4th out of 122 trusts. On 62-Day GP referral standards

6 -wk Diagnostic – 1st OF *122*



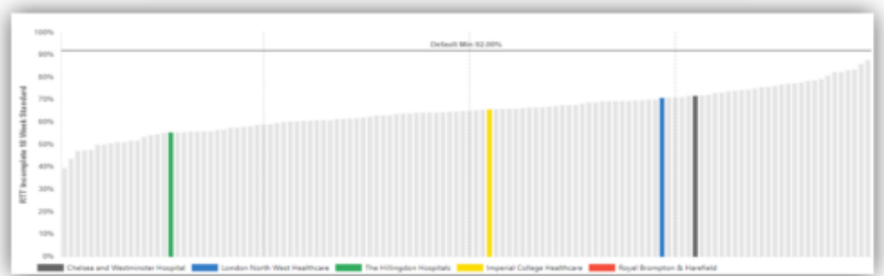
6 Week Diagnostic Standard: The Trust remains at top ranking nationally for two consecutive months

RTT 52 wks- 29TH OF 122



RTT 52 Week Breaches: The Trust is currently ranked 29th of 122 Trusts, a marginal decrease in ranking when compared to the previous month

RTT 18-wk Incomplete Pathway 27TH OF *122*



RTT 18 Week Standard: This position is an improvement on the previous months ranking.

Safety

Safety Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site Jan-22	Feb-22	Mar-22	2021-2022	West Middlesex University Hospital Site Jan-22	Feb-22	Mar-22	2021-2022	Combined Trust Performance Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trust data 13 months Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	1	0	0	0	4	0	0	0	0	5		-
	Hand hygiene compliance (Target: >90%)	91.7%	93.9%	92.1%	91.7%	95.3%	89.7%	96.3%	92.7%	93.2%	92.2%	93.8%	93.1%	92.1%		-
Incidents	Number of serious incidents	6	2	1	35	3	4	2	40	9	6	3	18	75		-
	Incident reporting rate per 100 admissions (Target: >8.5)	8.1	9.1	8.1	8.4	11.1	10.6	9.7	10.2	9.5	9.8	8.8	9.4	9.3		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions	0.02	0.04	0.02	0.02	0.04	0.04	0.04	0.02	0.03	0.04	0.02	0.03	0.02		-
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	3.79	5.69	3.71	4.58	2.79	4.69	1.66	2.99	3.28	5.19	2.47	3.40	3.74		-
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	2.1%	0.0%	0.0%	0.6%	0.0%	1.9%	0.0%	0.4%	1.2%	0.9%	0.0%	0.7%	0.5%		-
Harm	Never Events (Target: 0)	0	0	0	1	0	0	0	1	0	0	0	0	2		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	1	0	3	0	0	0	2	0	1	0	1	5		-
	Safeguarding adults - number of referrals	34	18	20	250	31	42	47	438	65	60	67	192	688		-
	Safeguarding children - number of referrals	22	26	20	304	91	115	112	1294	113	141	132	386	1598		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	71	72	71	71	71	72	71	71	71	72	71	72	71		-
	Number of hospital deaths - Adult	35	39	46	456	73	55	52	686	108	94	98	300	1142		-
	Number of hospital deaths - Paediatric	0	0	1	4	0	0	0	0	0	0	1	1	4		-
	Number of hospital deaths - Neonatal	1	4	1	13	1	0	0	9	2	4	1	7	22		-
	Number of deaths in A&E - Adult	0	0	0	0	0	4	2	34	0	4	2	6	34		-
	Number of deaths in A&E - Paediatric	0	0	0	0	1	0	0	2	1	0	0	1	2		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	1	0	1	0	1	0	1	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

Incidents: There were 13 serious incident declared in March 2022; 10 Internal and 3 External. The number of patient safety incident per 100 admissions is lower at CW compared to WM. It is anticipated that reporting rates will increase following the implementation of the new Patient Safety Incident Response Framework (PSIRF); staff training will be an integral part of the roll out.

Medication Related Safety Incidents
A total of 119 medication-related incidents were reported in March 2022. CW site reported 68 incidents, WM site reported 47 incidents and there were 4 incidents reported in community. The number of incidents reported in March has decreased across the Trust since February (133), which is attributed to a reduced number of incidents reported at WM site.

Medication-related (NRLS reportable) safety incidents per 1000 FCE bed days
The Trust position of medication-related incidents involving patients (NRLS reportable) for March 2022 was 3.73 per 1,000 FCE bed days which falls below the Trust target of 4.2 per 1,000 FCE bed days. The MSG continues to work through their action plan on improving the reporting of medication-related incidents across the Trust. Focus on a sustained approach particularly at WM site is required.

Medication-related (NRLS reportable) safety incidents % with harm
The Trust had 0% of medication-related safety incidents with moderate harm and above in March 2022, which is within the Trust target of ≤2%.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts	
Friends & Family Test	FFT: Inpatient satisfaction % (Target: >90%)	96.8%	92.6%	95.3%	95.1%	97.0%	96.3%	95.7%	95.8%	96.9%	95.1%	95.6%	95.8%	95.5%		-
	FFT: Inpatient not satisfaction % (Target: <10%)	0.6%	3.9%	2.5%	2.3%	0.9%	1.1%	1.6%	1.7%	0.8%	2.0%	1.9%	1.6%	1.9%		-
	FFT: Inpatient response rate (Target: >30%)	20.6%	20.0%	16.9%	38.7%	36.2%	51.8%	49.9%	61.6%	27.7%	34.6%	31.1%	31.1%	49.8%		!
	FFT: A&E satisfaction % (Target: >90%)	84.9%	81.3%	79.1%	82.3%	82.8%	81.3%	75.5%	81.9%	84.4%	81.3%	78.1%	81.2%	82.2%		!
	FFT: A&E not satisfaction % (Target: <10%)	9.1%	12.5%	14.0%	11.3%	12.6%	12.2%	18.0%	12.3%	9.9%	12.4%	15.1%	12.6%	11.6%		!
	FFT: A&E response rate (Target: >30%)	21.1%	21.6%	20.6%	21.2%	18.1%	20.3%	20.2%	22.4%	20.3%	21.2%	20.5%	20.6%	21.5%		!
	FFT: Maternity satisfaction % (Target: >90%)	85.5%	94.4%	86.1%	87.6%	87.5%	100.0%	90.9%	92.1%	85.7%	94.8%	86.6%	88.6%	88.0%		-
	FFT: Maternity not satisfaction % (Target: <10%)	8.3%	5.6%	9.7%	9.4%	12.5%	0.0%	9.1%	5.6%	8.7%	5.2%	9.6%	8.1%	9.0%		-
	FFT: Maternity response rate (Target: >30%)	26.9%	26.9%	30.2%	27.4%	34.0%	25.0%	40.0%	37.8%	27.5%	26.8%	31.1%	28.6%	28.1%		-
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	15	0	19	34	15	0	19	34	34		-
Complaints	Complaints (informal) through PALS	79	93	135	1035	31	32	41	393	110	125	176	411	1428		-
	Complaints formal: Number of complaints received	14	32	27	285	17	22	9	188	31	54	36	121	473		-
	Complaints formal: Number responded to < 25 days	7	26	5	153	4	16	2	92	11	42	7	60	245		-
	Complaints sent through to the Ombudsman	0	0	0	0	1	0	0	2	1	0	0	1	2		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	1	0	0	1	1	0	0	1	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

PALS and Complaints

98% of complaints were responded to within the 25 day KPI (target 95%) The number of PALS concerns logged and resolved during March 2022 increased by almost 40% compared to February. The Trust resolved 55% of the total concerns received for March at the time they were raised. It noted that there is one complaint awaiting an outcome from the PHSO

FFT

The Trust inpatient wards have maintained a satisfaction rate of above 90% across both sites, with West Middlesex maintaining a good response rate & continued focus on improving the response rate at Chelsea & Westminster. ED on both sites remain below 90% satisfaction for the month of March and this is reported to be due to long waiting times (feedback through FFT). The positive feedback for ED is that patients are generally happy with the care received. Maternity at Chelsea & Westminster have dropped below 90% satisfaction for the month of March. The Patient Experience Team are working with Maternity & ED Matrons to improve these statistics. Themes from feedback are also being reviewed to ensure we are addressing any issues raised.

Same Sex Accommodation

The Same Sex Breaches reported occurred at West Middlesex hospital on the Intensive Care Unit. The “Guidelines for the Provision of Intensive Care Services” require “discharge from critical care to a general ward must occur within four hours of the decision” and where this does not occur and the patient remains in a shared bay or room this would be classified as a same sex breach. Work between the Critical Care team and the Clinical Site Management team is ongoing to address this issue and ensure timely transfer out of the critical care units. It is worth noting that same sex breaches on the Chelsea ITU is mitigated by all patients being cared for in individual rooms – though timely step down remains a focus.

Efficiency and Productivity

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.02	2.34	2.78	2.32	3.41	3.35	2.19	2.41	2.29	2.59	2.63	2.51	2.34		-
	Average length of stay - non-elective (Target: <3.95)	3.94	3.92	4.59	3.65	3.57	3.33	6.01	3.45	3.74	3.60	5.36	4.29	3.54		!
	Emergency care pathway - average LoS (Target: <4.5)	4.60	4.46	4.36	3.92	3.96	3.75	3.81	3.62	4.20	4.04	4.03	4.09	3.74		-
	Emergency care pathway - discharges	213	236	275	2999	346	339	390	4613	559	576	665	1801	7612		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	6.01%	6.75%	5.94%	6.22%	8.36%	7.44%	7.11%	7.90%	7.13%	7.08%	6.48%	6.88%	7.03%		!
	Non-elective long-stayers	390	387	290	4559	357	322	263	4155	747	709	553	2009	8714		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	85.0%	83.0%	87.6%	83.2%	86.7%	84.6%	84.2%	85.0%	85.5%	83.5%	86.8%	85.3%	83.7%		-
	Operations canc on the day for non-clinical reasons: actuals	5	0	6	32	5	0	4	11	10	0	10	20	43		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.21%	0.00%	0.22%	0.11%	0.41%	0.00%	0.28%	0.07%	0.28%	0.00%	0.24%	0.17%	0.09%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	0	4	0	0	0	2	0	0	0	0	6		-
	Theatre Utilisation Model Hospital (Target > 85%)									80.0%	83.3%	80.3%				-
Outpatients	First to follow-up ratio (Target: <1.5)	2.10	2.20	2.07	2.40	2.00	1.83	1.84	1.92	2.06	2.05	1.98	2.03	2.19		!
	Average wait to first outpatient attendance (Target: <6 wks)	9.0	8.5	9.0	7.6	8.8	9.2	8.4	7.8	8.9	8.8	8.8	8.8	7.7		!
	DNA rate: first appointment	11.3%	10.3%	10.9%	10.5%	9.7%	9.9%	9.5%	9.5%	10.7%	10.1%	10.3%	10.4%	10.1%		-
	DNA rate: follow-up appointment	9.9%	9.2%	9.8%	9.4%	8.5%	8.1%	8.3%	8.0%	9.4%	8.8%	9.3%	9.2%	8.8%		-

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

ALOS (Non Elective): In March 2022, the impact of COVID affected all areas of Health & Social Care and increased staffing challenges resulted in the Trust having significant difficulties in discharging patients to alternative care settings. A weekly review of all >21 day stay patients at each site with the medical, nursing and discharge teams, chaired by the DCEO/COO has been introduced to ensure any delays within the Trusts direct control are minimised and to provide for earlier escalation with partner agencies.

Outpatients: At Trust Level average waits for first attendances have stabilised over the past three months. A reduction was seen on the CW site however WM is noted to have marginally increased waits in March 2022. The new Operating Plan for 2022/23 sees more focus placed on increased first appointments with a targeted reduction in follow up appointments.

New to Follow Up: In line with the 2022-23 Operating Plan, focus is now being shifted to reduction of follow up activity with patient's care being managed in other ways, for example, patient initiated follow up and virtual appointments. Divisional plans are currently being worked up and further improvement is expected over the coming months.

Theatre Utilisation: Theatres had a positive month in March; compliant with day case rates, the percentage of operations cancelled OTD and 28 re-books. Further focus is required at WM to increase the number of cases on our HVLC lists. Overbooking of lists has commenced to mitigate patient cancellations and additional staff have been allocated (HCA level) to improve turnaround times between cases.

Theatre utilisation is the main focus across both sites to achieve the EL operating plan. We are currently achieving 80.3% utilisation against the national aim of 85%. Additional support has been provided to our scheduling team to enable scheduling of theatre lists 6 weeks ahead. Tools such as the Palantir platform have increased visibility of patient availability and readiness; which supports replacing short notice cancellations on lists and ensuring patients have been tracked through the perioperative process preventing cancellations on the day. A medium term piece of work includes clinicians reviewing all timings of procedures inclusive of anaesthetic time, in an opportunity to ensure lists are fully maximised.

Clinical Effectiveness

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
Domain	Indicator	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts
Best Practice	Dementia screening case finding (Target: >90%)	96.4%	92.1%	90.2%	93.4%	93.8%	93.5%	92.5%	94.5%	94.9%	92.9%	91.5%	93.1%	94.0%	
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	55.0%	50.0%	71.4%	74.3%	76.5%	83.3%	63.6%	81.8%	64.9%	68.8%	67.4%	67.0%	78.4%	
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	91.7%	97.7%	76.9%	83.3%	93.3%	91.5%	82.4%	88.9%	92.6%	88.7%	93.8%	
VTE	VTE: Hospital acquired	0	0	0	2	4	6	4	24	4	6	4	14	26	
	VTE risk assessment (Target: >95%)	90.4%	90.1%	89.2%	89.8%	96.8%	96.4%	96.3%	96.1%	93.7%	93.4%	92.9%	93.3%	93.1%	
TB Care	TB: Number of active cases identified and notified	1	2	4	33	2	5	9	68	3	7	13	23	101	
Sepsis	ED % of patients with high NEWS score screened for Sepsis	91.8%	91.8%	88.8%	92.1%	82.7%	82.8%	79.0%	83.5%	88.0%	88.3%	84.9%	86.9%	88.5%	
	ED % of patients at risk of developing sepsis receiving antibiotics	65.2%	53.4%	43.1%	54.2%	82.3%	83.1%	81.2%	83.5%	74.9%	66.6%	58.4%	66.4%	68.9%	
	ED % of patients at risk of developing sepsis receiving antibiotics within 1 hour	32.1%	24.4%	20.7%	25.5%	55.1%	55.4%	47.3%	55.7%	45.1%	38.2%	31.4%	38.1%	40.6%	
	AAU/AMU % of patients with high NEWS score screened for Sepsis	93.5%	95.0%	90.7%	85.9%	93.8%	93.4%	91.9%	92.8%	93.6%	94.2%	91.2%	93.1%	89.2%	
	AAU/AMU % of patients at risk of developing sepsis receiving antibiotics	88.0%	94.9%	94.0%	93.4%	96.0%	96.6%	96.3%	96.9%	92.7%	95.7%	95.1%	94.4%	95.5%	
	Inpatient Wards % of patients with high NEWS score screened for Sepsis	87.4%	87.1%	83.9%	84.8%	94.1%	94.5%	93.3%	92.5%	90.7%	90.7%	88.3%	89.8%	88.5%	
Improving outcomes for Inpatient diabetes patients	% of patients identified and triaged as having diabetes														
	Number of inpatient nurses/HCAs that have received 10-point training	0	10	0	46	0	7	0	33	0	17	0	17	79	
	Length of stay for elective (surgical specialties only) patients with recorded diabetes	2.7	3.1	4.7	3.9	9.2	3.7	2.1	4.1	5.8	3.4	3.3	4.1	4.0	
Improving clinical handover	% staff trained on the principles of safe and effective handover (Target >=50%)														
	% of handover meetings-medical downstream ward (Target >=95%)														

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

Clinical Handover data unavailable

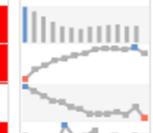
Dementia screening: The Trust continues to achieve this target both at Trust level and across both sites. West Middlesex reported performance of 90.2% and Chelsea and Westminster is at 92.5%

VTE Risk Assessments: Despite non-compliance at Trust level, West Middlesex Hospital is reporting sustained compliance whilst Chelsea and Westminster Hospitals is reporting a marginal decrease in performance in March 2022. The EIC Division continues to perform well and well above the standard. Planned Care Division performed well for non-elective patients but less so with elective patients. Work is ongoing to improve this performance further and to embed lasting BAU practices.

NoF Time to Theatre: In the Chelsea site 10 out 25 patients (40%) did not achieve surgery within 36hours. This translated to 6 out of 25 cases (24%) related to medically unfit reasons and 4 out of 25 cases (16%) cases related to other non-medical reasons. 2 of these medically fit patients were awaiting space on the theatre list, cancellations due to staff shortages and 2 patients were awaiting a Hip specialist for surgery.

Access

Access Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	276	244	246	3632	256	237	246	2958	532	481	492	1505	6590		!
	Diagnostic waiting times <6 weeks: % (Target: >99%)	99.31%	99.17%	96.68%	97.53%	98.45%	99.51%	99.31%	97.94%	98.88%	99.34%	98.05%	98.74%	97.75%		-
	Diagnostic waiting times >6 weeks: breach actuals	25	31	124	953	56	17	28	924	81	48	152	281	1877		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	8.7%	8.9%	9.0%	8.7%	7.7%	8.5%	8.2%	8.3%	8.3%	8.8%	8.7%	8.6%	8.6%		!
	A&E time to treatment - Median (Target: <60')	00:29	00:33	00:32	00:30	01:01	01:06	01:06	01:04	00:45	00:46	00:46	00:46	00:46		!
	London Ambulance Service - patient handover 30' breaches	23	50	74	407	111	117	174	1205	134	167	248	549	1612		-
	London Ambulance Service - patient handover 60' breaches	2	5	10	29	10	11	30	84	12	16	40	68	113		!

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

RTT Incomplete: The Trust achieved its trajectory of zero 104 week waiter at the end of March 2022 and focus is now placed on those waiting over 52 weeks. A focused piece of data quality work has also helped to reduce the size of the PTL over the last month.

Diagnostic Waits < 6 weeks: There has been a marginal decrease in performance as the Trust is reporting non-compliance against the 99% diagnostic standard in M12 due to underperformance in the West Middlesex site. The Chelsea site is observed to be complaint against the set target. It is noted that the Trust retains its standing as the best performing Trust Nationally in this area and is committed to achieving the diagnostic standard in 2022/23.

A&E and LAS: Unplanned re-attendances remain above target but on trend for the year. Both Emergency Departments continue to focus on redirection of patients to alternative care settings such as primary care and SDEC to ensure that only patients who need to be are seen in the ED.

LAS handover breaches increased in month, reflecting the high volume of activity seen in the Emergency Departments. The teams continue to focus on eliminating 60 minute breaches and reducing 30 minute breaches and anticipate an improvement in performance in April. Both sites continue to perform incredibly well when compared regionally.

RTT Positions Dashboard

		Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust Performance		
Domain	Indicator	Jan-22	Feb-22	Mar-22	Jan-22	Feb-22	Mar-22	Jan-22	Feb-22	Mar-22
RTT waiting list positions	Total RTT waiting list	26836	28452	26942	19493	20344	20525	46329	48796	47467
	Total Non-Admitted waiting list	21568	23232	22286	17117	18095	18537	38685	41327	40823
	Non-Admitted with a date	8120	11076	13038	8158	10760	12552	16278	21836	25590
	Non-Admitted without a date	13448	12156	9248	8959	7335	5985	22407	19491	15233
	Total Admitted waiting list	5268	5220	4656	2376	2249	1988	7644	7469	6644
	Admitted with a date	874	1061	1202	421	523	639	1295	1584	1841
	Admitted without a date	4394	4159	3454	1955	1726	1349	6349	5885	4803
	Patients waiting >78 weeks	26	21	8	24	19	18	50	40	26
	Patients waiting >104 weeks	5	3	0	5	4	0	10	7	0

RTT 52 week waiters Specialty Dashboard

	Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust position		
Specialty Name	Jan-22	Feb-22	Mar-22	Jan-22	Feb-22	Mar-22	Jan-22	Feb-22	Mar-22
Total	**276**	**244**	**246**	**256**	**237**	**246**	**532**	**481**	**492**
Burns Care	1	1	1				1	1	1
Cardiology	1						1		
Colorectal Surgery	3	3	3	3	5	3	6	8	6
Community Paediatrics	1	1					1	1	
Dermatology			1	1		1	1		2
ENT	1	1	1	30	27	42	31	28	43
General Surgery	19	19	19	44	32	28	63	51	47
Gynaecology	9	9	3			1	9	9	4
Maxillo-Facial Surgery	1	1	1				1	1	1
Ophthalmology	12	8	10				12	8	10
Oral Surgery				3	3	6	3	3	6
Orthodontics	1						1		
Paediatric Cardiology		1						1	
Paediatric Dentistry	72	46	35				72	46	35
Paediatric Dermatology			2						2
Paediatric Ear Nose and Throat	7	4	4	6	6	3	13	10	7
Paediatric Maxillo-Facial Surg		1	1					1	1
Paediatric Ophthalmology		1						1	
Paediatric Plastic Surgery	11	7	10				11	7	10
Paediatric Surgery	4		3	1	1		5	1	3
Paediatric Urology		2	2		1			3	2
Paediatrics	1						1		
Pain Management	1		1				1		1
Plastic Surgery	44	44	35	40	37	21	84	81	56
Podiatric Surgery					1	1		1	1
Podiatry				1		1	1		1
Trauma & Orthopaedics	18	18	27	6	5	6	24	23	33
Urology	47	59	71	15	7	15	62	66	86
Vascular Surgery	22	18	16	106	112	118	128	130	134

Maternity

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022	Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	Trend charts	
Workforce	Midwife to birth ratio (Target: 1:30)	1:27	1:27	1:28	1:27	1:29	1:29	1:29	1:28	1:28	1:28	1:28.5	1:28.17	1:27.5		-
	Hours dedicated consultant presence on labour ward (Target 1:98)	1:77	1:98	1:98	1:77	1:98	1:98	1:98	1:98	1:87.5	1:98	1:98	1:94.50	1:89.25		-
Birth indicators	Total number of NHS births	448	391	451	5553	369	310	359	4573	817	701	810	2328	10126		-
	Total number of bookings	554	516	508	6739	428	420	509	5241	982	936	1017	2935	11980		-
	Maternity 1:1 care in established labour (Target: >95%)	98.7%	100.0%	97.1%	98.0%	98.2%	96.5%	95.1%	96.6%	98.5%	98.3%	96.1%	97.6%	97.3%		-
Safety	Admissions >37/40 to NICU/SCBU	17	6	12	175	n/a	n/a	n/a	n/a	17	6	12	35	175		-
	Number of reported Serious Incidents	3	1	0	10	2	1	0	16	5	2	0	7	26		-
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Pre-term (gestation <37 weeks) as % of mothers delivered	9.2%	12.1%	4.6%	7.6%	7.9%	6.0%	8.1%	6.5%	8.6%	9.3%	6.2%	8.0%	7.1%		-
	Number of stillbirths	1	2	1	14	0	1	2	16	1	3	3	7	30		-
	Number of Infant deaths	1	2	0	12	1	0	0	10	2	2	0	4	22		-
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Outcomes	% of women on a continuity of care pathway	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	9.5%	n/a	n/a	n/a	0.0%	13.3%		-
	Spontaneous unassisted vaginal births	30.9%	24.4%	29.7%	29.4%	34.4%	30.8%	29.6%	35.1%	32.5%	27.3%	29.7%	29.9%	32.0%		-
	Vaginal Births - spontaneous & induced	59.0%	56.7%	61.5%	60.2%	62.3%	60.2%	58.6%	63.2%	60.5%	58.3%	60.2%	59.7%	61.5%		-
	Instrumental deliveries	13.4%	18.1%	16.4%	15.2%	13.5%	12.4%	14.8%	13.3%	13.5%	15.5%	15.7%	14.9%	14.3%		-
	Pre-labour elective caesarean sections	61	60	74	862	44	42	48	561	105	102	122	329	1423		-
	Emergency caesarean sections in labour	58	47	49	679	60	52	64	720	118	99	113	330	1399		-

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

Workforce
The current midwifery ratios on each site for the month of March is 1:27 at Chelsea and 1:29 at West Middlesex. The recommended ratios are 1:24.9 Chelsea and 1:21.7 West Middlesex and a business case for investment to achieve this has been submitted. Both sites are now compliant for the 98 hours dedicated consultant labour ward presence and twice a day ward rounds. For the CWH site diary carding will commence after 2 weeks of implementation and after 6 weeks of embedding, an audit of the ward rounds will be undertaken. Consultant job planning across both sites have been completed and the senior leadership team is currently undertaking a review of the workforce in line with the activity currently delivered across both obstetrics and gynaecology.

Birth indicators
Our attrition rate is still fluctuating widely due to the pandemic. In March there were 451 births at the Chelsea site and 359 at the West Mid site, acuity and complexity of the women continue to be high. Demand/capacity planning strategy in place to ensure our activity does not vary widely compared to plan. A review of all women who did not receive 121 care in labour at WM is currently being undertaken as for the month of March this dropped to 95.1%.

Safety
Our safety outcomes remain stable and we are not an outlier for stillbirth or infant deaths across the sector. All of our SI reports continue to have exec oversight before final sign off to ensure that there are SMART action plans and the SIs and the 72 hr reports are discussed regionally. The service is now compliant with 95% of the 7 immediate and essential actions (IEAs) from the interim Ockenden report, with a plan to be fully compliant by June 22 at the latest. The final Ockenden report was published on the 30th March 2022 and the leadership team will be undertaking a review of our compliance against the additional 15 IEAs over the next 4 weeks. This will then be presented to the Trust board.

Avoidable term admissions to NICU: here were 10 term admissions to NICU at the CWH site in February (7 respiratory distress, 2 hypoglycaemia and 1 for observation) and 4 of these were avoidable (1 earlier maternity escalation of MEWS and 3 cases a different neonatal management would have made a difference. At the WMUH site, there were 14 admissions in February and 13 in March. In February none of the cases were avoidable. One baby was transferred out for cooling for HIE, 11 babies for respiratory support, and one for jaundice and one for other reasons. Across both sites there is a plan to increase awareness of ensuring babies are kept warm and the Red Hat initiative is ongoing. The ATAIN working groups are currently increasing awareness of ATAIN and the jaundice guidelines among the staff in maternity. March cases are currently being reviewed by the ATAIN working groups.

Stillbirths and neonatal deaths: are reviewed and discussed in the Perinatal Mortality MDT team and reported via the PMRT tool. At the Chelsea site there were 1 stillbirth and 2 neonatal deaths. At the West Mid site there were 2 women with previable pregnancy losses from mothers of British Asian and Asian Afghanistan. The cases are being reviewed.

Outcomes
Our outcomes are in line with the NWL sector and we are not an outlier for our CS rates or assisted births. Our dashboard is discussed at the monthly Pillar 1 LMNS meeting. Our PTB rate and outcomes are currently being audited at both sites to ensure compliance with Ockenden and SBLV2. We also plan to monitor the IUT at the Chelsea site to review the factors that affect acceptance of IUTs by our neonatal and maternity teams. At a regional level it was raised that staffing has affected the ability of other units to safely transfer women at risk of PTB within our network and the women had to be transferred outside of network as far as Oxford. The LMNS is putting together a working group to review the data and develop a strategy to support safe IUT in sector.

62 day Cancer referrals by tumour Dashboard

Target of 85%

Domain	Tumour site	Chelsea & Westminster Hospital Site Jan-22	Feb-22	Mar-22	2021-2022	YTD breac...	West Middlesex University Hospital Site Jan-22	Feb-22	Mar-22	2021-2022	YTD breac...	Combined Trust Performance Jan-22	Feb-22	Mar-22	2021-2022 Q4	2021-2022	YTD breac...	Trust data 13 months Trend charts	
62 day Cancer referrals by site of tumour	Breast	n/a	n/a	n/a	n/a		66.7%	70.0%	88.9%	88.8%	14	66.7%	70.0%	88.9%	68.8%	88.8%	14		-
	Colorectal / Lower GI	85.7%	64.3%	70.6%	75.4%	18	66.7%	87.5%	66.7%	66.4%	21	82.4%	72.7%	68.6%	76.9%	71.2%	39		!
	Gynaecological	100%	0.0%	44.4%	63.2%	9.5	100%	100%	55.6%	73.5%	6.5	100%	33.3%	50.0%	77.8%	68.1%	16		-
	Haematological	100%	100%	100%	82.1%	2.5	100%	100%	80.0%	87.5%	3	100%	100%	88.2%	100%	85.0%	5.5		-
	Head and neck	n/a	100%	n/a	88.9%	1	100%	50.0%	100%	86.7%	1	100%	83.3%	100%	88.9%	87.9%	2		-
	Lung	100%	100%	66.7%	80.8%	3	50.0%	33.3%	80.0%	77.4%	4	75.0%	50.0%	75.0%	62.5%	78.9%	7		!
	Sarcoma	n/a	n/a	n/a	n/a		0.0%	n/a	0.0%	36.4%	4	0.0%	n/a	0.0%	0.0%	36.4%	4		-
	Skin	95.0%	80.0%	100%	91.9%	8.5	87.5%	64.3%	75.0%	86.1%	12	92.9%	70.8%	87.5%	82.7%	89.5%	20.5		-
	Upper gastrointestinal	100%	0.0%	100%	84.4%	2.5	100%	100%	40.0%	73.5%	6	100%	20.0%	75.0%	60.0%	78.8%	8.5		-
	Urological	91.7%	71.4%	90.9%	78.3%	19	87.5%	72.5%	86.7%	75.4%	50.5	88.5%	72.2%	89.2%	79.0%	76.2%	69.5		-
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	100%	n/a	100%	0	100%	100%	n/a	100%	100%	0		-
	Site not stated	n/a	n/a	n/a	n/a		100%	100%	n/a	76.5%	2	100%	100%	n/a	100%	76.5%	2		-

Improving personalised cancer care at diagnosis

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

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

Please note the following n/a Refers to those indicators where there is no data to report. Such months will not appear in the trend graphs ! Either Site or Trust overall performance red in each of the past three months

Please note that all indicators show interim, unvalidated positions for the latest month (Mar-22) and are not included in quarterly or yearly totals

Trust commentary (Unvalidated)

62-Day Referral to First Treatment: 62-Day target is non-compliant, currently showing at 78.7%. This has been driven by the impact of COVID on the diagnostic part of the pathway and patient initiated delays.

Tumour Site	Chelsea & Westminster		West Middlesex	
	Breaches	Treatments	Breaches	Treatments
Breast	0	0	3	7
Gynaecology	1	0	0	0.5
Haematology	0	1.5	0	1
Head and Neck	0	2	0.5	0.5
Colorectal	2.5	4.5	0.5	3.5
Lung	0	0.5	1	0.5
Other	0	0	0	0.5
Skin	1	4	2.5	4.5
Testicular	0	0	0	2
Upper GI	2	0	0	0.5
Urology	3	7.5	7	18.5
Total	9.5	20	14.5	39

Safer Staffing

Chelsea and Westminster Site (March 22)

Safe Nursing and Midwifery Staffing – Chelsea Site

	Average fill rate				CHPPD					National Benchmark	Vacancy Rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer				Medication incidents		Complaints		FFT	Red Flags
	Day		Night		RN	HCA	RNA	ANA	Total			Qualified	Unqualified	No harm & Mild		Moderate & Severe		Stage 1 & 2		Stage 3, 4 & nonstage		Moderate & Severe					
	registered	care staff	registered	care staff										M	YTD	M	YTD	M	YTD	M	YTD	M	YTD	M	YTD		
Maternity	105%	76%	97%	97%	8.3	2.9	0.0	0.0	11.2		12.17%	12.83%	19.09%		3								1	2	58	82.53%	
Annie Zunz	126%	68%	98%	107%	9.2	3.4	0.0	0.0	12.5	9.4	-2.90%	17.45%	0%		6								1		3	100%	1
Apollo	83%	-	82%	-	15.1	0.0	0.0	0.0	15.1	10.9	10.37%	28.56%	50%	1	2										2	100%	
Mercury	98%	-	100%	-	8.7	0.0	0.0	0.0	8.7	11	17.92%	21.98%	80%												3	88.24%	
Neptune	125%	-	134%	-	11.1	0.0	0.0	0.0	11.1	15	10.64%	31.23%	0%	1	5										6	93.6%	
NICU	90%	-	93%	-	14.6	0.0	0.2	0.0	14.8	26.7	15.10%	17.64%	0%												1	100%	
AAU	100%	51%	106%	86%	8.5	1.9	0.2	0.1	10.6	9.4	9.34%	12.32%	49.71%	7	115		2				2				15	94.12%	1
Nell Gwynne	103%	60%	143%	81%	4.7	3.0	0.0	0.2	7.9	7.9	20.51%	10.86%	40.74%	3	51									1	8	75%	1
David Erskine	99%	68%	112%	108%	5.3	3.3	0.0	0.4	8.9	8. 6	13.16%	43.9%	22.01%											1	10		2
Edgar Horne	90%	49%	97%	110%	3.5	2.4	0.0	0.4	6.3	6.9	20.01%	5.56%	26.90%	7	35		1				1			2	7	100%	1
Lord Wigram	82%	92%	102%	100%	4.3	3.4	0.0	0.1	7.8	8.2	9.32%	8.18%	8.55%	2	41									1	11	100%	4
St Mary Abbots	90%	111%	120%	103%	4.5	3.4	0.2	0.0	8.1	8.3	25.52%	15.37%	21.01%	1	23		1							1	8	95.35%	
David Evans	78%	58%	94%	155%	5.2	1.7	0.0	0.4	7.3	8.3	7.67%	5.04%	12.24%	1	26		1							1	13	100%	
Chelsea Wing	59%	62%	48%	81%	10.6	6.1	0.0	0.0	16.7	8.3	14.67%	21.43%	25.62%	2	11									2	4		1
Burns Unit	114%	95%	214%	241%	16.4	3.8	0.0	0.0	20.2	N/A	5.88%	10.83%	0%	1	14									1	5	92.31%	
Ron Johnson	79%	89%	67%	125%	4.3	3.3	0.0	0.0	7.6	9	21.54%	22.21%	22.42%	2	11											100%	1
ICU	100%	26%	100%	44%	27.0	2.5	0.0	0.0	29.4	27.7	3.67%	12.25%	0%	1	1					1	1						
Rainsford Mowlem	94%	51%	100%	81%	3.7	2.7	0.0	0.3	6.7	7.3	11.45%	12.85%	10.08%	4	54		1				1			1	5	60%	4
Nightingale	74%	34%	82%	90%	4.2	2.9	0.0	0.1	7.2	7.7				6	71		2							1	3		

West Middlesex Site (March 22)

Safe Nursing and Midwifery Staffing – West Middlesex Site

	Average fill rate				CHPPD					National Benchmark	Vacancy Rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer				Medication incidents		Complaints		FFT	Red flags
	Day		Night		RN	HCA	RNA	ANA	Total			Qualified	Unqualified	No harm & Mild		Moderate & Severe		Stage 1 & 2		Stage 3, 4 & nonstage		Moderate & Severe					
	registered	care staff	registered	care staff										M	YTD	M	YTD	M	YTD	M	YTD	M	YTD	M	YTD		
Lampton	98%	109%	100%	155%	3.2	3.9	0.0	0.0	7.1	7.7	0.49%	11.74%	11.51%	1	38										3	97.73%	6
Richmond	39%	-	72%	45%	8.0	0.8	0.0	0.1	8.9	7.2	16.56%	0%	34.48%		8		1								6	97.50%	
Syon 1 cardiology	92%	75%	92%	111%	4.3	2.0	0.0	0.0	6.3	8.8	11.27%	3.74%	19.12%	4	48										9	94%	2
Syon 2	107%	77%	102%	93%	4.4	3.1	0.0	0.3	7.8	8.6	14.05%	16.57%	6.67%	3	60		1							1	4	97.78%	
Starlight	76%	-	89%	-	6.3	0.0	0.0	0.3	6.6	15	28.14%	24.31%	0%		1								1		3	72.97%	
Kew	108%	133%	101%	179%	3.4	4.4	0.0	0.1	7.9	7.9	8.70%	4.65%	19.23%	3	86	1	2						1		6	93.75%	3
Crane	102%	61%	100%	102%	3.5	2.3	0.1	0.2	6.2	7.7	7.38%	0%	12.27%	4	36										2	97.37%	
Osterley 1	103%	83%	99%	115%	3.4	2.6	0.0	0.2	6.1	7	2.71%	16.33%	24.37%	1	51						2				4	94.74%	3
Osterley 2	96%	73%	98%	125%	3.9	2.3	0.0	0.2	6.3	7.2	-3.77%	3.92%	4.72%	2	34		1							1	19	90.48%	7
MAU	85%	73%	99%	100%	6.2	2.4	0.0	0.0	8.6	9.4	19.47%	18.75%	21.58%	7	63		1				1			2	8	73%	
Maternity	87%	61%	86%	80%	7.2	2.0	0.0	0.0	9.3		10.31%	8.15%	9.72%		1										4	83.67%	
Special Care Baby Unit	87%	100%	93%	120%	10.0	1.3	0.0	0.0	11.3	15	8.15%	3.86%	10.94%													100%	
Marble Hill 1	134%	100%	100%	233%	3.8	3.2	0.0	0.1	7.1	6.9	13.63%	14.61%	14.37%	7	92		1								2	84.38%	1
Marble Hill 2	92%	107%	111%	190%	3.4	3.7	0.2	0.0	7.3	6.8	0.60%	23.96%	0%		46		3				1			2	4	93.88%	1
ITU	105%	-	108%	-	30.6	0.0	0.0	0.0	30.6	26	14.33%	8%	0%		1						2			1	2	100%	

Safe Staffing & Patient Quality Indicator Report

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours per Patient Day (CHPPD). This is then benchmarked against the national benchmark and triangulated with associated quality indicators and patient experience for the same month. Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience.

Low fill rate on Richmond reflects a decrease in elective activity. Osterley 2 higher HCA cover at night was due to increased requirement for 1:1 specials and lower HCA fill during the day owing to sickness, vacancies and an inability to fill shifts with bank and agency. Richmond and DSU supported where possible. SMA has an increased fill rate at night due to the increased patient acuity. David Evans had decreased fill rate due to lower levels of elective activity in the day however at night required an increase due to the acuity of ICU steps downs.

Chelsea wing and Ron Johnson had a low fill rate due to a combination of staff sickness and bank unable to fill but CHPPD was not compromised. Annie Zunz had high day fill rate for RNs due to the requirement of an extra RN to cover patients admitted through the Surgical Admissions Lounge. Maternity remained challenged for Maternity Support Worker (MSW) cover due to vacancies and further resignations. MSW lined up for interview in April. Staff have been flexed across the service to ensure workload is evenly distributed.

High Fill rates in Neptune due to RMNs required for patients with mental health needs. Nell Gwynne ward had a requiring additional RN cover over night to support the patients with tracheostomies. Marble Hill 2 had high HCA fill rates due to confused, at risk of falls patients requiring one to one care. Marble Hill 1 required RMNs on day shifts and 2 HCAs at night for an aggressive mental health patient while they awaited placement.

Low fill rate of HCAs across medical wards due to high vacancy rates and low fill with temporary staffing. Staffing spread across areas to support patient safety. 4 days of interviews for HCAs planned in April in addition to Trust participating in NWL ICS recruitment event at the end of the month.

Vacancy and turnover rates relate to February rather than March.

Falls with severe harm occurred on Kew where the patient was requiring 1:1 monitoring for aggression and confusion. The patient sustained a fractured neck of femur and is now recovering post-surgery

A hospital Acquired Pressure Ulcer occurred at CW ITU on a patient with multi-organ failure. Correct pressure relieving mattress, pressure care given appropriately, risk assessments and care plans interventions in place.

No moderate or severe medication errors noted for the month.

During March the Friends and Family test showed 7 wards at CW and 2 wards at WM scored 100%, all other wards scored above 80% except Nell Gwynne 75%, Rainsford Mowlem 60%, Starlight 72.97% and MAU 73%. An action plan to improve the recommendation from Friends and Family has been formalised for those below 80% in EIC.

Please note all incident figures are correct at time of extraction from Datix. Red flags are now being reported and for March 39 flags were raised of which 30 were related to a shortfall in RN time. Staffing is somewhat compromised by staff who are COVID positive. Twice daily staffing meetings continue to mitigate the risk.

Finance M12 (March 2022) 2021/2022

There has been a request to exclude Finance from the report this month pending audit.

CQUIN Dashboard ***(2021/22 CQUIN Schemes)***

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE:	Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	2.3
TITLE OF REPORT	Maternity Improvement Programme
AUTHOR NAME AND ROLE	Victoria Cochrane, Director of Midwifery
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Bleasdale, Chief Nursing Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: x Info Only: Advice: Please tick below and then describe the requirement in the opposite column	As per the recommendation in the letter received by Trust on the 1st of April 2022 from Amanda Pritchard NHS CEO the purpose of this paper is to: • Share the final Ockenden report and its proposed actions nationally with the executive and non-executive board members to ensure the failings of Shewbury and Telford are not replicated in our organisation • Share an update on maternity continuity of carer nationally and the proposed actions • Update on the planned assurance visits based on the 7 Immediate and essential actions from the Interim Ockenden report • Provide a Chelsea and Westminster update on the Interim Ockenden compliance, assurance visit, next steps for the final Ockenden report and staff engagement events • Provide an update on our plans for maternity continuity of carer (this was submitted to quality committee and public

<table>
<tr><td></td><td>board in January 22)</td></tr>
<tr><td>REPORT HISTORY
Committees/Meetings where this item has been considered)</td><td>
<table>
<tr><td>Name of Committee</td><td>Date of Meeting</td><td>Outcome</td></tr>
<tr><td></td><td></td><td></td></tr>
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<tr><td>SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND</td><td>
The final Ockenden report was published on the 30th March 2022. The report includes 1,592 clinical incidents involving 1,486 families. The majority of the incidents were between 2000-2019.

The report includes 15 additional immediate and essential actions:

1. Workforce planning and sustainability
2. Safe staffing
3. Escalation and accountability
4. Clinical governance- leadership
5. Clinical governance- incident investigation and complaints
6. Learning from maternal deaths
7. Multidisciplinary training
8. Complex antenatal care
9. Preterm birth
10. Labour and birth
11. Postnatal care
12. Bereavement care
13. Neonatal care
14. Supporting families

These 15 IEAs include over 90 individual action points. The report has 4 key pillars that need to be the focus:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families
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	The service is undertaking a full gap analysis and this will be presented at the next quality committee and public board. Engagement events are being held with staff to share the report and get their feedback. The paper includes an update on compliance with the 7 IEAs in Interim Ockenden report. The Trust is currently 100% compliant with 5 IEA's with an action plan to be complaint with the areas of partial compliance in the last 2 IEAs by June 2022. Assurance visits are planned to all maternity services by September 2022 and as yet the Trust has not received the date for their visit. As per the letter a full review and risk assessment of the current maternity continuity of carer teams is taking place and included is the proposed plans to achieve 100% of women on a continuity of carer pathway (this paper was presented in January 2022 to quality committee and board and the plan remains the same) There has been an announcement of significant national funding following the final report of to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. We are awaiting further information regarding the bidding process for this funding.
KEY RISKS ARISING FROM THIS REPORT	There remains 3 elements of 2 Questions within the 7 IEAs that the service is non-compliant with currently following the 2nd submission of evidence in March Securing investment to achieve compliance with the 15 IEAs of the final Ockenden report Recruitment to the posts once investment is secured

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y

Be the employer of Choice	
Deliver better care at lower cost	

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	Y
Quality	Y
People (Workforce or Patients/ Families/Carers)	Y
Operational Performance	Y
Finance	Y
Public Consultation	
Council of Governors	

please mark Y/N – where Y is indicated please explain the implications in the opposite column

Alongside other key national reports and namely the Maternity Transformation Project ambitions, Ockenden further highlights the necessity for equality of care for all women, birthing people and their families. To succeed in equality of care we must ensure that we are compliant with the 7 IEAs and the 15 IEAS of the final report which impact on quality and experience outcomes for our service users.

Ockenden provides safety recommendations that directly impact on quality outcomes, these are measured via our local dashboards (for example unexpected admissions to NICU, stillbirths)

Compliance with the Ockenden recommendations involve detailed workforce assessment and analysis. This then provides advice on workforce establishments which are specific to each maternity unit.

There is significant investment required, in addition to the investment from NHS England, in order to be compliant with the Ockenden recommendations.

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

(please describe)	

Appendix A
Board of Directors (Public Meeting) January 2022

AGENDA ITEM NO.	2.3
REPORT NAME	Midwifery Continuity of Care (MCoC) as the default model of care within maternity services at the Chelsea & Westminster NHS Foundation Trust
AUTHOR	Natalie Carter (Consultant Midwife) & Victoria Cochrane (Director of Midwifery & Gynaecology)
LEAD	Pippa Nightingale (Chief Nurse)
PURPOSE	Provide the board with the background, current position and implementation plan for the adoption of midwifery MCoC as the default model of care in the maternity services on both sites. The national requirement is that each Trust board has approved the trust implementation plan to achieve this by 2023 at their public board by the end of January 2022. The paper provides the background, the current position, the plan for implementation and equality and equity considerations to achieve 100% of women and birthing people receiving midwifery MCoC.
SUMMARY OF REPORT	The national ambition for maternity services in England is that all women living within the local geographical area of each hospital will be booked onto a Midwifery Continuity of Care (MCoC) pathway by March 2023. At present on average 16-18% of women at 29 weeks of pregnancy are booked onto a MCoC pathway across the two maternity services at Chelsea and Westminster NHS Foundation Trust. This paper provides the background to this national recommendations, the Trust current position, the plan for implementation with the timeline to achieving this, the equality and equity considerations and the standards required to achieve true MCoC.

KEY RISKS ASSOCIATED	• Failure to implement and sustain this model of care means key quality improvements and outcome measures will not improve for women and babies. Improved outcomes include a reduction in baby loss, pre-term birth, certain interventions in labour and birth and improved experience. • Safe staffing must be achieved prior to any change taking place as the restructuring of the midwifery workforce has the potential to destabilise certain core services if certain ratios of care are not maintained throughout the change and implementation process. • Not all midwives will want to work in this model of care and staff engagement throughout this process is essential, however there may be resignations as a result of the change. • Unlikely to meet the target of MCoC as the default model by March 2023.
FINANCIAL IMPLICATIONS	• The success of this model demonstrated in the national evidence achieves financial sustainability by reducing preterm birth by 19% therefore reducing neonatal admission and Length of stay. • The financial model will be calculated in detail and approved by executive board once the final workforce plan is agreed.
QUALITY IMPLICATIONS	This model of care is driven by a national recommendation to improve safety and outcomes for women and babies by providing MCoC as set out in the *Better Births* and *NHS Long Term Plan* recommendations and maternity transformation programme.
EQUALITY & DIVERSITY IMPLICATIONS	Women and birthing people from the lowest areas of deprivation and those from Black, Asian and mixed ethnicity backgrounds experience poorer outcomes than their counterparts and therefore these groups of women will be prioritised to receive MCoC in the first waves of implementation.
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and integrated care
DECISION/ ACTION	• This paper is for noting by the board • Support maternity service in delivery of transformed model of care including funding of birthrate+ establishment • National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review

Midwifery Continuity of Carer as the default model of care in maternity services

Background

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (detailed implementation plan/communication and engagement with staff/education programme for new teams including team building/estate and equipment) are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first**.**

Women who receive MCoC are:

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 15% less likely to have regional analgesia
- 24% less likely to experience preterm birth
- 16% less likely to have an episiotomy
- Increased maternal satisfaction

Sandall, J. (2016) Cochrane Review

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of MCoC across antenatal, intrapartum, and postnatal care. Not all women will be in a position to receive MCoC, as some will have chosen to receive some of their care at another maternity service and in a small number of cases women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and

2. Putting in place clinical capacity to provide Midwifery Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

This plan includes:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care.
- **Building blocks** that demonstrate readiness for implementation and sustainability assessment – ensuring all the key building blocks are in place.
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision that is phased alongside the fulfilment of safe staffing levels within the acute service.
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity.
- How **rollout will be prioritised** to those most likely to experience poor outcomes.
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set

Current Position

The following table shows the number of women who booked at both hospital sites for the 2020/21 financial year who live either within area or who choose to book from out of area. It also highlights the number of births that took place at both sites and in which birth setting – showing level of attrition.

Table 1:

	Chelsea	*West Middlesex*
Total bookings 20/21 of which;	7542	5775
In area	2972	4758
Out of area	4600	1017
Total births 20/21 of which;	5362	4524
Homebirth	101	120
MLU	798	698
Labour ward	4563	3699
Attrition rate (approx.)	28.9% *	22%*

*Pandemic year

Women who book from out of area do not receive postnatal care from our service and do not therefore meet the requirement for MCoC because they do not receive all elements of care with us (antenatal, intrapartum, postnatal care). At Chelsea this is a particularly high number of women (60%), more so than those who live within area (40%) and in the future re-assessing our community boundaries is an important piece of work to undertake to understand the choices women are making and why, for example a significant number of women book out of area at Chelsea who live just below the river because actually it is their nearest hospital.

Women and birthing people eligible for MCoC at Chelsea is therefore around 2972 and at West Middlesex this is 4758. Women from a Black, Asian or mixed ethnic group equal approximately 23% of those who book for care at Chelsea and 50% of those who book for care at West Middlesex. A heat map has been produced which also includes deprivation data for women booked in the services to assess geographically in the community where these groups of women live and therefore where the priority is for the first waves of MCoC teams in the current implementation plan. Around 1-2% of women live in the lowest decile of deprivation at both sites.

Attrition due to women leaving care fluctuates significantly and can be high as identified in table 1. This proves challenging with MCoC models to know the safest ratio of midwife to women to book to and an on-going measure of this is crucial throughout the implementation of each wave to ensure any changes in attrition are identified and addressed in a timely way. Women experiencing MCoC may be less likely to leave the service when it is not related to outcomes such as miscarriage.

The Birthrate + national midwifery staffing assessment tool was completed in May 2021 and recommendations have been made for increasing the workforce at each site based on the activity and acuity of women receiving care. Achieving these increases is an essential building block that needs to be in place for the readiness of the service to adopt MCoC. A recruitment plan is in the process of being developed and at present the service are continually recruiting to their vacancies. Staff communication and engagement is a crucial component of the building blocks and a detailed engagement plan has been written.

The plan for implementation

Chelsea Hospital aims to provide MCoC to 3266 women and birthing people while at West Middlesex Hospital the plan is to provide care for 4758 women and birthing people.

The building blocks required for readiness of implementation include a fully recruited workforce, completed staff engagement and a plan for equipment and training needs. As part of the recruitment plan it is essential that the recommendations from the recent Birthrate+ assessment are funded. To minimise the risk of destabilising the core services as they are currently and impacting on safe staffing there must be safe establishment in the areas of intrapartum care and community settings prior to commencing MCoC improvements.

It is anticipated that the Maternity Transformation Project (MTP) funding year on year will be utilised to support equipment and training needs. The Practice Development Midwives and Professional Midwifery Advocates will support personal training needs analysis and tailored support plans for midwives. Some training may be able to take place in current work time, however some funding will be required to backfill staff time for training prior to launch of the teams. It is anticipated that this will come from the MTP funding. This programme will be developed once training needs analysis is completed for each wave.

The workforce plan outlines in detail how the service would transition to this workforce model. It is expected that in order to embed and evaluate each wave, a period of 3 months will be required followed by a period of 6 months planning and recruiting to the next teams, therefore each wave will take approximately 9 months with the potential for this to get quicker as confidence and scale increases. A suggested timeline is in the table below including the number of MCoC teams in each wave and % of MCoC reached:

Aim & Objective	**Milestone**	**Due Date**
Phase 1 - Readiness	Acceptance of Birthrate+ Staff engagement Recruitment	March 2022
Phase 2 – Wave 1	Total 6 teams: CW – 18% (2 teams) & WM – 21.02% (4 teams)	November 2022
Phase 3 – Wave 2	Total 10 teams: CW – 36% (4 teams) & WM – 32% (6 teams)	July 2023
Phase 4 – Wave 3	Total 15 teams: CW – 63.01% (7 teams) & WM – 44.56% (8 teams)	March 2024
Phase 5 – Wave 4	Total 19 teams: CW – 81.02% (9 teams) & WM – 56.33% (10 teams)	November 2024
Phase 6 – Wave 5	Total 21 teams: CW – 99.02% (11 teams) & WM – 56.33% (10 teams)	July 2025
Final phases wave 6&7 for West Mid	Total 28 teams: CW – 99.02% (11 teams) & WM – 100.04% (17 teams)	March 2026 November 2026

It will be essential that support for staff considers both those entering MCoC models and those remaining in the core areas across maternity. Skill mix is an important consideration in the workforce planning and the aim is that no more than 1 band 5 preceptorship midwife will be placed in a MCoC at any one time to ensure their own adequate support and the safety of the team. The band 7 labour ward co-ordinators are an integral part of the communication strategy making sure they are fully informed and involved in the changes, the reassurance around safe staffing and mechanisms for feedback and escalation.

Maternity Continuity of Care Standards

In meeting the standards set out nationally for MCoC we will ensure the teams reflect true MCoC with the following:

- 7 WTE, no more than 8 midwives per team
- Caseload ratio of 1:42 at Chelsea & 1:40 at West Middlesex taking into account attrition meaning the birth ration for midwives will be 1:36.

- The team of midwives will be known to women and birthing people through 'meet the midwives' initiatives but the aim will be that an individual woman or birthing person will meet only 3 different midwives across their pathway of care and that their named midwife will provide 70% of their care. A certain level of autonomy will be provided to the team in managing their diaries and 'availability' rotas but there will be a reasonable chance across all teams that the named midwife may be present for their woman's birth.
- Every team will have a link obstetrician for obstetric continuity and continued relational care.
- A Standard Operating Procedure (SOP) guide will be agreed for the working practices of the teams.
- It is essential midwives are remunerated appropriately for working in these models, particularly model 1 (availability model) and national support is being sought in this matter as there is a wide variation on how Trusts are supporting this. Currently at Chelsea & Westminster NHS Foundation Trust midwives working in model 1 complete time sheets at the end of each month detailing their on call periods and any unsocial hours worked. This ensures fairness of pay while a working group look at the potential for a standard uplift to their salaries.
- Community based MCoC teams already in existence currently see women at home for antenatal care and therefore clinic locations have not been required. It is anticipated that it will not be appropriate for all teams to work this way and therefore finding additional community spaces will be essential and may require the support of the ICS. A community base also supports team working and potentially classes for women and birthing people as well as 'meet the midwife' sessions.

Equality and Equity

Rollout of the teams will be prioritised to women and birthing people residing in the lowest areas of deprivation and those who are Black, Asian or mixed ethnicity background as these groups of people have the worst outcomes currently including baby loss and pre-term birth as well as maternal mortality rates. They are therefore a priority for this model of care which has been proven to improve these outcomes. For the purposes of this project a heat map was devised from 2 year's of data that enables us to observe the geographical areas of where these women and birthing people reside. This allows us to identify the geographical boundaries for team implementation at each wave.

We intend to under-take an evaluation at each phase to check that all our systems and processes work as per our expectations and plans. We also want to observe if there are any emerging patterns such as a reduction in foot fall/length of stay in antenatal ward, postnatal ward and triage. We will also continually review the impact of the change on all other services to understand if there if there have been any unintended consequences. The Trust has taken a decision to invest in an end to end digital solution for maternity documentation and data collection. It is expected that this will be implemented by June 2022 and will enable high quality data reporting on the National Maternity Services Data Set (MSDS). This will enable effective and efficient evaluation of each wave of the implementation phases. In order to ascertain the quality improvement outcomes we will be able to collect data on birth outcomes, midwifery appointments and levels of continuity and named midwife involvement , personalised care and support plans and levels of intervention and acuity. A maternal satisfaction evaluation will also take place through the use of a survey to assess experience. At each phase of implementation a reflection on the data will take place and any necessary modifications to the plan will be made before any further waves launch.

Conclusion

Midwifery Continuity of Carer has been proven in research evidence to achieve safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England. This plan sets out how the organisation aims to achieve this model of care for local women and birthing people, supported by a detailed service redesign plan, staff engagement plan and a workforce planning tool along with a recruitment plan. The leadership team are committed and support this model of care to achieve safer maternity care for women and babies. The business case to achieve this in a staged approach will be taken to executive board for approval once finalised.

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NHS England (2019) The NHS Long Term Plan. NHS Long Term Plan v1.2 August 2019.

Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity modeles versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4, Art. No. CD004667.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Maternity update: Ockenden Report (including timeline for self-assessment and plan for Continuity of Carer)

Victoria Cochrane (Director of Midwifery & Gynaecology)

Overview of Presentation

Regional briefing update

- The final Ockenden report briefing and areas of proposed action
- Contents of the letter to the system from the 1st April 2022
- Midwifery Continuity of Carer (MCoC)
- Assurance visits based on the 7 Immediate and Essential Action's (IEA's) from the Interim Ockenden report
- Timetable and format of the assurance visits

Chelsea and Westminster update

- Interim Ockenden compliance, assurance visit, next steps for final Ockenden report and staff engagement events
- Maternity Continuity of Carer
- Next steps

Ockenden regional report briefing

- Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford Hospital Trust by the Secretary of State
- She and her team reviewed 1,592 clinical incidents involving 1,486 families. The majority of these incidents were between 2000 and 2019
- In addition to actions from the interim report, today's final report proposes:
    - over 60 Local Actions for Learning for the Trust
    - 15 areas for national action (with 90+ individual points)

<u>First steps the NHS have taken:</u>

- Welcomed the report and apologised to the families involved
- Wrote to all Trusts, LMS and ICS asking them to consider the report and held webinars with senior leadership
- Planning a maternity meeting with each region in early June to take stock of performance, reflect on the report, and inform national plans
- Proposal to develop a refreshed delivery plan in the Autumn bringing together existing work with learning from Ockenden and East Kent

Areas of proposed action in the Ockenden final report
(wording is from the report)

1. Workforce planning and sustainability	**Essential action – financing a safe maternity workforce** The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented
	Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented
2. Safe Staffing	**Essential action** All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.
3. Escalation and Accountability	**Essential action** Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.
4. Clinical Governance-Leadership	**Essential action** Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems
5. Clinical Governance - Incident Investigation and Complaints	**Essential action** Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner

Areas of proposed action in the Ockenden final report
(wording is from the report)

6. Learning from Maternal Deaths	**Essential action** Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.
7. Multidisciplinary Training	**Essential action** Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training
8. Complex Antenatal Care	**Essential action** Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy
9. Preterm Birth	**Essential action** The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)
10. Labour and Birth	**Essential action** Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units.

Areas of proposed action in the Ockenden final report

(wording is from the report)

11. Obstetric Anasethesia	**Essential action** In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.
12. Postnatal Care	**Essential action** Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.
13. Bereavement Care	**Essential action** Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.
14. Neonatal Care	**Essential action** There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.
15. Supporting Families	**Essential action** Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.

Ockenden regional report briefing

Considerations:

- The trust should review the report and identify learning for the trust, LMNS & region
- The region will support Trusts, LMS and ICS with taking the report to Boards: Briefing Chief Execs, CNs, MDs, HoMs/DoMs and CDs
- Trust should assess need to signpost or mobilise support for staff
- Need to maintain the confidence of local families in maternity services – local communications on safe services
- Trust is collaborating with region in developing the assurance visits in region – visit is scheduled between May-September (ChelWest does not have a date yet)
- Wider implications for services beyond Maternity & neonatal – especially given reflections on governance, learning from incidents, culture, complaints, listening to patients & families and Freedom to Speak Up.
- NHS publishing, at trust level, the Ockenden first report IEA compliance at the May 19th Public Board meeting – this will reflect return to region on 15th April 2022 on Morecombe Bay, Ockenden, Workforce and Self-assessment tool

Letter of 1st April 2022 Ockenden- final report (From Amanda Pritchard- NHS CEO, Ruth May- NHS CNO & Stephen Powis Medical Director)

- 127 million investment on top of 95 million last year
- 45 million for neonatal cot capacity
- The rest for workforce expansion, leadership development, additional support to LMNS and retention support
- *'Your board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system'*
- The Ockenden report should be taken to next public Board meeting and be shared with all relevant staff
- We must take action to mitigate any risks identified and develop robust plans against areas where the service need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

Letter of 1st April 2022 cont…

- Expectation for every trust board to have:
    - Robust Freedom to Speak Up training for all managers and leaders
    - A regular series of listening events.
    - A dedicated maternity listening event should take place in the coming months.
    - Board oversight of any maternity and neonatal reviews and consequences for their maternity service, including sustained implementation of actions/recommendations
    - Considered the current progress of the 7 original IEAs within their service and completed return by 15th April to regional team
    - Had executive level oversight to ensure that maternity is providing reliable data to the regular provider workforce return
- A revised national policy and guidance on speaking up will be published soon
- *The Kirkup report on East Kent will follow*

MATERNITY CONTINUITY OF CARE (National recommendations)

*'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

- Trusts have already been asked to submit their MCoC plans by 15 June 2022.
- Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing **meets safe minimum requirements can continue** existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that **cannot meet safe minimum staffing requirements for further roll out of MCoC**, but can meet the safe minimum staffing requirements for existing MCoC provision, should **cease further roll out and continue to support at the current level of provision** or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that **cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision** and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Timetable of Assurance Visits

- Visits will be from May to September
- Scheduling of visits – a minimum of six weeks' notice must be given to trusts to allow staff capacity to attend
- This will be managed within Region being mindful that co-ordination will be needed (Region/LMNS/trust/MVP)
- Visits have been prioritised by those trusts who have the most work to do

Format of visits – Presentations/Meetings with individuals/meetings with staff/review of paperwork

- The regional team/LMNS will review and decide on areas of focus for the day of visit based on existing knowledge
- For a visit – anticipate introduction from region/LMNS, with overview and rationale for visit, to all staff – CEO/CNO included
- Trust to start the day with a presentation of Ockenden action plan, their response to the heat map and the things that they are most proud of and challenges for the service
- Members of visit team will meet with members of the trust leadership and members of staff, making notes for collation
- Chair of the visit: The LMNS or Regional Chief Midwifery Officer will co chair with Maternity Voices Partnership Chair. This will be to ensure the visit runs smoothly and lead collation of notes and prepare briefing at the end of the day
- It is anticipated that the visit will be up to a day per site, however the whole team may not be required for the whole day

Chelsea and Westminster position- Interim and final Ockenden report

- Interim Ockenden report: Evidence and compliance submitted to the regional team in February. Updated compliance as agreed in March and associated action plan (Appendix 1)
- The 2 areas of current non-compliance are:

1. IEA 2: service users voice representation at board- maternity now has 3 slots timetabled per year at public board
2. IEA 5: formal risk assessment and review of place of birth at every appointment: the updated notes have been in practice since the 4.4.22 and an audit of compliance will take place in June. The drop in compliance is to ensure the evidence submitted is robust

IEA's	Dec-21	Mar-22
IEA 1	94%	100%
IEA 2	88%	94%
IEA 3	94%	100%
IEA 4	100%	100%
IEA 5	67%	60%
IEA 6	94%	100%
IEA 7	100%	100%

- Assurance visit: No date given for this yet
- Final Ockenden report: Service leaders currently working through the 92 actions contained within the 15 IEA's from the final Ockenden report. Internal benchmarking will be complete by mid May. No current national requirement to submit compliance (full report included in the pack)
- 18 Engagement events running over 5 weeks, days and nights started on 11/4/22. To date over 170 staff have attended the events

Maternity Continuity of Carer (MCoC): Chelsea position

- Currently 4 rostered and 2 on-call based continuity teams across the 2 sites (reduction of 2 on-call based teams due to staffing challenges within the teams in the last 6 months)
- Formal risk assessment of the 6 current teams to be undertaken once regional risk assessment received
- MCoC plan submitted to Quality Committee and Public board in January 2022. All building blocks need to be in place (safe staffing/Staff engagement/engagement) before the service can start to implement in wave – service plan remains the same
- Awaiting the outcome of the Birthrate + business case presented to the executive team in March. Safe staffing is the first phase required to ensure readiness for phase 2 (Wave 1 implementation)
- Full January paper included in the pack

Next steps

- Maternity service will continue to work through the 15 IEA's and benchmark itself against them. Once completed the initial gap analysis will be presented at the next quality committee and public board
- Once the risk assessment for MCoC has been received all teams and the wider service will be risk assessed against this
- Await the outcome of the Birthrate + plus business case to plan safer staffing and next steps of MCoC teams
- Await the date for the Ockenden assurance visit and prepare accordingly

Appendix 1- Interim Ockenden action plan

IEA/Question	Question No and info and rag rating	Evidence required	Action	Update
IEA 2 /Q11	11 Non-executive director who has oversight of maternity services	Evidence of how all voices are represented board	Agreed that DOM will present 3 times per year at board	Maternity now on the agenda to present at board x3 times per year. The evidence from this will be shared with the regional team as part of the assurance visit.
IEA 5 / Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Review and discussed and documented intended place of birth at every visit.	Importance of risk assessment highlighted on mandatory education in HOM/DOM session since March 2021. Large piece of work to enhance clinical documentation in handheld notes to ensure documented risk assessment at every contact and documented discussion regarding place of birth. Development of digital end to end maternity pathway K2 has risk assessment and place of birth prompts and fully integration.	Audit of complex pathway demonstates high levels of compliance as evidenced in submision for IEA4 Q26. Risk assessment and place of birth now part of the annual audit- due April 2022. Updated handheld notes due to arrive on site by end of Feb and will be used from the beginning of March for all new bookings. Communication and dissemination strategy in place to ensure these are embedded and used appropriately. Full complaince planned for June 2022
IEA 5 / Q33	33A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	How this is achieved in the organisation	Plan for implementation in March 2022/then yearly audit cycle	Updated notes implemented on the 4/4/22 which contain risk assessment at every contact and on-going review and discussion of intended place of birth. Full complaince planned for June 2022. Evidence submitted on 22/2/22-AN care guideline- CW/WM (currently being harmonised), Intrapartum care guidelinebased on NICE.
IEA 5 / Q33	same	SOP to describe risk assessment being undertaken at every contact.	Submit further supporting evidence	Evidence: AN care guideline- CW/WM (currently being harmonised), Intrapartum care guidelinebased on NICE, Updated notes- used from 4/4/22 highlighting discussed and documented place of birth at every visit
IEA 5/Q33	same	What is being risk assessed.	Submit further supporting evidence	Evidence: AN care guideline- CW/WM (currently being harmonised), Intrapartum care guidelinebased on NICE, Updated notes- used from 4/4/22 highlighting discussed and documented place of birth at every visit

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

30 March 2022

Return to an Address of the
Honourable the House of Commons
dated 30 March 2022 for

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS **FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES** at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

HC 1219

Ordered by the House of Commons to be printed on 30 March 2022

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Letter to the Secretary of State for Health and Social Care from Donna Ockenden

30 March 2022

Dear Secretary of State

I publish the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, at a time when the NHS continues to face significant challenges arising from the Covid-19 pandemic. In the 2 years of this pandemic since early 2020 the NHS and its staff have had to be ever more innovative in the ways services are delivered to ensure the provision of high quality care to patients.

NHS staff, including maternity teams who have worked throughout this pandemic, are exhausted. We have seen so many frontline NHS staff go above and beyond the call of duty to support and care for their patients in these truly extraordinary times. Our NHS is rightly held in high regard by so many for the lives it saves and the care it provides.

However, this final report of the Independent Maternity Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.

This review owes its origins to Kate Stanton Davies, and her parents Rhiannon Davies and Richard Stanton; and to Pippa Griffiths, and her parents Kayleigh and Colin Griffiths. Kate's and Pippa's parents have shown an unrelenting commitment to ensuring their daughters' short lives make a difference to the safety of maternity care. It was through their efforts that your predecessor, the former Secretary of State for Health Jeremy Hunt requested this independent review. When it commenced this review was of 23 families' cases, but it grew to include reviews of nearly 1,500 families, whose experiences occurred predominantly between 2000 and 2019.

This final report follows on from our first report which was published in December 2020. In the first report we outlined the Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. This second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed. For this second report my independent maternity review team have identified a number of new themes which we believe must now be shared across all maternity services in England as a matter of urgency to bring about positive and essential change. Our Local Actions for Learning for the Trust and Immediate and Essential Actions, must be implemented by The Shrewsbury and Telford Hospital NHS Trust with the IEAs considered by all Trusts across England in a timely manner.

Since the publication of our first report, the Government has introduced a range of measures[1] and invested very significantly in supporting maternity services across the country. This focus and funding is a significant stride in the right direction. Much of this funding is for workforce expansion. NHS Providers[2], as cited in the recent Select Committee report[3] has estimated the cost of full expansion of the maternity services workforce to be £200m - £350m. We endorse and support this view.

In the last year since our first report was published we have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing

1 https://www.gov.uk/government/publications/safety-of-maternity-services-in-england-government-response/the-governments-response-to-the-health-and-social-care-committee-report-safety-of-maternity-services-in-england

2 https://nhsproviders.org/media/690887/2021-02-04-letter-from-nhs-providers-to-hscc.pdf

3 https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

attrition of maternity staff and providing the required funding for a sustainable and safe maternity workforce is essential. Continuing progress on funding the maternity multi-professional workforce requirements now and into the future will mean that we can continue to ensure the safety of mothers and their babies and meet the Government's key commitment to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring soon or after birth by 2025[4].

In our first report we wanted to ensure that families' voices were central, as for far too long women and families who accessed maternity care at the Trust were denied the opportunity to voice their concerns about the quality of care they had received. Many hundreds of families who received maternity care at the Trust have told us of experiencing life-changing tragedies which have caused untold pain and distress. In order to ensure families' voices are heard, listened to and acted upon within maternity services the NHS will need to continue progress on the role of the independent senior advocate role within maternity services that was an Immediate and Essential Action in our first report.

Secretary of State, through our work to date we have recognised a critical need for timely and independent reviews of serious maternity incidents to ensure lessons are learned and changes implemented effectively. We note and endorse the creation of a Special Health Authority[5] to oversee maternity investigations, taking over the work of HSIB. We fully support your view that the provision of 'independent, standardised and family focussed investigations of maternity cases that provide families with answers' is essential. We further urge that there must be a timeliness to this work since delay in introducing change and learning leads to the risk of repeated incidents, as we saw at The Shrewsbury and Telford Hospital NHS Trust. We would expect that learning and service change from maternity incidents be introduced into clinical practice within six months of the incident occurring and that all investigations are independently chaired.

Finally and importantly Secretary of State we state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

Thank you Secretary of State for your ongoing support,

Yours sincerely,



Donna Ockenden

Chair of the Independent Maternity Review

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 https://questions-statements.parliament.uk/written-statements/detail/2022-01-26/hcws560

Acknowledgements

The work contained in this final report and the first report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, came about from the exceptional efforts of parents Rhiannon Davies, Richard Stanton, and Kayleigh and Colin Griffiths, who daughters died as a result of the care they received at the Trust.

The deaths of Rhiannon and Richard's daughter Kate in 2009, and Kayleigh and Colin's daughter Pippa in 2016 were both avoidable. Owing to their unshakeable commitment to ensure the precious lives of their babies were not lost in vain, this review has implementation of meaningful change, not only in maternity services at The Shrewsbury and Telford Hospital NHS Trust – but also across England. As we publish this final report, we want to acknowledge and pay tribute to Rhiannon, Richard, Kayleigh and Colin.

Very importantly, and as Chair of this review, I want to extend my heartfelt thanks to all of the families who have come forward to share their experiences. So many families have explained to me that for more than two decades they have tried to raise concerns but were brushed aside, ignored and not listened to. My review team and I have listened to families and heard their concerns and distress. This final report has come about following the careful consideration by my review team of 1,592 clinical incidents involving mothers and babies resulting from the maternity care of 1,486 families. Their contribution to this review and report has, in my view, been central to a review of maternity services which I hope and believe will now save lives and reduce harm in maternity services across England.

Thanks to the bravery and determination of all the families in sharing their experiences we have produced this report, which my review team colleagues and I believe will continue to shape the learning which will profoundly change maternity care now and in the years to come. Never again should families be left to grieve or suffer in isolation, with the additional pain of feeling their legitimate concerns are being ignored. Our intention is that this report will underpin the future journey of maternity services in England, so that maternity services will be safer, will hear families better and will be more accountable.

Why this Report is Important

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent.

The families who have bravely contributed to this review know all too well the devastation which follows such events, and have explained to my review team and me that they want this review to answer their questions. Families have also clearly explained that they want what happened to them to matter and to ensure that in future voices, such as their own, are listened to and heard and that meaningful and sustained changes will be made to try to ensure that what happened to them will not happen to others in future.

The accounts of families involved in events at maternity services at The Shrewsbury and Telford Hospital NHS Trust has not only put a spotlight on this service but also on other maternity services across England, as can be seen by recent reports of concerns in a number of other trusts. That is why this report aims to not only address specific concerns about The Shrewsbury and Telford Hospital NHS Trust but to provide Immediate and Essential Actions for all maternity services across England. Sometimes that spotlight can feel harsh to staff on the front line doing their very best in what are often extremely challenging circumstances. As a multi-professional clinical review team, largely made up of midwives and doctors currently working on a daily basis in NHS maternity services across England, we understand that.

Even now, early in 2022 there remains concern that NHS maternity services and their trust boards are still failing to adequately address and learn lessons from serious maternity events occurring now. We recognise that maternity services have very significant workforce challenges and this must change. Clearly, workforce challenges that have existed for more than a decade cannot be put right overnight. However, it is our belief that if the ‘whole system’ underpinning maternity services commits to implementation of all the Immediate and Essential Actions within this report with the necessary funding provided then this review could be said to have led to far reaching improvements for all families and all NHS staff working within maternity services.

The size and scale of this review is unprecedented in NHS history. After reviewing the experiences of so many families and listening carefully to both those families and to the past and present staff who came forward, we have been given a once in a generation opportunity to improve the safety and quality of maternity service provision for families across England, now and in the future.

Donna Ockenden

Chair

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Explanation of Terminology

In this report the review team has used words or medical terms which some readers may not be familiar with. While we have tried to keep the use of such words and terminology to a minimum, at times it is unavoidable. This is so we can accurately address specific clinical issues we found within our review as well as make recommendations to improve maternity care now and in the future at the Trust and across the NHS in England.

To try to aid readers' understanding where we think language has become technical, where the terms are used for the first time, we direct readers to a glossary (found at the end of the report) which will give further explanation of their meaning.

Executive summary

This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust ("the Trust") commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. It has previously been reported that this review was considering 1,862 family cases. However after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the Trust's internal investigations where they occurred. In addition, the review team has considered external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner's reports.

Throughout this process our priority has been to ensure that the families impacted by the maternity services at the Trust are heard. They wanted to understand what had happened to them, as well as ensure that finally lessons are learned so that no further families experience the same harm and distress that they did. Families were offered a variety of methods to engage with the review team and share accounts of their care and treatment. Throughout this report we have included vignettes of the care received by families either through our review of their maternity care considering the documentation that was received from the Trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard as well. In 2021 the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard. In the final weeks leading up to publication of the report, a number of staff withdrew their cooperation from the report and therefore their content (or "voice") was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as 'a staff member told the review team...'

Within this report we have included a timeline of events which led up to the commissioning of this independent review (see chapter 1). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies which took place during the period under review. It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion due to concerns around other clinical areas within the Trust and also due to the significant turnover at Executive and Board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua's mother was considered to have a low risk pregnancy, and even after she reported episodes of severe uterine tenderness and tightening at 31 weeks this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but on her admission the baby's heart rate was not monitored appropriately. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this a ventouse delivery was attempted before an emergency caesarean was conducted. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at six hours of age.

The review team found evidence of poor investigation into all three of these cases which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the Trust.

Unfortunately these three cases were not isolated incidents and throughout this review we have found repeated errors in care, which led to injury to either mothers or their babies. During our work we have considered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

In total 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and in three-quarters of cases the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not, recognise system and service-wide failings to follow appropriate procedures and guidance. As a result significant omissions in care were not identified and in some incidents women themselves were also held responsible for the outcomes.

As part of the review 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in maternity care which if managed appropriately might, or would have, resulted in a different outcome. Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns, however these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care provided which might or would have resulted in a different outcome.

The review team found that throughout the review period staff were overly-confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For

example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the Trust women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report, where there were delays in women being admitted to the labour ward during induction of labour, being assessed for emergency intervention during labour or reviewed by consultants in the postnatal environment. On occasion this resulted in families being discharged from hospital but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care the review team has identified a failing to follow national clinical guidelines whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst the Trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes.

Unfortunately these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care and in some cases even including explanations which laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians, in part these delays in care could be attributed to staffing and training gaps at the Trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce, which negatively affected the operational running of the service. The review team identified how it was widely accepted that the labour ward coordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and on occasions unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient to staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore it failed to foster a positive environment to support and encourage service improvement at all levels. In addition the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity

service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the Trust went unknown until this review was undertaken.

Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/2019 considered as part of this review.

This meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies including local Clinical Commissioning Groups and the Care Quality Commission during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the Trust sooner.

Local Actions for Learning and Immediate and Essential Actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that following our first report in December 2020 there does seem to have been a recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed.

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.

Section 1

History, methodology and families

- Introduction
- Chapter 1. Concerns that led to this review - a timeline
- A case study highlighting failure to investigate, inform and listen
- Chapter 2. How we approached our review
- Chapter 3. Supporting the families during our review

Introduction

Our first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*, was published in December 2020[1]. The report, which was outside the terms of reference for this review, was prepared at the request of the then Minister of State for Patient Safety, Suicide Prevention and Mental Health Nadine Dorries MP. It observed important emerging themes which required urgent action following review of the maternity care experienced by 250 families. The aim was to focus on immediate improvements for the Trust through **Local Actions for Learning** (LAfL) and the wider maternity system across England with **Immediate and Essential Actions** (IEAs).

This second publication reports on the care of all families included in this review of maternity services at Shrewsbury and Telford Hospital NHS Trust. It explores internal and external factors that may have contributed to the failings in care we have found. Of importance, and in accordance with the Terms of Reference, this report is particularly focussed on the Trust's failings in governance processes which directly led to the harm that families experienced.

From its start, in the summer of 2017, we have seen the number of families included in this Secretary of State Independent Maternity Review increase substantially from the original 23 families. It is now recognised that this review is likely to include the largest ever number of clinical reviews conducted as part of an inquiry relating to a single service in the history of the NHS.

We reported in July 2020 that 1,862 individual families were included in this review. After further analysis and validation of data with the Trust, the total number of families included in this review is now established to be 1,486 resulting in 1,592 clinical reviews of care. The majority of cases are from the years 2000 to 2019. However, a number of families came forward in the early period of the review whose care preceded these years and it was agreed by NHS England that, where possible, their care would also be reviewed.

All care and treatment provided to families, the quality of any Trust-led incident investigations, Trust-led reviews, external reviews and the resultant recommendations, actions and learning have been considered with reference to the relevant guidance and standards of the day, by clinicians who were in clinical practice at the time.

Every clinical review undertaken has been led by expert clinicians and each case has been carefully considered using a consistent standardised methodology. The multidisciplinary review team has been expanded during the process to reflect the growing number of families. The majority of reviewers currently work in clinical posts at trusts across England, with the number of team members who have been a part of the review since its start exceeding 90.

Over the course of the review, the team has faced many challenges and these are explained in more detail within the report. These have been mainly related to systems and processes required in order to undertake a review of this size, as it became evident that the required protocols, procedures and structures were not immediately available to support it. The COVID-19 pandemic at times impeded progress as our clinicians quite rightly prioritised their NHS commitments.

We have always emphasised that the voices of the families are central to this review. Throughout, we have ensured that families have been updated on the review's progress and we have worked closely with support agencies to ensure that listening, counselling and psychological help is and has been available for those in need.

The voices of staff at the Trust have also been important to assist with our understanding of events. We launched our Staff Voices engagement strategy to reach out to both former and current staff at the Trust. They were offered the opportunity to engage with us through an initial questionnaire survey and further conversations to share their experiences of working at the Trust. Despite reaching out through social media and the local press including radio, TV and a local newspaper and joint messaging with the Trust, fewer staff and ex-staff contacted us than we had anticipated or hoped for.

1 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

At the time of publication only just over 100 current and former staff had contributed to the review with a further number of staff withdrawing from the review in the weeks before publication. This led to a number of last minute changes to the report as we were unable to use staff contributions without their consent. Those staff withdrawing were apologetic but most were concerned about being identified in the report. Despite our assurances, they maintained that they did not want to be quoted in the final report and we respected their decision.

Since our first report, we are encouraged to hear of progress at the Trust through its improvement programme in response to both our **Local Actions for Learning and Immediate and Essential Actions**. Indeed, we heard through staff of the willingness of their colleagues and themselves to learn from the review, in order to continue to improve and work towards building and maintaining a safer local maternity service.

The review team was particularly encouraged by the overwhelming positive response to our first report from maternity colleagues across England and the wider NHS. We were equally encouraged to see that our call for action to ensure investigations, reviews and reports that lead to meaningful change was heard.

We acknowledge that the proposed funding of £95million towards workforce and training provided by NHS England and Improvement is a major stride in the right direction. However, we are equally conscious that this is only the start of the journey and state that what is required in order to continually improve safety in maternity services is a multi-year funding increase for workforce expansion and training, in forthcoming years.

Our **Immediate and Essential Actions** from this report, based on our findings from the clinical reviews and listening to the voices of both families and staff, identify that the wider system must invest further in staffing across the whole maternity team to ensure that there are sufficient numbers, and that the workforce is equipped with the right skills and is able to deliver care in the right place at the right time.

Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services.

Whilst the review has been heartened by the Trust's progress over the last year, NHS England and Improvement must continue to provide appropriate support and ongoing oversight of its continued progress. Regulators such as the Care Quality Commission together with the Royal Colleges, including those of Midwives, Obstetricians and Gynaecologists, Anaesthetists, and Paediatrics and Child Health must continue to strengthen their collective efforts of collaborative working to hasten the implementation of these further **Local Actions for Learning** and **Immediate and Essential Actions** outlined in this final report.

We are aware that since the inception of this review, there are now at least two other independent maternity service reviews in progress. This may be indicative of some wider systemic issues. At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning.

Over and over, families have expressed their two key wishes for this review. They want answers so that they can understand what happened during the care they received and why. We hope that this report will go some way in identifying and explaining the factors that contributed to the systemic failures which led to the harm they experienced. Secondly, they want the system to learn. We note that as a result of our findings in our first report, through our **Local Actions for Learning** and **Immediate and Essential Actions** the Trust and the wider NHS are beginning to learn and improve. We anticipate that through this report the learning will be sustained. No more families should have to live with the consequences of poor governance systems and structures within the NHS.

We must ensure that for all the families who contributed to this review there continues to be visible, measurable and sustainable change at the Trust and across the wider maternity system in England. That change through the implementation of our **Local Actions for Learning** and **Immediate and Essential Actions** will be the legacy of these families and the terrible loss and harm they have experienced.

Chapter 1

Concerns that led to this review

1.1 The Ockenden Review into the Shrewsbury and Telford Hospital NHS Trust maternity services spans the period from 2000 to 2019 and was commissioned by the then Secretary of State for Health Jeremy Hunt MP at the end of 2016. Donna Ockenden was asked to lead the review, then comprising of 23 families, in the summer of 2017. The following is a chronology of reports and reviews into the Trust's maternity services over this time.

1.2 This timeline shows the failure of the Trust's maternity services to listen to families and to learn from critical incidents spanning the entire period of the review. In 2001, a woman gave birth to a baby in very poor condition who subsequently died at 21 minutes of age. The cause was due to failure to recognise abnormalities in the fetal heart monitoring. The family felt that there was no attempt to be honest with them in subsequent correspondence from the Trust and they claimed that as well as clinical mistakes, there was obfuscation, and a cover-up. The family subsequently took legal action against the Trust in order to get answers that they had been unable to get from the Trust before litigation commenced.

1.3 In 2002 a baby girl named Olivia died following a traumatic ventouse and forceps delivery. The subsequent independent medical report prepared for this family found severe failings in obstetric care. The mother described how at that time she felt like a *'lone voice in the wind'* trying to raise concerns about the Trust's maternity unit. Olivia's mother made multiple attempts to publicise what had happened to her daughter including appearing on national television on the 'This Morning' programme in 2006.

1.4 Olivia's mother told the review chair in late 2018: *'I hope that by speaking out other women who've suffered in childbirth will come forward …to expose the cover-ups that clearly happen…at the time, because I ended up on This Morning as well, talking about this, and the amount of women that day that phoned in, who'd gone through similar things, and it gave me a kind of peace because I knew that they were getting help in the right direction…'*

2007 Healthcare Commission

1.5 In 2004, two babies were born in poor condition which resulted in cerebral palsy. These cases were reported in the local press at the time and the solicitor who represented both families wrote to the then regulator of NHS trusts, the Healthcare Commission (HCC), and the Shropshire and Staffordshire Strategic Health Authority calling for an inquiry. The review team has not seen any evidence that an inquiry took place.

1.6 Three years after the experience of these families in April 2007 the Healthcare Commission wrote to the then CEO of the Royal Shrewsbury Hospital[2] regarding its concerns about the maternity service. The HCC said they had received concerns in March 2006 with regards to poor care resulting in birth injuries. The allegations raised with the HCC were that staff failed to recognise and act upon abnormal cardiotocograph[3] (CTG) tracings, that there was non-adherence to the National Institute of Health and Clinical Excellence (NICE) guidelines and there was a lack of, and inappropriate, staff training.

1.7 The HCC visited the maternity service and said it was satisfied that CTG training for staff and audit had been introduced and that the Trust then used NICE guidance. The HCC considered that the concerns raised with it did not meet its criteria for an investigation and therefore did not undertake one, but suggested areas for improvement with a plan to monitor the implementation of the recommendations until it was satisfied that sufficient progress had been made. The HCC noted the Trust's low caesarean section rate of 14 per cent in 2005 compared to the UK national average of 23.2 per cent. The HCC did not examine unplanned

2 Healthcare Commission Letter to the Trust's Chief Executive Officer 18 April 2007 https://www.sath.nhs.uk/wp-content/uploads/2017/05/Doc-1-Letter-from-Healthcare-Commission-to-Trust-April-2007.pdf

3 See glossary

admissions to the Neonatal Intensive Care Unit (NICU), rates of hypoxic ischaemic encephalopathy (HIE) or relevant other near misses. This was a significant lost opportunity for learning at an already troubled Trust.

1.8 In the letter from the HCC to the Trust dated April 2007, the following recommendations were made:

RECOMMENDATIONS	
CTG	The Trust should send a copy of the latest CTG audit to the Commission and ensure that staff are aware of it for their learning. Trends, learning and improvements should be identified and acted upon.
Lack of/inappropriate staff training	Skills drills training programmes should be evaluated and revised where necessary.
Risk Management Systems (including incident reporting, root cause analysis, actions plans, follow-up and learning from incidents)	The Trust needs to improve the quality of the action plans resulting from clinical incident cases and high risk case reviews, i.e. the actions need to be clearly measurable, the accountable person named and they should have timescales.
How policies and procedures are rolled out to staff and embedded in practice	Policies and procedures should be reviewed in a timely manner, in line with national guidance, and staff should be clear of any revisions.
Clinical Governance	The Trust should share its revised Clinical Governance structure with the Commission.
Clinical Risk Adviser	The Trust should consider the need for permanent additional resource for the Clinical Risk Adviser for the Children and Maternity Service.

2008 Baby Joshua, and baby Kate Stanton-Davies in 2009

1.9 In March 2009 baby Kate Stanton-Davies died following her birth at Ludlow birth centre. Richard Stanton and Rhiannon Davies, Kate's parents have up to the present day voiced their concerns about the circumstances surrounding Kate's death and about the safety of maternity services at the Trust. The Ockenden review team notes that another baby was born the year before, in May 2008, also at Ludlow Birth Centre. Baby Joshua died a few days after birth after also being born in a very poor condition. A review of this case by the review team has noted that there were significant concerns in the care provided to Joshua's mother and that there was not an appropriate investigation. The coroner did not hold an inquest, following receiving information provided by the Trust, but the family explained to the review chair that they were not involved in these discussions between the Trust and the coroner.

1.10 In summary, the births of baby Joshua and Kate Stanton-Davies have similar features. Both mothers presented with antenatal clinical concerns and reduced fetal movements, there were concerns during the labours, there were resuscitation concerns for both babies and both babies required air ambulance transfer. Both families were dissatisfied with the internal investigations and failure to obtain answers to their questions.

1.11 A paediatric death review (an internal investigation by the Trust) occurred in September 2008 following the death of baby Joshua in May 2008. The minutes of the meeting state that all midwives were up to date with neonatal resuscitation and *'advised all midwives to call 999 at the first sign of mother or baby being compromised'.* This was also stated in the action plan which said: *'an ambulance should be called as soon as there are indications that transfer of mother or baby may be required due to the time lag in the ambulance arriving.'* When Kate Stanton-Davies was born 10 months after baby Joshua in the same birth centre an ambulance was not called for 90 minutes, despite signs that Kate was seriously unwell from birth.

1.12 One overarching theme from this review is that over the years there has been a failure within maternity services at the Trust to investigate and learn from serious clinical incidents. It is apparent that baby Joshua's death in 2008 did not result in any actions or learning. It is also noted that when the subsequent death of Kate Stanton-Davies was investigated[4] by Debbie Graham Ms Graham could not locate any definitive guidance for the operating of Ludlow MLU for 2009[5]. This was despite the fact that after the earlier death of baby Joshua these issues were raised as being of importance to ensure the safety of mothers and babies, yet no action appears to have been taken.

1.13 Joshua's parents were scathing of the Trust and their lack of transparency and openness and their failure to learn. In a meeting with the review chair in early 2022 Joshua's mother told of *'phoning and phoning the [Royal] Shrewsbury Hospital for over a year, waiting and waiting for answers, they were always on leave, always in surgery, always not available. No one spoke to me..'* Joshua's father described the Trust as *'ducking and diving, avoiding telling the truth, they've been dodging and weaving all these years..*' Joshua's parents eventually commenced litigation in order to get the answers they wanted from the Trust.

1.14 The Ockenden review team has also searched within the vast amount of information provided by the Trust for relevant guidelines. The SaTH guideline *Resuscitation of the Neonate at a Midwife-Led Unit or a Home Birth by a Midwife and When to Summon Assistance* was first implemented in June 2010. It took just over 2 years after the death of baby Joshua and 15 months after the death of Kate Stanton-Davies to ensure this critically important clinical guideline was introduced.

1.15 In 2015 a woman had a delayed transfer from the midwifery-led unit and fetal monitoring was not undertaken during the transfer period. The baby was delivered in very poor condition and subsequently died. The family were critical of the ensuing investigation, and of correspondence with the Trust, and said during a meeting with the Ockenden review team that they had been *"put off, fobbed off and had obstacles put in our way".*

2013 Clinical Commissioning Groups' (CCGs) review

1.16 In 2013, there was a review into the maternity services at the Trust by the two Clinical Commissioning Groups[6]. This review was commissioned following concerns over an increased incidence of serious clinical adverse events and the safety of the clinical model of maternity care in Shropshire.

1.17 The CCGs' review of risk management focussed on reported serious incidents and near misses in the period April 1, 2012 to March 31, 2013[7]. The review team has found evidence of significant underreporting and cases that should have been investigated not being investigated, so it is our view that the CCGs' review would have underestimated the scale and volume of the incidents at the time. The CCG review also looked at policies, clinical governance systems, care pathways, and training, and concluded that *'there was an openness and transparency in reporting and investigation culture, which has led to a higher*

4 Graham, D. Independent Review of the case of Kate Seren Stanton-Davies at the Shrewsbury and Telford Hospital NHS Trust (2015) https://www.sath.nhs.uk/wp-content/uploads/2016/12/IndependentReview.pdf

5 Ibid n3 p25

6 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group. Maternity Services Review The Shrewsbury and Telford Hospital NHS Trust (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

7 Ibid n5 p5

reporting of serious incidents than would have been reported elsewhere'. The review stated further *'there is a robust approach to risk management, clinical governance, and learning from incidents'.* The higher reported rate of unexpected admissions to the NICU compared to other local units was attributed in part to *'diligent reporting*[8]" and a thematic analysis was recommended to understand the reasons for this higher NICU admission rate.

1.18 Of note in this CCGs' report is a recommendation for neonatal services that *'measures to implement standards for 'Local Neonatal Units' are actioned immediately so that babies less than 27 weeks gestation receive initial stabilisation and intensive care in Shropshire before being transferred to an appropriate unit for ongoing intensive care'.* There is evidence within this second Ockenden report that this recommendation was not implemented, (see more in neonatal chapter 12). Furthermore a recommendation concerning serious incidents said that the Trust must *'ensure serious incident reporting is congruent with the National Patient Safety Agency (2010) and NHS England (2013) Serious Incident Framework'.* There is no evidence in the documentation provided to the review team by the Trust that this recommendation was actioned, (see more in clinical governance chapter 4). There is also no evidence that the CCG held the Trust to account for meeting these very important recommendations.

1.19 The 2013 CCG review also included comments from 47 women across 13 maternity service user focus groups[9]. It should be noted that this survey took place when the labour ward was at the much older Royal Shrewsbury Hospital prior to a move in 2014 to a new purpose-built maternity unit at the Princess Royal Hospital, Telford, so any negative comments on the condition of the estate could be reasonably disregarded.

1.20 Within the 2013 report there were some very positive comments from women:

All of the staff involved in my care both during my pregnancy and in labour were excellent. The midwife who dealt with my labour was first rate.

The care we had was excellent - the midwives acted swiftly to save my daughter's life, as did the neonatal ward in Shrewsbury.

However, there were also some very concerning negative comments:

I had a terrible experience and ended up being treated for post-traumatic stress following this birth, ahead of my second child. I felt frightened and not listened to during the birth and was 'cared' for by a rude uncaring doctor.

The whole experience of labour and the birth was horrific. The midwife was horrible, the on-call consultant was bad tempered.

I felt the midwives were unprofessional and rude. I had no help with feeding and consequently felt really alone. I thought midwives would be kind and they weren't a bit, they just kept telling me how busy they were. I don't want to have another baby at Shrewsbury.

I had an awful experience giving birth, the midwife was horrible to me, I felt I got no support. Afterwards in the ward I got no help with breastfeeding.

I felt that my concerns during labour were not addressed, that I was made to have a natural birth when an emergency c section was more appropriate just so they didn't dent their precious natural birth rate target. I felt like I was on a butcher's slab.

1.21 Although, as commented by the authors of the CCG report, 90 per cent of the patient feedback was favourable the 10 per cent negative feedback contains some very concerning family stories indicating poor maternity care. The sample size of 47 women was also very small. The report thanks *'the young mums*

8 Ibid n5 p7

9 Ibid n5 p19

who provided valuable feedback[10]' It is of note that the families' concerns, which do not appear to have been followed up by the CCG, are very similar to many of those heard by the Ockenden review team.

1.22 The overall assessment from this CCG review was that this was a safe and good quality service. The report states: *'it is clear that Shropshire has a maternity service to be proud of and that the model of service provision is safe and robust…'* The Trust Board reviewed this report[11] and in the minutes it noted '[*some] concern about some families' experiences but this was in the context of generally good services.'*

NHS Litigation Authority

1.23 In March 2014 the Trust was assessed by the NHS Litigation Authority[12]. This assessed the maternity service for organisation, clinical care, high risk conditions, communication, and postnatal and newborn care. The Trust was awarded the Level 3 standard, this was the highest standard available to be awarded. It should be noted that the Clinical Negligence Scheme for Trusts (CNST) standards at the time were assessed almost entirely from self-reporting of guidelines and procedures.

1.24 In 2014 there was a Deanery (medical training) review[13] into the training received by obstetrics and gynaecology staff. Under areas for improvement and with reference to clinical governance it said:

1.25 *'The Trust must integrate Clinical Governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from Clinical Incidents and that any learning points are clearly disseminated to trainees appropriately.'* There is no evidence that has been seen by the review team that this was actioned by the Trust.

2015 Care Quality Commission

1.26 In 2015 there was a Care Quality Commission Quality Report on SaTH[14] which followed on from a visit to the Trust in 2014. The overall rating for maternity services was "good". It is noticeable that in this CQC report other Trust services such as medical care, surgery and urgent and emergency services were rated as 'requires improvement'. The CQC did comment that staffing levels should be improved on the labour ward and also commented that: *'the Trust must ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised, so that service development and learning can take place'.* However, this comment was a Trust-wide action and not specific to the maternity service.

2015 Debbie Graham independent review

1.27 In 2015 there was an independent review by Debbie Graham[15] which reviewed the high profile case of Kate Stanton-Davies and made some criticisms of the Trust's response to the family.

1.28 The independent review by Graham found that although clinical governance processes were in place in 2009, at the time of Kate's birth there was a disconnect between policy, and the systemic mechanisms in place, which prevented effective clinical governance activity from being embedded into the culture of the organisation. This lack of a safety culture within maternity services at the Trust prevented Kate's death being raised as a Serious Incident (SI). Instead of an SI investigation the death was investigated as a High Risk Case Review (HRCR), and secondly as an unconnected midwifery supervisory investigation, therefore no learning started to occur from Kate's death until the findings of the coroner's inquest in 2015, 6 years after Kate died.

10 Ibid n5 p3

11 2014 Trust Board papers supplied to the review team

12 NHS Litigation Authority Clinical Negligence Scheme for Trusts. Maternity Clinical Risk Management Standards 2013-14. The Shrewsbury and Telford Hospital NHS Trust. Level 3. (2014)

13 NHS Health Education West Midlands. PMET Review Findings Report Summary (2014)

14 Care Quality Commission. Shrewsbury and Telford Hospital NHS Trust Quality Report (2015) https://api.cqc.org.uk/public/v1/reports/0826982d-e4d9-48da-bc92-a78c8fc9b933?20210518113404

15 Ibid n3

1.29 In its conclusions the Graham report stated that *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services…In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.*

2016 Baby Pippa Griffiths

1.30 Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa's feeding, breathing and other symptoms a number of times overnight after her birth and before she died, but had been reassured. It was established at the coroner's inquest that Pippa would have survived had post-delivery literature been given to Pippa's parents, and had a complete systematic enquiry into her neonatal health taken place.

1.31 Kate's and Pippa's parents (Rhiannon Davies, Richard Stanton, Kayleigh and Colin Griffiths) wrote a joint letter to the Trust Board in April 2017 expressing concern about maternity services at the Trust, discussing their own losses and other cases and saying that nothing had been learned and nothing had changed with regards to maternity services since Kate's death in 2009. At interview with the chair of this review in December 2017 Colin Griffiths, Pippa's father, described the behaviour of the Trust at the time of her death and afterwards as feeling *'like it was a sweep under the carpet, that's what it felt like'.*

1.32 Kayleigh, Pippa's mother, described to the Chair of the review in November 2017 the significant effort the family made to try to get the Trust to investigate her death in April 2016. She said: *'so…I left it until late May, and then it went into June and we'd heard nothing at all from them so I phoned...and said what's happening, surely there's an investigation taking place? And [X[16]] said to me "oh, it's just an internal thing, we're looking into it, but if you've got any questions just send them to me and I'll ask them to look at them…" '*Kayleigh continued: *'I…said "it's not right, you don't just have a sudden, unexplained death and then say there's no investigation and the family's not going to be involved". So I went online straight away and got some NHS England guidance up about involving families and sent it…emailed it…And said there's got to be more to it, and I sent…some questions… And, from there, I contacted…I was just thinking something's not right and I'd seen a lot about Richard and Rhiannon Davies and I made contact with them…I contacted the Chief Exec at SaTH and said, you know, this has got to be investigated…'*

2017 Ovington Review (internal)

1.33 In 2017 the Quality and Safety Committee of SaTH commissioned an internal review into the maternity services following on from concerns raised by bereaved parents and the increased perinatal mortality rate, which had resulted in public attention. This report, Review of Maternity Services 2007-2017[17] was authored by Colin Ovington, then working within the Trust, and published in 2017.

1.34 The Ovington report made recommendations that the maternity service should ensure that governance arrangements are more transparent and open, and should improve the learning from incidents and investigations. It recommended engaging peers from other trusts to assist in the investigation and learning from incidents, and that the Trust should use a standardised process for investigating stillbirths and neonatal deaths. It is unclear whether these recommendations were ever acted upon since the review team has not been provided with or seen any connected action plan or any evidence of completion of the actions following that report.

16 X – identifier removed by review team

17 Ovington, C. Report Review of Maternity Services 2007-2017 Shrewsbury and Telford Hospital NHS Trust (2017) https://www.sath.nhs.uk/wp-content/uploads/2019/12/170629-06-Safety-of-Maternity-Services-2007-17-final-version-June-17.pdf

2017 Royal College of Obstetricians and Gynaecologists Invited Review

1.35 In 2017 there was a Royal College of Obstetricians and Gynaecologists Invited Review and subsequent report into the maternity services based on a visit to maternity services at the Trust carried out from 12-14 July 2017[18]. This report noted the following:

- There were workforce issues, with insufficient numbers of consultants providing obstetric cover. It also noted that middle grade rotas were not always filled by the deanery meaning that the maternity service relied on overseas trainees and locums.
- Risk management and governance systems were inadequate with a lack of resources.
- Incident reporting was inadequate with little evidence of widespread learning from incidents.
- The assessors viewed the allocation of the workforce across the sites as a patient safety issue.
- Current morale among the midwifery workforce was very low.
- The midwifery manager on-call rota required managers to deal with clinical areas they had no experience with.
- The perinatal mortality rates had remained above average compared with rates in similar trusts. The assessors did not see evidence of action plans and resulting changes in practice to act on this concern.

The RCOG report was not presented to the Trust Board until July 2018, and when presented it was prefaced by a report addendum dated 27 April 2018 which reported on interim progress on the recommendations from the original report.

2020 NHS Improvement response

1.36 Concerns were raised by families as to the time taken for this report to be presented to the Trust Board. On 29 November 2019 a letter of complaint was sent to the National Medical Director by two families. The letter alleged that the RCOG report was withheld from the Trust Board for 12 months. Furthermore, it alleged that Trust management sought to 'water down' the RCOG report by requesting a further document (the addendum) to be produced by the RCOG acknowledging improvements that had apparently been made. This addendum document was then added to the original report before being presented to the Trust Board in July 2018.

1.37 In response to this letter, NHS Improvement's Investigation Team conducted a review into these allegations and published the document *Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust* in July 2020[19].

1.38 This NHSI review noted that twelve months elapsed between the RCOG's site visit and the report being presented to the Trust's Board. It noted that when the draft report was received three months after RCOG's site visit, a number of Trust staff were unhappy with the findings feeling it was not an accurate representation of the service. The CEO, in part guided by maternity staff feedback, initially did not accept the RCOG draft report.

1.39 Following further discussions with RCOG, the Trust did then accept the report in early January 2018 but remained concerned about its tone and content, particularly in relation to the executive summary. The Trust made representations to RCOG to address this, and also proposed a follow-up exercise to evidence improvements the Trust felt it had made. The RCOG declined to make any further changes to the report,

18 Royal College of Obstetricians and Gynaecologists. Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust (2017)

19 NHS Improvement. Review of the handling of a report produced by the Royal College of Obstetricians and Gynaecologists on maternity services at Shrewsbury and Telford NHS Trust (2020) https://www.england.nhs.uk/midlands/publications/review-of-the-handling-of-a-report-produced-by-the-royal-college-of-obstetricians-and-gynaecologists-on-maternity-services-at-shrewsbury-and-telford-nhs-trust/

but did agree to this follow-up exercise, to be conducted as a 'progress review meeting' at the RCOG's premises in London. The RCOG did not visit the Trust to assess the 'improvements' for themselves.

1.40 When the report was finally presented to the Trust Board the covering paper was overwhelmingly positive in tone, with its twelve-point summary reflecting only the most complimentary aspects of the addendum itself. The overall result was a document that gave the impression that issues in the maternity service had been largely resolved, when in fact there was still significant further work to do.

1.41 The NHS Improvement report further found that governance arrangements at the maternity service and care group level were not operating effectively in relation to the report and associated action plan. Although a lot of work was initially done to implement actions and keep the action plan updated, there had been very limited ongoing scrutiny of the plan by local or corporate governance forums. This was concerning given the severity of some of the issues identified in the 2017 RCOG report.

1.42 The NHS Improvement report noted that the Trust was not obligated to commission the RCOG Invited Review but chose to do so and committed from the start to publish the results, knowing that this would open it up to further scrutiny. However, when the outcome was less favourable than hoped for, the primary focus of maternity services and the Trust seemed to shift towards the perceived public reaction to the report, rather than getting the right internal assurance and scrutiny to ensure the necessary improvement of patient services.

1.43 Following the publication of the RCOG report there was significant criticism in the media and from families that the body had not alerted the regulator (the CQC) with regard to its findings. Instead the RCOG had only released the report to the Trust. At the time[20] the RCOG sent reports arising from Invited Reviews to the service/Trust that had been reviewed, without always notifying regulators[21]. The 2015 policy was clear that the RCOG would *'encourage dialogue…with regulatory agencies and authorities'* and *'encourages the sharing of the report with the CQC...'* (RCOG 2015, p3).The RCOG policy was subsequently strengthened in 2020 with the policy stating that *'the RCOG will send a copy of the final report to the organisation's healthcare regulatory bodies'.*[22]

2018 Care Quality Commission

1.44 In 2018 there was a CQC report[23] which rated the maternity service inadequate under the safety domain. Of note there were concerns about cardiotocograph training and mandatory training. The report also commented: *'We found areas of concern that were raised in our last inspection December 2016, for example service wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning'*.

1.45 The review team has been contacted by and interviewed a number of staff who have worked at the Trust over the period of this review. A number of Trust staff at Board level have also been contacted by the review team and interviewed, these have included some current and former Chief Executive Officers, Chairs of the Trust, Chief Nurses and Medical Directors.

1.46 A number of themes have come from these interviews and broadly this feedback forms a consistent picture of the culture in the Trust during the period of this review, with the documentary evidence also considered by the review team.

20 Royal College of Obstetricians and Gynaecologists Invited Reviews a guide (2015) https://www.rcog.org.uk/globalassets/documents/about-us/invited-reviews/rcog-invited-reviews---a-guide-oct-2015.pdf

21 Royal College of Obstetricians and Gynaecologists. Statement regarding an Invited Review by Royal College of Obstetricians and Gynaecologists (RCOG) into maternity services at Shrewsbury and Telford Hospital NHS Trust (2020) https://www.rcog.org.uk/en/news/statement-regarding-an-invited-review-by-royal-college-of-obstetricians-and-gynaecologists-rcog-into-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust/

22 Royal College of Obstetricians and Gynaecologists. Invited Review Service: https://www.rcog.org.uk/en/about-us/invited-review-policy/

23 Care Quality Commission 2018 report Shrewsbury and Telford NHS Trusts https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

1.47 It was clear from a number of staff interviews that this was a Trust which had a number of problems. A Board member told the review team that: *'there seemed to be a number of political issues making reform of services difficult'* and there were comments that the populations of Shrewsbury and Telford differed and that *'everybody in Telford wanted all the services in Telford and everybody in Shrewsbury wanted all the services in Shrewsbury'.*

1.48 One staff member said to the review team *'people just didn't do anything… and there just wasn't a culture of accountability for completion..'* and another commented: that *'this wasn't just a maternity unit in chaos and under pressure, this was a whole organisation where it was difficult to find an area which was not under pressure'*. The review team has noted that for many years there have been concerns with regard to safety and performance across the whole of the Trust, including the emergency department.

1.49 One interviewee described the maternity service as the *'Republic of Maternity, where, often, the maternity service seemed to consume its own smoke, and didn't like having oversight by the corporate team'."*The same interviewee commented that *'there was a disconnect both ways actually, I believe, from the corporate team to maternity and maternity to the corporate team'.*

1.50 Over a prolonged period, the Trust Board and executive team were dealing with a situation where the general standard of the whole organisation was poor and according to a staff member *'women's and children's was largely trusted to take responsibility for their own affairs and, to some extent, there was less scrutiny of them by virtue of the fact that they were perceived as being satisfactory to good'.* The impression given from multiple staff interviews with the review team was that the maternity department preferred to manage its service without Trust oversight.

1.51 The Trust had an executive team and Board that had continual change and churn over the period of this review, with documentation provided to the review team by the Trust[24] showing 10 Board Chairs from 2000, with 10 Chief Executive Officers (CEO) from 2000 to early 2020, of which 8 were in post between 2010 and the current day. This lack of continuity at Board and CEO level resulted in a loss of organisational memory and contributed to this "self-management" and lack of oversight of a maternity service that had clearly been in trouble for many years. The overwhelming impression of the staff interviews is that despite significant evidence to the contrary, the maternity unit up until about 2017 was actually not considered to be a trust risk.

1.52 One staff member interviewed stated that following serious incident reports there would have been recommendations made and that often these reports and recommendations were good but what was missing was the follow-up of the actions from the recommendations. It was said that *'there just wasn't a culture of accountability for completion'.*

Concerns from local external bodies

1.53 In late 2021 the review team also spoke to some senior staff of the Clinical Commissioning Groups (CCG) in post between the years 2013 to 2020. We were told that the CCGs did have concerns about maternity services at the time and were aware of the local press reports and family concerns. The CCGs had concerns about the length of time that SIs took to be reported and we were told by a contributor that *'reviews of serious incidents seemed to take a long, long, time to happen and there was an impression of evasiveness around how the learning from those reviews was shared'.* The same contributor told the review team that the CCG did have meetings with the maternity service representatives from the Trust but were assured that *'things were improving',* and were told that the CCGs were in any event *'limited in their power to change things for the better'.* It should be recognised that the CCGs were also concerned about SI investigations and learning from other services across the whole Trust and not just maternity.

24 Who's Who at the Trust – internal document received by the review team on 9 September 2020

Missed opportunities

1.54 In summary this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk. The consistent message coming from both senior maternity staff and from Trust Board members was that external reports into the maternity service were generally favourable and that there were more pressing problems in other services at the Trust. The management of the maternity service was perceived to be competent and able and governance concerns seem to have been managed within the service and not escalated.

1.55 The review team believes that the Trust Board and the CCGs were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns.

Case Study

Thematic review of three cases at the Trust sharing similar themes within a nine month period (2008-2009)

1a.1 Here we examine the case of Kate Stanton Davies and deaths of two other babies which occurred within a short time period at the Trust. Throughout this report we highlight repeated incidents where maternity services at the Trust failed to investigate, learn and make impactful changes to improve patient safety.

1a.2 Within nine months, between May 2008 and March 2009, there were three neonatal deaths of babies that should have led to a systematic review of governance processes, strong actions and learning as well as a coronial inquiry into safety at the Trust. In all three cases there are significant failings in the care and treatment provided, omissions in the subsequent investigation into care, and failure to learn and establish processes for safe delivery in the midwifery-led unit (MLU) and consultant unit.

1a.3 Most concerning is a lack of transparency and honesty in communication with the families concerned despite internal recognition at the Trust that the investigations were not robust.

Baby Joshua 2008:

1a.4 The maternity review team has found evidence of a case that occurred nine months earlier than that of Kate Stanton Davies. In May 2008 a baby boy called Joshua was born at Ludlow midwifery led unit (MLU) in poor condition. Joshua was transferred by air ambulance to the Royal Shrewsbury Hospital (RSH) Neonatal Unit and died there on day 6 after his care was withdrawn.

1a.5 Joshua's mother was considered low risk with a previous pregnancy and birth and it seems an assumption was made that she would deliver in the freestanding MLU at Ludlow. There was no analysis of risk to ensure normality and whether or not it was appropriate or not to deliver in Ludlow. However, from 31 weeks of pregnancy the maternal risk changed. Joshua's mother reported three episodes of severe uterine tenderness and tightening. One occasion led to an ambulance admission to RSH and this review team believes that concealed abruption should have been considered by clinicians at the time.

1a.6 Joshua's mother reported decreased fetal movements the day prior to labour at 37+5 weeks gestation. No admission CTG was performed; she progressed quickly in labour, and an amniotomy[25] performed at 9cm revealed significant meconium. Seventeen minutes later her baby was delivered with no sign of life. No ambulance had been called in preparation for delivery and no attempt was made to perform a CTG once the meconium was identified.

1a.7 Two midwives at the unit attempted to resuscitate the baby but did not follow UK resuscitation guidance. A paediatrician doing a peripheral clinic took over the resuscitation. An ambulance road crew arrived to help. Joshua was transferred unsecured on a stretcher and ventilated by valve and mask in the air ambulance to RSH where he was ventilated, and remained comatose until treatment was withdrawn on day 6, after a head scan revealed severe widespread damage to Joshua's brain.

1a.8 The review team observes that timely intermittent auscultation was not performed in labour, and what monitoring did occur was not described in an accepted manner. The review team is concerned by alterations added to the notes in a different pen that appear to change the fetal heart rate recordings documented during labour.

1a.9 Placental histology confirmed a significant abruption with an attached and organised blood clot. The pathologist concluded that the abruption was silent and established. Despite this, the explanation given

25 See glossary

to the parents at the bereavement consultation was that the abruption must have been acute in the final 15 minutes of labour, perhaps secondary to a tight umbilical cord causing an unpredicted, acute placental detachment. This is despite no evidence of fresh blood loss at birth or post-partum haemorrhage. The bereavement letter stated: *'nothing could have been done or predicted'* and lacked any apology or reassurance that lessons would be learned.

1a.10 The review team do not accept this opinion of the likely pathology. In addition, we observe from the maternity records supplied by the Trust that the meconium revealed prior to birth was thick and established, indicating that the release was likely to have been some time before, perhaps in the days leading to labour when decreased fetal movements were reported. The review team consider that concealed abruption most likely occurred in the third trimester, contrary to the opinion offered to the parents at the bereavement appointment.

1a.11 There are a number of documents provided to the review team by the Trust which show discrepancies between the factual events and what was actually discussed with the parents. There are also extracts that contain additional information which was not disclosed to the family. This information is found in incident reports filed by members of staff and communications between professionals, provided to the review team by the Trust.

1a.12 The review team conclude that the risk management review of this incident by the Trust failed to follow appropriate local investigation processes to identify the root cause. The Trust also failed to decide on appropriate actions in order to prevent similar harm in the future. It is of concern that a decision to refer to the coroner was reversed by a small number of individuals within the Trust who decided to manage this incident internally.

1a.13 The review team has been aware of internal reports of concern around the lack of vital resuscitation equipment being available at Ludlow. As well as a lack of familiarity with equipment and poor standards of resuscitation, including the failure of midwives to achieve respiratory resuscitation. In addition the lack of ability to monitor oxygen saturation and to monitor the baby during resuscitation, and the lack of facility to thermoregulate and monitor the baby in the air ambulance.

1a.14 Documents shared with the review team by the Trust show that the lack of a portable resuscitaire in Ludlow MLU had been on the maternity risk register since 2005. The Trust did not support this concern and excused the lack of equipment on the basis that it would only be used by a neonatologist. There was an assessment of the resuscitation equipment at the unit but no details were given of the outcome. The review team is concerned by the response to this risk as it demonstrates poor evidence of learning. The additional information around the maternity risk register and the fact that this was a known risk regarding Ludlow MLU was never detailed to the parents during their meeting with the obstetrician or to any other professionals outside the organisation.

1a.15 A few weak action points from this case were circulated via a memorandum suggesting that change in practice was not mandatory and it was optional whether to use CTG monitoring if a woman presented with reduced fetal movements at the MLU. It also suggested it was optional to summon an ambulance when amniotomy was performed with evidence of meconium.

1a.16 A clinician who cared for the baby initially, stated in a letter to the Clinical Director in July 2008 that they had serious concerns regarding the quality of the case review. They pointed out a number of inaccuracies in the findings of the review and wrote: *'I really do wonder whether they have actually read these notes and wonder [about] the quality of the case review'*, and *'I am concerned that there is evidence the parents have not received an accurate explanation of the events leading up to the birth, during the birth and the resuscitation'.*

Baby Thomas 2009

1a.17 In January 2009, after the birth and death of Joshua but before Kate Stanton-Davies was born, a multiparous mother delivered in the consultant unit. Uterine rupture was diagnosed at caesarean section after a failed ventouse and prolonged labour with injudicious oxytocin use. The baby, named Thomas died at 34 minutes of age and was classified as an early neonatal death. The coroner agreed to the stated cause of death as: 1. Multiple organ failure; 2. Severe HIE; 3. Ruptured uterus and placental abruption. No post mortem was performed.

1a.18 The mother was booked for an MLU delivery despite having had a very long previous labour with a macrosomic[26] baby. No gestational diabetes testing was performed in this second pregnancy. Numerous attendances in a long latent phase of labour were apparent and all clinical midwifery reviews highlighted a large for dates baby with poor engagement of the fetal head.

1a.19 The mother was admitted to the consultant-led antenatal ward, contracting at 4cm dilatation. 19 hours later she was taken to the labour ward for amniotomy at 5cm. During the 11 hours following amniotomy there were repeated periods of abnormal CTG and high dose oxytocin infusion was administered for long periods of time leading to and after full dilatation. The contraction frequency was 5 in 10 minutes for long periods and poor medical input was noted. Vaginal examinations revealed classic signs of obstructed labour of a baby in the deflexed occipito-posterior position[27]. An hour prior to eventual birth by caesarean section there were classic signs of uterine rupture including haematuria[28], breakthrough pain, hypotension, and diminished uterine activity, failure to establish between a clear fetal or maternal heart rate. The midwife sought assistance for possible uterine rupture[29]. A ventouse delivery was initiated 35 minutes later and failed after 3 pulls. A caesarean was conducted 10 minutes later and uterine rupture with placental abruption[30] was found. The baby briefly had a heartbeat, but at 34 minutes of age resuscitation was discontinued.

1a.20 A DATIX[31] submission was generated following this event and the outcome of uterine rupture, early neonatal death and major obstetric haemorrhage (4.8 litres) was classified as low harm. It was stated that the case would be discussed in a case review meeting that same month but to date the review team has received no documents from the Trust pertaining to a risk review or outcomes.

1a.21 The review team has graded this incident as Grade 3 (the highest grade of harm) and has major concerns with the management of the incident and the apparent lack of scrutiny.

1a.22 In a bereavement letter, the Trust inaccurately informed the parents that the demise was acute and no one could be certain when the rupture occurred. No reference is made in the letter to the reasons why the mother's uterus was ruptured, or to the chronic hypoxia revealed by the cord ph. There is no reference in the letter to lessons being learned or actions that could prevent such tragedy in the future.

The Stanton Davies family and baby Kate 2009:

1a.23 Two months after the birth and death of baby Thomas and 9 months after the birth and death of baby Joshua, baby Kate died avoidably on 1 March 2009 after her birth at Ludlow MLU. Kate died at 6 hours of age following cardiopulmonary collapse at 90 minutes of life. She was severely anaemic and paediatric help should have been sought earlier.

1a.24 The case has been reviewed extensively: with a highly criticised supervisory investigation, multiple external opinion reports and finally in 2012 a coroner's inquest with jury, all of these occurring after constant pressure from Kate's grieving parents. The inquest concluded that Kate should not have been born at Ludlow. The 2 weeks of reduced fetal movements prior to labour was a factor in Kate being born anaemic, as she had likely suffered repeated episodes of feto-maternal haemorrhage[32]. The MLU staff failed to provide Kate and

26 See glossary
27 See glossary
28 See glossary
29 See glossary
30 See glossary
31 See glossary
32 See glossary

her mother Rhiannon with midwifery expertise. Intermittent auscultation in labour was not adequate and opportunities to manage a baby in difficulty during the first hours of life were missed. Kate died shortly after arrival by air ambulance at a tertiary neonatal unit.

1a.25 There have been numerous specialist opinions on this case over a long period of time. It is clear that the Trust failed to fulfil its responsibility to establish the facts and establish accountability. In particular, the Trust failed to investigate Kate's death appropriately, failed to hold staff to account and failed to address her parent's concerns, and particularly those pertaining to the inadequacy of the supervisory investigation. Further external opinions revealed that midwives did not consider her mother Rhiannon's antenatal care as a whole and did not consider the bigger picture, which would have indicated that Kate should not have been delivered in an MLU. The Trust's investigation into midwifery practice is described as ineffective and half-hearted and the consultant feedback is criticised as being badly considered.

1a.26 Consideration of these three cases of term babies, Joshua, Thomas and Kate who were born and died within 10 months of each other show that by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.

1a.27 The review team is particularly concerned by the lack of transparency internally within the Trust and the lack of honesty and transparency with families. This is all the more concerning, when it is clear that major issues in safety were apparent in both MLU and consultant settings during the period leading up to the birth and death of Kate Stanton-Davies, and before her the birth and death of baby Joshua and then baby Thomas.

Chapter 2

How we approached this review

2.1 This Independent Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (SaTH or similar abbreviation) was commissioned in May 2017 by NHS Improvement (NHSI) at the request of the Right Honourable Jeremy Hunt MP, then Secretary of State for Health and Social Care. This was in response to concerns raised with Mr Hunt by Rhiannon and Richard Stanton Davies and Kayleigh and Colin Griffiths about the deaths of their daughters in 2009 and 2016 respectively and about 21 further families which experienced adverse outcomes at SaTH. These concerns were with regards to the maternity care received at the Trust and with the failure of the Trust to provide satisfactory answers to questions asked about the care it provided.

2.2 The first terms of reference in 2018 were written for the planned review of 23 families, but were amended in November 2019 to encompass a much larger number of families. Both the first and the current terms of reference are found in appendices 5 and 6.

2.3 This is the second report published by the Ockenden review team. The original plan was to publish one complete report when the reviews of all the cases had been completed. However in July 2020, following an increase in the number of families included in the review, the then Minister of State for Mental Health, Suicide Prevention and Patient Safety, Nadine Dorries MP, requested a first report focussing on important early actions and learning to improve local and national maternity services. That first report, based on the first 250 clinical reviews, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Hospital Trust*[33] was published on 10 December 2020.

2.4 For this second report we have reviewed all reported cases of maternal and neonatal harm in the period 2000-2019. As stated in the terms of reference, these comprise cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other complications in mothers and newborn babies. A number of cases were reviewed outside of these years and the earliest case reviewed was in 1973 and the latest in 2020. In total this review has examined the maternity care of 1,486 families resulting in 1,592 clinical incidents involving mothers and babies.

The start of the review in 2017

2.5 When this review began in late 2017 a small team of six obstetricians, midwives, neonatologists and administrative staff were recruited by Donna Ockenden (chair of the review) to begin work as agreed with NHSI. During summer 2017 and early 2018 some original hospital records were transported securely from the Trust to the review's office in Chichester, West Sussex and reviews were undertaken by the clinical team using these records.

2.6 Although this review commenced with 23 families many more came into the review through a number of different channels up until July 2020. This was in response to Trust-led action, word of mouth, social media and press reports. As a consequence the review continued to change and grow throughout the period, as we describe below.

2.7 The period under review has been largely determined by the data the Trust provided to the review team and the terms of reference (TOR) formulated by the review team and NHSI. The year 2000 was identified as a starting point because the first case within the original 23 Secretary of State cohort occurred in 2000.

33 Ockenden, D. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2020) https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

2.8 The terms of reference for the review were revised in November 2019 to take account of many further families' cases coming to the review's attention. Many of these additional clinical cases came from the Trust directly reporting families to the review. For instance, a large number of additional cases were reported to the review team by the Trust following a data collection exercise referred to as the 'Open Book', in which the Trust (supported by NHSI) undertook an internal investigation to identify cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. This started as an electronic review in autumn 2018 but further cases were added later in July 2020 (Extended Open Book) after analysis of paper records held by the Trust. The Open Book and Extended Open Book exercises resulted in more than 700 cases of poor outcomes across the four categories within the period 2000-2018 being referred to the review.

2.9 As requested by NHS Improvement, (NHSI) the Ockenden review team drafted an interim report based on early findings and progress which was sent to NHSI in January 2019. Prior to this in autumn 2018 NHSI had formed an oversight committee to scrutinise the work of the Ockenden review team, comprising NHSI, RCOG, RCM and CQC, to which it circulated the interim report. This committee was subsequently withdrawn after concerns were raised by families and in the media.

2.10 The interim report was leaked to the media by an unknown source in November 2019. In response, the number of families contacting the review rose rapidly. Over the course of the review further media coverage resulting from debates in Parliament and from police enquiries resulted in large numbers of families contacting the review.

2.11 In addition, further families were referred to the review by local solicitors representing families and there were additions to the review following contact with the local coroner.

The families within the review have been assigned to a number of different cohorts as shown in Table 1.

Table 1: Family cohorts and timing on entering the review

COHORT	DESCRIPTION	YEAR
Secretary of State (SOS)	The original 23 families at the foundation of the review	2017
Original Direct Contact	Families contacted the Chair having learnt of the review through contact with other families or via social media	2018-2019
Legacy (the Trust named this the 'Legacy' cohort)	Trust-led investigation of further cases identified by the review team following scrutiny of documents pertaining to the Secretary of State cohort of 23	2018
Original post-media coverage	In response to growing media interest	2018-2019
Open Book (Trust-named)	NHSI-led data gathering at the Trust (electronic records only)	May 2019
Post-November 2019 media coverage	In response to the interim status update to NHSI which was leaked to the media	November 2019
Post-parliamentary adjournment	In response to a parliamentary adjournment debate on the review	January 2020
Solicitor	Families approached a law firm in response to media coverage which then referred them to the review team	April 2020
Extended Open Book	Trust-led data gathering (to include all paper copies of medical records)	July 2020
Post-West Mercia Police announcement	In response to West Mercia Police statement regarding the launch of an investigation	July 2020
Coroner	Coronial referrals to the review	July 2020
Saves and Learning (Trust-named)	The Trust identified a number of cases to demonstrate learning within maternity services – a selection of these cases were then passed to the review team	October 2020

Changes to the organisation of the review

2.12 By the time of the first COVID-related national lockdown in March 2020 the review had received only a small number of medical records and associated governance documents from the Trust. There were significant delays in receiving medical records from the Trust throughout 2018 and 2019 with NHS Improvement needing to intervene to try to secure the release of records on an ongoing basis.

2.13 In consequence of the growth in the size of the review's investigation NHSE&I commissioned a company to provide the review with an Electronic Document Records Management System (EDRMS) so that the team could access securely Trust medical records which were scanned and uploaded remotely. This was expedited because owing to lockdown the review team's progress was temporarily halted as the team were unable to travel to the review office. The team commenced accessing the medical records via this secure platform from July 2020. All medical records that had been received from the Trust were securely returned to the Trust once the EDRMS system was up and running.

2.14 The review's internal governance structures were adjusted in response to the high volume of enquiries from families who contacted through emails, social media and telephone calls. All of the initial family contacts were recorded, with follow-up arranged, then an assessment and full clinical reviews were conducted where required. In April 2020 a press statement was released advising the public that the review would close to new families in July 2020.

2.15 The first Ockenden report published on 10 December 2020 was outside the original terms of reference but was requested by the Minister to ensure early learning was disseminated to the Trust and the wider NHS. That first report has occasioned some delay to the publication of the final report.

Closure to new families and progression to final report

2.16 When the review closed to new families in July 2020 it confirmed that 1,862 families came within the review. This was widely reported in the media.

2.17 It should be noted that well over this number of families contacted the review; however the events experienced by some of those families fell outside the review's terms of reference and the review team advised them of the alternative routes they could explore, including approaching the Trust through the email address it had set up for families if they had any concerns.

2.18 Once the screening process had been completed there were 1,815 families for whom the review requested medical records in order to conduct full medical reviews. The reduction of 47 cases arose from a number of duplicate cases, (where for example the Trust and the review team had two different names for a woman following marriage).

2.19 After excluding cases where there were missing hospital records or where consent for participation in the review was not given or could not be obtained the final number of families included was 1,486. Some mothers had more than one incident reviewed over the period of this review and in total 1,592 clinical incidents have been reviewed.

Clinical incident categories and data validation

2.20 Families have been assigned to clinical incident categories. The four clinical incident categories described above (maternal deaths, stillbirths, neonatal deaths, and HIE) were defined by NHSI and the Trust when undertaking the Open Book data collection exercise. The remaining categories (maternal morbidity, cerebral palsy, and the combined category) were defined by the review team to encompass other clinical incidents and issues the families experienced.

Table 2: Clinical incident categories

CLINICAL INCIDENT CATEGORIES
Maternal deaths
Stillbirths
Neonatal deaths
Hypoxic ischaemic encephalopathy
Maternal morbidity
Cerebral palsy
Combined category*

**Combined category: comprises medical termination of pregnancy, missed fetal abnormality, intraventricular haemorrhage, infant death, child death*

2.21 All of the families assigned to the maternal morbidity category self-referred to the review and were largely motivated to do this following reports about the review in the media, or through speaking to other families already within the review. The Trust was aware of a few of these cases, where the family had initially raised concerns through the Trust's complaints process. However, the majority did not have any form of governance investigation, whether initiated through the Trust's clinical incident investigation process at the time of the incident or through the complaints process. The overall conclusion by the review team is that the Trust appeared not to be aware of these families' concerns.

2.22 The majority of the families in the cerebral palsy category also self-referred. Similarly, the majority of these families did not have a Trust investigation at the time of their maternity episode. Many of the families reported being concerned about their baby from the time immediately following their birth and spent a number of years trying to find out from health professionals, or through commencing litigation, why their child had been damaged.Whilst the review spans the years 2000 to 2019 it should be recognised that the review team were contacted by many families whose maternity episode at the Trust occurred before 2000 and the earliest case reviewed was in 1973.

2.23 A total of 170 families from before 2000 and 15 families from after 2019 are included in this review by agreement with NHSE&I as a variation to the original terms of reference. Reviews of these cases have been largely determined by the availability of medical records, with the team being unable to review family cases where there were no medical records. For all the cases under review the standards of care that would have been considered acceptable at the time the incident or concern occurred, and the policies and normal practice at that time, have been used as the benchmark.

2.24 Families included within the review after December 2018 are those who self-referred and a small cohort named by the Trust as 'Saves and Learning'. The families within the Saves and Learning cohort were offered to the review team by the Trust as it wished to demonstrate learning and positive service change in its approach to categorising and investigating serious incidents. Some of these cases had been investigated by the Healthcare Safety Investigation Branch (HSIB). The review team felt that as these cases were offered as examples of change and progression, the governance processes for them should also be reviewed. More detailed commentary on this cohort is included within the clinical governance chapter.

2.25 Families who contacted the review with more recent concerns about their maternity experience were referred back to the Trust to be addressed through the Trust's formal complaints process and timeline. The small number of families from 2019 who self-referred and who remained with the review were those who continued to be dissatisfied with the Trust's response to their concerns. The review includes 15 families

from 2019-2020. Some families from 2021 and 2022 also came forward wishing to share HSIB reports and their experience. The review team advised these families to contact the Trust as we were unable to consider their case due to the review being closed.

2.26 The review received some enquiries and heard accounts from a small number of families with poor maternity experiences at other NHS Trusts across England. Following discussion with NHSE&I the review team advised those families to contact the trusts concerned.

Clinical review methodology

2.27 The core review team comprised obstetricians, midwives, obstetric anaesthetists and neonatologists, with professionals from other disciplines joining the team as and when their specialist expertise was required. Over the course of the review the number of clinical reviewers recruited increased to reflect the growing number of families to be considered. The majority of reviewers retained clinical posts at NHS trusts across England, from Leeds to Plymouth, and all review team members remain on their relevant professional registers.

2.28 As the family numbers grew, the methodology for the clinical reviews underwent several iterations, with the process more efficiently managed once the bespoke electronic platform had been built. Each of the family cases has been reviewed, discussed and graded in accordance with the methodology agreed. The clinical care has been graded using a long-established grading of care[34] scoring system developed by the University of Leicester which was also used in the *Report of the Morecambe Bay Investigation*[35] (2015) by Dr Bill Kirkup.

Governance documentation

2.29 Much of this review centres on the quality of the governance processes in place within the Trust, the quality of clinical incident investigations and any subsequent learning following clinical incident investigations. In our first report, we mentioned that we had received a large volume of governance documentation from the Trust which we had yet to consider. We also reported that in the 250 cases considered to date there was evidence that some serious incidents were not investigated. Subsequently we have found that a number of these cases were investigated, but the governance documentation had not been sent to the review team.

2.30 In the summer of 2021 we were advised by the Trust that it had located many boxes of documents potentially relating to former patients and staff, which had been stored in an unused accommodation block. Subsequently it was confirmed that 171 of those boxes contained information relating to maternity cases. Initially the Trust advised the review team that the maternity governance records found were copies of information already sent to us. This was not correct.

2.31 The review had forecast completion of most of the clinical reviews by mid-August 2021 in order to commence writing the report, which was then planned for publication in December 2021. The Trust provided the review team with information relevant to the families we were aware of, undertaking the screening and sorting of this information themselves, the review team were not involved. Having received this new governance documentation concerning so many families in July 2021, concerns were escalated to NHSE&I as this meant that the reviews already undertaken would need to be reconsidered in light of the new information. Our ability to deliver a second report in December was now severely compromised. The Trust continued to send governance documentation until the end of September 2021, which we agreed as a cut-off date. At this late stage, we had received documentation concerning more than 500 families within the review meaning that each case needed to be reopened and the new documents needed to be reviewed in order to determine whether they changed the reviewer's findings and conclusions following the clinical review which had already been completed.

34 https://pubmed.ncbi.nlm.nih.gov/12390986/

35 Kirkup, B. The Report of the Morecambe Bay Investigation. (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Family voices

2.32 Many families have been offered the opportunity to meet with the chair of the review. From December 2017 until the beginning of 2020 these meetings were through one-to-one meetings in Shrewsbury. These were supported by telephone and email conversations with senior midwives working as part of the review team. Following severe flooding in the Shrewsbury area, and as the COVID pandemic ensued, video-conferencing platforms were used. Conversations were recorded and transcribed, the families were offered copies of the transcript so that they could review and add to their conversation, and the recordings were deleted.

2.33 The review has contacted the families regularly with an all families update on the review's progress. As the review grew in size and the pandemic lengthened, making travel very difficult, it was clear that the review chair would not be able to offer all families a face-to-face meeting. Instead families were invited to submit their accounts and questions via email, phone call or in writing to the review team.

2.34 Families have been offered support through a collaboration with SANDS, Bereavement Training International, and Child Bereavement UK. There is also a psychological support service provided by Midlands Partnership NHS Foundation Trust which will be discussed in detail later on in this report.

Staff Voices

2.35 The Staff Voices engagement strategy, which will be discussed in detail later in the report, was also significantly delayed. This was firstly and understandably at the request of the Trust due to the enormous pressures that it was facing due to the impact of the COVID pandemic. The Trust then delayed the launch of the Staff Voices process which was scheduled for February 2021, until April and then 11th May 2021. There were several hurdles which the review team had to overcome owing to the way that the Trust launched the process within its organisation. This, alongside the late delivery of significant amounts of governance documentation contributed to further concerns about the ability to publish this report by December 2021.

Data platform

2.36 The review team spent many hours screening telephone conversations and emails in order to ensure that the families included within the review met the terms of reference. From November 2019 it became increasingly evident that maintaining records on a system originally intended for 23 families was no longer viable.

2.37 NHSE&I were unable to either provide us access to a fit for purpose secure electronic platform or suggest any other review or public enquiry which could help with recommending a platform for holding the review data, as a review of this volume appeared to be unprecedented. In August 2020 the review commenced conversations with an external provider and were able to secure a contract for development of a bespoke data platform which could be accessed remotely. This data platform was able to securely hold family details and it enabled the review team to write up their clinical findings directly onto the platform.

2.38 The review team started using the platform in April 2021 and transferred over all data from previously completed reports, including the 250 cases reported on in the first report. This enabled the review team to work more responsively and flexibly as the majority of clinical reviewers were now working remotely.

Limitations with regard to data comparisons

2.39 There are limitations that should be acknowledged when interpreting the data presented in this review. For instance, we are unable to be certain whether all cases which meet the terms of reference between 2000 and 2019 have been identified and shared with the review. We anticipate that, using the approaches described above, most of the cases have been identified. However it remains the case, (especially with so much governance material found stored at the Trust in an inappropriate setting and provided to the review team so late in the review process) that there may have been cases that have not been provided to us.

2.40 Finally, we are also cognisant that the Trust has not provided us with information regarding families who experienced adverse outcomes more recently than December 2018, which is the cut-off date it applied in the Open Book and Extended Open Book exercises.

Working with the Shrewsbury and Telford NHS Hospital Trust

2.41 Throughout, the review has been keen to maintain good working relationships with the Trust. There have been several attempts to establish consistency and good communication by ensuring that the review team have a key point of contact at the Trust to assist with swift responses to requests. These contacts changed over time as staff joined and left the Trust.

2.42 The review team also received a very small number of emails from families who have received good care at the Trust. These were acknowledged and shared with the Trust.

Reporting progress to NHSE&I

2.43 The review team has been conscious of the time this review has taken. Following on from the publication of the first report in December 2020 the review team and NHSE&I both wished to follow this up with the final report in December 2021. As outlined earlier the delay in publication to March 2022 has been due to several factors: introducing new electronic data systems, delays in receiving information from the Trust and delays in engaging Trust staff for their views, the complexities of managing a review of this size, and the fact that most of the reviewers in the team held full-time NHS positions.

2.44 During the national COVID restrictions in January 2021, we became increasingly worried regarding the reduced availability of our clinical team owing to the pandemic pressures and the need for them to quite rightly prioritise their NHS commitments. We raised this concern with NHSE&I and with their assistance, and that of the Royal Colleges, we were able to welcome additional colleagues to the team between March and May 2021. This was essential as our projected plan between January and July 2021 was to complete in excess of 1,200 clinical reviews.

Request to delay publication

2.45 In August 2021, recognising that the December publication date was now compromised owing to the late delivery of the large amount of governance documentation from the Trust and the delay with the staff voices engagement strategy, the review team wrote to the Secretary of State for Health and Social Care raising concerns and suggesting an alternative publication date of March 2022. Following discussions this extension of time was agreed by the Parliamentary Under Secretary of State, Minister for Primary Care and Patient Safety, Maria Caulfield MP.

Family feedback

2.46 It is not possible or appropriate to publish clinical reviews of all individual families' experiences in the report. However it has always been intended that the review team would feedback to families in a way that will help them to understand what happened during their maternity care. In August 2021, the review team wrote to NHSE&I outlining the reasons why giving individualised feedback to families about what had happened in their care was so important and why the feedback should be given by the review team. This process of feedback has been agreed and will take place throughout April, May and June 2022.

Closedown of the review

2.47 The review team has used an independent legal team for advice throughout the review. In particular we have received advice on data protection aspects of the review, and will be closing down the review and archiving its records in accordance with all legislative requirements.

Cost of the review

2.48 From its inception, the review has always been mindful that it has been financed through public funding. The review chair has held senior positions within the NHS and is well aware that large budgets have to be managed accordingly with demonstrable accountability for expenditure. All costs have been clearly accounted for each month and ranged from day to day office costs, to the management of the various secure platforms.

2.49 Since 2017, it is publicly reported that the Trust (via NHS Resolution) has paid out at least £50million to families as compensation for babies who have suffered brain damage or have died. In 2018/19, across England, there were 188 successful maternity claims averaging £9.9million each, amounting to £1.86billion in total (NHS Resolution 2019)[36].

2.50 The additional hidden costs for patients of failures in clinical care include relationship breakdowns, mental health issues and ongoing family suffering, which invariably lead to an increase in demand for resources across health and social care. All of these consequences have been acknowledged, recognised and witnessed through the review team's meetings with families in the course of the review.

2.51 Whilst the review team recognises that the costs for conducting this review are significant, they are a fraction of the cost of one successful cerebral palsy claim. It is intended that our **Local Actions for Learning** and the **Immediate and Essential Actions** are deemed strong enough to continue their positive influence of enhancing the safety culture within maternity services across England, in addition to clearly stating the essential sustainable improvements required within the maternity service at the Trust. They are intended to help with the ongoing repair and restoration of public confidence and trust in maternity services both locally in Shropshire and more widely across England.

36 https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/

Chapter 3

Supporting the families during our review

Three tiers of dedicated family support

The Listening Ear service (Tiers 1 and 2)

3.1 The Listening Ear service, comprising three partner organisations: Bereavement Training International, Child Bereavement UK, and SANDS, was commissioned directly by the review team to be available for all families involved in this review. We recognised that the experience of families coming forward and their case being discussed and revisited with them would reignite difficult and painful feelings.

3.2 Key objectives of the Listening Ear service were as follows:

- To offer a support service, not a counselling service, providing in most cases a one-off listening ear session to families.
- To act as a second tier sign-posting service, providing details of national and regional support services for ongoing or specialist support.
- To provide onward referral to a dedicated team of psychologists offering specialist psychological support (Tier 3) where appropriate, or if requested by the family.

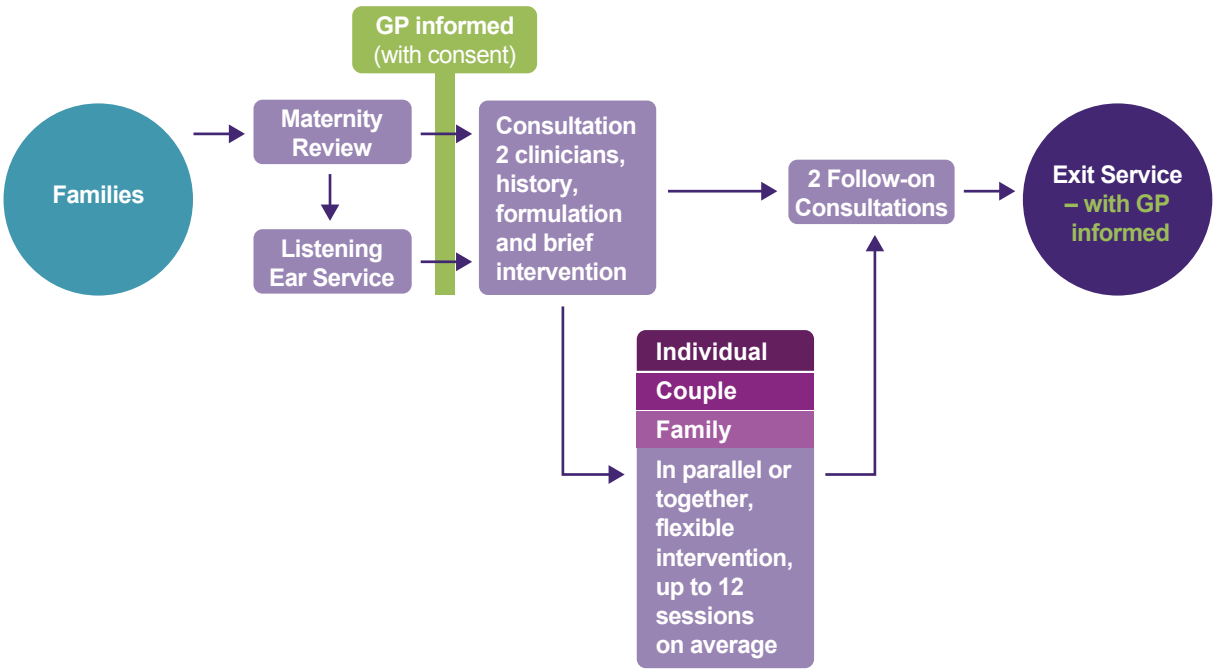
Specialist psychology service (Tier 3)

3.3 As the review team began meeting with families to review their adverse maternity experiences the Chair of the review identified that further support was needed for some families. There was recognition of a gap in service provision for those with complex grief, trauma and emotional distress. This service was beyond the scope of primary care services, but in most cases would not reach the criteria for secondary mental health services. Working in collaboration with the local clinical network and other system-wide stakeholders a specialist psychology service, hosted by Midlands Partnership NHS Foundation Trust (MPFT) and commissioned by NHS England and Improvement (NHSE&I) was established. This dedicated service was designed for families to benefit from an experienced clinician "front-loaded" model, differing from existing services which deliver a stepped model of care.

3.4 A consultant psychologist-led team was recruited to work on a flexible, and at points due to the COVID-19 pandemic remote, basis which also enabled access for those families now living out of the area. Face-to-face provision was also available to any families requesting this, where possible. The duration of support was planned for an 18 month to two year period, with key stakeholders and related care pathways across the local system involved in active, regular review of the emerging clinical data, in order to develop clear plans for transition into relevant care-pathways at the conclusion of this time-limited provision. Extension of the service beyond this timeframe for a period of 3-6 months, to the end of 2022 has recently been requested, in anticipation of the increase in demand following publication of the final report and as families begin to process its findings.

3.5 Access to the specialist psychology service has been via the maternity review team and the Listening Ear service. All families referred were offered a minimum of two consultations (an initial appointment, with the offer of 1-2 subsequent sessions as required) with two psychologists, providing them with an opportunity to feel that their experiences had been listened to and heard. Through embedding this model it was

anticipated that many families would be able to receive support and sufficient intervention at the point of consultation: promoting a positive, strengths-based model, acknowledging the resources families had drawn upon, often over many years, in their own lives to cope with what they had been through. The option of further intervention sessions with two clinicians provided the versatility of either two clinicians working with the whole family, or different parts of a family working in parallel with a different clinician. This model was designed specifically with the importance of continuity of care in mind, in order that families would not have to repeat their story. The diagram below provides an overview of the offer:



3.6 Where initial consultations indicated the need for further psychological interventions, families have been offered a range of NICE recommended treatments based on the individual formulation of their experiences. Treatments have included trauma-focussed Cognitive Behavioural Therapy[37] or CBT, Eye Movement Desensitization and Reprocessing or EMDR[38], couples therapy, and family or systemic interventions. The quality and effectiveness of these interventions has been routinely measured with the use of validated outcome measures, and bespoke client experience measures.

3.7 From the outset the specialist psychology service was developed with a clear exit strategy, remaining responsive to the needs of families, but with the flexibility to adapt the delivery and type of interventions as appropriate, given the time available. Communication with the families has been transparent to explain the scope, access and duration of the service, and with stakeholders preparing for the transition to relevant care pathways both within the NHS and wider local system at the close of this specialist provision.

3.8 Family feedback to the service has highlighted the importance to them of having a dedicated team of specialists with specific knowledge and expertise in the psychological impact of adverse maternity experiences. In particular families have valued the ease of access to the service, with an absence of waiting lists or restrictive referral criteria. Families have also reported how important to them it has been to have the experience of being listened to, understood, and believed, offering the opportunity for a restorative experience of compassionate care.

37 See glossary

38 See glossary

In conclusion

3.9 The provision of a comprehensive package of emotional and specialist psychological support available to all families involved in the review process has been central to helping them navigate the profoundly significant and potentially very painful process of their adverse maternity experiences being reviewed. Many families will have found their maternity experiences to have been life-changing, involving many layers of distress and trauma, with the ripple effects felt by whole families, the wider community, and across generations. The availability of dedicated expert support has meant that families have not had to manage this latest process alone, and have been empowered to have the opportunity to reflect on and understand what they have been through, with professionals committed to facilitating this with care and compassion.

3.10 It is strongly recommended that should any review or investigation be required in the future, this model of family support should be used to inform good practice, drawing on what has been learnt with regards to procedures, protocols and pathways. Above all, there must be recognition that any review of this nature will inevitably impact on those involved, and that the provision of emotional and psychological support should be integral to how the system responds to this need.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER OUR REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

3.11 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

3.12 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Section 2

Internal oversight and external scrutiny

- Background information about the Trust
- Chapter 4. Clinical governance
- Chapter 5. Clinical leadership
- Chapter 6. Our findings following review of family cases

Background information about the Trust

Service overview

3a.1 The maternity service at the Trust is provided as a 'hub and spoke' model with a consultant-led maternity unit surrounded by various midwifery-led units within the Shropshire region.

3a.2 The consultant maternity unit was originally based at the Royal Shrewsbury Hospital site (RSH) until 2014 when consultant-led services were transferred to the Princess Royal Hospital (PRH) site at Telford. Throughout the years there have been a number of midwifery-led units, however some of these are temporarily or permanently closed for intrapartum care due to operational reasons. The current five midwifery-led units are based at Royal Shrewsbury Hospital, the Princess Royal Hospital Telford (the Wrekin unit), Bridgnorth, Oswestry and Ludlow. At the time of publication of this report, the only midwifery-led unit providing intrapartum care is the Wrekin unit co-located (or alongside unit) at the PRH in Telford. There are additional community bases at Whitchurch and Market Drayton.

Geographical area

3a.3 The geographical area covered by the service is approximately 2,500 square miles (including the local authority areas of Shropshire, Telford and Wrekin and parts of mid-Wales). A significant amount of the catchment area is rural; this is likely to be a contributing factor to the number of midwifery-led units within the region and the Trust's ongoing community midwifery service provision.

Birth rate

3a.4 The birth rate figures below have been extracted from the Trust's maternity dashboard and are based on financial years (April - March). The birth rate is gradually decreasing; whilst a proportion of this change is recognised as being in line with the national birth rate, some staff also shared concerns with the review team that women are choosing to give birth elsewhere within the region, rather than at the Trust. One staff member told the review:

'We have a lot of women who come under the Trust's locality but they are choosing to birth elsewhere because they do not want to go there.'

Table 1. Annual birth rate at the Trust 2008 – 2020

	YEAR											
WARD	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	**5234**	**5250**	**5219**	**5240**	**5154**	**5012**	**4654**	**4859**	**4928**	**4655**	**4511**	**4422**

Reference: Shrewsbury and Telford Hospital NHS Trust Maternity Dashboard

Demographic

3a.5 The term demographic refers to the structure of a population including (but not limited to) factors such as age, ethnicity, employment and education status. Data was available from a variety of sources including local data from the Trust, as well as large-scale reports such as the Indices of Deprivation[39]. Now more than ever, it is recognised that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality[40]. Therefore, the continual monitoring of the local demographic is vital in terms of ongoing planning and provision of maternity services[41].

3a.5 The use of electronic maternity information systems (MIS) is now standard in most maternity units in England. However it is important to acknowledge that MIS data is at times incomplete, sometimes because of incomplete data capture as well as individual user input error. Missing data can also be attributed to the constraints and designs of data capture systems, however this is likely to improve with the ongoing development of electronic maternity information systems. It has been recommended that quality improvement indicators should incorporate metrics on data completeness[42].

Ethnicity

3a.6 The majority of women receiving maternity care at the Trust were reported to identify as white British[43]; whilst approximately 10 per cent of the maternity population identified as originating from a Black, Asian or Minority Ethnic background, (BAME) in comparison to a national average of 19-22 per cent[44].

3a.7 Unfortunately, there were 9,276 missing ethnic background details within the data provided by the Trust, which accounts for approximately 9 per cent of the overall data throughout the timescale of the review. It is also evident that the trend of incomplete data on ethnic background is increasing in recent years (Figure 1). The incomplete datasets are also recognised within the Trust's annual perinatal mortality reports between 2013 and 2018[45].

3a.8 Consequently, there are limitations with regard to the correlation of any trends or themes directly linked to ethnicity. However, due to the evidential links of poor maternal and neonatal outcomes of women from ethnic minority backgrounds, as previously stated, it is suggested that all trusts should aim to improve the accuracy of their datasets as part of quality and safety monitoring. Research suggests this is achievable with the use of self-declaration within maternity booking systems[46].

39 Ministry of Housing, Communities and Local Government (2019) 2019 Indices of Deprivation – Telford and Wrekin. https://www.telford.gov.uk/download/dowidnloads//15603/index_of_multiple_deprivation_2019_-_telford_and_wrekin.pdf

40 Knight, M., Bunch, T., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. Kurinczuk, JJ. (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19*. (2021) Oxford: National Perinatal Epidemiology Unit, University of Oxford.

41 NHS England and NHS Improvement. *Equity and equality. Guidance for local maternity systems.* (2021) https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

42 *National Maternity and Perinatal Audit Clinical Report 2017* https://maternityaudit.org.uk/downloads/RCOG%20NMPA%20Clinical%20Report(web).pdf

43 Shrewsbury and Telford Hospitals NHS Trust (2020). Deliveries by Ethnic category and age – 2000-2020.

44 MBRRACE-UK. *Perinatal mortality surveillance report for births* (2013-2018)

45 Ibid n7

46 Jardine, JE., Fremeaux, A., Coe, M., Urganci, IG., Pasupathy, D. and Walker, K. *Validation of ethnicity in administrative hospital data in women giving birth in England: cohort study* (2021) British Medical Journal Open, 11(8). doi: https://doi.org/10.1136/bmjopen-2021-051977

Figure 1. Number of records with incomplete ethnicity data at the Trust 2000 – 2020



Reference: Shrewsbury and Telford Hospital NHS Trust[47]

Age

3a.9 The lower and upper ranges of maternal reproductive age are recognised as a risk factor for adverse outcomes in pregnancy. Although research is limited, evidence suggests younger mothers are at increased risk of various complications including preterm birth and are more likely to have a baby with a low birth weight[48]. Mothers of advanced maternal age are recognised to be at greater risk of complications including pre-eclampsia, preterm birth, stillbirth and neonatal morbidity and mortality[49].

3a.10 Upon analysis of national data for younger mothers, it was observed that the age parameters for 'teenage pregnancy' vary. Whilst the Office for National Statistics (ONS) collates data on conception rates of women aged 15 to 17 years old, national reports into perinatal morbidity and mortality categorise 'teenage' pregnancies as mothers under 20 years old[50]. It is therefore not possible to correlate national teenage pregnancies with perinatal morbidity and mortality.

3a.11 Data from the Trust was compared with data from the ONS to identify whether there was a greater incidence of teenage pregnancies, and pregnancies to women of advanced age, within this review than the national average.

3a.12 The review team noted the Trust predominantly covers two local authority areas, Shropshire as well as Telford and Wrekin. Although the local rates of conceptions to younger mothers have fallen in line with the national average, within Telford and Wrekin teenage conception rates were consistently higher than the national average throughout the timescale of the review (Figures 2 and 3). These findings are also recognised within the Trust's annual perinatal mortality reports[51].

47 Ibid n6

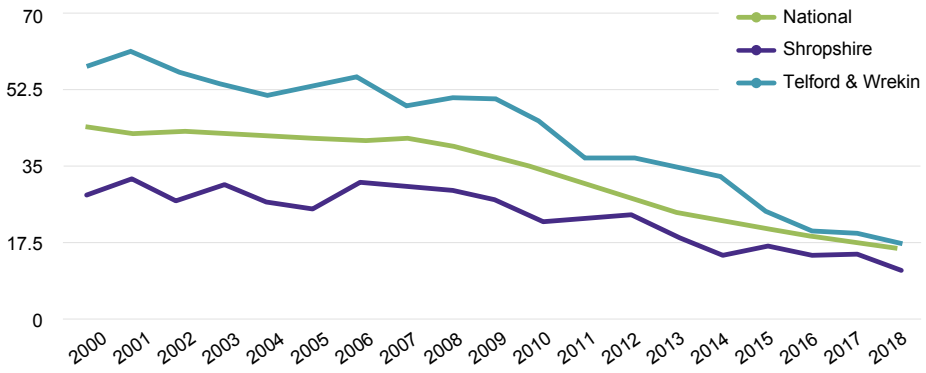
48 World Health Organisation. *Adolescent pregnancy.* (2020) https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

49 Royal College of Obstetricians and Gynaecologists. *Induction of Labour at Term in Older Mothers.* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_34.pdfe

50 Ibid n3

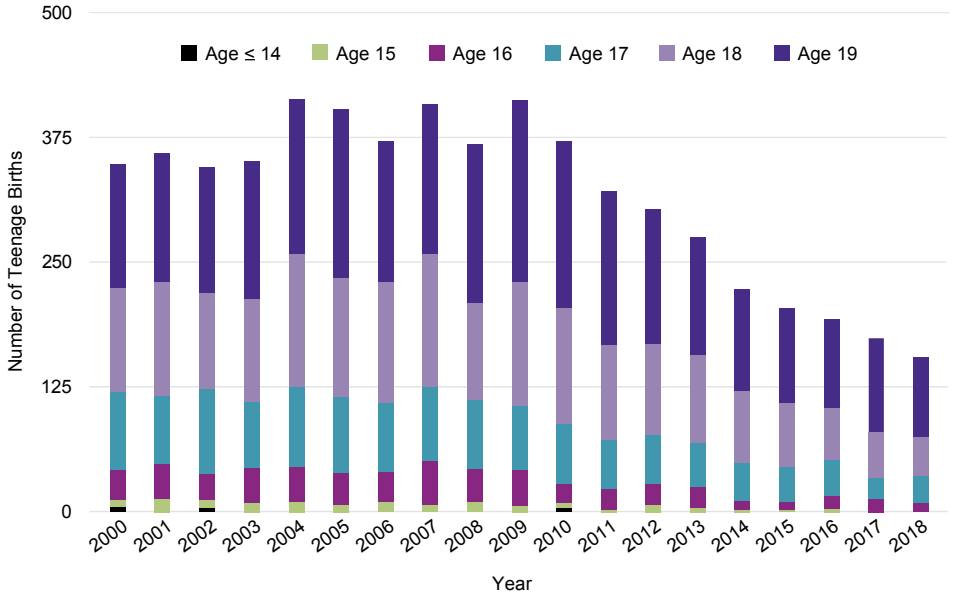
51 Ibid n7

Figure 2: Aged 15 – 17 years of age conception rates per 1000 women



Reference: ONS[52]

Figure 3: Number of teenage births (mothers under 20) at the Trust



**Data from 2019 and 2020 are not reported due to the observed discordance of the annual birth rate reported within the maternity dashboard and birth rate stratified by maternal age provided by the Trust*

Reference: Shrewsbury and Telford Hospital NHS Trust[53]

3a.13 Despite there being a higher proportion of teenage pregnancies at the Trust than the national average, teenage pregnancy cases within the review population (i.e. with adverse outcomes) comprise only 6.4 per cent of cases, which is comparable to the overall proportion of teenage pregnancies at the Trust during the timescale of the review. Consequently, the review team concluded that the increased rate of adverse outcomes observed in the Trust against the national average is unlikely to be due to teenage pregnancies.

3a.14 The incidence of women with advanced maternal age was found to be less than or similar to the national average during the timescale of the review[54]. The lower parameter of advanced maternal age is 35 years old, above which there is a statistically significant increase in the risk of stillbirth and other adverse outcomes

52 Office for National Statistics. *Conceptions in England and Wales:* 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-area-of-usual-residence

53 Ibid n6

54 Ibid n7

listed above. The proportion of women with advanced maternal age at the start of the review was 15 per cent in 2000 and gradually increased to 20 per cent in 2007, after which the proportion did not increase further. This was noted to be in line with national rates of maternities for women aged 35 years and over[55]; therefore, it should not disproportionately affect morbidity and mortality rates at the Trust.

Deprivation

3a.15 Similarly to ethnicity, social deprivation is recognised to be a significant risk factor for morbidity and mortality. MBRRACE-UK reports that women living in the most socially deprived areas[56] are three times more likely to die during or within the year that follows pregnancy than those living in the least deprived areas. Deprivation rates are monitored throughout the country by the assessment of factors such as income, employment, education, living environment, crime, health and barriers to housing.

3a.16 Throughout the time period of the review, a proportion of the geographical area covered by the Trust was regularly ranked within the top 10 per cent of the most deprived areas within the country[57]. Despite this, due to other areas within the region being classified as the 'least deprived', annual perinatal mortality reports consistently highlight the levels of deprivation as similar to the national average[58], therefore morbidity and mortality rates should not be disproportionately affected.

3a.17 The overall conclusion of the review team was that the ethnicity data (though incomplete), the deprivation rates, and the maternal age distribution for the Trust should not have caused any disproportionate effect on morbidity and mortality rates at the Trust when compared with the national average.

55 Office for National Statistics. *Birth characteristics in England and Wales:* 2019. (2020) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2019#age-of-parents

56 Ibid n3

57 Ibid n2

58 Ibid n7

Chapter 4

Clinical governance

Introduction

4.1 In line with the terms of reference of the review, this chapter aims to explore whether the local governance within maternity services at the Trust met the standards that would be reasonably expected of it between 2000 and 2019. In doing this, the review team examined a broad range of governance documents supplied by the Trust including, but not limited to, risk management documentation, minutes of meetings, job descriptions, incident notifications, investigation reports, policies, guidelines, audits and complaint responses.

4.2 Whilst acknowledging that the review covers a considerable time frame, and taking account of the fact that governance requirements changed over time, the review team found that the working practices and prevailing attitudes within the maternity service and the maternity governance team at the Trust did not pay sufficient attention to the safety of mothers and babies.

4.3 The key themes identified requiring improvement within maternity services at the Trust were:

- The poor quality of incident investigations
- Poor complaints handling
- Local concerns with statutory supervision of midwifery investigations
- Concerns with clinical guidelines and clinical audit

1. Quality of incident investigation

Background and historical context of incident investigation.

4.4 The definitions and processes for reporting and investigating incidents have changed throughout the time period of the review and therefore the review team has been careful to examine how the Trust reported and investigated incidents in relation to the expected standards at the time.

4.5 A patient safety incident is any unintended or unexpected event which can, or does, lead to harm for one or more patients receiving healthcare[59]. In 2003 the National Reporting and Learning System **(NRLS)**, which is a central database where trusts report incidents, was created and thereafter the culture of reporting incidents to improve safety in healthcare improved nationally. Serious Incidents **(SI)** are acts or omissions in care that results in unexpected or avoidable death or serious harm: 'where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified'[60] to prevent it from occurring again. However it was not until 2010 that a nationally consistent definition of what constituted a SI was published and the use of a specific methodology, Root Cause Analysis[61] **(RCA)**, was recommended for conducting these investigations[62].

59 NHS England, *Report a patient safety incident* https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/

60 NHS England, *Serious Incident Framework*, (2015) https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

61 See glossary

62 National Patient Safety Agency *National framework for reporting and learning from serious incidents requiring investigation.* (2010) https://www.afpp.org.uk/filegrab/NPSAconsultationdocument.pdf?ref=1064

4.6 In our first report, we identified some of the key issues from the 250 cases we reviewed, which included inconsistent multidisciplinary input to SI investigations which were often cursory and did not identify underlying systemic failings, and failed to learn lessons. In fact we found that some significant cases of concern were not investigated at all.

4.7 Having now considered the care of all families included in the review, in addition to the aforementioned cases for our first report, the review team has identified the following concerns regarding governance in maternity services at the Trust:

a) Incidents that should have triggered a Serious Incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review **(HRCR)**, apparently to avoid external scrutiny.

b) When serious incident investigations were conducted many were of poor quality.

c) There was a lack of learning and missed opportunities to improve safety.

d) There was a lack of oversight of serious incidents by the Trust's commissioners.

e) There were repeated persistent failings in some incident investigations as late as 2018-2019.

a. Incidents that should have triggered a serious incident investigation were inappropriately downgraded to a local investigation methodology known as a High Risk Case Review (HRCR), apparently to avoid external scrutiny

4.8 The review team has found a concerning and repeated culture at the Trust of not declaring adverse outcomes as an SI in line with the national framework. Instead, they were inappropriately downgraded and investigated by what the Trust termed a High Risk Case Review (HRCR). This method of investigating incidents, created by the Trust, was less robust, varied considerably in quality and lacked the rigour and transparency of an SI investigation. Notably, HRCRs were not reported to NHS England, the Clinical Commissioning Groups **(CCGs)** or the Trust Board, and therefore avoided external scrutiny.

4.9 In October 2021 during the 'staff voices' 'interviews the review team asked a member of staff for the circumstances in which the HRCR process started appearing within the Trust's local investigation process they responded:

4.10 *One year we were criticised for over-reporting too many Serious Incident investigations. This raised a red flag with the CCG, or the PCT or whatever it was at the time, and they said you've got an awful lot of SIs. We looked back at them and when they were reviewed again, it was decided was that some of them shouldn't have been reported as SIs, we were over-reporting. In our mind these are cases that needed significant review, so we designated them as a High-Risk Case Review, where we will spend quite considerable time looking at them and examining them and trying to learn from them because they are important, but they didn't hit the SI criteria.'*

4.11 The review team saw that frequently an early assessment was made by the maternity service that there was no act or omission in care, which meant that the investigation was downgraded to a HRCR. This meant that the true scale of serious incidents within maternity services at the Trust went unknown over a long period of time.

4.12 The earliest version of the maternity service's Risk Management Strategy available to the review team, version 5, June 2010, correctly defines a Serious Incident (or what was then termed a Serious Untoward Incident) in line with the national guidance[63] and, within section 8.7, includes a clear list of maternity-specific categories that must be investigated as an SI. This list included but was not limited to:

- Maternal death (booked at The Trust and who died up to 1 year following delivery)
- Intrauterine death: over 37 weeks gestation and during an inpatient admission
- Intrapartum death: specifically those that die during labour or during an inpatient admission

- Unexpected neonatal death: from 37 weeks gestation to 28 days post delivery
- Maternal unplanned admission to ITU
- Unexpected admission to NICU: where APGARS[64] are below 4 at 10 minutes and/or the baby has already required intubation.

4.13 Section 8.7.1 said: 'Arrangements for ensuring that all Serious Untoward Incidents undergo a root cause analysis', explains that within the maternity governance meeting 'a decision is made to whether a high risk case review is needed'. Within the document, there is no definition of what an HRCR is. In Version 6.1 from March 2014, section 9.2.9 states that an HRCR will be conducted for those cases 'where there is a poor outcome, patient experience or near miss not fitting the Serious Incident criteria. This additional scrutiny will be an opportunity for transparency, learning and service enhancement'.

4.14 The review team however, found many examples of families who met the criteria to have a full SI investigation, but had an internal HRCR conducted instead. For example, between 2011 and 2019 there were a number of maternal deaths, stillbirths, neonatal deaths and babies born with HIE where an HRCR was conducted. Where these cases correctly underwent a SI investigation, rather than an HRCR, the subsequent investigations were often found by the review team to be of poor quality. Examples of this are found throughout this chapter and other clinical chapters in this report.

4.15 This practice of conducting an internal HRCR when an SI was required is illustrated by a family in **2015**. This involved a baby born by instrumental delivery, which clearly fell outside national guidelines (this delivery occurring with 10 pulls of three sequential instruments). This baby suffered significant skull fractures, brain injury and has ongoing long-term disabilities as a result. Despite this meeting national SI criteria as an act or omission in care which resulted in serious harm[65], the decision was made to conduct an HRCR instead. The HRCR did follow an RCA approach but the quality of the investigation was poor. It did not involve the family, did not identify the root causes but instead concentrated on the incidental findings and the mitigations. Seemingly, the action plan did not offer any learning to the Trust so that similar incidents were prevented from happening again in the future.

4.16 In a typed transcript provided to the review team by the Trust, of a recording of the meeting at which the decision was made to undertake an HRCR instead of an SI for the case of this family, it is stated that an HRCR approach was utilised because *'A high risk case review has a very similar process, but it doesn't get reported to our non-executive, Health England and Tom, Dick and Harry… an SI gets reported all over the patch as far as I can see...'* This approach was taken despite the fact that following its 2014 visit the CQC highlighted its concern to the Trust about an under-reporting of SIs in maternity. There is also evidence from the same meeting that some individual members of staff present were not happy with how the investigation process was being run, with one attendee, (a staff member) insisting that the meeting was recorded. They said: *'My experience of the way that some of the investigations have been run have led me to believe that I should record this'.*

4.17 From the documentation supplied to us by the Trust the review team has been unable to identify when the Trust started using HRCRs or why they were implemented but the 2014 Maternity and Risk Management Strategy, version 6.1 stated that their aim was to *'establish a clear and complete chronology of what happened on the date of the incident and any preceding events that could have impacted on the outcome for the family'.* This is too narrowly focused and so, in many cases, an HRCR failed to identify why the incident occurred, meaning that many learning opportunities were missed. Confusingly, the HRCR investigations often used phrases such as 'Root Cause Outcome', 'RCA meeting' and 'RCA discussion', when in fact a root cause analysis was often not performed. Failing to do this properly meant that families were not given the answers they sought and deserved, the Trust did not identify the underlying issues that led to the incident occurring, and lessons were not learnt, so increasing the risk of further harm to families under the care of the Trust.

64 See glossary

65 Ibid n2

b. When Serious Incident Investigations were conducted many were of poor quality

4.18 When an SI was declared and a full RCA was conducted the quality of the reports was better than for the HRCRs, however many were still not of the standard that would have been expected. The review team has described the specific omissions with regards to serious incident investigation within the chapter on maternal deaths, however the review also found similar themes when assessing other serious adverse outcomes.

4.19 The Royal College of Obstetricians and Gynaecologists **(RCOG)** undertook an Invited Review of maternity services at Shrewsbury and Telford Hospital NHS Trust on 12–14 July 2017. This identified that the Trust's process of investigating SIs was complex and failed to adhere to recommended timescales; in one case reviewed by the RCOG team some 8 months after a stillbirth the report was still incomplete. The RCOG team also identified that the Trust's internal team conducting the investigations was not appropriately resourced or trained in RCA methodology. It also identified that there was no culture of shared learning, that the RCAs often focused on the wrong issues, lacked system wide actions and focused instead on non-specific actions such as 'share report widely' and 'learn from events'. There was no documentation that action plans were completed and recommendations often focused on individuals, rather than recommendations for system changes.

4.20 The Ockenden review team has found similar failings to those identified by the RCOG team in 2017 including long waits for families to be given answers, investigations that focused on describing what happened rather than why, a focus on individual errors rather than systemic issues, and actions that were unlikely to prevent recurrence.

4.21 *A young mother in **2013** had what the RCA described as a 'prolonged pregnancy with intrauterine death' but failed to examine why this occurred and missed causative factors identified by the review team such as lack of fetal monitoring for 15 hours during the induction of labour process. The review team also identified terminology in the Trust report which could be seen as imparting blame on the mother, suggesting that 'patients liked to be left to sleep', putting the emphasis on the mother for not reporting fetal movement concerns, rather than assessing why there was a lack of fetal monitoring. The RCA recommended that fetal viability should be assessed at least once per shift and the Maternity Governance meeting (06.08.13) 'Confirmed with the… manager, [this recommendation was] now embedded in practice and agreed that manager to undertake audit'. The review team however has found no evidence that an audit was undertaken and even within the Trust's 2017 v5.5 Induction of Labour guideline, there is no evidence this practice has been embedded. (2013)*

4.22 *In **2015**, a family did not receive an apology from the Trust, were not involved in the investigation, were not asked to submit questions and waited over 12 months to find out why they suffered an intrapartum stillbirth. The subsequent report focused on individual errors, for example "educational need for midwife – sticker regarding fetal movements absent" and missed the systemic issues contributing to the incident. (2015)*

4.23 *In **2015**, a family waited more than 9 months for an SI to be declared after they suffered an early neonatal death, despite the Trust's 2014 Maternity Service's Risk Management Strategy Version 6.1 stating an SI should have been conducted from the outset. The RCA described the cause of death as a 'sub-acute cord compression leading to acute cord obstruction', but failed to identify why this happened. There was no mention of concerns identified by this review team such as a failure to upgrade intrapartum care to a high risk pathway, and staffing issues and shortages meaning that 1:1 care could not be provided. There was also a failure to monitor the fetal heart rate adequately. This lack of attention to the root cause of the incident meant the systemic issues related to why the incident occurred were not identified and the recommendations that were made did not address the systemic issues within the Trust's maternity services at the time. (2015)*

4.24 In later years there is evidence of improvement in the quality of some SI investigations. In **2017**, a family suffered a similar incident to earlier cases, namely an intrauterine death whilst awaiting an induction of

labour in hospital. The RCA identified multiple systemic and organisational issues resulting in a delay in transferring the mother to the labour ward. The recommendations focused on addressing the issues that created the delay, for example the closure of triage at 8pm putting additional pressure on the labour ward, and how these could be addressed. The report also highlighted that there was *'a culture of normalising long waits for women undergoing induction of labour, who are ready to be transferred to the delivery suite [labour ward] when the delivery suite is busy'*. It should be acknowledged that this was highlighted and multiple recommendations were focused on making improvements. However the review team is of the opinion that the poor investigation of the earlier incident from 2013 represents a missed opportunity to improve and to potentially prevent future incidents, such as this incident in 2017.

c. Lack of learning and missed opportunities to improve safety

4.25 Once investigations were conducted the review team still found there were multiple missed opportunities for the Trust's maternity service to learn, improve and prevent future harm occurring to other women and babies.

4.26 There have been some attempts to improve the safety culture and learn from incidents. In June 2017 the Trust conducted an internal review[66] of maternity services. It considered the history of maternity services between 2007 and 2017, focussed on issues of patient safety, learning, and engagement with bereaved parents. The report further stated that the service must 'create a coordinated approach to the maternity safety improvement plan' and that 'safety in maternity is protected by the efforts of the staff and supported by leaders'. The review concluded that 'all patient safety actions should be in one plan against a framework that makes sense to the staff that run the service'. As of January 2022, the review team has not been provided with this action plan or seen any evidence of its existence in the information provided by the Trust and therefore we cannot comment on the efforts made and any impact of this plan in improving learning and safety at the Trust.

4.27 *In **2010** a woman developed chorioamnionitis[67] and the baby was born in a poor condition, requiring cardiac massage, and subsequently developed brain damage. At the time there was no incident report completed, no review of the care provided, no investigation performed and therefore no learning. In 2018, the Trust asked external experts to review the care provided to the family and they found that the CTG heart monitoring was abnormal for most of the duration of the labour and that there was a lack of obstetric reviews despite midwifery concerns. Oxytocin was started and increased inappropriately when the CTG was abnormal and was also increased despite hyperstimulation in the second stage. They also found that there was a long period of fetal bradycardia not acted upon, and despite performing an instrumental delivery with meconium present the neonatal team were not called to be present at the delivery. This was not one failing in care, but multiple failings. What is clear from the intrapartum section of this report is that issues with the inappropriate use of oxytocin, amongst other failings identified in this case, did continue after 2010.*

4.28 *The lack of investigation in **2010** for a family resulted in a missed opportunity to learn and, due to this it is likely to have resulted in similar situations occurring to other women. Also concerning is that the family were seen a week after the birth of their baby by an obstetric consultant who explained that 'You made good progress in labour and had a very straightforward ventouse delivery for delay in the second stage of labour. Your baby's condition was much unexpected… what is very confusing is that the continuous heart rate monitoring that was performed during labour did not show any signs of your baby becoming distressed and this is unusual'. This was either an unintentional misunderstanding of the clinical situation or a purposeful lack of transparency and honesty. Either way, this follow-up and review was not fit for purpose. The poor governance processes at the time meant that this family waited 8 years to find out there had been significant failings in care that led to their child suffering brain damage. (2010)*

66 Review of Maternity Services 2007 – 2017 by Colin Ovington, on behalf of the Quality and Safety Committee, dated 27th June 2017, provided to the review team by the Trust

67 See glossary

4.29 The review team also found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm. The following three examples over a 12-year period demonstrate exactly this:

4.30 *Firstly, in **2006** a child was born with brain damage (HIE) after the mother developed an infection (chorioamnionitis) due, in part, to multiple inappropriate vaginal examinations after her waters had broken before she was in labour. No investigation was done, no learning identified and therefore no actions were taken to prevent a recurrence. (2006)*

4.31 *Secondly, in **2011** a child developed multiple long term disabilities secondary to inappropriate care in a similar situation (waters breaking before labour). Despite the baby spending 23 days on the neonatal unit there was no investigation performed and again, a missed opportunity for learning. The Trust acknowledged at the time that the 2004 guideline followed at the time was inappropriate and 'very out of date'. Nevertheless, it was still not updated for another three years until 2014. (2011)*

4.32 *Thirdly, in **2015** a very similar incident occurred, with repeated unnecessary vaginal examinations despite the woman's waters having been broken for more than 48 hours before labour and this subsequently led to an infection (chorioamnionitis) and a poor outcome for the baby This poor outcome could potentially have been prevented had investigations been conducted in previous years following competent and appropriate multi-professional governance processes by a team with a willingness to learn. (2015)*

4.33 *In **2016**, the Trust had a second opportunity to review the care provided to a family but this opportunity was again missed. The mother initially made a complaint but after receiving an inadequate response from the Trust, contacted the Parliamentary and Health Service Ombudsman (PHSO[68]), who conducted a review in 2018 and identified failings in care. It was only at this point, three years after this third incident, that the Trust created an action plan to reduce the likelihood of recurrence in the future. The review team however has been unable to find any clear evidence from the information supplied to us by the Trust that the change following the PHSO report has been implemented. (2016)*

4.34 Sadly, the review team encountered many further examples of repeated missed opportunities to learn:

*In **2009** a baby born at the Trust was admitted to the neonatal unit with severe hypoxia and suspected HIE. The baby subsequently died within 12 months of birth due to complications from severe cerebral palsy. There was no investigation performed after the baby was admitted to the neonatal unit with HIE and a missed opportunity for improvement. After the birth the parents met with two consultants who could not identify what went wrong and decided against asking for an external investigation. (2009)*

4.35 *In **2010**, the Trust had a further opportunity to review this case after receiving a complaint letter from the family. However the family have explained to the review team that this response lacked sympathy and compassion and again did not identify any failings in care. The issue of a lack of learning is multi-professional and the neonatal team did not review the care they provided either. Subsequently a letter to the GP from the consultant obstetrician explained that the labour care was 'appropriate' and nothing could have been done differently.*

4.36 *It was only after a second complaint response in **2017**, with a new Chief Executive at the Trust that an external investigation was conducted. In 2018, 9 years after the initial incident occurred, an investigation*

68 See references – various documents on PHSO consulted for this chapter inc:

1. Parliamentary and Health Service Ombudsman (PHSO). Learning from mistakes. 2016.
2. Parliamentary and Health Service Ombudsman (PHSO). A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. 2015.
3. House of Commons Public Administration and Constitutional Affairs Committee. Will the
4. NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England. 2017.

identified multiple failings, substandard care and that the delivery should have been sooner. Despite the long delay and the multiple failings, the review team could not find any evidence that this report was shared with the family.

4.37 *In **2011** a woman was inappropriately discharged home with severe pre-eclampsia and subsequently had an eclamptic seizure within 24 hours. No incident form was completed, no investigation occurred (2011)*

4.38 *A mother at 36 weeks gestation with diabetes whose antenatal CTG was persistently abnormal for 3 days whilst in hospital, which should have prompted delivery, was discharged home without a plan in place and subsequently her baby died (2011)*

4.39 In the second case above the review team found the care provided to the mother to be significantly suboptimal, however only a cursory internal review was conducted, (notably the CTGs had disappeared) and no clear recommendations for improvement were made.

4.40 The review team also identified that many governance documents between 2009 and 2019 included the following inappropriate images. These images were found on multiple SI reviews, HRCR reviews, minutes of maternity governance meetings, quarterly maternity safety reports, patient safety events, feedback of learning documents and an external letter to the ambulance service. The review team felt that having such images on governance documents was insensitive and demonstrated a lack of professionalism.





d. Lack of oversight of Serious Incidents by the Trust's commissioners

4.41 When an SI investigation is completed locally, it is reviewed by the local Clinical Commissioning Group (CCG) for approval and closure if the investigation and action plan are deemed appropriate. Previous national reports have highlighted concerns that despite closure of incidents, once external scrutiny is applied to the original investigations they are often found to be of poor quality, thereby questioning the oversight of commissioners in this process[69]. The review team also identified extensive and repeated concerns with the quality of SIs undertaken by the Trust, which may indicate a lack of external scrutiny.

4.42 The Telford and Wrekin, and Shropshire, CCGs undertook a review of the Trust's maternity services which was published in 2013 and found the Trust was *'a safe and good quality service, which is delivered in a learning organisation'*[70]. The commissioners' review of risk management focused on reported SIs and near misses in the period 1 April 2012 to 31 March 2013, which was likely to have underestimated the scale and volume of incidents. It also looked at policies, clinical governance systems, care pathways, and training, and concluded that: *'There was an openness and transparency in reporting and investigation culture,*

69 *Magro M, Learning from five years of cerebral palsy litigation claims.* (2017) NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2017/09/Five-years-of-cerebral-palsy-claims_A-thematic-review-of-NHS-Resolution-data.pdf

70 Telford and Wrekin Clinical Commissioning Group, Shropshire Clinical Commissioning Group, *Maternity Services Review: The Shrewsbury and Telford Hospital NHS Trust* (2013) https://apps.telford.gov.uk/CouncilAndDemocracy/Meetings/Download/MTU5OTY%3D

which has led to a higher reporting of serious incidents than would have been reported elsewhere'. The review stated further *'There is a robust approach to risk management, clinical governance, and learning from incidents'.* The review team has identified failings in a lack of incident reporting, low levels of SIs being declared, poor quality RCAs and investigations where lessons are not learnt and further harm is caused at the same time. These failings beg the question as to whether the CCG review process was fit for purpose.

e. Persistent failings in incident investigations as late as 2018-2019

4.43 The Trust shared with the review team a selection of self-selected maternity incident investigations from 2019 which the Trust entitled 'Saves and Learning.' These maternity cases were submitted to the review team with the aim of demonstrating improvements in maternity investigation methodology during the latter years and as examples of good practice. There were 12 cases in total. The total number of maternity incidents occurring in the Trust during 2019 are unknown. Improvements in investigation processes have been developed since 2018 and there is now more focus on learning and feedback in different forums, however what is not clear from the evidence seen by the review team is whether these forums are open to all staff groups and whether staff are enabled and encouraged to attend. Extracts from the Maternity and Neonatal Collaboration Survey in 2018[71] demonstrate that staff felt that feedback from incidents was still not disseminated as well as it could have been *'Ensure feedback from any incidents is clearly communicated to staff to ensure continued staff learning and development'.*

4.44 The 'Saves and Learning' investigations demonstrated improvements in asking families to contribute to investigations, they were asked to forward their concerns and recollections or attend a meeting if preferred. There was also improved oversight of the recommendations and actions at governance meetings and when actions were delayed, the review team saw evidence that there was timely follow up with action leads. However, the review team identified from the small sample provided by the Trust that the local processes needed to be further improved, in particular:

- There was a lack of consistency in the seniority and staff groups that attended the rapid review meetings and the panels did not comprise of staff members senior enough to decide on the level of investigation.
- There was no oversight or accountability from the Director of Midwifery nor the Clinical Director for obstetrics or the consultant lead for risk.
- There was still a reluctance to declare an SI and in most cases a HRCR was still conducted, when an SI would be the appropriate investigation.
- Actions did not always correlate with the findings of the investigation.
- Action plans were monitored by the quality improvement midwife however there was no evidence in the cases reviewed that they were overseen by the senior leadership team. During the staff voices meetings in late 2021 a member from the senior Trust team raised concerns to the review on the suitability of staff who were responsible for quality improvement and safety. They explained that staff were promoted to roles without previous substantive clinical experience and without any means of formal support.
- Significant delays in completing all of the 12 Saves and Learning cases from 2019 that were shared with the review team by the Trust.
- Despite families being asked to contribute to the investigation they were not actively involved or empowered to do so. This is in stark contrast to the recommendations from NHS Resolution[72] that

71 Maternity and Neonatal Collaboration survey 2018, provided by the Trust

72 Ibid n11

women and their families should be actively involved in investigations. Best practice from HSIB[73] shows that with a dedicated focus on actively encouraging families to be involved, 86% of families within maternity investigations will engage with investigations.

- In discussing the safety of the unit and the robustness of governance processes, during the time they worked there, some staff showed a willingness to bring in changes to improve safety in an unsupportive system. When asked if the unit was safe they responded: *'I don't … I don't even know if I can answer that. I felt it was safe on a day-to-day business basis, based on day-to-day firefighting and operational exhaustion from people trying to do the right thing'.*

4.45 Despite the improvements the Trust believes it has made, anonymised extracts from the Maternity and Neonatal Collaboration Survey in 2018 demonstrate concerns by their own staff regarding an unsupportive culture and one of blame following SI investigations. One extract included *'I am concerned that midwives who have made errors are treated badly, one midwife was on the verge of suicide due to the way she was treated in her involvement in a SI. More support and care, counselling and help needed in these situations so that the practitioner is not pushed to breaking point or self-harm from intense pressure.'* Another contributor to the same 2018 survey said: *'senior management in care group or above not understanding real issues. Not learning from mistakes'.*

4.46 These findings by the review team differ from the publicly presented findings of two external reviews; firstly, the addendum to the RCOG Review of Maternity Services on 27 April 2018[74]. The original report, which was more critical, had been completed in 2017, but was not presented to the Trust's Board until an addendum had been prepared which highlighted a much more positive situation with risk management than actually existed. This is discussed in more detail elsewhere in this report. The 2018 addendum to the 2017 RCOG report stated that: *'The Care Group has strengthened its risk management structure, risk management meetings are held regularly and rapid review meetings following incidents are executive led' and that 'RCA investigations follow the NHS Improvement SI Framework'.* Secondly, the 2019 CQC[75] report of maternity services at Princess Royal which felt that *'the service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service'.*

4.47 Patient safety relies on maternity services receiving appropriate and timely feedback from regulating bodies to ensure improvements can be made and in these examples above the external systems for review and monitoring of the Trust seem to have failed.

2. Poor complaints handling

4.48 Effective local complaints handling is a part of good clinical governance, enshrined in the NHS Constitution[76]. Done well and in a timely manner, a complaint response can provide patients and families with the answers they deserve, allows areas of concern to be identified and can be used to analyse trends to improve services. In Wales[77] the NHS has published extensively on the benefits of complaints to a service. The review team identified that the Trust performed poorly in all of these areas and identified the following concerns:

a) Lack of senior oversight and input into complaints handling and patient experience

b) Lack of openness and transparency.

73 Healthcare Safety Investigation Branch *Annual Review 2020/21* (2021) https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/HSIB_Annual_Review_Brochure_2020-21_FINAL.pdf

74 Shrewsbury and Telford Hospitals NHS Trust Board Report (2018) outlining the Royal College of Obstetricians and Gynaecologists review of maternity services. https://www.sath.nhs.uk/wp-content/uploads/2018/07/12-RCOG-Report.pdf

75 CQC report provided by the Trust to the review team, site visits were November 2019 and the report published in January 2020

76 NHS Constitution; NHS Complaints Guide, (updated January 2021). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/how-do-i-give-feedback-or-make-a-complaint-about-an-nhs-service [Accessed on 28 October 2021]

77 NHS Wales Using the gift of complaints (2014) http://www.wales.nhs.uk/usingthegiftofcomplaints

a. Lack of senior oversight and input into complaints handling and patient experience

4.49 The review team identified that there was a lack of input from senior members of the leadership team in the writing, review, approval, quality control and trend analysis of complaints. There is no evidence available that the Head of Midwifery, Director of Midwifery and Clinical Director were ever advisory on complaint responses before they were sent to the Trust's Patient Experience Team for the then CEO's signoff. Neither is there any evidence, that complaint themes and trends were analysed and used proactively to improve the service. Even in the latter years of the review period it was unclear what structure was in place for answering complaints and where the accountability lies.

4.50 The review team identified that in 2009, the Trust created a Patient Experience Midwife post. This role was created to provide an effective and timely complaints and claims procedure framework. One of the main objectives of the role was to develop a patient involvement strategy to contribute to the clinical governance agenda and to maternity service development. This role and scope was innovative for the time, however there is no evidence shared with the review team that the objectives of the role were actually ever met. Despite the creation of this role many years earlier there has been no documentation provided of a patient experience strategy or any evidence seen that the Maternity Services Liaison Committee **(MSLC)** or (from 2017) that Maternity Voices Partnership **(MVP)** meetings were included within the terms of reference for clinical governance meetings.

4.51 Whilst the review team acknowledges that the role and job description was forward thinking, the patient experience midwife post lacked the required experience and authority to lead on patient experience, complaints and claims. This meant that from its introduction the post was undervalued. Additionally, it devolved responsibility and oversight from the divisional senior leadership team to members of staff who had no real influence in changing practice.

4.52 Between 2007 and 2013 it appears from information provided by the Trust that complaints were managed between two members of staff who worked part time, one of them a retired member of staff who returned to work one day a week.

4.53 One staff member described the process of responding to a complaint to the maternity review team as: *'[the second midwife] would look up some of the notes or [they] would get information, [they] would start to put a response together and then I would look at it, tidy it up or ask for more information when I came in. The actual complaint came in and we started to look at the notes, look at all the things that had been written down and then talked to the people that were involved in that case. Then from their comments and from what was written and from the patient's letter, we started to investigate what had happened and understand what had happened and then try to put a response together for the patient. Those all had to go, of course, to the Chief Executive office because they all go out in [their] name, not ours'*. There was no evidence that other members of the maternity department contributed, or that responses were reviewed before being sent to the CEO for approval.

4.54 With regards to trend analysis, the review team has seen evidence that complaint trends were identified at maternity governance meetings but there was no evidence that actions were taken to prevent similar incidents occurring. In 2009, the Clinical Director informed the members at the maternity governance meeting about the existence of a separate monthly meeting where complaint themes were discussed and that monitoring of actions would occur at the maternity governance meeting. The review team however has seen no evidence that this forum was ever formed and no evidence of action plans being presented to the governance meeting.

b. Lack of openness and transparency

4.55 There is evidence that complaint responses lacked transparency and honesty, especially with regards to clinical care. The review team has identified families where care was sub-optimal, where different management would likely have made a difference to the outcome, however the complaint responses

justified actions, delays and omissions in care. In addition, they often lacked compassion and in a number of responses it was implied that the woman herself was to blame.

4.56 There are examples of families whose complaint letters were dismissed, only for external investigations, sometimes many years later, to identify failings which should have been evident at the time, had a thorough complaints investigation been conducted.

4.57 *In one example from **2013** a baby was born in a midwifery-led unit and diagnosed with Hypoxic Ischemic Encephalopathy (HIE) secondary, due to a failure to monitor the fetal heart rate (FHR) appropriately in labour. The complaint response from the CEO stated that the fetal heart rate was normal, and that it was recorded at specified intervals of every 30 minutes in labour. The multi-professional review team did not agree that the heart rate was normal and thinks the response to the family is incorrect. (2013)*

4.58 On a number of occasions parents wrote to the Trust find out whether their case had been investigated, often in situations where an investigation should have been conducted and the family involved from the outset; cases range from intrapartum deaths to severe physical and developmental disabilities.

4.59 *After complaining in **2009** a mother reported to the review team that: 'The response to my complaint made me so angry. It didn't address any of my concerns…and was misspelt.' (2009)*

4.60 *In **2009** another family wrote to the Trust pleading for them to open an investigation into the death of their baby, requesting to be involved in the investigation and asked whether if things were done differently the outcome would have been different. In the response received the Trust said: 'The protocols for dealing with CTGs are clear and laid down for all staff. All staff, both midwives and doctors receive updates on the interpretation of CTG traces every 6 months. The loss of X was unexpected therefore difficult to prevent as [the] CTG trace was not indicative of an at-risk fetus that needed immediately delivery. If every dubious or worrying CTG resulted in an emergency caesarean section then ⅓ of all women would be delivered surgically'.*

4.61 The Trust continued: *'Patients cannot demand a caesarean section. They can request one and discuss the issues with the consultant but if the attending medic does not agree that a caesarean is necessary they will not undertake one'.* (2009)

4.62 This is a tragic case of a neonatal death where an independent investigation undertaken in 2018 identified significant failings in care and also a failure of the Trust at the time to learn lessons and recognise that earlier delivery could have altered the outcome for this family.

4.63 *In **2018** an investigation was started without the woman being told an investigation was ongoing or being asked to contribute. This is despite Duty of Candour[78] being well embedded nationally and being a legal requirement. The family received a written complaint response that outlined actions the Trust had put in place and completed but at a subsequent complaint meeting the parents questioned the honesty and transparency of the written response as the actions had not started at the time of the meeting. The family said: 'It's the fact that, when all this first happened, we went through an awful lot…and to be told that you had spoken to Dr X. Dr X had completed some key learns and due to that, you thought nothing was wrong, so you closed the investigation…but since then, obviously, we've found out that none of that actually took place'. (2018)*

3. Local concerns with statutory supervision of midwifery investigations

4.64 The overarching responsibility of the Local Supervisory Authority (LSA) and Midwifery Supervision was to protect the public by monitoring midwives' fitness to practice and instigate remedial actions where necessary.

78 General Medical Council, The professional duty of candour https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

4.65 From 2001, the Nursing and Midwifery Council **(NMC)** gave powers to the midwifery body, composed of trained Supervisors of Midwives **(SoMs)**, in the form of statutory supervision in accordance with the NMC's rules and standards to regulate midwives. Supervision was subsequently removed from statute in 2017 and replaced by a new model which was based on midwifery education and quality improvement. The review team has considered the role of midwifery supervision in-line with what was current practice from 2000 to 2017.

4.66 As a consequence of family complaints there were a number of independent reviews commissioned into the quality of supervisory investigations undertaken by SoMs at the Trust. From the governance documents the review team has received from the Trust there is minimal evidence that investigations were taking place, however there are some SoM updates within the maternity governance reports which indicate that investigations were taking place. We have received a small number of investigation reports which were of poor quality and which, from their dates, appear to have been conducted many years after the incident.

4.67 A significant number of SoM investigations provided by the Trust to the review team were all dated during one week in December 2016 and written by a single SoM. Some of these investigations related to incidents that occurred over 10 years prior. The review team were informed that this was due to a member of staff recognising that the original investigations lacked objectivity, with gaps in their quality.

4.68 This appears to be a conscious attempt to identify any significant practice issues, however it is unclear whether the midwives involved in the older clinical incidents received feedback - although this would have been out of date given the length of time since many of the incidents took place.

Findings from an RCA review and supervisory records:

4.69 A family experienced an unexpected admission of a term baby to the neonatal unit in **2015**, with the baby subsequently dying aged 5 months. A rapid response meeting was held to review the care and identify any immediate learning. At this meeting there were no identified SoMs present.

4.70 This initial review recommended that, due to the potential for long term harm, the RCA level should be undertaken as a serious incident. The supervision, (SoM) team was notified 2 weeks after the incident and a supervisory investigation was undertaken a month later. The investigation went ahead, however there was no chronology to benchmark the midwifery care against the standards of care at the time. From the initial 72 hour review there appeared to be a primary fixation on the lack of differentiation between the maternal and fetal heart rate, contributing to the difficulty in interpreting the fetal heart rate.

4.71 At this first meeting, it is unclear whether the maternity team considered the overall picture of this mother's labour. A further rapid review meeting was held 3 weeks later. The discussion at this stage still failed to demonstrate a detailed understanding of the 66 minute period when the fetal head was on the perineum, at a time when the umbilical cord will have been compressed. (2015)

How staff members described the SoM team:

4.72 Staff members described to the review team that the culture of the SoM team between 2010 and 2016 was discriminatory and non-inclusive. The review team heard from a midwife, in October 2021 who stated that they '*never felt [they} could fit in with the culture of the unit and were made to feel like an outsider by [their] colleagues'.* Though initially supported upon qualification to undertake the SoM Preparation Course [X] was not appointed into a SoM role because 'the existing SoM team did not want [X] appointed'.

4.73 Another member of staff raised concerns that SoM investigations were not transparent or fair and lacked rigour: *'I started to see gaps and I started to point them out and say, "Well actually, look, we've got the same people. The same people are involved in these reviews. The same people did the supervisory investigations, the same people marked them, the same people in the LSA marked them, we've got these patterns".'* It is evident that staff raised concerns about the quality of the investigations at the time, and

some conscious attempts were made to establish some objectivity, the same staff member added: *'There were reviews from a supervisory perspective and we still just about had supervision then [2016] so we did do that and we did some deep dives into…so we did reviews, but if you like, we were still marking our own homework.'*

External reviews of the SoM function at the Trust

4.74 Information provided to the review team indicates that there have been two external independent reviews of a midwifery supervisory investigation previously undertaken by the Trust's SoMs. The Local Supervising Authority Midwifery Officer (LSAMO) – the senior person who was responsible for upholding the standards of midwifery supervision at a regional level - Annual Report April 2014 – March 2015 stated that a complaint was received regarding the LSA function during the 2014-2015 supervisory year. The complaint related to a family who requested a review of a supervisory investigation in relation to the birth of their daughter in 2009. The family were gravely concerned at the lack of quality and accuracy of the initial investigation.

4.75 The external review concluded that the quality of the supervisory investigation was poor. There were a number of inaccuracies in the timeline and events, the facts of the incident were not established and the principles of the midwifery supervisory investigation were not adhered to. In the period between the initial investigation and the external report in 2015, there was no local learning or safeguarding of the public during a 6 year hiatus. Following the external review, the investigating SoM was found to be unsuitable for the role and they were removed from their supervisory duties by the LSAMO.

4.76 The second independent review was of a case of maternal death and intrauterine death. It was commissioned by the regional Chief Nurse in 2016. From information provided to the review team we found that the original investigation is incomplete, and has focused on the methodology of the investigation rather than the actual investigation of the incident.

4.77 The external investigation identified that two of the nine midwives who cared for the family would benefit from more support and development and the remaining seven should reflect on the care they provided. The original Trust investigation had only reviewed the care of one midwife and found no further learning was required. It had concluded that there were not any serious concerns in relation to midwifery practice.

4.78 The review team considered the language used at times in the reports seem to be inappropriate for the tragic outcomes and impact on the whole family. When discussing a meeting with family members as part of the investigation, they used terms such as the family being 'brave'. The external reviewers thanked the family member for involvement in the second review and described their 'graciousness' for taking part in the investigation.

4.79 The review team's opinion is that the external (or second) investigation also failed to identify that with improved care the outcome for the woman could have been significantly different. The first investigation failed to identify any systemic issues around CTG interpretation and sepsis management, which were relevant, factors. It was also felt by the review team that the few recommendations for improvements made would not have prevented a similar situation occurring in the future. The second investigation relied on the presumed cause of death (amniotic fluid embolism) as 'unavoidable' and therefore did not address salient issues particularly around the identification and management of the critically ill mother, sound escalation plans and multidisciplinary team working.

4.80 Two years after the mother's tragic death, the external assessors acknowledged that some of the recommendations for improved care were still *'in progress'.* It is the review team's opinion that despite being a second investigation the LSA (external) investigation still missed significant points for learning, and improvement, specifically that had the sepsis been treated more promptly earlier, that the outcome might have been significantly different.

Causes of supervisory failings and failure to learn:

4.81 The review team identified the causes of supervisory failings as:

- The supervision function was not independent from the management team, therefore the same people scrutinised clinical incidents regardless of whether this was a supervisory review or not.
- The short staffing levels did not appear to provide supervisors with protected time to carry out supervisory activities.
- A lack of involvement of supervisors in risk management and incident reviews which prevented them from identifying the incidents that warranted supervisory review.
- A lack of integration between supervision and clinical governance.
- A lack of leadership within the maternity governance structure.

4. Concerns relating to clinical guidelines and audits

4.82 The writing, review and use of clinical guidelines to inform best practice and the conducting of clinical audits to monitor compliance with these guidelines is an integral part of ensuring a service is safe. The review team has identified the following concerns:

a) A lack of multidisciplinary input into guideline management and audits

b) A lack of a change in practice and monitoring of compliance in response to clinical incidents

c) The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

a. A lack of multidisciplinary input into guideline management and audits

4.83 Before 2010, and following review of the guidelines supplied to the review team by the Trust, the approach to guideline and protocol management lacked a multidisciplinary approach at the Trust. Guidelines appeared to have been drafted by midwifery staff, with no input or oversight by the obstetric consultants.

4.84 From 2012 onwards the review team identified a named guidelines midwife in post, and identified that subsequent to this, there was a more consistent approach to how guidelines were written, reviewed and then referenced. The review team were unable to find evidence of a named obstetric lead, and obstetric input was not well defined, which meant that there was a lack of multidisciplinary input into guideline management. A member of staff stated '*practice wasn't evidence-based but there was nobody qualified, competent or capable to update guidelines or to even write guidelines. They didn't have very many and what they had weren't evidence-based...I know full well that their guidelines were woefully out of date'.*

4.85 With regard to audits, there is evidence supplied by the Trust of formal registration of women's and children's audits throughout the review period, forming part of the yearly corporate audit plan. This is in line with general practice in maternity units and the majority were conducted by an audit midwife with only a small number, in comparison, having obstetrician involvement. Anaesthetists were involved in audits in earlier years, then no longer featured at the audit meetings and their involvement in maternity audits was not seen in recent years.

4.86 Experience from the multidisciplinary members of the review team is that good practice for most maternity units would be for audit meetings to be multidisciplinary, where all clinicians learn together. The review team noted that the attendance record at audit meetings, especially prior to 2012, demonstrated that, in general, very few midwifery and nursing staff attended, with no midwives present at some. The meetings were often obstetrician-led, attended by the obstetric team and had obstetricians conducting the audits. This shows a culture of exclusion and disparity between the staff groups. After 2012 there was clearly a shift, as most audits were midwife-led, usually by the audit midwife with little involvement by other staff groups. Actions to try to improve obstetric attendance were noted at meetings as late as July 2017.

4.87 For example, in September 2018 the operative vaginal delivery audit was conducted by a midwife and demonstrated that no analgesia was used for ventouse deliveries. The review team felt this was unlikely to be correct, as it would be surprising if none of the women who had a ventouse had an epidural, which is known to increase the risk of instrumental delivery. However, a suggestion was made at audit meetings for this to be investigated and for consultants to supervise future audits with the aim that their presence would promote evidence-based practice and influence a change in practice. The lack of obstetric involvement in the initial audit would have made it difficult for the auditor to develop a robust plan to effect change as it is based on the individual's limited knowledge and experience on the subject.

4.88 Audits were also presented within the maternity governance meetings which to 2012 were mostly attended by midwifery staff. After this time, the review team has noted good attendance by consultant obstetricians and midwives but attendance by junior medical staff was often lacking. The updating of guidelines and leaflets was a regular item on the agenda, however this item was often cancelled when there were more pressing matters being discussed, at the expense of guideline updates.

4.89 Maternity audit action plans were also agreed at these meetings, but discussion when it occurred commonly appeared as perfunctory which was inappropriate as the forum did not have full representation and authority to make decisions. Many action plans merely stated the means of dissemination of findings, rather than addressing the discrepancies identified. Often there was no action plan to improve compliance and then to re-audit. The review team found therefore that management of maternity audits were a significant lost opportunity to improve the quality of maternity care at the Trust throughout the entire period of the maternity review.

b. A lack of a change in practice and monitoring of compliance in response to clinical incidents.

4.90 The review team has identified cases where similar and continuing errors in practice have occurred over the years, which suggests a failure to learn lessons and implement change in maternity practice. When an incident has been investigated and an action plan created, it is vital that these actions are implemented to prevent future harm occurring. The review team has found repeated instances where this has not been the case in maternity services at the Trust.

4.91 *In **2015** a woman with a previous baby on the 5.5th centile was not offered an obstetric review or growth scans. She subsequently suffered a stillbirth at 37 weeks. The baby had a birth weight less than the 3rd centile. The subsequent investigation into this stillbirth recommended that: 'Any previous birth weight between 5.0 and 5.5 centile will be rounded down to 5th centile for the purposes of ascertaining which patients will be offered routine scans at 32 and 36 weeks'. This recommendation however was not written into the Assessment (Antenatal) Guideline Version 11 (2015) nor any versions afterwards. Despite the 2013 RCOG Green Top Guideline[79] recommending use of the 10th centile to determine when ultrasound scans are required, this was not followed at the Trust until 2018. (2015)*

4.92 *In **2016** a woman, for whom English was not her first language, telephoned maternity triage with abdominal pain and was advised to remain at home and sadly attended with a concealed placental abruption and had a neonatal death. The recommendation from the investigation was to update the maternity triage operating procedures to include that women for whom English is not their first language should be invited in for assessment to avoid issues with communication. There is no evidence this occurred. (2016)*

4.93 *In **2018** a woman in early labour telephoned the maternity triage as she believed her 'waters had broken' but she was not invited in for assessment, and the outcome in this case was an early neonatal death. The Latent Phase of Labour and Intrapartum Care on an MLU guideline was updated following this incident and a compliance audit was recorded as being completed, however no evidence of this compliance audit has been supplied to the review team by the Trust. (2018)*

4.94 There is evidence of sharing audit findings at audit meetings. However, there is lack of consistent evidence

79 Royal College of Obstetrics and Gynaecology *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

that practice changed as a result of audits. Of particular note is that the majority of audits did not make reference to previous audit findings, hence the opportunity for comparison and therefore learning to improve the quality of maternity care was lost.

4.95 One example is that an electronic training package used by staff for CTG training was discussed at the maternity governance meeting held in February 2016 and it was said to be in routine use. However, in the July 2017 governance meeting, it is reported that staff were unfamiliar with the aforementioned training package. This is inconsistent with the assurances given at prior maternity governance meetings and to external bodies such as the Commission for Health Improvement as far back as 2007. Poor CTG interpretation leading to poor outcomes for babies was a recurring theme among many cases over the period of time considered by the review team.

c. The repayment of an NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Incentive scheme payment.

4.96 The Clinical Negligence Scheme for Trusts, better known as CNST, is an insurance scheme administered by NHS Resolution (previously known as the NHS Litigation Authority), whereby individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence. In the earlier years the CNST standards were met by auditing practice against prescribed standards and identifying evidence of improvement in practice informed by those audits. Successful achievement of Level 1, 2 or 3 resulted in a percentage reduction of trust payments to the NHSLA for indemnity insurance.

4.97 The review team saw evidence that guidelines were amended and updated based on the CNST assessment reviewer's comments and the maternity unit was successful at gaining Level 1. A member of staff stated in a meeting with the review team that as early as 2009 there were significant concerns amongst individuals about standards of maternity care and governance at the Trust.

4.98 In discussing CNST, a staff member told the review team *'…in 2009, there were signs then that governance was not as it should be and I fought a battle even then just with regard to CNST and I was told we're going to get CNST Level 2, and I said, "We're not", and I was told, "We are", and I said, "We're not", and that was the first time that I experienced having a battle with the…leadership at the time, and the Board…but you know what's right and you can't get beyond that barrier. So I considered that I won that battle, in that we did the right thing…we weren't going to get Level 2 unless we fudged it, so those are my words…but it was met with absolute disdain and I remember…being dragged into [X's] office and told, "Sit there with your laptop, we're going to do this action plan for CNST together..." .'*

4.99 This was also confirmed by another member of staff stating: *'I don't think that anybody on the Board expected me to be finding us non-compliant, because obviously that had gone through the Board, so that was a really difficult time as well. …It was a really difficult time, because we were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it, and then obviously we had to look at year one and then we owed a significant amount of money. I think that, you know, that's an example of where they didn't know how much information they should have.'*

4.100 The Trust subsequently gained level 2 in 2012. The review team saw some of the best conducted audits in 2013–2014, with the Transfer of Women Audit being noted as an example of good practice in its structure and findings.

4.101 During 2013/14 the Trust was preparing for Level 3 assessment. The Trust scored a remarkable 48/50 of the required criteria. NHS Resolution **(NHSR)** stated[80] *'the audit reports were in general of a high quality, with readily identifiable measurable standards'* and *'Particularly impressive was the spread of actions that had been implemented as a result of the audit findings…It was clear to the assessors that each deficit identified had been carefully considered and time and effort had been put into drilling down to the root causes and applying meaningful measures to rectify the issues'.* However, there is a distinct disparity

80 NHS Resolution, NHS Litigation Authority. *NHS Litigation Authority Clinical Negligence Scheme for Trusts: Maternity Clinical Risk Management Standards 2013-14, The Shrewsbury and Telford Hospital NHS Trust*, Level 3, p23 (March 2014)

between those observations of NHSR and the findings of the review team as in subsequent years the audit reports did not lead to sustainable safety improvements in maternity services at the Trust.

4.102 In 2017 NHS Resolution changed the CNST assessment to become an incentive towards improving safety. Maternity services provided self-assessments which were signed off at Board level on 10 safety actions which it was thought, if achieved, would demonstrate that a Trust was providing safer maternity care[81]. By achieving all 10 safety actions Trusts would recover the elements of their contribution to the CNST maternity incentive fund and also receive a share of any unallocated funds.

4.103 The Trust received its rebate in 2018, but after a CQC inspection report in November 2018 rated the maternity services as inadequate[82] the Trust was obliged to return the money it had received. The review team has heard from a member of staff that it was obvious the Trust would not achieve the CNST standard. This is evidenced by the fact that although the Trust declared in 2019 a 90% or more compliance with the multidisciplinary training target in 2018 and 2019 the maternity clinical governance meeting minutes on 25 February 2019 records that there was discussion of the risk that the Trust would not achieve this target.

4.104 In August 2019 the Training Figures document states that the *'maternity incentive scheme training requirements were achieved'*. However the review team has heard evidence from a member of staff that actions were signed off as *'actions met'* without appropriate evidence being either shared with, or requested by, the executive team and Board.

4.105 A member of staff said to the review team: *'...I have thought a great deal since my interview and how things will not change unless we are prepared to push aside feelings of dismay, anxiety and fear and unless we are prepared to act by the very principles we are expecting from others.'* The staff member stated to the review team that *'X advised me when I was undertaking a review of CNST year 2 submission to "be careful what you find" as it will cause "reputational damage" to the Trust'.*

4.106 The review team has identified multiple and repeated failings in maternity governance throughout the timeframe of this review, spanning poor quality incident investigations, poor complaints handling, concerns with how the Trust implemented statutory supervision of midwifery supervisors and concerns with implementation of the systems for guideline development and clinical audit. The review team feel that these serious failings led to unnecessary harm occurring to mothers and babies over a prolonged time period.

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.107 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

4.108 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

4.109 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

4.110 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

81 NHS Resolution. The maternity incentive scheme year 2 results. Published 13th February 2020. https://resolution.nhs.uk/2020/02/13/the-maternity-incentive-scheme-year-two-results/#:~:text=The%20maternity%20incentive%20scheme%20was%20launched%20by%20NHS,but%20also%20a%20share%20of%20any%20unallocated%20monies.

82 Care Quality Commission, Shrewsbury and Telford Hospital NHS Trusts Inspection report (2018)https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust

4.111 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

4.112 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

4.113 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

4.114 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

4.115 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.116 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

4.117 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

4.118 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.119 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

4.120 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.121 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

4.122 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

4.123 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.124 There must be midwifery and obstetric co-leads for audits.

4.125 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

4.126 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

4.127 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

4.128 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.129 There must be midwifery and obstetric co-leads for developing guidelines.

4.130 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

4.131 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

4.132 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[83] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

4.133 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

83 NHS England. Maternity self-assessment tool (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

The NHS Patient Safety Incident Response Framework (PSIRF)

4.134 As has been clearly explained within this chapter, there have been many failings in how maternity incidents were investigated in-line with the national frameworks at the time, namely the 2010 National Framework for reporting and learning from serious incidents requiring investigation[84] and the 2013 and 2015 Serious Incident Frameworks[85]. It is also widely accepted that prior to this review, multiple reports, including maternity specific reports, have already highlighted significant shortcomings in the way patient safety incidents are investigated and learned from[86].

4.135 To improve this situation, NHS England published the 2019 NHS Patient Safety Strategy[87] and will be implementing the Patient Safety Incident Response Framework (PSIRF)[88] which is due for gradual implementation across all organisations from spring 2022. Taking into account that at the time of publishing this report there will be more than 20 organisations working within the PSIRF framework[89] who will continue their work after this report is published, the review team has discussed the PSIRF methodology with NHS England. These discussions have helped ensure that the approaches and principles within the PSIRF are aligned with those of this maternity review.

4.136 The PSIRF differs from the current SI framework, which it will replace, in a number of ways and the review team support the fact that it will have a broader scope, moving away from 'hard-to-define thresholds for serious incident investigations' and that it is committed to engaging and supporting patients, families, carers and staff in accordance with a just culture. The PSIRF Introductory framework , published in March 2020, identifies the process currently being used by early adopter sites and has been published 'so that all parts of the NHS, patients, families and other stakeholders can engage with the proposals and help [NHSE] learn how we best ensure our aim is met'.

4.137 The review team has engaged in dialogue with NHS England based on the findings of this review to receive assurances that the PSIRF works effectively for maternity services. The following issues are of key importance:

PSIRF- Resources and expertise:

4.138 The review team discussed with NHS England that the National Maternity Assessment Tool recommends the following minimum staffing levels for governance teams:

- Maternity governance lead (who is a midwife registered with the NMC)
- Consultant obstetrician governance lead (Minimum 2 PAs[90])
- Maternity safety manager (who is a midwife registered with the NMC or relevant transferable skills).
- Maternity clinical incident leads
- Audit midwife - a lead midwife for audit and effectiveness

84 Ibid n4

85 Ibid n2

86 Royal College of Obstetrics and Gynaecologists. Each Baby Counts: key messages from 2015 (2016) https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/rcog-each-baby-counts-report.pdf

Parliamentary and Health Service Ombudsman. Learning from mistakes. (2016) https://www.ombudsman.org.uk/publications/learning-mistakes-0

Parliamentary and Health Service Ombudsman. A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged. (2015) https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has

House of Commons Public Administration and Constitutional Affairs Committee. *Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England*. (2017) https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/743/743.pdf

87 NHS England website. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

88 NHS England. NHS Patient Safety Strategy 2019. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

89 NHS England. Introductory Patient Safety Incident Response Framework. (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

90 A PA or 'programmed activity' is the unit of currency in a consultant contract, each PA broadly equalling 4 hours – see https://www.nhsemployers.org/sites/default/files/2021-06/consultant-contract-faqs_0.pdf

- Practice development midwife
- Clinical educators, to include leading preceptorship programme
- Appropriate governance facilitator and administrative support within the maternity department.

4.139 The review team is assured that these are key team members who will need to understand PSIRF principles and should be involved in planning preparations locally for implementation of PSIRF.

PSIRF and Training:

4.140 The review team is assured that appropriate training in patient safety incident investigations, and safety science more widely, will be a core feature of the PSIRF and that NHSE&I will set minimum levels of training required for investigation leads.

4.141 The review team strongly supports the notion that training must be available prior to PSIRF implementation and are assured that this will be set out within an investigation training framework which will include a straightforward mechanism for providers to commission the training that their staff need.

4.142 The review team is assured that all relevant tools and templates will be available prior to rollout and should further investigation skills training become necessary over time, the minimum training standards requirement will be adapted as appropriate.

PSIRF- What to investigate and ensuring effective oversight

4.143 Maternity and neonatal incidents which meet the Each Baby Counts and maternal deaths criteria will be referred to HSIB for a HSIB-led PSII (or new statutory body). Organisations will also be required to continue to report to NHSR Early Notification Scheme, RCOG EBC project and MBRRACE-UK as well as the PMRT being used for all stillbirths and neonatal deaths. The review team supports this approach of maintaining set criteria for what must be investigated externally.

4.144 The review team also supports the move away from subjective and hard to define thresholds for SI investigations and towards a proactive approach to safety and learning investigations, which can be based on findings from more than one similar completed incident investigation.

4.145 The review team raised concerns that the PSIRF focuses on trusts determining locally what to investigate and although well intentioned to promote a culture of learning, felt this could lead to similar problems as found at Shrewsbury and Telford Hospital NHS Trust, where incidents were downgraded and not appropriately investigated. The review team has been assured that there will be appropriate oversight built into the PSIRF framework with organisations expected to conduct a gap analysis to assess this, whilst also being assured that a training specification for oversight training will be in place before roll out begins. It is the expectation of NHSE&I that the relevant individuals in oversight roles will have received the appropriate training prior to organisations transitioning to PSIRF.

PSIRF and linking complaints to investigations to aid learning

4.146 The review team has been informed that although this is not part of the PSIRF, providers will be encouraged to bring patient safety and complaints teams together as part of the PSIRF implementation and encourage a collaborative and coordinated process. As stated in the IEAs underpinning this final report all trusts must ensure the maternity complaints process is incorporated within the maternity governance team structure responsible for incident investigations to ensure that complaints are not completed and responded to in isolation. The review team states that **NHSE&I must undertake work to provide those dealing with complaints appropriate training in effective complaints handling**.

PSIRF and reducing variation in investigations

4.147 The review team support the notion of a standardised investigation template and are assured that the patient safety incident investigation (PSII) template has been built on the principles developed by HSIB and that the template will be available prior to PSIRF implementation.

Patient and family involvement in investigations

4.148 The review team has been assured that the active involvement of women and families in investigations is fundamental to the PSIRF and that NHSE&I are currently working with HSIB and a group of independent stakeholders (including academics, patients and patient advocates) to develop an involvement guide that will ensure these requirements are covered in detail.

Chapter 5

Clinical leadership

Introduction

5.1 Safe, high-quality maternity care across England is not an ambitious or unrealistic goal and should be the minimum expectation for all women, their families and their babies. Effective clinical engagement and leadership is critical to improving quality, safety and patient outcomes within the NHS[91]. Frontline teams do not operate[92] in a vacuum; leadership is the key determinant of the organisational culture in which frontline teams operate. 'When things go well, it is down to good leadership and when they don't, who takes responsibility? Does it rest with the 'senior' midwife, the trust's chief executive, the board or the midwife delivering the care?'[93]

5.2 Historically, strategic and operational leadership roles within maternity services were held by the obstetric clinical lead, the clinical director and the director of midwifery[94]. These roles have overarching responsibility for the daily operational delivery and strategic management of maternity services locally and are accountable to the trust board for quality, performance, governance and professional leadership. This responsibility includes making positive changes in the workplace where necessary to shape a fair and positive environment, and encouraging a culture which supports improved clinical outcomes for women and their families. The review team has identified that these responsibilities were not always met within maternity services at Shrewsbury and Telford Hospital (SaTH) NHS Trust.

5.3 During a 'Staff Voices' interview with the review team in late 2021 a member of staff reported how the Trust's board did not have oversight of the concerns relating to patient safety, quality and performance or poor clinical outcomes within maternity services.

5.4 The staff member told the review team: *'I don't think that actually the Board knew what was needed in maternity services. I was giving them information that they'd never had before'.*

5.5 The primary influence of clinical leadership is through the expression of clinical expertise, with direct involvement in patient care. A recent RCOG publication[95] (2021) reiterated how the role of the consultant obstetrician is that of the clinical expert, one who influences both clinical decision-making and standards of clinical practice thereby reducing variation in patient care and optimising clinical outcomes in maternity settings by being physically present and visible[96]. The absence of such clinical leadership has been identified by the review team as a contributory factor in the failure of maternity services at the Trust to provide high quality and safe maternity care to women and their families, and is an overarching theme in this report. This has been widely reported in many national maternity reports over many years[97]. These national maternity reports include those by the Department of Health, Royal Colleges and CEMACH.

91 Joseph & Huber 2015, https://pubmed.ncbi.nlm.nih.gov/29355179/ 2015

92 NHS England: *National Maternity Review: Better Births: Improving Outcomes of maternity services in England* (2016) p72: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

93 Royal College of Midwives (RCM) (2012). Leadership - what's that got to do with me? Midwives Magazine Issue 2 2012 [online]. Available at: https://www.rcm.org.uk/news-views/rcm-opinion/leadership-what-s-that-got-to-do-with-me/ [Accessed 24th November 2021].

94 Royal College of Obstetricians and Gynaecologists (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf [Accessed 01 December 2021].

95 Royal College of Obstetricians and Gynaecologists (2021) *Workplace Behaviour Toolkit.* Available at: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/workplace-behaviour/toolkit/ [Accessed 01 December 2021].

96 Ibid n4 RCOG (2007 and 2021)

97 Department of Health *Why Mothers Die. Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1994–1996*. (1998). RCOG, 2004, CEMACH, 2007, Kirkup, B. (2015) *The Report of the Morecambe Bay Investigation*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021]. Knight et al, 2016 and NHS, 2019.

Review of independent reports

5.6 It is acknowledged that the assessment of maternity services has continually evolved over the 20-year span of this independent review, and that different standards and priorities have been expected of maternity services at different times. Key national reports continued to highlight poor leadership as the reason that maternity services were failing women and hampering continued development of the professions[98]. In assessing the quality of leadership within maternity services at the Trust, the review team has considered the most recent external reports reviewing maternity services at the Trust and whether the leadership team were responsive in making effective changes following the recommendations made in those reports.

5.7 A review of maternity services at the Trust was undertaken by the two local clinical commissioning groups[99] (CCG's) in 2013. This was in response to concerns regarding the increased number of serious incidents (SIs) at the Trust, and the safety of the 'hub and spoke' model[100] of maternity care. The findings from the CCG's were favourable, with the overall assessment noting that maternity services provision at SaTH was a safe and good quality service. The Trust board reviewed this report noting: *'There had been concern about some families' experiences but this was in the context of generally good services'.*[101]

5.8 In March 2014, the Trust was reviewed by the NHS Litigation Authority and awarded Level 3, the highest standard under the Clinical Negligence Scheme for Trusts (CNST). The Trust was benchmarked against the requirement to demonstrate good leadership, with an open and supportive culture, providing a service that can fulfil the needs and expectations of women and their families. A maximum score of 10 out of 10 was awarded in 2014, suggesting there were no concerns regarding leadership and management at that time.

5.9 Following the successful submission of CNST data, a staff member explained to the review team that they had voiced concerns regarding the accuracy of the data submitted, suggesting there was no evidence to support that the service was ever compliant in meeting the criteria. The staff member told the review team:

5.10 *'We were then saying to the Board that information that they'd signed off six months previously, they didn't have the evidence for it.'*

5.11 In 2014, a Deanery review of medical training was undertaken. Clinical governance was identified as an area for improvement. The Deanery report stated:

5.12 *'The Trust must integrate clinical governance into learning outcomes for trainees and ensure that there are clear and robust mechanisms in place to learn from clinical incidents and that any learning points are clearly disseminated to trainees appropriately.'*

5.13 An independent review in 2015 by Debbie Graham which considered the case of a family who had suffered the death of their baby daughter criticised the Trust's response to the family. However the report concluded *'…the learning from these events, in conjunction with the appointment of key personnel, have led to considerable improvements in the provision of maternity services and the strengthening of the Trust's clinical governance and complaints processes. In particular the development of advocate roles within the Trust that will work to strengthen the voices of patients and their families so they may be heard in the future'.* Graham (2015) does not state the basis upon which this conclusion was reached. When considering a number of cases after 2015 and through until 2019 the review team has not seen evidence that this belief came to fruition.

5.14 For instance, in 2018 a family in conversation with the review's Chair described the approach of the Trust at listening to families following critical incidents as *'tinkering at the edges'*. In reviewing the SI report into the

98 RCM 2012

99 See glossary

100 See glossary

101 2014 Trust Board papers supplied to the review team

death of their baby the family (who had significant professional experience in risk management and root cause analysis) said of the Trust's SI report: *'It's not getting down [to the detail]…it says here root cause analysis, they're fine words but the words don't mean anything because they don't understand…and, again with all due respect to them, as I say, from my world I live, eat, sleep and breathe root cause analysis…'*.

5.15 The 2017 Ovington report compiled internally within the Trust stated how *'safety in maternity is protected by the efforts of the staff and supported by leaders'.* It concluded that governance arrangements should be more transparent and open. It also highlighted how learning from incidents and investigations should be improved. No action plan to meet these recommendations in Ovington (2017) has been provided to the review team at the time of writing this report in spring 2022.

5.16 In 2017, there was an invited review of the maternity services by the RCOG. This review found that while there was evidence of strong leadership and good working relationships between the various staff groups, concerns relating to workforce numbers and insufficient numbers of consultants providing obstetric cover were identified. There was evidence of middle grade rotas not always filled by the Deanery, resulting in maternity services relying on overseas trainees and locums. In accordance with other previous reviews, the RCOG report identified a lack of resources and inadequate incident reporting, risk management and governance systems. This report was subsequently not presented to the Trust Board until May 2018. The Trust's 2018 Care Quality Commission report concluded within the 'Well Led' domain that leadership required improvement and also raised governance concerns stating:

5.17 '*Staff were overwhelmingly positive regarding the local management of the service in the hospital. They told us that the senior team were visible and they were approachable and able to raise issues and concerns. However, they were not certain that these issues were then heard at board level. We were not assured that the executive team had engaged well with staff to develop the vision for the service.'*

5.18 *'We found areas of concern that were raised in our last inspection in December 2016, for example service-wide sharing of learning from serious incidents was not evident, not all staff could give an example of learning.'*

Obstetric services, workforce and clinical leadership

5.19 It is clear from the evidence provided by the Trust to the review team that prior to 2012 the obstetric medical staffing at both consultant and junior doctor level at the Trust was inadequate for the size of the unit at around 5,000 births per year. The number of consultants, and the number of women that they were responsible for meant that timely reviews of women on the labour ward, or in other inpatient areas would have been very difficult, if not impossible, to provide at times. Therefore, midwives wishing to escalate clinical concerns would have been regularly working in an environment in which it would have been difficult to obtain a timely senior obstetric review.

5.20 The poor provision of medical staffing resulted or certainly contributed to delays in the instigation of appropriate medical management. This created an environment in which it was accepted within maternity services at the Trust that it was normal practice to wait for an obstetric review, thus leading to clinical risks, which ultimately contributed to poor maternity outcomes. The review team has heard from one member of the medical staff who confirmed that for many years the registrar had to cover both gynaecology and obstetrics clinical areas.

5.21 This staff contributor told the review team:

'One of the problems...in this sort of context that I've been describing, was a very, very overburdened and thinly stretched middle tier in the obstetric team. I was, frankly, flabbergasted at what I was being told, you know, doctors were being asked to cover services that, it was manifestly clear, you couldn't possibly do that on your own.'

5.22 There is evidence within business plans to the Board (provided by the Trust to the review team) that the Trust was working to increase the number of doctors at both middle grade and consultant level. The number of hours of consultant presence on the labour ward subsequently increased from 40 hours in 2011 to 76 hours in 2013. These plans included evidence that solutions were being sought to support this, including better provision of elective caesarean section lists, for example. In spite of these efforts, in 2016 the Trust had difficulty in being able to appoint the required number of middle grade doctors, resulting in the staffing levels being below the recommended standard for both consultant and middle grade staff. At the time of writing this report in early 2022 there has been further consultant expansion at the Trust supporting an increase in resident consultant hours on the labour ward.

Neonatal services, workforce and leadership

5.23 It is clear from the majority of medical records reviewed that involvement of the consultant neonatologists in clinical decision-making, in the provision of neonatal care and in communication with parents and other family members was of a high quality. The medical records suggest that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They often wrote discharge summaries themselves and were also usually involved in the long-term follow-up of their patients, providing continuity of care for their parents. For some of the clinical cases reviewed, the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This may compromise the availability of skilled care, and, given the size of the neonatal service at the Trust, it would be important to have separate consultant cover for the neonatal and general paediatrics services. This has now been achieved.

5.24 Advanced neonatal nurse practitioners (ANNPs) played an important role in the management of sick infants on the NNU and of babies on the postnatal ward. As far as can be judged it appeared that their practice was appropriate and likely to have made an important contribution to neonatal practice within the Trust. For some of the cases reviewed it was clear that, out-of-hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care in both units. The employment of ANNPs has undoubtedly provided some mitigation of this but it was not clear whether the service was adequately covered to this level at all times.

5.25 The review found some evidence of senior neonatal leadership within maternity and perinatal governance processes, and on occasions in raising concerns about individual cases in the perinatal service. We heard evidence of attendance by a neonatologist at Perinatal Mortality and Morbidity (M&M) meetings. In interviews with the review team, we were told of neonatologists attending joint mortality meetings from the early 2000's. Neonatologists contributed data to the national neonatal audit project, which collects important neonatal outcomes. Neonatologists and obstetricians told the review team that they usually met bereaved parents independently, but the review team found some evidence of correspondence between them, including selected cases where a neonatologist wrote to the consultant obstetrician requesting a case review after an adverse outcome.

5.26 Some of the neonatologists told the review team that they raised concerns in the early 2000s about a perceived higher than expected incidence of hypoxic ischaemic encephalopathy (HIE). They also raised concerns about lack of recognition of IUGR and of trauma secondary to instrumental delivery. At interview members of the neonatal team told the review team that these concerns were raised with clinical colleagues and the divisional management team, however the outcome remains unclear.

5.27 A staff member told the review team: *'We have been always very closely involved because we have regular monthly perinatal mortality reviews, meetings every third Wednesday, third Friday of every month and we would actually attend all the late fetal losses, stillbirths, everything, it's not just neonates…so we would robustly challenge them…and those were very well attended meetings, including midwives, obstetric, neonatal teams, perinatal pathologist and geneticist etc.'*

5.29 They continued:

'I think the consistent feature from the neonatal side for us for many stillbirths etc. was the lack of recognition for fetal growth restriction and I think that's another part we repeatedly brought out. I think that led to the introduction of the customised growth centiles as well as the GROW programme.'

Midwifery roles, workforce and leadership

5.30 Frontline midwifery leadership incorporates a myriad of midwifery roles across maternity services including midwives[102], matrons, senior midwifery managers, labour ward coordinators, community clinical leads and specialist midwives. It is notable that, in spite of the RCOG safety recommendations from 2007 on standardising an approach to clinical leadership roles, the Trust did not have any consultant midwife posts for all of the time period considered for this review. The Trust has informed the review team that their first consultant midwife is due to take up employment in early 2022. The national recommendation remains that midwifery-led units (MLU) have one full-time consultant midwife post and obstetric-led units have one additional full-time consultant midwife post to every 900 births, based on 60 per cent low risk women receiving midwifery-led care[103].

5.31 The review found no evidence that there was a consideration of developing the role of the consultant midwife, during the time period under consideration. In conjunction with the consultant obstetrician, the consultant midwife could have provided the balance of professional and effective clinical leadership to ensure the improvement of both quality and safety across maternity services.

The labour ward co-ordinator

5.32 The role of the labour ward coordinator is multi-faceted and central to ensuring the safety of pregnant and labouring women and babies. It encompasses the role of midwifery clinical expert; to inform and challenge practice, and to escalate clinical concerns whilst prioritising and managing the complex demands of contemporary midwifery and maternity care in the high-risk clinical setting of the labour ward.

5.33 Maintaining oversight and knowledge of the management of all clinical cases, the coordinator acts as a source of clinical support for junior midwifery and obstetric staff and a professional conduit across multidisciplinary teams thereby ensuring appropriate use of resources to enable the effective and safe provision of care. While there were some examples of good midwifery leadership seen, staff within maternity services at the Trust shared with the review team their own lived experiences of when this was not always the case.

5.34 A staff member told the review team:

'I was, I think, three months into my labour ward rotation and I kept pressing the call bell saying she's bleeding a lot quicker than I'd like, you know, I think we're up to 500mls now, and the coordinator kept coming in saying I'm on [the] ward round, it'll have to wait…I felt like I'd let that woman down because my skills weren't good enough, that's how I was made to feel when, actually, that was a situation I should have had help in…if she was bleeding that much I should have had help.'

5.35 Each labour ward must have a team of experienced senior midwives rostered as labour ward coordinators, who have supernumerary status; this is defined as having no caseload of their own during a shift and is fundamental to the effective running of the labour ward, which is a high risk clinical area. This is also a recognised requirement in the CNST safety standards[104].

102 Ibid n4 RCOG (2007) & Kings Fund, 2008https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/safe-births-everybodys-business-onora-oneill-february-2008.pdf

103 Ibid n4 RCOG (2007) RCM, RCA, RCPCH, 2007 and Kings Fund, 2008

104 NHSR, 2020

5.36 The review team found that the Trust allocated one band 7 labour ward coordinator per shift who had overall responsibility for coordinating the care throughout a clinical shift, and for the allocation of staff (Labour Ward Staffing v2, 2015). Out-of-hours in the absence of the management team, the coordinator was also responsible for overseeing the clinical activity across the whole of maternity services, including the distant MLUs, and community activity across Shropshire, with escalation to the on-call manager at home, according to the Future Model of Care, 2016 document, shared with the review team by the Trust.

5.37 Reports by the CCG in 2013 and the RCOG in 2018 found that due to midwifery staffing shortfalls, the coordinator was supernumerary for only 50% of the time (RCOG, 2018). This mirrored the findings of the review team who identified that, in many instances, the coordinator had their own women for whom they were responsible for providing clinical care and were therefore not able to fulfil their required role, in particular the provision of support for junior midwives and doctors. Nor were they able in these circumstances to achieve and maintain the necessary 'birds eye' view of the labour ward.

5.38 A staff member told the review team:

5.39 *'The shift leader was constantly having a patient and from the time that I was working on their labour ward, ...you sometimes couldn't get hold of the shift leader because she was in looking after a woman.'*

5.40 Another staff member told us:

5.41 *'I was frightened about putting in…being put into an area that I just, just wasn't my area of expertise and not having support. But it wasn't just lack of support, it was actually, I was just frightened of going past a labour ward; I didn't want to do it, it wasn't my area of expertise and at the time if you voiced those concerns that was probably going to mean you were going to go there full time…'*

Midwifery matron

5.42 The role of the midwifery matron is deemed to be the cornerstone for improving the quality of clinical care through visible, compassionate and inclusive leadership and management. The role has evolved considerably since the publication of The Matron's 10 Key Responsibilities in 2003, and the Matron's Charter in 2004. However, the fundamental aspects remain the same: this includes promoting professionalism in the workplace, ensuring good patient safety and service-user experience, control of infection responsibilities, and monitoring the cleanliness of the clinical environment. It is widely acknowledged that midwifery matron roles also encompass workforce management, budgetary responsibilities and effective resourcing of equipment and maintenance of estates. The recommended minimum requirement for presence is one full-time equivalent, with additional on call and out-of-hours cover, ensuring 24-hour managerial cover[105].

5.43 The review has identified that as late as 2015 the Trust did not meet these recommendations, as the labour ward manager was found to be a hybrid of roles consisting of two shifts working as a labour ward coordinator and three shifts as a matron according to Labour Ward Staffing v2, 2015. In addition, the lead midwife/clinical risk co-ordinator role for consultant inpatient service also had responsibility for leading midwifery care and management on the labour ward. This combination of roles would have resulted in a workload that was not manageable and would have led to key issues being overlooked.

Statutory supervision of midwifery

5.44 Prior to its removal as a statutory function in March 2017, the West Midlands Local Supervisory Authority (WMLSA) had overarching responsibility for statutory supervision of midwifery at the Trust. While there were many professional principles for midwifery supervision, in terms of clinical leadership its purpose was to maintain and improve quality, and to protect women and babies by actively promoting a safe standard of

105 bid n4 RCOG (2007) and RCM, RCA, RCPCH, 2007

midwifery practice, which contributed to the protection of the public. The role of a supervisor of midwives (SoM), who was appointed by the WMLSA was intended to play an important part in providing expert, professional leadership for midwifery at both local and regional level[106].

5.45 A SoM timeline produced by the review team consisting of information extracted from documentation provided to the review including WMLSA audit reports, identified a high level of confidence in the supervisors of midwives at both Trust executive and clinical levels. The supervisors were said to be 'cohesive', had a 'very good team dynamic', and were said to be actively involved in staff training, which included participating and leading in obstetric emergency drills.

5.46 In 2012, a WMLSA visit reviewed the Trust's SoMs' investigation process, which concluded that the team would benefit from further support and guidance around report writing. This training was said to be provided in a supplementary visit to the Trust, however there is no evidence in the documentation provided to the review team that the WMLSA ever returned to the Trust to ensure improvement had occurred.

5.47 Until 2017, the caseload numbers of SoMs at the Trust were repeatedly identified as being above the then recommended ratio of one SoM to 15 midwives. To address these concerns, four of the current supervisors held a double caseload (i.e. 30 midwives) and received double financial remuneration and 15 hours of time in which to manage the additional workload. Similarly, appropriately qualified staff who had retired or previously left the Trust were recruited on a bank basis to provide further support to the supervisory team. There is also evidence which suggests the SoMs were supporting the CNST team; while the context of this is unclear, this may have given rise to a perceived conflict of interest as documented in the Midwifery Regulation in the United Kingdom report (Kings Fund 2015).[107]

5.48 In response to a complaint from a family, an external review was commissioned by the Trust to review an original investigation, which had been conducted by the Trust and signed off by the Local Supervisory Authority Midwifery Officer (or LSAMO) in 2009. The external review concluded that the quality of the supervisory investigation was poor, noting that the principles of root cause analysis were not applied, resulting in key events not being investigated. A repeat investigation by two midwives independent of the Trust made a number of recommendations relating to midwives involved in the clinical care; these included consideration of supervised practice, development support and referral to the Nursing and Midwifery Council (NMC). Furthermore, a significant number of systems issues were identified, that had not been identified in the original investigation including the escalation of staffing issues during times of increased activity/emergency. The absence of a systematic root cause analysis and the lack of support available to the investigating SoM, in particular when interviewing midwives, was also highlighted.

5.49 An independent review was instigated of WMLSA governance and assurance arrangements to determine whether the management and oversight of midwifery supervision was adequate. The review, which was carried out by NICHE patient safety[108] identified a lack of rigour around oversight of the investigative process, best practice was not followed and the quality of reports was not sufficient to prevent reoccurrences. With the purpose of statutory supervision of midwifery being to maintain and improve quality, and to protect women and babies by promoting a safe standard of midwifery practice, these were lost opportunities to achieve these objectives over a long period of time.

5.50 In late 2016, the WMLSA instructed the Trust to review a number of its cases internally. These appear to be some of the cases of the original 23 families, from 2000 onwards which make up the cohort that was highlighted to the Secretary of State and began the process of this review. This task appears to have been undertaken by one SoM at the Trust. The Trust found that none of the nine case investigations, which have been made available to the review required further investigation, thereby missing valuable opportunities for wider organisational learning and further improvement to processes. None of the families were contacted to be involved. Despite the complexity of some of the cases, this was a single professional review, failing

106 NMC, 2015

107 https://www.kingsfund.org.uk/projects/midwifery-regulation-united-kingdom

108 NICHE 2016 Independent Review of West Midlands local Supervising authority (LSA) Supervisory Investigations Governance arrangements dated 31st August 2016, ref 2031-16, supplied by the Trust

to involve other key colleagues who could have potentially provided significant assistance; for example obstetric, neonatal or anaesthesia colleagues. The review team believes that the WMLSA's instruction to undertake a further internal supervisory review of the investigations is questionable as we have not been able to evidence that assurance had been sought arising from the LSA's initial concerns regarding the quality of supervisory investigations, originally identified several years before.

Concerns regarding governance and concerns from families

5.51 Independent reports into maternity services at the Trust, including Graham (2015), identified governance issues, concerns from families and failure to learn from incidents and investigations. There is often a clear disconnect between the issues raised by the families and the findings in the subsequent investigations report. It is also clear that the maternity department, the Trust and the CCG were aware of these issues raised by families. The governance chapter of this report reviews this in more detail, but the evidence available and seen by the review team is that whilst the various reports made recommendations these did not translate into consistent improvements. As indicated in the first Ockenden Report (page 15) there were examples in 2016 and 2017 of families' dissatisfaction with investigation reports. Further examples were found in multiple interviews with families by the review chair throughout 2018 and 2019.

5.52 The RCOG undertook an invited review of maternity services at the Trust during July 2017, which was commissioned by the Trust's Medical Director to evaluate the culture within the service and to assess the safety and effectiveness of maternity and neonatal services.

5.53 The review team was provided with documentation updating on the progress of actions against the recommendations of the RCOG review; including an addendum to the report received during June 2018. This addendum had been prepared following a visit to the RCOG in London by a Trust team. The RCOG had not returned to the Trust to assess the accuracy of the evidence submitted. Quotes from the 'addendum' include the following: *'Review had been undertaken of the manager on-call rota and the rota is now "working better". The escalation policy is firmly in place and was referred to on many occasions, particularly during times when an MLU is closed and services are diverted to another unit.'*

Team working, culture and civility

5.54 The complexities and challenges of team working are not exclusive to healthcare settings, however unlike in some specialities, the effect of poor relationships and collaboration can have catastrophic long-term consequences for individuals, teams and organisations[109].

5.55 National reports into failing maternity services over a number of years have highlighted conflicting agendas and poor teamwork as significant contributory factors towards adverse maternal and neonatal outcomes[110]. Whilst there was some evidence of multidisciplinary team working at the Trust, there was often a notable lack of leadership, accountability and situational awareness.

5.56 *'In **2015** a woman in labour with a twin pregnancy at 36 weeks gestation did not receive an obstetric review on arrival to the labour ward. The neonatal unit were not informed of the admission. No progress in cervical dilatation was escalated to the labour ward coordinator, however there was no change to the management plan or escalation for obstetric review.'*

5.57 *'At full dilatation, an obstetrician attempted to perform a ventouse delivery of twin two. The ventouse cup came off after four pulls. Keilland's forceps were subsequently applied and five pulls were attempted. Neville Barnes forceps were then applied and the baby was delivered in poor condition with one further pull (ten with an instrument in total). The baby had moderate to severe hypoxic ischaemic encephalopathy.' (2015)*

109 Fatolitis, P. and Masalonis, A. 'Human Factors in Aviation and Healthcare: Best Practices, Safety Culture and the Way Ahead for Patient Safety', Journal of Ergonomics vol 11 issue 5. (2021) Available at: https://www.longdom.org/open-access/human-factors-in-aviation-and-healthcare-best-practices-safety-culture-and-the-way-ahead-for-patient-safety.pdf [Accessed 01 December 2021].

110 Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 01 December 2021].

5.58 Due to the requirement for 24/7 cover of a significant proportion of service provision, teams within maternity units increasingly involve various practitioners of different clinical expertise[111]. Teams are also rarely constant, resulting in a number of individuals practising their specific roles within interchangeable groups. As such, training should enable maternity practitioners to function effectively in whichever team or environment they find themselves working in.

5.59 Furthermore, the labour ward can be a particularly challenging environment for even the most cohesive teams or groups due to its acute, unpredictable and specialist nature.

5.60 A staff contributor told the review team in late 2021:

'The fear was being pulled to somewhere else in the middle of a nightshift or being on-call for homebirths or midwife-led units. Being on-call perhaps having worked the day before, working the next day and then being called in to the labour ward to work a whole night shift because it was lacking in staff and that was very fearful…'

5.61 *'Yes, I certainly wasn't equipped because I was a community midwife…those were my areas of expertise, and I was expected to go in and act as a manager on labour ward and I was terrified. I was terrified and much stressed, and very emotional all the time about it.'*

5.62 Throughout the years, there have been multiple reports and research detailing the intricacies of team working and its direct relationship with safety outcomes and patient experience[112]. Additionally, there have been recommendations from leading organisations over a long period of time with the aim to improve safety through the standardisation of minimum multidisciplinary staffing requirements[113]. Despite this, the overall team working at the Trust remained suboptimal, which contributed towards many preventable incidents and adverse outcomes.

5.63 A staff contributor told the review team in autumn 2021:

'Culture is a big thing because I feel there's a reluctance to change there. Yes, they do need to change because this has resulted in lots of families having a terrible event happen in their lives that shouldn't have happened and I'm a midwife, and I know that things don't always go to plan. I don't believe that anybody has set out to go to work to cause harm or anything like that, but I think that probably some processes, some attitudes have definitely been a reason as to why things have not gone to plan.'

5.64 Another staff member said the following to the review team in early 2022:

'If I could say anything to the families it would be that there were people who tried to make changes, we tried to escalate our concerns and be heard but every process we used was set up not to acknowledge our voices or the problems we were highlighting. We were ignored and made out to be the problem but ultimately we failed to make ourselves heard....'

5.65 Many different factors affect the dynamics of team working which are well illustrated within various national programmes including Each Baby Counts. The following feature as contributory factors in adverse incidents:

- Individual human factors (present within 58 per cent of cases)
- Team communication issues (present within 53 per cent of cases)
- Lack of team leadership (present within 24 per cent of cases)
- Poor intra- or inter-professional communication (present within 43 per cent of cases).[114]

111 Flin, R., O'Connor, P. and Crichton, M. Safety At The Sharp End. (2008) CRC Press; Florida.

112 Ibid n20 and Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., Chew, S. and Dixon-Woods, M. (2019) *How to be a very safe maternity unit: An ethnographic study*. Available at: https://www.thisinstitute.cam.ac.uk/research-articles/safe-maternity-unit-ethnographic-study/ (Accessed 01 December 2021).

113 National Institute for Health and Care Excellence Safe *midwifery staffing for maternity settings*. (2015) Available at: https://www.nice.org.uk/guidance/ng4 [Accessed 01 December 2021] and Ibid n4

114 Royal College of Obstetricians and Gynaecologists (2020) Each Baby Counts. 2020 Final Progress Report.

5.66 Similarly, Civility Saves Lives (2017)[115] articulates how negative behaviour such as rudeness or bullying results in a significant decrease in a clinician's performance and/or cognitive ability. Furthermore, incivility is recognised to not only affect an individual recipient, but also bystanders, patients/relatives and the wider team within healthcare settings[116].

5.67 A staff member told the review team that:

'There is culture of bullying on labour ward 24. Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it. I was told that I was a band 6 midwife so I should have no problems. I also got told by one shift co-ordinator that I was qualified longer than her and why was I asking her to support me with what was a difficult delivery?'

5.68 Whilst the identification of human factors will always remain integral to patient safety, there is more recent emphasis on addressing and preventing such issues from occurring in the first instance. Consequently, there is an increasing recognition of the importance and value of workplace culture and civility.

5.69 Workplace culture can be defined as 'shared ways of thinking, feeling and behaving within an organisation'[117]. The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).

5.70 It is imperative to ensure the 'culture' within all healthcare settings is one that promotes openness, transparency and the psychological safety to escalate concerns. Yet the review team found evidence of disempowerment, with staff encouraged not to complain or raise awareness of poor practice within both personal and professional capacities.

5.71 A staff contributor told the review team that:

'You feel like you're penalised constantly in this organisation. I'm keeping my head down now. I have raised it before, I went to HR and it was almost as though I was causing trouble.'

5.72 Another staff member told the review team:

'Whilst reviewing the governance and assurance processes, I was approached by a consultant [obstetrician] who said be careful what you find.'

5.73 Reflecting on the harm caused to families a current staff member told the review team in early 2022:

'I am sorry and I know that sorry is not enough but by engaging with this review we hope that our voices will finally be acknowledged and that change will happen so that there are robust and independent places for clinicians to speak out that acknowledge what we are saying, what needs changing and act on this without fearing reprisals..'

5.74 Positive behaviour strategies have been designed to address negative cultures within healthcare, to improve the working environment for staff and so promote the delivery of safe and compassionate care for patients. Some of these strategies include the implementation of a Workplace Behaviour Toolkit (RCOG, 2021), Civility Toolkit (HEE, 2021) and the creation of national patient safety movements such as Civility Saves Lives (2017) and Learning from Excellence (2014).

5.75 Whilst it is of equal importance for all staff within maternity settings to demonstrate positive behaviours in their everyday practice, it is vital that leaders, such as the labour ward coordinator and senior obstetricians,

Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/each-baby-counts/ebc-2020-final-progress-report.pdf [Accessed 01 December 2021].

115 Civility Saves Lives (2017) Civility Saves Lives. Available at: https://www.civilitysaveslives.com/ [Accessed 01 December 2021].

116 Youngson, G. and Flin, R. Patient safety in surgery: non-technical aspects of safe surgical performance (2010). doi: 10.1186/1754-9493-4-4.

117 Mannion, R. and Davies, H. Understanding organisational culture for healthcare quality improvement, British Medical Journal (2018) doi: 10.1136/bmj.k4907.

are acutely aware of their own behaviour and how this influences other members of the wider team. Where negative workplace practices or behaviours are identified, leaders should ensure they take proactive steps to support individuals, address concerns and prevent the creation of a systemic negative culture similar to that described by staff at the Trust.

5.76 During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.

5.77 A staff member told the review team:

'At a study day in 2016/2017, following the Kirkup report, a senior manager made the comment "we (SaTH) are not a Morecambe Bay". I made the comment that we absolutely were a Morecambe Bay - a trust full of unhappy staff with ineffective poor leadership, looking to hide or ignore poor care and poor management. I have worked for [another NHS Trust] which learned from its mistakes and supported its staff for the past [number of] years'.

5.78 *'I didn't realise how bad things were in SaTH until I left. The bullying culture from top down breeds bullying. I used to be proud to work there, but that changed from 2006.'*

5.79 Another member of staff told the review team of events within maternity services in 2019:

5.80 *'SaTH was managed with a big…stick from behind, there was no forward thinking leadership. We had changes in policy imposed on us, we did not contribute to changes. We were bullied, everything was done under the guise of 'clinical need' or 'your contract says.' We had issues with pay being withheld, managers not happy to reconcile hours/wages. The on-call rotas and change lists were both used as bullying tools. [An] entire team of five experienced midwives left the Trust in less than 18 months…I tried to raise a concern and instead of being listened to I was referred straight to occupational health. It seemed that as I dared raise a concern I must obviously be mentally unwell (this was in 2019)…this whole conversation was held in public unbeknown to me. Other midwives sitting in the office were listening to the way the manager spoke to me. I was and am still absolutely appalled by that action. I resigned…There are a lot of, I would say, home grown midwives, there are cliques there and, you know, they are Band 6s, Band 7s, Band 8s and they are a little gang, and, yes, they will make your life hell'.*

5.81 They continued: *'It's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work…'*

5.82 The staff interviews with the review team also highlighted that there was a lack of respect and role appreciation between the consultant unit staff and the community teams.

5.83 A staff member told the review team that *'There was a…bit of a feeling that because they were the consultant unit, they knew better than you, but actually, we're in the outlying units because we're experienced and we know what we're doing, but…we didn't feel like that respect was always there. Often our decisions were questioned as to, "Well, try this, try that", "Well no, actually, I'm sending her... [the mother in]" '.*

5.84 They continued:

5.85 *'Actually, they need to know our role; they need to know what it's like half an hour, 45 minutes. ...Nearly an hour away from the consultant unit, and they forget that you have to think that far ahead because of what might happen. We don't have an emergency buzzer to have the whole team in, so we have to think ahead and I think they forget that.'*

Conclusion

5.86 External reviews of the maternity services at the Trust between 2013 and 2017 gave the overall message that this was a safe maternity service. This review is concerned that some of those messages gave false reassurance and as a consequence opportunities were lost to have improved maternity services at the Trust sooner. For example, there were a number of concerns arising from these reports regarding governance issues and concerns raised by families, however these issues did not appear to have been prioritised.

5.87 The workforce is a cause for concern, and there were missed opportunities to address the shortfalls in staffing. It is clear that there were insufficient numbers of consultant obstetricians and junior obstetric staff and that there was inadequate anaesthetic support to the maternity unit. It is clear that the midwifery staffing across the service was poor and resulted in the service constantly working in escalation. This impacted on staff confidence and morale, creating a culture of fear and anxiety. There is also evidence of a lack of role appreciation across the service, particularly with those providing maternity services in the community.

5.88 The review team found evidence from documents provided by the Trust (2013-2016) that the local leadership had identified and escalated workforce issues and business plans had been drawn up to increase consultant and middle grade staffing. In recent times there has been a significant expansion in consultant obstetrician staffing.

5.89 Overall, there is a picture of external, independent and internal reports not being critical of clinical leadership at the Trust. However, the review team is concerned that even where recommendations were made, there is no evidence of who was accountable for their implementation or who, within the context of leadership, was responsible for maintaining oversight of these. Because of this, there was no effective strategy for meaningful change within maternity services at the Trust which further perpetuated the cycle of harm to women and families accessing maternity services at the Trust over an extended period of time. Staff who are currently employed in maternity services at the Trust and who engaged with the maternity review team as recently as early 2022 told us of a fear of speaking out in maternity services that persist to the current time. This is of very significant concern to the review team and has been shared with the Trust in advance of publication of this report.

Chapter 6

Our findings following the review of family cases

6.1 A total of 1,862 cases were either reported by the Trust or self-referred to the review. After the closure date for referrals the database was reviewed and 47 duplications were identified and removed leaving 1,815 cases.

6.2 The review was intended to span the years 2000-2019. However, as discussed in previous chapters, some earlier and later cases were reviewed in line with the updated terms of reference. The earliest case reviewed occurred in 1973 and the latest in 2020.

6.3 After excluding cases for which hospital records were missing, or where consent for participation in the review was not given or could not be obtained, the **final number of families whose cases were reviewed was 1,486**. It is important to note that some families had more than one clinical incident reviewed, as some mothers had more than one pregnancy during the review period. **In total 1,592 clinical incidents were reviewed.** Table 1 outlines the number of families and clinical incidents throughout the review period.

Table 1: Time period of family cases included in this review

YEARS	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	**1,486***	**1,592**

** Four families had clinical incidents that fell both within the 2000-2019 years and outside these years. Therefore there are 1,486 unique families in total.*

6.4 In line with the terms of reference underpinning this review we reviewed all 1,592 clinical incidents and analysed two aspects. Firstly, we graded the care provided by the Trust as set out overleaf. Secondly, we reviewed all the maternity governance documentation provided to the review team and graded the quality and appropriateness of the incident investigation in line with national frameworks at the time.

Grading of care

6.5 All the clinical incidents were reviewed by members of the review team which comprised obstetricians, midwives, neonatologists, and other specialists where appropriate. The clinical care was graded using an established grading of care scoring system (Table 2) developed by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), which was similarly used in the Morecambe Bay investigation report by Dr Bill Kirkup, OBE. Further details on the findings and the Immediate and Essential Actions recommended by this review are described in the accompanying chapters.

Table 2: Grading of maternal and newborn care provided

GRADE	SUMMARY DESCRIPTION OF CARE	DETAILED DESCRIPTION OF CARE
0	Appropriate	Appropriate care in line with best practice at the time
1	Minor concerns	Care could have been improved, but different management would have made no difference to the outcome
2	Significant concerns	Suboptimal care in which different management might have made a difference to the outcome
3	Major concerns	Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome

6.6 Table 3 shows the grading of care for the major incident categories. For the incident categories HIE, neonatal death and cerebral palsy / brain damage the investigation into mother and baby is considered as one family. **It is important to note that a mother or baby can be in more than one category and this includes the maternal morbidity category and the combined category.**

Table 3: Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

**Some mothers had more than one pregnancy where a clinical incident occurred during the period of the review (for example a stillbirth in one pregnancy followed by another incident in a subsequent category).*

***Review of the care provided to the mother*

****Review of the neonatal care provided to the baby after birth*

Maternal deaths

6.7 There were 12 maternal deaths reviewed and in nine of the 12 cases (75 per cent) the review team identified significant or major concerns in the care received. Maternal deaths are further discussed in chapter 10.

Stillbirth

6.8 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in care which if managed appropriately might, or would have, resulted in a different outcome.

Hypoxic Ischaemic Encephalopathy (HIE)

6.9 HIE is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns however these were unlikely to influence the outcome observed.

Neonatal death

6.10 Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care which might or would have resulted in a different outcome.

Cerebral palsy

6.11 All of the families in this group self-reported to the review. The diagnosis of cerebral palsy was often made some years following their maternity episode. On reviewing the medical records, where it was found that the neonatologists at the Trust had recorded a diagnosis of HIE in the early neonatal period, a small proportion of families were subsequently transferred to the HIE incident category. From the remaining cases of cerebral palsy, more than 40 per cent were identified to have significant or major concerns in maternity care which might have resulted in a different outcome. The grading of neonatal care in most of the cases was either appropriate or with only minor concerns.

Maternal morbidity

6.12 Within this group were families who did not meet the incident categories identified in the NHS England and Improvement (NHSE&I) and Trust-led Open Book exercise conducted in the autumn of 2018 (maternal death, stillbirth, neonatal death and HIE). There were 614 women in this group, and they included women who experienced morbidity such as admission to intensive care, women who had had a caesarean hysterectomy, women who had severe sepsis or major haemorrhage or reported having experienced rare adverse outcomes such as eclampsia, amniotic fluid embolus or a cardiac arrest. Our reviewers identified significant and major concerns in the care provided to one in four women in this group. The care provided to the baby was considered appropriate in more than 90 per cent of records reviewed.

Combined category

6.13 This group included families who were outside the other categories. Some of these families self-reported. This category included medical termination of pregnancy, missed fetal abnormality, neonatal intraventricular haemorrhage, infant death and child death. There were 58 cases reviewed in this group. Most of these cases were graded as receiving appropriate care or care with only minor concerns.

Quality of investigation

6.14 We graded the quality and appropriateness of clinical incident investigations undertaken at the Trust throughout the time period of the review. Nationally, investigative processes have improved over time and this is described further in Chapter 4. Table 4 outlines the grading system used for the clinical incidents from 2011 onwards.

Table 4: Grading of investigations from 2011 onwards

GRADE	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with family at time of incident. Feedback to family once investigation concluded.
Poor	Any of the above missing (state which).	Very little family involvement, or feedback to family lacking after investigation.
None	Incident not investigated.	No family involvement.

6.15 The tables below show the results for stillbirths and neonatal deaths for the period 2011-2019. The maternal death investigations are discussed more fully in Chapter 10. Where there was no Trust investigation this is shown. In some cases the review team reported "unable to grade" which was usually due to incomplete documentation. Only where there was sufficient documentation for a review was a grading of appropriate or poor given.

Table 5: Stillbirths (2011-2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%	85	32.9%	40.0%	27.1%

6.16 In the period 2011-2019, 68 (40 per cent) of the 168 stillbirths reviewed did not have an investigation. Of those where an investigation occurred 36 per cent were found to be appropriate. Family involvement was graded as appropriate in 33 per cent of cases.

Table 6 Neonatal Deaths (2011 – 2019)

Total number of cases	GRADING OF INVESTIGATION				GRADING OF FAMILY INVOLVEMENT IN INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade	Total number of cases where an investigation took place (with enough data)	Appropriate	Poor	Unable to grade
77	44	54.5%	34.1%	11.4%	41	41.5%	31.7%	26.8%

6.17 In the period 2011-2019, 33 (43 per cent) of the 77 neonatal deaths reviewed did not have an investigation. Of those where an investigation occurred 55 per cent were considered to have been appropriately investigated. Family involvement was graded as appropriate in 42 per cent of cases.

6.18 In the hypoxic ischaemic encephalopathy group there were 12 cases reviewed for the period 2011-2019 and of these eight were investigated by the Trust. This group was considered too small to draw conclusions on the quality of the investigation.

Section 3

Our findings of what happened to the families

- Chapter 7. Antenatal care
- Chapter 8. Intrapartum care
- Chapter 9. Postnatal care
- Chapter 10. Maternal deaths
- Chapter 11. Obstetric anaesthesia
- Chapter 12. Neonatal care

Chapter 7

Antenatal care

7.1 Safe and individualised antenatal care must be the foundation underpinning a woman's pregnancy and birth journey. From the point at which a woman notifies her pregnancy, often to her GP, and then attends a booking appointment with a midwife, a detailed and thorough risk assessment must be undertaken. Comprehensive, individual and woman and family-focussed questioning permits an accurate risk assessment so that care can be personalised and women can be signposted to the most appropriate antenatal care pathway.

7.2 For many women antenatal care is provided by a wide group of professionals including midwives, doctors and sonographers, as well as individuals from external agencies such as social care. This relies upon the sharing of accurate information between primary care and hospital maternity services and on occasion other medical specialities. Throughout antenatal care provision there is a necessity for close interdisciplinary working between these groups to ensure optimal and safe antenatal care is delivered. This chapter focuses on aspects of antenatal care that were not previously addressed in the first report and aims to highlight areas within the maternity service provided by the Trust which the review team felt warranted further attention.

Good practice in antenatal care and missed opportunities for learning

7.3 Throughout the time period of the review our multi-professional review team found a number of examples of good practice, of compassionate and safe antenatal care. However, also throughout the entire period of the review our team found poor standards of antenatal care, showing a lack of consistency and significant opportunity for improvement. Unfortunately there were significant numbers of poor standards of investigation when things went wrong or investigations that should have taken place which did not. Overall, the Trust continued to miss significant opportunities for significant learning throughout the entire time period of the review.

Care of vulnerable women

7.4 Pregnancy is a well-documented catalyst that may increase maternal vulnerability and inequalities already present in the lives of some women[118]. Vulnerability can be seen in women that have previously or are currently experiencing poverty, homelessness, domestic abuse, learning difficulties, seeking asylum, substance misuse, poor mental health, complex co-morbidities and teenage pregnancy. It is widely recognised that pregnancy carries a great deal of uncertainty. Women who are vulnerable in pregnancy are more likely to be exposed to additional harm, stress and anxiety.

7.5 The review team found evidence of missed opportunities to further investigate women from vulnerable groups. There was a lack of professional concern and in some cases a lack of appropriate referral in cases where further exploration was warranted. It is recognised that vulnerable women who receive appropriate support and intervention have improved outcomes[119].

7.6 *In **2009** a young woman in her first pregnancy was booked for consultant-led care due to her age and was diagnosed as having a baby with fetal gastroschisis[120]. She was not referred for additional support from the teenage pregnancy midwives but instead was seen by multiple midwives. As a result there were missed opportunities to explore her possible complex social needs as her care continued to be focused largely on the fetal gastroschisis (2009).*

118 NHS England. Better Births (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

119 Centre for Maternal and Child Enquires. Perinatal Mortality 2008 (2010) https://www.publichealth.hscni.net/sites/default/files/Perinatal%20Mortality%202008.pdf

120 See glossary

7.7 *A very young woman was booked for her first pregnancy in **2013**. There was no referral to the teenage pregnancy service nor any further exploration relating to her social circumstances, particularly as her partner was significantly older than her. She was not offered appropriate additional support and care. (2013)*

7.8 *In **2013**, a young teenage woman presented with a history of three previous pregnancies, all of these ending in miscarriage. Whilst she was appropriately referred to the teenage pregnancy midwife there was a lack of professional exploration or questioning around her social background, support networks and mental health. Appropriate signposting and referrals were not made in the pregnancy, and she did not receive the necessary additional offers of care and support. (2013)*

7.9 National guidance for women with complex social factors was updated in 2010[121] and emphasised the need to improve support for women with additional needs. The Trust has guidance available with care pathways and referral processes for specialist practitioners such as the safeguarding team and teenage pregnancy midwife. The review team considered many cases where guidance was followed and referrals had been appropriately made

7.10 *In **2018**, the review team had concerns around a lack of appropriate safeguarding and domestic violence screening- not completed at the booking visit. There were a number of missed opportunities to follow up the questions about domestic violence. It is appreciated there is always a possibility that an individual may not disclose any concerns. Following what was thought to be a domestic violence incident there was significant maternal morbidity and stillbirth. The review team subsequently saw evidence of learning from the Trust and changes to practice following this case. (2018)*

Good practice

7.11 *In **2008** a young teenage woman in her first pregnancy received appropriate input and referrals from the teenage pregnancy midwives and additional input and investigation from the fetal medicine consultant. Bilateral talipes[122] were identified on an ultrasound scan. The baby was born at term and had an extended stay on the neonatal unit for nearly 1 month due to its inability to feed and the need for nasogastric feeding. There were extensive investigations for a possible neuro-muscular disorder and the family were counselled and supported by a geneticist about this. (2008)*

7.12 *A young woman in her first pregnancy in **2016** was appropriately referred to the teenage pregnancy team. The review team observed use of interpreters and the offer of a comprehensive assessment which would have resulted in an holistic consideration of the family strengths and needs. This was declined by the mother and the family (2016).*

7.13 Whilst highlighting these examples of good practice, the review team found that overall there was a lack of consistency, potentially exposing women and their babies to increased risk and potentially unnecessary harm.

Fetal growth assessment and management

7.14 Monitoring fetal growth is an integral component of safe and effective antenatal care. Over the last 20 years there has been increasing evidence that fetal growth restriction (FGR) is associated with stillbirth, neonatal death and increased perinatal morbidity. The Perinatal MBBRACE report in 2015[123] on term antepartum stillbirths found that 'about one in three term, normally formed, antepartum stillbirths are related to abnormalities of fetal growth'.

121 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010) https://www.nice.org.uk/guidance/cg110

122 See glossary

123 MBRRACE-UK. Perinatal Confidential Enquiry. *Term, singleton, normally-formed, antepartum stillbirth* (2015) https://www.hqip.org.uk/wp-content/uploads/2018/02/perinatal-confidential-enquiry-term-singleton-normally-formed-antepartum-stillbirth-report-2015.pdf

7.15 In November 2015, the Department of Health[124] announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030. The National Maternity Review, Better Births[125] (2016) highlighted a range of measures which can enhance the safety of care for women and babies, and identified a 'care bundle' as good practice in reducing stillbirths.

7.16 NICE (2003, 2008)[126] and RCOG (2013)[127] guidance advocates the use of symphysis fundal height (SFH) measurement and plotting these on a growth chart in the maternity handheld notes as essential to the care of low risk women. A referral for an ultrasound growth assessment is indicated where thresholds are reached or for women who are deemed to be high risk.

7.17 In 2016 NHS England produced the Saving Babies Lives Care Bundle Toolkit for maternity units to reduce the risk of stillbirth. The 'toolkit' was a range of measures that could be deployed to improve safety for mothers and their babies. One element of this has been the detection and surveillance of fetal growth restriction (FGR); (version 2 published 2019)[128]. However, it must be acknowledged that historically, national guidance for monitoring of fetal growth has been conflicting and this has been a contentious issue across the UK over the last 20 years. There remains extensive regional variation in the adoption of guidance and practice.

7.18 In 2007-2008 the Trust introduced customised growth charts as part of the national Growth Assessment Protocol (GAP)[129] and Gestation Related Optimal weight (GROW)[130] programme with the West Midlands being one of the first regions to introduce the programme. Prior to this time the non-customised SFH and ultrasound growth charts were in use within the Trust's handheld antenatal notes.

7.19 The review team found many instances where fetal growth restriction occurred but was not identified. Whilst it is recognised that despite following guidance it is not always possible to detect FGR (given the limitations of available methods including ultrasound) there were definite themes that emerged from review of these cases:

- The SFH measurement was not always completed and documented at each antenatal visit from 24 weeks.
- The SFH measurements taken were both inconsistently and inaccurately plotted onto the growth chart.
- A lack of appropriate referral when SFH measurements would have triggered an ultrasound scan.
- Failure to monitor growth by ultrasound in babies at high risk of FGR (e.g. women with underlying hypertension).
- Lack of recognition, action and wider learning by the Trust when babies were born growth restricted, including those who died.

7.20 *In 2017 a nulliparous[131] women was assessed at her an antenatal visit at 27 weeks and it was noted that the symphysis fundal height (SFH) plotted above 90th centile when plotted on the customised growth chart. Following this fetal growth appeared to be reducing in trajectory. According to local guidance a fetal growth scan should have taken place .This did not occur. At 35 weeks gestation a stillbirth occurred of a grossly fetal growth restricted baby (birthweight at delivery on the 1st centile). The Trust recognised that*

124 https://www.england.nhs.uk/mat-transformation/saving-babies/

125 Ibid n1

126 National Institute for Health and Care Excellence. Antenatal Care Clinical Guidance 6 (2003) https://www.nice.org.uk/guidance/cg6 and Antenatal Care for uncomplicated pregnancies Clinical Guidance 62 (2008) https://www.nice.org.uk/guidance/cg62

127 Royal College of Obstetrics and Gynaecologists *Investigation and Management of the Small-For-Gestational-Age Fetus Green-Top Guideline number 31* (2013) https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_31.pdf

128 NHS England. Saving Babies' Lives Version 2: a care bundle for perinatal mortality (2019) https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

129 Clifford, S., Giddings, S., Southam, M., Williams, M., Gardosi, J., *The Growth Assessment Protocol: a national programme to improve patient safety in maternity care.* (2013) https://www.perinatal.org.uk/wwwroot/pdf/nz/GAP_article_MIDIRS_Dec_2013.pdf

130 Gestation Network. Growth Charts GROW https://www.gestation.net/growthcharts.htm

131 See glossary

there were missed opportunities to detect IUGR and refer appropriately. There was confusion from staff about guidance and when a woman should be referred for a scan. Had this severe IUGR been detected earlier delivery may have been expedited prior to stillbirth occurring. (2017)

Staff voices on fetal growth:

7.21 A staff contributor told the review that that they had encountered problems with women being referred for growth scans and had found that some clinical colleagues were uncertain of SFH measurement technique:

'When I was doing some of the clinics, I would be seeing antenatal women who should have had a scan… and in one clinic session, there were three women who should really have been referred for a growth scan and obviously, I did refer them, but I mean even the one partner had plotted the growth on the chart because they said the midwife hadn't plotted it…'

7.22 *The staff member continued: 'I was even asked the one time, "How do you measure fundal height?" by a midwife? I don't know, having a joke or something, I says, "How do you mean?" and [midwife] said, "Well…" literally [they] described how they measure the fundal height, I said, "Well, it's clear on the growth chart how to measure it you know, this is how you do it; it's on the growth chart itself how to measure it," and [they] says: "I do it the opposite way", which wouldn't give you the correct measurement'.*

7.23 Incorrect assessment of fetal growth was repeatedly observed by the review team. Some examples of this include:

*In **2011** a woman had continuity of care with the same midwife during her antenatal care, however the SFH measurements were incorrectly documented at some visits (not written in centimetres), and were incorrectly plotted in their position and mark used on the growth chart. The plots, if correct should have alerted referral for an ultrasound scan to assess growth. The pregnancy ended in a stillbirth of a baby with growth restriction. (2011)*

7.24 The Trust's initial investigation in June 2011 did not recognise that there had been missed growth restriction. The governance documentation reviewed was poorly completed and there was no indication that any of the actions had been achieved. Following a complaint from the family in October 2011 a further investigation took place and it was acknowledged that the growth measurement and plotting did not identify growth restriction. An action plan was made and evidence subsequently supplied to the family that the actions had been completed. However the learning only took place after a family complaint and not before. Families consistently told the review team of investigation only commencing after receipt of a complaint or commencement of litigation. The review team has seen this was a regular feature during the whole time period of this review. (2011)

7.25 *At 36 weeks' gestation in **2013** a woman experienced an intrauterine death. Following birth it was found the baby was significantly growth restricted. On case review it was established the SFH was not plotted on the GROW chart. The SFH was persistently measured as >90th centile (when retrospectively plotted) but the baby was profoundly growth restricted, and weighed 1.53kg at birth (1st centile). This case highlights poor SFH measurement techniques by several different antenatal care providers. (2013)*

7.26 Governance documents supplied by the Trust to the review team for the above case recognised that growth was not plotted appropriately and there had been missed FGR. Actions stated by the Trust were to ensure GROW training was being accessed by all, including GPs. GAP training was due to start in 2014. A further meeting in 2015 found that the CCGs had not progressed these actions and the GPs had not accessed the GAP training. Following this meeting the action was for the patient safety manager to highlight the need for the GAP training with the CCGs in conjunction with the recent MBRRACE report. The target date was February 2016, 3 years after the case. The review team has not been provided with evidence by the Trust to demonstrate this actually happened despite the significant passage of time.

7.27 *In **2015**, a woman became pregnant who had previously had a small baby with a birth weight just above the threshold in the local guideline to merit referral for an ultrasound scan. She was a current smoker and in this current pregnancy missed antenatal appointments due to issues with scheduling and non-attendance. Despite these risk factors, in the pregnancy in 2015 the complete clinical picture was not considered and she was not appropriately referred for an obstetric review or serial growth scans. (2015)*

7.28 *Her baby was stillborn at 37 weeks, with a birth weight less than the 3rd centile. The investigation by the Trust recommended a change to guidelines, to clarify exactly which centiles must be included in the risk assessment guidance for referral for scans in a subsequent pregnancy. The following two versions of the guidance did not change and the antenatal risk assessment was not updated until **2018**, a gap of 3 years following the incident.*

7.29 *A woman who was known to have large uterine fibroids had midwifery-led care throughout her pregnancy in **2016**. There were errors in the interpretation of the baby's growth, fetal and growth restriction was not detected and an obstetric opinion on the ultrasound scan was not obtained. The baby was born at 31 weeks and was severely growth restricted with a birthweight less than the 1st centile. The baby died the same day from a severe hypoxic birth injury. Local investigation recognised there was a missed opportunity for earlier specialist ultrasound scanning. (2016)*

7.30 Staff interviews undertaken during late 2021, as part of the Staff Voices initiative, supported the view that the Trust remained slow in implementing recommended changes. A staff member told the review team: *'so we're going to put that into our protocols and policies and before it was just 'mañana', we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.*

Specialist antenatal care

7.31 Some aspects of antenatal care require the input of specialised services. The review team identified the following areas of concern with specialist services that were being delivered at the Trust.

Fetal medicine care

7.32 A number of cases were considered where fetal medicine care was provided at the Trust. The review team identified incidences where a baby was born with an abnormality which was not detected until after birth or where a fetal abnormality was detected during the pregnancy and the review team had concerns about the care provided. From review of clinical records, in most cases the quality of fetal medicine care at the Trust appears to have been appropriate or good for the year that the pregnancy occurred. Some fetal abnormalities would not necessarily have been expected to be diagnosed antenatally and for those diagnosed it was evident that appropriate, kind and compassionate care had been provided both during the pregnancy and following a pregnancy loss.

Good care

7.33 *In **2007** a woman had a pregnancy complicated by multiple abnormalities found on the anomaly scan. She was seen by the fetal medicine consultant at the Trust and counselled regarding the increased chance of a chromosomal abnormality and she had an amniocentesis. The baby was confirmed to have a chromosomal abnormality and a referral to the genetics team was made. The parents decided to terminate the pregnancy. There was documented evidence of good communication with the parents and GP antenatally and postnatally and evidence of compassionate antenatal and bereavement care. (2007)*

7.34 *In **2012**, a baby was diagnosed with a significant brain abnormality at the anomaly scan. There was referral to the tertiary centre and the parents were counselled by the geneticists and paediatric neurologists at the tertiary centre and the neonatal and fetal medicine team at the Trust. The woman had regular scans and thorough investigations during the pregnancy with good multidisciplinary antenatal care and*

communication noted. The baby was delivered at 37 weeks and the baby died at a few hours of age. There was appropriate follow-up with the neonatal and genetic teams. (2012)

7.35 *A woman had a pregnancy in **2016** complicated by multiple fetal abnormalities identified at the anomaly scan at 19 weeks. She was seen by a fetal medicine consultant and offered an amniocentesis (invasive testing) and possible termination of pregnancy which she declined and had a stillbirth at 36 weeks. She was seen regularly by the midwives and obstetricians throughout the pregnancy and offered bereavement support. (2016)*

7.36 These cases demonstrate that there was often appropriate multidisciplinary care, support, counselling and bereavement care for the parents, including care at the tertiary centre where appropriate, following the diagnosis of a significant fetal abnormality.

Poor care

7.37 However, the review team found a number of cases where care was substandard. For fetal abnormalities such as cardiac abnormalities, babies that require surgery immediately post birth, babies with multiple abnormalities suggestive of a genetic syndrome or babies with severe early onset FGR, then referral to a tertiary fetal medicine centre during the antenatal period is the appropriate care pathway expected. This would ensure multidisciplinary counselling and expert care and for many babies birth in a unit with a Level 3 neonatal unit would be appropriate. There appeared to be a reluctance by some clinicians to refer some women for tertiary centre fetal medicine care for advice and counselling, or to transfer care to a Level 3 centre as a more appropriate place for birth. In cases where a fetal abnormality was detected postnatally or a baby died with abnormalities there was often no Trust investigation of the screening process or care. Thus opportunities for learning were lost.

7.38 When interviewed by the review team a member of staff at the Trust agreed that there was sometimes a reluctance to refer fetal medicine cases for an external review.

7.39 The contributor told the review: *'I think I'd probably, in retrospect, agree…to some extent. I think there was a degree of fetal medicine clinical overconfidence…but there are other things that you thought perhaps ought to have been referred elsewhere earlier on, yes'.*

7.39 *A woman booked in her third pregnancy in **2015**; although the 20/40 week anomaly scan was normal, significant fetal abnormalities were diagnosed at a later scan, which were likely to be associated with a poor outcome for the baby. She was counselled by a Trust fetal medicine consultant; although documentation of the discussion and possible outcomes were poor. The plan was made for the baby to be delivered at the Trust and for the neonatal team to be at the birth. The baby was delivered at 36 weeks and died within the first 24 hours of life. (2015)*

7.40 This case highlights the importance of appropriate antenatal communication and consideration for best place for birth. Although in cases, such as this, where the outcome is likely to be poor and the pregnancy is continuing, the outcome may be unchanged by referral to a tertiary centre, appropriate practice would be offering referral to a tertiary fetal medicine unit to ensure the provision of detailed counselling regarding the prognosis, including counselling from the wider multidisciplinary specialists. The specialist team would comprise geneticists, neonatal surgeons and speciality paediatricians to plan appropriate antenatal surveillance and postnatal care and ensure informed decision making by the parents.

7.41 Ongoing antenatal care following referral can be shared between the local and tertiary centre but at least one visit to the tertiary centre will ensure that key expertise is sought. Consideration must also be given to birth in the tertiary centre in complex cases, where the abnormality is likely to require early surgery and where level 3 neonatal care may be required to ensure optimisation of care at birth. With all of this information provided to the woman and her family they are then able to make an informed choice.

7.42 *In **2008** a women in her sixth pregnancy was identified as having a baby with a significant congenital abnormality at the anomaly scan. She was counselled by a Trust obstetric consultant, the neonatal team and neonatal surgeons at the tertiary centre. She decided to continue her pregnancy and delivered her baby at the Trust. The baby was transferred to the tertiary centre postnatally and died aged four days. Following review of this case it was agreed that referral to tertiary fetal medicine service should have been made and consideration given to the appropriate place of birth. (2008)*

7.43 *In **2019**, a woman had a pregnancy affected by severe early onset fetal growth restriction. There was no referral to a tertiary centre for specialist review, counselling or advice, particularly when the woman was reluctant to consider local advice regarding birth. The review team found there was limited evidence, pointing to inadequate counselling, and fetal medicine management was not in keeping with best practice. (2019)*

7.44 In the chapter focussing on neonatal care the review team discuss the change in designation of the neonatal unit in 2006 from level 3, (neonatal intensive care unit or NICU) to level 2, or a 'local' neonatal unit. Staff interviews supported the culture of reluctance to transfer women in utero or neonates to a Level 3 tertiary unit following the Royal Shrewsbury Hospital being designated a Level 2 or local neonatal unit, (LNU) in 2006. Staff described a gap of circa 8 years before the changes introduced in 2006 were actually implemented, but some were reluctant to be quoted within the report. Some staff members from the Trust stated that there was a lack of capacity at the designated level 3 units in the surrounding area, leading to the Royal Shrewsbury Hospital continuing to care for babies outside its designation. However this was disputed by the neonatal network.

7.45 One staff contributor told the review: *'Part of the sense of futility is that we have raised concerns, you know, sometimes we've actually had quite heated debates about…if on the obstetric side they feel that they don't want to send to Stoke or Birmingham, and…want...to keep the patient, and you're made to feel that you're letting the side down by not agreeing to proceed…I think for some of them there is a reluctance, and I don't know if that is a cultural thing because I think for a long time, particularly while based at RSH, there was a feeling that it was a very standalone unit and it did its own thing. So I think culturally there's been that feeling…'.*

Multiple pregnancies

7.46 About 1 in 60 pregnancies is a twin or triplet pregnancy (NICE 2015). A unit with approximately 5,000 births a year such as the Trust would expect on average 65-75 pregnancies resulting in multiple births a year. Multiple pregnancies are known to be at greater risk of adverse obstetric outcomes and so additional antenatal care is required.

7.47 NICE guidelines on twins and triplet pregnancy were first published in 2011 and have since been updated in 2019[132]. Guidance has emphasised the importance of detailed antenatal counselling for women with twins or triplets especially with regards to intrapartum management. This is best facilitated through a specialist clinic. The review found multiple cases where limited or no counselling was evident with regards to management of twin pregnancies.

7.48 *In **2013**, a multiparous[133] woman booked with a DCDA[134], twin pregnancy. At 31 weeks she was seen by a registrar and requested birth by caesarean section. She was told this was not necessary but there was no documented discussion regarding the risks associated with vaginal birth for the second twin. Twin 2 experienced a complicated birth and suffered HIE Grade 3. The child is now profoundly disabled and the mother suffered post-traumatic stress disorder. (2013)*

132 National Institute for Health and Care Excellence. Twin and triplet pregnancy NICE Guideline NG137 (2019) https://www.nice.org.uk/guidance/ng137

133 See glossary

134 See glossary

7.49 *In **2014**, a 41-year-old first time mother who conceived through assisted conception was advised an induction of labour at 36+ weeks as her twins were small. There was no evidence of any antenatal counselling. Labour was induced and she required an assisted vaginal birth for both twins in theatre. The second twin had a very complicated birth and as a consequence suffered HIE. (2014)*

7.50 *In **2017**, a primiparous[135] woman was induced at 37 weeks and 5 days as she had a DCDA[136] twin pregnancy, this was in accordance with local guidance. There was inadequate documented antenatal discussion with regards to the process of induction of labour, consideration of epidural analgesia and the potential risk of caesarean section for twin 2. Furthermore, at the time of induction prostaglandin (medication given to start the labour) was given without an obstetric review or an ultrasound scan to confirm presentation of the twins. An emergency caesarean section was undertaken for a fetal heart rate abnormality. There was a postpartum haemorrhage of 2500mls which was appropriately managed. (2017)*

7.51 Further cases of concern regarding the management of multiple pregnancies were seen by the review team. In conclusion, the review team found that multiple pregnancy management at the Trust gave cause for concern across the entire review period.

Diabetic Care

7.52 The care of women with diabetes encompasses women with both pre-existing diabetes and women who develop diabetes during pregnancy, known as gestational diabetes mellitus (GDM). UK rates of GDM have steadily increased over the last decade with Diabetes UK estimating that about 1 in 16 women will develop GDM. Women with pre-existing diabetes make up a smaller proportion of the women requiring diabetes care, but pregnancy complications are greater in this group.

7.53 UK guidance for the management of diabetes in pregnancy was first published by NICE in 2008 (revised in 2015 and updated 2020)[137]. Prior to NICE guidance CEMACH[138] published a landmark report in 2007 that highlighted women with pre-existing diabetes had a fivefold increased risk of stillbirth and a threefold increased risk of perinatal mortality. All these reports emphasise the importance of multidisciplinary care for women with diabetes and that women must have ready access to specialists with expertise in the care of diabetes in pregnancy.

7.54 Diabetes care at the Trust must be led by a named consultant obstetrician who acts as a lead for the service. This lead consultant must have sufficient time in their job plan to lead the diabetes service effectively. This can be benchmarked against other similar sized trusts. The lead consultant must work in conjunction with a consultant diabetologist, specialist nurses, midwives and also a diabetes dietician. It is imperative that these individuals work together in a collaborative manner. The diabetes service at the Trust was created in 1999 and has increased in size over the last 20 years. The number of women presenting with diabetes has been increasing significantly.

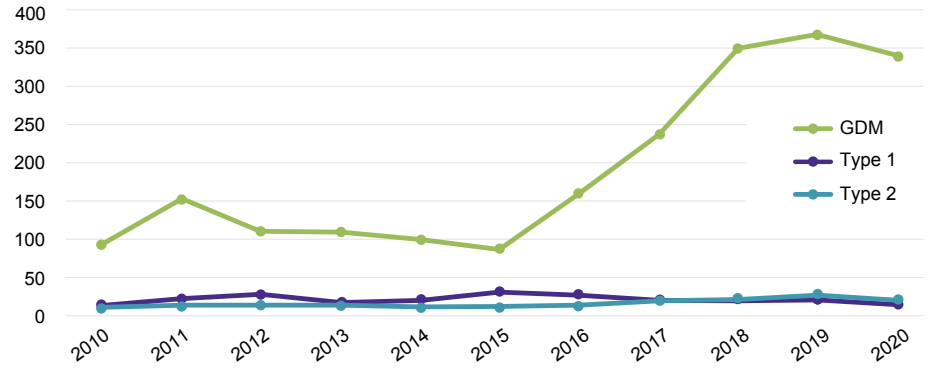
135 See glossary

136 See glossary

137 National Institute for Health and Care Excellence. *Diabetes in pregnancy: management from preconception to the postnatal period NICE guideline NG3* (2020) https://www.nice.org.uk/guidance/ng3

138 Confidential Enquiry into Maternal and Child Health. Diabetes in pregnancy: are we providing the best care? (2007) https://www.publichealth.hscni.net/publications/diabetes-pregnancy-are-we-providing-best-care

Diabetes yearly breakdown



Source: Shrewsbury and Telford Hospital NHS Trust

7.55 *In **2016**, a woman had appropriate multidisciplinary team antenatal care that involved senior obstetric, diabetic specialists and midwifery input. However there was failure not to act or further investigate increasing ketonuria[139] and fetal macrosomia[140] in a diabetic smoker all of which are individual risk factors for intrauterine fetal death. An antepartum stillbirth occurred at 34 weeks and 6 days. There was no evidence provided to the review team that this case was discussed at a governance meeting or that any learning was identified. (2016)*

7.56 *In **2016** a women with Type 1 diabetes who had poor control prior to pregnancy, suffered a stillbirth at 34 weeks' gestation. There were multiple missed opportunities to improve diabetic control and care sometimes seemed fragmented. The risks of the pregnancy were not shared with the patient. The patient had a pregnancy the following year where the care was much improved with evidence of better multidisciplinary team working. (2016)*

Staffing of the maternity diabetic service at the Trust

7.57 The Trust has advised the review team that the present diabetic service consists of two consultant obstetricians, and two endocrinologists. There is one Band 7 midwife and two band 6 midwives who both provide less than 0.5 full time equivalent cover. The service also has access to diabetes nurse specialists. The review noted current problems with staffing and capacity within the diabetic service, especially given the increasing workload. Firstly, there is no current provision for consultant cover during periods of annual leave, study leave and other absences, meaning women have limited access to the correct specialist during their antenatal care.

7.57 Furthermore, from the documentation provided to the review team there appears to be only one fortnightly clinic run for women with GDM. This is inadequate for the number of women managed with GDM in the service, which is on average 29 women a week (based on the Trust's data for the last 3 years). Having such limited appointments available for complex pregnancies means that an appropriately detailed assessment is unlikely to be made, which increases the likelihood that omissions will occur and errors will be made.

Good practice

7.59 Whist the review had concerns regarding the maternity department's ability to support the diabetes service it saw good practice, in that the department had invested to develop a midwifery non-medical prescriber. This model of care means a specialist midwife has a greater depth and understanding of diabetes and also continues to manage women with gestational diabetes when medical therapy is required.

139 See glossary

140 See glossary

Preconception care and diabetes

7.60 An important facet of diabetes management is access to preconception care for women with pre-existing diabetes. Women with very poor diabetic control must be advised against becoming pregnant until better diabetic control is established and must have access to appropriate advice on contraception and medications to avoid when embarking upon pregnancy. The review found evidence of numerous cases of women with pre-existing diabetes who had not had access to preconception care. This includes the case below, which is relatively recent.

7.61 *In **2019** a woman with underlying type 2 diabetes and an elevated BMI booked with an average blood glucose level of 117 prior to pregnancy (desired upper level for pregnancy is 48). Whilst she was first seen prior to 10 weeks of gestation, she unfortunately suffered an intrauterine death at 16 weeks, which may have been related to her pre-pregnancy diabetic control. (2019)*

7.62 Cases such as this evidence the disconnect between diabetes care, general practice and maternity services and the need for greater emphasis on preconception care. With better access to preconception care and provision of appropriate contraception services, this will help reduce or minimise cases of pregnancy loss associated with a woman's diabetic status.

7.63 As pregnancies in women with underlying diabetes are at elevated risk of poor fetal outcome it is imperative that women undergo thorough clinical and risk assessment at all antenatal visits. This includes assessment of blood pressure, urine and measuring and plotting the SFH.

7.64 A further important component of antenatal care for women with diabetes is that of birth planning. Women with diabetes are far more likely to require induction of labour or birth by planned caesarean section, particularly in the presence of fetal macrosomia or fetal growth restriction. There was evidence that this failed to occur in several cases leading to poor fetal outcome at the Trust.

7.65 *In **2014** a woman with type 1 diabetes was seen at 35 weeks and a plan was made for induction of labour at 38 weeks. There was no assessment of fetal growth beyond 35 weeks, but it was noted the abdominal circumference plotted above the 95th centile. At the time of induction, it was noted that the SFH measured 46cm and yet this was not acted upon. The patient underwent induction of labour which culminated in a vaginal birth complicated by a shoulder dystocia and abnormal fetal blood gases. Unfortunately, an early neonatal death occurred which was related to fetal hypoxemia at birth. (2014)*

7.66 When planning the place and mode of birth, maternity team members must provide women with evidence-based advice and recommendations. This will enable women to make an informed choice about their pregnancy and birth. This discussion must be fully documented in the maternity notes.

Good practice

7.67 There is evidence within the diabetes service that the Trust has made efforts to enhance antenatal care for diabetic women. The Trust has invested in the use of smartphone technology to allow remote reviews and telephone consultations for women with gestational diabetes. Additionally, NHS England recently mandated funding for all women with type 1 diabetes to have access to continuous glucose monitoring (CGM) in pregnancy. This funding stream has commenced after the period of the review but it is nevertheless important that the Trust ensures women have equity of access to CGM early in pregnancy.

Hypertension management

7.68 Gestational hypertension (also referred to as pregnancy induced hypertension) is a common disorder and may affect up to 1 in 10 pregnancies. It describes new onset hypertension in pregnancy occurring after 20 weeks gestation where maternal blood pressure is greater than 140/90 on two separate readings more than 4 hours apart. Hypertension identified prior to this point is known as chronic hypertension and affects about 1-2% of women. Gestational hypertension as well as chronic hypertension are known to be

risk factors for the development of complications in pregnancy and so women must undergo assessment of blood pressure at every antenatal visit. Furthermore, women who develop hypertension may require antihypertensive treatment during pregnancy to reduce the risk of developing severe hypertension.

7.69 National guidance for hypertension management was first published by NICE 2010 with collaboration from the RCOG and the RCM. It has since undergone revision in 2019[141]. Prior to 2010, the UK confidential enquiry in maternal deaths (CEMACH)[142] emphasised the importance of treating severe hypertension which may have contributed to cases of maternal death. Given how common hypertension is, all healthcare professionals working in maternity services must be aware of the need for monitoring and onward referral of woman with hypertension for obstetric review.

7.70 The Trust shared with the review team its first guidance for hypertension in pregnancy. This appears to have been created in 2006. The document is entitled Hypertension Severe (it has no implementation date but was due for review in 2008). It is noteworthy that the guidance stated that the initiation of antihypertensive medication for high blood pressure was only required if the systolic was 170 or greater, and they acknowledge that the Confidential Enquiry recommendation (published 2007) stated a lower blood pressure of 160 systolic required treatment. This potentially indicates a reluctance within the Trust's maternity service to treat severe hypertension according to national guidance. It must be noted these thresholds are much higher than the current guidance set out from NICE where blood pressure requires treatment when it is 150/100 or greater.

7.71 This review covers an extended period over 20 years and underpinning the review is a methodology acknowledging that assessment of cases must utilise the national guidance in use at the time. When reviewing the management of hypertension, the review team has focused on cases from 2009 onwards so that maximum learning could be established for the Trust as regards current service provision from the cases reviewed. Nevertheless, it must be acknowledged that there were many significant cases that were encountered where there was suboptimal management of hypertension prior to 2009. One example is:

7.72 *In **2001**, a woman developed severe hypertension with a blood pressure 165/100 and proteinuria at 36 weeks' gestation. A 24 hour urine collection was raised at 0.5g/l. No treatment was started, instead her elevated blood pressure was attributed to anxiety, despite clinical signs of severe hypertension. Over a week later induction of labour was finally decided upon when she developed epigastric pain and felt very unwell. There was no long term harm to mother or baby in this case. (2001)*

7.73 Following publication of the 2010 NICE guidance the review team found continued deviation from NICE guidance in the treatment of women with hypertension at the Trust.

7.74 *In **2011** a woman developed hypertension at 38 weeks' gestation in her first pregnancy, despite multiple elevated blood pressure readings that would have justified treatment, no treatment was started. She suffered an intrapartum stillbirth during the induction of labour, (IOL) process. The review team felt this was a high risk case, and a scan should have been carried out prior to IOL. In addition, assessment should have been made by an experienced midwife, not a student. If the CTG had been normal at the beginning of induction, then it is more likely than not that with adequate and ongoing observation and assessment, the outcome would have been different. (2011)*

7.75 *A woman developed hypertension and proteinuria at 33 weeks gestation in **2011**. She was admitted to the antenatal ward and started on treatment and given intramuscular steroids in anticipation of early birth. She had persistent vomiting and an ongoing headache. A consultant review occurred and it was decided she could have outpatient management. The woman was discharged but had an eclamptic seizure at home and was transferred and delivered by emergency caesarean at another hospital. The review team have not been provided with any documentation by the Trust that indicated any investigation or subsequent learning occurred as a result of this case. (2011)*

141 National Institute for Health and Care Excellence. Hypertension in pregnancy: *diagnosis and management NICE guideline NG133* (2019) https://www.nice.org.uk/guidance/ng133

142 Confidential Enquiry into Maternal and Child Health. *Saving Mothers' Lives 2003-2005* (2007) https://www.publichealth.hscni.net/publications/saving-mothers-lives-2003-2005

7.76 *In a **2013** pregnancy a woman with type 1 diabetes was reviewed as an inpatient at 37 weeks as she had developed hypertension and proteinuria. Her blood pressure was elevated at 162/98mmhg. Her case was escalated to a consultant who despite clinical signs of hypertension and proteinurea indicated that no treatment was required. The review team found had concerns that such a high risk case had induction of labour started on the antenatal ward. There was poor management of her pre-eclampsia; earlier medication/treatment for pre-eclampsia would be recommended in this case. The review team notes with concern the management of a high risk IOL on the antenatal ward. Due to the complexity of this case, IOL should have been managed on the labour ward. There were also concerns regarding the management of this woman's diabetes with a delay in starting an insulin 'sliding scale'. (2013)*

Chronic hypertension

7.77 Another key element to managing hypertension in pregnancy is the recognition of women who have chronic hypertension. This cohort of women are at greater risk of developing severe hypertension in pregnancy as well as pre-eclampsia, having a preterm birth or a baby born small for gestational age. Women identified with chronic hypertension must be cared for throughout their antenatal period on a consultant-led care pathway. Current evidence suggests women should be advised to take aspirin from 12 weeks' gestation[143]. Additionally, women may require additional fetal growth scans to assess for growth restriction, which is more common in this cohort of women.

7.78 *A 42-year-old woman with a history of previous pregnancy affected by pre-eclampsia had a booking blood pressure of 140/80 with dipstick proteinuria in **2015**. She was appropriately referred to see a consultant at 11 weeks. However, there was no consideration that this might be chronic hypertension with an underlying renal disease. Unfortunately, the woman developed superimposed pre-eclampsia and experienced a stillbirth at 27 weeks' gestation. (2015)*

Inpatient antenatal care

7.79 It is estimated that about 12 per cent of all pregnant women are admitted to the antenatal ward during their pregnancy[144]. Women admitted for hospital care antenatally are more likely to need extra surveillance for an existing or new condition during their pregnancy. As a review team we acknowledge that there is an absence of national guidance that sets thresholds for when a woman must be admitted. Nevertheless, when women are admitted to the antenatal ward a clear consultant obstetrician-led plan of care is required as a standard.

Obstetric ward rounds

7.80 The Trust's Maternity Clinical Operation Policy (2015) describes the cover and support for the wards (wards described as labour ward; antenatal ward; postnatal ward and other pregnant women in hospital such as ITU) with a consultant on site from 08.30 to 20.30 from Monday to Friday and 08.00 to 16.00 on weekends and bank holidays. However, there is no clear description of what this 'support' entails. There is no mention of dedicated ward rounds on the antenatal ward. The RCOG Roles and Responsibility of a Consultant[145] (published 2009 and updated 2021) has identified that obstetric ward rounds enable staff to monitor, anticipate and respond in a timely way to emerging problems. They permit women to voice their concerns and enable them to ask questions and receive answers with regard to their care.

143 Ibid n25

144 Tracy, K. et al. *Caseload midwifery care versus standard maternity care for women of any risk: M@NGO*, A randomised controlled trial. (2013) Lancet. Vol 382, Issue 9906 p1,723-32

145 Royal College of Obstetrics and Gynaecologists. Roles and Responsibilities of a Consultant – Workforce Report (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

7.81 Handovers must also include high risk women in the antenatal ward, enabling the out of hours team to be aware of concerns and possible reviews needed during their shifts (RCOG 2010[146], NHS1 2019[147]).

7.82 The review team found many incidents of high-risk women admitted to hospital not being reviewed by consultants. There was a lack of consultant presence on the antenatal ward and no evidence seen of a structured antenatal ward round. Medical assessments of antenatal inpatient women seemed to happen when a midwife asked for a clinical review rather than being part of the daily routine in maternity services.

7.83 When a plan for treatment or intervention was decided, documentation of detailed discussions with the women and their partners was rarely found within the records supplied to the review by the Trust.

7.84 *In **2005**, a woman with a complex pregnancy had an amniotic fluid drainage (removal of excess amniotic fluid around the baby) on the ward. There was no mention of a discussion of the procedure with the woman or any record of the procedure itself. The only documentation in the medical records provided to the review team by the Trust is the amniotic fluid biochemistry. (2005)*

7.85 During the staff voices interviews in autumn 2021, staff were asked about inpatient care and if registrars couldn't get hold of consultants to see high-risk antenatal patients, whether they would make it known that it was a concern. A staff member replied: *'No, they wouldn't, they would just act on whatever... they would just do whatever they can'.*

7.86 *In **2017** a woman was booked in for low risk midwifery care, but placed on aspirin as there was a family history of pre-eclampsia. The woman presented as large for her dates, had oedema and reduced fetal movements on presentation at 39 weeks and 6 days gestation. She was booked for an induction of labour. Following Propess[148] times 1 and Prostin[149] times 3, when ready for artificial rupture of membranes (ARM) the labour ward was too busy to accept her transfer, so the mother remained on the antenatal ward. Approximately 12 hours later, she was transferred to the labour ward. However, on attempting to auscultate the fetal heart, intrauterine death was identified and confirmed on ultrasound scan. (2017)*

7.87 Additionally, the review team encountered multiple instances where women who were admitted for induction of labour did not have a clinical review at all prior to commencing the induction process.

7.88 *A woman was admitted for induction of labour at 40+1 weeks in **2013**. Through the documentation provided by the Trust to the review team the indication for induction was not clear. Prostaglandins were given as the cervix was unfavourable. No obstetric review is documented in the notes until 48 hours after admission. Baby was born delivered by emergency caesarean section. Parents report their experience around induction, labour and the immediate postnatal experience being 'horrific.' (2013)*

Escalation of concerns

7.89 The RCOG Each Baby Counts (2020)[150] documented that 'failure to escalate/act upon risk/transfer appropriately' occurred in 36 per cent of reviewed reports. Factors affecting escalation nationally included site-based or professional team alliances, and skill gaps within specialisms and wider teams.

7.90 The review team identified many cases where midwifery staff appeared reluctant to escalate their concerns regarding care and treatment to obstetric and neonatal colleagues. High risk and complex cases were not escalated to the right person in a timely manner. Sometimes, there was recognition by the midwifery team of the need to escalate but as the junior doctor was often busy, they just waited despite their concerns.

146 Royal College of Obstetrics and Gynaecologists. Improving patient handover: Good practice no. 12 (2010) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-12/

147 NHS Improvement. Implementing huddles and handovers 0- a framework for practice in maternity units (2019) https://www.pslhub.org/learn/patient-safety-in-health-and-care/transitions-of-care/handover/nhs-improvement-implementing-huddles-and-handovers-%E2%80%94-a-framework-for-practice-in-maternity-units-25-march-2019-r136/

148 https://www.medicines.org.uk/emc/files/pil.135.pdf

149 https://bnf.nice.org.uk/drug/dinoprostone.html

150 Royal College of Obstetrics and Gynaecologists. *Each Baby Counts: 2019 progress report* (2020) https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2019-progress-report/

In other cases, they did not recognise a sick or deteriorating women and failed to escalate. The cases below are examples from across the timespan of the review. In addition, frequently women with confirmed preterm pre-labour ruptured membranes were not given antibiotics in keeping with national guidelines.

7.91 *In **2002** a woman was admitted with repeated episodes of antenatal bleeding. Her waters then broke at 25 weeks' gestation. She reported tightenings but was asked to go for a walk and given some analgesia. It was eventually realised that the so called tightenings were labour and she experienced a vaginal breech birth just 75 minutes later. (2002)*

7.92 *A woman with a history of ruptured membranes for 3 days in **2011** was admitted feeling unwell and had a raised pulse. Despite raised inflammatory markers on her admission bloods, there was a delay in recognising how unwell the woman was and she was transferred to labour ward with overwhelming sepsis 14 hours later. (2011)*

7.93 *In **2016**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation. Antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously even though the baby was breech. She experienced an intrapartum stillbirth with evidence of E.coli sepsis. (2016)*

7.94 The review team also saw multiple cases where women who were considered high risk were admitted to the antenatal ward to commence an induction of labour when induction should have occurred (or it should at least have been considered) on the labour ward. Lack of senior review or awareness meant that care provision happened in the wrong place and often without full consideration of the clinical risks involved in the care provided.

7.95 *In **2010** a woman was transferred from the midwife-led unit, (MLU) by ambulance to the consultant-led unit. There was high clinical activity at the time and yet there was no escalation to the labour ward consultant. The registrar was unable to make a full assessment because they were conducting a twin delivery with another patient at the time. This case sadly resulted in the baby needing to be cooled and developing HIE. (2010)*

7.96 *In **2012**, a 25-year-old mother with a history of previous caesarean section for breech decided to attempt vaginal birth after her membranes ruptured at 36 weeks. Prostaglandin was given on the antenatal ward. There was no documentation in the records provided by the Trust with regard to information given on the increased risk to the mother or her baby. The mother suffered a uterine rupture and the baby was born in poor condition. The baby died at 7 days of age. (2012)*

7.97 *In **2014**, a woman with preterm pre-labour ruptured membranes was admitted at 35 weeks' gestation however antibiotics were not given. She was seen by several different doctors and advised to try for a vaginal birth if her labour started spontaneously, even though the baby was breech. Her baby was born showing no signs of life. Resuscitation was initiated, but neonatal death was confirmed at 27 minutes of age. (2014)*

7.98 *A woman who was 25 weeks' gestation in **2016**, was admitted to the antenatal ward with preterm pre-labour ruptured membranes, she developed a MEOWS score of 7 indicating that she was severely unwell. The midwife contacted the registrar who was busy, but there was no escalation to another clinician until almost an hour later. At this point the women was severely unwell and a decision was then made for an emergency caesarean section. (2016)*

7.99 *In **2019**, a 35-year-old woman in her third pregnancy was induced as her baby was severely growth restricted, with absent end diastolic flow[151]. She also had gestational hypertension. A decision was made to commence the induction on the antenatal ward. The CTG was deemed suspicious on admission and she was transferred to the labour ward. The consultant review was at first to prescribe prostaglandin, but*

151 See glossary

fetal monitoring remained suspicious and a category 2 caesarean section was performed. The review team is of the view that induction should have been started on the labour ward in the first instance due to consideration of the mother's known hypertension and a severely growth restricted fetus (placental pathology). This baby therefore needed frequent monitoring. (2019)

Delay in transfer of women to the labour ward

7.100 The review team found many incidences where there was a delay in transfer of women in established labour to the labour ward. Women were frequently not monitored appropriately despite being identified as high risk. There were also several cases of women experiencing induction of labour where following delays in transferring to labour ward an intrauterine death occurred. In other cases, the delay subsequently led to a category 1 caesarean section.

7.101 *In **2003**, a 28–year-old woman was admitted to the antenatal ward at 29 weeks with abdominal pain. On the ward she collapsed with a tender abdomen. It took nearly 50 minutes to transfer her to the labour ward and conduct an emergency caesarean where a placental abruption was confirmed along with the death of her baby. (2003)*

7.102 *In **2013**, a woman undergoing induction of labour on the antenatal ward was delayed in transfer to the labour ward. When the family requested for the fetal heart to be monitored as it had not been for an hour, the fetal heart could not be located. The midwife asked the woman to go for a walk and have a drink as it was handover. An intrauterine death was diagnosed on her return an hour later. (2013)*

7.103 *A type 1 diabetic mother had a high risk pregnancy in **2013** and was admitted having evidence of pre-eclampsia. There was delay in planning induction of labour (IOL). When IOL commenced it was conducted on the antenatal ward and transfer to labour ward was not arranged until the mother had reached 4cm cervical dilatation. The baby was born by emergency caesarean section and initially responded well to resuscitation, but required transfer to the neonatal unit at seven hours of age. The baby remained an inpatient for three weeks, and is now doing well. However, as well as a delay in transfer to the labour ward the review team also has concerns regarding the care provided in labour once transfer occurred. (2013)*

7.104 *In **2015** a woman who experienced an antepartum haemorrhage in late pregnancy was inappropriately advised by the consultant obstetrician that her plans to birth in a midwifery led unit (MLU) did not need to be reconsidered or changed. When problems were identified in labour there was a delay in transfer to the labour ward, and fetal wellbeing was not adequately monitored during the transfer period. The baby was delivered in very poor condition and hypoxic ischaemic encephalopathy (HIE) was later confirmed. The baby subsequently died. The family were critical of the ensuing investigation and correspondence with the Trust. (2015)*

7.105 *In **2017**, a woman whose transfer to labour ward was delayed during the induction process as the unit was very busy experienced an antepartum stillbirth whilst on the antenatal ward. During their investigation into what happened, the Trust through their Root Cause Analysis (RCA) recognised there were delays in transfer primarily due to maternity unit activity. In the RCA analysis section of the report the causes were identified as a lack of capacity on the labour ward, increased activity and emergency caesarean sections being undertaken. It also found that there was a 'culture of normalising long waits for women undergoing induction of labour when labour ward is busy'. (2017)*

7.106 Various versions of the Trust's Escalation of Maternity Services policy have been provided to the review team by the Trust since version 1 from June 2010 to version 5 in 2018. The policy repeatedly states that if the labour ward is busy, this must be escalated to the highest level and if women are waiting more than eight hours to be transferred to continue induction of labour then a senior obstetric review must occur. The review team found numerous cases where the trust did not follow its own escalation policy.

Misinterpretation of the antenatal cardiotocograph (CTG)

7.107 Fetal well-being assessments are a significant component of antenatal inpatient care and this will frequently be through CTG monitoring. Typically, women admitted to the antenatal ward may need enhanced fetal monitoring so it is imperative that CTG monitoring is undertaken appropriately and interpreted correctly. Delaying action or misinterpreting an antenatal CTG may lead to a poor fetal outcome. This is especially true in high risk women, such as those with pre-eclampsia, diabetes or severe fetal growth restriction.

7.108 The RCOG 'Green Top' guidelines Reduced Fetal Movements[152] advises that all women have an antenatal CTG from 28 weeks (pre-computerised CTG) if they are not in labour. CTG monitoring for at least 20 minutes provides an easy and accessible means of detecting fetal compromise. The presence of a normal fetal heart indicates a healthy fetus with a functioning autonomic nervous system. Interpretation of the CTG must be according to the NICE classification of fetal heart patterns.

7.109 The review team found there were many cases where an antenatal CTG was incorrectly classified, or there was a delay in acting upon a clearly abnormal CTG leading to poor fetal outcome.

7.110 *In **2003**, at 37+4 weeks gestation, a woman reported to the maternity triage unit with reduced fetal movements. The CTG was reported as having a baseline rate of 90 beats per minute (grossly abnormal) but there was no escalation made to an obstetrician, an intrauterine death was confirmed 30 minutes later. (2003)*

7.111 *In **2011**, a woman at 34 weeks' gestation attended the day assessment unit with reduced fetal movements and symptoms of pre-eclampsia. She was sent home and informed to return at a later time. When she was eventually seen by a locum registrar four hours later the CTG was interpreted as being abnormal but was not correctly classified and immediate escalation did not occur. Even when the case was reviewed by the consultant there was a delay in expediting birth to a category one caesarean section, instead, opting to perform an obstetric ultrasound scan. The baby was born requiring admission to the neonatal unit and was later diagnosed with hypoxic ischaemic encephalopathy grade 3. (2011)*

7.112 *In **2010**, a woman with a complex social history was admitted to the antenatal ward with preterm pre-labour ruptured membranes, (PPROM) at 29 weeks gestation. The review team found a failure to obtain adequate CTG's and a failure to perform additional fetal wellbeing tests such as a fetal biophysical profile whilst the woman was an inpatient. The review team also found no use of prophylactic use of antibiotics once there was confirmed PPROM, which may have reduced the risk of maternal infection and its complications. There was a lack of communication to the woman and her family and a lack of a clear obstetric plan. An intrauterine fetal death occurred 4 days after ruptured membranes occurred. Examination of the placenta showed there was histological evidence of acute chorioamnionitis[153] and funisitis[154]. There was a complaint made by the family regarding treatment and plans were made with lessons to be learned but there is no evidence from the documentation shared with the review team by the Trust of these actions having been put in place. (2010)*

152 Royal College of Obstetrics and Gynaecologists. Reduced fetal movements: Green top guideline 57 (2011) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/

153 See glossary

154 See glossary

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.113 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.114 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

7.115 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019).

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.116 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

7.117 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.118 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.119 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD AND CLINICAL REVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.120 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

7.121 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021.

7.122 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

7.123 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

7.124 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

7.125 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts and Saving Babies Lives. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Chapter 8

Intrapartum care

Multidisciplinary working

Failure to escalate and lack of senior obstetric input

8.1 Effective communication between healthcare professionals and women is an integral component of safe maternity care, this is absolutely vital during intrapartum care. Maternity services should foster a team approach based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication[155].

8.2 In our first report[156], which was a review of 250 cases across the timespan of the review, evidence was provided that concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women. In this second report the review team has selected vignettes from more recent years to highlight both a failure to learn and a lack of progression at the Trust in terms of governance and learning.

8.3 All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant. The consultant should be responsive and attend in person in complex situations such as the cases outlined in the vignettes below[157].

8.4 *In **2014**, a pathological CTG in the second stage of labour failed to attract the attention of the obstetric team for too long. The trainee was busy but even during the daytime, there was no apparent attempt to call the consultant obstetrician despite a complicated operative delivery of a baby in the operating theatre. This baby now suffers cerebral palsy and no governance review was conducted. (2014)*

8.5 *In **2016** a woman was taken to the operating theatre for an attempted forceps delivery. The baby's head was in the posterior position and the delivery was undertaken by a junior registrar. No attempt was made to rotate the baby's head to the correct position and during the forceps delivery the woman sustained a 4th degree tear. There was no evidence of duty of candour being performed and the issue does not appear to have been raised with the junior doctor as a training issue. (2016)*

Consultant presence on labour ward

8.6 The requirement for consultant obstetricians to be directly involved and lead in the management of all complex pregnancies, labour and delivery, with planned twice daily consultant-led ward rounds was identified as a local action for learning for the Trust within our first report. As the review team has continued to review all of the cases for this report we have found little evidence of planned consultant level reviews throughout the time period of this review. There were many cases which demonstrated that the supervision of trainee doctors during day and night time did not meet the required standards. Many high risk women received minimal obstetric care during the induction of labour and intrapartum period, until a point of midwifery request for review.

155 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *Safer Childbirth Minimum Standards for the organization and delivery of care in labour (2007)* https://www.rcog.org.uk/globalassets/documents/guidelines/wprsaferchildbirthreport2007.pdf

National Institute for Health and Care Excellence Safe midwifery staffing for maternity settings (2015) https://www.nice.org.uk/guidance/ng4

156 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.* (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

157 Royal College of Obstetricians and Gynaecologists Safe Staffing (2021) https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing/

8.7 *In **2007**, in the death of a woman who was a practicing Jehovah's Witness and who laboured and gave birth to twins, no middle grade or more senior review was received until the final stages of her second stage of labour. Consultant input into her care was only sought when an extensive perineal haematoma was discovered many hours after the birth. (2007)*

8.8 *In **2012** a woman who did not initially want a vaginal birth after a previous caesarean section birth was advised to undergo an induction of labour after pre-labour preterm rupture of membranes with signs of infection. The registrar advised oxytocin to be administered after 2 hours of pushing and the woman pushed in the second stage of labour as the oxytocin continued to be increased for over 4 hours until she suffered a uterine rupture and her baby died. No consultant input was evident within this birth or during the immediate postpartum period. Oxytocin was prescribed by the registrar during advanced labour when there were signs of obstructed labour without first performing a medical review. No apology was given for the mismanagement of this case and the conclusions of the subsequent Trust risk review were not appropriate or relevant to the real issues at the time. (2012)*

8.9 One midwife spoke to the review team in autumn 2021, describing that in a previous trust they had been familiar with a system in which a senior trainee, anaesthetist and obstetric consultant would lead a ward round after handover twice a day. The midwife was concerned that there were no ward rounds at the Trust however when questioning this, the response they received was: *'No, no, no, you are the Band 7 coordinator, you should know when the doctor needs to see the patient'.* The midwife described to the review team how she was laughed at and ridiculed for suggesting that multi professional ward rounds were necessary.

8.10 Evidence was found by the review team that when care was escalated at the Trust there was a failure of the senior clinical team to respond appropriately:

*In **2016**, a woman was admitted to the labour ward with evidence of excessive uterine contractions with a reassuring CTG and severe hypertension. This was escalated to the registrar who decided upon no further intervention. The midwife's written statement indicated unhappiness with this response however these concerns were not escalated further. The CTG was pathological for one hour before delivery of a large for dates baby with significant shoulder dystocia and postpartum haemorrhage (PPH). The baby was later diagnosed with grade 3 hypoxic ischemic encephalopathy (HIE). Escalation and obstetric involvement in this case was poor throughout. (2016)*

8.11 *In **2016**, a woman spent approximately 8 hours on the labour ward, where she received minimal medical input despite midwifery requests for a medical review of her raised blood pressure (BP). At numerous times during the late first and second stages of labour the woman's BP was recorded as 160/105 mmHg or higher which is a medical emergency. Repeated attempts to have the woman reviewed due to her high BP were unsuccessful and when the consultant was informed, nothing was written in the notes and the consultant did not review the woman, instead prescribing an anti-hypertensive which had little effect. During a subsequent major postpartum haemorrhage this same consultant attended, advised on drug use and again documented nothing. The governance review failed to address these issues of lack of consultant review and action. (2016)*

Midwifery leadership and culture on the labour ward

8.12 A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case. Although the role of the coordinator is challenging, with contemporaneous documentation sometimes difficult when dealing with emergency situations, many cases reviewed have failed to demonstrate even any good quality retrospective documentation. The verbal and written communication between the coordinator and obstetrician is paramount and there is evidence that it failed in numerous cases.

8.13 *In **2015**, a woman with a raised BP had her labour augmented with oxytocin for 12 hours without an obstetric review. The labour ward was so busy that the labour ward coordinator was caring for another*

labouring woman and did not perform a 'fresh eyes' assessment on a CTG when asked. The midwife had previously attempted to escalate clinical findings of raised maternal BP, significant proteinuria and an abnormal CTG with no documented evidence that she was supported by senior obstetric or midwifery staff even when the emergency buzzer was pulled due to fetal bradycardia. Eventually a decision was made to expedite the delivery using forceps and the baby required admission to the neonatal unit for suspected infection. (2015)

8.14 It is not ideal for the coordinator to be caring for a woman in labour, although the review team appreciates this can happen occasionally in an emergency situation. This role must be supernumerary so that the labour ward remains safe and there is senior presence available to assist midwives and to facilitate escalation to the obstetric team[158]. Midwives also have a duty to escalate care and challenge decisions when there is a concern about safety[159].

8.15 *In **2016**, a woman who laboured at the birth centre was not adequately monitored as 'the unit was busy'. When problems were eventually identified in labour there was a delay in transferring the mother to the labour ward, where her baby was delivered in a very poor condition having suffered a brain injury. The baby subsequently died. (2016)*

8.16 There is evidence that over a long period of time midwives may have been reluctant to ask for help when working on the Trust's labour ward. One midwife explained to the review team in late 2021 how *'you just tried to keep your head down...asking for help was seen as a bad thing. People were derided for asking for help. Even something simple like a junior midwife asking for support suturing, they were like … [ridiculed]...'.*

8.17 Midwives providing intrapartum care outside the labour ward described facing reproach from labour ward colleagues when they telephoned regarding a possible need to transfer the woman to labour ward. One midwife outlined the challenges midwives faced when transferring women into labour ward or planning ahead when the clinical picture of the woman they were caring for started to change stating that there was *'a bullying culture'* on the labour ward.

8.18 The same midwife explained to the review team how the general culture on the labour ward was to joke that the transferring midwife did not know how to look after a woman in labour, for example, *'Do you not know how to look after a woman in labour? So that was the culture. It started off as being a little bit more of a jokey sort of thing, then it became really quite insidious so that I used to dread it, I would dread ringing. In the end I would say…this is the situation I am bringing the lady up, expect me in an ambulance in forty five minutes, and then I would always get, well if you bring her up, you would have to look after her yourself'.*

8.19 Another midwife told the review team in autumn 2021 of a culture of bullying on labour ward. *'Staff don't always feel supported by the shift co-ordinators. As I have said previously even though I am experienced I still felt I needed support and didn't always get it.'*

8.20 A further example was provided by a midwife who described being belittled when asking for support on the midwifery-led unit due to an excessive and complex workload. *'I said: "I can't accept somebody in labour because there are nine women, nine babies, a midwife who's not familiar that needs my support as well and I don't feel it's safe…" [A manager] came storming down and said, "You've got no authority to close this MLU", and I was like, "I'm not closing the MLU, I'm saying that we need further support to be able to safely do this." [The manager] belittled me in front of a group of staff there and told me, "You're taking this woman".'*

8.21 The same midwife also commented on how midwives were belittled when transferring women to the labour ward: *'You'll hand over care to somebody on the consultant-led unit and the comments that they make*

158 Ibid n1 and Royal College of Midwives. *RCM guidance on implementing the NICE safe staffing guideline on midwifery staffing in maternity settings* (2016) https://www.rcm.org.uk/publications/publications/rcm-guidance-on-implementing-the-nice-safe-staffing-guideline-on-midwifery-staffing-in-maternity-settings/

159 Nursing Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* (2015, updated 2018) https://www.nmc.org.uk/standards/code/

in front of the woman, can be very belittling and degrading to your face in front of a family and that's not cohesive. That's not putting the woman first'.

8.22 It is evident from considering numerous reviews and hearing staff voices throughout the autumn and winter of 2021 that there continues to be some major issues relating to the culture of intrapartum care at the Trust. Influencing factors include human factors, leadership from senior clinicians, lack of escalation, locum doctors working for many years with little supervision, lack of robust governance processes and a lack of multi-professional working.

8.23 The culture of intrapartum care at the Trust may have resulted in harm to mothers and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance (for example unsafe operative delivery and, in particular, a number of inappropriate breech deliveries). These examples continue throughout the period of the review to the very end. Examples of these are detailed throughout this report.

8.24 The direct links between incivility and patient safety have been well documented. Civility Saves Lives[160] sets out the detrimental impact uncivil behaviours have on team functioning, decision-making, performance and safety. The consultant obstetrician and labour ward coordinators have an integral role to play in role-modelling the professional behaviours and personal values that are consistent with positive team working, including the demonstration of respect for colleagues and women[161].

Use of medical locums at obstetric middle grade

8.25 The review team found that there appeared to be a high reliance on the locum medical workforce working at middle grade at the Trust without evidence of documented supervision and governance.

8.26 *During the birth of twins in **2015**, a family told the review team the doctor was 'so aggressive, he was shouting. The midwives didn't like him; that was obvious'. The doctor conducted a poorly managed twin delivery and walked out of the room (not to return) during a postpartum haemorrhage and episode of extreme hypotension. The Trust has not shared any evidence of learning or the development of actions following this case with the review team. (2015)*

8.27 *In **2016** a locum doctor failed to recognise or intervene during a 40 minute terminal bradycardia resulting from acute intrapartum hypoxia. After alienating both the midwife and woman, he was told to leave the room and did so without any further delivery of care. The baby was born with HIE and severely acidotic cord blood results. The Trust risk review process was not robust and there was no evidence of internal reflection. The RCA report failed to investigate and recognise that this incident occurred due to gross lack of team working, failure in escalation, failure to monitor the actions of locum staff, failure to recognise acute bradycardia in labour and failure to document to an expected standard. The report concluded that, 'it is difficult to understand the team dynamics'. (2016)*

8.28 The review team found several examples where locum doctors acted unsupervised, leading to poor outcomes for mothers and babies. Equally it appears that there were not clear escalation plans to the consultant or midwife in charge. In cases of adverse outcomes there is evidence that these were not investigated in line with the incident framework utilised at the time and individuals were not held to account.

8.29 Consultants must be visible, approachable and demonstrate effective leadership skills, enabling other team members to speak up when something is wrong, ensuring good information flow and clinical prioritisation[162].

8.30 The widespread shortage of suitably qualified obstetricians who can safely undertake the role of senior resident doctor out-of-hours with indirect supervision from a consultant who is non-resident has been well documented. The RCOG has highlighted the need for adequate support and supervision of locums

160 Civility Saves Lives. Civility Saves Lives (2017) https://www.civilitysaveslives.com

161 Ibid n3

162 Ibid n3

who enter the workplace and has recently released guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales[163].

8.31 Locum doctors are employed to cover staffing shortfalls and trusts should have appropriately robust recruitment processes in place including assessment of their skills and knowledge, with structured feedback and support before they are released to work independently.

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.32 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

8.33 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

8.34 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

8.35 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

8.36 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out and feel able to speak out when they have concerns about safe care.

Fetal Assessment and Monitoring

8.37 National intrapartum guidelines[164] recommend intermittent auscultation (IA) of the fetal heart rate (FHR) in low-risk pregnancies and continuous FHR monitoring if there are abnormalities such as tachycardia or decelerations, meconium, bleeding, or interventions such as epidural analgesia or oxytocin administration.

8.38 Intrapartum monitoring of the baseline FHR, presence of decelerations, and visually determined FHR variability are used to assess the risk of fetal acidaemia[165] via a set of clinical guidelines. However, FHR abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia.

8.39 On the one hand this mismatch results in increased operative delivery of non-acidotic babies; whilst clinicians on the other hand may miss fetal compromise because current guidelines remain silent on the adverse role played by intrapartum factors, which impair fetal adaptation to the challenges of labour such as fever, chorioamnionitis, meconium, abnormal fetal behavioural states, and excessive head moulding. National perinatal audits and quality improvement programmes such as the Confidential Enquiries into

163 Royal College of Obstetricians and Gynaecologists *Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland and Wales*. (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/safe-staffing/rcog-guidance-on-the-engagement-of-long-term-locums-in-maternity-care.pdf

164 National Institute for Health and Care Excellence *Intrapartum care for healthy women and babies* (2017) https://www.nice.org.uk/guidance/cg190

165 See glossary

Stillbirths and Deaths in Infancy (CESDI) and Each Baby Counts (EBC) have highlighted the significant contributions of these conditions to adverse perinatal outcomes.

8.40 In our first report we found significant problems with the conduct of intermittent auscultation and the interpretation of CTG traces. The review team found problems with intermittent auscultation of labour throughout the entirety of the review period right up to the very end of the review timeline. Vignettes from the cases considered by the review team are presented below which continue to illustrate significant knowledge gaps and examples where the care of complex cases was left in the hands of inexperienced staff.

Failure to recognise and/or escalate the abnormal CTG in early labour

8.41 *In **2012**, a woman presented to the MLU in labour. A CTG was performed on admission, which was reassuring, and early labour was diagnosed. The woman described her pain as constant, but the midwife did not perform an abdominal examination. Intermittent auscultation (IA) showed a significant drop in the baseline fetal heart rate (FHR) although remaining within normal parameters. The FHR was not auscultated for 1 full minute following a contraction. The FHR was auscultated prior to the lady entering the pool and found to be 90bpm. There was a delay in escalation. The baby was born in very poor condition and was later diagnosed with cerebral palsy. The family had concerns that the FHR was not listened to enough. The Chief Executive's letter to the family incorrectly stated that the FHR would be auscultated every 30 minutes during labour. (2012)*

8.42 Fetal bradycardia should be reviewed urgently by an experienced obstetrician to exclude irreversible obstetric emergencies (abruption, cord prolapse and uterine rupture) and to correct reversible causes such as supine or epidural hypotension and uterine hyperstimulation due to excessive oxytocin use. Urgent delivery should be undertaken where indicated if the bradycardia does not improve.

8.43 *In **2012**, a multiparous woman with an uneventful pregnancy had a membrane sweep at 41^{+2} and at 41^{+4} weeks and later admitted to the MLU contracting regularly. The woman presented with a temperature of 37.7^{0}C, maternal heart rate (MHR) 120bpm, and cervix 3cm dilated. Following concerns the woman was transferred and arrived on the labour ward 2 hours later. A female baby was delivered in poor condition by ventouse with an Apgar score of 1[166] at 1 minute and 1 at 5 minutes. Despite intensive resuscitation the baby died after 40 minutes. Post-mortem findings were consistent with infection as a cause of the death. (2012)*

8.44 Clinicians should always consider factors which can influence the fetus. Antenatal factors such as placental insufficiency, intrauterine infection, meconium aspiration, hypoglycaemia, recreational substance abuse or fetal brain injury can all influence fetal heart rate patterns. Where suspected, these cases should all be escalated urgently to make an appropriate plan for delivery.

8.45 *In **2018**, a woman in labour had meconium stained liquor and fetal tachycardia. The family were given the option to 'carry on' with the labour or opt for immediate caesarean. There is no evidence of discussion with the consultant regarding an appropriate plan of care. The CTG was not considered pathological by the maternity review team and therefore to give the woman 'an option' to have a category 1 caesarean is not the standard practice. There is also no evidence that a further vaginal examination was performed prior to the caesarean to exclude or confirm full dilatation, in which case an emergency caesarean may not have been necessary. (2018)*

8.46 Fetal heart rate tachycardia associated with meconium staining of the amniotic fluid raises the likelihood of fetal infection significantly. The team should involve a consultant in the management as soon as possible to set out a plan of care, and the family should be involved in a Montgomery[167] compliant manner.

166 See glossary

167 https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/december-2016/montgomery.pdf

Augmentation

8.47 Augmentation of labour is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour. This can be achieved either by intravenous oxytocin infusion and/or artificial rupture of membranes.

Use of oxytocin

8.48 Oxytocin can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and to facilitate cervical dilatation and vaginal birth.

8.49 Many examples of the injudicious use of oxytocin were highlighted in our first report. The review team has found further examples of inappropriate oxytocin use which impacted upon fetal wellbeing and neonatal outcomes suggesting that sufficient learning from previous cases had not occurred. A common theme identified by the review team was the inappropriate commencement and continuation of oxytocin despite evidence of deterioration of the baby's condition.

8.50 Oxytocin should only be used when there is a valid indication and potential benefit for its use and appropriate guidelines and equipment available to support its safe administration. One-to-one midwifery care must be provided and the FHR rate and maternal contractions must be closely monitored. The identification and escalation of any concerning features relating to CTG changes should occur promptly and oxytocin reduced or discontinued in the presence of excessive uterine contractions or fetal heart rate concerns.

8.51 Appropriate risk assessment should be carried out before oxytocin use in the first stage of labour, and again before use in the second stage of labour. Decision-making regarding the plan of care and mode of birth should consider any additional risk or intrapartum factors which impair fetal adaptation to the challenges of labour and the stage of labour that has been reached.

8.52 *In **2012** a woman presented in spontaneous labour at 30 weeks' gestation. After an hour of pushing in the second stage, the fetus remained high in the pelvis with a pathological CTG. An oxytocin infusion was commenced. After a further hour of pushing, the woman consented to a trial of instrumental delivery in theatre. A manual rotation was undertaken followed by the application of Wrigley's forceps with a presenting part level with the ischial spines. No descent was noted after one pull. An emergency caesarean section was undertaken, and the infant was delivered in poor condition. The infant was resuscitated, but later died due to complications of severe hypoxic ischaemic injury and massive hypoxic damage to multiple organs. (2012)*

8.53 *In **2014**, a woman who had a previous caesarean section was in active labour. Despite FHR abnormalities, oxytocin was commenced and was continued despite evidence of deterioration of the baby's condition. The baby was born in poor condition and died a few months later. A case review was undertaken by the Trust but it failed to identity or address the errors in the management of the mother's labour thus leading to a complete failure to learn lessons or change future clinical practice. (2014)*

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.54 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

8.55 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

8.56 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors

Midwifery-led units

8.57 There are five Midwifery-led-units (MLUs) that have provided antenatal, intrapartum and postnatal care in addition to the consultant maternity unit at the Trust, during most of the time period of this review. The Royal Shrewsbury Hospital, (RSH) in Shrewsbury, provided consultant-led care until 2014. Consultant obstetric services were relocated to the Princess Royal Hospital (PRH) in Telford in 2014. An overview of births by each MLU is provided in table 1 below. The review team is advised that Wrekin MLU has recently moved to a new location adjacent to the Shropshire Women and Children's Centre at the PRH.

Table 1: Births by MLU Overview (Source: SaTH Clinical Dashboards)

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

8.58 Issues relating to MLU closures and staffing availability have been highlighted within the local press and Telford and Wrekin CCG's Quality and Safety Report in 2013. Staff shortages within maternity are also raised as an issue within the Trust's 2021 CQC report[168] and remain an urgent wider issue for maternity care on a national basis.

8.59 Evidence from staff who have contacted the review team suggest that there was an expectation for midwives working on the MLU to manage with reduced staffing. A midwife who had worked at the Trust until 2021 commented that: *'historically, whilst working in the MLU, there was an expectation to stretch the boundaries of what was considered normal…MLU staff are seen as less important, less valuable, and less skilled. There can be poor conversations between teams frequently but teams working together stick together and support one another. This remains to this day. There is a very toxic culture within the place and it seems impossible to break despite some individuals trying to raise as an issue - myself included and part of the reason I have now left'.*

8.60 Another long term community midwife reflected on the impact this had on safe care provision on the MLU where there were *'...incidents where we are caring for a woman and the second midwife has been told to leave the unit to move to another area. This is unsafe practice as there should be two midwives on the unit when a woman is birthing at all times'.*

168 Care Quality Commission Inspection (2021) https://www.cqc.org.uk/provider/RXW?referer=widget3

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

8.61 Midwifery-led units must complete yearly operational risk assessments.

8.62 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

8.63 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

Delay in escalation and taking appropriate action

8.64 The review team found evidence of failure to appropriately document the FHR and undertake continuous electronic fetal monitoring (CEFM) using a CTG when abnormal FHR changes were detected on the MLU. Evidence of this has also been presented above. Information gained from any investigations performed after a birth were not always shared with women and families, and evidence of appropriate governance and shared learning from such incidents is frequently unavailable.

8.65 *In **2006**, a multiparous woman was noted to have an abnormal FHR whilst in labour on the MLU. This was not acted upon, a CTG was not performed nor was the case escalated. The woman suffered a stillbirth. In the bereavement follow-up appointment the consultant gave incorrect information and initially withheld information from the parents about the possible cause for their baby's death. (2006)*

8.66 *In **2010**, a primiparous[169] woman attended the MLU in labour. Intermittent auscultation (IA) was started, however there was a delay in starting CEFM when this became abnormal. Eventually the CTG was started and a further examination was undertaken which revealed a cord prolapse. Emergency transfer was arranged and delivery by caesarean section. The baby was born in poor condition and required cooling. There were missed opportunities for earlier transfer. (2010)*

8.67 *In **2010** there was a failure to appropriately document intermittent auscultation (IA) of the fetal heart and commence CTG monitoring for a woman labouring in the pool with meconium. There was a significant delay from the time of decision to transfer to the Royal Shrewsbury Hospital (RSH) to calling the ambulance for transfer. The midwife failed to ascertain the fetal wellbeing during transfer. Following admission to labour ward a CTG was commenced and was abnormal. The midwife escalated her concerns to the registrar and prepared the woman for an emergency caesarean section. Due to the workload of the labour ward the registrar was called away to attend a twin birth and there should have been escalation to the on-call consultant, who should have attended. The baby was born in poor condition, intubated and received cardiac compressions before receiving hypothermic cooling. (2010)*

8.68 A number of the MLU cases reviewed by our team reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon. Evidence of poor teamwork and communication during transfer has also been presented elsewhere in this and other chapters of this report.

169 See glossary

8.69 *In **2010** a mother self-referred to Wrekin MLU with absent fetal movements and abdominal pain. There was a failure of the two midwives working there to recognise the evident clinical signs of placental abruption: an obstetric emergency. There was no attempt to cannulate the mother and it took 80 minutes to assess her and order a "blue light" ambulance transfer from Telford to Shrewsbury. No paramedic crew were requested. Arrival time at the consultant-unit from initial admission was 1 hours 45 minutes. Following arrival there was appropriate assessment and whilst the baby's death appeared unpreventable there are many care delivery issues that suggest that learning from this event was required. Postnatal care was not appropriate and there was no obstetric documentation in the notes until 09.45 the next day. There is no evidence of a governance review or learning from this case by the Trust. (2010)*

8.70 *In **2013** a woman with a history of multiple miscarriages attended the MLU for a post-term membrane sweep at 40+5 weeks gestation. A fetal bradycardia was noted prior to the procedure and the woman walked over to the consultant-unit and was in theatre within 20 minutes for a category 1 caesarean section. There followed a delay of 17 minutes after the consultant arrived in theatre where he discussed the possibility of not performing a caesarean section. The parents opted to proceed and the baby was born in poor condition and developed severe cerebral palsy. Neonatal care at all points within this case was excellent. The SI investigating team was solely made up of midwifery staff with no evidence of inclusion of an obstetrician, neonatologist or Trust executive all of whom would be expected to have involvement in this level of investigation. (2013)*

8.71 *In **2016** a primigravid[170] woman called Wrekin MLU at 09:18 stating that she did not think things were right as her baby was not moving as much and the pattern of movements had changed. She was advised to lie on her side, have a cold drink, and focus on the baby's movements over the next two hours. The woman responded that she had done all of that already and still had reduced fetal movements. The MLU staff member responded that they had a lot on that morning so to wait until lunchtime before coming in. On arrival there was difficulty ascertaining the FHR, an ultrasound scan (USS) performed and urgent transfer to the consultant-unit was arranged where a category 1 caesarean section was performed. The baby was born in poor condition and died the following day. The parent's comments suggest that they were put off attending the MLU earlier that day when they phoned with concerns because the unit was busy. The parents expressed many concerns about the bereavement care, the lack of information and their belief that the emphasis was on damage limitation for the hospital. (2016)*

8.72 A midwife employed at SaTH for many years who left in recent years[171] told the review team that: *'The MLU's practice needed to be standardised and updated as practice was not evidence-based. There was nobody competent to update guidelines, what guidelines they had were not evidence-based'.* In relation to learning from incidents the midwife emphasised that there was a reluctance to rotate staff to different clinical areas for updating for fear of upsetting people and *'When an incident happened, once the cause had been identified and the actions agreed it took too long to implement change'.* The review team notes that many guidelines have since been reviewed and updated.

8.73 Recent findings from national perinatal surveillance data which focussed on intrapartum stillbirths and intrapartum-related neonatal deaths in planned births at freestanding MLUs and those alongside consultant-led units found that in 75 per cent of deaths improvements in care were identified that might have made a difference to the outcome for the baby[172]. The authors conclude that these findings do not address the overall safety of midwifery-led settings for healthy women with straightforward pregnancies, but suggest areas where the safety of care can be improved. Issues with care were identified around risk assessment and decisions about planning place of birth, intermittent auscultation, transfer during labour, resuscitation and neonatal transfer, follow-up and local review.

170 See glossary

171 Date of leaving provided to review team but not stated to maintain confidentiality of staff member

172 Rowe, R, Draper, ES, Kenyon, S, Bevan, C, Dickens, J, Forrester, M, Scanlan, R, Tuffnell, D, Kurinczuk, JJ. I*ntrapartum-related perinatal deaths in births planned in midwifery-led settings in Great Britain: findings and recommendations from the ESMiE confidential enquiry*. (2020) BJOG 127

8.74 Findings published from a national cross-sectional survey of all 122 UK maternity services found that 92 per cent of local admission guidelines varied from national guidance[173]. These findings suggest that variation in admission criteria for MLUs exists nationally which presents a potentially confusing and inequitable basis for women making choices about planned place of birth. An earlier study also found that local guidance for transfer of women from MLUs to consultant units were of poor quality[174].

8.75 *In **2018** a woman made numerous contacts with Wrekin MLU triage throughout her pregnancy and early labour due to concerns about reduced fetal movements, bleeding and spontaneous rupture of membranes (SROM). Based upon national guidance it would have been appropriate for the woman to have been transferred to the consultant unit. Local Trust guidance did not align with national guidance. The baby was born in poor condition on the MLU and despite extensive resuscitation and neonatal support a decision was made to withdraw care and the baby subsequently died. (2018)*

8.76 National guidance recommends that when there are maternal concerns about fetal movements, the woman and the baby should be assessed (NICE, 2021). It is important that this assessment takes into consideration the full clinical picture and previous history of reduced fetal movements.

8.77 The importance of ensuring that women undergo a risk assessment at each contact throughout the pregnancy pathway was presented as an essential action in report 1. The review team continued to find evidence that this did not always happen. All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made.

Vaginal breech birth

8.78 Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women's wishes in relation to mode of birth were evident within the vaginal breech cases reviewed across the timespan of the review. Women reported to the review team that they were persuaded to have a vaginal breech birth without the associated risks being explained or there was a failure to make decisions regarding mode of birth in a timely way. There is a lack of evidence that governance processes were fully implemented which may have provided the Trust the opportunity to refine its decision-making processes, define the personnel needed for a safe breech vaginal delivery and refine the escalation pathways on the labour ward.

8.79 *Request for consultant advice or attendance was never made for the vaginal breech birth of a woman at 36/40 weeks gestation in **2003**. There was a lack of formal documentation regarding the mother's birth wishes and advantages and disadvantages of mode of birth. The middle grade doctor was asked by the midwife to examine for footling breech but declined to do so. It was inappropriate for the most inexperienced member of the medical team (SHO) to be conducting a footling breech delivery alone in the labour room without registrar or consultant attendance. During the birth an emergency caesarean section was arranged. There is no documentation of involving the consultant in any way and when the consultant attends in theatre [they] appear surprised in [their] notes at the impending situation. The baby was born with no signs of life and after extensive resuscitation died at approximately 3 hours of age. (2003)*

8.80 *There was a failure to appropriately plan and escalate care for a woman at 31 weeks' gestation in labour with prolonged premature rupture of membranes in **2011**. On the day of delivery, there was a failure to escalate for consultant decision-making, failure to make definitive decisions regarding the mode of delivery, failure to have adequate and highly trained individuals at the delivery, and failure to understand that a footling breech delivery at 31/40 weeks is relatively contraindicated by local and national guidelines. There was also no internal investigation of this case and so no evidence of lessons learned. (2011)*

173 Glenister C, Burns E, Rowe R. *Local guidelines for admission to UK midwifery units compared with national guidance: A national survey using the UK Midwifery Study System (UKMidSS).* (2020) PLoS One. Oct 20;15(10):e0239311. doi: 10.1371/journal.pone.0239311. PMID: 33079940; PMCID: PMC7575094.

174 Rowe RE. *Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality.* (2010) Quality and Safety in Health Care19 (2):90-4.

Management of twin pregnancies and births

8.81 Some of the issues within this section reflect the findings presented previously in this chapter, namely unsafe operative delivery, inappropriate use of oxytocin and a failure to escalate care with the added complication of a twin delivery to consider. The review team found significant concerns with the management of twin labour and births throughout the whole of the review period right to the very end of the review.

8.82 *In **2013**, a primiparous woman with an IVF conceived twin pregnancy was induced at 36+5 weeks gestation as the second twin was found to be small. After one hour of pushing a decision was made for trial of instrumental delivery in theatre under spinal anaesthetic by a consultant and registrar. The first twin was born in good condition following a Keilland's forceps rotation. The second twin was born 37 minutes later by Neville Barnes forceps, after a total of 9 attempts at delivery by ventouse and Keilland's forceps. The baby was born in very poor condition and required resuscitation and transfer to the NNU where he underwent cooling and had multiple blood transfusions. He was subsequently diagnosed with moderate to severe HIE, subgaleal and subdural haemorrhage with depressed bilateral skull fractures. The administration of second stage oxytocin did not follow any guideline or regime. There was no concluded Trust investigation provided to the review team. (2013)*

8.83 *Inappropriate use of oxytocin and poor CTG management was noted with no escalation during the labour of a woman with a twin pregnancy at 35+4 weeks gestation in **2013**. The second twin's birth was not expedited when it should have been and the baby was diagnosed with HIE 2. There was no obstetrician or neonatologist in the room for the birth of twin 1 despite twin 2 being breech, they were called to assist with twin 2 following a placental abruption and the baby required a vaginal breech extraction. (2013)*

8.84 *A woman was admitted to hospital in **2014** at 34+6/40 weeks gestation with a suspected urinary infection with uterine tightenings. It was found that that both twins had died in utero. Placental abruption was noted at birth, with partial dehiscence of the uterine scar. Brown liquor was also noted which was mildly offensive. (2014)*

8.85 *The antenatal care was complex as the woman had numerous admissions to hospital for abdominal pain and tightenings, urinary symptoms and back ache. It was noted that the CTGs during admissions often had loss of contact or poor quality interpretation that was not escalated. The woman's voice was not heard as it was documented that there were reduced fetal movements but no action was taken. The woman met with the Trust who made promises around improving bereavement support, but the mother told this review that it felt that this was not actioned. (2014 until 2020)*

8.86 *In **2016** a woman who had a twin pregnancy, complicated by twin to twin transfusion syndrome, developed pre-eclampsia and was allowed to go home despite signs of evolving pre-eclampsia. Subsequently one twin died and the governance review documentation leans towards blaming the woman for the outcome, as she decided to go home rather than accept the 'offer' to remain in the unit as an inpatient. (2016)*

Management of high-risk and complex mothers

8.87 In a significant number of cases the review team found evidence that the poor outcomes in mothers and babies were caused mainly because clinicians failed to recognise women at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications such as severe hypertension and significant antepartum haemorrhage. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.

8.88 *A woman presented on multiple occasions around term with hypertension and proteinuria in **2009**. There were missed opportunities to manage hypertension appropriately with the woman returning at least four times for assessment of blood pressure, when there could have been consideration for delivery. During this time she saw a relatively junior member of medical staff and there was a failure to consider the worsening*

picture of pre-eclampsia and no involvement of the labour ward coordinator. There appeared to be no urgency to treat the severe hypertension and there was little thought as to whether to give magnesium when this was appropriate. The baby was born in poor condition with Apgar scores 1 at 1 minute and 6 at 5 minutes. (2009)

8.89 *In **2017** a primigravid woman in spontaneous labour developed mild intrapartum hypertension. She required emergency caesarean delivery and received ergometrine intraoperatively. Subsequently, she developed significant postnatal hypertension and required treatment. Her medical records and subsequent correspondence indicate significant friction between the midwives and the registrar over the administration of ergometrine and its subsequent effect. The parents' concerns and communication about investigation of the drug error were poorly handled, leading to a formal complaint. (2017)*

Psychological birth trauma

8.90 The degree of life-long psychological trauma revealed by families in this report is harrowing and profound. Women and families have given graphic written and verbal accounts describing their recollection of events that have led to long-term depression, anxiety, distressing memories and post-traumatic stress disorder (PTSD). Some have sought psychological treatment, whilst others have remained silent until now.

8.91 Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.

8.92 *A woman who gave birth in **2009** told the review team: 'I was lying on the table and was prepared for surgery but they couldn't find the anaesthetist. The senior midwife said to the assistant who was there "If this baby dies it's on his head". I reminded her I was still awake and she said "sorry no it will all be fine...". After the anaesthetist was found I was put under. My husband who was waiting outside was told 'go and walk round the car park for 45 minutes. But I have to prepare you don't hold out much hope for the baby' I had counselling after the experience but still felt I needed to complain as I knew how lucky we had been that our daughter was not only alive but well. I wrote my concerns down and the response I had just made me so angry. It didn't address any of my concerns…it was so bad that to be honest I gave up and just tried not to think about it.' (2009)*

8.93 There were many cases reviewed in which the care provided aligns with national standards and where there is evidence of the maternity team at the Trust going above and beyond the usual expectations in an attempt to support women. It is evident that for many women, any deviation from the expected progress of events, such as passage of meconium, bleeding of any degree or suspicious features on CTG is recalled by them years later as a failure of appropriate care.

8.94 Sometimes, despite documented good quality care and reassurances, the woman's recollection is terror, guilt, suspicion and feelings of Trust cover up. In addition, many women perceived any deviation from normality to be an indicator that a caesarean section was needed and that this was subsequently denied to them by the Trust. Despite this, the review team has seen many cases of meconium stained liquor, marginal placental abruption and mild infection that were managed appropriately with a trial of labour and outcomes that have been satisfactory.

8.95 *In **2017**, a woman whose baby presented in the occipito-posterior position laboured for 15 hours having experienced a small antepartum haemorrhage. The woman received very good care during labour with ongoing and appropriate efforts to address her anxiety and analgesia requirements. A caesarean section was performed within a standard timeframe and both mother and baby were well following this. Despite good care, the woman's recollection of labour has developed into ongoing treatment for PTSD. (2017)*

8.96 Formal diagnosis of PTSD is a common finding in the review and despite the evidence of some good care as detailed above, there were also many cases reviewed that demonstrate poor management in labour that resulted in ongoing physical and psychological harm for women as detailed in the following vignettes.

8.97 *In **2011**, a woman suffered psychological harm after being accused of 'being lazy in labour'. Also, as an employee of the Trust, she was advised against making a complaint. (2011)*

8.98 The review team has heard recollections from women relating to feelings of loss of control and power, **(2016)**, excessive and painful vaginal examinations **(2003)**, not being listened to **(2002; 2004; 2015; and 2016)** which resulted in psychological trauma for themselves and on occasion their birth partners.

8.99 *In the case of a forceps delivery and a missed recto vaginal fistula in **2009**, a woman told the review team: 'Following my daughter's birth by forceps, I was passing wind through my vagina. My wound was never checked whilst I was a patient in the hospital. It was only when I got home that a midwife asked me how I was and I said I felt something wasn't right. She did then check me at home but found no problem. A couple of weeks later I went to see my GP about it and I was referred back to the hospital.*

8.100 *I saw a consultant obstetrician. After examining me the doctor informed me that I'd had a large baby and that had caused in her words "a baggy fanny". To say I was upset is an understatement and despite telling her that I could tell the wind was coming from my back passage and passing through to the front, she said no further investigation was required. My issues got worse and the anxiety of going outside and embarrassing myself by having no control of passing wind meant I became nervous, anxious and depressed which seemed to exacerbate the situation. All of which resulted in upset stomachs and loose stools which resulted in my passing faeces through my vagina. Feeling that I should have pushed this matter further in the hospital made me feel inadequate as a mother. With the fistula causing personal care issues for me, the depression got worse. It wasn't diagnosed for quite some time. The emotional effects of all this still affect me 10 years on.' (2009 -2019)*

8.101 *A consultant said to a woman with physical disabilities in* **2008***: 'How do people like me get pregnant, who would do that [have sexual intercourse] to me, and did I know what I was doing?'. (*2008*)*

8.102 *Many women describe how they moved to different units for subsequent births or even to other countries. One woman in **2013** described to the review team how she could never contemplate giving birth in the UK again and found her experiences in the USA far more acceptable. (2013)*

8.103 *After not feeling listened to in **2016** another woman described: 'not having the courage to stand up and advocate for herself'. (2016)*

8.104 The few cases of maternal ICU admission for life-threatening illness are strongly associated with ongoing psychological morbidity and PTSD and women have expressed their strong desire for professional psychology services to be available to them.

8.105 *In a case of chorioamnionitis and failure to act on a pathological CTG in **2012** a woman told the review team: 'They spent half an hour trying to resuscitate my daughter in the corner of the room, didn't say anything to us until it was: "I'm sorry, but we couldn't save her". [I said] "But you were telling us everything was fine". On top of that, the aftercare was absolutely appalling as well. They left us in the [delivery] room for I don't know how long and then they put me in a wheelchair, gave my daughter to me, put us in a room and left us there basically. What was even worse, they put us on the maternity ward so we could hear babies crying. We could hear people being congratulated'. (2012)*

8.106 *Following a cardiac arrest in **2014**, a woman still finds it difficult to come to terms with her condition and feelings she could still die. She described to the review team unhelpful comments from an unknown doctor saying, ' "Hi, I was the guy that restarted your heart". I couldn't cope with that. I was really struggling with the gratitude I felt for the people that had saved my life but also needed some counselling.' (2014)*

8.107 *There were failings within the MDT in **2014** to manage a woman's history and experience of childhood sexual violence. There was evidence of a disconnect between the midwifery notes and the woman's recollection of events. Following her birth experience, the mother contacted the review team to help her to determine if her PTSD, and a birth injury which took years to heal, and left her unable to work is 'normal and acceptable'. The woman explained to the review team that she had been unable to leave the house between 2014 and 2018.*

8.108 Evidence that staff at the Trust often try to settle fears and anxieties is present in many case reviews yet long term psychological harm has still occurred. Postnatal discussion meetings have routinely been offered to women at the Trust over many years but a debrief with a midwife is often not enough for women who have harboured deep seated anxieties and memories and have complex clinical questions that require answers. Most midwives in the UK are not trained to provide professional counselling and may not have the clinical knowledge to adequately explain clinical scenarios that require the input of an obstetrician, neonatologist or anaesthetist.

8.109 It would seem that women receiving their maternity care at the Trust may require the opportunity to review their birth experience more often and in a different way than is currently provided, even if the care was perceived as good. In cases where clinical care was below optimal or complications occurred, ongoing psychological support for women is necessary.

8.110 The NHS Long Term Plan[175] renewed the commitment for the NHS to improve specialist perinatal mental health services. The Perinatal Mental Health Programme and the Maternity Transformation Programme are working together to fulfil this ambition to enable maternal mental health services to be improved by establishing nationwide Maternity Outreach Clinics by 2023/24. This service will help provide support for women with moderate to severe complex mental health problems resulting from their maternity experience and is expected to address issues such as PTSD, perinatal loss and tocophobia (fear of childbirth).

8.111 In July 2020, NHS England and NHS Improvement invited proposals for pilot areas for the testing and development of a maternal mental health service. Shropshire Telford and Wrekin were selected as an early implementer and have revised and updated their Maternity Mental Health guidance. There is evidence that the Trust is working towards improving access to perinatal mental health services.

Conclusion

8.112 This second report builds upon our first report[176] published in December 2020. In that first report, evidence was provided that concerns were not appropriately escalated, leading to a direct impact on the safety and quality of care provided to women and their babies. In this second report which concludes our review of family cases the review team has highlighted both a failure to learn and a lack of progression at the Trust in terms of governance and learning across the timespan of the review.

8.113 In this chapter the review team has highlighted the essential need for effective communication between all healthcare professionals providing maternity care and the women they provide that care for. We have highlighted numerous examples where communication was not at the standard expected or required. As with other chapters in the report there is an ongoing concern from maternity staff at the Trust feeling unable to speak out and raise concerns about care at the Trust. This is an issue that requires urgent action and resolution at the time of publishing this report.

175 NHS England. *The NHS Long Term Plan* (2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

176 Ockenden, D. *Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust*. (2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

Chapter 9

Postnatal care

9.1 There is a need for continuing midwifery and multi-professional observation of the mother and her baby during the postnatal period since serious events or deterioration of already known conditions can occur in this time. The time after the birth of a baby is often when new mothers report they feel most vulnerable, with vulnerability increased where a woman already experiences social disadvantage or pre-existing medical co-morbidities. It is essential, therefore that postnatal care is safe, supportive and compassionate.

9.2 The importance of senior (consultant) involvement in acute care, including postnatal care, was emphasised by the RCOG 2021[177] when it noted that 'consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission' and that 'this standard also applies to postnatal admissions'. This is not new advice, and reiterates Keogh[178] standard 2 first published in 2015 and emphasised by MBRRACE UK 2019[179]. MBRRACE advised a 'review of guidance [was] needed to ensure that deviation from the usual clinical pathway, with unexpected, or unexplained, symptoms [then] triggers a consultant review'. MBRRACE also noted 'These enquiries have emphasised repeatedly the importance of senior review in relation to abnormal postnatal symptoms'.

9.3 Overall improvements in postnatal care across the wider maternity system require significant investment in both workforce, and technology, especially the improved availability of information technology on postnatal wards and across the community too. Midwifery and support staffing on postnatal wards is often poor, and across England maternity teams will recognise that staff are moved from postnatal wards and the community when there are staff shortages in those areas considered to be more acute, such as the labour ward. Across postnatal care the staff at the Trust have described to the review team how they are stretched beyond capacity. This can then lead to poor physical, social and emotional care provision for mothers and their babies.

9.4 Early postnatal discharge from hospital to home is not always appropriate, despite pressure (which can be from families or the maternity service) for women to leave hospital soon after birth. It must therefore only occur if clinically appropriate, and there must be appropriate support in the community after discharge. Across England, improved midwifery and support staffing levels in postnatal care will improve the safety of that care and lead to an increase in family satisfaction. Consultant job planning must also be considered to ensure that postnatal reviews are a timetabled activity.

Lack of consultant involvement in the management of complex postnatal cases at the Trust

9.5 The review team noted many cases where there was no consultant review, or inadequate consultant involvement, in the management of complex postnatal problems in maternity services at the Trust. For example:

9.6 *In **2002** a woman spent 17 postnatal days in critical care, and sadly died. During that time she was only reviewed on four occasions by an obstetric consultant. There should have been greater consultant obstetrician input into her ongoing care. (2002)*

9.7 *In **2006** a woman with known cardiac problems was discharged home soon after birth without consultant review, despite having been fluid overloaded in labour requiring treatment with diuretics and oxygen. She was admitted some three weeks later in significant heart failure and died. (2006)*

177 Royal College of Obstetricians and Gynaecologists, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021) https://www.rcog.org.uk/globalassets/documents/careers-and-training/workplace-and-workforce-issues/roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf

178 Keogh B, *Seven Days a Week*, NHS England (2015) https://www.england.nhs.uk/seven-day-hospital-services/the-clinical-case/

179 Knight M, Bunch K, Tuffnell D, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17.* Oxford: National Perinatal Epidemiology Unit, University of Oxford (2019). https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

9.8 *In **2007** there was no postnatal consultant review after a difficult caesarean section, even though the registrar who performed the surgery informed a consultant that they were concerned that there might have been bladder damage during the operation. The consultant simply advised an indwelling catheter for 14 days, however, after the woman was discharged home on day five she was readmitted on day 12 but was not reviewed by a consultant until day 15 when she was finally diagnosed with a ureteric injury which occurred during her caesarean section. (2007)*

9.9 *In **2011** a woman with known pregnancy induced hypertension, who required a prolonged postnatal stay in hospital because of labile blood pressure, had no postnatal consultant review. Earlier consultant review could have identified seriously deteriorating HELLP[180], from which the mother subsequently died. (2011)*

9.10 *In **2018** a woman who underwent a caesarean hysterectomy because of a placenta accreta[181] had her surgery performed by a consultant, who also reviewed her the day after surgery, but there was no further consultant involvement in her care after this. (2018)*

Complex postnatal care requiring readmissions

9.11 Postnatal readmissions, for maternal complications, are uncommon, and are by definition complex. Management should therefore include review by a consultant. However, there were several cases where timely consultant review did not occur:

9.12 *In **2006** a woman was admitted with postnatal faecal incontinence, but was not seen by a consultant until 4 days after admission. (2006)*

9.13 *In **2009** a woman remained on the postnatal ward for 15 days after a caesarean hysterectomy for placenta accreta. In the first week she had regular obstetric review, including consultant reviews on days 1, 3 and 8. In the second week recording of maternal observations was very ad hoc and all the reviews were by very junior doctors. This woman was discharged home on day 15 by a junior doctor but was readmitted later the same day with severe sepsis, requiring ITU admission. Adequate observations, and thorough review before discharge, should have alerted clinicians to the developing sepsis, and would have allowed more timely management, possibly avoiding the need for ITU care. (2009)*

9.14 *In **2018** a woman was admitted with postnatal endometritis[182], but did not have any consultant reviews. In this case the management was not timely, as it was not recognised that she had retained placental tissue requiring removal under anaesthetic until 3 days after admission. (2018)*

Observations and appropriate responses

9.15 Observation of vital signs, and appropriate response if they are not normal, underpins the provision of safe maternity care. This should occur at all stages of pregnancy, including the postnatal period. The review has noted many cases where this did not occur across the timespan of the review.

9.16 *In **2000** there were very limited postnatal observations recorded of a woman who had experienced a stillbirth, with abruption, and a 3 litre blood loss, which required a blood transfusion. (2000)*

9.17 *In **2008** there had been abnormal observations recorded but the midwife simply discontinued observations without explanation. This resulted in a delay arranging the blood transfusion this woman required. (2008)*

9.18 The review team has also noted a number of cases where women with known pregnancy-induced hypertension either had few postnatal observations recorded, or had hypertension recorded but there was no response to the abnormal readings (both on the postnatal ward and in the community). These cases include examples seen in **2008** and in **2011**.

180 See Glossary
181 See Glossary
182 See glossary

9.19 *In **2008** when a woman reported severe rectal pain after a forceps delivery there was little consideration that she may have a serious complication. She was given analgesia, but very few observations of her vital signs were made, even when it was noted that she had only passed small volumes of concentrated urine. It was eventually realised, when it was noted that her heart rate was 140–160 bpm that an internal haemorrhage was likely, and her management was discussed with the on-call consultant who advised examination under anaesthetic (EUA) in theatre. Initially no plans were made for the consultant to attend theatre, but as the woman had still not gone to theatre 90 minutes after the decision for EUA, the consultant did attend. The woman went on to have a laparotomy[183], and drainage of a large retropubic haematoma[184]. She also required a 6 unit blood transfusion. Earlier recognition of her blood loss should have led to more timely management. (2008)*

9.20 Shock in the postnatal period should be recognised by all members of the multidisciplinary maternity team. The team must be aware that as most pregnant women are fit and healthy they can compensate for blood loss, and therefore may not show all the classic signs of hypovolaemia[185], which are an increasing heart rate with a fall in blood pressure, usually secondary to blood loss. The review team noted a number of cases where there was a significant delay in either recognising postnatal shock, or a slow response to the situation by clinicians. These are discussed below:

9.21 *In **2006** a woman was admitted with a significant secondary postpartum haemorrhage (PPH). Fluid resuscitation was slow, as was the decision for an examination under anaesthetic (EUA) during which the mother required a hysterectomy. (2006)*

9.22 *In **2006** the midwife noted excessive blood in the drains after an emergency caesarean section with an associated tachycardia and fall in oxygen saturation. The midwife did inform both the registrar and consultant of her concerns. A litre of colloid fluid did not improve the mother's tachycardia, and her oxygen saturation deteriorated, but the obstetric team did not appear concerned as the blood pressure remained normal. It was not until approximately 2.5 hours after leaving theatre that a bedside blood test was performed which revealed a life threateningly low haemoglobin level of 3.3g/dL. She was then rapidly transfused and returned to theatre where she underwent repair of a bleeding left uterine artery. (2006)*

9.23 *In **2008** a woman with known severe pre-eclampsia developed pulmonary oedema some 36 hours after an emergency caesarean section. This is a recognised potential complication, which is why her postnatal care should have been multidisciplinary (obstetrics and anaesthetics) and should have included a clearly documented postnatal MDT[186] management plan of fluid restriction, careful monitoring of fluid balance and regular MDT clinical review including chest auscultation[187]. In this case the care was not multidisciplinary, and did not involve appropriate fluid management. Had this occurred she would certainly have been better managed, and the pulmonary oedema possibly avoided, or managed earlier, so that admission to the medical HDU where her pulmonary oedema was well managed might have been avoided. (2008)*

9.24 *In **2016** a consultant obstetrician ignored clinical signs suggesting an ongoing problem. After a normal birth a woman had a high uterus and ongoing bleeding, this was managed with an oxytocin infusion but the heavy trickle of blood continued. She developed symptoms of light headedness, as well as a fast heart rate, and low blood pressure. Her blood loss was recognised, and managed with one unit blood transfusion. As her bleeding was still ongoing 7 hours after birth the registrar planned for her to have an examination under anaesthetic (EUA) to check for any retained placental tissues, or unrecognised tears. When she was reviewed by a consultant, some 9 hours after the birth, the consultant decided that EUA was not needed. The woman was transferred to the postnatal ward, where she had a further 3 unit blood transfusion the*

183 See glossary
184 See glossary
185 See glossary
186 See glossary
187 See glossary

next day, and was discharged home on day 3. She was readmitted 20 days later with heavy bleeding, and when she did undergo the EUA a large (9 x 5 x 3cm) piece of placental tissue was removed. Clearly the initial management controlled the immediate symptoms, but did not treat the underlying cause of retained placental tissue. Had the EUA occurred 7–8 hours after the birth, as planned by the registrar, then this woman would not have been exposed to the increased risk of infection and secondary haemorrhage. (2016)

Escalation

9.25 The review team has noted many cases where abnormal findings by midwives have then not been escalated to the midwife in charge of the ward/unit or to appropriately senior medical staff.

9.26 *In **2008** a postnatal woman, with known pre-eclampsia, had her blood pressure taken 5 times over a 20 minute period with all readings showing significant hypertension with no further escalation. A junior doctor came to review, but on attending found the woman asleep so the review did not occur until she woke up very confused, and with a headache about 2.5 hours after the hypertension was first noted. She was subsequently managed with a magnesium infusion and antihypertensive medication. (2008)*

9.27 In some cases midwives appropriately escalated concerns to medical staff, but the response to the escalation was poor.

9.28 *In **2019** a midwife escalated concerns about a woman's one-sided weakness the day after a manual removal of placenta was performed under spinal anaesthetic. The midwife's concerns were raised after the woman had been reviewed by an anaesthetist on a routine ward round, when no issues had been identified. The anaesthetist had not documented their clinical review in the medical records. The midwife's concerns led to a further review by an anaesthetic registrar who concluded that the woman's weakness could be explained as "prolonged effects from spinal". This was incorrect as spinal anaesthetic does not cause one-sided weakness. The midwife again raised her concerns, and the woman was then reviewed by a consultant anaesthetist who arranged a head CT scan which diagnosed a subarachnoid haemorrhage. In this case there was a delayed diagnosis of a serious condition. (2019)*

What Trust staff have told the review team

9.29 In late 2021 a number of maternity staff from the Trust, including current and past employees, spoke to the review team:

9.30 One contributor told the review team that '*There wasn't really much working together at all, it was very much we're midwives, they're obstetricians…if you knew certain obstetricians were on [duty] you would be fearful of calling them…because of their way with women…not very nice to the women'.* Another contributor, also noted *'A midwife couldn't ring the consultant on-call…afraid to ring with any concerns'.* A further staff member told the review team: *'It seems to be [with] processes, protocols, guidelines, some are using it, and some are not…policies and guidelines are all there…but not being followed'.*

9.31 A staff member described *'a very, very overburdened and thinly stretched middle tier in the obstetric team… doctors were being asked to cover services that you couldn't possibly do on your own'.*

9.32 Another staff contributor described: *'There were one or two, or even three, consultants that would intimidate the midwives and junior doctors, and make sure they were not approachable…many registrars have been intimidated not to contact the consultant during the night, and if they contact they get told off'.* The same contributor also commented on the relationship between consultants and midwives: *'They don't get on well…there is a barrier'.* Another contributor, commented on the relationship between consultants and midwives and said: *'Some you were seriously on your guard with… [would] bite your head off…I wouldn't have phoned a consultant lightly… [They] weren't particularly approachable'.*

9.33 Some staff also shared with the review team the lack of a supportive culture for junior or inexperienced staff that they had experienced very recently but declined to have their words used directly. It was explained to the review team that asking for help was seen as a bad thing and that junior staff at the start of their careers were often too frightened to ask for support when needed.

9.34 Overall staff feedback to the review team in late 2021 describes poor team working, failure to follow guidelines and an overstretched middle tier of obstetricians. This undoubtedly influenced the ability of postnatal ward midwives and junior doctors to be able to escalate potential clinical complications appropriately. These issues with lack of escalation were found within our first report and feedback directly to the review team from current maternity staff supports the findings in report 1.

9.35 There were however some encouraging reports from staff that the culture has started to change within maternity services at the Trust over recent years. A member of staff, interviewed in October 2021, who had only been with the Trust for a short period reported: *'Overall I think the culture is good…on the postnatal ward'.* The same contributor reported: *'Two new consultants [are]…trying to update the MEWS (modified early warning system) charts'* in reference to escalation from the postnatal ward, a recommendation from our first report.

9.36 Another staff contributor, referring to previously poor escalation at night commented *'Doesn't happen now…consultant now covering labour ward at night'.* The same contributor also commented that the relationship between doctors and midwives was *'improved now'*. Another member of staff, commented on the appointment of an individual consultant in 2018 who changed the culture *'in terms of consultant engagement…is engaged, approachable, woman-centred…and was the start of potentially the tide turning with what was quite an old and staid consultant body…it's much better now…24/7 consultant cover on labour ward'.* The same contributor said *'that is a good thing to come out of all this scrutiny'.*

Clinical follow-up in the postnatal period:

9.37 Clinical follow-up is comprised of two main aspects: firstly, follow up of results of investigations with potential amendments to already existing plans of care. Secondly, follow-up discussion and debriefing of care especially for families who have experienced perinatal loss, or a serious adverse event. This is essential to help women and their families understand, and begin to come to terms with, what has happened to them.

9.38 Follow-up discussions should address ongoing care needs, and discussion about any implications that events within the current/most recent pregnancy may have for care in a future pregnancy. In some cases it may be appropriate for this discussion/debrief to occur before discharge from the postnatal ward, but in others a formal follow-up appointment is required.

9.39 Such discussions require effective and timely communication with both the mother and her GP. It is therefore vital that the appointment occurs in an appropriate setting, within a reasonable timescale and is accurately documented and that the appointment is with a senior doctor who gives the family time for adequate discussion. The doctor also needs to listen to the family, who may hope that any investigation of their case could lead to learning and changes that might avoid another family experiencing a similar event. When a stillbirth occurs MBRACE-UK 2017[188] advised that *'All parents should be offered a follow-up appointment, in an appropriate setting, with a consultant obstetrician to discuss events leading to their baby's stillbirth, the actual or potential cause, chances of recurrence and plans for any future pregnancy'.* The same report also advised that *'A summary of their follow-up appointment, written in plain English, should be sent to the parents, and their GP'.* The review team found many examples where this did not happen:

9.40 *Failure to address the mother's ongoing care needs were noted by the review team when in **2007** a woman was discharged from maternity care still on antihypertensive medication, which had been started during the pregnancy, but with no instructions to either the GP or the woman, about ongoing blood pressure management. (2007)*

188 MBRACE-UK Perinatal Mortality Surveillance Report: *UK Perinatal Deaths for Births from January to December 2015* (2017) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2015%20FINAL%20FULL%20REPORT.pdf

9.41 *In **2014** a mother's membranes ruptured well before 24 weeks, and she went on to have a very pre-term birth and neonatal death after a few hours. In her pregnancy she had been informed of a positive test result, and advised to collect a prescription for treatment, which she did not do. This test result was noted when she was admitted, and appropriate treatment prescribed, but it was never given. This information was not relayed to the GP, nor was it addressed when the mother saw the consultant for follow-up. (2014)*

9.42 Similarly there are cases of women who experienced serious physical trauma at birth with potential implications for future births, where they and their GP do not appear to have been advised about these implications. One example is the following:

9.43 *There was a lack of information given to a mother in **2018** when a woman had an 'inverted T incision' on the uterus at caesarean section for the birth of the second very pre-term twin (25 weeks gestation). Sadly both twins died in the neonatal period. In the records provided by the Trust there was no evidence that the parents were made aware of the unusual incision on the uterus which does have implications for a future pregnancy: if this woman were to labour in the future there is a high risk of uterine rupture, which can be catastrophic for both mother and baby. The discharge summary to the GP did not include any information about the 'inverted T' incision. (2018)*

9.44 The review noted many perinatal loss cases where there was no evidence in the medical notes that the family had been offered a follow-up appointment; this was noted across the years of the review (2000–2019). For most of the last 20 years the majority of maternity units have arranged that these follow-up appointments take place away from any clinic associated with maternity care, but the Trust was still seeing these families in the gynaecology clinic as late as 2014.

9.45 These appointments are often distressing for the families, and must therefore be conducted sensitively. The written summary of the discussion must also be both sensitive, accurate and easily understood by the family. This was often not the case for the families considered by the review team.

9.46 *A family told the review that they felt that the consultant was 'unprofessional' during their post-stillbirth appointment in **2006**, as he was ill-prepared, had not read the post-mortem report, and sent a letter with multiple factual errors after the appointment. The family explained to the review team that the consultant exacerbated their distress in an already extremely difficult situation, and they then had to write back to the consultant to get the factual errors in the letter corrected. (2006)*

9.47 *A family described their post-stillbirth consultant appointment in **2011** as 'very brief in and out in less than five minutes, and 'did not give [them] any answers'. The consultant was described to the review team as 'inattentive' and he is said to have 'sat on the table swinging his legs'. (2011)*

9.48 *A family who suffered a neonatal death in **2013**, after a traumatic birth, reported that at the follow-up appointment the consultant 'showed no compassion or understanding of the trauma experienced'. (2013)*

9.49 In some cases the letter sent to the family after the follow-up appointment did not offer condolences, or was written using a lot of unfamiliar medical terminology. The review team has seen examples of this in both **2016 and 2018**. In other cases the letter used inaccurate wording that the family found upsetting for example in **2018** the consultant's letter after a stillbirth noted that the mother had *'gone through labour and delivered a very healthy girl'* which is inappropriate given that the baby was stillborn. (2018)

9.50 It is expected that families are given complete and honest information both before discharge from the hospital and at the follow-up appointment. The review team found a number of instances where the information given was either incomplete, or misleading:

9.51 *In **2002** after an intrapartum stillbirth, the consultant's postnatal letter stated 'all the findings would probably suggest there was a little bit of growth restriction at the end, and that labour on top of a compromised baby caused the ultimate demise'. However, the letter failed to mention that the CTG was grossly abnormal for nearly 90 minutes before the stillbirth, that there was thick meconium, and that earlier birth by caesarean section would probably have resulted in a live birth. (2002)*

9.52 *In **2005** after a stillbirth there was appropriate discussion of the family's concerns, but no discussion about the growth restriction noted at post-mortem (not detected in the antenatal period) as a cause of the stillbirth, as well as an infection after probable pre-labour rupture of membranes. (2005)*

9.53 *In **2006** a family whose baby died at 3 days of age with severe HIE[189] and bleeding into an arachnoid cyst, noted that at post-mortem they were given the impression that 'haemorrhage into the cyst had caused the HIE' rather than hypoxia during labour. The multi-professional review team concluded there was clear evidence of a pathological CTG prior to birth and that the resulting features of HIE would be consistent with an intrapartum hypoxic insult which was likely to be due to cord compression worsened by injudicious use of oxytocin. (2006)*

9.54 *In **2008** a woman who experienced an abdominal wound dehiscence 5 days after caesarean section was told that 'the suture had snapped, and this was an equipment failure, not a medical issue'. (2008)*

9.55 *In **2013** after an intrauterine death that occurred in hospital during induction of labour, the family and GP were told that the cause of death was that the labour ward was too busy for her to be transferred for artificial rupture of the membranes (ARM). The Trust RCA did not consider that failure to monitor the fetal heart for 15 hours, (which contravened Trust policy), was the true cause. (2013)*

9.56 *In **2014** following IUD of 28 week twins, the consultant told the family that the scan a week before fetal demise showed that 'Doppler assessments of flow in the cord and brain were normal'. However, there was no evidence in the medical records that they measured Doppler flow in the brain when performing this scan. (2014)*

9.57 *In **2015** after a traumatic operative vaginal birth of the second twin, using 3 sequential instruments, a consultant discussed issues around the birth with the mother, on the postnatal ward, and explained that the baby was 'short of oxygen' during the birth, but did not mention the skull fractures that the baby had sustained. (2015)*

9.58 *Similarly in **2018** a family were told that there was no evidence of pre-eclampsia before a mother was admitted with an abruption and intrauterine death. However the review team noted that in the 2 weeks prior to the abruption the mother was being managed as an outpatient with proteinuria (measured by urinary PCR) and blood pressure that was increased from that recorded at booking. This does indicate that this mother did have known pre-eclampsia, which was a risk factor for abruption. Abruption cannot be predicted, or prevented, but if this woman had been managed as an inpatient, then urgent delivery as soon as the abruption was recognised might have achieved a different outcome. (2018)*

9.59 In a number of cases families felt that the Trust was reluctant to undertake investigations, or to change practice.

9.60 *After experiencing a neonatal death in **2005** a family told the review team: 'We just wanted to understand and maybe work with the hospital to try to change practice to avoid any parents having to go through the same painful ordeal. However, this certainly wasn't an option. It was like the door had been slammed in my face'. (2005)*

9.61 *In **2012** a family were told that there was a Trust investigation after the mother had to return to theatre because of intra-abdominal bleeding after an elective caesarean section, and that nothing different could have been done. However, the Trust has not given the review team any evidence of an internal investigation. The review team is critical of the care this woman received after her elective surgery. (2012)*

9.62 *In **2014** a meeting with the family to discuss the findings of the Trust investigation did not occur until more than 2 years after the birth, and the baby's neonatal admission, from an MLU with severe sepsis. After this meeting the Medical Director did send the family a letter outlining the results of the investigation, but also indicated that the letter had been composed from the Head of Midwifery's notes and transcription (it was obviously 'cut and pasted'). The letter concludes that there were still questions to be answered and confirmation was still required as to whether actions from the investigation had been undertaken.*

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This was 2 years after the case occurred. The review concluded that this letter was unprofessional and reinforced the apathy shown towards the case. The review team considers there appeared to have been little involvement with or support shown to the family. (2014)

Compassion and kindness

9.63 Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.

9.64 *In **2002** a woman with pre-eclampsia discharged herself 36 hours after delivering 25 week stillborn twins as she felt her care 'was appalling'. (2002)*

9.65 *In **2008** a woman reported her distress about the care she received on the postnatal ward after undergoing a postnatal laparotomy for a retropubic haematoma. She felt that on the ward 'There was no communication at all. I was shouted at, ordered about and forgotten…I was made to feel like an inadequate mother and made to feel like I was making up how poorly I was and I like I shouldn't have rung the bell or asked for help'. (2008)*

9.66 *In **2011** two families commented that 'midwives didn't care', 'showed no kindness [and] support' and 'there was no caring involved'. One mother told the review that she felt unsupported after suffering a cardiac arrest and was not offered any psychological support. She told the review that she was made to feel 'I was in the way and they wanted rid of me, they were in no way subtle about it once they decided that I had spent enough time in the unit'. (2011)*

9.67 *Another woman in **2015** told the review that she felt she had received poor care that also lacked empathy. (2015)*

9.68 The review team heard from families who felt unsupported and uncared for when their babies were unwell:

*In **2010** a baby was readmitted with significant jaundice. The family felt that their baby was 'starving to death' and complained about lack of feeding support. A review of the medical records indicated that inconsistent advice had been given to the parents. (2010)*

9.69 *In **2012** a mother felt ridiculed for having followed another staff member's advice on how to put on her daughter's nappy. (2012)*

9.70 *In **2014** a mother reported , whose baby was on the neonatal unit, that she was 'told off' for 'worrying about her pain too much'. The woman reported to the review team that she was told by staff 'what we tend to find is that those women who have babies next to them have more important things to think about. People like you who do not, are only concerned with themselves'. (2014)*

9.71 *In **2015** two families described the postnatal care as being 'truly awful' and that they 'felt like a burden' and 'not listened to'. One of these families also described a midwife calling the mother 'a princess' for asking for formulafeed for her baby. (2015)*

9.72 *In **2016** a mother reported being left alone in the birth room, with the call bell out of reach, just 40 minutes after giving birth. (2016)*

9.73 Concerning attitude issues towards families were also reported by some staff. One contributor to the staff voices process, reported to the review team that *'some staff [on the wards] ignored buzzers unless it was "their buzzers".'* This meant that some women asking for help could not access any support if their own midwife was busy, off the ward, or on a break. This contributed to some families feeling that *'midwives didn't care'.* The same contributor also commented that postnatal ward staff were probably quite unhappy and described *'not much understanding between labour ward and the postnatal ward'.* The same member of staff also stated: *'I wouldn't have wanted to go there as a patient'.*

9.74 Staff members told the review team that asking for help was seen negatively but were unwilling to be quoted directly as having said this, despite assurances of anonymity. This was not an attitude likely to foster a good working environment for staff, nor likely to lead to good care for families. Another member

of staff, stated that the Trust was *'a dreadful place to work…practice wasn't evidence based …guidelines woefully out of date…I tried to raise concerns unsuccessfully'.*

9.75 Whilst the review team noted that the Trust had a perineal follow-up clinic for women who had experienced 3rd and 4th degree tears, or other perineal problems, they also noted issues with some staff communication in this clinic.

9.76 *In **2009** a woman was referred to this clinic because of persistent perineal symptoms, despite no known history of significant perineal trauma at birth. In the clinic the consultant who saw her dismissed her symptoms, and said that no further investigation was required, without even examining the woman. This woman was subsequently seen in another hospital where a rectovaginal fistula was diagnosed, which must have occurred because of significant trauma at birth, probably a missed 3rd or 4th degree tear. (2009)*

9.77 *In **2014** when a woman was reviewed in this clinic after a 3rd degree tear the doctor wrote in the notes: 'Well, but fat and very anxious. Can try for a vaginal birth – risk of re-occurrence low'. (2014)*

Receiving postnatal care in the correct location

9.78 Care in the postnatal period for mother and babies must take place in an appropriate setting, according to clinical need.

9.79 *In **2012** there was inappropriate transfer to midwifery-led care in the postnatal period which led to poor management. The transfer of care, to a distant MLU, occurred 3 days after birth despite a complex caesarean section, massive obstetric haemorrhage, anaemia, postpartum pyrexia, persistent tachycardia and persistent pain. The mother was eventually transferred back, very unwell, to the consultant-led unit (inappropriately by car) on day 8 with severe sepsis, with both a pelvic abscess and a lung empyema[190]. (2012)*

9.80 *In **2017** a woman with known pre-eclampsia was transferred to a distant MLU for ongoing postnatal care on day 3, despite her blood pressure remaining elevated. (2017)*

9.81 *In **2017** a mother and baby who had been transferred to a standalone midwifery-led unit (MLU) for postnatal care after birth was advised by a midwife: 'Don't tell them the baby is 'grunty' or they will send you back to the consultant unit'. A family member subsequently highlighted their concerns and the mother and baby were transferred back to the consultant-led unit (2017)*

9.82 *In **2018** a mother and baby were discharged home 4 hours after vaginal birth but the baby's temperature was 36.1°C with no evidence of repeat measurement, the review team felt this was inappropriate. (2018)*

9.83 Follow-up appointments by community midwives after postnatal discharge from hospital should aim to both support the mother, and to detect and appropriately refer any maternal, or baby problems identified. In some cases this did not occur.

9.84 *In **2011** when a woman reported 'very little bowel control' on day 10, the midwife advised her to report this to her GP, rather than referring her to the obstetric team for review and management, or continuing to* review the situation herself. (2011)

9.85 In other cases women who had experienced pregnancy loss were advised to see their GP to get a prescription for therapeutic lactation suppression. It is normal practice to offer women lactation suppression after perinatal loss. The review noted evidence that lactation suppression was discussed with parents, but from the records of a **2016** early neonatal death it appears that Cabergoline was not stocked on the labour ward. This suggests that the management for families experiencing loss was not holistic.

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Staffing

9.86 Poor staffing levels, both midwifery and obstetric, will affect both the quality of patient postnatal care, and staff morale. It would appear that staffing levels and staff morale were an issue for some time at the Trust.

9.87 When contributing to the Staff Voices initiative in late 2021 one contributor graphically described the stress staff felt because of poor staffing levels, with postnatal ward midwives regularly being *'pulled to labour ward'* and described the way this affected care as: *'you … try and just do the work as quickly as possible, and there wouldn't be any quality of care'.* The same contributor also described that this prioritisation of the labour ward, leaving the postnatal ward understaffed *'really increased our stress levels because obviously, it's upsetting when you can't give the care that you want to give…especially on a postnatal ward where it led to healthcare assistants or the women's services assistants doing most of the clinical care with midwives just running in with some painkillers or IV antibiotics, or doing a quick check'.*

9.88 The response from the staff member, when asked about escalation of concerns regarding staffing levels on the postnatal ward, was *'you know, you can escalate, but you know if there's nowhere to pull, there's nowhere to pull. You're just left and you just have to get on with it'.* The contributor also reported pressure for early discharge *'they [postnatal women] can't even stay in for breastfeeding support'.*

9.89 Many staff contributors also reported significant staffing issues. They described: [a] '*shortage of midwives… needing to pull in staff (from wards and community)…robbing Peter to pay Paul,'* and *'[being] concerned about safety and staffing'.*

Bereavement

9.90 It is sadly inevitable that many of the families included in this review have experienced the loss of a baby, which can have a huge impact on their long-term wellbeing. As noted by SANDS (2021) *'Good care cannot remove the pain and devastation that bereaved parents experience, but poor or insensitive care makes things worse, both immediately and in the months and years that follow'.*

9.91 Compassionate bereavement care must begin when a family are told that their baby has died (or before death if the baby is known to have an abnormality incompatible with survival), it is therefore vital that all staff communicate compassionately with families at this very difficult time. Below are some cases from across the timespan of the review identified by the review team where families felt this did not happen:

9.92 *In **2002** a family complained about the way that a midwife sonographer informed them that one of the twins had died when the mother presented with ruptured membranes at 37 weeks gestation. (2002)*

9.93 *Similarly in **2009** a family complained about the manner of the doctor who diagnosed the absence of fetal heart activity, which they felt was insensitive. (2009)*

9.94 *In **2018** the review team noted that a family wished to continue a pregnancy with known abnormalities incompatible with survival and they were seen by the bereavement midwife and consultant neonatologist together during the pregnancy to plan care at the time of birth. After these meetings a letter outlining the plans for care was sent to the family. However, this information was inadequately conveyed to the labour ward staff, who were unaware of the agreed plans. This led to the inappropriate repeated discussion of the issues when the mother was in labour, and after the baby was born. It was also noted that some of the agreed plans were not followed, such as the family spending as much time with the baby as possible before discharge from the hospital. It is clear from the documentation that at the time of birth there was little, or no, discussion with the family with regards to meeting their individual requirements, nor to fulfil their required cultural and religious practices despite these having been agreed at the pre-birth meetings. (2018)*

9.95 In most maternity units it is routine practice to suggest that women go home after being given oral mifepristone following the diagnosis of an intrauterine death, to return after 36-48hrs for further management to induce labour. It is however very important that staff ensure that parents are given the option of staying in the hospital if they prefer, or that they are clearly informed that they can return to the hospital at any time if they wish.

9.96 *A mother described how she felt in **2010** 'When I left the hospital on the day I found out that my baby had died [at a scan]. I was told that they wouldn't expect me to return for 48 hours, from when the tablet was taken'. This family reported that they felt unsupported. (2010)*

9.97 *Similarly a mother raised concerns regarding staff attitudes after the very early neonatal death of a very premature baby in **2014**, who was born at 21+ week's gestation. She explained that she had to 'wait for the corridors to be empty before carrying her son back to the birth suite'. In her notes there was minimal documentation regarding postnatal bereavement care. (2014)*

9.98 Women who experience perinatal loss need to be cared for in a clinically appropriate area, so that both their physical and emotional needs can be addressed.

9.99 *In **2012** a family reported that their care after an intrapartum stillbirth was upsetting. Firstly the family were 'left in the room for I don't know how long…then put me in a wheelchair, gave baby to me (to hold), put us in a room and left us there'. This family also reported 'what was worse they put us in the maternity ward so we could hear babies crying'. Families have clearly explained to the review team how both compassion and an appropriate place of care can help make the unbearable more bearable. (2012)*

Consent to post-mortem examination

9.100 Post-mortem is the most useful investigation in supporting the determination of cause of death and its value is frequently underestimated by health professionals[191]. Deciding on whether to have a post-mortem investigation conducted can be one of the most difficult decisions bereaved parents face in the period immediately after their baby dies. It is essential that this is dealt with in a sensitive way by a professional trained to take post-mortem consent. The review team noted cases where discussion with families about having a post-mortem examination was insensitive or unhelpful. Below are two examples:

9.101 *A family in **2009** told the review team that: 'The doctor who went through the consent process for the post-mortem examination was observed by the midwife who documented "Noted that he went through documents very quickly and with little empathy. Family distressed by this and told me they were not happy with this when he left. Apologies given".' (2009)*

9.102 *Also in **2009**, a family reported that following the stillbirth of their daughter 'there wasn't time or space to make the important and difficult decision about consenting to, or declining, a post-mortem examination'. In this case the post-mortem consent was discussed only 6 hours after an unexpected stillbirth, and the family felt that the consultant obstetrician counselled them against having a post-mortem, and this was their 'largest concern about the care' the family received. (2009)*

Ongoing care after bereavement

9.103 Not surprisingly parents are very fragile at this difficult time, something all maternity staff should be aware of. Some families reported experiencing a lack of sensitivity to the review team. A family told the review team that in **2009** they found a consultant's attitude to be *'rude and completely dismissive of [their] concerns'.* (2009)

9.104 A family in **2011** felt deeply about *'the lack of compassion and empathy exhibited by the midwife'*. Also from **2011** the review team noted poor bereavement care and support and that there was evidence of a breach of confidentiality as there had been disclosure of the death of the baby to the woman's father without her consent. This had caused a strain in their relationship ever since. (2011)

9.105 It is reasonable to expect that maternity staff are careful to obtain accurate information when caring for bereaved families, or those with sick babies on the neonatal unit.

9.106 *A mother complained about the postnatal care she received in **2009** following a bereavement saying that the staff appeared unaware of the issues and she had to keep explaining distressing details at every shift change. (2009)*

191 https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

9.107 *In another instance in **2014** a bereaved family reported seeing a different community midwife at each postnatal visit. (2014)*

Specialist bereavement care

9.108 Families who have experienced baby loss must have ongoing support, either from their own community midwife, or from a bereavement midwife. The review team noted a lack of support for bereaved families in many cases, over a long period of time.

9.109 *From a case in **2003** the review team noted that one woman said she was happy with the antenatal and intrapartum care she received but when she needed support following her term stillbirth this was 'sadly lacking'. In this case there was no information in the medical records about bereavement care apart from a checklist and mention of counselling in the bereavement follow-up letter. It is unclear whether this was ever arranged. (2003)*

9.110 *Following the loss of her baby in **2010** the clinical records indicated that the mother was discharged from maternity care on day 8 and advised to 'call if further support needed'. (2010)*

9.111 *In **2011** the review team noted an apparent lack of bereavement support after a stillbirth. The only evidence of involvement from the Trust was a single telephone call some four weeks after the birth. The notes from this call, provided by the Trust, indicate that the mother was advised to contact other healthcare professionals for support if she wished. (2011)*

9.112 *In **2012** one family reported that the bereavement care they received was 'appalling' and another family felt that the bereavement support was 'very tick box' and that they found the maternity bereavement service 'of no help'. (2012)*

9.113 *In **2016** the review team heard from parents of a lack of care and compassion in bereavement care following the neonatal death of their baby shortly after birth. (2016)*

9.114 Another important aspect of care at this difficult time is ensuring that parents receive all the information they require, or request, and that all appropriate services are informed of the bereavement.

9.115 *A family reported that in **2010** when they requested that the community midwife follow up the missing photographs of their stillborn baby that this did not occur. As the photographs had still not been sent to her months later the woman had to phone the ward herself to obtain them. (2010)*

9.116 *A family reported that in **2011** there was a delay in them being told that their baby had been returned following the post-mortem, which led to a significant delay in arranging the funeral. (2011)*

9.117 *In **2016** a health visitor was unaware of the neonatal death and provided congratulations and Bounty literature continued to be sent to the family, which they found distressing. (2016)*

Good bereavement care

9.118 In some cases, there was evidence of kind and compassionate support given to families after bereavement. The following are examples of that kind and compassionate care.

9.119 *In **2006** the community midwife was praised by the family for her care and compassion and they specifically asked for her in subsequent pregnancies. (2006)*

9.120 *In one case in **2011** the obstetric registrar offered condolences and gave a detailed discussion about post-mortem and the parents opted for a limited one with the knowledge that there was a limit to the information they would receive. (2011)*

9.121 *There was evidence in some cases that the maternity staff tried to help families with stillbirth registration. In **2014** a couple with English as a second language were escorted to the registry office to register their stillborn twins. It was also arranged for an interpreter to be present when the couple came to see their consultant for a follow-up appointment. (2014)*

9.122 *In **2012** the family reported that through bereavement support it was ensured that the family's concerns and questions were addressed in the Trust investigation.*

9.123 *In **2017** the parents reported effective information sharing, good levels of care including continuity of care after bereavement. (2017)*

Good postnatal care

9.124 Whilst the review has identified poor postnatal care it should be acknowledged that in the cases the maternity review team considered we also found examples of women receiving good, safe and supportive postnatal care.

9.125 *In **2011** there was evidence of effective team work with appropriate referral and involvement of social services, GP and health visitors. (2011)*

9.126 *In **2014** the review team also noted that 'the immediate midwifery care provided during the postnatal period was of good standard and aligned with local and national guidelines'. (2014)*

9.127 *In **2014** evidence was noted of extra postnatal community visits to provide more emotional support to a new mother. (2014)*

Good record keeping and good care planning

9.128 Good record keeping is fundamental to safe and high quality maternity care, and remains so in the postnatal period. Whilst the review has criticised poor record keeping, examples demonstrating appropriate and good quality postnatal record keeping were identified in **2010** and **2013**. The review team also identified sensitive documentation in the care of a family in **2008** and in another case involving a family in 2016 documentation was described as having a *'detailed midwifery record'* by the review team.

9.129 The review team also identified examples where problems likely to lead to a difficult outcome were identified during the pregnancy with evidence of good care planning in 2008. In cases from **2011** and **2015** the review team also noted evidence of family involvement in the planning of care.

9.130 Some cases of good clinical care were also noted. In **2011** timely multidisciplinary management was noted when a woman was readmitted with a severe wound infection after a caesarean section. The infection was promptly recognised as the severe life threatening condition of necrotising fasciitis, which was managed well.

9.131 In **2013** when a woman informed her community midwife that she felt 'unwell' at a routine visit, the community midwife recognised the severity of her condition and arranged prompt referral directly to the labour ward. When this woman arrived on the labour ward the midwives ensured that she was seen promptly by the obstetric registrar, who rapidly diagnosed sepsis and appropriately administered intravenous fluids and antibiotics within 30 minutes of her arrival in the maternity unit. She then went on to have good multidisciplinary management, including a short spell in ITU, and made an excellent, and fairly rapid, recovery. (2013)

LOCAL ACTIONS FOR LEARNING: POSTNATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

9.132 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

9.133 The Trust must ensure complete and accurate information is given to families after poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

Chapter 10

Maternal deaths

The impact on families when a mother dies

10.1 Families have explained to the review team that the impact of a maternal death and thus losing a mother, wife, daughter, sister, or grandchild is far reaching across a whole extended family and the effect of this remains with them forever. Here are some of the ways families who have spoken to the review team about maternal death have described this to us:

10.2 'It never goes away…you just kind of…and it's a natural thing, you just kind of withdraw within yourself a little bit. Usually, for me, that's like a month, six weeks, two months.' (**2002**)

10.3 'It's just sad, I ache for her every day, every day.' (**2007**)

10.4 'I think her Mum and Dad, they're still grieving now…Even now like, I mean you go round the house and there's always a candle lit, you know, they've got our wedding photos still up, you know, it's just a constant reminder when you go round to their house.' (Husband talking about his wife who died in **2011**)

10.5 '…she was having some problems and eventually she said to her step mum that she felt bad that her Mummy had died because she'd wanted to have a brother or sister.' This example is from a bereaved husband, talking about his first-born daughter whose mother died during a later pregnancy. His daughter believed that her wanting a sibling was the reason her mother had died in **2016**.

10.6 The review team noted that several families felt their questions surrounding the maternal death had not been addressed by the Trust. Bereavement support after the event was also described by families as inconsistent:

10.7 When asked as to whether an investigation into the death had been performed a husband whose wife had died in **2002** responded: *'There was no…it was just the…it was pulmonary oedema and obviously pre-eclampsia was like mentioned, or part of it. Yes, fluid on the lungs. No, they never gave an explanation for that, for why'.*

10.8 Another family member said to the review chair: *'It's what makes me angry, because I feel like the Trust got off lightly at the time with me, because I feel that they recognised, in that meeting, how desperately distraught I was and they just decided…like everything was done, you know…We can't find any reason for, but if you want to take a complaint elsewhere that's up to you…but as far as we're concerned there's no case to answer…is what they basically said. And I came out flabbergasted because I think I'd expected them to offer me a big apology, you know, and say oh yes, we've made loads of failings here, and all this, that and the other...And of course they didn't and when they didn't do it I just thought I can't do any more, like I haven't got the energy to do any more. So I think they got off lightly really, and it makes me feel bad that I didn't have the energy to do it, but it would have been too much for me to go through…because I want to go through this process [the Ockenden review] to get some answers for my own peace of mind as to what happened, because I laid a lot of blame on myself afterwards…'*

10.9 The family member further recalled: *'one doctor that wasn't so pleasant or helpful…when I rang him to ask some of the questions, his exact words to me were "if you keep digging into this you'll just find things you don't want to find". That's what he said to me, and then he put the phone down'.* (This feedback is from the partner of a mother who died in **2002**)

10.10 A partner of a woman who died in **2014** told the review chair: *'I was actually told that I would get to see [the investigations], they did an independent review on their midwives and then they did another one, I saw another lot…so the ones above them also went back on her case and went through all that, I was also told I would get them...[investigation reports] and we've never had them'.*

Number of maternal deaths reviewed

10.11 At the time of concluding this review, in total 19 maternal deaths were noted by the review team. Three of these occurred prior to the core review period (before 2000) and one death in **2015** occurred after the mother was transferred in labour to another trust. This woman's pregnancy care was reviewed by the team as the majority of the pregnancy care occurred at the Shrewsbury and Telford Trust's maternity services, but her death was not.

10.12 Of the 16 cases that occurred within the core review period, there were eight direct[192], and seven indirect maternal deaths[193], plus one accidental death resulting from a road accident, which was not investigated further by the review team.

10.13 One death which occurred at the Trust during pregnancy in **2019** was comprehensively investigated by the regional Healthcare Safety Investigation Branch[194] (HSIB) as per NHS policy. This case was not reviewed further by our team.

10.14 One mother who delivered at the Trust died in another hospital in **2019** and the family declined the HSIB review. It was not possible to obtain permission from the family regarding inclusion into our review. In cases such as this, there is ultimately learning for the whole maternity system and trusts involved must learn together through digital or remote means if necessary. The review team is not aware of any such joint learning in this case.

10.15 Clinical notes were unavailable for one woman who died in **2001**, despite recommendations that all maternity records should remain available for 25 years after the birth of the last child[195]. An external governance review was arranged after the family complained to the Trust and provided to the review team by the Trust. The review team was therefore able to review the quality of the Trust's internal investigation after the death, but not the clinical care.

Analysis of the maternal deaths

10.16 The remaining 12 maternal deaths were each reviewed by a multi-professional team of midwives, consultant obstetricians, a consultant obstetric physician and a consultant anaesthetist, with special interest in obstetric and cardiothoracic anaesthesia. Further experts (including experts in intensive care, cardiology, neurology and others) joined the team to give expert opinion or answer specific clinical questions where required.

10.17 As with all other reviews, for each maternal death review the team adopted a holistic and multi-professional approach, including access to all available governance documentation provided by the Trust and communication with the family of the deceased mother.

10.18 Although statistical analysis of the maternal deaths is limited due to the small numbers, the review team noted the relatively high number of direct maternal deaths at the Trust. This is in contrast to the overall national trend, where direct deaths have been declining since 2004[196]. This may be an indication that the care for pregnancy related conditions such as pre-eclampsia (PET), sepsis and major obstetric haemorrhage needs to be further improved locally.

10.19 The review team noted that all but one woman who died were of white ethnicity, a patient group which usually has a lower risk for mortality in pregnancy. Seven of the women who died were classified as obese at booking for maternity care (BMI> 30 kg/m2) and therefore were of higher risk for pregnancy related complications.

192 See glossary

193 See glossary

194 See glossary

195 Department of Health, Records Management: NHS Code of Practice: Parts 1 and 2: 2006, revised 2009 and 2016, include reference to HSC 1998/217: Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients (Replacement for FHSL (94) (30))

196 MBRRACE-UK, Saving Lives, Improving Mother's Care (2020)

10.20 Two maternal deaths did not have a coroner's inquest. In three cases where there was a coroner's inquest the review team commented further on the cause of death as stated by the coroner:

*In **2002** a woman with pre-existing lung disease developed pre-eclampsia and had inappropriate fluid management with significant fluid overload, over many days. She later died from acute respiratory distress syndrome (ARDS). The pathologist at the inquest speculated that very high oxygen levels during ventilation on the intensive care unit led to the ARDS. The underlying respiratory condition and inappropriate fluid management were not identified at the inquest. The review team is of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.21 *In **2014** a woman with poorly managed sepsis and prolonged resuscitation efforts was found to have squamous epithelial cells in the pulmonary vessels at the post-mortem investigation and the cause of death was determined as amniotic fluid embolism (AFE). The review ream is of the opinion that fetal squamous cells in the systemic or pulmonary circulation of the deceased is not necessarily proof that she died of AFE and that sepsis was a significant contributing factor. The review team is also of the opinion that this was a missed opportunity for learning from the death of this woman.*

10.22 *The post-mortem investigation in a woman who died of major obstetric haemorrhage in **2017** found evidence for an undiagnosed cardiac condition, which was classified as contributory to the death The review team is of the opinion that there is no evidence that the woman was affected by the cardiac condition in any way and that this did not contribute to her death.*

10.23 The clinical care and quality of the subsequent investigation were rated by agreement between the review team members as per below:

GRADING OF CARE	DEFINITION
0 Appropriate	Appropriate care in line with best practice at the time.
1 Minor Concerns	Care could have been improved, but different management would have made no difference to the outcome.
2 Significant Concerns	Sub-optimal care in which different management might have made a difference to the outcome.
3 Major Concerns	Sub-optimal care in which different management would reasonably be expected to have made a difference to the outcome.

10.24 The quality of the incident investigation root cause analysis or RCA at the Trust was rated differently depending on the year the incident occurred, to reflect the national developments in incident reporting and investigation.

For cases up to and including 2010:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

For cases from 2011:

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Appropriate collection of evidence (statements, notes, policies etc.) Appropriate care and service delivery problems identified. Strong recommendations for improvement with clear plan for implementation.	Families involved in investigation by compassionate communication with them at the time of incident. Feedback to the family once investigation concluded.
Poor	Any of the above missing.	Very little family involvement or feedback after the investigation.
None	Incident not investigated.	No family involvement.

Grading of care

10.25 The review team reviewed the maternal death cases individually prior to agreeing the grading at multidisciplinary team discussions. With hindsight, one will often judge a past decision by its outcome instead of based on the quality of the decision at the time it was made, given what was known at that time. The review team is conscious of the fact that there is a danger of judging past care decisions by the outcome, instead of based on the quality of the decision made at the time, which can lead to outcome bias when applying any grading of care. It is important to note that all cases were reviewed in accordance with best clinical practice and guidelines available at the time of the incident, to avoid outcome bias as much as possible.

10.26 The reviewers found none of the maternal death cases had received care in line with best practice at the time (grade 0). Three cases were found as requiring improvement in care, however, the eventual outcome would not have changed (grade 1). In six cases the care was rated as 2, meaning the reviewers found suboptimal care of the women and different management might have changed the eventual outcome. Three cases were graded as 3, where the eventual outcome could have reasonably been expected to be avoidable, had the care been different.

Grading and analysis of internal investigations

10.27 In line with the Terms of Reference of the review, all available governance documentation and family communication were reviewed in the context of best practice at the relevant time. A total of 11 incident investigations were considered. However, in some cases no comprehensive serious incident (SI) report was available (as would have been the expectation), but rather an abbreviated High Risk Case Review (HRCR), in the form of a spreadsheet. This appears to have been an internal Trust review process that has not been seen outside the Trust by review team members. It was not always clear to the review team whether, and if so how, these were shared with the families of the deceased women.

10.28 One maternal death in **2017** was investigated by an external provider. The review team agreed that the standard of the investigation was appropriate.

10.29 A maternal death that occurred in **2002** was not investigated by the Trust as the care was rated by them as appropriate, a finding with which the review team fundamentally disagree. The Trust maternity governance team noted *'This case was reported as a serious untoward incident and also a full report sent to CEMD (Confidential Enquiry into Maternal Death). It was also discussed at the mortality meeting, but it was felt*

that there were no lessons to be learned. This was a high risk pregnancy and Mrs X was aware of the potential effect this could have on her future. The staff were extremely saddened by her death'.

10.30 The review team acknowledges that the pregnancy in this case from **2002** was high risk, however there were multiple missed opportunities and a lack of understanding in regard to the mother's underlying condition and poor management of developing complications. The family in conversation with the chair of the review has explained how they felt the Trust 'blamed' the mother and her husband for her death, because had the mother not got pregnant she would not have died.

10.31 In another case in **2001** the family made three requests via the NHS complaints procedure for an external review into the death of the mother. It was finally arranged by the Trust's lay chairman and complaints convenor two years after the death in 2003 and identified significant issues in the care. In their letter to the family it is stated *'The lay chairman and I agree that there has been a long period of local resolution, including a meeting with the consultant in charge…and several letters from the chief executive. In fact, this is the third request for an independent review. The independent clinical advice supports your view that there are still significant issues which need to be addressed concerning the standard of care provided…'* From the available documentation the review team can conclude that the initial investigation into the death by the Trust was poor.

10.32 The review team rated all available Trust investigations into these maternal deaths as poor. We found repeatedly that significant omissions in care were not identified by the Trust investigators, leading to missed opportunities for learning that could affect the outcome for other women and babies in the future.

Findings

10.33 Many RCAs did not involve a multidisciplinary team, even if there were multiple professions involved in the care of the woman (for example there was usually an absence of specialities such as obstetric anaesthesia, intensive care, infectious diseases, cardiology and/or haematology). Frequently only a few internal maternity staff performed the investigations and even at mortality and morbidity review meetings a truly multidisciplinary discussion did not happen.

10.34 It appears that all these cases of maternal deaths were investigated purely internally, with no external expert opinion sought, except in the one case mentioned above.

10.35 If and when post-mortem results became available during the investigation that seemingly pointed to a direction of an 'inevitable outcome', the direction of the investigation changed in such a way that detailed scrutiny and holistic review of the entire care did not happen.

10.36 Issues in care that were identified were frequently treated as individual failings and actioned by 'internal reflection' of involved staff. The investigations did not follow the appropriate systems-based approach as outlined in the relevant NHS incident frameworks and significant learning opportunities for the Trust and the wider maternity teams were lost. These frameworks are discussed further in the report chapter focussing on clinical governance.

10.37 The review team noted that frequently the women themselves were blamed or held responsible for the adverse outcomes, without identifying underlying and obvious failings in care. A husband recalled how in **2011** his deceased wife was blamed when he was told: *'[it was] difficult for the midwives to listen to baby's heart beat due to her size'.* This was also recorded in the maternity records. Trust documentation pertaining to a maternal death in **2002** stated *'…she knew of the risks [related to pregnancy] and accepted these'.* In another case in 2002 the following was said *'...she must have been responsible for some of that because she clearly did not complain very much and tended to ignore many of her symptoms…'.*

10.38 In one case in 2014 there was a significant discordance between what was discussed with the relevant clinicians involved in the incident by email and the stated outcome of the internal incident investigation. The Trust investigation concluded *'no deviation in care and management identified relating to root cause'.* However, in emails that were sent by one of the lead investigators to individual staff involved in the care

of the mother, it is clear that significant omissions in care were identified: '*…none felt that discharge to the antenatal ward at that point was the correct action'.* This case highlights significant cultural problems in the Trust at the time. There appeared to be a lack of ability to come together and examine why this happened. There was no insight into the problem resulting in a poor investigation, which later informed the coroner's inquest. This affirms the overall findings of the review team that significant contributory factors and/or the root causes for poor outcomes were not identified, or to the extent they were identified, were not addressed with a robust action plan; demonstrating a lack of rigour and transparency in the RCA investigations.

10.39 There is also evidence from the available governance documentation and conversations with families that in some cases failings in care were not communicated in an open and transparent way, once the investigations were completed.

10.40 *In **2006** a woman with an underlying cardiac condition, developed significant tachycardia and low blood pressure after the delivery. In a meeting with the family after the investigation they were told that 'The ECG of a pregnant woman can be misleading to a junior doctor with general medical experience; as it can appear to suggest the heart is not coping; which is incorrect and a normal rhythm in pregnancy.' At no point was it discussed with the family as to whether this complication should have been escalated to a more senior doctor or cardiologist. There was also a missed opportunity to manage and treat the underlying causes of the tachycardia.*

10.41 *In **2014** another family who questioned the appropriateness of treatment for maternal sepsis were told in a debriefing meeting that 'she did not have signs of profound infection' which is not corroborated by the clinical notes. The internal discussion at the Trust regarding the serious incident found that the sepsis treatment had been not well coordinated, but this was not disclosed to the family.*

Learning from maternal deaths

Local Actions for Learning and Immediate and Essential Actions from report 1:

10.42 The review team re-emphasises the importance of the previous Local Actions for Learning for the Trust and Immediate and Essential Actions for the wider maternity system from their first report regarding the learning from the maternal deaths at the Trust. They can be found in Appendix 2 and form a vital part of the ongoing learning for the Trust and wider maternity system. In particular continued focus must be around timely escalation to an appropriately senior level and multidisciplinary team working. MDT training involving maternity teams working with ITU, anaesthetic and other colleagues in management of the deteriorating pregnant woman is needed. This will ensure the right team are always available with the skills to manage complexity.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

10.43 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

Chapter 11

Obstetric anaesthesia

11.1 Expert advice was sought from anaesthetist colleagues within the Maternity Review Team for a number of cases. Criteria for anaesthetic review for this report were the presence of severe pre-eclampsia or HELLP; eclampsia; postpartum haemorrhage of 3000ml or more; significant pre-existing maternal medical disease; and concerns regarding the management of obstetric anaesthesia. As a consequence, 68 cases were referred to anaesthetists within the Review Team. This is a small percentage of the overall number of cases reviewed in this report and an even smaller proportion of the overall number of maternities taking place at the Trust during the past two decades. Consequently, there is a limit as to how representative of anaesthetic provision at the Trust these cases can be considered to be. However, there were a number of recurring themes that are worthy of comment to facilitate further learning.

Anaesthetists and the multidisciplinary team

11.2 The role of the anaesthetist on duty for obstetric anaesthesia is much broader than being merely a technician for provision of pain relief and anaesthesia. They must also work as part of the multidisciplinary team in the management of women experiencing pregnancies or childbirth, complicated by certain obstetric issues or pre-existing medical disease. As described in the first report, the review team again found evidence that anaesthetic input on the labour ward was often task-focussed and lacking consideration of the wider clinical picture of the women in their care.

11.3 *In **2012**, ten days after emergency caesarean a woman was displaying florid signs of sepsis and a decision was made to reopen her wound. The specialty doctor anaesthetist gave appropriate intraoperative care at laparotomy which revealed pus in the caesarean wound and pus within the peritoneum[197]. However, there was no evidence of discussion regarding where the patient would be best managed postoperatively and no postoperative instructions were documented by the anaesthetist. She was discharged back to the labour ward overnight and stepped down to the postnatal ward the following day despite the patient's concerns about her breathing. A respiratory examination was not undertaken until the second postoperative day when the patient was experiencing chest pain and had a significant oxygen requirement. She was later found to have a loculated empyema[198] for which she was admitted to the high dependency unit and later transferred to another hospital for surgical management. There was no anaesthetic input into the subsequent high risk case review. (2012)*

11.4 *In **2019**, a woman developed severe intraoperative hypertension under spinal anaesthesia. Early the following morning the midwife noted unilateral arm and leg weakness and requested an assessment by the anaesthetist who suggested that this was a residual effect of the spinal anaesthetic, but did not document their review. Later in the day, after no improvement, a further review was requested and documented and the anaesthetist escalated their concerns to the consultant anaesthetist and medical team. A CT scan ten hours after initial concerns were raised revealed a subarachnoid haemorrhage[199] an internal Trust review of the case by a consultant anaesthetist found no problems with the anaesthetic care. (2019)*

11.5 As well as occasions where anaesthetists failed to involve themselves in the care of critically ill women, there were cases where the obstetric and midwifery teams failed to involve or inform the anaesthetist on duty about women with significant morbidity. Often the anaesthetist was only called to review a patient once a decision had been made to take them to theatre, sometimes for very urgent surgery, thus denying the anaesthetist the opportunity to make a considered assessment of the patient and to take steps to optimise the patient's condition prior to anaesthesia.

197 See glossary
198 See glossary
199 See glossary

11.6 *In **2004**, at 0520h, 50 minutes after a vaginal delivery, a woman had bled in excess of 1000ml. The midwife did not escalate this to the obstetric team until 0550h who, in turn, did not alert the anaesthetist until 0730h, just prior to transferring the patient to theatre for an examination under anaesthetic. Local guidelines regarding key personnel to be notified in the event of post-partum haemorrhage were therefore not followed. The woman raised concerns about her care when she subsequently attended an obstetric outpatient appointment. There is no evidence that her case was reviewed by the maternity governance team even though the consultant obstetrician stated in his letter from that appointment that it should be. The consultant mentioned that she would have a midwifery debrief appointment in order to address 'her various anxieties'. (2004)*

11.7 *In **2006**, ten days after an emergency caesarean section a woman was readmitted with collapse and blood loss in excess of a litre. Despite a decision within 20 minutes of admission by the consultant obstetrician that the patient would need an examination under anaesthesia, there is no evidence that the anaesthetist was notified for more than 4 hours (contrary to the Trust's postpartum haemorrhage guidance at the time). The anaesthetist assessed the patient 9 minutes before she was transferred to theatre. She was so unstable that she required a general anaesthetic, hysterectomy, and a blood transfusion of 11 units. An incident report was submitted but a consultant obstetrician decided that a high risk case review was not required. The consultant wrote to the obstetrician who performed the caesarean section stating that 'care throughout [the readmission with postpartum haemorrhage] seems to have been appropriate and decision making made at the appropriate level' but queried the possibility of injury to the uterus at caesarean section. (2006)*

11.8 *In **2008**, a multiparous woman was admitted with raised inflammatory markers[200] after premature rupture of membranes at 33 weeks of pregnancy. A scan the day after admission showed the baby was in a footling breech position. Despite a recognised high probability of the need for early delivery, the anaesthetist was not called to review the patient until a decision was made for a category 1 caesarean section when the patient had reached 7cm cervical dilatation 6 days later. There is no evidence of learning arising from this case. (2008)*

11.9 *In **2018**, despite repeated previous admissions with antepartum haemorrhage in a woman with known low anterior placenta accreta[201], the duty anaesthetist was not alerted to the presence of the woman in the hospital until the decision was made that she required a category 2 caesarean section, almost 36 hours after her admission with a further antepartum haemorrhage. Escalation by the duty anaesthetist to senior anaesthetic staff and involvement of additional theatre staff was then swift and her overall anaesthetic care good and safe. There is no governance documentation relating to this case. (2018)*

11.10 Failure of anaesthetic and obstetric resident on-call teams to escalate promptly to senior staff during times of high workload or when managing deteriorating or very ill women was noted in this review's first report and seen again in further cases reviewed for this current report. In response to a Local Action for Learning point from the first report, the Trust now has a specific guideline advising when the on-call consultant anaesthetist must be contacted by the resident anaesthetist. However, as with all guidelines advising on escalation to specific personnel (including the ones that were not followed in the vignettes below), this will only result in service improvement if its advice is adhered to, and if the consultant on-call is free to attend. Anaesthetic staffing at the Trust remains a concern which is discussed later in this chapter.

11.11 *In **2004**, the resident anaesthetist was called at 0530h to see a woman in labour following an intrauterine death thought to be due to placental abruption. He was unable to attend for an hour and a half due to workload, by which time the patient had bled 1400ml and was tachycardic[202].There is no evidence that this incident was reported or that any investigation or learning occurred.(2004)*

11.12 *In **2013**, a woman had labour induced due to pre-eclampsia. She had significant oedema, headache and visual disturbance. Her blood pressure was 166/115mmHg and she was struggling to cope with the impact*

200 See glossary
201 See glossary
202 See glossary

of an oxytocin infusion on her labour pains. 2h 25min elapsed between the duty anaesthetist being called and their attendance to site the epidural as they were busy in theatre. During this time the oxytocin infusion had to be switched off due to the woman's distress. Once the epidural was sited, the anaesthetist left the midwife to administer the initial doses, contrary to Trust guidance, as they were called for a category 1 caesarean section for another patient. There is no evidence that efforts were made to contact another resident anaesthetist or the consultant on-call to assist with the workload. An incident report was submitted about an unrelated aspect of her peripartum care, but no action plan or investigation was documented or made available to the review team. (2013)

Anaesthetic services, workforce and leadership

11.13 The first report raised concerns about anaesthetic staffing at the Trust, in particular at consultant level. The 2017 RCOG report[203] commented that anaesthetic consultant staffing was non-compliant with the 2013 Obstetric Anaesthetists' Association/Association of Anaesthetists of Great Britain & Ireland (OAA/AAGBI) Guidelines for Obstetric Anaesthesia Services[204] which recommended 12 consultant anaesthetist sessions per week to cover just the emergency work of the labour ward, with additional sessions required for management of clinics and elective caesarean list workload.

11.14 The Trust has a document reflecting its anaesthetic staffing and plans: Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants. Its first iteration was in 2010 and it has been amended over the years in response to service changes, audits, and a Clinical Negligence Scheme for Trusts (CNST) report, with a full review and update in 2015. At that point, the Trust self-evaluated that it required 14 sessions of anaesthetic consultant cover in order to comply with the OAA/AAGBI guidance but that it had a shortfall of three consultant sessions. Prospective cover for leave involved cover by another consultant or a specialty doctor.

11.15 By 2018 the self-evaluated number of sessions that required cover had risen to 16 but actual staffing remained static at coverage of 11 sessions only, a deficit of 5 sessions. Since the publication of the first report, the Trust has advised the review team that elective lists and clinics are almost always staffed by a consultant grade anaesthetist but that the labour ward only has dedicated consultant cover 50% of normal daytime hours. This falls short of current guidance from the Royal College of Anaesthetists (RCoA) as detailed in the Guidelines for the Provision of Anaesthetic Services (GPAS)[205].

11.16 The review team has been advised by the Trust that, out-of-hours, the anaesthetic consultant on-call at The Princess Royal Hospital, Telford, has responsibility for general theatres, intensive care, paediatrics, and the head and neck surgical service as well as obstetrics. This results in situations where, understandably, they are unable to be in more than one place at a time. The review team has been advised by staff that attempts to recruit new consultant anaesthetists in order to provide a separate rota to cover intensive care have so far been unsuccessful. The required training and skillset of the obstetric anaesthetists and also that required for the non-obstetric anaesthetists who cover the maternity service out-of-hours is not specified in RCoA's guidelines. The Trust's Strategy for Staffing Levels – Obstetric Anaesthetists and Assistants document states that *'Staff are made aware of the availability and access to all guidelines, protocols and policies during their induction'* but does not give any more detail on any measures taken to assure staff training and updates. A list of consultants who provide input to the on-call service has been provided by the Trust and it is notable that a significant proportion are locums. There is a nominated lead obstetric anaesthetist who has an active role in leading and managing the service, and this is reflected in their job plan.

11.17 A team of specialty doctors provide the out-of-hours and much of the within hours resident cover to the maternity service. They are described by the lead obstetric anaesthetist as a 'senior stable workforce'.

203 The RCOG report -Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust July 2017

204 OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, June 2013, London

205 Guidelines for Provision of Anaesthesia Services (Chapter 9 Guidelines for Provision of Anaesthesia Services for an Obstetric Population 2020). RCoA. (https://rcoa.ac.uk/gpas/chapter-9)

Doctors in training spend daytime hours on obstetrics but have not contributed to out-of-hours provision since 2011. The Trust has provided no detail to describe the training and ongoing development of the specialty doctor group of anaesthetists upon which the service relies so very heavily. Access to learning and development opportunities can be limited for staff grade, associate specialist and specialty doctors (SAS) generally within the NHS, specifically in comparison to consultant colleagues or doctors in formal training programmes. This may be due to the role of SAS doctors in managing service pressures and their lower supporting professional activity (SPA) allowance compared to consultant staff.

11.18 A member of staff talking to the review team in the autumn of 2021 told us; *'We're just about functioning but we are having to use locums and every week you look at the system and it's just a mess of extra people doing different lists, slotting in. So we're getting by, you know, week to week. It's quite a challenge…you raise your concerns and everybody says yes, yes, this is a big concern but nothing really happens'.*

Management of common obstetric conditions

11.19 In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines. There is evidence of women receiving excessive volumes of intravenous fluid prescribed by both anaesthetists and obstetricians. This took place in the presence of severe pre-eclampsia, contrary to local and national guidance regarding fluid restriction in such circumstances, and also after post-partum haemorrhage. In some cases, the women were displaying clear signs and symptoms of fluid overload over a protracted period before it was noted by medical staff.

11.20 *In **2004**, after discharge to recovery following examination under anaesthesia for post-partum haemorrhage, the patient continued with 100-150ml intravenous fluids per hour despite plentiful oral intake. Some 3.5 hours later she was noted to be desaturating and an hour after that she complained that her hands felt 'tight' and they were documented as oedematous. Her urine output overnight peaked at 320ml/h. An obstetric SHO prescribed a further two units of blood as there was a decrease in the woman's haemoglobin. The following morning, with oxygen saturations of 88% on air, she was finally diagnosed as being fluid overloaded. She passed 1600ml of urine in the hour after she was given intravenous furosemide[206] and shortly afterwards was able to stop oxygen therapy. (2004)*

11.21 *A woman who had symptoms and signs of severe pre-eclampsia in **2008** had her baby delivered by caesarean section after failed induction of labour. She was diagnosed with left ventricular failure[207] and pulmonary oedema[208] in the postoperative period when she had a positive fluid balance in excess of 2000mls. Fluid administration was consistently in excess of the nationally advised limit of 80ml/h with 1500ml being given in theatre alone. A handwritten note in the patient's hospital records stated that her case had been discussed at a governance meeting, but no documents reflecting this were supplied to the review team by the Trust. (2008)*

11.22 Obstetric haemorrhage is a common condition that all staff involved in the care of obstetric patients must be confident in recognising and managing. However, there were a number of instances where the obstetric and anaesthetic teams seemed slow to diagnose bleeding as the underlying cause of a woman's deterioration. For example:

11.23 *In the early hours of the morning after an elective caesarean section in **2012**, a woman became progressively tachycardic and hypotensive[209] feeling hot, clammy and dizzy, with a sense of ringing in her ears, vomiting, and loss of consciousness with a brief seizure. Despite a 30g/l drop in haemoglobin on blood gas sample analysis, raised lactate, and uterine tenderness, the staff grade anaesthetist who was called to see her (and the obstetric on-call team) did not recognise that the patient was bleeding as there was 'no excessive*

206 See glossary
207 See glossary
208 See glossary
209 See glossary

blood loss seen'. The medical registrar was called to comment on the seizure and suggested bleeding as an underlying cause. She was finally diagnosed as such once the obstetric consultant was contacted. An incident report was submitted, but there are no other documents available related to the case. (2012)

11.24 *Following a vaginal delivery in **2016** a woman suffered a postpartum haemorrhage which resulted in tachycardia, hypotension, and the administration of 3.5 litres of crystalloid[210] by the obstetric team. The haemoglobin pre-delivery was 123g/l and at its lowest was 60g/l. The obstetric registrar estimated blood loss as 1000ml and wanted to take the patient to theatre for an examination under anaesthetic. The consultant anaesthetist estimated blood loss as 2000-3000ml. The consultant obstetrician estimated blood loss as 1200ml and overruled the plan for examination under anaesthesia. After a unit of blood that day and three the following day, the haemoglobin improved to 89g/l. A blood loss of just 800ml was later documented on the woman's discharge summary. When the woman was readmitted a month later she had a large remnant of placenta removed under anaesthesia and required a further blood transfusion. There was no incident reporting concerning these events. (2016)*

11.25 Local Actions for Learning from our first report highlighted the need for development of evidence-based guidelines and multidisciplinary training for developing and maintaining staff skills in the diagnosis and management of obstetric conditions. The Trust's anaesthetists have worked to create a full range of obstetric anaesthesia guidelines in response to the first report, and now acknowledge the challenge in embedding them into clinical practice and monitoring adherence to them. It is reassuring to hear from staff interviews that obstetric skills and drills are now undertaken regularly on the labour ward and involve the multidisciplinary team, including the anaesthetists.

Postnatal follow-up

11.26 In the process of undertaking reviews of clinical records for the purposes of this report, it is apparent that many women who experienced complications did not have the opportunity to have a proper discussion with clinicians about their peripartum care. On occasion there has been poor practice and care on the part of the Trust that has not been adequately discussed, and on other occasions women have had a complicated and difficult childbirth. From the communications between women, their families and the review team it is clear that a sense of not being listened to, as well as a lack of understanding about peripartum events, has persisted for some women and families for many years, impacting negatively on their psychological state, even now.

11.27 With the power of retrospection, it is clear that many women would benefit from postnatal discussion with clinicians who can actually give individualised answers about their care. Such discussion can occur at the time of events taking place but must be reinforced after discharge, when women are more able to gather their thoughts and questions in advance of a meeting, be supported by the presence of a friend, relative or advocate if they so choose, and take notes of answers.

11.28 Outpatient postnatal follow-up by an anaesthetist must be offered for women for whom significant issues have occurred, especially where they may impact on anaesthesia management or anxiety during future childbirth. Such issues include inherent anaesthetic complications such as intraoperative pain, including where conversion to general anaesthesia became necessary, suboptimal epidural pain control with significant consequent distress, and postdural puncture headache. More serious complications such as awareness under general anaesthetic and neurological complications related to anaesthesia must also be followed-up in an outpatient setting. Clinicians must also recognise situations where women would benefit from a conversation and explanations regarding their anaesthetic care even when nothing has actually gone wrong. Provision of such appointments must be seen as part of a culture of openness and willingness to maximise improvement of patient care, rather than as an admission of failure on the part of the Trust.

210 See glossary

11.29 *A woman made contact with the Review Team regarding her 'horrendous' experience of pain during caesarean section under epidural top-up with intraoperative conversion to general anaesthesia in **1999**. Despite the passage of time, the experience still causes the woman distress to this day. On review of the medical records it is clear that the epidural never offered adequate pain relief in labour and there is no evidence that the top-up for surgery was checked for adequacy. Twenty minutes after arriving in theatre the patient was given a general anaesthetic with a note documenting 'switch to GA after initial incision for surgical reasons'. After a midwifery debrief, the patient's notes were passed to a consultant anaesthetist who wrote a note saying that 'bar reassurance, probably there is no specific reason to see her'. Although this case occurred before the main period of the review, it is included here as a reminder to all clinicians involved in maternity care how psychological injuries may persist for years afterwards. Efforts must be made to minimise such occurrences and to provide adequate help to manage the consequences of such events when they do occur.*

11.30 *Two days after an emergency caesarean in **2017**, a woman was admitted to HDU with acute lung injury. A confusing and conflicting range of underlying diagnoses were reflected in the notes and discussed with the patient by the obstetric, anaesthetic and respiratory teams. At discharge, the patient asked about the possibility of a debrief with an obstetrician. She later had a debrief with a midwife only, where no further insights on the woman's underlying medical diagnoses were discussed and she remained unclear as to what had caused her significant illness. Over a year later she was still requiring psychological support. In this case a multi-professional meeting with clinicians who had been involved in her care would have been more appropriate than a midwife-only debrief. (2017)*

Documentation

11.31 On performing reviews of medical records for this report, midwifery documentation has tended to offer the most consistent evidence for understanding the development and timing of events. Brief reviews by both obstetric and anaesthetic doctors are often not documented by the doctors themselves despite being of clinical significance, and anaesthetic documentation is commonly restricted to an anaesthetic chart only. Documentation on the anaesthetic charts was frequently patchy, lacking detail of block adequacy achieved before surgery, or medication administered.

11.32 *Despite attending a patient with massive antepartum haemorrhage, the duty anaesthetist in **2004** did not document their actions or plan. The patient was reviewed a number of times over the course of the subsequent day by a consultant anaesthetist who again did not document anything. Their reviews, actions and advice were documented by the midwife only. (2004)*

11.33 *Following a category 1 caesarean section for antepartum haemorrhage complicated by massive obstetric haemorrhage in **2015** the patient remained cardiovascularly compromised for a time period in recovery, as evidenced by low blood pressure and high heart rate on her observation chart. The healthcare worker who completed the observation chart also documented the presence of the consultant anaesthetist for the full 45 minutes of that instability, although the anaesthetist made no entry in the notes. (2015)*

Learning from adverse outcomes

11.34 An important part of the purpose of reporting adverse events is in order to inform staff about the possibility of risks, to learn from the adverse outcomes of the practice of others, as well as oneself, and to take steps, where possible, to minimise similar occurrences in future. Failure to learn from such occurrences and share reflections with colleagues, risks a failure of 'institutional memory' and may result in repeated and needless patient harm. Staff of all grades and specialties benefit from continual peer and self-review of their practice in the form of morbidity and mortality meetings. Just 39 incident reports concerning obstetric anaesthesia were submitted in the Trust during the time period 2008-2021. The Trust must consider whether such a low reporting rate indicates staff acceptance of poor practice and complications, or a lack of faith that reporting can effect change.

11.35 *A spinal anaesthetic was sited for a forceps delivery in **2010**. Documentation on the anaesthetic chart stated 'no pain on insertion/injection'. The woman developed foot and leg pain the following day but the anaesthetist declined to review the patient as they 'thought it unlikely to be related to spinal anaesthesia'. An MRI requested by the orthopaedic team showed oedema[211] of a low-lying and tethered conus[212]. Documentation of subsequent discussion between the anaesthetist and the woman reflects that she had actually experienced 'electric shock' pains on initial spinal insertion but the anaesthetist wrote that they had withdrawn the spinal needle when this had occurred. There was no explanation as to why there was a discrepancy between the documentation on the anaesthetic chart and the subsequent conversation. The patient needed ongoing management for neuropathic pain and foot drop after discharge. The chief executive's response to a complaint letter included the statement: 'Training is not an issue as [the anaesthetist's] main activity is undertaking epidural and spinal anaesthetics in the maternity department'. (2010)*

11.36 *In **2012**, a woman experienced non-postural headache and focal neurological symptoms after an epidural for labour by a staff grade anaesthetist (which took a number of attempts to insert, worked sub-optimally, and was sited more than five hours after it was requested due to labour ward workload). It was only on her fourth readmission with symptoms that brain imaging was undertaken and bilateral subdural haemorrhage diagnosed. In the Trust's response to her complaint letter, it stated that the anaesthetist had said that the subdural haemorrhage could not have related to an accidental dural puncture as none was noted at the time of epidural insertion, thus failing to acknowledge that unrecognised dural puncture may take place. Possible causes suggested in the letter were high blood pressure in labour, the stress of her baby being admitted to the neonatal unit, and a pre-existing neurological susceptibility. (2012)*

11.37 *In **2018**, a root cause analysis into the management of a woman with what was considered to be an atypical presentation of pre-eclampsia (drowsiness, reduced level of consciousness in conjunction with elevated blood pressure, headache, vomiting and epigastric pain) looked at statements from three midwives and an obstetric middle grade. It did not involve the consultant anaesthetist or consultant obstetrician involved in the patient's care at the time culminating in her emergency caesarean section and seizure. Nor did it address the failure of the obstetric and midwifery teams to check on blood results taken in triage the night before, when the woman was assessed and discharged home, which would have shown her to be severely hypercalcaemic[213]. Nor did it investigate how an incorrect (elevated) value of INR[214] was verbally reported to the team caring for her, resulting in unnecessary administration of blood products, a decision not to perform a planned lumbar puncture, and a decision not to manage a fibroid at the time of caesarean section. (2018)*

11.38 Anaesthetists should be included in and engage fully with the multidisciplinary team, both clinically, and in maternity governance activity. The Trust's Women's and Children's Root Cause Analysis planning proforma in use in 2018 has a list of job roles with the option of indicating who should be present. None of the 17 job roles listed is that of consultant anaesthetist.

11.39 Involvement of the anaesthetic team in governance activity requires a change in culture and attitude but also requires time and planning. Departmental leads and the executive team must address the resource requirements necessary for anaesthetists to take an active role in obstetric governance and ensure time away from clinical commitments is allowed for this purpose in anaesthetic staff job plans. This will necessarily have cost and recruitment implications. Conflicts of demands on the time of consultant anaesthetists must be addressed at executive level and not left solely to individual anaesthetists to resolve.

11.40 The terms of reference for the Trust's maternity governance meetings from January 2018 state that an anaesthetist is required to attend every three months – minutes of attendance suggest that even this low benchmark is not being achieved. It is important that, even in times of high clinical workload, anaesthetic presence at governance meetings must be maintained to ensure the safety and the integrity of the service in the longer term. This is certainly challenging if, as Trust staff advised the review team, there are still considerable issues with consultant anaesthetic staffing.

211 See glossary
212 See glossary
213 See glossary
214 See glossary

Local Actions for Learning

11.41 The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

11.42 The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

11.43 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

11.44 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

11.45 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by GPAS in 2020.

11.46 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice.

11.47 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

Chapter 12

Neonatal care

Introduction

12.1 In this chapter we focus primarily on the clinical care provided by the neonatal team to babies delivered at the Trust. The majority of the care reviewed took place on the neonatal unit (NNU), but the neonatal team were involved in resuscitation of babies on the labour ward as well as managing some babies on the postnatal wards.

12.2 It is important to emphasise that in line with the terms of reference the cases reviewed only represent less than two per cent of the total births at the Trust and a small minority of neonatal admissions over the review period. Cases were ascertained due to either parental concerns about the quality of maternity care or due to poor outcomes - specifically neonatal death or brain injury. In addition, some cases came to light in the Open Book exercise arranged by the Trust which considered HIE and neonatal death as factors for referral to the review.

12.3 As well as identifying areas for improvement and learning, the review team also noted many examples of good neonatal practice and often excellent communication. The number of complaints by families about the care they received in the neonatal unit was quite low.

Organisation of neonatal services in the UK (2000-2019)

12.4 In 2001 the British Association of Perinatal Medicine (BAPM) updated its 1996 standards for hospitals providing neonatal intensive care. There was a recommendation that hospitals work together in networks and care of the smallest and sickest infants be centralised into larger centres, neonatal intensive care units (or NICU), known as level 3 units. This led to the development of managed neonatal networks and was incorporated into the Maternity Services National Service Framework in 2004. It was also recognised that clinical skills needed to be maintained in the local neonatal units (LNU), known as level 2 units, to provide short term intensive care (usually up to 48 hrs) for more mature babies in close liaison with their designated level 3 NICU.

12.5 In 2009 a Department of Health taskforce of neonatal professionals and parent representatives published a Toolkit for High Quality Neonatal Services[215] with service specifications to standardise special care, high dependency care and intensive care. In 2010 the National Institute for Health and Care Excellence (NICE)[216] published quality standards for neonatal specialist care. In most trusts compliance with these standards is reviewed through clinical governance processes.

12.6 NHS England commissions all levels of neonatal critical care. The commissioning of care is usually agreed with the neonatal network but ultimately is a formal agreement between the commissioners and the provider unit trusts.

Neonatal transport

12.7 Babies should ideally be delivered in the most appropriate setting for their predicted care needs. In utero (before delivery) transfer is preferable to postnatal transfer and has been shown to improve outcomes. However babies do sometimes need to be transferred after birth for escalation of care, or to access

215 Department of Health. Toolkit for High-Quality Neonatal Services (2009) https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

216 National Institute for Health and Care Excellence. Neonatal specialist care Quality Standard (QS4) (2010)

specialist care (e.g. for neonatal surgery). Over the period of this review, neonatal transport services, which were traditionally provided and staffed by the larger NICUs, were centralised in all networks so that a dedicated transport team is responsible for moving babies between units, and since 2015 most services have had a centralised telephone triage system. In the West Midlands, a centralised team has provided transport services 24/7 since 2008. Teleconferenced triage has become available in very recent years.

Organisation of neonatal services at the Trust (2000-2019)

12.8 Following the establishment of neonatal networks in England in 2004, the Trust's neonatal services initially formed part of the Staffordshire, Shropshire and Black Country Neonatal Network (SSBCNN) becoming an operational delivery network in 2013 (SSBCODN). The NNU and the obstetric services at the Trust are located within the Shropshire Women and Children's Centre, based at the Princess Royal Hospital (PRH) in Telford, having moved there from the Royal Shrewsbury Hospital (RSH) in late 2014.

12.9 Prior to 2006 the neonatal service at the Trust provided intensive care. Since 2006, when unit categories were first defined, it has been designated as a Local Neonatal Unit (LNU) of level 2. This means that it is commissioned to provide special care and high dependency care for newborn babies, as well as intensive care for periods of up to about 48 hours. Babies requiring longer-term intensive care and singletons born at less than 27 weeks gestation, if not transferred in utero, should be discussed with and transferred to a level 3 unit (NICU).

12.10 The neonatal unit at the PRH in Telford has 22 cots and is busy compared to other LNUs with above average numbers of preterm babies admitted. In 2018-19 it provided 7,425 care episodes, which was in the top quartile of critical care activity for neonatal units providing critical care in England.

12.11 The review team heard that the neonatal service at the Trust disputed its revised designation and did not work in line with the new scope of its responsibilities. There is debate why this was. Some at the Trust felt that due to the unit's size, expertise and geographical location (including receiving babies from Wales) it should have been designated as a level 3 unit. Others at the Trust have stated that there were insufficient cots and expertise elsewhere throughout the region, although this is disputed by the neonatal network[217]. The West Midlands Neonatal Operational Delivery Network confirmed in correspondence with the Chair of this review that *'capacity in both University Hospital North Midlands (which is the care pathway for SaTH and Royal Wolverhampton Hospital NHS Trust) has rarely been so that they would not take a baby that required NICU care'.* Despite this, the review team found evidence of non-compliance by the Trust with its 2006 level 2 designation until at least 2015.

12.12 The review team noted that for a period of nine years after the designation to a level 2 unit, transfer of babies from the Trust that required intensive care did not consistently occur in line with the national and network guidelines. According to the neonatal network capacity issues were not causative. The review team is of the clear opinion that NICU care relies on a properly resourced multidisciplinary team and that the designation as a level 2 unit after 2006 should have been respected and adhered to.

12.13 Following the contested designation as a level 2 unit in 2006, the review team has been advised that network leadership and the commissioners met with the Trust on several occasions, especially after the publication of a network care pathway document in 2011 to try to ensure that neonatal care within the Trust followed the guidance.

12.14 The Royal College of Paediatrics and Child Health (RCPCH)[218] carried out an invited review in 2013. They noted that *'given the availability of experienced and dedicated neonatologists, at the time of the visit the unit cared for a number of babies under 27 weeks and provided an enhanced range of intensive care services'.* They noted that this intensive care activity was not supported by the neonatal network and that the unit would in future work as a standard level 2 local neonatal unit. The Trust continued to deliver some aspects of intensive care outside the agreed care pathway until the unit moved to the Telford site in 2014.

217 Letter to Donna Ockenden from West Midlands Neonatal ODN dated 3rd September 2021

218 Report provided to the review team by the Trust

Cases considered by the review team also demonstrated that this progressive change in neonatal care took many years to be embedded into clinical practice:

12.15 *In **2011** a baby was delivered at 26 weeks gestation after threatened preterm delivery from 23 weeks with no record of consideration of in utero transfer Senior staff were closely involved in care at the Trust with a good relationship with the family and evidence of compassionate care was seen after the poor outcome. (2011)*

12.16 In the next revision of the network care pathway in 2015, it was made more explicit that advanced therapies should not be delivered at the Trust, unless in exceptional circumstances and after discussion with a neonatologist at the Royal Stoke Hospital (now University Hospitals of North Midlands) NICU. Sometime after the move to the new unit in Telford the neonatal unit started operating at the designated level 2.

Perinatal and neonatal mortality

12.17 The perinatal mortality rate (PMR) and the neonatal mortality rate (NMR) are measures which are used as benchmarks of the quality of obstetric and neonatal care, although other factors such as socioeconomic circumstances and maternal age also have an important influence on these measures.

12.18 The MBRRACE-UK perinatal surveillance annual reports have been available since 2013, and they have provided PMR and NMR data, 'adjusted and stabilised' with regard to key contributory factors, for individual trusts from 2014[219]. The neonatal mortality rate (NMR) for the Trust was above the average for similar providers (similar numbers of births LNUs) for the years 2014–2016, but in 2017 it dropped to below the average. In 2018 and 2019 it was 'red' (more than 5 per cent above the group average). It should be noted that in all these years the NMR and PMR were comparable to many similar units and were not statistical outliers. Mortality rates for preterm babies born between 2015 -2018 were also high for babies born within the SSBCODN network and for two of its neighbouring networks.

12.19 In 2009 the neonatal service at the Trust described itself in the National Neonatal Audit Programme (NNAP) report as a NICU, despite having been designated as a level 2 NNU in 2006. This review has also been provided with documentation of a presentation to the CCG in 2018 where a Trust representative outlined that one of the reasons that the Trust felt its neonatal unit had higher perinatal mortality than its peers was because it was being compared with level 2 units (LNUs) when it had in fact been operating as a level 3 unit (and therefore accepting and continuing to care for more complex cases) until 2016. In this presentation the Trust representative made the case that therefore the figures were not representative. They stated the reason for operating at level 3 was due to capacity issues elsewhere in the network. There has been no evidence seen by the review team that capacity in other units was an issue and this has been confirmed by the neonatal network. The review team note that the data is difficult to interpret as the Trust had consistently not worked at the level it had been allocated and that it should not have taken in excess of eight years for the Trust to have worked at the level it had been designated.

National Neonatal Audit Programme

12.20 The National Neonatal Audit Programme (NNAP) has measured the quality of care delivered by neonatal units since 2006. NNAP reports available online (2014-2019) indicate that, for the limited number of quality indicators, the NNU at the Trust was performing at above the average for LNUs in the UK. In particular, the Trust NNU achieved one of the best scores compared with other LNUs for communication (the proportion of parents who meet with a senior member of the neonatal staff within the first 24 hours of admission). Temperature control of babies was also above average and eye-screening was excellent for this period.

12.21 The length of stay on the NNU at the Trust for late preterm babies and more mature babies was reported to be longer than in other NNUs - this may reflect a need to improve transitional care facilities at the Trust. In 2018 and 2019 the proportion of neonatal nurses working in the NNU at PRH who had a specific

219 MBRRACE Perinatal mortality surveillance reports 2013-2016 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
MBRRACE Perinatal mortality surveillance report 2017 https://www.npeu.ox.ac.uk/mbrrace-uk/reports

qualification in the care of sick newborn infants was lower than the average for LNUs in the UK and appears to be falling.

Review of neonatal clinical care at the Trust

12.22 During our reviews we identified a number of cases where individual errors were made or there was poor practice. However, these were very much the exception and we have found no evidence of systemic poor neonatal practice or lack of care or compassion in the neonatal service. The review found evidence that identified failings in care were addressed by the Trust with the development of appropriate guidelines, but the review team does not know if the development of these guidelines then led to improvements in care. However, some incidents occurred with sufficient frequency, or were sufficiently important, that we feel there is scope for wider learning on a national level.

12.23 It appears from the majority of the medical records reviewed that involvement of the consultant neonatologists in the provision of neonatal care and in communication with parents was of a very high quality. The medical records invariably record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. There were frequent examples of the consultants being called to assist with resuscitations of newborn babies on the labour ward and in many cases their interventions led to an improvement in the short-term outcome.

12.24 Review of the medical records shows that the Trust was an early adopter of the Advanced Neonatal Nurse Practitioner (ANNP) model and that ANNPs played an important role in the management of sick or premature infants at delivery, on the neonatal unit and on the postnatal ward. We noted their practice to be appropriate and that the ANNPs formed an important part of the neonatal staffing model. The quality of their entries in the medical records was generally noted to be of a very high standard. During the reviews we did not identify any systematic concerns about nursing care.

Transfers, referrals and escalation of care

12.25 Neonatal care is most effective when delivered in close partnership with other services as discussed above. When reviewing individual cases we found evidence of effective joint working:

12.26 *In **2005**, after an uncomplicated term delivery a baby became progressively seriously ill with breathing and neurological problems. On the first day of illness the problem had been recognised as a very severe metabolic disorder and advice on care was obtained from regional and national specialist services. Despite transport to the national centre being arranged sadly it was not possible for the baby to survive. Successful genetic diagnosis allowed counselling about future risk to be provided to the family. (2005)*

12.27 *In **2010** antenatal scans had suggested the possibility that a baby might have problems and a plan was in place for assessment and care at birth After delivery it became clear that the baby could not manage to breathe strongly enough on their own and needed support from a ventilator. Specialist reviews were arranged in Shrewsbury and the required investigations quickly carried out with close involvement of regional and national services. A definitive diagnosis of a neuromuscular disorder was very quickly established and palliative care agreed with the family. We found good evidence of highly effective and compassionate care with input from multiple specialists. (2010)*

12.28 We found evidence of appropriate communication with tertiary specialists when babies required escalation for specialist care, including surgical or cardiac care and good liaison with Alder Hey and Birmingham specialists regarding MRI scans and post-mortem reports. However, in some other cases we found planned deliveries being arranged at the Trust which had not had the involvement of specialist services as would have been expected.

12.29 *In **2008**, a baby was diagnosed with significant spina bifida[220] (lumbar myelomeningocoele) with severe hydrocephalus in the antenatal period. There was no evidence of tertiary fetal medicine or neurosurgical*

220 See glossary

discussion regarding appropriate tertiary referral. The baby delivered at the Trust. There were challenges delivering respiratory support in head box oxygen[221] and baby needed support with a ventilator when the transport team arrived at 30 hours of age, before they could be moved to Birmingham Children's Hospital, (BCH). Despite continuing intensive care in the regional unit the baby developed worsening respiratory distress at BCH as well as a coagulopathy[222] and remained too ill for surgery and died. (2008)

12.30 During the period when the neonatal service continued to operate as a NICU, despite its designation as a neonatal unit, some babies were delivered with major congenital anomalies requiring high level intensive care.

12.31 *In **2008**, there was an antenatal diagnosis of diaphragmatic hernia[223]. The parents were seen by a neonatologist and plans for delivery in Shrewsbury were discussed. An antenatal appointment was offered at Alder Hey. Parents declined this as they felt they had too many appointments to attend. The surgical service were aware of the plan to deliver locally and to transfer the baby after stabilisation. No major difficulties were encountered with the baby's initial care at Shrewsbury and baby was transferred but at the tertiary unit the baby progressively deteriorated and did not survive. (2008)*

12.32 In the same year another baby with the same major anomaly was delivered in Shrewsbury:

*The baby was diagnosed in the antenatal period in **2008** with a diaphragmatic hernia. The neonatologist wrote a letter to the parents and another to the paediatric surgeons in the local surgical centre at Birmingham Children's Hospital (BCH). This states 'baby has diaphragmatic hernia, booked to deliver at RSH and as a unit that is able to perform all levels of intensive care we feel that we are in a position to offer neonatal resuscitation and stabilisation pre-surgery at Shrewsbury. One of the neonatologists will personally be on call for the lady's delivery'. (2008)*

12.33 *The regional surgical service were aware of the planned delivery with no evidence seen by the review team that that they suggested any alternative plan. The baby died after three hours after challenges in delivering aspects of intensive care. Whilst the outcome might not have been different it was not clear that the parents had been offered the opportunity to discuss options with the specialist surgeons in Birmingham prior to delivery.*

12.34 Babies found to have diaphragmatic hernia during antenatal scans are now transferred for delivery in Birmingham Women's Hospital or Liverpool Women's Hospital. In our review of the medical records it was not always apparent that early consultation with a tertiary centre, to consider planning of transfer of care where appropriate, had taken place. It is possible that such consultations did take place but were not documented in the medical records to which we had access.

12.35 *In **2011** a woman presented at 25 weeks, with a twin pregnancy complicated by twin to twin transfusion syndrome[224]. There was antenatal discussion with Birmingham but the babies were born at RSH. The first twin needed prolonged resuscitation at birth. Later in the first week he required exceptionally extensive intensive care after a large brain bleed. There was no recorded discussion with a NICU and missed opportunities to transfer out in the first 2 days before baby became critically unstable. Sadly, the baby died. The other twin died at 5 months of age in a specialist centre, with airway problems. (2011)*

Management of babies with Hypoxic-Ischaemic Encephalopathy

12.36 Hypoxic-Ischaemic Encephalopathy (HIE) is due to impaired delivery of oxygen to the brain. Until around 2010 treatment was largely supportive, although clinical trials of brain or body hypothermia were undertaken in the early 2000s and published in 2005-2009 and cooling therapy was initially offered in a limited number

221 See glossary
222 See glossary
223 See glossary
224 See glossary

of centres participating in these trials. By 2009 it was established that therapeutic hypothermia significantly reduced the incidence of death or disability from HIE and the BAPM issued a position statement on its use. At this time therapeutic hypothermia (cooling) was normally delivered in NICUs although some larger LNUs in the UK still undertook this therapy on a transitional arrangement if agreed by the network.

12.37 To be most effective, cooling should be commenced (either passively or actively) by 6 hours of age. It is important that cooling therapy follows evidence-based pathways wherever possible. We found some examples of cooling outside this pathway.

12.38 *In **2010,** a baby born after cord prolapse with an umbilical cord pH 6.8 was cooled quickly and effectively, required full intensive care including inotropes to support blood pressure and mechanical ventilation to support breathing. The baby was not discussed with or transferred to a NICU. (2010)*

12.39 The review found that the clinical management of HIE in many cases was of a good quality but found that the cooling therapy delivered at the Trust was outside the agreed network pathway for this provider which stated: *'Newly born infants who require cooling for treatment of perinatal asphyxia will have active cooling initiated at RSH prior to being transferred with continued active cooling to UHNS or New Cross Hospital the Network Lead Centres or an appropriate neonatal intensive care unit'.*

12.40 *In **2011** a baby was cooled because of HIE. The seizures were very difficult to control despite anticonvulsants and so there was a documented discussion with a NICU outside the network but with a strong research reputation for cooling, who suggested it could be extended by 24 hours. The cooling in fact continued for a total of 6 days. Whilst there was no evidence of direct harm from this, it was unusual practice and outside the advised practice. The child continued to have epilepsy through early childhood. (2011)*

12.41 We did however find evidence of good practice in that the Trust diligently reported babies receiving therapeutic hypothermia for HIE to the 'cooling registry' which gathered data after the TOBY[225] study on hypothermia was published.

Resuscitation and stabilisation at birth

12.42 The review found a number of cases where the Newborn Life Support algorithm was not followed in the correct order. In particular, where cardiac compressions were started before lung inflation had been achieved. It is vital that an airway is established and effective lung inflation achieved before moving on to cardiac compressions as they otherwise will not be effective.

12.43 Intubation of small babies is a difficult skill, and one that is increasingly hard to gain competence in as intubation opportunities have become less frequent with greater use of non-invasive ventilation. We found in general that babies were intubated on the labour ward appropriately. The Trust appeared to be relatively late adopters of CO_2 detectors (which can help confirm the endotracheal tube is correctly placed). In some cases babies had multiple extubations and intubations in the first minutes of life, either due to uncertainty about their position or due to accidental extubation.

12.44 *In **2007**, an extremely preterm baby weighing just over 500g was in poor condition at birth, and had five intubation attempts including the use of a bougie. When successfully inserted, the ET tube was inserted too far. (2007)*

12.45 *In **2008** a baby at 23 weeks born in the Trust had two accidental extubations within the first hours of life, so required three intubations in four hours. The baby deteriorated on day 10 for which they were given a third dose of surfactant (unusually late). Deterioration was found to be secondary to intestinal perforation and they were then transferred to a surgical NICU. (2008)*

225 TOBY study group. Whole body hypothermia for the treatment of perinatal asphyxial encephalopathy: A randomised controlled trial (2008) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2409316/

Communication during neonatal resuscitation

12.46 In the cases considered by this review we sometimes found that a structured approach to communication to a senior doctor in a crisis situation did not always happen. Our view is that there should be a shift in expectations such that, when it is known that senior help cannot attend immediately, a formal two-way telephone dialogue, based on the SBAR (Situation, Background, Assessment, and Recommendation) structure, should take place at the time of calling for the senior help. This two way conversation directly with the resuscitation team should involve a review of the interventions which have been tried and advice from the senior help concerning the actions to be taken pending their arrival. This situation is not unique to this Trust.

Management of hypoglycaemia (low sugar levels)

12.47 The review identified a number of cases where there was prolonged hypoglycaemia without effective or timely intervention. In some instances this was due to the need to transfer from the midwife-led unit (MLU) to the neonatal unit.

12.48 *In **2018**, a term baby was born at the MLU in Princess Royal Hospital, Telford, at 03:44 with a very slow heart rate. After the neonatal team arrived and baby was intubated the heart rate improved. On arrival at the NNU at 04:55 the baby was hypotensive, hypothermic (planned) and had an apparently unrecordable blood glucose at 05:26 and 05:43. There is no evidence of it having been measured prior to this. An emergency blood transfusion was given for low haemoglobin, but the glucose was not addressed (even having been measured) until a bolus and infusion of dextrose were given at 07:05. This is 3 hours and 20 minutes after a major resuscitation (known to deplete glucose stores) and 1.5 hours after the glucose was first noted to be unrecordable. This may have contributed to the failure of the heart to respond to inotropes, fluids and other resuscitation measures. The first dose of antibiotics was not administered until 3 hours after admission to NNU and 2 hours after it was prescribed, despite IV access being in place. This is an unacceptable delay. Sadly, the baby died. (2018)*

12.49 *In **2007**, a growth restricted term baby had very low cord pH at birth (but the baby quickly recovered with Apgar[226] scores of 8 and 10), and required only facial oxygen. A paediatrician appropriately requested to keep baby warm and establish feeds. On review at 30 minutes, they noted profound hypoglycaemia. The paediatrician instructed "commence feeds as soon as mum ready and if concerned to inform NNU". A doctor was called to review the baby when it was noted to be dusky aged 1 hour. The requested senior review said baby did not need admission. No further glucose levels documented until admitted at 13 hours, when they were normal. This baby was later diagnosed with HIE. (2007)*

Management of sepsis

12.50 In general the management of babies with suspected sepsis was in line with national recommendations and common practice. However, in the majority of cases reviewed where infection or suspected infection were part of the clinical picture, it did not seem that the use of infection markers such as C-reactive protein[227] (CRP) for 'tracking' of the progress of the infection was standard practice. This was an active decision on the part of the neonatal consultants. We have not been able to identify a situation where the absence of these measurements was likely to have had a significant influence on the clinical outcome. However, infection markers can be useful in both the identification of infection and in guiding treatment and are widely used in neonatal practice. In more recent years the Trust has adopted the use of CRP.

226 See glossary

227 See glossary

Communication with families and documentation

12.51 Case reviews almost invariably showed evidence of good communication with the parents, especially by the ANNPs and consultants. There was evidence of compassionate care for the babies and their families, especially at the end of life or when considering reorientation of care towards comfort-orientated care.

12.52 *In **2002** a baby was born at full term and unexpectedly found to have severe respiratory problems from birth. The baby was diagnosed on the neonatal unit at Shrewsbury with severe pulmonary hypoplasia, (under-development of the lungs) and sadly this was untreatable and the baby died on the first day of life. There was extensive consultant involvement in the baby's short life, including the involvement of a second consultant in reviewing an unexpectedly serious case, a consultant doing the summary letter and, most importantly, sometime after the sad death, when all results were back, the consultant visited the family at home to go through the results of the baby's post-mortem examination and other specialised tests. The review observed this as an example of exceptionally good practice. (2002)*

12.53 We also found evidence that some parents had confidence in the quality of the consultant-led neonatal follow up:

*In **2001**, a baby was delivered by forceps after an eight hour 2nd stage of labour and developed HIE. The baby was discharged home well on day 9. The parents moved to Leicestershire but declined transfer of care to a local consultant and chose to come back to Shrewsbury for each neonatal follow-up visit to maintain continuity of care. (2001)*

12.54 We found some examples where neonatologists requested that obstetricians at the Trust review a baby's care when they perceived there were unexpectedly poor outcomes.

12.55 *In **2009**, a baby was born at 42 weeks, 50 hours after rupture of membranes with the cord tightly round its neck and thick meconium, and with a low cord pH of 6.5. Fortuitously the baby had a normal MRI brain scan and was said to be developing normally at 2 years of age. After seeing the family at an outpatient appointment the neonatologist wrote first to the risk manager in August suggesting the case was reviewed. The neonatologist also wrote to the obstetrician requesting a parental meeting and wrote again in November chasing this up as the family had still not heard anything. The long term outcome of this case is not known. (2009)*

12.56 In another case the neonatologist had concerns about the care of a baby after transfer between other NICUs:

12.57 *In **2008**, a baby was born at 23+1 weeks in RSH after in utero transfer and received 11 days intensive care before being transferred to a surgical NICU due to intestinal perforation. Having received surgery the baby was repatriated to a third neonatal unit and apparently arrived in a 'shocked' condition, hypotensive and hypothermic and died 1 week later. The neonatal consultant at RSH wrote to the neonatologist at the receiving hospital suggesting they raise this with the referring surgical centre as this was 'unacceptable'. This represents evidence of concern for governance and ensuring quality of care. These examples were infrequent, but evidence a desire to ensure good quality of care for patients and their families. (2008)*

Combined medical and nursing notes

12.58 The clinical records that were reviewed had separate medical and nursing entries. This has the potential for important information not being accessed by key members of staff involved in the care of individual babies. The standard of medical and ANNP note-keeping was generally good and the admission clerking in particular was generally very comprehensive. However, there was no obvious systematic approach for daily ward round reviews, which meant that continuity of potentially important information was sometimes lacking.

12.59 Although by no means universal, prior to the introduction of electronic clinical records many NNUs had moved to having combined medical and nursing notes. The Trust now uses joint neonatal and medical notes and are moving to an electronic patient record.

Middle grade or Trust Tier 2 neonatal staffing

12.60 For some of the cases reviewed it was clear that, out of hours, middle-grade neonatal medical staff were covering the paediatric unit as well as the neonatal unit. This can compromise the availability of skilled care to both units. It is for this reason that it is a service specification for level 3 NICUs that there is separate middle-grade cover for neonatal and paediatric units and why level 2 LNUs should not undertake prolonged intensive care.

12.61 The review found evidence that in some cases this led to a delay in middle-grade attendance at deliveries and in reviewing sick babies on the neonatal unit. As already discussed the Trust were early adopters of the ANNP model and this undoubtedly provided some mitigation but it was not clear whether the neonatal unit was adequately covered at middle-grade level at all times.

Consultant neonatologist staffing

12.62 It is clear from the majority of case notes reviewed that involvement of the consultant neonatologists in clinical decision making, in the provision of neonatal care and in communication with parents and other family members was of a very high quality. The case notes usually record that the consultants were physically present for much of the working day, and often at night, and that they gave priority to communication with parents. They were usually involved in the long-term clinic follow-up of their individual patients, providing continuity of care. Information sharing was aided by the neonatal discharge summaries often being written by a consultant. Having met with staff it is apparent to the review team that this high level of direct consultant input may have been at some personal cost and may have been offered in part due to a desire to continue as a NICU after designation as a LNU in 2006.

12.63 For some of the cases reviewed the consultant providing cover for the neonatal unit was also covering the general paediatrics service. This can also compromise the availability of skilled care. Given the size of the maternity and neonatal service at the Trust, if it was aiming to provide ongoing neonatal intensive care at the time, it would be essential to have designated neonatal consultants on call 24/7. This was highlighted by the RCPCH invited review in 2013:

12.64 *'The neonatal rota is not compliant with BAPM staffing arrangements given the level of intensity of services provided at the RSH site. There is an enthusiastic staff team keen to develop their skills and care for babies locally, and a consultant group that provides prospective cover out-of-hours, coming in to support juniors and general paediatric consultants even when not on call. This is not sustainable and must be addressed when the service moves. The current enhanced status is not supported by the network following a CCG-commissioned review of maternity services and will in future operate as a standard level 2.'*

12.65 It is the review team's understanding that separation of the neonatal and paediatric consultant on call rotas has now been achieved, and we found evidence that the neonatal service has, since the move to Telford and publication of the updated care pathway by the neonatal network in 2015, largely been operating appropriately as a level 2 Local Neonatal Unit.

LOCAL ACTIONS FOR LEARNING: NEONATAL CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

12.66 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

12.67 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

12.68 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

12.69 The number of neonatal nurses at the Trust who are 'qualified-in-specialty' must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

Section 4

Our call for essential action following completion of this review

- Chapter 13. What happened in maternity services after our first report
- Chapter 14. Local Actions for Learning (LAfL) - the Trust
- Chapter 15. Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

Chapter 13

What happened in maternity services across England after our first report

13.1 Our first report Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was based on a review of 250 family cases and was published on 10 December 2020. The report outlined seven Immediate and Essential Actions, (IEAs) for maternity systems across England and 27 Local Actions for Learning, (LAfL) for the Trust.

13.2 Since the publication of the first report, trusts and maternity services across England have shared their plans to ensure full implementation of the seven IEAs takes place. The NHS has been working with regions, systems and Royal Colleges to implement the IEAs. Significant funding has been provided by the NHS, although we all recognise that much more is needed. The NHS has also reviewed the Maternity Transformation Programme to ensure future plans are in line with the seven IEAs.

13.3 All trusts have now assessed their position against the IEAs and submitted evidence to demonstrate compliance which has been independently quality assured. The commitment to system-wide improvement in maternity services has also seen all NHS standard contracts include conditions whereby any provider delivering maternity services must provide and implement an action plan, approved by its governing body, describing, with timescales, how it will implement the immediate and essential actions set out in the Ockenden Review.

Additional funding for maternity services

13.4 Our first report highlighted that the amount of improvement required must be backed by real investment in maternity services.

13.5 In March 2021[228] the Government made available £95.6million of investment for maternity services across England for:

- 1,200 additional midwifery roles
- 100 whole-time equivalent consultant obstetricians
- Backfill to allow for multidisciplinary team training
- An additional midwife in every unit to support newly qualified midwives as they begin their careers.

13.6 Alongside this, in July 2021 the Government announced £2.45m[229] to be invested into maternity services. These funds were allocated to the Royal College of Obstetricians and Gynaecologists (RCOG) to find the best ways of spotting early warning signs of infants in distress.

13.7 For 2021/22, more than £80m of additional funding has been allocated to be distributed as targeted System Development Funding (SDF)[230]. This funding will be focused on areas where it will have the biggest impact on delivering the immediate and essential actions and ensuring the safety of women, babies and their families.

228 NHS England and NHS Improvement Board Meeting November 2021. Agenda Item 6: Maternity and Neonatal Services Update https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-6-251121-maternity-and-neonatal-update.pdf

229 Gov.uk press release. Government pledges £2.45million to improve childbirth care (2021) https://www.gov.uk/government/news/government-pledges-245-million-to-improve-childbirth-care

230 NHS England. Guidance on finance and contracting arrangements for H1 2021/22 (2021) https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-h1-21-22-guidance-on-finance-and-contracts-arrangements.pdf

13.8 With a shortage of midwives, and concerns around continuing attrition of midwives and obstetricians, actions have been taken to increase the workforce by recruiting midwives internationally and £4.5m funding for 2021/22 has been allocated. Additional investment has also been made in Professional Midwifery Advocates, who provide educational and psychological support for midwives, increasing the number to 800 in England. To support retention of midwives, NHSE&I has also funded a pastoral care midwife[231] role in every maternity unit during 2021/22.

13.9 With midwifery and obstetric staffing numbers continuing to cause significant concern and attrition from the midwifery profession, midwives and doctors remaining on the frontline are working tirelessly to support mothers and their babies in achieving a safe outcome.

Our call to action

Funding

13.10 Whilst the funding announcements we have seen have already made significant strides in the right direction in improving maternity services for all, much more still needs to be done. The Health and Social Care Committee report[232] on maternity safety in England, published in June 2021, stated that NHS maternity units in England needed an investment of £200-£350m to prevent women and babies dying or sustaining avoidable harm. This view was supported by the NHS Confederation[233] and we state this level of investment must be forthcoming.

Continuity of carer (CoC)

13.11 We recognise the original aim of CoC which seeks to ensure a mother receives safe and personalised care from the same midwifery team with a named midwife who coordinates the care and takes responsibility for ensuring that the needs of the woman and her baby are met through all stages of maternity care. The CoC model was introduced with little recognition of its potential impact on an already pressured maternity system across England.

13.12 Recent guidance[234] has aimed to address the concerns expressed that CoC will lead to unsafe and inconsistent staffing and provides guidance for local planning and implementation of CoC. At a time of unprecedented stress on NHS resources we continue to hear concerns relating to attempts to support this model, which can lead to inequities in care provision. The CoC model must be reviewed and suspended until all Trusts demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that CoC models of care place on maternity services already under significant strain. The reinstatement of CoC should be withheld until robust evidence is available to support its reintroduction

13.13 As a multi-professional clinical review team comprising midwives, obstetricians, neonatologists and other specialist colleagues who work within (and closely with) maternity services in trusts across England, we strive to ensure that all women receive high-quality, safe care throughout their pregnancy pathway which is tailored to their individual needs. We all recognise the challenges faced by maternity services across England as they work to ensure that the maternity care provided leads to the best possible outcomes for mothers and their babies.

13.14 In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time. This is a Trust that was also failed by the wider maternity system which did not act, and this must not happen again.

231 Ibid n1

232 Ibid n2

233 NHS Providers letter to Rt. Hon Jeremy Hunt MP Chair, Health and Social Care Select Committee (2021) https://committees.parliament.uk/publications/6290/documents/69337/default/

234 NHS England/ I (2021) *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22* Available: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf

13.15 We urge maternity services across England to continue their work in implementing the IEAs from our first report. We have seen so much excellent practice and a real desire to improve. Now, the NHS across England and the Shrewsbury and Telford Hospital NHS Trust must make ambitious plans to ensure timely implementation of the additional Local Actions for Learning, (LAfL) and Immediate and Essential Actions, (IEA) from our final report.

13.16 As difficult decisions loom about NHS funding post the COVID-pandemic, maternity services in England **must not slip down the priority list.** The scale of this review is unprecedented in NHS history and after listening to so many families, we have been given an unrivalled opportunity to change and improve maternity service provision for all parents and their families now and in the future. Together the changes we have outlined, and the demand for better funding will ensure safer outcomes for more women and families, reducing the risk of unnecessary loss of life, injury and resultant heartbreak.

Chapter 14

Local Actions for Learning (LAfL) - the Trust

Clinical governance

LOCAL ACTIONS FOR LEARNING: IMPROVING MANAGEMENT OF PATIENT SAFETY INCIDENTS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.1 Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.

14.2 The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for midwives, obstetricians, neonatologists and anaesthetists to undertake incident investigations.

14.3 All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession.

14.4 The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and terminology must be used in line with the relevant Serious Incident Framework.

14.5 Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.

14.6 All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.

14.7 All members of the governance team who lead on incident investigations should attend regular appropriate training courses not less than three yearly. This should be included in local governance policy. These training courses must commence within the next 12 months

14.8 The governance team must ensure their incident investigation reports are easier for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.

14.9 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.

LOCAL ACTIONS FOR LEARNING: PATIENT AND FAMILY INVOLVEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.10 The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.

14.11 All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.

14.12 The maternity governance team must work with their Maternity Voices Partnership (MVP) to improve how families are contacted, invited and encouraged to be involved in incident investigations.

LOCAL ACTIONS FOR LEARNING: SUPPORT FOR STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.13 There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.

14.14 The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support the maternity department going forwards.

LOCAL ACTIONS FOR LEARNING: IMPROVING COMPLAINTS HANDLING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.15 Complaint responses should be empathetic and kind in their nature. The local MVP must be involved in helping design and implement a complaints response template which is relevant and appropriate for maternity services.

14.16 Complaints themes and trends should be monitored at the maternity governance meeting, with actions to follow and shared with the MVP.

14.17 All staff involved in preparing complaint responses must receive training in complaints handling.

LOCAL ACTIONS FOR LEARNING: IMPROVING AUDIT PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.18 There must be midwifery and obstetric co-leads for audits.

14.19 Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.

14.20 Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.

14.21 Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.

14.21 Matters arising from clinical incidents must contribute to the annual audit plan.

LOCAL ACTIONS FOR LEARNING: IMPROVING GUIDELINES PROCESS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.22 There must be midwifery and obstetric co-leads for developing guidelines.

14.23 A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.

LOCAL ACTIONS FOR LEARNING: LEADERSHIP AND OVERSIGHT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.24 The Trust Board must review the progress of the maternity improvement and transformation plan every month.

14.25 The maternity services senior leadership team must use appreciative inquiry to complete the National Maternity Self-Assessment[235] Tool published in July 2021, to benchmark their services and governance structures against national standards and best practice guidance. They must provide a comprehensive report of their self-assessment, including any remedial plans which must be shared with the Trust Board.

14.26 The Director of Midwifery must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.

235 NHS England. *Maternity self-assessment tool* (2021) https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

Antenatal care

LOCAL ACTIONS FOR LEARNING: CARE OF VULNERABLE AND HIGH RISK WOMEN

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.27 The Trust must adopt a consistent and systematic approach to risk assessment at booking and throughout pregnancy to ensure women are supported effectively and referred to specialist services where required.

LOCAL ACTIONS FOR LEARNING: FETAL GROWTH ASSESSMENT AND MANAGEMENT

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.28 The Trust must have robust local guidance in place for the assessment of fetal growth. There must be training in symphysis fundal height (SFH) measurements and audit of the documentation of it, at least annually.

14.29 Audits must be undertaken of babies born with fetal growth restriction to ensure guidance has been followed. These recommendations are part of the Saving Babies Lives Toolkit (2015 and 2019)[236].

LOCAL ACTIONS FOR LEARNING: FETAL MEDICINE CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.30 The Trust must ensure parents receive appropriate information in all cases of fetal abnormality, including involvement of the wider multidisciplinary team at the tertiary unit. Consideration must be given for birth in the tertiary centre as the best option in complex cases.

14.31 Parents must be provided with all the relevant information, including the opportunity for a consultation at a tertiary unit in order to facilitate an informed choice. All discussions must be fully documented in the maternity records.

LOCAL ACTIONS FOR LEARNING: DIABETES CARE

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.32 The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave.

236 Ibid n11

LOCAL ACTIONS FOR LEARNING: HYPERTENSION

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.33 Staff working in maternity care at the Trust must be vigilant with regard to management of gestational hypertension in pregnancy. Hospital guidance must be updated to reflect national guidelines in a timely manner particularly when changes occur. Where there is deviation in local guidance from national guidance a comprehensive local risk assessment must be undertaken with the reasons for the deviation documented clearly in the guidance.

LOCAL ACTIONS FOR LEARNING: CONSULTANT OBSTETRIC WARD ROUNDS AND CLINICALREVIEW

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.34 All patients with unplanned acute admissions to the antenatal ward, excluding women in early labour, must have a consultant review within 14 hours of admission (Seven Day Clinical Services NHSE 2017[237]). These consultant reviews must occur with a clearly documented plan recorded in the maternity records.

14.35 All women admitted for induction of labour, apart from those that are for post-dates, require a full clinical review prior to commencing the induction as recommended by the NICE Guidance Induction of Labour 2021[238].

14.36 The Trust must strive to develop a safe environment and a culture where all staff are empowered to escalate to the correct person. They should use a standardised system of communication such as an SBAR[239] to enable all staff to escalate and communicate their concerns.

LOCAL ACTIONS FOR LEARNING: ESCALATION OF CONCERNS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.37 The Trust's escalation policy must be adhered to and highlighted on training days to all maternity staff.

14.38 The maternity service at the Trust must have a framework for categorising the level of risk for women awaiting transfer to the labour ward. Fetal monitoring must be performed depending on risk and at least once in every shift whilst the woman is on the ward.

237 NHS England. *Seven day services clinical standards* (2017) https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

238 National Institute for Health and Care Excellence. Inducing labour NICE Guideline 207 (2021) https://www.nice.org.uk/guidance/ng207

239 See glossary

14.39 The use of standardised computerised CTGs for antenatal care is recommended, and has been highlighted by national documents such as Each Baby Counts[240] and Saving Babies Lives[241]. The Trust has used computerised CTGs since 2015 with local guidance to support its use. Processes must be in place to be able to escalate cases of concern quickly for obstetric review and likewise this must be reflected in appropriate decision making. Local mandatory electronic fetal monitoring training must include sharing local incidences for learning across the multi-professional team.

Intrapartum care

LOCAL ACTIONS FOR LEARNING: MULTIDISCIPLINARY WORKING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.40 The labour ward coordinator must be the first point of referral and be proactive in role modelling the professional behaviours and personal values that are consistent with positive team working and providing timely support for midwives when asked or when abnormality in labour presents.

14.41 The labour ward coordinator at the Trust must be supernumerary from labour care provision and provide the professional and operational link between midwifery and the most appropriately trained obstetrician.

14.42 There must be a clear line of communication from the duty obstetrician and coordinating midwife to the supervising consultant at all times. Consultant support and on call availability are essential 24 hours per day, 7 days a week.

14.43 Senior clinicians such as consultant obstetricians and band 7 coordinators must receive training in civility, human factors and leadership.

14.44 All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.

LOCAL ACTIONS FOR LEARNING: FETAL ASSESSMENT AND MONITORING

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.45 Obstetricians must not assess fetal wellbeing with fetal blood sampling (FBS) in the presence of suspected fetal infection.

14.46 The Trust must provide protected time to ensure that all clinicians are able to continuously update their knowledge, skills and techniques relevant to their clinical work.

14.46 Midwives and obstetricians must undertake annual training on CTG interpretation taking into account the physiological basis for FHR changes and the impact of pre-existing antenatal and additional intrapartum risk factors.

240 Ibid n32

241 Ibid n11

LOCAL ACTIONS FOR LEARNING: SPECIFIC TO MIDWIFERY-LED UNITS AND OUT-OF-HOSPITAL BIRTHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.47 Midwifery-led units must complete yearly operational risk assessments.

14.48 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

14.49 It is mandatory that all women are given written information with regards to the transfer time to the consultant obstetric unit when choosing an out-of-hospital birth. This information must be jointly developed and agreed between maternity services and the local ambulance trust.

LOCAL ACTIONS FOR LEARNING: MATERNAL DEATHS

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.50 In view of the relatively high number of direct maternal deaths, the Trust's current mandatory multidisciplinary team training for common obstetric emergencies must be reviewed in partnership with a neighbouring tertiary unit to ensure they are fit for purpose. This outcome of the review and potential action plan for improvement must be monitored by the LMS.

LOCAL ACTIONS FOR LEARNING: OBSTETRIC ANAESTHESIA

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

The review team re-emphasises the importance of the Local Actions for Learning and Immediate and Essential Actions for obstetric anaesthesia services from the first report. These can be found in Appendices 5 and 6 and form a vital part of the ongoing learning for both the Trust and maternity services nationally.

The following Local Actions for Learning are based on themes recognised whilst undertaking the current review and must be addressed by the Trust as a priority. The RCoA 'Guidelines for Provision of Anaesthetic Services' (GPAS) document stipulates the key requirements in the provision of obstetric anaesthesia services and these Local Actions for Learning address requirements where the Trust currently falls short. We place a responsibility on the Trust's executive team to support the anaesthetic department in achieving compliance. They are also applicable to hospitals experiencing similar issues and should therefore be used to inform wider improvements in obstetric anaesthesia care.

14.51 The Trust's executive team must urgently address the deficiency in consultant anaesthetic staffing affecting daytime obstetric clinical work. Minimum consultant staffing must be in line with GPAS at all times. It is essential that sufficient consultant appointments are made to ensure adequate consultant cover for absences relating to annual, study and professional leave.

14.52 The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all of the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service.

14.53 The Trust's executive team must support the anaesthetic department to ensure that job planning facilitates the engagement of consultant anaesthetists in maternity governance activity, and all anaesthetists who cover obstetric anaesthesia in multidisciplinary maternity education and training as recommended by RCoA in 2020.

14.54 The Trust's anaesthetists have responded to the first report with the development of a wide range of new and updated obstetric anaesthesia guidelines. Audit of compliance with these guidelines must now be undertaken to ensure evidence-based care is being embedded in day-to-day practice[242].

14.55 The Trust's department of anaesthesia must reflect on how it will ensure learning and development based on incident reporting. After discussion within the department, written guidance must be provided to staff regarding events that require reporting.

LOCAL ACTIONS FOR LEARNING: NEONATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.56 The Trust must ensure that there is a clearly documented, early consultation with a tertiary NICU for babies who require, or are anticipated to require, continuing intensive care. This must be the subject of regular audit.

14.57 As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention and training of ANNPs.

14.58 The Trust must ensure that sufficient resources are available to provide safe neonatal medical or ANNP cover at all times commensurate with a unit of this size and designation, such that short term intensive care can be safely delivered, in consultation with a NICU.

14.59 The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review.

LOCAL ACTIONS FOR LEARNING: POSTNATAL

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.60 The Trust must ensure that a woman's GP is given complete, accurate and timely, information when a woman experiences a perinatal loss, or any other serious adverse event during pregnancy, birth or postnatal continuum.

242 RCoA Raising the Standards: RCoA Quality Improvement Compendium. Chapter 7 Obstetric Practice. 4th Edition September 2020

14.61 The Trust must ensure complete and accurate information is given to families after any poor obstetric outcome. The Trust must give families the option of receiving the governance reports, which must also be explained to them. Written summaries of any debrief meetings must also be sent to both the family and the GP.

LOCAL ACTIONS FOR LEARNING: STAFF VOICES

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.62 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey.

LOCAL ACTIONS FOR LEARNING: SUPPORTING FAMILIES AFTER THIS REVIEW IS PUBLISHED

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

14.63 Maternity care must be delivered by the Trust recognising that there will be an ongoing legacy of maternity related trauma within the local community, felt through generations of families.

14.64 There must be dialogue with NHS England and Improvement and commissioners and the mental health trust and wider system locally, aiming to secure resources which reflect the ongoing consequences of such large scale adverse maternity experiences. Specifically this must ensure multi-year investment in the provision of specialist support for the mental health and wellbeing of women and their families in the local area.

Chapter 15

Immediate and Essential Actions to improve care and safety in maternity services (IEA) across England

15.1 We include these **Immediate and Essential Actions, (IEAs)** to improve safety in maternity services across England. These IEAs complement and expand upon the **Immediate and Essential Actions** issued in our first report. We note that NHS England and Improvement (NHSE&I) has supported the implementation of these actions in trusts across England since our first report was published.

15.2 These further **Immediate and Essential Actions** arise from findings from this large review into maternity services at Shrewsbury and Telford Hospitals NHS Trust. However, we are aware that similar problems may occur in other trusts across England and therefore these actions must be implemented widely in all maternity services.

15.3 This review is supporting and endorsing the latest Health and Social Care Committee Report "The Safety of Maternity Services in England"[243]. We agree with the select committee that the budget for maternity services be increased by £200-350million per annum with immediate effect. This funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.

15.4 We further agree that the Department of Health and Social care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists, (RCOG) and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts, to enable trusts to deliver safe obstetric staffing over the years to come. This work must also consider the anaesthetic and neonatal workforce and be advised by the Royal College of Anaesthetists (RCOA), Obstetric Anaesthetists' Association (OAA), Royal College of Paediatrics and Child Health (RCPCH) and British Association of Perinatal Medicine (BAPM). In this regard, the review team is also aware of and endorses the initiatives on workforce planning by the RCOA and the current national review of the obstetric anaesthesia workforce by the OAA in response to the first report.

15.5 We endorse the Health Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit. We also agree that NHS trusts must report this in public through their annual Financial and Quality Accounts.

15.6 We endorse the Health Select Committee recommendation that the Maternity Transformation Programme Board should establish what proportion of maternity budgets should be ring-fenced for training but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.

15.7 We endorse the recommendation that a single set of maternity training targets agreed in all maternity services in England should be established by the Maternity Transformation Programme board, working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).

15.8 We endorse the recommendation that training targets should be enforced by NHSE&I's Maternity Transformation Programme, the Royal College of Midwives (RCM), the RCOG and the CQC through a regular collaborative inspection programme.

15.9 Along with staffing and training the Health Select Committee clearly articulated the need to learn from patient safety incidents. This issue has taken up a large part of both this second report and our first report and we endorse the committee's findings that families must be involved in the investigative process and that lessons must be learned and implemented in a timely way to prevent further tragedies.

243 Health and Social Care Committee. *The Safety of Maternity Services in England* (2021) https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm

15.10 We also note the committee recognised that maternity units appear to have been penalised for high caesarean section rates and recommended that there should be an end to the use of total caesarean section percentages as a metric for maternity services. We note the progress on this with the recent advice from NHS England and NHS Improvement to Trusts[244] to stop monitoring caesarean section rates. The recognition that Shrewsbury and Telford Hospital NHS Trust had a lower than average caesarean section rate (and was often praised for this) was identified in our first report. We noted that some mothers and babies had been harmed by this approach and we welcome the committee's findings and the progress on this.

15.11 This review also supports the NHS Maternity Digital Programme. We recognise this as a key enabler to improve quality and safety. The use of maternity digital notes will empower women by providing them with their own digital maternity care plan and record, discussed and agreed with them and their midwife. Enhancing and improving the digital programme will improve communication, and ultimately contribute to making maternity care safer.

15.12 The Parliamentary Health and Social Care Committee Report recommendations on staffing, training and learning from patient safety incidents echoes much of the work of our first and now this final report. We believe there is still so much more to do in order to make the maternity service in England the safest it can be. It is our intention that implementation of these further Immediate and Essential Actions will make a significant contribution to the delivery of safe maternity care.

15.13 Importantly: We state that DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared.

244 Letter dated 15th February 2022- Ref PAR 1393

1: WORKFORCE PLANNING AND SUSTAINABILITY	
Essential action – financing a safe maternity workforce The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	• The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements. • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.
Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	• All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this. • All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.

1. WORKFORCE PLANNING AND SUSTAINABILITY (CONTINUED)	
	• All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. • All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development. • All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7. • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.

2: SAFE STAFFING

Essential action

All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

- When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.
- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.
- All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.
- All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.
- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction
- The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.
- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.
- Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.

2: SAFE STAFFING (CONTINUED)	
	• All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. • All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.

3: ESCALATION AND ACCOUNTABILITY	
Essential action Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	• All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. • When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role. • Trusts should aim to increase resident consultant obstetrician presence where this is achievable. • There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit. • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.

4: CLINICAL GOVERNANCE-LEADERSHIP	
Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	• Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans. • All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. • Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. • All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement. • All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. • All maternity services must ensure they have midwifery and obstetric co-leads for audits.

5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS

Essential action

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.

- All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.
- Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
- Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.
- Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.
- All trusts must ensure that complaints which meet SI threshold must be investigated as such.
- All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.
- Complaints themes and trends must be monitored by the maternity governance team.

6: LEARNING FROM MATERNAL DEATHS

Essential action

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.

In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

- NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.
- This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.
- Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.

7: MULTIDISCIPLINARY TRAINING

Essential action

Staff who work together must train together

Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

- All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.
- Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.
- All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.
- There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.
- There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.
- Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.
- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.

8: COMPLEX ANTENATAL CARE

Essential action

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.

Trusts must provide services for women with multiple pregnancy in line with national guidance

Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

- Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.
- Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.
- NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.
- When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.
- Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

9: PRETERM BIRTH

Essential action

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.

Trusts must implement NHS Saving Babies Lives Version 2 (2019)

- Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.
- Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.
- Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.
- There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.

10: LABOUR AND BIRTH	
Essential action Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	• All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made • Midwifery-led units must complete yearly operational risk assessments. • Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. • It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. • Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing. • Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.

11: OBSTETRIC ANAESTHESIA

Essential action

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.

Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.

Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

- Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.
- Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.
- All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC
- Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.

Obstetric anaesthesia staffing guidance to include:

- The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.
- Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.

12: POSTNATAL CARE

Essential action

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.

Postnatal wards must be adequately staffed at all times

- All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.
- Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.
- Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.
- Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.

13. BEREAVEMENT CARE

Essential action

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

- Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.
- All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.
- All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.
- Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.

14: NEONATAL CARE

Essential action

There must be clear pathways of care for provision of neonatal care.

This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

- Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.
- Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.
- Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.
- Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.
- Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.
- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

14: NEONATAL CARE (CONTINUED)	
	• Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.

15: SUPPORTING FAMILIES	
Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	• There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.

Appendices

- Appendix 1: Hearing the voices of staff
- Appendix 2: Immediate and Essential Actions (IEAs) from our first report
- Appendix 3: Glossary of terms
- Appendix 4: References
- Appendix 5: Terms of reference (TOR) - May 2018
- Appendix 6: Revised terms of reference (TOR) - Nov 2019
- Appendix 7: Review team members and who we worked with

Appendix 1: Hearing the voices of staff

Staff voices engagement strategy

1.1 In engaging with and listening to current and former staff at the Trust, we intended to highlight where they saw and see scope for improvement, but also to report on good practice in maternity services over the years. Staff were offered the opportunity to share any information with us that they felt would support them in having their views and voices heard. The culture within the Trust and specifically maternity services and whether it has changed over time is an important factor in order to understand the potential cause of any systemic problems.

1.2 Prior to conducting the staff survey for this review we reviewed the results from annual NHS staff surveys at the Trust over the previous 10 years. Staff across NHS organisations are encouraged to complete this survey each year and data are used to improve staff experiences locally and throughout the NHS, ultimately benefitting patient care. We also reviewed the Trust results from the Maternity and Neonatal Health Safety Collaborative (MatNeo) Culture Survey in 2018, which was part of the national Maternity and Neonatal Improvement Programme.

1.3 The NHS annual staff survey has undergone several iterations over the years and the Trust has restructured its service centres/ clinical divisions on a number of occasions. It therefore proved difficult to attribute the available data specifically to staff who worked directly within maternity services. The MatNeo Survey[245], although identifying themes particular to the service, had limits in covering historical aspects of the culture at the Trust.

1.4 The review team worked directly with the Trust to ensure that past and present staff were offered the opportunity to contribute to this review. Reassurances were given with regards to anonymity and confidentiality and that responses would not be shared with the Trust. We developed a staff voices engagement strategy - known as 'Staff Voices', using a bespoke questionnaire survey followed by conversations with staff. The chair of the review also conveyed messaging regarding the Staff Voices strategy through local radio stations and via social media with the aim to reach out to as many former and current staff as possible.

1.5 Despite the assurances around confidentiality and not sharing findings with the Trust there is evidence from multiple conversations and contacts from staff themselves that they remained reluctant to participate. There appeared to be two main concerns from the staff who contacted the review who were uncertain about whether to participate or not - firstly they described being dissuaded from participating by their managers at the Trust. Secondly they expressed concerns about the ongoing police investigation at the Trust, Operation Lincoln, and whether the review team intended to pass information from staff to the police as a matter of routine. Whilst this was not the intention of the review team, the police have requested that we retain any relevant material and we may be required to disclose information to the police in due course.

1.6 In total only 109 staff came forward and participated in the review, some completed the survey only, some both completed the survey and spoke to us and some only spoke to us, declining to fill in the survey. We are sorry that so few staff members felt able to participate. In the last few weeks immediately prior to publication, 11 of the 109 staff who had come forward either fully or partially withdrew their cooperation or did not respond to multiple requests to use their content. This means that overall we have been able to use the staff voices of only 98 current or former staff at the Trust.

245 Provided to the review team by the Trust

The launch of Staff Voices

1.7 The staff voices survey was conducted from 12 May until 30 June 2021, with follow up conversations with staff occurring until January 2022.

1.8 Some staff employed by the Trust contacted the review team directly using the designated staff voices email address and asking for the link to the survey rather than accessing the link provided through the Trust. Many of these messages sought reassurance that the Trust would not know they had completed the survey. Some staff messaged the review chair directly, seeking assurance of confidentiality.

'...[I am] working for the trust and would like to take part in this survey but only if 100% confidential'. (Staff member, email to the review team)

'[working]...within SaTH [the Trust] as long as my name won't be mentioned and whatever I say is kept confidential I'm willing to take part in the survey'. (Staff member, email to the review team)

'Some staff were told be careful about how they answered this survey and were told to remember any comments made could be considered as part of the police investigation. This is the kind of passive aggressive approach of threat that NHS organisations use to deter staff from speaking up. It is so historically ingrained in the culture and possibly will have put staff off participating in the survey'. (Staff member, email to the review team)

1.9 These concerns were further confirmed during conversations held with current staff. One member of staff said: :

'…….and I know a lot of my colleagues didn't want to get involved because they were frightened, they were intimidated by the process'.

1.10 Another member of staff told the review team:

'I said, "Have you written out your questionnaire yet?" "No, we have been told not to"……...but people won't because they have to put their name against the allegations and that sort of thing, and these people they've, as I have said before, they've got their friends and they just will not speak up, they daren't, they daren't speak up, you know.'

'So I know multiple people that have not approached you to speak because of fear, because of how it was put in that briefing [from the Trust to staff] …….. there were people that had every intention of completing their survey and then after that, no way. I was like but this is your chance to speak. How can you make any changes? How can you do anything about it when we're given this opportunity but they're still working there? I think they were perhaps fearful of their jobs, I don't know'.

Another member of staff describing how fearful they felt about speaking up in the maternity service in early 2022 told the review:

'We used freedom to speak up and because of the reporting process they have to follow those concerns ended up going back to those we had concerns about...'

1.11 Overall, when taking into consideration the number of staff who are currently employed within the service and the number of former staff employed throughout the twenty years of the review's timeframe, we are disappointed that just 84 staff completed the survey. By comparison, in 2018, 192 (58%) staff who were working within the maternity and neonatal services at the Trust completed the MatNeo culture survey. Therefore we appreciate that our findings and conclusions are of limited value. However, having put considerable effort into hearing the voices of staff and having been told by the staff who participated how important it was to them to be heard, we believe this content is important despite the low number of participants.

Staff Conversations

1.12 Staff were asked within the questionnaire survey whether they agreed to a confidential face-to-face video interview with members of the review team and 76% of those completing the survey responded with 'yes'. Some staff contacted the review team via email requesting to speak with us, but did not want to complete the questionnaire survey.

1.13 The review team was also keen to speak with staff who held leadership positions within the Trust, maternity services and Clinical Commissioning Groups (CCG) to gain insight into the culture and changes over the years. The Trust and CCG contacted those staff who were of potential interest to the review to advise them of the request and to gain their consent for sharing their contact details. Other Trust and CCG staff were also able to contact us directly if they wished.

1.14 All interviews were conducted via a videoconferencing platform. Participants were advised they would receive a copy of the transcript of the conversation which they could annotate as they wished and that they could send additional information to the review team.

Staff Voices Results

1.15 In total, we received 84 staff survey questionnaires and conducted 60 staff interviews. Each staff member was allocated a confidential staff number. Of the survey respondents, 49% had been employed by the Trust for less than 10 years, 39% for between 10 and 20 years and 12% for more than 20 years. The majority of staff who engaged with the review were still employed by the Trust. The majority of staff were either employed or had been employed in clinical roles.

	Question	Yes	Sometimes	No	Total	Percentage 'Yes'
Professional and / or clinical concerns	Have you ever raised any professional or clinical concerns?	48	-	36	84	57.1%
	Have you ever been concerned about patient safety?	52	-	32	84	61.9%
Bullying	Have you personally witnessed or experienced bullying in the workplace at SaTH?	55	-	29	84	65.5%
Mandatory training	Do / did you have managerial support to attend mandatory training days?	55	20	9	84	65.5%
Teamwork	Did / do you think your multidisciplinary team works well together?	37	36	11	84	44.0%
Staffing Levels	Have you ever escalated concerns about staffing levels during your shift?	51	-	22	84	60.7%
Improvements	Did / do you feel there were / are any barriers to attempts to make improvements to the maternity service?	42	21	21	84	50.0%
Family and Friends Test	Would you recommend SaTH to family and friends for maternity care?	38	27	19	84	45.2%

Category	Question	Never	Rarely	Sometimes	Often	Always	Total
Culture	Whilst at SaTH did / do you enjoy coming to work?	2	16	34	27	5	84
	How often did / do you take part in multidisciplinary traning) (e.g. obstetricians, midwives, neonatologists, support staff training together)	15	16	30	12	11	84

1.16 Many staff who spoke to us appeared very committed to the Trust, spoke of pride in the service and demonstrated loyalty and support towards their colleagues. Staff members told us: *'…So I wanted to make clear that was what I'd seen. These people I've worked with have been trying really hard'*…Another member of staff said: *'I do actually enjoy it and the team that I work with are a fantastic team…'*

1.17 From the questionnaires and interviews we identified key themes that had an impact on staff working in the Trust over the years and can give (albeit limited due to the small numbers) some insight into the culture throughout the years.

Merger of two trusts to form one trust

1.18 Staff described the difficulties they felt they experienced caused by the merging of the two sites to form one Trust and subsequently the move of consultant maternity services to Telford in 2014. One staff member said:

'…I think it's really tough for the management board. I think there was a disconnect in previous Trust boards, I think it was really hard. We did have quite an aggressive management structure when it was all about reconfiguration. It clearly felt like a new Chief Exec had come, Department of Health driving through, reconfiguration and relocating to Telford. We felt pretty coerced into agreeing to relocate to Telford, which clearly is wrong, and now, there's talk about it was the wrong decision, the services are in the wrong place, but the majority of us thought that in the first place'.

1.19 Another staff member said:

'As far as I could tell, you know, the Trust had been stuck, basically, for about twenty years, unable to make any progress, the two local authorities, the two populations at daggers drawn, you know, resisting every single change. …..trying to find a way through that log jam and come out the other side of it with a set of proposals that would make services less unsustainable.'

1.20 Another staff member told the review:

'…..we hadn't merged yet, …. and one of the great things that made me take the job in Telford was because the management team were based in Telford, because it was just one hospital, and they were incredibly responsive. You would bump into the Chief Exec on the corridor, the Medical Director, you could raise a concern or make a suggestion,…. oh, I wonder if this could actually improve patient care or this would be a good thing for safety, and it was really easy to get things …..changed because there was that responsiveness. With the merger…..the management structure was almost entirely based at RSH. They don't come over, they're not based at Telford, so you get none of the corridor conversations, which shouldn't really be the way we communicate but actually is often the way communication happens, so we don't have that access.'

Trust leadership

1.21 In our first report we discussed the high turnover of Chief Executives (CEOs), executives, non executives and other leadership roles at the Trust. Such a high turnover will inevitably impact on the performance of an organisation. One staff member told the review team:

'…..I think that's part of the problem…. they haven't got a consistent leadership…..and it was a mess, you know, you can't describe it any other way, there'd been no leadership whatsoever'.

1.22 Another staff member said:

'One of the historical factors for the Trust is that there have been several management restructures, many different chief execs, and a real churn at the Trust board level as well…… I went through three management restructures, reappointed each time to a slightly different role…… Each of those management restructures sometimes took up to about eighteen months from the first letter of people being put at risk to people being

in place…… each time you lose good people, because there's only so many management restructures……. So, no sooner had you made a working relationship with an executive, than the next one was on their way. And also, with each of those structures came, obviously, slightly new ways of doing things, new policies, new training, some of the previous ways were not required, and there was a new focus'.

1.23 Another staff member said:

'….I guess that takes time, developing that trust in leadership does take time, and certainly one of the things that SaTH has not benefited from is longevity of leadership.'

1.24 Three other staff members told the review:

'So, there's been little in the way of corporate memory and additionally, the new incumbents would have to establish their relationships with the existing management structure'.

'We'd just had another Chief Executive who wanted to do yet another reorganisation and we were all supposed to apply for our posts and do maths tests and English and chemistry and I just thought, "I can't…..".

'…it's really bizarre, we've had … we're on our third Medical Director since I've been in this role and we're on our third Director of Nursing. The current establishment, it seems to have much more traction and we seem to see much more evidence of things happening. The previous people that were in post, similarly, were saying all of the right things but it just wasn't translating it, the action wasn't happening. It was like there was a disconnect. The executives knew of the problem, they didn't understand the core cause of the problem'.

Culture

1.25 A priority when reaching out to staff at the Trust was to understand the culture within the maternity service and possibly the wider Trust. Through the survey, staff were asked 'Have you personally witnessed or experienced bullying in the workplace at the Trust? 65% of respondents replied with 'yes'. Of those 65%, 38% felt able to report it and of these, 33% felt it was adequately dealt with.

1.26 One staff member told the review team:

'Culture is a big thing because I feel there's a reluctance to change there.'

1.27 Another staff member told us:

'I feel that there are historical organisational/cultural issues that are very complex in how this situation has developed. I really believe that there are wider system errors that have let down women and their families but also staff. There are some really good people who care immensely about what they do but operating in a system that is in crisis management continually, can have significant impact on the ability to maintain passion and compassion.'

1.28 A further contributor stated: *'…. the fear of speaking out is all-pervasive in SaTH and it's a very difficult thing to get rid of if that has been the culture for not just ten years, but twenty years, thirty years, it's inbred within the culture at SaTH that if you speak out, something is going to happen to you……you'll be bullied or you'll be moved or you'll be … you know, something will happen, something will be … make it difficult for you.'*

1.29 One staff member described their own experience: *'X .was so strident that you tended not to argue with her, she was a bully, 100%'.*

1.30 Another contributor said: *'*

….when I joined. We just had the conversation about the need to change the culture, in terms of safety culture, that was very clear, and the organisation went with that process, including Listening into Action, which was another initiative that was brought in…… which is important, because I think staff hadn't felt previously that they'd got a voice to be heard. So, I think that Listening into Action was very important at that stage in terms of changing that culture within the organisation'.

1.31 Three different staff members told the review team:

'….previously, these groups have been split up in clinical areas but they go elsewhere and still behave in the same way. They are…big voices, they're dominating, they're intimidating…'

And: *'There are cliques there and, you know……. they are a little gang, and, yes, they will make your life hell…… I am speaking to colleagues now and they won't speak out… you couldn't speak to senior management, if you tried you got shot down'.*

And: *'And the safety huddles that we used to go to, I mean some of them were…. would speak to some of the managers like absolute … it was just you'd stand back and think, "This is bullying".'*

1.32 Other staff members described a 'clique' on the labour ward at the Trust with a culture of undermining and bullying. Some staff members described that this had negatively and seriously affected their mental health. Other staff members described that the behaviour experienced on the labour ward was so bad that they had difficulty finishing their shifts and cried secretly whilst in work. These staff declined for their direct quotes to be used, because they were fearful of being identified.

1.33 Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.

1.34 One staff member said: *'….it's very hard to speak up because despite what anybody will tell you, there are consequences to speaking up and the consequences are your life gets made very difficult or you get subtle … you can't really pinpoint it as bullying, it's like subtle, made to feel uncomfortable when you go to work, not sure how people are going to be with you, not being invited out onto nights out. Simple things like that, not being included in coffee mornings, and things like that….. it's very difficult to speak out, I've been there myself and I ended up going off ill with it'.*

1.35 A current staff member in maternity services at the Trust spoke to the review team in early 2022 but described themselves as fearful to do so. The staff member said *'I really had to think very carefully about approaching the staff voices….when we were told not to speak out, but I will do it and take the consequences because it is the right thing to do…I am clear that there is no support for those that speak up...'.*

1.36 Periodic rotation through the clinical areas within a maternity service is a system evident in most maternity services. Its aim is to ensure that staff remain competent to deliver care in the main clinical environments and gain wider experience, and it also enhances professional development. It is also believed to improve communication as there is an understanding and awareness of what happens in other clinical areas. Some staff commented on the process within maternity services at the Trust, with some saying that poor behaviours still remain at the Trust.

'…they would have almost three or four months of these rumours going around, "There's going to be a change list; there's going to be a change list", and then finally, when the change list came out, there was a lot of anxiety from quite a few midwives.'

'The communication of the change list over the years has been very poor and has caused a massive amount of stress for all of us because you just find out that you're on the change list and off you go.'

'There was a lot of cliques there, a lot of managers were cliquey, there was the change list that was used as a… you had the impression that if you were a pain you would get moved, you know and nobody wanted that and, you know, it still goes on today….. I think that the managers, I think they are aware of the clique and I think they have tried to separate them but they're so deeply ingrained into the system… the management's almost scared to get rid of them because they almost form the core of the delivery suite expertise.'

'…they just didn't want students at all, they were not happy to have students…'

Governance

1.37 We routinely questioned staff regarding the governance systems across the wider Trust. Two staff contributors said:

'……one of my concerns at the time was really that…, I don't think the Trust had a robust governance framework, to be honest.' '….and we ended up having to just work within our department, because when we asked within the Trust there just wasn't that resource... the Trust wasn't as advanced as that, they just didn't understand what we needed, so we ended up doing that'.

'certainly my experience is it's not about the people on the floor doing the work, it's the whole system behind it that isn't always as helpful as it could be and that affects those people that are trying their best …'

1.38 Another contributor told the review: *'……yes, it did feel as though we weren't perhaps hearing all that we should have been hearing…….. We struggled consistently to get information from SaTH in those meetings from 2009 -2012. Reviews of serious incidents seemed to take a long, long, long time to happen and there was an impression of evasiveness around how the learning from those reviews was shared. Reading the last Ockenden Report it was clear to me that whatever learning was taken from the incidents that are described wasn't actually shared and taken forward, so the same things were happening over and over and over again, and in the context of an organisation who may describe themselves as a learning organisation I never felt that it really was'.*

1.39 A number of other staff members told the review team of their experiences:

'It was a system wide failure to be able to escalate these priority pieces of work and to push it through, there didn't seem to be the guidance, there didn't seem to be the governance, there didn't seem to be the process of challenge…'

1.40 Another staff contributor said:

'This has just started recently, by recently I would say in the past four or five years, but before then we didn't have this system, you see. We didn't have clinical governance, it was just on the go, word of mouth, that if there was an issue you would get it discussed between you and the consultant, for example, or whoever was involved, but we didn't have this learning procedure or learning process as is currently being done.'

1.41 Another staff member said

'….things started to become visible when the CQC went in and we were given [an] inadequate rating……. but prior to that, it would be that things were kind of filtered down really by word. To be honest, there was a lack of process, a real lack of processes.'

Staff voices on statutory supervision of midwifery

1.42 Commenting on the ineffective nature of the process of statutory supervision of midwifery at the Trust one contributor said: *'My recommendation was that there was a supervisory investigation. At the time it was dismissed because it was such a tight, tight group of supervisors, it was impenetrable and if you're in, you're in, and X was in. So, they were not keen to conduct that….. If they decided that this particular practitioner did not need a supervisory investigation then it was up to them. So, if your face fits, then you were okay.'*

1.43 Other contributors told the review team that the same people were involved in supervision investigations as in internal maternity governance investigations and that statutory supervision was only a process of internally 'marking their own homework'.

Improvements in maternity governance from the perspective of staff

1.44 Some staff reported that in more recent years, the governance processes within maternity services at the Trust have improved.

'It has improved, there is no doubt that it has improved in comparison to the past, whether this is enough I don't know now. Obviously time will tell, but definitely there is now clinical governance, there are high-risk case discussions, meetings, and these issues that we've never had in the first ten, twelve years of my work here in this hospital.'

'…..there were lots and lots of changes that were really, really for the better, and the MDT really came together. I think also there was organisational developments as well, because the anaesthetist started doing some scenario-based training that we would all be invited to.'

'….there is a much better process now of incidences being shared. Certainly in the last five years, maybe even less than that……. Some line managers are very good at sharing all memos and other managers not so'.

1.45 Other staff cautioned that the improvements seen within maternity services at the Trust remain very fragile and that the Trust needs further observation, scrutiny and support as of spring 2022. A staff member said: *'Ladies are being cancelled, rebooked and cancelled due to staffing issues and I have considered leaving as I worry about the impact this is having…'. The staff member added: 'I have been really worried…it is important people are aware of the situation...'.*

Oversight of safety and performance within maternity services

1.46 A number of contributors reported to us that, for a long time, executives and board members viewed the maternity service as performing well and as a result did not apply a high level of scrutiny to the service. Equally external scrutiny did not raise sufficient concerns at board level. The following remarks illustrate this:

'….whilst they were confident and very strong individuals, very clear about their ability to manage their teams and manage the business, I didn't have any reason to question that they would come to me if they had concerns'.

Another contributor added: *'…at no stage did me, and this is my fault, but at no stage did I pick up that there was such a deep-seated problem in that service…'*

1.47 Other staff members told the review team:

'…….we got best performing and we got CNST Level 3, you know, so these are independent organisations coming in, looking at it. Therefore……. you should have some confidence in what these bodies are telling you…'

'……when scrutinised by quality and safety, when scrutinised by the Trust Board to give a reasonable account of their abilities to maintain their service. We did develop "deep dive" reviews at various stages and there was a sense that compared with some other areas of difficulty within the Trust, Maternity was not on the radar at that stage. That, of course, was triangulated with other perspectives, so views from the CQC, and you'll be aware that in the early phases, the CQC reports were positive ones. They were rated as good.'

'….it was published and it obviously came to our Board meeting, we discussed it in the Board. I think, I mean the overall message from that report was that…. they said safe and good quality services in a learning organisation.'

'It was presented to us, I think, by SaTH as being more positive than it actually was. It was a kind of oh well, the RCOG think we're okay.'

'They were one of the ones I trusted and, given all the external results we were getting that actually confirmed how good the service was they ran'.

'…..we were working within a Trust that had considerable financial challenges, some challenged services, and that was the focus of the Trust, really. So, maternity and women's and children's was referred to as the flagship of the organisation, and trying to get additional resources into the care group was really difficult.'

'….we'd achieved CNST level three gold standards, and that was … I don't know, not a badge of honour, but there was a lot of interest within the Trust that we should be awarded that….gave evidence with others at a parliamentary review into maternity care, and we were asked to go as one of those services that was considered to be providing good care, and we gave our evidence there. So, I think from that time, 2004 onwards there was this perception that we had a really good service, and we were regularly reviewed and visited.'

'As a maternity service, we were considered to be very good, which is why it's been a bit of a shock, all this happening. We were considered to be very good….'

Staffing

1.48 It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response. The following six vignettes highlight some of the concerns expressed about staffing:

'…it was really clear just how difficult it was to sustain a safe level of cover…'

'I don't remember them actually saying that they needed more funding for midwifery staff, but certainly they raised staffing as an issue repeatedly.'

'I asked for a Birthrate Plus review…… which - surprise, surprise - really showed everything that we'd felt…… deficit 30 whole time [posts]…. Were your co-coordinators supernumerary? Not always, usually because of the staffing levels.'

'…the midwives, they were obviously short-staffed….. The shift leader was constantly having a patient…. When you're working on the labour ward, you sometimes couldn't get hold of the shift leader because she was in looking after a woman….. Was not supernumerary and it was really difficult.'

'….but a lot of the shifts there were like by the grace of God that one could have been me… it was scary…. it was a system issue, as in this lady needs to go and we can't get her, she can't go, there aren't enough midwives, you know. They were the issues.'

'I feel like there isn't enough of everyone to kind of go round to make sure that everybody's getting the care that they need.'

In 2018, 46% of respondents to the MatNeo survey reported concerns about poor levels of staffing.

Patient Safety

1.49 Within the staff voices survey, 62% of respondents reported they had been concerned about patient safety, with many feeling their concerns were not adequately addressed.

'T*he patient safety issues I would say they were probably more when I worked on the wards, and that was mainly again just staffing. I spent a lot of time on the antenatal ward, and the amount of times, you know, you needed to get a lady to labour ward and "no staff, no staff, I can't take her, I can't take her" or "Yes, you can bring her, but you will have to come with her", you know, leaving just one other member of staff, you know, that, that, they were the main things really, was trying to get ladies to labour ward in a timely manner. I think they would be the biggest, biggest issues I had seen really.'*

'..Nobody went out at any time wanting to harm anybody, it's just we didn't have the training and we didn't have the staff and that's how it was, unfortunately, and we didn't know any different.'

'We're not giving them the right tools here, we're not supporting them, and we're not giving them the right staffing levels.'

Caesarean section

1.50 Staff commented on the low caesarean section rate at the Trust, which was discussed in our first report. There was disagreement from the staff who contributed to the review as to whether there was a reluctance to offer caesarean section when requested. One staff member said:

'There was always a perception that we were reluctant to offer maternal request caesarean section, which wasn't true but we had a policy to arrange appointments with senior clinicians in order to fully understand the request and provide advice.'

1.51 However, a number of other staff interviewed had differing recollections on the same topic, with examples from four staff shared below:

'….and they would definitely try to avoid a caesarean section…… they were always trying to, how can you put it, try for a normal birth all the time…… it was a couple of times, I pulled the emergency bell because I had a bradycardia going on. They came in and I was actually told off for pulling the emergency bell. I thought to myself, "What's going on here?" I absolutely did not understand it. It's like, you know, they would just let things run purely because they didn't want the doctors to come in, and sometimes you could see some of the shift leaders not wanting to call the registrar in or any of the doctors in …..'

'They were always very proud of their low caesarean rates…….I personally found all the failed/attempted instrumental deliveries very difficult to deal with. I had never seen so many injuries/HIE/resuscitations from this. Nothing to be proud of.'

'I was worried with this escalation thing especially with the patients who are going with the emergency caesarean section….. when we are worried about, for example, a CTG, and they will try and try and try at the end until the baby is really poorly…..because they told me they want to keep the caesarean section really low.'

'I couldn't believe that that was still, the culture was the same – it was almost we have to do everything to get a vaginal delivery and we've got to keep the section rate low, we've got to keep the epidural rate low…….. In 2014 it was the same guys that I'd seen in early 90s', very much the same culture.'

Midwifery led units

1.52 A number of staff discussed the safety of working in the Midwifery Led Units (MLUs) and the challenges they faced. Examples from three staff are shared below:

'….that to run five midwifery-led units out of our establishment, I questioned whether our model was fit for modern-day purpose…….. but Shropshire, you know, its accolade was, "We've got five midwifery-led units". … one of the consultants described it as, you know, the MLU as being the sacred cow, and that's how it felt, that it was okay to have five midwifery-led units if we were staffing the whole organisation in the way that it needed to be done, but we weren't, and it just felt as if you'd got two completely opposite ends of the care that was being given.'

'So, I was put in this really difficult situation of knowing what to do with this woman who's booked at the consultant unit and they could have transferred her earlier. I mean, by the time I went into the room, right, I mean this woman was delivering anyway, but it was… you could say it's a near-miss really, that it was a near miss.'

'The one thing I was really struggling with was whenever the consultant unit was short-staffed, they would take MLU staff, but they wouldn't close the MLUs at that time. So some MLUs were left with one midwife available and no on-call midwife and hope that a woman didn't come in in labour because there wouldn't be a second MLU midwife to back her up and that troubled me no end. It was not a safe situation and it was a disaster waiting to happen.'

Escalating concerns

1.53 Within the survey, when asked whether they had ever raised any professional or clinical concerns, 57% responded with 'yes'. Of these, 52% said there was a clear pathway to follow to escalate professional or clinical concerns. Examples from staff are shared below:

'The culture at SaTH is that if you have done something wrong, keep it in-house and we punish you for that, you know, whether that's you're investigated or whether that's you're moved on a change list or we make your life very difficult or you end up handing your notice in because you have been almost hounded in a way to the point where you have left because of your mental health, you become more and more reluctant to speak out and that's the danger, isn't it?'

'….has actually told us off for putting in Datix, or raising critical incidents about concerns we have, because this is, [they] would describe it as whistleblowing and it's wrong….. to have significant individuals in the organisation telling you that isn't what you should do is very harmful.'

'….So I went along and was basically, yes, told that everything was, I shouldn't be raising concerns and, you know, that I didn't understand the system and that everything was fine and, you know, again just not to raise concerns. I was in tears because I was basically a rotten person and I shouldn't be upsetting the apple cart and, you know, it was irresponsible to go raising these concerns. Afterwards I was completely shocked, I actually couldn't face going in for a few days.'

'It is difficult to know where to take concerns when you have escalated through relatively senior channels and there is no improvement. A clear pathway or process would, I believe, support staff in expressing these frustrations - everyone is under immense pressure and everything is a priority however there needs to be a means of acknowledging concerns and identifying how to implement an improvement strategy irrespective of if this needs to be over a long period of time.'

'So I think we've been proportionate when we've raised concerns but most of the time people say yes, we understand, that's a valid concern, but there's no practical solution to it.'

Multidisciplinary team (MDT) working and training

1.54 Some staff were keen to share with the review team that they had positive working relationships across the multidisciplinary teams, that the Trust was a good place to work and they were focussed on giving high standards of care. When asked within the survey whether they felt the MDT works well together 87% responded with 'yes' or 'sometimes'. 37% of respondents replied that they 'rarely' or 'never' took part in MDT training, 36% said 'sometimes' and 27% 'often' and 'always'.

1.55 Some staff described fractious relationships amongst the teams that may have presented as barriers to effective communication.

'……but there were fallings out between the Band 7s and the consultants, I remember there being arguments, maybe clashes in personality….. some of the Band 7s…., maybe weren't as much good communicators.'

'…was so arrogant and rude, you'd be afraid to ring [X} with any concerns. [X] was intimidating….. was very derogatory about midwives,… the midwives found [X] very rude and arrogant and intimidating and would prefer not to deal with [X]...'

'We would find that the doctors would walk in and just come and look at what was going on because there wouldn't be that communication from the coordinator to the doctors. You just felt like there was very much an "us and them".'

'I think bullying was rife on the maternity unit and this is part of it, that these consultants, there were one or two or even three that would intimidate the midwives and junior doctors, and make sure that they are not approachable'.

'…this collaboration of training together, it really wasn't happening'.

Improvements

1.56 Within the survey, staff were asked whether they felt there were any barriers to attempts to make improvements to the maternity service. 50% of respondents replied 'yes' and a further 25% replied 'sometimes'.

'So we're going to put that into our protocols and policies and before it was just "mañana", we'll do it tomorrow. Tomorrow never comes. There's no urgency to address or change or do anything. They'll do that and if it works for them, we'll do it. No, we have to do it. We're answerable, we're accountable'.

'I think we have always wanted to improve the services because things never, you know, they must obviously change in order to improve, you just can't carry on the same way as you are. So, as far as I was concerned, yes, there was a thirst for improvement, for learning, you know, and how we can actually change things as well'.

'I wholeheartedly believe, and I know my colleagues believe senior management ….. have been a barrier for change'.

1.57 Other staff, however, reported that continuous improvements within maternity had been made over the years and the unit had engaged with national initiatives such as customised growth charts, the maternity early warning score and 'Saving Babies Lives'. A staff member told the review team:

'Since my appointment to consultant I have been involved in, instigated and led a number of improvement projects within the maternity department. All of the projects became multidisciplinary from an early stage.'

Impact of the review on staff

1.58 Staff reported being deeply affected by the ongoing review. Some staff explained that they would decline to meet with the review team for this very reason. One of the criticisms levied at the review team was there were misconceptions regarding the culture at the Trust.

'I feel that the culture in the unit now is different, I think there's a lot of people who have struggled, and personally my health's not been good as a result of this. ..there's been a lot of people who have really struggled from a mental health point of view, physical health point of view, because of this….. there's a resolve in the unit that we will improve and get better but there's also a sadness in the unit that we've ended up where we've ended up, and I think it is quite hard for the staff who've been there a long time.'

1.59 Other members of staff told the review team:

'…there's a number of colleagues who will never recover from this…'

'From the media perspective, it feels like people like me or my colleagues are portrayed as some sort of perpetrators, villains, but actually, I do feel we should all be on the same side here, but it doesn't feel like it.'

Response to the Independent Maternity Review

1.60 Staff who spoke to the review team were generally positive about the changes they had witnessed following the publication of our first report and the maternity services improvement programme:

'I think that the lessons from this inquiry are going to be transferable to the whole NHS'. The same staff member continued: *'….so the really great thing to come out of the external review has actually been the funding to expand … and I'm really grateful for that, really, really grateful'.*

1.61 Another staff member told the review team:

'No, I really hope that things change. I hope it changes for the…..good….. It's not all bad, and for the families, first and foremost really, because it's heart-breaking to see some things on Facebook where [The] Shropshire Star have put something up and if you read the comments from public members it's horrible to see people questioning whether they're going to be safe or not, when I know that there are so many staff there, I would quite happily let them look after me and have done.'

1.62 Further staff comments included their distress at not being listened to when they had tried to raise concerns at an earlier time *'… we were all just shell-shocked. Whenever a report comes in, you read it and there are bits you identify with and I couldn't even talk. I broke down ……I remember breaking down and they were proper angry sobs, it's not just, "I'm upset because families have gone through this, clinicians have gone through this", I am angry and I am hurt and I'm angry because nobody has listened and I don't believe the change has happened quick enough and I tried to explain that.'*

'I do feel very sorry about what's happened and I've reflected a lot on what I could have done differently…'

There were a number of positive comments about the first report from a range of staff including:

'I was impressed by the report identifying the need for nationwide improvements, learning from this experience. I think there's a story there that has been identified and it will be lovely to see that being implemented more effectively, more widely.'

'I mean maybe actually we didn't know necessarily the right questions to ask, so knowing some of the right questions to ask would have been helpful. For instance, I had no idea that they didn't have an adequate anaesthetic service, so that, if you haven't got adequate anaesthetic cover for your sections, obviously you're not going to do one if you can get away with it, or think you can get away with it, and that was something I had never thought of asking. So maybe it's about actually having a national sense of exactly what we should be checking on, as commissioners, so that we're not falsely reassured.'

'….it was shocking and very upsetting to see that those things hadn't come to light during the time that I thought that we were doing as good a job as we could at understanding what was going on in the services that we commissioned.'

Conclusions

1.63 This engagement strategy reached out to staff through liaising directly with the Trust and through social media platforms and local media reporting. We are extremely grateful to the staff who have been willing to share their experiences as we appreciate how difficult it has been to make that decision. Some expressed feelings of guilt at speaking with us and many were tearful as they recalled individual experiences and what they had observed in dealing with other colleagues and within their service over many years.

1.64 The members of staff who engaged with us really matter and their voices must be heard. They speak about the culture and raising concerns but not being heard. They speak about trying to do things to the best of their ability without the necessary frameworks in place that would enable them to learn from any errors made. What they say is supported by what we have seen throughout this review- that maternity services within the Trust had poor governance systems for a long time, which allowed it as an individual service to develop its own systems in isolation without effective internal and external surveillance.

1.65 We cannot underestimate the toll on staff of being under constant intense scrutiny. We met staff who were deeply affected by what had happened in their service. However, many of the staff who engaged with us stated that they were adamant to learn and do all they could to ensure their maternity services were safe for the families in Shropshire.

LOCAL ACTIONS FOR LEARNING: HEARING THE VOICES OF STAFF

The learning and action points outlined here are designed to assist The Shrewsbury and Telford Hospital NHS Trust with making immediate and significant improvements to the safety and quality of their maternity services.

1.66 The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying, which remain apparent within the maternity service as illustrated by the results of the 2018 MatNeo culture survey and the recent feedback from current staff.

Appendix 2: Immediate and Essential Actions from our first report

Immediate and Essential Actions to improve care and safety in maternity services as outlined in our first report

1: ENHANCED SAFETY	
Essential Action Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	• Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them. • An LMS cannot function as one maternity service only. • The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2: LISTENING TO WOMEN AND FAMILIES

Essential Action

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
- CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

3: STAFF TRAINING AND WORKING TOGETHER

Essential Action

Staff who work together must train together.

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4: MANAGING COMPLEX PREGNANCY	
Essential Action There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	• Women with complex pregnancies must have a named consultant lead. • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. • The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians. • This must also include regional integration of maternal mental health services..

5: RISK ASSESSMENT THROUGHOUT PREGNANCY	
Essential Action Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional. • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6: MONITORING FETAL WELLBEING	
Essential Action All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	• The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on he review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

7: INFORMED CONSENT	
Essential Action All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	• All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care • Women must be enabled to participate equally in all decision making processes and to make informed choices about their care. • Women's choices following a shared and informed decision making process must be respected.

Appendix 3: Glossary of terms

Definitions and medical and midwifery terms used throughout our report

Abruption	Is the early separation of a placenta (afterbirth) from the lining of the uterus before completion of the second stage of labour. It is one of the causes of bleeding during the second half of pregnancy.
Abscess	Collection of pus
Absent End-Diastolic Flow	Is a useful feature which indicates underlying fetal vascular stress if detected in mid or late pregnancy
Acidaemia	A condition of raised blood acidity
Acute respiratory distress syndrome (ARDS)	A life-threatening lung injury that allows fluid to leak into the lungs. Breathing becomes difficult and oxygen cannot get into the body
Advanced neonatal nurse practitioners (ANNP)	Introduced to undertake the Tier 1 duties on the neonatal rota, jointly shared with ST1 - 3s. The post holders practice at a senior practitioner level to provide autonomous clinical care
Anomalous Left Coronary Artery to Pulmonary Artery (ALCAPA)	A very rare form of congenital heart disease
Amniocentesis	A medical procedure to obtain a small amount of amniotic fluid that is used to further investigate suspected fetal chromosomal abnormalities
Amnio-infusion	Refers to the instillation of fluid into the amniotic cavity
Amniotic Fluid Embolism	A rare condition where the amniotic fluid – which surrounds and protects a baby inside the womb – can leak into the mother's blood vessels during labour, causing a blockage. This can lead to breathing problems, a drop in blood pressure and loss of consciousness. A small number of women survive amniotic fluid embolism with risks of long-term complications including neurological problems because of a lack of oxygen to the brain, however most women do not survive
Amniotomy	Artificial rupture of the membranes (ARM)
Anaemic	Lack of enough red blood cells to carry adequate oxygen to the body's tissues
Antepartum	The period of pregnancy that includes the 24th week of pregnancy until birth

Antihypertensive medication	Drugs used to control high blood pressure
Apgar score	This is an accepted method of assessing how a newborn baby has adapted to extrauterine life, immediately following birth
Augmentation of labour	Is the process of increasing the frequency, length and strength of uterine contractions after the onset of labour either by intravenous oxytocin infusion and/ or artificial rupture of membranes. It can be used to increase uterine contractions when they are reduced, particularly during prolonged labour and facilitate cervical dilatation and vaginal birth
Auscultation	A method of periodically listening to the fetal heart with a stethoscope
Arachnoid cyst	Benign cyst in the brain
BCH	Birmingham Children's Hospital
Birthing centre	A birth centre staffed by midwives, they may be "stand alone", (some distance from a consultant-led unit) or alongside, often in the same building/ on the same floor as a consultant-led unit.
Birthrate Plus® (BRP)	Is a method for assessing the needs of women for midwifery care throughout pregnancy, labour and the postnatal period in both hospital and community settings. From the data collated, the methodology calculates the number of midwives required to meet the defined standards and models of care whilst informing local workforce requirements, holiday and travel allowances etc
BLISS	A charity for babies born premature or sick
Born Before Arrival (BBA)	Refers to a birth which takes place before arrival to a maternity unit, or a homebirth before the arrival of a midwife
Bougie	A small wire over which a breathing tube can be passed in difficult airways
British Association of Perinatal Medicine (BAPM)	Is a professional association and registered charity. They aim to improve standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, deliver and share high quality safe and innovative practice, undertake research, and promote the needs of babies and their families
Cabergoline	A drug used to suppress lactation (milk production).
Caesarean hysterectomy	Hysterectomy (surgical removal of the womb) at the time of, or soon after, delivery by caesarean section

CAF	Common Assessment Framework is a tool designed to help practitioners working with children, young people and families to assess children and young people's additional needs and strengths for earlier, and more effective services, and develop a common understanding of those needs and how to work together to meet them
Cardiopulmonary	Relating to the heart and lungs
Cardiotocograph (CTG)	A technical means of recording the fetal heart rate and the uterine contractions during pregnancy and labour
Care Quality Commission (CQC)	An executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England
Category 1 caesarean section	Is when there is immediate threat to the life of the woman or fetus and delivery is recommended within 30 minutes
Category 2 caesarean section	Is when there is maternal or fetal compromise which is not immediately life-threatening and delivery is recommended within 75 minutes.
Catheter	Tube (usually to drain the bladder)
CBT	Cognitive Behavioural Therapy
CDH	Congenital diaphragmatic hernia, a serious congenital anomaly where some of the bowel lies within the chest and causes breathing difficulties
CEMACH	Confidential Enquiry into Maternal and Child Health
Cerebral Palsy	Is caused by a problem within the brain that develops before, during or soon after birth. Cerebral Palsy affects movement and coordination
Clinical Commissioning Groups (CCG)	Were established as part of the Health and Social Care Act in 2012, and consist of groups of general practices (GPs) which come together in each area to commission the best services for their patients and population
Clinical Negligence Scheme for Trusts (CNST)	An insurance scheme administered by NHS Resolution (NHSR) in which individual NHS organisations pay an annual premium to mitigate against the cost of clinical negligence claims. Trusts which achieve standards set by the scheme receive a reduction in premiums
Chorioamnionitis	A serious condition in pregnant women in which the membranes that surround the fetus and the amniotic fluid are infected by bacteria. It can also cause serious complications in the newborn baby. This includes infection (such as pneumonia or meningitis), brain damage, or death

Coagulopathy	Coagulopathy is often broadly defined as any derangement of haemostasis resulting in either excessive bleeding or clotting, although most typically it is defined as impaired clot formation
Colloid fluid	Non-crystal fluid used as a temporary substitute for blood
Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)	Was created to improve the understanding of the causes of death in late fetal life (from 20 weeks post-conception) to infancy (one year after birth). CESDI created a standardised grading system to categorise mortality reviews and identify cases of suboptimal care
Consultant-led Unit (CU)	Refers to a maternity unit which has the support of obstetricians and midwives to facilitate high-risk care during the antenatal, intrapartum or postnatal period. Consultant-led units also require the support of the wider multi-disciplinary team including (but not limited to) anaesthetists, theatres and a neonatal team
Consultant obstetric unit	A place to give birth staffed by obstetricians, midwives and anaesthetists. They have a neonatal unit staffed by neonatologists and nurses
Continuous Positive Airway Pressure (CPAP)	It is a type of non-invasive ventilation (NIV) or breathing support
Cooling	Therapeutic hypothermia is an effective way to treat newborn babies who have experienced a lack of oxygen and/or blood flow to the brain and other organs before or during labour and delivery. Reducing a baby's body temperature to 33.5oC to protect the brain
Cord prolapse	Happens when the umbilical cord slips down in front of the baby after the waters have broken. The cord can then come through the open cervix (entrance of the womb)
Counselling	Professional guidance and discussion to support complex choices with families that ensures sharing of evidenced-based information to enable informed decision and personalised care
CPR	Cardio pulmonary resuscitation (chest compressions and breaths)
Critical care unit	Intensive care or high dependency care unit
CRP	C-reactive protein. A marker of infection or inflammation
Crystalloid	A solution of water and salts for intravenous administration
Culture	Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations

Diaphragmatic Hernia	Diaphragmatic hernia is a birth defect where there is a hole in the diaphragm
DATIX	An incident reporting form
Dichorionic, diamniotic (DCDA) twins	Each has their own separate placenta with its own separate inner membrane (amnion) and outer membrane (chorion)
Direct Maternal Deaths	Are defined as those related to obstetric complications during pregnancy, labour or puerperium (six weeks) or resulting from any treatment received.
Deflexed occipito-posterior position	Poor position of the fetal head
Diuretics	Drugs used to increase urine production
Doppler assessment	Assessment of the blood flow in various fetal blood vessels, commonly the umbilical vessels or the middle cerebral artery (MCA)
Dual instruments	There are two main instruments used in operative deliveries – the ventouse and the forceps. In general, the first instrument used is the most likely to succeed. Dual instrumentation describes both types of instruments being used to perform an operative vaginal delivery
Duty of candour	Legislation to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Each Baby Counts	A national quality improvement programme set by Royal College of Obstetricians and Gynaecologists (RCOG) to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. This improvement programme is now closed
Eclamptic fit	A fit occurring as a consequence of severe pre-eclampsia
E. Coli	A bacterium that can cause infection
EMDR	Eye Movement Desensitisation and Reprocessing
Empyema	Pus in a body cavity
Endometritis	Infection within the uterus (womb)
Escalate	To become more important or serious, or to make something or someone do this.
Executive Director	A member of a board of directors who also has managerial responsibilities
Extended perinatal death	A stillbirth or neonatal death

External Cephalic Version (ECV)	Is a process by which a breech baby can sometimes be turned from buttocks or foot first to head first. It is a manual procedure that is recommended by national guidelines for breech presentation of a pregnancy with a single baby, in order to enable vaginal delivery
Extradural haematoma	A sub-periosteal haematoma located on the inside of the skull, between the inner table of the skull and parietal layer of the dura mater (which is the periosteum)
Extubation	Removal of an artificial breathing tube from a baby's airway
EUA	Examination under anaesthetic
Faecal incontinence	Lack of bowel control
Fetal blood sampling (FBS)	Is a procedure to take a small amount of blood from an unborn baby (fetus) during pregnancy. FBS should be advised in the presence of a pathological fetal heart rate (FHR) trace unless there is clear evidence of acute compromise (i.e. immediate delivery is thought necessary)
Fetal bradycardia	Fetal heart rate of less than 120 beats per minute
Fetomaternal haemorrhage	The entry of fetal blood into the maternal circulation before or during delivery
Fibroids	A benign tumour of muscular and fibrous tissue which develops in the wall of the uterus
Footling breech	Is when one or both of the baby's feet are born first
Forceps	An instrument shaped like a pair of large spoons which are applied to the baby's head in order to guide the baby out of the birth canal
Fresh eyes assessment	Refers to a "buddy system" of CTG review to improve interpretation and documentation
Funisitis	Inflammation of the connective tissue of the umbilical cord that occurs with chorioamnionitis
Furosemide	A drug that promotes removal of fluid from the body by production of urine, a diuretic
GAP	The Growth Assessment Protocol: a national programme to improve patient safety in maternity care
Gastroschisis	A defect of the abdominal wall where intestines are found outside of the baby's body, exiting through a hole alongside the umbilicus (belly button)
General Medical Council (GMC)	A statutory body with the purpose to protect, promote and maintain the health and safety of the public by working to protect patient safety and support medical education and practice across the UK. The GMC works with doctors, employers, educators, patients and other key stakeholders in the UK's healthcare systems

Governance	The way that organisations are managed at the highest level, and the systems for doing this. Clinical governance can be defined as a framework through which the National Health Service (NHS) organisations and their staff are accountable for continuously improving the quality of patient care. NHS staff need to ensure that the appropriate systems and processes are in place to monitor clinical practice and safeguard high quality of care
GROW Chart	Customised antenatal charts for plotting fundal height and estimated fetal weight
Growth retardation	Growth significantly less than expected
Grunting/grunty	An abnormal noise made by a newborn baby with breathing issues
Guedel airway	A device placed in the mouth to keep the airway open
Haematoma	Blood clot (not in a blood vessel)
Haematologist	A doctor specialising in disorders of the blood
Haematuria	Blood in the urine
Haemodynamic	Relating to the flow of blood
Haemoperitoneum	Blood in the abdominal cavity
Hb	Haemoglobin level i.e. assessment of anaemia
HDU	High Dependency Unit
Healthcare Commission (HCC)	The Commission for Healthcare Audit and Inspection, also known as the Healthcare Commission was created in 2004. It was responsible for assessing standards of care provided by the NHS. Its responsibilities were taken over by the Care Quality Commission in 2009
Headbox oxygen	An oxygen hood or head box is used for babies who can breathe on their own but still need extra oxygen. A hood is a plastic dome or box with warm, moist oxygen inside. The hood is placed over the baby's head
HELLP	Haemolysis (of red blood cells): Elevated Liver (enzymes): Low Platelets. HELLP is a syndrome that occurs with serious pre-eclampsia, and indicates severely deteriorating organ function
High frequency oscillatory ventilation (HFOV)	An advanced form of respiratory support
Hypoxic ischemic encephalopathy (HIE)	Refers to the damage caused in a baby's brain when the baby does not receive enough oxygen and / or blood flow around the time of birth, or during pregnancy. Graded into HIE grades 1-3 depending on severity
High Risk Case Review (HRCR)	An internal process used in Shrewsbury and Telford Hospitals NHS Trust over the period of this review created to investigate incidents which were said to not meet the threshold for being a Serious Incident

The Healthcare Safety Investigation Branch (HSIB)	They investigate incidents that meet the Each Baby Counts criteria and their defined criteria for maternal deaths *www.hsib.org.uk/maternity/what-we-investigate/*
Higher Specialist Trainee (HST)	Middle grade, or Tier 2 doctor, registrar
'Hub and Spoke' Model	Refers to a specific type of service model design consisting of a main base supported by additional bases or branches. In maternity services, the hub is the consultant-led unit and the spokes are midwiferyled units or community bases
Human factors	Refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety
Humerus	The long bone in the arm
Hydronephrosis	Swelling of the system that collects urine from the kidney, usually because of obstruction lower down the renal tract
Hypercalcaemic	High calcium levels in the blood
Hyperinsulinism	Excessive secretion of insulin, leading to low blood sugar
Hypertension	High blood pressure
Hypotension	Low blood pressure
Hypotensive	Abnormally low blood pressure
Hypothermic cooling	Involves cooling the baby down to a temperature below homeostasis to allow the brain to recover from a hypoxic-ischemic injury
Hypovolaemia	Low blood volume, usually secondary to blood loss
Hypoxia/Hypoxic	Is a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia)
Indirect Maternal Deaths	Are those associated with a disorder, the effect of which is exacerbated by pregnancy
Indices of Deprivation	Are datasets used to classify levels of deprivation within small areas. Deprivation rates are measured by the assessment of various factors including income, employment rates, education, housing and crime
Inflammatory markers	Substances that can be measured in blood tests that, when elevated, indicate that there is inflammation occurring within the body
Infused	Given intravenous fluid (not blood)
Inotropes	Intravenous medication to treat very low blood pressure

International Normalised Ratio (INR)	A blood test/ calculation which assesses the time taken for blood to clot
Intermittent auscultation (IA)	The technique of listening to and counting the fetal heart rate (FHR) for short periods during active labour
Instrumental delivery	An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cup are used to help deliver the baby
Intrapartum	During labour
Intrauterine death (IUD)	Also called stillbirth: An unborn baby dies inside the womb before birth. This is described as 'late' when it happens in a woman who is 24 weeks pregnant or more, and is estimated to occur in 1% of all pregnancies
Intraventricular Haemorrhage (IVH)	Bleeding inside or around the ventricles within the brain
ITU	Intensive therapy (care) unit
Intubation	Placing a breathing tube in a baby's airway to assist ventilation
Intraventricular haemorrhage (IVH)	Bleeding into the fluid cavities within the brain, usually in preterm babies
Ketonuria	Occurs when high levels of ketone bodies which occur when cells are broken down for energy are present in the urine
KIDS-NTS	Children's and Neonatal Transport team for the West Midlands
Labour ward coordinator	Senior midwives who coordinate the clinical workload and activity on the labour ward
Laparotomy	Surgical opening of the abdomen
Laryngeal mask	A device placed in the airway instead of intubation
Liquor	The water surrounding the baby in the womb
Left ventricular failure	When the left side of the heart is unable to pump blood to the body effectively such that it is insufficient for the body's needs
Level 3 neonatal unit	Neonatal units are graded 1-3, 3 being equipped to care for the most pre-term and unwell infants requiring the highest levels of investigation and treatment
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit (formerly known as level 2 neonatal unit)
Local Authority	Refers to an organisation within local government which is responsible for public services and facilities.

Local Maternity System (LMS)	The Local Maternity Systems are the mechanism through which it is expected that a Sustainability and Transformation Partnership (STP) will collaboratively transform maternity services with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes for women and their families. The LMS's are overseen by the Maternity Transformation Board
Local Supervising Authority Midwifery Officer (LSAMO)	A senior officer who was responsible for upholding the standards of statutory midwifery supervision at a regional level. Statutory supervision was abolished in 2017
Local Supervisory Authority (LSA)	This organisation was responsible for the function of statutory supervision of midwives. The LSA was accountable to the Nursing and Midwifery Council (NMC) which set rules and standards for midwifery. This authority was disbanded when Supervision of Midwifery was abolished
Loculated empyema	Pockets of pus that have collected inside a body cavity
LSCS	Lower segment caesarean section
Lower specialist trainee (LST)	Tier 1 doctor or Senior House Officer
Macrosomic	A newborn baby that is much larger than expected
Magnesium infusion	Drip used to decrease the risk of an eclamptic fit
Malpositioned baby	Usually the fetal head engages in the occipito-anterior position (more often left occipito-anterior (LOA) rather than right) and then undergoes a short rotation to be directly occipito-anterior in the mid-cavity. Malpositions are abnormal positions of the vertex of the fetal head relative to the maternal pelvis
Maternal death	Defined as the death of a woman while pregnant or within 42 days of termination of pregnancy
Maternity Dashboard	Is a tool which can be used within clinical governance to benchmark activity, and to monitor quality and performance indicators such as birth complications and mode of delivery
Maternity and Neonatal Collaboration	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
Maternity Transformation Programme	The purpose of the Maternity Workforce Transformation Strategy is to support NHS maternity services to deliver more personalised and safer care and improve outcomes for women by ensuring that there is the capacity in the workforce nationally

Maternity Voices Partnerships (MVP)	A team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care
Mat Neo collaborative	The maternity and neonatal safety collaborative is a programme to support improvement in the quality and safety of maternity and neonatal units across England
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. A national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths
MDT	Multi-disciplinary Team
Meconium	Baby's bowel contents in the liquor (water) which sometimes suggests fetal distress (thick meconium is more likely to suggest this)
MEWS or MEOWS	An early warning score or guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs. The MEOWS is a Modified Early Obstetric Warning System
Midwife-led units (MLU)	Are another name for birth centres that are run by midwives and have a home-like environment. They are most suitable for women without complications and can be next to a hospital maternity unit ('alongside') or situated in the community ('freestanding')
Midwifery Continuity of Carer (MCoC)	Midwifery continuity of care is a model of care, which aims to limit the number of different healthcare professionals a woman sees throughout her pregnancy. Its aim is that the pregnant woman will receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity
Mifepristone	A drug used to prepare the uterus (womb) for early contractions usually induced by another drug given approximately 36 hours later
Monochorionic twins	Twins sharing the same blood supply from the placenta. This can lead to unequal sharing of the blood supply which can lead to the death of one or both twins
Moulding	The bones of the fetal head can move closer together or overlap to help the head fit through the pelvis.
MRI scan	Magnetic Resonance Imaging –detailed scan, often of the brain
Multiparous	A woman who has given birth once or more

Multidisciplinary team	Is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended care. In maternity this tends to be midwives, obstetricians, anaesthetists and neonatologists
Myelomeningocele	A form of spina bifida where the spinal cord is exposed at birth. This is when a sac of fluid comes through an opening in the baby's back. Part of the spinal cord/ nerves can be in the sac and are damaged
Neonatal Data Analysis Unit (NDAU)	Analyses neonatal data nationally
National Reporting and Learning System (NRLS)	Is a central database of patient safety incident reports
Neonate	Refers to an infant in the first 28 days after birth
Neonatal death	An infant who dies in the first 28 days of life • Early neonatal death - a live born baby who died before 7 completed days after birth • Late neonatal death - a live born baby who died after 7 completed days but before 28 completed days after birth
Neonatal Networks	A network of neonatal units working together to provide neonatal care to a geographical area. Also knows as 'managed clinical networks' or 'operational delivery networks'
NHS England and NHS Improvement (NHSE&I)	The body that leads the NHS in England
NHS Litigation Authority (NHSLA)	The NHS Litigation Authority (NHSLA), now known as NHS Resolution (NHSR), manages negligence and other claims against the NHS in England on behalf of its member organisations. Its aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff
NHS Resolution	A body of the Department of Health and Social Care. It provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care
National Institute for Health and Care Excellence (NICE)	Provides national guidance and advice to improve health and social care
NICHE	An independent consultancy service available to all healthcare providers (including mental health, acute, specialist, ambulance, primary and community), social care partners, commissioners, local authorities and regulatory organisations
NICU	Neonatal intensive care unit
NLS	Newborn Life Support Course (national training course)

NMR	Neonatal mortality rate (deaths within 28 days of life)
National Neonatal Audit Project (NNAP)	National audit of neonatal outcomes
NNU	Neonatal unit
Non-Executive Director (NED)	A board member without responsibilities for daily management or operations of the organisation
NQM	Newly qualified midwife of less than one year since becoming a professional registrant.
Nulliparous	Describes a mother who has not given birth before
Nursing and Midwifery Council (NMC)	The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
Occipito posterior position	Common malpresentation in labour, which can be associated with a prolonged labour
Oedema	Accumulation of fluid in bodily tissues
Office of National Statistics (ONS)	Is responsible for collating and publishing statistics relating to health, economy, population and society at local, regional and national levels
Open Book	The cases identified by the Open Book arose from the Shrewsbury and Telford Hospital NHS Trust (supported by NHSI) undergoing its own investigation of cases of stillbirth, neonatal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and maternal deaths. These were then reported to the review team
Operative delivery	Refers to a delivery in which the operator uses forceps, a vacuum, or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing
Operative vaginal delivery	Vaginal birth assisted with forceps or ventouse
Organisational structure	The way in which a large company or organisation is organised, for example, the types of relationships that exist between managers and employees
Oscillator	A form of high frequency ventilatory support that keeps the lungs open with a constant positive end-expiratory pressure
Oxygen saturation	Concentration of oxygen carried in the blood
Oxytocin	A hormone commonly used in obstetric practice to increase uterine activity
Paediatric	Branch of medicine that is dealing with infants, children and adolescents
Parliamentary and Health Service Ombudsman (PHSO)	An organisation which works with individuals and groups in an organisation to explore and assist them in determining options to help resolve conflicts, problematic issues or concerns, and to bring systemic concerns to the attention of the organisation for resolution

PCT	Primary Care Trust
Perinatal	The period of time that includes the entirety of pregnancy up until and including the first complete year following birth
Perinatal death	A stillbirth or early neonatal death
Perineal tear	A tear occurring during childbirth. 1st and 2nd degree tears are common, and not serious. A 3rd degree tear involves the anal sphincters as well as skin, vagina and muscle. A 4th degree tear extends into the rectum
Perineal follow-up clinic	A clinic to follow-up women who have experienced 3rd and 4th degree tears
Perinatal loss	Loss of a baby during pregnancy or soon after birth. Includes stillbirths and neonatal deaths
Peritoneum	The membrane which lines part of the abdominal cavity and covers the organs that lie within it
Placental	Reference to the 'afterbirth'
Placental abruption	When the placenta separates from the uterine wall either before or during labour
Placenta accreta	Abnormally deep attachment of the placenta into the muscle of the uterus (womb)
Perinatal mortality rate (PMR)	Stillbirths and deaths within 7 days of life
Post-partum haemorrhage (PPH)	Significant bleed after giving birth
Post-partum	After the birth
Pre-eclampsia (PET)	A condition that affects some pregnant women, usually during the second half of pregnancy (from 20 weeks) or soon after their baby is delivered. Early signs of pre-eclampsia include having high blood pressure (hypertension) and protein in the urine (proteinuria). The condition can be very serious for mother and baby
Pre-labour preterm rupture of membranes (P-PROM)	Is the rupture of membranes prior to the onset of labour, in a patient who is at less than 37 weeks of gestation
PRH	Princess Royal Hospital- Telford- current location of neonatal service
Primary Care Trust (PCT)	Were part of the National Health Service in England from 2001 to 2013. PCTs were responsible for commissioning primary, community and secondary health services from providers. Primary care trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups (CCGs)
Primiparous or Primigravid	A woman who is pregnant for the first time

Professional Midwifery Advocates (PMAs)	Support midwives to ensure that women and babies receive good quality, safe care
Prophylactic	Intended to prevent something occurring by being given early – for example a medication
Prostaglandin	A synthetic hormone that is used in obstetrics to encourage uterine contractions and cervical ripening (Shortening and dilatation)
Proteinuria	Protein detected in a urine sample
Pulmonary	Relating to the lungs
Pulmonary oedema	An excess of watery fluid in the lungs
Pyelonephritis	Severe kidney infection
Pyrexia	High temperature
Qualified in Speciality (QIS)	Postgraduate specialist training for neonatal nurses
Royal College of Midwives (RCM)	A professional organisation and trade union committed to serving midwifery and its workforce
Royal College of Obstetricians & Gynaecologists (RCOG)	Professional body of obstetricians to improve healthcare for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's healthcare worldwide
RCPCH	Royal College of Paediatrics and Child Health
Respiratory Distress Syndrome (RDS)	Breathing difficulty, usually in preterm babies due to immature lungs
Retained products	Pieces of placenta and/or membrane left in the uterus (womb) after delivery of the placenta (afterbirth)
Retropubic haematoma	Blood clot formed behind the pubic bone
Rectovaginal fistula	An abnormal channel that has developed between the rectum and vagina usually as a consequence of childbirth
Rectus sheath haematoma	Blood clot caused by bleeding from the rectus abdominus muscle (i.e. abdominal wall muscle)
Risk Management Strategy	The systematic identification, assessment and evaluation of risk. Used properly in healthcare, it can not only be a process to report incidents, but also minimise the harm that clinical or resourcing errors can cause to patients and staff
Root Cause Analysis (RCA)	Is the process of examining what happened in order to establish, how and fundamentally why an adverse event occurred. It should result in preventative measures to minimise future risk of reoccurrence.
RSH	Royal Shrewsbury Hospital – former location of neonatal service
SANDS	Stillbirth and neonatal death support charity

SaTH	Shrewsbury and Telford Hospital or NHS Trust or the Trust
Situation, Background, Assessment and Recommendation (SBAR)	An easy to use, structured form of communication that enables information to be transferred accurately between individuals
SBR	Serum bilirubin – to determine the level of jaundice in a baby
Serious Incidents (SI)	Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death, serious harm or injury. Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Previously known as Serious Untoward Incidents (SUI)
Sepsis	Severe infection
Septicaemia	Blood poisoning
Shock	Fall in blood perfusing organs, usually recognised because of a fall in blood pressure and a rise in heart rate. Shock has a number of possible causes, blood loss being the most common in maternity patients
Shoulder dystocia	Shoulder dystocia is when a baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body
Situational awareness	Can be defined simply as 'knowing what is going on around us', or – more technically – as 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future'
Spina Bifida	A condition that affects the spine and is usually apparent at birth. It is a type of neural tube defect (NTD)
Squamous epithelial cells in the pulmonary vessels	Cells from the baby found in the lung vessels of the mother
SSCBCN	Staffordshire, Shropshire and Black Country Neonatal Network
SSCBCODN	Staffordshire, Shropshire and Black Country Operational Delivery Network
Stillbirth	A stillbirth is the death of a baby occurring before or during birth once a pregnancy has reached 24 weeks. An antenatal stillbirth occurs at or prior to the onset of labour. An intrapartum stillbirth occurs after the onset of labour

Subarachnoid haemorrhage	Bleeding in the space between the brain and the skull
Surfactant	A medicine given directly into the lungs of premature babies
Symphysis fundal height	A measurement from the Symphysis Pubis to the top of the fundus (womb) that monitors fetal growth
'T' incision	When the cut made on the uterus is both horizontal and vertical. The subsequent scar is weak, and therefore there is a greater risk of uterine rupture in a future pregnancy
Tachycardia	Fast heart rate
Talipes	A condition affecting one or both feet that is caused by a shortened Achilles tendon or as a result of fetal lie within the womb. Usually self-resolving with exercise or physiotherapy, but in some cases requires further intervention
Tethered Conus	Neurological condition where the end of the spinal cord is fixed by tissue attachments at the bottom of the spinal canal rather than moving freely
Therapeutic lactation suppression	Use of drugs to suppress milk production
Thermoregulate	Whereby the body maintains its core temperature
Third or fourth degree perineal tear	A perineal tear which involves damage to the fourchette, perineal skin, vaginal mucosa, muscles, and anal sphincter
Thrombosis	Blood clot in a blood vessel, usually in a vein
TOBY registry	A national register of babies that received cooling for HIE
Tocophobia	Is a pathological fear of pregnancy and can lead to avoidance of childbirth
Transfused	Given a blood transfusion
Transport team	A specialist service for safely transferring babies between care providers
Trial of instrumental birth	A term used when a difficult instrumental birth is anticipated, usually performed in an operating theatre with quick and easy recourse to caesarean section
Twin to twin transfusion syndrome (TTTS)	Is a rare condition that occurs during a twin pregnancy when blood moves from one twin (the 'donor twin') to the other (the 'recipient twin') while in the womb
UHNM	University Hospitals of North Midlands (Royal Stoke University Hospital)
Ureter	Tube down which urine passes from the kidney to the bladder
Ureteric obstruction	Blockage of the ureter

Urologist	A doctor specialising in disorders of the urinary tract
Uterine artery	Main artery (but not only artery) supplying blood to the uterus (womb)
Uterine rupture	When the uterine wall bursts, this usually occurs during labour, but can occur during pregnancy. Uterine rupture generally occurs when the uterus has a previous scar. Some types of scar, increase the risk of rupture in future pregnancies
Urinary PCR	Protein/creatinine ratio in the urine to measure the level of protein more accurately than a dipstick assessment
Ventouse delivery	A suction cap is applied to the baby's head in order to deliver the baby through the birth canal
WMNODN	West Midlands Neonatal Operational Delivery Network

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Hearing the voices of staff

Provided to the review team by the Trust

Appendix 5: Terms of reference (TOR)

Original terms of reference as of May 2018

An independent review of the quality of investigations and implementation of their recommendations relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust).

The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary **REVIEW TEAM** of independent external reviewers who will submit their findings to an **INDEPENDENT REVIEW PANEL**.

The **REVIEW TEAM** will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary **REVIEW TEAM** will undertake to:

- Review only those cases for which consent is granted to access the records pertaining to the case;
- Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
- Consider how the parents, patients and families of patients were engaged with during these investigations;
- Reserve the right to undertake a second-stage review of primary cases should the considerations

above justify such action following agreement with the Executive Medical Director NHS Improvement and

- Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The **INDEPENDENT REVIEW PANEL** will undertake to:

Receive and quality assure the **REVIEW TEAM's** findings in each case reviewed;

- Under the leadership of the chair, develop the report of the findings of the review and
- Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review's findings and recommendations.

In addition the **INDEPENDENT REVIEW TEAM** will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:

- A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
- A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
- Contact with parents or relatives to establish their understanding of their involvement in previous investigations.

The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

The Review Panel

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manger from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/ neonatologist
- NHS England midwifery representative from outside the region.

Key Principles

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

Timeframe

The final review report and proposals should ideally be available within one month of the review being completed.

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. Did the Trust have in place at the time of each incident mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?
2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?
3. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?
4. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 6: Revised terms of Reference (TOR)

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.
2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospital (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.
3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

   a. appropriate investigations were conducted; and

   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.
6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.
7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.
8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be review

Review approach

10. The multidisciplinary Review Team will:

a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;

b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;

c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;

d. Consider how the parents, patients and families of patients were engaged with during these investigations;

e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and

f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:

a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Appendix 7: Review team members

Ms Donna Ockenden – Director, Donna Ockenden Limited, Chair of the review.

Donna Ockenden was assisted and supported by the following team members (In alphabetical order from their first name):

Obstetricians

Mr Alexander Taylor – from June 2020

Dr Anthony Falconer – from November 2018 until September 2020

Dr Antoinette Johnson – from March 2021

Dr Austin Ugwumadu – from July 2020

Dr Bode Williams – from April 2021

Dr Bronwyn Middleton – from November 2020

Dr Clare Tower – from March 2021

Professor Dharmintra Pasupathy – from October 2019

Dr Elisabeth Peregrine – from February 2021

Dr Heather Brown – from November 2018 until June 2020

Dr Joanne Page – from November 2020

Dr Jonathan Frappell – from December 2019 until March 2021

Dr Louise M Page – from November 2018 until October 2020

Dr Karin Leslie – from August 2020 until March 2021

Dr Marwan Salloum – from August 2020

Dr Matthew Cauldwell – from January 2021

Dr Michael Magro – from March 2021

Dr Nikki Jackson – from October 2020

Dr Paula Galea – from September 2020

Dr Penny Law – from November 2018 until June 2021

Dr Rachel Marshall-Roberts – from September 2020 until November 2021

Mr Richard Howard – from November 2018

Dr Sandra Newbold – from January 2020

Dr Umber Agarwal – from April 2021

Midwives

Amanda Mansfield – from November 2018 until June 2020 and from March 2021

Amanda Davey – from May 2017

Angela Frankland – from May 2021

Angie West – from May 2017

Bronwen Grigg – from January 2021

Caroline Clarke – from May 2017

Carolyn Romer – from November 2018 until August 2021

Ceri Staples – from September 2020

Charlotte James – from July 2019 until January 2022

Helen Harling – from December 2020 until May 2021

Helen Smith – from March 2020

Jacqueline Oliver – from May 2019

Jane Patten – from May 2017

Jessica Scoble – from September 2019 until September 2020

John Bell – from July 2019

Julie Jones – from November 2018

Dr Kate Nash – from April 2020

Kerry Madgwick – from January 2021

Kerry Thompson – from June 2020

Konstantina Stavrakelli – from September 2020

Lauren Graham – from September 2020

Merida Sculthorpe – from November 2020

Natalie Adams – from September 2020

Nicola Rose-Stone – from November 2019 until November 2020

Teresa Manders – from October 2019

Tina Spiers – from October 2020

Neonatologists

Dr Alison Jobling – from April 2020 until October 2021

Dr Chris Day – from March 2021

Dr Charlotte Groves – from November 2018 until June 2020

Dr Eilean Crosbie – from March 2021

Dr Huw Jones – from November 2018 until March 2021

Dr Lawrence Miall – from March 2021

Dr Michelle Parr – from March 2021

Dr Michael Hall – from March 2019

Professor Minesh Khashu – from June 2021

Dr Ngozi Edi-Osagie – from March 2021

Dr Paul Crawshaw – from February 2019

Dr Ranganna Ranganath – from April 2021 until October 2021

Dr Ryan Watkins – from December 2018 until March 2021

Dr Sarah Davidson – from July 2021

Dr Sunita Seal – from April 2021

Dr Tosin Otunla – from February 2020

Dr Vimal Vasu – from February 2019 until September 2020

Paediatricians

Dr David Gibson – from August 2021

Professor Ian Maconochie – from November 2018 until June 2021

Dr Julian Sandell – from March 2019 until April 2021

Obstetric Physician

Dr Anita Banerjee – from November 2018

Anaesthetist

Dr Andrew Combeer – from February 2021

Dr Elizabeth Combeer – from February 2021

Dr Renate Wendler – from November 2018

Neurologist

Dr Sean J Slaght – from December 2019

Cardiologist

Dr Richard Jones – from May 2020

Intensivist

Dr Phil Young – from July 2020 until March 2021

Dr Frank Schroeder – from May 2021 until December 2021

Family Support and Psychology Provision for Families

Maternity Review Psychology Service, hosted by Midlands Partnership NHS Foundation Trust

Dr Katie Bohane – Lead for Psychology Service from January 2021

Dr Katie Woodward – Clinical Psychologist from April 2021

Eloise Lea – Clinical Psychologist from April 2021

Emma Campbell – Assistant Psychologist from October 2021

Dr Kirsty Langley – Clinical Psychologist from July 2021

Dr Rachel Lucas – Trust Recovery Lead and Director of Psychological Services from June 2020

Dr Ursula Bacon – Clinical Psychologist from September 2021

Dr Victoria Caines – Clinical Psychologist from November 2021

SANDS – Stillbirth and neonatal death charity

Dr Clea Harmer – Chief Executive of Sands from January 2021

Jen Coates – Director of Bereavement Support and Volunteering from June 2020

Maria Huant – Bereavement Support Services Manager from June 2020

Bereavement Training International

Paula Abramson - Bereavement Training International and lead for the Listening Ear Service from June 2020

CBUK – Child Bereavement UK

Ann Chalmers – CEO, Child Bereavement UK from June 2020

Karen Smith – PA to the Chief Executive & Executive Manager from June 2020

Sarah Harris – Director of Bereavement Support and Education from November 2021

Administrative support provided by:

Aimee Humphrey - Administration for the Maternity Review from May 2021

Barbara Watkinson – Administration for the Maternity Review from April 2019 until July 2020

Charlotte Lidster – Administration for the Maternity Review from January 2020 until December 2020

Michelle Wright – First Rate PA, Administration for the Maternity Review from April 2018

Monika Niziol – Administration Assistant to Donna Ockenden the Chair of the Maternity Review from July 2020

Rebecca Jones – Administration Assistant for the Maternity Review from October 2020 until December 2021

Sara Kempton-Hayes – Administration for the Maternity Review from February 2019 until July 2020

Zoe Bolt – Administration for the Maternity Review until September 2018

HR and Employment Law specialist:

Dianne Lambdin, Director Sussex HR Hub Ltd

Communications and media support provided by:

Kristianah Fasunloye – Astraea PR

Shaline Manhertz – Exceeding your potential

Kim Inam – Editing and proofreading

Kirsa Wilkenschildt - Graphic design

Pam Rene – Events support and logistics

Ben Cloud – Millstream Productions, film and video production

Louis Dady – Millstream Productions, film and video production

Legal advice was provided by Gowling WLG:

Nicholas Cunningham

Patrick Arben

Sarah Grey

Claire Van Ristell

Finance support

Jane Blaber – Liberty Bookkeeping

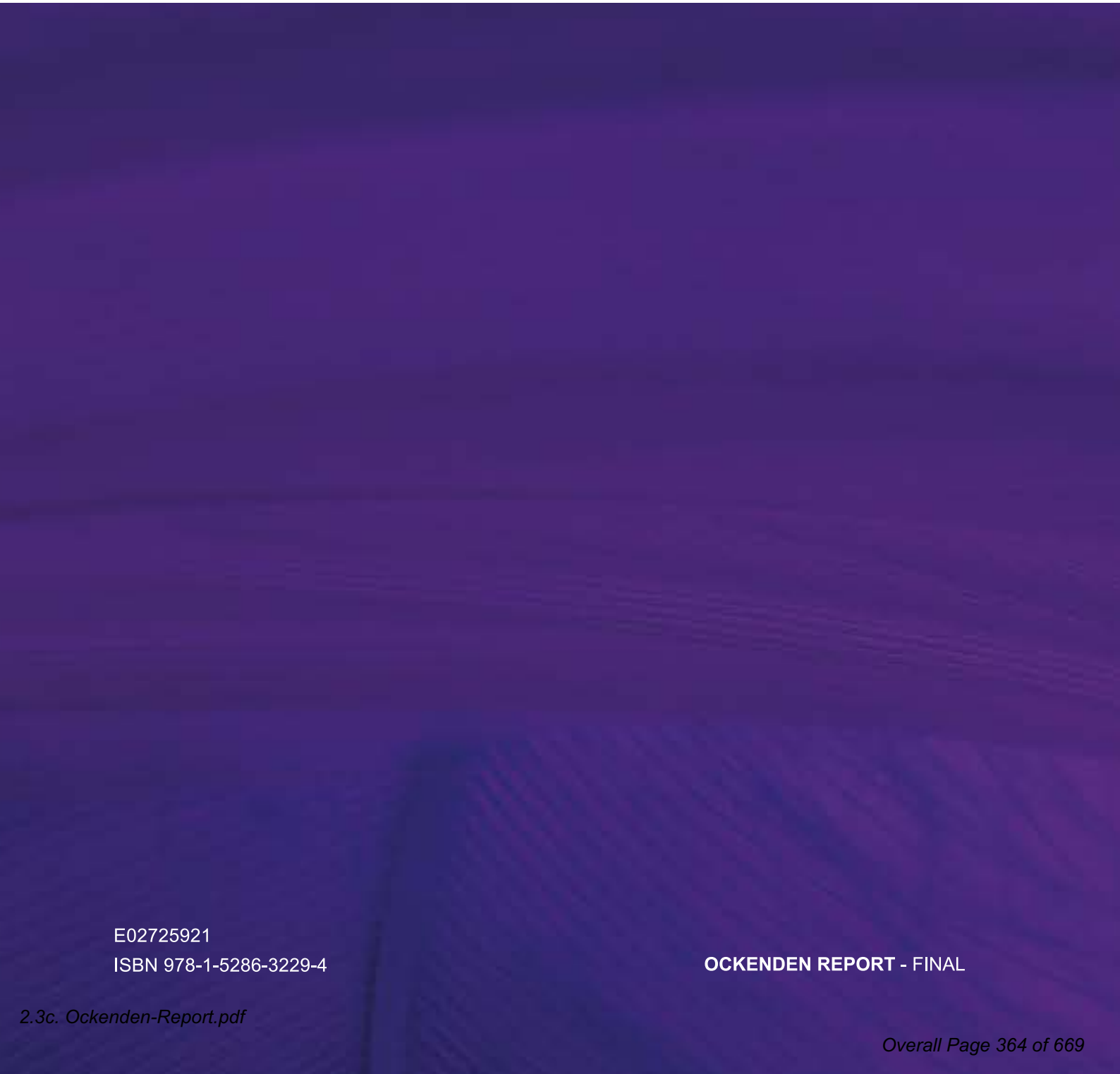
Carol Warmington – Specialist Payroll Services

Hilary Julian – Maximus Accountancy Services Limited

IT support

VENOM IT – IT services provider

Samuel Thompson – Samuel Thompson Corporate Ltd – Website design



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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors (Public) 5th May 2022

AGENDA ITEM NO.	2.4
TITLE OF REPORT	Staff Survey Results and Improvement Plan
AUTHOR NAME AND ROLE	Sam Slaytor – Head of Wellbeing, Inclusion and Engagement Karen Adewoyin – Deputy Director of People and OD
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith – Interim Director of HR
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	The report gives a detailed summary of the Trusts 2021 staff survey results and the themes and response to key questions. The Trust has in place its newly developed People Strategy with clear programmes of work and a number of key plans in place, therefore throughout the discussions that have been undertaken in Divisional forums and at specific committees, such as Workforce Development Committee and People and OD Committee the focus has been on understanding out staff feedback and agreeing what key actions needs to take place above and beyond what is already in place based on this year's results. The report highlights progress against our People Strategy plans and specific elements of the People Promise, which the staff survey now feeds back on, highlighting progress at an organisational level and also an update on the progress made through the Divisional led work as a result of last year's feedback.
REPORT HISTORY Committees/Meetings where this item has been considered)	See table below
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	47% of our staff completed the survey last October which is 3025 members of staff having their say about working with us through what has been another very challenging year. The report compares us as an organisation to 126 other Acute and Acute and Community Trusts across the country, where the median response rate was 46% and 444,326 staff responded in total. There are some changes to the 2021 reporting to be aware of, the main one being from this year the questions in the NHS Staff Survey are aligned to the People Promise. In the reports, scores relating to the

Name of Committee	Date of Meeting	Outcome
Workforce Development Committee	21st March 2022	Initial survey results reviewed
People and OD Committee	29th March 2022	Initial discussion in relation to results and areas of focus
Workforce Development Committee	20th April 2022	Review of performance across London, comments report and progress against Divisional pledges

	seven elements of the People Promise replace the old theme scores (with the exception of Staff Engagement and Morale). The reporting will now be reflected in this way at least for the next 5 years, which was the timeline set out for NHS organisations to deliver on the people promise for all staff. There is also a completely new section on burnout, which has 7 questions which is based on the Copenhagen index research tool, which is a valid and robust measure of "burnout" which the GMC trainee survey also uses. The seven People Promise elements are: • We are compassionate and inclusive • We are recognised and rewarded • We each have a voice that counts • We are safe and healthy • We are always learning • We work flexibly • We are a team Last year as an organisation we focused on areas we were below average, EDI, H&W, Morale and safe environment. This year the Trust is above average for learning, safety culture and staff engagement, average for Compassionate and inclusive, Recognised and Rewarded, having a voice, safe and healthy, team working and morale. We are below average for just one area which is flexible working. Acute trusts in London have unsurprisingly seen more challenging results in general than mental health and community Trusts. What is encouraging when looking at the London picture for Acute Trusts is across the 7 people promise elements and for engagement and morale, as a Trust we are scoring in the top 3 for compassionate and inclusive and recognised and rewarded, we are a team and staff engagement and top 4 for having a voice, safe and healthy, always learning. The two areas where we don't compare as favourably in the context of London Acute's is we work flexibly and morale. It is also worth noting that 56.4% of staff responding had worked on a COVID ward compared to 43.6% and 32.5% had been redeployed compared to 20.4% and 25.1% had worked remotely compared to 20.6% average. In the main report the themes are also broken down by where staff worked over the pandemic and compassionate and inclusive, recognised and rewarded, we have a voice that counts, and we are safe and healthy, we work flexibly, we are a team, all lowest for those redeployed or on COVID area, highest for those working from home, except for we are always learning which was higher for those working on COVID or being redeployed and lowest for those working at remotely. The report details progress against our People Strategy across our 4 key areas, of Looking After our People, Belonging, New Ways of Working and Growing for our Future and delivering our People Promise and making all of our staffs experience of working with us a great one, with specific focus on: • We are Compassionate and Inclusive – delivering our EDI and leadership plans • We are recognised and rewarded - rolling out our new people recognition programme and team events

	• We are safe and healthy – delivery of our Year 2 H&W programme and our focus on staff safety in terms of violence and aggression • We work flexibly – delivering our Timewise Action Plan The report highlights the additional data sets which are being reviewed at various meeting, and our staff networks. This includes differences by Division, department, by band, staff group, age, and protected characteristics, and highlights some clear areas of difference in experience and areas of focus for our plans. The comments report, is really helpful for us to understand more meaningfully what staff have to say, 653 of our people took the time to write their thoughts. Overall 47% of the feedback was positive it shows the frequent mentions and whether positive, neutral and the strength of sentiment. My job was the most common theme mentioned 698 times, followed by the organisation, H&W and my team. The report highlights some of the comments made, some very positive comments from people, whilst also highlighting some real concerns from staff. Not unexpectedly due to pandemic but clearly main concerns from the comments report rest around workloads, staffing challenges, hours expected to work. H&W encouraging to see support positive but the main issues relate to stress, pressure and long hours. Each triumvirate have been sent non-identifiable comments to support local planning. In addition to Trust wide led work, HRBP's have worked with Divisions to review the departmental and Divisional results and reflect and review on the staff pledges made in specific areas and if improvements have been made, and start to develop this year's local plans, including any listening and feedback events. The report highlights communications and engagement plans and a key timeline of activity leading to the 2022 staff survey in October 2022. The report also highlights the additional feedback mechanisms in place and some of the findings from the monthly Pulse and joiner and leaver feedback, to ensure triangulation and more regularly track progress.
KEY RISKS ARISING FROM THIS REPORT	Risks relate to areas where improvements are needed and also highlight the impact of the pandemic on our staff.

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	
Be the employer of Choice	Y
Deliver better care at lower cost	

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

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

2021 Staff Survey Results and Improvement Plan

Board of Directors Meeting

5th May 2022

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

We each have **a voice that counts**

Contents

- 2021 Staff Survey Results
- Comparison to 2020
- Comparison across London
- Areas of strength and areas of focus
- Analysing the detail and our peoples feedback
- Our People Strategy and People Promise
- Key achievements during the Year
- Delivering the People Strategy – Progress to Date
- Divisional Led Plans
- Communications and Engagement Plans
- Regularly listening to staff through feedback mechanisms

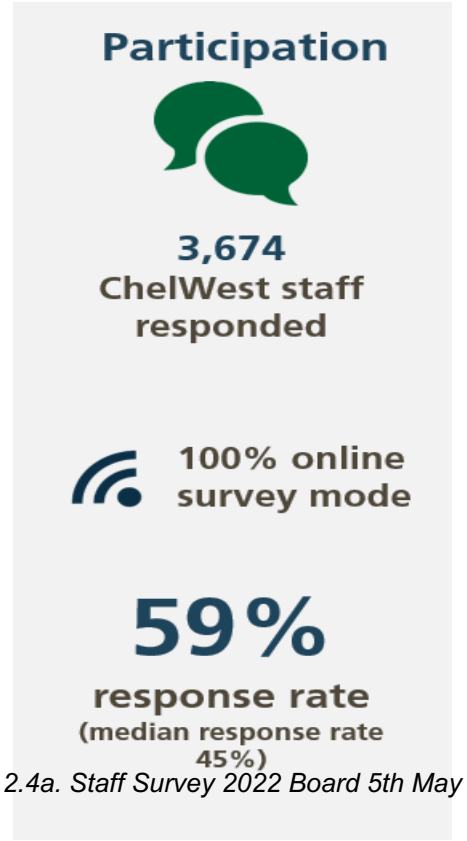
Appendices

- Appendix 1 - Key trends
- Appendix 2 – Further analysis

Staff Survey Findings 2021: Trust Level Summary

Our response rate was 12% lower compared to 2020

The 2020 response rate:



Survey Coordination Centre

Organisation details

NHS

Chelsea and Westminster Hospital NHS Foundation Trust

2021 NHS Staff Survey

Organisation details

Completed questionnaires	3,025
2021 response rate	47%

See response rate trend for the last 5 years

Survey details

Survey mode	Online
Sample type	Census

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2021 benchmarking group details

Organisations in group: 126

Median response rate: 46%

No. of completed questionnaires: 444,326

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Staff Survey 2021: Changes

Its more difficult to compare and contrast our staff survey changes as 2020 was not aligned to the people plan and the staff survey results for 2021 are:



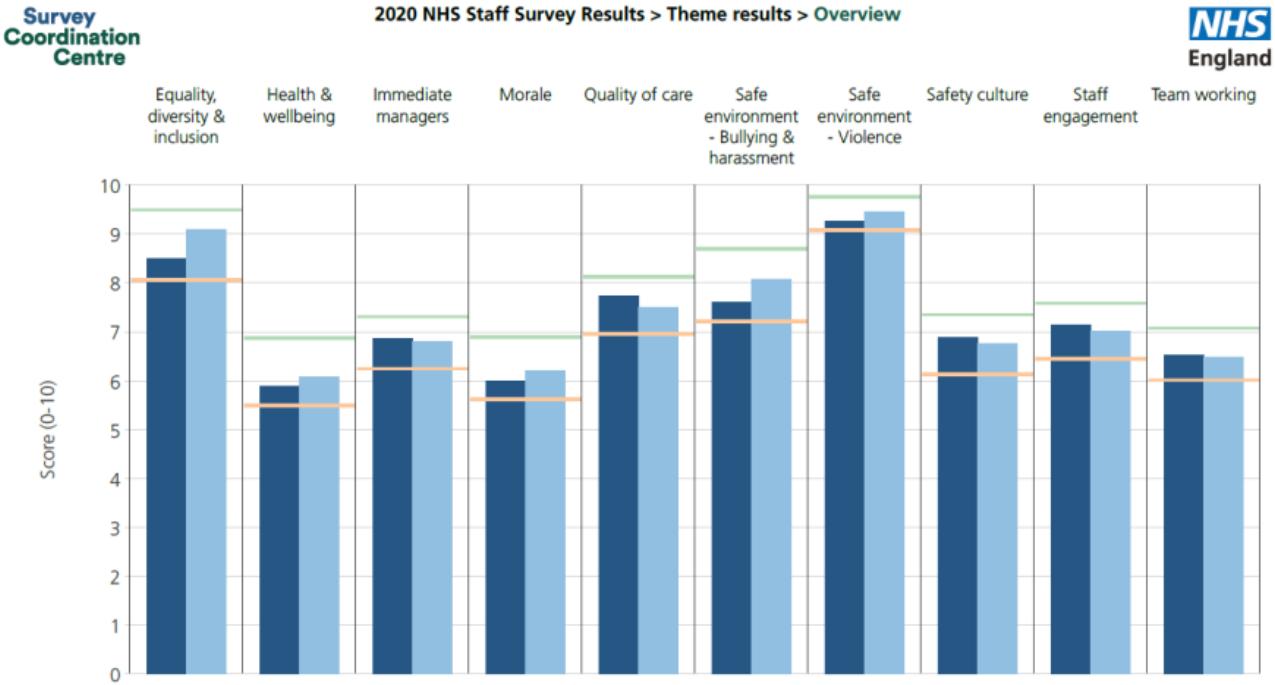
Staff Survey Findings 2020: Trust Level Summary

Above average:

- Immediate managers
- Quality of care
- Safety culture
- Staff engagement
- Team working

Below average:

- EDI
- H&W
- Morale
- Safe environment



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

Staff Survey Findings 2021: Trust Level Summary

Above average:

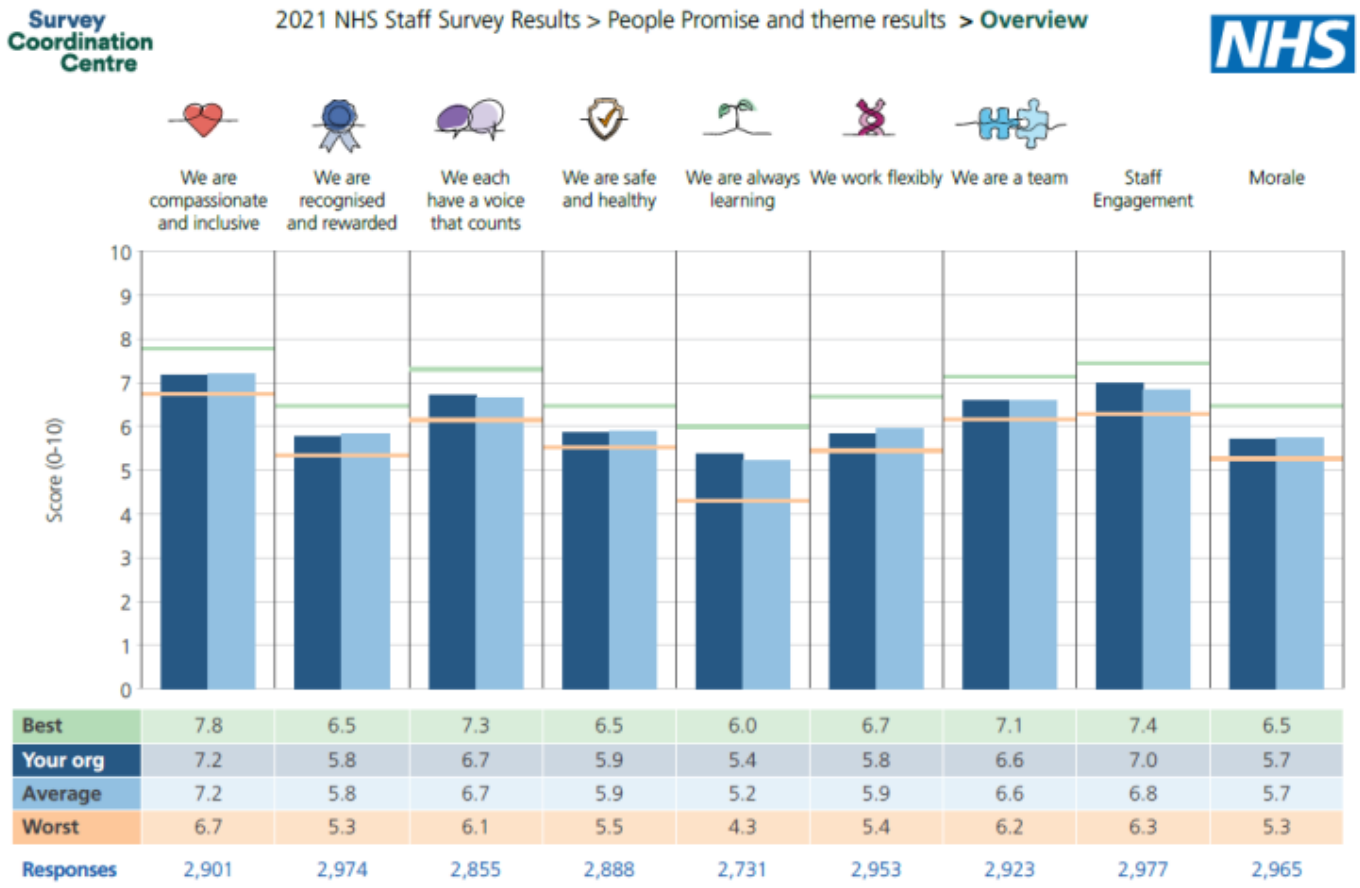
- Learning
- Staff engagement

We are average:

- EDI
- R&R
- Safe and healthy
- Team working
- Morale

Below average:

- Flexible working



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.2	5.8	6.7	5.9	5.4	5.8	6.6	7.0	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,901	2,974	2,855	2,888	2,731	2,953	2,923	2,977	2,965

London Comparison

Recommending the Trust as a place to work

Overall Staff Engagement Scores

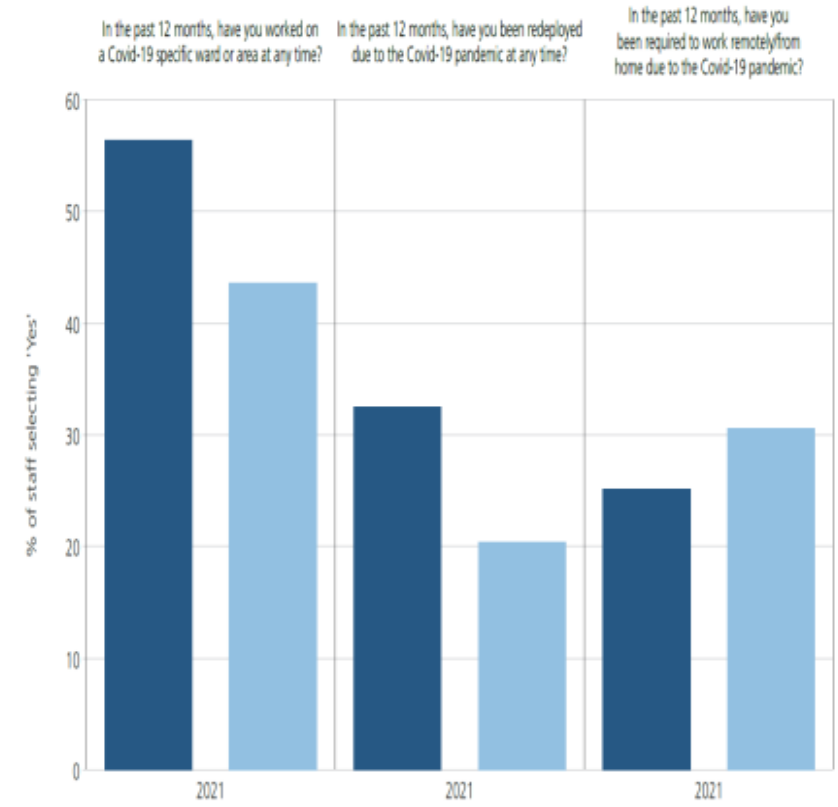
All London

Trust	2016	2017	2018	2019	2020	2021	Change 2020 to 2021
University College London Hospitals NHS Foundation Trust	70%	71%	69%	72%	78%	74%	-4.1
Guy's and St Thomas' NHS Foundation Trust*	79%	78%	77%	78%	81%	73%	-7.3
Chelsea and Westminster Hospital NHS Foundation Trust	63%	69%	72%	70%	71%	67%	-3.8
Homerton University Hospital NHS Foundation Trust	70%	67%	68%	67%	69%	65%	-3.5
Imperial College Healthcare NHS Trust	61%	66%	61%	67%	71%	64%	-7.0
Kingston Hospital NHS Foundation Trust	69%	71%	74%	73%	75%	62%	-12.5
Royal Free London NHS Foundation Trust	62%	61%	62%	62%	69%	61%	-7.4
Barts Health NHS Trust	58%	57%	63%	62%	66%	60%	-6.1
Whittington Health NHS Trust	58%	59%	59%	63%	66%	59%	-7.1
Epsom and St Helier University Hospitals NHS Trust	59%	57%	57%	62%	64%	59%	-5.6
St George's University Hospitals NHS Foundation Trust	51%	59%	57%	61%	67%	58%	-8.7
Croydon Health Services NHS Trust	55%	57%	54%	59%	61%	56%	-5.6
Lewisham and Greenwich NHS Trust	60%	51%	58%	60%	60%	56%	-4.7
London North West University Healthcare NHS Trust	52%	54%	53%	54%	59%	55%	-3.7
King's College Hospital NHS Foundation Trust	55%	57%	55%	56%	60%	55%	-4.7
North Middlesex University Hospital NHS Trust	53%	57%	59%	64%	60%	53%	-6.6
Barking, Havering and Redbridge University Hospitals NHS Trust	59%	56%	53%	57%	54%	49%	-5.2
The Hillingdon Hospitals NHS Foundation Trust	63%	62%	55%	54%	50%	46%	-3.5



- We have scored higher than average for staff engagement when compared to all Acute and Community Trusts across the country and across London we are in the top 3 Acute Trusts for staff recommending their employer as a place to work, noting all Acute Trusts have seen a decline, due to the challenging year.
- Across the 7 People Promise elements and for engagement and morale as an Acute Trust in London we are scoring in the top 3 out of the 18 Trusts for compassionate and inclusive, recognised and rewarded, we are a team and staff engagement, top 4 for having a voice, safe and healthy and always learning. The two areas where we do not compare as favourable are morale and flexible working.

COVID-19 Pandemic



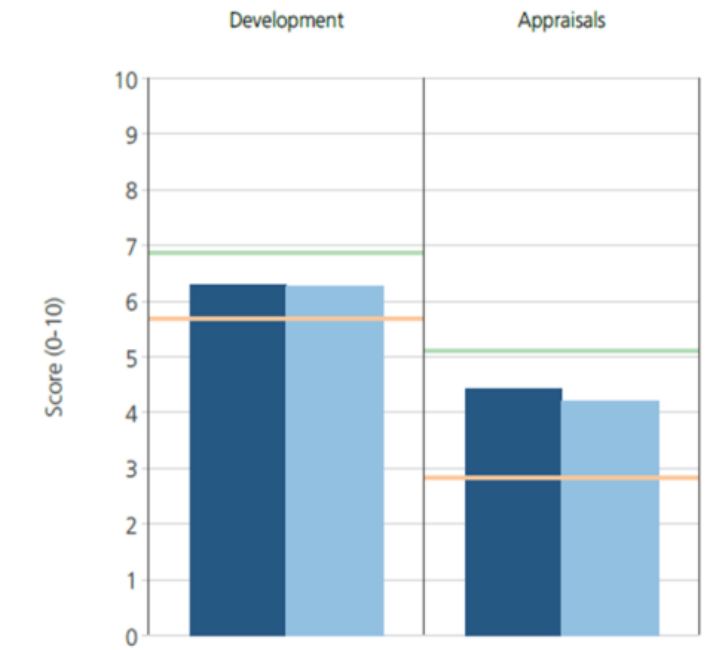
Your org	56.4%	32.5%	25.1%
Average	43.6%	20.4%	30.6%
Responses	2,871	2,859	2,864

- 56.4% of staff responding had worked on a COVID ward compared to 43.6% and 32.5% had been redeployed compared to 20.4% and 25.1% had worked remotely compared to 20.6% average.
- In the main report the themes are also broken down by where staff worked over the pandemic and compassionate and inclusive, recognised and rewarded, we have a voice that counts, and we are safe and healthy, we work flexibly, we are a team, all lowest for those redeployed or on COVID area, highest for those working from home, except for we are always learning which was higher for those working on COVID or being redeployed and lowest for those working at remotely

Areas of Strength

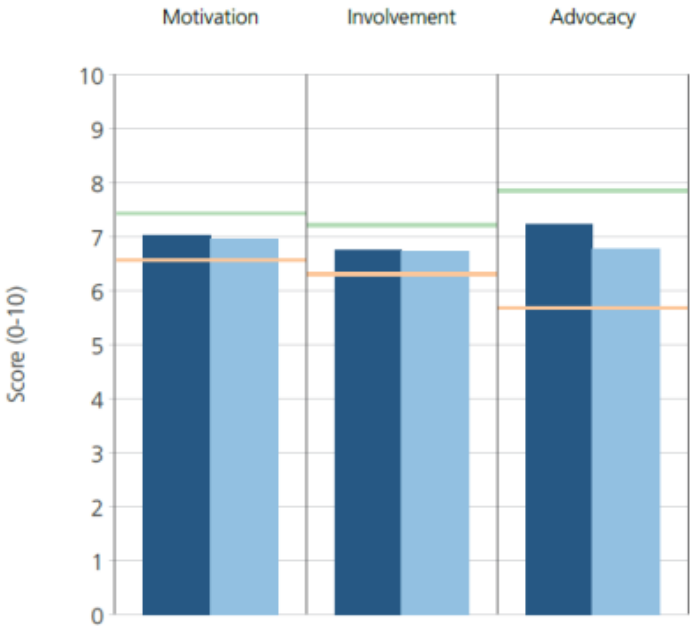
- We have maintained a strong staff engagement score and are above average for we are always learning, with a higher than average score for appraisals.

Promise element 5: We are always learning



	Development	Appraisals
Best	6.9	5.1
Your org	6.3	4.4
Average	6.3	4.2
Worst	5.7	2.8
Responses	2,882	2,746

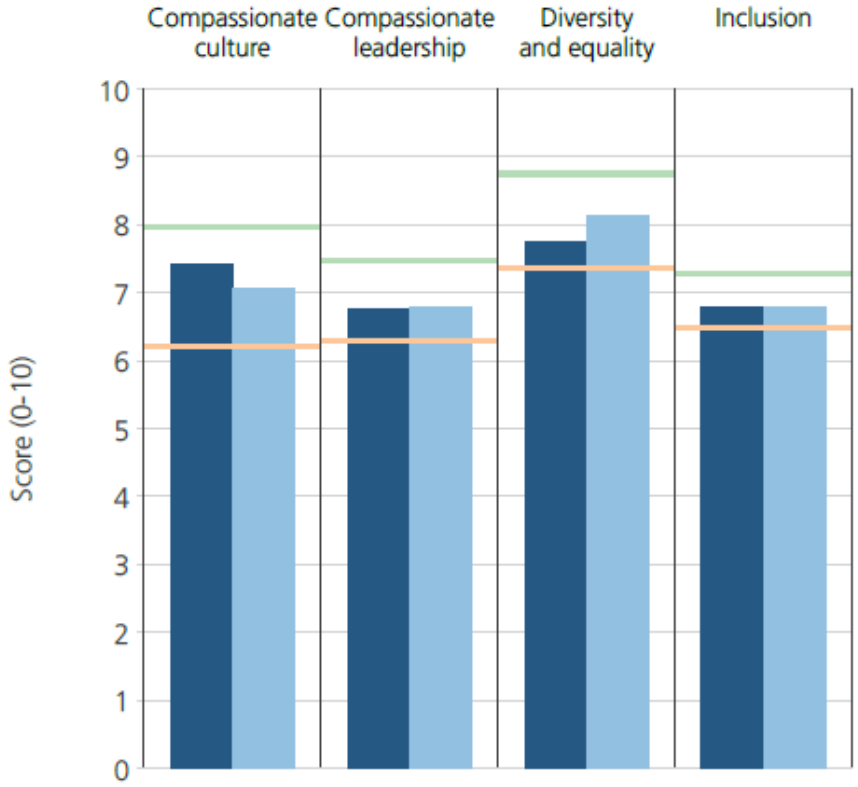
Staff Engagement



	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.0	6.8	7.2
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	2,958	2,976	2,874

Our Continued Areas of Focus

Promise element 1: We are compassionate and inclusive

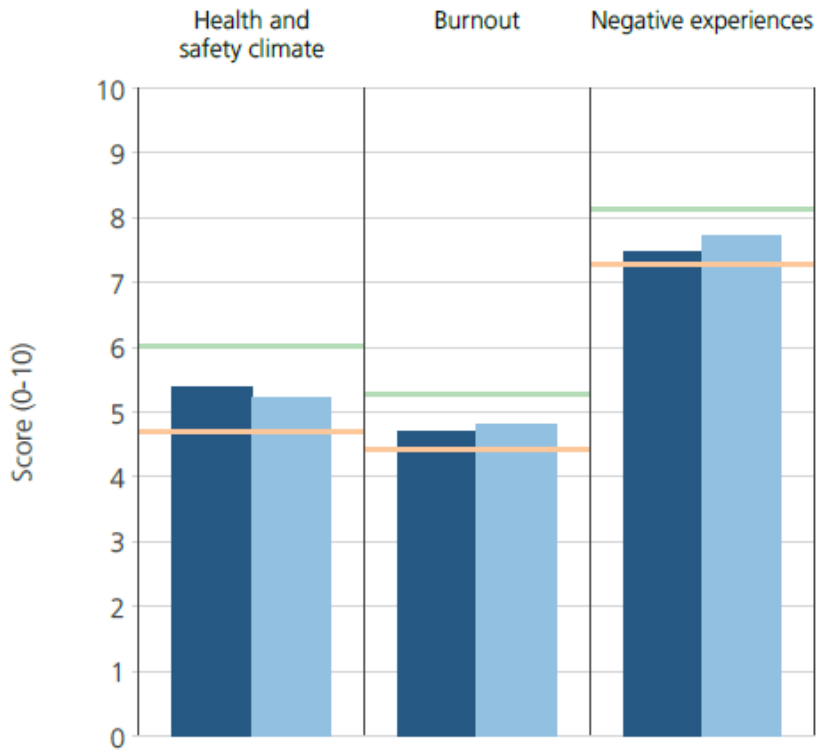


	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Best	8.0	7.5	8.8	7.3
Your org	7.4	6.8	7.7	6.8
Average	7.1	6.8	8.1	6.8
Worst	6.2	6.3	7.4	6.5
Responses	2,874	2,920	2,898	2,937

- Although we have made improvements around our compassionate culture and score higher than average in this area we still have more to do across the Trust to ensure diversity and equality is felt for all of our staff and our results show that for some staff groups their experience is worse than others.
- The Board agreed the Trust's 3 year EDI strategy and there is a clear programme of work continuing in year 2 of the plan.

Our Continued Areas of Focus

Promise element 4: We are safe and healthy

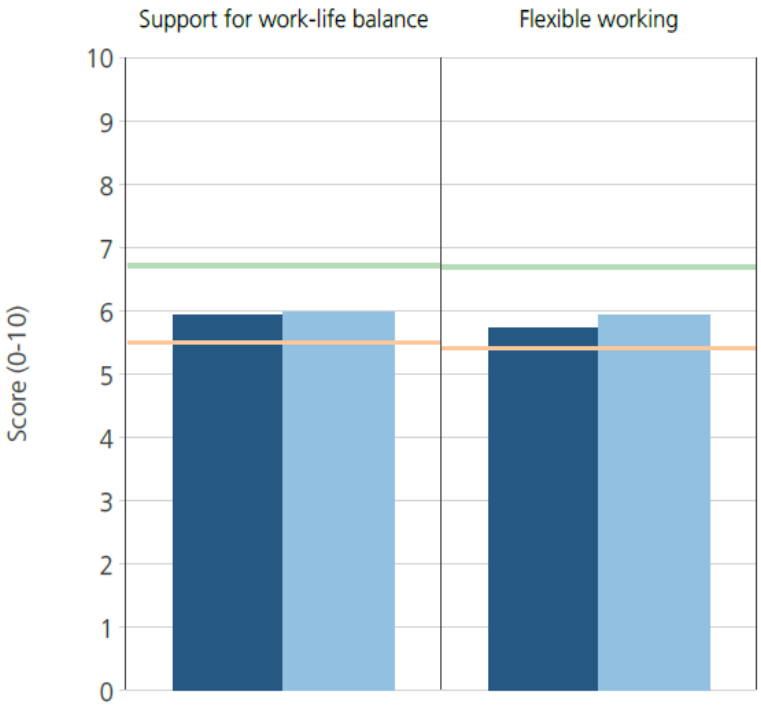


	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.4	4.7	7.5
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	2,977	2,908	2,896

- It is positive that 58 % of our staff now feel our organisation takes positive action on H&W which is above average, given all the investment and commitment to our 3 year health and wellbeing programme.
- The main issues not just in our organisation but across the board relate to being able to meet conflicting demands, having enough staff to do jobs well, and the questions on burnout, finding work exhausting worn out at the end of a shift. Within this area we are also well above average for abuse from patients 33.9% and also have the highest score for physical violence against staff 14.9% of staff compared to average of 6.9%, we have obviously been recognised for our Kindness campaign.
- positive by managers has declined since 2019 from 15.6 to 13.1%, but from other work colleagues this has increased to 21.8%.
- We have a good safety culture at the Trust but our staff are feeling burned out and are having negative experiences.

Our Areas for a Refreshed Focus

Promise element 6: We work flexibly

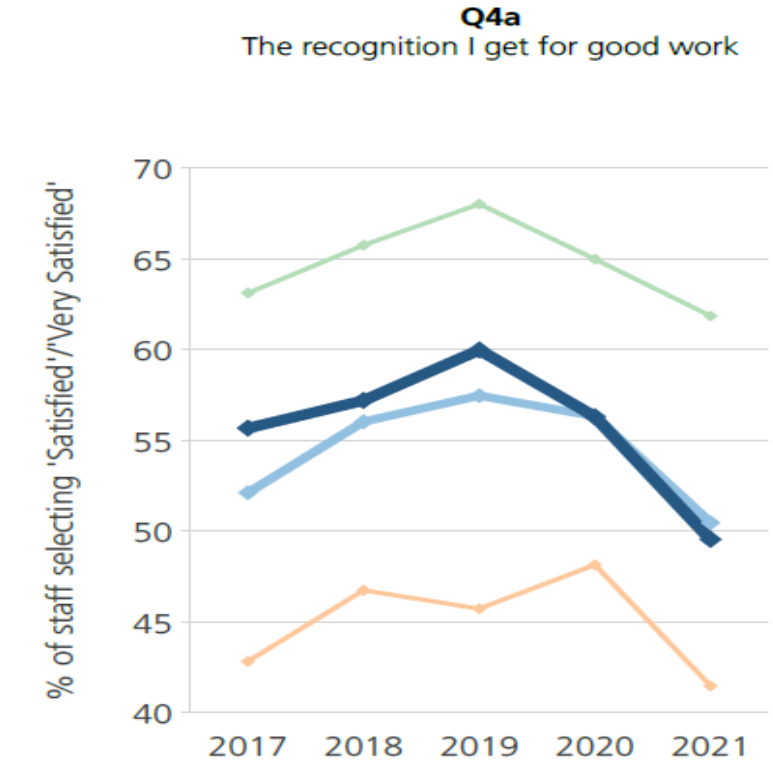


	Support for work-life balance	Flexible working
Best	6.7	6.7
Your org	5.9	5.7
Average	6.0	5.9
Worst	5.5	5.4
Responses	2,963	2,966

- We score below average for working flexibly and even when compared to other London Acute Trusts have a lower score and we will need to ensure we have more programmes of to improve the experience of our staff and their work life balance, set against challenging recovery plans.

- Ways in which we can do this is through our approach across the divisions to flexible working, rostering, role design and though our Timewise accreditation programme action plan which was approved by Executive Management Board prior to wave 4 of the pandemic.

Our Areas for a Refreshed Focus

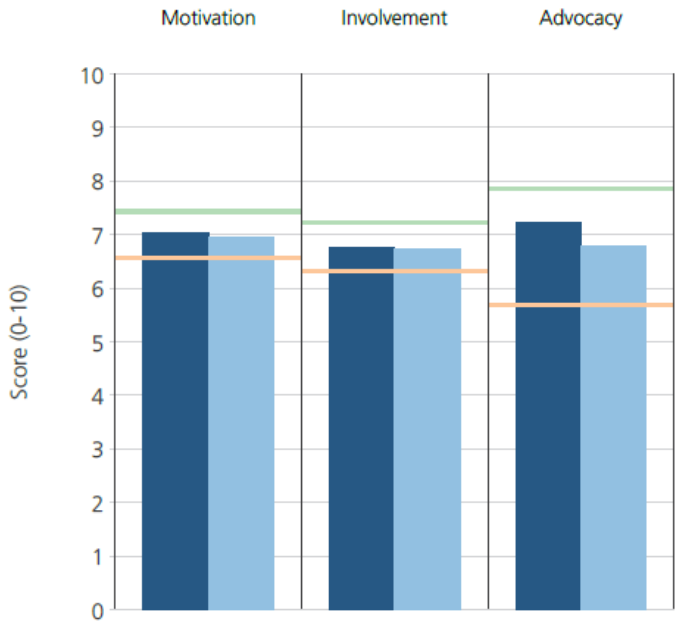


	2017	2018	2019	2020	2021
Best	63.1%	65.8%	68.0%	65.0%	61.9%
Your org	55.7%	57.2%	60.0%	56.3%	49.5%
Average	52.1%	56.0%	57.5%	56.3%	50.5%
Worst	42.8%	46.7%	45.7%	48.1%	41.5%
Responses	1,726	2,302	2,719	3,597	2,961

- For recognised and rewarded, across the board downward trends since 2019, the Trust remains above average for the extent the organisation values my work but less so for recognition at individual level and from immediate manager.
- In April the Workforce Development Committee agreed a new approach to reward and recognition which includes more focus on individual level recognition, as well as the Trust wide programmes, such as restarting our annual STAR awards, long service awards, monthly awards and instant recognition.

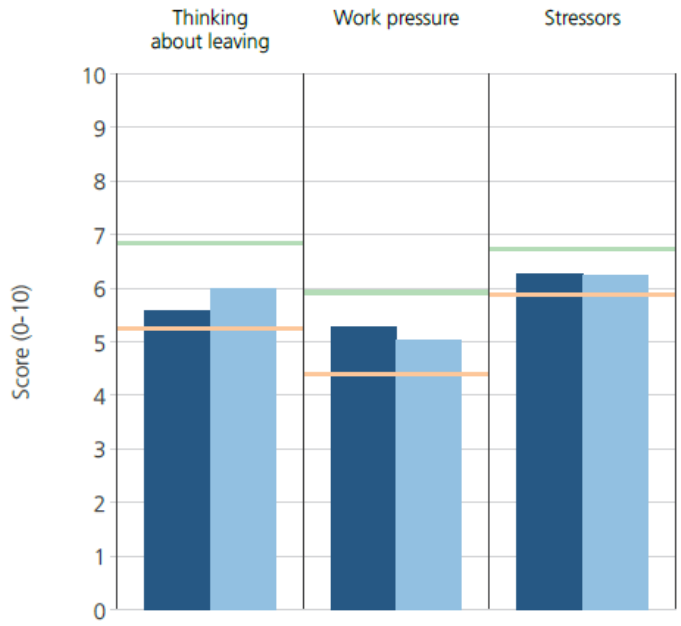
Areas where we have mixed messages

Staff Engagement



	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	7.0	6.8	7.2
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	2,958	2,976	2,874

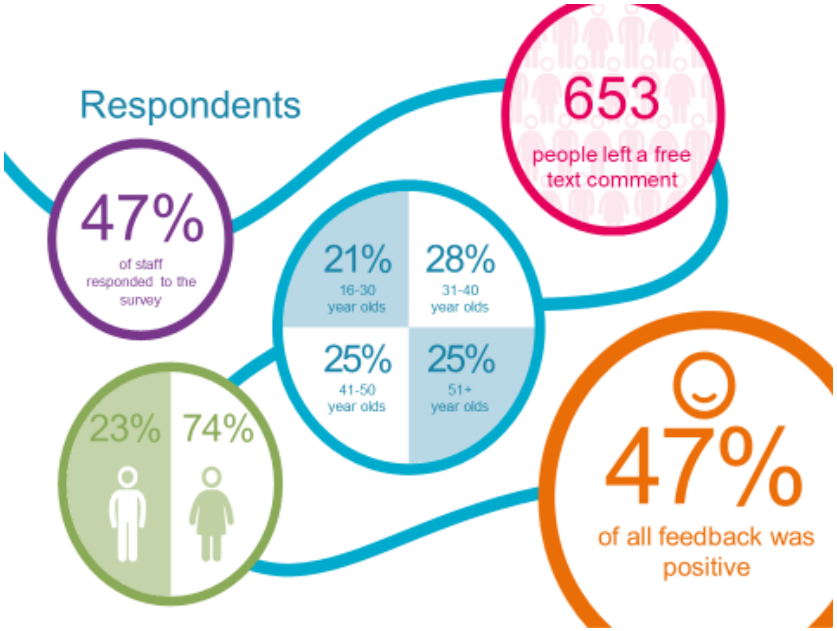
Morale

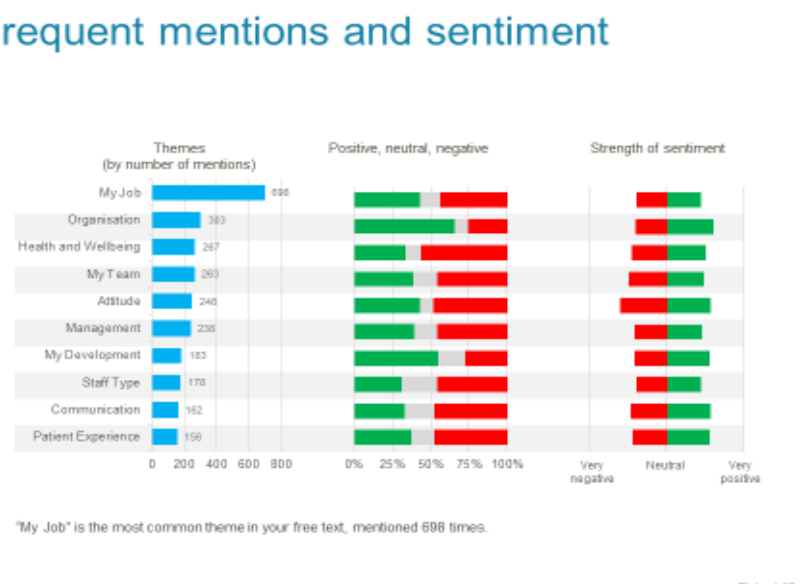


	Thinking about leaving	Work pressure	Stressors
Best	6.8	5.9	6.7
Your org	5.6	5.3	6.3
Average	6.0	5.0	6.2
Worst	5.2	4.4	5.9
Responses	2,848	2,978	2,954

- We are above average for Staff Engagement but have challenges with staff morale, hence the area of focus being on recognition of our staff.

People Feedback Report





- The comments report, is really helpful for us to understand more meaningfully what staff have to say, 653 of our people took the time to write their thoughts.
- Overall 47% of the feedback was positive and the Workforce Development Committee has reviewed the full report which includes the frequent mentions and whether positive, neutral and the strength of sentiment. My job was the most common theme mentioned 698 times, followed by the organisation, Health and Wellbeing and my team. The report highlights some of the comments made, some very positive comments, whilst also highlighting some real concerns from staff. Not unexpectedly due to pandemic but the main concerns from the comments report rest around workloads, staffing challenges, hours expected to work. For health and wellbeing it is encouraging to see support positive but the main issues relate to stress, pressure and long hours. The comments report has also been prepared at Divisional level, which each triumvirate have been reviewing to support departmental and Divisional led plans

Our People Strategy

Our People Strategy sets out our people agenda with clear performance measures, our baseline position and our ambition for, 22/23 this includes compassionate and inclusive leadership, our EDI plan, continuing year 2 of our health and wellbeing plans, growing our workforce and supporting new ways of working.

How we will measure our success

Strategic goal	Key themes of people plan	Performance measure	2020/21 baseline	2023/24 ambition
To be the Employer of Choice	Looking after our people ICS Goal 1 – Care *We have a happy, healthy and engaged workforce.*	H&W Staff Survey result	5.9	6.1
		Voluntary turnover of staff	18%	10%
		Sickness (average days)	5.8	5
		% of staff coming in despite being unwell	47.7%	40%
		Uptake of health and wellbeing offers	<2%	>10%
	Belonging in the NHS ICS Goal 2 – Lead ICS Goal 3 - Include *We care and staff report positive experiences and we are inclusive and succeed because of our differences.*	EDI staff survey score	8.5	9.1
		WRES/WDES/Gender Pay Gap Improvements	6 WRES + 10 WDES 3 grades not met target	Positive improvement in all indicators (outlined in Belonging section)
		Increase in numbers of BAME staff in Bands 8a and above	Disproportionate 3 grades not met target	All grades meeting set targets
		Staff Survey engagement score	7.1	7.4
	New ways of working and delivering care ICS Goal 4 – Transform *We have the skills to deliver 21st Century Care.*	Number of staff transitioning to qualified posts	<20	>70
		Increase in new roles (Physician Associate and Nursing Associate)	<1%	>5%
		Flexible working staff survey score	56%	65%
		e-job planning implemented	Not yet implemented	65% of consultants and SAS doctors have e-job plan by March 2022, 100% by 2024
		Number of staff using e-roster	82%	100%
	Growing For the Future ICS Goal 3 – Grow *We have the capacity to deliver great care.*	Utilisation of the apprenticeship levy	39%	70%
		% of volunteers into employment	4.5%	10%
		Increased local employment	Not currently measured	10%
		Reduced vacancy rates in core professions	N&M 5.5%, M&D 3% AHP 6%	N&M 5-8%, M&D <5%, AHP <7%

The Year Ahead……

- The year ahead will be focused on the delivery of the 4 key elements of our People Strategy.

- We will be focused on delivering our People Promise and making all of our staffs experience of working with us a great one, with specific focus on:

- We are Compassionate and Inclusive – delivering our EDI and leadership plans
- We are recognised and rewarded - rolling out our new people recognition programme and team events
- We are safe and healthy – delivery of our Year 2 H&W programme and our focus on staff safety in terms of violence and aggression
- We work flexibly – delivering our Timewise Action Plan



Key Successes over the past year

90% of our staff fully vaccinated

Maintained low vacancy rates

New Acceptable Behaviour Policy and introduced staff safety champions to support, new Kindness campaign to support reduction of violence and aggression

33% of staff on our new MBA and 45% on the new Msc are from a BAME background, both in Leadership and 2 staff seconded as part of the NWL Leadership Ladder

Maintained high engagement scores in our staff survey and delivery of staff departmental pledges in response to staff survey results

Maintained our Disability Confident Status Level 2 and working towards Level 3.

Continued weekly clinical reference group to ensure we review updated and new staff individual risk assessments to ensure the physical and psychological safety of our people in response to COVID-19.

Launched our new Disability Staff Network and continued development of our 3 other staff networks, Women's, LGBTQ+ and BAME

104 MHFA's and Representation from diverse backgrounds as health and wellbeing champions and mental health first aiders.

Key Successes over the past year

Talent Management & Succession Planning strategy drafted, Get In, Get on, Go Further

Continued uptake and knowledge of health and wellbeing offers with positive feedback

200+apprentices employed and 60% of levy utilised and employer provider status achieved

Development of the collaborative bank helping to support staffing challenges

Improved our Gender Pay Gap

Implementation new ways of working, 80% of staff on e-rostering and commenced roll out of e-job planning

NWL collaboration to improve core services to support our staff such as Occupational Health and Payroll

Deployed workforce as the Lead Employer for the mass vaccination centres Phase 1-3

Reduced the number of formal disciplinary processes

Key Successes over the past year

Focused on a Flexible and Agile Working Plan and achieved Timewise Accreditation

Embraced new roles, Nursing Associate and Physicians Associates

Active RIQI team, supporting Horizon fellows and virtual reality training for our EDI work

Leadership Framework from management fundamentals to MBA to support leadership development

Recognised externally by being shortlisted for a HSJ Partnership Award for our innovative back up care service as part of our health and wellbeing offer to staff

Successful delivery of our first reciprocal mentoring programme

Retention of the NWL Mass vaccination workforce, most of whom were recruited locally. 194 retained into roles within the ICS

Reset and Recovery programme in place supporting annual leave take up and additional rest and recovery days for staff

213 volunteers across both sites, who contributed 2691 hours of volunteering.

Delivering on our People Strategy

Theme	Performance Measure	20/21 Baseline	23/24 Ambition	Progress Update
Looking After Our People	H&W Staff Survey Score Voluntary Turnover of Staff Sickness (average days) % of staff coming in despite being unwell Uptake of H&W offers	5.9 18% 5.8 47.7% <2%	6.1 10% 5 40% >10%	• NWL Keeping Well Programme providing support to staff as well as 3 year Trust level H&W business case including innovative back up care solution which has received great feedback from staff and recently a finalist at HSJ Partnership Awards, psychology support team recruited and in place, active commutes, reset health programme with 100 taking part in programme, Virgin Go, Peppy App piloted to support menopause, fast track physio and Nursery partnership programmes are in development. There have been over 4300 uses of H&W offers, with some specific positivity days held, where the wellbeing team provide mindfulness sessions tea/coffee and fruit and give advice on sleep. • 66 Health and Wellbeing Champions & 104 Mental Aid First Aiders trained and in place to support staff locally and increase awareness and knowledge of H&W offers as well as wellbeing workshops run by the team at department level. • H&W conversations and additional training to have compassionate conversations for line managers in place. • The staff safety group have developed a new behavioural standards policy and recruited a number of Safety Champions and held numerous safety events for staff, the most recent being for women. • A new recognition programme has been presented at Workforce Development Committee in April and this year there will be an increased focus on individual and local recognition as well as restarting annual staff awards, long service awards, and continuing with the monthly CW+ PROUD awards and our monthly excellence reporting.
Belonging in the NHS	EDI Staff Survey Score WRES/WDES/Gender Pay Gap Improvements Increase in number of BAME staff in Bands 8a and above Staff Engagement Score	8.5 6 WRES, 10 WDES 3 not met target Disproportionate – not all grades met target 7.1	9.1 Positive improvement across all All grades met set targets 7.4	• Year 2 of 3 year EDI action plan in progress, promotion of key achievements in the last year produced each year to provide a summary of achievements and work, which will be presented at the webinar. • Continued engagement and embedding of the Staff Networks, all attend Workforce Development Committee, and meeting regularly to bring together the work of the networks with activity across all networks. • Focus on resolution strategies to resolve concerns at an early point for B&H, grievance and some disciplinary cases e.g. mediation, confident conversations, and a focus on time to resolve and support for staff in processes, disciplinary investigations <30 days. • Diversity Champions in place but a clear focus on ensuring consistency of application and widening the panels having a D&I champion on. • Participating in the NWL Leadership Ladder pilot • Reciprocal Mentoring pilot programme completed and evaluation taken place and plans being developed for Autumn future roll-out • Participation in the WRES Experts programme, sponsoring our BAME Network Chair and Advisor to the Board and 1 senior leader on the white allies programme. • NWL Compassionate and Inclusive Leadership Programme pilot running with 4 participants from the Trust. • Leadership Development through MBA and Msc with 17 and 33 participating on the programmes and a new two-day joint virtual leadership programme for Hillingdon and ChelWest and is designed for colleagues with line management responsibility. The programme is designed to build leadership confidence and capability and equip staff with the ability to: foster psychological safety, create inclusive environments and have compassionate conversations. • Another achievement was our programme of work for LGBT History month and the array of activities available to staff. We also received our Workplace Equality Index results for 2022, and we have ranked 271 out of 403 participants, and 36 out of 56 participants for Healthcare Services
New Ways of Working and Delivering Care	Number of staff transitioning to qualified posts Increase in new roles (PA and NA) Flexible Working staff survey score E-job planning implemented Number of staff using e-roster	<20 <1% 56% N/A 82%	>70 >5% 65% 100% by 2024 100%	• Continued roll-out of e-roster programme which is due to complete and have all staff on e-roster by August 2022, All Doctors across the Trust now have a profile on Health Roster (this includes pre-implementation areas). Leave can be manually captured by Ops Leads, grouped into teams, service oversight of leave to be gained prior to full implementation as well as roll-out of e-job planning. Job plans are being uploaded onto the system and circa 40% have been received. • The team are working to ensure all new role types are coded correctly for accurate reporting purposes and this now features as part of the new workforce report for our Workforce Development Committee and business plans have set out in workforce planning terms new roles being introduced. • The Trust has renewed its Flexible working policy and now reports in the monthly workforce report flexible working applications, 34 have been received, the majority of the applications were made by female employees and the gender split is 28 female employees and 6 male employees. Of this total, 56% relates to requests made by BAME members of staff. The % of requests accepted is currently 65%. The Trust has received Timewise accreditation and has committed as part of the People Promise to deliver the action plan to support staff work flexibly whilst still delivering services.
Growing for the Future	Utilisation of the apprenticeship levy % of volunteers into employment Increased local employment Reduced vacancy rates in core professions	39% 4.5% Not currently measured N&M 5.5%, M7D 3% AHP 7%	>70% 10% 10% N&M 5-8%, M&D <5% AHP <7%	• The apprenticeship levy spend is currently 52% and 192 apprentices are current on programmes, with a further 20 due to start, with 62 completions to date. • ChelWest remain the host employer for the mass vaccination and lead on the retention to employment programme. The retention programme continues with a further 13 colleagues retained since last month 194 in total and is one of the best performing in the country for retention into employment. • The Trust continues to perform well against target with over 20% of staff employed from the local area, further work underway across NWL ICS to develop innovative ways of engaging with local communities to find pathways into employment. • There was an 3% increase in volunteering numbers from January to February, and volunteering hours remained unchanged. In February, there were 212 volunteers across both sites, who contributed 2651 hours of volunteering. Volunteers were deployed to strategic priority areas such as wards and outpatient departments. Volunteers also consistently supporting the new discharge project which aims to support patients after discharge and pilot site for NWL ICS volunteering into employment initiative. • Vacancy rates across core professions are tracked monthly and there are key campaigns to improve vacancy rates in key areas with a specific ICS plan on HCA recruitment.

Divisional Led Plans

Number of Pledges	Division
17	Clinical Support Division
15	Emergency and Integrated Care Division
17	Planned Care Division
14	Women's and Chidren's Division

- In addition to Trust wide areas of focus, last year across the Trust teams reviewed their departmental staff survey feedback and designed pledges together to improve staff experience at work at a local level.
- There was huge engagement from all areas across the Trust with **63** team pledges developed
- Divisional Panels reviewed departmental pledges and announced winners from each Division who won 'best pledge of commitment' prizes for their work.
- Winners were celebrated in Trust communications
- In September departments were invited to present to Divisional panels progress on their pledges and a winner for each area was selected to recognise the commitment and progress made by teams.









Divisional Led Plans

- Out of the 63 pledges developed in 2021, 31 departments had improvement in the areas demonstrating a 49% success rate.

- There was significant engagement from the teams regarding the 2020 staff survey pledges and continuing this is welcomed by the Leads across the Divisions.

- The divisions are committed to building on the positive engagement from teams for the 2020 staff survey pledges for 2021.

- As well as pledges, further interventions will need to continue to be designed in line with departmental concerns i.e. focus groups, spin off surveys, drop in sessions, team meetings as well as broader organisational interventions i.e. health and wellbeing, equality, diversity and inclusion, rewards and benefits.

- In line with the People Promise, we are requesting views on Pledges to be renamed to People Promises



Improving Communications and Engagement & Next Steps

- Key focus on regular Trust wide communications on key areas focusing on delivery of our People Plan and delivering on our People Promise in addition to Divisional local level commitments to improve staff experience at team level.

- All Staff Webinars have featured regular updates on Wellbeing, more frequent updates on Equality, Diversity and Inclusion, Safe Environment an update on Violence and Aggression, Staff Experience surveys and launch of Pulse and key elements of the programme will continue to be launched and updated on through a variety of channels.

- July, August and September structured communication's campaign to update on key work undertaken in the key areas, through the all staff webinars, weekly bulletin, team meetings, and our new People weeks.

Staff Survey Findings: High level timeline

March	• Communicate Results with key Stakeholders
April	• Develop Departmental People commitments at Divisional Level
May	• Circulate people commitments to all staff, People Promise and plan
June	• You Said…We did communications and events
July	• You Said….We did communicate key themes and quick wins • Publicise Winners of Pledges and focus on winning teams Pledges of Commitment
August	• You Said…..We did communicate key themes and quick wins
September	• You said….We did communicate progress on key Trust level priorities • Divisional Commitments – progress against commitment judging panels
October	• Launch 2022 Staff Survey

Our People Strategy: Communication and Engagement Focus

We are working with the Communications Team on a calendar of events to raise the profile of the People Promise and our commitments to be a great employer, including:



Employees of the month being recognised at the All Staff Webinars and STAR awards, long service and instant recognition schemes all re-starting



Launch of the Agile Working Policy and promotion of Flexible working policy



Staff Survey Promises being developed as a result of the Staff Survey



A week where we celebrate Chelwest People



A week where we launch the People Strategy, go out and about all sites of the Trust



Various health and wellbeing events on issues such as burnout, better sleep



Celebrating completed apprenticeships, MBA, MSc and Emerging Leaders and development opportunities

Hearing from staff regularly and tracking progress

- In addition to the annual staff survey it is important to triangulate different sets of feedback, which is reviewed regularly at our committees.

- The Trust launched from April 2021 the monthly People Pulse to increase regular engagement and seek views from staff. The response rates have been less than 5% each month which is similar to other Trusts and therefore it has been agreed to conduct the Pulse quarterly and focus on improving response rates to get meaningful feedback, once per quarter.

- Joiners and Leavers surveys are undertaken monthly and for the year for our joiners we received a 23% response rate with 87% positive scores with our top areas relating to intent to stay which improved from 9% to 92%, over 90% were made to feel welcome, 90% felt colleagues behaved in accordance with our values and 94% felt the Trust values diversity and 95% enjoy working within our Trust. Leavers surveys had a 25% response rate, and 77% positive scores, with 90% believing patient care was a top priority, managers treated staff with respect had improved by 6% and 86% were proud to work for the Trust. Development areas across both joiners and leavers which is line with staff survey feedback relate to a lack of flexibility, and 40% stating it impacted their work-life balance, as well as for leavers a development need related to managers praise, support, recognition and feedback.

- In addition Divisions are holding listening events as part of their local plans.

Make joiners' experience better by...

7 comments

"Early knowledge re cycle to work schemes etc before starting"

"An induction for all trainees joining at the same level (e.g IMTs/CSTs etc)"

"Introducing a local departmental induction, that covers the West Middlesex Hospital site as well.."

"Test that logins work before joining rather than on the day. Still not working 3 days in"

Make the Trust a better employer...

46 comments

"Improve culture and work life balance"

"More diversity in management roles"

"Consider the experience of the employers and give them rewards (Band) that deserve"

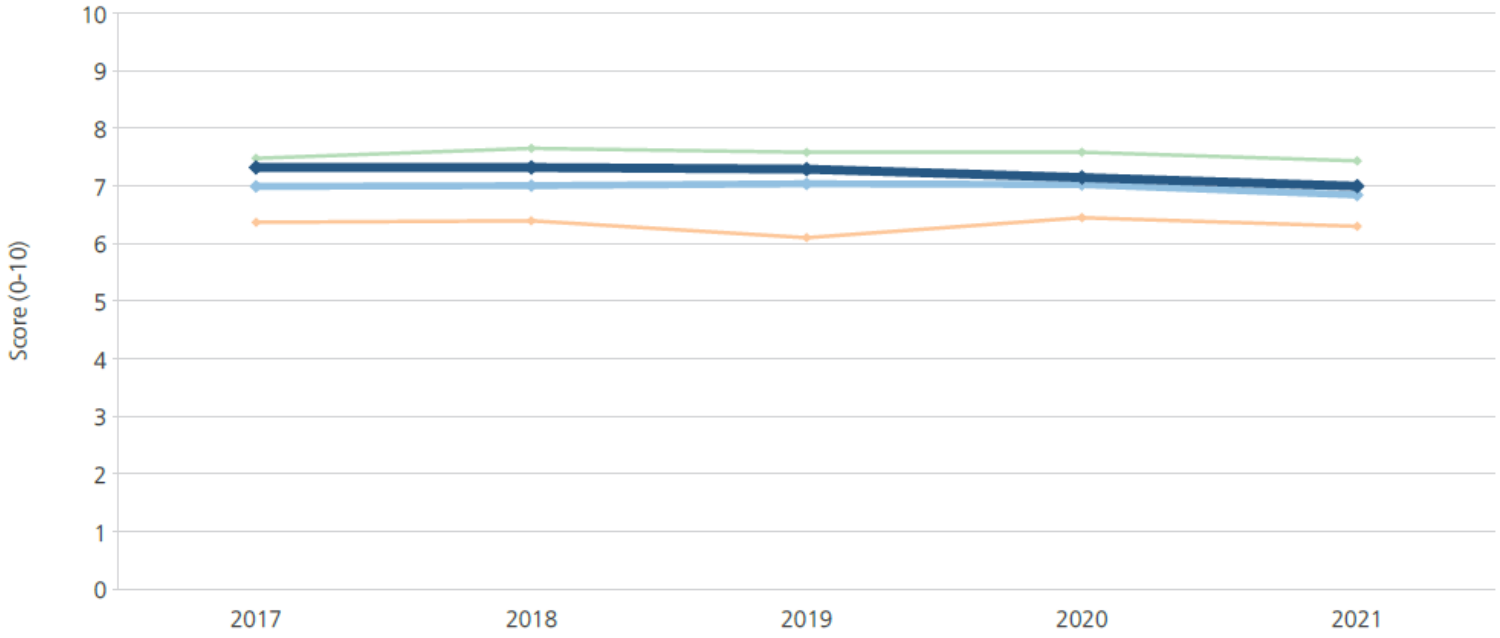
"To allow employees to have flexible working patterns without compromising their jobs hence allowing them to hold a job and also be able to care for their families."

Appendix 1 – Key Trends

Full staff survey report and results available

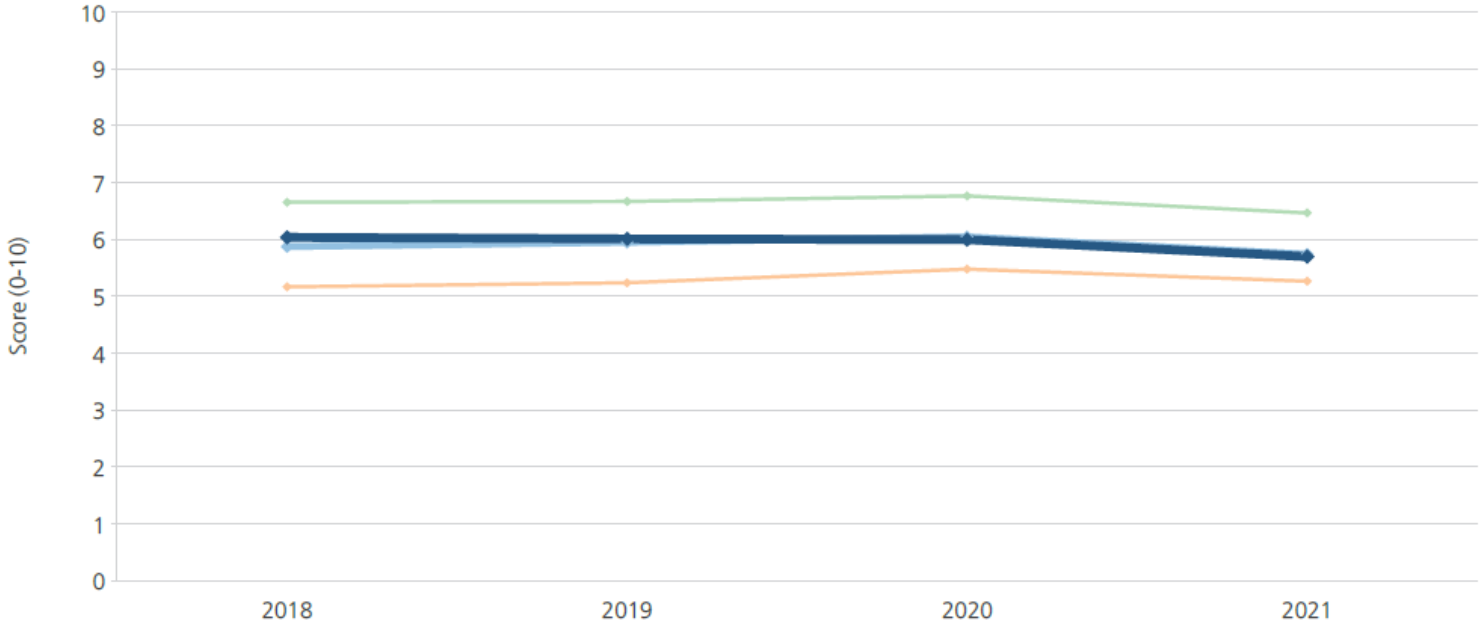
[NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com)]

Staff Engagement– Trends



	2017	2018	2019	2020	2021
Best	7.5	7.7	7.6	7.6	7.4
Your org	7.3	7.3	7.3	7.1	7.0
Average	7.0	7.0	7.0	7.0	6.8
Worst	6.4	6.4	6.1	6.4	6.3
Responses	1,733	2,317	2,742	3,615	2,977

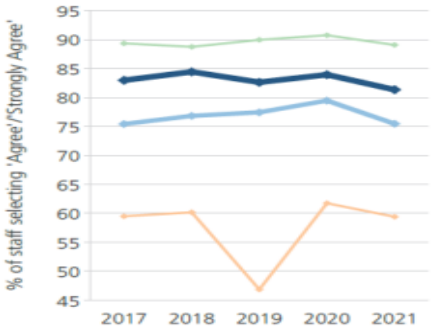
Morale – Trends



	2018	2019	2020	2021
Best	6.7	6.7	6.8	6.5
Your org	6.0	6.0	6.0	5.7
Average	5.9	5.9	6.0	5.7
Worst	5.2	5.2	5.5	5.3
Responses	2,317	2,728	3,605	2,965

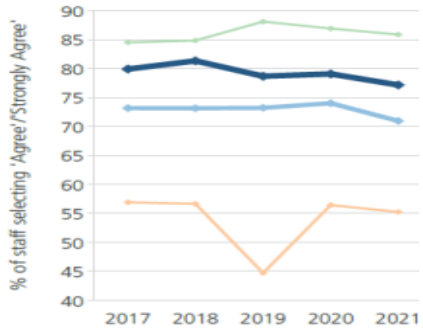
We are compassionate and inclusive – Trends

Q21a
Care of patients / service users is my organisation's top priority



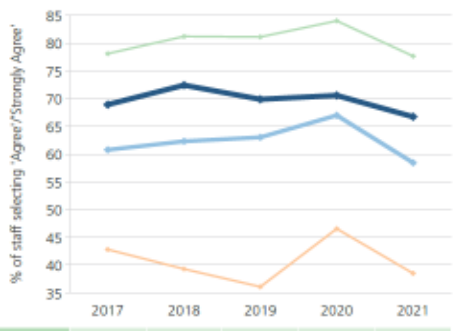
	2017	2018	2019	2020	2021
Best	89.3%	88.7%	90.0%	90.7%	89.1%
Your org	83.0%	84.4%	82.6%	83.9%	81.3%
Average	75.4%	76.8%	77.4%	79.5%	75.5%
Worst	59.5%	60.2%	46.9%	61.7%	59.4%
Responses	1,711	2,309	2,698	3,542	2,870

Q21b
My organisation acts on concerns raised by patients / service users



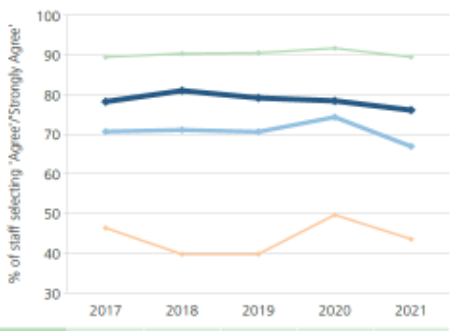
	2017	2018	2019	2020	2021
Best	84.5%	84.8%	88.1%	86.9%	85.9%
Your org	79.9%	81.3%	78.7%	79.1%	77.2%
Average	73.2%	73.1%	73.2%	74.0%	71.0%
Worst	56.9%	56.6%	44.7%	56.4%	55.2%
Responses	1,706	2,297	2,688	3,538	2,871

Q21c
I would recommend my organisation as a place to work



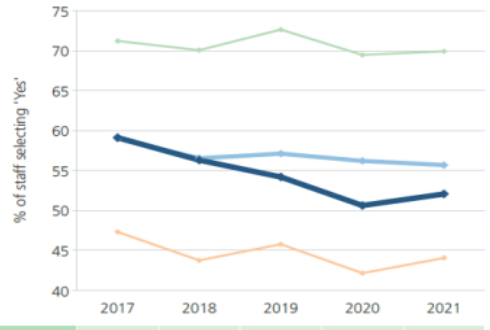
	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	68.9%	72.4%	69.9%	70.6%	66.7%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	1,707	2,303	2,676	3,535	2,872

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



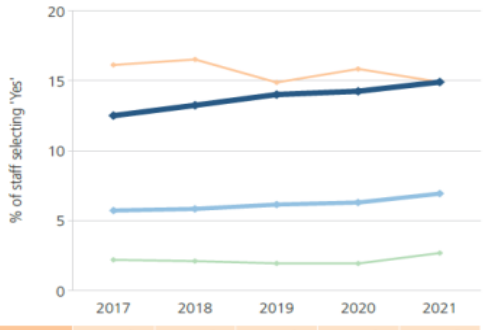
	2017	2018	2019	2020	2021
Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	78.2%	81.0%	79.2%	78.4%	76.1%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%
Responses	1,693	2,286	2,692	3,536	2,868

Q15
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



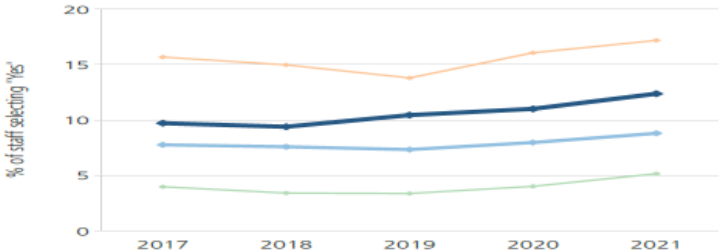
	2017	2018	2019	2020	2021
Best	71.2%	70.1%	72.6%	69.5%	69.9%
Your org	59.1%	56.3%	54.2%	50.6%	52.1%
Average	59.0%	56.5%	57.1%	56.2%	55.7%
Worst	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Responses	1,703	2,287	2,691	3,531	2,886

Q16a
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2017	2018	2019	2020	2021
Worst	16.1%	16.5%	14.9%	15.8%	14.9%
Your org	12.5%	13.2%	14.0%	14.2%	14.9%
Average	5.7%	5.8%	6.1%	6.3%	6.9%
Best	1.9%	2.1%	1.9%	1.9%	2.7%
Responses	1,711	2,294	2,682	3,556	2,889

Q16b
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?

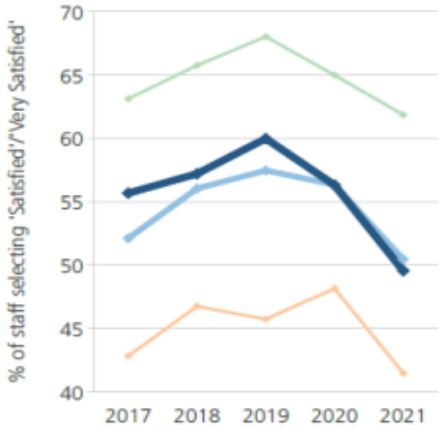


	2017	2018	2019	2020	2021
Worst	15.7%	15.0%	13.8%	16.1%	17.2%
Your org	9.7%	9.4%	10.4%	11.0%	12.4%
Average	7.8%	7.6%	7.3%	8.0%	8.8%
Best	4.0%	3.4%	3.4%	4.0%	5.1%
Responses	1,696	2,258	2,661	3,532	2,877

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

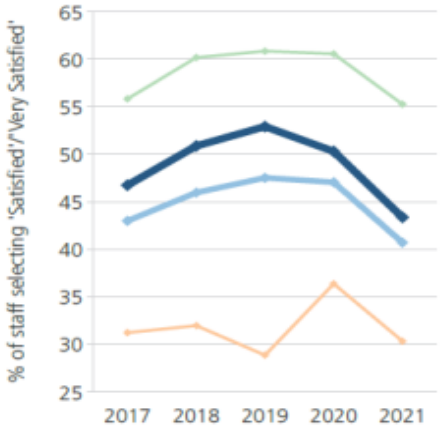
We are recognised and rewarded– Trends

Q4a
The recognition I get for good work



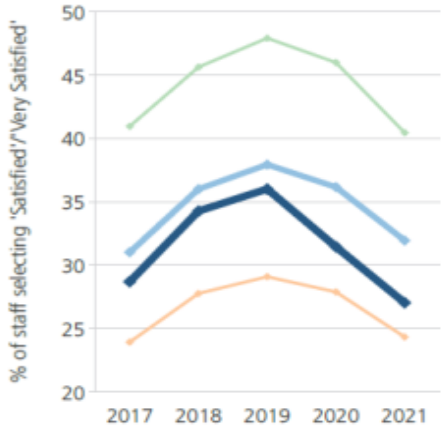
	2017	2018	2019	2020	2021
Best	63.1%	65.8%	68.0%	65.0%	61.9%
Your org	55.7%	57.2%	60.0%	56.3%	49.5%
Average	52.1%	56.0%	57.5%	56.3%	50.5%
Worst	42.8%	46.7%	45.7%	48.1%	41.5%
Responses	1,726	2,302	2,719	3,597	2,961

Q4b
The extent to which my organisation values my work



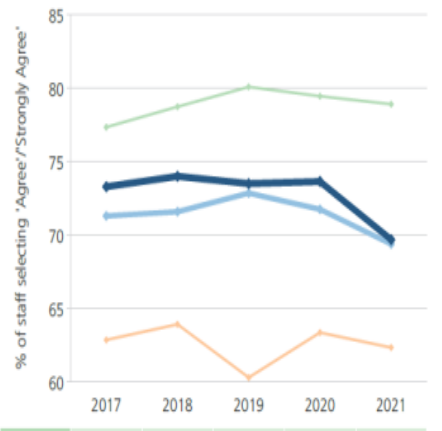
	2017	2018	2019	2020	2021
Best	55.8%	60.2%	60.8%	60.6%	55.2%
Your org	46.7%	50.9%	52.9%	50.3%	43.3%
Average	43.0%	45.9%	47.5%	47.0%	40.7%
Worst	31.2%	31.9%	28.8%	36.3%	30.3%
Responses	1,714	2,301	2,715	3,596	2,967

Q4c
My level of pay



	2017	2018	2019	2020	2021
Best	40.9%	45.6%	47.9%	46.0%	40.4%
Your org	28.7%	34.3%	36.0%	31.4%	27.0%
Average	31.0%	36.0%	37.9%	36.1%	31.9%
Worst	23.9%	27.8%	29.1%	27.9%	24.3%
Responses	1,723	2,307	2,716	3,601	2,964

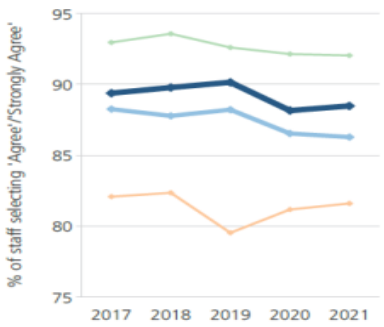
Q9e
My immediate manager values my work



	2017	2018	2019	2020	2021
Best	77.3%	78.7%	80.1%	79.4%	78.9%
Your org	73.3%	74.0%	73.5%	73.6%	69.7%
Average	71.3%	71.6%	72.8%	71.7%	69.4%
Worst	62.8%	63.9%	60.3%	63.3%	62.3%
Responses	1,711	2,294	2,707	3,581	2,917

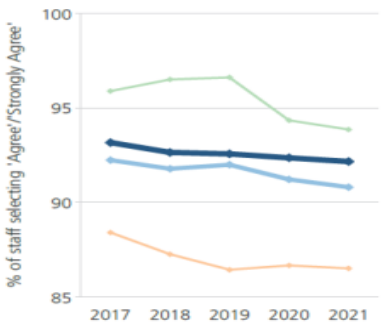
We each have a voice that counts– Trends

Q3a
I always know what my work responsibilities are



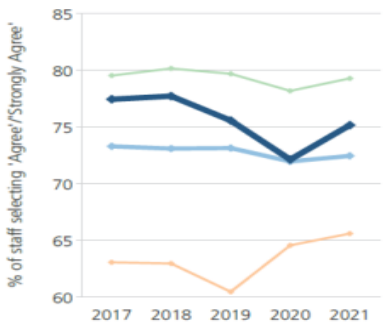
	2017	2018	2019	2020	2021
Best	93.0%	93.6%	92.6%	92.1%	92.0%
Your org	89.4%	89.8%	90.1%	88.1%	88.5%
Average	88.2%	87.8%	88.2%	86.5%	86.3%
Worst	82.1%	82.3%	79.5%	81.2%	81.6%
Responses	1,726	2,309	2,732	3,651	2,961

Q3b
I am trusted to do my job



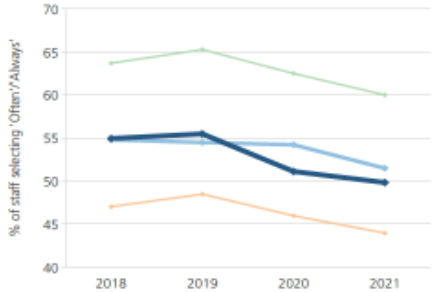
	2017	2018	2019	2020	2021
Best	95.9%	96.5%	96.6%	94.3%	93.9%
Your org	93.2%	92.6%	92.6%	92.4%	92.2%
Average	92.2%	91.8%	92.0%	91.2%	90.8%
Worst	88.4%	87.3%	86.4%	86.7%	86.5%
Responses	1,718	2,296	2,724	3,639	2,971

Q3c
There are frequent opportunities for me to show initiative in my role



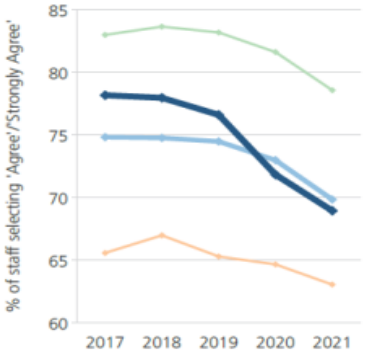
	2017	2018	2019	2020	2021
Best	79.5%	80.1%	79.7%	78.2%	79.3%
Your org	77.4%	77.7%	75.6%	72.1%	75.1%
Average	73.3%	73.1%	73.1%	71.9%	72.4%
Worst	63.0%	62.9%	60.4%	64.5%	65.6%
Responses	1,726	2,308	2,726	3,610	2,975

Q5b
I have a choice in deciding how to do my work



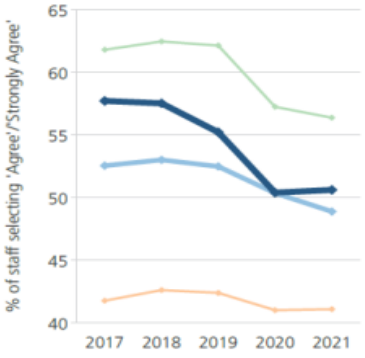
	2018	2019	2020	2021
Best	63.7%	65.3%	62.5%	60.0%
Your org	54.9%	55.5%	51.1%	49.8%
Average	54.8%	54.5%	54.2%	51.5%
Worst	47.0%	48.5%	45.9%	43.9%
Responses	2,294	2,706	3,596	2,951

Q3d
I am able to make suggestions to improve the work of my team / department



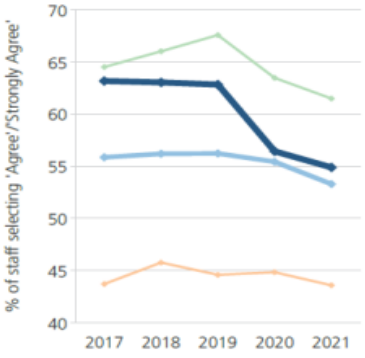
	2017	2018	2019	2020	2021
Best	83.0%	83.7%	83.2%	81.6%	78.6%
Your org	78.2%	78.0%	76.6%	71.8%	68.9%
Average	74.8%	74.8%	74.5%	73.0%	69.8%
Worst	65.6%	67.0%	65.3%	64.7%	63.0%
Responses	1,721	2,309	2,730	3,609	2,971

Q3e
I am involved in deciding on changes introduced that affect my work area / team / department



	2017	2018	2019	2020	2021
Best	61.8%	62.5%	62.1%	57.2%	56.4%
Your org	57.7%	57.5%	55.2%	50.4%	50.6%
Average	52.5%	53.0%	52.5%	50.4%	48.9%
Worst	41.7%	42.6%	42.4%	41.0%	41.1%
Responses	1,720	2,301	2,732	3,609	2,970

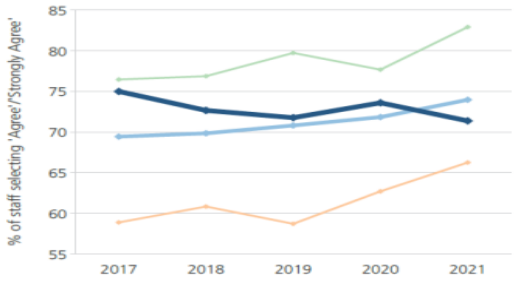
Q3f
I am able to make improvements happen in my area of work



	2017	2018	2019	2020	2021
Best	64.5%	66.0%	67.6%	63.5%	61.5%
Your org	63.2%	63.0%	62.8%	56.4%	54.9%
Average	55.9%	56.2%	56.2%	55.4%	53.3%
Worst	43.7%	45.8%	44.6%	44.8%	43.6%
Responses	1,717	2,296	2,724	3,607	2,972

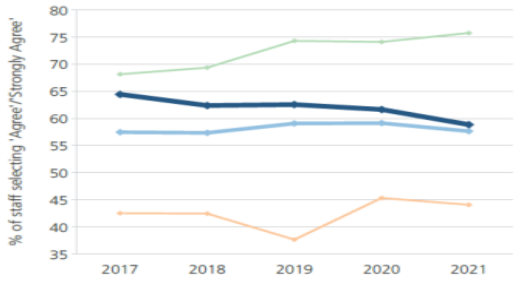
We each have a voice that counts– Trends

Q17a
I would feel secure raising concerns about unsafe clinical practice



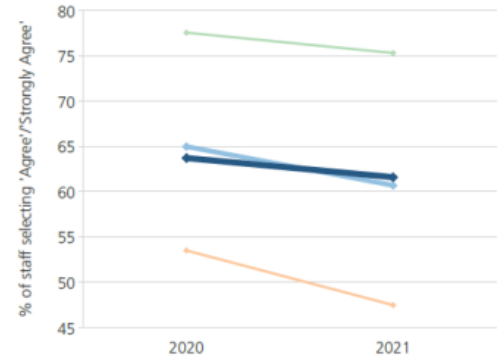
	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	75.0%	72.6%	71.7%	73.6%	71.4%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	1,724	2,291	2,696	3,555	2,887

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	64.4%	62.4%	62.5%	61.6%	58.8%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	1,709	2,284	2,694	3,555	2,889

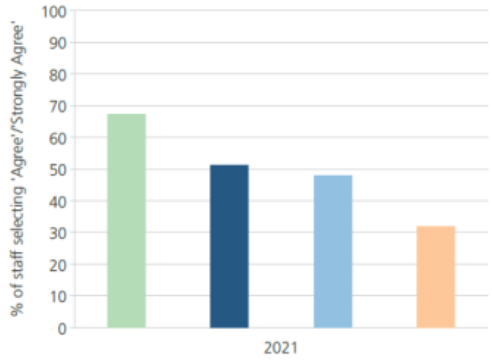
Q21e
I feel safe to speak up about anything that concerns me in this organisation



	2020	2021
Best	77.6%	75.3%
Your org	63.7%	61.6%
Average	65.0%	60.7%
Worst	53.1%	49.1%
Responses	3,538	2,864

Q21f
If I spoke up about something that concerned me I am confident my organisation would address my concern

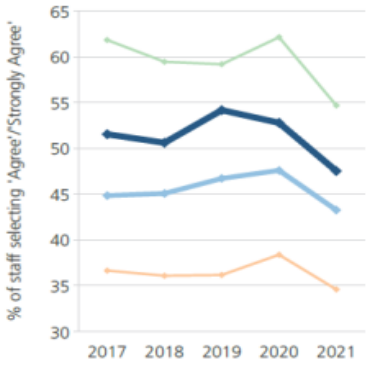
No trend data are shown as this is a new question



	2021
Best	67.2%
Your org	51.2%
Average	47.9%
Worst	31.9%
Responses	2,865

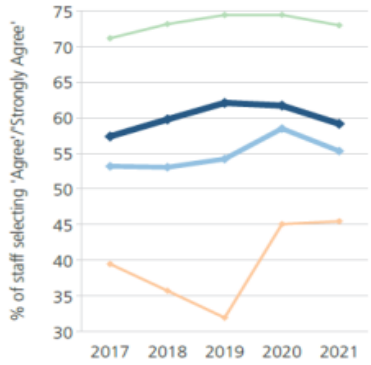
We are safe and healthy– Trends

Q3g
I am able to meet all the conflicting demands on my time at work



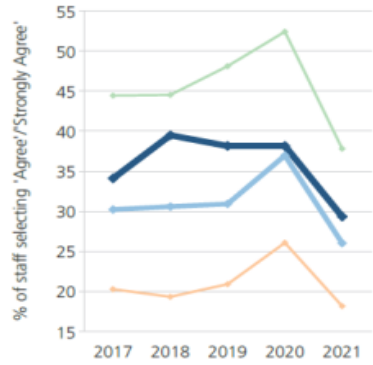
	2017	2018	2019	2020	2021
Best	61.8%	59.4%	59.2%	62.1%	54.7%
Your org	51.5%	50.6%	54.2%	52.8%	47.5%
Average	44.8%	45.1%	46.7%	47.6%	43.3%
Worst	36.6%	36.1%	36.2%	38.4%	34.6%
Responses	1,716	2,300	2,715	3,590	2,968

Q3h
I have adequate materials, supplies and equipment to do my work



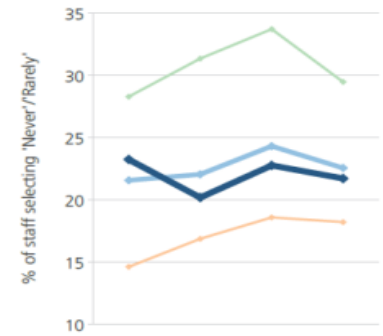
	2017	2018	2019	2020	2021
Best	71.2%	73.2%	74.4%	74.4%	73.0%
Your org	57.4%	59.8%	62.1%	61.7%	59.1%
Average	53.2%	53.0%	54.2%	58.5%	55.3%
Worst	39.5%	35.7%	31.9%	45.1%	45.5%
Responses	1,722	2,293	2,720	3,604	2,974

Q3i
There are enough staff at this organisation for me to do my job properly



	2017	2018	2019	2020	2021
Best	44.4%	44.5%	48.1%	52.4%	37.8%
Your org	34.1%	39.5%	38.1%	38.2%	29.3%
Average	30.2%	30.6%	30.9%	36.9%	26.0%
Worst	20.3%	19.3%	20.9%	26.1%	18.2%
Responses	1,721	2,307	2,728	3,601	2,976

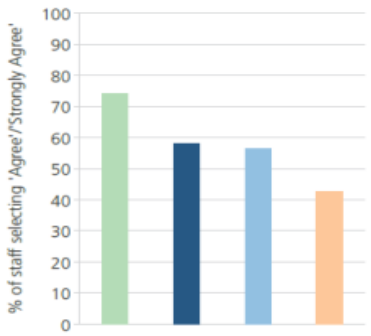
Q5a
I have unrealistic time pressures



	2018	2019	2020	2021
Best	28.3%	31.3%	33.7%	29.5%
Your org	23.2%	20.2%	22.8%	21.7%
Average	21.6%	22.6%	24.5%	22.3%
Worst	14.6%	16.9%	18.6%	18.2%
Responses	2,302	2,697	3,594	2,944

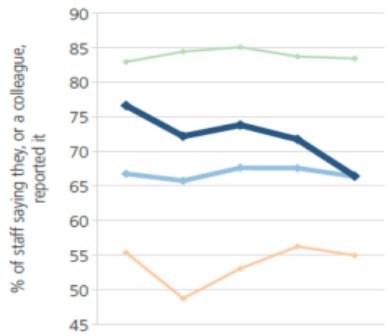
Q11a
My organisation takes positive action on health and well-being

No trend data are shown as this is a new question



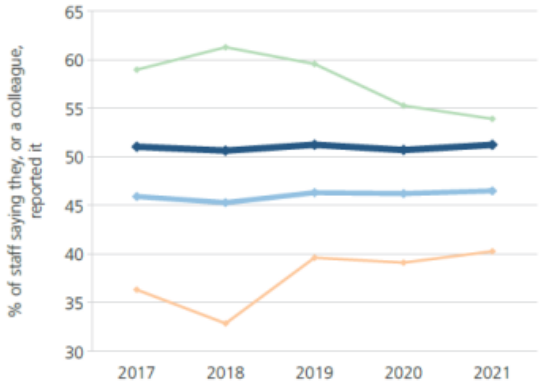
	2021
Best	74.0%
Your org	58.1%
Average	56.4%
Worst	42.5%
Responses	2,837

Q13d
The last time you experienced physical violence at work, did you or a colleague report it?



	2017	2018	2019	2020	2021
Best	83.0%	84.4%	85.1%	83.7%	83.4%
Your org	76.6%	72.2%	73.8%	71.7%	66.4%
Average	66.8%	65.7%	67.6%	67.6%	66.3%
Worst	55.4%	48.7%	53.0%	56.2%	54.9%
Responses	237	368	407	604	481

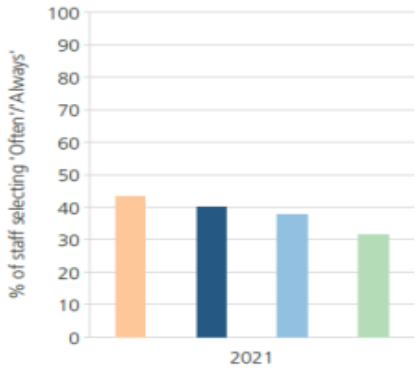
Q14d
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?



	2017	2018	2019	2020	2021
Best	59.0%	61.3%	59.5%	55.3%	53.9%
Your org	51.0%	50.6%	51.2%	50.7%	51.2%
Average	45.9%	45.3%	46.3%	46.2%	46.5%
Worst	36.3%	32.8%	39.6%	39.1%	40.3%
Responses	704	973	1,158	1,515	1,228

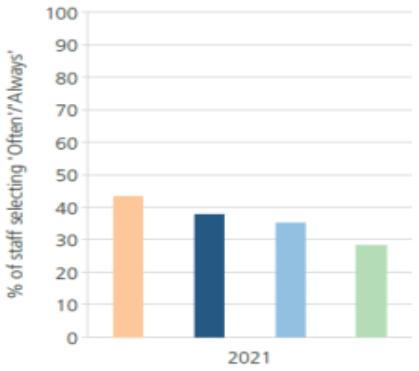
We are safe and healthy– Trends

Q12a
How often, if at all, do you find your work emotionally exhausting?
No trend data are shown as this is a new question



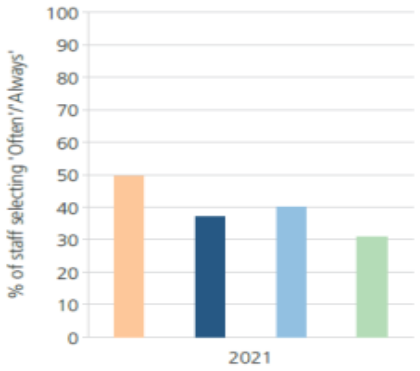
Worst	43.4%
Your org	40.0%
Average	37.7%
Best	31.4%
Responses	2,905

Q12b
How often, if at all, do you feel burnt out because of your work?
No trend data are shown as this is a new question



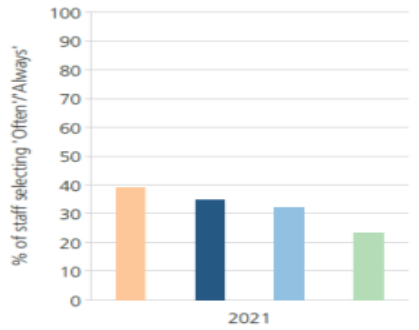
Worst	43.3%
Your org	37.8%
Average	35.2%
Best	28.1%
Responses	2,905

Q12c
How often, if at all, does your work frustrate you?
No trend data are shown as this is a new question



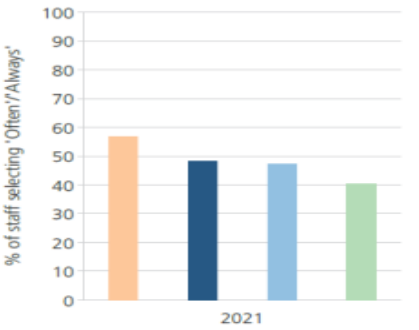
Worst	49.7%
Your org	37.1%
Average	39.9%
Best	30.8%
Responses	2,905

Q12d
How often, if at all, are you exhausted at the thought of another day/shift at work?
No trend data are shown as this is a new question



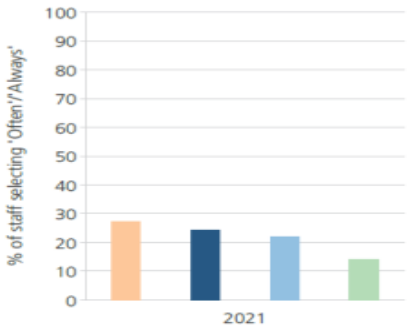
Worst	39.0%
Your org	34.6%
Average	[illegible]
Best	23.4%
Responses	2,903

Q12e
How often, if at all, do you feel worn out at the end of your working day/shift?
No trend data are shown as this is a new question



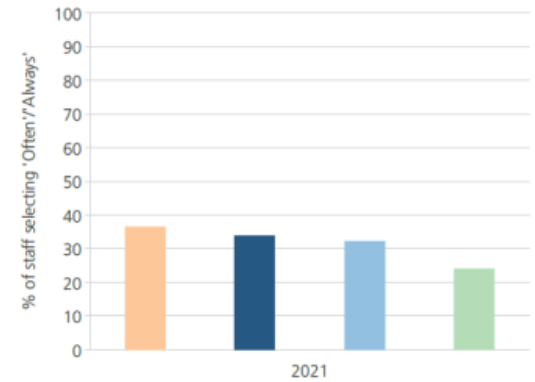
Worst	56.7%
Your org	48.2%
Average	47.2%
Best	40.2%
Responses	2,903

Q12f
How often, if at all, do you feel that every working hour is tiring for you?
No trend data are shown as this is a new question



Worst	27.3%
Your org	24.3%
Average	21.9%
Best	14.1%
Responses	2,904

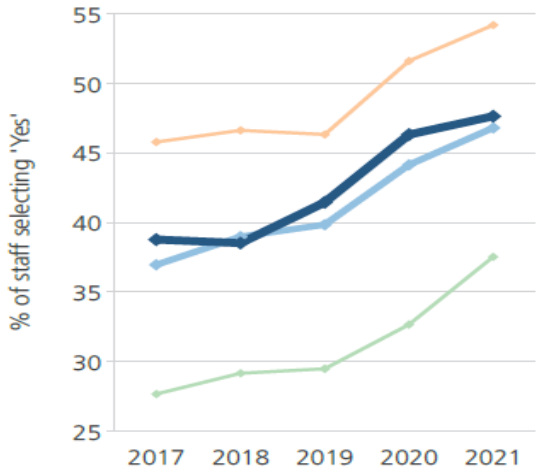
Q12g
How often, if at all, do you not have enough energy for family and friends during leisure time?
No trend data are shown as this is a new question



Worst	36.3%
Your org	33.7%
Average	32.1%
Best	23.9%
Responses	2,907

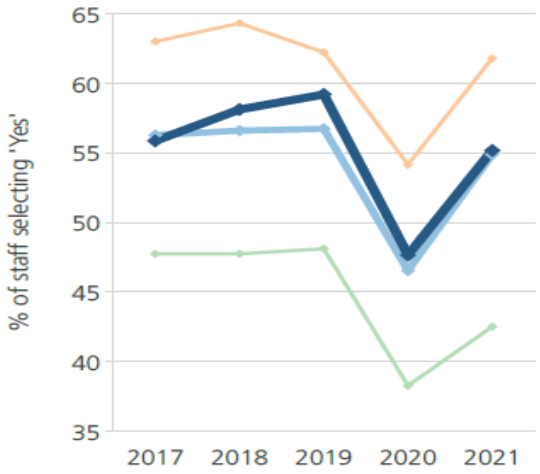
We are safe and healthy– Trends

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



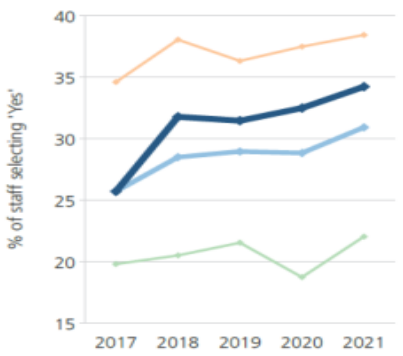
	2017	2018	2019	2020	2021
Worst	45.8%	46.6%	46.3%	51.6%	54.2%
Your org	38.8%	38.5%	41.4%	46.3%	47.6%
Average	36.9%	39.0%	39.8%	44.1%	46.8%
Best	27.7%	29.1%	29.5%	32.6%	37.5%
Responses	1,721	2,301	2,708	3,578	2,914

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2017	2018	2019	2020	2021
Worst	63.0%	64.3%	62.2%	54.2%	61.8%
Your org	55.9%	58.1%	59.2%	47.6%	55.2%
Average	56.3%	56.6%	56.7%	46.5%	54.9%
Best	47.7%	47.7%	48.1%	38.3%	42.5%
Responses	1,713	2,301	2,702	3,579	2,914

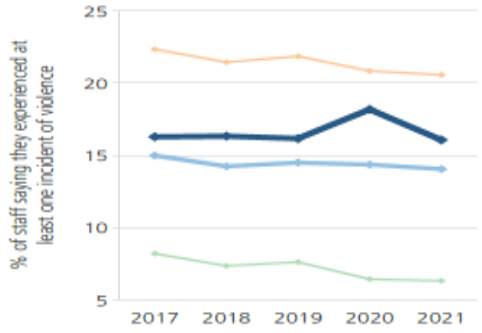
Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



	2017	2018	2019	2020	2021
Worst	34.6%	38.0%	36.3%	37.5%	38.4%
Your org	25.7%	31.8%	31.5%	32.5%	34.2%
Average	25.7%	28.5%	29.0%	28.8%	30.9%
Best	19.8%	20.5%	21.5%	18.7%	22.0%
Responses	1,724	2,301	2,708	3,580	2,914

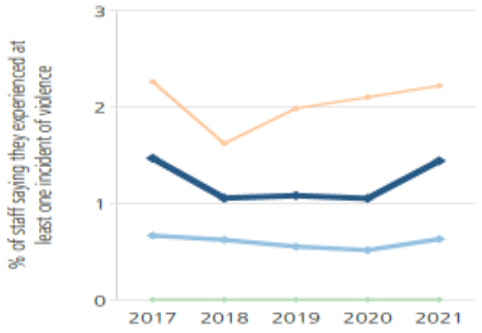
We are safe and healthy– Trends

Q13a
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



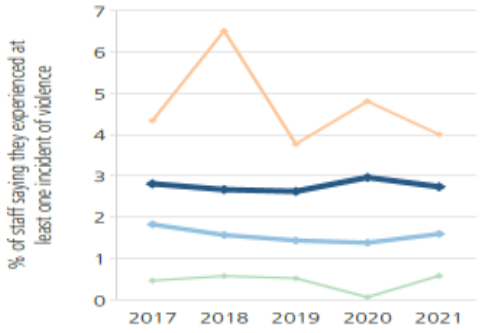
	2017	2018	2019	2020	2021
Worst	22.3%	21.4%	21.8%	20.8%	20.6%
Your org	16.3%	16.3%	16.2%	18.2%	16.1%
Average	15.0%	14.2%	14.5%	14.3%	14.0%
Best	8.2%	7.3%	7.6%	6.4%	6.3%
Responses	1,717	2,301	2,698	3,581	2,904

Q13b
In the last 12 months how many times have you personally experienced physical violence at work from managers?



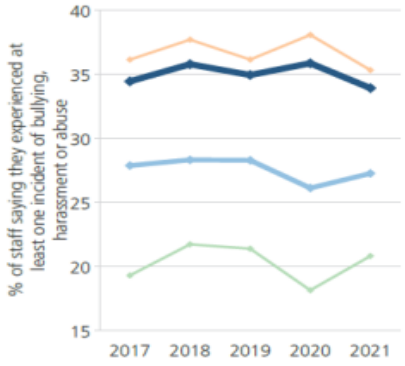
	2017	2018	2019	2020	2021
Worst	2.3%	1.6%	2.0%	2.1%	2.2%
Your org	1.5%	1.1%	1.1%	1.1%	1.4%
Average	0.7%	0.6%	0.6%	0.5%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.0%
Responses	1,706	2,284	2,682	3,562	2,864

Q13c
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



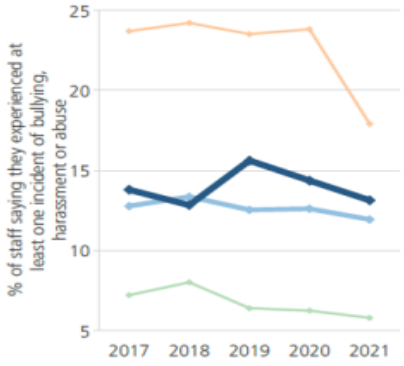
	2017	2018	2019	2020	2021
Worst	4.3%	6.5%	3.8%	4.8%	4.0%
Your org	2.8%	2.7%	2.6%	3.0%	2.7%
Average	1.8%	1.6%	1.4%	1.4%	1.6%
Best	0.5%	0.6%	0.5%	0.1%	0.6%
Responses	1,695	2,265	2,675	3,572	2,816

Q14a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



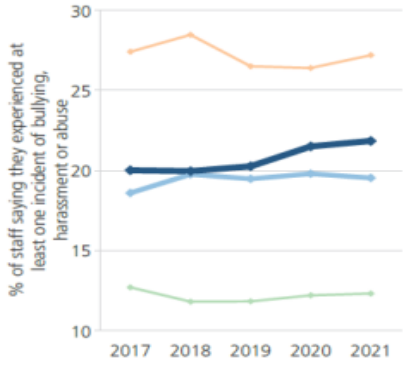
	2017	2018	2019	2020	2021
Worst	36.1%	37.7%	36.1%	38.1%	35.3%
Your org	34.4%	35.8%	34.9%	35.9%	33.9%
Average	27.9%	28.3%	28.3%	26.1%	27.3%
Best	[illegible]	[illegible]	[illegible]	6.4%	6.2%	5.8%
Responses	1,710	2,292	2,691	3,472	2,830

Q14b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2017	2018	2019	2020	2021
Worst	23.7%	24.2%	23.5%	23.8%	17.9%
Your org	13.8%	12.8%	15.6%	14.4%	13.1%
Average	12.8%	13.3%	12.5%	12.6%	11.9%
Best	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Responses	1,693	2,269	2,681	3,455	2,798

Q14c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2017	2018	2019	2020	2021
Worst	27.4%	28.5%	26.5%	26.4%	27.2%
Your org	20.0%	19.9%	20.3%	21.5%	21.8%
Average	18.6%	19.7%	19.5%	19.8%	19.5%
Best	12.7%	11.8%	11.8%	12.2%	12.3%
Responses	1,696	2,266	2,672	3,462	2,746

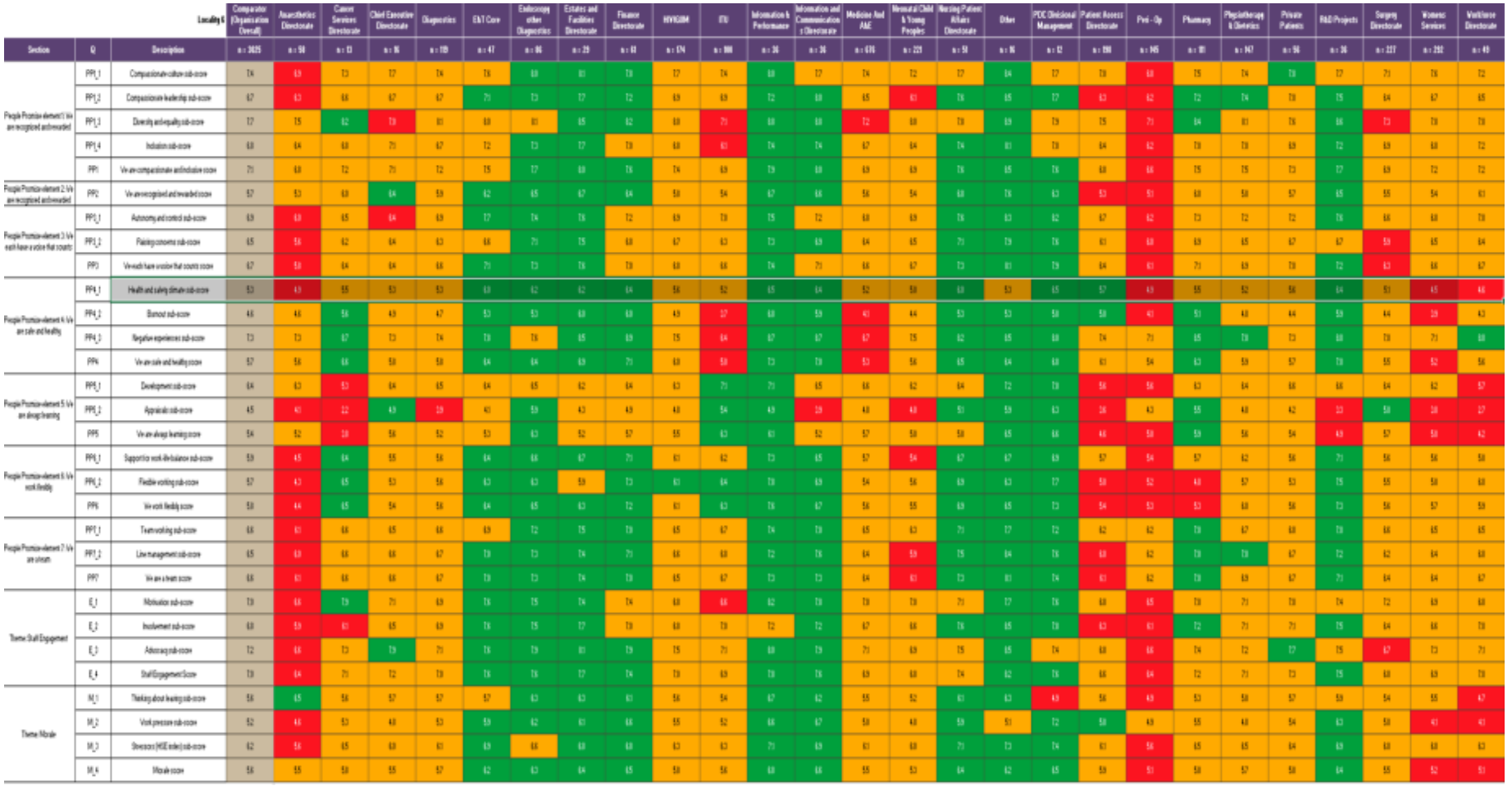
Appendix 2 – Additional Analysis

The following highlights the ways various groups are looking at the data including WDC, Divisions and our staff networks. This obviously highlights by Division, department, by band, staff group, age, and protected characteristics and highlights some clear areas of difference in experience and areas of focus for our plans.

Additional Reports - Division

Section	Q	Description	Comparator (Organisation Overall)	COR Corporate Division	CSD Clinical Support Division	EIC Emergency & Integrated Care Division	PDC Planned Care Division	[illegible] Childrens and Sexual Health Division
			n = 3025	n = 378	n = 530	n = 823	n = 542	n = 744
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score	7.4	7.7	7.4	7.4	7.1	7.5
	PP1_2	Compassionate leadership sub-score	6.7	7.3	6.7	6.7	6.5	6.6
	PP1_3	Diversity and equality sub-score	7.7	8.2	7.9	7.4	7.2	7.9
	PP1_4	Inclusion sub-score	6.8	7.3	6.7	6.7	6.5	6.7
	PP1	We are compassionate and inclusive score	7.1	7.6	7.2	7.0	6.8	7.2
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	5.7	6.5	5.8	5.7	5.4	5.5
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	6.9	7.4	7.0	6.9	6.5	6.9
	PP3_2	Raising concerns sub-score	6.5	6.9	6.5	6.4	6.0	6.5
	PP3	We each have a voice that counts score	6.7	7.2	6.8	6.7	6.3	6.7
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.3	6.0	5.6	5.2	5.0	5.0
	PP4_2	Burnout sub-score	4.6	5.6	5.0	4.2	4.3	4.3
	PP4_3	Negative experiences sub-score	7.3	8.4	7.7	6.9	7.0	7.3
	PP4	We are safe and healthy score	5.7	6.6	6.1	5.4	5.4	5.5
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.4	6.4	6.1	6.6	6.3	6.2
	PP5_2	Appraisals sub-score	4.5	4.2	4.4	4.8	4.8	4.1
	PP5	We are always learning score	5.4	5.3	5.3	5.7	5.6	5.2
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	5.9	6.7	5.9	5.8	5.6	5.7
	PP6_2	Flexible working sub-score	5.7	6.7	5.3	5.5	5.5	5.8
	PP6	We work flexibly score	5.8	6.7	5.6	5.6	5.5	5.8
People Promise element 7: We are a team	PP7_1	Team working sub-score	6.6	7.0	6.6	6.5	6.5	6.4
	PP7_2	Line management sub-score	6.5	7.2	6.6	6.5	6.3	6.3
	PP7	We are a team score	6.6	7.1	6.6	6.5	6.4	6.4
Theme: Staff Engagement	E_1	Motivation sub-score	7.0	7.4	7.0	7.0	6.9	6.9
	E_2	Involvement sub-score	6.8	7.3	6.8	6.7	6.4	6.7
	E_3	Advocacy sub-score	7.2	7.7	7.2	7.1	6.8	7.3
	E_4	Staff Engagement Score	7.0	7.5	7.0	7.0	6.7	6.9
Theme: Morale	M_1	Thinking about leaving sub-score	5.6	5.9	5.7	5.5	5.4	5.5
	M_2	Work pressure sub-score	5.2	5.9	5.7	5.0	5.0	4.7
	M_3	Stressors (HSE index) sub-score	6.2	6.8	6.3	6.2	5.9	6.1
	M_4	Morale score	5.6	6.2	5.9	5.5	5.4	5.4

Additional Reports – Department



Section	Q	Description	Locality 6	Comparator (Organisation Overall)	Anaesthetics Directorate	Cancer Services Directorate	Chief Executive Directorate	Diagnostics	E&T Core	Endoscopy other Diagnostics	Estates and Facilities Directorate	Finance Directorate	HIV/GUM	ITU	Information & Performance	Information and Communication s Directorate	Medicine And AAE	Neonatal Child & Young Peoples	Nursing Patient Affairs Directorate	Other	POE Divisional Management	Patient Access Directorate	Prof - Op	Pharmacy	Physiotherapy & Dietetics	Private Patients	R&D Projects	Surgery Directorate	Womens Services	Workforce Directorate
			n = 3625	n = 58	n = 13	n = 16	n = 115	n = 47	n = 86	n = 29	n = 83	n = 174	n = 888	n = 34	n = 34	n = 476	n = 229	n = 58	n = 16	n = 12	n = 198	n = 145	n = 181	n = 147	n = 56	n = 36	n = 227	n = 252	n = 48
People Promise element 1: We are recognised and rewarded	PPI_1	Compassionate culture sub-score	74	69	73	77	74	78	68	81	78	77	74	68	77	74	72	77	64	77	78	68	75	74	78	77	71	76	72
	PPI_2	Compassionate leadership sub-score	67	63	66	67	67	71	73	77	72	69	69	72	68	65	63	76	65	77	63	62	72	74	78	75	64	67	65
	PPI_3	Diversity and equality sub-score	77	75	82	78	81	68	81	85	82	68	71	68	68	72	68	78	69	79	75	71	84	81	76	66	73	78	78
	PPI_4	Inclusion sub-score	68	64	68	71	67	72	73	77	78	68	61	74	74	67	64	74	61	78	84	62	78	78	69	72	69	68	72
	PPI	We are compassionate and inclusive score	71	68	72	71	72	75	77	69	76	74	69	79	68	69	69	76	65	76	68	66	75	75	73	77	69	72	72
People Promise element 2: We are recognised and rewarded	PPC	We are recognised and rewarded score	57	53	68	64	59	62	65	67	64	58	54	67	68	56	54	68	76	63	53	51	68	58	57	65	55	54	61
People Promise element 3: We each have a voice that counts	PPI_1	Autonomy and control sub-score	69	69	65	64	69	77	74	78	72	69	78	75	72	68	69	78	63	82	67	62	73	72	72	78	66	68	78
	PPI_2	Raising concerns sub-score	65	56	62	64	63	66	71	75	68	67	63	73	69	64	65	71	79	78	81	68	69	65	67	67	59	65	64
	PPI3	We each have a voice that counts score	67	58	64	64	66	71	73	78	78	68	66	74	71	66	67	73	81	79	84	63	71	69	78	72	63	66	67
People Promise element 4: We are safe and healthy	PPI_1	Health and safety climate sub-score	53	43	55	63	53	68	62	62	64	56	62	65	64	62	58	68	53	65	57	43	55	62	56	64	53	45	46
	PPI_2	Burnout sub-score	46	46	56	49	47	53	53	68	68	49	37	68	59	43	44	53	53	58	58	43	53	48	44	59	44	28	43
	PPI_3	Negative experiences sub-score	73	73	67	73	74	78	76	85	69	75	84	67	67	67	75	82	85	68	74	71	85	78	73	68	78	71	68
	PPH	We are safe and healthy score	57	56	66	58	58	64	64	69	71	68	58	73	78	53	56	65	64	68	61	54	63	59	57	78	55	52	56
People Promise element 5: We are always learning	PPI_1	Development sub-score	64	63	53	64	65	64	65	62	64	63	71	71	65	66	62	64	72	78	56	56	63	64	66	66	64	62	57
	PPI_2	Appraisals sub-score	45	43	22	49	28	43	59	43	49	48	54	49	28	48	48	53	59	63	28	43	55	48	42	33	59	28	27
	PPS	We are always learning score	54	52	28	56	52	53	63	52	57	55	63	61	52	57	58	58	65	66	46	58	59	56	54	49	57	58	42
People Promise element 6: We work flexibly	PPI_1	Supportive work-life balance sub-score	59	45	64	55	56	64	66	67	71	61	62	73	65	57	54	67	67	69	57	54	57	62	56	71	56	56	58
	PPI_2	Flexible working sub-score	57	43	65	53	56	63	63	59	73	61	64	78	69	54	56	69	63	77	58	52	48	57	53	75	55	58	68
	PPF	We work flexibly score	58	44	65	54	56	64	65	63	72	61	63	76	67	56	55	69	65	73	54	53	53	68	56	73	56	57	59
People Promise element 7: We are a team	PPT_1	Team working sub-score	68	61	68	65	66	69	72	75	78	65	67	74	78	65	63	71	77	72	82	62	78	67	68	78	66	65	65
	PPT_2	Line management sub-score	65	58	68	68	67	78	73	74	71	68	68	72	76	64	58	76	64	76	68	62	78	78	67	72	62	64	68
	PPT	We are a team score	66	61	68	68	67	78	73	74	78	65	67	73	73	64	61	73	61	74	61	62	78	69	67	71	64	64	67
Theme: Staff Engagement	E_1	Motivation sub-score	78	68	78	71	69	76	75	74	74	68	68	82	78	78	78	71	77	76	68	65	78	71	78	74	72	69	68
	E_2	Involvement sub-score	68	59	61	65	69	76	75	77	78	68	78	72	72	67	66	76	65	78	63	61	72	71	71	75	64	66	78
	E_3	Advocacy sub-score	72	66	73	78	71	76	78	81	78	75	71	68	78	71	69	75	65	74	68	66	74	72	77	75	67	73	71
	E_4	Staff Engagement Score	78	64	71	72	78	76	76	77	74	78	69	78	76	69	68	74	62	76	66	64	72	71	72	75	68	69	78
Theme: Morale	M_1	Thinking about leaving sub-score	56	65	56	57	57	57	63	63	61	56	54	67	62	55	52	61	63	49	56	49	53	58	57	59	54	55	67
	M_2	Work pressure sub-score	52	46	53	48	53	59	62	61	66	55	52	66	67	58	48	59	51	72	58	48	55	48	54	63	58	41	41
	M_3	Stressors (HSE index) sub-score	62	56	65	68	61	69	66	68	68	63	63	71	69	61	68	71	73	74	61	56	65	65	64	69	68	68	63
	M_4	Morale score	56	55	58	55	57	62	63	64	65	58	56	68	68	55	53	64	62	65	59	51	58	57	58	64	55	52	51

Additional Reports - Band

Section	Q	Description	Locality 8	Comparator (Organisation Overall)	Ad Hoc	Apprentice	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	Medical Consultant	Medical Staff Grade	Medical Trust/Training
				n = 3025	n = 12	n = 18	n = 235	n = 250	n = 193	n = 597	n = 562	n = 446	n = 167	n = 70	n = 30	n = 20	n = 11	n = 254	n = 18	n = 135
ople Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score		5.3	6.4	5.7	5.8	5.9	5.9	5.3	5.1	5.2	5.3	5.2	5.8	4.9	6.6	4.6	4.7	4.7
	PP4_2	Burnout sub-score		4.6	6.2	4.8	4.9	5.2	5.2	4.3	4.1	4.5	4.7	5.1	5.7	5.0	5.4	4.5	5.2	4.2
	PP4_3	Negative experiences sub-score		7.3	8.7	7.8	6.8	7.4	8.1	7.0	7.1	7.4	7.8	8.3	8.6	8.1	8.8	7.5	7.5	7.4
	PP4	We are safe and healthy score		5.7	7.1	5.9	5.9	6.1	6.4	5.5	5.4	5.7	5.9	6.2	6.7	6.0	6.9	5.5	5.9	5.4
ople Promise element 5: We are always learning	PP5_1	Development sub-score		6.4	7.6	7.5	6.3	5.7	5.6	6.6	6.4	6.2	6.5	6.7	7.3	7.2	8.2	6.4	5.1	6.7
	PP5_2	Appraisals sub-score		4.5	6.0	3.8	4.9	4.5	3.7	5.3	4.7	4.0	4.0	4.2	5.1	3.1	6.7	3.9	4.4	3.6
	PP5	We are always learning score		5.4	6.8	5.8	5.6	5.1	4.6	6.0	5.5	5.1	5.3	5.4	6.2	5.1	7.4	5.1	4.8	5.2
ople Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score		5.9	7.0	6.2	6.1	6.1	6.0	6.0	5.8	6.0	6.1	6.3	6.8	5.6	7.1	5.0	5.1	4.5
	PP6_2	Flexible working sub-score		5.7	6.5	5.3	5.6	5.7	5.4	5.5	5.7	6.0	6.4	7.0	7.9	5.9	8.2	5.5	4.4	4.0
	PP6	We work flexibly score		5.8	6.7	5.7	5.8	5.9	5.8	5.8	5.8	6.0	6.3	6.6	7.4	5.8	7.7	5.3	4.9	4.3
ople Promise element 7: We are a team	PP7_1	Team working sub-score		6.6	7.8	7.1	6.5	6.3	6.7	6.7	6.6	6.5	6.7	7.3	7.6	7.1	8.5	6.3	5.8	6.5
	PP7_2	Line management sub-score		6.5	7.7	7.1	6.0	6.5	6.7	6.6	6.6	6.6	6.9	7.3	7.6	7.4	8.4	5.9	6.1	6.1
	PP7	We are a team score		6.6	7.8	7.1	6.2	6.4	6.7	6.6	6.6	6.6	6.8	7.3	7.6	7.2	8.4	6.1	5.9	6.3
Theme: Staff Engagement	E_1	Motivation sub-score		7.0	8.8	7.7	7.3	7.1	7.0	6.9	6.8	7.0	7.4	7.3	8.1	7.4	8.1	6.9	6.3	6.9
	E_2	Involvement sub-score		6.8	8.6	6.3	6.3	6.3	6.6	6.6	6.7	7.2	7.2	8.1	8.7	8.4	9.6	6.6	5.1	6.2
	E_3	Advocacy sub-score		7.2	9.2	7.8	7.2	7.3	7.2	7.2	7.1	7.1	7.4	7.6	8.5	8.0	9.2	6.8	6.8	6.7
	E_4	Staff Engagement Score		7.0	8.8	7.2	6.9	6.9	6.9	6.9	6.9	7.1	7.3	7.7	8.5	7.9	9.0	6.7	6.1	6.6
Theme: Morale	M_1	Thinking about leaving sub-score		5.6	7.1	6.7	5.9	6.0	5.4	5.2	5.2	5.4	5.6	6.0	6.3	6.3	7.2	6.5	6.4	5.5
	M_2	Work pressure sub-score		5.2	6.3	5.7	5.6	5.8	5.9	5.3	4.9	4.9	5.0	5.1	5.8	4.9	6.7	4.3	5.0	4.9
	M_3	Stressors (HSE index) sub-score		6.2	7.4	6.2	6.0	6.1	6.4	6.2	6.1	6.3	6.5	6.9	7.3	6.9	7.7	6.0	5.1	5.7
	M_4	Morale score		5.6	6.9	6.2	5.8	6.0	6.0	5.5	5.4	5.5	5.7	6.0	6.5	6.0	7.2	5.6	5.3	5.4

Additional Reports – Staff Group

Section	Q	Description	Staff group	Comparator (Organisation Overall)	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Students
				n = 3025	n = 145	n = 375	n = 631	n = 183	n = 1	n = 16	n = 410	n = 1260	n = 4
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score		7.4	7.3	7.6	7.5	7.4	*	7.7	7.1	7.4	*
	PP1_2	Compassionate leadership sub-score		6.7	7.0	6.4	7.0	7.3	*	6.9	6.2	6.7	*
	PP1_3	Diversity and equality sub-score		7.7	8.0	7.5	8.0	8.3	*	7.3	7.6	7.5	*
	PP1_4	Inclusion sub-score		6.8	6.9	6.5	6.9	7.1	*	6.5	6.5	6.8	*
	PP1	We are compassionate and inclusive score		7.1	7.3	7.0	7.4	7.5	*	7.1	6.9	7.1	*
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score		5.7	5.9	5.5	6.1	6.0	*	6.3	5.5	5.6	*
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score		6.9	7.0	6.6	7.2	7.3	*	7.0	6.6	6.9	*
	PP3_2	Raising concerns sub-score		6.5	6.5	6.5	6.7	6.6	*	6.6	6.1	6.5	*
	PP3	We each have a voice that counts score		6.7	6.8	6.5	6.9	6.9	*	6.8	6.3	6.7	*
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score		5.3	5.2	5.7	5.9	5.1	*	5.2	4.6	5.1	*
	PP4_2	Burnout sub-score		4.6	4.7	4.9	5.4	4.6	*	5.2	4.5	4.0	*
	PP4_3	Negative experiences sub-score		7.3	8.2	7.0	8.1	7.6	*	7.6	7.5	6.9	*
	PP4	We are safe and healthy score		5.7	6.0	5.8	6.5	5.8	*	6.0	5.5	5.3	*
People Promise element 5: We are always learning	PP5_1	Development sub-score		6.4	6.0	6.2	6.0	6.7	*	6.1	6.4	6.5	*
	PP5_2	Appraisals sub-score		4.5	4.8	5.1	3.7	4.6	*	3.7	3.9	4.8	*
	PP5	We are always learning score		5.4	5.5	5.7	4.9	5.6	*	4.9	5.1	5.7	*
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score		5.9	5.6	6.0	6.4	6.0	*	5.9	4.9	5.9	*
	PP6_2	Flexible working sub-score		5.7	4.9	5.6	6.2	5.7	*	5.3	5.0	5.8	*
	PP6	We work flexibly score		5.8	5.2	5.8	6.3	5.9	*	5.6	4.9	5.9	*
People Promise element 7: We are a team	PP7_1	Team working sub-score		6.6	6.8	6.5	6.7	6.8	*	6.4	6.4	6.6	*
	PP7_2	Line management sub-score		6.5	6.9	6.2	6.9	7.1	*	6.7	6.0	6.5	*
	PP7	We are a team score		6.6	6.8	6.4	6.8	7.0	*	6.5	6.2	6.5	*
Theme: Staff Engagement	E_1	Motivation sub-score		7.0	6.9	7.2	7.3	7.1	*	7.1	6.9	6.9	*
	E_2	Involvement sub-score		6.8	6.9	6.4	6.9	7.3	*	6.6	6.4	6.8	*
	E_3	Advocacy sub-score		7.2	7.1	7.4	7.4	7.2	*	7.5	6.8	7.1	*
	E_4	Staff Engagement Score		7.0	7.0	7.0	7.2	7.2	*	7.1	6.7	6.9	*
Theme: Morale	M_1	Thinking about leaving sub-score		5.6	5.2	6.0	5.7	5.7	*	5.8	6.1	5.2	*
	M_2	Work pressure sub-score		5.2	5.3	5.6	5.9	4.9	*	4.9	4.5	4.9	*
	M_3	Stressors (HSE index) sub-score		6.2	6.4	6.0	6.6	6.5	*	6.1	5.9	6.1	*
	M_4	Morale score		5.6	5.6	5.8	6.1	5.7	*	5.6	5.5	5.4	*

Additional Reports - Age

Section	Q	Description	Age (q24c) / Comparator (Organisation Overall)	16-20	21-30	31-40	41-50	51-65	66+
			n = 3025	n = 6	n = 607	n = 806	n = 720	n = 678	n = 44
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score	7.4	*	7.1	7.4	7.5	7.5	8.1
	PP1_2	Compassionate leadership sub-score	6.7	*	6.7	6.8	6.8	6.6	7.0
	PP1_3	Diversity and equality sub-score	7.7	*	7.8	7.7	7.7	7.6	8.3
	PP1_4	Inclusion sub-score	6.8	*	6.6	6.8	6.9	6.8	7.4
	PP1	We are compassionate and inclusive score	7.1	*	7.1	7.2	7.2	7.1	7.7
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	5.7	*	5.4	5.7	5.9	5.9	6.7
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	6.9	*	6.7	6.9	7.1	6.9	7.4
	PP3_2	Raising concerns sub-score	6.5	*	6.2	6.4	6.6	6.6	7.4
	PP3	We each have a voice that counts score	6.7	*	6.4	6.7	6.9	6.8	7.4
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.3	*	5.0	5.3	5.4	5.5	6.4
	PP4_2	Burnout sub-score	4.6	*	3.9	4.5	4.7	4.9	6.7
	PP4_3	Negative experiences sub-score	7.3	*	7.0	7.3	7.4	7.5	8.7
	PP4	We are safe and healthy score	5.7	*	5.3	5.7	5.8	6.0	7.2
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.4	*	6.6	6.5	6.3	6.1	6.7
	PP5_2	Appraisals sub-score	4.5	*	4.2	4.6	4.7	4.3	5.4
	PP5	We are always learning score	5.4	*	5.4	5.5	5.5	5.2	6.0
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	5.9	*	5.4	5.9	6.1	6.0	7.0
	PP6_2	Flexible working sub-score	5.7	*	4.9	5.7	6.2	5.9	7.6
	PP6	We work flexibly score	5.8	*	5.1	5.8	6.1	6.0	7.3
People Promise element 7: We are a team	PP7_1	Team working sub-score	6.6	*	6.5	6.6	6.7	6.6	7.1
	PP7_2	Line management sub-score	6.5	*	6.4	6.7	6.7	6.4	6.8
	PP7	We are a team score	6.6	*	6.4	6.7	6.7	6.5	7.0
Theme: Staff Engagement	E_1	Motivation sub-score	7.0	*	6.6	7.0	7.3	7.3	8.4
	E_2	Involvement sub-score	6.8	*	6.5	6.8	7.0	6.7	7.1
	E_3	Advocacy sub-score	7.2	*	6.9	7.2	7.3	7.3	8.1
	E_4	Staff Engagement Score	7.0	*	6.7	7.0	7.2	7.1	7.8
Theme: Morale	M_1	Thinking about leaving sub-score	5.6	*	5.0	5.2	5.8	6.0	8.0
	M_2	Work pressure sub-score	5.2	*	4.8	5.2	5.3	5.3	6.3
	M_3	Stressors (HSE index) sub-score	6.2	*	6.0	6.3	6.3	6.2	6.8
	M_4	Morale score	5.6	*	5.3	5.6	5.8	5.9	7.0

Additional Reports - Disability

		Disability (q28a)	Comparator (Organisation Overall)	Yes	No
Section	Q	Description	n = 3025	n = 403	n = 2454
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score	7.4	7.0	7.5
	PP1_2	Compassionate leadership sub-score	6.7	6.3	6.8
	PP1_3	Diversity and equality sub-score	7.7	7.2	7.8
	PP1_4	Inclusion sub-score	6.8	6.4	6.9
	PP1	We are compassionate and inclusive score	7.1	6.7	7.2
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	5.7	5.2	5.8
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	6.9	6.6	7.0
	PP3_2	Raising concerns sub-score	6.5	5.9	6.6
	PP3	We each have a voice that counts score	6.7	6.2	6.8
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.3	4.7	5.4
	PP4_2	Burnout sub-score	4.6	3.8	4.7
	PP4_3	Negative experiences sub-score	7.3	6.6	7.5
	PP4	We are safe and healthy score	5.7	5.0	5.9
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.4	5.9	6.5
	PP5_2	Appraisals sub-score	4.5	3.3	4.7
	PP5	We are always learning score	5.4	4.6	5.6
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	5.9	5.3	6.0
	PP6_2	Flexible working sub-score	5.7	5.4	5.8
	PP6	We work flexibly score	5.8	5.4	5.9
People Promise element 7: We are a team	PP7_1	Team working sub-score	6.6	6.2	6.7
	PP7_2	Line management sub-score	6.5	6.1	6.6
	PP7	We are a team score	6.6	6.2	6.7
Theme: Staff Engagement	E_1	Motivation sub-score	7.0	6.6	7.1
	E_2	Involvement sub-score	6.8	6.4	6.9
	E_3	Advocacy sub-score	7.2	6.8	7.3
	E_4	Staff Engagement Score	7.0	6.6	7.1
Theme: Morale	M_1	Thinking about leaving sub-score	5.6	5.1	5.7
	M_2	Work pressure sub-score	5.2	4.4	5.3
	M_3	Stressors (HSE index) sub-score	6.2	5.8	6.3
	M_4	Morale score	5.6	5.1	5.8

Additional Reports - Ethnicity

		Ethnicity - Grouped (q25)	Comparator (Organisation Overall)	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other Ethnic Group	White
Section	Q	Description	n = 3025	n = 837	n = 337	n = 113	n = 103	n = 1399
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score	7.4	7.5	7.8	7.0	7.5	7.3
	PP1_2	Compassionate leadership sub-score	6.7	6.7	6.9	6.4	6.3	6.8
	PP1_3	Diversity and equality sub-score	7.7	7.4	6.9	7.2	7.1	8.2
	PP1_4	Inclusion sub-score	6.8	6.8	6.7	6.5	6.4	6.9
	PP1	We are compassionate and inclusive score	7.1	7.1	7.1	6.8	6.8	7.3
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	5.7	5.9	5.8	5.3	5.5	5.8
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	6.9	7.0	6.8	6.4	6.8	6.9
	PP3_2	Raising concerns sub-score	6.5	6.4	6.6	5.7	6.3	6.6
	PP3	We each have a voice that counts score	6.7	6.7	6.7	6.0	6.6	6.8
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.3	5.5	5.8	4.8	5.4	5.1
	PP4_2	Burnout sub-score	4.6	4.4	5.1	4.1	4.3	4.6
	PP4_3	Negative experiences sub-score	7.3	7.1	7.5	7.1	6.8	7.5
	PP4	We are safe and healthy score	5.7	5.7	6.1	5.3	5.5	5.7
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.4	6.5	6.2	5.8	6.5	6.3
	PP5_2	Appraisals sub-score	4.5	5.5	5.2	3.6	5.2	3.8
	PP5	We are always learning score	5.4	6.0	5.7	4.7	5.9	5.1
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	5.9	6.0	6.3	5.0	5.9	5.8
	PP6_2	Flexible working sub-score	5.7	5.7	6.0	5.1	5.2	5.8
	PP6	We work flexibly score	5.8	5.9	6.2	5.0	5.6	5.8
People Promise element 7: We are a team	PP7_1	Team working sub-score	6.6	6.8	6.8	6.3	6.4	6.5
	PP7_2	Line management sub-score	6.5	6.7	6.7	6.2	6.1	6.5
	PP7	We are a team score	6.6	6.7	6.7	6.3	6.2	6.5
Theme: Staff Engagement	E_1	Motivation sub-score	7.0	7.3	7.3	6.5	7.1	6.9
	E_2	Involvement sub-score	6.8	6.9	6.7	6.1	6.6	6.8
	E_3	Advocacy sub-score	7.2	7.3	7.6	6.6	7.2	7.1
	E_4	Staff Engagement Score	7.0	7.2	7.2	6.4	7.0	6.9
Theme: Morale	M_1	Thinking about leaving sub-score	5.6	5.5	5.5	5.0	5.5	5.7
	M_2	Work pressure sub-score	5.2	5.6	5.5	4.4	5.7	4.9
	M_3	Stressors (HSE index) sub-score	6.2	6.3	6.3	6.0	5.9	6.2
	M_4	Morale score	5.6	5.8	5.8	5.1	5.7	5.6

Sexual Orientation

		Sexuality grouped (q26)	Comparator (Organisation Overall)	Gay, Lesbian, Bisexual and Other	Heterosexual or Straight	I would prefer not to say
Section	Q	Description	n = 3025	n = 205	n = 2465	n = 179
People Promise element 1: We are recognised and rewarded	PP1_1	Compassionate culture sub-score	7.4	7.4	7.5	6.6
	PP1_2	Compassionate leadership sub-score	6.7	6.7	6.8	5.7
	PP1_3	Diversity and equality sub-score	7.7	7.7	7.8	6.8
	PP1_4	Inclusion sub-score	6.8	6.6	6.9	6.1
	PP1	We are compassionate and inclusive score	7.1	7.1	7.2	6.3
People Promise element 2: We are recognised and rewarded	PP2	We are recognised and rewarded score	5.7	5.7	5.8	5.0
People Promise element 3: We each have a voice that counts	PP3_1	Autonomy and control sub-score	6.9	6.8	7.0	6.2
	PP3_2	Raising concerns sub-score	6.5	6.4	6.5	5.6
	PP3	We each have a voice that counts score	6.7	6.6	6.8	5.9
People Promise element 4: We are safe and healthy	PP4_1	Health and safety climate sub-score	5.3	5.2	5.4	4.5
	PP4_2	Burnout sub-score	4.6	4.3	4.6	4.1
	PP4_3	Negative experiences sub-score	7.3	7.0	7.4	6.7
	PP4	We are safe and healthy score	5.7	5.5	5.8	5.1
People Promise element 5: We are always learning	PP5_1	Development sub-score	6.4	6.5	6.4	5.7
	PP5_2	Appraisals sub-score	4.5	4.2	4.6	3.6
	PP5	We are always learning score	5.4	5.4	5.5	4.7
People Promise element 6: We work flexibly	PP6_1	Support for work-life balance sub-score	5.9	5.9	5.9	5.1
	PP6_2	Flexible working sub-score	5.7	5.5	5.8	5.0
	PP6	We work flexibly score	5.8	5.7	5.9	5.0
People Promise element 7: We are a team	PP7_1	Team working sub-score	6.6	6.4	6.7	6.0
	PP7_2	Line management sub-score	6.5	6.5	6.6	5.6
	PP7	We are a team score	6.6	6.4	6.6	5.8
Theme: Staff Engagement	E_1	Motivation sub-score	7.0	6.6	7.1	6.2
	E_2	Involvement sub-score	6.8	6.7	6.9	5.9
	E_3	Advocacy sub-score	7.2	7.1	7.3	6.2
	E_4	Staff Engagement Score	7.0	6.8	7.1	6.1
Theme: Morale	M_1	Thinking about leaving sub-score	5.6	5.1	5.7	4.5
	M_2	Work pressure sub-score	5.2	5.0	5.2	4.3
	M_3	Stressors (HSE index) sub-score	6.2	6.1	6.3	5.5
	M_4	Morale score	5.6	5.4	5.7	4.8

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting 5 May 2022

AGENDA ITEM NO.	3.1
TITLE OF REPORT	Board Assurance Framework 2022-23
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To present the revised and opening Board Assurance Framework for 2022/23 and to:- • Seek approval from the Board that this represents our most significant strategic risks • Seek assurance from the Board that the controls, assurances, gaps and actions are sufficient to support mitigation of the described risks
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome CEO Cabinet / Feb 22 / Agreed EMB / March 22 / Agreed Quality Committee / April and May 22 / Agreed Audit and Risk Committee / March 22 / Agreed Finance and Investment Committee / March and April 22 / Agreed People and OD Committee / March 22 and via e governance April 22 / Agreed
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	During February 2022, the Board dedicated a development and strategy session to the redevelopment of the Board Assurance Framework. This included a review of the architecture of the Framework alongside a review of our most significant strategic risks. The attached document has been populated in partnership with each relevant governing Committee with strong engagement from the Chair and Executive Lead of each Committee, together with the Interim Director of Corporate Governance and Compliance.

	Whilst some gross inherent risk scores are noted as 'red', these have been mitigated by a range of controls and assurances as detailed in the supporting templates to this covering report. Actions to further mitigate risks are also detailed where risks sit outside our risk tolerance/appetite level.
KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	X
Quality	X
People (Workforce or Patients/ Families/Carers)	X
Operational Performance	X
Finance	X
Public Consultation	
Council of Governors	
please mark Y/N – where Y is indicated please explain the implications in the opposite column	

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

CHELSEA AND WESTMINSTER NHS FOUNDATION TRUST BOARD ASSURANCE FRAMEWORK - APRIL 2022

	BAF SUMMARY					
	LEAD EXEC. DIRECTOR (ED) ---------- MONITORING COMMITTEE	RISK	RATING	TARGET/RISK APPETITE	MOVEMENT SINCE LAST REVIEW	LAST ED REVIEW ---------- MONITORING COMMITTEE
	1. Deliver High Quality Patient Centred Care – Patients, their families and carers will be treated with unfailing kindness and respect by every member of staff in every department and their experience and quality of care will be second to none					
1.1	Chief Nursing Officer and Chief Medical Officer Quality Committee	Failure to ensure the application of clinical and operational processes within an increasingly complex environment could compromise the delivery of outstanding high quality, safe and patient-centred care	9	4-6 AVOID	⟷	April 2022
1.2	Chief Nursing Officer and Chief Medical Officer Quality Committee	Failure to innovate and co-produce quality improvements with our staff, patients, carers and stakeholders/partners could drive health inequalities in outcomes and patient experience	8	4-6 AVOID	⟷	April 2022
1.3	Chief Medical Officer Quality Committee	Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.	9	8-12 SEEK	⟷	April 2022
1.4	Deputy Chief Executive/COO Quality Committee	Risk that the population's continuously changing need for services exceeds the Trust's capability and capacity to respond in a timely way. Where there are instances of demand outstripping supply, there is a risk that quality and safety of care will be compromised, the needs of the service users could be insufficiently met and this will lead to poorer health outcomes and experiences.	12	6-9 OPEN	⟷	April 2022
	2. Be the Employer of Choice – We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers and we will recruit and retain people we need to deliver high-quality services to our patients					

2.1	Director of People and OD People and OD Committee	Insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives	12	6-9 OPEN		April 2022
2.2	Director of People and OD People and OD Committee	A failure to look after our staff's physical and mental wellbeing could lead to: reduced retention of staff, increased sickness levels, pressure on staff and decreased resilience, poor staff morale; over-reliance on agency staffing at high cost/premiums, the potential impairment in service quality; and loss of the Trusts strategic ambition to be the Employer of Choice	12	4-8 CAUTIOUS		April 2022
2.3	Director of People and OD People and OD Committee	Failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain	12	8-12 SEEK		April 2022
2.4	Director of People and OD People and OD Committee	A failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of which could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.	12	4-8 CAUTIOUS		April 2022

	3. Sustainability:- We will look to continuously improve the quality of care and patient experience through the best use of our financial, physical and human resources including collaborative working					
3.1	Chief Executive Trust Board	Failure of the Integrated Care Systems and Provider Collaboratives in which we work to deliver transformation, reduce health inequalities, integrated care, maintain financial equilibrium and share risk responsibly may impact adversely compromising service delivery and the quality of patient care.	12	8-12 SEEK	⟷	April 2022
3.2	Chief Financial Officer Finance and Investment Committee	Failure to deliver a fit for purpose digital and physical estate to deliver the Trust's clinical strategy and strategic objectives through ineffective business planning arrangements and/or inadequate mechanisms to track and control delivery of plans and programmes.,	12	8-12 SEEK	⟷	April 2022
3.3	Chief Financial Officer Finance and Investment Committee	Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England & Improvement; NWL ICS constraints; and insufficient cash to fund future capital programmes.	12	6-9 OPEN	⟷	April 2022
3.4	Chief Information Officer Audit and Risk Committee	Failure to protect the integrity and security of our information could lead to: cyberattacks which could compromise the Trust's infrastructure and ability to deliver services and patient care; data loss or theft affecting patients, staff or finances; reputational damage and/or personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions)	12	4-8 CAUTIOUS	⟷	April 2022
3.5	Chief Financial Officer Finance and Investment Committee	A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line	9	8-12 SEEK	⟷	April 2022

		with national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (30%, 50% and 80% reduction in emissions by 2023, 2025 and 2030 respectively, and net zero carbon by 2040), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.				
3.6	Deputy Chief Executive/ COO Finance and Investment Committee	Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.	12	6-9 OPEN		April 2022

RISK TARGET SCORE/RISK APPETITE KEY

AVOID	Unsafe Delivery is the Priority	4-6
CAUTIOUS	Safe Delivery Required	4-8
OPEN	A Balance of Risk and Reward	6-9
SEEK	Eager to be Innovative	8-12

Strategic Objective: Deliver High Quality Patient Centred Care

1.1: Failure to ensure the application of clinical and operational processes within an increasingly complex environment could compromise the delivery of outstanding high quality, safe and patient-centred care.

Date added to BAF	March 2022
Monitoring Committee	Quality Committee
Executive Lead	Chief Nursing Officer / Chief Medical Officer
Date of last review	09/04/2022
Risk movement	N/A (New risk)
Date of next review	July 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	Major (4)	Likely (4)	Extreme (16)
Current risk rating	Moderate (3)	Possible (3)	High (9)
Target risk rating			4-6

Controls	Assurance	Gaps	Actions
• Clinical Guidelines • Policies and Procedures • Mandatory Training • Clinical Audit Programme • Internal Audit Programme • External Audit Programme • Complaints Management • Serious Incident Root Cause Analysis • Quality Deep Dives • Link Director Scheme • Ward Accreditation Process • Hospital and Divisional Triumvirates • Integrated Performance and Quality Report • Patient Safety Specialists • Clinical Pathway Leads • Governance Infrastructure (tier 3 and 4)	**Level 1: team level** • Performance review including quality issues (ad hoc) **Level 2: Trust level** • Trust clinical audit outcomes • Trust NICE compliance • Integrated Quality Report KPI performance • CEG reports to Quality Committee • Mortality reports to Quality Committee • PSG and HSERG reports to Quality Committee • SI Reports to Quality Committee and Board • Complaint levels and trends • FFT ratings **Level 3: independent** CQC ratings – good/o/s	**Gaps in Controls** • Lack of routine governance of non clinical policies • Lack of integrated approach, analysis and reporting for common themes impacting on safety, effectiveness and experience • Ward accreditation process needs strengthening to include broader safety and quality indicators • Link Director scheme needs refreshing post covid • Trust documents not accessible outside the organisations network • Trust's electronic document library obsolete **Gaps in Assurance** • SI actions are not	• Recovery plan for non clinical policies to be in place by May 2021 • New intranet / document library to be procured during 2022/23 • Ward accreditation process to be refreshed and implemented by 30 June 2022 • Link Director scheme to be refreshed and implemented by 30 June 2022 • Overdue SI actions to be eradicated by 30 June 2022 • 95% of complaints to be responded to within agreed timeframes by 30 June 2022

• Quality Committee • Trust Board • Audit and Risk Committee • Clinical Effectiveness Group • Patient Safety Group • Mortality Group • QI Programme • Executive Management Board • Medico Legal Grp • CQEIA for change management and new schemes • Clinical Supervision • Peer Reviews • Accreditation Visits • SOM meetings • CQC engagement Meetings • Annual Self Certifications	Accreditation results Peer Review findings Internal Audit Ratings HOIA SHMI and HSMI benchmark levels GIRFT	always being closed in a timely manner • Complaints are not always being closed in a timely manner	

1.2: Failure to innovate and co-produce quality improvements with our staff, patients, carers and stakeholders/partners could drive health inequalities in outcomes and patient experience			
Date added to BAF	March 2022		
Monitoring Committee	Quality Committee		
Executive Lead	Chief Nursing Officer / Chief Medical Officer		
Date of last review	09/04/2022		
Risk movement	N/A (New risk)		
Date of next review	09/10/2022		
	Impact	**Likelihood**	**Rating**
Gross (Inherent) risk rating	Moderate (2)	Almost Certain (5)	High Risk (10)
Current risk rating	Moderate (2)	Likely (4)	High Risk (8)
Target risk rating			4-6
Controls	**Assurance**	**Gaps**	**Actions**
• Quality Improvement Team • Quality Improvement Training Programme • Quality Improvement Methodology and Framework aligned to the Model for Improvement • Quality Committee • Research Patient and Public Involvement	**Level 1: reassurance** **Level 2: internal** **Level 3: independent**	Lack of QI training programme for experts by experience/patients/public Lack of Trust coordination and engagement with groups / forums within North West London and beyond Lack of QI Coach positions	• Redesign QI Training Programme to include Dosing Matrix and Coproduction/Expert by Experience Training Module • Publicise co-production/training module via PPI group and

Forum **Processes** • Quality Strategy (2019-24) • Patient and Public Involvement Strategy • Quality Priorities re patient experience		Lack of QI training dosing matrix No consistent approach to coproduction with patients/carers etc through existing QI approach Lack of interconnectivity between PPI work and QI **<u>Lack of Assurance</u>** No reporting on extent of co-production in QI projects	patients/public • Commence reporting on extent of co-production within QI involving experts by experience • Increase social media presence re QI and coproduction

1.3: Failure to fully realise the Trust's academic and Research and Development (R&D) potential may adversely affect its reputation and lead to loss of opportunity.			
Date added to BAF	March 2022		
Monitoring Committee	Quality Committee		
Executive Lead	Chief Medical Officer		
Date of last review	09/04/2022		
Risk movement	N/A (New risk)		
Date of next review	09/07/2022		
	Impact	**Likelihood**	**Rating**
Gross (Inherent) risk rating	3	4	High Risk (12)
Current risk rating	3	3	High Risk (9)
Target risk rating			8-12
Controls	**Assurance**	**Gaps**	**Actions**
• Research Strategy Board • Executive Management Board • Improvement Board • Quality Committee • Research and Innovation Strategy/Strategic Implementation Plan • Imperial College Relationship • CW+ Innovation Programme and Grants • RIQI Programme • Enterprise Division • Commercial Assurance Board (CAB)	**Level 1: reassurance** Research Operational Group reports to EMB Innovation Programme Tracker Improvement Board reports to EMB **Level 2: internal** R&D reports to Quality Committee and Trust Board Improvement board reports to Quality Committee CAB reports to FIC **Level 3: independent** • Clinical Research	R&D Strategy needs to be aligned to the strategic objectives of the Trust Relationship between R&D, QI , Innovation etc needs review as the Enterprise Division governance is developed so that R&D reports into the division. Making research applicable to our patient population	Refresh of R&D Strategy to be complete by March 2023 Enterprise Division reporting structure to be confirmed by September 2022 Development of at least 1-2 new real world studies related to our patient population by end of 2022-2023

	• Network Benchmarking • Internal Audit Reports		

1.4: Risk that the population's continuously changing need for services exceeds the Trust's capability and capacity to respond in a timely way. Where there are instances of demand outstripping supply, there is a risk that quality and safety of care will be compromised, the needs of the service users could be insufficiently met and this will lead to poorer health outcomes and experiences.

Date added to BAF	March 2022
Monitoring Committee	Quality Committee
Executive Lead	Deputy Chief Executive Officer
Date of last review	09/04/2022
Risk movement	N/A (New risk)
Date of next review	July 2022

	Impact	Likelihood	Rating
Gross Inherent Risk Rating	Major (4)	Likely (4)	Extreme (16)
Current risk rating	Moderate (3)	Likely (4)	High(12)
Target risk rating	Moderate (3)	Possible (3)	(9)

Controls	Assurance	Gaps	Actions
Internal oversight: • Trust Board • Executive Management Board (EMB) • Divisional Quality Boards • Elective recovery Board • Cancer Board • Improvement Board • Accident and Emergency Delivery Board (AEDB) • Productivity Group (Beds) • Productivity Group (Outpatients) • Productivity Group (Theatres) **Sector oversight:** • North West London (NWL) Integrated Care System (ICS) Board • NWL Acute Provider Collaborative CEO Meetings	**Level 1: reassurance** • COO briefings @ EMB / Board **Level 2: internal** Integrated Board performance report: • All constitutional Standards & quality standards Elective Recovery report • All Points of delivery inc Waiting list data • Clinical Prioritisation data Development of End-to-end pathway solution for total oversight (Foundry)	**Gaps in Controls** • Oversight of outpatient pathway demand • Workforce constraints in certain specialties • Funding for NHS contract • Insufficient mental health provision (increasing inappropriate activity and impacting discharge) • Insufficient primary care provision (increasing inappropriate activity) • Insufficient specialist beds / nursing home provision (increasing inappropriate activity and impacting discharge)	• Review outpatient pathways and flow to reduce new to follow up ratio • Develop Medical Workforce Transformation Strategy in close partnership with CMO • Develop new and innovative roles to meet the clinical and therapeutic needs of patients with CNO • Implementation of the Digital Innovation Strategy • Development of the ADC at West Mid and Ground Floor Treatment Centre at Chelsea to provide the physical infrastructure to meet changing patient demand • Continued collaboration at Acute provider and ICS level to identify

• NWL Acute Provider Collaborative COO Meetings • NWL Elective Care Board **Planning / Strategy:** • Demand and capacity modelling • Elective care recovery plan • Engagement with independent sector • Mutual aid provision within acute sector • Site / estate development plans • Operating Plan (22/23) • Getting it right first time (GIRFT) • Business Planning Process	**Level 3: independent** Weekly London Regional Comparative data set	**Gaps in Assurances** • Clinical harm review associated with re-prioritisation (theatres, diagnostic, outpatients)	opportunities to remove barriers and align systems to aid patient flow

Strategic Objective: Be the Employer of Choice

2.1: Growing for the future: insufficient or ineffective planning for current and future workforce requirements (including number of staff, skill-mix and training) may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.

Date added to BAF	March 2022		
Monitoring Committee	People & Organisational Development (P&OD) Committee		
Executive Lead	Interim Director of People & Organisational Development		
Date of last review	March 2022		
Risk movement	N/A		
Date of next review	May 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	Extreme (16)
Current risk rating	4	3	High (12)
Target risk rating	3	2	6

Controls	Assurance	Gaps	Actions
• People Strategy • Workforce Development Committee • Education Strategy Board • Executive Management Board • P&OD Committee • Trust Board • System Oversight Meeting • NWL ICS Growing for the Future Board	**Level 1: reassurance** • Divisional performance reports and deep dives **Level 2: internal** • Monthly Workforce report • Quarterly heat maps • Utilisation of apprenticeship levy • % volunteers into employment • Increased local employment • Reduced vacancy rates in core professions **Level 3: independent** • NWL ICS People Plan Goal 3: Grow We have the capacity to delivery great care	• People reset & recovery programme actions • Reset of the People Programme to deliver against the agreed 4 key sections of the new People Strategy • HCSW vacancies (17%) • Hard to recruit roles identified • Voluntary turnover increasing (14%)	• Focus on appraisal recovery plan • Recruitment to key vacancies to support delivery • NWL ICS HCSW campaign (28 04 22) • North West London Academy launched • Retention Steering Group to be relaunched

2.2: Looking after our people: a failure to look after our staff's physical and mental wellbeing could lead to: reduced retention of staff, increased sickness levels, pressure on staff and decreased resilience, poor staff morale; over-reliance on agency staffing at high cost/premiums, the potential impairment in service quality; and loss of the Trusts strategic ambition to be the Employer of Choice.

Date added to BAF	March 2022		
Monitoring Committee	People & Organisational Development Committee		
Executive Lead	Interim Director of People & Organisational Development		
Date of last review	March 2022		
Risk movement	N/A		
Date of next review	May 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	Extreme (16)
Current risk rating	4	3	High (12)
Target risk rating	3	2	6

Controls	Assurance	Gaps	Actions
• People Strategy • Workforce Development Committee • Executive Management Board • P&OD Committee • Trust Board • System Oversight Meeting • NWL ICS Keeping Well Programme Board	**Level 1: reassurance** • Divisional performance reports and deep dives **Level 2: internal** • Monthly People Strategy report • Quarterly heat maps • Staff Survey Results • Uptake of health and wellbeing offers • 3 year Health and Wellbeing Action plan • Health & Wellbeing Guardian (NED) **Level 3: independent** • NWL ICS People Plan Goal 1: Care We have a happy, healthy and engaged workforce	• Review and refresh year 2 of the action plan • Refresh Appraisal Policy to embed the health & wellbeing conversation for all staff • Expansion and continued support for H&WB Champions (66) and MHFAs (104)	• Workforce development Committee (May '22) • Draft Appraisal Policy to go to Partnership Forum (June '22) • Additional MHFAs and Champions to be trained.

2.3: New ways of working & delivering care: a failure to maintain a coherent and co-ordinated structure and approach to succession planning, organisational development and leadership development may jeopardise: the development of robust clinical and non-clinical leadership to support service delivery and change; staff being supported in their career development and to maintain competencies and training attendance; staff retention; and the Trust being a "well-led" organisation under the CQC domain.

Date added to BAF	March 2022		
Monitoring Committee	People & Organisational Development Committee		
Executive Lead	Interim Director of People & Organisational Development		
Date of last review	March 2022		
Risk movement	N/A		
Date of next review	May 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	Extreme (16)
Current risk rating	4	3	High (12)
Target risk rating	3	2	6

Controls	Assurance	Gaps	Actions
• People Strategy • Workforce Development Committee • Executive Management Board • P&OD Committee • Trust Board • System Oversight Meeting • NWL ICS Growing for the Future Board	**Level 1: reassurance** • Divisional performance reports and deep dives **Level 2: internal** • Monthly People Strategy report • Quarterly heat maps • Numbers of staff transitioning to qualitied posts • Increase in new roles (physician Associates & Nursing Associates) • Staff Survey Results • Timewise Accredited Partnership Programme • Number of staff using e roster • Training Needs Analysis – clinical staff **Level 3: independent** • NWL ICS People Plan Goal 4: Transform We have the skills to deliver 21st Century Care	• Succession planning process • Initiatives to identify future leaders (talent management) including how these link to EDI strategy • Staff survey results – flexible working • Rollout of e rostering • Rollout of e job planning • Increase volunteering into employment	• Work with acute collaborative to adopt a best practice approach for roll out in Q3 • Work with acute collaborative to develop a Talent Management Strategy to be piloted in Q4 • Relaunch approach to flexible working • All staff on e roster by Aug '22 • All medical staff on e job plans by 2024 • Pilot site for NWL ICS volunteering into employment initiative

2.4: Belonging at our inclusive organisation: a failure to develop and maintain our culture in line with the Trust values and the NHS people promise which includes: being compassionate and inclusive, recognition and reward, having a voice that counts, health, safety & wellbeing of staff, working flexibly, supporting learning & development, promoting equality, diversity & inclusivity and fostering a team culture. The absence of which could result in; harm to staff; an inability to recruit and retain staff; a workforce which does not reflect Trust and NHS values; and poorer service delivery.

Date added to BAF	March 2022		
Monitoring Committee	People & Organisational Development Committee		
Executive Lead	Interim Director of People & Organisational Development		
Date of last review	March 2022		
Risk movement	N/A		
Date of next review	May 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	Extreme (16)
Current risk rating	4	3	High (12)
Target risk rating	3	2	6

Controls	Assurance	Gaps	Actions
• People Strategy • Workforce Development Committee (WDC) • Executive Management Board • P&OD Committee • Trust Board • System Oversight Meeting • NWL ICS Inclusion Board	**Level 1: reassurance** • Divisional staff survey pledges / action plans **Level 2: internal** • EDI 3 year plan agreed with key actions including harassment and bullying • Kindness campaign • Staff Survey Report • Staff networks updates quarterly to committees • WRES/WDES/EDS2/Gender Pay Gap Improvements • Increase in numbers of BAME staff in Bands 8a and above • Reciprocal mentoring programme • Maintain Fairness and a Just Culture in response to disciplinary, grievance, and performance management processes and culture • Leadership Ladder initiative • Freedom to Speak Up Guardian • **Level 3: independent** • NWL ICS People Plan Goal 2: Lead Goal 3: Include	• Disability Confident Status level 3 • Delivery of year 2 of the EDI action plan • Continue to work to improve our metrics across WRES.WDES/Gender Pay Gap/ EDS2 and deliver our model employer targets • Fairness in recruitment processes and progression opportunities for underrepresented staff (model employer)	• Currently Level 2 but action plan in place to achieve level 3 • Refresh Year 2 EDI plan to be signed off by WDC (May 2022) • Agree refreshed action plans through WDC • Increase D&I champions in support of panels @ band 6 & 7

	We care and staff report positive experiences and we are inclusive and succeed because of our differences		

Strategic Objective: Sustainability

3.1: Failure of the Integrated Care Systems and Provider Collaboratives in which we work to deliver transformation, reduce health inequalities, integrated care, maintain financial equilibrium and share risk responsibly may impact adversely compromising service delivery and the quality of patient care.

Date added to BAF	March 2022		
Monitoring Committee	Trust Board		
Executive Lead	Chief Financial Officer		
Date of last review	April 2022		
Risk movement	⟷		
Date of next review	June 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	4	3	12
Target risk rating			8-12

Controls	Assurance	Gaps	Actions
• ICS Chair and CEO • NWL ICS Provider Board • ICS Exec Meetings • NWL CEO Group Forum • NWL Elective Recovery Programme • Single Oversight Meetings • Mutual Aid Arrangements • NWL Chair in Common • NWL Acute Provider Collaborative Chairs Meetings • NWL Acute Provider Collaborative CEO Meetings • NWL Acute Provider Collaborative Director of Governance Meetings	**Level 1: reassurance** Divisional performance reports and deep dives **Level 2: internal** Elective Recovery programme reports to Quality Committee and Trust Board CEO Reports on ICS Developments to Board **Level 3: independent**	• Statement of Intent • Single Board Governance arrangements for Provider Collaborative • Alignment of Provider Board Committee cycles and timings • Common reporting dataset across Acute Provider Collaborative • Delayed Transfers of Care Remain a challenge – wider system working needed to support patients to be discharged to suitable place of residence	• Statement of Intent to Board April/May 2022 • Single Board Governance arrangements to be in place by September 2022 • Alignment of Provider Board Committee cycles and timings to be in place by June 2022 • Common reporting dataset commissioned • Chelwest CEO leading national discharge programme

• NWL CFO Meetings • NWL COO Meetings			

3.2: Failure to deliver a fit for purpose digital and physical estate to deliver the Trust's clinical strategy and strategic objectives through ineffective business planning arrangements and/or inadequate mechanisms to track and control delivery of plans and programmes.

Date added to BAF	March 2022		
Monitoring Committee	Finance & Investment Committee		
Executive Lead	Chief Financial Officer		
Date of last review	April 2022		
Risk movement	⟷		
Date of next review	June 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	Extreme (16)
Current risk rating	4	3	High (12)
Target risk rating			8-12

Controls	Assurance	Gaps	Actions
• Capital Programme Board, FIC & Board. • Sub-groups in place to review & monitor estates and medical equipment capital programmes • Annual & 5 year capital plan signed off by EMB, FIC & Board • Capital governance framework in place • Project Boards in place for large estates projects with named SRO • Digital and IT Strategy • Estates Strategy	**Level 1: reassurance** • Estates, IT and Medical equipment capital reports and review meetings are in place **Level 2: internal** • Monthly reports on overall Trust delivery of capital plan to Capital Programme Board, FIC & Board • Annual capital plan scrutinised and approved through Capital Programme Board, FIC & Board **Level 3: independent**	• Recent internal audit identified gaps in governance for large capital projects	• External review of estates capital projects process and planning underway – due to be completed April 2022

	• Internal audit programme reviews capital planning and reporting on a regular basis		

3.3: Failure to deliver financial plan and maintain financial sustainability, including, but not limited to: through non-delivery of CIP savings; budget overspends; under-funding and constraints of block contracts in the context of increasing levels of activity and demand, could lead to: an inability to deliver core services and health outcomes; financial deficit; intervention by NHS England & Improvement; NWL ICS constraints; and insufficient cash to fund future capital programmes.

Date added to BAF	March 2022		
Monitoring Committee	Finance & Investment Committee		
Executive Lead	Chief Financial Officer		
Date of last review	April 2022		
Risk movement	⟷		
Date of next review	June 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	4	20
Current risk rating	4	3	12
Target risk rating			6-9

Controls	Assurance	Gaps	Actions
• Capital Review Group • Finance and Investment Committee • CIP Process and associated Quality Impact Assessments • Divisional Finance Meetings and Deep Dives • Triple Aim as part of the Quality Improvement Process • Contractual meetings with Commissioners • Long term financial strategy reviewed quarterly at FIC • The effective use of	**Level 1: reassurance** • Divisional finance reports and review meetings are in place **Level 2: internal** • Monthly reports on overall Trust delivery of financial plan & CIPs monitored to EMB, FIC & Board • Annual financial plan scrutinised and approved through EMB, FIC & Board **Level 3: independent**		• NWL Acute Collaborative to develop financial recovery plan to focus on acute underlying deficit • CIP detailed plan and run-rate trajectories to be developed by Division and tracked through Improvement Board & Divisional Finance Review meetings.

resources is monitored against external benchmarks through the Improvement Board and individual programme boards • Financial policies and controls are in place, such as standing financial instructions, treasury management policy, budget holder manuals • NWL Financial governance framework is in place	• The effectiveness of the Trust's financial control systems are monitored through the internal audit programme • Overall accuracy of financial statements is reviewed by External Auditor • Use of resources assessment undertaken by NHSE/I		

3.4: Failure to protect the integrity and security of our information could lead to: cyberattacks which could compromise the Trust's infrastructure and ability to deliver services and patient care; data loss or theft affecting patients, staff or finances; reputational damage and/or personal data and information being processed unlawfully (with resultant legal or regulatory fines or sanctions)

Date added to BAF	March 2022
Monitoring Committee	Audit and Risk Committee
Executive Lead	Chief Information Officer
Date of last review	April 2022
Risk movement	⟷
Date of next review	June 2022

	Impact	Likelihood	Rating
Gross (Inherent) risk rating	4	4	16
Current risk rating	3	4	12
Target risk rating			4-8

Controls	Assurance	Gaps	Actions
Information Governance Team Cyber Security Lead CCIO CIO Caldicott Guardian Info Gov Steering Grp IG Training and Cyber Security Training Trust Induction Information Assets and Systems are risk	**Level 1: reassurance** Reports to Information Governance Steering Group **Level 2: internal** Cyber Security Reports quarterly to ARC and EMB Cyber Security Dashboard Indicator Scores	Annual business continuity testing exercise 268 devices do not have an antivirus signature installed Excessive number of	incident management, response and business continuity plans to be tested via exercise May 2022 and annual thereafter Replace Trend Antivrus Client this year and implement Microsoft Defender in active mode.

assessed using the DPIA Tool Penetration Testing Cyber Security and Info Security Board Training Cyber Security and Phishing Communications to staff Principle of Least privilege IG Policies Information Security Policies and Procedures IG Audit Schedule Patch Management Policy	Monitoring of IG Training IG Steering Grp reports to ARC and EMB Incident management and response process **Level 3: independent** • BDO Audit 2022 – Cyber Security Limited Assurance • BDO Audit DPST 2022 – confidence high -risk assessment - moderate	accounts with highest level of privilege Network Access Control software for Medical Devices	A PAM product to manage privilege access has been procured and is in the process of being installed and configured. Business Case under development for 2022-23 capital investment programme

3.5: A failure to take reasonable steps to minimise the Trust's adverse impact on the environment, maintain and deliver a Green Plan, and maintain improvements in sustainability in line with national targets, the NHS Long Term Plan and 'For a Greener NHS' ambitions (30%, 50% and 80% reduction in emissions by 2023, 2025 and 2030 respectively, and net zero carbon by 2040), could lead to: a failure to meet Trust and System objectives, reputational damage, loss of contracts, contribution to increased pollution within the wider community, and loss of cost saving opportunities.

Date added to BAF	March 2022		
Monitoring Committee	Finance & Investment Committee		
Executive Lead	Chief Financial Officer		
Date of last review	April 2022		
Risk movement	⟷		
Date of next review	June 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	3	4	High (12)
Current risk rating	3	3	High (9)
Target risk rating			(6-9)

Controls	Assurance	Gaps	Actions
• Sustainability Strategy • Sustainability Board in place, reporting to FIC and Trust Board • Sustainability Exec SRO in place • Sustainability workstreams in place reporting to Sustainability Board • Decarbonisation schemes included in	**Level 1: reassurance** • Workstreams report monthly to Sustainability Board on progress against work plan **Level 2: internal** • Trust green plan scrutinised and approved by FIC & Board		• Detailed plans and trajectories to the Greener NHS targets to be developed and monitored through the Sustainability Board and to FIC • Collaborate with NWL Sustainability programme on joint schemes.

Trust Estates capital plan	**Level 3: independent**		

3.6: Failure to maintain adequate business continuity and emergency planning arrangements in order to sustain core functions and deliver safe and effective services during a wide-spread and sustained emergency or incident, for example a pandemic, could result in harm to patients, pressure on and harm to staff, reputational damage, regulator intervention.

Date added to BAF	March 2022		
Monitoring Committee	Finance & Investment Committee		
Executive Lead	Deputy Chief Executive/Chief Operating Officer		
Date of last review	April 2022		
Risk movement	⟺		
Date of next review	June 2022		
	Impact	Likelihood	Rating
Gross (Inherent) risk rating	5	3	Extreme (15)
Current risk rating	4	3	High (12)
Target risk rating			TBC

Controls	**Assurance**	**Gaps**	**Actions**
Accountable Emergency Officer Designated Emergency Planning Lead Major Incident Plan Service Business Continuity Plans Trustwide Business Continuity Plan Director on-call system and escalation procedures EPRR Exercises and Training	**Level 1: reassurance** Emergency Planning Resilience and Response (EPRR) Group Service Business Continuity Plans signed off by heads of service. **Level 2: internal** Self assessment with NHSE/I EPRR Core Standards to FIC and Board Annual Emergency Planning, Resilience and Response report EPRR Exercises, with learning incorporated into major incident plans, business continuity plans and shared with partners; **Level 3: independent** Self-assessment examined and accepted by CCG on behalf of NHSE/I		

Chelsea and Westminster Hospital NHS
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TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting 5 May 2022

AGENDA ITEM NO.	3.2
TITLE OF REPORT	Board and Committee Governance inc Terms of Reference 2022/23
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To present the guidance for Board and Committee meetings for 2022-23 including the Terms of Reference and Business Cycles/Forward Plans To seek approval from the Board to the Committee Terms of Reference contained within the document

REPORT HISTORY
Committees/Meetings where this item has been considered)

Name of Committee	Date of Meeting	Outcome
Quality Committee	April 22	Agreed TORs and forward plan
Audit and Risk Committee	March 22	Agreed TORs and forward plan
Finance and Investment Committee	March 22	Agreed TORs and forward plan
People and OD Committee	March 22	Agreed TORs and forward plan

SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND

During March and April 2022, our Board Committees reviewed their terms of reference and forward plans/business cycles for 2022/23.

The terms of reference and forward plans/business cycles are recommended for approval by the Board and form part of a wider guide to the Governance of our Board and Committee meetings.

KEY RISKS ARISING FROM THIS REPORT	

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	X
Quality	X
People (Workforce or Patients/ Families/Carers)	X
Operational Performance	X
Finance	X
Public Consultation	
Council of Governors	

please mark Y/N – where Y is indicated please explain the implications in the opposite column

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Guidance for Board and Committees

April 2022

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Version control

Version Date	Change
Issue 1.0	April 2022
Author	Dawn Clift, Interim Director of Corporate Governance and Compliance

Guidance for Board and Board Committees

Introduction

1. This guidance is designed to help:

    - members of the Board and its committees,
    - authors of papers to the Board and its committees
    - those who provide committee secretary and minute taking support to the Board and its committees

2. It is not prescriptive but does set expectations of standards so that a consistent and high standard of governance is achieved and maintained.

3. The guidance covers:

    - Agenda setting protocol and papers deadline
    - Minute taking, drafting and approving
    - Cover sheet purpose and contents
    - Freedom of Information considerations
    - Committee Terms of Reference and Forward Plans

Agenda setting protocol and papers deadline

4. The Board and Committee schedule planner includes the relevant papers deadline. The Board and Committee schedule planner for 2022/23 is attached at Appendix 'A'

5. Each Board and committee has terms of reference and a forward work plan/business cycle setting out how it will fulfil its delegated responsibilities across the course of the year. The forward plans set the core standards and additional items may be added as discussions evolve throughout the year. The forward plan is the basis on which agendas are developed for our Board and Committee Meetings. The forward plan is a standing agenda item for each Board and Committee Meeting.

6. Deadlines:

    - The agenda is to be agreed and circulated a minimum of 3 weeks before the meeting takes place. Agenda setting meetings will take place with the relevant Chair and Executive Lead for each Committee along with the Director of Corporate Governance and Compliance and/or Board Governance Manager.

- Papers should be ready for circulation 5 working days before the meeting and is specified in the relevant Terms of Reference.

Minute taking, drafting and approving

8. Recording the meeting accurately and relevantly is essential. There is an onus on the chair of the meeting to ensure that the discussion is summarised and that the action arising is clear. Detailed guidance is at Annex B.

Cover sheet purpose and contents

9. Cover sheets provide a succinct summary of the paper under consideration and indicate the action that the author wishes the Board or committee to take.

10. Cover sheets are required for all papers to Board and Board Committees. The coversheet template to be used is attached at Appendix C. Papers intended for discussion or where a decision / approval is required should be allocated agenda time appropriate to the complexity or significance of the paper. Papers which are provided for information / noting should not be expected to take up agenda time.

11. Cover sheets should be focussed and precise. The reader should be in no doubt as to what action the author is seeking. It is imperative that an Executive Summary of the appended main paper is completed as part of the coversheet. The Executive Summary should distil the key messages contained in the main report that need to be brought to the attention of the Board/Committee/Group.

Freedom of information: is the paper confidential?

14. The public may request information from the Trust under the Freedom of Information Act 2000. The aim of the Act is to be clear and transparent and exemptions to publication should only be engaged when necessary.

15. The Trust Board meets in both public and private sessions, whereas other committees, do not extend an invitation to the public to attend.

16. If a paper is considered to be confidential then, for Board meetings, it should be placed on the private board agenda and the cover sheet annotated accordingly. For Board Committees, the cover sheet should clearly indicate the FOI status; either disclosable or confidential. The accountable director for the paper should judge whether the contents of the paper justify classifying it as confidential and if this is the case, should detail the rational for non-disclosure in the public domain.

17. When information is released in a response to an FOI request, it is released to the public in general and this should be considered when reviewing and releasing information.

18. Advice may be sought from the Trust's Information Governance department for matters relating to FOI, including where a request has been made for release of information which has been previously judged to be confidential.

Committee terms of reference

19. The Committee terms of reference are at Appendix D along with the relevant forward plans/business cycles for 2022/23.

Feedback

20. Comments or suggestions for improvements are welcome, and should be addressed to the Director of Corporate Governance and Compliance.

Appendices

A number of appendices are supplied overleaf.

Annex A: Board and Committee High Level Calendar and Paper Deadlines 2022/23

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Board Development	**07-Apr** 12.30-13.30 Virtual/CWHB	**05-May**	**09-Jun** **BOARD AWAY DAY** (External venue)	**07-Jul**		**08-Sept**	**06-Oct** 12.30-13.30 Virtual/WMA	**03-Nov**	**01-Dec** 12.30-13.30 Virtual/CWHB	**05-Jan**	**02-Feb** 12.30-13.30 Virtual/WMA	**09-Mar**
NEDs Triangulation		10.30-11.00 Virtual/CWEB		10.30-11.00 Virtual/WMB		10.30-11.00 Virtual/CWEB		10.30-11.00 Virtual/WMF		10.30-11.00 Virtual/CWEB		10.30-11.00 Virtual/WMF
Board PUBLIC		11.00-13.30 Virtual/CWHB		11.00-13.30 Virtual/WMA		11.00-13.30 Virtual/CWHB		11.00-13.30 Virtual/WMA		11.00-13.30 Virtual/CWHB		11.00-13.30 Virtual/WMA
Board LUNCH	13.30-14.00	13.30-14.00		13.30-14.00		13.30-14.00	13.30-14.00	13.30-14.00	13.30-14.00	13.30-14.00	13.30-14.00	13.30-14.00
Board CLOSED		14.00-15.30 Virtual/CWHB		14.00-15.30 Virtual/WMA		14.00-15.30 Virtual/CWHB		14.00-15.30 Virtual/WMA		14.00-15.30 Virtual/CWHB		14.00-15.30 Virtual/WMA
DEADLINE FOR PAPERS		*27 Apr*		*29 Jun*		*31 Aug*		*26 Oct*		*28 Dec*		*01 Mar*
Extraordinary Board												
DEADLINE FOR PAPERS												
Board Strategy	**07-Apr** 14.00-16.00 Virtual/CWHB						**06-Oct** 14.00-16.00 Virtual/WMA		**01-Dec** 14.00-16.00 Virtual/CWHB		**02-Feb** 14.00-16.00 Virtual/WMA	
DEADLINE FOR PAPERS	*30 Mar*						*28 Sept*		*23 Nov*		*25 Jan*	
Board Nominations & Remuneration Committee						**08-Sept** 09.30-10.30 Virtual/CWHB						**09-Mar** 09.30-10.30 Virtual/WMF
DEADLINE FOR PAPERS						*31 Aug*						*01 Mar*
Audit & Risk Committee			**15 June** 14.00-16.00 Virtual/CWHB	**28-Jul** 10.00-12.00 Virtual/CWHB			**27-Oct** 10.00-12.00 Virtual/CWHB			**31-Jan** 10.00-12.00 Virtual/CWHB		**30-Mar** 10.00-12.00 Virtual/CWHB
DEADLINE FOR PAPERS			*8 June*	*20 Jul*			*19 Oct*			*23 Jan*		*22 Mar*
Finance & Investment Committee	**28-Apr** 10.00-12.00 Virtual/CWHB	**24-May** 10.00-12.00 Virtual/CWHB		**27-Jul** 10.00-12.00 Virtual/CWHB		**29-Sep** 10.00-12.00 Virtual/CWHB	**25-Oct** 10.00-12.00 Virtual/CWHB	**30-Nov** 10.00-12.00 Virtual/CWHB		**30-Jan** 10.00-12.00 Virtual/CWHB	**27-Feb** 10.00-12.00 Virtual/CWHB	**27-Mar** 10.00-12.00 Virtual/CWHB
DEADLINE FOR PAPERS	*20 Apr*	*16 May*		*19 Jul*		*21-Sept*	*17 Oct*	*22-Nov*		*22 Jan*	*19 Feb*	*19 -Mar*
People & OD Committee	**28-Apr** 13.00-15.00 Virtual/CWHB	**23-May** 13.00-15.00 Virtual/CWHB		**27-Jul** 13.00-15.00 Virtual/CWHB		**29-Sep** 13.00-15.00 Virtual/CWHB	**24-Oct** 13.00-15.00 Virtual/CWHB	**30-Nov** 13.00-15.00 Virtual/CWHB		**30-Jan** 13.00-15.00 Virtual/CWHB	**27-Feb** 13.00-15.00 Virtual/CWHB	**27-Mar** 13.00-15.00 **Virtual/CWHB**
DEADLINE FOR PAPERS	*20 Apr*	*15-May*		*19 Jul*		*21-Sept*	*16 Oct*	*22-Nov*		*22 Jan*	*19 -Feb*	*19 Mar*
Quality Committee	**05-Apr** 13.00-15.00 Virtual/CWHB	**03-May** 13.00-15.00 Virtual/WMA	**07-Jun** 13.00-15.00 Virtual/CWHB	**05-Jul** 13.00-15.00 Virtual/WMA		**06-Sep** 13.00-15.00 Virtual/CWHB	**04-Oct** 13.00-15.00 Virtual/WMA	**01-Nov** 13.00-15.00 Virtual/CWHB		**03-Jan** 13.00-15.00 Virtual/WMA	**07-Feb** 13.00-15.00 Virtual/CWHB	**07-Mar** 13.00-15.00 Virtual/WMA
DEADLINE FOR PAPERS	*28-Mar*	*25 Apr*	*30 May*	*27 Jun*		*29 Aug*	*26 Sept*	*24-Oct*		*26 Dec*	*30-Jan*	*27 Feb*

Bank Holidays 2022/2023 15-Apr 22, 18-Apr 22, 02-May 22, 2-Jun 22, 3-Jun 22, 29-Aug 22, 26-De 22c, 27-Dec 22; 02-Jan 23

Annex B: minute taking

1. Recording the meeting accurately and relevantly is essential. There is an onus on the chair of the meeting to ensure that the discussion is summarised and that the action arising is clear. Some of the discussions at meetings can be wide ranging. The essence of the minute should be to record:

    - What was the nature of the item under discussion?
    - Material amendments / additions / clarifications of the paper made by the presenter in their introduction.
    - What were the decisions / outcomes / actions (resolutions)? It is here that the key issues or comments or challenges pertinent to the decision (other than those raised in the paper) should be captured.
    - There may be a particular point or comment which is essential to capture accurately or where care is needed in the minutes. The meeting chair should draw the minute takers attention where particular care is required and the minute taker should feel comfortable with asking for clarification if unclear as to what is being asked for.
    - A summary from the Chair is required after each item having been discussed. (If this is not done, then the minute taker should ask the meeting chair as it may have been overlooked.)

2. The record of the minutes shall include the names of:

    - every member present at the meeting;
    - any other person present;
    - any apologies tendered by an absent member;
    - any senior employee in attendance representing an executive director
    - the withdrawal from a meeting of any member on account of a conflict of interest; and
    - any declarations of interest.

3. Formal membership of a committee is usually specified in the Terms of Reference. Those who are not “members” are deemed to be “attendees.”

4. Production of minutes:

    - The aim is to have draft minutes at the meeting which can be accepted without the need for time being spent on correcting them at the meeting.
    - Minutes of the Board and Board committees should be produced in draft and circulated to the exec lead for the committee within 4 working days of the meeting.

- The exec lead should return the draft minutes with any comments within 2 working days.
- The minutes should then be circulated to the committee chair for any further comment and amendment.
- Actions should be specified in the minutes and added to the action log.

5. Minutes: draft and approved:

- Draft minutes should be clearly marked as draft using the DRAFT watermark and a filename which includes DRAFT.
- If committee members on receiving the draft minutes have further proposed amendments to the draft minutes then they should propose their amendments which the administrative staff should note: typos should be corrected and language to achieve clarity should be accepted, but material changes to the sense of the minute will need to be brought to the committee for amendment. If actions are unclear or inaccurate, then the exec lead for the action should clarify with the committee chair.
- Approved Committee minutes will be shared with the full Board of Directors.

6. Actions at the Board or at Board committee meetings
   - Actions should usually be confined to the executives who are members of, or formal attendees at, the meeting.
   - If an action is required from someone who is not at the meeting then the committee administrator is to ensure that the action is sent to the relevant exec lead.

7. The minute taking template for Board and Board Committees is set out overleaf:-

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

NAME OF MEETING

DATE AND TIME OF MEETING PLUS LOCATION (PHYSICAL OR VIRTUAL)

Present	Insert Name	Insert Title	Insert Initials
In Attendance			
Members of the Public/Observers (where relevant)			
Apologies for Absence			

Minute Reference		Action
1.0	**INSERT TITLE OF SECTION OF MEETING**	
1.1	**Welcome and Apologies for Absence**	
1.2	**Declarations of Interest**	
1.3	**Minutes of the Previous Meeting held on xxxxxxx**	
1.4	**Matters Arising and Board Action Log**	
	Resolution:-	
1.5	**Insert agenda item report titles**	
2.0	**Any Other Business**	
3.0	**Date of the Next Meeting**	
	The next meeting will take place on XXX at XXXam until XXXpm. The meeting closed at XXXX hours.	

Annex C: Board and Committee Covernote

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CONFIDENTIAL

TITLE AND DATE *(of meeting at which report to be presented)*	

AGENDA ITEM NO.	
TITLE OF REPORT	
AUTHOR NAME AND ROLE	
ACCOUNTABLE EXECUTIVE DIRECTOR	
PURPOSE OF REPORT Decision/Approval Assurance Info Only Advice Please tick above and then describe the requirement in the opposite column	
REPORT HISTORY Committees/Meetings where this item has been considered	Committee / Date of Meeting / Outcome
SUMMARY OF REPORT AND KEY MESSAGES THE MEETING NEEDS TO UNDERSTAND	
KEY RISKS ARISING FROM REPORT	

STRATEGIC PRIORITIES THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	
Be the employer of Choice	
Deliver better care at lower cost	

IMPLICATIONS ASSOCIATED WITH THIS REPORT:	
Equality And Diversity	
Quality	
People (Workforce or Patients/Families/Carers)	
Operational Performance	
Finance	

Public Consultation		
Council of Governors		
please mark Y/N – where Y is indicated please explain the implications in the opposite column		

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

Annex D: Committee Terms of Reference

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 Trust's 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 information and 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, Chief Nursing Officer, 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 Meeting minutes, agendas and forward work plans to be maintained by the Director of Corporate Governance and Compliance.

9.2 Minutes, agenda and papers to be circulated by the Board Governance Manager.

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: March 2020
Review date: January 2021
Approved by: Board of Directors
Date: March 2021
Reviewed by: Audit Committee
Date: March 2022

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 of Directors.

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 the Trust's Maternity Improvement Programme and to monitor Trust performance in this area

- 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
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer
- Associate Director of Quality Governance
- Medical Director
- Director of Corporate Governance and Compliance

6.2 The Chief Nursing Officer, Chief Medical Officer 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) 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
- Chief Medical Officer or deputy
- Chief Nursing Officer or deputy
- Chief Operating Officer or deputy
- Associate 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 Head of Quality & Clinical Governance.

9.2 Minutes, agenda and papers to be circulated by the Board Governance Manager.

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:

- Clinical Effectiveness Group
- Patient Safety Group
- Patient & Public Experience Group
- Health, Safety and Environmental Risk Group
- Joint Safeguarding 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, Chief Medical Officer and Chief Nursing Officer.

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
Approved by:	Board of Directors
Date:	March 2021
Reviewed by:	Quality Committee
Review Date:	April 2022

Finance and Investment Committee
Terms of Reference

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.

Authority

The FIC is directly accountable to the Trust's Board of Directors.

The FIC is authorised by the Trust 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.

Aim

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

Objectives

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

- To consider, advise and govern the Trust's medium-term financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial targets and govern performance against them.
- To review the annual budget, before recommending approval 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 between funding and 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 investments and/ or business cases

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.
- To maintain an oversight of the Commercial Development Opportunities and Workstreams within the Trust ensuring these are aligned to Trust Strategy and objectives

In relation to**: Estates and Sustainability**

- The Committee will monitor and oversee the delivery of the Trust's Estates, Facilities and capital development annual plan including funding and ongoing alignment with the Trust's objectives
- The Committee will advise on and govern the delivery of the Estates Strategy ensuring ongoing alignment to Trust objectives
- The Committee will monitor and oversee the delivery of the Trust's Sustainability Strategy through the receipt of periodic reports against sustainability Key Performance Indicators

In relation to**: Information Management and Technology (IM&T)**

- The Committee will monitor and oversee the delivery of the Trust's annual plan for IM&T including funding and ongoing alignment with Trust objectives
- The Committee will advise on and govern the delivery of the IM&T Strategy

In relation to Risk:-

- The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee
- The Committee will establish and maintain an overview of the Trust's financial risks and risks to the delivery of the Trusts IM&T, estates, facilities and sustainability plans and ensure the effectiveness and implementation of controls to mitigate risks

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.
- 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.

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.

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
- Director of Corporate Governance and Compliance

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.

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

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

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 e-governance, and email

Secretariat

Meeting minutes, agendas and forward work plans to be maintained by the Governance Manager. .

9.2 Minutes, agenda and papers to be circulated by the Board Governance Manager.

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. Verbal 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 and Digital Programme Board will routinely report to the Finance and Investment Committee.

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:	25 November 2019
Approved by:	Board of Directors
Date:	March 2020
Review date:	January 2021
Approved by:	Board of Directors
Reviewed by:	Finance and Investment Committee
Date:	March 2022

People and Organisational Development Committee Terms of Reference

Date of Review: March 2022

1.0 Constitution

The People and Organisational Development Committee (the Committee) is a non-statutory Committee and has been formally constituted by the Board of Directors in accordance with its Standing Orders. The Committee will oversee the development and ongoing implementation of the Trust's People Strategy so that we can achieve our goal to become an outstanding place to work.

2.0 Authority

The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions. The Committee is authorised to obtain such internal information as is necessary to the fulfilment of its functions. The Committee shall have the power to establish subcommittees/Groups and/or task and finish groups for the purpose of addressing specific tasks or areas of responsibility.

3.0 Purpose

The purpose of the Committee is to gain assurance, on behalf of the Board of Directors that the Trust is making sufficient progress towards delivery of its People Strategy, with a focus on health and wellbeing and a more consistent and an inclusive positive experience for all staff.

The Committee will:

- Ensure that the Trust's activities enable colleagues to feel supported in their work, and consistently experience and live the Trust's PROUD values
- Oversee the development of a consistent culture where people feel safe and able to raise concerns and that concerns raised are suitably addressed;
- Ensure the Trust's activities are systematically and effectively promoting health and wellbeing, and psychological safety.
- Ensure the Trust is actively seeking to reduce inequalities in staff experience and is promoting equality, diversity and inclusion in a systematic and effective way.
- Shape, approve and drive the Trust's People and Organisational Development Strategy and assure its implementation to ensure appropriate impact;
- Ensure that the Trust has a comprehensive Leadership Development and Talent Management Programme in place designed to reinforce the culture the Trust is seeking to achieve and evaluate the effectiveness of the programme to inform further improvements.
- Ensure that the Trust has oversight of the Education, Skills and Capability agenda and that this is shaped to meet the needs of the changing workforce
- Review all relevant people-related policies to ensure they will positively enhance the Trust's culture and receive assurance on their implementation timeliness, fairness, integrity and consistency.
- Shape, approve and drive improvements arising from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and other sources.
- Ensure engagement and consultation processes with staff, stakeholders and communities reflect the ambition and values of the Trust and also meet statutory requirements

- Scrutinise and provide assurance on the self-certification to NHSI of continuity of service condition 7 – availability of resources and the corporate governance statement in so far as they relate to the aims and objectives of the Committee
- Review and drive innovative performance improvement against key elements of the People Strategy including:
    - Looking after our people;
    - Belonging at our trust;
    - New ways of working and delivering care;
    - Growing for the future;
- Review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the Committee's purpose and function.

4.0 Cycle of Business

The Committee will set an Annual Plan for its work to form part of the Board's Annual Cycle of Business, including reference to the Board Assurance Framework, and report to the Board on its progress.

5.0 Statutory compliance

The Committee will ensure that current statutory and regulatory compliance and reporting requirements are met and appropriate action is taken in respect of:

- Standards of professional conduct and practice
- Freedom to Speak Up Guardian
- Equality, diversity and inclusion
- Health and Wellbeing Guardian

6.0 Risk

The Committee will:

- Identify, assess and manage strategic risks in relation to the Committee's area of focus via the Board Assurance Framework
- Review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives.
- Provide the Audit Committee and the Board with assurance on the effectiveness of management of the principal risks relating to the Committee's purpose and function.

7.0 Membership (Voting Rights)

Members are expected to attend a minimum of 75% of all meetings in any one given year.

The Committee membership will be agreed by the Board of Directors to consist of:

- 2 Non-executive Directors (of which one will be the Chair)
- 3 Executive Directors (Chief Executive or suitable deputy, Chief Medical Officer, Chief Nursing Officer (or deputy)

Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum. The Chair of the Committee should ensure the membership promotes equality, diversity and inclusion.

8.0 In Attendance

The following will attend the meeting in a non-voting capacity:

- Director of People and Organisational Development

- Director of Corporate Governance and Compliance
- Deputy Director of HR and OD (x2)
- Deputy Director of Learning and Development
- Inclusion Advisor to the Board
- 1x Honorary Non-executive Director

9.0 Ad-Hoc Attendance

To support the working of the Committee the following members will attend as and when required:

- Freedom to Speak Up Guardian
- Chairs of the Staff Networks
- Guardian of Safe Working
- Any other staff deemed appropriate to enable delivery of the business of the Committee

An attendance record will be held for each meeting.

10.0 Quorum

The Committee will be deemed quorate to the extent that at least two Non-executive Directors and two Executive Directors are present plus the Director of People and Organisational Development or her nominated deputy. For the purpose of Non-executive Directors quoracy is extended to include the Honorary Non-executive Director.

Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. (Nominated deputies shall not count towards the quorum).

11.0 Committee Administration

The Committee will meet at least six times a year in order to allow the Committee to discharge all of its responsibilities. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

The agenda will be set in advance by the Chair, with the Director of People and Organisational Development and the Director of Corporate Governance and Compliance, reflecting an integrated cycle of meetings and business. Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form.

The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

The Committee Secretary shall minute the proceedings of all Committee meetings.

The Committee shall, at least once a year, review its own performance, using a process agreed for all Board Committees by the Board of Directors.

11.0 Reporting and Accountability

The Committee Chair will report to the Board of Directors after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed. The Committee will report to the Board and Council of Governors annually on its work in support of the Annual Report and will describe how the Committee is discharging its responsibilities against its Terms of Reference. The Committee Chair shall attend the Annual General Meeting to respond to any stakeholder questions on the Committee's activities.

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

- Education Strategy Board

- Workforce Development Committee
- Health and Well-being Committee
- Partnership Forum and Local Negotiating Committee

12.0 Review

The Terms of Reference of the Committee will be reviewed by the Committee and Board at least annually.

Board of Directors Nominations and Remuneration Committee
Terms of Reference

1. Constitution

The Board of Directors' Nominations and Remuneration Committee (the Committee) is established as a sub-committee of Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) Board of Directors in accordance with the Trust's Constitution.

The Committee will review these Terms of Reference on an annual basis as part of a self-assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require approval of the Board of Directors.

2. Authority

The Committee is directly accountable to the Board of Directors.

3. Aim

3.1 The Committee has the delegated power to act on behalf of the Board in making decisions upon the remuneration and terms of service for the Chief Executive and other Executive Directors[1]. These decisions will cover all aspects of salary, including the approval of arrangements for termination of employment and other major contractual terms. The Committee will operate in accordance with principles outlined in the Monitor Code of Governance.

3.2 The Committee will give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in future. The Committee will be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive. The Committee will also advise upon and oversee the contractual arrangements of the Chief Executive and other Executive Board Directors.

3.3 The Committee will also have a role in overseeing the Chief Executive's plans and proposals with regard to "very senior manager" ("VSM") appointments[2] (including non-voting Directors, but excluding Non-Executive Directors) and remuneration and, having regard to national guidance (for example from NHS Improvement, NHS Employers, NHS England and/or their successors), and in particular, will:

- Review any 'on payroll' appointment or salary change that attracts or results in a remuneration at or above £150,000; including where this does not relate to the appointment of an Executive Director, but excluding Non-Executive Directors;

- Review any 'off payroll' arrangement which, when annualised, remunerates the contractor in excess of £100,000 per annum;

- Keep under review the Trust's Policy on Executive and Senior Management Remuneration.

4. Objectives

4.1 The Nominations and Remuneration Committee will:

[1] Defined for these purposes as 'voting Directors' of the Board.
[2] Defined in accordance with NHS Improvement guidance

- Promote the Trust's objectives and values in its work;

- Semi-annually review the structure, size and composition (including the skills, knowledge, experience and diversity) required of the Executive Directors of the Board as a whole and make recommendations to the Board as appropriate;

- Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive;

- Before an Executive Director appointment (excluding Non-Executive Directors) is made, the Chief Executive must evaluate the balance of skills, knowledge, experience and diversity across the team, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. The Committee will seek to ensure that this has been completed and input where necessary.

- In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds, the Trust's commitment to equality, diversity and inclusion and that the recruitment process will consider candidates on merit against objective criteria; as well as meeting the 'fit and proper' persons test described in the Provider Licence;

- Monitor and evaluate the performance of individual Executive Directors and consider any matter relating to the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust. Where such matters are discussed, the Chief Executive will be present. The Chief Executive will not be present when the committee is dealing with matters concerning his/her own appointment or removal;

- Ensure a formal and transparent procedure for developing policy on Executive remuneration and contractual terms of individual directors. Ensure levels of remuneration are sufficient to attract, retain and motivate Executive Directors of the required quality, whilst adhering to all relevant laws, regulations, Trust policy and remaining cost effective;

- Make decisions as to Executive Director remuneration in accordance with the Trust's Policy on Executive and Senior Management Remuneration;

- Consider the exit arrangements which need to put in place to address poor performance of any Executive Director;

- Consider all non-contractual severance payments and redundancy payments in excess of £100, 000.

5. Method of working

5.1 The Nomination and Remuneration Committee will have a standard agenda and accompanying work plan. At every meeting, the following items 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, including work plan
5. Any Other Business
6. Date of next meeting

5.2 All Minutes of the Nominations and Remuneration Committee will be presented in a standard format.

5.3 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 Nominations and Remuneration Committee comprises all Non-Executive Directors and the Chair. The Chair of the Nominations and Remuneration Committee is the Chair of the Trust. In the absence of the Committee Chairman and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting, subject to 6.2 below.

6.2 Where:

- the appointment or removal of an Executive Director is to be considered; or
- the Committee considers recommended salary increases in excess of the national NHS uplift the Chief Executive or, in the Chief Executive's absence, the Deputy Chief Executive, shall also be a member of the Committee.

6.3 The Director of Human Resources and Organisational Development and Company Secretary, or equivalent, will also attend Committee meetings, unless considered inappropriate.

7. Quorum

7.1 The quorum will be four members, comprising three Non-Executive Directors and the Chair, subject to 7.2 below.

7.2 Where:

- the appointment or removal of an Executive Director is to be considered; or
- the Committee considers recommended salary increases in excess of the national NHS uplift the Chief Executive or in the Chief Executive's absence, the Deputy Chief Executive, shall also be required for quorum.

8. Frequency of meetings

8.1 The Nominations and Remuneration Committee will meet quarterly and as and when circumstances dictate and may 'meet virtually', provided that the quorum requirements referred to above are met.

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

9. Secretariat

9.1 Meeting minutes, agendas and forward work plans to be maintained by Company Secretary or equivalent.

9.2 Minutes, agenda and papers to be circulated by the Board Governance Manager.

10. Reporting lines

10.1 Decisions made within the committee on new appointments will be reported at the Board and Council of Governors.

10.2 Where a significant risk emerges either through a report or from discussion at a Committee meeting, this will be reported to the Board.

11. Openness

11.1 The Nominations and Remuneration Committee agenda, papers and minutes are considered to be confidential.

Reviewed and approved by:	Board of Directors
Date:	January 2018
Committee Review date:	March 2020
Board of Director approval:	March 2020
Committee Review date:	February 2021
Board of Director approval:	March 2021
Committee Review date:	March 2022 (note increased frequency of meetings to quarterly)

Audit & Risk Committee Forward Plan 2022/23

	28 March 2022	26 May 2022	27 July 2022	27 October 2022	31 January 2023	30 March 2023
	DEADLINE FOR PAPERS: 18.03.22	**DEADLINE FOR PAPERS:**	**DEADLINE FOR PAPERS:**	**DEADLINE FOR PAPERS: 19.10.22 (9am)**	**DEADLINE FOR PAPERS: 27.01.23 (9am)**	**DEADLINE FOR PAPERS: 20.03.23 (9am)**
COUNTER FRAUD	• Counter Fraud Progress Report • Counter Fraud 2021/22 Annual Work Plan	• Counter Fraud Annual Report • Anti-fraud, bribery and corruption assessment	• Counter Fraud Progress Report • Counter Fraud 2022/23 Annual Work Plan	• Counter Fraud Progress Report	• Counter Fraud Progress Report	• Counter Fraud Progress Report • Anti-fraud, bribery and corruption assessment • Counter Fraud Reports:
INTERNAL AUDIT	• Internal Audit 2021/22 Progress Report • Internal Audit Recommendations and Implementations • Internal Audit Reports: - IT Architecture Maturity - Cyber Security - Key Financial Systems - Safeguarding Children - HR Systems	• Internal Audit Annual Report, including Head of Internal Audit Opinion • Internal Audit Recommendations and Implementations • Internal Audit Reports: - Budget Setting & Reporting - Transformation Project Management - Data Security & Protection Toolkit	• Internal Audit 2022/23 Annual Work Plan • Internal Audit Recommendations and Implementations • Internal Audit Reports	• Internal Audit 2022/23 Progress Report • Internal Audit Recommendations and Implementations • Internal Audit Reports	• Internal Audit 2022/23 Progress Report • Internal Audit Recommendations and Implementations • Internal Audit Reports	• Internal Audit 2022/23 Progress Report • Internal Audit Recommendations and Implementations • Internal Audit Reports
EXTERNAL AUDIT	• External Audit 2021/22 progress report	• Annual Report & Annual Governance Statement, including going concern statement Sign-Off • Quality Account	External Audit Plan 2022/23 progress report and sector update	• External Audit Plan 2022/23 progress report and sector update	• External Audit Plan 2022/23 progress report and sector update	• External Audit Plan 2022/23 progress report and sector update

		• Annual Accounts • External Auditors Report, including ISA 260 • Data Quality • Covid Restore & Recovery				
GOVERNANCE	• Risk Assurance Framework • Board Assurance Framework • Cyber Security Report • Information Governance update • Policies for approval: - Reservation of Power and Scheme of Delegation (due March 2022) - Standing Financial Instructions (due March 2022) • Policies for approval: - Losses and Special Payments	Estates Project Management QS Report (ref minutes 28.2.33)	• Risk Assurance Framework, including Risk Management Policy and Risk Appetite and Statement Review • Board Assurance Framework • National Cost Collection Board Assurance • Cyber Security Report • Policies for approval:	• Board Assurance Framework • Risk Assurance Framework • Risk Maturity Report • Cyber Security Report • Information Governance Update • Better Payments Practice Code • Impact of new accounting standards • Proposal for review of Committee effectiveness • Policies for approval:	• Board Assurance Framework • Risk Assurance Framework • Cyber Security Report • Information Governance Update • Better Payments Practice Code • Impact of new accounting standards • Proposal for review of Committee effectiveness • Policies for approval:	• Review of Committee effectiveness, including ARC Terms of Reference and reporting structure • Board Assurance Framework • Risk Assurance Framework • Cyber Security Report • Information Governance Update • Clinical Audit update; • National Cost Collection Submission - Post Submission Summary • Annual Report and Accounts Process & Timetable • Annual Review of Banking Arrangements

						• Better Payment Practice Code Report • International Financial Reporting Standard (IFRS) report and expected impacts • Policies for approval:
ITEMS FOR INFORMATION	• Losses and Special Payments including Write Offs • Waiver of SFIs • Audit Committee Forward Plan	• Losses and Special Payments including Write Offs • Waiver of SFIs • Audit Committee Forward Plan • Matters of Governance Escalation associated with the ICS/Provider Collaborative	• Losses and Special Payments including Write Offs • Waiver of SFIs • Audit Committee Forward Plan • Matters of Governance Escalation associated with the ICS/Provider Collaborative	• Losses and Special Payments including Write Offs • Waiver of SFIs • Audit contract renewals • Audit Committee Forward Plan • Matters of Governance Escalation associated with the ICS/Provider Collaborative	• Losses and Special Payments including Write Offs • Waiver of SFIs • Audit contract renewals • Audit Committee Forward Plan • Matters of Governance Escalation associated with the ICS/Provider Collaborative	• Property, plant and equipment valuation assumptions and judgements • Losses and Special Payments including Write Offs • Waiver of SFIs • Audit Committee Forward Plan • Matters of Governance Escalation associated with the ICS/Provider Collaborative

Quality Committee Forward Plan – as at 25.04.2022

No presentations unless prior approval from Chair. All papers should summarise the topic and present a balanced assessment of achievements as well as setbacks or areas of concern and should include a summary of future plans.

DATE	ITEM	PRESENTER/LEAD
TO BE CONFIRMED	New service: gender affirmation surgery New integrated HIV service – quality review of first months	
3 May 2022	**Matters arising:** GIRFT: briefing on revised approach Ward Accreditation: full list of results plus improvement actions e-Governance update – Board Assurance Framework **Agenda items:** Trust Quality & Performance Report (March 2022 data) Elective Recovery Programme Annual Quality Account – final approval Shared ICS pathway – ophthalmology update Learning from Deaths: mortality report Q4 2021-22 Clinical Effectiveness Group: 6-monthly report Learning from SIs: Feb-Mar 2022 Maternity update: Ockenden Report incl timeline for self-assessment & plan for Continuity of Carer ~~Regulatory Standards –~~ defer to next month Annual EPRR assurance report	 Roger Chinn Vanessa Sloane/Robert Bleasdale Dawn Clift Rob Hodgkiss Rob Hodgkiss Vanessa Sloane/Robert Bleasdale Rob Hodgkiss/Roger Chinn Iain Beveridge Iain Beveridge Alex Bolton Vicki Cochrane Dawn Clift Rob Hodgkiss

7 June 2022	Trust Quality & Performance Report (April 2022 data) Elective Recovery Programme Annual Infection Prevention and Control report Falls prevention strategy - update Maternity quality & safety improvement programme: quarterly update West London Children's Healthcare: update Joint Safeguarding Group: 6-monthly report Learning from claims: annual report	Rob Hodgkiss Rob Hodgkiss Nabeela Mughal Vanessa Sloane (Jacky Sinclair) Vicki Cochrane Nicola Grinstead Vanessa Sloane Roger Chinn
5 July 2022	Trust Quality & Performance Report (May 2022 data) Elective Recovery Programme Learning from SIs: Apr-May 2022 Annual report from the Medical Examiner's office Learning from deaths: mortality review Q1 2022-23 Review of deaths associated with nosocomial COVID-19 Risk Assurance Framework (quality risks) Q1 2022-23 Board Assurance Framework (quality risks) Q1 2022-23	Roger Chinn Rob Hodgkiss Alex Bolton Sarah Cox & Elora Mukherjee Iain Beveridge Iain Beveridge Alex Bolton Dawn Clift
6 Sept 2022	Trust Quality & Performance Report (June-July 2022 data) Elective Recovery Programme Learning from SIs: Jun-Jul 2022 Medication related incidents: updated action plan Maternity quality & safety improvement programme: quarterly update Patient Safety Group: 6-monthly report (to include update on PSIRF implementation)	Rob Hodgkiss Rob Hodgkiss Alex Bolton Roger Chinn Vicki Cochrane Gary Davies
4 Oct 2022	Trust Quality & Performance Report (Aug 2022 data) Elective Recovery Programme Annual safeguarding report Annual safe staffing report	

	Learning from deaths: mortality report Q2 2022-23 Health, Safety & Environmental Risk Group: 6-monthly report Risk Assurance Framework (quality risks) Q2 2022-23 Board Assurance Framework (quality risks) Q2 2022-23 Patient & Public Experience Group: 6-monthly report Learning from complaints: 6-monthly report	
1 Nov 2022	Trust Quality & Performance Report (Sept 2022 data) Learning from SIs: Aug-Sept 2022 Clinical Effectiveness Group: 6-monthly report	
6 Dec 2022	Learning from claims: 6-monthly report Trust Quality & Performance Report (Oct 2022 data) Maternity quality & safety improvement programme: quarterly update Joint Safeguarding Group: 6-monthly report	

Finance and Investment Committee Forward Plan 2022/23

	28 April 2022	24 May 2022	27 July 2022
	DEADLINE FOR PAPERS: 20 April 2022	**DEADLINE FOR PAPERS: 16 May 2022**	**DEADLINE FOR PAPERS: 19 July 2022**
Deep Dive			
STRATEGY	• Ambulatory Diagnostics Centre • Cerner Lessons Learnt & Benefits Realisation	• Ambulatory Diagnostics Centre • Estates Review Update • Cerner Lessons Learnt & Benefits Realisation	• Ambulatory Diagnostics Centre • Digital Strategy • Robotic Surgery Post-Investment Review
PERFORMANCE	• Monthly Financial Performance Report M12 • Improvement Programme Update	• Monthly Financial Performance Report M1 • Improvement Programme Update	• Monthly Financial Performance Report M3 • Improvement Programme Update • Treatment Centre Business Case • Commercial Assurance Board • RAF: Extreme Risks • Board Assurance Framework: review of risks relevant to finance
OTHER BUSINESS	• Digital Programme Board Minutes • Capital Programme Board Report M12 • Forward Plan	• Forward Plan • Digital Programme Board Minutes	• Digital Programme Board Minutes • Forward Plan

	29 September 2022	25 October 2022	30 November 2022
	DEADLINE FOR PAPERS: 21 September 2022	**DEADLINE FOR PAPERS: 17 October 2022**	**DEADLINE FOR PAPERS: 22 November 2022**
Deep Dive			

STRATEGY	• Ambulatory Diagnostics Centre	• Ambulatory Diagnostics Centre	• Ambulatory Diagnostics Centre
PERFORMANCE	• Monthly Financial Performance Report M5 • Improvement Programme Update • Commercial Assurance Board	• Monthly Financial Performance Report M6 • Improvement Programme Update	• Monthly Financial Performance Report M7 • Improvement Programme Update • RAF: Extreme Risks • Board Assurance Framework: review of risks relevant to finance
OTHER BUSINESS	• Digital Programme Board Minutes • Forward Plan • Capital Programme Board Report M3	• Digital Programme Board Minutes • Forward Plan	• Digital Programme Board Minutes • Forward Plan

	30 January 2023	**27 February 2023**	**27 March 2023**
	DEADLINE FOR PAPERS: 22 January 2023	**DEADLINE FOR PAPERS: 19 February 2023**	**DEADLINE FOR PAPERS: 19 March 2023**
Deep Dive			
STRATEGY	• Ambulatory Diagnostics Centre • Business Plan 23/24	• Ambulatory Diagnostics Centre • Business Plan 23/24	• Ambulatory Diagnostics Centre • Business Plan 23/24
PERFORMANCE	• Monthly Financial Performance Report M9 • Improvement Programme Update • Commercial Assurance Board	• Monthly Financial Performance Report M10 • Improvement Programme Update	• Monthly Financial Performance Report M11 • Improvement Programme Update • RAF: Extreme Risks • Board Assurance Framework: review of risks relevant to finance

OTHER BUSINESS	• Digital Programme Board Minutes • Forward Plan • Capital Programme Board Report M6	• Digital Programme Board Minutes • Forward Plan	• Digital Programme Board Minutes • Forward Plan

People and Organisational Development Committee Forward Planner 2022/23

PEOPLE COMMITTEE FORWARD PLANNER 2022-23			
Agenda Items	**May 2022**	**July**	**September**
	1.5 hours	1.5 hours	1.5 hours
	Deadline for papers xx xx xx	Deadline for papers xx xx xx	Deadline for papers xx xx xx
General	• Apologies • Minutes • Actions	• Apologies • Minutes • Actions	• Apologies • Minutes • Actions
Performance	• Performance Report • Quarterly Heatmap	• Performance Report	• Performance Report • Quarterly Heatmap
People Strategy		• Looking After Our People	• Belonging (including staff networks)
Formal Reports	• Guardian of Safe Working Q4 Report • Freedom to speak up Q4 Report	• Guardian of Safe Working Q1 Report • Freedom to speak up Q1 Report	• Annual Workforce Equality and Diversity Report – sign off
Risk	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people
Sub-Group Reports	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)
NWL ICS	• System update	• System update	• System update
Top concerns	• Members top concerns	• Members top concerns	• Members top concerns
Forward plan	• Review forward plan	• Review forward plan	• Review forward plan

Agenda Items	November 2022	January 2023	March 2023
	1.5 hours	1.5 hours	1.5 hours
	Deadline for papers xx xx xx	Deadline for papers xx xx xx	Deadline for papers xx xx xx
General	• Apologies • Minutes • Actions	• Apologies • Minutes • Actions	• Apologies • Minutes • Actions
Performance	• Performance Report	• Performance Report • Quarterly Heatmap	• Performance Report
People Strategy	• New Ways of Working and Delivering Care	• Growing for the Future	• People Strategy – annual review • NHS Staff Survey Results
Risk	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people	• Board Assurance Framework and Risk Assurance Framework: review of risks relevant to people
Formal Reports	• Freedom to Speak Up Q2 Report • Guardian of Safe Working Q2 Report	• Freedom to Speak Up Q3 Report • Guardian of Safe Working Q3 Report •	• Committee Effectiveness Report • NMC and Medical Revalidation Annual report • Safer Staffing Annual Report
Sub-Group Reports	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)	• Workforce Development Committee • Education Strategy Board • Partnership Forum • People Strategy Delivery Groups (from April 2022)
NWL ICS	• System update	• System update	• System update
Top concerns	• Members top concerns	• Members top concerns	• Members top concerns
Forward plan	• Review forward plan	• Review forward plan	• Review forward plan

Board of Directors Nomination and Remuneration Committee Cycle of Business 2022 Calendar Year

Item	9 March	June	8 Sept	Dec	Lead
Standing Items					
Apologies for Absence	X	X	X	X	Chair
Minutes of the Last Meeting	X	X	X	X	Chair
Declarations of Interest	X	X	X	X	Chair
Action Log	X	X	X	X	Chair
Executive Director Vacancies and Recruitment Plans	X	X	X	X	Director of People and OD
Non-contractual severance payments and redundancies exceeding £100,000	X	X	X	X	Director of People and OD
Semi Annual Items					
Semi Annual Review of Executive Director skills, knowledge, experience and diversity	X		X		CEO/Director of People and OD
Annual Items					
Succession Planning for Executive Directors and CEO		X			Chair/CEO
VSM and Executive Director and CEO Remuneration and Benchmarking				X	Director of People and HR
Review any 'on payroll' appointment or salary change that attracts or results in a remuneration at or above £150,000; including where this does not relate to the appointment of an Executive Director, but excluding Non-Executive Directors				X	Director of People and HR
Review any 'off payroll' arrangement which, when annualised, remunerates the contractor in excess of £100,000 per annum				X	Director of People and HR
Executive Director Appraisal and Performance Reviews				X	Chief Executive
Chief Executive Appraisal and Performance Review				X	Chair
Review of Terms of Reference	X				Director of Corporate Governance and Compliance

Approval of Annual Business Cycle	X				Director of Corporate Governance and Compliance

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting 5 May 2022

AGENDA ITEM NO.	3.3
TITLE OF REPORT	Board Business Cycle 2022-23
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To present the Board Business Cycle for 22-23 in accordance with best practice governance. To note that this may evolve during the course of the year as our approach to collaborative working develops within the acute provider collaborative.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	Best practice governance recommends that Boards hold a business cycle/forward plan which demonstrates how they will fulfil their duties and statutory responsibilities throughout the course of the year. The attached business cycle is proposed for the Public Board meetings of Chelsea and Westminster Hospital NHS Foundation Trust. As we develop our acute provider collaborative model, the business cycle may change and evolve.
KEY RISKS ARISING FROM THIS REPORT	
STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)	

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	X
Quality	X
People (Workforce or Patients/ Families/Carers)	X
Operational Performance	X
Finance	X
Public Consultation	
Council of Governors	
please mark Y/N – where Y is indicated please explain the implications in the opposite column	

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

BOARD OF DIRECTORS CYCLE OF BUSINESS 2022-2023 – PUBLIC BOARD

Item	May	July	Sept	Nov	Jan	March	Lead	Assuring Committee
Apologies for Absence	X	X	X	X	X	X		
Minutes of the Last Meeting	X	X	X	X	X	X		
Declarations of Interest	X	X	X	X	X	X		
Action Log and Matters Arising	X	X	X	X	X	X		
Chair's Report	X	X	X	X	X	X	Chair	
Chief Executive's Report	X	X	X	X	X	X	Chief Executive	
Patient Story/Staff Story/Service Presentation	X	X	X	X	X	X	Chief Nurse	
Integrated Performance and Quality Report	X	X	X	X	X	X	Deputy CEO/Chief Operating Officer	QC
Elective Recovery Plan Report	X	X	X	X	X	X	Deputy CEO/Chief Operating Officer	QC
Learning from Serious Incidents Report	X	X	X	X	X	X	Chief Nurse	QC
People Performance Report	X	X	X	X	X	X	Director of People and OD	POD
Quarterly Items								
	May	July	Sept	Nov	Jan	March	Lead	Assuring Committee
Board Assurance Framework	X		X		X		Director of Corp Gov and Compliance	ARC
Risk Assurance Framework							Chief Nurse	ARC

Maternity Improvement Report	X	X	X	X	X	X	Chief Nurse	QC
Learning from Deaths/Mortality Report	X		X		X	X	Chief Medical Officer	QC
Improvement programme and Quality Priorities Progress Report		X		X		X	Chief Nurse	QC
Guardian of Safe Working Report	~~X~~	X		X		X	Chief Medical Officer	POD
Freedom to Speak Up Report (as defined in national NHSE/I FTSU guidance)		X			X		Direc of HR and OD	POD
Annual Items								
Complaints Annual Report		X					Chief Nurse	QC
Health and Safety Annual Report		X					Chief Nurse	FIC
Safeguarding Annual Report		X					Chief Nurse	QC
Infection Prevention and Control Annual Report		X					Chief Nurse	QC
National Inpatient Survey Results and Improvement Plan							Chief Nurse	QC
Bi-Annual Safer Staffing Report			X			X	Chief Nurse	QC
GMC Results and Improvement Plan				X			Chief Medical Officer	POD
Staff Survey Results and Improvement Plan	X						Dir of HR and OD	POD
Medical Appraisal and Revalidation Annual Report			X				Chief Medical Officer	POD
NMC Annual Report			X				Chief Nurse	POD
Equalities & Diversity (EDI) Annual Report inc WRES,WDES and Gender Pay Gap	~~X~~	X		X			Dir of HR and OD	POD
Annual Patient Equality Report		X					Chief Nurse	QC
Winter Plan				X			COO	
Seasonal Flu Plan				X			COO	
Annual Report and Accounts		X					Chief Finance Officer	ARC
Annual Governance Statement		X					Director of Corp Governance and Compliance	ARC

Emergency Planning Core Standards Annual Report (EPRR)	X						Deputy CEO/Chief Operating Officer	FIC
Review of Risk Management Strategy		X					Chief Nurse/Dir of Corp Gov and Compliance	ARC
Standing Financial Instructions, Standing Orders and Scheme of Delegation	X						Chief Finance Officer/Dir of Corp Gov and Compliance	ARC
Research Strategy and associated governance- Annual Update			X				Chief Medical Officer	QC
Board Self Certification Declarations		X					Dir of Corp Gov and Compliance	ARC
Report on Board Committee and Board Effectiveness and Terms of Reference						X	Dir of Corp Gov and Compliance	ARC
Board Committee Terms of Reference approval: Quality Committee; Finance and Investment Committee; People and Organisational Development Committee; Audit and Risk Committee	X						Dir of Corp Gov and Compliance	ALL
As and When Required								
Sustainability Strategy (for approval)							Chief Financial Officer	FIC
Estates Strategy							Dep CEO/Chief Operating Officer	FIC
Digital Strategy and IT and Innovation Strategy							Dep CEO/CCIO	FIC
Research and Innovation Strategy							Chief Medical Officer	QC
People Strategy							Dir of HR and	POD
Patient and Public Engagement and Experience Strategy 2019-2024 – progress update (Board action)								

Quality Strategy							Chief Nurse	QC
Financial Strategy							Chief Finance Officer	FIC
Externally facilitated developmental review of leadership and governance using the NHSI well-led framework (every three – five years)							Dir of Corp Gov and Compliance	ARC
Outline/Full Business Cases							As approp	FIC
CQC and Other Relevant Regulatory Reports							Chief Nurse/Dir of Corp Gov and Comp	QC
Appointment of the Senior Independent Director							Chair	CoG
Amendments to the Foundation Trust Constitution							Dir of Corp Gov and Compliance	CoG
Review of Transactions Policy							Chief Finance Officer	FIC and CoG
Award of Legal Contracts							Chief Nurse	
Application of the Trust Seal	X			X			Dir of Corp Gov and Compliance	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Trust Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	3.4
TITLE OF REPORT	Standing Financial Instructions and Scheme of Delegation
AUTHOR NAME AND ROLE	Peter Chapman – Deputy Director of Finance
ACCOUNTABLE EXECUTIVE DIRECTOR	Virginia Massaro – Chief Financial Officer
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To recommend approval of the Standing Financial Instructions and Scheme of Delegation following detailed review by the Audit and Risk Committee in March 2022
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: ARC Date of Meeting: March 2022 Outcome: Recommended for approval
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The annual review of the Standing Financial Instructions and Scheme of Delegation has taken place and has been considered by the most recent meeting of the Audit and Risk Committee. There have been a number of changes/updates made including minor changes for job titles, organisation references and formatting, amendments in the litigation section; and also changes to the procurement sign-off limits as follows: • Increased the limit to go to formal tender for Estates building works from £50k to £150k, in line with the Chelsea Wing investigation recommendations. This now requires a minimum of 4 quotes for all works between £10k-£150k and formal tender for all works above £150k • Reflect the change from OJEU to Public Contract Regulations (PCR). This has reduced the value at which the Trust is required to go to a full PCR tender to £138,760 incl VAT for goods and services and £5,336,937 inc vat for building works.
KEY RISKS ARISING FROM THIS REPORT	N/A

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	**As noted above.**

Equality And Diversity	N
Quality	Y
People (Workforce or Patients/ Families/Carers)	Y
Operational Performance	Y
Finance	Y
Public Consultation	N
Council of Governors	N

please mark Y/N – where Y is indicated please explain the implications in the opposite column

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS			
START DATE:	March 2022	**EXPIRY DATE**	March 2023
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE:**	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee **DATE:** 28.03.22		
DISTRIBUTION	Trust-wide		
RELATED DOCUMENTS/ OTHER INFORMATION:	• Scheme of Delegation • Standing Orders – Annex 9 to Constitution of Chelsea & Westminster Hospital NHS Foundation Trust September 2017 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interests and Anti-Bribery Policy • Treasury Management Policy • Raising Concerns (Whistleblowing) Policy • Governance Framework • Capital Governance Framework Policy • Information Governance Policy • Information Security Policy • Data Protection and Confidentiality Policy • Freedom of Information Policy • Losses and Special Payments Guidance Notes and Procedures • Purchase Order Compliance Policy • Patient Property Policy and Procedure • Other Trust-wide Policies and Procedures		
AUTHOR:	Chief Financial Officer virginia.massaro@nhs.net		
STAKEHOLDERS INVOLVED:	Chairs of key Trust committees Human Resources (in particular Equality and Diversity Manager) All Trust staff		
IS AN EQUALITY ANALYIS REQUIRED?		NO	

IF AN EQUALITY ANALYIS IS REQUIRED, HAS IT BEEN SENT TO THE EQUALITY AND DIVERSITY MANAGER?	NO

DOCUMENT REVIEW HISTORY:			
Date	**Version**	**Responsibility**	**Comments**
January 2018	13	Chief Financial Officer	Revised front sheet in line with Policy on Non-Clinical Policies Updates to: Current legislation and guidance Changes to regulatory framework Job titles and committee names to reflect current structure Changes to reflect current Trust policies Other minor updates
January 2019	14	Chief Financial Officer	Comprehensive refresh and rewrite for ease of use and cross-check with refreshed Schedule of Decisions Reserved and Delegated
March 2020	15	Acting Chief Financial Officer	Minor changes; including job titles changes; HRD authorising employment related payments; changes to authorisations in "**Table 1 – Capital Only Business Cases"**.
Mar 2021	16	Chief Financial Officer	Minor changes; largely in respect of updates to staff approval categories in section 7.3 and Annex 1 (table 1)..
March 2022	17	Chief Financial Officer	Minor changes, including updates for contact details & Job Titles; change from Monitor to NHSE/I; numbering references. Addition to employee roles around leases (section 6). Updated for tending/procurement sign-off limits and correct system names (section 7 & 8). Update to MoU wording (section 8.1) Updated approval list for business cases (section 12). Status of each contracting organisation (section 15). Delete references to Sphere (section 15). Clarification of Trusts responsibility for Patient Property (section 17) Updated policy names (section 18). Addition of CAB (section 19). Additional reporting process (section 20.2). Various updates to Litigation elements (section 21). Updated wording for settlement/compromise agreements (section 22). Small change to Annex 2, to be consistent with Losses & Special Payments Policy.

STANDING FINANCIAL INSTRUCTIONS

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STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st October 2006, following authorisation by "NHSE/I", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS Improvement, which this document represents).

1.1.3 The Single Oversight Framework details how NHSE/I oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DH GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and any hosted organisations (subject to para 23.2). They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Financial Officer (CFO) must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non- compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit and Risk Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and Delegation

Foundation Trust Board of Directors

1.2.1 The Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the “Scheme of Delegation.”

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “‘Schedule of Decisions Reserved to the Board” document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Chief Financial Officer (CFO)

1.2.4 The Chief Executive and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust’s activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust’s system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Chief Financial Officer

1.2.7 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust’s financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust’s transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties;

iv) Developing the Trust's financial strategy including:

- Managing cash resources

- Ensuring a robust system of budgetary control is in place

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHSE/I, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

1.3 TERMINOLOGY

1.3.1 Any expression to which a meaning is given in the National Health Service Act 2006, Health and Social Care Act 2012 and other Acts relating to the National Health Service, or in the Financial Directions made under the Acts, or in the Authorisation or Constitution shall have the same meaning in these instructions; and in addition:

- "Authorisation" means the authorisation of the Trust by NHSE/I, the Independent Regulator of NHS Foundation Trusts

- "Board" means the Board of Directors of the Trust

- "Budget" means a resource, expressed in financial, activity or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

- "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation or capital project; and

- "Chief Executive" means the Chief Officer of the Trust;

- "Constitution" means the constitution of the Trust as approved from time to time by NHSE/I, the Independent Regulator of NHS Foundations Trusts;

- "Chief Financial Officer" means the Chief Financial Officer of the Trust;

- "Executive Director" means a director who is an officer of the Trust appointed in accordance with the Standing Orders of the Trust. For the purposes of this document, 'Director' shall not include an employee whose job title incorporates the word Director but who has not been appointed in this manner;

- "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice;

- "Trust" means Chelsea and Westminster Hospital NHS Foundation Trust;

1.3.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2. AUDIT

2.1 Audit and Risk Committee

2.1.1 In accordance with the Constitution, the Board shall establish an Audit and Risk Committee with clearly defined terms of reference which will provide an independent and objective view of internal control by:

a) Overseeing external audit and internal audit and counter fraud services;

b) Reviewing financial and non-financial systems and processes;

c) Monitoring compliance with SOs and SFIs;

d) Reviewing losses and compensations and making recommendations to the Board.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Independent Regulator, NHS E/I, in consultation with the Chief Executive.

2.1.3 It is the responsibility of the Audit and Risk Committee, supported by the CFO, to ensure that an adequate internal audit and counter fraud service is provided and the Committee is involved in the selection process when providers are changed.

2.2 Chief Financial Officer

2.2.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHSE/I's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.5 in relation to fraud, corruption and bribery);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DH, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit and Risk Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit plan recommendations;

iv) Progress against plan over the previous year;

v) A strategic audit plan covering the coming three years;

vi) A detailed work-plan for the coming year.

2.2.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit

and Risk Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.3.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Counter Fraud Specialist);

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DH;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.3.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Counter Fraud Service (CFS) must be notified.

2.3.4 The Head of Internal Audit, or equivalent title, will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chair and Chief Executive.

2.3.5 The reporting system for internal audit shall be agreed between the CFO, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DH Group Accounting Manual", the "NHS FT Accounting Officer memorandum" and other relevant NHS Internal Audit Standards guidance.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.

2.4.2 Audit and Risk Committee must ensure a cost-effective service is provided and agree audit

work-plans over and above the statutory requirements.

2.4.3 The External Auditor must ensure that this service fulfills the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.4.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.4.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.4.6 Prior approval must be sought from the Audit and Risk Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the CFO is required to authorise expenditure.

2.4.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit and Risk Committee and shall be entitled to meet the Audit and Risk Committee in the absence of Trust employees if they so wish.

2.5 Fraud, Corruption and Bribery

2.5.1 In line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority's ("NHSCFA") standards.

2.5.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.5.3 The Trust shall nominate a professionally accredited person to carry out the duties of the Counter Fraud Specialist ("CFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified by NHSCFA implementing their good practice and guidance.

2.5.4 The CFS shall liaise with the CFO and NHSCFA in accordance with the NHS Counter Fraud and Corruption Manual and working in line with the current "Standards for Providers – Fraud, Bribery and Corruption" and the NHSCFA organisational strategy.

2.5.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the CFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action.

2.5.6 The Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.5.7 The CFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit and Risk Committee.

2.5.8 In accordance with the "Whistle-Blowing Policy", the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHSCFA.

2.5.9 The Trust will report annually on how it has met the standards set by NHSCFA in relation to anti-fraud, bribery and corruption work and the CFO shall sign-off the annual self-review and authorise its submission to NHSCFA. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant

authority.

2.6 Security Management

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHSCFA's standards.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHSCFA's anti-crime standards.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD), who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in workload, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHSE/I.

3.1.2 The annual plan must be submitted to NHSE/I in accordance with NHS Improvement's requirements and timescales.

3.1.3 The CFO will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with workload and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the regulatory framework for foundation trusts.

3.1.4 The Board shall have regard to the views of the Council of Governors in preparing the forward plan.

3.1.5 The CFO shall monitor financial performance against budget, and report to the Finance and

Investment Committee (the "FIC") and the Board.

3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.7 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the strategic review and annual planning processes. Only approved business cases or expected 'base case' will be included in the annual plan and budget setting. An adjustment to plans will be made in year for those that are subsequently approved. The approval process for business cases is contained within SFI 12.2.

3.1.8 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

d) Authority to exercise virement;

e) Achievement of planned levels of service;

f) The provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Except where otherwise approved by the Chief Executive, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.2.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.2.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive or the CFO.

3.2.6 Clinical Directors, Divisional Director or Service Leads (or equivalent) who are responsible for "trading activities" must ensure the integrity and supply of information to other users. Price increases in such departments shall be monitored by the CFO to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the FIC and the Board in a form approved by the Board containing sufficient information to allow the FIC and the Board to ascertain the financial performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Workforce spend and whole time equivalents (“WTEs”);

iii) NHS Commissioners’ contractual performance to date;

iv) Movements in working capital including cash;

v) Capital project spend and projected outturn against plan;

vi) Explanations of any material variances from budget and/or plan;

vii) Details of any corrective action where necessary and the Chief Executive's and/or CFO's view of whether such actions are sufficient to correct the situation.

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 Budget holders are not authorised to overspend their budget. Where an over spend occurs, the budget holder must account to their divisional management team or line manager for the over spend and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to phasing.

3.3.3 Each budget holder is responsible for ensuring that:

a) Any likely overspend or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

b) The amount provided in the approved budget is not used for any purpose other than that authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive , other than those provided for within the budgeted workforce establishment as approved by the Board.

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvement programmes (“CIPs”) and income generation initiatives in order to deliver a budget that will enable compliance with NHSE/I’s risk rating regime.

3.3.5 The CFO will include a written introduction to the Trust’s SFIs, SOs and Scheme of Delegation in the induction pack for all Trust induction attendees.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual and DH GAM. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms and returns are submitted to “NHSE/I.” The performance figures to the Board should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHSE/I and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHSE/I as to their technical accounting content and information/data shown therein, before submission to NHSE/I.

4.2 The Director of Corporate Governance and Compliance will prepare the Annual Report in accordance with the guidance in the DH Group Accounting Manual.

4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHSE/I must be audited by the external auditor in accordance with appropriate international auditing standards.

4.4 The Annual Report and Accounts, including the auditor's report, shall be approved by the Board or, by the Audit and Risk Committee when specifically delegated the power to do so under the authority of the Board.

4.5 The Annual Report and Accounts, including the auditor's report, is submitted to NHSE/I (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.6 The Annual Report and Accounts, including the auditor's report, must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website.

4.7 The Chief Nurse will prepare the Annual Quality Report in the format prescribed by NHSE/I/Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Trust's performance over the financial year and up to the agreed submission date.

4.8 The Chief Executive and Chair shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010.

4.9 The Chief Executive, Chair and CFO, as appropriate, shall sign other documentation relating to the Annual Report, Annual Accounts, Annual Quality Report and financial returns to NHS Improvement on behalf of the Board.

5 BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The Board will review banking arrangements periodically.

5.1.3 The Board shall approve the banking arrangements, including CFO recommendations, regarding the opening or closing of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will

apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services (refer to the Treasury Management Policy for further details);

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from its bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

e) Monitoring compliance with NHSE/I or DH guidance on the level of cleared funds;

f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit if applicable;

b) Those members of staff with mandated authority to carry out transactions either electronically, by signing transfer authorities or cheques or other orders, in accordance with the authorisation framework of each bank account.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

5.5 Trust Credit Card

5.5.1 The Chief Financial Officer has overall responsibility for Trust credit cards including security, approval for issue, authorised use and purchasing limits.

5.5.2 Responsibility for the security and use of an individual Trust credit card is the named holder of the card. Each card must only be used for the purpose for which it is authorised.

5.5.3 Each cardholder must comply with the administrative requirements of the Trust's Purchasing Cards guidance.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the NHSE/I guidance on "National Tariff" when entering into contracts for patient services where applicable.

6.2.2 The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care ("DH") or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income, including items in kind such as subsidised goods or loans of equipment, is considered, the guidance in the DH's "Commercial Sponsorship – Ethical Standards in the NHS" shall be followed.

6.2.3 All employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, private patient undertakings and other transactions. No employee is permitted to take out a lease, a license or a tenancy agreement on behalf of the Trust or rent any of the Trust estate out without authority from the CFO.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 1.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed, should be written off in accordance with agreed procedures for reporting losses in SFI 14.

6.3.3 The following VAT exclusive approval limits shall be applied to individual debt write offs or partial write offs:

Monetary Value	Approval
Up to £1,000 (where necessary as part of the complaints process)	General Manager or non-Board Director
Up to £5,000	Head of Financial Operations
Up to £20,000	Deputy Director of Finance
Up to £50,000	Chief Financial Officer
Up to £100,000	Chief Executive
£100,000 and above	Decision referred to the Audit and Risk Committee

6.3.4 The following VAT exclusive approval limits shall be applied to packages of debt:

Monetary Value	Approval
Up to £5,000	Head of Financial Operations
Up to £20,000	Deputy Director of Finance
Up to £100,000	Chief Financial Officer
Up to £250,000	Chief Executive
£250,000 and above	Decision referred to the Board

6.3.5 A schedule of all written off debt shall be presented to the Audit and Risk Committee at least annually.

6.3.6 A schedule of debts written off in excess of £100,000 should be presented to the Trust Board for noting at least annually.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The CFO shall be responsible for the security arrangements.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received before banking except under arrangements approved by the CFO.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safe, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed "declarations of indemnity" must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses in SFI 14

7 TENDERING AND CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions and Procurement Law

7.1.1 The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders.

7.1.2 The Procurement Department shall maintain standard tendering procedures and documents in accordance with best practice and EU procurement law.

7.1.3 Tenders for building and engineering works will be let in accordance with SFIs, SOs, "Procurement Policies and Procedures" document and NEC/JCT or relevant engineering or construction contracts as authorised by the Director of Estates.

7.2 Thresholds Tender Guide

7.2.1 The formal tendering process is facilitated by the Procurement Department. It is applied to all expenditure over £50,000 and must be adhered to unless the expenditure fits the criteria under which formal tendering may be waived in line with the procedures in SFI 7.9 below.

7.2.2 All requests for a Single Tender Waiver must be made in line with SFI's through the Procurement Department.

7.2.3 All tendering activity is to be processed through the Trust's e-tendering system, Atamis. Paper tenders will not be accepted and will be deemed to be non-compliant.

7.2.4 The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

7.2.5 Where goods, services and/or capital works are to be supplied over a period of time, the threshold limits represent the total value of the contract and include the whole life costs e.g. a 5 year contract of £25,000 per year would be a contract value of £125,000

7.2.6 The tables below detail the procurement thresholds for goods and services

Products and Services Procurement (Revenue and Capital)

Contract Value (Excl VAT)	Quotations/Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	Single quotation may be obtained by end user	1	Purchase Order
£10,001 - £50,000	Quotation. Authorisation required from Procurement prior to obtaining quotes	3 (of which 2 must be returned)	Purchase Order or Contract
£50,001 – to £138,760 inc vat)	Tender by Procurement	6 (of which 3 must be returned)	Contract as specified in Tender and Purchase Order
Public Contracts Regulations (PCR) 2015 (Currently £138,760 inc vat)	PCR 2015 Tender by Procurement	Whole market invited	Contract as specified in Tender and Purchase Order

Works: Building and Estates Engineering Procurement (Revenue and Capital)*
* Does not apply to Facilities expenditure.

Contract Value (Excl VAT)	Tender for Building & Engineering	Min number invited to Quote/Tender	Form of Contract
Up to £10,000	Single quotation may be obtained by end user	1	Purchase Order
£10,001 - £150,000	Quotation. Authorisation required from Procurement prior to obtaining quotes	5 (of which 4must be returned)	Purchase Order or Contract
£150,000 to PCR 2015	Formal tender issued by the Procurement department	6 of which 5 must be returned	Purchase Order or Contract
PCR 2015 Over £5,336,937 inc vat	PCR 2015 Tender	Whole market invited	Contract as specified in Tender and Purchase Order

7.2.7 In circumstances where the specified number of quotations and/or tenders cannot be obtained (e.g. where there are a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded.

7.3 Placing Contracts

7.3.1 Contract negotiations with suppliers can only be entered into by the Procurement Department.

7.3.2 Agreement of contracts for goods and services are subject to approval in line with the authorisation levels in the table below:

Contracts for Goods and Services

Value	Authoriser
Contract value up to £10,000	Budget Holder
Contract value up to £50,000	General Manager (including Divisional Nurse Leads, Heads of Service e.g. Therapies; DDoFs/HR).
Contract value up to £100,000	Non-Board Director or Clinical Director (including Divisional Director(s) of Operations).
Contract value up to £200,000	Executive Director
Contract value up to £500,000	Chief Executive or CFO
Contract value over £500,000	Trust Board

7.3.3 Contracts sign off for all goods and services must be facilitated through by Procurement.

7.3.4 Variations to revenue contracts are subject to approval in line with the authorisation levels in the table below:

Variations to Revenue Contracts

Value	Authoriser
Contract value up to £100,000	Non-Board Director or Clinical Director
Contract value up to £200,000	Executive Director or CFO
Contract value up to £500,000	Chief Executive or CFO
Contract value over £500,000	Trust Board

7.3.5 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff and temporary staff and agency staff contracts.

7.4 Electronic Tendering

7.4.1 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal, Atemis.

7.4.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.9. Issue of all tender documentation should be

undertaken electronically by the Procurement Department through the Atamis system with controlled access using secure login, authentication and viewing rules.

7.4.3 No communications will be permitted outside of the Atamis system. Any bidders attempting to communicate with staff in relation to a tender outside of this facility may be disqualified from the process.

7.4.4 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time.

7.4.5 A “Declaration of Interests” form must be completed by all participants in a tender process without exception. Procurement will retain responsibility for reviewing forms and excluding participants where a conflict of interest is noted.

7.5 Opening Formal Tenders

7.5.1 The Atamis e-tendering system will automatically open the tender once the closing date and time has passed. Details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. Tender responses can then be downloaded and assessed.

7.5.2 The Atamis system automatically maintains a full audit trail of all actions and communications by both procurement staff and suppliers. A permanent record shall therefore be maintained to show for each set of competitive tender invitations despatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening.

7.5.3 Except as in SFI 7.5.4 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record will be recorded in the audit trail.

7.5.4 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure set out in Section 7.5.3 above unreasonable.

7.6 Admissibility and Acceptance of Formal Electronic Tenders

7.6.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the CFO or nominated officer.

7.6.2 Tenders received after the due time and date may be considered only if the Chief Executive or CFO decides that there are exceptional circumstances, e.g. where the e-tendering facility does not allow successful uploads of tendering documentation or there is a fault with the system. Each case will be judged on its merits and according to current case law. The Chief Executive or CFO shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

7.6.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Chief Executive or CFO be regarded as having arrived in due time. A record supporting this decision should be logged.

7.6.4 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative after the due time for receipt) should be dealt with in the same way as late tenders under Section 7.6.2.

7.6.5 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

7.6.6 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

7.6.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the CFO.

7.6.8 Where only one tender/quotation is received the Chief Executive or CFO shall, as far as practicable, ensure that the price to be paid is fair and reasonable. All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

7.6.9 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (SFI 7.8 below).

7.6.10 All tenders should be treated as confidential and should be retained for inspection.

7.7 Extensions to Contract

7.7.1 In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Estates and /or Director of Procurement (DoP) up to the value of the original contract (including formally agreed variations).

7.8 Quotation and Tendering Procedures

7.8.1 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts and the supply or goods and/or services according to the financial limits specified in SFI 7.2.

7.8.2 The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

7.8.3 Quotations may be obtained by the Procurement Department or requisitioner for single purchases where the estimated value does not exceed £10,000.

7.8.4 No Pre Qualifications stages should be conducted for below OJEU threshold quotations/tenders in accordance with Public Contract Regulation 2015 (Regulation 111)

7.8.5 Where the total contract value exceeds the published OJEU Thresholds then the Trust is committed to EU Regulations and conducting an EU compliant procurement process.

7.8.6 Tender documents will be issued by the Procurement Department using the Atamis system and will incorporate standard NHS Terms and Conditions as appropriate.

7.8.7 Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that

they advertise the opportunity through the national Government Contracts Finder portal and must subsequently ensure the respective award is also published

7.8.8 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

7.8.9 Tender lists for building and engineering works will be compiled in conjunction with the Director of Estates from "Construction Line" the Trust's approved list of contractors.

7.8.10 Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the CFO for further instructions.

7.8.11 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

7.8.12 After tenders/quotations have been opened, the DoP will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.

7.8.13 A Contract Approval Document and Ratification Report prepared by the Procurement Team should be submitted to the DoP for approval or to seek authorisation from the Chief Executive/Trust Board, according to delegated limits.

7.8.14 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

7.8.15 Where a competitive tender ratification process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the DoP to approve any subsequent lease contract award for the same goods or equipment.

7.8.16 All contract documentation must be finalised promptly after the award of the contract and ideally prior to its commencement.

7.8.17 The waiving of variation of competitive tendering/quotation procedures shall be reported to Audit and Risk Committee meetings.

7.8.18 All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Contract database. Any exceptions to this are at the discretion of the DoP.

7.9 Waiving of Formal Tendering/Quotation Process

7.9.1 Single tender waivers must not be used for the purpose of avoiding competition, for administrative convenience or to award further work to a consultant original appointed through a competitive process. They must be approved by the CFO or Chief Executive prior to any procurement taking place and can only be sought in the following circumstances:

a) Supply under special arrangements negotiated by the Department of Health which must therefore be complied with;

b) Timescales preclude competitive tendering (cannot apply to OJEU- explicit in Public Sector Regulations);

c) Specialist expertise is sought and is available from only one source (refer to Procurement Department to validate the issue of a MEAT notice if applicable);

d) There is clear benefit from continuity with an earlier project or to complete an existing project.

7.9.2 Tender waivers must be reported to the next Audit and Risk Committee meeting.

7.9.3 Formal competition need not be applied and therefore a waiver is not required as follows:

a) In circumstances after market engagement has been conducted and the specified number of quotations or tenders cannot be obtained (e.g. limited number of suppliers). The reason for receiving a lower number of quotations/tenders must be recorded;

b) The estimated expenditure does not, or is reasonably expected not to, exceed £10,000;

c) The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (e.g. change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor;

d) A direct award to a supplier on a national or regional framework is permissible and recommended according to the rules of the framework. On these occasions a report will require authorisation in accordance with SFI 7.3.2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust;

e) A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

f) A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed.

g) The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute procurement but the nominated Officer must still ensure value for money.

8 CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England, Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health or NHSE/I are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts (excluding Memorandums of Understanding) shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users. Memorandums of Understanding are not legally binding and can be used to support partnership working, but only where the partnership is non-commercial and comes with no financial obligations of either party.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

a) Costing and pricing of services (in accordance with Payment by Results) and the activity / volume of services planned;

b) The standards of service quality expected;

c) The relevant national service framework (if any);

d) Payment terms and conditions;

e) Amendments to contracts and extra-contractual arrangements; and

f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff.

8.1.7 The CFO shall produce regular reports detailing actual and forecast income linked to contract activity with a detailed assessment of the variable elements of income.

8.1.8 Any pricing of contracts at marginal costs must be undertaken by the CFO and reported to the Board.

8.1.9 The authorisation limits for signing service contracts are set out in SFI Annex 1.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where the Trust is a competing body)

8.3.1 Where the Trust participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Divisional Director of Operations	Procurement Steering Group	CEO	Trust Board
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£12.5m	<£25m	>£25m
Annual value	£20k pa	<£5m pa	>£5m<£10m pa	>£10m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to the CFO and Board for noting.

8.3.4 Staff who participate in a tendering exercise must follow the processes as outlined in the Procurement Procedures and the Evaluation protocol

9 TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Nominations and Remuneration Committee

9.1.1 The Board shall establish a Nominations and Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 The Committee will:

a) Decide the remuneration, allowances and other terms and conditions of office of Executive Directors and the Director of Corporate Governance and Compliance;

b) Approve recommendations for the remuneration, allowances and other terms and conditions of office of other senior managers under their remit;

c) Decide such rates at which the travelling and other expenses incurred by all Directors may be reimbursed;

d) Report in writing to the Board on any decisions made and the basis for such decisions.

9.1.3 Trust Board and most Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.4 In line with March 2018 NHSI guidance, the opinion of NHSI, DHSC and the Minister of State for Health must be sought before confirming any senior manager or Director salary at appointment or any increase in salary where the annual salary is £150,000 or above.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Vacancy Control panel(if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) staff should be sourced through Bank whenever possible. The use of bank must be in line with the Trust's procedures for booking temporary staff. If the use of Bank is not possible, staff may be sourced through an Agency. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulations are complied with. Any off payroll engagements must be approved by the CFO prior to contract signature.

9.2.3 All staff employed by the Trust shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be retained by the HR Department.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the Trust intranet.

9.2.6 A leavers form shall be completed via the E-Pay system by the employee's line manager and submitted electronically to HR immediately upon the date of an employee's resignation, retirement or termination becoming known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the line manager shall inform HR immediately.

9.2.7 A "Change of Employment Circumstance Form, available through ePAY covering changes to the employee's existing contract shall be completed by the employee's line manager and submitted electronically to HR immediately upon the date of change becoming known.

9.2.8 The employee is responsible for notifying HR of changes to personal details such as name, address or bank details. Changes can be notified online via the ESR (Electronic Staff Record) portal.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its "Managing Organisational Change Policy".

9.2.11 The Nominations and Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.12 The Trust must seek approval from NHSE/I before commissioning Management Consultants above a cap of £50,000.

9.3 Processing Payroll

9.3.1 The CFO shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts, the proper compilation of the payroll and for payments made.

9.3.2 No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the CFO.

9.3.3 All pay records including expense claim forms, supported by vouchers/ receipts where appropriate, shall be in a form approved by the CFO and shall be certified and submitted in accordance with his/her instructions be it in manual or electronic format.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed in advance by the CFO, on the date determined by the CFO.

9.3.5 Payment in full or in part shall not be made in advance of the pay date determined in 9.3.4 above except where prior approval has been obtained from the Chief Executive, CFO or duly appointed representative. In such cases payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.

9.3.7 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The processes and procedures related to pay related claims and under/

overpayments are contained in the Trust's "Expenses Policy" and "Salary Under/Overpayment Policy".

9.3.9 The "Expenses Policy" sets out that claims for reimbursement will only be paid within 90 days of the expenditure being incurred. Additionally, pay claims in excess of normal contractual hours will only be paid within 90 days of the extra shift/hours. Any claims over 90 days old will only be paid in exceptional circumstances and require CFO approval.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Council of Governors will be consulted on significant transactions – see Annex 3.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Chief Executive will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought. Where this advice is not acceptable to the requisitioner, the DoP and/or the CFO shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition for a purchase order (PO) to be raised.

10.3.3 In line with the "Procurement Policies and Procedures", the Trust operates a "No Purchase Order, No Pay" policy. With the exception of items specifically detailed as "exceptions" within the policy (such as agency staff and utilities), all goods and services will be procured by means of a PO in the Trust's e-ordering system, or using the Trust's Credit Card, in which case the order must also comply with the Trust's "Credit Card Policy" (refer to the Procurement Department for further guidance).

10.3.4 Official POs must:

a) Must be uniquely identified by use of an internally approved process;

b) Be in a form approved by the CFO;

c) State the Trust's terms and conditions of trade;

d) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.3.5 Orders for goods and services listed as "exceptions" in the "Procurement Policies and Procedures" must contain sufficient information to enable the supplier's invoice to be allocated to the correct budget. In line with the policy, the minimum information required on both the PO and supplier's invoice is:

a) Department;

b) Cost centre and account code;

c) Approver's name.

10.3.6 The Procurement Department is both obliged and authorised to divert a requisition to an alternative supplier or equivalent product in pursuit of best value or to ensure contractual obligation compliance.

10.3.7 The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.8 The CFO will:

a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the SFIs and regularly reviewed (SFI 7.2.6);

b) Prepare procedural instructions (where not already provided in the SFIs, Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Authorisation:

- A list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) Certification:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;

- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;

- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- Where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are evidenced;

- In the case of contract for building and engineering works which require

payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

- The account is arithmetically correct and is in order for payment

iii) Payments and Creditors:

- A timetable and system for submission to the CFO, or delegated officer, of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Financial Procedures:

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

d) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.9 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement is unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director and CFO if problems are encountered.

10.3.10 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the SFIs, Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;

c) Verbal orders must only be issued by a member of the Procurement Department and then only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked as “Confirmation Order”;

d) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds referred to in 10.3.8 above;

e) Goods are not taken on trial or loan in circumstances that could commit the Trust to future uncompetitive purchase or without appropriate indemnity;

f) No order shall be issued to a firm which has made an offer of gifts, reward or benefit to Directors or employees other than isolated gifts of a trivial nature (e.g. calendars) or conventional hospitality such as lunch in the course of a working visit;

g) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board and are notified to the CFO;

h) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the CFO who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Advice on the VAT status of individual transactions will be provided by the Finance Department as required.

10.5 Petty Cash

10.5.1 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO.

10.5.2 Staff reimbursements for expenses incurred must not be made through petty cash but through payroll (see SFI 9.3.2).

10.5.3 Petty cash records are maintained in a form as determined by the CFO.

11 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHSE/I's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.1.6 The CFO must prepare detailed procedural instructions concerning applications for loans or overdrafts.

11.1.7 The CFO is responsible for reporting Trust borrowing annually to the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 The amount of Public Dividend Capital at the point in time when the former NHS Trust became an authorised Foundation Trust will become the initial PDC of the Trust to be held on the same conditions.

11.2.2 Any application for an increase in PDC on behalf of the Trust shall only be made by the CFO, Deputy Director of Finance or their nominated representative and will be notified to the Board or FIC on the Board's behalf.

11.2.3 The Trust will comply with the guidance on dividend payments contained in the DH Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The "Treasury Management Policy" shall set out the guidelines and shall be approved by the Audit and Risk Committee.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHSE/I and meeting the criteria approved by the "Treasury Management Policy". The "Treasury Management Policy" will be refreshed and approved by the Audit and Risk Committee on a bi-annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Board through the Audit and Risk Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the "Treasury Management Policy" at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

12 INVESTMENT (CAPITAL AND REVENUE), PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Investment (Capital and Revenue)

12.1.1 The Trust will establish a Capital Programme Board (CPB) chaired by the CFO to oversee its allocation of capital investment and to approve business cases for both capital and revenue investment. The CFO will ensure that there is an adequate appraisal and approval process in place for determining expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The CPB will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The CFO shall establish systems to ensure that approved investment schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The CPB may approve in year virements.

12.1.5 The financial performance of the capital programme, including virements above £250,000, shall be reported to Trust Board, via the Finance and Investment Committee, on a monthly basis.

12.2 Approval of Investment (Capital and Revenue) Business Cases

12.2.1 The Chief Executive shall require that a business case is produced for investment proposals in line with the Trust's "Capital Governance Framework" and "Business Case Guidance" and NHSE/I's "Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts."

12.2.2 Business cases must meet the following criteria:

a) Strategic case – Ensures strategic fit with organisational priorities and outlines the case for change;

b) Economic case – Demonstrates that the proposal optimises public value, evaluates options and identifies the preferred option;

c) Financial Case – Evidences that the preferred option will result in a fundable and affordable deal;

d) Commercial Case – Demonstrates that the preferred option will result in a viable procurement;

e) Management case – Demonstrates that the preferred option is capable of being delivered successfully.

12.2.3 Business cases should be developed for all schemes given approval to proceed to business case irrelevant of funding source. The approval for business cases is as per the tables below dependent on whether the investment is capital only (Table 1) or revenue only or a combination of capital and revenue (Table 2):

Table 1 – Capital Only Business Cases

Capital Asset Category	Business Case Value (incl VAT)	Within Trust Plan	Approval Process	Report to
Medical Equipment	< /= £200k	Yes	Approved by the relevant Divisional Board and then Equipment Sub Group, within delegated budget and reported to the Capital Programme Board for information	Capital Programme Board
IM&T equipment or systems business cases	< /= £200k	Yes	Approved by the relevant Divisional Board and then approved by Chief Operating Officer/Chief Information Officer	Capital Programme Board

Capital Asset Category	Business Case Value (incl VAT)	Within Trust Plan	Approval Process	Report to
Capital Works to maintain Condition B and other building capital works (Estates)	</ = £200k	Yes	Approved by the relevant Divisional Board and then approved by Estates Capital Sub Group, within delegated budget and reported to the Capital Programme Board for information	Capital Programme Board
Non-Medical Equipment	</ = £200k	Yes	Approved by the relevant Divisional Board and then approved by Chief Operating Officer	Capital Programme Board
All capital types	< £200k	No	Approved by the relevant Divisional Board and then approved by Chief Operating Officer and Chief Financial Officer	Capital Programme Board.
All capital types	£200k-£1m	Yes	Approved by Executive Board, then Capital Programme Board for approval.	Capital Programme Board.
All capital types	£200k-£1m	No	Approved by Executive Board and Capital Programme Board then FIC/ Trust Board/ for approval. Any urgent capital business cases in this category (i.e. greater than £200k and with no capital budget) must be approved by the Chief Executive and Chief Financial Officer and Chairman's action.	FIC/ Trust Board
All capital types	>£1m	No	Approved by Executive Board and specific approval from the Finance Investment Committee for recommendation to the Trust Board	FIC/ Trust Board
All capital types	>£1m	Yes	Approved by Executive Board and then approval by Finance Investment Committee	FIC/ Trust Board
Variations to all capital types	£200k-£1m	N/A	Approved by Executive Board and then approval by Capital Programme Board for them to decide the subsequent authorisation process for the variation prior to additional commitment being made with the supplier.	Capital Programme Board.
Variations to all capital	>£1m	No	Approved by Executive Board and then approval by the	FIC/ Trust Board

Capital Asset Category	Business Case Value (incl VAT)	Within Trust Plan	Approval Process	Report to
types			Finance Investment Committee for recommendation to the Trust Board	

Table 2 – Revenue Only or Combination of Revenue and Capital Business Cases

Capital Asset Category	Business Case Value including VAT	Within Trust Plan	Approval Process	Report to
Revenue Expenditure only	< / = £50k	N/A	Approved by Divisional Director up to an annual limit of £200k.	
Revenue & Capital Investment	>£50k plus capital investment		Approved by the relevant Divisional Board and then up to an annual limit of £200k and then follow the capital process as described in the table above. If the aggregate is exceeded then the Executive Board must approve the business case.	Capital Programme Board
Revenue & Capital Investment	< £200k	Yes	Approved by the relevant Divisional Board and then approved by relevant Chair of Subgroup, Chief Operating Officer , Chief Financial Officer	Capital Programme Board
Revenue & Capital Investment	£200k-£1m	Yes	Approved by Executive Board and then for Capital - Approved by relevant Chair of Capital Subgroup, Chief Executive, Capital Programme Board. Revenue – Divisional director, Chief Operating Officer/ Chief Financial Officer and then Chief Executive	Capital Programme Board
Revenue & Capital Investment	£200k-£1m	No	Approved by Executive Board and then for Capital - Approved by relevant Chair of Capital Subgroup, Chief Executive, Capital Programme Board and then Trust Board for approval. Revenue – Divisional director, Chief Operating Officer/ Chief Financial Officer and then Chief Executive	FIC/ Trust Board
Revenue & Capital Investment	>£1m	Yes	Approved by Executive Board and then approved by Finance Investment Committee.	FIC/ Trust Board
Revenue & Capital Investment	>£1m	No	Approved by Executive Board and to the Finance Investment Committee for recommendation to the Trust Board	FIC/ Trust Board

12.2.4 Expenditure must not be incurred on any scheme prior to the above approval process unless with the express consent of the Chief Executive or CFO.

12.2.5 Any proposed scheme defined as major within the Foundation Trust Compliance arrangements must be approved by the Board and reported to NHSE/I.

12.2.6 Investment funded entirely by donations must follow the approval process above.

12.3 Private Finance Initiative (PFI) and Leasing

12.3.1 The Trust should normally test for PFI and leasing when considering capital procurement through its business planning process (See “Capital Governance Framework” and “Business Case Guidance” on the Trust intranet)

12.3.2 When the Trust proposes to use private external finance, the following procedures apply:

a) The CFO shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

b) The proposal, in addition to any requirements under the business case approval process, must be specifically agreed by the Board.

12.3.3 Finance and operating leases must be agreed and signed off by the CFO

12.4 Asset Registers

12.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register, the method of updating and arranging for a periodic physical check of assets against the registers.

12.4.2 The Trust shall maintain an asset register recording both tangible and intangible fixed assets with an individual or grouped value of over £5,000. The register must be adjusted to reflect assets currently in use. The minimum data set to be held within the register shall be as specified in DH and NHSE/I guidance.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect’s certificates, supplier’s invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads;

c) Lease agreements in respect of asses held under a lease and capitalised.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.4.7 The CFO shall prepare procedural instructions on the disposal of assets.

12.5 Security of Assets

12.5.1 The overall control of assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported.

12.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.6 Whenever practicable, assets should be marked as Trust property.

12.5.7 An inventory shall also be maintained and receipts obtained for equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's estate must receive the prior approval of the Capital Programme Board and Trust Executive Management Board. .

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £250,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £250,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £250,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 Any contracts to acquire property must be signed by two Executive Directors, one of whom should be the Chief Executive, subject to any requirement to affix the Company Seal being conducted in accordance with the requirements of the Trust's Constitution at Annex 7 (Standing Orders) Section 11.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £250,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.7 The disposal must be effected in full accord with Estate code.

12.6.8 Disposals of protected/relevant assets (as defined in the Trust's License) require the approval of NHSE/I.

12.6.9 Major divestments as defined in the Foundation Trust Compliance Framework require the approval of NHSE/I (See Annex 3).

12.6.10 Granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £250,000.

13 INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 All goods delivered to the Trust should be routed via the Goods Receipt Point unless formally agreed in advance by Procurement. In this way goods can be properly accounted for via the electronic purchasing and receipt system and invoices matched and paid appropriately.

13.1.2 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First in first out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.3 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; and the control of fuel oil of a designated Estates Manager.

13.1.4 The responsibility for security arrangements and the custody of keys for all inventory stores and locations shall be clearly defined in writing by the designated manager / Pharmaceutical Officer. Wherever practicable, stocks should be marked as Health Service property.

13.1.5 The CFO, in conjunction with the DoP, shall set out procedures and systems to regulate the inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.6 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures for the control of consignment stock;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.7 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.8 The designated manager/ Pharmaceutical Officer shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.9 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.10 Inventory that has deteriorated, or are not usable for any other reason for their intended

purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.

13.1.11 For goods supplied via the NHS Supply Chain central warehouses, the CFO shall identify those authorised to requisition and accept goods from the store.

13.1.12 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100,000 (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DH Group Accounting Manual and prepare a register (See Trust “Losses and Special Payments Guidance”).

14.2.2 The CFO must also prepare a ‘fraud response plan’ that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See “Counter Fraud and Corruption Policy and Response Plan”).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust’s “Counter Fraud and Corruption Policy and Response Plan”.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHSCFA.

14.2.5 The Divisional or Service Manager shall inform the CFO of all other losses or recoveries of

previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether an insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. The categories for classification of losses and special payments are defined at Annex 2.

14.2.10 The CFO shall report all losses and special payments to the Audit and Risk Committee on a regular basis. Losses in excess of £100,000 approved by the Audit and Risk Committee should be presented to the Trust Board for noting at least annually.

15 INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Chief Executive, supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised data of the Trust, shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation framework;

b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that adequate controls are in place to manage and develop IT systems;

d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out

e) Ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and clearly state the status of each contracting organisation (controller or joint controller). The contract should also ensure rights of access for

audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Information Strategy;

b) Data produced for use with financial systems is adequate, accurate, fit for reporting purposes, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data on a need-to-know basis;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on Trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Trust's ICT Team. Any quotes to purchase software should therefore be managed through the online IT self-service portal.

15.1.7 No hardware equipment should be connected to the network without the approval of the Trust IT team. Any quotes to purchase hardware should therefore be managed through the online Sphere IT self-service portal.

15.1.8 ICT business cases for both hardware and software are subject to procedures and limits contained in SFI 12 and the "Business Case Guidance" on the Trust intranet.

16 FREEDOM OF INFORMATION

16.1.1 The Responsible Director shall publish and maintain a 'Freedom of Information (FOI) Publication Scheme', or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.1.2 It is the responsibility of the Responsible Manager to notify the Trust Responsible Director of any new documents to be included in a Publication Scheme.

17 PATIENTS' PROPERTY

17.1 Patients' Property and Income

17.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of to inform patients that any possessions, which are not handed in for safe keeping, are the responsibility of the patients and no responsibility is accepted by the Trust for theft, loss or damage. Patients are discouraged from bringing valuables into the Trust. Staff have a duty to make efforts to take care of patients' property where the patient does not have the capacity to look after their own possessions, and this includes items of daily living such as glasses, false teeth, hearing aids etc.

17.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of

administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, and only where it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

17.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

17.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

17.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, (Small Payments), Act 1965), the production of the Grant of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of identity shall be obtained.

17.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's personal representative as appropriate, in writing.

17.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Care instructions and guidelines.

17.1.9 Where a deceased patient is intestate and there is no relative who is entitled to apply for Letters of Administration, details of any monies or valuables should be notified to the Treasury Solicitor.

17.1.10 Funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any patient's monies held by the Trust.

18 STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest and Anti-Bribery Policy. This policy details the behavior expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Director of Corporate Governance and Compliance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors. It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

18.2.1 Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

18.2.2 These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically "Raising Concerns (Whistleblowing) Policy", "Counter Fraud and Corruption Policy and Response Plan Policy" and "Related Party Disclosure Policy" available via the Trust intranet).

18.2.3 The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

18.2.4 Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Counter Fraud Specialist (CFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www. cfa.nhs.uk/reportfraud .

19 RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHSE/I / DH guidelines. The Trust Corporate Records Management Policy sets out the processes and procedures. Archives may be held electronically.

19.2 The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, and maintenance of a register shall be as follows:

Document	Responsible
Property deeds	Director of Estates
Building and engineering contracts	Director of Estates
Estate maintenance contracts	Director of Estates
Maintenance and clinical contracts	Director of Procurement
Contracts for goods and services other than the above	Director of Procurement
Schedule of Commercial Partnerships	Chair of the Commercial Assurance Board (CFO)

Any other contracts not covered by the above which may be held by other managers must be

reported to the Director of Corporate Governance and Compliance for a register to be maintained.

19.3 Any records held in archives shall be capable of retrieval by authorised persons. Destruction of archived records must only be undertaken by authorised personnel and a full audit trail must be maintained.

19.4 Records and information held in accordance with latest NHSE/I / DH guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or CFO. Proper details shall be maintained of records and information so destroyed.

20 GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Trust Board and its delegated sub committees with responsibility for risk management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

a) Provisions for keeping and maintaining risk registers and the Board Assurance Framework;

b) Engendering amongst all levels of staff a positive attitude towards the control of risk;

c) The authority of all managers with regard to managing the control and mitigation of risk;

d) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of residual risk;

e) Contingency plans to offset the impact of adverse events;

f) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review;

g) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHSE/I guidance.

20.2 Insurance

20.2.1 On an annual basis, with the advice of the Head of Legal Services, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Head of Legal Services shall act as the Trust's contact on insurance matters.

20.2.3 The Head of Legal Services shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Head of Legal Services shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.2.5 The Head of Legal Services shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.2.6 No loss, incident or claim can be reported to NHS Resolution without authority from the Head of Legal Services.

20.3 Clinical Risk Management / CNST

20.3.1 The Chief Nurse shall:

a) Provide a central point of contact within the Trust for NHS Resolution issues;

b) Report on claims to Trust Board within the set limits and values.

21 LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public (excluding Employment Tribunal and commercial matters) shall be made where NHS Resolution considers it appropriate to do so. Public liability claims carry an excess of £3,000 and employer liability claims carry an excess of £10,000.

21.1.2 Given that financial responsibility for the payment on all claims is the sole responsibility of NHS Resolution, the Chief Nurse and the Chief Medical Officer are informed by the Legal Services staff in advance where it is known that NHS Resolution authorised settlement. The amounts of damages in all settled claims against the TRUST (excluding Employment Tribunal and debt recovery matters) is reported at the monthly Medico-Legal Group, and the overall statistics is included in the annual legal report.

The DH must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

22 EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the CFO.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the CFO and the Chief Executive. In certain cases, additional approval should be sought from NHSE/I and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the CFO advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value	Approval
< £30,000	CFO/HRD
£30,001 - £100,000	Chief Executive
> £100,001	Trust Board

22.4 NHSE/I must be consulted before making any special payments that are novel, contentious or repercussive. The CFO, in the case of any such settlement agreements, shall submit a business case to be approved by Treasury (compromise agreements don't require a business case). Any payments made against legal advice must be approved by the Trust Board.

23 WHOLLY OWNED SUBSIDIARIES, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries

23.1.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

23.2 Hosted Bodies, Partnerships and Collaborations including Joint Ventures and Joint Operations

23.2.1 Hosted bodies are organisations for which the Trust provides services under a service level agreement (SLA).

23.2.2 The Trust also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.3 Dependent on the terms of the SLA, memorandum of understanding etc., these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding etc. should be referred to on a case by case basis.

24 RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, "Attributing the Costs of Health and Social Care Research and Development" (ACoRD DH2012) using the national costing guidance/templates.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 SOs and SFIs apply equally to the undertaking of research including budgetary control, purchasing and contracting, security of assets, and declarations of interest and Standards of Business Conduct amongst others.

24.5 The submission of grant applications to support research shall be signed by the CFO or designated representative.

26.6 The principles governing probity and public accounting shall apply equally to work undertaken through research.

25 GRANT APPLICATIONS

25.1 All applications for grant funding, whether for revenue or capital purposes, must be approved

by the CFO or designated representative in advance of submission.

Annex 1: Authorisation Levels

Table 1

Authorisation levels for:

- Requisitioning of goods, works and services excluding pharmaceutical drugs (see table 2);
- Contract approval for goods and services;
- Signing call-off orders against existing contracts;
- Approval of invoices against existing service contracts excluding pharmacy (see table 3);
- Approval of contracts for income*

Table 1	
Value	**Authoriser**
Up to £10,000	Budget Holder
Up to £50,000	General Manager (including Divisional Nurse Leads, Heads of Service e.g. Therapies; DDoFs/HR).
Up to £100,000	Non-Board Director or Clinical Director (including Divisional Director(s) of Operations).
Up to £200,000	Executive Director or CFO
Up to £500,000	Chief Executive and CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

* All income contracts with a value of up to £100,000 must be countersigned by:

- Procurement, in order to review legal aspects of the contract;
- CFO, Deputy Director of Finance, Head of Financial Operations or Head of Management Accounts to review the financial aspects of the contract and ensure budget exists for any related expenditure;
- Head of ICT Operations for ICT related contracts

Annex 1: Authorisation Levels

Table 2

Authorisation levels for requisitioning of pharmaceutical drugs.

Table 2	
Value	**Authoriser**
Up to £10,000	Pharmacy Purchasing Coordinator or; Pharmacy Payments Administrator or; Pharmacy Buying Office and Stores Manager or; Homecare Administrator (for Healthcare at Home only) or; Highly Specialist Pharmacist W&C or; Operational Dispensary Manager
Up to £50,000	Pharmacy Purchasing and Distribution Manager or; Pharmacy invoicing manager or; Lead Pharmacist Clinical Commissioning (NHSE)
Up to £300,000	Lead Pharmacist Procurement or; Associate Chief Pharmacist or; Head of Pharmacy or; Chief Pharmacist or; CFO
Up to £500,000	Chief Executive or CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

Annex 1: Authorisation Levels

Table 3

Authorisation levels for approval of invoices against existing pharmacy service contracts.

Table 2	
Value	**Authoriser**
Up to £10,000	Pharmacy Buying Office Manager or; Pharmacy Payments Administrator or; Operational Dispensary Manager or; Lead Clinical Dispensary Pharmacist or; Chief Technician Technical Services or; Homecare Administrator (for Healthcare at Home only) or; Highly Specialist Pharmacist W&C
Up to £50,000	Pharmacy Purchasing and Distribution Manager or; Lead Directorate Pharmacist Medicine or; Lead Directorate Pharmacist W&C or; Lead Directorate Pharmacist HIV/GUM or; Pharmacy invoicing manager or; Lead Pharmacist Clinical Commissioning (NHSE)
Up to £300,000	Lead Pharmacist Procurement or; Associate Chief Pharmacist or; Head of Pharmacy or; Chief Pharmacist or; CFO
Up to £500,000	Chief Executive or CFO
Over £500,000	Trust Board and delegated to Chief Executive or CFO

Annex 2: Classification of Losses and Special Payments

Losses and special payments are divided into two different categories:

Category A - Losses which include:

1. Losses of cash:

    a) Theft, fraud, arson, neglect of duty or gross carelessness
    b) Overpayments of salaries, wages, fees and allowances
    c) Other causes for example physical losses of cash due to fire, accident or similar causes

2. Fruitless payments, including abandoned capital schemes, and constructive losses

3. Bad debts and claims abandoned covering cases involving:

    a) Private patients
    b) Overseas visitors
    c) Other irrecoverable losses, such as claim abandoned in regard to recovery under contract provisions

4. Damages to buildings, their fittings, furniture and equipment and loss of all other equipment and property in stores and in use:

    a) Theft, fraud etc.
    b) Stores losses including expired pharmacy stock
    c) Other causes

Category B - Special payments which include:

5. Compensation payments made under legal obligation

6. Extra contractual payments to contractors

7. Ex gratia payments:

    a) Loss of personal effects
    b) Clinical negligence with advice
    c) Personal injury with advice
    d) Other negligence and injury
    e) Other employment payments including ex-gratia payments for employment cases
    f) Patient referrals outside the UK and EEA guidelines
    g) Other payments
    h) Maladministration cases, no financial loss

8. Special severance payments on termination of employment (Excludes contractual redundancy payments and MARS)

9. Extra statutory and regulatory payments

Further guidance is given in H M Treasury's Managing Public Money, Annex 4.10 Losses and write offs and Annex 4.13 Special Payments

Annex 3: Significant Transactions

The Trust is obliged to report significant transactions to NHSE/It (the independent regulator of NHS Foundation Trusts) prior to entering the transaction. Such transactions may take the form of major investments such as PFI's, long term contracts for the provision of services or acquisitions or mergers with other NHS organisations or private sector companies.

The Trust would require both Trust Board and more than half of the Council of Governors voting to approve all significant transactions prior to submission to NHSE/I, in accordance with the Clause 46 of the Constitution

Significant transactions are defined by NHSE/I as being equivalent to a 10% change in any one of the following three financial criteria:

1 Gross Assets

2 Attributable Income

3 Capital

The full details of the NHSE/I guidance on significant transactions can be found in annex 13 of the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts (published November 2015).

RESERVATION OF POWERS AND SCHEME OF DELEGATION			
START DATE:	March 2022	**EXPIRY DATE**	March 2023
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE** Nick Gash	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee **DATE: March 2022**		
DISTRIBUTION	Trust-wide		
RELATED DOCUMENTS/ OTHER INFORMATION:	• Standing Financial Instructions • Standing Orders – Annex 9 to Constitution of Chelsea & Westminster Hospital NHS Foundation Trust September 2017 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interests and Anti-Bribery Policy • Treasury Management Policy • Raising Concerns (Whistleblowing) Policy • Governance Framework • Capital Governance Framework Policy • Information Governance Policy • Information Security Policy • Data Protection and Confidentiality Policy • Freedom of Information Policy • Losses and Special Payments Guidance Notes and Procedures • Purchase Order Compliance Policy • Patient Property Policy and Procedure • Other Trust-wide Policies and Procedures		
AUTHOR:	Chief Financial Officer virginia.massaro@nhs.net		
STAKEHOLDERS INVOLVED:	Chairs of key Trust committees Human Resources (in particular Equality and Diversity Manager) Director of Corporate Governance & Compliance All Trust staff		

IS AN EQUALITY ANALYIS REQUIRED?	NO
IF AN EQUALITY ANALYIS IS REQUIRED, HAS IT BEEN SENT TO THE EQUALITY AND DIVERSITY MANAGER?	NO

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
March 2018	14	Chief Financial Officer	Revised front sheet in line with Policy on Non-Clinical Policies. Updates to: References to legislation Job titles and committee names to reflect current structure Regulatory body from Monitor to NHS Improvement Increase to limit for lowest level of expenditure approval from £7,500 to £10,000 Updates to cross referencing to SOs and SFIs Other minor updates
January 2019	14	Chief Financial Officer	Comprehensive refresh and rewrite for ease of use and cross-check with refreshed Standing Financial Instructions.
March 2020	15	Acting Chief Financial Officer	Minor changes, including job title changes; paragraph 7.3 Commercial Opportunities; sections 11.2.2 and 7.1/7.2 to reflect actual process and staff change
March 2021	16	Chief Financial Officer	Minor changes, including additional approvers added in to electronic services payments approvers (section 8.1.1), Amendments to section 7.3 – commercial opportunities and amendments to responsible officers for other matters to be delegated (section 7.1).
March 2022	17	Chief Financial Officer	Minor changes, for job titles and email addresses; updates to references to NHSE/I; correcting of numbering; deleting reference to Sphere and adding in CW Medicines (7.1); changing Redundancy approval to the CFO (9.1.13).

SCHEDULE OF DECISIONS RESERVED TO THE BOARD AND THE SCHEME OF DELEGATION

March 2022

CONTENTS		
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1	Introduction	
2	Schedule of Decisions Reserved to the Board	
3	Decisions / Duties Delegated by the Board to Committees	
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5	Scheme of Delegation of Powers from Standing Orders (Annex 9 to the Constitution)	
6	Scheme of Delegation of Powers from Standing Financial Instructions	
7	Other Issues to be delegated	
	7.1 Matters not covered by SFIs or SOs	
	7.2 Scheme of Budgetary Delegation	
8	Financial Control	
9	Human Resources	

1. INTRODUCTION

1.1 The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. This document sets out the powers reserved to the Board and those that the Board has delegated.

1.2 The Board remains accountable for all of its functions; even those delegated to Committees, individual executive directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee of the Board shall be exercised on behalf of the Board by the Chief Executive or another executive director.

1.4 The Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligations. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that targets are met.

1.5 The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. Whilst the detailed responsibility can be further delegated, the Chief Executive remains accountable for that responsibility to the Board. All powers delegated can be re-assumed by him/her should the need arise.

1.6 The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust (see 7.2).

1.7 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Executive Director who is formally acting-up as Chief Executive. Formal acting-up status shall be confirmed in writing by either the Chief Executive or the Chair.

1.8 The Scheme of Delegation is reviewed annually.

1.9 As part of ensuring a sound system of corporate governance prevails, there is a requirement for staff with budgetary and/or senior managerial responsibility to sign a statement acknowledging awareness of this document and the Standing Financial Instructions, and agreeing to apply them to their everyday approach to carrying their work for the Trust. This approach promotes compliance and effectiveness.

1.10 **Caution over the Use of Delegated Powers**

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter which, in their judgement, was likely to be a cause for public concern.

2 SCHEDULE OF DECISIONS RESERVED TO THE BOARD

The Board retains the right to determine any matter it wishes in full session within its statutory powers.

Constitution Reference	Decision Reserved to the Board
4	To exercise the powers of the Trust as set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation, or delegated to a Committee of the Board of Directors or to an executive director.
22	Determine the rates for travelling and other expenses payable to members of the Council of Governors.
28.2	Appoint one of the non-executive directors as a Senior Independent Director to act in accordance with NHSE/I's NHS Foundation Trust Code of Governance, as may be amended and replaced from time to time, and the Trust's Standing Orders (SOs).
29	Appoint or remove the Chief Executive and other executive directors.
34.2	Establish a Committee of non-executive directors to decide the remuneration, allowances and other terms and conditions of the Chief Executive and other executive directors.
38	Make available for inspection by members of the public: • The Constitution • Latest Annual Accounts and Auditor's report • Latest Annual Report • A copy of any notice under section 65 of the 2006 Act.
40	Establish an Audit and Risk Committee.
41	Keep accounts.
42.1	Prepare an Annual Report and send it to NHSE/I.
42.2 – 42.6	Prepare an annual forward plan and send it to NHSE/I.
42.4	Receive the views of the Council of Governors on the annual forward plan.
43	Present the Annual Accounts, Auditor's report and Annual Report to the Council of Governors.
44	Authorise the fixing of the Trust seal.
Annex 5 Rule 4	Appoint a returning officer for elections to the Council of Governors
Annex 5 Rule 6	Determine the remuneration and expenses payable to the returning officer
Annex 4, Rule16	Make available for inspection by members of the public the statement of nominated candidates and nomination papers.
Annex 4, Rule 22	Provide the returning officer with a list of constituency members eligible to vote.

Annex 4, Rule 57& 58	Retain documents relating to elections to the Council of Governors and make these available for public inspection, subject to the restrictions in the election rules.
Annex 4, Rule 63 & 64	Compile information about the candidates and publish information about the candidates and the election.
Annex 7 9.5	Agree procedures for resolution of Council of Governors membership queries and any voting or legislation issues.
Annex 10 1	Decide to disqualify a Member of the Trust if they are likely to cause harm or detriment to the Trust
Standing Order Reference (Annex 9 to the Constitution)	
3	Determine the timing and location of Board meetings, including whether these should be held in public, and set the agenda.
3.29 – 3.34	Suspend or amend SOs subject to contravention of any statutory provision or direction from NHSE/Iand criteria within the SFIs
4	Determine the functions to be delegated to committee, sub-committee or an officer of the Trust.
4.5	Approve scheme of delegation
5	Appoint committees subject to such directions and guidance as may be given by NHSE/Iand appoint persons to sit on such committees formally constituted.
5.5	Authorise committees to delegate executive powers to a sub-committee.
5.8	Establish the following committees and approve the Terms of Reference of: • Audit and Risk Committee • Nominations and Remuneration Committee • Finance and Investment Committee • People and Organisational Development Committee • Quality Committee • Any other committee or sub-committee required to discharge the Board's responsibilities.
10.2	Enter into contracts on behalf of the Trust and within its statutory powers
11.2	Authorise use of the Trust seal
12.2	Authorise Chief Executive, Chief Financial Officer or executive director to sign documents on behalf of the Trust
13.2	Review SOs annually
13.3	Resolve disputes arising out of or in connection with the Constitution including interpretation of SOs and procedure to be followed at meetings of the Board of Directors

Standing Financial Instructions Reference	
1.2.1	• Formulate the financial strategy • Approve budgets • Defining and approving essential features in respect of important procedures and financial systems • Define delegated responsibilities
1.2.2	Approve terms of reference of all committees reporting directly to the Board.
1.2.8	Responsible for security of Trust property, avoiding loss, exercising economy and efficiency in use of resources and conforming to the Constitution, Standing Orders, SFIs and Scheme of Delegation and requirements of NHSE/I
2.1.1	Establish an Audit and Risk Committee
2.5.3	Nominate a professionally accredited person to carry out the duties of the Counter Fraud Specialist
2.6.2	Nominate a suitable person to carry out the duties of the Local Security Management Specialist
4.4	Approve the Annual Report and Accounts, including the auditor's report, unless specifically delegated to the Audit and Risk Committee.
5.1.2-5.1.3	Review and approve banking arrangements including CFO recommendations regarding the opening or closing of Trust bank accounts.
6.3.3 – 6.3.4	Approve individual or packages of debt write offs over £100,000.
7.3.2 – 7.3.4	Approve contracts for goods and services and variations to revenue contracts with a contract value over £500,000
8.1.1	Regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.
8.3.2	Approval of tenders over £25m in total or £10m per annum where the Trust is a competing body
9.1.1	Establish a Nominations and Remuneration Committee
10.1.1	Approve the level of non-pay expenditure on an annual basis
11.1.3	Approve applications for loans or overdraft facilities
11.1.5	Approve long-term borrowing
11.3.3	Approve investments in forming and/or acquiring an interest in bodies corporate
12.1.2	Approve the annual capital plan

12.2.5	Approve capital or revenue schemes defined as major within the Foundation Trust Compliance arrangements
12.3.2	Approve proposal to use private external finance for capital procurement including PFI and leasing
12.6.2	Approve estate strategy and acquisition of property, freehold and lease, over £250,000 excluding VAT.
12.6.8	Approve disposal of property over £250,000 excl. VAT
12.6.8 -12.6.9	Seek approval from NHSE/Ifor the disposal of protected/relevant assets and major disinvestments.
12.6.10	Approve the granting of property leases where the annual value is in excess of £250,000
17.1	Provide safe custody for money and other personal property of patients.
20.1.1	Monitor risk management policy and procedures.
21.1.2	Approve litigation payments against legal advice
22.3	Approve out of court settlement of Employment Tribunal applications over £100,000.
22.4	Approve out of court settlement of Employment Tribunal applications against legal advice

3 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

Committee	Duties delegated by the Board	
Audit and Risk Committee	See Terms of Reference (available from Director of Corporate Governance and Compliance)	
	SFI 1.1.8	Ratify or refer non-compliance with SFIs for action
	SFI 2.1.1	- Oversee external audit, internal audit and counter fraud services. - Review financial and non-financial systems and processes. -Monitor compliance with SOs and SFIs. -Review losses and compensations and make recommendations to the Board.
	SFI 2.1.3	Ensure adequate internal audit and counter fraud service is provided and participate in selection process when providers are changed.

	SFI 2.4.1	Advise on appointment of external auditor.
	SFI 2.4.2	Agree non statutory external audit work plans and ensure cost-effective service is provided.
	SFI 4.4	Approve Annual Report and Accounts, including auditor's report when delegated to do so by the Board.
	SFI 11.3.2	Set the investment policy and oversee all investment transactions.
	SFI 11.3.4	Approve the "Treasury Management Policy"
	SFI 11.3.7	Review and monitor all investments.
Nominations and Remuneration Committee	See Terms of Reference (available from Director of Corporate Governance and Compliance)	
	SFI 9.1.2	- Decide remuneration package and terms and conditions of office of Executive Directors and Director of Corporate Governance and Compliance. - Approve recommendations for remuneration package and terms and conditions of office of senior managers under their remit. - Decide rates at which Directors' travel and other expenses may be reimbursed. - Refer appointment to posts at a salary above £150,000 to NHSE/I.
	SFI 9.2.11	Approve procedures for determination of pay rates, conditions of service etc. for employees on local contracts.
Finance and Investment Committee	See Terms of Reference (available from Trust Director of Corporate Governance and Compliance)	
	SFI 12.2.3	Approval of business cases: - Over £200,000 not in Trust plan (Capital only) - Over £1m Approval of variations to capital: - Over £1m

People and Organisational Development Committee	See Terms of Reference (available from Director of Corporate Governance and Compliance)
Quality Committee	See Terms of Reference (available from Director of Corporate Governance and Compliance)

4 SCHEME OF DELEGATION OF POWERS FROM THE CONSTITUTION

Constitution reference	Delegated to	Authorities / duties delegated
1.4	Chair	Interpretation of the Constitution.
18.1 and Annex 7 Section 2.5	Chair	Preside at meetings of the Council of Governors.
18.3	Chair	Exclude any person from a meeting of the Council of Governors if that person is preventing the proper conduct of the meeting.
29.1	Chair and Non-Executive Directors	Appoint or remove the Chief Executive.
29.3	Chair and Non-Executive Directors and Chief Executive	Appoint or remove executive directors.
36.1	Director of Corporate Governance and Compliance	Remove from the members register the names of members no longer entitled to be a member under the Constitution.
Annex 6 Section 2	Director of Corporate Governance and Compliance	Monitor the eligibility of individuals to serve on the Council of Governors.
Annex 6 Section 2.5	Chair	Casting vote at Council of Governor meetings.
Annex 6 Section 2.6.1	Chair	Invite public and patient governors to put themselves forward for the post of Lead Governor when vacant.
Annex 6 Section 4.1	Director of Corporate	Request the appointing organisation to appoint a replacement to hold office for the remainder of the term when a vacancy arises on the Council of Governors.

	Governance and Compliance	
Annex 7 Section 3.4	Chair or Director of Corporate Governance and Compliance	Call meetings of the Council of Governors including “other” or “emergency” meetings and serve notice to the governors.
Annex 7 Section 3.12	Director of Corporate Governance and Compliance	Determine whether matters should be included on the Council of Governors’ meeting agenda if a request for inclusion is made less than 15 days before the meeting.
Annex 7 Section 3.13	Chair	Exercise Council of Governors’ powers in an emergency together with at least one-third of the Governors elected from the Patient and Public Constituency combined.
Annex 7 Section 3.20	Chair	Final decision at meetings of Council of Governors on questions of order, relevancy, regularity and any other matters.
Annex 7 Section 3.14	Director of Corporate Governance and Compliance	Determine motions to be included on the Council of Governors’ meeting agenda
Annex 7 Section 6	Director of Corporate Governance and Compliance	Maintain Governor register of interests.
Annex 7 Section 9	Director of Corporate Governance and Compliance	Ensure existing Governors, officers and new appointees are notified of and understand their responsibilities as set out in the Standing Orders of the Council of Governors (Annex 7 to the Constitution). Deal with any membership queries
Annex 7 Section 9.4	Senior Independent Director	Mediate a settlement to disputes involving the Chair arising on interpretation of the Standing Orders of the Council of Governors.

5 SCHEME OF DELEGATION OF POWERS FROM STANDING ORDERS (ANNEX 9 TO THE CONSTITUTION)

Standing Order reference (Annex 9)	Delegated to	Authorities / duties delegated
2.8	Vice Chair	Act as Chair until a new Chair is appointed or existing Chair resumes duty where the Chair has died, ceased to hold office or is unable to perform his/her duties.
3.3	Chair or Director of Corporate Governance and Compliance	Call meetings of the Board of Directors.
3.9	Chair	Determine whether matters should be included on the Board's meeting agenda if a request for inclusion is made less than 10 days before the meeting.
3.18	Chair	Final decision at Board meetings on questions of order, relevancy, regularity and any other matters.
3.19	Chair	Second and casting vote at Board meetings if equality of votes.
4.2	Chief Executive and Chair	Exercise the powers of the Board in an emergency.
4.4	Chief Executive	Exercise on behalf of the Board of Directors those functions of the Trust that have not been retained as reserved by the Board or delegated to an executive Committee or sub-committee. Determine the functions he/she will perform personally and nominate officers to perform the remaining functions.
4.5	Chief Executive	Prepare a scheme of delegation.
4.6	Chief Financial Officer	Accountable for providing information and advising the Board in accordance with statute or NHSE/Irequirements.
6	Director of Corporate Governance and Compliance	Maintain Board register of interests.

8.4	Chief Executive	Report any director's relationship with a candidate of whose candidature the director is aware to the Board
10.3	Chief Executive	Nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
11	Director of Corporate Governance and Compliance	Custody of common seal of the Trust and maintenance of a register of sealing.
12.1	Chief Executive or Chief Finance Officer or Executive Director	Authorised by resolution of the Board to sign any agreement or document on behalf of the Trust.
13.1	Chief Executive or Director of Corporate Governance and Compliance	Ensure Directors are notified of and understand their responsibilities as set out in the Standing Orders of the Board of Directors (Annex 9 to the Constitution) and Trust Standing Financial Instructions (SFIs).
13.2	Senior Independent Director	Mediate a settlement to disputes involving the Chair arising on interpretation of the Standing Orders of the Board of Directors (Annex 9 to the Constitution).
13.5	Director of Corporate Governance and Compliance	Deal with any membership queries.

6 SCHEME OF DELEGATION OF POWERS FROM STANDING FINANCIAL INSTRUCTONS

Standing Financial Instructions Reference	Delegated to	Authorities / duties delegated
1.1.6	Chief Financial Officer (CFO)	Interpretation or application of Standing Financial Instructions (SFIs)
1.2.4	Chief Executive (CE) and CFO	Accountable for financial control
1.2.5	CE	Overall executive responsibility for Trust activities; ensuring financial obligations are met and responsible for Trust's system of internal control.
1.2.6	CE	Ensure members of the Board, employees and new appointees are notified of and understand their responsibilities under SFIs
1.2.7	CFO	• Maintenance of SFIs • Implementing Trust financial policies • Maintaining effective system of internal control • Provision of financial advice to Trust Board and employees • Preparation of accounts and such other documents required to fulfil statutory duties • Developing Trust's financial strategy
1.2.8 – 1.2.9	All directors, employees and contractors	Responsible for security of Trust property, avoiding loss, exercising economy and efficiency in use of resources and conforming to the Constitution, Standing Orders, SFIs and Scheme of Delegation and requirements of NHSE/I
2.2.1	CFO	• Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. • Ensuring that the Internal Audit service to the Trust is adequate and meets NHSE/I's mandatory internal audit standards. • Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities

		• Ensuring that an annual internal audit report is prepared for the consideration of the Audit and Assurance Committee.
2.3.2	Head of Internal Audit	Reviewing, appraising and reporting upon compliance with established policies, plans and procedures.
2.3.4	Head of Internal Audit	Right of access to Audit and Risk Committee members, the Chair and Chief Executive and to attend Audit and Risk Committee meetings.
2.5.1	CE and CFO	Monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority's ("NHSCFA") standards.
2.5.2 -2.5.7	CFO	Responsible for countering fraud, bribery and corruption in the Trust including monitoring of work of Counter Fraud Specialist
2.5.5	CFO	Authorise appropriate route for action when the Counter Fraud Specialist considers prosecution is desirable
2.6.1	CE	Monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHSCFA's standards.
2.6.4	Chief Operating Officer (COO) and Local Security Management Specialist	Responsibility for controlling and coordinating security.
3.1.1	CE	Submit to the Board and Council of Governors the Annual Trust Business Plan which takes into account financial targets and forecast limits of available resources.
3.1.3	CFO	Prepare and submit an annual budget for approval by the Board .
3.1.5	CFO	Monitor financial performance against budget and report to Finance and Investment Committee (FIC) and Board.
3.1.6	Budget Holders	Provide information as required by the CFO to enable budgets to be compiled.

3.1.8	CFO	Ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.
3.2.1	CFO	Delegate management of a budget to permit performance of a defined range of activities.
3.2.1 – 3.2.4	Budget holders	The management of a budget to permit performance of a defined range of activities that must not exceed total or virement limits set by the Board
3.3	CFO	Devise and maintain systems of budgetary control including monthly reports to FIC and the Board containing sufficient information to ascertain financial performance.
3.3.4	CE	Identify and implement cost improvement programmes and income generation initiatives.
3.3.5	CFO	Prepare written introduction to the Trust's SFIs, SOs and Scheme of Delegation in the induction pack for all Trust induction attendees.
3.5.1	CE	Appropriate monitoring forms and returns are submitted to NHSE/I.
4.1	CFO	Prepare annual financial accounts and returns ensuring that they comply with current guidelines.
4.2	Director of Corporate Governance and Compliance	Prepare an Annual Report in accordance with current guidance.
4.5	CFO	Submit the Annual Report and Accounts to NHSE/Iand put forward to be laid before Parliament in accordance with prescribed timetable.
4.7	Chief Nurse	Prepare the Annual Quality Report in accordance with current guidance.
4.8	CE and Chair	Sign the "Statement of Directors' Responsibilities in Respect of the Quality Report".
5.1	CFO	Manage the Trust's banking arrangements and advise the Trust on the provision of banking services and operation of accounts.

5.2.2	CFO	Managing the Trust's Government Banking Service (GBS) and non GBS bank accounts, establishing non-exchequer bank accounts, ensuring funds stay in credit unless arrangements have been made, monitoring the level of cleared funds and ensuring they comply with guidance, and covenants are adhered to.
5.3	CFO	Prepare detailed instructions of the operation of bank accounts and advise the Trust's bankers of the conditions under which accounts will be operated.
5.4	CFO	Review commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.
5.5	CFO	Responsibility for Trust purchasing cards including security, approval for issue, authorised use and purchasing limits
5.5.2	Named Purchasing Card Holder	Responsible for security and use of an individual named Trust purchasing card
6.1	CFO	Design, maintain and ensure compliance with income systems including prompt banking of monies received.
6.2.2	CFO	Approve and review the level of all fees and charges other than those determined by DH or statute.
6.2.3	All Staff	Inform the CFO of income arising from transactions which they have initiated.
6.2.4	Table in SFI Annex 1	Approval limits for approval of contracts for goods and services
6.3.1 and 6.3.5	CFO	Take appropriate recovery action on all outstanding debts and report to Audit and Risk Committee.
6.3.3	Per table in SFI 6.3.3	Delegated VAT exclusive approval limits for individual debt write offs or partial write offs
6.3.4	Per table in SFI 6.3.4	Delegated VAT exclusive approval limits for packages of debt
6.4	CFO	Provide the required documents for recording cash, cheques and negotiable instruments, and ensure adequate system and procedures for handling cash etc. including security arrangements
7	CE	Arrangements for tenders where the Trust is the procuring body.
7.1.2 and 7.2.1	Procurement Department	Maintain standard tendering procedures and documents in accordance with best practice and EU procurement law and facilitate formal tendering process.

7.2.2	CE	Nominate a representative to conduct tender process if a conflict of interest exists between the Procurement Department and the tender.
7.3.1	Procurement Department	Contract negotiations with suppliers.
7.3.2	Per table in SFI 7.3.2	Delegated authorisation levels for agreement of contracts for goods and services
7.3.4	Per table in SFI 7.3.4	Delegated authorisation levels for variations to revenue contracts
7.3.5	CE	Nominate officers with delegated authority to enter into contracts of employment regarding staff and temporary staff and agency staff contracts.
7.6.2	CE or CFO	Decision to accept late tenders or whether re-tendering is desirable. Report to Board.
7.6.9	CE	Approve form of contract including a fluctuation clause for price variations or nominate officer to approve.
7.7.1	Director of Estates and/or Director of (DoP)	Approve contract extensions where optional extensions to contract are outlined at the time of tendering up to the value of the original contract (including formally agreed variations).
7.8.12	DoP	Arrange for adjudication of tenders/quotations in accordance with SFI 7.7.
7.8.15	DoP	Approve any subsequent lease contract award for the same goods or equipment where a competitive tender ratification process has already been conducted and approved within the delegated levels.
7.9	CE or CFO	Approval of single tender waivers and reporting of same to Audit and Risk Committee.
8.1	CE	Arrangements for contracts re provision of services.
8.1.7	CFO	Production of regular income reports.
8.1.8	CFO	Pricing of contracts at marginal cost and reporting of same to Board.
8.1.9	Table in SFI Annex 1	Authorisation levels for approval of income contracts.

8.3.2	Table in 8.3.2	Authorisation levels for decisions to bid or bid sign off relating to tenders where the Trust is a competing body.
9.1.3	Human Resources Department	Maintenance of list of applicable posts subject to the requirements of the Fit and Proper Persons Test. Administer the test.
9.2.1	Budget holder	Recruit to vacancies provided that this is within the establishment. Regrade employees after consultation with the Human Resources Business Partner and job evaluation has taken place.
9.2.6 – 9.2.7	Employee line manager	Notify Human Resources of any changes in employee circumstances immediately on becoming known.
9.2.8	Employee	Notify Human Resources of changes to personal details.
9.2.11	CE	Determine local contract pay rates and conditions of service and present to Nominations and Remuneration Committee for approval.
9.3.1	CFO	Final determination of pay, proper compilation of the payroll and payments made.
9.3.2	CFO	Approval for monetary payment to staff outside the payroll system.
9.3.5	CE or CFO	Approval of payment of pay in full or in part in advance of the determined pay date.
9.3.6	CFO	Agreement to and management of external provider payroll contract.
9.3.8 – 9.3.9	Managers and employees	Jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered.
10.1.1	CE	Determine level of delegation of non-pay expenditure to budget managers.
10.2.1	CE	Set out the list of managers and their limits for requisitioning goods and services.
10.2.1	Table in SFI Annex 1	Delegated authorisation limits for requisitioning of goods and services.
10.3.7	CFO	Prompt payment of accounts and claims.
10.3.8	CFO	Recommend the thresholds for quotations or tenders and prepare procedural instructions, ensure prompt payment and maintain a system for managing all amounts payable.

10.3.9	CFO	Approval of prepayments where financial advantages outweigh disadvantages.
10.3.10	CFO	Authorise requisitions/orders for which there is no budget provision.
10.4	CFO	Ensure procedures and systems are in place to account correctly for VAT including payment and recovery.
10.5	CFO	Determine form of petty cash records and issue instructions re petty cash purchases.
11.1.3	CFO	Approve use of loan or overdraft facilities approved by the Board.
11.1.4	CFO	Authorise short term borrowing in excess of one month.
11.1.6 – 11.1.7	CFO	Prepare instructions concerning applications for loans and borrowing and report borrowing to the Board.
11.2.2	CFO	Apply for increase in Public Dividend Capital or nominate Deputy Director of Finance or other nominated representative to make application. Report to delegated committee
11.3.5 – 11.3.6	CFO	Advise Board on investments and ensure that policies and procedures are drawn up for the operation and maintenance of investment accounts.
11.3.7	CFO	Authorise all investment transactions ensuring compliance with “Treasury Management Policy” or delegate responsibility to nominated senior finance manager
12.1	Capital Programme Board (CPB)	Oversee allocation of capital investment; approve capital and revenue business cases and report financial performance of capital programme to Board.
12.1	CFO	Chair CPB and ensure that there is an adequate appraisal and approval process in place for determining expenditure priorities. Oversee development and monitoring of annual capital plan, establish systems to ensure schemes are progressed and budgets and cash flows monitored and approve in year virements
12.2.3	Table 1 in 12.2.3	Delegated limits for approval of capital only business cases
12.2.3	Table 2 in 12.2.3	Delegated limits for approval of revenue only or combination of revenue and capital business cases
12.2.4	CE or CFO	Approve expenditure incurred on a scheme in advance of approval through the business case process.
12.4.1	CE	Maintain registers of assets.

12.4.5	CFO	Approve procedures for reconciling fixed asset accounts in the general ledger to the fixed asset register.
12.4.7	CFO	Prepare procedural instructions on the disposal of assets.
12.5.1	CE	Control and security of assets.
12.5.2	CFO	Approve asset control procedures and manage process.
12.6.3	CE	Approve property purchases, licences and leases up to £250,000 each (excluding VAT)
13.1.3	CFO	Establish systems of control for Inventory Stores and Inventory
13.1.3	ADFP	Control of Inventory Stores and Inventory subject to above. Responsibility may be delegated subject to being entered in a record available to the CFO
13.1.3	Designated Pharmaceutical Officer	Control of pharmaceutical stocks.
13.1.3	Designated Estates Manager	Control of fuel oil stocks.
14.1.1	CFO	Prepare detailed procedures for the disposal of assets including capital assets and condemnations.
14.1.5	CE	Approve disposal of assets valued at over £100,000
14.2	CFO	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments and maintain a register. Prepare a fraud response plan, and take appropriate actions for any losses, condemnations and special payments. Report all losses and special payments to Audit and Risk Committee
15.1.1	CE and Chief Information Officer	Devise and implement procedures to safeguard the Trust's data, programs and computer hardware, having regard to the General Data Protection Regulation framework; ensure adequate controls over data entry, processing, storage etc.
15.1.4 – 15.1.5	CFO	Ensure that financial systems are appropriately procured, tested and that adequate controls are in place.

16.1.1	Responsible Director	Maintain a “Freedom of Information Publication Scheme”
16.1.2	Responsible Manager	Notify the Responsible Director of any new documents to be included in a Publication Scheme .
17.1.2	CE	Inform patients or their guardians that the Trust will not accept responsibility or liability for patients’ property brought into Health Service premises.
17.1.3	CFO	Arrangements for the administration of patient property.
18.1	CE	Ensure all staff, volunteers and persons associated with the Trust are aware of and comply with the Trust’s “Conflicts of Interest and Anti-Bribery Policy”.
18.1	Director of Corporate Governance and Compliance	Maintain register of declarations of interest and hospitality under the Trust’s “Conflicts of Interest and Anti-Bribery Policy”.
19.1	Chief Executive	Maintain archives for all records, information and data required to be retained in accordance with current guidance.
19.2	Table in 19.2	Delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, and maintenance of a register.
20.1.1	Chief Executive	Ensure that the Trust has a risk management policy and procedures and processes and that these are monitored.
20.2.1	CFO	Review membership of the Non-Clinical Risk Pooling Scheme and other insurance arrangements.
20.2.2 – 20.2.5	Director of Corporate Governance and Compliance	Liaise with insurance brokers; ensure timely reporting of incidents, losses and submission of claims against the third party liability scheme and insurance provision.
20.3.1	Chief Nurse	Provide a central point of contact within the Trust for NHS Resolution /CNST issues and report activity to Board.
21.1.2	CEO and Board	Approve litigation payments against legal advice.

22.1	CE	Approve all employment tribunal settlement agreements.
22.2	CFO	Approve employment tribunal settlement agreements in excess of contractual entitlement.
22.3	Table in 22.3	Approval limits for out of court settlements of employment tribunal applications.
22.4	CFO	Submit business case to Treasury for compromise agreements.
25.1	CFO	Approve submission of applications for grant funding.

7 OTHER ISSUES TO BE DELEGATED

7.1 Matters not covered by SFIs or SOs

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of Responsibility	Overall Responsibility
Information governance including: • Information Governance Statement of Compliance (IGSoC) • General Data Protection Regulation framework requirement	Director of Corporate Governance & Compliance and Head of Information Governance
Health and safety arrangements	Chief Nurse
Caldicott Guardian	Chief Medical Officer (delegated to Operational Medical lead)tbc)
Corporate governance	Director of Corporate Governance and Compliance
Clinical governance	Chief Nurse
Accountable officer for controlled drugs	Chief Medical Officer
North West London Pathology (NWLP) – Joint Operation	Chief Executive and Chief Financial Officer
Named responsible officer (various)	See separate register (to be prepared and maintained by Director of Corporate Governance and Compliance)
Hosted bodies (various organisations and arrangements)	See separate register (to be prepared and maintained by Director of Corporate Governance and Compliance)
CW Medicines – Wholly Owned Subsidiary	Chief Financial Officer and Chief Pharmacist

7.2 Schedule of Budgetary Responsibility

This Scheme of Delegation covers only matters delegated by the Board and certain other specific matters referred to in the Constitution, SOs and SFIs. Each Divisional Medical Director, Divisional Director of Nursing and Divisional Director of Operations is responsible for delegation in their division and for maintaining a "Schedule of Budgetary Responsibility" to be approved by the Chief Financial Officer. The Schedule indicates who within each Directorate fulfils the roles identified throughout the Scheme of Delegation. The Divisional Director is also responsible for ensuring that the Finance Department is kept informed of any amendments to the Schedule within their delegated limits.

Budget Holders must confirm either in writing or via online confirmation that they have read the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before they are approved as authorised signatories within the appropriate delegated limits.

7.3 Commercial Opportunities - Subsidiaries, Joint Ventures or Joint Operations.

The Commercial Assurance Board will oversee the initiation and monitoring of commercial partnerships. Approvals for business cases for commercial partnerships and the setting up of subsidiaries or joint ventures will be subject to the Trust's Standing Financial Instructions.

Any commercial subsidiaries, joint ventures or joint operations- involving the creation of a new corporate entity shall require authorisation by the Board.

The Executive Directors are authorised to develop commercial opportunities which may (or may not) lead to the establishment of a joint venture, either contractual or corporate; the formation of a subsidiary company or other commercial partnership. This includes authority to sign non legally binding documents that may be associated with the development of commercial opportunities prior to the Board sign off, where it is required, for example Memorandum of Understanding or Articles of Association. The Executive Directors shall keep the Commercial Assurance Board, and as appropriate the Finance Investment Committee and/ or the Board appraised of the subject matter and of any non-legally binding documents entered into via the Chief Executive (or nominated officer).

8.1 FINANCIAL CONTROL

8.1.1 Bank Accounts

Maintenance and operation of bank accounts:

- Chief Financial Officer

Approval of cheque signatories:

- Chief Executive and Chief Financial Officer

Signing cheques or approval of direct electronic payments up to £50,000:

- Two approved signatories

Signing cheques or approval of direct electronic payments over £50,000:

Two approved signatories including at least one signatory from the following:
- Chief Financial Officer
- Deputy Director of Finance
- Finance Business Partner

Electronic authoriser of direct electronic services payments approved as above by two approved signatories:

- Head of Financial Operations
- Head of Financial Management
- Deputy Head of Financial Operations
- Other delegated Finance staff (list of names kept on file).

The only exception to the limits for approval of direct electronic payments over £50,000 is in the case of the transmission of funds to the National Loans Fund for short term deposits. In this case only, the transmission of funds can be approved by any two approved signatories.

8.1.2 BACS payments transmission

BACS payments transmission of approved invoices is prepared by Accounts Payable and approved in line with schedule 8.1.1 above.

BACS payments transmission of salaries is prepared and authorised by the outsourced payroll provider.

8.1.3 Patients Monies and Valuables

The General Manager / Clinical Director is responsible for the control and safe-handling of patient monies and valuables up to the point of receipt by the Cashiers Officer after which the Chief Financial Officer is responsible for their safe-keeping and recording.

Withdrawal of patient monies (maximum £100 per day).	Ward Manager
Reimbursement of closing balance of patient monies and valuables.	Ward Manager

These transactions must also be authorised by the Patient.

In the event of a patient's death where no next of kin is known, the claimant must provide evidence that he/she is the executor of the patient's estate. If there is no such evidence available then if the claimant can show the original death certificate then the monies and valuables will be returned to the claimant.

8.1.4 Charitable Donations

The following criteria must be considered when making charitable donations from the Trust funded budgets:

- Whether the donation is an appropriate use of NHS funds
- Whether the donation directly supports the department's objectives

Any donation for an amount greater than £5,000 must be countersigned by an Executive Director and donations may only be made to arm's length charities, i.e. charities that are not controlled by the budget holder making the donation.

9.1 HUMAN RESOURCES

9.1.1 Engagement of Staff on the Establishment

Authority to fill funded post on the Establishment with permanent staff	Refer to Establishment Vacancy Panel Guidance

9.1.2 Engagement of Staff not on the Establishment

This is bound by the rules governing revenue expenditure including the need for quotation and tender, and the Trust's policy on the use of contract staff as owned by Human Resources (HR).

9.1.2 Additional Staff to the agreed Establishment

With specifically allocated finance	General Manager/Chief Financial Officer/
Without specifically allocated finance	Chief Executive or Chief Financial Officer

9.1.3 Fixed Term Contracts

Authorisation or renewal of fixed term contracts	Trust Establishment Panel, including Finance Business Partner sign-off

9.1.4 Pay Increases/Decreases

The granting of additional increments to staff within budgets	General Manager and HR Business Partner
All requests for upgrading/re-grading	Trust Establishment Panel dealt with in accordance with Trust procedure
Authority to complete standing data affecting pay, new starters, variations and leavers	Budget Holder and HR representative forms
Authority to complete and authorise timesheets	Budget Manager (subject to limits to be set by the General Manager)
Authority to authorise overtime	Budget Manager (subject to limits to be set by the General Manager)
Authority to authorise travel and subsistence expenses	Budget Manager (subject to limits to be set by the General Manager)
Approval of performance related pay	Chief Executive / Remuneration Committee

9.1.5 Annual Leave

Approval of annual leave	Line / General Manager
Approval of carry forward of annual leave to a maximum of 5 days	Line / General Manager
Time off in lieu	Line / General Manager

9.1.6 Bereavement Leave

Up to 6 days on full pay	*Line / General Manager

*With guidance from Human Resources

9.1.7 Special Leave

Dependents leave	*Line / General Manager

*With guidance from Human Resources

9.1.8 Maternity, Paternity and Adoption Leave

Maternity leave – Paid and unpaid	*General Manager
Adoption leave – Paid and unpaid	*General Manager
Paternity leave – Paid and unpaid	*General Manager

*With guidance from Human Resources and outsourced payroll provider

9.1.11 Sick leave

Extension of sick leave on half pay up to three months	General Manager and Chief Financial Officer and Chief Executive Officer/Deputy Director of People & OD
Return to work part-time on full pay to assist recovery	General Manager with Occupational Health and/or HR advice
Extension of sick leave on full pay	General Manager and Chief Financial Officer and/or Chief Executive and HR Director/Deputy

9.1.12 Study leave

Study leave	General Manager

9.1.13 Redundancy

Redundancy	Chief Financial Officer

9.1.14 Ill Health Retirement

Decision to pursue retirement on the grounds of ill health	Line Manager with Occupational Health and HR Support

9.1.15 Dismissal

Dismissal	Dismissing Officers

9.1.16 Removal Expenses

Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview):

Up to £3,000	Human Resources / General Manager
Over £3,000	General Manager / Chief Executive

9.1.17 Reporting of Incidents to the Police

Where a criminal offence is suspected:	
• Of a violent nature	Executive Director/Chief Financial Officer / on call Manager
• Other	Executive Director on call

• Where a fraud is involved	Chief Financial Officer

9.1.18 Condemning and Disposal

Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively:	
• With estimated replacement cost under £5,000	General Manager
• With estimated replacement cost over £5,000	Chief Financial Officer
Disposal of x-ray films:	
• Estimated sale proceeds under £5,000	General Manager
• Estimated sale proceeds over £5,000	Chief Financial Officer
Disposal of mechanical & engineering plant:	
• Estimated sale proceeds under £5,000	Chief Operating Officer
• Estimated sale proceeds over £5,000	Chief Operating Officer / Chief Financial Officer

Chelsea and Westminster Hospital
NHS Foundation Trust

TITLE AND DATE	Trust Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	4.1
TITLE OF REPORT	EPRR Assurance Report
AUTHOR NAME AND ROLE	Robert Hodgkiss, Deputy CEO and Chief Operating Officer
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Hodgkiss, Deputy CEO and Chief Operating Officer
PURPOSE OF REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick above and then describe the requirement in the opposite column	To give assurance on the strength of controls surrounding EPRR at the Trust.
REPORT HISTORY Committees/Meetings where this item has been considered	Nil
SUMMARY OF REPORT AND KEY MESSAGES THE MEETING NEEDS TO UNDERSTAND	In accordance with the requirements laid out in the EPRR 2021-22 Assurance Process Letter (27th July 2021), the overall level of compliance is based on the total percentage of amber and red ratings. Red: 0 | Amber: 2 | Green: 44 An overall level of substantial assurance has been awarded to the Trust
KEY RISKS ARISING FROM REPORT	

STRATEGIC PRIORITIES THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	N
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT:

Equality And Diversity	N
Quality	N
People (Workforce or Patients/Families/Carers)	N

Operational Performance	N	
Finance	N	
Public Consultation	N	
Council of Governors	N	
please mark Y/N – where Y is indicated please explain the implications in the opposite column		

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

2021 EPRR Assurance Report

Chelsea and Westminster Hospital NHS Foundation Trust

Version number: v1.0

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Prepared by: NHS England & NHS Improvement NWL EPRR Team

Classification: OFFICIAL

NHS England and NHS Improvement

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1 2021-22 Assurance review summary

Annually, all NHS funded organisations are asked to provide an assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The London regional office then holds individual review meetings with each organisation to discuss and agree a level of compliance.

For 2020-21, in recognition of the ongoing COVID response, a decision was made that the majority of organisations would not be required to participate in a review meeting to discuss their self-assessment return.

In 2021-22 the regional team returned to holding individual review meetings with all organisations. Nationally the core standards have been amended to reflect the ongoing challenges of the COVID response and the simultaneous recovery and restoration work. Regionally the meetings and reviews have focused on operational effectiveness and the safety of patients and staff.

A number of standards were removed for this year's process and others modified to reflect the potential interruptions from the pandemic on the usual planning cycles but, does not detract from their importance within EPRR. It is essential for all organisations to maintain their resilience and preparedness but inevitable that the COVID response will have impacted on areas of EPRR in the same way it has across all parts of the NHS. The regional team recognise this may result in some organisations assurance ratings not matching their previous achievements.

The regional team will use the results of the assurance process to highlight targeted support for the system through the regional business plan, work programme and ongoing EPRR engagement activities.

The Trust has easily achieved a compliance level of substantial this year and has also managed to maintain a lot of core training, despite the additional pressures the Trust and the Head of Emergency Planning has been under.

2 Assurance review process

The assurance process for Chelsea and Westminster Hospital NHS Foundation Trust was conducted as follows,

Assurance Meeting	Date of Visit	Assurance Review attendance
Main Assurance Meeting	10th November 2021	**Chelsea & Westminster Hospital NHS Foundation Trust** Catherine Sands Robert Hodgkiss **Review Panel** Hannah Evetts Chair - NHS England and NHS Improvement (London) Katy John NHS England and NHS Improvement (London Sharon Pienarosa – North West London Clinical Commissioning Group Andrew Godfrey – LAS, CBRNe Lead

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2021-22 Assurance Process Letter (27th July 2021), the overall level of compliance is based on the total percentage of amber and red ratings.

In respect of Chelsea and Westminster Hospital NHS Foundation Trust for Core Standards 1 – 69, the following RAG ratings were agreed at the review meeting:

Red ratings	Amber ratings	Green ratings
0	2	44

Total number of red / amber ratings	2

This means Chelsea and Westminster Hospital NHS Foundation Trust has an assessed level of compliance of ***SUBSTANTIAL***

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

Amber ratings were received for the following core standards:

- CS51 – Business Continuity, Business Continuity Plans
- CS55 – Business Continuity, Assurance of Commissioned Providers

Full details of the assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.1.2 Deep dive outcomes – Oxygen Supply

The deep dive was reviewed by EPRR practitioners and not technical experts or authorised individuals. As such, the outcomes below are based on the expert opinion of the organisation

Amber ratings were received for the following core standards:

- DD1 – Oxygen Supply, Medical Gasses, Governance

It is suggested that these areas of partial compliance be included in the estates action plan for the forthcoming year.

Full details of the deep dive review, agreed RAG ratings and discussion points can be found in appendix A. The deep dive does not contribute to the overall compliance level.

4.2 Assurance review meeting agreed actions

NHS England and NHS Improvement (London) EPRR / Panel-agreed actions as follows:

- **Trust** to ensure PHE is updated to UKSHA in future iterations of all incident plans
- CS6: **Trust** to add the continual improvement, monitoring process (as discussed) into the EPRR Policy
- CS11&32: Trust to send Overarching BCP to NWL EPRR Team post Assurance Meeting
- CS54: **Trust** to add a BC plan org chart in the Policy under BCMS to show the plan structure and add text to show the cycle that the Trust goes through to ensure continuous improvement of BCMS
- CS55: **Review Panel** to provide Procurement BC checklist to CS and link in with Stephen Maxwell for Acute groups to work on

4.3 Identified areas of good practice

- EPRR Policy v4, Command and Control Structure Page 11
- EPRR Policy v4, Dashboard on page 12
- IRP 2a, Major Incident Plan, Quick Reference Guide, Page 7

5 Next Steps: Action Plans and Governance

Chelsea and Westminster Hospital NHS Foundation Trust is required to submit the following documentation to england.london-assurance@nhs.net by 23 December 2021.

- The organisation's final EPRR RAG scores, as agreed at the review meeting using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Red or Amber using the self-assessment tool
- A declaration from the AEO of the overall level of compliance achieved.

5.1 Identified key priorities

The key priorities as identified at the assurance review meeting for the next twelve months include:

- Action to maintain or improve upon the current level of compliance and update plans in line with the ICS developments and post enquires/ debriefs

6 Conclusion

The Trust maintains a good overall position in respect of its EPRR and CBRN/HAZMAT functions. The main tasks following this year's assurance will be, to focus on sustaining a substantial compliance level and addressing any outcomes from enquiries and debriefs. The panel noted and commended the Trust on its continued work in respect of EPRR and the work undertaken by the Emergency Planning Team over the last 18 months whilst responding to the pandemic.

The Review Panel would like to record their thanks to Rob Hodgkiss and Catherine Sands for their support of the process and their continued efforts in maintaining the Trust's overall level of preparedness.

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

EPRR Core Standards					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG rating**	**Agreed 2021 RAG rating**	**RAG rating rationale and review meeting comments**
Governance					
1	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.			• Rob Hodgkiss is still in place as the Trust's AEO and is actively engaged • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.			• The Trust was able to confirm and evidence that an EPRR Policy was in place and therefore the Review Panel were assured that they have fully met this core standard. • Elements of the EPRR Policy v4 were picked up as good practice and have been noted above. **Peer reviewer comments were fed back as part of the Assurance Meeting and will also be fed back as part of the Trusts Action Plan Review meetings going forward.**
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.			• The Trust confirmed that the report goes to a public Board and therefore, the Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from:			**This Core Standard is not assessed this year**

		• incidents and exercises • identified risks • outcomes from assurance processes.			
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.			• The Trust was able to confirm that Debrief Reports go to the Board and then actions sit on Datix and given ownership. The Trust's Head of EP then manages these and monitors their progress. • **ACTION**: Trust to add the monitoring process (above) into the Policy • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
Duty to maintain plans					
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.			**This Core Standard is not assessed this year**
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).			The Trust confirmed that the document submitted as evidence (Incident Response Plan 7a) describes how Business Continuity and Critical Incidents are managed. The Review Panel commented that the name of the document didn't reflect its content or purpose and thanks the Trust for the clarity. The Trust is planning on merging this document with the Trust BCP in the near future adding that the response is the same. The Review Panel suggested creating a C3 overarching document to help keep the new combined document cleaner. **ACTION**: Trust to send BCP to NWL EPRR Team post Assurance Meeting • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).			• The Trust was able to confirm and evidence that an Incident Response plan for Major Incidents is in place and therefore the Review Panel were assured that they have fully met this core standard. • Elements of good practice were picked up by the Review Panel and this has been noted in the main body of the report above.

					• The Review Panel commented that the review date on the plan of three yearly was too long. The Trust fed back that due to the Trust committee/Board cadence and availability of these, that it makes it difficult to review the plan annually. The Trust gave assurance that plans are reviewed after an incident or exercise to capture learning. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard. **Peer reviewer comments were fed back as part of the Assurance Meeting and will also be fed back as part of the Trusts Action Plan Review meetings going forward.**
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.			**This Core Standard is not assessed this year**
16	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.			**This Core Standard is not assessed this year**
17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.			**This Core Standard is not assessed this year**

18	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.			• The Trust confirmed that they have a separate plan in place for Mass Casualty. The Trust also commented that being able to discharge patients from the Chelsea site in the required timescales can be difficult due to the position of the site on a main road and potential for a lot of people to be outside the hospital obstructing access and egress. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.			• The Trust commented that this plan has been updated following an evacuation exercise that was undertaken in 2019 and the shelter of patients is included in this plan. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.			• The Trust confirmed that the Trust LSMS is the lead for this plan and has also held training sessions for Lockdown. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.			• The Trust confirmed that there is an IRP for VIP and a separate one for VVIP due to the Royal Household connection. This plan is written in connection with MPS and cannot be shared widely. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.			**This Core Standard is not assessed this year**
Command & Control					
24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
25	**Trained on call staff**	On-call staff are trained and competent to perform their role and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group			**This Core Standard is not assessed this year**

		Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.			
Training & exercising					
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept demonstrating this.			**This Core Standard is not assessed this year**
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.			**This Core Standard is not assessed this year**
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation			**This Core Standard is not assessed this year**
Response					
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose and supported with documentation for its			• The Review Panel suggested that the Trust consider including any virtual ICC capability in the plan. The Trust explained that they are not very reliant on their IT so therefore a full ICC is not virtual, although they have the ability for the main ICC roles if needed, they would prefer to keep the ICC in person.

		activation and operation.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
31	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.			**This Core Standard is not assessed this year**
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.			**ACTION: Trust to send BCP to the Review Panel after the meeting** • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
33	**Loggist**	The organisation has 24-hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.			**This Core Standard is not assessed this year**
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
35	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
Warning & Informing					
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.			• The Trust commented that have a new comms Director in place and do have a separate Comms plan with processes in place to contact partners and stakeholders within it. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to trained media spokespeople able to represent the organisation to the media at all times.			**As per CS 37** • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
Cooperation					

40	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.			**This Core Standard is not assessed this year**
41	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.			**This Core Standard is not assessed this year**
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).			• The Trust confirmed that they took MACA out as it was misleading staff into thinking they could use it, the Review Panel suggested this could be written back into the plan with explicit text as to how MACA is activated via NHS England and NHS Improvement. • Discussion was had around the initial NWL MOU document created by the NW AEO group. It was felt by the Trust that specific MOU's are not always helpful as it would always depend on the incident at hand. The Trust confirmed that they do have identified NHS partners in place for assistance in an incident and ICS colleagues are also supportive of the collaborative way in which NWL now works following the Covid19 response. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
Business Continuity					
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).			**This Core Standard is not assessed this year**
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.			• The Review Panel noted that the DPST was reported to have been met on the 15/6/2021 • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors			• The Trust confirmed that not all Service BC plans are up to date due to time pressures during Covid and that a full review is due. • The Review Panel agreed with the Trust's self-assessment of partially compliant for this Core Standard

		• IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.			
52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.			**This Core Standard is not assessed this year**
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.			• The Trust confirmed that they have a review process in place and this is monitored by the EPRR Group and Committee's. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard. **ACTION: Trust to add a BC plan org chart in the Policy under BCMS to show the plan structure and add text to show the cycle that the Trust goes through to ensure continuous improvement of BCMS**
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.			• The Trust is not assured that when BC plans are asked for by procurement that they are being signed off with any informed knowledge of BC and are looking to make this process more robust. Discussion has also been had amongst EPO's at the November Acute Learning Set around this area. **ACTION: Review panel to provide Procurement BC checklist to CS and link in with Stephen Maxwell for Acute groups to work on**
CBRN					
56	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.			• The Trust were able to confirm that the main number does not change so does not get routinely checked, however, all other numbers are checked. The Trust added that they had to use the plan for acid attacks over the summer. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).			• Andy Godfrey gave thorough feedback on the Trust CBRN Plan and this will also be fed back as part of the Action Plan Review Meetings with the Trust going forward. • It was acknowledged by the Trust that the plan is highly technical, and they fed back that this was a requirement of trainers in the Trust. They also commented that staff would not use the plan in anger, however, would use the Action Cards. • Andy questioned the 24/7 radiation management, especially out of hours. The Trust confirmed that OOH they do not have medical physics in place but they do have robust support from neighbouring and other NHS Trusts which has been tried and tested.

					• It was agreed that the plan contains all information needed for this core standard, therefore, the Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.			• The Trust were able to confirm that a detailed risk assessment is undertaken using a tried and tested template which Covid has now been include in. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
59	**Decontamination capability availability 24/7**	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.			• The Trust commented that Porter Teams are trained to put up the decontamination tent along with the security team. ED medics are also trained on both sites as well as Therapy staff. OOH the Trust rely on ED staff to activate the tent. F2F training is now completed on e-learning to keep it socially distanced. The Trust confirmed that they have many more people trained in suits now than ever. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
61	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.			**This Core Standard is not assessed this year**
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
63	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAMGENE (radiation monitor)			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.

		• Other equipment			
64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
65	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training			• The Trust confirmed that the Head of EP (Catherine Sands) is the CBRNe Lead • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.			**This Core Standard is not assessed this year**
67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.			• Andy Godfrey fed back that the train the trainer course is currently under review and will be changing going forward which was received well by the Trust. This should begin being to be rolled out in the new year. • The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.			• The Trust confirmed that this has dedicated resource which sit outside of EPRR and therefore, the review Panel were happy that the Trust had provided sufficient evidence that this Core Standard has been fully met.

					Columns to be copied to report
Deep Dive					
CS Ref	**Standard**	**Suggested areas for review & evidence suggested by national**	**Self-assessed RAG**	**Agreed 2021 RAG rating**	**RAG rating rationale & meeting comments**
Oxygen Supply Response					
1	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.			• The NWL Review Panel have agreed that the Trust shall remain rated as Partially Compliant due to the outstanding action in relation to the DD standard.
2	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
3	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.

4	**Medical gasses - workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
5	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
6	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.
7	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6			• The Trust provided sufficient evidence for the Review Panel to be assured that they have fully met this core standard.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Trust Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	4.2
TITLE OF REPORT	Learning from Serious Incidents (February and March 2022 data)
AUTHOR NAME AND ROLE	Stacey Humphries, Quality and Clinical Governance Assurance Manager
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Bleasdale, Chief Nursing Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	This paper provides an update on the process compliance, key metrics and learning opportunities arising from Serious Incident investigations.

REPORT HISTORY
Committees/Meetings where this item has been considered)

Name of Committee	Date of Meeting	Outcome
Quality Committee	03/05/2022	
PSG	27/04/2022	

SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND

During February 2022 and March 2022 the Trust declared 13 External SIs.

There were 10 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the NWL Collaborative (Commissioners).

At the time of writing this report (25/04/2022), there are 36 overdue actions. There are 16 strong actions recorded with a criticality score of 5; these actions are absolutely critical to the management and reduction of risk. 13 of these actions have been completed and 3 actions are yet to be closed.

Key themes contributing to serious incidents include:

- Complexity of patients clinical condition
- Low staff to patient ratio/ High acuity
- Sub optimal/Poorly designed process
- Documentation incomplete or not contemporaneous
- Guidelines, Policies and Procedures: Not adhered to / not followed

KEY RISKS ARISING FROM THIS REPORT	• Critical external findings linked patient harm • Reputational risk associated with Never Events.

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	
Deliver better care at lower cost	

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR: Equality And Diversity: Quality: Y People (Workforce or Patients/ Families/Carers): Operational Performance: Finance: Public Consultation: Council of Governors: please mark Y/N – where Y is indicated please explain the implications in the opposite column	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.

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

1. Introduction

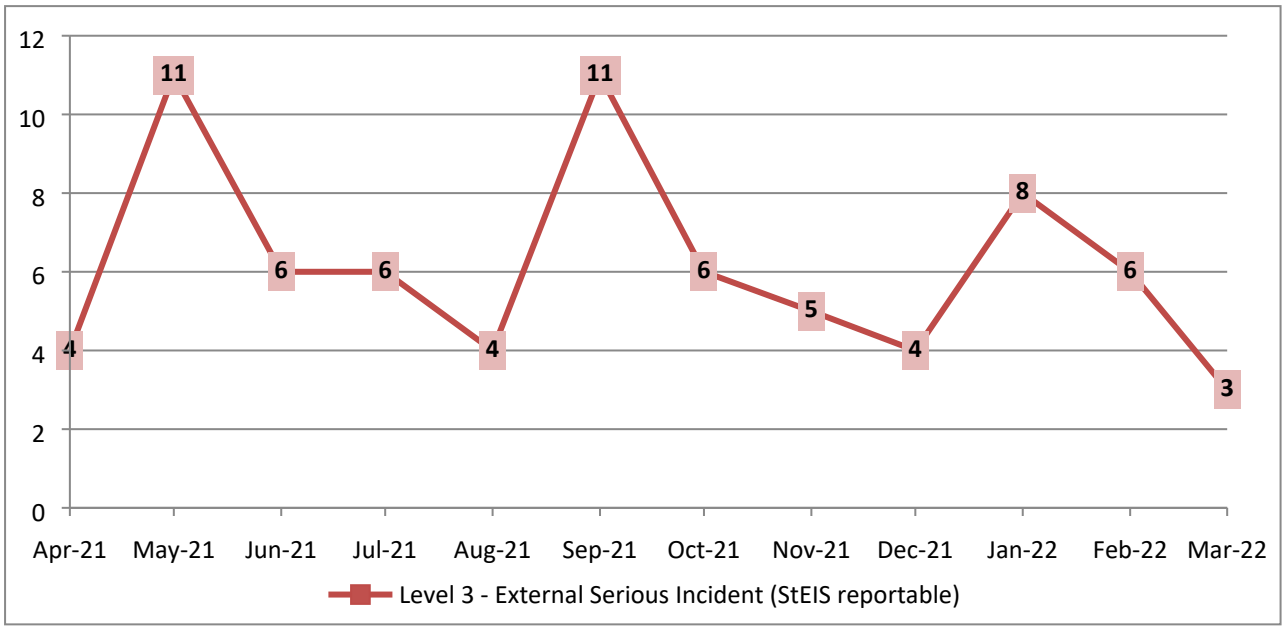
The Chelsea and Westminster Hospital NHS Foundation Trust is committed to the provision of high quality, patient centred care. Responding appropriately when things go wrong is one of the ways the Trust demonstrates its commitment to continually improve the safety of the services it provides.

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

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

2. Serious Incidents activity last 12 months

Between April 2021 and March 2022 the Trust reported 74 External Serious Incidents (34 CW/ 40 WM)



Graph 1: External SIs declared by month declared between April 2021 and March 2022

A Never Event occurred in July 2021 concerning the use of the wrong implant (ref 2021/14007). A second Never Event occurred in September 2021 concerning wrong site surgery (ref. 2021/18242).

3. Serious Incidents declared February & March 2022

The Trust started 9 External Serious Incident Investigations:

Division	Site	Specialty or ward	Ref	Brief description
February 2022				
CORP	WM	Estates Operations	INC91659	Power outage
EIC	CW	David Erskine	INC92703	Patient fall resulting in a fractured NOF.
EIC	WM	Emergency Dept.	INC91800	Sub-optimal care of the deteriorating patient.
EIC	WM	Kew	INC92368	Patient fall resulting in a fractured NOF.
WCHGD	CW	Maternity / Obstetrics	INC92249	Unexpected term admission to NICU.
WCHGD	WM	Maternity / Obstetrics	INC91872	***HSIB*** Baby transferred out for cooling.
March 2022				
EIC	WM	Marble Hill 2	INC92944	Patient fall resulting in a fractured NOF.
EIC	CW	Edgar Horne	INC93036	Patient fall resulting in a fractured NOF.
EIC	WM	Kew	INC93325	Patient fall resulting in a fractured NOF.

Table 1: External SIs declared in February 2022 – March 2022

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

4. External Serious Incident completed February & March 2022

Following review and agreement by the Divisional Serious Incident Panel and the Chief Nurse / Medical Director 10 Serious Incident reports were submitted to the NWL Collaborative (Commissioners).

Division	Site	StEIS Category	Specialty	StEIS ref.	Degree of harm
February 2022					
CSD	WM	Environmental incident (Appointment/Clerical issue)	Clinical Administration	2021/23661	No harm
EIC	WM	Sub-optimal care of the deteriorating patient	Acute Medicine	2021/22851	Moderate
WCHGD	WM	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/18987	Low
WCHGD	WM	Maternity/Obstetric incident: baby only *HSIB*	Maternity / Obstetrics	2021/16164	Moderate
March 2022					
PCD	CW	Self-inflicted harm	General Surgery	2021/21279	No harm
EIC	CW	Pressure ulcer	Care Of Elderly	2021/25051	Moderate
CSD	CW	Treatment delay	Imaging	2021/25084	Moderate
WCHGD	WM	Maternity/Obstetric incident: mother and baby	Maternity / Obstetrics	2021/14048	Moderate
WCHGD	CW	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/18115	Moderate
WCHGD	WM	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/19860	No harm

Table 3: External SI reports submitted to the Commissioners in February 2022 – March 2022

5. Learning from Serious Incidents

The Serious Incident investigations are designed to identify weaknesses in our systems and processes that could lead to harm occurring. It is incumbent on the Trust to continually strive to reduce the occurrence of avoidable harm by embedding effective controls and a robust programme of quality improvement.

Lessons learned are shared at multiple forums including specialty MDT meetings, Clinical Governance half days and divisional quality boards. Departmental newsletters and the monthly serious incident report also highlight findings from SI investigations.

5.1. Serious Incident action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan is developed to address these factors. Action plan completion is monitored by the Patient Safety Group and the Executive Management Board to ensure barriers to completion are addressed and change is introduced across the organisation (when required).

There are 87 open SI actions of which 44 are overdue.

5.1.1. Measuring the effectiveness of Serious Incident actions

In the majority of cases SIs occur not because there were no controls in place at the time but because the existing controls failed. The organisation has implemented a process designed to measure the effectiveness of actions arising from serious incident investigations. The focus is on type of control recommended (hierarchy of controls) and the impact the control is expected to have at mitigating the likelihood and/or consequence (criticality score).

There are 16 actions recorded as a strong action and with a criticality score of 5 thus meaning the action is absolutely critical to the management and reduction of the risk.

13 actions have been completed and include the following:

- Cease using stainless steel heads within hip replacement surgery
- Amend maternity appointment pathway relating to patient not attending (next appointment made for non-English speaking patients before they leave current appointment, no patients discharged from the clinic system until a next appointment is booked).
- Demand and capacity analysis in the ophthalmology clinic undertaken September 2021 (deficit of 63 slots a week).
- Patient Access Process maps and roles and responsibilities of admin staff involved in ophthalmology booking process developed to ensure standardisation and clarify functions
- Mini pilot; spycra dressing introduced to prevent shearing and friction to patients with neck injuries. Colleagues have attended training and will roll-out to teams.

Monitoring the effectiveness of SI actions to examine whether highly criticality controls are embedded and effective will provide assurance that the Trust is learning from Serious Incidents.

5.2. Thematic review

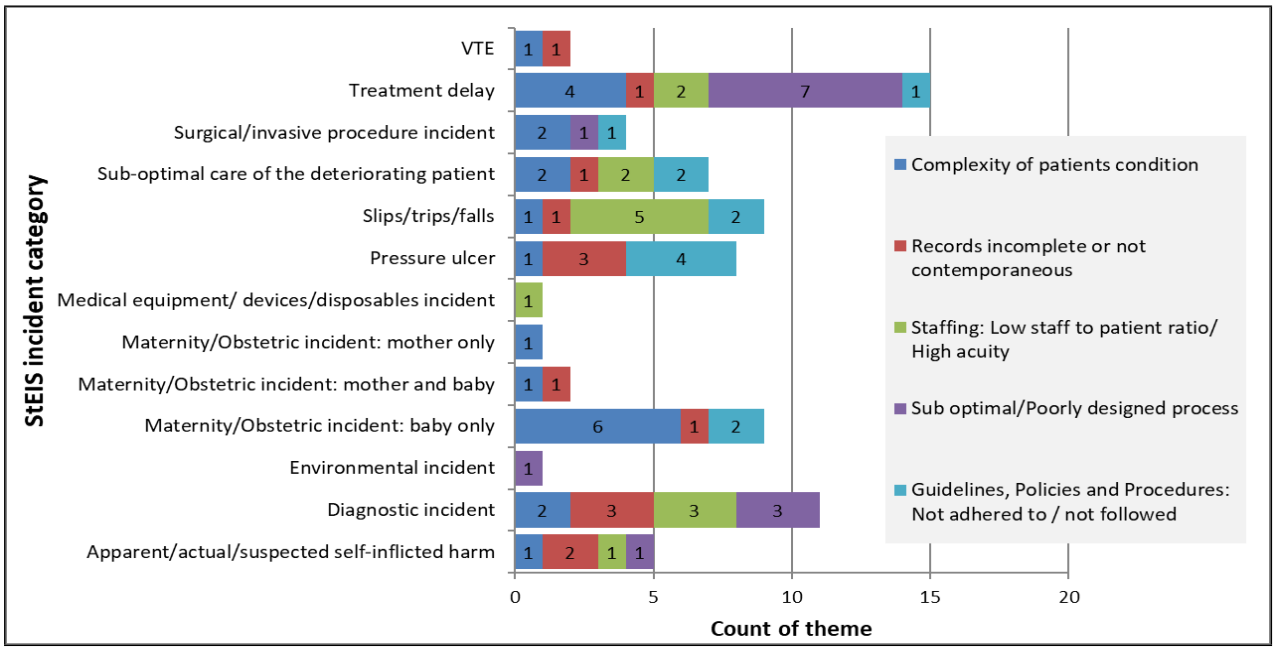
Serious Incident investigations explore problems in care (what?), the contributing factors to such problems (how?) and the root causes (i.e the underlying/fundamental issues (why?). To support understanding, a process of theming across these areas has been implemented to identify commonalities across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

Reviews do not seek to weight the themes according to their influence on an event, but merely to identify their occurrence; this provides increased insight into the more common factors associated with serious incident investigation and increases the opportunity to identify overarching improvement actions.

In the past 12 months to March 2022, 58 external SI reports have been reviewed. Key themes contributing to the serious incidents include:

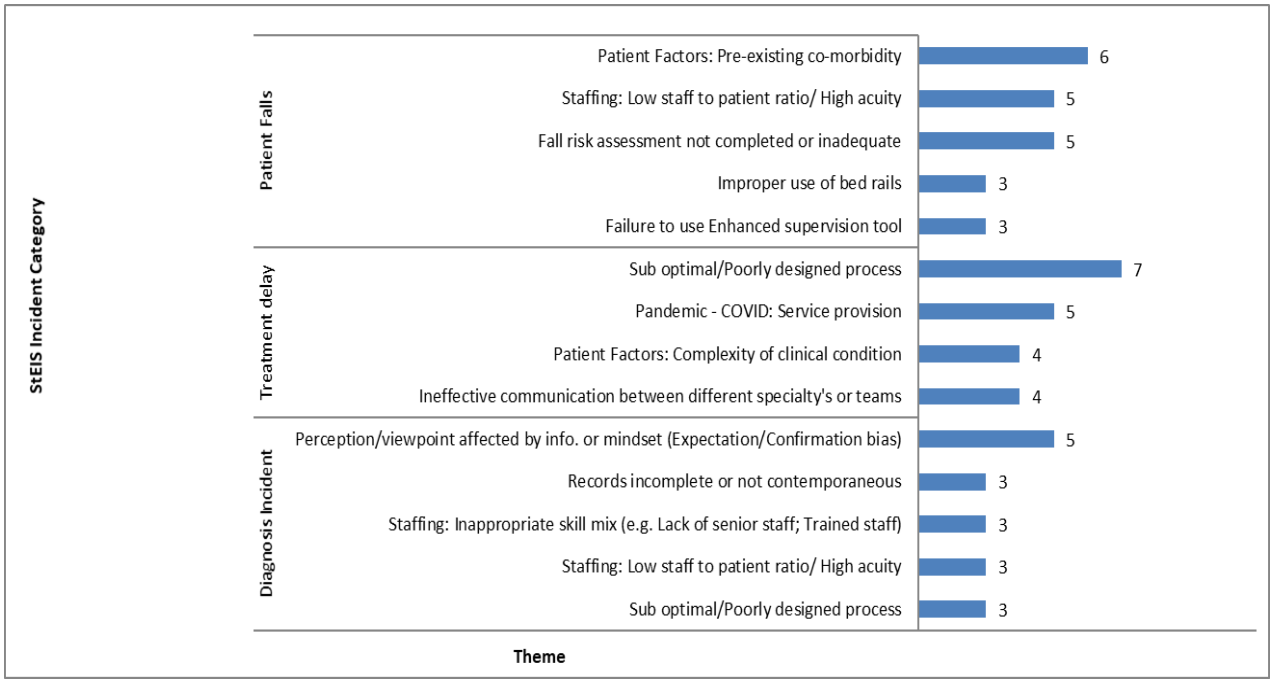
- Complexity of patients clinical condition – 22 SIs
- Documentation incomplete or not contemporaneous – 14 SIs
- Staffing: Low staff to patient ratio/ High acuity – 14 SIs
- Procedural or Task Design: Sub optimal/Poorly designed process – 13 SIs
- Guidelines, Policies and Procedures: Not adhered to / not followed– 12 SIs

The chart below highlights the most commonly occurring themes and the StEIS category they are linked to.



Graph 2: Top 5 occurring themes (External SI reports submitted between April 2021 and March 2022)

The chart below highlights the most common root cause, contributory factor or care/service delivery issues for the three highest reported SI incident categories:



Graph 3: Common themes for the highest reported external SI categories

6. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Key themes will be submitted to the Patient Safety Group and the Executive Management Group for consideration of requirement for further Quality Improvement Projects, deep-dives, or targeted action. Updates on these programmes of work will be reported to the Quality Committee.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors (Public) 5th May 2022

AGENDA ITEM NO.	4.3
TITLE OF REPORT	Workforce Performance report March 2021 including quarterly heatmap
AUTHOR NAME AND ROLE	Karen Adewoyin- Deputy Director of People and OD Lindsey Stafford-Scott - Deputy Director of People and OD
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith- Interim Director of HR
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: x Info Only: x Advice: Please tick below and then describe the requirement in the opposite column	The attached performance report provides an update to the Committee against key themes and deliverables in the Trust's People Strategy. It provides an update on key performance metrics, trends and themes and narrative to provide assurance that the members of the committee are aware of the risks and challenges associated with workforce and has the necessary plans in place to address them.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Workforce Development Committee Date of Meeting: 20th April 2022 Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	This Performance report is in the new draft format which seeks to reflect more transparently the activities and performance against a range of key themes and deliverables as set out within the Trusts People Strategy. **Workforce Performance Report** Overall sickness levels have decreased but remain higher than pre-COVID in line with the NWL region at 4.16%. Turnover continued to increase in March to 14.2% (voluntary) which will make the ambition target of 10% in the People Strategy difficult to deliver, but is in line with the NWL sector. One of the top reasons for leaving is relocation, almost 30% of the leavers in the last 12 months. Leaver surveys highlight key areas to improve are work-life balance, clearer feedback and the need for more value and recognition.

	Appraisal targets have improved to 91% which closes the appraisal reporting in shadow form and the new reporting will start from 1st April 2022, and Divisions are working through their trajectories. Mandatory training overall compliance has increased to 90%. ER cases have remained relatively static with compliance against timeframes increasingly slightly due to a number of reasons, however a series of actions are in place and the team have now trained 333 managers across the organisation. Work continues to deliver against our EDI targets, with a specific focus in line with the NWL Inclusion Board on NWL and each Trusts model employer targets. The Trust is continuing to support 2 placements on the NWL Leadership Ladder programme, Three quarters of flexible working requests have been accepted and the Trust has also received Timewise accreditation. The Trust is performing well against the target to have workforce recruited from our local communities with current performance at 20% against a target of 10%. Significant work has been delivered in the NWL Mass Vaccination programme with particular success in retaining Mass Vaccination workers into roles across the ICS, with 194 (20%) colleagues now in employment against a target of 25% and the NHS reservist programme has resulted in 79 candidates details put forward. The apprenticeship levvy usage has increased at 52% and 192 apprentices are currently studying within the Trust. Volunteering numbers have increased by 18% with 232 volunteers contributing 3128 hours of volunteering. Vacancy rates have reduced to 7.3% and time to hire remains positive at 7.6 weeks against a target of less than 9 weeks. The main concerns relate to support to nursing and rate at 17.6% although this has reduced over the last 3 months. A large scale health care support worker ICS led recruitment campaign is taking place on 28th April 2022. Temporary staffing shift fill rates are challenged at 83% but this is primarily due to a significant increase in demand, and the team are working on a tender for a new Master Vend supplier. **Quarterly Heatmap** The heatmap reviews the key performance against a number of key metrics and split by Division to highlight areas of positive progress or any areas of concern so that interventions can be made. The new People Promise elements of the staff survey results have also now been integrated in to the heatmap. Overall the areas of concern by Division are highlighted below: **Clinical Support Division** Sickness remains high, and whilst COVID related the Division have a high proportion of staff off with anxiety and depression, with Patient Access as the area with the highest sickness, and a bi-monthly meeting has been arranged to review sickness and other key related issues. The Division is also an outlier for voluntary

	turnover and has high turnover in the first year. This is particularly high in Neurophysiology and an overarching plan is in place. **Enterprise Division** is a new Division and has high sickness particularly in December but a large proportion related to COVID and half of those on long term sick have now returned. Turnover is also a specific are of concern with turnover averaging 25%, the reasons for leaving relate to promotion and work life balance, and voluntary turnover in Year 1 is also high at over 6%. The Division is also having a clear focus on PDRs as this is below Trust targets. **EIC -** like other Divisions has seen high sickness rates but the majority relate to COVID. Voluntary turnover is above target and is high specifically in Therapies, Acute Medicine and HCA staff group and there will be clear focus on retention in the Divisions business plan. The Division has received more positive responses from leavers to 97% from 77%. Specific areas of focus from the staff survey are EDI and Safe Environment, and many of the staff survey pledges related to these areas. **Planned Care** has negative net joiners and lower levels of joiner survey response rates which will remain a focus for management to improve. Sickness also remains high and is COVID related followed by stress, anxiety and depression. KPI's for grievances and disciplinary cases are also above set time periods and ER review meetings have been re-established to identify any challenges and issues. One of the key issues for the Division was the safe environment score and key actions are in place to improve this area through the staff survey action plan in the Division. **W, C, D and SH** has been impacted by high sickness levels and over 40% of the total episodes of sickness in the Trust related to stress, anxiety and depression are within the Division. The Division have had good time to hire and net joiners but became an outlier in December. Staff wellbeing and safe environment remain a focus and dominate the staff survey pledges and the Division have been focused on listening events, and a large proportion of FTSU (40%) are within the Division. Focus has been on resolving interpersonal conflicts. **Corporate –** Corporate areas as a whole remain relatively positive however there were negative net joiners and the leavers feedback in the quarter was 67% and PDR compliance levels are the lowest across all the Divisions so needs a clear focus.
KEY RISKS ARISING FROM THIS REPORT	Risk are as set out within the report – key to note is the impact of staff sickness on service provision and staff.

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	X
Quality	
People (Workforce or Patients/ Families/Carers)	X
Operational Performance	
Finance	
Public Consultation	
Council of Governors	

please mark Y/N – where Y is indicated please explain the implications in the opposite column

The key risks are highlighted above and throughout the report.

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Quarterly People Dashboard
January to March 2022

Purpose

- The report triangulates key data sets to review key areas within the Trust in relation to people metrics. This includes for example staff survey data, new starter and exit interview data in terms of engagement levels, turnover, vacancy rates, sickness rates, bullying and harassment complaints, grievances, monthly survey results.

- The purpose is to highlight areas of good practice and areas of concern at an early stage so that interventions can be made.

- This update will focus on delivery against key workforce metrics, highlighting the trajectories to meet the Trust wide targets, some of which have been detailed within the People Strategy and others which are nationally set in the NHS People Plan or set by NHSI/E such as the agency ceiling.

- This will be in the form of an exception report which provides further narrative on areas where the targets are not being delivered to give assurance that there will be improvements in the KPI's over an agreed period and what interventions are being taken. This report will include the position on our workforce planning assumptions for the year and key progress against this on a quarterly basis.

Quarterly Heatmap – Quarter 4 January to March

		COR				CSD				EIC				ENT				PCD				WCH				TRUST			
Marker	Target	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement	Jan	Feb	Mar	Movement
Established Size of Division (FTE)	-	598.88	598.88	602.88	∩	1108.13	1067.59	1065.15	∪	1793.06	1779.07	1764.90	∪	199.41	201.41	201.41	∩	1227.09	1230.49	1233.99	∩	1714.18	1723.57	1715.27	∩	6640.75	6601.01	6583.60	∪
Size of Division (FTE)	-	578.32	574.27	580.35	∩	959.57	958.01	965.96	∩	1635.70	1642.14	1652.15	∩	181.90	186.18	185.55	∩	1148.41	1148.55	1153.78	∩	1553.06	1564.00	1562.11	∩	6056.96	6073.14	6099.88	∩
Size of Division (HC)	-	592	591	599	∩	1042	1039	1050	∩	1729	1736	1749	∩	195	200	200	∩	1215	1215	1221	∩	1738	1745	1745	∩	6511	6526	6564	∩
Vacancy Rate %	<10.00%	3.43%	4.11%	3.74%	∩	13.41%	10.26%	9.31%	∪	8.78%	7.70%	6.39%	∪	8.78%	7.56%	7.88%	∪	6.41%	6.66%	6.50%	∩	9.45%	9.31%	8.98%	∪	8.79%	8.00%	7.35%	∪
Time to Hire (Weeks)	<9 Weeks	7.3	8.0	7.4	∩	9.5	8.4	7.3	∪	4.1	8.1	7.5	∩	-	-	-	Ø	8.5	6.4	8.5	Ø	14.2	9.7	9.5	∪	8.22	8.06	7.66	∪
Net Joiners (FTE)	>0.00	1.13	-4.00	-5.20	∪	-1.89	-2.35	-2.69	∪	6.59	2.34	15.80	∩	2.00	2.00	-0.60	∪	15.33	-4.88	-1.71	∪	-3.42	-6.77	-15.93	∪	19.74	-13.66	-10.33	∪
Temp Staffing Usage (FTE)	-	66.60	58.68	66.16	∪	108.65	105.60	119.90	∩	319.13	309.26	353.37	∩	20.15	20.11	22.98	∩	204.76	181.18	210.91	∩	171.48	169.21	191.81	∩	890.77	844.03	965.13	∩
Bank Usage (FTE)	-	58.08	51.35	58.14	∩	108.60	105.26	118.21	∩	229.70	217.27	239.19	∩	18.74	18.28	20.01	∩	152.02	138.05	162.05	∩	149.13	147.59	170.17	∩	716.27	677.81	767.77	∩
Agency Usage (FTE)	-	8.51	7.33	8.02	∪	0.05	0.33	1.69	∩	66.47	69.02	93.08	∩	1.41	1.83	2.96	∩	46.79	37.17	45.05	∪	19.95	19.22	19.76	∪	143.18	134.90	170.57	∩
Temp Staff Costs £	-	308.7 K	525.7 K	960.8 K	∩	478.7 K	530.3 K	439.5 K	∪	1,568.3 K	1,526.0 K	1,162.2 K	∪	91.2 K	81.6 K	22.3 K	∪	1,040.6 K	1,048.0 K	866.2 K	∪	723.2 K	892.7 K	527.1 K	∪	4,210.7 K	4,604.2 K	3,978.1 K	∪
Agency Usage Costs £	-	37.0 K	235.6 K	79.9 K	∩	19.5 K	10.1 K	18.9 K	∪	494.6 K	388.8 K	127.4 K	∪	27.9 K	9.0 K	-7.5 K	∪	282.7 K	249.9 K	192.6 K	∪	106.0 K	163.9 K	45.0 K	∪	967.7 K	1,057.2 K	456.3 K	∪
Bank Usage Costs £	-	271.7 K	290.1 K	880.9 K	∩	459.2 K	520.2 K	420.6 K	∪	1,073.7 K	1,137.2 K	1,034.8 K	∪	63.3 K	72.6 K	29.8 K	∪	757.9 K	798.1 K	673.6 K	∪	617.1 K	728.8 K	482.1 K	∪	3,243.0 K	3,547.0 K	3,521.8 K	∩
Bank Proportion of Temp Staffing Usage	70%	87.2%	87.5%	87.9%	∩	100.0%	99.7%	98.6%	∪	72.0%	70.3%	67.7%	∪	93.0%	90.9%	87.1%		74.2%	76.2%	76.8%	∩	87.0%	87.2%	88.7%	∩	80.4%	80.3%	79.6%	∪
In Month Sickness %	<3.3%	2.41%	2.16%	2.11%	∪	6.71%	5.31%	5.31%	∪	5.55%	4.31%	3.54%	∪	6.60%	4.58%	4.32%	∪	5.74%	3.57%	3.94%	∪	6.30%	5.20%	5.04%	∪	5.69%	4.36%	4.17%	∪
Sickness Cases being managed	-	2	1	4	∩	19	20	16	∪	9	9	12	∩	0	0	0	Ø	15	13	9	∪	30	29	29	∪	76	72	70	∪
Absence Episodes in month due to Stress/ Anxiety/ Depression or other Psychological Conditions	-	1	1	0	∪	15	14	11	∪	20	16	6	∪	2	2	1	∪	10	11	2	∪	25	25	14	∪	73	69	34	∪
Gross 12 month Turnover (FTE)%	<17.00%	17.69%	20.42%	20.61%	∩	18.32%	19.44%	19.88%	∩	17.30%	16.69%	16.79%	∪	26.19%	25.93%	24.91%	∪	13.01%	13.91%	13.58%	∩	17.22%	17.64%	18.69%	∩	17.04%	17.61%	17.92%	∩
% Voluntary 12 month Turnover (FTE)*	<13.00%	12.09%	14.58%	14.15%	∩	14.41%	15.24%	15.55%	∩	14.84%	14.54%	14.54%	∪	23.34%	23.16%	22.13%	∪	8.88%	9.87%	9.51%	∩	13.87%	14.36%	14.99%	∩	13.48%	14.10%	14.17%	∩
% Vol Turnover in 1st 12 months (FTE)*	<3.00%	3.14%	4.09%	3.88%	∩	3.10%	3.34%	3.43%	∩	3.25%	2.94%	3.00%	∪	6.59%	5.86%	6.40%	∪	1.71%	1.70%	1.38%	∪	2.88%	2.66%	3.07%	∩	2.96%	2.93%	3.02%	∩
Staff Survey - We are Compassionate and Incusive	>7.2		7.6				7.2				7.0								6.8				7.2				7.2		
Staff Survey - We are Recognised and Rewarded	>5.8		6.5				5.8				5.7								5.4				5.5				5.8		
Staff Survey - We Each Have a Voice that Counts	>6.7		7.2				6.8				6.7								6.3				6.7				6.7		
Staff Survey - We are health and Safe	>5.9		6.6				6.1				5.4								5.4				5.5				5.9		
Staff Survey - We are Always Learning	>5.2		5.3				5.3				5.7								5.6				5.2				5.4		
Staff Survey - We Work Flexibly	>5.9		6.7				5.6				5.6								5.5				5.8				5.8		
Staff Survey - We are a Team	>6.6		7.1				6.6				6.5								6.4				6.4				6.6		
Staff Survey - Staff Engagement	>7.6		7.5				7.0				7.0								6.7				6.9				7.0		
Staff Survey - Moral	>5.7		6.2				5.9				5.5								5.4				5.4				5.7		
Staff Survey EDI Score** (D&E)	>8.1		8.2				7.9				7.4								7.2				7.9				7.7		
Staff Survey Safe Environment Score** (Health and Safety Climate)	>5.2		6.0				5.6				5.2								5.0				5.0				5.4		
Joiners Survey % Positive Responses*** Quarterly	-		under 5 responses				under 5 responses				81.00%				under 5 responses				under 5 responses				under 5 responses				81.00%		
Leavers Survey % Positive Responses Engagement***Quarterly	-		80.00%				76.00%				78.00%				under 5 responses				88.00%				75.00%				79.00%		
No of Proud Nominations***	-	0	4	4		8	3	4		1	3	6		0	0	0		2	3	2		3	1	5		14	14	21	
No of Excellence Awards***	-	2	4	2		2	2	2		7	22	9		0	0	0		1	2	9		2	3	6		14	33	28	
Grievance Cases (Open)	-	0	0	0	Ø	0	4	4	∩	0	0	0	Ø	0	0	0	Ø	0	2	2	∩	0	0	0	Ø	7	6	6	∪
Grievance Average Days Open	<60 Days	104.5	104.5	104.5	Ø	146.08	146.08	146.08	Ø	109	109	109	Ø	-	-	-	Ø	156.5	156.5	156.5	Ø	119	115.36	115.36	∪	128.02	126.68	126.63	∪
FTSU Cases	-	0	0	0	Ø	0	0	0	Ø	0	0	2	∩	0	0	0	Ø	0	0	3	∩	1	0	2	∩	1	0	7	∩
PDR Compliance Rate	>90%	76.33%	77.02%	89.62%	∩	81.12%	83.44%	92.76%	∩	83.01%	84.79%	92.27%	∩	84.21%	88.14%	92.70%	∩	87.71%	88.96%	93.01%	∩	77.27%	78.84%	87.53%	∩	81.27%	82.97%	91.01%	∩
Core 10 Training Compliance Rate	>90%	88.0%	88.0%	89.0%	∩	92.0%	93.0%	91.0%	∪	89.0%	87.0%	91.0%	∩	91.0%	89.0%	92.0%	∩	89.0%	88.0%	90.0%	∩	87.0%	85.0%	89.0%	∩	89.0%	89.0%	90.0%	∩
Disciplinary Cases	-	0	0	0	Ø	3	3	3	Ø	2	1	1	∪	0	0	0	Ø	0	0	0	Ø	1	2	3	∩	6	6	7	∩
Disciplinary Average Days Open	<60 Days	104.67	104.67	104.67	Ø	59.7	99.5	99.5	∩	76.59	168.46	168.46	∩	-	-	-	Ø	66.12	149.6	149.6	∩	80.4	119.39	119.38	∩	73.82	133.39	133.39	∩

Exceptions – Clinical Support Division

- Sickness absence within CSD has remained high, averaging at 5.78% against the Trust target of 3.30%. The top reason for sickness absence in March was due to Chest and Respiratory Covid 19 (27.68%) followed by Cold, Cough & Flu (19.97%). Patient Access Directorate has the highest in month sickness absence (7.13%). A bi-weekly workforce working group has been arranged to review sickness absence as well as other matters i.e. recruitment, retention etc.

- Voluntary turnover within CSD has progressively increased since September 2021 averaging at 15.06% in Quarter 4 against the Trust target of 13%. High turnover is seen in CW Neurophysiology (86.96%) and an overarching Organisational Development plan is in progress to improve retention, culture and staff experience within the department. Further plans are in progress to review and improve retention across the Division with a paper to be taken to Divisional Board in May 2022 for further discussion.

- The Division scored lower than the Trust average for their 2021 Staff Survey results for the themes; We Work Flexibly and Equality and Diversity. The Division is committed to trialling and role modelling flexible working and this priority been included in Business Planning. The staff survey results have been shared with the Divisional Management team and this is currently being disseminated throughout the Division with Teams looking to develop People Promises in line with areas of concern from the results.

Exceptions – Clinical Support Division

- There are 4 open grievance cases within CSD, with average investigation time at 146.08 days against the target of 60 days. All of these cases are quite complex in nature and some of them requires input from the IG and the Legal team hence the delays. The ER team has taken some actions including case plans and allocating additional to manage each case. Meetings have taken place with Commissioning Managers to review cases and formulate plans to progress these cases and remove the blockers.

- At the point of this report we had 3 open disciplinary cases with average investigation time of 99.5 days. We have since completed and closed one disciplinary case with two pending completion. There has been a delay due to Long Sickness Absence, but there is plan in place to arrange a hearing for one the cases pending OH referral outcome.

Exceptions – Enterprise Division

- Sickness absence within ENT has progressively decreased in Quarter 4 averaging at 5.16% against the Trust target of 3.30%. The top reason for sickness absence in March 2022 was due to Chest and Respiratory Covid 19 (30.00%) followed by Cold, Cough & Flu (19.20%). Private Patients has the highest in month sickness absence (6.77%) and this is mainly due to 4 long term sickness cases.

- Voluntary Turnover has progressively decreased in Quarter 4 averaging at 22.88% against the Trust target of 13.00%, however this still remains the highest in the Trust. Whilst turnover is high for all directorates, it is particularly high in Private Maternity Unit (27.02%) and Chelsea Wing (23.11%). An overarching Organisational Development plan is in progress to improve retention, culture and staff experience within the departments.

Exceptions – Emergency and Integrated Care Division

- Emergency and Integrated Care Division have maintained a stable vacancy rate under Trust target with time to hire under the Trust target.

- In month sickness has remained above target at 5.31% This has mainly been driven by Covid sickness across the Division with Chest and Respiratory the highest reason for sickness for number of episodes and number of days for Q4.

- Voluntary turnover remains above target for Q4. High turnover is seen in Therapies, Acute Medicine and across the HCA staff group. Plans are in progress to review and improve retention across the Division and specifically in these areas to improve staffing levels moving forward and looking to improve staff experience.

- We have seen a decline in Q4 in the positive responses quarterly in the Leaver survey to from 97% to 76%, but EIC was the only Division with a high enough response rate to receive specific data.

Exceptions – Emergency and Integrated Care Division

- PDR and Core training increased and are now above Trust target in Q4. Focus on PDR is high in the Division to align to the shadow reporting which commences in March 22. On the current trajectory, EIC will meet the 90% target in September 22.

- The Division score lower than the Trust average for their 2021 Staff Survey results for the themes; We are safe and Healthy, and We work flexibly. The results have been shared with the Divisional Management team and this is currently being disseminated throughout the Division with Teams looking to develop People Pledges in line with areas of concern from the results. This is expected to be completed in May in order to give the teams 5 months to progress against the pledges before the 2022 staff survey is launched.

- There are no grievance cases within the division. There is only one disciplinary case opened in February 2022 and the investigation time is currently at 38 working days which is within the Trust investigation and closing timeline.

Exceptions – Planned Care

- PCD has fluctuating levels of net joiners over this quarter, starting the year positively with 15.33 wte, with a significant drop to -4.88 in February improving slightly for March but remaining in negative figures. It is hoped that planned recruitment events for Theatres and HCA's will contribute to an improved position.

- In month sickness has remained above target for quarter 4, but has reduced during that time to 3.94%. Covid related sickness absence has contributed with absence due to Chest and respiratory problems reported as the highest reason for absence, followed by Cough, Cold and Flu.

- The Division score lower than the Trust average for their 2021 Staff Survey results across all themes except We are always learning. The results have been shared with the Divisional Management team, with plans to discuss with Teams/staff groups across the Division. As well as refreshing existing pledges and developing new and relevant People Promises with Teams, the Division would like to seek additional methods of engaging with different staff groups. This may include focus groups, listening events, short survey monkey questions, and staff suggestions.

- Joiner survey responses remain low. Increasing these will provide more meaningful results to inform actions and positive changes to the joiner experience. Managers will be encouraged to provide protected time to all new joiners to complete the joiner survey.

- PDR and Core training increased and are now above Trust target in Q4. Focus on improving compliance to align to the shadow reporting from April continues. On the current trajectory, PCD will meet the 90% target in February 2023, but the division hopes to improve this timeline.

Exceptions – Planned Care

- There are 2 open grievance cases within PCD as at the time of this report, with average investigation time at 156.5 days against the target of 60 days. However one of the cases has now been completed and closed. There is a plan in place to progress the pending case which was delayed to non-engagement. This new plan will aim to complete this case by the end of April 22.

Exceptions – Women's Children's, Dermatology, Sexual Health

- Sickness absence within WCH has progressively decreased, averaging at 5.51% against the Trust target of 3.30%.

- Voluntary turnover within WCH has progressively increased averaging at 14.41% in Quarter 4 against the Trust target of 13%.

- The Division scored lower than the Trust average for their 2021 Staff Survey results for the themes; We Work are Recognised and Rewarded, We are Safe and Healthy, We Work Flexibly, We are a Team.

- There are 3 open disciplinary cases as at the time of this report, however one has now been completed and closed. One is pending hearing due to on going external process and one is MHPS which will be concluded by the end of April.

Exceptions – Corporate

- Voluntary turnover within Corp has progressively increased averaging at 13.60% in Quarter 4 against the Trust target of 13%. High turnover is seen in Workforce Directorate (33.82%), followed by Chief Executive Directorate (24.62%) driven by the Communications Department (68.18%).

- An external company is completing a retention piece of work with the workforce directorate. This includes interviewing recent leavers as well as interviewing current staff. A report will be produced with recommendations for implementation.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People Plan & Workforce Performance Report

to the Workforce Development Committee and People and Organisational Development Committee

Month 12 – Mar 2022

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Our People, Our Ambition

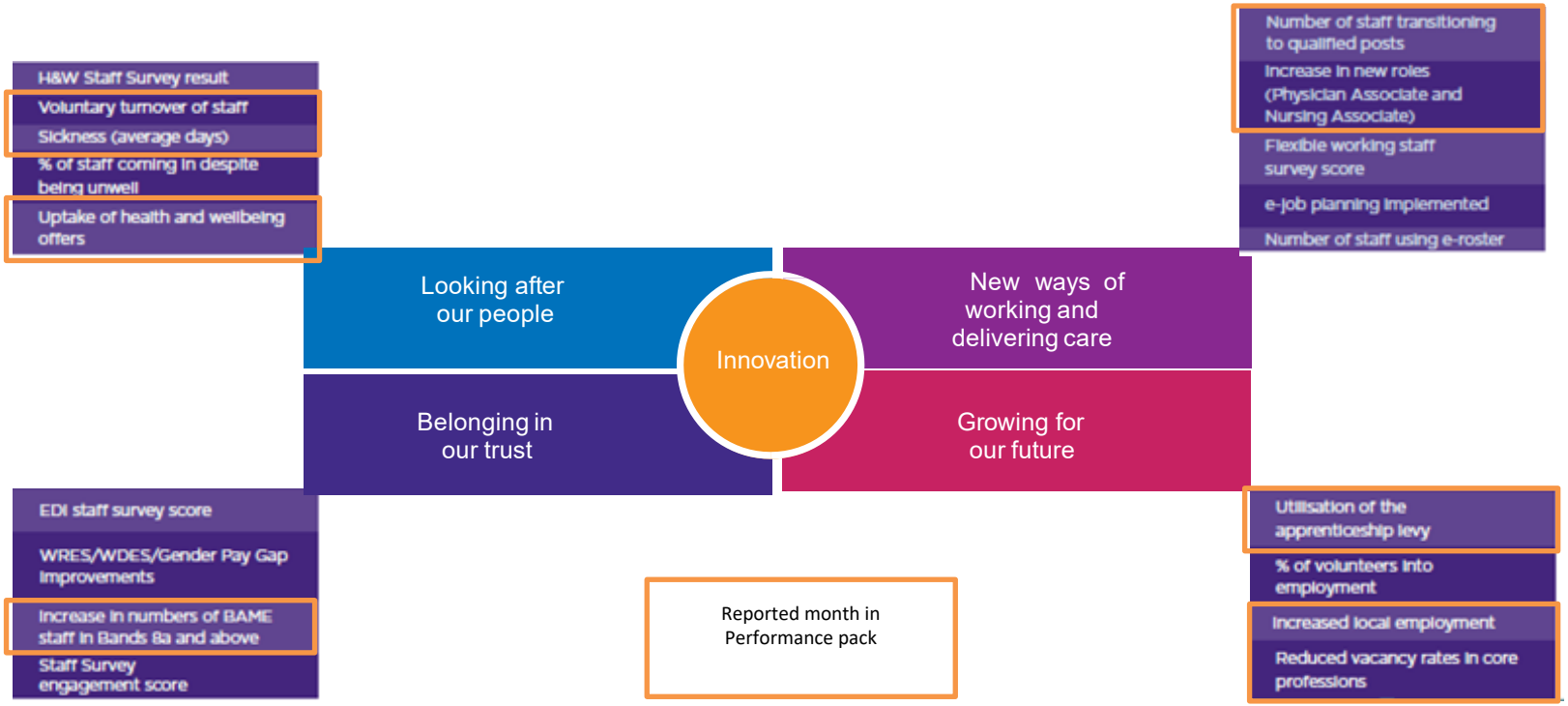
Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and people are able to provide the environments they work in are inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.

How we will measure our success

Strategic goal	Key themes of people plan	Performance measure	2020/21 baseline	2023/24 ambition
To be the Employer of Choice	**Looking after our people** ICS Goal 1 – Care *We have a happy, healthy and engaged workforce.*	H&W Staff Survey result	5.9	6.1
		Voluntary turnover of staff	18%	10%
		Sickness (average days)	5.8	5
		% of staff coming in despite being unwell	47.7%	40%
		Uptake of health and wellbeing offers	<2%	>10%
	Belonging in the NHS ICS Goal 2 – Lead ICS Goal 3 - Include *We care and staff report positive experiences and we are inclusive and succeed because of our differences.*	EDI staff survey score	8.5	9.1
		WRES/WDES/Gender Pay Gap Improvements	6 WRES + 10 WDES 3 grades not met target	Positive improvement in all indicators (outlined in Belonging section)
		Increase in numbers of BAME staff in Bands 8a and above	Disproportionate 3 grades not met target	All grades meeting set targets
		Staff Survey engagement score	7.1	7.4
	New ways of working and delivering care ICS Goal 4 – Transform *We have the skills to deliver 21st Century Care.*	Number of staff transitioning to qualified posts	<20	>70
		Increase in new roles (Physician Associate and Nursing Associate)	<1%	>5%
		Flexible working staff survey score	56%	65%
		e-job planning implemented	Not yet implemented	65% of consultants and SAS doctors have e-job plan by March 2022, 100% by 2024
		Number of staff using e-roster	82%	100%
	Growing For the Future ICS Goal 3 – Grow *We have the capacity to deliver great care.*	Utilisation of the apprenticeship levy	39%	70%
		% of volunteers into employment	4.5%	10%
		Increased local employment	Not currently measured	10%
		Reduced vacancy rates in core professions	N&M 5.5%, M&D 3% AHP 6%	N&M 5-8%, M&D <5%, AHP <7%

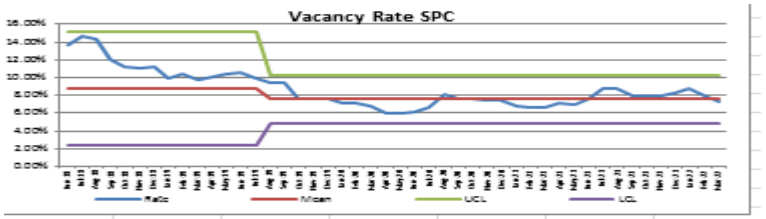
Our People, Our Ambition

Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and people are able to provide the environments they work in are inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.

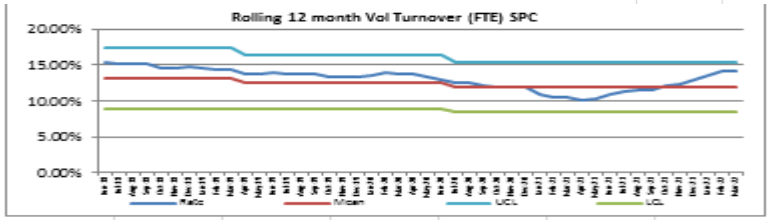


Key Indicators Over time

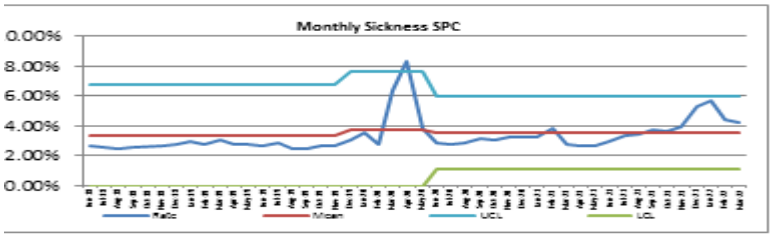
Division	Trust																		
KPI	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Vacancy Rate	8.06%	7.55%	7.63%	7.52%	6.89%	6.82%	6.67%	6.54%	7.16%	7.02%	7.56%	8.76%	8.83%	7.86%	7.94%	7.89%	8.35%	8.80%	8.01%	7.36%
Voluntary Turnover	12.59%	12.10%	11.95%	11.95%	11.53%	10.95%	10.52%	10.50%	10.19%	10.32%	10.66%	11.20%	11.53%	11.47%	12.19%	12.32%	13.00%	13.50%	14.16%	14.24%
Sickness (1 month)	2.85%	3.15%	3.01%	3.28%	4.16%	3.23%	3.79%	2.73%	2.64%	2.69%	2.93%	3.31%	3.48%	3.76%	3.66%	3.90%	5.29%	5.69%	4.36%	4.17%
PRD Rate	90.51%	88.75%	88.77%	90.32%	88.72%	89.43%	89.62%	89.19%	89.91%	85.90%	85.55%	77.14%	71.65%	76.30%	88.12%	79.49%	81.79%	81.27%	82.97%	91.01%
Medical Appraisal Rate											90.19%	89.76%	89.20%	88.28%	85.47%	86.64%	89.10%	89.89%	89.89%	87.08%
Core Training Rate	93.0%	91.0%	90.0%	89.0%	89.0%	89.0%	87.0%	89.0%	88.0%	88.0%	89.0%	89.0%	88.0%	88.0%	87.0%	88.0%	88.0%	89.0%	89.0%	90.0%



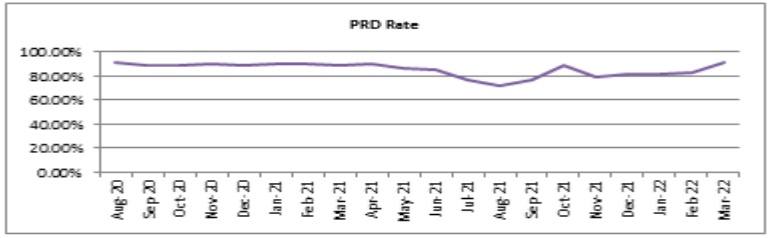
Movement in Month	⬇
Movement Year to Date	⬆
Movement over Last 12 months	⬆



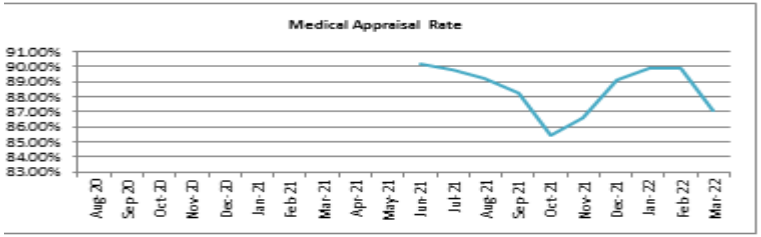
Movement in Month	⬆
Movement Year to Date	⬆
Movement over Last 12 months	⬆



Movement in Month	⬇
Movement Year to Date	⬆
Movement over Last 12 months	⬆



Movement in Month	⬆
Movement Year to Date	⬆
Movement over Last 12 months	⬆



Movement in Month	⬇
Movement Year to Date	
Movement over Last 12 months	

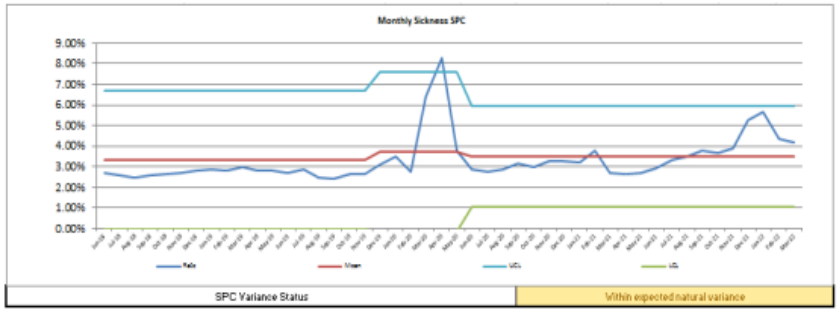


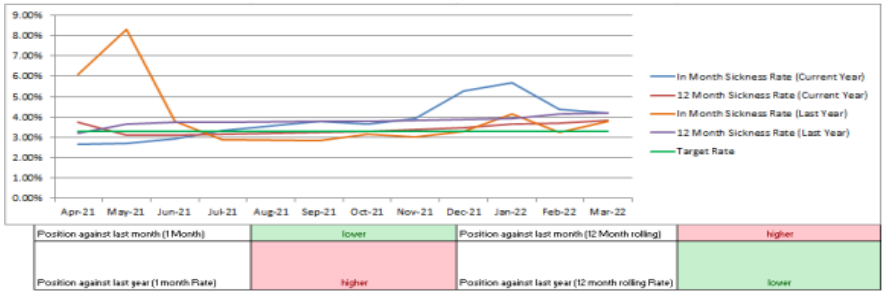
Movement in Month	⬆
Movement Year to Date	⬆
Movement over Last 12 months	⬆

People Plan - Looking after our people

ICS Goal 1 - Care

Performance Measure	2020/21 baseline	2023/24 ambition
Sickness (average days)	5.8 days	5 days





Divisional	Trust	COR	CSD	EIC	ENT	PCD	WCH
FTE Days Lost to Sickness (In month)	7881.82	377.37	1584.96	1809.76	247.56	1408.01	2454.14
FTE Days Available	189125.96	17907.70	29837.21	51171.67	5734.01	35736.67	48738.69
Staff Headcount	6564	599	1050	1749	200	1221	1745
In Month Sickness Rate	4.17%	2.11%	5.31%	3.54%	4.32%	3.94%	5.04%
of which Short Term	2.44%	0.66%	3.03%	2.83%	1.39%	2.08%	2.70%
of which Long Term	1.73%	1.45%	2.28%	0.71%	2.93%	1.86%	2.33%
No of Episodes in Month	1382	62	247	374	38	249	412
New Active Sickness Triggers	311	19	52	91	11	50	88
Triggers Downgraded	92	2	16	23	3	22	26
Previous Months 1 Month Sickness Rate	4.36%	2.16%	5.31%	4.31%	4.58%	3.57%	5.20%
In Month Movement	-0.19%	-0.05%	0.00%	-0.77%	-0.27%	0.37%	-0.16%
12 Month Sickness Rate	3.83%	2.05%	5.08%	3.22%	5.02%	3.51%	4.49%
Number of Active Sickness Triggers	2428	107	452	658	76	429	706

Staff Groups**	Administrative & Clerical	Allied Health Professionals	Medical & Dental	Nursing & Midwifery (Qualified)	Nursing & Midwifery (Unqualified)	Other Additional Clinical Staff	Scientific & Technical (Qualified)
FTE Days Lost to Sickness (In month)	1587.35	330.55	503.06	3607.24	1960.18	214.67	478.78
FTE Days Available	36731.95	10015.47	38851.07	71687.47	18138.96	4902.71	8798.33
Staff Headcount	1240	357	766	2494	629	185	309
In Month Sickness Rate	4.32%	3.30%	1.29%	5.03%	6.40%	4.38%	5.44%
of which Short Term	2.21%	2.92%	0.80%	3.59%	3.72%	2.56%	2.76%
of which Long Term	2.11%	0.38%	0.49%	1.44%	2.68%	1.82%	2.74%
12 Month Sickness Rate	4.02%	3.28%	1.00%	4.59%	5.92%	5.01%	4.67%
Previous Months 1 Month Sickness Rate	4.87%	4.79%	0.85%	5.25%	6.25%	6.06%	5.22%
In Month Movement	-0.55%	-1.49%	0.45%	-0.22%	0.15%	-1.68%	0.23%

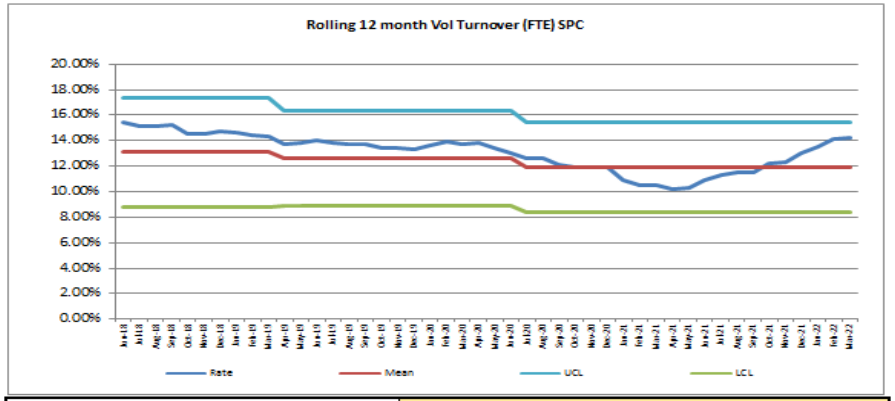
Highest Sickness Reason	In Month Episode %	Highest Sickness Reason	In Month FTE Lost %
S15 Chest & respiratory problems	25.10%	S15 Chest & respiratory problems	23.99%
S10 Anxiety/stress/depression/other psychiatric illnesses	13.13%	S10 Anxiety/stress/depression/other psychiatric illnesses	18.38%
S13 Cold, Cough, Flu - Influenza	12.74%	S98 Other known causes - not elsewhere classified	11.91%
S98 Other known causes - not elsewhere classified	10.42%	S12 Other musculoskeletal problems	7.55%
S25 Gastrointestinal problems	7.72%	S13 Cold, Cough, Flu - Influenza	6.32%

Sickness rates although remain high continue to reduce in line with the abating of the fourth wave of the pandemic during the month of March. Daily sickness reports to GOLD and to NWL have been recommenced but the Covid rates remain nominal. The impact is still highlighted in the reasons for sickness absence lead by chest and respiratory problems (where Covid is coded).

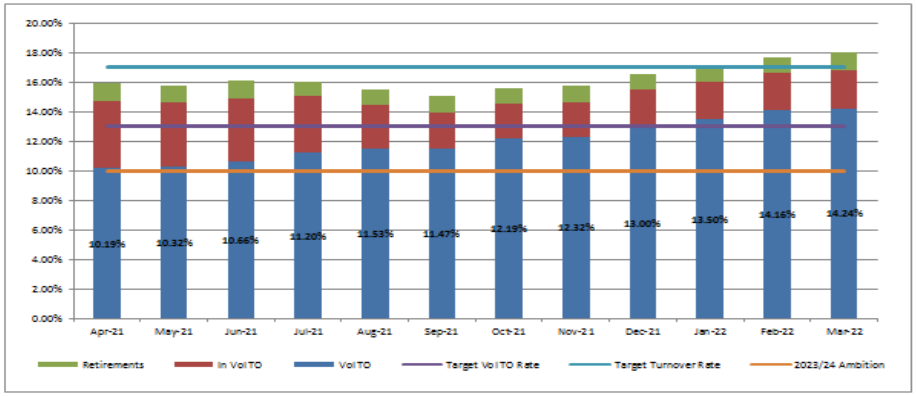
The second highest reason for absence in month by impact was Anxiety/stress/depression/other psychiatric illnesses and the Trust is proactively trying to manage health and wellbeing during a period where staff will be susceptible to burn out after the last 2 years of pandemic response.

People Plan - Looking after our people | ICS Goal 1 - Care

Performance Measure	2020/21 baseline	2023/24 ambition
Voluntary Turnover of Staff	18%	10%



SPC Variance Status	Within expected natural variance



Position against last month (1 Month)	higher
Position against last year (1 month Rate)	higher

Divisional	Trust	COR	CSD	EIC	ENT	PCD	WCH
Voluntary Leaves (FTE) in last 12 months	776.11	76.63	147.92	205.32	41.47	91.36	213.41
Voluntary Leaves (HC) in last 12 months	843	76	163	220	45	99	240
Voluntary Turnover Rate	14.24%	13.14%	15.32%	14.71%	23.42%	9.66%	14.66%
Retirement Rate	1.16%	1.65%	1.40%	0.66%	0.23%	1.19%	1.33%
Gross Turnover Rate	18.01%	19.14%	19.60%	16.99%	26.35%	13.80%	18.28%
Previous Vol TO Months Rate	14.16%	13.40%	14.90%	14.68%	24.69%	10.11%	13.95%
Movement	0.09%	-0.26%	0.42%	0.03%	-1.28%	-0.44%	0.71%
Last Years Vol TO Rate	10.50%	12.10%	9.80%	12.80%	12.10%	8.30%	9.50%
Movement	3.74%	1.04%	5.52%	1.91%	11.32%	1.36%	5.16%

Staff Groups	Administrative & Clerical	Allied Health Professionals	Medical & Dental	Nursing & Midwifery (Qualified)	Nursing & Midwifery (Unqualified)	Other Additional Clinical Staff	Scientific & Technical (Qualified)
Voluntary Leaves (FTE) in last 12 months	164.87	70.99	26.06	330.80	102.65	22.02	58.74
Voluntary Leaves (HC) in last 12 months	169	77	31	361	110	29	66
Voluntary Turnover Rate	14.03%	22.13%	4.08%	14.47%	17.49%	14.11%	20.55%
Retirement Rate	1.48%	0.31%	0.46%	1.20%	1.11%	1.93%	1.75%
Gross Turnover Rate	18.10%	24.93%	14.79%	15.89%	20.08%	25.30%	25.36%
Previous Vol TO Months Rate	13.90%	22.45%	3.76%	14.34%	17.83%	13.95%	20.65%
Movement	0.13%	0.32%	0.32%	0.13%	-0.34%	0.16%	-0.10%

Top 5 Vol Leaver Reasons	WTE Leavers in 12 Months	%
Voluntary Resignation - Relocation	445.60	31.38%
Voluntary Resignation - Other/Not Known	222.06	15.64%
Voluntary Resignation - Promotion	182.31	12.84%
Voluntary Resignation - To undertake further education or training	122.68	8.64%
Voluntary Resignation - Work Life Balance	135.12	9.51%

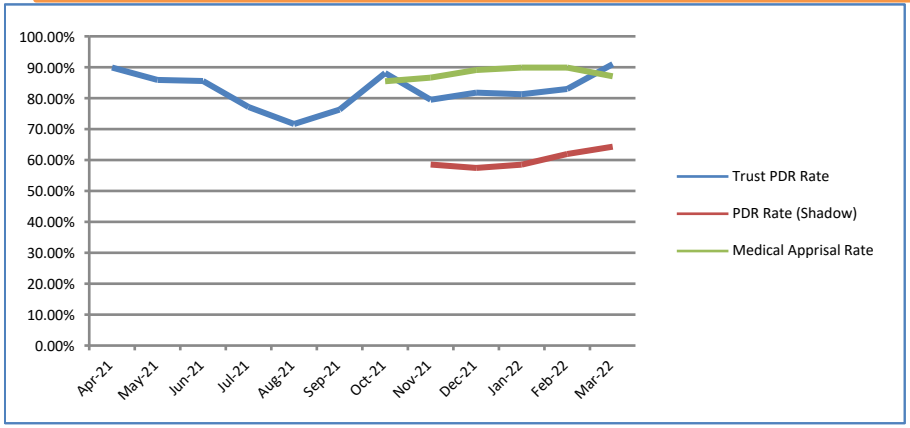
Turnover has continued to increase to 14.24%, this is higher compared to last year but the rate of increase has slowed materially and is back to being under the Sector position. Mobility of staff post pandemic and pressure on staff may be contributing to the higher rates. Focus on retention continues to be a key part of the Divisional business plans with focus on ODPs and Theatre nurses, Therapies and HCAs across the Divisions. Retention for HCAs, linking in with the mass recruitment plan for the Acute Collaborative in NWL is a priority for March and April with a large recruitment event being planned for the end of April. A Theatre Nursing recruitment day is planned for 23 April at CW. The Trust continues to develop a new staff recognition programme, engaging across various groups within the Trust, Staff Networks and Staff side to ensure an inclusive and impactful programme of activities.

People Plan - Looking after our people

ICS Goal 1 - Care

Appraisal Rates

Target – 90%



Month	Dec-21	Jan-22	Feb-22	Mar-22
A&C PDR Rate	79.31%	78.93%	80.73%	88.49%
AHP PDR Rate	72.43%	72.84%	75.83%	93.07%
Nursing (Q) PDR Rate	84.27%	83.05%	84.64%	90.69%
Nursing (UQ) PDR Rate	82.44%	83.25%	84.45%	93.01%
OACS PDR Rate	79.76%	81.50%	82.56%	93.89%
STT(Q) PDR Rate	82.33%	81.85%	83.78%	95.61%
A&C Shadow PDR Rate	49.36%	48.62%	51.78%	54.60%
AHP Shadow PDR Rate	52.30%	54.61%	58.15%	65.33%
Nursing (Q) Shadow PDR Rate	60.48%	61.90%	65.17%	66.60%
Nursing (UQ) Shadow PDR Rate	59.47%	61.69%	65.53%	68.04%
OACS Shadow PDR Rate	49.32%	52.08%	60.84%	63.23%
STT(Q) Shadow PDR Rate	72.59%	73.62%	75.81%	78.97%

Month	Dec-21	Jan-22	Feb-22	Mar-22
Trust PDR Rate	81.79%	81.27%	82.97%	91.01%
COR PDR Rate	78.10%	76.33%	77.02%	89.62%
CSD PDR Rate	80.74%	81.12%	83.44%	92.76%
EIC PDR Rate	82.73%	83.01%	84.79%	92.27%
ENT PDR Rate	84.52%	84.21%	88.14%	92.70%
PCD PDR Rate	87.03%	87.71%	88.96%	93.01%
WCH PDR Rate	79.58%	77.27%	78.84%	87.53%

Month	Dec-21	Jan-22	Feb-22	Mar-22
Trust PDR Shadow Rate	57.44%	58.50%	61.95%	64.31%
COR PDR ShadowRate	53.50%	53.40%	55.88%	61.93%
CSD PDR Shadow Rate	60.40%	60.19%	65.03%	65.99%
EIC PDR Shadow Rate	63.24%	66.20%	69.60%	71.85%
ENT PDR Shadow Rate	50.68%	60.14%	66.43%	71.53%
PCD PDR Shadow Rate	65.17%	68.18%	71.72%	75.24%
WCH PDR Shadow Rate	47.39%	45.53%	48.04%	48.79%

Month	Dec-21	Jan-22	Feb-22	Mar-22
Trust Med App Rate	89.10%	89.89%	89.89%	87.08%
CSD Med App Rate	86.96%	89.58%	89.58%	85.42%
EIC Med App Rate	88.24%	88.80%	88.80%	84.03%
PCD Med App Rate	89.17%	89.21%	89.21%	85.92%
WCH Med App Rate	90.19%	91.67%	91.67%	91.32%

The overall Trust position for non-medical appraisals increased materially by 8.04% to 91.01% which closes the final reporting month under the old methodology at target with no Division outside the acceptable tolerances. .

Appraisal reports are sent out to divisions on a monthly basis and targeted communications is sent out by the HRBP team in order to increase compliance. Compliance is further discussed in monthly HR meetings. PDR training is provided on a monthly basis. Operational pressures over the last 9 months need to be considered and moving into 2022/23 performance should be considered on an improvement trajectory to the target over a period of time.

The HRBP team are focusing on the shadow compliance and recovery plans before appraisal reporting changes in next month. Overall this has continued to see improvements but there is more work to do with divisions. It is notable that all divisions have targeted and made significant improvements in the last 4 months with the exemption of WCH. Forecasting indicated that only two areas (COR and WCH) would not achieve the target rate by the close of 2022/23 but the in month improvement in Corporate shows interventions following the last WDC are having an effect.

For medical staff, the overall Trust appraisal rates has fallen to 87.08% within acceptable tolerances but a material drop. Divisionally the rates for month 12 are between 84% to 92%. This is due to the number of appraisals overdue but these are being followed up by the Medical Workforce Team in line with Trust processes.

People Plan - Looking after our people

ICS Goal 1 - Care

Statutory and Mandatory Training Rates

Target – 90% (IG 95%)

Mar-22	Core Training			
Course	Last Month	This Month	Target	Trend
Core Training Rate	89%	90%	90%	↑
Theory Adult BLS	81%	81%	90%	→
Practical Adult BLS	78%	92%	90%	↑
Conflict Resolution - Level 1	95%	95%	90%	→
Equality & Diversity	92%	92%	90%	→
Fire	90%	90%	90%	→
Health & Safety	93%	92%	90%	↓
Infection Control (Hand Hygiene)	88%	88%	90%	→
Infection Control - Level 2	90%	91%	90%	↑
Information Governance	90%	91%	95%	↑
Moving & Handling - Level 1	89%	89%	90%	→
Moving & Handling - Level 2 Theory	88%	89%	90%	↑
Moving & Handling - Level 2 Patient	83%	83%	90%	→
Safeguarding Adults Level 1	90%	90%	90%	→
Safeguarding Adults Level 2	88%	89%	90%	↑
Safeguarding Adults Level 3	71%	73%	90%	↑
Safeguarding Children Level 1	92%	92%	90%	→
Safeguarding Children Level 2	91%	91%	90%	→
Safeguarding Children Level 3	75%	74%	90%	↓

	Last Month	This Month	Trend
TRUST	88%	90%	↑
Clinical Support Division	93%	91%	↓
Corporate Division	88%	89%	↑
Emergency & Integrated Care Division	87%	91%	↑
Enterprise Division	89%	92%	↑
Planned Care Division	88%	90%	↑
Womens, Childrens and Sexual Health Division	85%	89%	↑

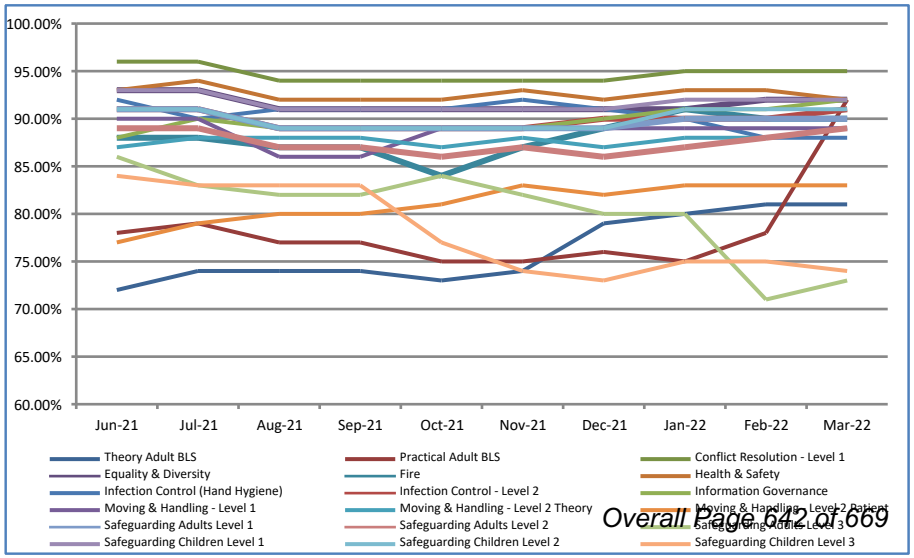
Overall compliance is **90%.**

Basic Life Support – Practical is currently at 78% - the team is currently recruiting into posts, once the team is up and running we should see compliance moving in the right direction.

Moving and Handling has maintained and is currently 83 %.The team had to cancel a few session in the month of Feb and a few in the upcoming months due to staff illness, once the team are back to full capacity we should see the number continue to increase.

Safeguarding Children & Adults Level 3 - Senior L&OD Information Analyst has had meeting with SMEs and will start looking into key areas in the Trust that need some support

IG is currently at 92% (national target 95%). Work is continuing to reach the national target, we have seen a 0.6% increase from the end of Feb. IG Lead is continuing to send targeted emails to Managers and Senior leaders to help cascade the message.

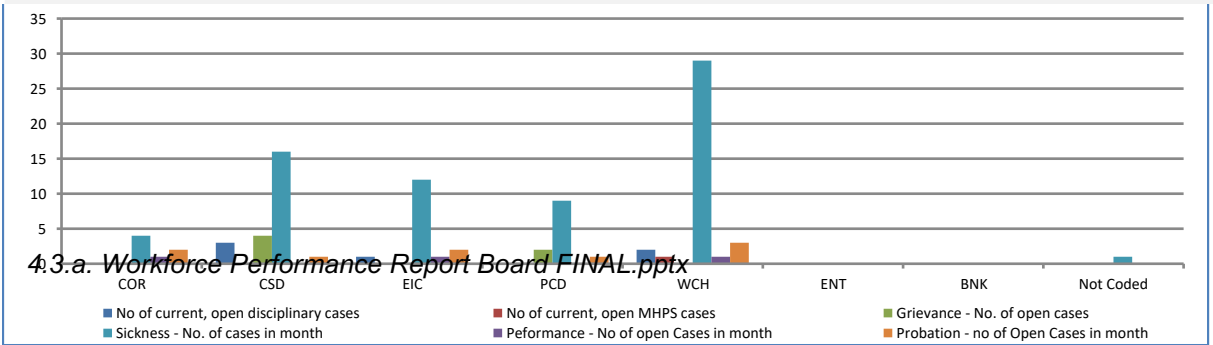


People Plan - Looking after our people

ICS Goal 1 - Care

Employee Relations

Category	Metric	Dec-21											
Non Medical Disciplinary		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
No of Disciplinary cases opened in month	Number	2	1	2	3	0	1	2	2	1	0	2	0
No of current, open disciplinary cases	Number								8	6	6	6	5
Average length of closed disciplinary cases (closed in the last 24 months)	Days <60	85.92	83.68	83.23	82.10	84.25	84.91	81.98	82.48	74.00	74.00	74.00	74.00
Average length of disciplinary Investigation	Days<30				21.00	30.00	34.30	31.28	57.00	46.86	45.83	49.83	55.66
Total Disciplinary cases opened in year (from April 21)	Number	2	3	5	8	8	9	11	13	14	14	16	16
% BAME Disciplinary Cases in year (from April 2021)	%	100.00%	66.67%	80.00%	87.50%	87.50%	88.89%	90.91%	92.31%	85.71%	85.71%	75.00%	75.00%
% BAME Disciplinary Cases opened in month	%	100.00%	0.00%	100.00%	100.00%		100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	0.00%
Exclusions - No. of live in month	Number									1	1	1	2
Medical Disciplinary		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
No of MHPS cases opened in month	Number	0	0	1	0	0	0	4	1	0	0	0	0
No of current, open MHPS cases	Number								5	1	1	1	1
Average length of closed MHPS cases (closed in the last 24 months)	Days <60	153.35	153.35	153.35	153.35	153.35	153.35	153.35	153.35	136.76	136.76	136.76	136.76
Average length of MHPS Investigation	Days<30				33.00	36.00	36.00	18.00	39.00	28.00	28.00	28.00	28.00
Total MHPS cases opened in year (from April 21)	Number	0	0	1	1	1	1	5	6	6	6	6	6
% BAME MHPS Cases in year (from April 2021)	%	-	-	0.00%	0.00%	0.00%	0.00%	40.00%	33.33%	33.33%	33.33%	33.33%	33.33%
% BAME MHPS Cases opened in month	%	-	-	0.00%	-	-	-	50.00%	0.00%	-	-	-	-
Exclusions - No. of live in month	Number									0	0	0	0
Grievance		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Grievance - No. of opened cases in month	Number	2	1	0	0	0	2	1	4	1	0	0	0
Grievance - No. of opened cases in year	Number	2	3	3	3	3	5	6	10	11	11	11	11
Grievance - No. of open cases	Number								6	6	6	6	6
Average length of closed grievance cases	Days	121.47	121.47	124.70	123.24	129.13	127.96	126.20	127.83	126.63	126.63	126.63	126.63
Grievances - % that are BAME Cases opened in month	%	0.00%	0.00%				50.00%	0.00%	75.00%	0.00%	0.00%	0.00%	
Grievances - % that are BAME Cases opened in year	%	0.00%	0.00%	0.00%	0.00%	0.00%	20.00%	16.67%	40.00%	36.36%	36.36%	36.36%	36.36%
B&H cases - included in grievance numbers (of those opened in year)	Number	1	1	1	1	1	1	2	4	4	4	4	5
Sickness		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Sickness - No. of cases opened in month	Number	18	8	12	12	9	11	22	18	19	21	9	12
Sickness - No. of open cases	Number								74	85	76	72	68
Long Term - sickness cases in month	Number	12	6	6	10	7	9	18	11	7	16	5	9
Short Term - sickness cases in month	Number	6	2	6	2	2	2	4	7	12	5	4	3
Ancilary		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
No. of Employment Tribunals (ET) active	Number	-	-	-	11	14	14	14	15	13	13	11	8
Staff attending ER training sessions in month aggregate	Number	-	-	-	84	84	92	92	98	98	110	132	333



There are currently 5 live disciplinary cases with 1 case closing since March 2022. The average length of disciplinary investigation has increased from **49.83** days to **55.66** days. There are currently 4 cases that exceed the KPI for case length i.e. **>60** . These 4 cases are complex disciplinary cases and have exceeded KPI due to a variety of issues, including complex legal issues and the need for specialist advice.

The following remedial actions have been taken:

- Case plans have been developed and additional time allocated to manage each case.
- Meetings have taken place with Commissioning Managers to review cases and delays.

The number of MHPS cases is **1** and the time frame for the current investigation is within KPI. The MHPS hearing has now taken place and a decision is being confirmed once further information has been sought. As a result the length of this open MHPS case is **86** days which is above the current KPI of 60 days. There are currently **6** open grievances. The general themes are around bullying, race discrimination, leadership and breakdown in relationships. The ER team have been working closely with managers to identify resolutions and schedule appropriate interventions for example mediation.

There are currently **68** active sickness cases under management. **12** new cases were opened in the month of March and 14 sickness cases closed since last month. There has been a slight increase in long term sickness cases. There are currently **8** Employment Tribunal (ET) cases which are currently managed by the Employee Relations Team. These claims relate specifically to issues pertaining to race discrimination, disability discrimination, unfair dismissal and whilst blowing. Since March, **3** ET claims have been closed. These ET cases have been dealt with by way of settlement. The number of ET case are currently reducing and risks to the Trust have been effectively managed. The outcomes to date remain positive by way of strong case management and early resolution where appropriate.

The ER team continues to engage in a programme of work to upskill managers on Essential Management Fundamentals. This training covers key skills in ER case management. The ER team have now trained **333** managers across the organisation. There has been positive feedback to this schedule of training.

People Plan - Belonging

ICS Goal 2- Lead/ Include

Performance Measure	2020/21 baseline	2023/24 ambition
Increase in the number of BAME staff 8a and above	Disproportionate – 3 grades not met	All grades meeting set targets

Projected Model Employer Targets	2019	2020	2021	2022	2023
Band 8a	74	78	82	86	90
Band 8b	25	27	29	31	33
Band 8c	10	11	12	13	14
Band 8d	6	6	7	7	8
Band 9	2	2	3	3	3
VSM	5	6	7	8	9

2021/22 Performance	2021/2 ambition	2021/2 current	Gap
Band 8a	82	86	+4
Band 8b	29	29	-
Band 8c	12	17	+5
Band 8d	7	4	-3
Band 9	3	2	-1
VSM	7	7	-

Divison	BAME Staff in Band 8A+ (Afc)	Staff in Band 8A+ (Afc)	Band 8A+ (Afc) BAME %	BAME Staff in Medical	Staff in Medical	Medical BAME %	Overall Staff Population BAME %
289 PDC Planned Care Division	10	43	23.26%	144	374	38.50%	55.53%
289 EIC Emergency & Integrated Care Division	28	105	26.67%	200	446	44.84%	55.12%
289 Enterprise Division	4	19	21.05%	1	11	9.09%	43.00%
289 CSD Clinical Support Division	43	89	48.31%	33	70	47.14%	52.00%
289 COR Corporate Division	35	141	24.82%	18	31	58.06%	44.41%
289 WCH Womens, Childrens and Sexual Health Division	10	66	15.15%	178	414	43.00%	39.54%
Trust	130	463	28.08%	574	1346	42.64%	49.21%

Factor	Current Month	Last Month	Start of Year
% of Diversity Champions on Band 8A+ Interview Panels	0.00%	20.00%	80.00%

Over the past month we have seen some progress on reaching our projected model employer targets . The notable shift has been in 8a roles and band 8c roles. For the 8a role we have achieved the model hospital target for the next year this year so we hall now aim for 90 for 22/23. The gap for 8c is far beyond the projected model employer targets of 12 as currently we are at 17 which surpasses the targets for 22/23 and 23/24.However our gap for band 8d has stayed the same from last month and this target has not been achieved at the end of this financial year. Our number of BAME staff in Senior Leader positions is currently 145 and our target is 140. The charts highlight our nationally set targets and how this is reflected across Divisions and by Agenda for Change and medical staff groups. To support BAME staff in to leadership positions across NWL the Trust has participated in the leadership ladder programme, supporting two staff seconded on to the programme, from Pharmacy and the Discharge team, who are undertaking two 6 month placements, at a band above the role they are employed in. The associate placements will begin their 2nd placements in April. We will also have two new associates start with us in April.

We still have a long way to go to improve our overall compliance ensuring a diversity champion is on interview panel. There has been a decrease of just of 20% since last month due to conflicting pressures to 0% which is the lowest it has been for the year and this is based on staff sickness absence and work pressures. We are hoping the launch of the new diversity champion role in 22/23 will eradicate this issue over time.

People Plan - New Ways of Working

ICS Goal 4- Transform

Performance Measure	2020/21 baseline	2023/24 ambition
Increase in the number of staff transitioning to qualified posts	<20	>70

Division	Number in Qualified Roles that were in unqualified roles 12 months before
289 PDC Planned Care Division	0
289 EIC Emergency & Integrated Care Division	0
289 WCH Women's, Children's and Sexual Health Division	0
289 CSD Clinical Support Division	0
289 COR Corporate Division	0
289 WCH Womens, Childrens and Sexual Health Division	0

Roles (Coded as per below)	Established (Mar 21)	Established Current	In Post (Mar 21)	In Post Current
Apprentice Nurse Associate	2.00	5.00	38.00	27.07
Nurse Associate (Qualified)	1.00	14.00	7.00	15.00
Advanced Clinical Practitioner (NMC)	0.00	0.00	0.00	0.00
Advanced Clinical Practitioner (HPC)	0.00	0.00	0.00	0.00
Physicians Assistant	6.00	4.00	6.00	3.00

The working group have met to discuss and an outline strategy is being developed which will then need consideration by the divisions to identify how they wish to implement in their areas. It is anticipated this work will be done by the summer.

People Plan - New Ways of Working

ICS Goal 4- Transform

Performance Measure	2020/21 baseline	2023/24 ambition
Flexible Working Staff Survey Score	56%	65%

Category	Metric	Number/%
Number of flexible working requests received since Sep 2021	Number	34
Disabilities	%	0%
%BAME - requested flexible working	%	56.00%
Average length arranging meeting	Days <28	TBC
Requests accepted	%	65.00%
Requests pending	Number	3
Requests rejected	%	27.00%
Number of appeals received in total	Number	4
Appeals accepted	Number	1
Appeals rejected	Number	TBC

The data for flexible working request is recorded as a rolling figure starting from September 2021. There have been an increase in the number of flexible working applications from **29** since the end of February 2022 to **34** at the end of March 2022.

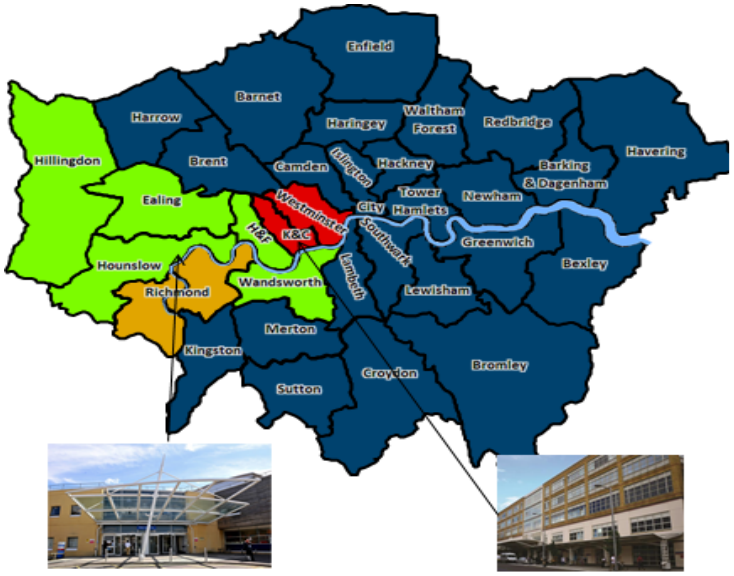
The majority of the applications continue to be made by female employees. The gender split is **28** female employees and **6** male employees. The total number of applications made by Black and Ethnic Minority (BME) employees has increased to **56%** compared to **52%** as at the end February 2022. The total number of applications accepted overall is **65%** at the end of March 2022. This represents an increase from **62%** at the end of February 2022. The number of flexible working requests subject to appeal is currently **4.** In addition, there are currently **3** applications awaiting a decision.

There continues to be a need to encourage more male employees to consider the Trust's flexible working options. The ER team will be looking at a communications campaign working with divisional managers to increase the understanding of the value of flexible working across the organisation.

People Plan - **Growing for our future**

ICS Goal 3- Grow

Performance Measure	2020/21 baseline	2023/24 ambition
Increased local employment	Not currently measured	10%
Utilisation of the apprenticeship levy	39%	70%



Narrative

The retention programme continues with a focus in April on roles within the PCN. On 12th April, 70 people attended a webinar designed to encourage mass vac workforce into roles including, care Coordinator, Admin and Wellbeing coaches and other Primary Care Vacancies. The event was hugely positive and had attendance from 3 Boroughs. The large scale ICS HCSW recruitment event is planned for 28th April aimed to encourage local applications to fill the high level of vacancies in these vital entry level posts. The initiation of an NHS reservists programme for NWL ICS continues, offering another opportunity for local community members to work within the NHS. We have received 79 candidates details sent from NHSE national expression of interest campaign and met the requirement to make first contact in 2 weeks of receipt.

Apprentices and Levy Update

Total Number of Apprentices:	192
EIC:	66
Planned Care:	35
WCH, HIV/GUM:	40
Clinical Support:	26
Corporate:	28

Levy Utilisation: 52%
As of: February 2022

Staffing % (substantive by Headcount on primary assignment by home addresses)

Divison	Ealing	Hammersmith and Fulham	Hillingdon	Hounslow	Kensington and Chelsea	Richmond upon Thames	Wandsworth	Westminster	Not local	Hounslow and K&C
289 PDC Planned Care Division	11.30%	11.88%	5.65%	20.15%	3.85%	4.91%	9.75%	1.88%	30.63%	24.00%
289 EIC Emergency & Integrated Care Division	11.02%	12.16%	6.51%	20.95%	4.22%	5.94%	8.33%	1.83%	29.05%	25.17%
289 Enterprise Division	9.50%	14.00%	0.50%	6.50%	6.00%	5.50%	15.50%	0.50%	42.00%	12.50%
289 CSD Clinical Support Division	15.43%	9.14%	7.05%	19.14%	3.62%	3.33%	7.24%	1.62%	33.43%	22.76%
289 COR Corporate Division	12.46%	5.17%	6.38%	9.88%	3.04%	2.74%	5.62%	1.22%	53.50%	12.92%
289 WCH Womens, Childrens and Sexual Health Division	11.32%	8.30%	5.03%	11.67%	4.18%	5.49%	9.32%	2.17%	42.51%	15.85%
Trust	11.95%	9.97%	5.85%	16.53%	3.98%	4.89%	8.63%	1.80%	36.46%	20.52%

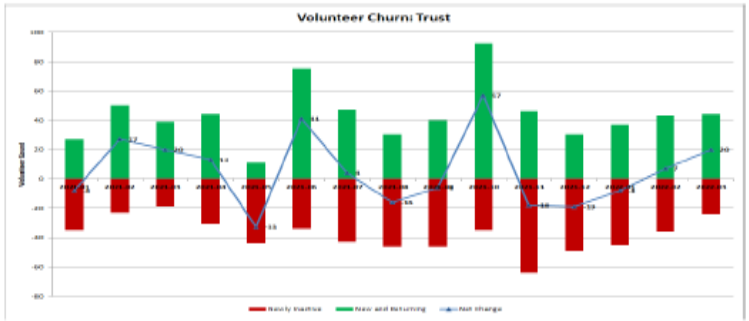
People Plan - **Growing for our future**

ICS Goal 3- Grow

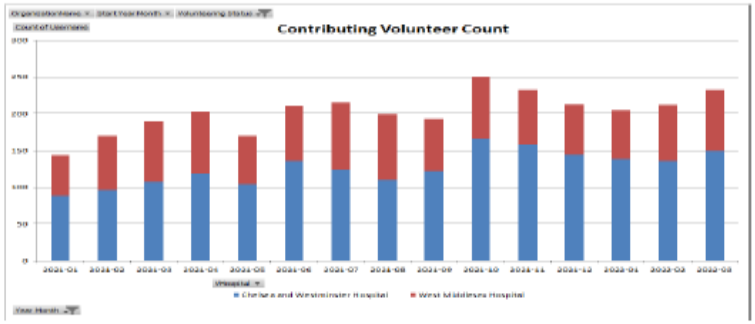
Volunteers	In March 232 volunteers contributed 3128 hours of volunteering to the Trust. There was an 18% increase in volunteering hours from February to March, and a 9% increase in numbers of active volunteers. Much of the increase was driven by increased activity in the volunteering partners such as the Friends and the Medicinema. The service has been working hard to help partners to restart their volunteering programmes. A new End of Life Care volunteering manager started and is in the process of launching a new volunteering programme to support patients who are end of life and their loved ones. Volunteers were deployed to strategic priority areas such as wards and outpatient departments. West Middlesex has seen an increase in volunteering activity, even though the volunteering manager at West Middlesex is still on long term sickness absence and the role is being covered by an interim manager through the staff bank. The post is only funded up until May 2022 so a longer-term solution may be needed. There was an ongoing sewage leak into the volunteering hub at Chelsea which continues to cause significant disruption to the service there for nearly a month. Estates have endeavoured to resolve but as no guarantee we have moved the offices around so if it reoccurs computers and documents hopefully will not be impacted. We are using the opportunity to refresh the Hub and make it more user friendly for staff and volunteers.

Trust Summary

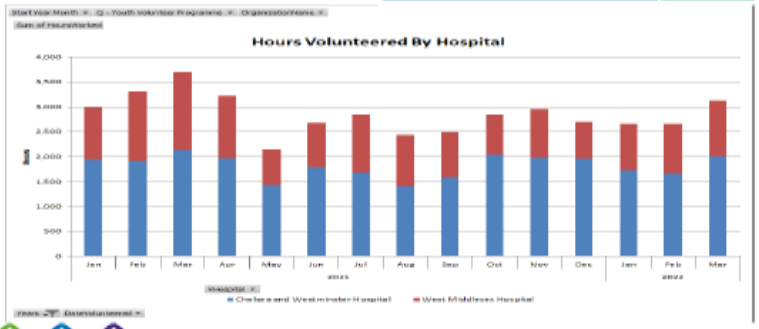
Change on Last Month +20

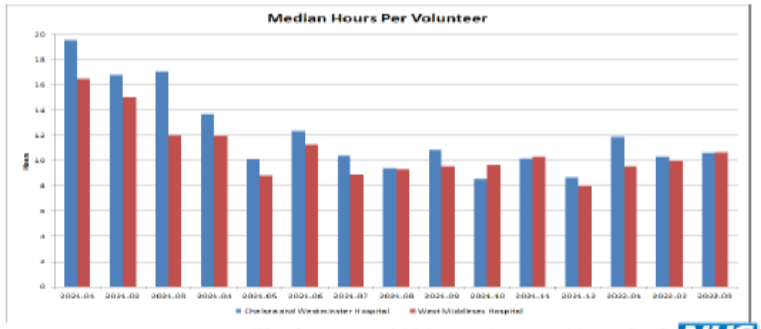


Change on Last Month +9%



Change on Last Month +18%



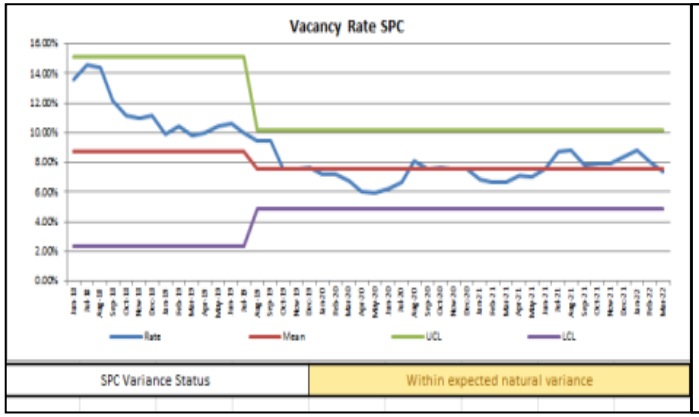


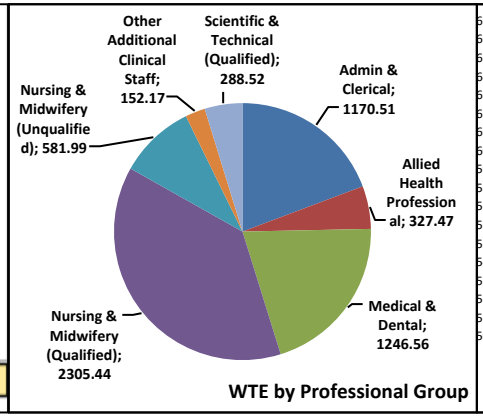
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

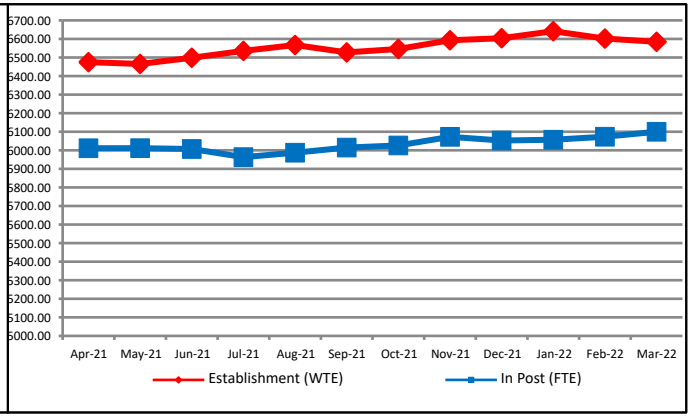
People Plan - **Growing for our future**

ICS Goal 3- Grow

Performance Measure	2020/21 baseline	2023/24 ambition
Reduced vacancy rates by Core Professions	N&M 5.5% M&D 3.5% AHPs 6%	N&M 5-8% M&D <5% AHPs <7%







The Trust vacancy rates remain within expected statistical variances. Establishments fell between March and February 2022 by 17.41FTE. During that same period there was a increase in the Trust in post FTE of 26.74FTE. The combination of reducing establishment and higher in post has driven the vacancy rate down to 7.36%.

Qualified nursing rates although are within the overall Trust target value remains outside the stretch targets in the people plan. It is notable however that the position has improved materially over the last 3 months but is forecast to remain outside of the stretch target over the next 3 months unless retention rates improve.

Support to nursing remains high at 17.60% but has improved over the last quarter. We know however that we are forecast to be over established at band 2 within 3 months whilst carrying significant vacancies at band 3.The unqualified staffing rates have been discussed at previous committees and is a known issue locally and nationally that has a plan to address the rates with refining recruitment quality and ensuring enhanced support to prevent avoidable retention issues. With supply pool at band 2 level, either a grow our own or skill mix reviews linked to safer staffing models maybe required. Other clinical support levels also remain high but have seen a material improvement of circa 5% within 3 months.

The AHP vacancy rates are deteriorating and are outside the stretch targets in the people plan. So need a focus in the 2022/23 period.

Month	Dec-21	Jan-22	Feb-22	Mar-22	Target Rate
Trust Rate	8.35%	8.80%	8.01%	7.36%	
COR Rate	-0.19%	3.43%	4.11%	3.74%	
CSD Rate	12.86%	13.41%	10.26%	9.31%	
EIC Rate	8.73%	8.78%	7.70%	6.39%	**10.00%**
ENT Rate	9.63%	8.78%	7.56%	7.87%	
PCD Rate	6.79%	6.41%	6.66%	6.50%	
WCH Rate	8.90%	9.45%	9.31%	8.98%	

Month	Dec-21	Jan-22	Feb-22	Mar-22	Target Rate
A&CRate	11.11%	10.92%	8.16%	7.77%	**10.00%**
AHP Rate	4.77%	5.97%	7.04%	7.36%	**5.00%**
Med Rate	-2.53%	-1.82%	-1.42%	-2.43%	**5.00%**
Nursing (Q) Rate	8.13%	8.75%	8.48%	8.06%	**5.00%**
Nursing (UQ) Rate	19.23%	20.07%	17.99%	17.60%	**8.00%**
OACS Rate	21.82%	19.57%	19.13%	15.63%	**10.00%**
STT(Q) Rate	11.63%	12.25%	12.14%	10.07%	**10.00%**

People Plan - **Growing for our future**

ICS Goal 3- Grow

Recruitment Data for non-medical

Performance

Metric	Units	Status	Avge YTD	Last mth	This mth
Advert published		**target > 2 days**			
Corporate	avge.	days	0.4	0.0	0.0
CSS	avge.	days	0.4	0.6	0.3
EIC	avge.	days	0.3	0.6	0.8
PCD	avge.	days	1.3	1.9	0.4
WCH	avge.	days	0.6	1.2	0.5
Total	avge.	days	**0.5**	**0.9**	**0.4**
Shortlisting sent		**target > 1 day**			
Corporate	avge.	days	1.4	1.0	1.5
CSS	avge.	days	1.0	1.0	1.2
EIC	avge.	days	1.0	1.2	1.0
PCD	avge.	days	1.2	1.3	1.0
WCH	avge.	days	1.0	1.2	1.0
Total	avge.	days	**1.1**	**1.1**	**1.2**
Arrange interview		**target > 2 days**			
Corporate	avge.	days	0.2	0.2	0.0
CSS	avge.	days	0.3	0.4	0.4
EIC	avge.	days	0.2	0.3	0.1
PCD	avge.	days	0.5	0.5	0.8
WCH	avge.	days	0.3	0.2	0.5
Total	avge.	days	0.3	**0.3**	**0.4**
Offer issued		**target > 2 days**			
Corporate	avge.	days	0.7	0.7	0.7
CSS	avge.	days	0.8	0.8	1.2
EIC	avge.	days	0.6	1.7	0.5
PCD	avge.	days	0.8	0.6	0.3
WCH	avge.	days	1.1	1.5	0.8
Total	avge.	days	**0.8**	**1.2**	**0.8**
Pre-employment checks		**target > 20 days**			
Corporate	avge.	days	12.4	10.3	12.1
CSS	avge.	days	18.5	19.1	23.7
EIC	avge.	days	15.0	29.5	15.2
PCD	avge.	days	24.1	59.5	30.0
WCH	avge.	days	20.1	29.0	22.0
Total	avge.	days	**16.9**	**28.6**	**17.6**
Time to hire		**target > 9 wks**			
Corporate	avge.	weeks	7.0	8.0	7.4
CSS	avge.	weeks	8.7	8.4	7.3
EIC	avge.	weeks	7.2	8.1	7.5
PCD	avge.	weeks	9.0	6.4	8.5
WCH	avge.	weeks	8.7	9.7	9.5
Total	avge.	weeks	**7.90**	**8.06**	**7.66**

Process times

Metric	Units	Status	Avge YTD	Last mth	This mth
Authorisation start to final approval					
Corporate	avge.	days	25.6	37.6	4.7
CSS	avge.	days	32.3	25.9	37.5
EIC	avge.	days	24.3	15.2	12.1
PCD	avge.	days	27.2	19.6	41.0
WCH	avge.	days	33.0	75.8	14.7
Total	avge.	days	29.7	44.2	23.0
Time taken to shortlist					
Corporate	avge.	days	8.1	6.0	3.4
CSS	avge.	days	6.7	4.7	6.0
EIC	avge.	days	5.4	3.5	4.0
PCD	avge.	days	5.3	2.9	5.4
WCH	avge.	days	5.7	4.3	4.3
Total	avge.	days	**6.2**	**4.4**	**4.8**
Interview date to informing recruitment team					
Corporate	avge.	days	2.7	2.3	4.0
CSS	avge.	days	3.0	3.4	4.4
EIC	avge.	days	1.5	1.4	2.0
PCD	avge.	days	1.1	1.5	1.0
WCH	avge.	days	2.4	1.1	2.0
Total	avge.	days	**2.3**	**2.2**	**2.9**



Metric	Units	Avg 12mth	Last mth	This mth
Vacancy created				
Corporate	no.	27	20	31
CSS	no.	35	39	33
EIC	no.	29	25	22
PCD	no.	29	32	15
WCH	no.	42	47	39
Mass recruitment	no.	4	3	13
Total	no.	166	166	153
Advertised vacancies				
Corporate	no.	28	24	45
CSS	no.	37	50	48
EIC	no.	29	36	26
PCD	no.	23	33	24
WCH	no.	44	50	57
Mass recruitment	no.	4	3	13
Total	no.	165	196	213
Offers made				
Corporate	no.	20	16	16
CSS	no.	34	31	53
EIC	no.	34	30	32
PCD	no.	24	21	30
WCH	no.	45	28	86
Mass recruitment	no.	7	15	20
Total	no.	164	141	237

March saw a rise in the number of vacancies advertised, from 196 to 213. There was a positive increase in the number of offers made seeing an increase of 96 from February, achieving a total of 213. The number of applicants recruited into post was 153, compared to 166 in February. The team continue to perform well further reducing the Time to Hire KPI from just over 8 weeks in February to 7.6 weeks in March. We continue to be impacted by the high volume of Visa applications which has led to a delay in our overseas applicants starting. This, in the main, has impacted our Nursing and Midwifery and Medical candidates although more recently a small pipeline of Radiographers.

As part of our programme of work to address our HCSW gap we are participating in a large scale recruitment even taking place at Lords cricket ground on the 28th April. Our clinical and HR teams will be supporting the event with interviews conducted and offers issued on the day. This event is designed to encourage new applicants into care and we will be targeting out apprenticeship and Band 2 entry routes. The collaborative AHP recruitment targeting overseas applicants is also underway with the first round of interviews scheduled to take place over the coming weeks.

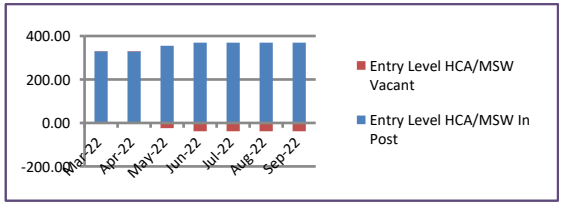
The recruitment team has recently interviewed for Band 4 Recruitment coordinators and we are delighted that we have sourced two applicants that will be joining the team over the next 6 weeks. This will support the increase in recruitment activity and ensure that the divisions have a dedicated point of contact.

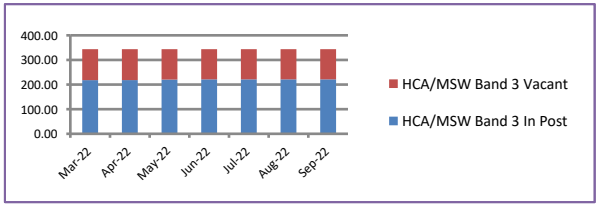
People Plan - **Growing for our future**

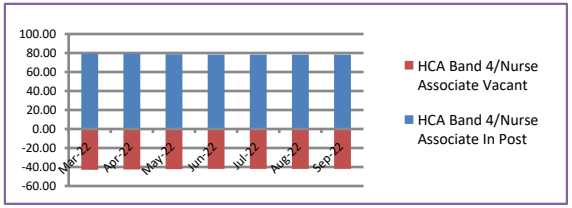
ICS Goal 3- Grow

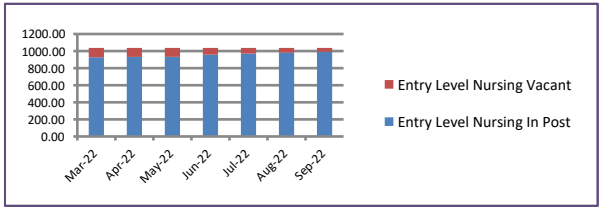
Nursing Pipeline Forecast

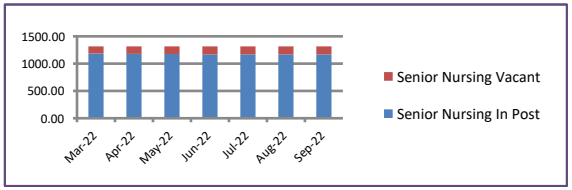
Band	Budget	In Post	Vacant FTE	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Apprentice	20.60	37.20	-16.60	38.53	50.37	57.37	57.37	57.37	57.37
Band 2	310.47	292.45	18.02	290.80	304.64	311.99	311.99	311.99	311.99
Band 3	343.75	218.06	125.69	218.21	220.37	221.19	221.19	221.19	221.19
Band 4	36.34	79.29	-42.95	78.96	78.63	78.29	78.29	78.29	78.29
Band 5	1036.98	927.40	109.58	931.84	932.28	957.28	970.28	981.28	992.28
Band 6	869.07	728.46	140.61	723.10	720.73	717.04	717.04	717.04	717.04
Band 7	446.71	456.23	-9.52	455.62	455.01	452.07	452.07	452.07	452.07











Support to Nursing

As can be seen in the close of Mar and continued forecast, although the Trust is carrying significant vacancies at Band 3 level, we are over established in the band 2/Apprenticeships and band 4 level. It has been identified under the new ways of working work stream that longer term planning of clinical models and establishments is required both to support the current pathways for ANAs is needed. The band 2 level will not account for the closure of current apprentices so is not a cause for concern however the need to establish the band 4 Nurse Associate roles within service line budgets is more pressing. Any push to recruit to band 2 roles beyond covering turnover from this point however will exacerbate the issue and would need for establishment reviews. Overall, between apprentice to band 4 unqualified posts , the best case scenario with a steady turnover rate and no withdrawals from the pipeline would be a reduction to a vacancy rate to 5.95% within 3 months but retains the imbalance in skill mix.

Qualified Nursing

The Trust has currently has 96 band 5 nurses in the recruitment pipeline and a further 89 in the international nursing pipeline. Accounting for a steady turnover rate ,internal appointments to band 6s and a nominal withdrawal factor from the pipeline we should be able to hit target vacancy rate of 5%. The focus in this area must be on retention efforts.

The picture on the band 6/7 Senior nursing posts differs with the projection of more leavers than starters due in the recruitment pipeline. The overall vacancy rate for Qualified Nursing is likely to over the next 3 months remain outside the 5% stretch target.

Entry Level HCA/MSW – Band 2 and Apprentices
HCA/MSW Band 3s – Band 3
HCA Band 4/Nurse Associate – Band 4
Entry Level Nursing – Band 5
Senior Nursing – Bands 6 and 7

Methodology:
Close of Month base position for In post and establishment, assume the establishment remains stable
Inflows:-
International Nursing Pipeline- Assumes all successful with arrival dates are deployable at 1.0 FTE per capita
Recruitment Pipeline:- Assumes not withdrawals from current pipeline, those with set start dates coded to the forecast month, those without start dates in place split between M2-M3 of the forecast
Outflows:- Assumes the average monthly leavers from last rolling quarter project forward to M1-3

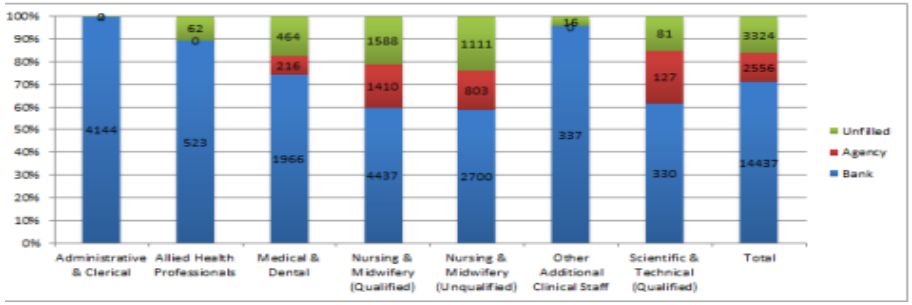
People Plan - **Growing for our future**

ICS Goal 3- Grow

Bank and Agency

Division	Bank	Agency	Unfilled	Total Requested	Bank Fill Rate	Overall Fille Rate
COR	1332	114	71	1517	87.80%	95.32%
CSD	2975	39	139	3153	94.35%	95.59%
EIC	3960	1364	1474	6798	58.25%	78.32%
ENT	188	20	20	228	82.46%	91.23%
PDC	3310	739	657	4706	70.34%	86.04%
WCH	2403	258	866	3527	68.13%	75.45%
Total	14437	2556	3324	20317	71.06%	83.64%

Group	Bank	Agency	Unfilled	Total Requested	Bank Fill Rate	Agency Fill Rate	Unfilled rate	Overall Fille Rate
dministrative & Clerical	4144	0	2	4146	99.95%	0.00%	0.05%	99.95%
llied Health Professionals	523	0	62	585	89.40%	0.00%	10.60%	89.40%
fedical & Dental	1966	216	464	2646	74.30%	8.16%	17.54%	82.46%
lursing & Midwifery (Qualified)	4437	1410	1588	7435	59.68%	18.96%	21.36%	78.64%
lursing & Midwifery (Unqualified)	2700	803	1111	4614	58.52%	17.40%	24.08%	75.92%
ther Additional Clinical Staff	337	0	16	353	95.47%	0.00%	4.53%	95.47%
cientific & Technical (Qualified)	330	127	81	538	61.34%	23.61%	15.06%	84.94%
otal	14437	2556	3324	20317	71.06%	12.58%	16.36%	83.64%



Demand for temporary staff saw an increase in March which we expect to see replicated in April over the Easter period. AHP requests have increased as a result of the vacancy rate seeing an increase. We continue to work with clinical areas to identify longer lines of work, with the focus to fill with bank / Framework agency offering consistency in addition to minimising cost.

Nursing and Midwifery (Unqualified) demand continues to be high, as expected. A targeted bank recruitment plan is being developed in addition to an auto enrolment process for all HCSW's recruited at a large scale event on the 28th April. Our Medical temporary staffing demand is also comparable year on year, although agency has increased to 8% this month. This is a combination of a greater increase in Agency requests (particularly long term requests) and a reduction in bank by staff.

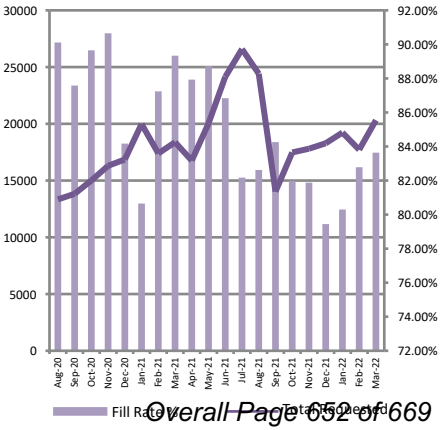
The Nursing Collaborative Bank was launched on 1st February for all acute Trusts in the North West London ICS. Whilst this has been communicated internally and externally on social media etc we would acknowledge that further engagement and proactive comms messaging is still required. For a bank worker to join the collaborative bank they are required to download the Patchwork App and 'opt in'. Enhancements are being made to this process to make it easier for bank workers to navigate to ensure that the registration numbers build. For Nursing and Midwifery to date we have 145 staff onboarded (This performance is currently 2nd out of the 4 participating trusts), with 18 shifts worked across 4 Trusts. CW continue to lead with 11 Shifts worked (4 workers from LNW and 1 from ICH) .

Tender documentation is being finalised for he procurement of a new Master Vend supplier. This is a joint procurement process with The Royal Marsden. Supplier Engagement events are scheduled to take place week commencing the 9th May with the contract award scheduled by the 29th July 2022.

Monthly shifts requested on Healthroster and Patchwork (Bank/Agency/Unfilled) by lead time (when the shift was booked in relation to start date).

Lead Time	Bank	Agency	Total Filled	Shifts %	Unfilled	Type
Minus 30 and Over	5	1	6	0.04%	1	Retro
Minus 15-29	110	14	124	0.73%	15	
Minus 8-14	259	40	299	1.76%	13	
Minus 7	203	5	208	1.22%	8	
Minus 6	241	4	245	1.44%	8	
Minus 5	313	7	320	1.88%	7	
Minus 4	351	16	367	2.16%	6	
Minus 3	349	14	363	2.14%	7	
Minus 2	427	16	443	2.61%	15	
Minus 1	970	328	1298	7.64%	284	
Same Day	1165	471	1636	9.63%	732	Same Day
1-3 Days Notice	2127	659	2786	16.40%	708	Very Short Notice
4-7 Days Notice	1685	377	2062	12.14%	480	
8-14 Days Notice	1521	282	1803	10.61%	335	Short Notice
15-30 Days Notice	2058	165	2222	13.08%	373	Medium Notice
Over 30 Days Notice	2645	162	2807	16.52%	373	Long Notice
Total	14429	2560	16989	100.00%	3324	

REQUEST REASON	BANK	AGENCY	TOTAL FILLED	SHIFTS %	Unfilled
Annual Leave	15	0	15	0.4%	3
Covid Operational	58	3	61	1.7%	5
Covid Sickness/Isolation Cover	135	17	152	4.1%	25
Mat Leave	28	3	31	0.8%	6
Other	18	0	18	0.5%	0
Other Leave	0	1	1	0.0%	0
Private Patients	24	4	28	0.8%	0
Sickness Cover	199	70	269	7.3%	84
Specialling	196	178	374	10.2%	92
Study Leave	62	4	66	1.8%	2
Vacancies	1337	138	1475	40.2%	117
Workload	1156	27	1183	32.2%	30
Total	**3228**	**445**	**3673**	**100%**	**364**



HR Programme Updates

Looking After Our People

Health & Wellbeing

During March the team have now concluded participation in the Health and Wellbeing Framework Trailblazer project with NHSE&I. This is included being part of a small national collective piloting the new Health and Wellbeing Framework, which came with £5,000 of funding to support our H&W programme. The team will now continue completing this piece of work with the London reginal team as NHSE&I embed this framework across England.

The team offered support to the Women's Network on International Women's day, including hosting a mindfulness session. The day of activities was well received by those staff who engaged on the day.

The team continued to be on the road again and this month engaged with all key sites. Two wellbeing sessions were held at Dean Street, an action from the visit was to organise a Bike Dr day for our cycling staff at this site. The team also visited Chelsea, 10HB and WestMid with fruit trolleys to promote the H&W programme with our hard-to-reach staff - another successful engagement reaching 500+ staff.

A further four wellbeing champions were trained, bringing our total to 70 across the Trust - another training date will be held on 5th April. We have renewed our contract with our mental health first aider provider and are now planning the next round of training - 16 staff have been offered a place on the May training dates. Over the next year we will trained another 64 MHFAs and we will also provide refresher training for those trained during 2020 to mid 2021.

We are now planning our next Schwartz Round to be held at the Chelsea site in May. We have four staff identified to become facilitators, which will help us embed the programme at our WestMid site. We will [illegible] Dean Street site.

Belonging

Diversity & Inclusion

Key highlights in the month include the Research Department continuing looking at ways to improve diversity and inclusion in research and are currently formulating their EDI action plan. The staff network chairs have agreed to contribute to a video to raise awareness and improve engagement with staff across all of the networks. It is envisaged that the video will be included as part of the Trust induction for all new employees into the Trust and also be available on both the Trust intranet and internet pages. Working with the Head of Resourcing we will be looking at how to improve and strengthen interview feedback for all internal applicants applying for roles with the organisation. Including EDI metrics as part of divisional performance reporting process is one of the ongoing aims to increase engagement with EDI at divisional level. The results of the NHS national staff surveys are now widely available and meetings are being planned to review these in detail through various forums. Work has also began to produce the Trust annual Workforce Equality and Diversity Report which will include the latest results for our Workforce Race Equality Standard, Workforce Equality Disability Standard as well as information on the composition of staff within the Trust as well as analysis of recruitment and employee relations activities. The LGBT+ staff network will relaunch in early April with a new chair.

Our proposal and job description for a new associate post as part of the ICS leadership ladder programme was accepted and the candidates were interviewed in March. The new role of Experience and Involvement Project Manager for 6 months starts on 4th April 2022. There other position offered Lead Nurse Workforce Development will continue from April till September. We have built in some key improvements from learning from the first cohort of associates so that we have a richer amount of learning.

New Ways of Working

Organisational Change

In March, two formal consultations closed affecting 21 staff. Of which, 15 M&D staff in Urology will commence a cross site on-call rota following job planning. Six members of staff in IT have moved into a new structure in the Integration team.

In addition, work continues around the wholly owned subsidiary in Pharmacy with an incoming TUPE of 17 staff that went live on 4th April 2022. This was a successful TUPE and plans are on track to ensure the staff are paid correctly on their first pay date of 25th April 2022. Work continues around the set up including HR Information System, NEST Pension, Policies and Procedures and to ultimately become an employer of choice.

Informal work is ongoing around NICU resident and non-resident rotas with a formal change process expected to be launched on 21st April. The commissioners have put the Sexual Health Herts service out to tender which Chelwest currently employ 6 Consultants to provide this service and may result in TUPE dependant on who is awarded the contract as part of the tendering process. The virtual North West London Children's Hospital went live from 1st April 2022, with work ongoing to determine collaborative Ops structures across Imperial and ChelWest during April, as well as to continue the engagement piece with affected Paediatric staff across both Imperial and Chelwest, as well as with StaffSide Reps.

HR Programmes Updates

Looking After Our People

Health & Wellbeing

In 2020 our hospital charity CW+, offered a group of staff an opportunity to attend a wellbeing retreat as a thank you from a donor. The project has had various delays and cancellations due to COVID but we are now in a position to send staff on the trip. Planning is underway to send the first cohort of staff in May, with future dates being held during the summer months. The trip has been offered to staff who had received psychological support during 2020 and were happy for their details to be shared with HR.

The team were also a finalist at the HSJ awards in a new category supporting health and wellbeing, we were shortlisted along with 8 other finalists for our Back up Care project with Bright Horizons - offering 10 days free back up care to staff with caring responsibilities. Sadly, the project did not win in the category but to be shortlisted was a great achievement.

Belonging

Leadership & Development

March saw the launch of NWL ICS pension seminars which have been well received across the ICS. At the end of March 18 colleagues had signed up to these sessions. Promotion and communication of these sessions will continue in April to try and increase sign up.

The Emerging Leaders Cohort 18 completed their programme 8th March, with Cohort 19 starting on 10th March and had three days together across the month. Management Fundamentals has continued with sessions on Influencing & Collaboration, Management vs. Leadership, Team Work and Motivation, and PDR.

The second placement of the NWL ICS Leadership Ladder programme starts at the beginning of April and the team have been working hard to make all of the arrangements for this.

New Ways of Working

E- Rostering

The Project is into the third (and final) stage, to layer in Consultant rota and medical daily activity. Individual Medic Online and HealthRoster login details and accounts will remain the same. Consultants are being asked to engage with Divisional/Service leads to ensure job plans are up-to-date and on-call rotas are available. Implementation due to fully complete by August 2022.

Medical Transformation Programme

Progress on the various workforce streams under this programme has been challenged due to staff absence and turnover. With 2 further staff leaving Trust employment at the end of April including the current Head of Medical Workforce, a review of priorities is underway regarding the delivery of this programme and the delivery of BAU in the next few months leading up to the junior doctors rotations in August – October 2022 (this is one of the busiest periods for the Medical Workforce Team). Recruitment for a new Head of Medical Workforce (AfC 8a) is currently underway and a new Interim Associate HR Director started in post at the beginning of April whose portfolio includes senior oversight of Medical Workforce.

Discussions are underway with Imperial College Healthcare NHS Foundation Trust and Imperial College Medical School regarding the new National Clinical Impact Awards (NCIA) round scheduled to open nationally on 27.04.22. Both Trusts and the Medical School will be working together to ensure there is alignment between the three organisations in the management of this new award scheme

HR Programmes Updates

Growing For Our Future

In addition to work under the mass vaccination retention programmes we continue to lead and engage with a number of collaborative initiatives across the ICS under the **GROW** Pillar of the ICS People Plan.

HCSW
The large scale ICS HCSW recruitment event is planned for 28th April aimed to encourage local applications to fill the high level of vacancies in these vital entry level posts.

Reservists
The initiation of an NHS reservists programme for NWL ICS continues, offering another opportunity for local community members to work within the NHS. We have received 79 candidates details sent from NHSE national expression of interest campaign and met the requirement to make first contact in 2 weeks of receipt.

NWL Academy
The development of the NWL Academy is increasing in pace with a project plan developed for delivery. The aim of the project is that 1750 people are supported to achieve employment in health, with a focus on underrepresented and disadvantaged groups in our local communities.

NWL Collaboration

NWL OH service

The NWL OH integration is continuing to work through the stages of the pilot stage of the business case. The service is currently running in-house with a managed service agreement in place to enable cross sector working and adoption of best practice. Our in-house OH team are continuing to work with CNWL on key activities to enable the service to be SEQOSH accredited. The V10 transition to the new COHORT (OH system) which sees all prototype partners of NWL on the same version of Cohort has a go live of 4th July.

Payroll services

The transfer of our Payroll service from SBS to ICHT went ahead on 1st April 2022 as planned. There have been teething problems with weekly payroll as a result of bank volumes, SBS legacy issues and ESR system issues which led to a delay in payment for timesheet submitted to 11th April. These were not paid on the 14th April as planned but on 19th April. Mitigating actions have been taken to avoid a recurrence of the issues. Initial staff feedback from interactions with ICHT Payroll team have been positive, with reports of quick turnaround to queries. ICHT are identifying historical issues arising form the SBS contract and taking steps to rectify, which will create some challenges in the short term but will ensure a more accurate payroll provision for employees in future.

Digital Innovation
We continue to develop a project to introduce Robotic Process Automation for a number of HR transactions. We are working with the Acute Collaborative to consider the pooling of resources (Blue Prism) to maximise the value of the project and increase the potential number of processes we can automate and improve. This will support our revised HR operating model and improve services to employees and managers.

COVID Specific

Mass vaccination/Lead Employer

Phase 4 of the mass Vaccination programme is taking shape. A number of key roles have been extended to March 2023 to bring stability to the workforce. The role of the vaccinator is being extend to 'make every contact count' with plans underway for recruitment to and additional development for these 'super vaccinator' roles.

Retention
The retention of the mass vaccination workforce programme continues with a focus in April on roles within the PCN. On 12th April, 70 people attended a webinar designed to encourage mass vac workforce into roles including, care Coordinator, Admin and Wellbeing coaches and other Primary Care Vacancies. The event was hugely positive and had attendance from 3 Boroughs.

March was Webinar Month with webinars run daily for the mass vaccination workforce, on Interview Skills, Application Support, Terms and Conditions, Bank terms. A Lead Career advisor has been recruited to strengthen relations with NWL Trusts and improve access to vacancies

The retention team are working with ChelWest to identify cohort of 30 staff to be put forward for recruitment to HCA Apprenticeships as part of the Trusts HCA project.

A Lead Career advisor has been recruited to strengthen relations with NWL Trusts and improve access to vacancies

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Trust Board of Directors (Public) 5th May 2022

AGENDA ITEM NO.	4.4
TITLE OF REPORT	Learning from deaths: mortality report Q4 2021-22
AUTHOR NAME AND ROLE	Alex Bolton, Associate Director of Quality Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Roger Chinn, Chief Medical Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	This paper provides an update on the process compliance, key metrics and outcomes arising from the mortality screening and review process.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Quality Committee; Date of Meeting: 03/05/2022; Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Trust remains one of the best performing in terms of relative risk of mortality with a Trustwide SHMI of 72.96 for period January 2021 – December 2021. This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality: • West Middlesex University Hospital: SHMI value 76.17 (1034 expected deaths, 788 observed deaths). • Chelsea and Westminster Hospital: SHMI value 65.93 (710 expected deaths, 485 observed deaths) It is the Trust's target to screen 100% of all in-hospital adult and child deaths and to undertake full mortality review on no less than 30% of cases. During the last 12 months 83% of in-hospital adult and child deaths have been screened and 33% have undergone full mortality review.

	During Q4 69% of in-hospital adult and child deaths have been screened and 17% undergone full mortality review. During this period 6 cases with areas of sub-optimal care, treatment or service delivery were identified but none of the issues identified impacted the outcome to the patient. Where the potential for improvement is identified learning is shared at Divisional review groups and presented to the Trust-wide Mortality Surveillance Group; this ensures outcomes are acted upon and learning is cascaded.
KEY RISKS ARISING FROM THIS REPORT	• Delayed mortality review closure could lead to missed opportunities to addresses weakness in service delivery. The Mortality Surveillance Group monitors process compliance.

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y	
Be the employer of Choice		
Deliver better care at lower cost		

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	
Equality And Diversity	
Quality	Y
People (Workforce or Patients/ Families/Carers)	
Operational Performance	
Finance	
Public Consultation	
Council of Governors	

please mark Y/N – where Y is indicated please explain the implications in the opposite column

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.

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT)	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**

Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Mortality Surveillance

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

The Trust's mortality surveillance programme supports overarching service improvement and offers assurance to our patients, stakeholders, and the Board that the causes and contributory factors of patient deaths have been considered and appropriately responded to in an open and transparent manner.

2. Process

All adult and child death are reviewed by consultant teams using the mortality screening tool within Datix; this is used to identify cases that require further review through the full mortality review form. Neonatal deaths, stillbirths, and late fetal losses are reviewed using the perinatal mortality review tool (PMRT); this is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK.

Trust targets:

- 100% of in-hospital adult and child deaths to be screen
- At least 30% of all adult and child death to undergo full mortality review
- 100% of neonatal death and stillbirths to undergo full mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review
- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

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 and the trust wide Mortality Surveillance Group (MSG).

3. Medical Examiner's office

On April 1st 2020 an independent Medical Examiner's service was introduced to the Trust to scrutinise all non-coronial deaths and:

- Provide greater safeguards for the public by ensuring robust scrutiny and flagging any potential learning
- Ensure the appropriate direction of deaths to the Coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

The Medical Examiner's Office (MEO) provides assurance that cases are being scrutinised by experienced medical professionals; however the service does not provide the entirety of the Trust's learning from deaths approach. The mortality review process is the focus of this report.

4. Relative risk of mortality

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

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

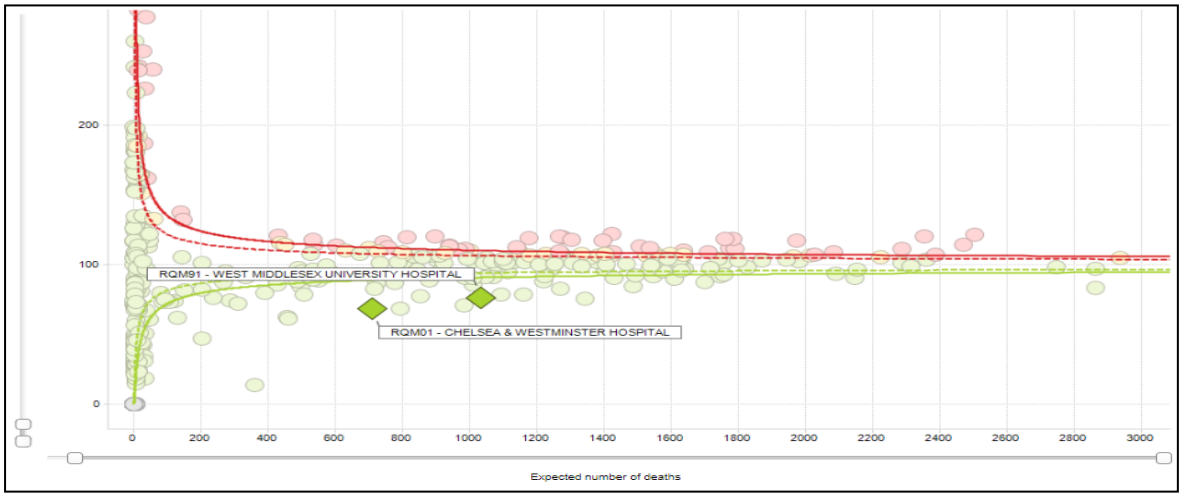


Fig 1 – SHMI comparison of England acute hospital sites based on outcomes, Updated 07/04/2022

The Trust remains one of the best performing in terms of relative risk of mortality with a Trustwide SHMI of 72.96 for period January 2021 – December 2021 (where average risk of mortality would be 100). This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- WestMid: SHMI value 76.17 (1034 expected deaths, 788 observed deaths).
- ChelWest: SHMI value 65.93 (710 expected deaths, 485 observed deaths)

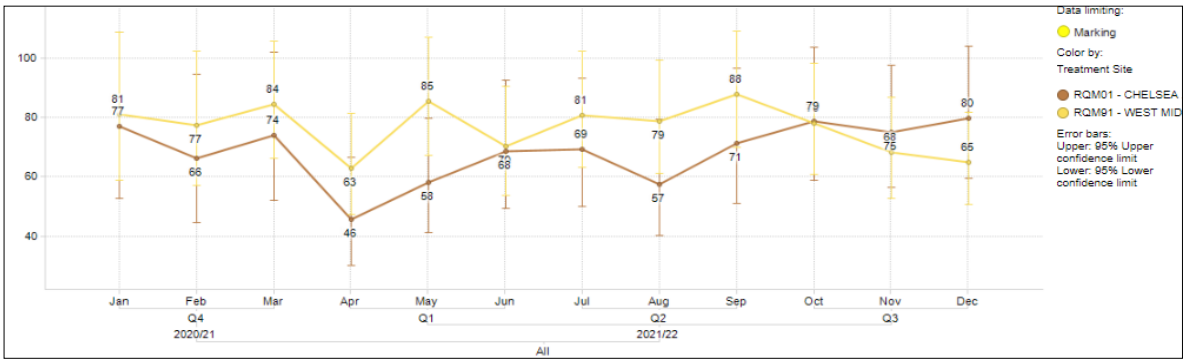


Figure 2: Monthly SHMI trend by site with 95% confidence limits (Updated 06/12/2021)

Deaths from Covid-19 are not included within the SHMI as the tool was not designed for this type of pandemic activity.

Crude mortality

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

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

The following crude rates only include adult emergency admitted spells by age band. This approach is used as it reduces some of the variation when comparing the two sites and support understanding and trend recognition undertaken by the Mortality Surveillance Group.

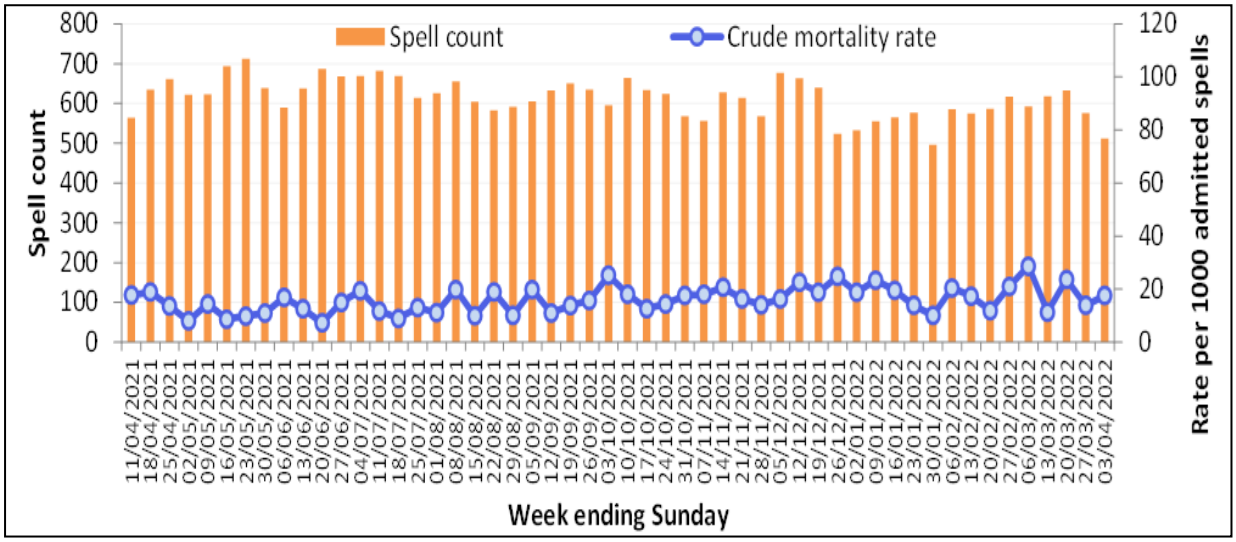


Figure 3: WestMid site, all adult deaths; crude mortality rate per 1000 emergency admissions

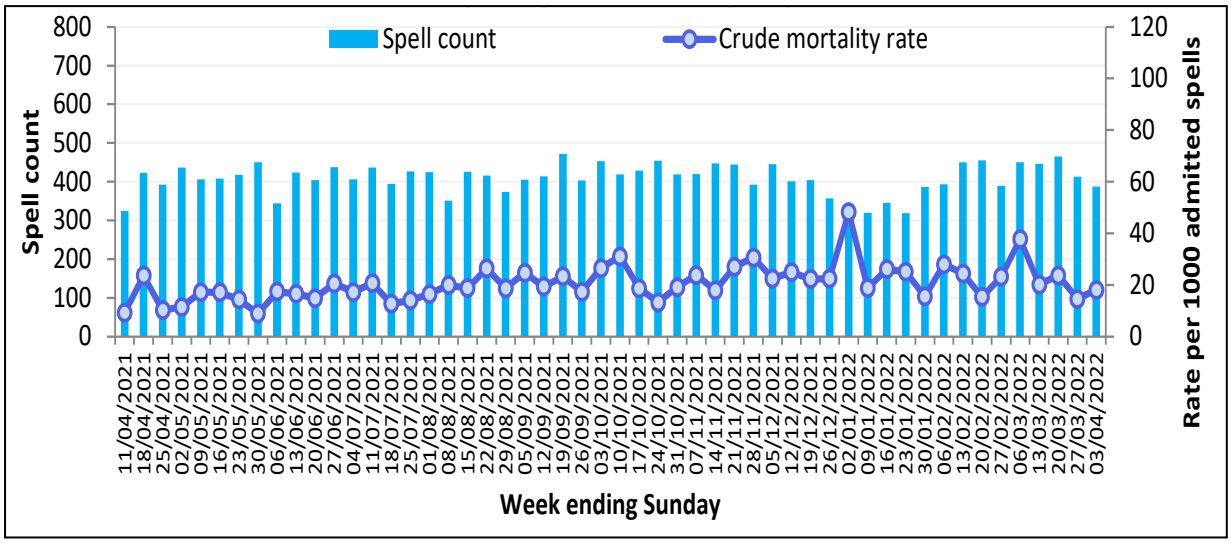


Figure 4: ChelWest site, all adult deaths; crude mortality rate per 1000 emergency admissions

Deaths from Covid-19 are included within the crude mortality monitoring

By comparing the actual number of emergency spell mortalities with the same week in the previous 5 year mean (2015-2019) a return to average is demonstrated from February 2021.

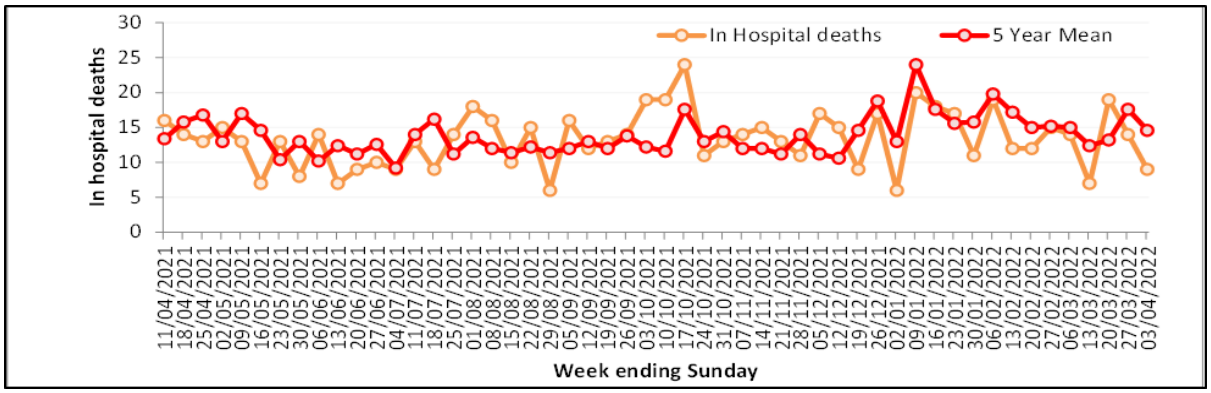


Figure 4: Weekly WestMid in hospital deaths compared to the 5 year average

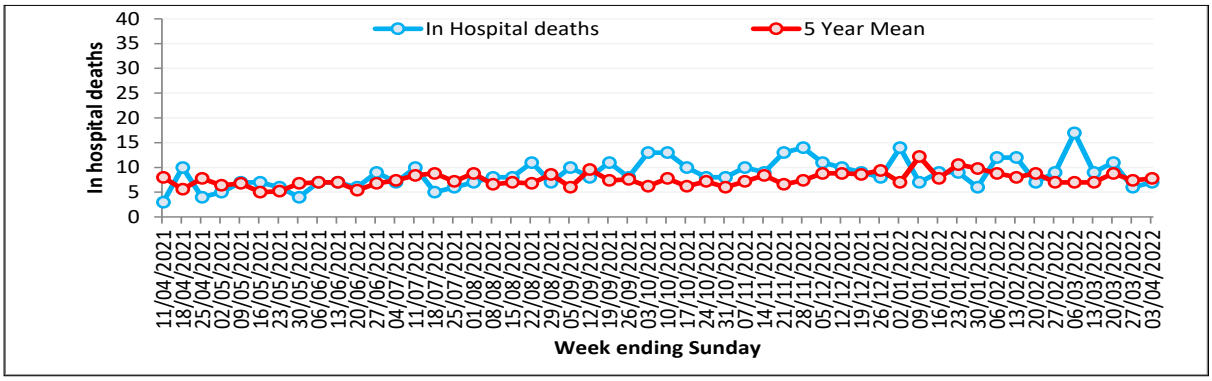


Figure 5: Weekly ChelWest in hospital deaths compared to the 5 year average

5. Learning from all deaths

It is the Trust's target to screen 100% of adult and child deaths and to undertake full mortality review on no less than 30% of cases. During this 12 month period 83% of cases have been screened and 33% of cases have been screened & undergone full mortality review.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending	% Screened	% With Full Review	% Pending
Apr	118	52	36	3	75%	31%	3%
May	102	50	37	3	85%	36%	3%
Jun	109	36	24	8	55%	22%	7%
Jul	84	45	42	5	104%	50%	6%
Aug	83	43	35	6	94%	42%	7%
Sep	83	51	47	7	118%	57%	8%
Oct	95	48	46	12	99%	48%	13%
Nov	103	62	37	14	96%	36%	14%
Dec	110	56	47	25	94%	43%	23%
Jan	133	75	37	29	84%	28%	22%
Feb	118	67	20	32	74%	17%	27%
Mar	125	53	6	67	47%	5%	54%
Total	1263	638	414	211	83%	33%	17%

It is the Trust's target that 30% of cases should undergo full mortality review; this target has been achieved over the 12 month period. 17% of in-hospital deaths that occurred during for Q4 21/22 have been reviewed and closed.

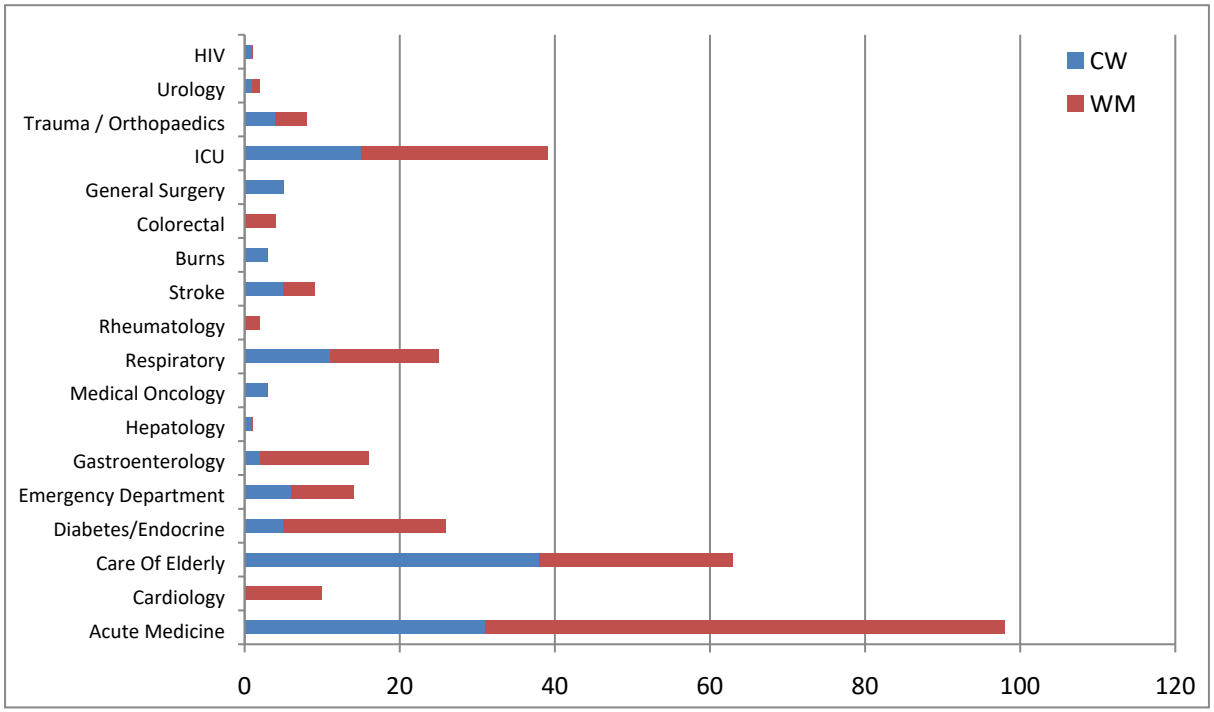


Figure 6: Q4 20/21 adult & child deaths by speciality

6. Sub-optimal care

Outcome avoidability and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing all adult and child deaths:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable

During Q4 2020/21 six cases with areas of sub-optimal care, treatment or service delivery were identified; these were all graded as CESDI 1 e.g. the sub-optimal issues identified would not have changed outcome.

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q1 21/22	84	11	2	0
Q2 21/22	112	10	1	1
Q3 21/22	109	21	0	0
Q4 21/22	57	6	0	0

During this 12 month period four cases of sub-optimal care that might have changed outcome or would reasonably be expected to have changed outcome have been identified via the mortality review process. Learning from these cases was gathered and shared via the organisation's serious incident process.

The Divisional Mortality Review Groups provide scrutiny to mortality cases so as to; identify themes and escalate any issues of concerns; during this reporting period the following issues have been raised:

- Documentation: Data accessibility & quality
- Communication: Unreliable response to bleep
- Communication: Handover between teams
- Communication: Feedback from external organisations
- Staffing: Lower numbers of substantive staff on wards may impact quality
- Planning: Escalation Plans (to be recorded on Cerner and communicated with families)
- End of life care: Need to reduce invasive monitoring at end of life
- Activity: Increasing demand within surgical teams, increasing complexity patients managed under surgery that also require significant medical team input.
- Services: Lack of echo availability within critical care (both sites)

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning.

7. Conclusion

The outcome of mortality review provides 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 Q4 2021/22; this is an indicator of improving outcomes and safety.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors (Public) 5 May 2022

AGENDA ITEM NO.	4.5
TITLE OF REPORT	Half year report on use of the Company Seal 2021/22
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Company Seal has not been used during the period 1 October 2021–31 March 2022. Whilst outside this particular reporting period, it was used on 1 April 2022. The details of the transaction are appended to this covering report.
KEY RISKS ARISING FROM THIS REPORT	None.

STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

Deliver high quality patient centred care	Y
Be the employer of Choice	Y
Deliver better care at lower cost	Y

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	Nil

Equality And Diversity		
Quality		
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance		
Public Consultation		
Council of Governors		
please mark Y/N – where Y is indicated please explain the implications in the opposite column		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Report on use of the Company Seal 2021/22

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

   Custody of Seal and Sealing of Documents

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

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

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

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

2. The Company Seal was not used during the period 1 October 2021 and 31 March 2022. Whilst outside this reporting period, it was used on 1 April 2022 under seal reference 212. The seal was affixed to a lease between Chelsea and Westminster Hospital NHS Foundation Trust and CW Medicines Limited relating to the pharmacy unit on the ground floor of the Chelsea and Westminster Hospital site. The seal was affixed by the Deputy Chief Executive Office Rob Hodgkiss and Chief Medical Officer Roger Chinn.