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

Zoom Conference: https://zoom.us/j/7812894174; Meeting ID 7812894174 5 November 2020 11:00 - 5 November 2020 13:30

### **INDEX**

1.0 Board Agenda 05.11.20 PUBLIC - FINAL.doc	4
1.2 Declaration of Interests Register Board as at 18.09.20.docx	6
1.3 Board minutes 03.09.20 PUBLIC - draft.doc	10
1.4 Board action log 03.09.20 PUBLIC.doc	18
1.5 Chairman's Report 5 Nov 2020.doc	19
1.6 CEO Report October 2020 - FINAL.doc	21
2.1 Recovery Programme update - cover sheet RH.doc	25
2.1.a 2020-10-23 Provider Recovery Elective Care Board RH.pptx	26
2.1.b CONFIDENCE LEVELS and UPDATE 261020 RH.docx	32
2.2 Integrated Performance Report cover - September Final RH.docx	35
2.2.a Trust Performance Report September 2020.docx	37
2.3 Medical Appraisal Revalidation.doc	52
2.3.a Medical Appraisal Revalidation Board Report 2019-20 final.docx	53
2.4 Front Cover_EDI Annual Report.doc	69
2.4.a 200914_Workforce Equality and Diversity Report 2020_FINAL POD.DOCX	71
2.5 Flu report to board November 2020.doc	122
2.5.a Seasonal Influenza Vaccination Programme Update.doc	127
2.6 Annual Safeguarding report to Board November 2020.doc	163
2.7 2020_10_20- Business Planning 2020-21 - Oct FIC (final).doc	168
3.1 GOSW Q2 2020 - cover sheet.doc	176
3.1.a GOSW Q2 2020.pdf	178
3.2 Trust Board_Improvement Programme Report - Nov 2020v1.docx	193
3.3 Serious Incident Report PUBLIC Board NOV20.docx	200
3.4 Mortality_Surveillance_Q2_EMB-OCT20 v2.docx	203
3.5 Front Cover_KPI report October.doc	209
3.5.a Workforce Performance Report.PPTX	211
3.6 NMC Revalidation October 2020 - cover sheet.doc	218
3.6.a Nursing and Midwifery Revalidation Annual 2020 report MvL POG.docx	220
3.7 Digital Programme Update - cover sheet.doc	224
3.7.a Digital and Innovation Programme - Nov 2020.pptx	225

3.8 BAF cover sheet Q3 Sept 2020.doc	.230
3.8.a BAF Q3 2020.pdf	.232
3.9 Half year report on use of the Company Seal 2020-21.doc	.246





#### **NHS Foundation Trust**

#### **Board of Directors Meeting (PUBLIC SESSION)**

**Date:** 5 November 2020 **Time:** 11.00 – 13.30

**Location:** Zoom Conference: <a href="https://zoom.us/j/7812894174">https://zoom.us/j/7812894174</a>; Meeting ID 7812894174

ЭR

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

#### 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 September 2020	Paper	Chairman
11.05	1.4	Matters arising and Board action log	Paper	Chairman
11.10	1.5	Chairman's Report	Paper	Chairman
11.15	1.6	Chief Executive's Report	Paper	Chief Executive Officer
11.25	1.7	Patient/Staff Experience Story	Verbal	Chief Nursing Officer
	2.0	FOR DISCUSSION		
11.45	2.1	Trust 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	Medical Revalidation Annual Report – for approval	Paper	Medical Director
12.15	2.4	Annual People Equality and Diversity Report 2019/2020 – for approval	Paper	Director of HR & OD
12.25	2.5	Seasonal Influenza Vaccination Programme – for approval	Paper	Chief Nursing Officer
12.35	2.6	Annual safeguarding update	Paper	Chief Nursing Officer
12.45	2.7	Business Planning 2020/21– update	Paper	Chief Financial Officer
	3.0	FOR NOTING – HIGHLIGHTS BY EXCEPTION		
	3.1	Guardian of Safe Working Report Q2	Paper	Medical Director
12.55	3.2	Improvement programme update Q2	Paper	Chief Nursing Officer
	3.3	Learning from Serious Incidents Q2	Paper	Chief Nursing Officer

	3.4	Mortality Surveillance Report Q2	Paper	Medical Director
	3.5	People Performance Report	Paper	Director of Human Resources & Organisational Development
	3.6 NMC Revalidation Annual Report		Paper	Chief Nursing Officer
	3.7	Digital Programme update	Paper	Chief Information Officer
	3.8	Board Assurance Framework	Paper	Director of Corporate Governance & Compliance
	3.9	Half-year report on use of the Company Seal 2020/21	Paper	Director of Corporate Governance & Compliance
	4.0	ITEMS FOR INFORMATION		
13.15	4.1	Questions from members of the public	Verbal	Chairman
13.25	4.2	Any other business, including 4.2.1 Disabled parking at West Middlesex	Verbal	Chairman
13.30	4.3	Date of next meeting – 7 January 2021; 11.00 – 13.30.		





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

Name	Role	Description of interest	Relevant dat	es	Comments
			From	То	
Sir Thomas Hughes-Hallett	Chairman	Director of HelpForce Community CIC & Trustee of Helpforce	April 2018	Ongoing	
		Community Trust			
		Chair of Advisory Council, Marshall Institute	June 2015	Ongoing	
		Trustee of Westminster Abbey Foundation	April 2018	Ongoing	
		Chair & Founder HelpForce	April 2018	Ongoing	
		Son and Daughter-in-law – NHS employees	April 2018	Ongoing	
		Visiting Professor at the Institute of Global Health Innovation, part of Imperial College	April 2018	Ongoing	
		Trustee, Civic	Jan 2020	Ongoing	
		Chair of BrYet Limited	Aug 2019	11 May 2020	
Aman Dalvi	Non-executive Director	Director of Aman Dalvi Ltd		Ongoing	
		Owner of Aman Dalvi Ltd		Ongoing	
		Employed two days a week with Canary Wharf Group via my company advising in Planning and Regeneration		Ongoing	
		Chair of Goram Homes in Bristol	2019	Ongoing	
		Chair of Homes for Haringey	2017	Ongoing	
		Chair of Kensington & Chelsea TMO Residuary Body	2019	Ongoing	
Nilkunj Dodhia	Non-executive Director	Directorships held in the following:			
		Express Diagnostic Imaging Ltd	Feb 2012	Ongoing	
		Macusoft Ltd - DigitalHealth.London Accelerator company	May 2017	Ongoing	
		Turning Points Ltd	Nov 2008	Ongoing	
		Examiner of St. John the Baptist Parish Church, Old Malden	April 2016	Ongoing	
		Spouse – Assistant Chief Nurse at University College London Hospitals NHS FT	Jan 2019	Ongoing	
Nick Gash	Non-executive Director	Trustee of CW + Charity	Jan 2017	Ongoing	
		Associate Director Interel (Public Affairs Company)	Nov 2015	Feb 2020	
		Lay Advisor to HEE London and South East for medical recruitment and trainee progression	Nov 2015	Ongoing	

		Chair North West London Advisory Panel for National Clinical Excellence Awards	Oct 2018	Ongoing	Lay Member of the Panel throughout my time as NED
		Spouse - Member of Parliament for the Brentford and Isleworth Constituency	Nov 2015	Ongoing	,
		Associate, Westbrook Strategy	Feb 2020	Ongoing	
Stephen Gill	Non-executive Director	Owner of S&PG Consulting	May 2014	Ongoing	
		Chair of Trustees, Age Concern Windsor	Jan 2018	Ongoing	
		Shareholder in HP Inc	April 2002	Ongoing	
		Shareholder in HP Enterprise	Nov 2015	Ongoing	
		Shareholder in DXC Services	April 2017	Ongoing	
		Shareholder in Microfocus Plc	Sep 2017	Ongoing	
		Member of the Finance and Audit Committee (FAC), Phyllis Court Members Club	Aug 2019	Ongoing	
Eliza Hermann	Non-executive Director	Former Board Trustee and current Marketing Committee Chairman, Campaign to Protect Rural England, Hertfordshire Branch	2013	Ongoing	
		Committee Member, Friends of the Hertfordshire Way	2013	Ongoing	
		Close personal friend – Chairman of Central & North West London NHS Foundation Trust	Ongoing	Ongoing	
Ajay Mehta	Non-executive Director	Director and Co-Founder at em4 Ltd		Ongoing	Company works with international funders and investors to build the capabilities of their grantees and partners in order to increase social impact
		Owner of Ki-Rin consultancy		Ongoing	The agency works with leaders of non-profit organisations globally to build their capabilities.
		Trustee, Watermans		Ongoing	The organisation showcases and delivers arts programmes to communities in West London
		Partner employee of Notting Hill Housing Trust		Ongoing	The Trust commissions the provision of care services to vulnerable people in LB Hammersmith and Fulham
		Head of Foundation, The Chalker Foundation for Africa		Ongoing	The Foundation invests in projects that build the capacity of health-related organisations, in particular healthcare workers, in sub-Saharan Africa.

		Volunteer with CWFT	01/03/2020	Ongoing	
Lesley Watts	Chief Executive Officer	Trustee of CW+ Charity	01/04/2018	Ongoing	
		Husband—consultant cardiology at Luton and Dunstable hospital	01/04/2018	Ongoing	
		Daughter—member of staff at Chelsea Westminster Hospital	01/04/2018	Ongoing	
		Son—Director of Travill construction	01/04/2018	Ongoing	
		ICS CEO NWL	Apr 2020	Ongoing	
		Special Advisor to THHT Board	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
Robert Hodgkiss	Chief Operating Officer / Deputy Chief Executive	No interests to declare.	31/03/2020	Ongoing	
Pippa Nightingale	Chief Nursing Officer	Trustee in Rennie Grove Hospice	2017	Ongoing	No direct conflict of interest.
		NWL ICS chief nurse and executive quality	Feb 2020	Ongoing	
		CQC specialist advisor	2016	Feb 2020	Ceased
		Specialist advisor PSO	2017	Feb 2020	Ceased
Virginia Massaro	Chief Financial Officer (Acting)	Director of Cafton Lodge Limited (Company holding the freehold of block of flats)	22/03/2014	Ongoing	
		Member of the Healthcare Financial Management Association London Branch Committee	Jun 2018	Ongoing	
		Director of Systems Powering Healthcare Limited	29/01/2020	Ongoing	
Dr Roger Chinn	Medical Director (Acting)	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	
		Attended Charitable event hosted by UK Cloud at the 'Music for Marsden'	03/03/20	03/03/20	If required, I would absent myself from any business decision involving UK Cloud
		Providing support to The Hillingdon Hospitals NHS Trust executive team	Aug 2020	Ongoing	Current and ongoing as part of NWL Integrated Care System mutual aid.
Kevin Jarrold	Chief information Officer	CWHFT representative on the SPHERE board	01/10/2016	Ongoing	
		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	Chief People Officer	Joint Chief People Officer role The Hillingdon Hospitals NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	Oct 2020	Ongoing
Gubby Ayda	Equality, Diversity and Inclusion Specialist Advisor to Board			
Serena Stirling	Director of Corporate Governance and	Local Authority Governor at Special Educational Needs School (Birmingham)	2019	Ongoing
	Compliance	Mentor on University of Birmingham Healthcare Careers Programme	2018	Ongoing
		Leadership Mentor for Council of Deans for Health	2017	Ongoing
		Partner is Princess Royal University Hospital site CEO at King's College Hospital NHS Foundation Trust	Feb 2020	Ongoing
		CW+ Fundraising Governance Committee Trust representative	Jul 2020	Ongoing





# DRAFT Minutes of the Board of Directors (Public Session) Held at 11.00am on 3 September 2020, Zoom

Present:	Sir Thomas Hughes-Hallett	Chair	(THH)
	Aman Dalvi	Non-Executive Director	(AD)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Non-Executive Director	(SG)
	Eliza Hermann	Non-Executive Director	(EH)
	Ajay Mehta	Non-Executive Director	(AM)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Acting Medical Director	(RC)
	Rob Hodgkiss	Deputy Chief Executive/COO	(RH)
	Virginia Massaro	Acting Chief Financial Officer	(VM)
	Pippa Nightingale	Chief Nursing Officer	(PN)
	Thomas Simons	Director of HR and OD	(TS)
In attendance:	Kevin Jarrold	Chief Information Officer	(KJ)
	Chris Chaney	Chief Executive Officer, CW+	(CC)
	Serena Stirling	Director of Corporate Governance & Compliance	(SS)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor	(GA)
	Vida Djelic (Minutes)	Board Governance Manager	(VD)
Apologies	Jeremy Jensen	Deputy Chair	(11)
	Martin Lupton	Honorary Non-Executive Director	(ML)

1.0	GENERAL BUSINESS
1.1	Welcome and apologies for absence
	THH welcomed the Board members and those in attendance to the Zoom Board public meeting.
	THE CONTRACT OF THE CONTRACT O
	THH expressed his pleasure of being able to come to CWFT office and visiting the Executive colleagues.
	Apologies received as above were noted.
	Appropries received as above were noted.
1.2	Declarations of Interest
	None
1.2	Minutes of the appring mosting held on 02 tale 2020
1.3	Minutes of the previous meeting held on 02 July 2020
	The minutes of the previous meeting were approved as a true and accurate record of the meeting.
	The final time of the previous meeting there approves us a trace and associate reservation the meeting.
1.4	Matters Arising and Board Action Log
	The Board noted the action log.
	In recognize to FIL's guery regarding the staff survivous recognized. To stated that the action was in relation to the
	In response to EH's query regarding the staff survey response, TS stated that the action was in relation to the

themes around the qualitative comments, in particular the themes around the negative comments (48%); the top themes included management behavior and attitude.

#### 1.5 Chairman's Report

The Board noted the report.

THH reported that the Non-Executive Director JJ was retiring from the Trust at the end of September having served the Trust six years as Non-Executive Director, Deputy Chairman and Senior Independent Director.

THH further reported that the Council of Governors unanimously elected the Non-Executive Director Steve Gill as the Senior Independent Director (SID) and the Deputy Chairman.

THH noted that alongside JJ, SG will be conducting the Chairman's appraisal, and the self-appraisal statement has been prepared to enable the discussion with the Executive and Non-Executive Directors and the Council of Governors.

THH noted his decision to retire as Chairman of CWFT. A great deal has been achieved under his leadership. He advised it was the right time to step aside to allow others to lead the Trust Board and the Council of Governors into a new exciting phase in the NHS development. THH will remain as Chairman until 31 March 2021 to enable a smooth handover.

#### 1.6 Chief Executive's Report

The Board noted the report.

LW advised while the Trust remains at the level 3 of pandemic, it is working hard on the following three activities: 1) increasing the elective care services; 2) preparing for winter; and 3) another potential surge of Covid-19. The Executive and staff are working hard to prepare as best as possible for all of the three activities. The Trust is working closely with NHS London and North West London health and care partners to ensure services are organised in such a way to safely and appropriately respond to any future patient demand. LW paid tribute to all staff at CWFT and the NWL sector on their coordinated effort to care for patients during the first Covid-19 surge.

LW acknowledged CWFT's commitment to its diverse workforce and announced that the Trust has received confirmation of 'Stonewall' membership, the UK's leading LGBT rights charity known for campaigning and lobbying for GBT rights, inclusivity and acceptance. The Trust will be working with Stonewall on the equality, diversity and inclusivity approach to help unlock the benefits of a truly diverse workforce.

LW reminded the Board of the importance of active engagement with health and care partners in NWL and advised that as part of a collaborative approach and recognising the duty to support others, she supports The Hillingdon Hospital NHS Foundation Trust as an adviser to the Hillingdon Board and the Deputy Chief Executive Officer with the management of the hospital until new leadership arrangements are put in place.

LW advised that the Director of HR & OD TS will be moving on to work at NHSE/I and wished him well in his career. She further advised that a due consideration will be given to succession plan and leadership development to ensure future sustainability.

SG asked if any themes arose from staff listening events with the staff from BAME backgrounds and any feedback to share from a pilot programme on Reciprocal Mentoring for inclusion. LW stated that the listening events provided an equal opportunity to all staff and acknowledged the Executive Team commitment; GA sated that some powerful stories emerged from the events with themes around career progression and recruitment.

THH queried to what extent CWFT networks with diverse patients. PN stated that there have been three

meetings with diverse groups with some future meetings planned.

NG referred to the recent HSJ article relating to rising Covid cases in hospitals and asked about current situation at CWFT. LW stated that during the initial phase of pandemic some Trust's staff tested positive on Covid; staff have been requested to adhere to social distancing rules and follow annual leave guidance. Generally, staff have been supportive and feedback received positive.

In response to THH's question relating to testing and if there was evidence of a surge in cases, LW explained that the situation in local boroughs is monitored closely on a daily basis. RC added that engagement with local boroughs is strong and numbers of positive cases in community are shared on weekly basis.

#### 1.7 Patient and Staff Experience Story – Covid-19

PN introduced Elaine Manderson (Lead Nurse for Critical Care), Gubby Ayida (Chair of BAME Network and Board Advisor), and Dr Pallav Shah (Respiratory Consultant) to present their reflections on patient and staff experience, and research activity throughout the Covid-19 pandemic.

Elaine Manderson (EM) reported that the Trust had to triple Critical Care capacity to respond to the pandemic. The Critical Care Team cared for over 150 patients throughout the pandemic, with some returning after they had been discharged from the units to meet the staff who cared for them during their admission. It was noted that the Trust was able to use the new ITU unit at the Chelsea site earlier than planned to meet the demand for care. Staff found the experience challenging, as communication with patients was affected with staff being in full Personal Protection Equipment. The team created badges with staff pictures to show patients who was caring for them. A number of staff were redeployed to support ITU teams, and there was a reduction in visiting hours for visitors. However, the team facilitated expectations for patients who were receiving care at the end of their life. Digital solutions were initiated to enable patients to speak with their families, and staff and patients have been supported by psychology services. A family relations team was formed to further support care. The team have now continued with video calling facilities as standard practice.

AM thanked the team for their care and professionalism, and asked how staff supported each other. EM noted that most staff found it a positive experience due to the learning opportunities and team work ethos, and the team have built a group of staff who could be redeployed again should the need arise. EM noted excellent support from the charity CW+ and the staff health and well-being facilities. THH noted that a significant amount of care can be delivered by volunteers and asked whether there were any future opportunities being considered in the team. EM reported that volunteers were involved through the response and supported staff and patients, and enhancing their role going forward will be considered. AD noted how humbled he was and thanked the team, and enquired about how the mental health of staff was being reported. LW reported that there is a full work programme for health and wellbeing, including mental health support. EM added that the team have weekly reflections and debrief sessions, and support is ongoing.

Gubby Ayida (GA) highlighted the experience of staff in vulnerable groups through the pandemic, noting that staff in particular from BAME backgrounds were scared and anxious with the media reports and emerging research findings about the overrepresentation of the BAME community in mortality figures. The Trust established fortnightly virtual meetings for BAME staff with the Executive to raise concerns, dispel myths and rumours, and gain feedback on actions. GA noted that the emergence of the Black Lives Matter Movement destabilised the BAME staff group further during the pandemic. The staff risk assessment was developed in partnership with the BAME Network, and the implementation supported by webinars. GA noted that opportunities exist to increase engagement, and encompass bank staff and facilities staff in the work. More latterly, the Executive have been hosting listening events and have started a reciprocal mentoring programme. AM asked GA what has come from the listening events in preparation for a further surge of the virus. GA noted that the meetings helped staff understand what systems and processes are in place to support them. PN added that staff were concerned about what they were hearing on the media but it was important that staff understood the Trust approach, sighting the example of continuing FIT testing

throughout the pandemic where other organisations had halted these activities.

Dr Shah noted that the Trust had been 'incredible' in responding to the 'new threat' and was keen to learn from it and formulate new therapeutic strategies. Throughout the pandemic approximately 1,382 patients were involved in studies, and focus is now on following up on these patients 3, 6, 12 months post infection. The PIONEER study was noted to have moved from the protocol stage to treatment of the first patient in six weeks, a process which normally takes six months. Dr Shah commended the team work between clinicians and research staff. Dr Shah highlighted that the support and encouragement offered by the charity CW+ was 'incredible' throughout the pandemic. RC noted that the appetite for discovery amongst the clinical body during the pandemic was phenomenal. ND asked if there was any research activity focusing on the social and behavioural aspects of the virus. Dr Shah confirmed that this was being looked at, noting that initial observations are showing that the aerosol component of the virus is low, and it is more droplet orientated, hence the importance of good hand hygiene. Des Walsh (Governor) noted that the Trust is now part of the Academic Health Science Centre (AHSC) and invited Dr Shah to join the AHSC Covid Research Committee which meets fortnightly.

#### 2.0 QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE

#### 2.1 Phase 3 of NHS Response to Covid-19

THH noted that all of the items in this section had been scrutinised by the Quality Committee (a Board Committee) and asked for key points be highlighted by the relevant Executive lead.

Key highlights provided included:

- The NHSE/I letters enclosed in the meeting pack; the key focus is on restoring and recovering services and preparing for winter pressure demands; this was followed by the implementation guidance to the health and care sector.
- Slide on p.50 of the meeting pack details ambitions outlined in the NHS Phase 3 letter to restore services to pre-pandemic levels.
- Slide on p.51 shows London Region's 52+ week waiting positions increased by 6,452 from June to a total of 21,349 patients waiting longer than 52 weeks for treatment.
- Slide 52 details patient tracking list by all specialties for the week ending 16 August by four North West London hospitals.
- CWFT appear to be in line with London's Phase 3 aspirations; NWL and other providers commitment will be shared with the Board in due course.

LW emphasised the importance of continuing collaborative system working between health and care partners in NWL to achieve equity of standards in treating patients in a way that inclusively supports those in the greatest need.

In response to NG's question regarding balance between elective and non-elective work, RH stated that non-Covid and Covid patient pathways have been segregated and clearing the waiting list will take time. EH added it was helpful being sighted on CWFT's and other providers theatre capacity, however a concern remains about elective waiting list backlog. LW confirmed that elective recovery is the top NHS priority on a national level, regional and the Trust's level.

In response to SG's question regarding NWL sector support, RH stated that where required CWFT supports other providers with clinical pathways whether it being expertise or resource. THH advised that the balance of maintaining good work of CWFT, its duty to support the health and care system and other providers in NWL is the main subjects for discussion by the Board in its private session later in the day. An update on this will be provided to Board in due course.

VM advised that Covid-19 financial arrangements are being extended to cover August and September 2020.

	For the latter part of the 2020/21 financial year the intention was to move towards a revised financial
	framework, once it has been finalised with Government.
2.2	Trust Recovery Plan update
	This item was discussed as part of item 2.1.
2.3	Integrated Performance and Quality Report, including Winter preparedness
	RH noted a number of performance metrics were either not available due to being suspended or not available due to reprioritisation of 'Business as Usual' tasks both Clinical and Non-Clinical as a consequence of significant impact of Covid-19. These remain under review and further updates will become available as recovery continues.
	Key highlights from July's performance report included:
	A&E validated position reported as 94.59%, which is an increase 0.54% from June.
	Cancer 62 day validated position of 74.16%.
	RTT performance continued to decline as a result of a suspension or routine elective activity.
	In response to SG's question relating to performance targets and financial plan, RH stated this is dependent on referral volumes; additional funding would accelerate CWFT activity.
	The Board noted an update on Trust's arrangements for ensuring service delivery throughout winter 2020/21.
2.4	Annual Infection Prevention and Control update
i	
	PN noted that the full Annual Infection Prevention and Control report was scrutinised by the Quality Committee.
2.5	Committee.  PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and
2.5	PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and Control mandatory training.
2.5	PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and Control mandatory training.  Safe Staffing annual report  PN noted that the full report had been presented to the Quality Committee. It provided assurance to the on the Trust's compliance in providing safe staffing across the clinical professions and demonstrating a benchmark against the national safe staffing guidance along with a declaration from the Chief Nursing Officer and Medical Director (Acting) providing assurance that safe staffing is currently in place across the organisation. The report suggests priorities for 2021 in terms of further improving compliance with some of
2.5	PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and Control mandatory training.  Safe Staffing annual report  PN noted that the full report had been presented to the Quality Committee. It provided assurance to the on the Trust's compliance in providing safe staffing across the clinical professions and demonstrating a benchmark against the national safe staffing guidance along with a declaration from the Chief Nursing Officer and Medical Director (Acting) providing assurance that safe staffing is currently in place across the organisation. The report suggests priorities for 2021 in terms of further improving compliance with some of the national guidance where the Trust is currently partially complaint.  EH added that the Quality Committee discussed the report and confirmed safe staffing is currently in place
2.5	PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and Control mandatory training.  Safe Staffing annual report  PN noted that the full report had been presented to the Quality Committee. It provided assurance to the on the Trust's compliance in providing safe staffing across the clinical professions and demonstrating a benchmark against the national safe staffing guidance along with a declaration from the Chief Nursing Officer and Medical Director (Acting) providing assurance that safe staffing is currently in place across the organisation. The report suggests priorities for 2021 in terms of further improving compliance with some of the national guidance where the Trust is currently partially complaint.  EH added that the Quality Committee discussed the report and confirmed safe staffing is currently in place across the organisation and acknowledged that some standards require further work be undertaken.
2.5	PN commended the hard work of the Infection Prevention and Control team during the pandemic. In addition, the team succeeded in reducing e coli and full compliance with the Infection Prevention and Control mandatory training.  Safe Staffing annual report  PN noted that the full report had been presented to the Quality Committee. It provided assurance to the on the Trust's compliance in providing safe staffing across the clinical professions and demonstrating a benchmark against the national safe staffing guidance along with a declaration from the Chief Nursing Officer and Medical Director (Acting) providing assurance that safe staffing is currently in place across the organisation. The report suggests priorities for 2021 in terms of further improving compliance with some of the national guidance where the Trust is currently partially complaint.  EH added that the Quality Committee discussed the report and confirmed safe staffing is currently in place across the organisation and acknowledged that some standards require further work be undertaken.  THH concluded the item by suggesting a people plan be reviewed earlier in the year.

THH asked for an ambitious plan be set up to capture all patient feedback that come to CWFT, as this is being one of JJ's ambitions, and asked PN to consider NEDs helping.

Action: Comprehensive Patient feedback plan to be presented to Board, date to be confirmed - PN

#### 2.8 Emergency Preparedness Resilience and Response (EPRR) 2019 NHSE Core Standards Feedback

RH introduced the paper by stating that it provides the Board with assurance of the Trust's compliance against the NHS England and Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards. For 2019/20 the Trust declared that it is fully compliant with all 69 core standards.

The 2020 EPRR NHSE Core Standards are expected to follow later this year.

The Board noted the report.

#### 3.0 FOR NOTING – HIGHLIGHTS BY EXCEPTION

#### 3.1 Guardian of Safe Working Report Q1

This report was noted.

RC stated that the report covered the rapidly evolving Covid-19 pandemic and highlighted that no exception reports were submitted during the quarter 1. This report has been approved by e-governance by the PODC NEDs and is scheduled for discussion and scrutiny by the People and OD Committee at its 30 September meeting.

EH commended the positive and illuminating report, however she queried two concerns raised in relation to occupational health. TS stated that the service had been affected pre-Covid-19 due to shortages of occupational health therapist. The full occupational health service was expected to resume in March, however it coincided with the pandemic. The Trust is in the process of evaluating the ongoing demand for occupational health service and assessing sustainability of the current arrangements.

THH concluded the discussion by asking the Chairman of the People and OD Committee to oversee progress with the management of occupational health service.

Action: TS to prepare a report and action plan on the management of the occupational health service for review at the October PODC.

#### 3.2 Improvement programme update

PN advised of significant progress made with obtaining accurate data for the quality priorities as set out in the report. Of note was dementia screening at West Middlesex which was impacted by the move to Cerner and the cancer holistic needs assessment which was impacted by Covid-19.

In response to AM's query relating to deep dive into the impact of volunteers, RC stated that it will be brought to the Board once the validation exercise has been complete.

NG queried changed to Friends and Family Test (FFT). PN stated that the FFT requirements had changed nationally and the team had implemented all changes at the Trust. The main changes are: a fixed period of time for patients to respond on patient experience and maternity touch-points.

THH concluded the item by congratulating PN on the progress with the ambition to achieve a 100% 5 day response rate for all PALS concerns.

#### 3.3 Learning from Serious Incidents (SIs)

PN introduced the item by stating that the full report was scrutinised by the Quality Committee. Of note was the apparent increase in number of serious harm SIs, which is due to the new national requirement around grading of hip fractures following a fall.

The Board noted the report.

#### 3.4 Mortality Surveillance Report Q1

RC introduced the report by stating that the mortality review process was paused in April 2020 due to the impact of Covid-19 pandemic.

The report had been scrutinised by the Quality Committee. The outcome of mortality review provides a rich source of learning; the resumption of the Trust wide review process during Q3 will support the Trust's improvement objectives and improve assurance reporting to the Quality Committee.

RC highlighted that Ajay Mehta had been confirmed as Trust's Non-Executive Director lead for mortality.

The Board noted the report.

#### 3.5 People Performance Report

TS noted that the report was scrutinised by the People and OD Committee via e-governance and will be duly reviewed at the Committee at its 30 September meeting.

The following highlights were provided:

- Voluntary turnover rate decreased to 12.60% and is below the Trust target of 13% for the first time and the lowest in recent years.
- Sickness absence rate reduced to 2.74%, which is lower compared to previous month and this time last years despite COVID19 related challenges.
- A pilot programme on Reciprocal Mentoring for inclusion launched.
- The 3 year business case approved for health and wellbeing and the team are mobilising the various elements of the programme and agreeing the staff engagement and communications plan to launch to all staff within the Trust.
- The partnership with Stonewall part of the Trust's commitment to being a lesbian, gay, bisexual, transgender and queer (or questioning) and others (LGBTQ+) inclusive employer.
- 100% completion of risk assessments best in London.

THH queried how many people out of 11 who commenced the Top Leaders programme are BAME. TS stated that it is around 39%.

EH commended the voluntary turnover rate achievement. In response to EH's query regarding setting up a new turnover target, TS confirmed that the People and OD Committee are working on setting up a new target. LW added the Trust offers a wide range of opportunities for staff development, training and carer progression.

The Board noted the report.

#### 3.6 Digital Programme update

The Board noted the report.

KJ noted that digital work has become a 'business as usual'; all patient appointment correspondence is offered electronically and circa 70% uptake from patients.

NG referred to recent BMJ article regarding digital exclusion and asked how this is addressed in the Trust. KJ stated that the benefit from digital outweighs any disadvantages and options to address this are being considered. THH added that some valuable work on digital inclusion has been undertaken by the King's Fund.

In repose to SG's query regarding cyber security, KJ stated that as part of the national initiative the Cyber Security dashboards had been developed; at the Trust level a number of initiatives are being undertaken to mitigate and manage cyber security related risks. All cyber security and digital related risks are considered by the Audit and Risk Committee on a quarterly basis.

#### 3.7 Board Assurance Framework (BAF)

SS noted that the report assures the Board that there is a structure and process which enables the Trust to focus on risks which might compromise achieving the strategic objectives. It identifies the key controls which are in place to manage and mitigate those risks, and gives assurance on the effectiveness of these controls. The BAF is monitored through the Board sub-committees on a quarterly basis, and the full Board on a biannual basis. The report provided outlines the summary of the BAF at the end of Q2.

THH asked for a deep dive into culture, values and leadership impacting on the quality of patient care.

Action: TS/PN to perform a deep dive into culture, values and leadership impacting on the quality of patient care.

The Board noted the report.

#### 4.0 ITEMS FOR INFORMATION

#### 4.1 Questions from members of the public

Nil of note.

#### 4.2 Any other business

Nil of note.

#### 4.3 Date of next meeting – 05 November 2020; 11.00am – 13.30.

The meeting closed at 13.08.



**NHS Foundation Trust** 

#### Trust Board Public - 3 September 2020 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
Sep 2020	2.5	People Plan	Action: TS to bring a people plan for review by Board in early 2021.	SSmith	First draft people plan discussed at People and Organisational Development Committee (28.10.20) and on forward plan schedule for March 2021 Board.
	2.7	Patient and Public Engagement and Experience Strategy 2019-2024 – progress update	Action: Comprehensive Patient feedback plan to be presented to Board, date to be confirmed.	PN	This is on forward plan for January 2021 Board.
	3.1	Occupational Health Service	Action: TS to prepare a report and action plan on the management of the occupational health service for review at the October PODC.	SSmith	Complete.
	3.7	People deep dive	Action: TS/PN to perform a deep dive into culture, values and leadership impacting on the quality of patient care.	TS/PN	Questions asked as part of the NHS Staff Survey and CWHFT score above the national average for culture of reporting and patient safety.



### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	1.5/Nov/20
REPORT NAME	Chairman's Report
AUTHOR	Sir Thomas Hughes-Hallett, Chairman
LEAD	Sir Thomas Hughes-Hallett, Chairman
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

#### Chairman's Report September 2020

As Chair, the last period has been occupied by supporting the Chief Executive Officer as she has implemented well-rehearsed plans for the care we will provide during the next phase of COVID. I am pleased with the resilience of the senior teams hard work in preparing us for further increased activity as a hard winter approaches.

I have now completed the appraisals of our non-executive directors. We are indeed fortunate to be supported by such committed and exceptional colleagues. Collectively, they are determined to ensure that to the greatest extent possible we maintain the recovery in business as usual while being ready to embrace the challenge that the winter will bring.

We welcomed Penny Dash, Chair of the Integrated Care System (ICS), to our recent Council of Governors meeting and are beginning to plan with the Chief Executive Officer, how best the Board can support her and Penny in shaping the future vision for North West London as a whole while at the same time continuing to deliver ever improving care to our own patients. Governors were briefed on the emerging shape of the ICS and also on succession plans for the retiring Chair. They expressed a willingness and wish to help support the shaping of the emerging system in a way that provides improving care to those who elected them, as well as the wider population.

The Trust is as ready as it can be for the challenges ahead. As Chair, one of my highest priorities remains to support the health and wellbeing of our own staff at a time of maximum stress.

The Non-Executive Directors are now meeting weekly with the Chief Executive Officer to be briefed on COVID, recovery, and the robustness of our staff, our services, and the quality of our care.

**Sir Thomas Hughes-Hallett** Chairman



**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	1.6/Nov/20
REPORT NAME	Chief Executive's Report
AUTHOR	Lesley Watts, Chief Executive Officer
LEAD	Lesley Watts, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.





**NHS Foundation Trust** 

#### Chief Executive's Report November 2020

#### Introduction

Since my last report to Public Board in September London is being declared at high risk of Covid-19. As a Trust, we have developed comprehensive plans in line with other North West London (NWL) healthcare providers to ensure a coordinated and timely response to any surge. We will continue to do as much elective work as we can for as long as we can. We commenced our annual influenza vaccination programme and our staff have demonstrated continued dedication to keep well for themselves and their patients and families.

#### Covid-19

We saw the rise in the number of Covid-positive test results in the community and London was placed in Tier 2 from midnight on Friday, 16 October 2020. We are now seeing more positive tests on our patients, and the second wave has arrived. An enormous amount of work has taken place and I want to thank all staff for their continued commitment and support. From both an operational and clinical perspective, we are in a much stronger position than earlier this year. We are aware of the challenge but we are better equipped and more informed and are supported by strengthened working relationships across the sector.

I am delighted to advise that we have been successful in returning to a high level of elective, diagnostic and outpatient work and we will play a significant role in the sector's Fast Track Surgical Hubs, especially at our West Middlesex site. We owe it to patients to do as much elective activity as we can, for as long as we can. This remains a priority for now. We have ensured our hospitals are safe for our patients to attend their appointments, through measures which include patient testing, and wherever possible separating patients known to be Covid free from other patients. Once again, I would remind every member of our local communities to take heed of the government guidance. This means in addition to the measures that are already in place:

- People must not meet with anybody outside their household or support bubble in any indoor setting, whether at home or in a public place
- People must not meet in a group of more than 6 outside, including in a garden or other space
- People should aim to reduce the number of journeys they make where possible. If they need to travel, they should walk or cycle where possible, or to plan ahead and avoid busy times and routes on public transport

Upon entering our hospitals, staff, patients and members of the public must wear a face covering (unless exempt), in addition to complying with social distancing and hand hygiene guidance. We have stations at the entrances of our hospitals to help you do this. The safety of our staff, patients and local communities is our utmost priority.

We are keen to see patients with the greatest clinical need and longest wait, to reduce the backlog of people waiting for treatment.

#### Equality, diversity and inclusion

We have been celebrating Black History Month this October, to mark the contributions of one in seven of our staff, who are largely of African or Caribbean heritage. We have been able to celebrate the occasion in a number of ways, largely virtual in nature but a befitting celebration nevertheless including stories on our website, internal bulletins, hospital radio shows, two days of special menus in the canteens, and films selected for our patients through the MediCinema and whole host of virtual events across North West London. *Vida possibly link to this video* Here is what some of our black staff say about the celebration <a href="https://vimeo.com/468499777/4cd587a4ae">https://vimeo.com/468499777/4cd587a4ae</a>

Earlier in September we launched a year of celebrations to mark the 100<sup>th</sup> birthday of West Middlesex University Hospital. To commemorate the occasion we commissioned a video (watch here), which we hope will make you feel an important a part of the Hospitals' centenary. There is a fascinating history behind our hospital and the community

we serve, and I do hope that by watching this video it will give you more insight into our contributions to the local community and beyond.

#### Service Development

The Trust contines to play a leading role in the work of the West London Childrens Health:

- The Chelsea site is established as the North West London hub for Paediatric Surgery
- Planning continues to set out a North West London option for retaining key Cardiac and Respiratory services (currently provided by Royal Brompton Hospital). The Trust is part of the team attending the Royal Borough of Kensington & Chelsea health scrutiny special meeting on 19 November

#### Research & Innovation

We continue to drive innovation, through our latest key initiatives such as:

- The Think 111 pilots offering a number of appointments at our Emergency Departments and aligning with community providers to offer patients digital booking and the appropriate setting of care.
- We have increased our same day emergency care to support earlier discharge.
- We are playing a key role in the programme of London's fast track surgical hubs
- The SYNE-COV product, led by Dr Marcela Vizaychipi and developed through the Sensyne Partnership, has been approved for use by the Medical & Healthcare products Regulatory Agency. This provides clinicians with near real-time risk prediction scores for three outcomes associated with COVID-19 infection; risk of intensive care unit (ICU) admission, the need for invasive mechanical ventilation and in-hospital mortality. The algorithm uses 40 variables within an individual patient's health records and analyses them in near real-time against the hospital's comprehensive database of electronic health records for thousands of patients.
- We are pleased to be one of forty providers of children's services across the globe to partner with KidsX Accelerator. Working with CW Innovation this will help us adopt new technologies to improve our services for children.

Our Trust's annual Research, Innovation and Quality Improvement (RIQI) online event is taking place on Tuesday 10, Wednesday 11 and Thursday 12 November. Never before has there been a more important time to incorporate research and innovation into our thinking and planning. RIQI 2020 will not only showcase our growing portfolio of staff-led research, innovation and improvement projects, it will also raise awareness of the support available to help staff bring new ideas that deliver better, more responsive and cost-effective care to fruition.

Our Trust is currently undertaking research trials for two COVID-19 vaccines and we regularly share details on our social media platforms. We are involved in well over forty other COVID related research projects.

#### Our Estate

I am delighted to report that along with our CW+ charity partners, the redevelopment and expansion of the NICU and ICU is progressing very well. We took possession of NICU phase 1 (ITU nurseries, new reception, staff and parent facilities) earlier this year in February, with adult ICU phase 1 going live in April, just in time to support the Trust's COVID response. The next milestone for the project is rapidly approaching, with the planned opening of NICU phase 2 (HDU nurseries) on 4th November. We are also due to take possession of the new NICU changing rooms, based on level 4 within the next few weeks. In early November, work will commence on NICU phase 3 (SCBU cots) with a planned completion of May 2021.

The second phase of adult ICU is also progressing well, with the new external structure now built and is also due to complete in May of next year. CW+ has been working with the adult ITU team to further develop the Sky Garden on level 5 into an area dedicated for patients and their loved ones for mobilisation and rehabilitation. It is hoped that this area will be completed in early spring.

We have rigorously planned how we might respond to an increase in patients who present with COVID-19, how we configure our wards and departments, and how our workforce can adapt to rise to the challenge once more. This is Page 3 of 4

in order to improve patient and staff experience through creative interventions across both sites. In recent months
we have invested over £7m in developing the St Mary Abbott Ward at Chelsea and the Richmond Ward at West
Middlesex to provide additional flexible capacity (should we need it) in order to be able to accommodate up to 64 ITU
patients.

**Lesley Watts** 

**Chief Executive** 





**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.1/Nov/20
REPORT NAME	Elective Care Programme Overview
AUTHOR	Rob Hodgkiss – SRO, NWL Elective Care Programme Janet Cree – Programme Director, NWL Elective Care Programme Xiao Cai – Head of Programme, NWL Elective Care Programme
LEAD	Robert Hodgkiss, Deputy Chief Executive
PURPOSE	To update the Quality Committee on the progress with Elective recovery plan and compliance against Phase 3 metrics and to provide confidence levels of delivery by the Programme Leads.
REPORT HISTORY	Elective care programme has been regularly reviewed and discussed by the Executive Management Board and Quality Committee.
SUMMARY OF REPORT	As attached.
KEY RISKS ASSOCIATED	As noted in the paper.
FINANCIAL IMPLICATIONS	As noted in the paper.
QUALITY IMPLICATIONS	As noted in the paper.
EQUALITY & DIVERSITY IMPLICATIONS	As noted in the paper.
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Delivering better care at lower cost</li> </ul>
DECISION/ ACTION	For information and discussion.



# NW London Elective Care Programme Overview

SRO – Rob Hodgkiss Programme Director – Janet Cree Head of programme – Xiao Cai

October 2020

### Weekly performance against Phase 3 targets (1/4)

# Rolling 8 weeks W/E 18/10/2020

		Aug	Sep	Sep	Sep	Sep	Oct	Oct	Oct
		30/08/2020	06/09/2020	13/09/2020	20/09/2020	27/09/2020	04/10/2020	11/10/2020	18/10/2020
		000/	<b>=00</b> /	<b>=0</b> 0/	<b>=0</b> 0/	000/	==0/	<b>=0</b> 0/	==0/
	CWHFT		59%	73%	78%	80%	77%	72%	75%
	ICHT	81%	62%	69%	68%	65%	71%	73%	72%
	LNWUHT	66%	48%	63%	65%	66%	69%	67%	65%
	RBHFT	46%	42%	55%	53%	54%	57%	59%	48%
Elective Day Case		58%	46%	74%	65%	64%	65%	70%	74%
% Achieved									
	NW London	1-10/2	54%	67%	67%	66%	70%	70%	73%
	Phase 3 Target	//10/2	80%	80%	80%	80%	90%	90%	90%
									_
	CWHFT	55%	42%	50%	54%	59%	62%	68%	86%
	ІСНТ	78%	72%	85%	86%	76%	102%	96%	108%
	LNWUHT	42%	33%	38%	31%	34%	39%	59%	59%
	RBHFT	0.40/	56%	64%	76%	72%	67%	61%	78%
Elective Ordinary	THHFT	000/	106%	84%	81%	102%	115%	102%	96%
% Achieved									
	NW London	64%	57%	66%	69%	66%	75%	75%	77%
	Phase 3 Target		80%	80%	80%	80%	90%	90%	90%

Prev. 4 wks
77%
71%
67%
54%
68%
30,0
90%
69%
86%
49%
69%
103%
90%

### Weekly performance against Phase 3 targets (2/4)

# Rolling 8 weeks W/E 18/10/2020

		Aug	Sep	Sep	Sep	Sep	Oct	Oct	Oct
		30/08/2020	06/09/2020	13/09/2020	20/09/2020	27/09/2020	04/10/2020	11/10/2020	18/10/2020
					<b>—</b> .0.				
	CWHFT	79%	57%	70%	74%	77%	75%	72%	77%
	ІСНТ	80%	63%	71%	71%	66%	75%	76%	72%
	LNWUHT	64%	47%	61%	62%	63%	66%	66%	64%
	RBHFT	53%	48%	59%	62%	61%	62%	60%	60%
	THHFT	60%	50%	75%	67%	67%	69%	73%	76%
Elective TOTAL  % Achieved					•		•	•	•
70 Admicvou	NW London	1 1 /0	55%	67%	67%	66%	71%	71%	73%
	Phase 3 Target		80%	80%	80%	80%	90%	90%	90%

77%
71%
65%
60%
71%

# Weekly performance against Phase 3 targets (3/4)

# Rolling 8 weeks W/E 18/10/2020

		Aug	Sep	Sep	Sep	Sep	Oct	Oct	Oct
		30/08/2020	06/09/2020	13/09/2020	20/09/2020	27/09/2020	04/10/2020	11/10/2020	18/10/2020
					1				
	CWHFT	111%	74%	97%	89%	101%	102%	100%	99%
	ICHT	134%	62%	85%	85%	87%	87%	93%	
	LNWUHT	62%	38%	53%	51%	51%			
	INNEI	25%	16%	22%	20%	29%	34%	27%	29%
Out Patients TOTAL		84%	53%	70%	68%	73%	76%	74%	76%
% Achieved									
	NW London	92%	53%	72%	69%	73%			
	Phase 3 Target	90%	100%	100%	100%	100%	100%	100%	100%

100%
29%
75%

100%

# Weekly performance against Phase 3 targets (4/4)

# Rolling 8 weeks W/E 18/10/2020

	_	Aug	Sep	Sep	Sep	Sep	Oct	Oct	Oct
	[	30/08/2020	06/09/2020	13/09/2020	20/09/2020	27/09/2020	04/10/2020	11/10/2020	18/10/2020
	сwнгт	78%	68%	85%	86%	87%	84%	89%	
	ICHT	8%	70%	88%	87%	90%	92%	95%	
	The state of the s	86%	73%	76%	79%	81%	81%	82%	82%
Diagnostics	LNWUHT								
Activity Total	RBHFT	64%	59%	78%	71%	83%	86%	89%	91%
(Not including	THHFT	63%	58%	62%	70%	76%	75%	79%	83%
Endoscopy)									
% Achieved	NW London	77%	68%	80%	82%	85%	85%	88%	
	London		ı		I			I .	
	Phase 3	90%	90%	90%	90%	90%	100%	100%	100%
	Target	3070	3070	30 70	30 70	3070	10070	10070	10070
		40.40/	000/	4040/	4400/	4000/	40.40/	4000/	4440/
	CWHFT	104%	80%	121%	113%	123%	134%	122%	111%
	ІСНТ	63%	86%	94%	87%	68%	107%	96%	99%
	LNWUHT	52%	32%	68%	62%	60%	63%	80%	87%
Diagnostics	RBHFT								
<b>Activity Total</b>	THHET	49%	74%	65%	81%	78%	100%	95%	80%
Endoscopy	İ								
% Achieved	NW	71%	68%	86%	83%	79%	96%	96%	95%
	London	70	3370	2370	1 3370	. 3 70	2370	2370	1 3370
	Phase 3			I	I	I		I	I
	Target	90%	90%	90%	90%	90%	100%	100%	100%

# **NHS** theatre activity in numbers

W/E 18/10/2020

### NHS activity / capacity

**Rolling 8 weeks** 

**1,463 elective patients** received surgery in NHS theatres **last week** 

	W/E	30/08/2020	06/09/2020	0 13/09/2020	0 20/09/2020	27/09/2020	0 04/10/2020	11/10/2020	0 18/10/2020
Trust	Site	Week 35	Week 36	Week 37	Week 38	Week 39	Week 40	Week 41	Week 42
CWHFT	PLANNED activity	340	272	2 340	340	340	340	430	430
CWHFT	ACTUAL activity	343	269	380	349	9 408	346	444	414
ICHT	PLANNED activity	387	309	387	7 387	7 387	7 387	474	500
ICHT	ACTUAL activity	387	329	415	5 421	1 416	6 455	478	511
LNWUHT	PLANNED activity	330	285	5 358	376	6 381	1 406	406	406
LNWUHT	ACTUAL activity	333	259	344	4 368	368	365	373	3 411
THHFT	PLANNED activity	74	97	7 147	7 159	9 177	7 174	204	201
THHFT	ACTUAL activity	104	100	125	5 118	116	128	157	166
TOTAL	PLANNED activity	1131	963	3 1232	2 1262	2 1285	5 1307	1514	1537
	ACTUAL activity	1167	957	<sup>7</sup> 1264	4 1256	6 1308	1294	1452	1502
	% utilisation	103%	99%	103%	<b>6</b> 100%	<b>6</b> 102%	<b>99%</b>	96%	98%

### **CONFIDENCE LEVELS and UPDATE 26/10/2020**

	Elective	Cancer	Outpatients	Endoscopy	Diagnostics
Overall comment	Theatre throughput trajectories are being developed this week. Surge plans and impact on elective activity will need to be accounted for.  Weekly monitoring dashboards in place that mirrors NHSE Phase 3 view.	Position in NWL is one of highest Nationally and in London with regard to Cancer long waiters.  NWL Overview  Mutual aid arrangements being discussed and mapped.  - 104 and 63 day work with imperial  - LNW focus to reduce waiting lists increases	GP / secondary care interface group TOR and meeting schedule to be agreed this week.  All Trusts offering F2F activity in addition to Virtual. F2F is offered where clinically (or socially) necessary. Need to improve data capture on differentiation on virtual /F2F for accurate reporting  DNA rates need to be monitored in parallel to activity, especially with increasing public anxiety around Covid.  RBH data is an outlier due to issues with baseline which is being escalated to NHSE/I.  'Cashing up' of clinics remains concern – delays mean data does not get reflected in activity that	Total NWL Trust activity for the w/e 04/10 for the last 3 weeks is 95% of last year's average weekly rate, based on an updated, reduced level agreed with NHS England  Increased utilisation of existing Trust and community capacity, including improving scheduling arrangements is being progressed  Impact of surge on Endoscopy focus for this week.	There has been an improvement in MR mainly at CW and ICHT. Overall CT performance remained the same. US performance is improving. Trusts are looking at how to support each other where capacity allows.  ISP capacity and bottoming out inHealth capacity and future contract arrangements  Standardising SOPs and process across NWL at modality level  Impact of surge on diagnostics focus for this week.
CWFT	HIGH  Total elective activity 77% of last year.	HIGH Incremental increase in terms of numbers of patients waiting- validated with Cancer team and	week.  HIGH  RISK: Concerns raised by H&F and WL GPs around Trust responses to A&G requests (slow or ignored) and	HIGH Consistently above Phase 3 requirements, with significant additional capacity being	MEDIUM to HIGH CT @ 86% MR @ 94%
	Theatre data capture has improved increasing the activity and meeting / exceeding trajectory plans	reductions expected to move further in next couple of weeks.	lack of response from Trust when escalated.	brought on line together with high utilisation	US @ 84%

ICHT	HIGH	LOW- MEDIUM	HIGH	MEDIUM	MEDIUM to HIGH
	Total Elective activity	Number of patients slightly	Activity increasing and good	Use of available capacity /	
	76% of last year	reduced in next week.	engagement from Trust in	remains stable and close to	
		Continue to await	addressing issues.	achievement against Phase 3	CT @ 91%
	Currently above	confirmation of the 104 and			140 0 000/
	trajectory, on track	63+ waiters in endoscopy			MR @ 80%
	to meet ramp up				US @ 102%
	plan in the next 2				03 @ 102%
	weeks				
LNW	LOW TO MEDIUM	LOW-MEDIUM (	EDIUM-	MEDIUM 1	MEDIUM
	Total Flactive activity	Sustained rise in patients	leaves with data avality this week	Steadily improving and	
	Total Elective activity 65% of last year	waiting more than 63 days over last few weeks- now more than	Issues with data quality this week that needs to be resolved and	actions being taken to address scheduling issues and increase	CT @ 101%
	05% Of last year	double numbers in August (211	understood	the number of points	C1 @ 101%
	Overall activity and	patients)	understood	delivered per session	MR @ 94%
	theatre throughput	patientsy		delivered per session	
	remain fairly static	Continue to await			US @ 54% and cannot
	but day cases lower	confirmation of the 104 and			reach target due to low
	than anticipated.	63+ waiters in endoscopy			demand
	'	.,			
THH	MEDIUM	HIGH	IUM TO HIGH	MEDIUM=	LOW
		2 patients over 104	Significant numbers of referrals		
	Total Elective activity	32 patients in total beyond day	being returned with advice.	Dip in activity was due to	CT @ 114%
	74% of last year	63 - position stable	Some capacity issue being reported	specific issues, including	/
				swabbing arrangements which	MR @ 55%
	Theatre throughput			have now been addressed	US @ 66%
	increased to 160				03 @ 00%
	cases. Trajectory also				
	increased to 200+.	HIGH	MEDIUM	2/2	LOW to BAFRHINA
RBHT		Tertiary referral centre for lung	Baseline issue identified as reporting	n/a	LOW to MEDIUM
		only; backlog numbers small	issue; formally requesting review		
		and very few 2ww	from NHSE/I		CT @ 102%
		Currently managing backlog			
		within trust internal deadlines			MR @ 65%
		(given late referrals).			
					US @ 56%

#### NWL Fast Track Hub View

249 patients treated at hubs for the past one week (235 planned). Data is missing for CXH Ophthal and CMH urology

#### NB NOT updated from w/c 20/10

Speciality	Assessment of current delivery confidence	Movement	Comment
Gynae	MEDIUM	1	Lists to be provided this week
Gen surgery	MEDIUM	1	First sector list planned for 6 November
Ortho	MEDIUM	1	Sector wide agreement in place for 'Joint Drive week'. This was piloted at ICHT last week, a great success, 27 joints completed.
ENT	MEDIUM	<b>\Rightarrow</b>	Paeds ENT sector list progressing at CW
Ophthalmology	HIGH	<b>\( \)</b>	THH patients continue to be treated at CMH.  CW surgeons have commenced operation at CXH; first list at CXH was on 15 <sup>th</sup> Oct.
Urology	LOW	1	Activity planned at CMH from THH PTL, still awaiting lists to be provided.



# Chelsea and Westminster Hospital **WHS**

**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.2/Nov/20		
REPORT NAME	Integrated Performance Report – September 2020		
AUTHOR	Robert Hodgkiss, Chief Operating Officer & Deputy CEO		
LEAD	Robert Hodgkiss, Chief Operating Officer & Deputy CEO		
PURPOSE	To report the combined Trust's performance for September 2020 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.		
REPORT HISTORY	Executive Management Board 28.10.20		
	Quality Committee 03.11.20		
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for September 2020.		
	Regulatory performance		
	A&E  A&E performance in September was not compliant at 93.9%. Overall activity in the month was 79.4% of activity seen in 2019, however ambulance conveyances have now returned to 2019 figures. Patient flow through A&E on both sites continue to be challenged by the impact of covid infection prevention and control guidance, particularly the need to ensure patients being admitted from A&E have been tested for Covid, and isolated until the result is available.		
	Cancer The Final validated position for August was 65.45%. This has been caused by the delays on patient pathways during the pandemic period. Recovery plans and robust clinical reviews are in place. Backlog continues to reduce and is at its lowest level since before the Covid surge. The latest un-validated position for September is 67.42%		
	RTT RTT performance is confirmed at 62.05% which is an improvement of c4% this is primarily due to the restart of elective care pathways and the increase in new demand.		
	Current Patient Tracking List stands at 37,181 which is an increase of 1,179. This is reflective of the increasing trend in referrals across all services. Validation continues as well as DQ management to ensure long waiters are accurately reflected and managed within the directorates. Recovery plans are in place as well as clinical reviews to establish prioritisation of patients waiting to be seen.		
	<b>DM01</b> Performance against the standard is improving month on month with total waiting patients reducing across all modalities. As with other parts of the Elective pathway the Trust is working with NWL and system partners to restart diagnostics and recover the position.		

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



# TRUST PERFORMANCE & QUALITY REPORT September 2020





# **NHSI** Dashboard

		CI		Westmins ital Site	ter	U		liddlesex Hospital S	ite		Combine	ed Trust P	erformanc	е	Trust data 13 months
Domain	Indicator \(\triangle \)	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	93.67%	93.84%	94.0%	93.17%	95.35%	94.65%	93.9%	94.09%	94.60%	94.30%	93.9%	94.20%	93.69%	
RTT	18 weeks RTT - Incomplete (Target: >92%)	48.87%	55.31%	60.41%	62.20%	54.28%	63.41%	69.52%	65.80%	50.81%	58.34%	63.87%	57.80%	63.52%	***************************************
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	96.06%	96,34%	96.54%	96.19%	96.58%	96.64%	96.07%	95.76%	96.36%	96.52%	96.26%	96.44%	95.87%	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	100%	100%	97.40%	100%	100%	100%	97.40%	100%	100%	
Please note that all Cancer	31 days diagnosis to first treatment (Target: >96%)	95.24%	87.50%	89.74%	91.11%	98.00%	94.87%	95.00%	96.79%	96.74%	90.80%	92.93%	93.85%	95.13%	
indicators show interim,	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	n/a	n/a	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	
unvalidated positions for the	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	n/a	n/a	n/a	33.33%	100%	100%	71.43%	33.33%	100%	100%	50.00%	71.43%	V
latest month (Sep-20) in this	62 days GP referral to first treatment (Target: >85%)	41.30%	40.00%	54.72%	52.47%	76.47%	75.00%	75.27%	71.95%	62.28%	65.45%	67.81%	63.84%	65.51%	VV-
report	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	60.00%	n/a	n/a	n/a	n/a	60.00%	V-V/
Patient Safety	Clostridium difficile infections (Year End Target: 26)	3	2	1	9	3	3	1	9	6	5	2	13	18	did is dis
Learning Difficulties	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	
	Please note the following three items	n/a	Can refer	to those inc	dicators not a	applicable (e	g Radiothe	rapy) or inc	licators whe	re there is г	no available	e data. Such	n months will	l not appear i	n the trend graphs.
			RTT Admir	tted & Non-	Admitted are	no longer N	Monitor Con	npliance Indi	icators	Either	Site or Tr	ust overall p	erformance	red in each o	of the past three moi
			Note that	all Cancer ir	ndicators sho	ow interim, u	unvalidated	positions fo	or the latest i	nonth (Sep-	20) and ar	e not includ	led in quarte	rly or yearly t	totals

## A&E

A&E performance in September was not compliant at 93.9%. Overall activity in the month was 79.4% of activity seen in 2019, however ambulance conveyances have now returned to 2019 figures. Patient flow through A&E on both sites continue to be challenged by the impact of covid infection prevention and control guidance, particularly the need to ensure patients being admitted from A&E have been tested for covid, and isolated until the result is available.

# Cancer

The Final validated position for August was 65.45%. This has been caused by the delays on patient pathways during the pandemic period. Recovery plans and robust clinical reviews are place. Backlog continues to reduce and is at its lowest level since before the COVID surge. The latest un-validated position for September is 67.42%

# **RTT**

RTT performance is confirmed at 62.05% which is an improvement of c4% this is primarily due to the restart of elective care pathways and the increase in new demand.

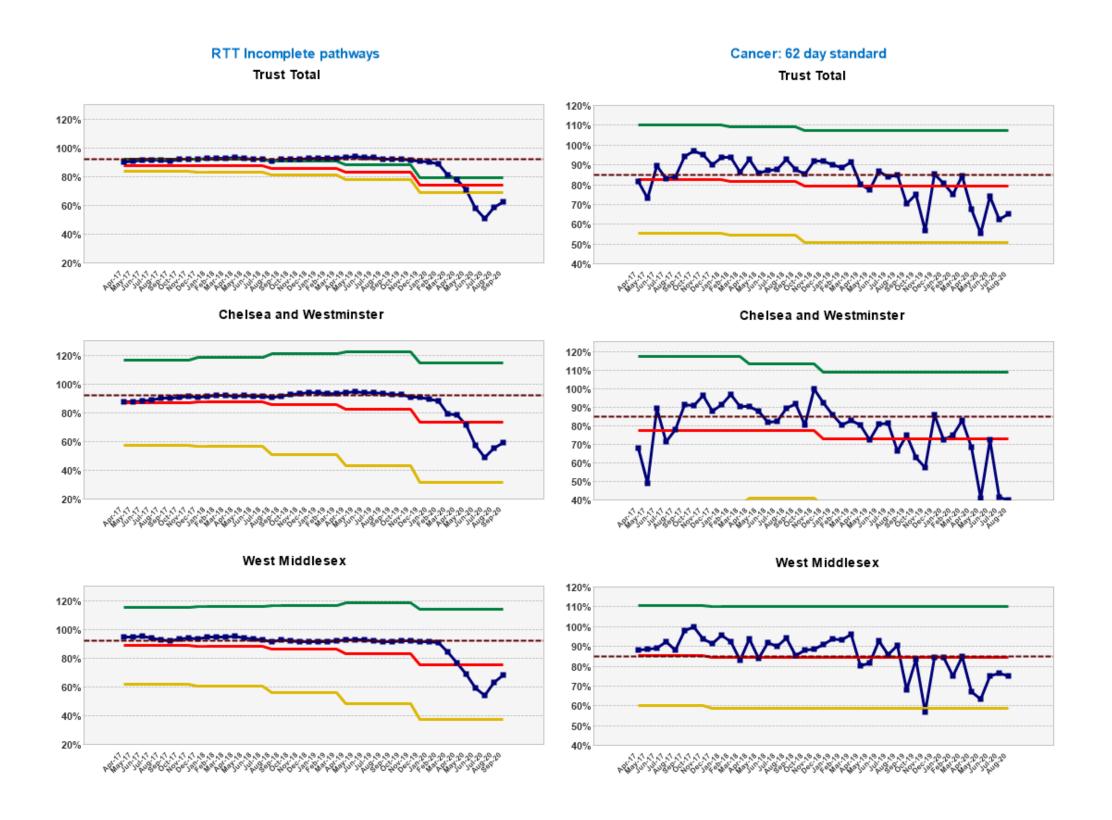
Current Patient Tracking List stands at 37,181 which is an increase of 1,179. This is reflective of the increasing trend in referrals across all services. Validation continues as well as DQ management to ensure long waiters are accurately reflected and managed within the directorates. Recovery plans are in place as well as clinical reviews to establish prioritisation of patients waiting to be seen.

# **C.Diff Infection**

There were two Trust attributed Clostridium difficile cases in September 2020, 1 hospital onset-healthcare associated (HOHA) occurring at the WM site and 1 HOHA occurring at the CW site. The WM site RCA identified no lapses in care that contributed to the development of Clostridium difficile and all antibiotic therapy was appropriate. The CW site RCA data is currently being collated and the meeting will be held in October 2020.



# Statistical Process Control Charts for the 37 months April 2017 to September 2020







# **Safety Dashboard**

		CI		Westmins ital Site	ter	U		liddlesex Hospital S	ite		Combine	ed Trust P	erformanc	e	Trust data 13 months
Domain	Indicator \(\triangle \)	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts
Hospital-acquired	MRSA Bacteraemia (Target: 0)	0	- 1	0	1	0	0	0	0	0	1	0	1	1	
infections	Hand hygiene compliance (Target: >90%)	98.7%	92.3%	90.3%	90.9%	85.1%	88.2%	90.8%	89.0%	92.4%	90.5%	90.5%	91.1%	90.1%	
	Number of serious incidents	8	3	1	25	3	2	2	13	11	5	3	19	38	addatda.
	Incident reporting rate per 100 admissions (Target: >8.5)	12.6	11.3	9.5	12.2	11.9	11.0	10.6	12.4	12.3	11.1	10.1	11.1	12.3	
Incidents	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.12	0.02	0.00	0.04	0.02	0.06	0.04	0.04	0.07	0.04	0.02	0.04	0.04	
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	5.39	4.48	5.73	5.64	3.96	3.65	2.40	3.60	4.77	4.06	4.11	4.32	4.66	1-1/1-
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	2.8%	2.1%	0.0%	1.1%	0.0%	2.5%	0.0%	1.4%	1.8%	2.3%	0.0%	1.3%	1.2%	$\wedge \wedge \wedge$
	Never Events (Target: 0)	0	0	0	0	0	0	0	1	0	0	0	0	1	$\wedge$
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Harm	NEWS compliance %														
папп	Safeguarding adults - number of referrals	28	33	23	153	16	32	28	143	44	65	51	160	296	
	Safeguarding children - number of referrals	47	39	38	188	101	100	145	554	148	139	183	470	742	thibath
	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.77	0.78	0.78	0.78	0.77	0.78	0.78	0.78	0.77	0.78	0.78	0.78	0.78	and the same
	Number of hospital deaths - Adult	16	27	37	229	43	56	47	414	59	83	84	226	643	111111
	Number of hospital deaths - Paediatric	1	1	1	5	0	0	0	0	1	1	1	3	5	11 11 111
h 4	Number of hospital deaths - Neonatal	2	1	0	8	1	0	1	4	3	1	1	5	12	1
Mortality	Number of deaths in A&E - Adult	4	2	2	11	8	4	5	36	12	6	7	25	47	11  11  11
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	0	2	0	0	0	0	2	

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

# Medication-related safety incidents

A total of 120 medication-related incidents were reported in September 2020. CW site reported 71 incidents, WM site reported 42 incidents and there were 7 incidents reported in community. There has been an increase in the total number of medication –related incidents reported across the Trust since August 2020.

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

The Trust position of medication-related incidents involving patients (NRLS reportable) was below target in September 2020 with 4.14 per 1,000 FCE bed days. Although this falls just below the target of 4.2, there has been an increase in the number of medication-related incidents reported since August (3.75/1000 FCE bed days). The importance of incident reporting continues to be shared through different forums including MSG, ward manager meetings and induction for new starters.

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

The Trust had 0% of medication-related safety incidents with moderate harm and above in September 2020, which is in line with the Trust target of ≤2%.

# **Harm Indicators**

In September 2020, one incident was reported that potentially caused the patients death and relates to a delayed ITU transfer. The incident has been declared an external serious incident; the degree of harm will be confirmed following completion of the SI investigation.





# **Patient Experience Dashboard**

		C		Westmins tal Site	ter	U		liddlesex Hospital S	ite		Combine	ed Trust P	erformanc	е	Trust data 13 months
Domain	Indicator	∆ Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts
	FFT: Inpatient recommend % (Target: >90%)	94.8%	96.4%	93.4%	94.6%	97.5%	95.9%	97.1%	96.6%	96.3%	96.1%	95.1%	95.8%	95.6%	
	FFT: Inpatient not recommend % (Target: <10%)	1.6%	1.2%	1.9%	1.6%	0.6%	1.1%	0.2%	0.7%	1.0%	1.2%	1.1%	1.1%	1.1%	
	FFT: Inpatient response rate (Target: >30%)	18.5%	16.6%	16.0%	15.5%	22.7%	25.5%	22.7%	19.7%	20.7%	21.3%	18.5%	19.9%	17.5%	
	FFT: A&E recommend % (Target: >90%)	89.4%	87.5%	88.4%	89.7%	93.7%	94.0%	90.9%	92.9%	90.9%	89.6%	89.2%	89.9%	90.6%	
Complaints	FFT: A&E not recommend % (Target: <10%)	6.1%	7.1%	6.1%	5.7%	4.0%	4.1%	6.3%	4.7%	5.3%	6.1%	6.1%	5.9%	5.4%	-
	FFT: A&E response rate (Target: >30%)	20.9%	20.9%	21.1%	22.1%	26.6%	25.4%	23.9%	25.3%	22.7%	22.2%	21.9%	22.2%	22.9%	
	FFT: Maternity recommend % (Target: >90%)	86.3%	84.0%	80.8%	84.0%	87.5%	96.3%	97.4%	94.0%	86.4%	88.1%	84.5%	86.5%	86.6%	li Illini.
	FFT: Maternity not recommend % (Target: <10%)	6.9%	11.0%	13.8%	10.3%	12.5%	2.5%	2.6%	4.8%	7.3%	8.2%	11.3%	8.8%	8.8%	11111
	FFT: Maternity response rate (Target: >30%)	17.8%	18.0%	13.3%	16.3%	3.0%	21.2%	9.9%	10.1%	12.6%	18.9%	12.3%	14.5%	14.0%	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Complaints (informal) through PALS	53	63	70	117	17	21	15	84	42	44	42	128	201	11111
	Complaints formal: Number of complaints received	25	23	27	75	15	11	3	49	34	26	14	74	124	llliii.
Complaints	Complaints formal: Number responded to < 25 days	19	15	11	264	34	52	41	250	87	115	111	313	514	
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0	
	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 denote:	s those indic	ators currer	ntly under d	development	t	Eithe	r Site or Tr	ust overall p	performance	red in each	of the past three mor
	Regarding Friends and Family Tests:	These m	etrics are c	urrently sus	spended and	will be re-ir	nstated it th	is report w	hen brought	back on line	;				

# Complaints

The number of formal complaints received remains low compared to the same month last year. All complaints were acknowledged within 2 working days and 95% of complaints were responded to within 25 working days.

# **PHSO**

4 cases remain under consideration by the PHSO, there has been no further update on these in month.

### **FFT**

The restart of FFT continues with most areas now achieving above the required recommendation score. WM Maternity has seen an improvement in satisfaction rates, however further work is required to improve the response rates on both sites. Postnatal care is the focus of an improvement plan for maternity services and will be monitored locally and through the patient experience group meetings. ED response rate remain above the national average which is 12.5%. All wards and departments are being monitored for compliance with areas below the required standard being provided with additional support





# **Efficiency & Productivity Dashboard**

		С		Westmins ital Site	ster	L		Middlesex Hospital S	Site		Combine	ed Trust P	erformanc	e	Trust data 13 months
Domain	Indicator \( \triangle \)	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts
	Average length of stay - elective (Target: <2.9)	23.00	3.38	6.55	8.33	1.75	1.00	2.47	2.16	22.11	3.32	6.30	9.21	8.06	
	Average length of stay - non-elective (Target: <3.95)	3.58	3.65	3.80	3.74	3.19	3.02	3.28	3.16	3.36	3.29	3.51	3.39	3.41	
Admitted Patient	Emergency care pathway - average LoS (Target: <4.5)	4.23	3.90	4.38	4.29	3.52	3.44	3.78	3.69	3.78	3.60	4.01	3.80	3.91	
Care	Emergency care pathway - discharges	190	191	208	1015	324	349	341	1724	514	541	549	1605	2739	111111111111111111111111111111111111111
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	6.14%	5.65%	5.38%	6.37%	11.63%	11.61%	11.28%	11.86%	9.01%	8.71%	8.36%	8.67%	9.25%	Jan. 1
	Non-elective long-stayers	325	347	233	1705	331	348	179	1432	656	695	412	1763	3137	1111111-111-
	Daycase rate (basket of 25 procedures) (Target: >85%)	87.4%	78.3%	81.5%	82.4%	97.6%	97.8%	97.9%	98.0%	90.9%	83.9%	87.4%	87.1%	87.8%	
	Operations canc on the day for non-clinical reasons: actuals	0	1	6	7	6	0	3	9	6	1	9	16	16	11111
Theatres	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.00%	0.05%	0.29%	0.10%	0.93%	0.00%	0.28%	0.31%	0.28%	0.04%	0.29%	0.20%	0.16%	
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	1	5	6	0	0	1	1	0	1	6	7	7	lilli i
	Theatre Utilisation (Target >85%)	53.7%	57.0%	64.1%	56.5%	54.8%	68.6%	69.7%	65.0%	54.0%	60.3%	65.8%	60.6%	58.9%	Variation of the same of the s
	First to follow-up ratio (Target: <1.5)	2.43	2.48	2.51	2.55	2.22	2.29	2.09	2.30	2.34	2.40	2.33	2.35	2.44	n IIII
Outpatients	Average wait to first outpatient attendance (Target: <6 wks)	9.4	8.3	8.8	9.4	10.3	9.5	8.2	9.6	9.8	8.8	8.5	9.1	9.5	
Outpatients	DNA rate: first appointment	7.3%	8.0%	7.6%	7.7%	5.7%	6.9%	6.4%	5.9%	6.6%	7.5%	7.1%	7.1%	6.9%	a.p. and
	DNA rate: follow-up appointment	7.5%	8.5%	7.7%	7.7%	6.2%	6.1%	5.9%	5.5%	7.0%	7.5%	7.0%	7.1%	6.8%	
	Please note the following	blank cell	An empty	cell denote	s those indic	ators curre	ntly under	developmen	nt	Either	r Site or Tr	ust overall į	performance	red in each	of the past three m

# LoS

A Number of records have been identified as being recorded incorrectly and is in the process of being updated. The LoS is expected to be in line with the previous month of 3.32

### Theatre Metrics

These indicators have been impacted by the cessation of activity over the period and are not comparable with recent months however there is an increase in Theatre usage and Utilisation from 60.3% in August 2020 to 65.7% in September 2020 as elective restart plans is enacted.

# Outpatient

These indicators would have been impacted by the cessation of activity over the period and are not comparable with recent months





# Clinical Effectiveness Dashboard

		CI		Westmins ital Site	ter	U		liddlesex Hospital S	iite		Combine	ed Trust P	erformanc	е	Trust data 13 months
Domain	Indicator \( \triangle \)	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts
	Dementia screening case finding (Target: >90%)	97.3%	98.6%	89.6%	80.8%	44.3%	68.9%	90.3%	66.9%	64.4%	80.4%	90.0%	78.2%	73.0%	
Best Practice	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	80.0%	100.0%	80.0%	90.8%	81.0%	92.3%	100.0%	91.1%	80.6%	96.4%	90.5%	88.8%	91.0%	W-VV
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	94.4%	50.0%	72.7%	83.7%	81.8%	100.0%	88.2%	89.4%	89.7%	78.9%	82.1%	83.2%	86.5%	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
VTE	VTE: Hospital acquired	0	0	1	1	0	1	0	5	0	1	1	2	6	
VIC	VTE risk assessment (Target: >95%)	83.7%	92.7%	90.8%	78.5%	92.8%	90.5%	93.7%	84.0%	88.9%	91.6%	92.2%	91.1%	81.3%	Total Control
TB Care	TB: Number of active cases identified and notified	83.7%         92.7%         90.8%         78.5%         92.8           1         1         3         12         4			4	10	10	42	5	11	13	29	54	anthlinal	
	Please note the following	blank cell	An empty	cell denote	s those indic	ators curre	ntly under d	developmen	t 🕕	Either Site	or Trust o	verall perfo	rmance red ir	n each of the	past three months

# **Dementia screening**

For September the Trust achieved 90% for dementia screening.

### VTE risk assessment

The Trust VTE risk assessment performance improved in September compared to previous month. Overall, divisional performance: EC 98%, PC 91% and WC 81%. At both sites, all maternity and adolescent (16 years and older) clinical areas/wards require improvement with staff embedding into practice – education and awareness provided at various meetings. QlikSense VTE application is available to provide real-time performance to support daily monitoring and action on outstanding assessments. Information team to develop and circulate weekly VTE performance reports to support clinical areas with monitoring and appropriate action. VTE performance is tracked weekly through the TW3 performance meetings to ensure improved compliance.

Site	Denominator	Numerator	%
Total	6,243	5,758	92.2%
CWH	3,157	2,867	90.8%
WMH	3,086	2,891	93.7%





# **Access Dashboard**

		CI		Westmins ital Site	ter	U		liddlesex Hospital S	iite		Combine	ed Trust P	erformanc	е	Trust data 13 months	
Domain	Indicator	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts	
	RTT Incompletes 52 week Patients at month end	175	294	415	981	87	144	233	496	262	438	648	1348	1477	1	Ø
RTT waits	Diagnostic waiting times <6 weeks: % (Target: >99%)	43.31%	62.47%	75.07%	52.73%	44.14%	69.66%	78.96%	49.51%	43.74%	66.10%	77.11%	61.11%	50.99%		Ø
	Diagnostic waiting times >6 weeks; breach actuals	3290	1910	1196	14987	3612	1576	1116	18680	6902	3486	2312	12700	33667		-
	A&E unplanned re-attendances (Target: <5%)	9.0%	9.9%	9.0%	9.6%	7.9%	9.3%	8.4%	8.5%	8.6%	9.7%	8.8%	9.0%	9.2%	<b>√</b> √-√\	Ø
A&E and LAS	A&E time to treatment - Median (Target: <60')	00:35	00:36	00:28	00:35	00:48	00:52	00:52	00:47	00:44	00:46	00:42	00:44	00:43	Tonas and	-
AGE BIID LAS	London Ambulance Service - patient handover 30' breaches	7	6	3	45	25	33	38	194	32	39	41	112	239		-
	London Ambulance Service - patient handover 60' breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	13 months Trend charts	-
	Please note the following	blank cell	An empty	cell denote	s those indic	ators curre	ntly under o	developmen	t 🕕	Either Site	or Trust ov	verall perfo	rmance red i	n each of the	past three months	S

# RTT 52 Week waits

Due to the cessation of routine elective activity the position against the Trust long waiters will remain challenged. All Long waiting patients will have been clinically reviewed and will be treated in clinical priority order. The position across London and nationally continues to worsen.

# Diagnostic wait times <6weeks

Performance against the standard is improving month on month with total waiting patients reducing across modalities

As with other parts of the Elective pathway the Trust is working with NWL and system partners to restart diagnostics and recover the position.





# **Maternity Dashboard**

		CI		Westmins ital Site	ter	U		liddlesex Hospital S	ite		Combine	ed Trust P	erformanc	е	Trust data 13 months	
Domain	Indicator	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	Trend charts	
	Total number of NHS births	473	439	485	2720	370	385	388	2302	843	824	873	2540	5022		-
Birth indicators	Total caesarean section rate (C&W Target: <27%; V/M Target: <29%)	37.6%	36.1%	39.2%	37.5%	36.2%	33.2%	34.0%	33.1%	37.0%	34.7%	36.9%	36.2%	35.5%	\\	•
Direct in falcator 5	Midwife to birth ratio (Target: 1:30)	1:29.5	1:29.5	1:29.5	1:29.5	1:29	1:29	1:29	1:29	1:29.25	1:29.25	1:29.25	1:29.25	1:29.13		-
	Maternity 1:1 care in established labour (Target: >95%)	96.8%	97.4%	96.5%	96.2%	95.2%	98.1%	98.8%	97.2%	96.0%	97.8%	97.5%	97.1%	96.6%	~~~~~	-
Safety	Admissions of full-term babies to NICU	11	14	18	86	n/a	n/a	n/a	n/a	11	14	18	43	86	tuta alut	-
	Please note the following	blank cell	An empty	cell denotes	s those indica	ators currer	itly under d	levelopment	0	Either Site	or Trust o	verall perfo	mance red in	n each of the	past three months	3

# Maternity

The Caesarean section rate at WM: 59 women (15.4%) had an elective CS, 71 women (18.6%) had an emergency CS.

The CS rate at CW: 87 women (17.8%) had an elective CS, 81 women (16.6%) had an emergency CS =34.5%.

The increase in CS rate on both sites is driven by an increase in planned CS rate, further work is focused on the factors influencing the Em CS rate at WM, with factors such as the increase in Induction of labour rate being reviewed.

The 1:1 care in labour at the CW site has dropped slightly with further work needed to implement the new escalation policy and ensure short term sickness is covered.





# **62 day Cancer referrals by tumour site Dashboard**

# Target of 85%

				ea & West Hospital S					est Middle rsity Hosp				Com	bined Trus	st Perforn	nance		Trust data 13 months	
Domain	Tumour site	Jul-20	Aug-20	Sep-20	2020- 2021	YTD breaches	Jul-20	Aug-20	Sep-20	2020- 2021	YTD breaches	Jul-20	Aug-20	Sep-20	2020- 2021 Q2	2020- 2021	YTD breaches	Trend charts	
	Breast	n/a	n/a	n/a	n/a		75.0%	50.0%	90.0%	69.2%	17	75.0%	50.0%	90.0%	68.8%	69.2%	17		
	Colorectal / Lower GI	14.3%	33.3%	50.0%	43.3%	11.5	77.8%	84.6%	63.6%	78.7%	7	50.0%	63.6%	56.5%	57.9%	64.9%	18.5		(
	Gynaecological	0.0%	n/a	20.0%	0.0%	2.5	100%	71.4%	60.0%	72.3%	7.5	75.0%	71.4%	40.0%	72.7%	70.8%	10		(
	Haematological	100%	n/a	n/a	61.5%	2.5	66.7%	100%	100%	83.3%	1	85.7%	100%	100%	88.9%	72.0%	3.5	$\sim$	
62 day	Head and neck	n/a	0.0%	0.0%	0.0%	2	n/a	n/a	100%	20.0%	4	n/a	0.0%	60.0%	0.0%	16.7%	6		
Cancer referrals	Lung	100%	n/a	100%	63.6%	2	100%	100%	50.0%	77.8%	1.5	100%	100%	66.7%	100%	70.0%	3.5	Illiald Ili	
by site of turnour	Sarcoma	n/a	n/a	n/a	n/a		n/a	n/a	n/a	0.0%	1.5	n/a	n/a	n/a	n/a	0.0%	1.5	Ш	
rail i a	Skin	53.3%	90.0%	83.3%	87.2%	6	100%	96.4%	100%	98.4%	0.5	66.7%	94.7%	90.9%	84.7%	92.1%	6.5	$\vee$	
	Upper gastrointestinal	n/a	n/a	100%	40.0%	3	100%	100%	100%	80.0%	1	100%	100%	100%	100%	60.0%	4	-WW\_	
	Urological	7.1%	0.0%	50.0%	8.7%	26	61.1%	42.1%	58.8%	45.2%	30	37.5%	28.6%	55.6%	33.3%	32.3%	56	·√\.	
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a	100%	0	100%	n/a	n/a	100%	100%	0		
	Site not stated	n/a	n/a	n/a	n/a		n/a	n/a	n/a	122.2%	-1	n/a	n/a	n/a	n/a	122.2%	-1		
	Please note the following	n/a	Refers to	those indica	ators wher	e there is no o	data to repo	ort. Such m	onths will n	ot appear ir	the trend gra	aphs 📵	Either S	te or Trust (	overall perf	ormance r	ed in each of	13 months	ont
			Please no	te that all in	dicators sh	ow interim, u	nvalidated p	oositions fo	or the latest	month (Sep	)-20) and are	not include	d in quarte	rly or yearly	/ totals				



# Safe Staffing & Patient Quality Indicator Report – Chelsea Site

# September 2020

Month	Da	у	Nig	ht	CHPPD	CHPPD	CHPPD	National Benchmark	August 20 Vacancy Rate	Augı Voluntary	ust 20 Turnover	Inp	atient fa	all with h	ıarm	pressu	cquired re ulcer tageable	Medic incid		FFT September
onui	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	НСА	Total			Qualified	Un- qualified	Mode	erate	Se	vere					2020/21
												Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Maternity	96%	43%	95%	47%	10	3.5	13.6	15.3	4%	9%	11%							8	45	
Annie Zunz	123%	23%	100%	77%	12.3	2.5	14.8	7.8	13%	32%	0%		2						8	
Apollo	100%	88%	100%		17.3	1.3	19.4	10.9	14%	28%	0%		1					7	19	
Jupiter								10.9	20%	21%	0%								1	
Mercury	100%	40%	100%		6.6	0.2	6.9	9.3	24%	4%	67%							3	25	
Neptune	81%	41%	82%		12	1.2	13.2	10.9	28%	26%	67%								5	
NICU	104%		103%		15.1		15.3	26	11%	11%	20%								24	
AAU	106%	68%	103%	88%	10.6	2.4	13.2	7.8	15%	10%	57%	5	33					3	29	97%
Nell Gwynne	105%	75%	120%	74%	4.4	3.4	8	7.3	2%	5%	22%	3	4					1	1	100%
David Erskine	115%	77%	125%	84%	6.2	3.9	10.6	7	16%	16%	20%									95%
Edgar Horne	98%	87%	104%	98%	3.2	2.4	5.9	6.9	7%	10%	16%		1					1	2	100%
Lord Wigram	101%	92%	111%	101%	5.1	3.1	8.3	7	12%	9%	5%	1	13					1	15	95%
St Mary Abbots	87%	53%	89%	118%	4.4	1.9	6.7	7.2	13%	21%	0%									
David Evans	92%	100%	98%	162%	7.7	3.6	11.3	7.2	4%	5%	0%	1	8					1	2	99%
Chelsea Wing								7.2	25%	20%	17%	1								
Burns Unit	98%	90%	101%	100%	18.7	2.5	21.2	N/A	3%	21%	14%	1	2					2	11	100%
Ron Johnson	89%	85%	99%	95%	4.8	2.5	7.3	7.4	12%	17%	21%									
ICU	93%		98%		23.9		23.9	26	0%	21%	200%							6	20	
Rainsford Mowlem	90%	68%	88%	76%	3.1	2.6	6	7.3	6%	8%	3%	11	57						26	90%
Nightingale								7.3	N/A	N/A	N/A	13	41					1	8	100%





# **Safe Staffing & Patient Quality Indicator Report – West Middlesex Site**

# September 2020

Ward	Da	У	Niç	ght	CHPPD	CHPPD	Total	National Benchmark	Vacancy Rate		) Voluntary nover	Inpa	atient fa	ıll with ha	arm	Trust ad pressui 3,4,unst	e ulcer	Medic incid		FFT September 2020/21
	Average fill rate -	Average fill rate - care	Average fill rate -	Average fill rate - care	Reg	НСА				Qualified	Un- Qualified	Mode	erate	Sev	ere					
	registered	staff	registered	staff							Qualified	Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Lampton	104%	99%	101%	99%	3.3	3	6.3	7.3	4%	0%	13%	4	25					2	5	99%
Richmond								7.2		21%	0%									
Syon 1 cardiology	132%	273%	123%		4.2	1.7	5.9	8		0%	0%	5	35						15	96%
Syon 2	109%	82%	122%	112%	4	3.2	7.2	7.3	19%	11%	20%	1	20					3	18	85%
Starlight	102%		113%		9.6		9.6	10.9	10%	22%	0%							6	15	100%
Kew	98%	75%	100%	89%	3.1	2.5	5.8	6.9	13%	10%	15%	8	26					1	14	93%
Crane	104%	93%	101%	80%	3.4	3.2	6.6	6.9	9%	0%	7%	7	35						6	100%
Osterley 1	108%	71%	102%	118%	4	2.5	7	7	11%	16%	7%	5	24					3	15	96%
Osterley 2	118%	54%	110%	76%	4.5	1.7	6.4	7.2	15%	3%	10%	5	27						8	100%
MAU	123%	123%	129%	100%	6.8	2.6	9.5	7.8	1%	8%	37%	5	53					6	39	98%
Maternity	100%	84%	104%	89%	7.5	2.3	9.9	15.3	-2%	6%	0%		1					1	14	
Special Care Baby Unit	101%	100%	87%	100%	8.6	3.1	11.7	10.9	10%	4%	0%							10	19	100%
Marble Hill 1	131%	97%	100%	146%	4.3	2.9	7.3	7.3	71%	14%	11%	10	19						12	100%
Marble Hill 2								6.5	10%	5%	22%	1	41							82%
ITU	93%		97%		29.9		30	26	-4%	13%	0%		2				1	2	11	





# **Safe Staffing & Patient Quality Indicator Report**

# September 2020

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours Per Patient Day (CHPPD). This is then benchmarked against the national benchmark and triangulated with associated quality indicators from the same month and staffing vacancy/turnover and patient experience for the 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.

A number of wards, Chelsea Wing, Marble Hill 2 and Richmond remained closed during September and to minimise risk and temporary staffing spend, staff were deployed across wards and the sites when necessary to minimise risk on a shift by shift basis, but this was not always correctly entered into the health roster system so some inaccuracies will exist and show low fill rates when this was not the case. Wards at the Chelsea Site such as Ron Johnson, David Erskine, Edgar Horne, David Evans and Saint Marys Abbots are referred to by their roster name rather than their present physical location. Annie Zunz, and Nell Gwynne staff and patients returned to their original location and Ron Johnson has now relocated to David Erskine ward.

David Erskine has high fills rate due to NIV and the number of side rooms.

AMU on the West Mid site have increased their bed capacity from 47 to 64 and increased their enhanced care beds from 6 to 10 beds hence require additional staff. The staffing template is currently being adjusted accordingly. Syon 1 Cardiology has increased bed capacity from 18 to 30 beds and the staffing template will be adjusted this month and staff recruitment is in progress. Kew has low fill rates for HCA's as they have a number of vacancies and shifts could not be filled by bank. Osterley 1 which moved to Marble Hill 1 has increased bed capacity from 30 to 33 and the staffing template requires adjustment.

Syon 2 required extra RNs and HCAs at night due to high acuity including patients with tracheostomies and Non-Invasive Ventilation.

Jupiter ward was closed and Neptune hosted their staff and all paediatric patients on admission until COVID screening results came back. The staffing resource for Neptune & Jupiter has thus been combined. Apollo has a high CHPPD due to the low number of admissions throughout September. Maternity on the Chelsea Site showed low fill rates but, in reality, aspiring midwives were rostered supernumerary shifts on the unit so assisted in delivering care.

Due to lower patient numbers on St Mary Abbots (based on David Evans) it was not necessary to fill all the HCA shifts and without the SAU it was unnecessary to fill the 6<sup>th</sup> RN shift. David Evans is based on Edgar Horne and admits elective surgery.

Annie Zunz had 2 HCAs on long term leave and had difficulty securing HCAs to work bank shifts. However, due to a reduced bed base and theatre list there was adequate RN cover. Rainsford Mowlem had low HCA fill rates as 8 beds were often closed and staff were deployed to other wards, they also experienced difficulty filling bank shifts. Nell Gwynne also had low HCA fill rates as they had 3 supernumerary Apprentice Nursing Associates covering some of the shifts. 33 HCAs have been recruited substantively in the last month to fill these vacancies. David Evans had high HCA fill rates at night due to high patient acuity and dependency and they only have one HCA Monday to Saturday in their template.

All falls in September were of no or low harm on both sites and there was one medication error with moderate harm on Apollo.

The Family and Friends report contains the August figures as the September percentages have not yet been released.





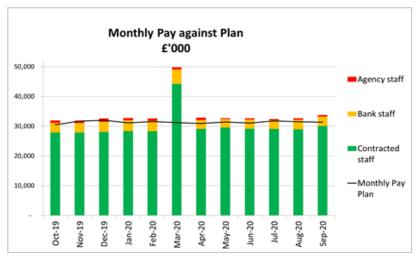
# Finance Dashboard M6 2020/21

	Combined Trust										
£'000	Plan to Date	Actual to Date	Variance to Date								
Income Expenditure	335,644	356,966	21,322								
Pay	(188,424)	(196,970)	(8,547)								
Non-Pay	(128,684)	(141,254)	(12,571)								
EBITDA	18,537	18,742	204								
EBITDA %	5.52%	5.25%	-0.3%								
Depreciation	(10,386)	(10,386)	0								
Non-Operational Exp-Inc	(8,073)	(8,278)	(204)								
Surplus/Deficit	78	78	0								
Adjust for - Donated asset, Impairment & Other	(78)	(78)									
Adjusted Surplus/Deficit	0	0									



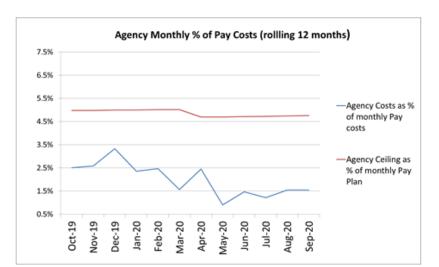
The Trust is reporting a breakeven position when adjusted for the financial impact of donated assets and income. The position includes an accrual/actual income of £22.9m to address shortfalls in our funding model and expenditure related to our COVID-19 response.

Income: Contractual income from CCG and NHS England continues on a block at the same level as M1-5. Local authority income was reported below the 20/21 baseline as we negotiate post-covid terms for this contract. NHS Non-contracted activity income is reported as COVID-19 loss of income, but sexual health is being billed as normal.



### Comment:

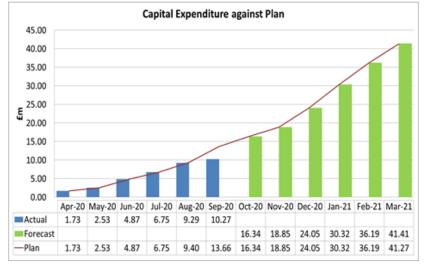
The pay cost spike in March includes two exceptional items of £14.6m full year notional charge for 6.3% employer Pension contributions and £2m COVID-19 holiday accruals costs. The increase in M6 is due to backdated consultant & trust grade pay awards c£1m.



# 12 Month Cash Flow 200 180 160 140 120 80 60 40 20 0 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Actual 166.08 177.14 167.12 165.26 170.29 169.05 Forecast Plan 161.85 156.42 152.63 153.43 145.67 135.25 135.39 129.47 127.28 127.60 122.60 71.49

### Comment:

The favourable cash variance to plan in M6 of £33.79m is favourable cash variance b/fwd from M5 of £24.6m, Higher cash receipts to plan of £2.88m (Extra NHS England Income + Covid Top Up (£6m) + £1.3m Local Authorities offset by lower FT Income -£1.8m, lower CCG -£474K, lower PSF -£1.6m and lower PP Income -£540k), plus lower cash outflows to plan £6.28m (PDC Dividend Payment deferred).



### Comment

The Trust has spent £0.99m in period 6 compared to the forecast from July of £4.26m, resulting in an underspend of £3.28m. The underspend is mainly associated with the reversal of costs previously accrued for the NICU project for disputed items. An agreement has now been reached with the main contractor over this and the actual costs incurred have been accounted for. The remaining underspend relates to the impact of the Covid-19 outbreak which has resulted in a number of projects being delayed. It is expected that this underspend will spent later in the year as it relates to timing differences between the timing of the planned spend and when the actual costs will be incurred.





# **CQUIN** Dashboard

# 2020/21 CQUIN Schemes

As contracting with NHS commissioning organisations has been suspended during the period of the COVID-19 response, the position relating to CQUIN remains unclear. Whilst national CQUIN schemes have been published, delivery





# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.3/Nov/20
REPORT NAME	Medical Appraisal & Revalidation Annual Report 2019/20
AUTHOR	Dr J Durbridge, Associate Medical Director for Professional Development S Chowdhury, Head of Medical Workforce
LEAD	Dr Roger Chinn, Medical Director
PURPOSE	For the committee to note prior to submission to the Board for approval and GMC.
REPORT HISTORY	Executive Management Board 14.10.20
SUMMARY OF REPORT	The Trust in its role as a Designated Body (DB) of the General Medical Council (GMC), must be assured that the doctor for whom it is the DB are Fit to Practise. This assurance is through a process of revalidation based upon annual professional appraisal and reflection.  The trust is the DB for doctors and there have been (80%) annual appraisals completed this year and the Responsible Officer (RO) has made a positive recommendation for revalidation for 177 (out of 227 due) for our doctors in 2019/20. The remainder were deferred (and since completed) to await further supporting documentation. We have not made any non-engagement recommendations and one doctor is deferred as there is an on-going process proceeding.
KEY RISKS ASSOCIATED	The key risk is that we are not assured of fitness to practise and the safety of our doctors
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Failure to provide high quality care.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Be the employer of choice</li> </ul>
DECISION/ ACTION	For approval.





# **Annual Appraisal & Revalidation Board Report 2019-2020**



# Chelsea and Westminster Hospital MHS

# NHS Foundation Trust

# **Contents**

1.		Executive summary	3
2.		Purpose of the Paper	3
3.		Background	3
4.		Governance Arrangements	4
	a.	Policy and Guidance	4
5.		Medical Appraisal	5
	a.	Appraisal and Revalidation Performance Data	5
	b	. Appraisers	5
	c.	Quality Assurance	5
d.		Access, Security and Confidentiality	5
	e.	Clinical governance	5
	f.	Update on Action Plan from 2018/19 Board Report	6
6.		Revalidation Recommendations	6
7.		Recruitment and engagement background checks	6
8.		Monitoring Performance	6
9.		Responding to Concerns and Remediation	7
1(	).	Risks and Issues	7
11	1.	Corrective Actions, Improvement Plan and Next Steps	7
12	2.	Recommendations	8
13	3.	Appendix A – Audit of all missed or incomplete appraisals	9
14	4.	Appendix B – Quality assurance of appraisal inputs and outputs	
16	3.	Appendix C– Audit of concerns about a doctor's practice	12
17		Appendix D– Audit of revalidation recommendations	
18	3.		



# 1. Executive summary

Due to the COVID pandemic and suspension of appraisal in Mid March, we are not statutorily required to submit an annual report for 2019/20. However, we recommenced the appraisal systems from July 2020 and wanted to review the 19/20 year to ensure that we provide the correct support for our doctors in complying with the appraisal & revalidation requirements going forward. Chelsea and Westminster Healthcare NHS Foundation Trust had 712 doctors eligible for an appraisal in 2019/20. There have been 572 (80.34%) completed appraisals for the appraisal year. The appraisal team capacity to follow up and investigate missing appraisals was impacted by the COVID pandemic during the last quarter of 19/20 and this has led to the lower than expected completion rate. Month on month during the 1st 3 quarters the appraisal completion rate has been approx. 90%. The Responsible Officer (RO) has made positive revalidation recommendations for 177 (out of 227 due for recommendations) of our doctors in 2019/20. The others have been deferred (but subsequently completed), mostly awaiting additional supporting information to be provided. We have made 0 non-engagement recommendations, and 2 deferrals for being in an ongoing process.

# 2. Purpose of the Paper

The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.

This report describes the progress against last year's improvement plans and sets out the future direction in light of new guidance from NHS England. This is a statement of compliance with the FQA to the board and higher level responsible officers.

# 3. Background

Medical staff appraisal is a process of facilitated self-review, supported by information gathered from the full scope of a doctor's work. At this organisation, medical staff appraisal has three main purposes.

- To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer's revalidation recommendation to the GMC:
- To enable doctors to enhance the quality of their professional work by planning their professional development;
- To enable doctors to consider their own needs in planning their professional development.

Revalidation is the process through which licensed doctors demonstrate they remain up to date and fit to practise. It is based on clinical governance and appraisal processes. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development.

Appraisal is focused on a doctor's fitness to practise and professional development to enhance this. This means that there is a clear distinction between appraisal and Job Planning, which is focused on determining the quantity and scope of a doctor's work to meet service and organisational objectives – and should be a process that is carried out at a





separate meeting.

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors:
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

# 4. Governance Arrangements

The RO is accountable to the Board for ensuring the implementation and operation of appraisals for all medical staff with whom the organisation has a "prescribed connection"; it is also a contractual requirement for all medical staff to participate in annual appraisal. Therefore, the objective will be to maintain an appraisal rate of 95% for medical staff over a twelve month period. The 2019/20 completion rate was 80.34%. Unfortunately this was impacted by the onset of the COVID pandemic which meant that appraisal was suspended in mid-March. Outstanding appraisals from Jan, Feb and March were not chased and cancelled in all but a few instances.

The Medical Appraisal and Revalidation officer provides monthly reports showing the appraisal rates for medical staff at organisational, Divisional and Directorate level and also show which appraisals are overdue. These monthly reports are circulated to (and should also be a standing agenda item at the monthly Divisional Board meetings):

- Clinical Directors, Divisional Medical Directors and the RO;
- Director of HR, Deputy Director of HR and HR Business Partners

We currently maintain our database of doctors by checking the monthly Starters and Leavers report supplied by the Workforce team. We also receive emails from the GMC documenting those doctors for whom we have a responsibility. We regularly audit our databases to ensure that these are up to date and are in alignment with GMC connect. We have set out a regular process to maintain this going forward.

# a. Policy and Guidance

The Trust Medical Appraisal policy was reviewed and updated in December 2018, the only substantial change was a move to fit with established GMC guidance regarding collecting patient & colleague feedback once in each 5 year revalidation.



# 5. Medical Appraisal

# a. Appraisal and Revalidation Performance Data

Please see Appendix A- Audit of all missed or incomplete appraisals

# b. Appraisers

We have 100 trained appraisers as at the end of 2019/20. During this period we held 3 new appraiser training sessions provided by internal facilitators (30 doctors trained). We held 2 appraiser forums to provide education and an opportunity to discuss the NHSE guidance and audit tools for appraisal; approximately 10% of our appraisers attended one of these. We introduced Appraiser Update sessions in 2016 and held three sessions in 2019/20, 15 appraisers attended these.

We collect electronic feedback from appraisees about their appraiser once they have completed their appraisal. This includes feedback on their listening, support and overall effectiveness. This is part of demonstrating fitness to practice as an appraiser. In 19/20 the AMD for professional development has continued to conduct 1:1 meetings with appraisers to improve the quality of appraisals. Appraisers are utilising this feedback for inclusion and reflection in their own appraisals.

# c. Quality Assurance

Throughout 2019/20 the AMD for professional development continued to review all appraisals in those requiring revalidation (approximately 20% of all appraisals) and provides feedback to both the individual and the appraiser regarding the inputs, supporting information presented and the quality of the summary written by the appraiser. On-going education of appraisers is aimed at improving the quality of the supporting information and reflection captured in the appraisal.

See *Appendix B*: Quality assurance of appraisal inputs and outputs

# d. Access, Security and Confidentiality

Appraisal documentation is provided by a web based system that is password protected. There is the capacity to lock documents for only the appraisee, appraiser, RO and delegate to see. The system meets the highest standards of IT security and document storage. There are warnings not to upload documents with patient information and advice to anonymise. No audit of information governance has been undertaken but staff are advised to remove any PID.

The licences are amalgamated however we have not been able to fully integrate the systems across both sites as yet.

# e. Clinical governance

Corporate data is used for individual doctors to contribute to supporting information. The Appraisal and Revalidation team have provided reports from the Datix system, for all individuals to enable review of their involvement in incidents and reflection and learning from them. This is an essential piece of supporting information that is required from all places of work.



See Appendix C; Audit of concerns about a doctor's practice.

# f. Update on Action Plan from 2018/19 Board Report

- Review connections listed on GMC connect and ensure alignment with Trust held databases.
  - Audit and alignment completed but is continuous process of keeping up to date
- Appoint a lead appraiser on each site to assist AMD with increased volume of recommendations required over next 2 years and to improve quality of appraisal. Appointment delayed by COVID in March but now completed and 2 site lead appraisers commenced in post July 2020
- Work with system provider to merge the two systems to improve functionality across site, implementation plan required from provider and implementation dates to be agreed. This work has been taken forward and implementation is due to be completed by end of Dec 2020..
- Continue to provide new appraiser training days, actively seek out suitable doctors to train as appraisers. 3 new appraiser training days completed, continual process of recruitment and training in place (x1 session missed due to COVID)
- Use Allocate to link with GMC Connect (medium long term objective) Remains an objective but not priority at present

# 6. Revalidation Recommendations

- Recommendations between April March 227
- Recommendations completed on time, 215
- Positive recommendations, 177
- Deferral requests, 48
- Non-engagement notifications, 0

Deferrals: All bar 1 deferral have been due to lack of essential supporting information or a need to realign the revalidation to the appraisal date. They have either now been completed or have been delayed due to COVID. 3 doctors have since left the Trust and 1 was deferred due to an on-going process. 2 doctors were on maternity leave & 1 on a sabbatical; hence the lack of appraisal or supporting information.

See Appendix D; Audit of revalidation recommendations

# 7. Recruitment and engagement background checks

HR and workforce have provided data regarding background checks made for new doctors including bank doctors. Locum agencies utilised are all framework agencies and hence conduct the appropriate checks. The checklist used corresponds to the data collected by the Trust for our own doctors.

See Appendix E



# 8. Monitoring Performance

A number of measures are used to assess the performance of doctors within the organisation:

- Appraisal, including feedback from patients and colleagues
- GMC referrals
- Clinical audit
- Incident and Serious Incident reports
- Mortality reviews
- Complaints
- Key Performance Indicators, such as healthcare associated infections and referral to treatment times
- Concerns raised by other staff.

Clinical Governance reporting is via Divisional Quality & Risk Groups, and a number of other committees (such as the Medicines group), which report into the Clinical risks or effectiveness group, which in turn report to the quality Committee, a sub-committee of the Trust Board. The Medical Director is the chair of the patient safety group and a member of the effectiveness group and the quality committee.

Following new guidance from NHS England the monthly revalidation/appraisal meeting has been formally constituted as the Responsible Officer Advisory group, with an agreed membership and terms of reference. The Medical Director and the Appraisal and Revalidation Lead also meet jointly with the GMC Employer Liaison Officer every 3-4 months, which includes discussion of medical staff subject to on-going GMC process.

# 9. Responding to Concerns and Remediation

See Appendix C- Audit of concerns about a doctor's practice

# 10. Risks and Issues

- HR carries out all pre-employment checks in line with Trust and NHS requirements.
   The collation of information via the MPIT process is being streamlined to ensure this information is systematically collated and communicated.
- During the 2019-20 period there has been a turnover of staff within the Medical Workforce Team especially at the senior level with the relevant specialist knowledge. However, since September 2019 we have a permanent HR Business Partner (Medical Workforce) who manages the team as Head of Service. We have also rebanded a role in the Medical Workforce Team to create a new Band 7 Medical Workforce Manager post to provide more day to day operational oversight of the Appraisal and Revalidation Officers. This post is currently out to advert closing on 28.09.20.
- Reduction in availability of appraisers and increased number of connected doctors have caused delays in allocating doctors appraisers and consequently their appraisals.



# 11. Corrective Actions, Improvement Plan and Next Steps

- Implement SOP for sending & receiving MPIT forms and audit process.
- Train lead appraisers to assist in delivery of quality assurance processes.
- Work with system provider to merge the two systems to improve functionality across site, implementation plan required from provider and implementation dates to be agreed.
- Continue to provide new appraiser training days, actively seek out suitable doctors to train as appraisers.
- Use Allocate to link with GMC Connect: This remains aspirational but requires Allocate to action and is unlikely to be achieved within the medium term.

# 12. Recommendations

- 1. Board to accept report (Please note it will be shared, along with the annual audit, with the higher level responsible officer) and continue to support resource requirements to deliver a higher standard of appraisal.
- 2. Board to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations





# 13. Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	Number
Maternity leave during the majority of the 'appraisal due window'	23
Sickness absence during the majority of the 'appraisal due window'	9
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	1
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	6
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	6
Lack of engagement of doctor	1
Other doctor factors	14
<ul> <li>Left the trust after appraisal due date without completing annual appraisal</li> </ul>	4
Appraiser factors	Number
Unplanned absence of appraiser	1
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	2
Other appraiser factors (describe) completion delayed but completed within year	1
WM doctor required a CW appraiser but there was delay in finding an appropriate appraiser.	
(describe)	
Organisational factors	Number
Administration or management factors	1
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	8
Other organisational factors COVID pandemic cancellations	59





NB This records the reasons for an appraisal to have been missed there may be more than 1 reason



# Chelsea and Westminster Hospital MHS

# **NHS Foundation Trust**

# **14. Annual Report Appendix B –** Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		572
	Number of appraisal portfolios sampled 208	Number of the sampled appraisal portfolios deemed to be acceptable against standards on 1st review by AMD 119
Appraisal inputs	208	69 ( portfolios had 1 or more of the below unacceptable)
Scope of work: Has a full scope of practice been described?	208	202
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	208	204
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	208	205
Patient feedback exercise: Has a patient feedback exercise been completed?	,	ack: patient & colleague is collected as a each revalidation cycle)
Colleague feedback exercise: Has a colleague feedback exercise been completed?		Yes: 202
Review of complaints: Have all complaints been included?	208	170, (number of portfolios with governance report attached on first review)
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	208	170, (number of portfolios with governance report attached on first review)
Is there sufficient supporting information from all the doctor's roles and places of work?	208	28 (number of portfolios with CG from PP required but not attached on first review)
Is the portfolio sufficiently complete for the stage of the revalidation cycle? Explanatory note: Has mandatory training record and CG report been included in portfolio?	208	170
Appraisal Outputs		
Appraisal Summary	208	192
Appraiser Statements	208	208
Personal Development Plan (PDP)	208	207

**NB**: All portfolios for doctors that had a positive recommendation conformed with the required standard after intervention by the AMD to ensure the appropriate SI. Feedback is provided by the AMD to both appraiser and appraisee regarding any deficiencies detected in order that they can be corrected prior to submission of a revalidation recommendation.





# 16. Appendix C- Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level <sup>1</sup>	Medium level <sup>2</sup>	Low level <sup>2</sup>	Total					
Number of doctors with concerns about their practice in the last 12 months  Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern									
Capability concerns (as the primary category) in the last 12 months	1	1	2	4					
Conduct concerns (as the primary category) in the last 12 months	1	2	2	5					
Health concerns (as the primary category) in the last 12 months	1	0	0	1					
Remediation/Reskilling/Retraining/Rehabilitation	on								
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2019 who have undergone formal remediation between 1 April 2018 and 31 March 2019.  Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice  A doctor should be included here if they were undergoing remediation at any point during the year									
Consultants (permanent employed staff including and other government /public body staff)	honorary c	contract holde	rs, NHS	1					
including hospital practitioners, clinical assistants	Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)								
General practitioner (for NHS England only; docto Armed Forces)	rs on a me	edical perform	ers list,	0					
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)									
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)									
Temporary or short-term contract holders (temporal locums who are directly employed, trust doctors, locumed research fellows, trainees not on national training term employment contracts, etc.) All Designated I	ocums for schemes,	service, clinic	al	0					

http://www.england.nhs.uk/revalidation/wpcontent/uploads/sites/10/2014/03/rst\_gauging\_concern\_level\_2013.pdf



# Chelsea and Westminster Hospital MHS

# NHS Foundation Trust

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All Designated Bodies	0
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March:	2
Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	
Duration of suspension:	1-3
Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	Months
Less than 1 week : 1	
1 week to 1 month	
1 – 3 months : 1	
3 - 6 months :	
6 - 12 months	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions:	
Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	5
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	6
Number of NCAS assessments performed	0





# 17. Appendix D- Audit of revalidation recommendations

Revalidation recommendations between 1 April 2019 to 31 March 2020	
Recommendations completed on time (within the GMC recommendation window)	215
Late recommendations (completed, but after the GMC recommendation window closed)	12
Missed recommendations (not completed)	0
TOTAL	227
Primary reason for all late/missed recommendations	
For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	12
TOTAL [sum of (late) + (missed)]	12

# Reasons:

12 "Other" were all due to late submission of appraisal documentation or supporting information

Deferrals: All bar 1 deferral have been due to lack of essential supporting information or a need to realign the revalidation to the appraisal date. They have either now been completed or have been delayed due to COVID. 3 doctors have since left the Trust and 1 was deferred due to an on-going process. 2 doctors were on maternity leave & 1 on a sabbatical; hence the lack of appraisal or supporting information.



# 18. Appendix E- Audit of recruitment and engagement background checks

Number of new doctors (in locum doctors)	cluding	all new	prescri	bed con	nections)	who ha	ve comr	menced in	last 12 r	months (in	ncluding	where a	ppropriat	е		
Permanent employed doctors										3	33					
Temporary employ	Temporary employed doctors											7	71			
Locums brought in	to the	designa	ted bod	y throug	h a locur	n agenc	у							(	)	
Locums brought in	to the	designa	ted bod	y throug	h 'Staff E	Bank' arr	angeme	ents						(	)	
Doctors on Perforr	ners Lis	its												(	)	
Other  Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc								l l	1 (Honorary Doctor)							
TOTAL																
For how many of these doo	ctors w	as the f	ollowing	informa	ation ava	ilable wit	thin 1 m	onth of the	e doctor's	s starting	date (nu	ımbers)		•		
	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors	33	33	33	33	33	33	33	0	0	33	33	33	0	0	0	33
Temporary employed doctors	71	71	71	71	71	71	71	0	0	71	71	71	0	0	0	71
Locums brought in to the designated body through a locum agency	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA



# Chelsea and Westminster Hospital

I NHS
-------

							NHS F	oundation	Trust							
Locums brought in to the designated body through 'Staff Bank' arrangements	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA						
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1
Total	105	105	105	105	105	105	105	0	0	105	105	105	0	0	0	105



# Chelsea and Westminster Hospital **MHS**

**NHS Foundation Trust** 

# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.4/Nov/20
REPORT NAME	Equality and Diversity Annual Report 2019-2020
AUTHOR	Karen Adewoyin, Deputy Director of People and OD
LEAD	Sue Smith, Chief People Officer
PURPOSE	This report provides an overview of Chelsea and Westminster's progress against our Equality Objectives and includes all the relevant workforce information in order to meet its compliance with the Equality Act 2010. The report covers the period 1st April 2019 to 31st March 2020. It does not cover the compliance for patients and service users which has previously been presented as a separate report.
REPORT HISTORY	This paper has been reviewed by the Executive Management Board, he Workforce & Development Committee and the People and Organisational Committee.
SUMMARY OF REPORT	The report provides assurance to the Board that the Trust is able to report against the general equality duty as outlined in the Equality Act 2019. The report also covers the Trust's compliance with the following mandatory frameworks:  • Workforce Race Equality Standards (WRES)  • Equality Delivery System2 (standards for staff)  • Gender Pay Gap  • Workforce Disability Standard (WDES)
KEY RISKS ASSOCIATED	Unsatisfactory performance in equality of employment which reflects the diverse nature of the population served by the Trust will present a risk to the reputation and can leave the Trust open to legal challenge.
FINANCIAL IMPLICATIONS	Legal costs of defending claims of discrimination.
QUALITY IMPLICATIONS	Evidence shows that organisations that embrace equality and diversity have better outcomes.
EQUALITY & DIVERSITY IMPLICATIONS	Indicators show poorer experience by some staff groups with protected characteristics.
LINK TO OBJECTIVES	Be the employer of choice.

DECISION/ ACTION	For approval.
------------------	---------------





# Workforce Equality and Diversity Report

2019/20











# **Table of contents**

Section 1 Workforce Equality report introduction	4
Section 2 Trust strategic priorities	5
Key findings	
Section 3 Key Achievements	6
Section 4 Future actions and priorities for 2019/20	7
Section 5 Workforce Composition	7
Workforce composition by ethnicity Workforce composition by age Workforce composition by gender Trust board of directors composition by gender and ethnicity Workforce composition by religious belief Workforce composition by sexual orientation Workforce composition by disability Workforce Disability Equality Standard (WDES)	
Section 6	
Recruitment	13
Recruitment by ethnicity	16
Section 7	
Non-mandatory Training	17
Section 8	
Promotions and Leavers	19
Promotions and leavers by ethnicityPromotions and leavers by gender	
Section 9	
Performance Development Reviews (PDRs)—non-medical staff	20
PDR outcomes by ethnicity	21

#### Section 10

Application of formal employee relations procedures 2019/20	22
Disciplinary cases	22
Sickness absence cases	
Probationary cases	
Performance (capability) cases	
Section 11	
Local clinical excellence awards for consultants	30
Section 12	
Staff experience—2020 NHS staff survey	30
NHS national staff survey questions mandated by the Workforce	
Race Equality Standard (WRES)	31
Appendix 1: Workforce Race Equality Standard (WRES)	32
Appendix 2: Gender Pay Gap 2019/20	33
Appendix 3: Workforce Disability Equality Standard (WDES)	34
Appendix 4: Improving Equality, Diversity and Inclusion Action Plan Years 2 -3	36

# **Section 1: Workforce Equality Report Introduction**

We are delighted to present our workforce equality report together with details of the actions taken to address the gaps in equality that were identified last year. This is one of our responsibilities under the Equality Act 2010 and supports the delivery of the general Public Sector Equality Duty (PSED).

At Chelsea and Westminster Hospital NHS Foundation Trust we are committed to providing fair and inclusive services and employment which meet the diverse needs of our patients and staff. Over the last 12 months we have continued to focus on embedding equality, diversity and inclusion in everything we do.

Covid-19 shone a real light on inequality and why equality, diversity and inclusion are crucial and important elements to be addressed in all NHS organisations. Our staff have been challenged by the response to COVID-19 and there are many lessons to be learnt and these will form part of our Year 2 and 3 Equality, Diversity and Inclusion plan. Over the next 2 years we want to foster a culture of inclusion and belonging and live our PROUD values which absolutely bring out our ambitions in relation to EDI alive. We can't put patients first or be responsive to patients and our staff if we don't take in to account their diverse needs, we need to be open and honest and have brave conversations about diversity and inclusion, and be unfailingly kind in all of our interactions, and be determined to develop in this area.

Our aim is no longer just embed equality but more about how we value people, and how we can encourage others to value people, reflect and improve our behaviours towards our people and our patients.

#### Our report includes:

- An outline of our vision at the Trust to be the employer of choice
- An overview of some key achievements
- The profile of our workforce and key findings
- Future plans for 2020/21 based on our priority areas for action

We certainly have more work to do to ensure that we improve the experience of all of our people but we remain confident that the plans we have in place and the launch of the NHS People Plan which has a clear focus on belonging in the NHS means we will achieve our ambition of ensuring all our staff have a great experience while working at the Trust.

My new role as Board Diversity and Inclusion Advisor could not have been more timely. I am assured of the Trust's resolve and determination to address the recognised equality gap. This will be achieved by both processes being implemented and by promoting an organisational culture that is both inclusive and culturally sensitive. Diversity is a fact in our Trust with 100 nations represented by our staff but inclusion is a choice. This report and the EDI plan will map our journey to ensuring that inclusion is **not** a choice but the way we work.

**Thomas Simons** 

Thomas finan

**Director of Human Resources and OD** 

Gubby Ayida

**Board Diversity and Inclusion Advisor** 

# **Section 2: Trust strategic priorities**

The Trust has three strategic priorities:

- Deliver high-quality, patient-centred care
- Be the employer of choice
- Deliver better care at lower cost

Our staff also work to a strong set of PROUD values which are:

- Putting patients first
- Responsive to patients and staff
- Open and honest
- Unfailingly kind
- Determined to develop



The Trust is committed to promoting equality of opportunity for all its employees and believe individuals should be treated fairly in all aspects of their employment, including training, career development and promotion, regardless of their race, gender or disability or any other protected characteristic. We aim to create a culture that respects and values individual differences and that encourages individuals to develop and maximise their true potential.

#### **Key findings**

Our workforce remains broadly representative of the population it serves and the workforce data is similar to previous years. The data in the report covers the monitoring period 1 Apr 2019 to 31 Mar 2020.



- Our staff survey results highlight that as a Trust we score below average at 8.6 for equality, diversity and inclusion compared to other Trusts, where the best Trust scored 9.4 and the average was 9.0.
- The staff survey highlighted that the percentage of staff experiencing bullying and harassment or abuse from patients or relatives reduced, team working and the quality of care improved and the quality of appraisals was significantly higher than last year. BAME staff were also more positive in believing that the Trust provides equal opportunities for career progression or promotion.
- There has been a continued increase in the number of BAME staff in post, an additional 2% since last year and BAME staff now represent 46% of our workforce which equals the same percentage as our Non BAME staff.
- Since April 2020 the Trust undertook an initiative aimed at decreasing the numbers of staff recorded under ethnicity as *Not Stated*. As a result of this initiative since April 2020 we have seen a 5% increase of staff declaring their ethnicity. This work will continue during 2020/21.
- BAME staff report a poorer experience than non-BAME staff, for example, non-BAME staff are 1.40 times more likely to be shortlisted than BAME staff, and there is still a higher proportion of BAME staff entering formal disciplinary processes at 2.41 times more likely than non-BAME staff, which is higher than the London acute Trust average.
- The gender pay gap report highlighted that female employees earn an hourly mean average pay of 17.7% less than men.
- Only 2% of staff have declared a disability yet 11.5% stated in the confidential staff survey that they had a disability which highlights significant under-reporting.

# **Section 3: Key achievements**

We are proud to have achieved the following as at August 2020:

- Launched an LGBT+ staff network sponsored by an executive board member and become of member of the Stonewall Diversity Champions Programme.
- Commenced a Reciprocal Mentoring Programme for Inclusion Programme in partnership with NHS Elect with executives and senior leaders being mentored by diverse under-represented members of staff from across the organisation.
- Joined the Timewise Accredited Partnership Programme which supports organisations to develop and drive cultural change and introduce best practice flexible working into the organisation.
- Launched Diversity and Inclusion Champions into Trust recruitment process for Band 8a and above roles as well as ensuring our recruitment practices encourage and enable all staff to be successful.
- Positive progress against are our Model Employer targets, with more of our BAME staff in leadership positions, and 33% of our BAME staff on our new MBA Leadership programme and 45% the Msc in Leadership.

- Introduced a check and challenge process when investigations and disciplinary action is being considered and reduced the number of staff going through formal processes.
- Executive led lived experience listening events specifically focusing on career progression and recruitment.
- Maintained our Disability Confident Status Level 2 and working towards Level 3.
- Ensured all our staff had an individual risk assessment, starting with those we knew were most "at risk" and achieved 100% compliance to ensure the physical and psychological safety of our people in response to COVID-19.

# Section 4: Future actions and priorities for 2020/21

- Implement the Improving Equality, Diversity and Inclusion Action Plan Years 2-3 and implementation of all Trust level priorities in the NHS People Plan.
- Key metrics for WRES/WDES/Gender Pay Gap will improve and be amongst the best performing nationally.
- Working collaboratively across North West London to collaborate across our system to ensure Equality, Diversity and Inclusion are given the priority and the focus and resources needed to make the changes necessary.

## **Section 5: Workforce composition**

The Trust had a headcount of 6,394 substantive staff at the end of financial year 2019/2020 which is an increase of 214 staff or a 3.5% increase over the same period last year and a smaller increase from 5.3% increase in 2018/2019. The following pages provide a high-level summary of the workforce composition by protected characteristics.

### Workforce composition by ethnicity

For the purposes of this report, the Trust has combined staff categories as *non-BAME*, *BAME* (Black, Asian and Minority Ethnic) and *not stated*. The national electronic staff record does not give the option of "do not wish to declare" for ethnicity so these are recorded by default as not stated.

The non-BAME category incorporates staff that identify as white British, white Irish and any other white background. BAME includes staff who identify as Asian (Indian, Pakistani, Bangladeshi), mixed (white black/Asian), black (Caribbean, African) and other (Chinese and any other). This is in line with the Office of National Statistics census categories.

(2,931) 46% of the workforce identify as non-BAME compared with (2,934) 46% as BAME staff. This compares with 48% and 44% respectively at the same point last year. 8% (529) of our staff are recorded as not stated, which has not changed from the previous year.

The Trust employs an ethnically diverse workforce reflective of the population of London.

	Asian %	Black %	Mixed %	White British %	White Other %	Other %
London 2020	18.5	13.3	5.0	44.9	14.9	3.4
Chelsea and Westminster	23.2	13.4	3.4	32.7	13.6	13.5

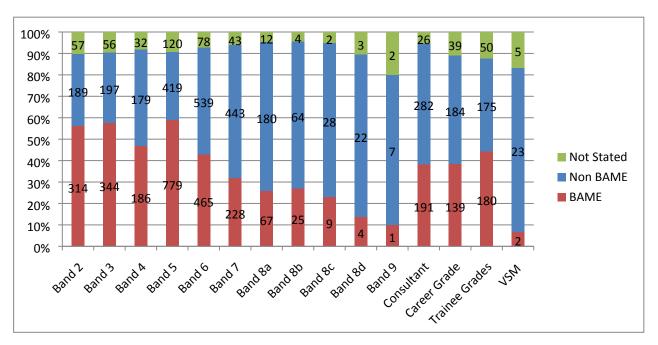
**Figure 1** shows the grade distribution of non-BAME and BAME staff (headcount) across all staff groups in the organisation.

BAME staff form the majority of staff in AfC bands 2–5. Within the BAME staff there have been increases in the numbers of staff in AfC Band 5 and trainee medical grades compared to last year. A 16% increase in band 5 and 127% increase in trainee medical grades

Non-BAME staff form the majority of staff from band 6 to VSM (very senior manager).

There have been no significant increases in Non- BAME staff across the staff groups, however medical career grades have shown reductions in both BAME and Non BAME at 63 and 60 respectively between April 2019 and March 2020.

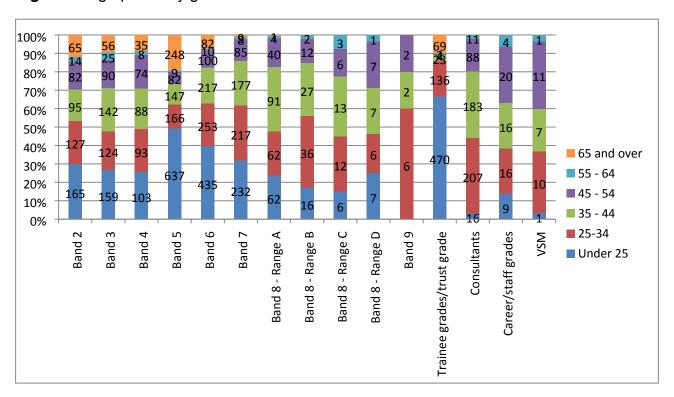
Figure 1: Ethnicity profile by grade



 $<sup>{\</sup>color{red}^*\underline{https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest}\\$ 

#### Workforce composition by age

Figure 2: Age profile by grade



Age Range	Percentage of Workforce
Under 25	9%
25 – 34	38%
35 – 44	24%
45 – 54	20%
55 – 64	11%
65 and over	2%

The 25 – 34 age range makes up the single largest age group accounting for 38% of the Trust workforce an increase of 3% on the previous year. The 35 -44 age range makes the second largest group at 24%. 55 and over account for 13% of workforce

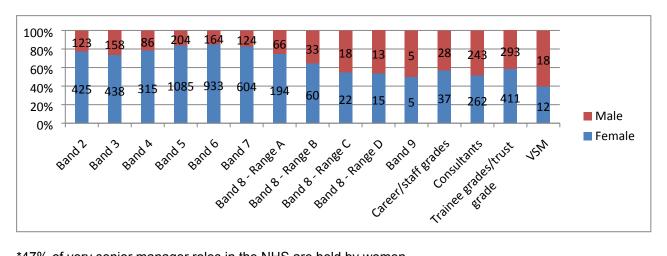
#### Workforce composition by gender

There were 4,818 females employed across the organisation who make up 75% of the total workforce and there were 1,576 males who make up 25% of the workforce.

The table shows that in Agenda for Change (AfC) Band 2 to Band 8D there are more females than males in each of the grades. At Band 9 the split is 50:50. In the medical grades, including consultant grade there are more females than males.

The very senior manager (VSM) grade is the only grade where the gender balance is in favour of males by 60% to 40%. This is an increase from last year from 56% males to 43% females last year.

Figure 3: Gender profile by band



<sup>\*47%</sup> of very senior manager roles in the NHS are held by women

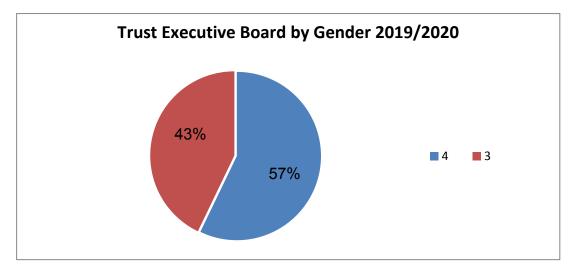
#### Trust board of executive directors composition by gender and ethnicity

The board of executive directors comprises seven posts—the chief executive supported by six executive directors:

Deputy Chief Executive and COO Medical Director and CCIO Chief Financial Officer Director of HR and OD Chief Nursing Officer Chief Information Officer

The gender balance at executive director level as at 31st March 2020 was 57% female and 43% male compared to the overall workforce profile of 75% female and 25% male.

Figure 4: Trust Executive Board by Gender



The ethnicity profile of the executive directors is 100% non-BAME with no BAME staff at this level within the organisation.

<sup>\*</sup> https://www.nhsemployers.org/-/media/Employers/Documents/Plan/DIVERSITY-AND-INCLUSION/EQW19/Gender-in-the-NHS-infographic.pdf

The Trust chair and seven non-executive directors complete the Trust Board. Of these, seven are male and one is female.

Five are non-BAME and three are BAME, which equates to 62.5% non-BAME and 37.5% BAME. BAME representation at non-executive director level within the organisation has increased by 24.5% from 13% in 2018/19 following more diverse recruitment channels to recruit Non-Executive Directors.

#### Workforce composition by religious belief

Table 1 below shows the data held on the religious beliefs of staff. The majority of staff identify as Christian at 42.9%. Christians were also the largest group last year at 41% so this has only slightly increased. Other religious groups have changed slightly, on average less than 1% from last year.

The percentage of staff recorded as unspecified, meaning no data is recorded on ESR is 18.3%, which has reduced from 21% the previous year.

**Table 1:** Religion profile

Religious Belief	Total	%
Atheism	616	9.6%
Buddhism	60	<1%
Christianity	2,740	42.9%
Hinduism	305	4.8%
Islam	412	6.4%
Jainism	16	<1%
Judaism	21	<1%%
Sikhism	106	1.7%
I do not wish to disclose my religion/belief	673	10.5%
Other	274	4.3%
Unspecified	1,171	18.3%
Grand Total	6,394	100%

#### Workforce composition by sexual orientation

Table 2 below shows the data held on the sexual orientation of staff. The majority of staff identify as heterosexual at 69% which has increased by 3% from last year with less than 3% of staff declaring themselves as gay or lesbian and less than 1% as bisexual.

Changes in declaration rates in the other groups have all changed by less than 1% from last year. The percentage in the undefined category is 18.28%, which has reduced from 21% last year.

**Table 2:** Sexual orientation profile

Sexual Orientation	Total	%
Bisexual	37	<1%
Gay or lesbian	161	2.52%
Heterosexual or straight	4,403	69%
Not stated (person asked but declined to provide a response)	616	9.63%
Other sexual orientation not listed	3	<1%
Undecided	5	<1%
Undefined	1,169	18.28%
Grand Total	6,394	100%

#### Workforce composition by disability

Figure 6 shows that there are five possible responses that staff can give in this category—yes, no, prefer not to answer, not declared and unspecified.

123 members of staff, 2% of the workforce are recorded on the electronic staff record (ESR) system as having declared that they have a disability.

1,476 staff were in the not declared and unspecified categories.170 staff did not declare if they had a disability and 16 members of staff preferred not to answer.

There has been a reduction in the not declared and unspecified data from the reporting period Apr 2018– Mar 2019 when the number was a 6% reduction.

The 2019 staff survey shows that 2,671 members of staff responded to the question "Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more? Of these respondents 11.6% (309) members of staff stated that they had. This means 186 have not declared their disability on their staff records. However, due to all staff undertaking a risk assessment which asked staff to declare if they had a disability, this data is being reviewed to update ESR.

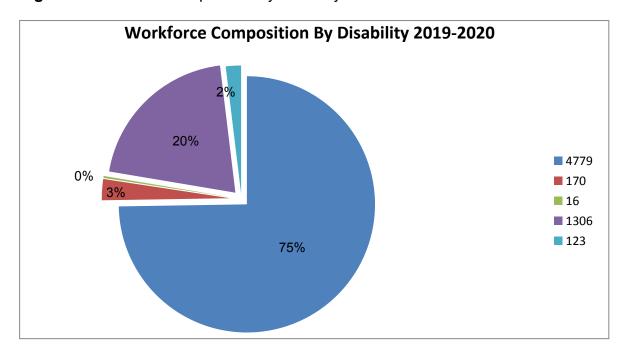


Figure 6: Workforce composition by disability

#### **Workforce Disability Equality Standard (WDES)**

Every NHS organisation is required to submit their 10 evidenced-based metrics and action plans to NHS England by 31st August 2020.

The Trust WDES metrics and action plan can be found here: <a href="https://www.chelwest.nhs.uk/about-us/organisation/our-way-of-working/equality-diversity/links/NHS-Workforce-Disability-Equality-Standard.pdf">https://www.chelwest.nhs.uk/about-us/organisation/our-way-of-working/equality-diversity/links/NHS-Workforce-Disability-Equality-Standard.pdf</a>

#### Data quality for disability, sexual orientation and religion 2019/20

The Trust data on disability, sexual orientation and religion has increased since last year see Table 3 below.

The Trust holds demographic information on 77% of staff by disability which has not changed from last year.

The Trust has increased the percentage of data collection are in relation to sexual orientation and religion from the previous reporting period. See Table 3 below.

We will highlight the importance of completing demographic data by promoting the use of self-service via ESR and by continuing further robust data capture processes when new employees join the Trust.

In respect to disability, we encourage staff who may become disabled over the course of their employment to declare their disability and ensure that, when identified that a member of staff has a disability, this is recorded on their ESR record if it wasn't at the time they started at the Trust.

Table 3: Disability, sexual orientation and religion records for all staff

Protected characteristic	Known status for all staff Mar 2019	Known status for all staff Mar 2020
Disability	77%	77%
Sexual Orientation	79%	82%
Religion	79%	82%

#### Staff Networks

The Trust's BAME, Women's and LGBTQ+ staff networks provide an important way for staff to have a voice within the organisation and provide opportunities to convey their experiences. They also allow staff to feel empowered to help shape workplace culture and the environment in which they work. During 2020/21 the Trust will develop a Disability staff network and bring the work of all the networks together in implementing the Improving Equality, Diversity and Inclusion Action Plan Years 2-3 in which they will play a pivotal role. The Network Chairs also participate in the Trusts Workforce Development Committee.

#### **Section 6: Recruitment**

The Trust is committed to deliver open, transparent recruitment processes that do not discriminate against people on the grounds of their protected characteristics. In support of this commitment, the Trust monitors the progress of applicants through the selection process. The Trust uses the NHS Jobs website as its main source for advertising internal and external vacancies and undertakes periodic overseas recruitment, primarily for nursing staff. TRAC is used as our recruitment management system. We also utilise social media platforms such as LinkedIn and Twitter and will be taking part in a London wide virtual careers fair in the autumn of 2020.

#### **Recruitment for Leadership Diversity**

In January 2020 the Trust in conjunction with the BAME staff network launched the Diversity and Inclusion Champions programme initially aimed at recruitment for AfC Band 8a and above. The diversity and inclusion champions are members of staff from diverse backgrounds from across the organisation who have received interview skills training to participate in these interview panels.

As at August 2020 the Trust has 28 trained diversity and inclusion champions with the number to increase with on-going monthly training sessions. It is planned that the programme be extended in years 2 and 3 to recruitment for AfC Bands 6 and 7 and to medical appointments. The data below sets out the projected numbers of BAME staff required in leadership posts to reflect the percentage of BAME staff within the workforce and Table 5 and 6 show an improvement across 3 pay bands

Table 4: Projected numbers of BAME staff in post

	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

Table 5: Number of BAME staff in post 2019

	2019 ambition	2019 actual	Gap
Band 8a	74	70	-4
Band 8b	25	20	-5
Band 8c	10	8	-2
Band 8d	6	4	-2
		4	
Ban 9	2	1	-1
VSM	5	2	-3

Table 6: Number of BAME staff in post 2020 (actual v projection)

	2020 actual	2020 ambition	Gap
Band 8a	78	71	-7
Band 8b	27	30	+3
Band 8c	11	14	+3
Band 8d	6	4	-2
Ban 9	2	4	+2
VSM	6	3	-3

#### Recruitment by ethnicity

67% of all non-medical job applications in 2019/20 were from candidates from a BAME background this has not changed from the previous year. For medical posts (excluding junior doctors in training), 85% of all applicants are from a BAME background an increase of 5% on the previous year.

3.5% of non-medical applicants choose not to disclose their ethnicity at application stage, a slight decrease from 4% the previous year. 2.8% of medical applicants, also a slight decrease from 3% the previous year choose not to disclose their ethnicity at application stage.

At shortlisting stage, 57% of BAME candidates are shortlisted for non-medical posts an increase of 2% from the previous year and 60% of BAME candidates for medical posts a decrease from 63% from the previous year.

In regards to being appointed following shortlisting the ratio is 40% for BAME applicants for non-medical posts, an increase of 1% from the previous year and 45% of BAME applicants for medical staff a decrease of 1% from the previous year.

**Table 7:** Recruitment analysis by ethnicity

Ethnia avaun		% of:			
Ethnic group	Applicants	Shortlisted	Appointed		
BAME	70%	58%	50%		
Not stated	5%	8%	18%		
Non-BAME	25%	34%	41%		
Grand Total	23,583	5,443	1, 142		

**Note:** The data on applicants and shortlisted candidates comes from TRAC and covers the period from 1 Apr 2019 to 30 Mar 2020. Junior doctors on rotation to the Trust are appointed via Health Education England and are not included as part of applicants, shortlisted or appointed candidates.

Table 8: Relative likelihood of being appointed from shortlisting by ethnicity 2019/20

Descriptor	Non-BAME	BAME
Number of shortlisted applicants	1,865	3,159
Number appointed from shortlisting	467	566
Relative likelihood of non-BAME candidates being appointed over BAME staff at shortlisting stage		

The likelihood of non-BAME candidates being appointed from shortlisting in 2019/20 is 1.40 times greater than BAME staff. This is an improvement from 2018/19 when the likelihood was 1.60 times greater.

#### Recruitment by gender

Recruitment analysis by gender shows that 62.6% of applications were from female applicants and 36.7% from male applicants. The table below females are disproportionately appointed from shortlisting and further work to review roles and professional groups will take place in 20/21.

Table 9: Recruitment analysis by gender 2019/20

Craun	% of			
Group	Applicants	Shortlisted	Appointed	
Female	62.6%	70.5%	72.3%	
Male	36.7%	28.9%	27.2%	
Do not wish to Disclose	<1 %	<1%	<1%	
Grand Total	23,583	5,443	1, 142	

#### Recruitment by age, disability, sexual orientation and religion

Analysis by religion, age, sexual orientation and disability shows the conversion rates from shortlisting to appointment are broadly in line with the breakdown of applicants and the Trust profile for age and disability.

- The 25–34 age group makes up the largest percentage of applicants and appointees
- 3.7 % of appointees declared a disability compared with 3.1% of applicants
- 87% of applicants identified as heterosexual
- 49% of applicants identified as Christian

The tables below give more detail on recruitment by these characteristics.

Table 10: Recruitment analysis by age 2019/20

<b>C</b>	% of		
Group	Applicants	Shortlisted	Appointed
Under 25	16%	14%	17%
25-34	47%	46%	47%
35-44	21%	22%	19%
45-54	11%	13%	13%
55-64	4%	4%	3%
65+	<1%	1%	<1%
Not stated	<1%	0%	0%
Grand Total	23,583	5,443	1, 142

Table 11: Recruitment analysis by disability 2019/20

Group		% of		
	Applicants	Shortlisted	Appointed	
No	94.3%	89.9%	79.4%	
Not stated	2.6%	6.3%	16.9%	
Yes	3.1%	3.8%	3.7%	
Grand Total	23,583	5,443	1,142	

**Table 12:** Recruitment analysis by sexual orientation 2019/20

Group	% of		
Group	Applicants	Shortlisted	Appointed
Bisexual	1%	1%	1%
Gay	2%	2%	2%
Heterosexual	87%	88%	86%
Lesbian	1%	1%	1%
Not stated	9%	8%	10%
Grand Total	23,583	5,443	1, 142

**Table 13:** Recruitment analysis by religion 2019/20

Crain	% of		
Group	Applicants	Shortlisted	Appointed
Atheism	9%	11%	10%
Buddhism	1%	5%	1%
Christianity	49%	47%	41%
Hinduism	7%	6%	13%
Not disclosed	13%	17%	9%
Islam	18%	11%	24%
Jainism	<1%	<1%	<1%
Judaism	<1%	<1%	<1%
Sikhism	2%	2%	1%
Grand Total	23,583	5,443	1, 142

## **Section 7: Non-mandatory training**

The Trust offers development through a variety of methods, eLearning, internal courses and access to external courses across a wide spectrum of topics from clinical specialist courses to personal and management development. We have also increased our use of the apprenticeship levy and offer a variety of programmes funded through that scheme.

Note that a large proportion of our professional development training is provided by external organisations from which we may not always receive participation rates.

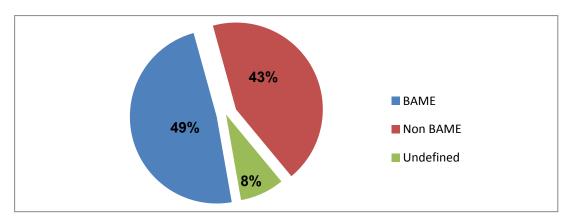
The data below is based on substantive staff and leavers only during the 2019/20 financial year recorded within ESR on the continuous personal professional database.

An additional 51 non-substantive staff attended non mandatory training during this period but are not included in the above statistics. (e.g. bank, honorary or secondee staff).

We have seen a decrease in funding from Health Education England for the past 4 years. Funding for 2019/20 was £197,000 from £250,000 in 2018/19. With less funding available

for the CPPD budget it remains challenging however development has been targeted towards specific clinical areas of focus.

Figure 7: Staff attending non-mandatory training by ethnicity



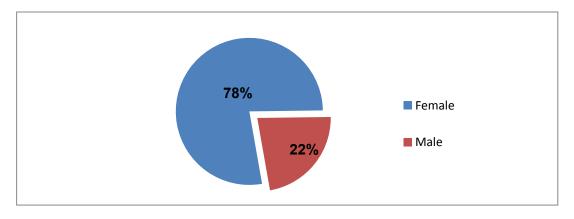
Analysis of non-mandatory training shows that the relative likelihood of non-BAME staff accessing non-mandatory training compared to BAME staff is 0.89. The ratio was 1.09 in the previous year.

This reflects that during the reporting period, proportionally more BAME staff have accessed non-mandatory training than Non BAME staff than the previous year.

Table 14: Relative likelihood of accessing non-mandatory training by ethnicity

Descriptor	Non-BAME	BAME
Number of staff in organisation	2,931	2, 934
Number of staff that have accessed non-mandatory training 515 577		577
Relative likelihood of non-BAME staff accessing non- mandatory training over BAME staff	0.89	

Figure 8: Staff attending non-mandatory training by gender



Female staff accounted for 78% of staff attending non mandatory training with males at 22%, whilst the gender composition of the workforce is 75% and 25% male.

77%

• Yes
• No
• Unspecified

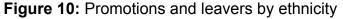
Figure 9: Staff attending non-mandatory training by disability

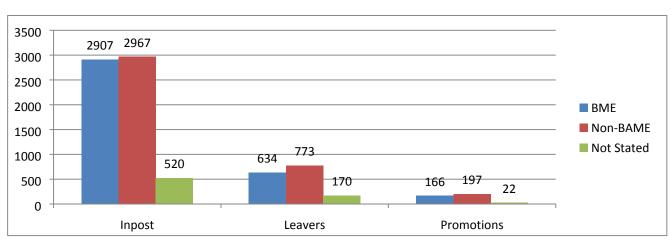
Disabled staff account for 2% of the overall number of staff accessing non-mandatory training courses, which reflects the percentage of staff recorded on ESR as having declared a disability.

#### **Section 8: Promotions and leavers**

#### Promotions and leavers by ethnicity

Figure 10 shows that of the leavers from the Trust April 2019 – March 2020 non-BAME staff account for 49% with BAME staff at 40%. Non BAME account for 51% of promotions with BAME staff at 43%.





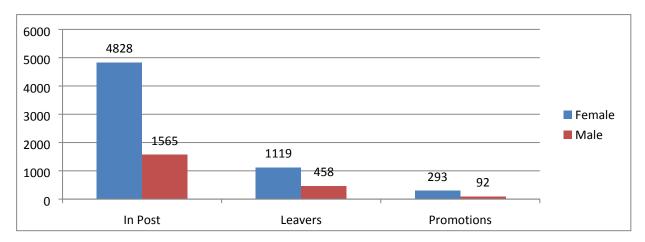
Group	Leavers	Promotions
BAME	40%	43%
Not Stated	11%	6%
Non-BAME	49%	51%

#### Promotions and leavers by gender

Figure 11 shows that in 2019/20, female staff accounted for 71% of leavers from the Trust whilst being 75% of the workforce, with male leavers accounting for 29% of leavers whilst being 24% of the workforce.

Promotions in 2019/20 show that females accounted for 76% of promotions with males at 24% which closely mirrors the gender distribution within the Trust.

Figure 11: Promotions and leavers by gender



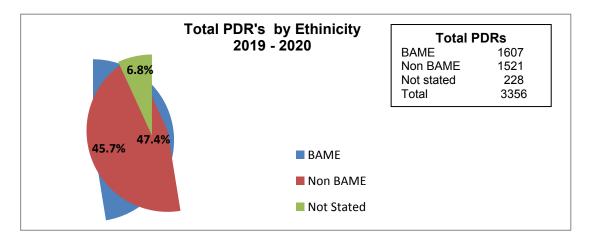
Group	Leavers	Promotions
Female	71%	76%
Male	29%	24%

# Section 9: Performance Development Reviews (PDRs)—non-medical staff

Excluding medical staff and those on maternity leave or career breaks 3356 PDRs were completed in the 12 month period Apr 2019–Mar 2020.

The figures below show the breakdown of PDRs completed by ethnicity and gender

Figure 12: PDRs in the last 12 months by ethnicity



Total PDR's by Gender 2019 - 2020

Total PDRs
Female 2654
Male 701
Total 3356

Female

Male

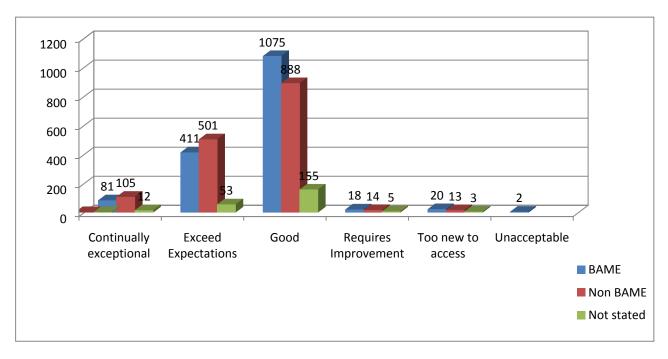
Male

Figure 13: PDRs in the last 12 months by gender

#### PDR outcomes by ethnicity

- Continually exceptional
- Exceeds expectations
- Good
- Requires improvement
- Unacceptable

Figure 14: PDR outcomes by ethnicity



The figure above shows that 'good' continues to be the most common PDR rating across the Trust, 'exceeds expectations' second and 'continually exceptional' the third most common.

2118 staff were in the 'good' category, 42% were non-BAME and 51% were BAME staff which is 9% in favour of BAME staff an increase of 2% from last year.

Of the 965 staff in the 'exceeded expectations' category, 52% were non-BAME and 43% were BAME. The percentage for Non BAME staff has reduced from 56% last year whilst BAME has increased by 7%.

198 staff scored *continually exceptional* of which 53% were non-BAME and 41% BAME which is a 12% difference in favour of non-BAME staff, whilst there has been no change for Non BAME staff this represents a 1% improvement for BAME staff from last year

Of the 37 staff in the 'requires improvement' category, 38% were Non-BAME staff and 49% were BAME staff. This a reduction of 4% in Non BAME staff from last year but an increase of 7% for BAME staff, however this has to be taken in context because of the small numbers of staff involved where small changes have larger impacts.

The number of staff with an 'unacceptable' rating were in single figures and related only to BAME staff.

# Section 10: Application of formal employee relations procedures 2019/20

All employee relations cases are recorded in the following categories:

- Disciplinary
- Sickness absence
- Probation
- Performance (capability)
- · Grievance including bullying and harassment

During financial year 2019/20 there were 327 formal employee relations cases, these are broken down by category. In comparison there were 451 cases in 2018/2019.

**Table 15: Employee Relations cases** 

Case Type	2018/2019	2019/2020
Disciplinary	79	48
Sickness absence	265	215
Probation	55	39
Performance (capability)	20	8
Grievance including bullying and harassment	32	17
Total	451	327

The cases in the above categories are broken down by ethnicity, gender and age to give an indication of how these relate to the composition of the workforce.

#### **Disciplinary cases**

There were 48 disciplinary cases during the period Apr 2019 – Mar 2020 compared to 79 cases in the same reporting period last year. BAME staff accounted for 29 of these (60%) in comparison to being 46% of the total workforce. Non BAME staff accounted for 12 (25%) of all cases whilst also being 46% of the workforce. In October 2019 the Trust introduced a Pre- Formal Disciplinary Investigation Checklist with the objective of reducing the overall numbers of cases and reducing the disproportionate impact on BAME staff.

As the overall number of cases has decreased so has the percentage of BAME staff being involved in disciplinary proceedings. This has fallen from 64% last year to 60% this year but still remains higher than the percentage of BAME staff in the workforce.

Undefined indicates that ethnicity data has not been recorded on the electronic staff record.

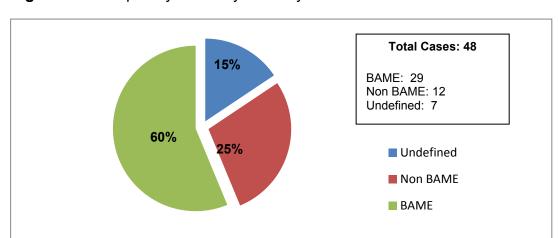


Figure 15: Disciplinary cases by ethnicity

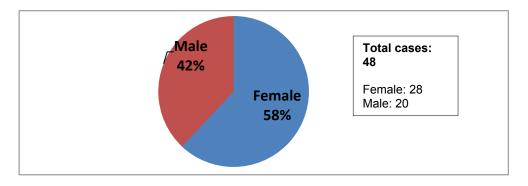
The table below shows that the relative likelihood of BAME staff entering the formal disciplinary procedure is 2.41 times greater than for non-BAME staff. This is an improvement from 2.73 times greater in 2018/2019

The calculation does take into account the changes in the overall number of BAME and non-BAME staff within the organisation.

DescriptorNon-BAMEBAMENumber of staff in organisation2,9312,934Number of staff who have entered into disciplinary proceedings1229Relative likelihood of BAME staff entering into disciplinary proceedings compared to non-BAME staff2.41

 Table 15: Likelihood of entering the formal disciplinary hearing by ethnicity 2019/20

Figure 16: Disciplinary cases by gender

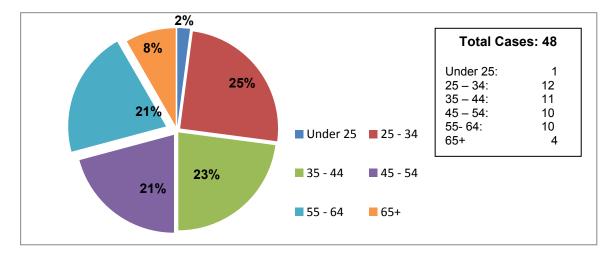


Analysis of disciplinary cases by gender shows that females account for 58% of cases, an increase of 2% from the previous year. Cases involving male staff have decreased by 1% to 42% from the previous year and is disproportionate compared to the number of male

staff and a review as part of our on-going review following the launch of our disciplinary checklist a review of these cases will take place.

Disciplinary cases by age shows that the 25–34 age group is the single largest age group at 25% of cases. The 25–34 age range make up 38% of the workforce.

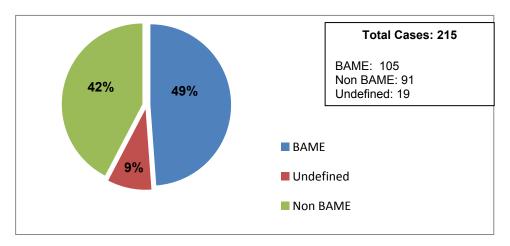
Figure 17: Disciplinary cases by age



#### Sickness absence cases

There were 215 sickness absence cases in 2019 /20 down from 265 in 2018/19.

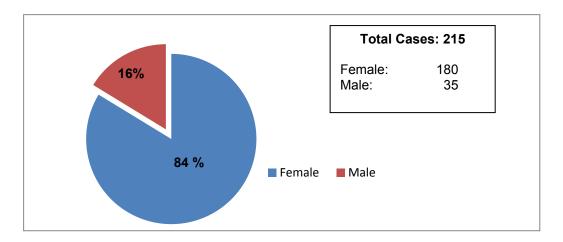
Figure 18: Sickness cases by ethnicity



Sickness absence by ethnicity shows that BAME staff accounted for 49% of cases. This is a rise of 8% on the previous year. Non BAME staff accounted for 42% of cases which is a reduction from 52% from the previous year.

The number of undefined, which indicates that data has not been recorded on the electronic staff record, has increased from 9% from 7% the previous year.

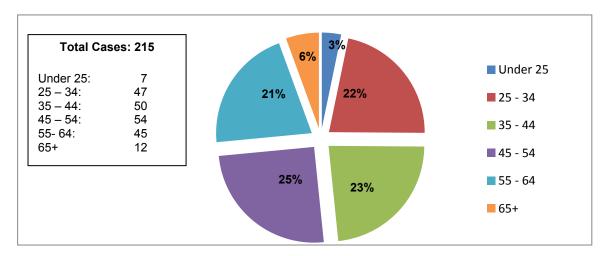
**Figure 19:** Sickness cases by gender



Sickness absence cases by gender shows that females accounted for 84% of cases and is an increase of 7% on the same period last year. In 2019/20 males accounted for 16%.of cases.

This a change from last year when females accounted for 77% of sickness absence cases and is in contrast to the current gender spilt of the workforce which is 75% female and 25% male.

Figure 20: Sickness cases by age

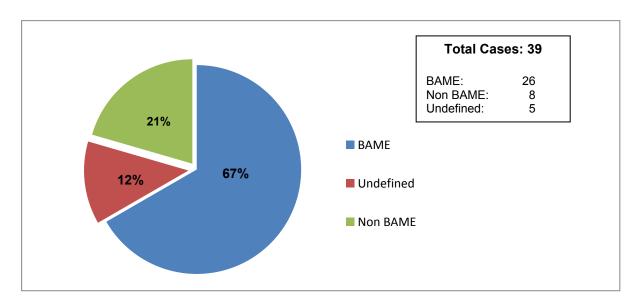


Sickness absence cases by age shows that the 45- 54 age group make up the single largest group of cases at 25%.

This has not changed from last year and the percentages across the other age ranges have remained unchanged.

#### **Probationary cases**

Figure 21: Probationary cases by ethnicity

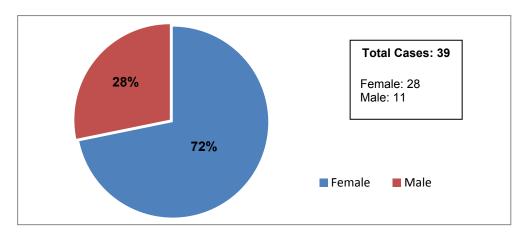


The number of probationary cases in 2019/20 decreased from 55 the previous year. BAME staff accounted for the majority of probationary cases at 67% of cases an increase of 5% on the previous year.

21% of probationary cases related to non-BAME staff who account for 46% of the Trust workforce profile

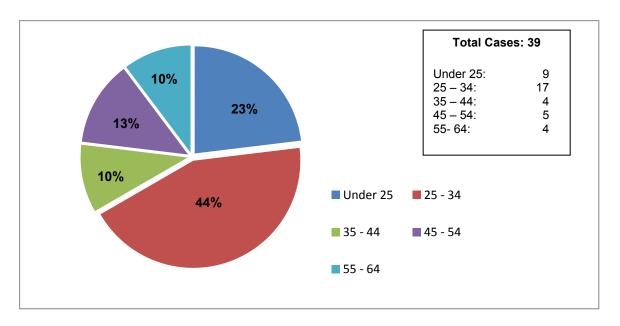
The number of undefined, where the data has not been recorded on the electronic staff record, has increased to 12% from 5% the previous year. The Trust is implementing a probation checklist similar to the disciplinary checklist to ensure a robust decision making process.

Figure 22: Probationary cases by gender



Female staff accounted for 72% of probation cases an increase from 65% the previous year. The percentage for males has decreased to 28% from 35% the previous year.

Figure 23: Probationary cases by age



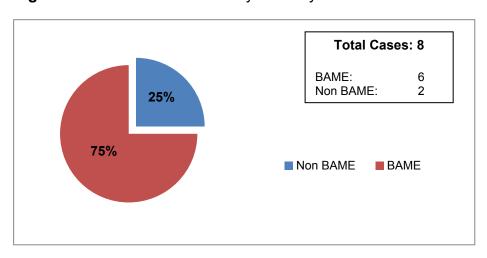
Probation cases by age show that the 25–34 age range account for the majority of cases at 44% cases which remains unchanged from last year.

This age group is also the largest single age range accounting for 38% of the total workforce.

#### Performance (capability) cases

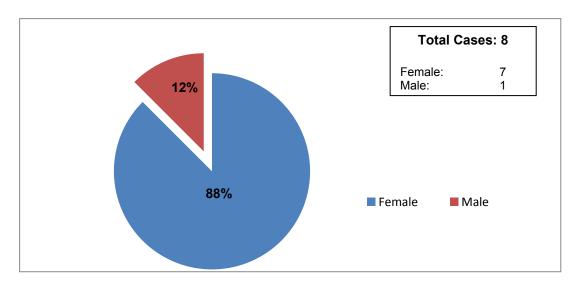
There were 8 performance cases in 2019/20 down from 20 the previous year.

Figure 24: Performance cases by ethnicity



BAME staff accounted for 6 cases which is 75% of the total. The percentage last year was 60% of cases which represents an increase of 15% in 2019/20 despite fewer cases. In line with the disciplinary checklist and probation checklist, a review of these cases will be undertaken as part of the actions in the EDI plan.

Figure 25: Performance cases by gender

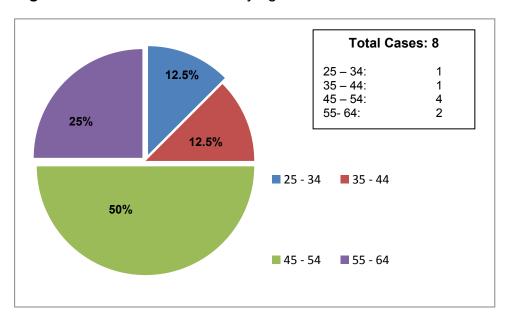


Performance cases by gender shows that of the 8 cases, 6 (88%) involved female staff and 1 case (12%) involving male staff.

In 2018/19 the percentage of cases involving female staff was 75% so has increased by 13% from last year.

The percentage involving male staff was 25% in 2018/2019 so has reduced by 13%.

Figure 26: Performance cases by age



Performance cases by age show that the 45 –54 age range account for 50% of cases. The percentage of cases in this is age range has increased from 30% in the previous year.

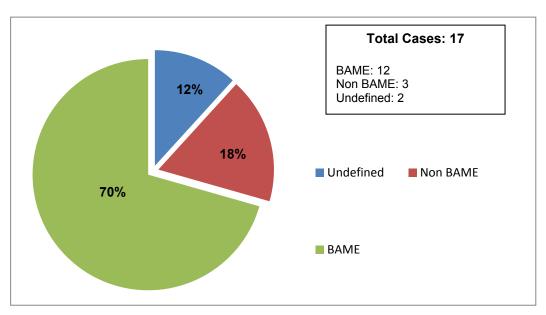
In the previous year the 55-64 age range accounted for the largest percentage of cases at 35%.

### **Grievance cases (including bullying and harassment)**

Grievance cases (which include bullying and harassment) often involve multiple employees—including the individual submitting the complaint and the person who may be accused of inappropriate behaviour.

There were 17 cases in 2019/20 a reduction from 32 in 2018/2019.

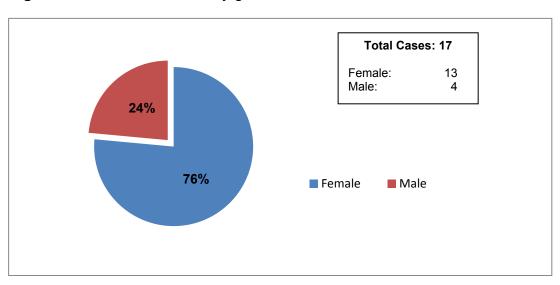
Figure 27: Grievance cases by ethnicity



12 (70%) of the grievance cases involved BAME staff, an increase from 41% the previous year. Non BAME staff accounted for 3 cases (18%) a reduction from 50% the previous year.

The percentage of undefined has increased to 12% in 2019/20 from 9% the previous year.

Figure 28: Grievance cases by gender



Female staff accounted for 76% of grievance cases in an increase from 66% the previous year. The percentage of male staff involved in these cases has reduced to 24% from 34% last year.

# Section 11: Local clinical excellence awards for consultants

The 2019 local clinical excellence round was cancelled and in its place the Trust was asked to pay a one off payment to all consultants who meet the eligibility criteria. 398 consultants met the criteria to receive the payment.

Table 16: One off payment by ethnicity

Ethnic origin	%
Non-BAME consultants	224 (56%)
BAME consultants	154 (39%)
Unknown	20 (5%)
Total	398

Table 17: One off payment by gender

Gender	%	
Female	214 (54%)	
Male	184 (46%)	
Total	398	

# Section 12: Staff experience—2020 NHS staff survey

The 2019 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender. The full results of the 2019 staff survey can be found at <a href="http://www.nhsstaffsurveyresults.com/">http://www.nhsstaffsurveyresults.com/</a>

**Table 18:** 2019 staff survey by gender

Theme	Female	Male
Staff engagement	7.3	7.4
Bullying and harassment	7.5	7.7
Equality diversity and inclusion	8.5	8.8
Morale	6.1	6.0
Health and wellbeing	5.7	6.0
Immediate managers	7.0	6.9
Quality of appraisals	6.3	6.3
Safety culture	7.0	7.0

Disabled staff are the least likely group to report positive experiences across a range of indicators as indicated below. The charts highlight our disabled staff are significantly less engaged than our non-disabled staff and score less positively on the majority of factors. Staff in the age groups of 21-30 are also the least engaged and interestingly score the lowest in relation to health and well-being whereas staff over 66 score the highest. BAME staff have a higher engagement score and are more positive than non-BAME staff across the majority of factors despite some of the WRES scores.

Table 19: 2019 staff survey by disability

Theme	Disabled	Non-Disabled
Staff engagement	6.9	7.4
Bullying and harassment	6.7	7.6
Equality diversity and inclusion	8.2	8.6
Morale	5.7	6.1
Health and wellbeing	4.6	5.9
Immediate managers	6.9	6.9
Quality of appraisals	5.3	6.4
Safety culture	6.6	7.0

Table 20: 2019 staff survey themes by age

Theme	21–30	31–40	41–50	51–65	66+
Staff engagement	7.1	7.3	7.4	7.4	7.9
Bullying and harassment	7.3	7.6	7.6	7.6	8.6
Equality diversity and inclusion	8.6	8.5	8.5	8.6	9.4
Morale	5.8	6.0	6.0	6.2	7.1
Health and wellbeing	5.4	5.8	5.8	5.8	7.3
Immediate managers	7.1	7.1	6.9	6.7	7.1
Quality of appraisals	6.4	6.4	6.4	6.0	6.1
Safety culture	6.9	6.9	7.0	7.0	7.3

Table 21: 2019 staff survey themes by ethnicity

Theme	Non-BAME	BAME
Staff engagement	7.2	7.5
Bullying and harassment	7.5	7.6
Equality diversity and inclusion	8.1	9.1
Morale	6.2	6.1
Health and wellbeing	5.7	5.8
Immediate managers	6.8	7.1
Quality of appraisals	5.6	7.0
Safety culture	6.9	7.1

# NHS national staff survey questions mandated by the Workforce Race Equality Standard (WRES)

Under the WRES, the Trust is required to publish the responses by ethnicity to specific NHS staff survey results at <a href="http://www.nhsstaffsurveyresults.com/homepage/local-results-2019/workforce-equality-standards-wres-2019/">http://www.nhsstaffsurveyresults.com/homepage/local-results-2019/workforce-equality-standards-wres-2019/</a> as detailed below.

Question	Ethnicity	%
5. Percentage of staff experiencing bullying, harassment or	Non-BAME	37%
abuse from patients or relatives	BAME	37%
6. Percentage of staff experiencing bullying, harassment or	Non-BAME	27%
abuse from staff	BAME	28%
7. Percentage believing the Trust provides equal opportunities	Non-BAME	87%
for career progression or promotion	BAME	75%
8. Percentage of staff experiencing discrimination at work from	Non-BAME	7%
managers or colleagues	BAME	13%

# **Appendix 1: Workforce Race Equality Standard (WRES)**

The table below summarises the Trust's annual WRES return which was submitted to the national WRES team in Aug 2020

WRES indicator	Ethnicity	Headcount	Explanatory notes	
	Non-BAME	2,931		
1. Workforce reporting	BAME	2,934	As at 31 Mar 2020	
	Unknown	529		
Relative likelihood of staff being appointed from shortlisting across all posts	Non-BAME staff 1.40 times more likely		Based on NHS Jobs and TRAC data captured during 2019/20	
Relative likelihood of staff entering the formal disciplinary process	BAME staff 2.41 times more likely		Based on 2019/20 cases	
4. Relative likelihood of staff accessing non-mandatory training and continuing professional development	Non-BAME staff 0.89 times more likely		Data should be read with caution, as not all non-mandatory training is captured through the current training databases across both sites	
5. Percentage of staff experiencing bullying, harassment or abuse from	Non-BAME	37%		
patients or relatives	BAME	37%		
6. Percentage of staff experiencing bullying, harassment or abuse from	Non-BAME	27%		
staff	BAME	28%	2019 staff survey	
7. Percentage believing the Trust provides equal opportunities for	Non-BAME	87%	2019 Stall Survey	
career progression or promotion	BAME	75%		
8. Percentage of staff experiencing discrimination at work from managers	Non-BAME	7%		
or colleagues	BAME	13%		
Percentage difference between     BAME Board voting membership and	BAME board members	19%	- As at 31 Mar 2020	
overall BAME workforce	Overall BAME workforce	46%	no at 31 Iviai 2020	

## Appendix 2: Gender pay gap 2019/20

Gender pay reporting legislation requires employers with 250 or more employees from to publish statutory calculations every year showing how large the pay gap is between their male and female employees.

The results must be published on both the employer's website and the government website <u>gender-pay-gap.service.gov.uk</u>. The requirements of the legislation are that employers must publish six calculations:

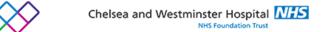
- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

The Trust's full gender pay gap report is published at <a href="www.chelwest.nhs.uk/genderpaygap">www.chelwest.nhs.uk/genderpaygap</a> and highlights that female employees earn an hourly mean average pay of 17.7% less than men and the actions the Trust is taking.

# **Appendix 3: Workforce Disability Equality Standard** (WDES) March 2020

Metric 1	Percentage of staff in Agenda for Change (AfC) pay bands or medical and dental subgroups and very senior managers (VSM)—including executive board members—compared to the percentage of staff in the overall workforce	Data from ESR—123 staff have a disability recorded on ESR. Data identified by:  Non-clinical or clinical  Band or grade
Metric 2	Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts	A figure below 1 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting. Trust score is 1.09.  Data comes from TRAC—207 applicants with disabilities shortlisted/38 appointed in 2019/20.  Doesn't take into account how many withdraw after shortlisting or attended interviews  Trust holds Disability Confident Employer Level 2 status until Oct 2020  Disability Confident Employer Level 2 info pack is available
Metric 3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	A figure above 1 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process. Trust score is 2.24.  Data from ESR 2018/19—13 cases where the employee had a disability recorded in ESR.  Breakdown by case type:  Sickness cases: 6  Disciplinary cases:0  Grievance/bullying and harassment cases: 2  Performance management cases:1  Probation cases: 4  The Trust on place Maintaining the Employment of People with Disabilities: Guidance for Line Managers
Metric 4a	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:  • patients/service users, their relatives or other members of the public  • managers  • other colleagues	Four questions from staff survey combined—higher percentages are worse  From patients/service users, their relatives or other members of the public:  N° of respondents: 2637  Disabled: 42% Non-disabled: 36%  From managers: N° of respondents: 2627  Disabled: 26% Non-disabled: 14%  From other colleagues: N° of respondents: 2617  Disabled: 30% Non-disabled: 20%

Metric 4b	Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	<ul> <li>N° of respondents: 1141</li> <li>Disabled: 48%</li> <li>Non-disabled: 52%</li> </ul>
Metric 5	Percentage of disabled staff compared to non-disabled staff believing the Trust provides equal opportunities for career progression or promotion	<ul> <li>Question from staff survey—higher percentages better</li> <li>N° of respondents: 1808</li> <li>Disabled: 79%</li> <li>Non-disabled: 81%</li> </ul>
Metric 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	<ul> <li>Question from staff survey—higher percentages worse</li> <li>N° of respondents: 1524</li> <li>Disabled: 30%</li> <li>Non-disabled:23%</li> </ul>
Metric 7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	<ul> <li>Question from staff survey—higher percentages better</li> <li>N° of respondents: 2651</li> <li>Disabled: 39%</li> <li>Non-disabled:55%</li> </ul>
Metric 8	Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work	<ul> <li>Question from staff survey—higher percentages better</li> <li>N° of respondents: 179</li> <li>Trust score: 74%</li> </ul>
Metric 9a	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation	One of 10 staff survey themes scored from 0–10  N° of respondents: 2742 Disabled: 6.9 Non-disabled: 7.4 Overall Trust score: 7.3
Metric 9b	Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard (yes or no)?	Yes—Trust had disabled staff start/finish a task group which helped produce the Maintaining the Employment of People with Disabilities: Guidance for Line Managers
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:  By voting membership of Board By executive membership of Board	Make-up of Trust Board including non-executive directors by disability:  Executive Board: 0%  Overall workforce: 2%



# **Appendix 4**

# Chelsea and Westminster Healthcare NHS Foundation Trust Improving Equality, Diversity and Inclusion Action Plan Years 2-3

Our Year 1 race equality plan has been updated to reflect our priorities for the next 2 years of our 3 year plan. It focuses on a shift from our commitment to ensuring processes are in place to ensure staff are treated fairly, equally and free from discrimination to ensuring all staff are provided with a positive working environment and therefore as well as embedding and reviewing processes implemented in Year 1 the plan focuses on creating a safe, inclusive work culture. This includes learning to listen more and understanding the lived experiences of our staff.

#### **Our Vision and Success Measures**

- Leadership commitment at all levels for the Equality, Diversity and Inclusion agenda
- Influential staff networks for BAME, LGBTQ+, Women and Disability operating and having a voice in the organisation
- Our key metrics for WRES/WDES/Gender Pay Gap will have improved and be amongst the best performing Trusts
  nationally
- Our staff survey results will see significant improvements for EDI and Harassment and Bullying





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
1. Continue to embed the Boards and Senior Managers commitment to improving Equality, Diversity and Inclusion	<ol> <li>The Board and Executive Cabinet sign-up to, and sign- off, the Year 2 and 3 of the Action Plan and pledge commitment to delivery</li> </ol>	End Q2	Staff, are clear of the Board commitment to provide a fair, inclusive and non-discriminatory work environment	Staff Experience Questions  9b 9c 9d  Commitment is published	Board Executive
	<ol> <li>All ward/ department managers and heads of services to be able to talk to their staff about the board commitment</li> </ol>	End Q4 2020	Improve staff awareness of the commitment to be a fair and inclusive employer	Staff Experience Questions 9b 9c 9d	Board Executive
	3. The Board, Executive and Senior managers participate in development and mandatory training on race equality, and compassionate and inclusive leadership annually	End Q4 each year	Increased awareness amongst senior staff of diversity, inclusion issues, and changes in leadership behaviour where appropriate	Staff Experience Questions  9b 9c 9d  Evidence of training  CQC Well Led domain	Board Executive





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	4. All Senior and middle managers to have an objective to embed inclusion as part of the appraisal process  •	Q4 2020	The Board, Executive Cabinet and Senior Managers act as role models for equality and inclusion	Staff Experience Questions 9c 9d	Board Executive
	5. All executives and senior managers to participate in Reciprocal Mentoring for Inclusion programme	Q2 2020	The Executive and Senior Managers are mentored by a member of staff from an underrepresented group to get a deep understanding about the lived experience of staff in the organisation. Create a safe environment to have uncomfortable conversations.	Staff Experience Q 9 9a 9d	Board Executive





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	<ol> <li>Share learning and celebration of staff participating in reciprocal mentoring scheme</li> </ol>	Q4 20/21	To determine benefits of reciprocal mentoring scheme and positive experiences	Staff experience Q 9 9a 9d	Deputy Director of People & OD
	7. On-going communication programme which aims to facilitate conversations about inclusivity and specific issues on (race, LGBT, disability) amongst Senior Managers.	End Q4	Increased awareness for managers of the BAME/LGBT/Disability/Women's staff experience	Staff Survey Questions 9c 9d	Director of HR&OD
	8. Trust People Strategy to include the key Equality Diversity and Inclusion outcomes aligned to the NWL tacking inequalities and creating inclusive cultures work streams	End Q4	Staff and managers understand the work to be undertaken over the next 3-5 years and key measures for improvement over period agreed	Staff Experience Question Q9a, Q9d Q14 WRES/WDES/GP G	Director of HR&OD





Objective		Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
2. Develop influential Staff Networks for BAME, LGBTQ+, Women and Disability	I.	Develop regular feedback/ listening events for staff attending the networks and undertake "look forward" surveys to assess how Trust can support staff using lessons learnt	End Q1 Every quarter	BAME staff share what they want from a BAME network and are involved in its creation	Staff Experience Questions 9c 9d	Network Chairs
	II.	Ensure Terms of Reference and governance arrangements for the Networks	End Q1 Annual review	Provides an opportunity for the Board and Executive Team to engage directly with BAME, LGBTQ+ Disability, Women about their experience		Equality and Diversity Manager/ Network Chairs
	III.	Launch the Disability network	End Q3	Provides a voice for disabled staff in the organisation	Staff experience and WDES scored	Equality and Diversity Manager/ Network Chairs





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	IV. Produce and develop calendevents of significance for BAME/LGBT/Nn/Disability states communities	Year or Wome	Improve staff experience through celebrating difference	Staff experience Q14	Equality and Diversity Manager/ Network Chairs
	V. Develop a communication strategy for the networks		Provides an opportunity for staff to directly influence Trust strategy		Equality and Diversity Manager/ Network Chairs/Staff Engagement Lead - Communications
	VI. Establish reso (financial and required to su network office effectively carr roles	time) ipport rs to	Network Officers support chair attending meetings, planning and undertaking network activities, producing network work plan and contributing to EDI plans	Improvement in effectiveness and impact of network and providing personal development opportunities for network officers	Director of HR&OD





Objective		Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	VII.	Network Chairs to produce an annual report to update the People and OD Committee	Q1-Q4 All schedule d dates	Communicate work and output from staff networks		Network Chairs
	VIII.	Set meetings/ agenda/ reporting structures	Q1-Q4	The Network has a demonstrable impact on the culture of the Trust		Equality and Diversity Manager/Network Chairs
	IX.	Develop annual work plan with detailed action plan	Q1-Q4	Record and evidence work from network and enable visibility of work plan		Equality and Diversity Manager/Network Chairs & officers
	X.	Celebrate success of BAME/LGBTQ+/Disa bility/Women in the organisation	End Q2	Increase awareness of all staff's contribution to the Trust	Staff Experience Question 9 Q9a, Q9d	
3. Ensure fairness in Trust disciplinary, grievance and performance management processes	I.	Review the impact of the disciplinary checklist for BAME staff	End Q1 each year	Provides a transparent and structured approach to the disciplinary process	WRES Indicator 3	Head of Employee Relations





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
			Reduction in the number of staff going through the disciplinary process		
	II. Articulate the lessons learned from the review of 79 disciplinary cases and implement changes in approasing required	year	Themes are understood and guide revisions in process	Staff Survey Question 15	Head of Employee Relations
	III. Identify and train interview experts from BAME backgrounds staff support and participate in disciplinary panels contribute and participate in training events		A sustained reduction in actual or perceived discrimination against BAME staff	Staff Survey Questions 12, 13 Q15c WRES Indicators 5, 6, 8	Head of Employee Relations
	IV. Undertake an analysis of the application of use of	End Q3	'Hot spots' identified and provide focus for additional support and performance process minimises	WRES Indicators 3, 7 WDES	Head of Employee Relations/Deputy Director of People and





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	performance management processes across the Trust by site, staff group and protected characteristics		bias		OD
	V. Develop a process for "check and challenge" for the review of probationary "failures"	Q3	Reduce the number of staff failing the probation process	Reduction in number of all staff and in particular BAME staff impacted	Head of Employee Relations





Objective	Key Acti	ons Due Date		act/Outcome Measure Impact	of Owner
	VI. Introduce Resolutio Framewo approach informally	n rk to ER issues	Reduction in formal Reduction in BAM the formal discipling supportive convertion handled through managers have incavareness	E staff entering nary process  Reduction in formal cases sations' Staff experience	Deputy Director of People and OD
4. Ensure fairness of recruitment processes and progression opportunities for under-represented staff	to post int processes	nt s to make they are quitable ut the from JD's	Competency-base discriminatory sele are used by the Tr	ection practices Question 14	Head of Resourcing/Deputy Director of People and tor 2 OD





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
II.	Further roll out of EDI champions from all protected characteristic to participate in panels band 6-7	Q3	To ensure check and challenge of potential biases within the interview process	Staff Engagement score in staff survey	Head of Resourcing/Deputy Director of People and OD
	Develop a process and associated guidance to ensure that unsuccessful internal candidates for band 8a roles initially and then Band 7 and above receive support when applying for roles and feedback and an associated personal / career development plan	End Q3	Processes in place to track the career progression of BAME and other under-represented groups	WRES Indicator 1, 2 Q19f WDES 2	AD Learning & OD
IV	Develop a consistent approach and process for providing "stretch" opportunities for under-represented	End Q2	Opportunities are provided to BAME staff for professional, career development  Numbers of BAME staff applying and getting on leadership courses	Staff Experience 4 & 5 Q19f Formal monitoring	AD Learning and OD





Objective	Key Ac		Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	included leadersh develop	ntation is d on senior nip		increases	and reporting to be included as part of evaluation process	
5. Address the negative experience that BAME and other groups have of bullying and harassment	the Staf Network Guardia and trial and soft	ard FTSU an, review ngulate hard intelligence ng staffs' nce of and	End Q2	Understand themes or areas of greater reporting of B&H	Staff Survey Question 14 WRES Indicator 6 WDES 4a	Deputy Director of People and OD
	of interv address	hensive set rentions to the issues og from the	Q3	A sustained reduction in actual or perceived discrimination against BAME/disability	Staff Survey Questions 12, 13 Q15c WRES Indicators 5, 6, 8	Deputy Director of People and OD





Objective	Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
	II. Develop a zero tolerance to 'racism' reported by staff	End Q3	Reduce impact of aggression from patients to all BAME staff	Staff Experience 4&5	Security Manager / site DoN
Γ	V. Hold 6 monthly focus groups with staff who have reported violence and aggression	Q4	Provide support and identify root causes to find practical solutions to reduce incidents of violence and aggression and improve staff experience	WRES indicator 5 & 6	V&A Lead
	V. Annual report on violence and aggression experienced by staff	Q1 20/21	Identify root causes to identify solutions to reduce violence and aggression from patients and staff on staff	WRES indicator 5 & 6	V&A Lead
	VI. Develop and educate managers on how to support staff who have experienced racially motivated violence and aggression	Q4	Improve support of staff who have experienced racial/homophobic/other abuse	Staff Experience 4&5 WRES indicator 5	V&A Lead





Objective		Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
6. Embed a culture of Inclusion and Compassion	I.	Undertake deep-dive into EDI metrics/ WRES/WDES/GPG	Q4 20/21	Develop action to move the needle on cultural indicators	WRES indicators 5,6, 7 & 8 WDES/GPG	Deputy Director of People and OD
	II.	Identify leaders to support areas which may required to transform workplace cultures	Q4	CW leaders who understand the causes of the distress of difficulties staff experience	WRES indicators 5,6, 7 & 8	Deputy Director of People and OD
	III.	Raise awareness of responsibility of all managers for the culture of the organisation.	Q4	Leaders embody compassion in their leadership, and that means for behaviours	Staff Experience	AD of Learning and OD/Deputy Director of People and OD
	IV.	Identify areas of focus within the organisation e.g. Divisions and where possible departments/ wards	Q4	Target areas to focus support and cultural transformation work	WRES indicators 5,6, 7 & 8	Deputy Director of People and OD
	V.	Buddy with NELF (organisation with improved WRES metrics)	Q3	Shared replicable good practice models of improvement	WRES indicators 5,6, 7 & 8	Deputy Director of People and OD
	VI.	Communicate to the public the Trust zero tolerance of violence	Q3	Reduce abuse and harassment from patients	WRES indicators 5,6, 7 & 8	Deputy Director of People and OD/Chief





Objective		Key Actions	Due Date	Intended Impact/Outcome	Measure of Impact	Owner
		and aggression to our staff				Nurse
7. Understand the impact of COVID-19 on specific staff groups and the underlying health inequalities to ensure all staff are kept safe all well at work	I.	Ensure that all risks are mitigated for staff through individual risk assessments/ workplace assessments/access to health and wellbeing services by ensuring they are culturally sensitive.	Q3	Ensure the health and wellbeing of those disproportionately impacted by COVID-19  Pro-active use of information from risk assessments about the health of our workforce to promote better health  Culturally sensitive services  Proportionate take up of counselling/EAP/psychological support services by BAME staff and men which are known to be under-represented	Staff Survey Q11 Health and Wellbeing	Director of HR
	II.	Understand lived experiences of specifically BAME staff adversely affected by COVID 19 pandemic working at the Trust	Q3	Staff are able to have conversations about and participate and contribute to changes needed that they have personally experienced	Staff Survey Q11  Health and Wellbeing  Specific survey – BAME Network	BAME Network Chair/Deputy Director of People and OD









**NHS Foundation Trust** 

# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.5/Nov/20	
REPORT NAME	Seasonal Influenza Vaccination Programme Update	
AUTHOR	Lee Watson, Director of Nursing	
LEAD	Pippa Nightingale, Chief Nursing Officer	
PURPOSE	This paper provides the board with an update of the seasonal influenza vaccination programme, including a self-assessment declaration which requires approval prior to submission to NHS England/Improvement (NHSE/I).	
REPORT HISTORY	Executive Management Board 14.10.20	
SUMMARY OF REPORT	As of 29 <sup>th</sup> October 62% of front line staff had been vaccinated against a target of 90%.  This year the vaccine was delivered in 4 phases; all deliveries have now been received at the Trust and the peer vaccination programme launched on the 21 <sup>st</sup> September.  The report provides an overview of the communications plan for the delivery of the seasonal vaccination programme	
KEY RISKS ASSOCIATED	Failure to achieve the required >90% vaccination level of front line staff may lead increased sickness and absence during the winter period, reducing the effectivene to provide high quality care and would put staff at additional risk in the event of a pandemic.	
FINANCIAL IMPLICATIONS	None	
QUALITY IMPLICATIONS	As above	
EQUALITY & DIVERSITY IMPLICATIONS	None	
LINK TO OBJECTIVES	All	
DECISION/ ACTION	The Board is asked to note the content of this report and to approve the self-assessment in appendix 1.	

#### **Seasonal Influenza Vaccination Programme**

#### Introduction

The 2020-21 seasonal influenza vaccination programme has been based on learning from the 2019-20 campaign, taking into account the areas of good practice and learning from issues that arose during the campaign. The campaign formally launched on 21<sup>st</sup> September with week-long launch events held on both sites.

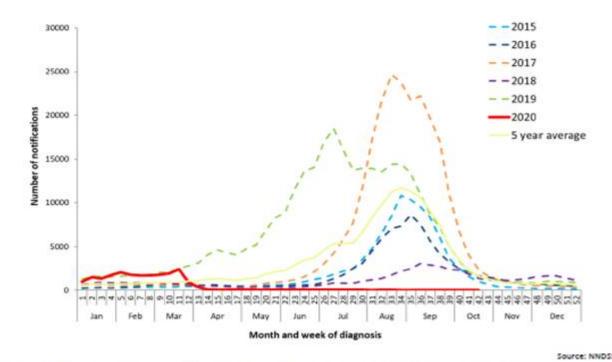
#### Strategic Flu Group

The Strategic Flu Group was formed in July 2020 and met throughout the summer to plan this year's programme. The group is chaired by the DIPC and has membership from all divisional and key corporate teams across all sites. The team meet every Thursday and assess the effectiveness of the programme against a standard agenda.

#### **Supply of Flu Vaccine**

The 2020 Australian flu season started higher than previous years, however currently influenza and influenza-like-illness (ILI) activity is lower than average. At the national level, notifications of laboratory-confirmed influenza have substantially decreased since mid-March and remain low, as outlined in figure 9 below:

Figure 9. Notifications of laboratory confirmed influenza, Australia, 01 January 2015 to 18 October 2020, by month and week of diagnosis\*



\*NNDSS notification data provided for the current and most recent weeks may be incomplete. All data are preliminary and subject to change as updates are received.

Similarly to the 2019/20 flu programme the supply of vaccines to all Trusts in the UK has been phased, however unlike last year this was due to demand rather than delay in preparing the vaccine. Chelsea and Westminster NHS Foundation Trust received the final delivery of our required vaccine on 29<sup>th</sup> October.

#### **Delivery Schedules**

CWFT site	Doses	Delivery Week
Quad Inact Vaccine	950	18/09/2020
Quad Inact Vaccine	760	09/10/2020
Quad Inact Vaccine	950	23/10/2020
Quad Inact Vaccine	1140	28/10/2020
	3,800	

WMUH site	Doses	Delivery Week
Quad Inact Vaccine	880	18/09/2020
Quad Inact Vaccine	700	09/10/2020
Quad Inact Vaccine	880	23/10/2020
Quad Inact Vaccine	1040	30/10/2020
	3,500	

#### **Peer Vaccinators**

140 staff have been trained as peer vaccinators during the summer. Last year demonstrated that the peer vaccinators were the most successful method of vaccination, having this delivered locally at ward and department level.

Occupational health will continue to ensure that there are drop in clinics on each site throughout the season.

#### **Communications and celebration**

The coms team have developed a robust plan and have revised the flu materials. There will be the continued celebration of success through various channels including social media, bulletin and team brief.

The flu trolley will return and staff will also be incentivised with the continued used of the voucher raffle monthly. There will also be additional drop in session in the Atrium of the CW site and Rumbles Restaurant on the WM site.

#### **Early Success**

As of 29<sup>th</sup> October 61.6% of front line clinical staff have been vaccinated and over 3400 vaccinations have been given. The breakdown by division and staff group is as follows:

Count of Want To Receive Flu Vaccine	Column Labels 🔻						
Row Labels	✓ Admin & Clerical	Allied Health Professions (PAMs)	Medics	Nurses and Midwives	Other	Support staff (ISS)	Grand Total
Clinical Support Services	81	160	37	97	23	12	410
Corporate	154	11	9	47	23	26	270
Emergency and Integrated Medicine	53	128	269	618	20		1088
Planned Care	56	78	153	365	19	1	672
Women, Children, Dermatology, HIV and GUN	1 96	57	253	592	45	2	1045
Grand Total	440	434	721	1719	130	41	3485
Target staff group		332	1275	3056			4663
% frontline staff		130.7	56.5	56.3			61.6

# Conclusion

The Board is asked to note the content of this report and to approve the submission of appendix 1 to NHSE/I as an accurate reflection of our self-assessment.

# **Appendix 1**Healthcare worker flu vaccination best practice management checklist

# For public assurance via trust boards by December 2020

Α	Committed leadership	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Completed - EMB 02/09/20
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed – arrived 18/09/20
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Completed – presented 24/06/20
A4	Agree on a board champion for flu campaign	Completed – CNO Pippa Nightingale
A5	All board members receive flu vaccination and publicise this	Completed – w/b 21/09/20
A6	Flu team formed with representatives from all directorates,	Completed – Nursing & Medical
	staff groups and trade union representatives	and HR representation
A7	Flu team to meet regularly from September 2020	Completed - commenced 10/09/20
В	Communications plan	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Completed
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Completed
В3	Board and senior managers having their vaccinations to be publicised	Completed - w/b 21/09/20
B4	Flu vaccination programme and access to vaccination on induction programmes	N/A – No physical induction (on Zoom) due to COVID-19
B5	Programme to be publicised on screensavers, posters and social media	Completed – 'jabometer' on desk-top displaying all Divisions
В6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Completed – available through Apex → Qlikview
С	Flexible accessibility	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Completed – 140 peer vaccinators across 5 Divisions
C2	Schedule for easy access drop in clinics agreed	Completed – launch events planned, roving trollies and OH drop-in clinics scheduled
C3	Schedule for 24 hour mobile vaccinations to be agreed	Completed – supported by Divisional peer vaccinators and SNOS out of hours
D	Incentives	
D1	Board to agree on incentives and how to publicise this	Completed – individual refreshments to take away & monthly incentive awards for peer vaccinator
D2	Success to be celebrated weekly	Completed – Divisional success cascade built in Apex → Qlikview





START DATE:	August 2020		NEXT REVIEW:	August 2021
COMMITTEE APPROVAL:	ENDORSED BY: Strategic Flu Group	<b>DATE:</b> 13/08/2020	CHAIR'S SIGNATU	

# Seasonal influenza plan 2020 - 2021

DISTRIBUTION:	Strategic Flu Group, Trust Board Members, Senior Managers, Medical and Nursing/Midwifery Clinicians and Ward/Departmental Managers within the Trust via Trust Intranet.
LOCATION:	Emergency Preparedness Folder Intranet - Seasonal Influenza file Flu intranet page http://connect/departments-and-mini-sites/eprr/seasonal-flu/
RELATED DOCUMENTS:	Infection Control Outbreak Policy, Trust's Surge Plans, Winter Planning, Service Continuity Plan
AUTHOR / FURTHER INFORMATION:	Lee Watson, Deputy Director of Nursing

## **DOCUMENT REVIEW HISTORY:**

Date	Version	Responsibility	Comments
13.12.2011	V 1	C Sands	Final Version for 2011/ 2012 season
03.08.2012	V 1.1	C Sands	Draft for 2012 / 2013 season, changing year and updating committee members.
13.09.2012	V 1.2	C Sands	Update of Paediatric Ward details
26.09.2012	V2	C Sands	Final Version for 2012/ 2013 season
03.09.2013	V3	C Sands	Final Version for 2013/2014 season
10.09.2014	V3.1	C Sands	Changing year and updating committee members, removing information related to pandemic flu as separate plan
03.11.2014	V4	C Sands	Final Version for 2014/2015 season
06.01.2017	V5	M van Limborgh	Amendment of plan for the Trust
2019	V6	C. Fry	Annual update
2020	V7	L Watson	Annual update

DATE EXPIRED	August 2021

# **CONTENTS**

Seasonal flu plan	4
Introduction	4
• Scope	4
• Aim	4
Objectives	4
• Definitions	5
Stakeholders	7
• Duties	6
Strategic flu group	9
Personal protective equipment	11
Staff vaccination	16
Vaccination of at risk inpatients	17
Communication	17
Clinical risk assessment	19
Influenza testing	20
Site management	20
Treatment & Prophylaxis	23
Reporting	25
Appendix 1: Occupational Health Flu Plan	
Appendix 2: Flu Management Checklist	
Glossary	33
References	36

# Clinical algorithms, links, posters, information and guidance can be found on the Seasonal Flu intranet page, or the antimicrobials page on the intranet

http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance-2016-17/

- Clinical algorithm Emergency Department (adults) Chelsea and Westminster
- Clinical algorithm Emergency Department (adults) West Middlesex
- Clinical algorithm Emergency Department (paediatric) Trust wide
- PPE poster Chelsea and Westminster site
- PPE poster West Middlesex site
- Prepare & Protect poster NHS England
- Visiting Restriction posters
- Swabbing Information for Chelsea and Westminster
- Trust Patient Information leaflet

This plan is not a standalone document and supplements the Trust's Infection Control Outbreak Policy, Surge Plans, Winter Plannning, Service Continuity Plan by providing additional information and guidance specific in line with national guidance. There is a separate Pandemic Influenza Policy

# **SEASONAL FLU PLAN**

#### 1. INTRODUCTION

All NHS organisations are required to plan for disruptions to services caused by infectious diseases. Increased service demands and reduced staffing levels may impact upon the Trust's ability to continue providing critical services whilst maintaining high standards of patient care.

Flu is also a key factor in NHS winter pressures and therefore NHS considers it as part of winter preparedness. Plans for a response to seasonal influenza builds on and enhances normal business continuity planning for more routine pressures such as bad weather and winter illness. Flu preparedness is therefore an integral part of wider emergency response and preparedness. This Flu plan sets out a coordinated and evidence-based approach to planning for and responding to the demands of flu taking account of lessons learnt during previous flu seasons.

The same good hygiene measures can reduce the spread of infection. Self-care measures – staying at home, keeping warm, drinking plenty of fluids and the use of over the counter cold and 'flu medicines to treat the symptoms of influenza - will be sufficient to meet the needs of most patients infected with an influenza virus that causes mild to moderate symptoms.

For most healthy people, seasonal flu is an unpleasant but usually self-limiting disease with recovery usually within a week. However, the very young and older people, pregnant women and those with underlying disease, particularly chronic respiratory or cardiac disease, or those who are immunosuppressed, are at particular risk of severe illness if they catch flu.

The impact of flu on the population can vary from year to year and is influenced by changes in the virus. The proportion of the population susceptible to infection depends on how many people have been exposed to the same or similar strains in the past as they will have some immunity and also how many have been vaccinated against the circulating strains. All this will influence the susceptibility to infection and the severity of the illness.

The Department of Health and Social Care and Public Health England sends a letter out in the spring of each year setting out target groups for immunisation and recommendations of which vaccines to order.

In light of the risk of flu and COVID-19 co-circulating this winter, the national flu immunisation programme will be absolutely essential to protecting vulnerable people and supporting the resilience of the health and care system.

#### 2. SCOPE

This plan covers the Trust's yearly planning and response to seasonal flu.

#### 3. AIM

The aim of this plan is to increase Trust resilience by ensuring those charged with managing an incident related to flu know and understand their role, are competent to carry out the tasks assigned to them and have access to available resources and facilities.

#### 4. OBJECTIVES

#### 4.1 Strategic Objectives

Planning is to minimise the health impact of the seasonal flu through effective monitoring, prevention and treatment:

- Ensuring the Trust is well prepared
- Monitoring flu activity, severity of the disease in risk groups, vaccine uptake and impact on the organisation
- Offering antiviral medicines to patients in at-risk groups for the treatment of flu in line with national guidance
- Vaccinating at risk patients with the seasonal flu vaccine
- Achieve a front line worker vaccination rate of >90%
- Having a plan that is based upon extensive experience held within the Trust and build on established systems for emergency management and business continuity
- Daily monitoring arrangements to be able to note key indicators of pressure across the Trust
- Ability to implement local management of pressure by activating the Surge Plan through a number of trigger factors e.g. to free up critical care beds
- Increase hand hygiene awareness programme
- Be part of a coordinated response at local, national and sharing information at international level

#### 4.2 During the Flu season - October - February

The main objectives of this Plan:

- Provide timely, authoritative and up-to-date information to all staff
- Staff welfare including reducing the spread of influenza promote hand hygiene, vaccinations, respirator fit test programme, availability of Personal Protective Equipment (PPE)
- Manage increased numbers of ill patients with appropriate isolation or cohorting
- Reduce morbidity and mortality from influenza patient care and vaccination where appropriate
- Comply with winter situation (Immform) reporting
- Implement a flexible, precautionary and proportionate response where needed
- Return to normal working after the season as rapidly and effectively as possible.

#### 5. DEFINITIONS

#### 5.1. Influenza

Influenza (often referred to as flu) is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs). There are three types of flu virus: A, B and C, with A and B responsible for most clinical illness.

#### 5.2. Pandemic Influenza

The World Health Organization (WHO) currently defines a pandemic as: "the worldwide spread of a new disease. An influenza pandemic occurs when a new influenza virus emerges and spreads around the world, and most people do not have immunity".

#### 5.3 Seasonal Influenza Types

There are three broad types of Influenza viruses –

- Influenza A: a group of viruses that cause most winter epidemics (and all known pandemics) and that can affect a wide range of animal species as well as humans.
- Influenza B: viruses that only infect humans (generally children) and circulate most winters and tend to cause less severe illnesses and smaller outbreaks than influenza A viruses.
- Influenza C: a group of viruses that are amongst the many causes of the common cold.

#### 6. STAKEHOLDERS

All staff working in the Trust.

#### 7. DUTIES

# 7.1 Responsible Director

• The overall responsibility of this procedure is from the Chief Executive with delegated responsibility to the Director of Infection Prevention and Control (DIPC).

# 7.2 Infection Prevention and Control (IPC) Team

- Ensures Seasonal Influenza Plan is in place and compliant with legislation and guidance
- Ensure maintenance of this plan, arranging for relevant training to be carried out as necessary
- Monitor and distribute any relevant information
- Prearrange dates, times, venues and invitations for Strategic Influenza meetings
- Taking minutes at strategic influenza meeting and cascading to attendees
- Monitor relevant sources of information during Influenza Incidents
- Arrange for the storage of all records and documentation in relation to any incident
- Undertakes quarterly and yearly reports to the Infection Prevention and Control Group
- Establish the Infection Control Policy
- Promote strategies to reduce infection, including staff training and awareness.

## 7.3 Respirator fit testing

• For the Trust nominated lead to advise on the train the trainer programme for fit testing and support staff fit testing and maintain a database of staff fit tested in key areas on both sites.

#### 7.4 Occupational Health

- Establish a staff vaccination programme which includes procurement and administration of the vaccine to staff and education about the vaccine.
- Monitor staff vaccination uptake, troubleshooting areas of low uptake and report centrally.

Further information regarding Occupational Health services can be found in the Occupational Health Influenza Plan 2020/21 (*Appendix 1*)

#### 7.5 Strategic Flu Group

- This group is chaired by the Director of Infection Prevention and Control or relevant nursing or medical IPC lead. The group includes representatives from each division and key areas,
- Provides the strategic focus in order to reduce the impact in responding to seasonal flu pressures and public health challenges
- From a yearly report learns from the ongoing experience and knowledge of previous years and acts on the recommendations
- The group updates the IPC Meeting and the Executive team when relevant during the active flu months of the year
- Members are responsible for onward liaison with staff in their own area
- Review the progress of the flu plan at the end of the flu season for future planning

#### 7.6 Pharmacy

- Responsible for procurement and supply of seasonal influenza vaccines and antiviral medicines.
- Development and dissemination of flu prophylaxis and treatment prescribing guidelines, the support of Patient Group Directives and memos

http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance

#### 7.7 Human Resources

- Establish and manage the staff reporting sick central point for use in a flu incident situation
- Establish during a flu incident, the Staff Welfare Team focusing on enabling staff to take appropriate leave, return to work, and reviewing vacancies/prioritising recruitment

#### 7.8 Communications Department

- Establish and deliver the Communications strategy to staff and the general public re vaccination programme and also during a flu incident
- Ensure staff are educated on the benefits of being vaccinated
- Help achieve a higher intake in lower resistant areas to vaccination
- Clearly communicate where and when vaccinations are taking place
- Encourage staff who haven't already been fit tested to do so
- Support the production of communications materials
- Undertake all media handling on behalf of the Trust
- During a flu incident, monitor and inform strategic (gold) and tactical (silver) of negative media relating to the wider NHS, and in particular the Trust
- Maintenance of Influenza folder on the Intranet folder http://connect/departments-and-minisites/antimicrobial-guidelines/flu-guidance

## 7.9 All Managers/Department Heads

- Brief staff as required/appropriate and encourage staff to be vaccinated being aware of vaccination numbers in own areas
- Monitor Staff absence and departmental capacity completing Situation Reports (SitReps) as required during flu season and actively recording if staff have flu like symptoms
- Maintain service/departmental Business Continuity Plans as appropriate/required.

# 7.10 Divisional Directors, Divisional Medical Directors, Divisional Directors of Nursing, Lead Clinicians, General Managers and Medical Consultants

- These post holders are accountable for the safe and effective care of patients in contact
  with their Division, ensuring that adequate resources are available and systems are in
  place to monitor and deliver appropriate infection prevention and control practice.
- Responsible for the implementation of this policy and ensuring that `staff is aware of and compliant with the procedure and that the guidance is followed.

#### 7.11 Ward or Departmental Managers

 Responsible for ensuring that infection prevention and control advice is followed and safe practices adhered to including the provision of resources to ensure compliance with this procedure.

- All managers are responsible for ensuring that infection prevention and control risk assessments are undertaken and that staff is familiar with the contents of this procedure and where to access it.
- Managers are responsible for ensuring staff has received relevant ongoing IPC training through induction and mandatory training.

#### 7.12 All Clinical Staff

- All are responsible for ensuring they access, understand and adhere to this procedure by
  ensuring that patients are managed in line with this procedure and liaise with the IPC
  team to ensure management is appropriate when necessary. All clinical staff should
  take actions to improve compliance with the procedure.
- All clinical staff has a responsibility to attend mandatory and other training sessions for IPC to ensure they are aware of any procedure updates.

#### 7.13 Estates and Facilities teams

- To ensure that the clinical environment is fit for purpose and cleaned in regard to the trust procedures based on national standards.
- Manage any outbreak in line with Trust policy and procedures.

# 7.14 The Clinical Site and Operations Teams

To place patients in a clinical area in line with IPC procedures and for escalating any situation where safe placement cannot be achieved.

**1. Strategic flu Group**A Strategic Flu Group meets Thursdays September – February, 08:30 – 09:00 unless meeting indicated as not required.

There is a core membership that meets initially for flu planning and immediate response. This membership is then adjusted as required from this list to include further representatives not already in attendance			
Executive Board Lead for Influenza	Lesley Watts, Chief Executive		
Medical Director, Divisional Operational and Divisional Medical Dir	ectors – for information		
CHAIR: Director of Infection Prevention and Control	Dr Berge Azadian		
Trust Flu Lead 2020	Lee Watson, Deputy Director of Nursing		
Lead Nurse for IPC	Jane Callaway		
	all staff below will receive email correspondence as named leads.		
EMERGENCY AND INTEGRATED MEDICAL CARE			
Divisional Director of Operations: Laura Bewick	Interim Therapy Services Manager: Richard Turton		
Medical Lead: Dr Dilys Lai	Divisional Director of Nursing: Helen Kelsall		
Emergency Department Consultants: CW: Dr Paramjeet Deol WM: Dr Jasmin Cheema	Emergency Department Matron: CW: Andrea Travers WM: Charlotte Scuse/Emma Bhuva		
Chelsea and Westminster Receiving Wards:	Acute Admissions Unit: Ward Managers Alison Bawden & Kristi van Rosenveld Medical Receiving Ward Ron Johnson: Alan van Mulders		
WMUH Receiving Wards:	Acute Admissions Unit: Annie Redwood  Medical Receiving Ward Syon 2: Cindy Pabroquez		
PLANNED CARE			
Divisional Director of Operations: Gareth Teakle	Divisional Director of Nursing: Nicola Rose		
Medical Lead: Mr Jason Smith	Lead Nurse ICU: Elaine Manderson		
WOMEN, NEONATAL, CHILDREN AND YOUNG PEOPLE, HIV/O	GUM AND DERMATOLOGY		
Divisional Director of Operations: Sheena Basnayake	Divisional Director of Nursing: Lorna Bramwells		
Medical Lead: Mr Nick Wales	Director of Midwifery: Victoria Cochrane		
CW Paediatric Neptune Receiving Ward: Stephanie Thomas	CW Receiving Ward David Erskine: Nicola Poveda		
WM Paediatric Starlight Receiving Ward: Catherine Medlycott	CW Maternity wards: Anne O'Sullivan WM Maternity areas: Marina Wingham, Barbara Butler		
CLINICAL SUPPORT			
Head of Professions/Chief Pharmacist	Deirdre Linnard		
Divisional Medical Director	Dr Julia Hillier		

Divisional Director of Operations	Peter Hyland
ADDITIONAL LEADS	
Consultant Microbiology/Infection Control	CW: Dr Nabeela Mughal
	WM: Dr Hugo Donaldson
Consultant Virologist	CWFT: Dr David Muir/Dr Paul Randell. virology advice provided by
	microbiology at WMUH
WM UCC	Nitish Saini/Sarah Lukes
Communication	Stephen Cox/Simone Onasanya
Lead Antimicrobial Pharmacist	Stephen Hughes
Occupational Health & Wellbeing Manager	Anna Marie Mitchell
Inventory & Materials Manager	Hashim Hussein
Site Manager(s)	Nicholas Wright WM
	Tracey Larocque CW
Deputy Director for Estates and Facilities	Marie Courtney

#### Terms of reference

The Strategic Flu Group is established as a sub-committee of the Infection Prevention and Control Group which reports to the Patient Safety Group.

The group is chaired by the Director of Infection Prevention and Control and includes representatives from each division and key areas. Members are responsible for sending a named deputy if unable to attend and for onward liaison with staff in their own area.

# **Strategic Objectives**

- Ensuring the Trust is well prepared
- · Reducing morbidity and mortality from influenza
- Monitoring flu activity, severity of the disease in risk groups, vaccine uptake and impact on the NHS
- Daily monitoring arrangements to be able to note key indicators of pressure across the Trust
- Ability to implement local management of pressure by activating the Surge Plan through a number of trigger factors e.g. to free up critical care beds
- Be part of a coordinated response at local, national and international level.
- Review the progress of the flu plan at the end of the flu season for future planning.

The group updates the IPC Group October – March and senior managers as required.

During the influenza season the Trust will develop a flu plan with the following objectives:

- Provide timely, authoritative and up-to-date information to all staff
- Vaccinate at risk patients with the seasonal flu vaccine
- Offering antiviral medicines to patients in at-risk groups for the treatment of flu in line with national guidance
- Manage increased numbers of ill patients with appropriate isolation or cohorting
- Offer vaccination to all frontline staff
- Increase uptake in areas where staff have been resistant to vaccination in previous years
- Maintain staff welfare by reducing the spread of influenza through vaccination, promotion of best practice in infection prevention and control, provision of personal protective equipment (PPE), and a respirator fit test programme.

#### Frequency of meetings

The Strategic Flu Group meets at Chelsea and Westminster and West Middlesex Hospitals on Thursdays between September – February, 08:30 – 09:00 unless meeting indicated as not required.

The infection prevention and control team will:

- Arrange dates, venues and invitations for the Strategic Influenza Group
- Takes notes and distributes minutes.
- Monitor relevant sources of information during influenza incidents.

# 2. Personal Protective Equipment (PPE)

PPE is any type of face mask, glove, or clothing that acts as a barrier between infectious materials and the skin, mouth, nose, or eyes (mucous membranes). When used properly, personal protective equipment can help prevent the spread of infection from one person to another.

The use of PPE alone will not fully protect staff from acquiring an infection; the correct order of donning and doffing PPE is essential. Furthermore PPE should always be used in accordance with Standard Infection Control Precautions and requirements for hand hygiene. Hand hygiene should extend to include washing of exposed forearms.

It is important to understand that if staff are exposed to infectious materials while wearing personal protective equipment, that this PPE should be considered contaminated. PPE should be removed promptly in the correct order and disposed of immediately as clinical waste. Improper removal, reuse or improper disposal of contaminated PPE may increase the risk of infection.

# **Respiratory Protective Equipment (RPE)**

#### Which RPE should staff wear?

**Surgical masks** will provide a physical barrier to large droplets but do not provide full respiratory protection against smaller suspended aerosols.

**Filtering face piece class 3 (FFP3) respirators** should be worn by frontline staff when carrying out potentially infectious aerosol-generating procedures, where a patient is known/suspected to have a respiratory infection e.g. Influenza, COVID-19. It is a legal requirement that anybody who might be required to wear an FFP3 respirator is **fit tested in order to check that an adequate seal can be achieved** with each specific model. It is also important that the user carries out a fit check each time an FFP3 respirator is worn.

Droplet precautions – when to use a surgical facemask	Aerosol precautions – when to use a FFP3 respirator	
Close patient contact (within two metres)  For example: providing direct patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy etc.	Close patient contact (within two metres) and carrying out potentially infectious aerosol generating procedures  The following is a list of procedures currently considered to be potentially infectious AGPs (PHE, 2020)	
<ul> <li>PPE to be worn</li> <li>Fluid resistant (Type IIR) surgical mask (FRSM)</li> <li>Eye protection</li> <li>Gloves</li> <li>Apron</li> </ul>	<ul> <li>Respiratory tract suctioning</li> <li>Bronchoscopy</li> <li>Manual ventilation</li> <li>Tracheal intubation and extubation</li> <li>Tracheotomy or tracheostomy procedures (insertion or removal)</li> <li>Upper ENT airway procedures that involve suctioning</li> <li>Upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract</li> <li>High speed cutting in surgery/post mortem procedures if this involves the respiratory tract or paranasal sinuses</li> <li>Dental procedures using high speed devices such as</li> </ul>	

ultrasonic scalers and high speed drills

- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum using nebulised saline
- High flow nasal oxygen (HFNO)

#### PPE to be worn

- FFP3 respirator\*
- Long-sleeved fluid repellent gown
- Gloves
- Eye/ face protection

\*Always perform a fit check before entering the work area.

# FFP3 respirator fit testing

Where a respirator is used, it must be able to provide adequate protection for individual wearers. Respirators cannot protect the wearer if it leaks. A major cause of leaks is poor fit – tight-fitting face pieces need to fit the wearer's face to be effective. As people come in all sorts of shapes and sizes it is unlikely that one particular type or size of respirator will fit everyone. Fit testing will ensure that the equipment selected is suitable for the wearer. Staff are fit tested only once on a particular model, unless there is significant weight loss or facial changes e.g. dental surgery.

#### Staff that have facial hair

It is important to ensure that facial hair does not cross the respirator sealing surface and if the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve. The following is a 'Facial hair and FFP3 respirators guide'

# Facial hair and FFP3 respirators



\*Ensure that hair does not cross the respirator sealing surface

For any style, hair should not cross or interfere with the respirator sealing surface. If the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve.

# Areas where staff require FFP3 respirator fit testing

Chelsea and Westminster Hospital		
AAU / David Erskine Paediatric Wards Emergency Department including Paediatrics Ron Johnson ISS staff in the key clinical areas Imaging Nell Gwynne	ICU/HDU Apollo HDU Theatres including maternity Endoscopy Infectious Diseases/ Microbiology Anaesthetics	
West Middlesex		
AMU/ Receiving ward	ICU/HDU	
Starlight and Sunshine Paediatric Wards	Endoscopy	
Emergency Department incl. Paediatrics	Midwifery areas	
ISS staff in the key clinical areas  Theatres including midwifery	Infectious Diseases/ Microbiology Imaging	
Anaesthetics	Syon 1 / Syon 2	

# 3. Staff Vaccination

The staff influenza immunisation programme supports the Trust in reducing absenteeism due to staff sickness and minimises the risk of staff infecting patients with flu and increasing length of stay in hospital.

In 2019/20, Chelsea and Westminster NHS Foundation Trust achieved an 81.1% staff immunisation uptake. This year, there is a commissioning aspiration of the Trust achieving an uptake of >90%. This is a target that can be achieved through collaborative working, excellent communication and senior flu champions supporting the campaign.

The 2020/20 campaign will focus on building on the success of the previous year and positive messaging to staff of the benefits of vaccination for their own protection from influenza and their professional duty to protect their patients. Immunisation against influenza is a duty of care that health care workers (HCW's) owe to their patients. In turn, Health Care Workers (HCWs) can gain protection against catching influenza themselves and transmitting it to their families. Vaccination cuts influenza illness and mortality in patients and reduces sickness absence in staff. There will be a need to dispel the myth that the vaccine causes flu and this will entail publicity and ongoing communication. Senior nurses and clinicians will be asked to champion the vaccine and encourage their staff to be immunised.

The Occupational Health Nurses will administer the immunisations with the support of a team of peer vaccinators. The immunisation programme will commence the last week in September and priority will be given to frontline staff. When these staff have been immunised then the programme will be progressed to include other HCW's and administrative staff in high risk areas and finally administration staff in other areas. Funding has been allocated in order to achieve the CQUIN and this funding will be used to employ a nurse to undertake planned clinics and roving visits to all wards and departments.

# Benefits of being vaccinated:

- reduces the risk of transmitting the flu virus to vulnerable patients
- protects staff, their families and patients
- protects healthcare workers to reduce the level of staff absenteeism that can add strain to NHS and care services
- increasing staff awareness and understanding the importance of staff vaccination against seasonal flu, leading by example to drive up rates of vaccination among frontline staff
- Prevents outbreaks of influenza in the hospital and community setting

Flu clinics are advertised on the intranet on a weekly basis. If staff are unable to attend any of the walk in clinics, then staff may book an appointment with Occupational Health on 0203 315 8330 (CW site) and 0208 321 5044 (WMUH site). In addition a team of peer

vaccinators are available in all clinical areas to assist staff in obtaining vaccination close to their place of work at a suitable time in their working day.

# 4. Vaccination of at risk inpatients

Patients who are most at risk of serious illness or death, should they develop influenza, such as immunocompromised patients and those aged 65 years or older, are strongly advised to receive an annual seasonal influenza vaccine from their General Practitioner (GP). Patients admitted to hospital during the winter period may miss the opportunity to receive vaccination from their GP. Additionally, these unvaccinated patients may be exposed to influenza in the hospital setting and develop hospital acquired influenza. This may lead to complications to patient care, delay discharge and result in further transmission of influenza to patients and staff.

The NHS England and commissioning aim this year is to further extend the vaccine programme in November and December 2020 to include the 50-64 year old age group subject to vaccine supply.

All hospitalised patients with a current or predicted length of stay of ≥ 14 days who have not yet been vaccinated in line with national recommendation should be offered the seasonal flu vaccine during the admission. Long term hospitalised patients who are unable to access their local GP should receive the flu vaccine, where indicated, during their admission. It is the responsibility of each consultant team to review and consider for vaccination. It is the responsibility of the pharmacy team to determine the vaccine history on admission to identify patients who have not been vaccinated appropriately. Further advice on the patient groups with indications for vaccine is available on http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance/

# 5. Communication

Clear and timely communication is vital to ensure that all parties involved in managing flu understand their roles and are equipped with the necessary information.

The communications team will develop a robust and flexible plan in relation to flu. This will be refined through the strategic flu meeting and will ensure that the Trust can promote positive messages in relation to flu vaccination and be responsive to the changing situation.

A multimedia approach will be utilised throughout the season and will include using the App, and social media to reach out widely to staff.

# Staff Information - intranet site

All relevant information for staff can be located on Emergency Preparedness 'quick links' intranet site, front page of the Trust intranet.

http://connect/departments-and-mini-sites/eprr/seasonal-flu/

# **Patient information**

The trust will display information for patients close to the main entrances of each site during the season; this will be primarily in the form of floor banners. There will also be information available on the external web site and through an automated message on the telephone service. Literature produced by PHE or the DH will be made available as required.

# **Communication Department Strategy**

ACTIVITY	DETAILS	DATE
Myth busting Videos	Videos circulated on the Trust Intranet and Vimeo - regular promotion internally. Signposting to my Chelwest app for updated information.	Launch of Flu Campaign in September
Flu Pop up stations	Utilising My Chelwest App	Pre Launch promotion
Leadership Flu Fighters	Images of SLT getting vaccines	Launch week
Myth Quiz night	Virtual quiz night hosted by Exec lead	Launch week
Recruit Peer vaccinators	Advertise need for volunteers on Daily Noticeboard	Periodically during 1 <sup>st</sup> and 2 <sup>nd</sup> weeks of September
Advertise staff vaccination sessions taking place w/c 1 & 8 October	Bulletin– text to include update on number of staff vaccinated	Periodically during last week of September and first week of October
	<b>Desktop Icon</b> – to be added to advertise vaccination sessions	Last week of September through to 2 <sup>nd</sup> week of October
	Winterwatch Emails – distributed to all staff as appropriate.	Weekly commencing end September to end of October
	September Team Brief	1st week of September (if taking place virtually)

	October Team Brief	1st week of October
1.1.1 Poster Campaign	Recruit staff especially low uptake areas, printing of posters and distribution, Banners in atrium and staff areas.	Ongoing throughout September
Social Media Campaign	Encouraging staff to share when they have a received their flu jab and badge on Twitter and Instagram	Throughout Flu Season #GotMyJab
Pin Badges	'I've had my flu jab to protect YOU'	Ordered in August, available for campaign in September
Website	Advice for staff and also on patient leaflets	As numbers start to increase

Using NWL Flu messages to amplify the messages internally and externally.

## 6. Clinical Risk Assessment

# Clinical Assessment and Emergency Department pathways/ assessments

Both sites have dedicated algorithms to manage the patients suspected of contracted influenza. These are as follows:

### **Chelsea and Westminster site**

- The Adult pathway is led by Dr Clare Emerson (Emergency Medicine Adult Consultant) the updated algorithm can be found on the antimicrobial guidelines pages and the seasonal flu intranet pages on the trust intranet http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance-2016-17/
- The paediatric pathway is led by Dr James Ross (Emergency Medicine Paediatric Consultants) - the updated algorithm can be found on the antimicrobial guidelines pages and the seasonal flu intranet pages on the trust intranet http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance-2016-17/

### **West Middlesex University Hospital**

- The adult pathway is led by Dr Jasmine Cheema, the updated algorithm can be found on the antimicrobial guidelines pages and the seasonal flu intranet pages on the trust intranet http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance-2016-17/
- The paediatric pathway is led by Dr Clare James, the updated algorithm can be found on the antimicrobial guidelines pages and the seasonal flu intranet pages on the trust intranet http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance-2016-17/

Due to the changes that may occur during the season, pathways are not included in this plan, so are located in the antimicrobial guidelines with the link above and are circulated to the 'flu group' email group.

# 7. Influenza testing

Testing should only be carried out on patients presenting with:

- Fever (>38° C) or history of fever AND
- Two or more of the following symptoms: cough, sore throat; headache; rhinorrhoea, limb or joint pain; vomiting or diarrhoea
- Where there is a clinical suspicion of influenza infection.

All patients will receive a rapid flu test unless there is clear indication that a full panel is required. Please see Trust intranet for dates of rapid influenza testing.

# 8. Site Management

### Chelsea and Westminster - Side room information

ADULTS	ADULTS	PAEDIATRICS	MATERNITY	LEVEL 1 +
-Resus: x1 –ve pressure room (room 7) -EOU x2 (rooms 1&2) -Majors x7 (rooms 9-12 & 19-21)	AAU - 8 side rooms	Emergency Department - Rooms 1-5 - Rooms 9-12 - Baby room	Labour ward  - 9 side rooms	AAU - 9 level 1 beds - includes 1 side room
	David Erskine	Neptune	Birthing Suite	ITU/HDU
	- 14 side rooms	- 3 cubicles	<ul> <li>6 side rooms</li> </ul>	- 11 beds

includes x2 -ve pressure rooms (rooms F&G)			- includes x1 -ve pressure room
Ron Johnson - 20 side rooms - x11 are -ve pressure	Mercury - 11 cubicles (2 are for private patients)	Anne Stewart  - 3 side rooms	
Nell Gwynne  – 2 side rooms	Jupiter - 2 cubicles	Josephine Barnes - 5 side rooms	
Chelsea Wing - 12 side rooms	Apollo HDU - 6 cubicles	Simpson Suite - 5 beds, no rooms	
Edgar Horne - 4 side rooms	Mars - 2 cubicles	Kensington Wing  - 15 side rooms  - + 1 suite	
Rainsford Mowlem  - 6 side rooms			
Nightingale  – 2 side rooms			

# **West Middlesex -Side room information**

ADULTS	ADULTS	PAEDIATRICS	MATERNITY	LEVEL 1 +
Emergency Department - side rooms x 5, Negative pressure room x1	AMU – side rooms x 14	Starlight- side room x 6, twin share side room x 5	Labour ward - Single rooms x 8	ITU- side room x 1, negative pressure room x 1
	CCU – side room x 2	Sunshine- side room x 1 Day care	HDU – side room x 1	HDU – side room x1
	Kew- side room x 6	Paediatric Assessment Unit – side room x 3	Bereavement ward- side room x 2	
	Lampton - side room x 5		Natural birthing centre – single room x 4	

MH1- Side room x 4	Post-natal - Top Floor (15 side rooms)	
MH 2 – Side room x 4	Ante natal - Ground Floor (5 side rooms)	
Crane – Side room x 4		
Osterley 1 - Side room x 8		
Osterley 2 - Side room x 8		
Richmond - Side room x 1		
Syon 1 – side room x 8		
Syon 2- side room x 6, negative pressure room x 2		

# Trust site management of seasonal flu

Increased activity of patients presenting with flu symptoms and also admissions of patients suspected or confirmed with flu will be monitored by the IPC team. Seasonal flu has the potential to necessitate increased requirements of clinical services and hospital beds and it is important that requirements during the flu season are managed in the working arrangements of the trust. During times of increased bed capacity due to influenza, the IPC Team will attend the operational bed meetings that are held on both sites at fixed times during each day.

The **Standard Operating Procedure Management of Escalation Bed Capacity** outlines the responsibilities of staff in all areas in relation to the operational status of the trust. The Trust Surge Plan is also relevant for increased numbers of flu patients requiring treatment in the trust.

# 9. Treatment & Prophylaxis

**Antiviral (AV) medicines,** known as neuraminidase inhibitors, prevent the influenza virus from replicating inside the body. They can lessen symptoms by a couple of days, reduce the severity of viral infections and help to reduce the likelihood of complications.

All patients, both adults and children, admitted to hospital suspected seasonal influenza infection should be prescribed antiviral therapy. Treatment should be promptly started based on initial diagnosis or clinical suspicion of viral infection rather than waiting for laboratory testing to confirm or refute influenza infection. Patients not requiring admission should only be prescribed antiviral medicines when the Chief Medical Officer (CMO) has announced that influenza is circulating within the community, unless the patient meet pre-defined triggers for complicated influenza infection (see below). A treatment algorithm will be available on the trust intranet and updated weekly to reflect the current CMO advice. Link - http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance/flu-treatment/

PHE guidance on use of Antivirals for influenza treatment and prophylaxis is updated annually and reflects current evidence based practice. This guidance combines on guidance previously issued by the Agency, the National Institute for Health and Clinical Excellence, the Department of Health (DH) and the World Health Organization. It is intended for use in secondary care for any patient where influenza is suspected or confirmed at any time.

The local trust Flu plan will be updated at the beginning of each Flu season and then weekly with any new updates from CMO or PHE. This is available on the trust intranet - http://connect/departments-and-mini-sites/antimicrobial-guidelines/flu-guidance/

# Influenza prophylaxis for non-vaccinated staff exposed to flu at work

Chemoprophylaxis with an antiviral following exposure to influenza **should be considered** in the following instances where the healthcare work has NOT had the seasonal vaccine:

- If a staff member is in the at-risk group (excluding immunocompromised individuals) and has a high risk exposure\*\*with a patient with influenza/suspected influenza (Note: If prophylaxis is not initiated, this patient group should be closely monitoring for deterioration and/or tested for influenza to decide if treatment indicated.)
- At risk groups for influenza include pregnancy (especially third trimester and up to 2 weeks post-partum), adults >65 years, chronic cardiac, pulmonary, renal or hepatic insufficiency, diabetes mellitus, debilitating neurological conditions and primary or secondary immunosuppression)
- If a staff member is immunosuppressed and has a high risk\*\* exposure with a patient with influenza/suspected influenza

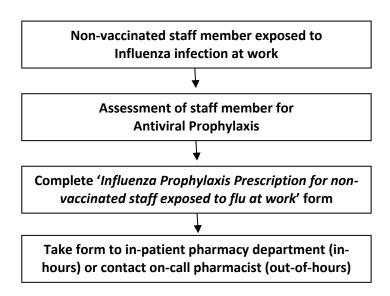
 Prophylaxis may be considered in staff members who have continuous or repeated exposure to a patient with suspected/ confirmed influenza. Flu vaccination should be considered at the next available opportunity for those who are likely to have ongoing exposure during the flu season.

\*\*High-risk exposure - providing direct patient care without suitable respiratory precautions or being in the same room or bay without suitable respiratory protection at the same time as, or within 15 minutes of aerosol generating procedures

Prescription for staff should be written by the hospital doctor for the patient who has exposed the non-vaccinated staff member to flu. Emergency Department (ED) doctors only prescribe for ED staff.

Antivirals should be started within 48 hours of last contact for Oseltamivir or 36 hours for Zanamivir.

Please complete an 'Influenza Prophylaxis Prescription for non-vaccinated staff exposed to flu at work' form which needs to be taken to in-patient pharmacy in working hours or bleep the on-call pharmacist out of hours.



Forms in the Seasonal flu and intranet site via these links:

# 10. Reporting

### Seasonal influenza healthcare workers vaccine uptake collection 2020/2021 – reporting from 1st October

This mandatory data collection is via the DH ImmForm website by the Occupational Health manager or nominated deputy. Staff definitions will remain the same as previous season and are consistent with NHS national workforce census definitions. It is the vaccine uptake data collected on all frontline Health Care Workers with direct patient care.

Cumulative data will be collected on vaccinations administered from 21 September 2020 onwards. The data collection will comprise four monthly surveys for October, November, December and January.

#### ICU mandatory surveillance

The DH have posted on UNIFY details of a new weekly Non-DCT collection covering the number of laboratory-confirmed influenza admissions/deaths in critical care beds. The collection will be undertaken by the DH, with data provided to the Public Health England (PHE) for surveillance purposes.

The data should correspond to admissions in the week up to midnight the previous Sunday (i.e. 00:00 Monday to 23:59 Sunday). The deadline for providers to submit will be 10am every Wednesday.

All patients admitted to HDU/ICU with laboratory-confirmed influenza infection (A (H1, H3 or novel) or B) should be reported.

- Cases should be included in weekly reporting based on date of admission to ICU and not by influenza laboratory test date.
- Cases that tested positive at another facility prior to admission to ICU should still be included.
- All cases who die in HDU/ICU and have a laboratory-confirmed influenza infection (A (H1, H3 or novel) or B) should be reported.
- All cases who die in HDU/ICU and have a laboratory-confirmed influenza infection (A (H1, H3 or novel) or B) should be reported.
- Cases should be included in weekly reporting based on week of death (i.e. when the date of death falls within the week for which data is being reported), and not by influenza laboratory test date or by HDU/ICU admission date. Cases should be reported regardless of the time period spent in HDU/ICU.
- Cases who were admitted to HDU/ICU and died after release into a general ward or discharge should be excluded from reporting
- The ICU senior staff on both sites complete the retrospective weekly ICU mandatory surveillance report which is sent to the Chief Operating Officer and Head of Emergency Preparedness (HOEP) to share at the Strategic meeting

#### ICU SURVEILLANCE MANDATORY SPECIFICATION

	Nun	Number of admissions in Level 2 and Level 3 Care (HDU/ITU)				ITU)	
			Age	Group			
Flu Type	Under 1	1 To 4	5 To 14	15 To 44	45 To 64	65+	Total
Influenza A (H1N1) 2009	0	0	0	0	0	0	
Influenza A (H3N2)	0	0	0	0	0	0	
Influenza A, unknown subtype	0	0	0	0	0	0	
Influenza B	0	0	0	0	0	0	
Total							

	Number of deaths in Level 2 and Level 3 Care (HDU/IT				U)		
Flu type	Under 1				65+	Total	
Influenza A (H1N1) 2009	0	0	0	0	0	0	
Influenza A (H3N2)	0	0	0	0	0	0	
Influenza A, unknown subtype	0	0	0	0	0	0	
Influenza B	0	0	0	0	0	0	
Total							

# Staff sickness absence reporting

- If employees are required to contact their line manager on the first day of absence to inform them that they will not be attending work. This should be done at the earliest possible opportunity **before** an employees expected starting time. Departments are required to have specific arrangements for reporting absences which should be made clear and observed by all staff. For more information please see the sickness absence policy
- Rising or higher numbers of staff reporting sick with flu like symptoms should be reported to the trust bed meetings
- Managers must ask any staff reporting sick if they have flu like symptoms to ensure records are accurate.
- Staff can return to work once they are asymptomatic and temperature free
- Any concerns or rising numbers of staff absent with flu symptoms should be highlighted to Occupational Health via numbers: Chelsea and Westminster site on **020 7363 8330** and at West Middlesex site **0208 321 5044**



## Appendix 1

### Occupational Health Influenza Plan 2020/21

An effective staff influenza immunisation programme will support the Trust in reducing absenteeism due to staff sickness and minimise the risk of staff infecting patients with flu and increasing length of stay in hospital.

Chelsea and Westminster NHS Foundation Trust has continued to improve annual vaccination levels, last year achieving 81% of front line clinical staff being vaccinated against flu. Overall this ranked the Trust 4th best performing for staff flu vaccination in London.

The 2020/21 campaign will centre on staff's responsibility. Immunisation against influenza is a duty of care that health care workers (HCW's) owe to their patients. In turn, HCW's can gain protection against catching influenza themselves and transmitting it to their families. Vaccination cuts influenza illness and mortality in patients and reduces sickness absence in staff. There will be a need to dispel the myth that the vaccine causes flu and this will entail publicity and ongoing communication. Senior nurses and clinicians will champion the vaccine and encourage their staff to be immunised.

Where staff decide to decline the vaccination they will be required to complete a form which will detail the reasons for their refusal, this information will be treated as confidential. The collation of this data will assist in the planning of future campaigns.

The flu vaccine will be administered by the Occupational Health Nurses in collaboration with Trust wide peer vaccinators. The Trust expects delivery of the vaccine in the week commencing 14<sup>th</sup> September and the immunisation programme will commence week beginning 21<sup>st</sup> September.

All staff will be encouraged to have the vaccine and communications will focus on the importance of front line health care workers to have their vaccination. The occupational health service will offer regular clinics in addition to the roving and peer vaccinators.

# Flu Action Plan 2020/21

Component	Actions	Responsible person	Target date
1. Publicity	<ul> <li>Posters displayed throughout the Trust advertising the flu vaccination programme</li> <li>-Newsletter with myth busting messages used</li> <li>Executive messages to encourage staff to have their vaccination</li> <li>Promotion of executive leads having their vaccination</li> <li>Use of screen savers (where possible) and desk tops to message importance of vaccination to staff</li> <li>Ensure a wide range of social media stories are used to promote the programme</li> <li>The use of the roving vaccinators and the 'flu trolley' incentives</li> <li>Vaccination progress updated weekly on the Trust desktops</li> </ul>	Coms	September 2020
2. OH immunisation programme and clinics	<ul> <li>Trust board, Matrons, Senior nurses, senior clinicians immunised at an early stage i.e.</li> <li>Nursing and Midwifery Groups-immunisation(Director of Nursing to inform Anna-Marie Mitchell AMM-Head of OH)</li> <li>Board meeting-(immunisation)</li> <li>Senior clinicians meetings-(Medical Director to inform AMM)</li> <li>Medical Staffing meetings-(Medical Director to inform AMM)</li> <li>FY2-teaching1-2pm Wednesdays, FY1 teaching Thursdays 2-3pm, Grand Round in Education Centre Tuesdays 1-2pm. OH to be present at these sessions during the month of Oct/Nov to immunise doctors</li> <li>Clinics in the atrium on the WMUH site and in OH</li> </ul>	Flu clinic preparation and clinics to be arranged by senior OH Advisers  Publicity by Communication Team.	Clinics to be arranged and publicised on a weekly basis

	<ul> <li>on the CW site for ease of access. These clinics to be held early mornings.</li> <li>Planned clinics starting 1st Oct in Clinical areas. Clinics to be of one hour duration and frequently. Start with high risk areas, Maternity, ED, Theatres, ITU, Education Centre (Doctors).</li> <li>Roving vaccinators to be available throughout the vaccination period</li> <li>Early morning clinics.</li> <li>Dates for clinics publicised in the Daily Notice Boards.</li> <li>Weekly flu Group meetings every Thursday morning chaired by the DIPC. To include representation from OH, IPC, pharmacy, senior nurses and medics.</li> <li>PGD developed for the OH staff to immunise and to include authorisation for roving Trust vaccinators.</li> <li>Peer vaccinators to be trained to mop up in each area. Training to begin August 2020</li> </ul>		
3. Managers	Flu vaccination will be recorded against staff in post		To be ready by September
responsibilities	report developed by the information team		2020
	Managers role		
	<ul> <li>Publicise flu vaccine, champion vaccine, allow staff time to have vaccine.</li> <li>Support the delivery of the vaccine to staff in their areas</li> <li>Liaise with staff that have not received the vaccine and discuss the reasons for this.</li> </ul>	Department managers	
4. Target	>90% immunisation of healthcare workers with direct	OH with support of	March 2021
Groups	patient contact. This includes nurses, midwives, doctors,	managers and peer	
	professions allied to medicine i.e. physiotherapists and	vaccinators	
	occupational therapists, pharmacists, radiographers.		

	Support staff and health care workers with patient contact are classed as frontline and are added to the target percentage.		
5. Reporting	Monthly reporting upon Immform. Public Health England reporting system.	Deputy Director of Nursing	Monthly October – March
	Weekly reports to the Trust upon uptake.	Senior OH Advisers	Wednesday 12.00

This plan will be reviewed on an on-going basis through the strategic flu meetings as required

Lee Watson, Deputy Director of Nursing August 2020



 $\begin{array}{l} \textbf{Appendix 2:} \\ \textbf{Healthcare worker flu vaccination best practice management checklist} \end{array}$ 

# For public assurance via trust boards by December 2020

Α	Committed leadership	Trust Self-Assessment
A1	Board record commitment to achieving the ambition of	Completed - EMB 02/09/20
	vaccinating all frontline healthcare workers	
A2	Trust has ordered and provided a quadrivalent (QIV) flu	Completed – arrived 18/09/20
	vaccine for healthcare workers	
A3	Board receive an evaluation of the flu programme 2019/20,	Completed – presented
	including data, successes, challenges and lessons learnt	24/06/20
A4	Agree on a board champion for flu campaign	Completed – CNO Pippa
		Nightingale (1.24 (2.24)
A5	All board members receive flu vaccination and publicise this	Completed – w/b 21/09/20
A6	Flu team formed with representatives from all directorates,	Completed – Nursing & Medical
^ 7	staff groups and trade union representatives	and HR representation
A7	Flu team to meet regularly from September 2020	Completed - commenced 10/09/20
В	Communications plan	10/09/20
B1	Rationale for the flu vaccination programme and facts to be	Completed
	published – sponsored by senior clinical leaders and trades	Completed
	unions	
B2	Drop in clinics and mobile vaccination schedule to be	Completed
	published electronically, on social media and on paper	
В3	Board and senior managers having their vaccinations to be	Completed - w/b 21/09/20
	publicised	
B4	Flu vaccination programme and access to vaccination on	N/A – No physical induction due
	induction programmes	to COVID-19
B5	Programme to be publicised on screensavers, posters and	Completed – 'jabometer' on
	social media	desk-top displaying all Divisions
В6	Weekly feedback on percentage uptake for directorates,	Completed – available through
	teams and professional groups	Apex → Qlikview
С	Flexible accessibility	
C1	Peer vaccinators, ideally at least one in each clinical area to	Completed – 140 peer
	be identified, trained, released to vaccinate and empowered	vaccinators across 5 Divisions
C2	Schedule for easy access drop in clinics agreed	Completed – launch events
		planned, roving trollies and OH
	Calcadada fan 24 hann na skila na sa'i a ti'r a sta fan a sa	drop-in clinics scheduled
C3	Schedule for 24 hour mobile vaccinations to be agreed	Completed – supported by
		Divisional peer vaccinators and SNOS out of hours
D	Incentives	SNOS OUT OF HOURS
D1	Board to agree on incentives and how to publicise this	Completed – individual
	Doubt to agree on intentives and now to publicise this	Completed Individual

		refreshments to take away &
		monthly incentive awards for
		peer vaccinator
D2	Success to be celebrated weekly	Completed – Divisional success
		cascade built in Apex ->
		Qlikview

# **Glossary**

**Acquired Immunity** Immune defence that develops following exposure to a pathogen (e.g. bacterium or virus) or vaccine. It involves the production of specific defensive blood cells (lymphocytes) and proteins (antibodies), and provides lasting immunity based on the experience or 'memory' of previous exposure.

**Aerosol** A gaseous suspension of fine solid or liquid particles which remain suspended in the air for prolonged periods of time.

**Airborne** Carried by or through the air.

**Airborne transmission** Movement of viral particles through the air either attached to solid particles (such as dust) or suspension in droplets of liquid.

Antiviral medicines Used to describe a chemical or drug that inhibits virus replication.

**Antiviral resistance** The lack of responsiveness of a virus to an antiviral drug, caused by natural variation or as a result of adaptation by the virus.

'At risk' groups Groups of people who, through their immune disposition or long-term illness (e.g. diabetes, chronic heart or respiratory disease) are deemed to be especially threatened by infection

**Case fatality ratio** The proportion of the population who develop symptoms, ranging from severe to mild during an influenza outbreak and who subsequently go on to die as a result of that infection

**Critical Care** Care of a patient in a life-threatening situation of an illness by staff specially trained in recognising and responding to emergencies.

Droplet Airborne particle which is larger than an aerosol and drops quickly to the ground

**Epidemic** The widespread occurrence of significantly more cases of a disease in a community or population than expected over a period of time.

**Epidemiological** Relating to the study of patterns causes and control of disease in groups of people

**Face mask** A protective covering for the mouth and nose.

**H1N1 (2009) influenza** The worldwide community spread of a new H1N1 pandemic influenza virus, originating in pigs and entering the human population in 2009.

**H5N1** Highly pathogenic avian influenza virus, enzootic in birds in South East Asia.

**Hand hygiene** Thorough, regular hand washing with soap and water, or the use of alcohol-based products containing an emollient that do not require the use of water to remove dirt and germs at critical times, e.g. after touching potentially infected people/objects and before touching others or eating.

**Incubation period** The time from the point at which infection occurs until the appearance of signs or symptoms of disease.

**Infection** The acquisition and active growth of a foreign microbial agent in a host, such as a human or animal, usually with a detrimental outcome.

**Infectious** A disease caused by a micro-organism that can be transmitted from one person to another.

**Isolation** Separation of individuals infected with a communicable disease from those who are not for the period they are likely to be infectious in order to prevent further spread.

**Osteltamivir** Antiviral drug, marketed by Roche Pharmaceuticals under the trade name Tamiflu®, that acts by inhibiting Neuraminidase activity and thus blocking viral spread.

**Outbreak** Sudden appearance of, or increase in, cases of a disease in a specific geographical area or population, e.g. in a village, town or closed institution.

**Pandemic** Worldwide epidemic – an influenza pandemic occurs when a new strain of influenza virus emerges which causes human illness and is able to spread rapidly within and between countries because people have little or no immunity to it.

**Prophylaxis** Administration of a medicine to prevent disease or a process that can lead to disease – with respect to pandemic influenza, this usually refers to the administration of antiviral medicines to healthy individuals to prevent influenza.

Relenza® See 'Zanamivir'.

**Seasonal flu / influenza** Annual period of widespread respiratory illness, typically occurring during the autumn and winter months in the UK, caused by the circulation of a strain of influenza virus that is slightly altered from the previous season.

**Surge capacity** The ability to expand provision beyond normal capacity to meet transient increases in demand, e.g. to provide care or services above usual capacity, or to expand manufacturing capacity to meet increased demand.

**Surgical mask** A disposable face mask that provides a physical barrier but no filtration.

**Surveillance** The continuing scrutiny of all aspects of the occurrence and spread of disease pertinent to effective control in order to inform and direct public health action.

**Suspected cases** Cases of illness identified through symptoms but not confirmed by laboratory analysis.

**Swine flu** H1N1 influenza arising in 2009 from pigs and the cause of the 2009 pandemic in humans.

Tamiflu® See 'Oseltamivir'.

**Transmission** Any mechanism by which an infectious agent is spread from a source or reservoir (including another person) to a person.

**Vaccine** A substance that is administered in order to generate an immune response, thereby inducing acquired immunological memory that protects against a specific disease.

Virulence The capacity of an infectious agent to infect and cause illness.

**Virus** A micro-organism containing genetic material (DNA or RNA) which reproduces by invading living cells and using their constituent parts to replicate itself.

**Zanamivir** Antiviral drug, marketed by GSK Pharmaceuticals under the trade name Relenza® that inhibits Neuraminidase activity, thus blocking viral spread.

#### **REFERENCES**

- Public Health England Influenza Plan 2014/2015 (Updated 28.11.2018)
- National Flu Plan 2019/2020
- Green Book Influenza Chapter
- NHS England Public Health Functions Agreement 2018-19 (known as Section 7A agreement)
- NHS England Public Health Functions Agreement 2016-17 Service Specifications No 13 and 13A
- NHS England enhanced service specification (For GP providers)
- Flu immunisation PGD templates
- National Q&As / training slide sets/ elearning programme
- Vaccination and Immunisation guidance and audit requirements (NHS Employers, BMA, DH
- NHS England Commissioning for Quality and Innovation (CQUIN)
- Guidance for 2019/20 Vaccine Update
- Vaccine Update
- PHE Immunisation home page

- https://www.gov.uk/government/collections /seasonal-influenza-guidance-data-andanalysis
- https://www.gov.uk/government/publication s/national-flu-immunisation-programmeplan
- https://www.gov.uk/government/publication s/influenza-the-green-book-chapter-19
- https://www.gov.uk/government/publication s/public-health-commissioning-in-the-nhs-2018-to-2019
- https://www.england.nhs.uk/commissionin g/pub-hlth-res/
- https://www.england.nhs.uk/publication/gpcontract-2019-20-nhs-england-enhancedservice-specifications/
- https://www.gov.uk/government/collections/immunisation-patient-group-direction-pgd
- https://www.gov.uk/government/collections/annual-flu-programme
- https://www.e-lfh.org.uk/programmes/fluimmunisation/
- https://www.nhsemployers.org/paypensions-and-reward/primary-carecontacts/general-medicalservices/vaccination-and-immunisation
- https://www.england.nhs.uk/nhs-standardcontract/cquin/cquin-19-20/
- https://www.gov.uk/government/collections /vaccine-update
- https://www.gov.uk/government/collections/immunisation





**NHS Foundation Trust** 

# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.6/Nov/20
REPORT NAME	Annual Safeguarding update
AUTHOR	Vanessa Sloane, Deputy Chief Nurse
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	This paper provides an annual overview of adult & children's safeguarding, domestic abuse, learning disability & mental health
SUMMARY OF REPORT	The report demonstrates referrals, training, and issues within adult & children's safeguarding, domestic abuse & learning disability.  It should be noted that our training figures in all areas continue to improve, leading to increased referrals particularly within domestic abuse.  We have an experienced & stable safeguarding team within the Trust.
KEY RISKS ASSOCIATED	Risk of staff not responding to needs, this is mitigated through ensuring senior staff in all areas have completed training to provide points of escalation/discussion 24/7 for each of the areas within the safeguarding agenda.
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	Noted above
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	All.
DECISION/ ACTION	The Board is asked to note the content of this report

#### **Safeguarding Children**

#### Team

There is a team on each main hospital site consisting of named nurse, named doctor & named midwife. This year we have had a change in the named nurse role for Chelsea & Westminster Hospital, but otherwise the teams remain consistent. During Covid our safeguarding teams were not redeployed but rather continued to work ensuring our prompt & appropriate response to any safeguarding children concerns.

#### **Training**

Trust by %	SG Children Level 1	SG Children Level 2	SG Children Level 3
Total	97%	95%	91%

#### Referrals

Referrals on both sites remain stable at approx. 30 per month from Chelsea & Westminster hospital, with approx. 60 per month from West Middlesex. This difference in figures is due to the way our local authorities require us to record referrals.

#### Issues

Safeguarding documentation has gone live within Cerner with the CIC form – confidential issues & concerns recorded under safeguarding. The Trust is represented at the 3 local children's safeguarding boards.

### **Safeguarding Adults**

#### Team

Within adult safeguarding there is a consistent team comprising Lead Nurse adult safeguarding, deputy lead nurse adult safeguarding & safeguarding project officer. The team work cross site. During Covid our safeguarding team were not redeployed but continued to support staff & patients in ensuring adult patients were safeguarded.

#### Training

Trust / Division by %	SG	SG	SG
	Adults	Adults	Adults
	Level 1	Level 2	Level 3
Total	94%	92%	68%

It should be noted that this was Q4 2019/20, in Q1 the figure for level 3 increased to 85%.

#### Referrals

CATEGORY	YTD	<b>Q</b> 1	Q2	Q3	Q4
Domestic Abuse	57	23	19	6	9
Physical	72	17	16	21	18
Financial	27	4	10	9	4
Self neglect	121	34	30	31	26
Psychological	29	4	6	7	12
Sexual	13	1	5	3	4
Neglect	165	53	50	26	36
Mental Health	6	4	1	0	1
Modern Slavery	2	0	0	1	1
Not					
known/unsure	17	9	5	1	2
Organisational	27	9	9	6	3
TOTAL	536	158	151	111	116

#### **Issues**

As with children's safeguarding Cerner CIC went live & is now in use. The Trust is represented by the Deputy Chief Nurse at our 3 local adult safeguarding boards.

#### **Learning Disability**

#### **Team**

We have a lead nurse for learning disability & transition who has been in post for a number of years. She was not redeployed during Covid but available to support staff, patients & families in ensuring appropriate care was provided to patients.

#### Training

- Training continues to be a key part of the Lead Nurse and Deputy's role with over 1,000 Trust staff trained, including over 60 junior doctors.
- Level 2 training included additional information about autism, diagnostic overshadowing and the LeDeR programme
- Level 2 training at WMUH site started in January 2020 together with Community LD teams and clients from Richmond Mencap group.
- Learning disability and autism was included in Clinical update as well as Corporate Welcome/Induction from 2020 across both sites
- Lead Nurse developed an LD scenario, with Health Education England and Full of Life, as an e-learning training module for the Care Certificate.

#### Referrals

Patients who have a confirmed learning disability or autism, either reported from their GP, themselves or from previous records, are flagged on Cerner allowing the LD lead to review a daily patient board of admissions & attendances.

#### Issues

**Project Search Programme** 

This project has been a key focus this year, having successfully completed the first year in July 2019, with a Graduation ceremony attended by 8 interns, their families and their Trust mentors.

- Our second year started in September 2019 with 8 new interns
- A new teacher from Queensmill School joined the WMUH team
- 2 interns from last year started employment at WMUH in January 2020, x2 started college, x1 obtained voluntary work in a local library, x3 interns re-joined the project for a second year

#### **Mental Health**

#### **Team**

Our mental health team consists of a lead nurse cross site, with a deputy lead nurse based on each site. Both deputies joined the team this year. The team remained available throughout Covid to support patients & staff. We have 5 RMN's based in each ED department as part of the team, & a bank of over 100 RMN's.

#### **Training**

Regular training is provided, with a focus on the mental capacity act & DOLS to ensure staff have an understanding of this legislation. Training has also been provided on de-escalating situations

#### Liaison

We continue to work closely with West London Trust & CNWL as our mental health providers.

#### Issues

The availability of inpatient mental health beds remains an issue for adults & children. Issues are escalated through the site triumvirates to liaise with local services & NHSE.

#### **Domestic Abuse**

#### Team

We have a Trust domestic abuse lead, Charlotte Cohen, working alongside our domestic abuse coordinator, who are supported by 3 IDVA's all of whom are externally funded.

### **Training**

Regular training is provided with numbers trained in 2019/20 below. DAL is domestic abuse links of which we now have 285.

Level 1 (Basic DA 2392

Awareness):

Level 2 (DA Awareness): 660 Level 3 (DAL Training): 86 Level 4 (DAL Supervision 73 and specialist training):

TOTAL: 3211

#### **Referrals**

In 2019/20, 373 IDVA referrals were made compared to 347 in 2018/19 representing a 7% increase. 71% of IDVA referrals came from CW sites and 29% from WM. As a proportion of IDVA referrals, 39% had a MARAC referral, demonstrating the highest risk.

The specialities making the highest number of IDVA referrals over 2019/20 were:

- Adult Emergency Department 144 (39%)
- HIV/GUM 102 (27%)
- Maternity 72 (19%)

#### **Issues**

As with other services work with Cerner has enabled improve recording although we are still working with the team on the reporting to be pulled from Cerner.





**NHS Foundation Trust** 

# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	2.7/Nov/20
REPORT NAME	Financial Plan Update 2020/21
AUTHOR	Graham Henry, Deputy Director of Finance
LEAD	Virginia Massaro, Acting Chief Financial Officer
PURPOSE	To update on the latest budget and financial plan for 2020/21
SUMMARY OF REPORT  KEY RISKS ASSOCIATED	<ul> <li>NHSI/E has published guidance covering funding and cash arrangements for the final 6 months of 2020/21 (October 2020 to March 2021).</li> <li>The funding arrangements are based on a fixed financial envelope for the ICS, including fixed funding for Covid-19.</li> <li>The overall NWL ICS gap is £62m, of which c£84m relates to lost non-NHS income</li> <li>The Trust's plan for months 7-12 is a deficit of £5.2m, of which £10.8m relates to lost non-NHS income</li> <li>The Trust's plan assumes delivery of £5.6m of CIPs</li> <li>The Trust will submit its M7-12 financial plan on 22nd October.</li> <li>Loss of non-NHS income not included in the system envelope</li> <li>Scale and pace of activity recovery</li> <li>Cost of future covid-19 surges</li> </ul>
	<ul> <li>Delivery of CIPs and lack of focus on financial grip due to covid-19</li> <li>Uncertainty over funding arrangements beyond 2020/21.</li> </ul>
FINANCIAL IMPLICATIONS	See above
QUALITY IMPLICATIONS	None noted
EQUALITY & DIVERSITY IMPLICATIONS	None noted
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Delivering better care at lower cost</li> </ul>
DECISION/ ACTION	For noting and discussion.

#### 1.0 Introduction

- 1.1 This paper provides an update on the 2020/21 budgets.
- 1.2 NHSI/E has published revised guidance in September 2020 covering funding and cash arrangements for the last 6 months of 2020/21 (October 2020 to March 2021). The funding arrangements originally set out for the first 4 months of 2020/21 were extended until the end of September 2020.

#### 2.0 2020/21 Funding Arrangements

- 2.1 As previously highlighted to the Finance Investment Committee, the funding arrangements for the first 6 months of 2020/21 were set on the principle of all Trusts reporting a break even position. Funding consisted of:
  - Block contract funding for NHS commissioners (CCGs & NHSE) Contract values set centrally and payment made in advance
  - Central top up from NHSE/I to reflect BAU costs
  - Separate funding for validated direct covid-19 costs (in arrears)
- 2.2 The funding arrangements from 1st October 2020 will be as follows:
  - Block funding from commissioners (e.g. CCGs and NHS England)
  - System top up funding allocated to the Integrated Care System (ICS)
  - Covid funding funding allocated to the ICS
  - Elective incentive scheme funding/ fines allocated to the ICS

**Block contract funding** – these block contract values are set nationally on Trust specific basis and are broadly in line with the first 6 months of 2020/21. There are some small changes for specific agreed service changes and some high cost drugs are now excluded from block funding to revert to cost and volume basis (on a pass-through basis). This funding is passed directly to the Trust from commissioners.

**System top ups/ system envelope** – fixed funding available to systems, which is intended to deliver a breakeven position (excluding covid-19 costs).

- This funding will be allocated directly to one CCG on behalf of the ICS.
- The system top up is broadly based on 2019/20 estimated costs (based on months 8-10 19/20 actual spend) plus inflation.
- The system envelope assumes that non-NHS income returns to 2019/20 outturn levels from October 2020 onwards (e.g. private patient, overseas visitors and local authority income)
- The funding will be for the ICS to allocate to individual organisations (see section 3).

**Covid-19 funding** – fixed funding available to systems to cover covid-19 costs.

- This funding will be allocated directly to one CCG on behalf of the ICS.
- The funding is estimated based on actual covid-19 spend in Q1 20/21
- Funding excludes PPE and national testing programmes (PPE to be directly procured by the national team and testing programmes will be funded directly).
- No additional funding will be allocated unless in exceptional circumstances.
- The funding will be for the ICS to allocate to individual organisations (see section 3).

**Elective Incentive Scheme** – marginal rate applied to over/ under performance on elective and outpatient trajectories at a system level.

- The target trajectory will be calculated as per the phase 3 activity % of the baseline (i.e. 80% for electives & OP procedures in Sept, 90% in Oct, 100% of OP attendances)
- If actual activity is less than the target trajectory on a system basis, there will be a deduction of 25% for elective/ 20% outpatients

- If actual activity is higher than the target trajectory on a system basis, there will be an additional payment of 75% for elective/ 70% outpatients
- The marginal rate adjustments will be calculated and applied at an ICS level and will be up to the ICS to allocate to individual organisations (see section).

#### 3.0 NWL Allocation and Funding

- 3.1 The NWL Sector system funding envelope is £2.1bn, which increases to £3.4bn overall once income from outside of the system is included. The ICS submitted a financial plan on 20<sup>th</sup> October for the 2<sup>nd</sup> half of the year with an overall deficit of £62m. This is comprised of £84m of lost non-NHS income (mainly private patients, overseas visitors and local authority), partly offset by £22m of other benefits. There is a £60m ICS contingency held within the NWL position.
- 3.2 A set of principles and rules have been developed across NWL to agree the allocation of the system top up and covid-19 funding between organisations, which is included in appendix 1. The impact of these funding principles is that all organisations are funded at 2019/20 outturn plus agreed adjustments, with the exception of lost non-NHS income which is not fully covered by the ICS funding envelope.
- 3.3 These principles were agreed by NWL CFOs and approved off by the ICS CEO Group and have been applied in allocating the system top up and covid-19 funding to all Trusts.
- 3.4 The base point for planning was the recurrent exit run rate for 2019/20 which is consistent with the assumptions for activity and staffing in the stage 3 plan submission. The following assumptions have been made in the NWL plans:
  - The cost of a second surge for covid-19 has not been included as this was explicitly excluded from the stage 3 return.
  - The cost of additional covid-19 testing is assumed to be funded in addition to the financial envelope (in line with national guidance).
  - Additional costs for elective re-start are included as per the agreed NWL programmes e.g. additional diagnostic capacity.
  - Reasonable covid-19 estimates for the on-going effect of the pandemic are included.
  - There is a minimum of CIP of at least 1% in every organisation for the remaining six months in all plans.
  - Where organisations failed to achieve their Control Total in 2019/20 they will increase efficiency to recover half of the control total miss
  - Unavoidable cost pressures or Balance Sheet write-offs are not funded and it is assumed that organisations will achieve additional benefit or efficiency to fund.
  - There is no adjustment in the annual leave provision or provision to buy back leave.
- 3.5 A set of principles has also been agreed to allocate any fines/ incentive payments associated with the elective incentive scheme (see appendix 2).
- 3.6 The allocation of NHS income by organisation within NWL is set out in the table below:

Organisation	Direct Block Funding (£000)	Sector top up/ Covid Funding (£000)	Total Income (£000)
CNWL	210.8	14.5	225.3
CLCH	104.6	4.1	108.7
CWFT	269.9	28.5	298.3
ICHT	482.0	55.2	537.2
LAS	204.5	43.6	248.1
LNWH	287.1	70.3	357.4
RBH	169.1	23.2	192.3
тнн	112.0	16.0	128.0
WLT	149.2	0.4	149.6
CCGs*	747.9	101.2	849.1
<b>Total Funding Allocated</b>	2,737.1	357.0	3,094.1

<sup>\*</sup> note that contingency and funding for covid-19 testing is held with CCGs

#### 4.0 CWFT Impact

- 4.1 The Trust is planning for a **deficit of £5.2m for months 7-12**, which will result in an overall deficit for the full year 2020/21 of £5.2m, as the first half of the year was breakeven.
- 4.2 The driver of the deficit position for the Trust is the contribution from lost non-NHS income sources, which are not currently covered by the NHSE/I funding arrangements. The impact of lost contribution for the Trust is £8.7m (see section 4.4), which is partly offset by the additional allocation of ICS top up funding.
- 4.3 The Trust's M7-12 planning assumptions are:
  - Start point is the 2019/20 recurrent outturn (based on M1-10)
  - 2020/21 inflation and other known cost pressures (e.g. CNST) added
  - Adjustments to NHS income as per the block contracts and allocation of sector top up and covid-19 funding (as per section 3).
  - Reduction in non-NHS income and associated direct variable costs based on the following:
    - Private patients Small improvement on M1-6 run rate as some services restart /increase activity
    - Overseas visitors M1-6 run rate continues to the end of the financial year
    - o GUM income recovery of activity to 70% of commissioner baselines
  - Additional costs for agreed NWL ICS activity recovery schemes for endoscopy and imaging
  - CIP delivery of £5.6m (in line with targets already set for divisions)
  - Covid-19 costs of £4.7m for the final 6 months of the year
  - Assumes that the phase 3 elective trajectories are achieved and therefore no impact of the elective incentive scheme

The bridge from 2019/20 outturn to the 2020/21 M7-12 plan is included in appendix 3.

4.4 The Trust's lost contribution from non-NHS income is broken down as per the table below. Discussions continue about the funding for lost non-NHS income with NHSE/I and this will be reviewed by NHSE/I following the Trust and ICS planning submissions in October.

Non-NHS Income Category	19/20 recurrent outturn	M7-12 Plan	Variance	Expenditure Savings	Reduced contribution
Local authorities	13,500	9,106	(4,394)	1,546	(2,848)
Non-NHS: private patients	9,924	5,520	(4,404)	558	(3,846)
Non-NHS: overseas patients	1,908	282	(1,626)		(1,626)
Car parking income	1,362	660	(702)		(702)
Other non-NHS	31,050	31,337	287		287
Total	57,744	46,905	(10,839)	2,104	(8,735)

#### 5.0 Key Risks

- 5.1 There are a number of financial risks to the financial plan for 2020/21, including:
  - Loss of non-NHS income not included in the system envelope
  - Scale and pace of activity recovery
  - Cost of future covid-19 surges
  - Delivery of CIPs and lack of focus on financial grip due to covid-19
  - Uncertainty over funding arrangements beyond 2020/21.

### 6.0 Summary and next steps

- NHSI/E has published guidance covering funding and cash arrangements for the final 6 months of 2020/21 (October 2020 to March 2021).
- The funding arrangements are based on a fixed financial envelope for the ICS, including fixed funding for Covid-19.
- The overall NWL ICS gap is £62m, of which c£84m relates to lost non-NHS income
- The Trust's plan for months 7-12 is a deficit of £5.2m, of which £10.8m relates to lost non-NHS income
- The Trust's plan assumes delivery of £5.6m of CIPs
- The Trust will submit its M7-12 financial plan on 22<sup>nd</sup> October.

#### 7.0 Decision/action required

7.1 The FIC is asked to approve the financial plan for the final 6 months of 2020/21.

# Appendix 1 – NWL Business Rules for ICS funding

Funded	Not Funded
19/20 recurrent outturn adjusted for inflation, prior year control total miss and reasonable efficiency	Directly funded expenditure
Loss of Non-NHS Income	Failed efficiency targets or business case benefits
Reasonable CV19 expenses with certain categories requiring agreement in advance	Avoidable cost pressures including unapproved business cases
MHIS	Balance sheet movements including bad debt write-off or property revaluation
Agreed NWLICS service changes e.g. low complexity high volume elective hubs including contribution to stranded costs for a period of time	
Agreed additional capacity as part of the NWLICS stage 3 plan	
Unavoidable cost pressures on a case by case basis	
Contribution to ICS partners e.g. Local Authorities for additional discharge services	
Pump-prime efficiency schemes agreed on a case by case basis	
Funding for transformation schemes e.g. IMT	

# Appendix 2 – System Based Fines and Incentives allocation to Trusts

Scenario		Agreed Position
Sector delivers activity plan	All Trusts deliver activity plan	All Trusts get full baseline funding
Sector over delivers activity plan	All Trusts over deliver activity plan	All Trusts get full baseline funding Plus share of marginal rate over-performance in proportion to activity over performance
Sector over delivers activity plan	Some Trusts over deliver activity plan and some under deliver	Only Trusts that have over delivered get a share of marginal rate over-performance in proportion to activity over performance  No further deduction for Trusts that have under delivered
Sector under delivers activity plan	All Trusts under deliver activity plan	All Trusts get full baseline funding Less share of marginal rate under-performance in proportion to activity over performance
Sector under delivers activity plan	Some Trusts over deliver activity plan and some under deliver	All Trusts get full baseline funding Trusts that have under delivered get a share of marginal rate under-performance in proportion to activity over performance  No further funding for Trusts that over deliver

# Appendix 3 – CWFT Bridge

				Non-	
(£000)	Income	Pay	Non-Pay	Opex	Total
19/20 recurrent outturn (6 months)	326,940	-191,802	-137,882	-7,187	-9,930
Bridging items:					
Commissioner block contract increases	6,213				
System Top up	18,682				
System Covid Funding	4,637				
System contribution to reduced non-NHS Income	6,278				
Local Authority Income (less expenditure savings)	-4,394		1,546		
Private Patient Income (less expenditure savings)	-4,404	558			
Overseas Patient Income	-1,626				
Car Parking Income	-702				
Items no longer separately billed to commissioners (included in					
blocks)	-3,030				
Pay awards & non-pay inflation		-6,543	-1,204		
Depreciation & Amortisation			-1,588		
Endoscopy & Imaging Recovery		-1,225	-266		
COVID costs		-2,719	-1,973		
CEA Award		-1,302			
CIPs		3,587	1,966		
CNST			-2,992		
Finance Income				-486	
PDC				-141	
Share of JV Income				-498	
Contingency/Other	-369	-1,606	-1,616	-19	
CWFT 20/21 Plan (M7-12)	348,226	-201,052	-144,009	-8,331	-5,165





**NHS Foundation Trust** 

# **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.1/Nov/20
REPORT NAME	Guardian of Safe Working Hours Report Q2
AUTHOR	Dr Rashmi Kaushal
LEAD	Dr Roger Chinn, Medical Director
PURPOSE	To provide an up-date on the implementation of the New Junior Doctor Contract and feedback from the Exception Reporting Process July-September 2019
REPORT HISTORY	Executive Management Board 14.10.20 People and Organisational Development Committee 28.10.20
SUMMARY OF REPORT	A review of all exception reports submitted with presentation of themes and processes to improve patient safety by improving junior doctor working conditions.  Work on current and anticipated rota gaps, Rest facilities charter and updates from the Junior Doctor Forum
KEY RISKS ASSOCIATED	Patient Safety. Safe working for Junior Doctors employed by the Trust.
FINANCIAL IMPLICATIONS	In accordance with the New Contract, Junior doctors are entitled to be remunerated for additional hours worked to maintain patient safety. This process needs to be agreed with the supervising consultant and can be a financial payment or agreed Time off in lieu.  Where there are recurring problems, changes should be made to working conditions to avoid a breach safe working hours after discussion with the supervising consultant. A failure of the supervising consultant to engage with the process will result in financial payment to the junior doctor and a fine levied against the consultant in question.
QUALITY IMPLICATIONS	Patient safety, Clinical supervision and safe working conditions for Junior doctors
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	All.

DECISION/ ACTION	For noting.
------------------	-------------

26/10/2020 Dr Rashmi Kaushal

#### **Guardian of Safe Working Hours Q2 2020**

#### 1. Executive Summary

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

Almost 300 new junior doctors have joined the Trust in the months of August and September. The safety of patients and all staff remains of paramount importance at all times.

All doctors employed by the Trust have had on site induction to enable them to become familiar with their working areas and senior staff prior to starting posts. The Trust has worked hard to employ creative and functional social distancing which has enabled doctors to settle quickly into the workplace.

This Trust has led nationally in terms of delivering the contractual compliance to the revised terms and conditions of the New Terms and Conditions introduced in 2018. Shamina Chowdhury and her team have ensured robust rota compliance with the exception of just 3 out of the 137 rotas that have been revised.

Exception reports submitted for this quarter continue on a downward trend of 97 compared to 245 reports submitted for Q2 2019.

88 reports were submitted at C&W site and 10 at WM site.

The number of rota gaps has been significantly reduced from 25 (Q3 2019) to 11 in Q2 2020. The senior management and divisional leads have worked hard to fill most anticipated gaps in good time to ensure that high standards of clinical care are maintained.

Due to the impact of the pandemic, it is anticipated that the number of Deanery vacancies will increase. The Trust has actively engaged in recruiting to ensure that we have just 2 Deanery gaps which is significantly lower than most other sites in London.

Uplift in payment for doctors impacted these rotas has also been successfully negotiated and implemented in July 2020 compliance with NHS employers and BMA standards. Shamima Chowdhury has been instrumental in delivering this.

NHS Employers and the BMA requisitioned payment supplements for all trainee doctors who had worked a weekend frequency of more than 1:2 during the first wave of the COVID-19 from the beginning of March to the end of June 2020. A deadline date of July 31<sup>st</sup> 2020 was set which gave many Trusts very little time to deliver without delay. Shamima Chowdhury has led on this with the Medical Workforce in conjunction with the LNC and BMA. This payment was made to 115 junior doctors employed by the Trust during this time.

There are no Amber flags identified for this quarter.

There are no Red flags identified for this quarter.

No fines have been levied

26/10/2020 Dr Rashmi Kaushal

### 2. Rota Gaps

Rota Gaps continue to be a national problem. The Trust has responded by ensuring that existing gaps have been filled promptly to ensure patient safety and maintain desired standards of clinical care.

Our Rota gap status has come down from 47 in Q2 2019 and 25 in Q3 2019 to 11 in Q2 2020.

This Trust has not been as adversely affected by Deanery vacancies as many juniors have chosen to return at higher grades having completed foundation and core training as part of their career progression.

Site	Department	Gaps for Q2 2020	Anticipated gaps for Q3 2020	Solutions
C&W	Paediatrics SPR, FY2	2		Recruitment in process
C&W	O&G FY2/CT1	1		Recruitment in process
C&W	General Surgery FY2/SHO	1		Recruitment in process
WM	Anaesthetics SHO/SPR	4		Recruitment in process
WM	Respiratory SPR Deanery vacancy	1		Recruitment in process. Interviews in October 2020
WM	Gastroenterology SPR Deanery Vacancy	1		Recruitment in process. Interviews in October 2020
WM	O&G ST6	1		Recruitment in process. Interviews in October 2020

26/10/2020 Dr Rashmi Kaushal

### 3. Rota design process for implementation of revised terms and conditions

- All training post rotas are complaint for 72 hour working week. This was established from the outset of the initial contract in August 2016. New Changes to the agreed terms and conditions are shown below.
- With regards to the maximum 1:3 weekend frequency, this has impacted many front line
  rotas in the emergency setting. 70 rotas required amendment and 8 remain noncompliant to the revised Terms and Conditions. These terms have been suspended for
  the foreseeable future to ensure that Trusts are able to provide patient care safely
  throughout the pandemic.
- The TCS has the provision that where the Clinical Director has confirmed that there is a clinical reason to maintain a weekend frequency of more than 1:3, the Guardian of safe working will confirm that it is appropriate in the interest of patient safety.
- The Rota's currently impacted are in A&E and Anaesthetics at West Middlesex and Paediatrics NICU C&W where the clinical skill set cannot be compromised by doctors who have not had specific and certified training.
- All doctors in training grades have complaint Rota's and the departments have trained and long term locums to cover the additional shifts.
- Active recruitment in search of suitably trained doctors continues.

Effective Date	Implementation	Additional Information	Trust Status
August 7 <sup>th</sup>	Additional 30 minute break when working a night shift of 12 or more hours.	All divisions informed and engaged	Compliant Aug 7 <sup>th</sup> 2019
December	Maximum of 72 hours worked in any  All training post rotas are complaint		Compliant Aug 7 <sup>th</sup>
2019	consecutive 168 hour period.	for 72 hour working week.	2019
February 2020	Rest after night shifts; 46 hours rest after any	137 rotas reviewed.	
	number of nights worked (reduced from 3 nights worked)  Maximum 1:3 weekend frequency	50 rota changes required at C&W 21 rota changes required at WM	C&W 48/50 complaint Jan 2020
		Information per division in Table 3	WM 15/21 complaint Jan 2020
August 2020	The maximum number of consecutive shifts worked to be reduced from 8 to 7.		Complaint Jan 2020
	The maximum number of consecutive long day shifts reduced from 5 to 4		

<u>Table 3: Table 3 shows the breakdown of rota changes required to achieve compliance by division at C&W site. 48 out of the 50 rotas are now compliant.</u>

Site	Division	Department	Rota	Breach	Outcome
C&W	Women and Children	HIV/GUM	2 XFY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule; Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	HIV/GUM	CT2	Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	HIV/GUM	ST3-8	Breach on minimum period off after consecutive shifts	Compliant
C&W	Women and Children	NICU	ST1-3	Breach Max of 1:3 weekend frequency  Breach on minimum period off after consecutive shifts.  Weekend 1:3 frequency approved by GOSW. Review needed within 6	Compliant  Non- Compliant
				months	
C&W	Women and Children	NICU	ST4-8	Fail on minimum period off after consecutive shifts.  Changes approved by GOSW	Compliant
C&W	Women and Children	Paediatrics	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
C&W	Women and Children	Paediatric Surgery	ST4-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule  Breach on minimum period off after consecutive shifts.	Complaint
C&W	Women and Children	ED Paediatrics	CT3 ST1-3	Breach Max of 1:3 weekend frequency  Weekend 1:3 frequency approved by GOSW. Review needed within 6 months	Compliant.  Non- Compliant
C&W	Women and Children	Obstetrics & Gynaecology	2XFY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule  Breach on minimum period off after consecutive shifts.	Compliant
C&W	Women and Children	Obstetrics & Gynaecology	St1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant

				Breach on minimum period off after	
				consecutive shifts.	
C&W	Women and Children	Infectious Diseases	2 X	Breach on minimum period off after consecutive shifts.	Compliant
			ST3-8		
C&W	Planned Care	General Surgery/T&O	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
C&W	Planned Care	General Surgery/T&O	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
				Breach on minimum period off after consecutive shifts.	
C&W	Planned Care	Plastic Surgery	SHO	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
			CT1-2	Breach on minimum period off after	
			ST1-2	consecutive shifts.	
C&W	Planned Care	Plastic Surgery	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
				Breach on minimum period off after consecutive shifts	
C&W	Planned Care	ICU	SPR	Breach of 46hrs rest rule for night shift between 23.00-06.00	Compliant
				Breach of maximum 4 long shifts rostered on 4 consecutive day rule	
				Fail on minimum rest requirement after long shifts.	
C&W	Planned Care	General Surgery	SPR	Breach of 46hrs rest rule for night shift between 23.00-06.00	Compliant
				Breach of maximum 7 shifts rostered over 7 consecutive days rule	
C&W	EIC	AAU	FY1	Breach of maximum 7 shifts rostered over 7 consecutive days rule	Compliant
				Breach on minimum period off after consecutive shifts.	
				Breach of maximum 4 long shifts rostered on 4 consecutive day rule	
C&W	EIC	AAU	SHO	Breach on minimum period off after consecutive shifts.	Compliant
				Includes the ST1-2, CT1-2 & ACCS	

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

				Breach on minimum period off after consecutive shifts	
C&W	EIC	Oncology	2X FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
				Breach on minimum period off after consecutive shifts	
C&W	EIC	A&E	FY2	Breach Max of 1:3 weekend frequency	Compliant
				Weekend 1:3 frequency: not	
				compliant but CD confirmation of	
				clinical reason to maintain current	
				frequency. Approved by GOSW	
C&W	EIC	A&E	ST1-3	Breach Max of 1:3 weekend frequency	Compliant
				Weekend 1:3 frequency: not	
				compliant but CD confirmation of	
				clinical reason to maintain current	
				frequency. Approved by GOSW	
C&W	EIC	GIM	CT1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
			ST1-2	Breach on minimum period off after consecutive shifts	
C&W	EIC	GIM	SPR	Breach of maximum 7 shifts rostered	Compliant
			CT2 0	over 7 consecutive days rule.	
			ST3-8	Breach on minimum period off after	
			СТ3	consecutive shifts	
C&W	EIC	Cardiology	ST3	Weekly hours are 49.5, needs to be reduced to 48 hours.	Compliant
C&W	EIC	CXH Medical Oncology	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
				Breach on minimum period off after consecutive shifts	

<u>Table 4: Table 3 shows the breakdown of rota changes required to achieve compliance by division at West Middlesex Site. 15/21 rotas are compliant.</u>

Site	Division	Department	Grade	Breach	Outcome
WM	Women and Children	Obstetrics and Gynaecology	FY2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
				Breach on minimum period off after consecutive shifts	
WM	Women and Children	Obstetrics and Gynaecology	ST1-2	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
				Breach on minimum period off after consecutive shifts	
WM	Women and Children	Obstetrics and Gynaecology	ST3-8	Breach of maximum 7 shifts rostered over 7 consecutive days rule.	Compliant
				Breach on minimum period off after consecutive shifts	
WM	Women and Children	Paediatrics	FY2	Breach Max of 1:3 weekend frequency	Compliant
				Breach on minimum period off after	
				GOSW approved. Robust Business	Non- Compliant
				plan needed within 6 months.	
WM	Women and Children	Paediatrics	ST1-3	Breach Max of 1:3 weekend frequency	Compliant
				Breach of maximum 7 shifts rostered over 7 consecutive days rule.	
				Breach on minimum period off after consecutive shifts	Non Compliant
				Weekend 1:3 frequency GOSW	Non- Compliant
				approved. Review August	
WM	Planned Care	Anaesthetics	CT1-2	Breach Max of 1:3 weekend frequency	Non- Complaint
			ST1-8		
WM	Planned Care	Anaesthetics	CT1-2	Breach Max of 1:3 weekend frequency	Non- Compliant
WM	Planned Care	General Surgery	FY1	Breach of maximum 7 shifts rostered	Compliant
VVIVI	i iailileu Cale	Jeneral Jurgery	' ' 1	over 7 consecutive days rule.	Compilant
				Breach on minimum period off after consecutive shifts	
WM	Planned Care	General Surgery	ST1-2	Breach of maximum 7 shifts rostered	Compliant

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

#### 4. The Junior Doctor Forum

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

JDF 19<sup>th</sup> August 2020

Gary Davies Medical Director addressed all the new doctors and representatives from all departments to discuss future planning for a second wave of the pandemic expected in the first two weeks of October.

All doctors were instructed to complete mask fit testing and sign posted to appropriate areas. Each doctor was also asked to complete a risk assessment form.

Doctors were advised to observe holiday destinations prior to leaving the country to ensure that they were not travelling to areas that would require quarantine on return.

Positive points to have arisen from working during COVID-19 were fed back as: Daily update from Trust Exec level, consultant present on the ward for 12 hours each day, hotels for doctors needing to isolate from family, Taxis for doctors getting home, Free meals during day and night, Effective testing service.

JDF 16<sup>th</sup> September 2020

Pippa Nightingale Chief Nursing Officer presented an update on PHE guidelines

The New Guidelines as of 20/08/20 have been implemented into the trust. All patients need risk assessment on presentation and stratified into low, medium and high risk. There will be different PPE guidance based on this. As with the Guidance, the Trust will cohort high risk patients together in the event of a second surge.

Information on current prevalence of COVID:

The current rate of infection remains very low locally, but rising in ages 20-29. We are expected to be 2-3 weeks behind France and Spain and can predict we are 2-3 weeks from a second rise in unwell and ventilated patients. Fit testing is essential for all staff working in COVID 19 areas immediately.

Shamima Chowdhury (HR) presented the NHS People's Plan

This plan is committed to looking after all staff working for the NHS and sets a people promise to ensure that all staff are safe and healthy, physically and mentally well and able to work flexibly where appropriate. The emphasis is on creating an inclusive and diverse work force where discrimination, violence and bullying do not occur.

COVID 19 has tested our ability and shown we can be flexible and make the best use of our combined skills and experience. It has also shown us some new positive ways of working with the expansion of multidisciplinary teams, virtual meetings and greater access to CPD.

The junior doctors have been asked to complete a short survey having seen her presentation which will be used by the medical force to take their feedback on board.

#### 5. Exception Reporting

A total of 97 reports were submitted for the quarter. 88 were at C&W site and 10 at WM site.

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

July 2020: A total of 8 reports were submitted. No Fines Levied.

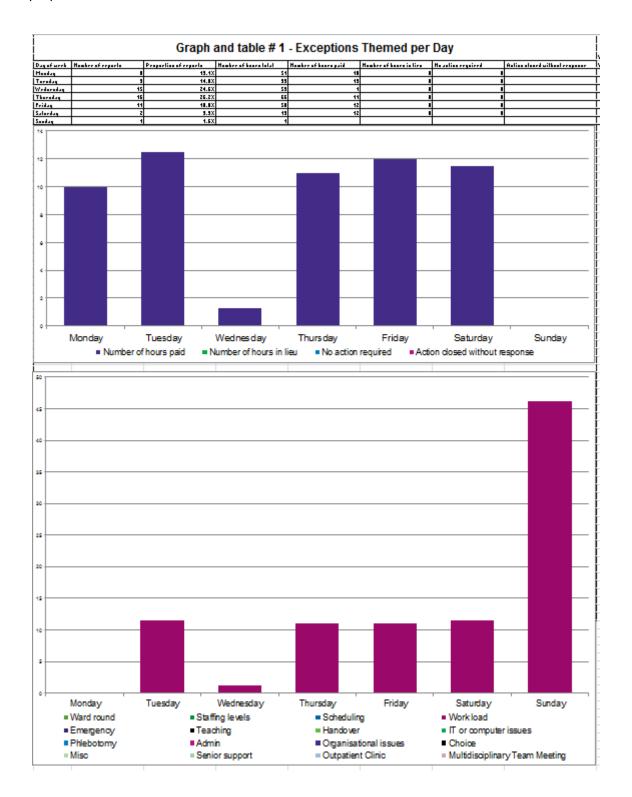
Division	C&W: 7	WMUH: 1
EIC	Neurology 6	Cardiology 1
Planned Care	General Surgery 1	

#### August 2020: A total of 27 reports were submitted. No Fines Levied.

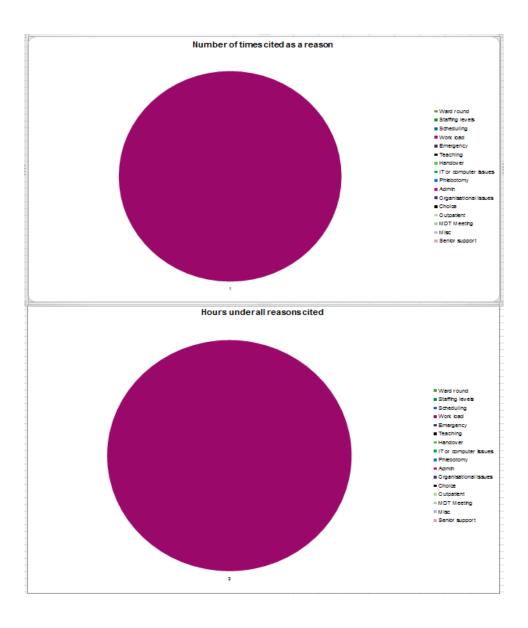
Division	C&W: 26	WMUH: 1
EIC	COTE 7 , GUM 3, Neurology 10	Cardiology 1
Planned Care	General Surgery 2, T&O 1. Urology 2	
Education	1	

#### September 2020: A total of 62 reports were submitted

Division	C&W: 52	WMUH: 10
EIC	COTE 6, Gastroenterology 14, Neurology 16, Acute medicine 4, Cardiology 3	Cardiology 6, COTE 3
Planned Care	General surgery 9	
Education		1

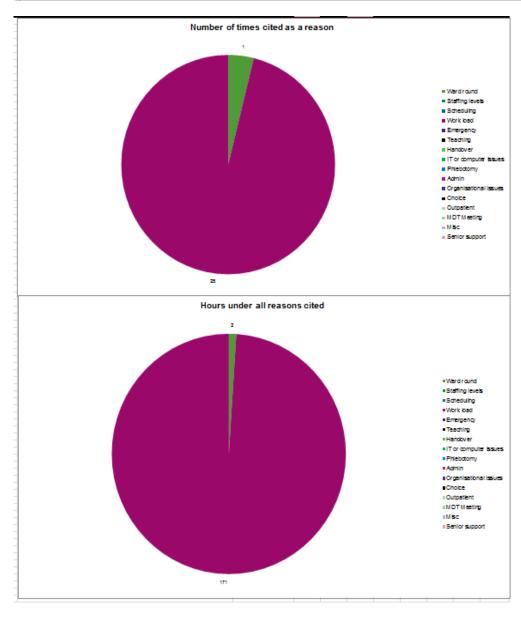


Overview	Graph and Table # 2 - Overview of Exception Themes - WM											
Theme short hand	Long Theme	Short Theme	Percent	Percent	In leiu	Paid	No action					
WR	Ward Round issues e.g. long or starting late	Ward round	0%	0%	0.0	0.0	0.0					
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	0%	0%	0.0	0.0	0.0					
SC	Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	0%	0%	0.0	0.0	0.0					
WL	Work Load exceeding the capacity of a full team	Work load	100%	100%	0.0	0.0	46.3					
	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	0%	0%	0.0	0.0	0.0					
TE	Teaching - either resulting in late stay; or missed at request of consultant	Teaching	0%	0%	0.0							
	Handover - doctor stayed as they felt handing over tasks to another team was unsafe or											
HA	inappropriate (must qualify)	Handover	0%	0%	0.0	0.0	0.0					
IT	IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0%	0%	0.0	0.0	0.0					
PL	Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0%	0%	0.0	0.0	0.0					
	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	0%	0%	0.0	0.0	0.0					
	Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high	Admin	0 70	070	0.0	0.0	0.0					
OR	volume of new patients (please specify)	Organisational issues	0%	0%	0.0	0.0	0.0					
CH	Choice - doctor chose to come in early / stay late - not directed by seniors	Choice	0%	0%	0.0	0.0	0.0					
OP	Outpatient Clinic	Outpatient	0%	0%	0.0	0.0	0.0					
MDT	Multidisciplinary Team Meeting	MDT Meeting	0%	0%	0.0	0.0	0.0					
MI	Miscellaneous reason for staying late	Misc	0%	0%	0.0	0.0	0.0					
SU	Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	0%	0%	0.0	0.0	0.0					



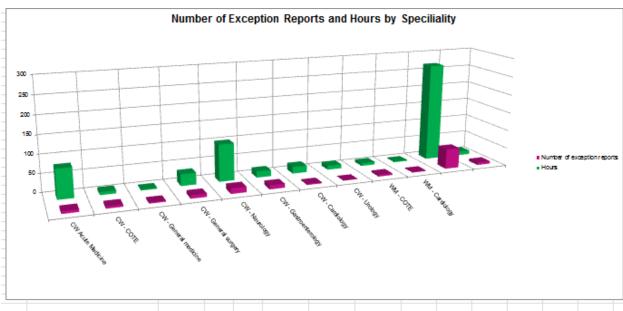
Graph and Table #3 - Overview of Exception Themes - CW

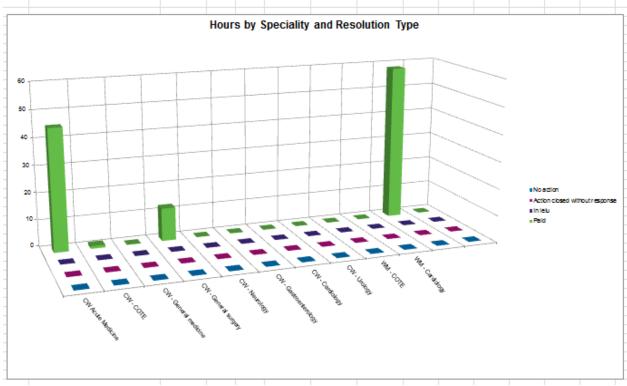
Look up	Long Theme	Short Theme	Count	Percent	Hours	Percent	In leiu
WR	Ward Round issues e.g. long or starting late	Ward round	1	4%	1.8	7%	0.0
SL	Staffing Level below agreed template for team or type of cover	Staffing levels	0	0%	0.0	0%	0.0
SC	Scheduling of duties outside normal working hours (N.B. this includes late handovers)	Scheduling	0	0%	0.0	0%	0.0
WL	Work Load exceeding the capacity of a full team	Work load	25	96%	170.5	656%	0.0
EM	Emergency situation occurring at close of day or after normal working hours required doctors continued presence	Emergency	0	0%	0.0	0%	0.0
TE	Teaching - either resulting in late stay; or missed at request of consultant	Teaching	0	0%	0.0	0%	0.0
	Handover - doctor stayed as they felt handing over tasks to another team was unsafe or						
HA	inappropriate (must qualify)	Handover	0	0%	0.0	0%	0.0
IT	IT or computer issues as the main cause of the exception (please qualify)	IT or computer issues	0	0%	0.0	0%	0.0
PL	Phlebotomy issues as the main cause of the exception (please qualify)	Phlebotomy	0	0%	0.0	0%	0.0
AD	Admin tasks taking up excessive time e.g TTA's, DOLS forms, completing theatre booking forms, making lists etc (please specify)	Admin	0	0%	0.0	0%	0.0
	Organisational issues as the main cause of the exception (please qualify) e.g. becoming aware a new patient is under your care late in the day; high volume of outliers; high						
OR	volume of new patients (please specify)	Organisational issues	0	0%		0%	
CH	Choice - doctor chose to come in early / stay late - not directed by seniors	Choice	0	0%		0%	0.0
OP	Outpatient Clinic	Outpatient	0	0%	0.0	0%	0.0
MDT	Multidisciplinary Team Meeting	MDT Meeting	0	0%	0.0	0%	0.0
MI	Miscellaneous reason for staying late	Misc	0	0%	0.0	0%	0.0
SU	Lack of Senior Support as the main cause of the exception (please qualify)	Senior support	0	0%	0.0	0%	0.0



Graph and Table # 4 - Overview of Exceptions per Site and Speciality

Site	Speciality at time of exception report	Number of								Action
		exception	Open	Percent	Number of staff on rota	Hours	In leiu	Paid	No action	closed without
		reports			5.3 51110.4					response
Chelsea	Acute Medicine	7	0	0%		79.3	0.0	45.0	0.0	0.0
Chelsea	COTE	6	0	0%		8.0	0.0	1.0	0.0	0.0
Chelsea	General medicine	3	0	0%		3.0	0.0	0.0	0.0	0.0
Chelsea	General surgery	9	0	0%		31.5	0.0	12.3	0.0	0.0
Chelsea	Neurology	15	0	0%		100.5	0.0	0.0	0.0	0.0
Chelsea	Gastroenterology	11	1	8.33%		16.5	0.0	0.0	0.0	0.0
Chelsea	Cardiology	3	0	0%		18.8	0.0	0.0	0.0	0.0
Chelsea	Urology	1	0	0%		11.0	0.0	0.0	0.0	0.0
West Mid	COTE	5	0	0%		7.5	0.0	0.0	0.0	0.0
West Mid	Cardiology	2	0	0%		2.8	0.0	0.0	0.0	0.0
Chelsea	Total (of reporting specialities)	55	1	0%	0	268.5	0.0	58.3	0.0	0.0
West Mic	Total (of reporting specialities)	7	0	0%	0	10.3	0.0	0.0	0.0	0.0









**NHS Foundation Trust** 

## **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.2/Nov/20		
REPORT NAME	Improvement Programme Update		
AUTHOR	Victoria Lyon, Head of Improvement		
LEAD	Pippa Nightingale, Chief Nursing Officer		
PURPOSE	To report on the progress of the Improvement Programme		
SUMMARY OF REPORT	This report provides an update on the progress of the Improvement Programme:  • Quality priorities for 2020/21  • Patient experience  • Culture of improvement and innovation  • Continuous improvement; CQC improvement plan, GIRFT  • Deep dives: quality priority – impact of volunteers		
KEY RISKS ASSOCIATED	Failure to continue to deliver high quality patient care		
FINANCIAL IMPLICATIONS	As above		
QUALITY IMPLICATIONS	Equality and Diversity implications have been considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nursing officer and Chief Medical Officer.		
EQUALITY & DIVERSITY IMPLICATIONS	These are considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nursing officer and Chief Medical Officer.		
LINK TO OBJECTIVES	<ul> <li>Deliver high-quality patient-centred care</li> <li>Deliver better care at lower cost</li> </ul>		
DECISION/ ACTION	For noting.		

#### 1. Quality priorities 2020/21

The quality priorities for 2020/21 are:

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

A summary of baseline position and progress for month 5 is outlined in Table 1 below.

During the end of March, April and May clinical teams were redeployed to support the Covid-19 response. This impacted progress in Q1 overall but the position has mainly recovered and progress is on track to deliver the stated aim by the end of the year.

Priority	Key Indicator	Baseline	EOY target	Progress	Next Steps / Commentary
Improving dementia care	No of patients >75 years screened at	81%	81% 90%	August: 99% CW and 69% WM	Daily list of outstanding screens, sent to ward managers, divisional medical directors and matrons  30% tier 2 – 82 nurses and HCA's
Care	admission				trained, with 4 further virtual teaching sessions planned for September.
2. Improving	% of newly diagnosed patients with a	Ď		Q1 53% of newly diagnosed patients with a HNA and 42% had care plan	During the Covid19 response North West London set up the Royal Marsden as the cancer hub for the sector, in order for the acute Trusts to prioritise Covid patients as a temporary measure. The Trust is reestablishing cancer pathways as priority.
cancer care	HNA appointment and personal care plan	61%	70%	Q2 to date 60. of newly diagnosed patients with a HNA and 53%	Cancer working group are focused on improving % newly diagnosed patients with HNA/ personal care plan in Q2. There has been an improvement in HNA/care plans month by month since April.
	% of patients screened for sepsis	81%*	90%	August:	With the launch of the Sepsis reporting dashboard from 22 September the team are focused on optimising performance in screening and antibiotic delivery within
	% of patient receiving IV antibiotics within 1hr	ng IV	90%	ED; 7.1% Trust  ED; 7.1% Trust  ea  of	1hr. The sepsis champions in ED and each inpatient area will have regular sight of the data and will be responsible for
3. Improving				1hr: Trust 38%	driving improvements.  Nursing deteriorating patient champions
sepsis care				*Corrected data with corrections to digital dashboard	identified, presented at quality round as well as junior doctor induction, another planned induction in October.
				% screened <1hr in ED; 49% Trust	New QI project - early antibiotic prescription in ED: antibiotics to be prescribed on completion of sepsis screen and potential red flag sepsis diagnosis, team appointed, go-live date 1 Oct
4. Improve the impact of volunteers	Number of volunteers April>March	600	900	243 (YTD)	There were 88 active volunteers in August. Volunteer responders have superseded the bleep role and contributed 819 hours across both sites in August.

Priority	Key Indicator	Baseline	EOY target	Progress	Next Steps / Commentary	
	Volunteer recruit to commence time	101 days	56 days	20 days	Time to recruit remains an average of 2 days as there have been no further recruitment rounds since the last report In the fastest cases the service reduced recruitment time to under 2 weeks, dow	
	Number of bleep volunteer bleeps, calculated in clinical hours saved	188h CW 10 h WM	400hours per month	819 h logged in August	from an average of around 100 days before the crisis.	

#### 2. **Improving patient experience**

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

- FFT improvement
   PALS improvement programme
   Patient information leaflets
- 4. Discharge Project

A summary of baseline position and year to date progress is outlined in Table 2 below.

Priority	Key Indicator	Baseline	EOY target	YTD progress	Next Steps / Commentary
1 FFT Improvement	All departments achieving a response rate and satisfaction scores above the national average	Satisfaction Score ED - 88 GUM- 95 Maternity - 91 Inpatients - 94 Paeds - 91 OPD - 92	Satisfaction Score ED - 85 GUM- 96 Maternity - 97 Inpatients - 96 Paeds - 96 OPD - 94	At time of reporting, results pending	NHS England suspended FFT reporting during the COVID pandemic. However the Trust has restarted data collection in June 2020 ahead of NHSE reporting schedule.  The FFT requirements have changed nationally and the team have implemented all changes at the Trust. The FFT contract has been retendered and the current supplier was reappointed to the contract.
2 PALS improvement program	To achieve a 100% 5 day response rate for all PALS concerns	67%	100%	95%	PALS have been rebranded and piloted alternative ways of working during COVID19. The service has been consistently poor as achieving resolution for patients within 5 working days.  Changes in the service provision have increased 5 day response rates to 94% and in addition demonstrated that 71% of PALS work is completed through immediate resolution.
3 Patient information leaflets	100% of departments to have all patient information leaflets available digitally through the Trust website	0%	100%	25%	Patient information website page created and 25% of all wards and departments have engaged with the migration process to move current paper information to electronic versions, an increase form 21% last month.  New Patient information policy produced and approval group has been set up this month.

Priority	Key Indicator	Baseline	EOY target	YTD progress	Next Steps / Commentary
4 Discharge projects	Improve experience of discharge process to be better than the national average	Not delayed 56% Home situation considered 74% Who to contact 70% Additional equipment 68%	Not delayed 60% Home situation considered 82% Who to contact 76% Additional equipment 79%	See comments	The discharge improvement project has been difficult to start due to the staff involved being committed to supporting covid19. However there is now an SRO for the work, an initial discovery phase has commenced to identify areas for improvement in the process  The programme will be monitored lo call throughout the year and updates against the KPI's are taken directly from the national survey

#### 3. Building a culture of innovation and improvement

#### CW+ Dragons Den

As part of our roadmap for this year and under the theme of 'gamify and reward innovation and improvement' we ran the annual CW+ Dragon's Den event.

This was a 'virtual' event where we provided shared improvement goals and then asked nursing, midwifery and AHP staff to generate ideas and enter a Dragon's Den style competition to win recognition and resources to support their project.

This year a total of 32 applications were received – an increase from 22 applications the previous year. Seven were shortlisted were selected to present to the 'dragons den' panel which took place on the 9 September 2020.

The finalist projects are highlighted below:

#### 1. Re-signage of LGF outpatients department (Project lead: Jessica Konadu, Junior Sister)

This project is focused on turning outpatient department into a friendly and warm environment and increase productivity among stressed staff with the use of music, light, colours and noise control. The project aligns to the Trust's 'unfailingly kind' PROUD values.

# 2. Enhancing infant-parental experience through specialised clothing (Purvi Patel, Neonatal Nurse)

Designing specialised clothing for preterm infants with the goal of de-medicalising their appearance. The clothing is designed to help complement parental-infant bonding without interfering with medical intervention or monitoring.

Runner up project 2020

# 3. Hand Therapy the exercise prescription app – fast access to treatment information at the click of a button (Hayley Fay, Hand Therapist)

Expand the patient exercise prescription app with new functionality and an increase in the video content by another 50 videos. This project is aligned to our Trust improvement priorities; digital transformation and enhanced recovery.

Winning project 2020

# 4. Biomechanics for birth – an innovative training programme for midwives to support physiological birth (Amanda Rogers, Birth Centre & Community Matron)

Providing training for 50 midwives. The training programme helps midwives develop a range of practical skills and techniques to support women during childbirth to achieve optimum physiological birth without the need for costly medical intervention.

## 5. SING & SHAKE: Interactive music therapy kits for families to use at home (Emma Bailey, Music Therapist)

Provide interactive music therapy kits for families to support engagement in the adapted music therapy offer through video sessions.

Runner up project 2020

# 6. Hear our story (Helen Kelsall, Divisional Director of Nursing, Emergency and Integrated Care)

Collaborating with patients and carers who have been involved in serious incidents and complaints to create videos telling the story of their healthcare experience. These stories would provide a permanent educational and training resource to promote patient safety, engage with improvement and encourage reflection.

#### 7. Video Library for Hand Therapy Induction (Ann Garewal, Hand Therapist)

Providing a self-directed video library for Hand Therapy induction to increase flexibility of the induction and reduce lost patient time.

#### 4. CQC Improvement Plan

The Trust received a rating of 'Good' overall, with 'Outstanding' in 'Use of Resources' and 'Well-Led' in the November 2019 CQC inspection. The CQC report recommended 22 actions to improve care, 18 of these were 'should do' actions. There were no 'must do' actions.

The CQC action plan is monitored through Improvement Board, and assured through Quality Committee. In September, three actions moved from green status to blue. The overall RAG position of the CQC actions are tabled below:

Actions Summary	Red	Amber	Green	Complete
Jun 2020	2	16	3	1
Jul 2020	-	6	13	3
Aug 2020	-	6	13	3
Sep 2020	-	6	10	6

#### 5. Focus topics – quality priority and patient experience

#### I. Improving Dementia Care

#### **Overview**

#### Vision statement

To provide high quality and patient-centred care for patients with dementia.

#### Case for change

We have a dementia strategy which outlines how we will work closely with our community partners to ensure we can avoid unnecessary admission of these patients. When an admission is necessary, we will provide outstanding care in environments that are dementia friendly.

#### Specific aims

To achieve that we will:

- Increase the number of patients >75 years who are screened at admission to reach 90% (baseline 81%)
- Increase the numbers of nurses trained in tier 2 dementia training to reach 90% (baseline 16%)

#### **Progress update**

Since the last update the team have been focused heavily on education and training. Education sessions have been provided to medical teams regarding the completion of AMTs on Cerner. The Older Adults Nursing team are delivering the Tier 2 dementia training on 'Excellence in Care' course, nurse preceptorship, clinical update day, older adults study day (monthly until December) and now offering two additional sessions per month on each site over Zoom, so far there has been a good uptake with an additional 82 nurses trained. The percentage of nurses trained in tier 2 dementia care is 30% (16% baseline). A further 52 members of staff will be trained in September (planned to reach 37%).

The new nursing dashboard is live and ward staff can monitor compliance and identify outstanding assessments and the wider MDT engaged to assist with dementia screening completion. In August 99% of patients >75 years were dementia screened at admission at Chelsea site and 69% at West Middlesex site.

#### **Next steps**

In the next quarter the older adult's team will be focused on a wider MDT approach to dementia screening, promoting and embedding use of the nursing and medical dashboards to monitor compliance and identify outstanding assessments in real-time and discuss those waiting to be assessed at each daily board round. This should result in a significant improvement, particularly at West Middlesex.

Improving Dementia Care					
Research	Innovation/ Digital	QI/audit			
Research project being undertaken using 'Paro' the robotic seal for patients living with Dementia, led by Dr Ruth Mizoguchi	New over bed at a glance 'All about me boards' being installed in newly refurbished wards. Providing insight into who a person is and what their likes and dislikes are.  Adapted our dementia tier 2 delivery using Zoom to reach more members of staff	Use of 'This is me' tool, this will be audited alongside a John's campaign mini audit. This will help us to promote the use of each and also educate staff on their importance and purpose			

#### Risks and challenges

There is currently a reliance on the Older Adults nurses to complete the dementia screening. This team also has to cover Frailty and dementia case management. There is a risk that the dementia screening is not mandatory on Cerner.

Currently only the Older adults nurses are delivering Tier 2 dementia training, we are a small team and currently dedicate a significant amount of time to dementia education alone. We should also be providing education on frailty and falls. Releasing staff from the ward and/or having access to a computer to join over zoom.

#### II. FFT improvement programme

#### Overview

Vision statement

To ensure response rates exceed 30%, the recommendation scores to be above the national average and data is being used to drive improvement at a service level

#### Case for change

Previously the Trust had response rate and recommendation score targets which were applied to all service areas. The Trust failed to achieve in some of these areas. Therefore the metrics have been changed to see each service area achieve above the national average

#### Aims

- All areas to achieve 30% response rate
- All areas to score above the national average for that service recommendation score
- Each department to have a local improvement plan that triangulates FFT, PALS, Complaints and local survey feedback

#### **Progress Update**

NHSE / I suspended FFT data collection during the COVID19 pandemic, and national reporting is currently still suspended. The Trust elected to restart the FFT feedback in June 2020. All areas have received the new FFTR forms, issues with data collection have been addressed and expectations of ward and department manages have been reiterated. The patient experience manager is working with areas who are struggling to achieve the correct response rate. FFT contract has been awarded and is in project roll out stage.

#### **Next Steps**

Within the next quarter the patient experience team are restructuring FFT live data warehouse with new data requirements, targeting areas with low response rates and peruse a system with the area manager to ensure the lifecycle of FFT is completed. The first target areas are under women's and children's division specifically where the team will be collaborating to investigate low response rates

#### Risks and challenges

There is a risk of poor staff engagement with FFT; this is being addressed through targeted regular meetings with areas that are struggling to achieve compliance.



# Chelsea and Westminster Hospital **MHS**

## **NHS Foundation Trust**

#### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.3/Nov/20				
REPORT NAME	Learning from Serious Incidents – Incidents reported/investigated – August/September 2020				
AUTHOR	stacey Humphries – Quality and Clinical Governance Assurance Manager				
LEADS	ippa Nightingale – Chief Nursing Officer				
PURPOSE	his paper provides an update on the process compliance, key metrics and learning opportunities rising from Serious Incident (SI) investigations.				
REPORT HISTORY	Executive Management Board 14.10.20 Quality Committee 03.11.20				
SUMMARY OF REPORT	During the 12 month period to September 2020 the Trust reported 75 serious incidents on StEIS:  34 declared by West Middlesex Hospital  41 declared by Chelsea and Westminster Hospital  During August/September 2020 the Trust declared 8 serious incidents:  Maternal, fetal, neonatal (x3)  Medication (x 2)  Death: Unexpected / unexplained (x 1)  Patient falls (x 1)  Imaging/Radiation (x 1)  There were 13 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the North West London Collaborative (Commissioners).  Root and contributory causes are identified as part of the serious incident investigation process. Themes relating to patient factors, human error, lack of risk assessment, adherence to Trust policies/procedures and suboptimal processes were identified.  Quality improvements projects will be undertaken to embed the learning identified from the Trusts highest reported SI categories relating to maternity safety, patient falls and delayed diagnosis.				
KEY RISKS ASSOCIATED	Critical external findings linked to severe harm or death of patients. Reputational risk associated with Never Events. Delayed delivery of action plans associated with serious incident investigations reduces risk.				
FINANCIAL IMPLICATIONS	Penalties and potential cost of litigation relating to serious incidents and never events:				
QUALITY IMPLICATIONS	Serious Incident investigation provides clinical teams with a structured approach to care and service delivery evaluation and supports the identification of learning opportunities designed to reduce the risk of harm to patients, staff and the public.				
EQUALITY & DIVERSITY IMPLICATIONS	N/A				
LINK TO OBJECTIVES	Delivering high quality patient centred care				
DECISION/ ACTION	For noting.				

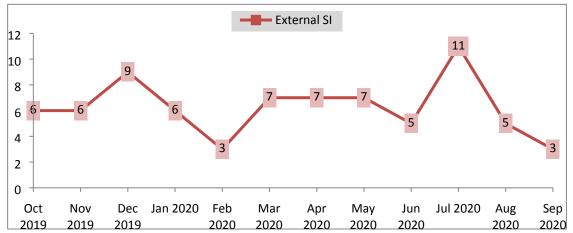
#### 1. Introduction

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

#### 2. Serious Incident activity – 12 month period

During the 12 month period to September 2020 the Trust reported 75 serious incidents on StEIS:

- 34 were declared by West Middlesex Hospital
- 41 were declared by Chelsea and Westminster Hospital



Graph 1: SIs reported by level and month reported on StEIS, October 2019 – September 2020

There was increased reporting of patient falls and maternity related SIs in July 2020 (Patient falls n=5; Maternity incidents n=3). The number of incidents reported under these categories declined in August and September 2020.

#### 3. Serious Incidents declared August/September 2020

During August/September 2020 the Trust reported 8 serious incidents.

Site	Datix ref	Category	Incident outline	Month/Year Reported on StEIS
CW	INC67502	Maternal, fetal, neonatal	Neonatal - Intrapartum fetal death	August 2020
CW	INC67765	Maternal, fetal, neonatal	Maternal - IUD/Stillbirth	August 2020
CW	INC67978	Patient falls	Fall from bed/trolley.	August 2020
WM	INC67446	Medication	Medication incident	August 2020
WM	INC68086	Imaging/Radiation	Unnecessary exposure to radiation (Imaging)	August 2020
CW	INC69890	Medication	Medication incident	September 2020
WM	INC68977	Death: Unexpected / unexplained	Unexpected death in ITU	September 2020
WM	INC697271	Maternal, fetal, neonatal	Baby transferred to tertiary unit for active cooling	September 2020

Table 1: No. of SIs reported on StEIS in August/September 2020

#### 4. Serious Incident reports submitted to Commissioners in August/September 2020

13 completed Serious Incident reports were approved by the Chief Nurse or Medical Director and submitted to the North West London (NWL) Collaborative (Commissioners).

Site	Speciality	StEIS ref	StEIS Category
WM	Trauma / Orthopaedics	2020/10575	Never Event - Unintentional connection of a patient requiring oxygen to an
			air flow meter
WM	Maternity / Obstetrics	2020/4674	Maternity/Obstetric incident: baby only
CW	Maternity / Obstetrics	2020/9131	Maternity/Obstetric incident: mother only
WM	Paediatrics	2020/9413	Medication incident
WM	Care Of Elderly	2020/10032	Slips/trips/falls
WM	Paediatrics	2020/6421	Unexpected death (Incident de-escalated by Clinical Commissioning Group)
WM	Maternity / Obstetrics	2019/8139	Maternity/Obstetric incident: baby only
WM	Maternity / Obstetrics	2020/13453	Maternity/Obstetric incident: baby only
WM	Maternity / Obstetrics	2020/184	Maternity/Obstetric incident: mother only
CW	Care Of Elderly	2020/12034	Slips/trips/falls
CW	Emergency Department	2020/12951	Slips/trips/falls
WM	Gastroenterology	2020/11831	Treatment delay
WM	Cancer Performance	2020/12382	Diagnostic incident

Table 2: SI reports submitted to the Commissioners in August/September 2020

#### 5. Never Events

'Never Events' are defined as 'serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

A Never Event was reported on the 8<sup>th</sup> June 2020 relating to the unintentional connection of a patient requiring oxygen to an air flowmeter (StEIS reference 2020/10575); the patient experienced no harm from this event.

#### 5.1. Root cause themes and Lessons Learned (SIs submitted in August/September 2020)

Root and contributory causes are identified as part of the serious incident investigation process. Primary themes identified during this reporting period include; patient factors, human error, a lack of risk assessment, a lack of adherence to Trust policies/procedures, and suboptimal processes. Learning from serious incident investigation is shared across the organisation to better support understanding and reduce the risk of recurrence.

To offer enhanced assurance that the outcome from serious incidents is leading to change themes identified during the investigation process are being linked to quality improvement programmes. Quality improvement projects will be undertaken to embed the learning identified from the Trust's highest reported SI categories.





**NHS Foundation Trust** 

## **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.4/Nov/20
REPORT NAME	Mortality Surveillance – Q2 2020/21
AUTHOR	Alex Bolton, Head of Health Safety and Risk
LEAD	lain Beveridge, Hospital Medical Director (WestMid)
PURPOSE	This paper updates the Board on key metrics relating to the Trust's learning from death approach.
REPORT HISTORY	Executive Management Board 14.10.20 Quality Committee 28.10.20
SUMMARY OF REPORT	The Trust wide SHMI relative risk of mortality between June 2019 and May 2020 demonstrates that both sites have outcomes below the expected range; the CWH site has an SHMI of 76.08, the WMUH site 81.66. Overall the Trust SHMI is 79.5
	Year to date the Medical Examiners service have scrutinised 97% of all cases, typically within 1 working day of death. The successful introduction of the ME function within the Trust provides additional quality assurance and has supported the organisations approach to learning from death so as to better focus resource on those cases that are expected to provide the most learning opportunities.
	A two stage learning from death process has been introduced in October 2020; all in-hospital deaths will be screened for potential learning and no less than 30% of all cases will undergo mortality review and presentation to Specialty Mortality & Morbidity group.
	The outcome of mortality review has provided a rich source of learning; the resumption of the Trust wide review process during Q3 will support the organisations improvement objectives and improve assurance reporting to the committee.
KEY RISKS ASSOCIATED	The paused mortality review process impacting the recognition and response to learning from death.
FINANCIAL IMPLICATIONS	Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
QUALITY IMPLICATIONS	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	Deliver high quality patient centred care
DECISION/ ACTION	For noting.

#### Mortality Surveillance - Q2 2020/21

#### 1. Background

The organisations Learning from Deaths process was introduced in October 2016; this outlined the Trust's commitment to undertake case review for all in-hospital deaths (adult, child, neonatal, stillbirth, late fetal loss).

In response to increasing clinical demand and impact on staffing as a result of the covid-19 pandemic the organisations mortality review process was paused in April 2020. The following interim arrangements were introduced:

- All in-hospital deaths to be logged to the mortality module by the Medical Examiner's Officers
- Medical Examiners to commissioned to scrutinise no less than 80% of in-hospital deaths
- Where ME scrutiny identifies the potential for Trust learning specialty case review or clinical governance input to be sought
- Potential learning opportunities identified via Medical Examiner scrutiny to be reported to the Mortality Surveillance Group

#### 2. Amendment to the Trust's learning from deaths approach

Year to date the Medical Examiners service have scrutinised 97% of all cases, typically within 1 working day of death. The successful introduction of the ME function within the Trust provides additional quality assurance and has supported the organisations approach to learning from death so as to better focus resource on those cases that are expected to provide the most learning opportunities.

#### 2.1. Mortality review process

A two stage learning from death process has been introduced

**Level 1 review (Screening):** all adult, child, and neonatal in-hospital deaths to be screened by linked specialty consultant team and the Medical Examiners Office. The screening form (on datix) contains a series of statements that will be used to identify cases for more detailed review

Consultants within lead Specialty would identify:

- Significant concerns raised by the bereaved (yes/no)
- Unexpected death (yes/no)
- Potential for further learning (yes/no)
- That the patient had learning disabilities (yes/no)
- That the patient had been detained under the mental health act (yes/no)

The Medical Examiners Officer would identify:

- HM Coroner referral / inquest (yes/no)
- Significant concerns raised by the bereaved (yes/no)
- Unexpected death (yes/no)
- Potential for further learning (yes/no)

If a positive response to any of the screening questions is provided a more in-depth mortality review to be undertaken by the patient's clinical team will be prompted.

**Level 2 review (mortality review)**: All cases flagged by screening (level 1) will undergo mortality review using a generic template (on datix) and requiring the consultant team to discuss the case at Specialty mortality review group with escalation of CESDI grade 2 and 3 to Divisional mortality review and Mortality Surveillance Group.

#### 2.2. Review Targets

The Trust aims to undertake level 2 mortality review for no less than 30% of the organisations inhospital deaths. Where screening has not identified a sufficient percentage of cases Divisional triumvirates and the Mortality Surveillance Group will lead on the identification of cases that support understanding and learning from death within key areas, procedures, or diagnostic groups to ensure required cases are identified to meet 30% target.

#### 3. Relative risk of mortality

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

The Trust wide SHMI relative risk of mortality between June 2019 and May 2020 demonstrates that both sites have outcomes below the expected range; the CWH site has a SHMI of 76.08, the WMUH site 81.66. Overall the Trust SHMI is 79.5

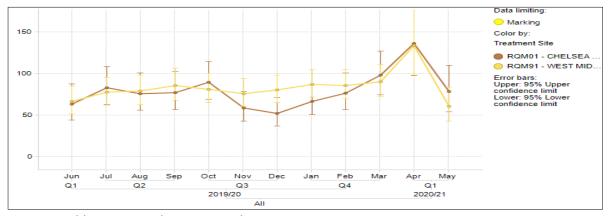


Fig 1: Monthly SHMI trend comparison by site

The data within figure 1 excludes deaths related to COVID-19, there is however a marked increase in the SHMI rate during April at the peak of the pandemic. Little significant variation between the Chelsea and Westminster Hospital (CWH) and West Middlesex University Hospital (WMUH) sites has been identified during this reporting period.

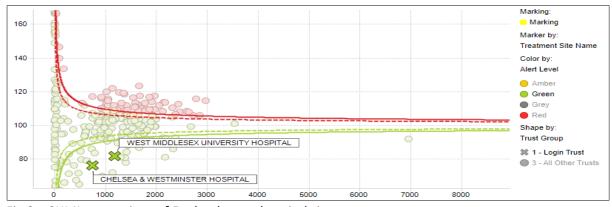
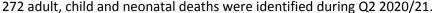


Fig 2 – SHMI comparison of England acute hospital sites

#### 4. Alarms

The overall relative risk of mortality on both sites is within the expected range, however, the Mortality Surveillance Group seeks further assurance by examining increases in relative risk associated with procedure and diagnostics groups. Where higher than expected relative risk linked to a diagnostic or procedure group is identified a clinical coding review is undertaken and where indicated comment from clinical team is sought. Reporting of 'alarms' from these groups recommenced in October 2020; outputs will be reported to subsequent sittings of the Quality Committee.

#### 5. Crude rate



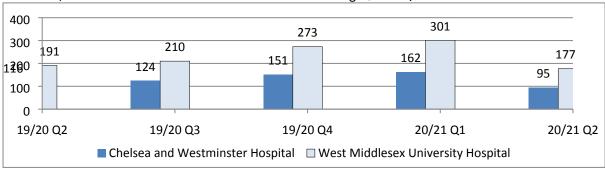


Fig 3: Total mortality cases logged to Datix by site and financial quarter

Crude mortality is the total number of deaths during a given time interval; a crude mortality rate can be calculated by dividing the number of deaths by the total number of patients within the hospital, the outcome is multiplied by 1000 to give the number of deaths per thousand patients.

Neither the total number of deaths nor the crude mortality rate for a hospital site can be used to compare the risk of mortality between sites or Trusts. This is because they are influenced by differences in population demographics, services provided and intermediate / community care in the surrounding areas. Therefore no two sites can be accurately compared using these metrics and instead the Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital-level Mortality Indicator (SHMI) are used to make comparisons of relative risk of mortality. Crude rates did however provide useful feedback during the initial COVID-19 epidemic between March and June 2020.

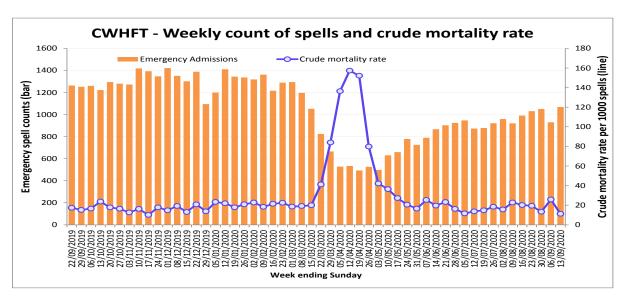


Fig 4: Crude Mortality—Weekly count of emergency spells and rate of mortality per 1000 spells Admitted patient numbers remain lower than pre-Covid, with activity falling dramatically from March, stabilizing at about 900 spells a week from late June. The weekly crude mortality rate appears within the normal, pre COVID-19 levels of variation.

The number of patient mortalities appears within the normal range when compared to the 5 year average (see Fig. 8). The number of deaths associated with COVID-19 is also now very low.

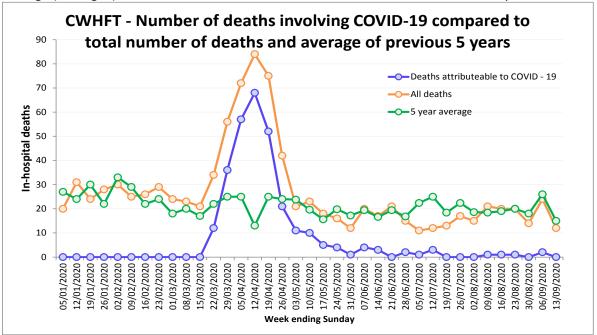
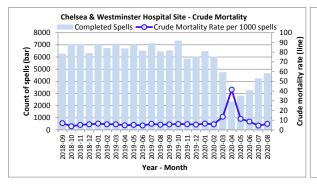
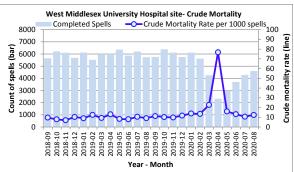


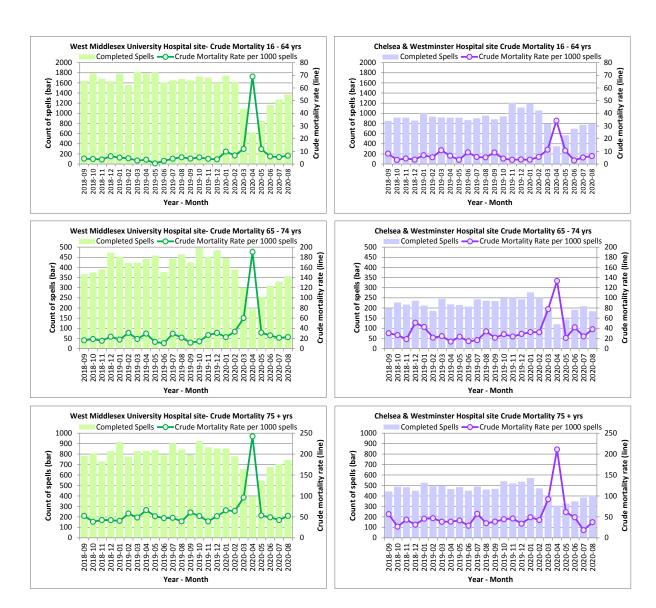
Fig 5: Weekly mortality compared to five year average.

The crude mortality rates (e.g. number of deaths vs. number of patients) between the two sites show great variance; this is primarily due to the difference in the number of elective and emergency admissions between the two hospitals.

When the crude mortality rates are compared using only adult emergency admissions the bias between the two sites appears to be reduced. The charts below shows the crude mortality rate at each site is similar (the line) but the number of completed hospital spells (the bars) are significantly higher at the WestMid site.







Improving relative risk of mortality has been experienced across both sites since March 2017. Within the London region there are only 3 acute Trusts with lower relative risk. The SHMI and HSMR provide an indicator of improving outcomes and safety that is evidenced at both sites; this position is monitored by the Mortality Surveillance Group.

#### 6. Conclusion

The outcome of mortality review has provided a rich source of learning; the resumption of the Trust wide review process during Q3 will support the organisations improvement objectives and improve assurance reporting to the committee.



# Chelsea and Westminster Hospital MHS

**NHS Foundation Trust** 

## **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.5/Nov/20
REPORT NAME	People and OD Committee KPI Dashboard
AUTHOR	Karen Adewoyin, Deputy Director of People and OD
LEAD	Sue Smith, Chief People Officer
PURPOSE	The People and OD Committee KPI Dashboard highlight's current KPIs and trends in workforce related metrics at the Trust.
REPORT HISTORY	Workforce Development Committee have reviewed a more in-depth, detailed version of the KPI's.  Executive Management Board 14.10.20
SUMMARY OF REPORT	The dashboard is to provide assurance of workforce activity across eight key performance indicator domains;
	<ul> <li>Workforce information – establishment and staff numbers</li> <li>HR Indicators – Sickness and turnover</li> <li>Employee relations – levels of employee relations activity</li> <li>Temporary staffing usage – number of bank and agency shifts filled</li> <li>Vacancy – number of vacant post and use of budgeted WTE</li> <li>Recruitment Activity – volume of activity, statutory checks and time taken</li> <li>PDRs – appraisals completed</li> <li>Core Training Compliance</li> <li>Volunteering</li> </ul>
	It also includes an update on the key work streams for Workforce and progress made during the month of September/October 2020.
KEY RISKS ASSOCIATED	The majority of KPI's have started to return to pre-COVID-19 levels
FINANCIAL IMPLICATIONS	Costs associated with turnover and sickness and the impact on staff of COVID-19
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability.
EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.

LINK TO OBJECTIVES	Be the employer of choice
DECISION/ ACTION	For noting.





# Workforce Performance Report to the People and Organisational Development Committee

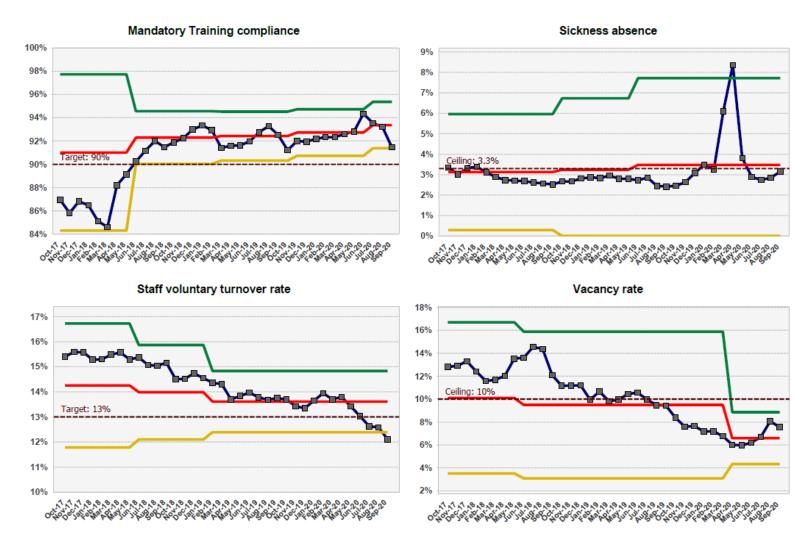
Month 06 – September 2020

# Statistical Process Control – Oct 2017 to Sep 2020





# WORKFORCE INDICATORS Statistical Process Control Charts for the last 36 months



#### People and Organisational Development Workforce Performance Report September 2020 Chelsea and Westminster Hospital Key Performance Indicators RAG Status This Month Last Month This Month Target / Trend Units **Hem** Last Year Ceiling Red Amber Green 1. Workforce Information ÷ 1.1 Establishment No. 6363.28 6,430.85 6,399.65 1.2 Whole time equivalent 5760.72 5912.57 Ϯ No. 5916.18 1.3 Headcount No. 6253 6388 6392 ₳ 1.5 Overpayments (Number) 54 26 30 No. 126,032.72 61,493.88 116,907.31 1.4 Overpayments (Costs). £ Φ. 2. HR Indicators 2.1 Sickness absence % 2.45% 2.85% 3.15% <3.3% ₳ Ť % 1.34% 2.2 Long Term Sickness absence 1.58% 1.48% 2.3 Short Term Sickness absence. % 1.10% 1.26% 1.67% 2.4 Gross Turnover % 18.12% 17.75% 17.45% <17% 2.5 Voluntary Turnover % 13.68% 12.59% 12.10% <13% 3. Employee Relations 3.1 Live Employment Relations Cases No. 176 93 103 <del>← →</del> 3.2 Formal Warnings No. 0 2 2 Ŧ 2 3 1 3.3 Dismissals No. 4. Temporary Staffing Usage 4.1 Total Temporary Staff Shifts Filled Nα. 14198 12019 12114 ₳ 4.2 Bank Shifts Filled No. 12565 11079 11118 ተ 4.3 Agency Shifts Filled Nα. 1633 940 996 4 Ŧ 5.1 Trust Vacancy Rate 7.55% % 9.47% 8.06% <10% 5.2 Corporate % 4.18% -10.14%-6.60%<10% ⇑ 5.3 Clinical Support Services 10.58% 12.18% <10% % 9.91% % 5.4 Emergency & Integrated Care 11.60% 9.35% 8.43% <10% 5.5 Planned Care % 7.86% 9.71% 7.28% <10% 5.6 Women's, Children and Sexual Health 9.91% 10.25% 8.72% <10% % 6.1 Offers Made Nα. 162 139 6.2 Pre-employment checks (days). Nα. 38.9 15.6 22.8 <20 ተ 8.54 8.02 9.34 6.3 Time to recruit (weeks). Nα. <9 ተ PDRs Undertaken (AfC Staff over 12 months) 7.1 Trust PDRs Rate (AFC Staff) 80.55% 26 90.51% 33.75% ≥90% 7.2 Corporate % 71.71% 33.13% 86.75% >90% 7.3 Clinical Support Services 96 76.77% 91.34% 90.73% ≥90% 7.4 Emergency & Integrated Care. % 86.24% 91.84% 90.53% ≥90% 7.5 Planned Care. % 80.84% 90.41% 87.43% ≥90%



7.6 Women's, Children and Sexual Health

96

81.75%

89.73%

87.24%

>90%



September 2020 SICKNESS									
Division	Sickness Abs.	RAG Status Ceilling <3.30%	Available WTE hours	Absence WTE hours	Episodes	Long Term (WTE hours)	% Long Term	Prev. Month	%+/-
Corporate	1.20%		19314.71	231.41	48	71.00	0.37%	1.13%	0.06%
Clinical Support	3.64%		28881.19	1052.10	221	371.96	1.29%	2.96%	0.68%
Emergency & Integrated Care	3.08%		48614.55	1497.89	233	857.72	1.76%	2.80%	0.28%
Planned Care	2.86%		30954.52	884.37	157	370.80	1.20%	2.39%	0.47%
Women's, Children and Sexual Health	3.85%		49918.77	1924.12	255	958.91	1.92%	3.81%	0.04%
Trust	3.15%		177683.75	5589.90	914	2630.39	1.48%	2.85%	0.30%

	Septer	mber 2020 Co	re Training		
Course	Last Month	This Month	Target	RAG Status	Trend
Core Training Compliance Overall	93%	91%	<90%		•
Theory Adult BLS	85%	82%	<90%		•
Practical Adult BLS	84%	80%	<90%		<b>+</b>
Conflict Resolution - Level 1	97%	96%	<90%		<b>+</b>
Equality & Diversity	96%	95%	<90%		<b>+</b>
Fire	91%	89%	<90%		•
Health & Safety	97%	95%	<90%		•
Infection Control (Hand Hygiene)	95%	95%	<90%		<del>←→</del>
Infection Control - Level 2	94%	93%	<95%		•
Information Governance	93%	93%	<95%		<del>←→</del>
Moving & Handling - Level 1	94%	92%	<90%		•
Moving & Handling - Level 2 Theory		82%	<90%		<b>↑</b>
Moving & Handling - Level 2 Patient	86%	83%	<90%		+
Safeguarding Adults Level 1	96%	95%	<90%		4
Safeguarding Adults Level 2	95%	93%	<90%		4
Safeguarding Adults Level 3	87%	86%	<90%		+
Safeguarding Children Level 1	97%	96%	<90%		+
Safeguarding Children Level 2	95%	94%	<90%		+
Safeguarding Children Level 3	87%	85%	<90%		Ψ

September 2020 Employee Relations						
Category	Metric	Number / %				
No of Disciplinary cases opened in month	Number	1				
No of current, live disciplinary cases	Number	6				
Length of Disciplinary cases	Days <60	48				
Total Disciplinary cases in year (from April 2	Number	12				
% BAME Disciplinary Cases in year	%	66%				
% BAME Disciplinary Cases in month	%	0%				
Exclusions - No. of live in month	Number	3				
Grievance - No. of live cases in month	Number	9				
Grievance – Average length of case	Days	45				
B&H cases - included in grievance numbers	Number	7				
Sickness - No. of cases in month	Number	80				
Long Term - sickness cases in month	Number	54				
Short Team - sickness cases in month	Number	26				
No. of Employment Tribunals (ET)	Number	8				
Managers having ER training (from April 20)	Number	20				
No. of informal queries (disciplinary process	Number	6				

September 2020 Vacancy / Bank and Agency Ratio on "Fill Rate"								
Division	Budgeted WTE	Staff in Post (WTE)	Vacancy (WTE)	Bank Usage (WTE)	Agency Usage (WTE)	**Total WTE Used	Budget minus Used WTE	RAG Status
Corporate	595.72	635.05	-39.33	28.88	5.00	653.16	-57.44	
Clinical Support	1098.63	964.85	133.78	122.80	2.00	1068.31	30.32	
Emergency & Integrated Care	1771.28	1621.92	149.36	209.25	14.95	1787.14	-15.86	
Planned Care	1114.31	1033.24	81.07	93.66	29.76	1127.94	-13.63	
Women's, Children and Sexual Health	1819.71	1661.12	158.59	123.13	17.13	1730.88	88.83	
TRUST	6399.65	5916.18	483.47	577.72	68.84	6367.43	32.22	

September 2020 Voluntary Turnover								
Division	Turnover	Prev Month	%+/-					
Corporate	12.54%	13.59%	-1.05%					
Clinical Support	13.91%	14.14%	-0.23%					
Emergency & Integrated Care	13.55%	13.75%	-0.20%					
Planned Care	9.88%	11.50%	-1.62%					
Women's, Children and Sexual Health	10.79%	10.80%	-0.01%					
TRUST	12.10%	12.59%	-0.48%					

Key to Sickness Figures						
Sickness Absence = Calendar days sickness as percentage of total available working days for past 3 months						
(days x ave FTE)						
Episodes = number of incidences of reported sickness						
A Long Term Episode is greater than 27 days						
**Total WTE Used Adjusted to account for staff currently on maternity leave & establishment adjustments	Ξ					

Chelsea and Westminster Hospital

NHS Foundation Trust

# People and Organisation Development Workforce Performance Report September 2020

#### Establishment, Staff in Post and Vacancies:

The Trust currently employs 6392 people working a whole time equivalent of 5917 which is 3.61 higher than August. This equates to 156wte more permanent members of staff than this time last year. There has been a decrease in the vacancy rate for September, 7.55% against the Trust ceiling of 10% and a significant improvement since the same time last year which was 9.47% The qualified nursing vacancy rate is 6.31% and remains one of the lowest in the country with a national median of 12.75%. The medical vacancy rate has decreased to 4.34% including staff recruited for COVID-19 and 4.74% not including additional recruits, which is quartile 2 in Model Hospital and national median of 7.43%. AHP (7.33%) S&T (7.10%) are also in line with the national median but AHP at this level sits in quartile 3. Vacancy rates have been impacted positively by COVID-19 additional recruitment, and the reason for the corporate vacancy rate being over established is due to the COVID-19 additional staff sitting in this cost centre.

#### Temporary Staffing:

Demand continues to rise month on month and we're now returning to the expected level of demand, albeit 12% lower than the same month last year. Our agency fill increased marginally (0.15%) compared to last month but we still used 500 fewer agency shifts compared to September last year. Shifts requested for COVID related reasons reduced by 11.5% in September but are expected now to increase. We continue to work closely with the divisions to reduce Medical spend; the Trust now only utilise agency Drs who are supplied via the Direct Engagement employment model, enabling the Trust to make a VAT efficiency. Additionally, October will see the launch of the North West London collaborative Bank for Medics, which enables Bank staff to pick up shifts and work at any of the acute Trusts in the ICS via Patchwork.

#### Core Training Compliance :

Overall compliance dropped from 93% to 91% this month although still above the Trust target of 90% (IG remaining at 93% against a national target of 95%). Moving & Handling and Basic Life Support – Practical, have both seen a drop of -3%

This is due to staffing issues and social distancing requirements that continue to effect the number of staff who can attend practical training. Individual reminders continue to be sent to staff to try and minimise the impact of this.



#### Sickness Absence:

The Trust's sickness rate has increased to 3.15%, which is higher compared to last month due COVID19 related challenges. Our sickness target of 3.3% has been breached three times during the last 25 months peaking in April '20 due to Covid-19 . This compares favorably with peers and the Trust remains in the lower quartile on Model Hospital. The three most common reasons for sickness were Anxiety/depression/other, Chest & respiratory problems which include Covid-19 related absence and other musculoskeletal problems. The top sickness reason for the number of days lost is anxiety/depression/other and it is also the highest reason for both number of episodes. Anxiety/depression over the last year has resulted in 17,000 days lost and a cost of £1.5 million and is the reason why there is a significant focus on healthy mind as part of the health and wellbeing 3 year plan. The ER team have agreed a targeted approach with the division to review this and plan accordingly. Sickness levels are monitored daily through GOLD and NWL.

#### Staff Turnover Rate: Voluntary

Voluntary turnover has decreased to 12.10% and is below the Trust target for the third consecutive time and lowest it's been in recent years. The third highest reason for leaving (preceded by promotion and relocation) is work/life balance. The recently approved health and well-being strategy has a key focus on solutions to help all our staff enjoy a good work -life balance, such as a better availability of flexible working options, offering a backup care service for staff who have children or care for elderly or vulnerable adults, as well as a nursery partnership to enable staff to afford childcare in London. In addition, the Trust has established a Staff Retention Group which had its first meeting in October. The group reporting into the Workforce development Committee and comprises of senior managers representing different divisions and staff groups. The group will meet bi-monthly with immediate focus on working with Timewise to achieve a Timewise flexible working employer accreditation and improving the quality of new starter and leaver data, as well as supporting local initiatives specific to staff groups and specialties.

#### **PDRs**

The PDR process has been updated for April 2020, with the new PDR process moving away from the window based system to staff pay step PDR system. The PDR rate for August was 88.75%, decreased by 1.76% from the previous month. All managers have been sent details of when staff PDR's are due and the new process. This does mean for reporting purposes for this year as staff's PDR dates are re-aligned to the month prior to their pay step that some PDR dates will be elongated if their original PDR date was prior to the date which has improved compliance figures in month. All those with pay steps in August will need to have managers confirmation of performance before they can go through their pay step. All other staff will remain automatic until next April 2021.

Chelsea and Westminster Hospital MHS

**NHS Foundation Trust** 

# People and Organisation Development Workforce Performance Report September 2020

#### Race Equality Plan & Inclusion:

During October the LGBTQ+ staff network held their first meeting with 12 members of staff joined who joined discussions along with a representative from Stonewall. The meeting reviewed the proposed terms of reference, future meeting dates and the proposed selection process for the chair/co-chairs and other network officers. October is Black History Month and in partnership with the CW+ charity the Trust recorded and published video messages from staff and personalities played on the Trust intranet and the CW+ video platform. CW+ funded the production of pop up banners and booklets showcasing historical black figures which was also published throughout October on the Trust intranet as well as a Special Black History Month Bulletin. In addition ISS laid on menus in the canteens to celebrate Black History. Three dates are arranged in October as Disability Focus Groups meeting to hear the experiences of staff who have a disability within the organisation and understand how they can be better supported as part of the work to launch a staff Disability Network.

#### Leadership and Development:

We have had 22 delegates attend 'New managers Induction'. To date 222 staff have attended 'Management Fundamentals' courses since it launched in January 2020. The Emerging Leaders Programme (Cohort 14) has 14 delegates. The programme has been revised to incorporate lessons learnt from the pandemic and Inclusive Leadership. The 4 months programme, have sessions facilitated virtually and face to face, to date 1562 staff have completed the programme. The Top leaders programme and the Senior Leaders programme have commenced. Progressive work is being conducted on the 'Management Fundamentals' and 'Emerging Leaders' programme to make it accessible virtually where possible.

#### Health and Wellbeing:

Recruitment to wellbeing champions has started and expressions of interest have been increasing from staff wishing to take up the role. It is hoped that we can attract 50 staff across each hospital site, to include all professional groups. The first wave of responses have been received and are currently being screened ahead of the first Champion training at the end of October. The Mental Health First aid programme launched, with 25 staff being trained in the first cohort. In total c80 staff have now signed up to volunteer for the programme. Promotion of World Mental Health Day through the development of infographic as part of the winter wellbeing series, where infographics will be published to promote self care, health promotion and to promote key wellbeing messages. Other infographics published this month include Back Talks and Cholesterol Facts. Back up care partnership will be launched as part of the benefits package in October. Staff will be entitled to up to 10 sessions/year. The scheme offers emergency short notice access to both child care (including nurseries, child minding), school holiday cover and elder care choices.

#### Apprenticeships:

We currently have 132 Apprentices on programme and 20 have achieved their qualifications. The Trust is delivering 31 different types of Apprenticeship (17 Clinical and 14 Non-Clinical) across Emergency and Integrated Care, Planned Care, Women's Services, Neonatal, Children's & Young People Services, HIV/GUM, Clinical Support and Corporate. Our Apprenticeships range from Level 2 (entry level) to Level 7 (MSc Level) and is highly embedded in our employees' career pathway. Apprenticeships are now heavily incorporated with the Trust recruitment for support workers and every department is highly encouraged to explore this process of recruitment.





# People and Organisation Development Workforce Performance Report September 2020

#### Transactional Plan:

The recruitment team has been working collaboratively with other Trusts across the sector to embed the 'growing the workforce' theme of the NHS people plan within the Trust. Over the last few months there has been focus around engaging with the NHSI/E central teams to streamline and expand our international recruitment processes, attract more people to the NHS through widening workforce supply routes and developing MOUs and digital passports to facilitate ease of movement and temporary NHS to NHS staff transfers.

The ER Team have continued to see an increase in activity, in particular with the number of grievance and MHPS cases received in month. The team triangulate the grievance cases with FTSU concerns on a monthly basis, to identify key themes, trends and areas of concern. Where applicable, the team are employing a proactive, resolution focused approach with the management of these cases and have increased the use of mediation and facilitated conversations as a means to resolve conflict. The ER team will be introducing a programme to train in house mediators soon and the project to introduce the Resolution Framework started the data analysis phase in October.

#### Volunteers:

There were 90 active volunteers in September, who contributed 1379 hours of volunteering across both hospital sites. There was a downward trend both in terms of the number of active volunteers week to week and the number of hours. Volunteers who joined for the Covid response have returned to work or study. New roles are coming online and it is difficult to meet the growing demand coming from different departments. Recruitment is underway on both sites with a focus on the Responder and Ward Helper roles. The service is assisting other partners to restart their volunteering services; this includes Macmillan, Medicinema and the Chaplaincy. A significant number of volunteers who paused their placements during the crisis are now returning to volunteer; upon completion of a health risk assessment. There have been considerable delays to deployment due to volunteers awaiting clearance through Occupational Health. The changing Covid risk is challenging and the service is creating a deployment plan for volunteers for each of the risk tiers that London might enter over the coming weeks.

#### Organisational Change

The HR team continue to support a number of organisational change programmes, 8 live at present within the Trust including a some complex TUPE transfer, organisational restructures, new ways of working resulting from changes to services. This currently includes activity within IT, Corporate Nursing, Clinical Site Team Operations which overall almost 100 staff. Across the NWL HR work-streams there is currently work underway to agree a NWL change protocol and a London wide has also been agreement to facilitate staff movement.









**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.6/Nov/20
REPORT NAME	Nursing & Midwifery Revalidation Annual Report
AUTHOR	Melanie van Limborgh, Deputy Director of Nursing
LEAD	Pippa Nightingale, Chief Nursing Officer
PURPOSE	This paper is presented to provide an overview of the process of revalidation in the Trust and the business as usual processes in place.
REPORT HISTORY	N/A
SUMMARY OF REPORT	The Nursing and Midwifery Council (NMC) launched revalidation with the first nurses and midwives to revalidate were those with a renewal date of 30 April 2016.  The Trust developed and delivered a range of mechanisms to prepare its nurses, midwives and managers for the requirements of revalidation. The report highlights that revalidation is the responsibility of each individual registrant in the Trust and the oversight for Nursing and Midwifery revalidation transferred to Divisions during 2016.  Reports are provided by the Workforce Team on a monthly report basis for managers to review revalidation that is imminently due in their staff groups. Other procedures and structures are in place that has embedded revalidation as a business as usual activity.
KEY RISKS ASSOCIATED	There are low risks for registrants not being able to revalidate as there is a notification process in place in the Trust and via the NMC. If a registrant fails to revalidate they would be unable to perform duties which has a risk to staffing in the relevant area.
FINANCIAL IMPLICATIONS	There is a financial implication of bank or agency staff to cover any duties of a lapsed registrant if this is appropriate.
QUALITY IMPLICATIONS	On the limited occasion a registrant does not register bank or agency staff may need to cover a position temporarily.

EQUALITY & DIVERSITY IMPLICATIONS	None identified.	
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Be the employer of choice</li> </ul>	
DECISION/ ACTION	For information.	

#### **Nursing & Midwifery Revalidation Annual Report 2020**

#### 1.0 Summary

This paper provides an update on revalidation with the Nursing and Midwifery Council, (NMC) and the process that is in place for registered nurses and midwives in the Trust.

This paper focuses on national and Trust progress with revalidation and the process the Trust used to support the introduction of revalidation for nurses, midwives and managers in 2016 and its move to the business as usual processes currently used to oversee revalidation in the organisation.

#### 2.0 Introduction

From April 2016 the Nursing and Midwifery Council (NMC) introduced revalidation for all registered nurses and midwives (and now to include nursing associates). This had formerly been in place nationally for medical staff via the General Medical Council, but was a new development for nurses and midwives.

Revalidation is the process that all nurses and midwives in the UK need to follow to renew their registration with the NMC every three years, (aside of paying a registration fee every year). The purpose of revalidation is to strengthen the regulatory framework for nurses and midwives, thereby improving public protection by ensuring that nurses and midwives continue to be fit to practise safely and effectively throughout their careers.

Revalidation was also designed for registrants to encourage reflection on the role of the NMC Code and demonstrate 'living' the standards set out within it. The first nurses and midwives to revalidate were those with a renewal date of 30 April 2016 and this was relevant to every registrant in every organisation in the UK. The NMC's requirements for revalidation are detailed in **Appendix 1**.

#### 3.0 National Progress with revalidation

With the launch of revalidation, the NMC published a range of guidance and education materials to support nurses, midwives, their managers and employers. All nurses and midwives received a direct mailing from the NMC and the Trust to help them prepare for revalidation. All NHS Trusts were asked initially to provide quarterly updates to the Trust Development Authority or Monitor regarding their project plan and readiness for revalidation. This was completed and is no longer required.

It should be noted that there is a significant difference between Nursing and Midwifery revalidation in comparison to Medical revalidation. Nursing and Midwifery revalidation was launched by the NMC as a registrant responsibility. Therefore this report highlights the measures that have been taken to support registrants to meet their revalidation requirements.

The NMC reported that the introduction of revalidation was generally successful, with the majority of nurses and midwives revalidating as required. A small number of applications can be granted an extension or may be subject to additional checks by the NMC, but this is dealt with directly with the registrant.

To add to this and for quality assurance purposes each year, the NMC selects a sample of nurses and midwives to provide further information about their revalidation application. This process is known as 'verification'. If selected, the confirmer (a health care professional who approves the portfolio the registrant has to submit to revalidate) and registrant will be required to complete an online form.

As part of the NMC's revalidation process they instituted a notification to registrants of their upcoming revalidation in the revalidation year alongside the NMC requirement requests for yearly fee. The NMC now contacts each registrant to highlight the responsibility to pay yearly fees and revalidate in advance of the relevant deadlines. It remains the responsibility of the registrant to revalidate within the NMC's timescales. Since the initial revalidation launch the NMC has provided good resources to support registrants which are available on their revalidation website pages.

#### 4.0 Trust progress with revalidation

The Trust introduced revalidation led by a project management process under the responsibility of the Chief Nurse and Director of Nursing in post at the time. A Lead Nurse for Revalidation acted as Project Manager and a dedicated Steering Group was in place including representation from the relevant unions. Reporting to ensure governance processes were observed was directed into the People and Organisation and Development Committee. The Steering Group completed its work at the end of the project and the oversight of revalidation was transferred into business as usual processes led by the Divisional teams by the close of 2016.

Prior to launch the Trust provided over two hundred face to face revalidation awareness sessions over the period of nine months leading up to just after April 2016. This included a variety of Trust designed 'takeaway' resources to assist registrants in preparing for revalidation. In addition, a Trust built revalidation intranet page was made this available for all registrants in the Trust. This revalidation site also links to the resources on the NMC website. Trust branded portfolio templates were also made available for staff members to download and use to compile their portfolios.

This intranet page is updated annually by the Corporate Nursing team via the Deputy Director of Nursing (Quality). The link is available below:

http://connect/departments-and-mini-sites/nursing-midwifery-revalidation/

#### Professional Development Review (PDR)

The process for revalidation was incorporated into the Trust's professional development review (PDR) document and the Trusts Appraisal Policy and Procedure in 2016. This embedded the opportunity for the registrant's manager to oversee progress in place with each member of their staff each year. Revalidation still remains, however, the requirement of each registrant in the Trust to complete on time in line with the requirements of the NMC and to demonstrate these during PDR.

#### Workforce Report

At the start of the Trust revalidation project a regular monthly report was established and is still distributed to ward and department managers, matrons and Divisional Nurses to inform them of the registrants due for revalidation and outlines revalidation dates three months in advance. This process has now become embedded in practice and the revalidation process is led by departmental manager and Matrons to oversee the upcoming revalidation required.

It should be noted that the Trust has a number of registered nurses in non-nursing roles where a nursing registration is not a pre-requisite. Staff wishing to maintain their NMC registration, who work within these roles can utilise the same resources as the registrants working within the Trust and via the NMC.

Table 1. Registrants in Chelsea and Westminster Hospita	I NHS Foundation Trust - October 2020
Nurses or midwives across all staff groups on the NMC register	2444
Nurses or midwives across all staff groups on the NMC register working in clinical roles and required to revalidate	2401
Nurses or midwives across all staff groups in the Trust on the NMC register due to receive revalidation by the end of October for the month of September 2020	17
Nurses or midwives for which <b>registration status is not confirmed</b> . Reported likely to incomplete data or duplicate reporting.	12 registrants - further clarification from Divisional leads required: 7 Emergency and Integrated Care 3 Planned Care 2 Women's and Children's, P Patients, Dermatology, HIV/Sexual Health

**Table 1** above provides an overview at a point in time of reporting. The report compiled by the workforce team on a monthly basis as noted, this permits the Divisional teams manage the revalidation status of their teams so they are sighted on upcoming and lapsing registrants.

#### Trust procedure for checking registration/qualification documents

Revalidation requirements were also included in the Trust's procedure which outlines nurses and midwives responsibilities. If registration lapses as a result of failure to complete revalidation, the member of staff will be subject to the principles of the Trust's Registration procedure.

#### Temporary staffing

To provide assurance that revalidation is in the contract with bank and agency providers the Staff Bank also undertakes checks on bank staff and the external agency providers are also required to provide the Trust with information about how they are supporting their staff with revalidation.

#### Internal audit

At the conclusion of the Trust's revalidation project the Chief Nurse in post commissioned an internal audit to examine the robustness of the Trust's approach to revalidation. This was undertaken by KPMG during 2016 to review the process that had been established. The audit reported a grading of 'significant assurance'. The one recommendation provided was that there could be the addition of a Divisional process to oversee progress of registrants revalidating in each Division.

#### 5.0 Staff feedback and other themes

Feedback from Trust staff who have revalidated since 2016 has been positive. Overall staff felt well prepared and did not find the process difficult and reported the direct 'hands on' awareness sessions helped demystify the revalidation process. Although there was uncertainty about revalidation before and just at the time of the first registrants to revalidate the enquiries made to the Corporate Nursing Team have diminished.

Although there are no ongoing awareness sessions for revalidation the Trust as the process is now embedded after 3 years, the Trust promotes different educational and learning opportunities relevant to revalidation that can provide evidence for professional portfolios. As well as the intranet and NMC website pages, staff is encouraged to approach their line managers or the Practice Development Teams for on-going support. There appears to have been no increase in the number of nurses or midwives choosing not to renew their registration as a direct result of revalidation.

#### 6.0 Summary

In 2016, the Nursing and Midwifery Council launched revalidation with the first nurses and midwives to revalidate were those with a renewal date of 30 April 2016. Chelsea and Westminster have developed and delivered a range of mechanisms to prepare its nurses, midwives and managers for the requirements of revalidation. The oversight for Nursing and Midwifery revalidation transferred to Divisions as normal business activity during 2016.

#### 7.0 Recommendations

This paper has been presented to update the People and Organisation and Development Committee of the revalidation process and its progress in the Trust since the revalidation requirements were put in place by the NMC. The report highlights that revalidation is the responsibility of each individual registrant in the Trust. The oversight for Nursing and Midwifery revalidation transferred to Divisions as normal business activity and from the autumn of 2016 reports are provided by the Workforce Team's monthly report basis to aid leads to review revalidation that is imminently due in their staff groups.

Melanie van Limborgh Deputy Director of Nursing, October 2020

### Appendix 1

### The NMC's requirements for revalidation

Requirement	Supporting evidence
450 practice hours for each registration	Maintain a record of practice hours completed, including:
Dual registration (e.g. nurse and midwife) requires 900 practice hours7	<ul> <li>dates of practice</li> <li>the number of hours undertaken</li> <li>name, address and postcode of the organisation</li> <li>scope of practice</li> <li>work setting</li> <li>a description of the work you undertook,</li> <li>evidence of practice hours</li> </ul>
35 hours of continuing professional development (of which 20 must be participatory)	<ul> <li>Maintain accurate and verifiable records of CPD activities, including:</li> <li>the CPD method (examples of 'CPD method' are self-learning, online learning, course)</li> <li>a brief description of the topic and how it relates to your scope of practice</li> <li>dates the CPD activity was undertaken</li> <li>the number of hours and participatory hours</li> <li>identification of the part of the Code most relevant to the CPD</li> <li>record evidence of the CPD activity</li> </ul>
Five pieces of practice-related feedback	Notes on the content of the feedback and how it was used to improve practice. This will be helpful to use when preparing reflective accounts. Notes must not include any personal data.
Five written reflective accounts	Five written reflective accounts that explain what is learnt from the CPD activity and/or feedback and/or an event or experience in practice, how it changed or improved work as a result, and how this is relevant to the Code.  Accounts must not include any personal data.
Reflective discussion	A reflective discussion form which includes the name and NMC PIN of the NMC-registered nurse, midwife or nursing associate that the registrant had the discussion with as well as the date of the discussion.  The discussion summary section must not contain any personal data
Health and character	The registrant must make a declaration as to their health and character as part of your online revalidation application.
Professional indemnity arrangement	Evidence to demonstrate that the registrant has an appropriate indemnity arrangement in place. This must be highlighted as if the indemnity arrangement is through the employer, membership of a professional body or through a private insurance arrangement. If the indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, the registrant will need to record the name of the professional body or provider.
Confirmation	A confirmation form signed by the confirmer.





**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

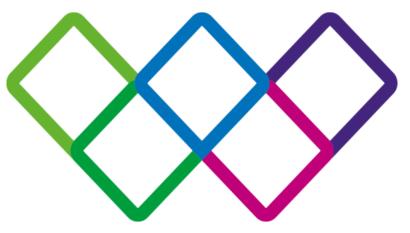
**PUBLIC SESSION** 

AGENDA ITEM NO.	3.7/Nov/20
REPORT NAME	Digital Programme Update
AUTHOR	Bruno Botelho – Director of Digital Operations
LEAD	Rob Hodgkiss – Deputy Chief Executive Kevin Jarrold – Chief Information Officer
PURPOSE	The purpose of the paper is to provide the Trust Board with an update on the Cerner Electronic Patient Programme and other digital programmes.
REPORT HISTORY	Executive Management Board 14.10.20
SUMMARY OF REPORT	As attached.
KEY RISKS ASSOCIATED	The main risks associated with the implementation of a complex EPR solution have been addressed or mitigated.
FINANCIAL IMPLICATIONS	
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Be the employer of choice</li> <li>Delivering better care at lower cost</li> </ul>
DECISION/ ACTION	For noting.



# **Public Trust Board Update**

# **Digital and Innovation Programme**



# Cerner Electronic Patient Record (EPR)

- Phase 3 (last phase of the initial Cerner deployment project ) completed in **June 2020** 
  - Chelsea and West Midd Hospitals now using same EPR system (same as Imperial College NHS Healthcare Trust)
- Next steps
  - Replace Order Comms at West Midd Hospital —to be completed by April 2021
    - Current system is out of date and plan is to move to ordering using Cerner
    - Optimize and support adoption of the relative system across clinical and non clinical teams





# **Other Digital Solutions**

- Improvements made on both Trust and Public websites to engage staff and inform patients of initiatives / platforms available to enhance their care.
- Patients adoption of Care Information Exchange (patient online platform to access their own records ) is increasing with over 10,000 Trust patients now registered (60,000 across North West London)
- All patient appointment correspondence is now offered electronically c.70% uptake from patients. If patients do not access via the link within 3days, the letter is automatically posted by normal mail.
- We have upgraded our Radiology Information System enabling clinicians better access and support on-going integration within North West London.
- **Continue to support patients and clinicians** during the pandemic by strengthen our offering of video consultations (including allowing patients to send us videos of their conditions), **improve communication** with a better text messaging and improve formatting of the patient correspondence



## **Future Projects and Vision**

### Innovation at Chelsea & Westminster Hospital

### The Vision



A modern, dynamic environment for multi-disciplinary clinical teams to work together to manage patients:

- · Triage referrals & existing lists
- Triaging + booking of Same Day Emergency Care (SDEC)
- · Clinical reviews (FU management)
- · Supporting & reporting to primary care clinicians
- · Comms with hospital colleagues
- Outcoming

Supported by user first IT, which brings data from across the ICS together to be used to deliver first class care

### **Used by Patients and Clinicians**



Clinical teams have tools to manage patients remotely and decide next steps

- Triage
- Scheduled virtual/F2F booking
- Patient initiated virtual/F2F bookings
- · Follow up management
- · Remote monitoring symptoms
- PROMs
- Discharge

Patients have access to the support they need, when they need it

- · Online advice and guidance
- · Appointment booking and access to SDEC
- · Virtual consultations



DrDoctor

### Managed and Monitored by operational teams



- Admin team managing patient tracking lists, down to the level of individual patients
- Statistics on cohorts of patients to assess performance and optimise
- · Live supply and demand visibility
- Dynamic deployment of patients to pathways automation of patient journeys
- Unifying process across the ICS, elevating the quality of care
- Build and surface your data set, increasing understanding of population health, and building the platform for machine learning and artificial intelligence driven optimisation

# **Additional Information / links**

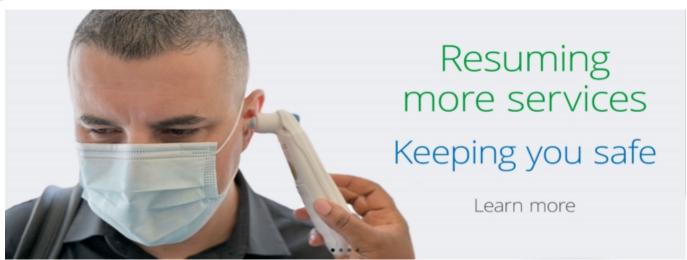
Trust Public Website: <a href="https://www.chelwest.nhs.uk/about-us/digital-solutions">https://www.chelwest.nhs.uk/about-us/digital-solutions</a>

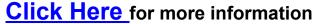
Our Digital Letters explained : <a href="https://vimeo.com/464954352">https://vimeo.com/464954352</a>

Your DrDoctor access link : <a href="https://my.drdoctor.co.uk/login">https://my.drdoctor.co.uk/login</a>

Your Care Information Exchange portal:

https://my.patientsknowbest.com/?team=cwhft\_cie









# Chelsea and Westminster Hospital MHS

**NHS Foundation Trust** 

### **Board of Directors Meeting, 5 November 2020**

**PUBLIC SESSION** 

AGENDA ITEM NO.	3.8/Nov/20			
REPORT NAME	Board Assurance Framework – Q3			
AUTHOR	Serena Stirling, Director of Corporate Governance			
LEAD	Serena Stirling, Director of Corporate Governance			
PURPOSE	To present the latest iteration of the Board Assurance Framework (BAF) for review and discussion			
REPORT HISTORY	CEO Cabinet 21.09.20 Executive Management Board 30.09.20 Audit and Risk Committee 21.10.20 Finance and Investment Committee 28.10.20 People and OD Committee 28.10.20 Quality Committee 03.11.20			
SUMMARY OF REPORT	The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks, and also enable the Board to gain assurance about the effectiveness of these controls. The BAF is monitored through the Board subcommittees on a quarterly basis, and the full Board on a bi-annual basis.			
KEY RISKS ASSOCIATED				
FINANCIAL IMPLICATIONS				
QUALITY IMPLICATIONS	The document sets out the key strategic risks facing the organisation including the financial and quality implications			
EQUALITY & DIVERSITY IMPLICATIONS				
LINK TO OBJECTIVES	<ul> <li>Deliver high quality patient centred care</li> <li>Be the employer of choice</li> <li>Delivering better care at lower cost</li> </ul>			
DECISION/ ACTION	For noting.			



#### **Board Assurance Framework – Q3**

#### Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks, and also enable the Board to gain assurance about the effectiveness of these controls. The BAF is monitored through the Board sub-committees on a quarterly basis, and the full Board on a bi-annual basis.

Since the September 2020 Board mid-year review of the BAF, and Board discussions on strategic risks following the first surge of the Covid-19 pandemic, the BAF has been reviewed and updated by the Executive Risk Owners, and reviewed by Executive Management Board. All of the individual risks and controls, means of assurance and any actions required have been reviewed to address any gaps in the controls, aimed at ensuring a consistent approach to the articulation of risks, controls and lines of assurance.

The risks are set out at two levels of increasing detail in the following sections of the report:

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

The BAF now comprises of eight risks, seven of which are open and one which has been closed in September 2020. Following the implementation of the Electronic Patient Record (Risk 7), a new risk has been identified with respect to the transformation capability and sustainability of the Digital Programme (Risk 8). The need to further improve patient experience has been identified in Risk 2 (Quality).

The Committee is asked to review and discuss the content of the paper, and consider whether it aligns to current and emerging risks, informing the next iteration BAF and future Board agendas.

### 1. Board Assurance Framework – Summary Matrix (Q3 2020)

				Likelihood		
		Rare	Unlikely	Possible	Likely	Almost
		1	2	3	4	Certain 5
	Cat					
	5					
	Major 4		2 3	6 7		
Impact	Mod 3			5		
	Minor 2					
	Negligible 1					

#### **Key Risks**

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

#### **Key: Control Assurance levels**

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

#### 2. Board Assurance Framework – Controls and Assurance (Q3 2020)

Board.

BAF Risk 1: Failure to deliver the NWL Health & Care Partnership (HCP) System Recovery Plan and build a sustainable portfolio of outstanding acute and specialised **Executive Owner:** services; consolidated across NWL (and beyond); leading to improved care and patient experience. **Chief Executive** Cause(s): No/partial delivery in NWL Provider Board back office support programmes No/partial delivery in NWL Provider Board clinical standardisation programmes • Insufficient progress with ICHT Joint Transformation Programme Failure of CCG consolidation and fragmentation of Commissioning Intentions • The system does not have appropriate management or governance arrangements in place to support the delivery of joined up, effective and efficient services across NWL. Impacting on: The Trust's ability to support growth in activity, with the impact on performance and quality of care • The Trust's ability to implement new models of care and the resulting impact on the availability and quality of services The Trust's freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance NB Extreme risk on Trust Risk Register is the continued growth in Non Elective activity impacting quality, safety and performance. Net (Current) risk score: Target risk score (risk appetite) **Risk Domain** Gross risk score Quality and Use of Resources  $4 \times 4 = 16$  (Extreme) 3x4 = 12 (High) 2x3 = 6 (Moderate) Strategic objective CQC Domain **Assurance Committee** Date of last review by Committee: Deliver better care at lower cost Well-Led Trust Board / Finance & Investment Board -03/09/20Finance and Investment Committee -Committee 30/07/20 Actions to further enhance risk management Current controls and assurance Key controls in place to address risks Means of assurance Action required to close any gaps in Action owner Action review date controls and assurances 1.1 **Programme Reports** CEO Oct 2020 A NWL STP Chair has been appointed. Delivery against NWL System Recovery Plan is Deep Dive Reports **NWL ICS System Recovery programmes** overseen by NWL System Recovery Board. Progress is also monitored through the NWL Provider Board. Both are chaired by the CWFT CEO as the SRO for the NWL ICS. 1) Programme of Care The CWFT Deputy CEO and CNO are members of the ICS Executive Team 2) Contract and Operating Plan 1.2 **NWL Clinical and Care Strategy** CEO Oct 2020 Ensure resources deployed to support CW Revised ICS Governance Structure now in place to support delivery of the key the **Programme Reports** Executive Directors leadership on major NWL Health & Care Partnership programmes and strategy. CW Directors have lead work programmes and aligned with **Deep Dive Reports** operational and relational roles for many of these programmes. Divisional business plans Joint Service Transformation Plan (high level) Ensure trust recovery plans build on NWL CEO Oct 2020 Joint programme of work with Imperial College Healthcare Trust in place Joint Programme update reports **CRG** Leadership underpinned by Memorandum of Understanding and overseen by Joint Executive **NWL Clinical Reference Groups** Ensure ICHT and CWFT lead on deploying

full capacity to support NWL recovery

BAF Risk 2: Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards Cause(s):

**Executive Owner: Deputy Chief Executive / Chief Nurse** 

- Governance structures not in place or ineffective
- Lack of alignment on priorities and plans across the organisation
- Poor adherence to policies and guidelines
- Quality of information does not support effective decision making
- Cerner EPR not implemented effectively (see Risk 7)
- Emergence of Covid-19 pandemic

- The ability to deliver the best patient experience and clinical outcomes
- . The Trust is subject to regulatory action and possible fines because it is not able to demonstrate compliance with relevant standards e.g. CQC, Health & Safety, GDPR
- The Trust is unable to demonstrate compliance with Single Operating Framework and falls below the standards set by our commissioners, regulators and those we set for ourselves including 4h A&E access, 18w RTT and Cancer standards
- The Trust does not make the most effective use of its resources
- The loss of reputation as a result of the above

Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk	appetite)
Quality	3 x 5 = 15 (Extreme)	2x4= 8 (Moderate )	1x4 = 4 (Moderate )	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Deliver high quality patient centred care	Well-Led	Quality Committee / Audit & Risk Committee	Audit & Risk Committee – 24/07/20 Quality Committee – 01/09/20	
Current controls and assurance	Ac	tions to further enhance risk management		
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
2.1 Establish Covid-19 Risk Register which includes infection control, PPE and FIT testing	Covid-19 Risk Register Report to Quality Committee and Trust Board		Chief Nurse	October 2020
2.2 Embedded top down and bottom up annual business planning process ensures alignment across strategic objectives and quality, financial and operational plans. Plans are signed off through Executive Management Board, the relevant Board Committee and Trust Board.	Annual Quality Priorities and Plans Annual Operating and Financial Plans	2020/21 business planning process due to complete in Q4 2019/20, however, due to emergence of Covid-19 pandemic and modifications to national financial management, this has been paused and will be established for 2021/22	Chief Financial Officer	January 2021
2.3  Maintain Quality Impact Assessment (QIA) process to ensure any quality risks associated with proposed service changes and financial improvement plans are effectively mitigated, and a Equality Impact Assessment is integral to this.	Risk matrix and mitigation output	QIA process applied to all Improvement opportunities	Chief Nurse/Medical Director	March 2021
2.4 Maintain and monitor medical staff appraisal and revalidation process	Annual Medical revalidation report	Quarterly meeting with GMC Liaison officer and quarterly GMC returns made.	Deputy Medical Director	March 2021
2.5 Completion of CQC Board Assurance Framework for Covid-19 Infection Control	Assurance report to Quality Committee and Trust Board		Chief Nurse	Compete – July 2020

2.6 Established Recovery Board for the Trust, and lead and engage with NWL Recovery Groups to ensure partnership working	Monthly Recovery Board reports to Executive Management Board, sub committees and Trust Board. NWL Recovery reports to Trust Board		Deputy CEO	Complete - March 2020
2.7 Established Board Governance structures and processed in place to monitor all relevant national and local quality, performance and regulatory standards including:	Patient experience, serious Incident , complaints and mortality surveillance reports Integrated Quality &Performance report	CQC inspection due in Q3 2019/20	Chief Nurse	Complete - February 2020
<ul> <li>Integrated Quality &amp;Performance report incorporating national quality, performance and financial standards monitored through Quality Committee and Trust Board</li> <li>CQC registration requirements monitored through Clinical Effectiveness Committee. CQC action plan monitored through Quality Committee</li> <li>Legal function, compliance and outcomes monitored at Executive Management Board and reported to Quality Committee including evidence of learning</li> <li>Annual internal audit programme agreed and monitored through Audit and Risk Committee</li> </ul>	National survey reports and action plans Annual legal report Clinical audit reports Internal and external audit reports NHSE/I Provider Oversight Meetings CQC self-assessment and Inspection reports Embedded quality assurance system Ward accreditation Deep Dives Benchmarking information	Annual self-evaluation of Board Committee effectiveness	Company Secretary	Complete – January 2020
<ul> <li>National patient experience surveys and in house PREMS patient feedback.</li> </ul>		National patient survey results	Chief Nurse	March 2021
2.8 Divisional oversight and governance structures in place to monitor all relevant national and local quality, performance and regulatory standards reporting to the Trust's Executive Management Board (EMB)	Divisional Update Reports to EMB Divisional Performance and Improvement Reports Divisional Finance Reports	Ensure Integrated Performance report is kept relevant and aligned to internal and national reporting requirements	Deputy CEO	Complete - March 2020
2.9 Mandatory training programme in place and compliance monitored through Divisional Performance & Improvement meetings, Executive Management Board, People & OD Committee and Quality Committee and Workforce Development Committee	Divisional Performance Reports Integrated Quality & Performance Report Workforce Report	Process in place	Director of Human Resources & Organisational Development	Complete – January 2020

BAF Risk 3: Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market.

#### Cause(s):

- . Requirement to re-deploy large numbers of staff at pace to expand key service provisions. e.g. ICU during Covid-19 pandemic
- . Failure to manage and mitigate the impact of COVID virus on our workforce and specific 'at risk' groups
- Psychological impact of dealing with the COVID incident across our key services
- Communication with our workforce may not sufficient to ensure understanding and commitment to our future outcomes
- Failure to respond to the staff survey (and other indicators)
- Failure to build an engaged, responsive, and inclusive workforce
- Staff do not feel valued, listened to and supported

#### Impacting on:

- The health and wellbeing of our people. e.g. absence rates
- Expectations of staff around the 'give and get' between staff and the trust
- Retention of 'hard to recruit' staff across key services
- The approach to training our staff to increase their versatility to be deployed
- . Where staff will work, the way in which they deliver care to our patients and in some cases the role they undertake
- The extension of our culture and values outside of the organization and for the benefit of the wider population
- The Trust's reputation with partners, commissioners, regulators, the NHS and the public

<ul> <li>The Trust's reputation with partners, commissioners, regulators</li> </ul>	, the NHS and the public			
Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Human Resources	4 x 4 = 16 (Extreme)	2x4= 8 (High)	2 x 3 = 6 (Moderate)	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Be the employer of choice	Well-Led	People & OD Committee	31/07/20	
Current controls and assurance	,	Actions to further enhance risk management		
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
3.1 People programme in place and delivery monitored through Workforce Development Committee and People and OD committee	People programme Staff survey report HR KPI dashboard (incl. voluntary turnover rate) People reset and recovery programme	Establishment of Retention Steering Group to consolidate plans and identify further actions.  People reset and recovery programme actions (including education recovery plan)	Director of Human Resources & Organisational Development	November 2020
3.2 EDI plan in place and delivery monitored through Workforce Development Committee and People & OD Committee	EDI action plan report Staff survey report Staff networks	New EDI plan agreed in July's PODC  Listening events with BAME staff with executive team	Director of Human Resources & Organisational Development	November 2020 October 2020 October 2020
		Undertake analysis of bullying and harassment issues and develop specific plan to address.  Review of EDI plan to ensure issue of BAME staff		October 2020  Commenced
		representation at senior levels (phase 3 letter) is		

Executive Owner:
Director of Human

Development

**Resources and Organisation** 

3.3  Health and Wellbeing plan in place and delivery monitored through Workforce Development Committee, People & OD Committee and Health and Wellbeing Steering Committee	Health and Wellbeing action plan report – 12-18 mths  Health and Wellbeing business case and associated two year work programme – approved at EMB, PODC, FIC in July 2020  Staff survey report	Reverse mentoring for Exec Team and Senior Staff - set up July 2020.  Establishment of NWL BAME Network to address cross sector issues - set up June 2020  Consolidation of OH services with alternative provider to give greater stability and service breath.  Interim arrangements with Imperial to cover clinical management elements of Occupational Health service.  Workplace risk assessment across the Trust to identify changes to the physical space and working arrangements for staff  Individual risk assessments for all staff plus appropriate personalised plans for all vulnerable staff groups completed July 2020.  Increase OH and clinical support to oversee risk assessments of staff  Increase in the level and breadth of psychological support packages. e.g. counseling, Schwartz Rounds, team de-briefs  Welfare checking model in place to ensure engagement with absent or shielding staff and planning to return staff safely to work  Extensive staff testing programme to protect staff and patients	Deputy Director of Human Resources & Organisational Development	November 2020
3.4 Systems in place to listen to and respond to staff feedback including listening events, staff networks, team brief, senior link leads and perfect day	Trust and Divisional Staff Survey Action Plans Senior link survey report Hotspot reporting New Starter 3 monthly drop in sessions Daily briefing to staff Talk to HR webinars Welfare calls to staff	Review starter and leaver survey process to ensure action is taken on feedback.  Review onboarding process to ensure optimum experience  Increased engagement with staff via online communication channels and re-promotion of existing channels such as FTSU	Deputy Director of Human Resources & Organisational Development	November 2020
3.5 External systems in place for staff feedback monitored through Divisional Boards, Executive Management Board and People & OD Committee	National staff survey report GMC survey Staff Friends and Family test	No further actions identified over and above current plans	Director of Human Resources &	November 2020

3.6 Systems in place to monitor key workforce metrics including Divisional Boards,	Freedom to Speak Up report Senior Link Partner Programme Perfect Day Workforce KPI dashboard (incl. voluntary turnover rate)	Workforce information improvement plan to develop reporting arrangements	Organisational Development  Director of Human	November 2020
Executive Management Board, Workforce Development Committee and the People & OD Committee	HR Transactional Services KPI dashboard	Development of EDI dashboard for the Trust and divisions	Resources & Organisational Development	October 2020
3.7 Partnership Forum and LNC reviews formal and informal staff feedback	Internal and National staff survey scores Quarterly FFT scores Leaver surveys Union feedback GOSW Staff Networks	No further actions identified over and above current plans  Weekly briefing with unions leaders related to COVID Bi-weekly briefings of all union representatives	Director of Human Resources & Organisational Development	August 2021
3.8  Development of a full people strategy for CW with alignment with ICS and national people plan (released July 2020).	People programme NWL People programme with NWL People Board Agreed engagement plan for the development of the CW people strategy	Execution of the engagement plan and drafting of CW People Strategy for exec cabinet, EMB, WDC and PODC	Director of Human Resources & Organisational Development	October 2020 (first draft) November 2020 (final draft

#### BAF Risk 4: Failure to maintain the financial sustainability of the Trust and the services it provides

#### Cause(s):

- NWL Sector affordability impacting on income (including reduction in MFF) and commissioner demand management schemes
- Uncertainty over NHS financial arrangements during 2020/21 and beyond due to covid-19
- Impact of inflationary costs and price changes, including CNST premium costs
- Loss of transaction funding not fully mitigated
- · Lack of robust financial management across operational and corporate teams to ensure the cumulative impact of all decisions is understood
- . Non-Delivery of financial efficiency targets and impact of reduced efficiency due to infection control requirements during covid-19 and back-log of elective patients
- Pathway changes and service redesign across the sector
- Digital and other innovations are not fully exploited

#### Impacting on:

- Capacity to support growth in activity, with the impact on performance
- . Ability to continue to invest in the workforce and infrastructure required to maintain and improve the quality of services
- Loss of freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance

<ul> <li>Loss of freedom to make investment and other decisions within the relevant regulatory freedom.</li> </ul>	ameworks, policies and guidance			
Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Use of Resources	4 x 5 = 20 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	30/07/20	
Current controls and assurance	A	ctions to further enhance risk management	t	
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
4.1 Long term financial strategy and position is reviewed quarterly by the Finance and Investment Committee	LTFM report	Detailed planning and budget setting underway for the 2020/21 financial plan.	Chief Financial Officer	October 2020
4.2 Delivery against the Trust's financial improvement plan (CIP) is monitored through Divisional Finance Review meetings, the Improvement Board, and Finance and Investment Committee	Improvement Programme Reports Monthly CIP Delivery Report Divisional and Financial Performance Reports	Divisional CIP plans for 2020/21 are in development.	Chief Financial Officer	October 2020
4.4 Capital plans are reviewed regularly and monitored through Capital Programme Board, Executive Management Board and Finance & Investment Committee. Large capital projects (e.g. NICU/ICU, EPR) have separate programme boards where progress is monitored and reported through to Capital Programme Board and Finance & Investment Committee	Capital programme report NICU/ICU programme update report EPR programme update report	Ongoing process in place	Chief Financial Officer	March 2021
4.5  NWL sector financial recovery plan and financial governance for sector decisions are reviewed and monitored through the NWL CFO group, then to NWL CEOs & Partnership Group.	NWL CFOs group NWL Partnership group	Ongoing process in place	Chief Financial Officer	March 2021
4.3 The effectiveness of the Trust's financial control systems are monitored through the Audit and Risk Committee as part of the internal audit programme	Internal Audit Reports	Recommendations from the 2019/20 financial controls internal audit to be implemented.	Chief Financial Officer	Complete - August 2020
4.6 Changes in commissioner contract terms are reviewed and signed off by the Executive Management Board, Finance and Investment Committee and Trust Board. Performance against the contract is monitored as part of the delivery against the Trust's overall financial plan.	Annual Financial Plan Divisional and Trust level monthly Financial Performance Reports	Process in place	Chief Financial Officer	Complete - January 2020

**Executive Owner:**Chief Financial Officer

4.7	Annual Financial Plan	Process in place	Chief Financial	Complete -
Annual financial plan signed off through Executive Management Board, Finance and Investment Committee			Officer	January 2020
and Trust Board				
4.8	Cost Improvement Plan	Process in place	Chief Financial	Complete -
Annual financial improvement plan (CIP) signed off through Improvement Board, Executive Management	Improvement Programme Plans		Officer	January 2020
Board and Finance and Investment Committee	Project Initiation Documents			
4.9	Divisional and Trust level monthly	Process in place	Chief Financial	Complete -
Delivery against the Trust's overall financial plan is monitored on a monthly basis through Divisional Finance	Financial Performance Reports		Officer	January 2020
Review meetings, the Executive Management Board, Finance and Investment Committee and Trust Board				
4.10	Programme Board Reports	Process in place	Chief Financial	Complete -
The effective use of resources is monitored against external benchmarks through the Improvement Board	Reference Costs & Model Hospital		Officer	January 2020
and individual programme boards (e.g. theatre productivity, bed productivity, outpatient transformation,	GIRFT Reports			
diagnostic demand management), as well as external visits and assessments (GIRFT, NHSI)	Use or Resources Assessment			

BAF Risk 5: Failure to embed innovation and improvement in our culture and deliver innovative, patient centered services at scale

# Executive Owner: Chief Nurse/Deputy CEO

#### Cause(s):

- Staff not encouraged and enabled to drive innovation and improvement
- Lack of capability and capacity to support idea generation, testing and scaling
- Failure to build partnerships to access innovative ideas and technology
- Failure to spread innovative practice
- Lack of funding to support innovation programme

- Transformative models of care, required to deliver wide ranging service improvement, are not adopted
- Research & Development agenda fails to grow and deliver
- Lost revenue opportunities from failure to commercialise innovations
- Ability to deliver world class care aspiration

Profile and reputation for innovation is negatively impacted  Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Innovation	4 x 4 = 12 (Extreme)	3x3 = 9 (High)	2x3 = 6 (Moderate )	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	30/07/20	
Current controls and assurance		Actions to further enhance risk management		
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
5.1 Innovation Strategy Group in place to oversee the implementation of the Trust's Innovation Strategy	Innovation strategy Research Strategy	Formalise approach to and oversight of commercialisation and partnership agenda. Consider opportunities for an NWL approach	Deputy CEO	Sept 2020
5.2 Improvement and Innovation Framework in place setting out clear approach to developing the Trust's improvement and innovation culture, and building the Trust's capability and capacity to support this	Improvement and Innovation Framework Innovation Project tracker Media footprint for innovation Staff survey results	Innovation and Improvement Champions in place across all departments. Support with case studies inc ROI Build capacity in business intelligence to support digital maturity	Deputy CEO	Sept 2020
<ul> <li>5.3</li> <li>CW Innovation Programme in place as vehicle for attracting new partners and funding.</li> <li>Overseen by an Innovation Advisory Board that brings together a broad set of third party skill sets and experience to provide guidance, challenge and support</li> <li>Supported by dedicated Innovation Business Partners</li> </ul>	Feedback from Advisory Board members Innovation project tracker Innovation fund growth Media footprint for innovation	Explore the creation of an innovation fund with corporate funders and partners	Deputy CEO	Sept 2020
5.4 Innovation Operations Group in place to oversee delivery of Trust's portfolio of innovation projects and support diffusion of innovative practice	Innovation Project tracker Projects plan and update reports against agreed project milestones and KPIs.	Incorporate innovation in to Improvement Board monitoring and reporting structure	Deputy CEO	Complete – January 2020
5.5 Strict alignment of innovation grant awards with Trust strategy supported through Improvement and Innovation Team and overseen by Executive Management Board and CW Grants Committee	Innovation Project tracker Grant applications CW+ Impact Report	New process supported by Improvement and Innovation team will support improved capture and tracking of the full end to end process	Deputy CEO	Complete – January 2020

BAF Risk 6: Failure to develop our estate in a sustainable way to support the delivery of high quality, effective and efficient care

# Executive Owner: Deputy Chief Executive

#### Cause(s):

- Commercial and cost improvement plans not delivered
- Capital development programme not delivered (including ITU/NICU development)
- Long term development plan for WMUH is not realised

- Capacity to support growth in activity, with the impact on performance
- Ability to transform models of care and improve the quality of services
- Environmental impact of how we deliver services

Environmental impact of now we deliver services				
Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Estate & Environment	4 x 4 = 16 (Extreme)	3x4 =12 (High)	2x3 = 6 (Moderate )	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	30/07/20	
Current controls and assurance		Actions to further enhance risk management		
Key controls in place to address risks	Means of assurance	Action required to close any gaps in	Action owner	Action review date
		controls and assurances		
6.1	Capital Development Programme Report	Establish rolling ward refurbishment	Deputy Chief	Sept 2020
Capital Development Programme, aligned to Estates Strategy, signed off and	ERIC report	programme led by the Hospital Directors	Executive	
regularly reviewed through Capital Programme Board, Finance and Investment	Targeted Deep Dive – Estates Capital Strategy	Consider impact of London ICP guidelines		
Committee and Trust Board	Senior Link Partner Programme	and establish 'Silver Site' status and		
	Ward Accreditation	COVID-19 protected pathways to support		
		all priority services		
6.2	Estates and Facilities Monthly Report	Review Capital requirements in light of	Deputy Chief	Sept 2020
Annual Operating Plan and budgets aligned with Capital Development Programme		NWL ICS development programmes;	Executive	
with clear scheme of delegation with regular updates to Executive Management		Critical Care expansion, Endoscopy, SDEC		
Board				
6.3	ITU/NICH Burney and Burney	And bearing from the NICH/ICH arrival	Devel Chief	C1 2020
ITU/NICU development overseen by dedicated Programme Board reporting to	ITU/NICU Programme Report Internal Audit	Apply learning from the NICU/ICU project and ensure that the contingency for	Deputy Chief Executive	Sept 2020
Finance and Investment Committee	Internal Addit	unknown risks in future major	Executive	
Finance and investment committee		developments is adequate		
6.4	Estates Strategy	Site Master Plan for WMUH and	Deputy Chief	Complete – January 2020
Estates Strategy approved by Trust Board and reviewed through Finance and	WMUH Site Master Plan	supporting arrangements in	Executive	Complete – January 2020
Investment Committee and Trust Board Strategy sessions	VVIVIOTI SILE IVIASLEI I IAII	development. Procurement process to	LACCULIVE	
investment committee and must board strategy sessions		be established.		
6.5	Estates and Facilities Monthly Report	Establish a sub-group to regularly review	Deputy Chief	Complete - February 2020
Rolling maintenance programme in place aligned to Annual Operating Plan	Targeted Deep Dive – Estates Capital Strategy	capital expenditure on each site	Executive	complete Tebruary 2020
noming maintenance programme in place diighed to Aimadi Operating Flam	Targeted Deep Dive Estates capital strategy	capital experience of cach site	EXCENTIVE	

BAF Risk 8 (opened September 2020): Risk that the implementation of work programmes within Digital and Innovation Strategy may not be delivered due to costs associated with purchase of software and hardware, costs of transformation, and sustainability of resources.

Executive Owner:
Deputy Chief Executive

#### Cause(s):

- Workforce capability
- Clinician, Executive and other staff engagement (including training)
- · Risks associated with system collaboration across NWL and decision making processes potentially delaying CWFT progress
- Budget constraints due to the need for recurrent investment in to both hardware and software
- Change management does not ensure adoption of best practice and / or benefits realization

- The running of the hospitals to deliver normal services and contractual responsibilities during periods of significant disruption
- The need to maintain and improve cyber security
- Adequately respond to the digital requirements of local communities
- The need to modernize and upskill the workforce
- Ability to respond to major incidents as well as the current global pandemic

Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)	
Digital and Innovation Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate )	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	New risk – not yet reviewed	
Current controls and assurance		Actions to further enhance risk management	t	
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
8.1 Review of IT Infrastructure upgrade costs in preparation of 2021/22 capital spend	Deep Dive to schedule for October 2020	None at present	Chief Financial Officer	December 2020
8.2 Review current Digital and Innovation projects and align with Trust / ICS objectives	Monthly Digital and Innovation Programme Board	None at present		December 2020
8.3 Joint EPR change board governance process with Imperial College Healthcare Trust in place	Monthly EPR Board Report	Continued monthly EPR/Digital Steering Group	Deputy Chief Executive	January 2021 (transferred from Risk 7)
8.4 Development of Digital Strategy in concert with NWL partners	EPR Board Report		Chief Information Officer	January 2021 (transferred from Risk 7)

#### Closed September 2020. New risk opened – Digital Programme.

#### BAF Risk 7:

Executive Owner:
Deputy Chief Executive

Short Term: Risk that the EPR programme will not be delivered on time or within budget and that any associated risks, including business continuity, are not effectively managed and mitigated

#### Cause(s):

- Capability/ resource risks
- Clinician, Executive and other staff engagement (including training)
- Risks associated with multiple clinical systems and legacy impact
- The data migration issues or operation of system causes data quality issues post go live impacting on reporting and quality of care
- Change management does not ensure adoption of best practice and / or benefits realization

#### Impacting on:

The running of the hospitals. The Trust is unable to deliver normal services and contractual responsibilities during periods of significant disruption. Key risks include:

- Cyber security
- EPR migration or operational systems
- Other Major Incidents

Medium to Long Term: Failure to maximize the benefits from the EPR programme and develop and implement a wider Digital Strategy to support:

- Modern workforce and requirements of future care
- Innovation & improvement programmes
- Needs and convenience of patients and population
- Wider requirements of London and NWL Strategie

Wider requirements of London and NWL Strategies					
Risk Domain	Gross risk score	Net (Current) risk score:	Target risk score (risk appetite)		
EPR and Digital Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate )	2x3 = 6 (Moderate )	
Strategic objective	CQC Domain	Assurance Committee	Date of last review by Committee:		
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	30/07/20		
Current controls and assurance	Actions to further enhance risk management				
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date	
7.1 Joint EPR change board governance process with Imperial College Healthcare Trust in place	Monthly EPR Board Report	Continued monthly EPR/Digital Steering Group	Deputy Chief Executive	January 2021 – transferred to Risk 8 (Digital Programme)	
7.2 Development of Digital Strategy in concert with NWL partners	EPR Board Report		Chief Information Officer	January 2021 (transferred to Risk 8 Digital Programme)	
7.3 Significant investment programme to address known cyber security weaknesses.	Cyber Security updates to Audit and Risk Committee		Chief Information Officer	Complete - May 2020	
7.4 Established series of external Gateway Reviews for Key Stages Go/No Go decisions External audit assurance and actions monitored at EPR Board and	Monthly EPR Programme Report External Audit gateway reports	Final gateway report due to be reviewed at Finance and Investment Committee	Deputy Chief Executive	Complete – January 2020	

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



### **Board of Directors Meeting, 5 November 2020**

### **PUBLIC SESSION**

AGENDA ITEM NO.	3.9/Nov/20
REPORT NAME	Half year report on use of the Company Seal 2020/21
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Serena Stirling, Director of Corporate Governance and Compliance
PURPOSE	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
REPORT HISTORY	N/A
SUMMARY OF REPORT	The Company Seal has not been used during the period 1 April 2020–30 September 2020.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For noting.

#### Report on use of the Company Seal 2020/21

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

#### **Custody of Seal and Sealing of Documents**

- 11.1. **Custody of Seal** the common seal of the Trust shall be kept by the Company Secretary in a secure place.
- 11.2. **Sealing of documents** where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.
- 11.3. **Register of sealing** an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.
- 11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.
- 2. The Company Seal has not been used during the period 1 April 2020–30 September 2020.