Chelsea & Westminster Hospital NHS Foundation Trust
Council of Governors Meeting

Zoom Conference https://zoom.us/j/7812894174; Meeting ID: 781894174 OR Dial in: +441314601196; Meeting ID: 781 289 4174# United Kingdom

29 October 2020 16:00 - 29 October 2020 18:00

INDEX

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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Agenda

15.40–15.55		**Chairman's Appraisal PRIVATE** *(attended by the Council of Governors, SID/Deputy Chairman & Board Governance Manager)*			
	1.0	**STATUTORY/MANDATORY BUSINESS**			
16.00	1.1	Welcome, apologies for absence and farewell to Governor Anna Hodson-Presinger	Verbal		Chairman
16.05	1.2	Declarations of interest	Verbal		Chairman
16.07	1.3	Minutes of previous meeting held on 23 July 2020 1.3.1 Action Log 1.3.2 External Audit Tender update *(COG action 23.07)*	Paper Paper Paper	For Approval For Information For Discussion / Approval	Chairman Chairman Chief Financial Officer (Acting)
16.10	1.4	Chairman's Report	Paper	For Information	Chairman
16.15	1.5	Chief Executive Officer's Report, including: - Recent CQC Radiation Protection inspection - Executive Director appointments	Paper / Verbal	For Information	Chief Executive Officer
		STRATEGY			
16.25	1.6	NWL Integrated Care System (ICS) • Introduction to Penny Dash, NWL ICS Chair • NWL system developments	Verbal	For Information	Chief Executive Officer / Penny Dash
16.35	1.7	Phase 3 of NHS Response to Covid-19	Paper	For Information	Chief Executive Officer
16.45	1.8	Support arrangements: The Hillingdon Hospital NHS Foundation Trust	Verbal	For Information	Chief Executive Officer
16.55	1.9	Chairman recruitment process – update	Verbal	For Information	Deputy Chairman / Senior Independent Director
		QUALITY			
17.05	1.10	Quality Committee Report to Council of Governors	Paper	For Information	Eliza Hermann, NED

17.20	1.11	COG sub-committees: 1.11.1 Membership and Engagement Sub-Committee report, including Meet a Governor Schedule 1.11.2 Quality Sub-Committee report	Verbal Paper	For Information / Discussion	Chair of Membership Sub-Committee Chair of Quality Sub-Committee
17.25	1.12	Accessibility Working Group – update	Paper	For Information	Steve Gill, NED
	2.0	**PAPERS FOR INFORMATION**			
17.30	2.1	Council of Governors elections update	Paper	For Information	Board Governance Manager
17.35	2.2	*Performance and Quality Report, including 2.2.1 Winter preparedness 2.2.2 People Performance Report	Papers	For Information	Chief Executive Officer
	3.0	**OTHER BUSINESS**			
17.40	3.1	Questions from the governors and the public	Verbal	For Information	Chairman / Chief Executive Officer
17.50	3.2	Any other business, including: 3.2.1 Governors Away Day January 2021 – plan 3.2.2 Forward plan 3.2.3 Schedule of meetings 2020/21 3.2.4 Governor attendance register	 Verbal Paper Paper Paper	 For Discussion For Information For Information For Information	Chairman
18.00	3.3	Date of next meeting: 28 January 2021, 09.30 – 15.30 Council of Governors Away Day 28 January 2021, 16.00 – 17.00 Council of Governors Meting			

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

Please note that the PRIVATE NED/COG Informal meeting will follow afterwards at 18.00.
(attended by the Non-Executive Directors and the Council of Governors)

DRAFT
MINUTES OF COUNCIL OF GOVERNORS (COG)
23 July 2020, 09.30 – 10.30
Zoom Conference

Present:	Sir Thomas Hughes-Hallett	Chairman	(THH)
	Nowell Anderson	Public Governor	(NAn)
	Richard Ballerand	Public Governor	(RB)
	Juliet Bauer	Patient Governor	(JB)
	Cass J. Cass-Horne	Public Governor	(CJCH)
	Tom Church	Patient Governor	(TC)
	Professor Nigel Davies	Public Governor	(NDa)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Dr Simon Dyer	Lead Governor/Patient Governor	(SD)
	Anna Hodson-Pressinger	Patient Governor	(AHP)
	Elaine Hutton	Staff Governor	(EHu)
	Richard Jackson	Staff Governor	(RJ)
	Kush Kanodia	Patient Governor	(KK)
	Paul Kitchener	Public Governor	(PK)
	Anthony Levy	Public Governor	(AL)
	Johanna Mayerhofer	Public Governor	(JMa)
	Professor Mark Nelson	Staff Governor	(MN)
	David Phillips	Patient Governor	(DP)
	Cllr Patricia Quigley	Local Authority Governor	(PG)
	Dr Desmond Walsh	Appointed Governor	(DW)
	Laura Wareing	Public Governor	(LJW)
In attendance:	Aman Dalvi	Non-Executive Director	(AD)
	Nick Gash	Non-executive Board member	(NG)
	Steve Gill	Non-Executive Director	(SG)
	Eliza Hermann	Non-Executive Director	(EHe)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Ajay Mehta	Non-Executive Director	(AM)
	Virginia Massaro	Acting Chief Financial Officer	(VM)
	Serena Stirling	Director of Corporate Governance & Compliance	(SS)
	Lesley Watts	Chief Executive Officer	(LWa)
	Vida Djelic (Minutes)	Board Governance Manager	(VD)
Apologies:	Caroline Boulliat	Public Governor	(CB)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Jodeine Grinham	Staff Governor	(JG)
	Minna Korjonen	Patient Governor	(MK)
	Thewodros Leka	Staff Governor	(TL)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Fiona O'Farrell	Public Governor	(FOF)
	Jacquei Scott	Staff Governor	(JS)
	Trusha Yardley	Public Governor	(TY)

1.0	**STATUTORY/MANDATORY BUSINESS**
1.1	**Welcome and apologies for absence** THH welcomed the Governors and those in attendance to Zoom conference meeting.

	THH noted, in the interest of time, a list of apologies would be circulated to all governors outside the meeting. **Action: VD to circulate a list of apologies for the meeting to all governors**.
1.2	**Declarations of interest** None declared.
1.3	**Minutes of previous meeting held on 23 April 2020** **Action Log and Governors' iLog** Minutes of previous meeting – approved. Action Log and iLog – noted. KK noted the recent Royal Borough of Kensington and Chelsea policy change for disabled parking in the borough and added that there are plans to replicate the policy change in the inner London boroughs. KK offered to share a link to the borough's website with the Accessibility Working Group.
1.4	**Nominations and Remuneration Committee:** **1.4.1 Succession plan for Deputy Chairman and Senior Independent Director** This item was discussed in private session at 10.30am.
1.5	**Chairman's Report** The report was noted. THH reported after serving the Trust for two terms JJ, the Deputy Chairman and Senior Independent Director will leave the organisation in September. During this time, JJ has also been the Chair of the Finance and Investment Committee and Non-Executive Lead for Strategy. ND will take over as Finance and Investment Committee Chair. THH extended a personal thanks to JJ for his commitment to the hospital and for his support which he has shown to himself, the Council of Governors and Board of Directors. THH further reported after serving the Trust for two terms Dr Andy Jones, Non-Executive Director, leaves the Trust. THH acknowledged Dr Jones's support with the Trust's quality agenda and as a valuable member of the Quality, and Audit and Risk Committees; in addition, Dr Jones was a Non-Executive Lead for Estates. On behalf of the Council of Governors and Board of Directors THH extended a sincere thanks to Dr Jones for his commitment and dedication to the hospital. THH highlighted that he has completed the NED appraisal process for the group.
1.6	**Chief Executive Officer's Report** LW noted that the NHS continues to be in a Level 4 emergency situation with respect to the Covid-19 pandemic. The Trust continues working closely with NHS England and Public Health England to support the national response to the Covid-19 incident, and acknowledged the outstanding commitment and dedication from staff in their response to this unprecedented challenge. LW noted that many staff are working in new areas with supervision, and the Trust is reviewing the long terms workforce model. She further acknowledged incredible support from the volunteers, local communities and businesses which enhanced patient and staff experience during the pandemic. LW highlighted that the hospitals look different, and will continue to do so for some time. This includes a reduced number of patients and staff on site, all staff and visitors must wear masks and gel their hands, and social distancing measures in place across the Trust. LW noted that there have been positive developments as a result of Covid-19, most notably the acceleration in the use of digital technology to enable virtual appointments for patients. LW noted the number of patients accessing emergency care is increasing, and reassured the Council and members of the public that they should continue to access care as needed. LW noted that the Trust has a focus on correct use of personal protective equipment (PPE) and testing

	programme for staff. THH invited LW to share with the Council the support which the Trust has given other providers. LW noted that a NWL acute Trust had an outbreak of Covid-19 in the workforce, resulting in the hospital being closed to admissions for some days. The Trust was supporting the organisation with staff testing and has since reopened. THH noted that the NHS remains in a Level 4 emergency and will be directed to support other organisations as required, in addition to working collaboratively with providers across the NWL sector. LW recognised the importance of identifying learning from Covid-19 and noted the Trust has been engaging with health and care partners to share emerging thinking and lessons learnt, some of which include: • Increasing critical care capacity at CW, WM and across the NWL sector to ensure that patients can access timely care in the event of a potential second wave of Covid-19 which may coincide with winter pressures; • Developing Covid protected and Covid managed pathways in order to keep staff and patients safe; • Safe restart of elective services; • Coordinated support across the NWL health and care sector, in particular acute, community, primary care, mental health, local authority and educational partners to keep patients and staff safe; and • Significant redeployment of staff during the pandemic to work in clinical areas to meet critical care capacity surge. NA asked if staff were being trained and supported appropriately. LW stated that this was the case, and the Trust will continue to develop and deploy effective practices to ensure best management and use of our human resource across the organisation. In response to a further question from NA regarding patient safety and staff Covid-19 testing, LW stated that a staff swabbing programme is in place in line with national guidance, for staff working in elective pathways and with vulnerable, high risk groups. All staff are being offered antibody testing, in addition to daily temperature and symptom checking. KK referred to the recent Chancellor's announcement that some public sector workers are to receive pay awards above inflation, and expressed disappointment that nurses are not being included. LW noted that nurses and doctors have individual negotiating bodies and stated that the Trust immensely values staff contributions, actively listens to their concerns, and invests in staff learning and development. LW noted that a revised approach to staff health and wellbeing was being considered in light of Covid-19. MN noted that some staff do not wear masks at all times while in hospital and posed a question how wearing a mask could be enforced. LW referred to her recent communication to all staff emphasising the importance of wearing masks, adhering to social distancing and following the correct hand hygiene protocols for the safety of colleagues and patients. LW reported that all staff have been encouraged to challenge each other when they notice these instances. In response to LJW about learning from this phase of the pandemic, LW stated some of examples include: supporting local initiative and flexibility; enhanced local system working; flexible and remote working; availability of appropriate supplies of PPE to keep staff safe; robust operational standards; establishment of Covid protected elective pathways; and above all, ensuring patients receive safe and high-quality care. LW reported that the discussions at a London level are considering how to protect elective care whilst managing winter pressures, and a potential second surge of Covid-19, to ensure patients on elective care lists are not disadvantaged by having treatment paused. LW noted that this would involve protecting not just pathways, but also whole hospitals. LW acknowledged that this could be controversial, but at the heart of discussions is how to keep people safe, whilst encouraging them to access treatment if needed. LW noted that community services and local authorities embraced new ways of working during the recent surge, and are in agreement that some changes will be permanent for the benefit of patients.
1.7	**Finance & Investment Committee Report to Council of Governors, Month 12 Financial Position**

	The Council of Governors noted the report. JJ presented the report and noted the following points as highlights during his service: • Expansion and redevelopment of the hospital's critical care units (NICU/ITU), one of hospital's most significant expansions and redevelopments; • The Trust was awarded an 'Outstanding' rating for use of resources by NHS Improvement (NHSI) for the second consecutive year, and has circa £100m cash balance; • Successful implementation of the Electronic Patient Record; And • Achieving a 2019/20 surplus of £29.5m and delivering £21.7m of cost improvement programme. JJ urged the Trust to measure all patient satisfaction and experience from the point of admission through to discharge in order to guide service improvement, and ensure that the anchor institution ethos is protected in the organisation. RJ noted that, as part of its recovery plan, as of August, the Trust will resume capturing patient experience. THH thanked JJ on providing a comprehensive report to the Governors. JJ thanked the Council for their support during his service, noting that it had been an honour to serve the Trust. PK stated that the Committee covers a wide portfolio, and has an emphasis on monitoring. PK asked JJ for his insight into areas for change. JJ noted that as incoming Committee Chair, ND would pick up this challenge.
1.7.1	**Audit and Risk Committee Report to Council of Governors** NG noted his written report provided in the meeting pack and highlighted the following points: • The Audit and Risk Committee is directly accountable to Board and provides assurance that probity and professional judgment is exercised in all financial and operational areas of governance. • At the most recent meeting held in 21 July the Committee considered and ratified the process to retender the internal audit, counter fraud and external audit contracts jointly across North West London sector. NG acknowledged the constitutional role of the governors in the appointment of the external auditors, and noted that this would be built in to the process. In response to SD's question regarding governors involvement in the tender process, NG stated that the process is in its early stages and the Governors will be kept updated. NG also note that the Trust is not the only Foundation Trust involved in the process. In response to KK's question regarding benefits of the joint tender, VM stated that the aim is to identify system efficiencies and standardisation opportunities through the joint tender. LW stated that this will support shared learning from audit recommendations from and counter fraud reports across the sector. The Council of Governors noted the report. **Action: VM to update COG on the process at next meeting.**
1.8	**COG sub-committees**
1.8.1	**Membership and Engagement Sub-Committee** DP drew Governors' attention to the following: • All major hospital events such as Open Days, Staff Awards and Christmas are currently under review by the Trust and may not be able to be physical gatherings; • Governors will no longer support the buying and preparation of gifts for Christmas event sand the activity will be led by the Communication Team. The Council of Governors noted the report.

1.8.2	**Quality Sub-Committee** LJW drew Governors attention to a comprehensive update on Covid-19 being provided by Lizzie Wallman and Nathan Askew. The Council of Governors noted the report.
2.0	**PAPERS FOR INFORMATION**
2.1	***Performance and Quality Report, including** ***2.1.1 People Performance Report** The Council of Governors noted the report.
2.2	**Cerner implementation** SG reported the Cerner Electronic Patient Record implementation, as alluded to earlier in the meeting by JJ, was successfully implemented across both hospital sites. The Finance and Investment Committee oversaw the gateway reviews conducted by Ernst and Young before they were presented to the Board, and helped to monitor implementation progress and project costs.
2.3	**Investment alignment to Strategic Objectives** VM noted that business cases explicitly align to strategic objectives, and the Finance Committee and Trust Board reviews the Capital Programme as part of annual planning. THH reported that as part of ND's appraisal, that it was a priority that the Trust reviewed the return on investment form the £32m Cerner Electronic Patient Record Programme.
2.4	**Governance of capital expenditure** VM noted that this was explained under the previous item. The Council of Governors noted the report.
3.0	**OTHER BUSINESS**
3.1	**Questions from the governors and the public** Nil of note.
3.2	**Any other business**, including: 2.1.1 Forward plan – Noted. 2.1.2 Schedule of meetings 2020/21 – Noted. 2.1.3 Governor attendance register – Noted. <u>COG Away Day 26 November 2020</u> KK proposed the Away Day be postponed to 28 January 2021. **Decision: The Council of Governors agreed the next Away Day be held on 28 January 2021.** <u>COG elections 2020</u> SS noted the Trust's decision to proceed with the Council of Governors election process, which is due to commence in early October, to fill vacant and seats coming up for election in November. An update on the election process will be provided at the next meeting. **Action: VD to provide an update on the Council of Governors elections at 29 October meeting.**

3.3	**Date of next meeting** – 29 October 2020, 16.00-18.00, Zoom Conference

Meeting closed at 10.30am.

Council of Govenrors (COG) – 23 July 2020 Action Log

Meeting Date	Minute number	Action	Current status	Lead
July 2020	1.1.	Action: VD to circulate a list of apologies for the meeting to all governors.	Complete.	VD
	1.7.1	Action: VM to update COG on the External Audit Tender process at next meeting.	This is on current agenda.	VM
	3.2	Action: VD to provide an update on the Council of Governors elections at 29 October meeting.	This is on current agenda.	VD
July 2020 PRIVATE	1.4.1	Action: VD to circulate Steve Gill's CV to all Governors.	Complete.	VD

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.3.2/Oct/20
REPORT NAME	Audit Contracts Options
AUTHOR	Virginia Massaro, Acting Chief Financial Officer
LEAD	Virginia Massaro, Acting Chief Financial Officer
PURPOSE	The purpose of this paper is to propose the timelines and process to retender external audit contract.
SUMMARY OF REPORT	The external audit contract is currently with Deloitte (ends March 2022). As part of the NWL Corporate consolidation work stream, it is proposed that external audit contracts are jointly tendered across NWL STP as part of a wider project to jointly tender finance contracts. The proposal is to have standalone contracts signed by each Trust and each Trust would be responsible for day to day contract management and setting audit plans directly with the relevant supplier. The specification for each contract would be jointly agreed. This is in order to identify efficiencies through the joint tender and to standardize across the NWL STP/ ICS, but also to support shared learning from recommendations from audit reports. Suggested timescales are to start market engagement in October 2020 in order to start the new contracts in April 2021 (CWFT would join in 2022 when the current contract with Deloitte comes to an end).
KEY RISKS ASSOCIATED	Tight timescales to complete joint tender and complexities of joint tender across NWL STP
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	Deliver financial sustainability
DECISION/ ACTION	The Council of Governors is asked to approve the proposed sector-wide tender process for external audit and to nominate a governor lead to support the tender process for external audit.

1. Introduction

The purpose of this paper is to propose the timelines and process to retender the external audit contract.

The external audit contract is currently with Deloitte and was originally undertaken as a joint tender with the Royal Marsden Hospital NHS FT.

2. Current Status of Contracts

External Audit contract (Deloitte):

- Start date 01/04/2017
- Initial term 3 years
- End date of initial term 31/03/2020
- Length of extension within contracts 2 years, end date of extended term **31/03/2022**
- Annual (2019/20) contract value £142k

3. Proposed Tender Process

As part of the NWL STP corporate work-stream, all outsourced/ external finance contracts across all organisations in the NWL STP/ ICS have been reviewed and it has been proposed by the NWL Chief Financial Officers that where possible and where timescales align, contracts are jointly tendered across NWL during 2020/21. There are 5 contracts proposed to be jointly tendered this financial year - external audit, internal audit, counter fraud, external debt collection and VAT advisors.

This is in order to identify efficiencies through the joint tender and to standardize across the NWL STP/ ICS, but also to support shared learning from recommendations from audit reports.

The process would include market engagement prior to procurement to test market appetite for a collaborative procurement and the resulting contract structure and the tender process would include relevant stakeholders from all organisations, also noting that external auditors are appointed by Trust Governors for Foundation Trusts.

The proposal is to have standalone contracts signed by each Trust and each Trust would be responsible for day to day contract management and setting audit and counter fraud plans directly with the relevant supplier.

It is proposed to tender external audit this financial year with a jointly agreed specification for Trusts whose contracts end this financial year, with the option for additional Trusts to join in subsequent years when contracts expire. For CWFT, this would mean joining the contract from April 2022.

It is requested that the Council of Governors nominate a governor lead to be part of the tender process and the final outcome of the tender process will be brought back to the Council of Governors for approval.

The outline timescales are below:

- Market engagement – October 2020
- Specification/offer schedule construction – end October 2020
- Tender process – mid-November 2020 to end December 2020
- Approval by Audit and Risk Committee and Council of Governors – January 2021
- Approval of award recommendation and standstill period – February 2021
- Contract start date – April 2021
- CWFT to join the contract from April 2022

4. Decision required

The Council of Governors is asked to approve the proposed sector-wide tender process for external audit and to nominate a governor lead to support the tender process for external audit.

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.4/Oct/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 Council of Governors on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Governors are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	N/A
DECISION/ ACTION	For information.

Chairman's Report
September 2020

Covid-19
On 19 June 2020 the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur.

The level of Covid demand on the NHS means that the Government agreed that the NHS incident level has moved from Level 4 (national) to Level 3 (regional) with effect from 1 August. Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration.

Within the Trust, we continue to follow government guidance on infection control measures. Staff, patients and visitors must wear face coverings within our hospitals, and maintain good hand hygiene and social distancing standards.

Leadership update
After two terms of service to the Trust, Jeremy Jensen, our Deputy Chairman and Senior Independent Director will leave the organisation at the end of September. During this time, Jeremy has also been the Chair of the Finance and Investment Committee and Non-Executive Lead for Strategy. I would like to extend a personal thanks to Jeremy for his commitment to the Trust, and for his support which he has shown to myself, the Board of Directors and Council of Governors.

On 23rd July, the Council of Governors confirmed Steve Gill as our new Deputy Chairman and Senior Independent Director. Steve is currently the Chair of the People and Organisational Development Committee, as well as a member of our Finance Committee. I am sure you will all join me on congratulating Steve on his new appointment. I look forward to working with him and the Board of Directors over the coming months to navigate the 'Recovery Phase' of our services, whilst planning for the future.

In July, we were also very sorry to say goodbye to Dr Andy Jones, Non-Executive Director, after serving the Trust for two terms. Andy championed and supported our quality agenda as a valuable member of the Quality and Audit and Risk Committees, and was also Non-Executive Lead for Estates. On behalf of the Board of Directors and Council of Governors I extend a sincere thank you to Andy for his commitment and dedication to our organisation.

Working with others
As you are aware, we have been actively engaging with our health and care partners in North West London to reset and restart elective care services for patients, whilst continuing to deliver urgent and emergency care across the sector. This continues to be a demanding and challenging time for both staff and patients.

In August, the Chief Executive of The Hillingdon Hospitals NHS Foundation Trust stood down for personal reasons, and as part of our collaborative approach, and recognising our duty to support others, Lesley Watts is working as an advisor to the Hillingdon Board. She will support the Deputy Chief Executive Officer with the management of the hospitals until new leadership arrangements are put in place.

Sir Thomas Hughes-Hallett
Chairman

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.5/Oct/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 Council of Governors on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Governors are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Chief Executive's Report
September 2020

Introduction
My last report to Public Board was in July, and since then, we have remained in a phase of recovery following the first Covid-19 surge, working hard to increase our elective care services, whilst preparing for winter and another potential surge of Covid-19. As we approach the autumn, you will start to see messages on winter wellness across the Trust, and we have started preparations for our annual Flu vaccination campaign. Last year we were one of the top scoring London Trusts for Flu vaccination uptake and this year, with the ongoing Covid-19 situation and winter pressure on services, we must make every effort to protect ourselves and those around us.

Covid-19
Although, the Government has agreed that the NHS incident level should be reduced from Level 4 (national) to Level 3 (regional), Covid-19 remains in general circulation within our communities. Alongside our NHS London and North West London health and care partners, we are keeping a watching brief on infection rates in order to shape our response and preparedness accordingly. Any future increases in Covid-19 demands on the NHS may mean that the level 4 incident will need to be reinstated.

However, for the time being, we have an opportunity to focus both within our organisation, and with our North West London partners, on accelerating the restart of non-Covid services, while still preparing for a possible second national surge of the virus. NHS England has set out three clear priorities for Trusts during this current phase:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter;
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally; and
- Doing the above in a way that takes account of lessons learned during the first Covid peak; maintains beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

I would remind every member of our local communities to take heed of the government guidance. 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.

Our services are open and we are keen to see patients with the greatest clinical need and longest wait, to reduce the backlog of people waiting for treatment. If we do offer you an appointment to get treatment which you need, please accept this opportunity. We will be happy to discuss any concerns.

Equality, diversity and inclusion
I am delighted to announce that our Trust has received confirmation of 'Stonewall' membership which is a sign of our commitment to celebrating our diverse workforce. Stonewall is the country's leading LGBT rights charity known for campaigning and lobbying for LGBT rights, inclusivity and acceptance. They support organisations in their quest to become truly LGBT inclusive which helps unlock the benefits of a truly diverse workforce, and I look forward to working with them on our equality, diversity and inclusion approach.

Members of our Executive team have been holding listening events with our staff from BAME backgrounds. These are confidential, 'listening only' events available to all clinical and non-clinical BAME staff, where they can openly discuss their lived experiences relating to recruitment and career progression, amongst other topics which we recognise need improving for fairness and equality at our Trust.

This September we are launching a pilot programme on Reciprocal Mentoring for Inclusion. The programme will provide opportunities for individuals from under-represented groups to apply to mentor our Executives and senior directors**.** This professional partnership will create alliances, where paired individuals share knowledge and understanding of their 'lived experience' to improve awareness and contribute towards each other's personal and professional growth.

Research
I am pleased to announce that the Trust has been asked to join the Imperial College Academic Health Science Centre (AHSC). AHSC's are formal collaborations which seek to turn scientific breakthroughs into practical treatments for patients, and better understand how to improve the broader public health. In this, we collaborate with some of our existing partners: Imperial College; Imperial Healthcare; the Brompton; the Marsden; and the Institute of Cancer Research, with whom we already work together in clinical services, research, and education. Covid-19 reminded us of the importance of working together, and the importance of research and innovation. The AHSC will help us all work towards common goals and achieve more for the people we serve.

Our Estate
Our hospital charity CW+ are constantly making improvements to the hospital environment. Most recently, refurbishments have started on the Marjory Warren block and Kew Ward at West Middlesex, as well as Nell Gwynne and St. Mary Abbots Wards at Chelsea and Westminster.

These updates are being carried out to help improve patient and staff experience through creative interventions. Improvements include dementia friendly signage and sensory equipment for patients. CW+ will also be commissioning artists to create bespoke artwork reflecting the hospital community across both sites.

Lesley Watts

Chief Executive

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.7/Oct/20
REPORT NAME	Third Phase of NHS Response to COVID-19
AUTHOR	NHS England and NHS Improvement
LEAD	Lesley Watts, Chief Executive Officer CWFT
PURPOSE	To share the NHS England and NHS Improvement communication with the Council of Governors.
SUMMARY OF REPORT	As enclosed.
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	N/A
LINK TO OBJECTIVES	All.
DECISION/ ACTION	For information.

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From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1 August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29 April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17 July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1 August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed

actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and

regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1 September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21 September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8 August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1 and 2 August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

Sir David Sloman
Regional Director (London)
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To: ICS Chairs and SROs
ICS lead LA CEO
Trust CEOs

Dear Colleagues,

Update on Journey to a new Health and Care system

In May 2020, we agreed an ambitious strategic plan for London: *Journey to a new Health and Care system*. This is based on the London Vision within the context of the Covid-19 pandemic and included 8 Tests for ICS Action Programmes. This letter is to update you on progress and our shared plans.

Firstly, thank you to you and to all staff and volunteers working in your health and care system. I am grateful to everyone who has contributed to the Covid-19 response across London so far.

As part of the development and implementation of the strategy, we held individual ICS Check and Challenge sessions looking at acute care, mental health and local community, primary and social care services. Thank you to everyone who participated in these sessions. They have helped us gain a real understanding of the impressive partnership work across London, particularly with our local government colleagues, where excellent progress is being made in integrating services for the benefit of Londoners. The last of these sessions was held on Friday 8th August, the same day as the publication of the Phase 3 letter and it now feels the right time to update you. Appendix A gives a comprehensive update on progress towards the 8 Tests across London.

We have formed a London Recovery Oversight Board with ICS Chairs and SROs, and the Public Health England (London) Director as key members, together with NHSE/I executives. We meet every two weeks to ensure we are making rapid progress.

As you may know over the last few months, we have held a series of dialogue and deliberation events with 100 people to hear what Londoners want from their health

and care system. These people were picked to ensure that they represent the rich diversity of London's population, with people from every borough. We have now held six very well-attended virtual workshops. The feedback from these sessions is a key part of our planning and is informing the work to implement our strategy for the London health and care system.

I hope you have found this update helpful. If you wish to know more about any of these areas of work, please contact Helen Pettersen on h.pettersen@nhs.net who will put you in touch with the relevant Programme Director. The next phase of work will focus on the draft plans for resilience, recovery and reset systems will be submitting to NHSE /I on 1st September with final plans due on 21st September. During October, the Recovery Oversight Board will be considering the ICS plans with a focus on the impact on inequalities and system readiness for the winter.

Your sincerely,

Sir David Sloman
London Regional Director

Appendix A

Meeting patient needs (Tests 1 – 3)

Test 1 Covid Treatment Infrastructure

Test 2 Non Covid Urgent Care

Test 3 Elective care

Elective care - High volume Low complexity surgery

NHSE/I have set all systems the target of restoring to 80% of last year's activity for both overnight elective, and for outpatient and day case procedures in September, rising to 90% in October. We are aiming to eliminate 52 week waits. David Probert, CEO of Moorfields Eye Hospital, is leading a programme of work to establish ICS fast track surgical hubs where high volume and low complexity surgery can take place at GIRFT-plus levels of efficiency. Professor Tim Briggs, National Director of Clinical Improvement is the clinical lead.

Each ICS has identified clinical leads for this work -

- Roger Chinn, Deputy Medical Director – NWL
- Chris Streather, Chief Medical Director – NCL
- Steve Edmondson, Consultant Cardiac Surgeon – NEL
- James Marsh, Consultant Nephrologist - SWL
- Kay Thomas, Consultant Urological Surgeon – SEL

The programme will support the STPs/ICSs to implement best practice in clinical outcomes and productivity across high volume, low complexity elective surgery in six specialties. This will be delivered by:

- Restarting high volume activity using GIRFT principles to achieve current top decile performance or better;
- Development of high-volume centres in a phased approach;
- Implementation of supporting enablers, for example system Patient Tracking Lists (PTLs);
- Transition to a 'one workforce, one estate' mindset; and
- Implementation of continuous improvement methodologies within STP/ICSs to remove all unwarranted variation in clinical outcomes.

We have established London-wide multi-disciplinary expert clinical advisory panels, with membership suggested by STPs/ICSs/providers, in six clinical specialties: orthopaedics, ophthalmology, urology, gynaecology, ENT and general surgery. These 6 specialities cover 70% of the total waiting list in London. We have held a very successful first pan-London expert clinical advisory design workshop engaging

over 135 multi-disciplinary professionals. Nineteen pan-London clinical procedure pathways spanning all six specialties will be signed off by mid-August. Discussions have commenced on a further nine procedures and we expect 26-28 clinical pathways to be ratified before the end of August. We have agreed London-wide principles for pre-operative assessment, patient information and consent, and for post-operative follow up. Telephone follow-up will be the default – it will be proforma based and, in most cases, nurse-led. Telephone follow up will be the default except in situations where it is in the patient's best interests to attend hospital.

Diagnostics

There is a national target for all systems to return swiftly to at least 90% of last year's level of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October. Our initial focus has been on Endoscopy and Imaging.

- Endoscopy

Professor Tim Orchard, CEO of Imperial, is leading this work with clinical leadership provided by Professor Andy Rhodes, Medical Director of the SWL acute provider collaborative, Dr Bu Hayee, Clinical Lead for Gastroenterology and Amyn Haji Clinical Lead for Endoscopy at Kings.

London is the lead *Adapt and Adopt* region for Endoscopy recovery.

Each ICS has identified an SRO lead for this work:

- Julie Lowe - Programme Director, SE London Acute Provider Collaborative - SEL
- Daniel Elkeles – Chief Operating Officer, Epsom and St Helier University Hospitals NHS Trust - SWL
- Rob Hodgkiss - Deputy Chief Executive and Chief Operating Officer, Chelsea and Westminster NHS Foundation Trust – NWL
- Rob Hurd- System Lead, North London Partners in Health and Care - NCL
- Angela Wong, Consultant Gastroenterologist, Barts Health NHS Trust - NEL

Endoscopy clinical leads:

- Bu Hayee, Clinical Lead for Gastroenterology, King's College Hospital NHS Foundation Trust - SEL
- Amyn Haji, Clinical Lead for Endoscopy, King's College Hospital NHS Foundation Trust – SWL
- Ralph Greaves, Consultant Endoscopist, Kingston Hospital NHS Foundation Trust - SEL
- Adam Humphries, Consultant Endoscopist, London North West University Healthcare NHS Trust - NWL
- Edward Seward, Consultant Endoscopist, University College London Hospitals NHS Foundation Trust - NCL
- Sean Preston, Consultant Endoscopist, Barts Health NHS Trust – NEL

- Saswata Banerjee, Consultant Endoscopist, Barking Havering and Redbridge University Hospitals NHS Trust

Our programme started at the end of June. We have identified a set of interventions that can be implemented at Trust, System and Regional level to rapidly recover pre-Covid activity levels and support systems to work through the screening backlog to reduce clinical risk. We are also developing our thinking on how Endoscopy services should be maintained and protected in the event of a second Covid surge, as well as how to move towards a more community-based model of Endoscopy and diagnostics services.

We have established a clinical working group with representatives from across London to define and spread best clinical practice. We have agreed a London-wide sessional pay rate for evening and weekend work for Endoscopy recovery. We also have confirmed IPC guidance and are promoting the most effective working practices (e.g. separating upper and lower GI lists to improve room turn-around time for lower GI). We are working with Health Education England (HEE) to design and roll out an Immersion Training course for ST5-7s, and working with the NHS supply chain to buy additional scopes and stacks at discounted rates to support the opening of additional capacity. Our focus has been on short-term recovery, but we are now starting to consider how we can grow the workforce, optimise clinical pathways and build in Covid resilience.

- Imaging

The Imaging recovery programme is being led by Dr Clive Kay, CEO of King's College Hospital NHS Foundation Trust, with clinical leadership provided by Professor Andy Rhodes, Consultant in Anaesthesia and Intensive Care Medicine at St George's University Hospitals NHS Foundation Trust, ,and Dr Amrish Mehta, Imaging Clinical Director at Imperial College Healthcare NHS Trust .

Each ICS has identified an SRO lead for this work:

- Julie Lowe, Programme Director, SE London Acute Provider Collaborative - SEL
- Daniel Elkeles, Chief Operating Officer, Epsom and St Helier University Hospitals NHS Trust - SWL
- Joe Huang, Divisional Director for Cancer & Clinical Support, Barking Havering and Redbridge University Hospitals NHS Trust - NEL
- John Quinn, Chief Operating Officer, Moorfields Eye Hospital NHS Foundation Trust - NCL
- Cally Palmer, Chief Operating Officer, The Royal Marsden NHS Foundation Trust - NWL

Imaging clinical leads:

- Julie Lowe (interim), Programme Director, SE London Acute Provider Collaborative - SEL
- Ketul Patel, Radiologist, Croydon Health Services NHS Trust - SWL
- Matt Matson, Radiologist, Barts Health NHS Trust - NEL

- Susan Jawad, Radiologist, University College London Hospitals NHS Foundation Trust - NCL
- Amrish Mehta, Imaging Clinical Director, Imperial College Healthcare NHS Trust - NWL

It was mobilised at the end of July. Our work is building on the national *Adapt and Adopt* programme led by the South West Region, and it will support STPs/ICSs to deliver best practice in clinical outcomes and to drive improved productivity. It will also support systems to mobilise radiology networks.

In the short term, the programme is focusing on interventions to recover services to pre-Covid capacity levels.

These include: double running machines being replaced as part of the wave 1/ 2 scanner replacement programme; maximising use of independent sector; improving productivity through DNA improvement initiatives and IPC measures; and radiologists and radiographers working at the top of their grade. In the medium term, as part of the programme's work to transform services, we will be working with systems to develop new clinical networks, revise best practice pathways, establish standardised protocols to reduce unwarranted variation, upskill existing staff and set up training academies.

So far, we have held an initial workshop with over 100 people to review and develop the work from the South West Region, established a clinical working group, started a programme of shared best practice across London and continued to manage the additional capacity provided by mobile scanners and 'relocatables'.

Critical care

Resilient and high-quality critical care services are a key part of our response to any future Covid surge and to restoring elective surgery capacity across London. Mark Turner, Director of Commissioning for NHSE/I London has been leading this work with clinical leadership provided by Professor Jules Wendon, Executive Medical Director of Kings / Clinical Director of London's Adult Critical Care Operational Delivery.

ICS leadership is provided by the 5 critical care network leads –

- Charlotte Hopkins, Deputy Chief Medical Officer, Barts Health NHS Trust - NEL
- Richard Beale, Associate Medical Director, Guys and St Thomas' NHS Foundation Trust- SEL
- Rafik Bedair, Clinical Director for Adult Clinical Care, St Georges NHS FT - SWL
- Julian Redhead, Medical Director, Imperial College Healthcare NHS Trust - NWL
- Gillian Smith, Deputy Medical Director, Royal Free Hospital and Geoff Bellingham, Medical Director for Surgery and Cancer Board, UCLH - NCL

The aim of this programme is to ensure London has high quality critical care services that can meet current and future need. We are looking to identify funding of £120–

130m for over 500 new critical care beds and aim to open these for the winter of 2020/21.

Independent sector

In March 2020, NHSE/I agreed contracts with a number of independent sector providers (ISPs) across England to buy all their available capacity and resource in response to COVID-19. This capacity was critical in ensuring we could continue to offer high priority capacity throughout the surge, and it remains critical as we restart elective surgery including complex cases e.g. cancer across London.

In early August, notice was served on some of the London providers that were signatories to the national Independent Sector (IS) contract. Contracts with these providers will end at midnight on 7th September. Although these sites are no longer part of the national contract, this does not mean the hospitals cannot be used for NHS activity, but rather that a migration to local contracts is needed. Work is underway to establish a new national procurement framework contract for NHS activity for IS providers, to be implemented later this calendar year. To cover the period between the termination of the central London contracts (7th September) and implementation of the national framework, London region is undertaking a rapid procurement with the aim of ensuring continuity in clinically critical capacity. Work has been undertaken with ICS leads and the clinical networks to determine the demand and case mix for these new IS contracts.

Nationally, contracts with the remaining London providers have been varied this week to allow 20-40% of their capacity to be used for private patients. There is a pressing need to quantify the available capacity and to develop NHS activity plans based on the available capacity for each of these in-contract IS providers for the period of September to November to ensure maximum value.

This work is being led by Ann Johnson, Regional Director of Finance, with Dr Chris Streather from Royal Free Hospital FT providing clinical leadership and James Eaton from Chelsea and Westminster NHS FT as Programme Director. A Steering Group has been established, with specialist expertise being provided by NHS executive directors from across London.

Urgent and Emergency care

A series of initiatives have been devised to transform the London Urgent and Emergency Care (UEC) landscape. This work is being led by Dr Vin Diwakar, Medical Director for NHSE/I London with clinical leadership being provided Dr Ruth Brown, emergency medical consultant at Imperial. Activity is currently at about 75% of pre Covid levels with performance over 90%across London. We are aiming to maintain this high level of performance throughout the winter.

The programme will make it easier and safer for patients to get the right treatment at the right time and prevent a return to previous overcrowding in Emergency Departments (EDs). It focuses on early assessment and triage of patients with urgent care needs to services which can best meet their needs thus

avoiding unnecessary attendance at an Emergency Department where possible. The two most significant initiatives are a rapid expansion of Same Day Emergency Care (SDEC) and the NHS 111 First programme.

There are named Executive leads for each ICS –

- Tina Benson, Chief Operating Officer, The Hillingdon Hospital NHS Trust - NWL
- Kate Slemeck, Chief Executive Officer, The Royal Free Hospital - NCL
- Tracey Fletcher, Chief Executive Officer, The Homerton Hospital NHS Foundation Trust - NEL
- Angela Helleur, Chief Nursing Officer, Lewisham and Greenwich NHS Trust - SEL
- Matthew Kershaw, Chief Executive Officer Croydon Health Services NHS Trust - SWL

Implementation of the 12 SDEC pathways (that make up 60% of SDEC activity across London) is being accelerated with an immediate focus on high risk groups such as pregnant women with hyperemesis gravidarum and paediatric asthma. The NHS 111 First Programme will deliver a new approach to streaming and direction of non-urgent patients into urgent care settings. It will promote NHS 111 to the public as the best route to care by including the scheduling of patients into an appointment slot in EDs where appropriate. In London, NHS 111 providers can book appointments for patients at the majority of UTCs and this is being expanded to include EDs. We have started a scheme where NHS 111 providers alert EDs via email to all patients that they refer, including important information about the patient's shielded status. It is expected that we will start booking patients at selected sites before the end of August. NHS 111 will also be able to schedule patients into SDEC services later this year, bypassing the need to attend ED altogether.

Across London, we have secured £49.6m capital investment to prevent nosocomial infection and to improve flow by increasing the capacity of EDs, UTCs and SDEC facilities. These changes are expected to be in place by the 1st January 2021 ahead of the busiest winter months.

Learning disability and Autism

We have continued to prioritise learning disability (LD) and autism services. Our priorities for phase 3 of the NHS response to Covid-19 are to: continue to reduce the number of inpatients in specialist services; to complete outstanding LD mortality reviews (LeDeR) by December 2020; carrying out Care, Education and Treatment Reviews (C(E)TRs) before any admission; and to undertake annual heath checks for all people with learning disabilities on GP registers. Although London continues to have gradual adult inpatient reduction, the overall number of admissions this month are nearly double the number of discharges. This increase in admissions relates to children and young people and all ICSs are working hard to ensure that children and young people can remain at home. C(E)TR performance as of June 2020 remains below target for most areas but is an improvement from May. Clinical networks and primary care colleagues have worked together with the aim of 'revitalising' annual

health checks. Across London work on LeDeR reviews continues, with four ICSs increasing the number of reviews in June 2020.

Primary care, community services and social care

We have been working closely with systems on primary care, community services and social care. This work is being coordinated by Liz Wise, Director of Primary Care and Public Health Commissioning, and Briony Slope, Senior Improvement Lead – Urgent and Emergency Care. We are fortunate to have social care leadership at a regional level from Aileen Buckton MBE, former Executive Director for Community Services in Lewisham Council and former Chair of ADASS for London. In ICSs this is being led at borough level by councils, primary care, community providers and social care providers.

Systems have made good progress in reducing delays in hospital discharge, consolidating the discharge to assess programme and supporting care homes and wider social care services. Primary care services have rapidly transformed to digital consultations, dentistry and optometry are now open again and most community services are now up and running. Pharmacy services have made a major contribution to managing the Covid pandemic.

Major progress has been made in the integration of primary care, community services and social care and we expect systems to focus on this over the next few months to prevent hospital admissions and rapid appropriate discharges to ensure hospital beds remain available for people needing in patient care. The new funding for health and care support will be available for 6 weeks and during this time comprehensive care and health assessments, including funding eligibility will need to be undertaken. We are also expecting systems to address the backlog of CHC assessments.

As we plan for the full restoration of all services outside of hospital, we will be focusing on screening services where there is significant work to do. We know that 115,000 women have missed breast screening appointments with a possible 450 cancers not found. There are major catch up programmes in all screening services.

There is significant work to do to ensure delivery of immunisations/ vaccinations particularly childhood immunisations, flu and when available the Covid vaccination.

Addressing new priorities - Tests 4 and 5

Test 4 Public health burden of pandemic response

Test 5 Staff and carer wellbeing

Mental Health

The NHS and our partners have long been committed to improving the quality of services and outcomes related to mental health and well-being for all our

communities across the capital. Most recently, we have focused our combined efforts on delivering this improvement through the priorities in the Long Term Plan and the London Vision.

During the first wave of the epidemic in London, we have seen some remarkable successes in supporting mental health service users and their carers. These include: the rapid roll out of digital services such as Good Thinking with increased investment that is being funded by the London partnerships ; Trusts providing services by video and telephone; and greater cross-sector working to support people in crisis and with co-morbidities. There has been rapid development of new crisis pathways through Mental Health Emergency Departments and we have managed growth in demand for services such as Substance Misuse and Support. We have also provided psychological support to NHS Staff in these unprecedented times.

We know that the impact on mental health and wellbeing will continue to be felt long after the Covid-19 pandemic. We are now planning how we can meet those needs. Priorities identified include: a focus on reducing health inequalities, particularly on Black, Asian and minority ethnic (BAME) and vulnerable groups; standardising the urgent care offer; and supporting people with enduring mental ill-health to remain in the community. We will also continue to focus on prevention and early intervention and developing and improving children and young people's mental health services.

Staff and carer well being

Ensuring staff wellbeing is a critical area of work for the London health and care system. As part of the wider Workforce Programme for London led by Ben Morrin, Director of Workforce at UCLH, we have a specific focus on caring for and celebrating our staff.

The impact of COVID-19 on the mental health of staff across the system has been recognised, and we are developing a comprehensive package of support to ensure timely access to appropriate interventions through a range of access points. We are taking a holistic approach to support recovery. The ambition for staff wellbeing shared in the People Plan will shape our response and all organisations are invited to participate as we build our plans for the health of our workforce. All activity is undertaken with the acknowledgement of the experience of our BAME communities as both colleagues and citizens. We are paying particular attention to respond to any specific issues raised. We are looking at childcare and financial wellbeing as part of the programme and a suite of digital resources has been promoted across London.

Methods of recognition and celebration for staff delivering care throughout the Covid-19 response are being explored through a series of 'Big Conversations', with the aspiration for a series of culturally-sensitive activities to continue into 2021 and beyond.

Reset to a better health and care system - tests 6, 7 and 8

Test 6 Innovation

Test 7 Equity

Test 8 The new health and care landscape

Innovation

During the early phase of the pandemic, there were several interventions to address emergent population needs in response to the increasing rate of Covid-19 infection. We need to rapidly evaluate and modify these responses. This work is being led by Dr Nnenna Osuji, Medical Director/Deputy Chief Executive of Croydon Health Services NHS Trust, supported by Malti Varshney, Director of Clinical Networks and Clinical Senate for NHSE/I. The work will be carried out through a partnership between NHSE/I, London AHSNs, AHSCs and ARCs.

The initial areas chosen for evaluation are: remote consultations with a focus on inequalities; digital tools for self-management; and integrated palliative care teams. The next areas for evaluation are likely to include primary care triage and Covid-19 survivorship.

Equity

The London Health Board agreed to prioritise addressing the deep-seated health inequalities exposed by the first wave of the Covid-19 pandemic and the disproportionate impact it has had on Londoners from Black, Asian and Minority Ethnic Groups and those experiencing the greatest inequalities. Given the prospect of a further outbreaks or a second wave of Covid-19 infections there is a need for partners to come together early to mobilise and support action to ensure that our communities are resilient, and we do all that we can to avoid further harm to those most at risk. As such, Public Health England is working with us, the Mayor and with London Councils to establish a London Health Equity Group co-chaired by Kevin Fenton the Regional Director of Public Health and Will Tuckley – Chief Executive of Tower Hamlets council with membership across the capital. Local action is the bedrock from where we start, with borough ICS/STP leadership key to London's collective success. Action is already being taken locally so the group will need effective mechanisms to engage with local leaders to provide the support they need to take effective action. Its role is to support and enable action at scale and pace:

Our work within the NHS is being led by Dr Vin Diwakar with clinical leadership provided by Dr Malti Varshney. The London Clinical Advisory Group has worked with clinicians in our ICSs and our AHSNs to develop tools which can be used to proactively identify those who are most at risk of COVID-19 in order that multidisciplinary teams can reach out and work with them to improve management of their long term conditions such as diabetes and hypertension.

As well as providing healthcare services, the NHS directs approximately 10% of the nation's economic activity, is the country's largest employer. The NHS therefore has significant influence over the wider determinants of health. NHS organisations are already adjusting how we employ staff, purchase goods, manage estates and

engage with local communities, alongside local partner to proactively improve local socio-economic conditions and tackle the underlying drivers of poor health and health inequalities. However, we don't have an agreed definition of what being a "good" anchor institution or anchor system involves. As such, we are setting up a London wide network of anchor institutions to develop a compelling vision of what we might achieve, to spread good practice, learn from international exemplars, and remove some of the barriers to progress.

The new health and care landscape

The health and care landscape has been evolving rapidly in London, with CCG mergers going live in SEL, SWL and NCL in April 2020, and NEL and NWL currently working towards CCG merger in April 2021. SWL and SEL have now been approved by NHSE/I as formal Integrated Care Systems. We have a new provider acute collaborative in SEL.

Primary care networks (PCNs) are now up and running in all areas of London and have developed rapidly over the past six months. These networks have played an important role in managing the Covid-19 surge. We will continue to support the development of PCNS, working with partnership with community services, local authorities, and the voluntary and community sector.

We are currently working with the Kings Fund and ICS chairs to explore thinking and plans for ICS governance and whether there would be benefit to a single London model, with variants for local circumstances. We will keep you updated on this work. There is work at a national level on ICS governance and this is currently focusing on commissioning, the financial framework, provider collaboration and leadership and governance. We are expecting national guidance on ICS governance in the autumn.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.10/Oct/20
REPORT NAME	Quality Committee Report to Council of Governors
AUTHOR	Eliza Hermann, Non-Executive Director Chair of the Quality Committee
LEAD	Eliza Hermann, Non-Executive Director Chair of the Quality Committee
PURPOSE	To provide the Council of Governors with an update on the work of the Quality Committee (a Board Committee) over the past 9 months.
SUMMARY OF REPORT	As enclosed.
KEY RISKS ASSOCIATED	N/A
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	N/A
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	All.
DECISION/ ACTION	For information and discussion.

Board Quality Committee - Chairman's Report to Council of Governors, October 2020

Following on from previous reports to the Council of Governors, this report summarises the work of the Board Quality Committee over the past 9 months since the beginning of 2020.

Committee Terms of Reference

The Trust aims to put the patient at the centre of care, and so the aim of the Committee is to provide the Board with assurance that the quality of care is delivered to the highest possible standards and that appropriate processes are in place to identify and manage any gaps. The Committee's remit includes oversight of -

- the ***safety*** of treatment and care provided to patients,
- the ***effectiveness*** of the treatment and care provided to patients, and
- the ***experience*** that patients have of the treatment and care they receive.

The Committee's work also relates directly to each of the Trust's PROUD Values.

Putting patients first
Responsive to and supportive of patients and staff
Open, welcoming and honest
Unfailingly kind, treating everyone with respect, compassion and dignity
Determined to develop our skills and continuously improve the quality of care

The Committee has a broad scope and a busy workload. The Quality governance architecture (attached) shows the four Groups that report to the Quality Committee, and their respective sub groups. The four Groups and their Chairs are

- Patient Safety (Peta Longstaff, Clinical Director for Patient Safety),
- Clinical Effectiveness (Roger Chinn, Medical Director),
- Patient and Public Experience and Engagement (Nathan Askew, Director of Nursing, Chelsea site), and
- Health, Safety & Environmental Risk (Pippa Nightingale, Chief Nursing Officer).

Committee Membership and Attendance

I was appointed Non Executive Director of the Trust in July 2014 and took up Chairmanship of the Quality Committee in October 2014.

Currently the other Non Executive Committee members are Nilkunj Dodhia and Ajay Mehta. The Executive Directors on the Committee are Lesley Watts (Chief Executive), Rob Hodgkiss (Deputy Chief Executive and Chief Operating Officer), Roger Chinn (Medical Director), Pippa Nightingale (Chief Nursing Officer), Lizzie Wallman (Director of Clinical Governance) and Serena Sterling (Director of Corporate Governance). Participants also include from time to time Iain Beveridge (Hospital

Medical Director – West Middlesex), Nathan Askew (Hospital Nursing Director – Chelsea & Westminster) and Peta Longstaff (Clinical Director for Patient Safety).

Attendance is excellent and everyone actively participates.

The Committee has met 8 times since the beginning of 2020, notwithstanding a hiatus in regular governance meetings in the early stages of the pandemic. Since June we have met monthly and our intention is to continue on a monthly schedule. Committee meetings have been virtual since March.

Significant Items Covered by the Committee

1. Patient Safety. The Committee spends considerable time overviewing how the Trust ensures treatment and care of patients is safe. This includes -

- **Infection Prevention and Control (IPC)**. Always an important focus area and even more so in the context of the pandemic. The Committee had an indepth review with the Director of IPC in July, and the Trust has recently had a satisfactory assessment by the CQC of our IPC processes and compliance.

- **Mortality Surveillance**. The mortality review process has continued throughout the pandemic, with the newly appointed Medical Examiners (a new role that is now mandated throughout the NHS) taking a lead in reviewing deaths in hospital. Iain Beveridge continues to Chair the Trustwide Mortality Group and Ajay Mehta has taken over from Andy Jones as the Non Executive Lead for Mortality. The Committee routinely scrutinises the mortality data and queries any specialty outliers. The Trust's mortality rate continues to be among the lowest in England with a Summary Hospital Mortality Indicator (SHMI) of 77.

- **Serious Incidents**. Quickly analysing root cause of incidents and putting in place actions to prevent them happening again has continued throughout the pandemic. The Trust has a robust incident investigation and review process, with appropriate follow up to ensure learnings are shared more widely. The Committee reviews a summary of each Serious Incident and always seeks evidence that the learnings have indeed been learned.

2. Effectiveness of Care. Recent areas of Committee focus include -

- **Cancer Pathways**. During the pandemic there has been concern about cancer pathways and ensuring cancer diagnosis and treatment remains timely. The Committee reviewed the Trust's cancer performance in September and there is a trajectory of improvement, but this remains a key focus area for the Trust.

- **Elective Care**. Throughout the NHS a large backlog of elective and planned care procedures has built up during the pandemic and this is also true for the Trust. Addressing this backlog and treating the patients who are waiting for care is a priority and the Committee receives a detailed report at every meeting.

3. Patient Experience. The Committee reviews patient experience data at every meeting. However, further work is needed to triangulate all the different patient experience information gathered by the Trust, including patient surveys, Friends and Family Test results, Complaints and PALs inquiries, and input from patient and public involvement sessions. The Committee is looking forward to seeing the results of this triangulation later this year.

Targeted 2020-21 patient experience priorities and metrics are -

Priority	Key Indicator	Baseline	Target by end of March 2021	Progress
Friends & Family Test Improve-ment	All departments response rate and satisfaction > national average	Satisfaction Emergency - 88 GUM- 95 Maternity - 91 Inpatients - 94 Paediatrics - 91 Outpatients - 92	Satisfaction Emergency - 95 GUM- 96 Maternity - 97 Inpatients - 96 Paediatrics - 96 Outpatients - 94	2% increase overall
PALS Improve-ment	100% five day response rate	67%	100%	95%
Digital Patient Leaflets	All departments have all patient leaflets on Trust website	0%	100%	25%
Discharge	Discharge experience better than 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%	Some improvements but project has been delayed due to covid

4. Overall Quality of Care

- As a result of the most recent CQC inspection in late 2019, the Trust as a whole continues to be rated "Good", with an "Outstanding" rating for "Well-Led" and for "Use of Resources". The Chelsea site is rated "Outstanding" and the West Middlesex site is rated "Good." Certain clinical services on each site are rated "Outstanding". The CQC did not specify any "must do" actions but they did identify 22 improvements of which 18 are "should do's". The Committee monitors progress in completing and embedding these. As of last month the status is

6	**Blue**	Action complete and embedded in daily practice
10	**Green**	Action on track for on-time completion
6	**Amber**	Action off track but plans in place to mitigate delay
0	**Red**	Action is off track and requires a re think

Several of the 6 "amber" actions relate to medical staffing particularly at night. Rotas have been adjusted and the Committee has been assured that staffing coverage is safe.

- **Quality Improvement (QI).** The Trust has a number of ongoing work-strands focussed on improving the quality of care, with the overarching objective of building an organisational culture of continuous learning and improvement . Some of these work-strands are
  - the Trust's bespoke virtual **Quality Improvement Hub** and **QI training** which have continued during the pandemic;
  - **Getting It Right First Time** (GIRFT) reviews. These are clinical specialty-based external peer reviews, intended to drive improvements in effectiveness and efficiency of clinical practice. Reviews have resumed virtually after pausing during the early stages of the pandemic, with recent or pending reviews of plastic surgery, lung cancer, and gastroenterology;
  - **Research, Innovation and QI** events to share learnings across departments and clinical specialty areas;
  - **Ward Accreditation**. The programme of ward based quality assessments is well-embedded at the Trust but has been paused during the pandemic.

- **2020-21 Quality Priorities.** A major Trust-wide focus of QI efforts are the four key Quality Priorities approved by Governors at year start. Due to the pandemic, in year progress has been delayed although efforts have been ramped up over the summer and early autumn. Status is -

Priority	Key Indicator	Baseline	Target	Progress
Improving dementia care	# patients >75 screened on admission	81%	90%	CW 99% WM 69%
Improving cancer care	% newly diagnosed patients with Holistic Needs Assessment (HNA) and personalised care plan (PCP)	61%	70%	60% HNA 53% PCP
Improving sepsis care	% patients screened for sepsis / receiving IV antibiotics < 1 hour	81% / 72%	90%	14% / 46% partial data
Improve volunteering impact	# volunteers / days from appointment to start / # clinical hours saved	600 vols / 101 days / 198 hours	900 vols / 56 days / 400 hours	842 vols ytd / 20 days / 819 hours

In addition to all of the above, the Committee regularly reviews the Trustwide **Performance and Quality Report** containing over 100 performance metrics. Not all are discussed but Committee members commend areas of strong performance and query areas where the Trust isn't meeting regulatory or Commissioner-specified targets.

We also review (in an ongoing rota) the work of the four Groups and their attendant sub groups i.e. **Patient Safety, Clinical Effectiveness, Patient and Public Engagement and Experience, and Health, Safety & Environmental Risk**. We query any issues and if needed, request follow-up assurance. A few recent examples where the Committee requested additional assurance are:

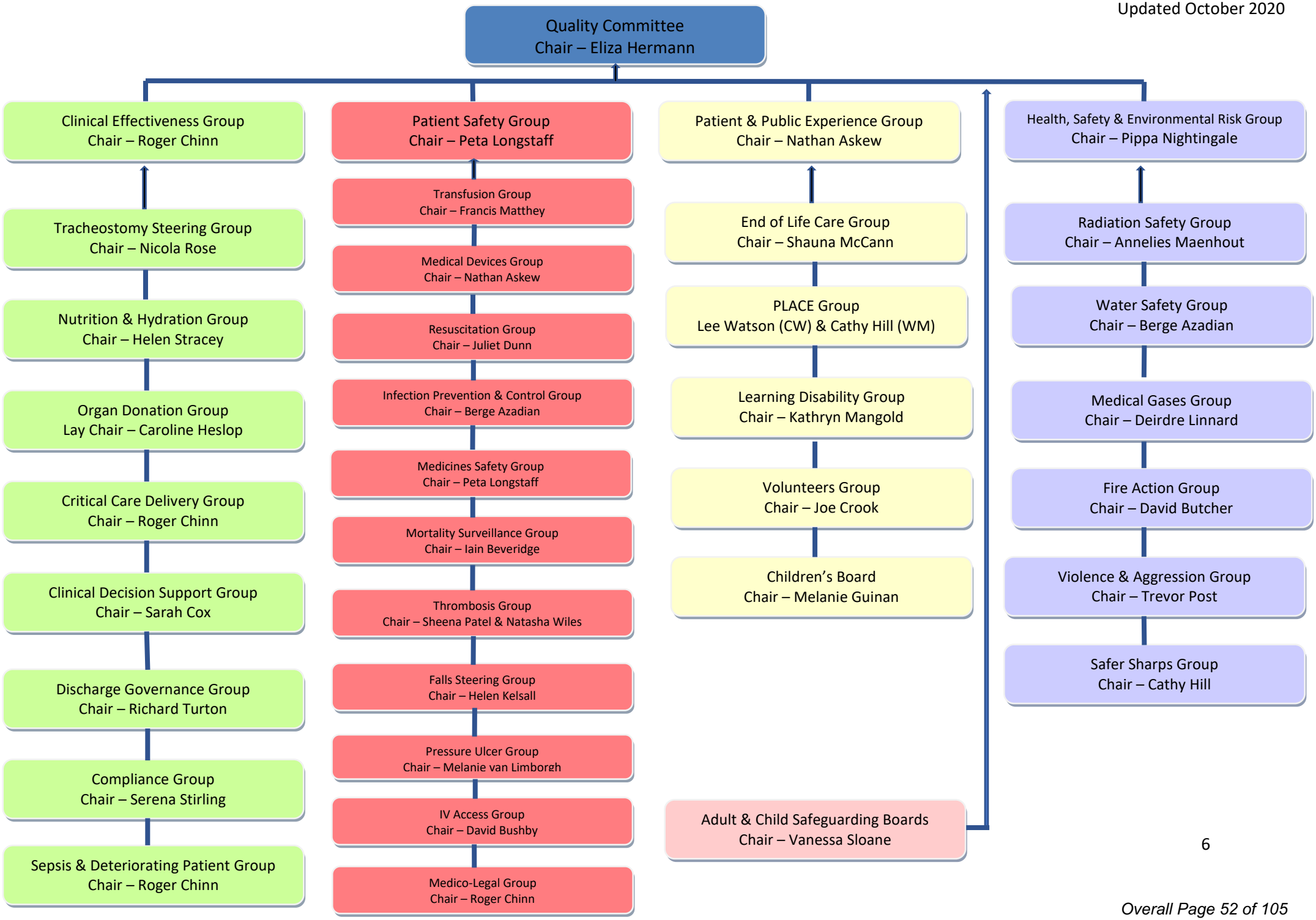
- Fire safety particularly building compartmentation and alarm systems;
- Infection prevention and control: antimicrobial stewardship system;
- Quality performance of Northwest London Pathology.

Conclusion

The Trust has coped well with the challenges created by the pandemic, but needs to recover to pre-pandemic performance levels in a number of areas while at the same time effectively caring for covid patients. Part of this performance recovery is dependent upon joined-up working among the different NHS organisations in North West London (the "ICS"). The Quality Committee will remain sighted on progress in this regard.

I look forward to discussing the work of the Committee and answering any questions at the 29 October meeting of the Council of Governors.

Eliza Hermann
Quality Committee Chairman
19 October 2020


Quality Committee
Chair – Eliza Hermann
Clinical Effectiveness Group
Chair – Roger Chinn
Tracheostomy Steering Group
Chair – Nicola Rose
Nutrition & Hydration Group
Chair – Helen Stracey
Organ Donation Group
Lay Chair – Caroline Heslop
Critical Care Delivery Group
Chair – Roger Chinn
Clinical Decision Support Group
Chair – Sarah Cox
Discharge Governance Group
Chair – Richard Turton
Compliance Group
Chair – Serena Stirling
Sepsis & Deteriorating Patient Group
Chair – Roger Chinn
Patient Safety Group
Chair – Peta Longstaff
Transfusion Group
Chair – Francis Matthey
Medical Devices Group
Chair – Nathan Askew
Resuscitation Group
Chair – Juliet Dunn
Infection Prevention & Control Group
Chair – Berge Azadian
Medicines Safety Group
Chair – Peta Longstaff
Mortality Surveillance Group
Chair – Iain Beveridge
Thrombosis Group
Chair – Sheena Patel & Natasha Wiles
Falls Steering Group
Chair – Helen Kelsall
Pressure Ulcer Group
Chair – Melanie van Limbergh
IV Access Group
Chair – David Bushby
Medico-Legal Group
Chair – Roger Chinn
Patient & Public Experience Group
Chair – Nathan Askew
End of Life Care Group
Chair – Shauna McCann
PLACE Group
Lee Watson (CW) & Cathy Hill (WM)
Learning Disability Group
Chair – Kathryn Mangold
Volunteers Group
Chair – Joe Crook
Children's Board
Chair – Melanie Guinan
Adult & Child Safeguarding Boards
Chair – Vanessa Sloane
Health, Safety & Environmental Risk Group
Chair – Pippa Nightingale
Radiation Safety Group
Chair – Annelies Maenhout
Water Safety Group
Chair – Berge Azadian
Medical Gases Group
Chair – Deirdre Linnard
Fire Action Group
Chair – David Butcher
Violence & Aggression Group
Chair – Trevor Post
Safer Sharps Group
Chair – Cathy Hill

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.11.2/Oct/20
REPORT NAME	Draft minutes of the Council of Governors Quality Sub-Committee meeting held on 11 September 2020
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Laura Wareing, Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Council of Governors Quality Sub-Committee meeting held on 11 September 2020.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

DRAFT
Minutes of a meeting of the Council of Governors Quality Sub-Committee
Held at 10am on 11 September 2020 (Zoom)

Attendees	Laura Wareing (Chair)	Chair / Public Governor	LJW
	Simon Dyer	Patient Governor, Lead Governor/Deputy Chair	SD
	Nowell Anderson	Public Governor	NAn
	Anna Hodson-Pressinger	Patient Governor	AHP
	Richard Jackson	Staff Governor	RJ
	Minna Korjonen	Patient Governor	MK
In attendance	Nathan Askew	Director of Nursing CW	NAsk
	Lizzie Wallman	Director of Quality Governance	LWall
	Stephen Cox (in part)	Head of Communications	SC
	Helen Kelsall (in part)	Divisional Director of Nursing, EIC	HK
	Vida Djelic (Minutes)	Board Governance Manager	VD
Apologies	Nigel Davies	Public Governor (Ealing)	ND
	David Phillips	Public Governor	DP
	Richard Jackson	Staff Governor	RJ
	Trusha Yardley	Public Governor (Hammersmith & Fulham)	TY

1.	**GENERAL BUSINESS**
1.1	**Welcome and Apologies** LJW welcomed all to the meeting. Apologies were noted as above.
1.2	**Declarations of interest** Nil of note.
1.3	**Minutes of previous meeting held on 26 June 2020** The minutes of the previous meeting held on 26 June 2020 were accepted as a true and accurate record.
1.4	**Matters Arising & Action Log** The Sub-Committee noted that all actions were either complete or on track to complete on target.
1.4.1	**1.4.1 Governor representative on Dementia Steering Group – for discussion & approval** The sub-committee discussed and confirmed SD to be a Governor representative on the Dementia Steering Group.
2.	**REGULAR REPORTS**
2.1	**Learning from Serious Incidents** *Lizzie Wallman, Director of Quality Governance* The paper was taken as read. LWall noted that during June 2020, 15 incidents were declared; of these 10 were internal and 5 external Serious Incidents (Sis). Of note is the increase in number of serious harm Sis; this is due to the new national requirement around grading of hip fractures following a fall. LWall drew attention to a never event which was reported during the reporting month of June relating to unintentional connection to air instead of oxygen (West Middlesex). This is being investigated and lessons

	learnt taken forward to prevent any similar future occurrence. In response to LJW query, LWall confirmed that no particular patterns or themes have been identified in relation to three maternity incidents submitted to Commissioners.
2.2	**Learning from complaints report Q1** *Nathan Askew, Director of Nursing (CW)* The sub-committee noted the new style quarterly complaints report focussing on themes and improvement. Although complaints performance is strong, numbers were much lower during the Covid-19 incident and are already rising. The operational teams working towards more timely de-escalation and local resolution by calling complainants directly on receipt. In repose to LJW question regarding how many Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) patients have registered with DrDoctor, a secure online patient portal which provides patients with the ability to view and manage their appointments, LWall replied that this will be confirmed outside the meeting. **Action: LWall to confirm the number of patients registered with DrDoctor.**
2.3	**Performance & Quality Report – July 2020** *Lizzie Wallman, Director of Quality Governance* LWall advised that due to significant impact of COVID-19 a number of performance metrics were either not available due to being suspended or not available due to reprioritisation of 'Business as Usual' tasks. The performance metrics remain under review and further updates will become available as recovery continues. LWall highlighted the following performance: • The A&E validated position being reported as 94.59% which is an increase 0.54% from June. • The cancer 62 day performance validated position being reported as 74.16%; work on-going to improve this position; challenges continue while the COVID related backlog is cleared over the coming weeks and months. • The RTT performance continued to decline as a result of a suspension of routine elective activity; recovery plans are in place as well as clinical reviews to establish prioritisation of patients waiting to be seen; there has been an increase in referrals in the past month as Primary Care restarts its routine referrals; the Trust is working closely with the Royal Marsden Cancer Hub and system partners to diagnose and treat patients to expedite recovery.
2.4	**Group reports**
2.4.1	**Falls Steering Group** LJW noted the Steering Group is progressing with the work plan and that the inpatient and outpatient policy has been harmonised and will be available on the Trust's Intranet.
2.4.2	**End of Life Care Group** AHP noted that Shauna McCann leads the End of Life Care Group. The work plan focuses on improving patient care which is informed by patient experience. The sub-committee discussed and agreed that AHP continues reporting back from End of Life Care Group.
2.4.3	**Test Bed Steering Group** SD noted that Steering Group meeting dates need to be reinstated in his calendar and he would take this

	forward with the Steering Group lead.
2.4.4	**Dementia work programme update** *Helen Kelsall, Divisional Director of Nursing, Emergency & Integrated Care Division* HK noted that the Trust has a 5 year Dementia Strategy and highlighted the following points: • Year 1 evaluation of the strategy implementation took place recently; a slow progress caused by the Covid-19 outbreak; • Work plan: finalise and implement a clear reliable and transparent delirium pathway which would be aligned at both Chelsea and West Middlesex sites; work is underway to do this; • Dementia screening for all patients >75 years presenting at hospital undertaken by Clinical Nurse Specialists; learning from Covid-19: more staff groups need to undertake the dementia assessment including nursing and medical teams; • Environment improvement work underway to redesign Marjorie Warren Ward (West Middlesex) to make it dementia-friendly; • Improving dementia care is a Trust quality priority for next financial year; • Delirium prompt on Cerner is now being used at the Chelsea site; West Middlesex site is not yet using Cerner, however they have a more established workforce for screening delirium and dementia; • Staff are being familiarised with the nursing dashboard and training sessions are being scheduled; and • Staff training underway with an enhanced dementia education programme. In response to a question from NAn regarding people with dementia life expectancy, HK stated that generally, the life expectancy of a person with dementia depends on the type of dementia they are diagnosed with; the life expectancy is better if people are being diagnosed earlier.
2.5	**Disability Steering Group update** MK noted that owing to technological issues she had experienced she was unable to prepare a report from the Steering Group. She undertook to provide a comprehensive report at the next sub-committee meeting. **Action: MK to provide a comprehensive report at the next sub-committee meeting**. At this point the sub-committee discussed and agreed to continue receiving regular updates from the following Trust Groups: • Falls Steering Group • End of life Care • Test Bed Steering Group • Dementia Steering Group • Disability Steering Group VD advised that the sub-committee Terms of Reference need reviewing and updating to reflect the reporting structure. **Action: The Terms of Reference review to be undertaken at the next sub-committee meeting. (LJW/VD)** LJW advised that Governor Caroline Boulliat expressed interest to join the sub-committee. The sub-committee discussed and agreed to invite Caroline to the next sub-committee meeting. **Action: LJW/VD to invite Governor Caroline Boulliat to the 4 December sub-committee meeting.**

2.6	**Governor's patient story and feedback on patient contacts** Nil of note.
3.	**AD HOC REPORTS**
3.1	**Staff awards** *Stephen Cox, Head of Communications* Stephen Cox noted that due to ongoing Covid-19 situation the Executive Team decided that it was inappropriate to stage either the staff awards or the traditional means of celebrating Christmas and other winter festivals. The Communications Team was tasked with bringing together interested parties to discuss possibilities of a virtual 'thanking and celebrating' at the end of 2020. The Communication Team will devise a proposal for the virtual celebration and will share with the sub-committee. The sub-committee members were supportive of the idea to create an appreciation video to thank all staff for their tireless support throughout the year. **Action: SC to share the proposal for the virtual celebration with the sub-committee and to involve a governor when creating a video for the virtual 'thanking and celebrating' event at the end of 2020.**
3.2	**Friends and Family Test (FFT) update** *Nathan Askew, Director of Nursing (CW)* NAsk noted that the FFT was suspended during the Covid-19 pandemic. This has delayed the work on improving performance against the national inpatient survey. The restart of this across all services has been slow and in some areas difficult to return to pre pandemic levels of response rate and satisfaction scores. There is a dedicated improvement project to focus on this programme of work. Demonstrating learning from complaints continues to be a challenge although there has been a vast improvement in this area. In response to NAn's question, NAsk responded that after being discharged from a service patients are invited to complete the FFT via text message. In response to LJW's question whether every patient coming through hospital's door could be invited to feedback on their experience, NAsk stated that it could be an ambition, however, it would be difficult to achieve 100% coverage due to an option to opt out of FFT, if patients would wish to.
4.	**OTHER BUSINESS**
4.1	**COG Quality Sub-Committee forward plan** The sub-committee noted the forward plan.
4.2	**Any other business** Hospital visiting policy – In light of ongoing Covid-19 situation NAn asked about the Trust's visiting policy and NAsk responded as follows: Adult ward – One named visitor per patient that is not interchangeable can visit during 3-7pm seven days a week. Social distancing measures must be followed and each visitor must be temperature and symptom checked at the entrance to the hospital; follow hand hygiene measures and wear their own face covering. End of life care patients who are negative for COVID-19, can have more than one family member visiting at any one time. End of life care patients who are positive with COVID-19 can have one family member visiting wearing full PPE. Visiting times need to be agreed locally for each EOLC patient. Maternity – One birth partner but they can now visit for the antenatal, intrapartum and postnatal stay, but cannot stay overnight in the antenatal and postnatal period; Birth support such as doulas and Independent Midwives can also be present at Birth if agreed in advance by the Head of Midwifery. Partners can also be present for scan appointments. All birth partners must follow social distancing measures and be

	temperature and symptom checked at the entrance to the hospital; follow hand hygiene measures and wear their own face covering. Paediatric wards – Two family members can visit if they live in the same household, they can both visit together but the two named visitors are not interchangeable. Social distancing measures must be followed and each visitor must be temperature checked and symptom checked on entering the hospital; follow hand hygiene measures and wear their own face covering. NAsk advised that he and LW were moving on to pursue other opportunities in the health and care sector. On behalf of the sub-committee LJW extended her sincere appreciation to both NAsk and LWall for their commitment to the sub-committee and wished them well in future.
4.3	**Date of next meeting** 4 December 2020; 10.00-12.00.

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	1.12/Oct/20
REPORT NAME	Draft minutes of the Accessibility Working Group meeting held on 15 October 2020
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Steve Gill, Non-Executive Director Chair
PURPOSE	To provide a record of any actions and decisions made at the meeting.
SUMMARY OF REPORT	This paper outlines a record of the proceedings of the Accessibility Working Group meeting held on 15 October 2020.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

DRAFT

Accessibility Working Group Meeting Minutes
15 October 2020, 15.00 – 16.00
Zoom Conference

Present:	Steve Gill	Chair, Non-Executive Director	(SG)
	David Butcher	Director of Estates and Facilities	(DB)
	Andy Denton	Head of Estates and Facilities	(AD)
	Christopher Digby-Bell	Patient Governor	(CDB)
	Kush Kanodia	Patient Governor	(KK)
	Minna Korjonen	Patient Governor	(MK)
	Sue Smith	Director of HR & OD	(SSmith)
	Patricia Quigley (+ PA)	Appointed Governor	(PQ)
	Lee Watson	Deputy Director of Nursing	(LW)
	Kathy Lanceley (in part)	Director of IT	(KL)
In attendance:	Vida Djelic (Minutes)	Board Governance Manager	(VD)
Apologies:	Simon Dyer	Lead Governor/Patient Governor	(SD)

1.	**Welcome and apologies for absence** SG welcomed members to the meeting. Apologies for absence were noted as per attendance list.
2.	**Declarations of interest** None noted.
3.	**Minutes of previous meeting held on 29 January 2020** Minutes of the previous meeting were noted as a true and accurate record.
4.	**Accessibility Working Group Status Update** **4.1 Full audit report on the virtual environment** **4.2 Scope of the physical environment review and appointment of contractor** **4.3 Review patient experience in the protected characteristics groups** **4.4 Transport: status quo** The Working Group noted the papers provided in advance of the meeting. The Working Group discussed the papers and the recommendations that have been put forward for consideration and the following points were noted and agreed: • Virtual audit: A formal audit of Trust's website to be undertaken and future development to be informed by the outcome. • In support of CWFT becoming an exemplar, KK offered to share the top three leading providers of web accessibility audit services namely, AbilityNet, MicroLink and Barrier Break; it was identified that the Communication Team input in this audit was required; SSmith undertook to link up with the Communication Team on the web accessibility audit. **Action: SSmith to link up with the Communication Team on the web accessibility audit.**

	• Physical audit: The National Register of Access Consultants (NRAC) has been invited to facilitate the identification of suitable auditor/consultant; KK and MK volunteered to be Governor representatives on the panel for shortlisting the contractor; funding has been secured; audit timetable due to be confirmed and audit aimed to be complete in November/December; physical attendance might be impracticable for auditors due to government restrictions and concerns about the safety, however the latest guidance will be adhered to; • A meeting is being arranged with AccessAble on 19 October in regards to undertaking a visual assessment of public spaces and detailed information for service users on what to expect when accessing services will be provided; it was confirmed that the Trust has a Changing Places facility on the Chelsea site and is in the process of providing a similar provision on the West Middlesex site. • Review patient experience in the protected characteristics groups: LW asked for clarity in relation to specifics surrounding this review; SG undertook to clarify this with LW outside the meeting. **Action: SG to clarify specifics surrounding the review of patient experience in the protected characteristics groups with LW.** • Transport: DB updated that the free parking charges for Blue Badge holders continue at the Chelsea site with an active engagement to secure funding to bring the West Middlesex site into line with this arrangement; it was noted that the current NHS guidance, supported by statements in parliament from the Secretary of State for Health and Social Care that from April 2020 disabled parking would be free with no Hospital Trust being disadvantaged financially based on additional funding being provided from NHSE/I; the implementation was postponed due to the Covid-19 pandemic; KK updated that this changes from being guidance to being UK law from January 2021; DB undertook to provide a paper to the 28 October FIC and subsequently to the 5 November Board ensuring that CWFT is legally compliant with the NHS guidance prior to the January 2021 deadline. **Action: DB to provide a paper to the 28 October FIC and subsequently to the 5 November Board ensuring that CWFT is legally compliant with the NHS guidance on disabled parking charges in the UK prior to the January 2021 deadline.**
5.	**Any other business** None.
6.	**Date of next meeting** – 10 December 2020; 15.00-16.00.

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	2.1/Oct/20
REPORT NAME	Council of Governors election 2020 – update
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Vida Djelic, Board Governance Manager
PURPOSE	To update the Council of Governors on the progress with the 2020 Governor elections.
SUMMARY OF REPORT	As enclosed.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	The agreed fees and charges for conducting the Council of Governors election.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	All
DECISION/ ACTION	For noting.

Council of Governors election 2020 – update

1.0 Introduction

As a Foundation Trust, we are accountable to our local communities and our staff through our membership and the Council of Governors which includes elected representatives of the public, patients and staff, as voted for by the Foundation Trust members.

2.0 Process

The election process commenced on 1 October 2020. The vacant seats and elections were publicised on all hospital sites, website and social media. In addition, a blurb from our Non-Executive Director Ajay Mehta encouraging diverse nominations was posted on the website. Furthermore, the former Public Governor Angela Henderson generously assisted with publicising elections through her local church and Women on Boards website. The Council of Governors and the Board of Directors were provided with the elections timetable and the Governor seats coming up for election.

The nominations stage of the election process closed on 16 October 2020. A list of candidates who had nominated themselves to stand for elections was published on the Trust's website on 19 October and shared with the Council of Governors and the Board of Directors. The statement of nominated candidates is appended to this paper.

Uncontested seats

As there was one candidate for each of vacant seats in the Staff Constituency: Contracted Class, Nicole Nunes, and the Public Constituency: London Borough of Hammersmith and Fulham, Rose Levy respectively were dully elected unopposed.

Contested seats

Elections are being held in the following constituencies of the Council of Governors:

- Patient—2 seats
- Public: Royal Borough of Kensington and Chelsea—1 seat
- Staff: Management Class—1 seat
- Staff: Medical and Dental Class—1 seat

The number of members putting themselves forward for election was satisfactory given the on-going COVID-19 situation.

Trust Members registered in these constituencies will be invited to have a say in the future of the hospital by voting for the governor candidate of their choice in this year's election when ballot papers are posted out on Wednesday 4 November 2020. All voting closes at

5pm on Wednesday 25 November 2020. Voting is by post or online, as in previous elections.

Election results will be available on Thursday 26 November 2020 and will be published on the Trust's website and shared with the Council of Governors and the Board of Directors.

Elected governors will serve a three year term on the Council of Governors, commencing from 30 November.

The Trust will run an Induction Session for newly elected governors in December 2020/January 2021. Individual meetings with the Trust Chair, the Chief Executive, the Director of Corporate Governance & Compliance and the Board Governance Manager will also be arranged for newly elected governors to discuss individual aspirations, support available and expectations.

3.0 Action/Decision

The Council of Governors is asked to note this paper.

Chelsea and Westminster Hospital NHS Foundation Trust

Election to the Council of Governors

CLOSE OF NOMINATIONS: 5:00:00 PM ON 16/10/2020

Further to the deadline for the nominations for the above election, the following valid nominations were received:

Constituency name	Candidate forename	Candidate surname	Political interests	Financial or other interest in the Trust
Patient	Jeremy	Booth	None	None
Patient	Christopher	Digby-Bell	None	None
Patient	Britt	Iversen	None	None
Patient	Stephen	Mumby	None	None
Patient	Guy	Pascoe	None	None
Patient	Jan	Rowland	None	None
Patient	Simon	Tan	None	None
Patient	Arun	Trivedi	Lib Dem	None
Patient	Sam	Walker	None	None
Patient	Harvey	Woolfe	The Labour Party	None
Public: London Borough of Hammersmith and Fulham	Rose	Levy	None	None
Public: Royal Borough of Kensington and Chelsea	Yvonne	Allison	Social Conservative	None
Public: Royal Borough of Kensington and Chelsea	Richard	Ballerand	None	None
Public: Royal Borough of Kensington and Chelsea	Maria	Escudero-Barbaza	None	None
Public: Royal Borough of Kensington and Chelsea	Tana	Focke	None	None

Public: Royal Borough of Kensington and Chelsea	Diane	Gibbs	None	None
Public: Royal Borough of Kensington and Chelsea	Beverly	Grassby	None	None
Staff: Contracted Class	Nicole	Nunes	None	None
Staff: Management Class	Catherine	Sands	None	I work at the Trust and my daughter is a bank member
Staff: Management Class	Jennifer	Warner	None	None
Staff: Medical and Dental Class	Sutapa	Biswas	None	None
Staff: Medical and Dental Class	Mark Richard	Nelson	None	None

The contact address for each of these candidates is C/O The Returning Officer, Chelsea and Westminster Hospital NHS Foundation Trust, Civica Election Services, The Election Centre, 33 Clarendon Road, London, N8 0NW, or email at ftnominations@cesvotes.com.

Ciara Hutchinson
Returning Officer
On behalf of Chelsea and Westminster Hospital NHS Foundation Trust

Report generated on: 19/10/2020

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	2.2/Oct/20
REPORT NAME	Integrated Performance Report – July 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 July 2020 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for July 2020. Please note that due to significant impact of COVID-19 a number of metrics are either not available due to being suspended, not available due to reprioritisation of 'Business as Usual' tasks both Clinical and Non-Clinical. These remain under review and further updates will become available as recovery continues **Regulatory performance** **A&E** Performance in July was consistent with June with the validated position being reported as 94.59% which is an increase 0.54% from June. **Cancer** Cancer 62 day performance has improved in June with a validated position of 74.16%. While there is an improvement, challenges continue while the COVID related backlog is cleared over the coming weeks and months especially as we make inroads into the Diagnostic backlogs. The Trust is working closely with the Royal Marsden Cancer Hub and system partners to diagnose and treat patients to expedite recovery. All 62 Day breaches are subject to a harm review and presented through the Cancer Board. **RTT** Performance has continued to decline as a result of a suspension of routine elective activity. The current Patient Tracking List stands at 34,469 which is an increase of c.1, 000 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. As indicated the Trust has started to see an increase in referrals in the past month as Primary Care restarts its routine referrals. **DM01** Validated Indicator not available at this time of the month

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.

TRUST PERFORMANCE & QUALITY REPORT

July 2020

NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	94.18%	93.85%	93.64%	92.68%	94.59%	94.21%	95.35%	94.07%	94.41%	94.05%	94.59%	94.59%	93.45%		!
RTT	18 weeks RTT - Incomplete (Target: >92%)	71.50%	57.31%	48.87%	64.37%	68.91%	59.30%	54.28%	65.43%	70.55%	58.02%	50.81%	50.81%	64.76%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	96.94%	97.68%	96.07%	97.38%	95.45%	95.99%	96.70%	94.83%	96.08%	96.70%	96.44%	n/a	95.74%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Jul-20) in this report	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	n/a	100%		-
	31 days diagnosis to first treatment (Target: >96%)	85.19%	90.91%	97.50%	88.33%	94.12%	100%	98.04%	96.90%	90.16%	95.89%	97.80%	n/a	94.18%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	n/a	100%	n/a	100%	n/a	100%	n/a	100%	n/a	n/a	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	n/a	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	n/a	100%		-
	62 days GP referral to first treatment (Target: >85%)	40.91%	72.41%	37.78%	62.79%	63.41%	75.00%	82.86%	68.89%	55.56%	74.16%	65.22%	n/a	66.92%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	50.00%	0.00%	n/a	60.00%	50.00%	0.00%	n/a	n/a	60.00%		-
Patient Safety	Clostridium difficile infections (Year End Target: 26)	1	1	3	6	0	1	3	5	1	2	6	6	11		!
Learning Difficulties	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-

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

A&E
Performance in July was consistent with June with the validated position being reported as 94.59% which is an increase 0.54% from June.

Cancer
Cancer 62 day performance has improved in June with a validated position of 74.16%. While there is an improvement challenges continue while the COVID related backlog is cleared in the coming conths.

As recovery continues and the backlog of diagnosis due to the cessation of key diagnostic tests is underway it is expected that this will continue to pose a challenge.

This measure of performance will be challenged going forwards due to the Pandemic impact and delays to patient's treatment. The Trust is working closely with the Royal Marsden Cancer Hub and system partners to diagnose and treat patients to expedite recovery. All 62 Day breaches are subject to a harm review and presented through the Cancer Board.

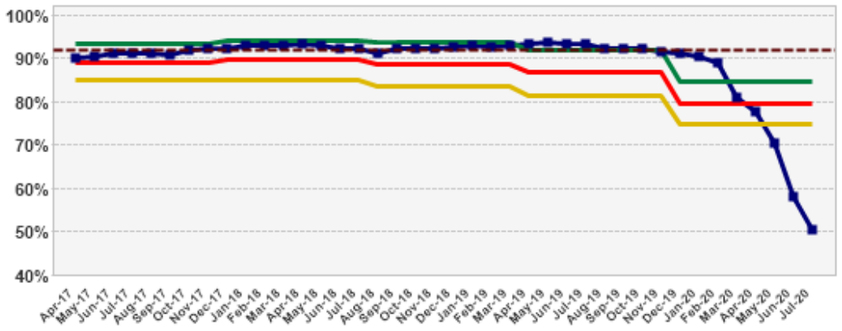
RTT
Performance has continued to decline as a result of a suspension of routine elective activity. Current Patient Tracking List stands at 34,469 which is an increase of c1,000 reflective of the increasing trend in referrals across all services. Validation continues as well as DQ Management to ensure 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. As indicated the Trust has started to see an increase in referrals in the past month as Primary Care restarts its routine referrals.

SELECTED BOARD REPORT NHSI INDICATORS

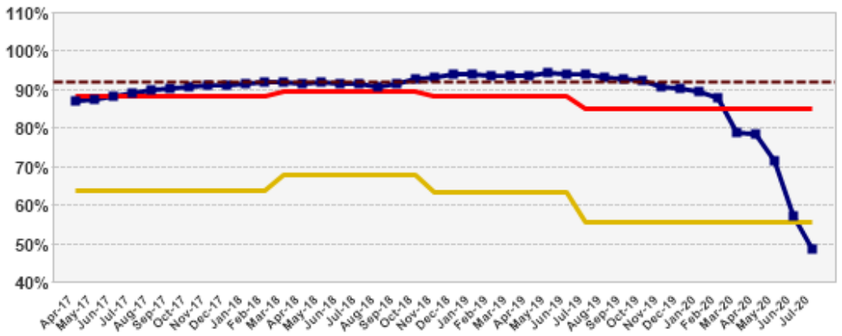
Statistical Process Control Charts for the 37 months April 2017 to July 2020

RTT Incomplete pathways

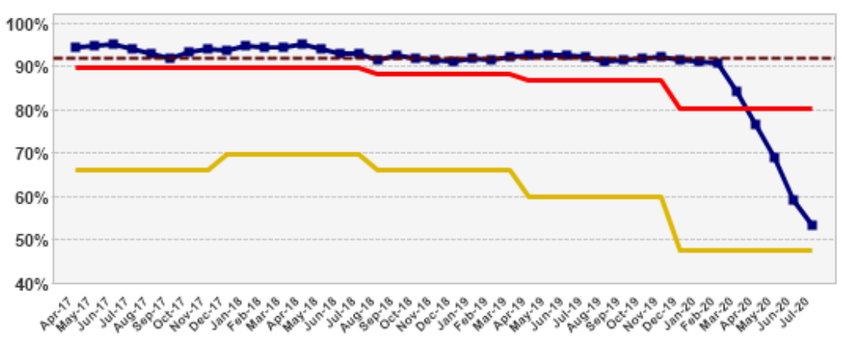
Trust Total



Chelsea and Westminster

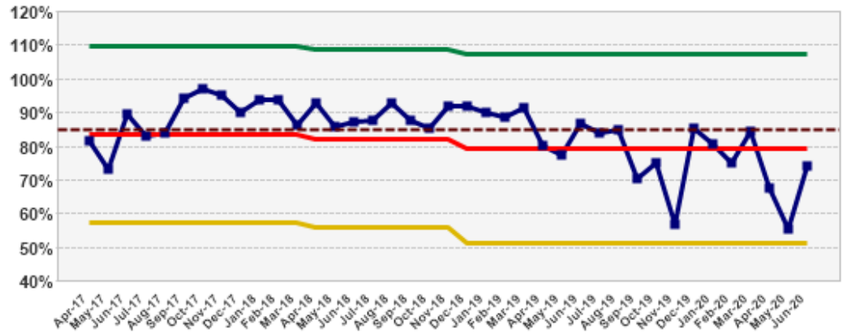


West Middlesex

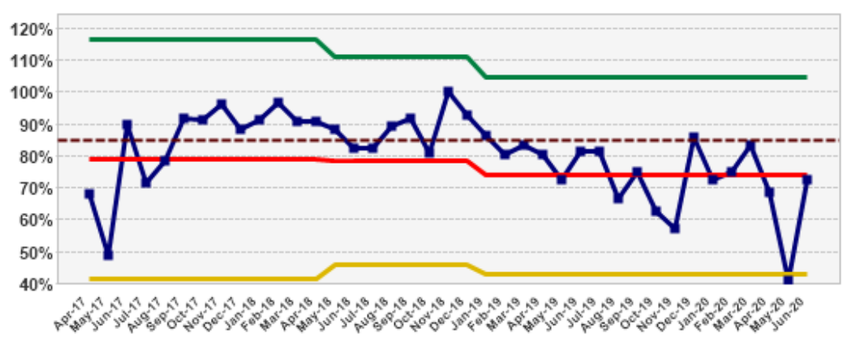


Cancer: 62 day standard

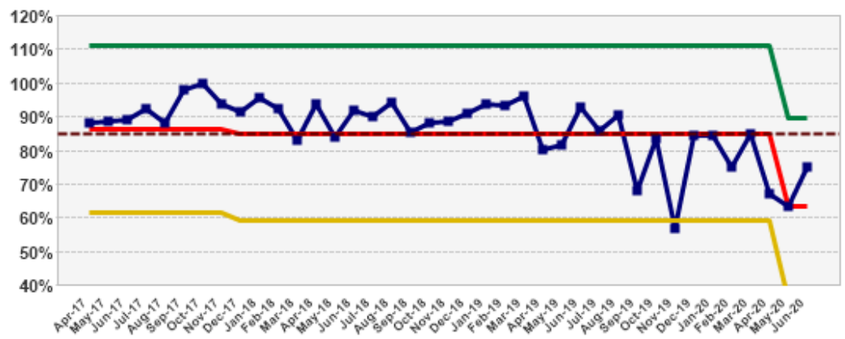
Trust Total



Chelsea and Westminster



West Middlesex



Safety Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Hand hygiene compliance (Target: >90%)		81.9%	98.7%	90.6%		91.9%	85.1%	88.6%		86.9%	92.4%	92.4%	89.6%		-
Incidents	Number of serious incidents	6	2	8	21	2	3	3	9	8	5	11	11	30		-
	Incident reporting rate per 100 admissions (Target: >8.5)	13.3	15.2	14.0	14.1	15.0	13.7	11.5	13.4	14.2	14.4	12.6	12.6	13.7		-
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.04	0.03	0.14	0.06	0.03	0.03	0.02	0.03	0.03	0.03	0.07	0.07	0.06		!
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	7.38	6.24	6.81	6.41	5.09	5.33	3.88	3.97	6.30	5.77	5.33	5.33	5.20		-
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	0.0%	0.0%	2.9%	1.3%	2.6%	2.0%	0.0%	1.4%	1.0%	0.9%	1.8%	1.8%	1.4%		-
Harm	Never Events (Target: 0)	0	0	0	0	0	1	0	1	0	1	0	0	1		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	NEWS compliance %															-
	Safeguarding adults - number of referrals	24	26	28	97	26	28	16	83	50	54	44	44	180		-
	Safeguarding children - number of referrals	24	22	49	113	65	114	101	309	89	136	150	150	422		-
	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.76	0.77	0.77	0.77	0.76	0.77	0.77	0.77	0.76	0.77	0.77	0.77	0.77		-
Mortality	Number of hospital deaths - Adult	29	27	16	165	47	48	43	311	76	75	59	59	476		-
	Number of hospital deaths - Paediatric	0	0	1	3	0	0	0	0	0	0	1	1	3		-
	Number of hospital deaths - Neonatal	2	1	2	7	1	0	1	3	3	1	3	3	10		-
	Number of deaths in A&E - Adult	1	0	4	7	5	6	8	27	6	6	12	12	34		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	1	0	2	0	1	0	0	2		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	0	0	0	0	0	0	0	0		-

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 131 medication-related incidents were reported in July 2020. CW site reported 78 incidents, WM site reported 49 incidents and there were 4 incidents reported in community. There has been an increase in the number of reported medication–related incidents at CW site, and a decrease in the number of reported medication-related incidents at WM site. A summary of the recent trends in medication-related incidents will be shared at the next ward managers meeting cross-site.

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

The Trust position of medication-related incidents involving patients (NRLS reportable) was above target in July 2020 with 5.25 per 1,000 FCE bed days.

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

Commentary for the integrated performance report in relation to medication-related incidents resulting in harm to patients has been aligned to mirror all other safety metrics, reporting moderate harm or above. The Trust had 1.9% of medication-related safety incidents with moderate harm or above in July 2020 which is below the Trust target of 2%. This accounts for 2 moderate harm incidents at CW site involving possible contamination of parenteral nutrition bags and profound hypotension in a patient who had been prescribed a combination of bisoprolol, diltiazem and digoxin.

Harm Indicators

In July 2020, there were six incidents reported that potentially caused severe harm to patients; all of which related to patient falls. Five of these events have been declared as external serious incidents and one has been declared as an internal Serious Incident. There was also an unexpected death declared following a cardiac arrest in theatres; the degree of harm is currently recorded as a death and an External Serious Incident declared. The degree of harm for all incidents will be confirmed following completion of the SI investigations.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
Complaints	FFT: Inpatient recommend % (Target: >90%)		94.8%	94.8%	94.8%		93.5%	97.5%	96.8%		94.3%	96.3%	96.3%	95.8%		-
	FFT: Inpatient not recommend % (Target: <10%)		1.6%	1.6%	1.6%		0.9%	0.6%	0.6%		1.3%	1.0%	1.0%	1.1%		-
	FFT: Inpatient response rate (Target: >30%)		9.8%	18.5%	14.3%		5.0%	22.7%	14.1%		7.3%	20.7%	20.7%	14.2%		-
	FFT: A&E recommend % (Target: >90%)		93.9%	89.4%	91.7%			93.7%	93.7%		93.9%	90.9%	90.9%	92.1%		-
	FFT: A&E not recommend % (Target: <10%)		3.4%	6.1%	4.7%			4.0%	4.0%		3.4%	5.3%	5.3%	4.6%		-
	FFT: A&E response rate (Target: >30%)		26.5%	20.9%	23.4%			26.6%	26.6%		26.5%	22.7%	22.7%	24.0%		-
	FFT: Maternity recommend % (Target: >90%)			86.3%	86.3%		88.2%	87.5%	88.0%		88.2%	86.4%	86.4%	86.7%		-
	FFT: Maternity not recommend % (Target: <10%)			6.9%	6.9%		8.8%	12.5%	10.0%		8.8%	7.3%	7.3%	7.6%		-
	FFT: Maternity response rate (Target: >30%)			17.8%	17.8%		9.0%	3.0%	5.5%		9.0%	12.6%	12.6%	11.9%		-
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Complaints	Complaints (informal) through PALS	15	29	53	68	10	12	19	51	18	33	45	45	119		-
	Complaints formal: Number of complaints received	8	21	26	45	6	11	9	30	11	26	24	24	75		-
	Complaints formal: Number responded to < 25 days	5	15	15	132	34	46	34	157	49	75	87	87	289		-
	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	0	0	1	1	0	0	1	1	1		-

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

Complaints
The number of complaints received continued to be low during May. Our performance with responding to complaints within the 25 day KPI continues to exceed the Trust target at 95%.
95% of PALS concerns were resolved within 5 working days, 71% of these being instantly resolved by the team at the time they were raised by the patient or member of the public.
We have four complaints with the PHSO – two of these have been re-opened after initially being closed by the PHSO. Three are for EIC and one is for WCH Division. The Trust await the outcomes of all cases.

FFT
The Trust restarted fata collection for FFT in June after the process being paused by NHSE / I during the pandemic. Recommendation scores continue to be high however there is more work required in increasing the response rates in all areas.

Same Sex Accommodation
There have been no same sex accommodation breaches

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	5.79	1.61	3.37	3.17	8.00	1.50	2.00	2.41	5.82	1.60	3.32	3.32	3.14		-
	Average length of stay - non-elective (Target: <3.95)	3.40	3.67	3.73	3.79	2.70	3.04	3.18	3.15	3.02	3.31	3.43	3.43	3.44		-
	Emergency care pathway - average LoS (Target: <4.5)	3.88	3.71	4.24	4.39	3.16	3.49	3.50	3.73	3.44	3.57	3.77	3.77	3.98		-
	Emergency care pathway - discharges	144	172	190	615	233	304	326	1035	377	476	516	516	1650		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	7.47%	7.74%	7.26%	7.60%	11.13%	13.35%	11.61%	12.21%	9.46%	10.88%	9.73%	9.73%	10.16%		!
	Non-elective long-stayers	261	334	316	1116	185	285	240	814	446	619	556	556	1930		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	100.0%	90.5%	87.4%	88.5%	100.0%	100.0%	97.6%	98.4%	100.0%	94.7%	90.9%	90.9%	92.4%		-
	Operations canc on the day for non-clinical reasons: actuals	0	0	0	0	0	0	6	6	0	0	6	6	6		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.88%	0.59%	0.00%	0.00%	0.36%	0.36%	0.17%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Theatre Utilisation (Target >85%)	33.1%	42.4%	53.5%	48.6%		36.9%	54.7%	54.1%	33.1%	41.8%	53.9%	53.9%	49.9%		!
Outpatients	First to follow-up ratio (Target: <1.5)	2.45	2.64	2.41	2.57	2.55	2.25	2.22	2.38	2.50	2.47	2.33	2.33	2.48		!
	Average wait to first outpatient attendance (Target: <6 wks)	10.3	10.2	9.4	9.9	10.2	10.5	10.2	10.1	10.2	10.3	9.8	9.8	10.0		!
	DNA rate: first appointment	7.1%	7.1%	6.9%	7.4%	4.9%	5.1%	5.6%	5.4%	6.1%	6.2%	6.3%	6.3%	6.5%		-
	DNA rate: follow-up appointment	7.5%	6.6%	7.3%	7.4%	4.0%	5.4%	6.2%	5.2%	5.9%	6.1%	6.8%	6.8%	6.5%		-

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

Theatre Metrics
These indicators would 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 41.8% in June 2020 to 53.9% in July 2020 as elective restart plans are 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

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	97.5%	97.1%	97.3%	72.9%	93.9%	41.9%	44.3%	58.1%	95.8%	63.9%	64.4%	64.4%	65.0%		-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	91.7%	90.0%	80.0%	90.0%	100.0%	100.0%	81.0%	91.3%	97.5%	96.2%	80.6%	80.6%	90.8%		!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	94.1%	100.0%	94.4%	94.9%	70.0%	92.9%	81.8%	84.8%	85.2%	96.3%	89.7%	89.7%	90.5%		-
VTE	VTE: Hospital acquired	0	0	0	0	1	3	0	4	1	3	0	0	4		-
	VTE risk assessment (Target: >95%)	52.0%	73.9%	83.7%	66.9%	74.3%	64.8%	92.8%	77.7%	63.2%	69.3%	88.9%	88.9%	72.6%		!
TB Care	TB: Number of active cases identified and notified	2	3	1	8	6	5	4	22	8	8	5	5	30		-

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

Dementia Screening

Chelsea and Westminster continue to achieve above target of 90%. West Middlesex achieved below target at 44%, there continues to be on-going education for junior doctors and wider conversations with the MDT to share the workload. Ward staff are being familiarised with the nursing dashboard, this will enable prompts at board rounds for a member of the MDT complete.

VTE

VTE Performance improving month on month with the full adoption of Cerner workflows across divisions. This is being supported by the development of live dashboards to highlight gaps in compliance

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	24	66	175	272	6	26	87	119	30	92	262	262	391		!
	Diagnostic waiting times <6 weeks: % (Target: >99%)	46.88%	43.14%	56.7%	46.35%	42.46%	30.48%	55.9%	38.22%	44.21%	36.91%	56.2%	53.2%	41.83%		-
	Diagnostic waiting times >6 weeks: breach actuals	2608	4138	0	8591	4337	4891	0	12376	6945	9029	0	0	20967		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.8%	10.1%	9.0%	9.6%	8.2%	8.8%	7.9%	8.3%	9.2%	9.6%	8.6%	8.6%	9.1%		!
	A&E time to treatment - Median (Target: <60')	00:37	00:38	00:35	00:38	00:40	00:47	00:48	00:44	00:39	00:44	00:44	00:44	00:42		-
	London Ambulance Service - patient handover 30' breaches	11	5	7	36	18	34	25	123	29	39	32	32	159		-
	London Ambulance Service - patient handover 60' breaches	0	0	0	0	0	0	0	0	0	0	0	0	0		-

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

RTT 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 done in clinical priority order.

Diagnostic wait times <6weeks
A combination of reduced volumes of diagnostic activity in a traditionally high volume activity area, a high number of patients that were delayed have now waited over 6 weeks. As with other parts of the Elective pathway the Trust is working with NWL and system partners to restart diagnostics and recover the position. The Waiting list across modalities is reducing following the increase of in-house, use of temporary capacity and accessing the Independent sector.

Following deployment of the new imaging system across the Trust work continues to align the reporting post migration. This has improved significantly during July. June data will be resubmitted to NHSE following on-going rectification of issues.

Maternity Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
		May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	Trend charts	
Birth indicators	Total number of NHS births	465	451	488	1838	413	381	370	1529	878	832	858	858	3367		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	36.4%	36.3%	37.4%	37.3%	29.9%	32.7%	36.2%	32.8%	33.4%	34.6%	36.9%	36.9%	35.2%		!
	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	1:29.06		-
	Maternity 1:1 care in established labour (Target: >95%)	93.6%	92.3%	89.6%	92.7%	97.4%	98.8%	99.0%	98.1%	94.8%	95.3%	93.2%	93.2%	94.8%		!
Safety	Admissions of full-term babies to NICU	14	20	11	54	n/a	n/a	n/a	n/a	14	20	11	11	54		-

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

Maternity West Middlesex
Attrition is fluctuating between 17-21% (previously planned at 17%, however births remain on plan. One to one care in labour achieved at WM site, through redeployment of staff on a daily basis and use of escalation policy (utilising specialist midwives and matrons for clinical areas)

Caesarean Births
WM – increasing cs rate, specifically the emergency cs rate in july (21.3% (78 women), increase of 2% from june)
The elective CS rate was 15% (55 women (10 women from CW)

Maternity Chelsea
The caesarean section rate is 37.4% which is the same as the YTD figure. There is no change to report here from previous months. This will remain static as we have had no change in process or guidance. We have a high proportion of women having caesareans for previous caesarean section. We have a dedicated service to counsel these women for vaginal birth and continue to work on encourage them to attempt a vaginal birth. This must be weighted with the perceived risk and maternal choice.
Emergency caesarean section in labour is also in keeping with the previous trends.

1:1 care in labour:
There were 6 cases in total where this care was not achieved, these were all women who birthed at home without a midwife. All cases have been reviewed to establish whether earlier access to the hospital could have been achieved, no concerns were identified.

Maternity VTE
New CRS VTE form implemented in July. Report now available for both sites. Daily monitoring via Qliksense, by matrons and admin is being implemented to increase compliance.

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	May-20	Jun-20	Jul-20	2020-2021	YTD breaches	May-20	Jun-20	Jul-20	2020-2021	YTD breaches	May-20	Jun-20	Jul-20	2020-2021 Q2	2020-2021	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Breast	n/a	n/a	n/a	n/a		50.0%	85.7%	83.3%	69.4%	13	50.0%	85.7%	83.3%	n/a	69.4%	13		-
	Colorectal / Lower GI	83.3%	33.3%	30.0%	64.3%	6	33.3%	60.0%	57.1%	76.0%	4.5	66.7%	50.0%	41.2%	n/a	71.8%	10.5		!
	Gynaecological	n/a	n/a	n/a	n/a		33.3%	84.6%	100%	70.3%	5.5	33.3%	84.6%	100%	n/a	70.3%	5.5		-
	Haematological	25.0%	100%	50.0%	44.4%	3.5	50.0%	100%	100%	85.7%	0.5	33.3%	100%	71.4%	n/a	62.5%	4		-
	Head and neck	n/a	n/a	n/a	n/a		33.3%	n/a	100%	20.0%	4	33.3%	n/a	100%	n/a	20.0%	4		-
	Lung	100%	0.0%	100%	33.3%	2	100%	0.0%	100%	66.7%	1	100%	0.0%	100%	n/a	50.0%	3		-
	Sarcoma	n/a	n/a	n/a	n/a		n/a	0.0%	n/a	0.0%	1.5	n/a	0.0%	n/a	n/a	0.0%	1.5		-
	Skin	100%	94.1%	70.0%	96.2%	2.5	100%	100%	70.0%	100%	1.5	100%	95.7%	70.0%	n/a	97.5%	4		-
	Upper gastrointestinal	0.0%	0.0%	n/a	40.0%	3	60.0%	100%	100%	71.4%	1	42.9%	33.3%	100%	n/a	52.9%	4		-
	Urological	0.0%	20.0%	11.1%	13.0%	18	66.7%	22.2%	85.7%	40.4%	15	36.4%	21.4%	43.8%	n/a	31.4%	33		!
	Urological (Testicular)	n/a	n/a	n/a	n/a		n/a	100%	n/a	100%	0	n/a	100%	n/a	n/a	100%	0		-
	Site not stated	n/a	n/a	n/a	n/a		n/a	128.6%	n/a	122.2%	-1	n/a	128.6%	n/a	n/a	122.2%	-1		-

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Safe Staffing & Patient Quality Indicator Report – Chelsea Site

July 2020

Month	Day		Night		CHPPD	CHPPD	CHPPD	National Benchmark		July 20 Vacancy Rate	July 20 Voluntary Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents		FFT June 2020/21
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA	Total				Qualified	Un-qualified	Moderate		Severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Maternity	95.40%	64.30%	96.80%	60.00%	11.6	5.5	17.1	15.3		7.30%	9.45%	12.66%								30	
Annie Zunz	-	-	-	-				7.8		9.10%	38.81%	0%	1	1					1	7	100%
Apollo	84.20%	87.50%	84.50%	-	24.9	2	27.7	10.9		17.80%	26.31%	34.35%								3	100%
Jupiter	-	-	-	-				10.9		25.80%	22.96%	50%							1	1	100%
Mercury	101.60%	158.70%	98.70%	-	7.1	1	8.2	9.3		13.10%	8.35%	174.22%							9	18	94.10%
Neptune	95.60%	132.30%	90.40%	-	9.2	1.8	11	10.9		8.10%	24.60%	50%								5	100%
NICU	88.70%	73.60%	91.30%	87.10%	12.7	1.2	13.9	26		15.10%	10.12%	22.83%							5	24	100%
AAU	100.00%	80.30%	94.90%	74.70%	8.6	2.5	11.2	7.8		13.70%	6.25%	53.94%	6	17	1	1			8	22	
Nell Gwynne	-	-	-	-	-	-	-	7.3		-1.30%	4.52%	11.23%									
David Erskine	51.90%	89.10%	49.70%	93.30%	8.5	6.6	15.2	7		13.80%	20.72%	27.21%									88.90%
Edgar Horne	94.20%	80.20%	98.90%	103.40%	4.1	3.3	7.8	6.9		12.50%	11.90%	15.40%							1	1	83.40%
Lord Wigram	98.70%	87.40%	103.20%	93.50%	5.2	3	8.3	7		12.10%	8.40%	5.13%	2	10					4	10	93.90%
St Mary Abbots	84.50%	63.10%	86.50%	107.50%	5.4	2.4	8	7.2		15.90%	22.59%	9.49%									91.30%
David Evans	91.40%	76.20%	78.30%	113.30%	16.7	5.6	23	7.2		4.40%	5.71%	0%	3	4					1	1	100%
Chelsea Wing	-	-	-	-	-	-	-	7.2		17.20%	12.12%	13.48%									
Burns Unit	101.00%	100.00%	101.20%	100.00%	36.9	5.5	42.4	N/A		5.90%	19.70%	14.34%	1	1					2	8	100%
Ron Johnson	73.10%	82.30%	73.10%	82.30%	7.9	4.7	12.6	7.4		12.70%	17.61%	21.23%									93.50%
ICU	99.50%	-	105.80%	-	22.6	0	22.9	26		7.80%	23.24%	200%	1	2					1	11	
Rainsford Mowlem	119.60%	86.50%	126.60%	79.40%	3.7	3.4	7.2	7.3		3.80%	13.62%	2.83%	5	34	1	1			7	23	82.30%
Nightingale	126.80%	84.50%	98.00%	86.20%	3.2	2.8	6.2	7.3		N/A			6	21	2	3			4	4	100%

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Safe Staffing & Patient Quality Indicator Report – West Middlesex Site

July 2020

Ward	Day		Night		CHPPD	CHPPD	Total	National Benchmark		Vacancy Rate	July 20 Voluntary Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents		FFT June 2020/21
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA					Qualified	Un-Qualified	Moderate		Severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Lampton	101.90%	110.70%	120.40%	145.20%	3.3	2.8	6.3	7.3		10.90%	0%	13.29%	4	16					2	2	100%
Richmond	-	-	-	-	-	-	-	7.2		41.40%	20.13%	0%									
Syon 1 cardiology	107.20%	84.60%	98.40%	96.80%	5.9	2.4	8.3	8		7.50%	0%	0%	6	25						12	
Syon 2	106.10%	101.20%	101.60%	119.40%	3.5	3.7	7.4	7.3		19.30%	11.63%	13.51%		13					4	10	100%
Starlight	95.30%	-	97.40%	-	10.6	0	10.6	10.9		14.30%	20.39%	0%							4	10	90.90%
Kew	-	-	-	-	-	-	-	6.9		9%	18.60%	14.32%	7	12					3	8	100%
Crane	92.30%	80.60%	92.50%	64.90%	5	4.6	9.6	6.9		5.90%	0%	6.99%	1	17					4	4	
Osterley 1	103.90%	69.00%	93.00%	96.50%	4.2	2.6	7.1	7		4.30%	10.66%	7.83%	3	16					2	10	100%
Osterley 2	108.80%	67.80%	111.10%	77.90%	4.7	2.4	7.1	7.2		-40.50%	6.79%	9.24%	1	21					1	6	90.90%
MAU	124.70%	168.30%	124.40%	139.80%	8.6	3.4	12.3	7.8		16.30%	11.97%	34.37%	5	38					13	26	93.30%
Maternity	101.70%	94.30%	106.40%	88.10%	7.7	2.5	10.2	15.3		-3.30%	5.75%	1.67%		1					3	9	
Special Care Baby Unit	107.90%	100.00%	90.40%	100.00%	6.2	1.4	7.5	10.9		11.60%	4.05%	0%								4	100%
Marble Hill 1	94.10%	77.60%	85.40%	92.40%	5.3	3.8	9.1	7.3		28.60%	14.01%	7.63%	2	9					3	9	33.30%
Marble Hill 2	101.00%	104.70%	120.40%	116.10%	3.6	2.6	6.4	6.5		6%	7.55%	7.03%	5	34					4	10	93.80%
ITU	99.00%	-	94.30%	-	31.4	0	31.4	26		-2.10%	14.73%	0%		2						7	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Safe Staffing & Patient Quality Indicator Report

July 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. Please note that CHPPD scores are inclusive of Apprentice Nursing Associates which are now required to be reported separately to NHSI.

A number of staff remained shielding in July and a number of wards were closed. 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, St Marys Abbots are referred to by their roster name rather than their present physical location. Annie Zunz staff and patients continued to remain on AAU.

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 will be adjusted accordingly once funding is in place.

As the designated Covid 19 ward on the Chelsea site, David Erskine, along with Crane at West Mid, had low admission rates hence low fill rates and staff were deployed elsewhere. Not all shifts were filled on these wards due to low patient numbers.

The figures for Rainsford Mowlem reflect that they are hosting Nell Gwynne ward and staffing was combined for the report but not all shifts from both staffing templates needed filling. However, in practice some Nell Gwynne staff were moved to assist Edgar Horne staffing (temporarily situated on David Erskine). Lampton had high fill rates for unqualified staff at night time due to change of speciality and subsequent patient dependency. An extra HCA will be funded in September to reflect this change. Ron Johnson shows high CHHPD as they are on a smaller bed base on Annie Zunz.

Chelsea wing and Richmond remained closed for the month and Kew closed for much of the month due to refurbishment. Burns treated the majority of their patients as day cases and therefore have a high CHPPD rate as the midnight census does not take account of these patients. 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 CHHPPD due to the low number of admissions throughout July and one patient requiring 1:1 nursing care.

St Mary Abbots is based on David Evans and admits non-elective surgical patients which have been low in numbers. David Evans moved to Edgar Horne mid-month and admits elective surgery. There are low staffing fill rates on David Evans & St Marys Abbots at the Chelsea Site due to low patient numbers.

There were five falls with moderate harm at the Chelsea site in July, two on AAU, one on Rainsford Mowlem and two on Nightingale.

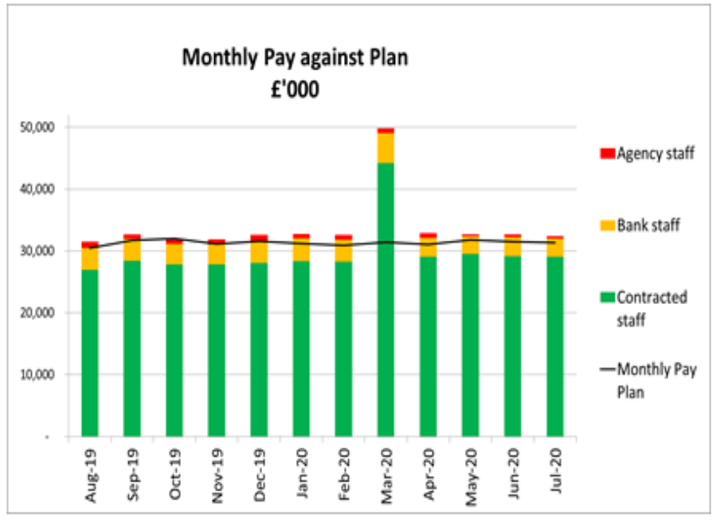
The numbers of admissions due to COVID 19 were neglible in the month of July. Occupancy in ICU was lower than normal at WM and the high CHHPD relates to staff external staff undertaking shifts on the unit to maintain their clinical skills to prepare for an anticipated second COVID wave. Family & Friends scores was recorded for July with eleven wards scoring 100%, however completion rates remain generally low.

Finance Dashboard M4 2020/21

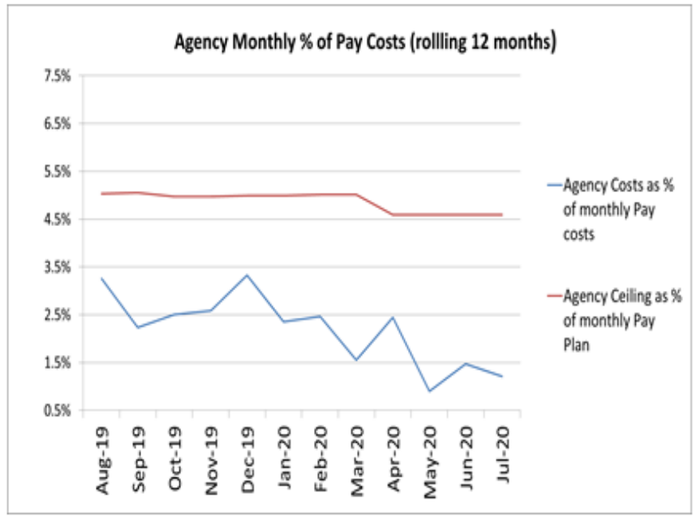
£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	225,420	236,849	11,429
Expenditure			
Pay	(125,701)	(130,586)	(4,885)
Non-Pay	(87,015)	(93,401)	(6,387)
EBITDA	12,704	12,862	157
EBITDA %	5.64%	5.43%	-0.2%
Depreciation	(6,933)	(6,933)	0
Non-Operational Exp-Inc	(5,627)	(5,785)	(157)
Surplus/Deficit	144	144	(0)
Adjust for - Donated asset, Impairment & Other	(144)	(144)	
Adjusted Surplus/Deficit	0	0	

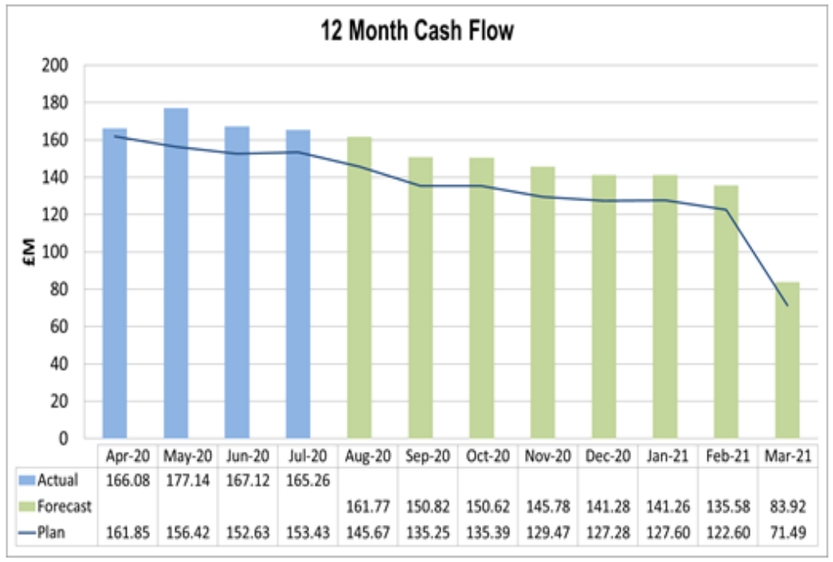
Comment : The Trust is reporting a breakeven position when adjusted for the financial impact of donated assets and income. The position includes an accrual for income of £13.1m to address shortfalls in our funding model and expenditure related to our COVID-19 response

Income: Contractual income from CCG, NHS England and Local Authorities is on a block through M4, any shortfalls in non-contracted activity income is reported as COVID-19 loss of income. Activity continues to steadily increased in M4, especially in outpatients and elective .



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 costs.

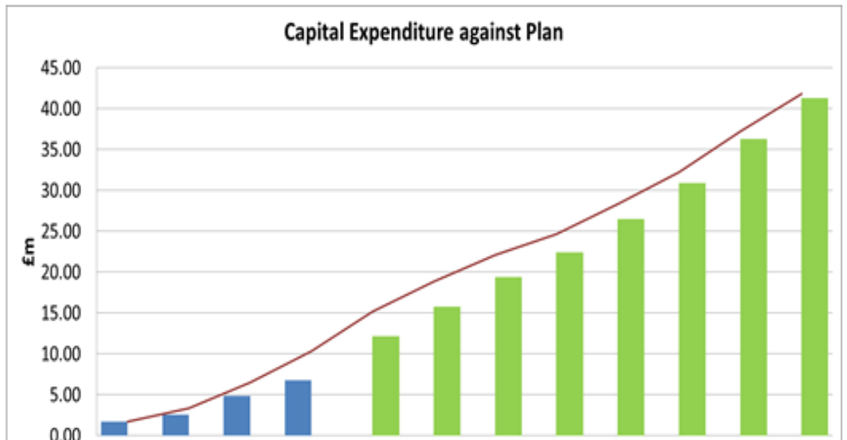




	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Actual	166.08	177.14	167.12	165.26								
Forecast					161.77	150.82	150.62	145.78	141.28	141.26	135.58	83.92
Plan	161.85	156.42	152.63	153.43	145.67	135.25	135.39	129.47	127.28	127.60	122.60	71.49

Comment:

The favourable cash variance to plan in M4 of £11.8m is a favourable cash variance b/fwd from M3 of £14.5m; lower cash receipts to plan of -£4.6m (Extra NHS England Income + Covid Top Up (2.5m) +1.37m CCG debt + £0.5m Extra Covid PDC, offset by lower FT Income -£3.1m + lower Health Education -£4.18m , lower Local Authority Income -£1.4m and lower PP Income -£0.7m); offset by lower cash outflows to plan £1.97m (lower creditor payments and higher VAT).



	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	1.73	2.53	4.87	6.75								
Forecast					12.14	15.77	19.39	22.37	26.47	30.84	36.27	41.27
Plan	1.73	3.34	6.50	10.31	15.21	18.84	22.06	24.64	28.34	32.21	37.24	41.84

Comment

The Trust has spent £1.88m in period 4 compared to the planned forecast of £3.80m, resulting in an underspend of £1.92m. The underspend is mainly associated with the impact of the Covid-19 outbreak which has resulted in a number of projects being delayed. It is expected that this underspend will be spent later in the year as it relates to timing differences between the timing of the planned spend and when the actual costs have been incurred. The plan for 2020/21 will be revised in M05 following the deferral of a number of schemes to 2021/22 in order to accomodate the critical care surge capacity at the Richmond and St Mary's Abbot wards.

CQUIN Dashboard

2020/21 CQUIN Schemes

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

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	2.2.1/Oct/20
REPORT NAME	Winter preparedness
AUTHOR	Robert Hodgkiss, Deputy Chief Executive / Chief Operating Officer
LEAD	Robert Hodgkiss, Deputy Chief Executive / Chief Operating Officer
PURPOSE	To share with the Council of Governors the Trust's arrangements for ensuring service delivery throughout winter 2020/21.
SUMMARY OF REPORT	As enclosed.
KEY RISKS ASSOCIATED	That winter planning schemes do not adequately mitigate demand.
FINANCIAL IMPLICATIONS	As noted in the paper.
QUALITY IMPLICATIONS	As noted in the paper.
EQUALITY & DIVERSITY IMPLICATIONS	As noted in the paper.
LINK TO OBJECTIVES	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Winter Planning 2020

Winter Plan 2020 – Key Initiatives

Managing Non Elective Demand

Front Door Schemes:

- '**Think 111' ED pilot** – encouraging patient use of 111 to schedule care in the most appropriate setting
- **Implementing SDEC at Pace** – expansion of surgical pathways and supporting earlier discharges
- **ED Full Capacity Triggers –** improved escalation and action during activity surges

Inpatient Flow:

- **Discharge within 12 hrs of Medically Fit** – (maintaining discharge hubs & improving discharge lounges)
- **24/7 Hospital inc Control Centre** - (improved 7 day working and review of support to site operations)
- **Managing Escalation Beds –** ensuring dedicated clinical teams to staff escalation areas, and managing bed pressures around:
- **Phasing of Elective Activity** – ensuring elective recovery programme is maintained
- **Transport** – supporting timely discharge and planning for IPC restrictions
- **System Mutual Aid** – supporting the wider acute system with repats & inpatient transfers

Winter Plan 2020 – Key Initiatives

Infection Prevention & Control:

- **Flu Planning** – including flu vaccinations and delivery of rapid flu testing
- **COVID** - Plans for zoning and escalation of covid beds
- **Side Room Availability** – clear prioritisation for usage and management of capacity

COVID-19 Surge Planning:

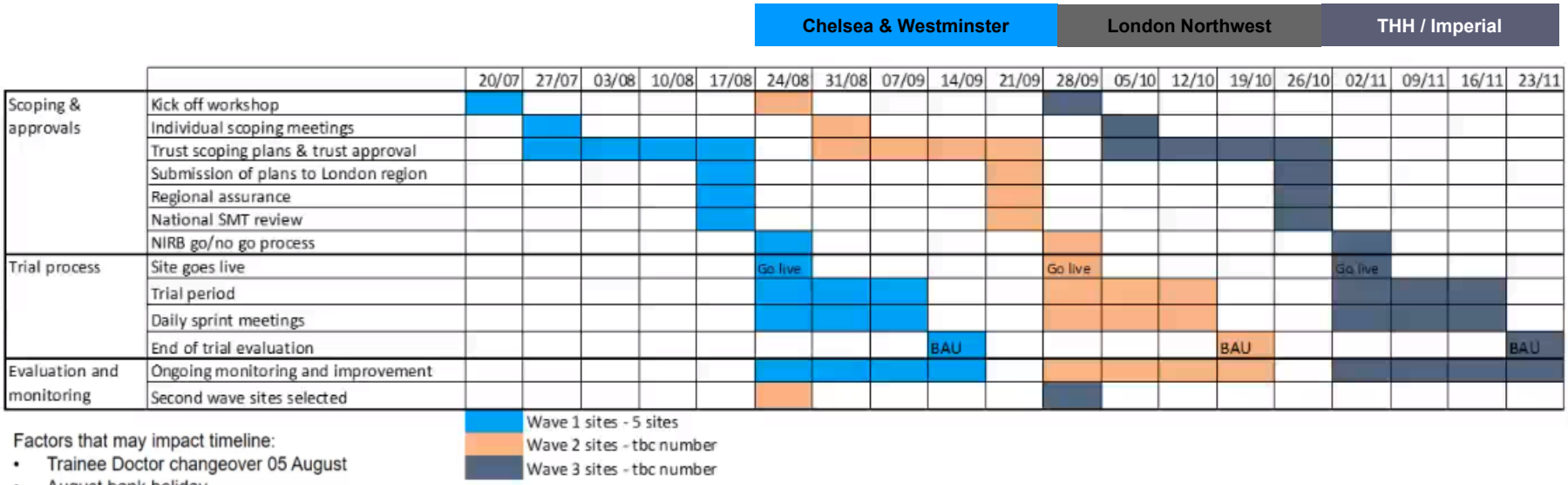
- **ITU surge plan**
- **NIV surge plan**

Think NHS 111 first: ED pathways priority to implement

- ED pathways for heralded and unheralded patients are a priority to implement before December
- UEC proof of concept models to roll out before December this year
- Chelsea & Westminster Trust is the NWL pilot with a suggestion that London Northwest is in phase 2 and Hillingdon and Imperial in phase 3
- Chelsea & Westminster proposal is to focus on heralded patients in the first instance
- NHS 111 aware of the pilot but not started developing 111 pathways/ solutions at this point

Proof of concept time line

If roll out in 3 waves, all sites will be live and evaluated prior to 1 December 2020
Assumes national team will need to approve each group of sites in advance of roll out



Factors that may impact timeline:
- Trainee Doctor changeover 05 August
- August bank holiday
- Increase in annual leave during annual leave

UEC Funding: A&E and SDEC capacity

No	**Scheme Title** *(A broad and unique title of the proposed scheme. Use the same scheme title if appearing across various sheets)*	**Site** *(to be entered manually)*	**Narrative** *(Qualitative information to briefly set out the need and how each scheme will meet that need)*	**Estimated capital cost** *(£,000)*
1	SDEC waiting room and 'Hot Clinic' capacity	West Middlesex	To increase the provision of SDEC services through both increasing clinical consulting space, as well as waiting room space to facilitate social distancing. This scheme will be achieved through repurposing 7 clinic rooms and waiting area from an adjacent outpatient space and will allow a clean pathway through the unit with designated entrance.	£170,000
2	Expansion of SDEC capacity to facilitate surgical pathways	Chelsea	To increase the SDEC footrpint through creation of additional treatment bays and 3 treatment rooms inb order to facilitate surgical SDEC pathways.	£216,000
3	SDEC POCT capability	Both sites	To invest in BNP & Troponin POCT testing machines to allow cardiac patients to be mananged through SDEC rather than ED/AMU	£60,000
4	Increased flexible Majors capacity - WM	West Middlesex	The department currently contains a 6 bedded Observation Bay. It is proposed to convert this into individual cubicle spaces, creating a flexbile space to be used for either suspected covid positive majors patients or short stay admissions with appropriate social distancing and IPC compliance	£80,000
5	Increased flexible Majors capacity - CW	Chelsea	The department currently contains2 x 3 bedded Observation Bays. It is proposed to convert these into individual cubicle spaces, creating a flexbile space to be used for either suspected covid positive majors patients or short stay admissions with appropriate social distancing and IPC compliance	£82,000
6	Increased waiting room capacity - UTC/ED CW	Chelsea	The need to social distance has significantly reduced waiting capacity. It is not possible to repurpose any capacity colocated to the Emergency Department for additional waiting room capacity, and so a modular build outside is proposed (x2 buildings with capacity for 25 patients).	£100,000
7	Increased waiting room capacity - UTC WM	West Middlesex	The need to social distance has significantly reduced waiting capacity. It is not possible to repurpose any capacity colocated to the Emergency Department for additional waiting room capacity, and so a modular build outside is proposed (x2 buildings with capacity for 25 patients). This can be used flexibly between ED/UTC/Paeds	£150,000
8	Increased Resus Capacity	West Middlesex	There are currently 4 resuscitation spaces within the Emergency Department, which is not sufficient for the departments activity (77,000 type 1 attends 19/20). This is recorded as a high risk on the Trust risk register. Increasing to 5 cubicles will provide a 20% increase in resus capacity. This will be provided through reconfiguration of existing space within the department. 2 month build	£700,000
9	IPC compliant paeds ED cubicle space	West Middlesex	To put doors on the treatment cubicle in paediatric majors to allow it to be used as a flexible space to isolate suspected or confirmed covid patients	£8,000

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Council of Governors Meeting, 29 October 2020

AGENDA ITEM NO.	2.2.2/Oct/20
REPORT NAME	People and OD Committee KPI Dashboard
AUTHOR	Karen Adewoyin, Deputy Director of People and OD
LEAD	Sue Smith, Director of Human Resources & Organisational Development
PURPOSE	The People and OD Committee KPI Dashboard highlight's current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	The dashboard is to provide assurance of workforce activity across eight key performance indicator domains: • Workforce information – establishment and staff numbers • HR Indicators – Sickness and turnover • Employee relations – levels of employee relations activity • Temporary staffing usage – number of bank and agency shifts filled • Vacancy – number of vacant post and use of budgeted WTE • Recruitment Activity – volume of activity, statutory checks and time taken • PDRs – appraisals completed • Core Training Compliance It also includes an update on the key workstreams for Workforce and progress made during the month of July 2020. Key Highlights and achievements are: • Voluntary and Gross turnover – first time under 13% target in 2 years • Sickness rate – under ceiling and better than this time last year • Risk assessments 100% - best in London • Reciprocal mentoring launched • Listening events held and extended The Workforce Report has been shared with the People and Organisational Development Committee via e-governance and reviewed in the Workforce Development Committee.
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	• Deliver high quality patient centred care • Be the employer of choice • Delivering better care at lower cost
DECISION/ ACTION	For noting.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the People and Organisational Development Committee

Month 04 – July 2020

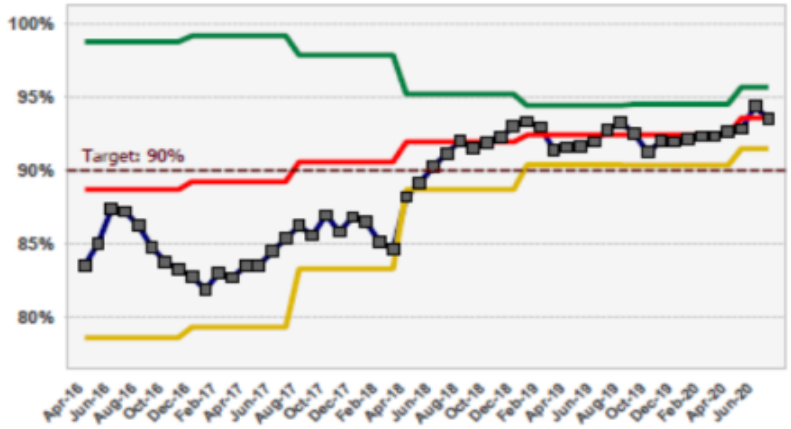
Statistical Process Control – April 2016 to July 2020

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

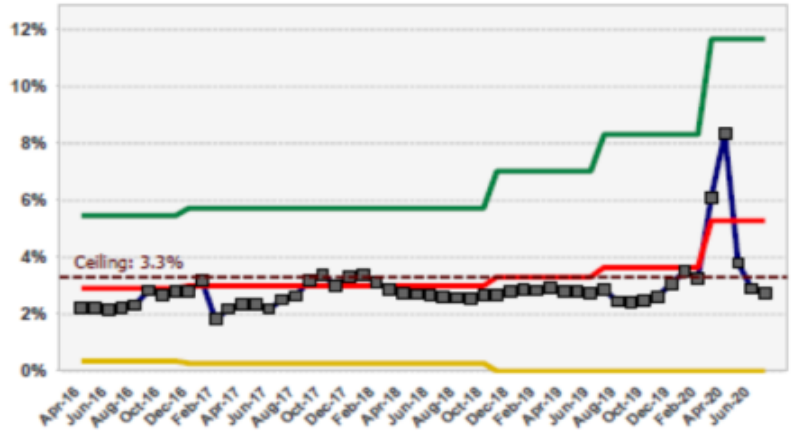
WORKFORCE INDICATORS

Statistical Process Control Charts for the 52 months April 2016 to July 2020

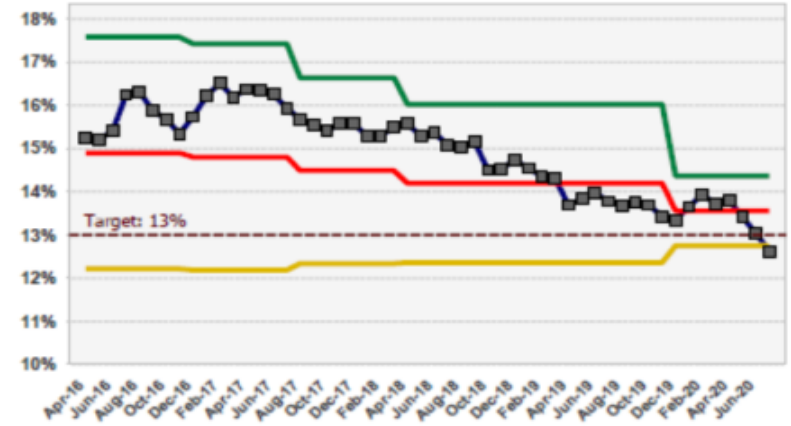
Mandatory Training compliance



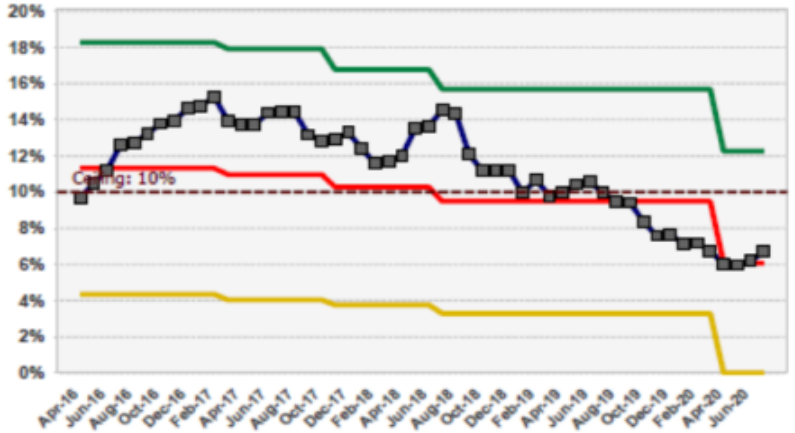
Sickness absence



Staff voluntary turnover rate



Vacancy rate



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

Chelsea and Westminster Hospital NHS Foundation Trust

Item	Units	This Month Last Year	Last Month	This Month	Target / Ceiling	RAG Status			Trend
						Red	Amber	Green	
1. Workforce Information									
1.1 Establishment	No.	6349.18	6,402.24	6,399.52					↓
1.2 Whole time equivalent	No.	5716.64	6005.34	5971.07					↓
1.3 Headcount	No.	6158	6491	6458					↓
1.5 Overpayments (Number)	No.	47	39	18					↓
1.4 Overpayments (Costs)	£	83,810.75	97,065.53	39,048.08					↓
2. HR Indicators									
2.1 Sickness absence	%	2.86%	2.89%	2.74%	<3.3%				↓
2.2 Long Term Sickness absence	%	1.41%	1.57%	1.49%					↓
2.3 Short Term Sickness absence	%	1.45%	1.32%	1.25%					↓
2.4 Gross Turnover	%	18.11%	17.17%	17.00%	<17%				↓
2.5 Voluntary Turnover	%	13.78%	13.03%	12.62%	<13%				↓
3. Employee Relations									
3.1 Live Employment Relations Cases	No.	161	122	95					↓
3.2 Formal Warnings	No.	1	3	0					↓
3.3 Dismissals	No.	2	1	0					↓
4. Temporary Staffing Usage									
4.1 Total Temporary Staff Shifts Filled	No.	14809	10390	11396					↑
4.2 Bank Shifts Filled	No.	12858	9902	10560					↑
4.3 Agency Shifts Filled	No.	1951	488	836					↑
5. Vacancy									
5.1 Trust Vacancy Rate	%	9.96%	6.20%	6.70%	<10%				↑
5.2 Corporate	%	4.86%	-19.98%	-21.05%	<10%				↓
5.3 Clinical Support Services	%	10.62%	9.91%	9.97%	<10%				↑
5.4 Emergency & Integrated Care	%	9.44%	9.32%	10.10%	<10%				↑
5.5 Planned Care	%	9.00%	9.81%	10.05%	<10%				↑
5.6 Women's, Children and Sexual Health	%	96.00%	7.58%	8.55%	<10%				↑
12.44									
6.1 Offers Made	No.	152	97	133					↑
6.2 Pre-employment checks (days)	No.	18	14.6	18.7	<20				↑
6.3 Time to recruit (weeks)	No.	8.58	8.96	7.66	<9				↓
7. PDRs Undertaken (AfC Staff over 12 months)									
7.1 Trust PDRs Rate (AfC Staff)	%	79.90%	94.33%	93.96%	≥90%				↓
7.2 Corporate	%	71.11%	92.00%	89.98%	≥90%				↓
7.3 Clinical Support Services	%	83.19%	94.16%	94.52%	≥90%				↑
7.4 Emergency & Integrated Care	%	81.07%	95.46%	95.28%	≥90%				↓
7.5 Planned Care	%	81.13%	95.82%	93.79%	≥90%				↓
7.6 Women's, Children and Sexual Health	%	78.29%	93.58%	94.08%	≥90%				↑

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

Chelsea and Westminster Hospital NHS Foundation Trust

July 2020 SICKNESS

Division	Sickness Abs.	RAG Status Ceiling <3.30%	Available WTE hours	Absence WTE hours	Episodes	Long Term (WTE Lost)	% Long Term	Prev. Month	% +/-
Corporate	1.17%		22359.29	260.65	50	123.60	0.55%	1.31%	-0.14%
Clinical Support	3.21%		29620.16	949.41	156	475.74	1.61%	3.25%	-0.04%
Emergency & Integrated Care	2.81%		49543.84	1390.54	220	859.47	1.73%	2.72%	0.09%
Planned Care	2.12%		31626.64	670.14	115	345.88	1.09%	2.60%	-0.48%
Women's, Children and Sexual Health	3.47%		51899.10	1802.33	237	949.46	1.83%	3.70%	-0.23%
Trust	**2.74%**		**185049.03**	**5073.07**	**778**	**2754.15**	**1.49%**	**2.89%**	**-0.15%**

July 20 Core Training

Course	Last Month	This Month	Target	RAG Status	Trend
Core Training Compliance Overall	94%	94%	<90%		↔
Theory Adult BLS	90%	89%	<90%		↓
Practical Adult BLS	87%	86%	<90%		↓
Conflict Resolution	96%	97%	<90%		↑
Equality, Diversity and Human Rights	96%	96%	<90%		↔
Fire	94%	91%	<90%		↓
Health & Safety	96%	96%	<90%		↔
Infection Control (Hand Hygiene)	97%	95%	<90%		↓
Infection Control - Level 2	93%	94%	<95%		↑
Information Governance	96%	93%	<95%		↓
Moving & Handling - Inanimate Loads	94%	94%	<90%		↔
Moving & Handling - Patient Handling	91%	91%	<90%		↔
Safeguarding Adults Level 1	96%	96%	<90%		↔
Safeguarding Adults Level 2	94%	94%	<90%		↔
Safeguarding Adults Level 3	85%	83%	<90%		↓
Safeguarding Children Level 1	97%	97%	<90%		↔
Safeguarding Children Level 2	95%	95%	<90%		↔
Safeguarding Children Level 3	91%	88%	<90%		↓

July 20 Employee Relations

Category	Metric	Number / %
No of Disciplinary cases opened in month	Number	2
No of current, live disciplinary cases	Number	8
Length of Disciplinary cases	Days <60	64
Total Disciplinary cases in year (from April 2	Number	4
% BAME Disciplinary Cases in year	%	75%
% BAME Disciplinary Cases in month	%	100%
Exclusions - No. of live in month	Number	3
Grievance - No. of live cases in month	Number	10
Grievance – Average length of case	Days	52
B&H cases - included in grievance numbers	Number	4
Sickness - No. of cases in month	Number	60
Long Term - sickness cases in month	Number	40
Short Team - sickness cases in month	Number	20
No. of Employment Tribunals (ET)	Number	7
Managers having ER training (from April 20)	Number	0
No. of informal queries (disciplinary process	Number	5

July 20 Vacancy / Bank and Agency Ratio on "Fill Rate"

Division	Budgeted WTE	Staff in Post (WTE)	Vacancy (WTE)	Bank Usage (WTE)	Agency Usage (WTE)	**Total WTE Used	Budget minus Used WTE	RAG Status
Corporate	602.52	729.34	-126.82	23.49	9.25	744.58	-142.06	
Clinical Support	1065.23	959.04	106.19	106.40	0.00	1042.70	22.53	
Emergency & Integrated Care	1770.47	1591.62	178.85	203.10	9.28	1763.38	7.09	
Planned Care	1130.09	1016.47	113.62	60.44	24.69	1075.62	54.47	
Women's, Children and Sexual Health	1831.21	1674.59	156.62	115.72	14.51	1734.06	97.15	
TRUST	**6399.52**	**5971.07**	**428.45**	**509.15**	**57.73**	**6360.33**	**39.19**	

July 20 Voluntary Turnover

Division	Turnover	Prev Month	% + / -
Corporate	12.36%	13.03%	-0.67%
Clinical Support	14.09%	15.01%	-0.92%
Emergency & Integrated Care	14.42%	14.73%	-0.31%
Planned Care	11.13%	10.79%	0.35%
Women's, Children and Sexual Health	11.06%	11.56%	-0.51%
TRUST	**12.62%**	**13.03%**	**-0.41%**

Key to Sickness Figures

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

Episodes = number of incidences of reported sickness

A Long Term Episode is greater than 27 days

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

People and Organisation Development Workforce Performance Report
July 2020

Establishment, Staff in Post and Vacancies:

The Trust currently employs 6458 people working a whole time equivalent of 5971 which is 34.27 WTE lower than June. This equates to 258 wte more permanent members of staff than this time last year. There has been a increase in the vacancy rate for July, 6.70% against the Trust ceiling of 10% and a significant improvement since the same time last year which was 9.96% The qualified nursing vacancy rate is 7.00% and remains one of the lowest in the country with a national median of 12.75%. The medical vacancy rate has increased to 5.60% including staff recruited for COVID-19 and 8.01% not including additional recruits, which is quartile 2 in Model Hospital and national median of 7.43%. AHP (9.72%) S&T (7.94%) 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:

Temporary staffing demand increased for the second month in succession, and overall was up 9.9% compared to June, albeit we remain 25% down year on year. Our agency fill increased 2.3% in July, but is 5% lower than last year. Medical temporary staffing requests increased significantly in July, up 46% with increases across all divisions, but predominantly in EIC which saw a 64.4% increase. The new process for Consultant additional list pay went live in July. The result of this is that the average hourly cost of medical bank shifts continues to decrease and we now pay an average of £6 less per hour than the same month last year. Following proactive work to reduce retrospective bookings, we saw a 5% reduction and overall the lowest number of bookings recorded retrospectively.

Core Training Compliance :

Overall compliance has remained at 94% this month against the Trust target of 90% (with IG dropping slightly to 93% against a national target of 95%).

It is anticipated that compliance will continue to fluctuate over the next few months as the social distancing requirements continue to impact the number of staff who can attend practical training. In addition, the previous 6-month compliance extension comes to an end and more staff will now be due to lapse. Individual reminders continue to be sent to managers and staff to try and minimise the impact of this.

Sickness Absence:

The Trust's sickness rate has reduced to 2.74%, which is lower compared to last month and this time last years despite COVID19 related challenges. Our sickness target of 3.3% has been breached three times during the last 24 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 and Cold, Chest & respiratory problems which include Covid-19 related absence, Cough, Flu – Influenza. The top sickness reason for the number of days lost has now returned from chest and respiratory due to COVID back to anxiety, depression and is the highest reason for both number of episodes and days lost. 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. Women's, Children & Sexual Health have the highest reported rates. The ER team have agreed a targeted approach with the division to review this and plan accordingly.

Staff Turnover Rate: Voluntary

Voluntary turnover has decreased to 12.60% and is below the Trust target for the first time and lowest it's been in recent years. The third highest reason for which action can be taken on is work/life balance and the health and well-being business case which has been approved has a key focus on work-life balance issues such as flexible working and establishing a relationship with Timewise to become an accredited flexible working employer, offering a back up 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.

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 July was 93.96%, decreased by 0.37% from the previous month. The clinical divisions all have rates higher than 93%.

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.

People and Organisation Development Workforce Performance Report

July 2020

Race Equality Plan & Inclusion :

Key highlights in the last month include the pairing of our 16 participants in the reciprocal mentoring programme, training for both is scheduled in August. The listening events have been expanded to 7 dates for all Executive Board members to listen to staff's experiences relating to recruitment promotion and career progression and have been taking place during July and August. The Women's Network and the BAME Network also collaboratively ran a further session on being a BAME women in the Trust and agreed the terms of reference for the network. The Trust in partnership with Stonewall has developed its Year 1 objectives as part of the Trust's commitment to being an LGBTQ+ inclusive employer which includes a policy review to ensure our language is inclusive, developing a transitioning at work policy, incorporating being a member of Stonewall into Trust advertising to ensure recruitment is inclusive, supporting the growth and development of the LQBTQ+ network. The outputs from the staff risk assessments, where staff declared whether they had a disability has enabled work to identify staff across the Trust who have a disability to increase reporting and develop a staff network. The Chair of the BAME Network is also being supported to become a WRES expert and has been nominated for the national training programme. The terms of reference of the Workforce Development Committee have also been reviewed and to ensure engagement with networks and staff side, all Chairs of our staff networks and joint chairs of staff side are now members of the committee. 25 Diversity and Inclusion Champions are now involved in all recruitment Band 8a above with monthly training sessions to increase the numbers of champions to ensure 100% compliance.

Leadership and Development:

Eleven people are commencing the Top Leaders programme in September and Seventeen will be commencing the Senior leaders. Ten people will commence the Top Leaders in January and a further twenty three will commence the Senior Leaders programme in the same month. The Leadership and management fundamentals programmes will be resuming in the Autumn.

Apprenticeships:

Clinical and Non-Clinical Apprenticeships are continuing and as well as the leadership apprenticeships we are also advertising for degree nurse apprenticeships to start in the Autumn of 2020. We currently have 112 Apprentices on programme and 3 have completed their level 5 qualification this month LSBU.

Health and Wellbeing:

The 3 year business case has been approved for health and wellbeing and the team are now mobilising the various elements of the programme and agreeing the staff engagement and communications plan to launch to all staff within the Trust. Overall 1986 staff have registered with Vivup the Trust's staff benefits platform which represents 35% of the workforce and is increasing by approximately 100 employees per month due to on-going communications and staff engagement about current health and well-being and staff benefits. The Trust also completed 100% of individual risk assessments and was the only London Trust to do so within the target timeline. The Occupational Health team have undertaken 1071 in depth risk assessments as a result of the individual risk assessment completion and the outcomes of the risk assessments are currently being recorded and reported on. The team are currently evaluating the on-going demand and assessing sustainability of the current arrangements.

The Trust now has a wealth of information about the health of the workforce which we are seeking to enable targeted wellbeing interventions, for example related to diabetes or obesity. There is continued focus on the healthy mind work programme and access to EAP and counselling services remains higher than normal. Up to end July 318 individuals had made contact with psychology CHAT services which led to 70 referrals and 165 of staff who had facilitated group discussions to talk about their experiences. The health and wellbeing business case also puts in place increased counseling provision which will be offered through VIVUP who offer counselors from various back grounds to enable staff a diverse offer and establishing the psychology service to be able to continue the support that has been in place during COVID-19. Over 80 members of staff have signed up to become mental health first aiders and training will commence in September 2020 to be able to sign post staff to the support available. The well-being team are also re-launching the health and well-being champion role and setting up regular quarterly meetings to develop and train champions in the workplace.

People and Organisation Development Workforce Performance Report

July 2020

Transactional Plan:

The recruitment team have further reduced time to hire from 8.9 weeks in June to 7.6 weeks in July. In addition, the recruitment & selection policy is currently being reviewed with a focus on equality, diversity and inclusion, mandating the requirement for diversity champions, increased visibility and a consistent process for internal opportunities (including acting up and secondments). There is also work on-going to enable seamless NHS to NHS staff transfers on a temporary basis which is supported by work across the NWL sector. The ER Team have continued to see an increase in activity, in particular with the number of grievance cases received in month. The analysis of those grievances has not identified specific areas or themes although the team continue to triangulate with FTSU concerns on a monthly basis. Where applicable, the team are employing a proactive, resolution focused approach with the management of these cases and have substantially increased the use of mediation this month as a means to resolve conflict. Thus the ER team are introducing a programme to train in house mediators soon. The project on introducing the Resolution Framework has started and working groups with the operational teams will start in September. Phase Two of the E-rostering project is on a positive trajectory to deliver the stage 1 of this phase (Consultant leave and others staff groups). 221 Consultants now live across EIC and PCD, a total of 480 by the end of September. Therapies services are going live on E-roster in October and Junior/Training grade implementations will start 1st October.

Volunteers:

There were 113 active volunteers in July, who contributed 2847 hours of volunteering across both hospital sites. There continues to be a downward trend both in terms of the number of active volunteers week to week and the number of hours. Many volunteers have requested a break during the summer. This is also due to the fact that activities associated with immediate crisis response have subsided whilst the 'regular' volunteering tasks associated with the Trust running business as usual have yet to pick up. Ward helpers continue to be deployed across wards as they open up. The service is assisting other departments to restart their volunteering services; this includes the infant feeding teams on both sites, and the Macmillan service and Friends. The team have started welcoming back volunteers over 70 and they can be deployed following risk assessments and Occupational Health clearance.

Organisational Change

The HR team continue to support an increasing number of organisational change programmes, 9 at present within the Trust including some complex TUPE transfers, organisational restructures, new ways of working resulting from changes to services. This currently includes activity within IT, Therapies, Sexual Health, Imperial Healthcare Partners. There are also some significant changes to core services where a NWL approach will be taken including payroll provision and core Occupational Health. Across the NWL HR work-streams there is currently work underway to agree a NWL change protocol.

Council of Governors Forward Plan 2020-21

	30 January 2020 AWAY DAY (incl. NED / Governor Strategy and Representation Group)	30 January 2020 Council of Governors	12 March 2020 Briefing Session – performance, quality workforce & finance

Statutory/Mandatory Business	• Announcement of Election results
	• Current position
	• Directors achievements (HSJ Video) and question session
	• How the digital agenda supports patient pathway
	• Showcase: Innovation
	• Strategy
	  ○ Understanding our patients and public
	  ○ Shaping of London
	  ○ North West London HCP Plan
	  ○ Our Clinical Services Strategy framework
	• Findings from the COG effectiveness survey
	• Council of Governors engagement
		• Announcement of Election results
		• Minutes of Previous Meeting, including Action Log and iLog
		• Quality: People & OD Committee Report to the Council of Governors (SG)
		• Draft 2020/21 Annual Plan
		• Disability Access Working Group – update
		• Quality Sub-Committee Report
		• Membership Sub-Committee Report
			• Finance

Papers for Information		• Chairman's Report • Chief Executive Officer's Report • Performance & Quality Report, including Workforce Performance Report	
Other Business		• Questions from the governors and the public • Froward plan • Schedule of meetings • Governor attendance register • Any other business	•

	02 April 2020 NED/Governor Strategy and Representation Group CANCELLED	23 April 2020 Council of Governors (Zoom Conference)	28 May 2020 Briefing Session (Zoom Conference)
Statutory/Mandatory Business	•	• Minutes of Previous Meeting, including Action Log • Draft Quality Report 2019/20, including Governor Commentary on the Quality Report • Nominations and Remuneration Committee Report, including Terms of Reference (for approval); NED configuration paper (for approval); • Membership Sub-Committee Terms of Reference (for approval) • Quality Sub-Committee Terms of Reference (for approval) • Coronavirus (COVID-19) Update	• Managing Complaints
Papers for Information	•	•	•
Other Business	•	• Any other business • Froward plan • Schedule of meetings • Governor attendance register	•

	23 July 2020 Council of Governors	24 September 2020 Briefing Session – performance, quality workforce & finance	29 October 2020 Council of Governors
Statutory/Mandatory Business	• Minutes of Previous Meeting, including Action Log • Nominations and Remuneration Committee Report: Succession plan for Deputy Chairman and Senior Independent Director • Chairman's Report • Chief Executive Officer's Report • Quality: Finance & Investment Committee Report to Council of Governors; including Month 12 Financial Position (JJ); Audit and Risk Committee Report to Council of Governors (NG) • COG Sub-Committees: Quality Sub-Committee Report; Membership Sub-Committee Report	• People	• Chairman's Appraisal PRIVATE • Minutes of Previous Meeting, including Action Log • External Audit Tender update *(COG action 23.07 VM)* • Chairman's Report • Chief Executive Officer's Report • Strategy: NWL Integrated Care System (ICS) - Introduction to Penny Dash, NWL ICS Chair; NWL system developments • Phase 3 of NHS Response to Covid-19 • Support arrangements: The Hillingdon Hospital NHS Foundation Trust • Quality: Quality Committee Report to Council of Governors (EH) • COG sub-committees: Membership & Engagement Sub-Committee Report, including Meet a Governor schedule; Quality Sub-Committee Report; • Accessibility Working Group – update
Papers for Information	• Performance & Quality Report, including Workforce Performance Report • Cerner implementation update (ND) • Investment alignment to Strategic Objectives (JJ) • Governance of capital expenditure (JJ)	•	• Governors Elections 2020 – update • Performance & Quality Report, including Winter Preparedness; People Performance Report;
Other Business	• Questions from the governors and the public • Froward plan • Schedule of meetings • Governor attendance register • Any other business	•	• Questions from the governors and the public • Governors Away Day January 2021 – plan • Froward plan • Schedule of meetings • Governor attendance register • Any other business

	10 December 2020 Briefing Session – performance, quality workforce & finance	~~28 January 2021 AWAY DAY~~ ~~NED/Governor Strategy and Representation Group~~ DEFER TO MARCH 2021 TO ALLOW FOR F2F	28 January 2021 Council of Governors

Statutory/Mandatory Business	• Finance	• Announcement of Election results
		• Strategy
		  ○ NWL configuration
		  ○ The Hillingdon Hospitals NHS Foundation Trust support
		  ○ Finance
		  ○ Responsibilities and Accountability
			• Announcement of Election results
			• Minutes of Previous Meeting, including Action Log
			• Quality: People & OD Committee Report to the Council of Governors (SG)
			• Draft 2021/22 Annual Plan
			• Quality Sub-Committee Report
			• Membership Sub-Committee Report
			• External Auditor appointment (VM)
			• COG Effectiveness evaluation
			• Strategy
			  ○ NWL configuration
			  ○ The Hillingdon Hospitals NHS Foundation Trust support
			  ○ COVID-19 Lessons learnt, current position and future

Papers for Information	•	•	• Chairman's Report • Chief Executive Officer's Report • Performance & Quality Report, including Workforce Performance Report
Other Business	•	•	• Questions from the governors and the public • Froward plan • Schedule of meetings • Governor attendance register • Any other business

High Level Meetings 20/21

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Board PUBLIC		**07-May** 11.00-13.00 Zoom Conference		**02-Jul** 11.00-13.00 Zoom Conference		**03-Sep** 11.00-13.30 Zoom Conference		**05-Nov** 11.00-13.30 Zoom Conference		**07-Jan** 11.00-13.30 Zoom Conference		**04-Mar** 11.00-13.30 WM Room A
Lead Governor & COG Informal Meeting										**28-Jan** 15.00-16.00 Zoom Conference		
Council of Governors	**23-Apr** 16.00-17.00 **Teleconference**			**23-Jul** 09.30-10.30 Zoom Conference			**29-Oct** 16.00-18.00 Zoom Conference			**28-Jan** 16.00-18.00 Zoom Conference		
COG Away Day 2020										**28-Jan TBC** 10.00-16.00 Venue: TBC		
Annual Members' Meeting				**23-Jul** 15.00-16.00 Zoom Conference								
NED/COG Informal Meeting	**23-Apr CANCELLED** 18.00-19.00						**29-Oct** 18.00-19.00 Zoom Conference					
COG Agenda Sub-Committee			**18-Jun** 16.00-17.00 Zoom Conference			**24-Sep** 15.00-16.00 Zoom Conference			**17-Dec** 15.00-16.00 CW Boardroom			**25-Mar** 16.00-17.00 CW Boardroom
COG Quality Sub-Committee			**26-Jun** 10.00-12.00 Zoom Conference			**11-Sep** 10.00-12.00 Zoom Conference			**4-Dec** 10.00-12.00 Zoom Conference			**26-Mar** 10.00-12.00 WM Room A
COG Membership & Engagement Sub-Committee			**25-Jun** 10.30-12.30 Zoom Conference					**19-Nov** 10.30-12.30 Zoom Conference				
NED/Governor Strategy and Representation Group	**02-Apr CANCELLED** 16.00-17.00 CW Boardroom									**28-Jan TBC** Part of Away Day		
Briefing sessions – performance, workforce, finance & quality		**28-May** 16.00-17.00 Zoom Conference				**24-Sep** 16.00-17.00 Zoom Conference			**10-Dec** 16.00-17.00 Zoom Conference			**11-Mar** 16.00-17.00 CW Boardroom

Bank Holidays 2020/21: 10 Apr; 13 Apr; 8 May; 25 May; 31 Aug; 25 Dec; 28 Dec; 1 Jan;

Council of Governors – Attendance Record 2020/21

Governor	Category	Constituency	23.04.20	23.07.20	29.10.20	28.01.21	TOTAL	28.01.21 TBC Away Day
Nowell Anderson	Public	Hounslow	✓	✓				
Richard Ballerand	Public	Kensington and Chelsea	✓	✓				
Juliet Bauer	Patient		✓	✓				
Caroline Boulliat	Public	London Borough of Wandsworth	✓	X				
Cass J. Cass-Horne	Public	City of Westminster	✓	✓				
Tom Church	Patient		✓	✓				
Nigel Davies	Public	Ealing	✓	✓				
Christopher Digby-Bell	Patient		✓	✓				
Simon Dyer	Patient		✓	✓				
Anna Hodson-Pressinger	Patient		✓	✓				
Elaine Hutton	Public	Wandsworth	✓	✓				
Richard Jackson	Staff	Support, Administrative and Clerical	✓	✓				
Jodeine Grinham	Staff	Contracted	✓	X				
Kush Kanodia	Patient		✓	✓				

Paul Kitchener	Public	Kensington and Chelsea	✓	✓				
Minna Korjonen	Patient		✓	X				
Thewodros Leka	Staff	Allied Health Professionals, Scientific and Technical	✓	X				
Anthony Levy	Public	City of Westminster	✓	✓				
Johanna Mayerhofer	Public	London Borough of Richmond upon Thames	✓	✓				
Mark Nelson	Staff	Medical and Dental	X	✓				
Fiona O'Farrell	Public	London Borough of Richmond upon Thames	✓	X				
David Phillips	Patient		✓	✓				
Cllr Patricia Quigley	Appointed	London Borough of Hammersmith and Fulham	✓	✓				
Jacquei Scott	Staff	Nursing and Midwifery	✓	X				
Dr Desmond Walsh	Appointed	Imperial College	✓	✓				
Laura Wareing	Public	Hounslow	✓	✓				
Trusha Yardley	Public	London Borough of Hammersmith and Fulham	✓	X				