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

Board of Directors

Please use https://zoom.us/j/7812894174 for video conference; Meeting ID: 781 289 4174Voice conference One Tap : +441314601196; Meeting ID: 781 289 4174# United Kingdom

4 November 2021 11:00 - 4 November 2021 13:30

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Date: 4 November 2021
Time: 11.00 – 13.30
Location: Via Zoom (https://zoom.us/j/7812894174)

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence	Verbal	Interim Chairman
11.01	1.2	Declarations of Interest, including register of interests	Paper	Interim Chairman
11.02	1.3	Minutes of the previous meeting held on 7 September 2021	Paper	Interim Chairman
11.05	1.4	Matters arising and Board action log	Paper	Interim Chairman
11.10	1.5	Interim Chairman's Report	Paper	Interim Chairman
11.15	1.6	Chief Executive's Report	Paper	Chief Executive Officer
11.25	1.7	Patient/Staff Experience Story	Verbal	Chief Nursing Officer
	2.0	**FOR DISCUSSION**		
11.45	2.1	Trust Elective Recovery Plan update	Paper	Deputy Chief Executive / Chief Operating Officer
11.55	2.2	Integrated Performance and Quality Report	Paper	Deputy Chief Executive / Chief Operating Officer
12.05	2.3	Business Planning 2021/22– update	Paper	Chief Financial Officer
	3.0	**FOR APPROVAL**		
12.15	3.1	Annual People Equality and Diversity Report 2020/2021	Paper	Director of HR & OD
12.35	3.2	Safeguarding Annual Report	Paper	Chief Nursing Officer
12.45	3.3	Winter Plan 2021/22	Paper	Deputy Chief Executive / Chief Operating Officer
12.55	3.4	Sustainability Strategy	Paper	Chief Financial Officer
13.05	3.5	People Strategy	Paper	Director of Human Resources & Organisational Development
	4.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**		
	4.1	Improvement programme update Q2	Paper	Chief Nursing Officer
	4.2	Learning from Serious Incidents Q2	Paper	Chief Nursing Officer

	4.3	Mortality Surveillance Report Q2	Paper	Medical Director
	4.4	People Performance Report	Paper	Director of Human Resources & Organisational Development
	4.5	Digital Programme update	Paper	Chief Information Officer
	4.6	Board Assurance Framework – Half Yearly Report	Paper	Interim Director of Corporate Governance & Compliance
	4.7	Half-year report on use of the Company Seal 2021/22	Paper	Interim Director of Corporate Governance & Compliance
	4.8	Committee Effectiveness Review 2021/22	Paper	Interim Director of Corporate Governance and Compliance
	5.0	**ITEMS FOR INFORMATION**		
13.15	5.1	Questions from members of the public	Verbal	Chairman
13.25	5.2	Any other business	Verbal	Chairman
13.30	5.3	Date of next meeting – 6 January 2022		

Minutes of the Board of Directors (Public Session)

Held at 11.00am on 9th September 2021 via Zoom

Present	Stephen Gill	Chair (Interim)	(SG)
	Aman Dalvi	Non-executive Director	(AD)
	Nilkunj Dodhia	Non-executive Director	(ND)
	Nick Gash	Deputy Chair (Interim)	(NG)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Chief Medical Officer	(RC)
	Rob Hodgkiss	Deputy Chief Executive and Chief Operating Officer	(RH)
	Virginia Massaro	Chief Financial Officer	(VM)
	Pippa Nightingale	Chief Nursing Officer	(PN)
In Attendance	Dawn Clift	Interim Director of Corporate Governance and Compliance	(DC)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Sue Smith	Interim Director of Human Resources and Organisational Development	(SSm)
Apologies for Absence	Eliza Hermann	Senior Independent Director (interim)	(EH)
	Ajay Mehta	Non-executive Director	(AM)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to the Board	(GA)
	Chris Chaney	Chief Executive Officer CW+	(CC)
	Serena Stirling	Director of Corporate Governance and Compliance	(SS)
	Vida Djelic	Board Governance Manager	(VD)

Minute Reference		Action
1.0	**GENERAL BUSINESS**	
1.1	**Welcome and Apologies for Absence**	
	SG welcomed the Board members, those in attendance and members of the public to the Zoom Board Public Meeting and introduced Dawn Clift as the Interim Director of Corporate Governance and Compliance. Apologies received as above were noted.	
1.2	**Declarations of Interest including the Board Register of Interest**	
	SG presented the Board Register of Interests and sought assurance that this represented all current actual or potential interests of Board members. SG confirmed that with effect from 1 September 2021 he had taken a role on	

	the main board of the Phyllis Court Members Club as a Non-executive Director and that this should be reflected on the register. AD confirmed that he had resigned from his role as Chair of Homes for Haringey some six months ago and that this could now therefore be removed as an interest on the Board Register in accordance with the approved Declarations of Interest Policy for the organisation. NG confirmed that with effect from 1 October 2021 he was assuming the role of Chair of the Audit and Risk Committee for the Royal Society of Medicine. It was agreed this would be added to the register. NG confirmed that he was no longer a lay advisor to HEE London and South East for medical recruitment and trainee progression. It was noted that this interest would remain on the register for six months' post resignation in accordance with approved organisational policy.	
	Resolution: The Board resolved to approve the Board Register of Interests subject to the above amendments by DC and to publish the revised register on the Trust Website.	DC – Sept 21
1.3	**Minutes of the Previous Meeting held on 8 July 2021**	
	The minutes of the previous meeting held on 8 July 2021 were approved as a correct and accurate record of proceedings.	
1.4	**Matters Arising and Board Action Log**	
	It was noted and agreed that there were no outstanding issues to address on the action log.	
1.5	**Interim Chair's Report**	
	SG presented the report and reiterated on behalf of the Trust Board his thanks to staff for their continued commitment over the last 2 years starting with 2019 Winter pressure and throughout the Covid pandemic. He noted that despite the challenges, there was a huge degree of resilience shown by staff working under extreme pressure in the spirit of high quality and safe patient care. He expressed his sincere thanks to every member of the team for their contribution and unfailing commitment to the Trust's PROUD values and the NHS. SG highlighted within his report the forthcoming Council of Governor election process which opens on 10 September 2021 and encouraged nomination from existing governors as appropriate and new interested parties. It was noted that the output of the election process would be confirmed on 25 November 2021. There were no additional questions and the report was taken as read.	
	Resolution: The Board resolved to note the content of the report	

1.6	**Chief Executive's Report**	
	LW presented her report and echoed her thanks to all staff across the organisation during an incredibly challenging time. LW noted that in addition to the ongoing presentation of Covid patients, colleagues were committed and working hard to deliver the elective recovery plan and continue to provide leadership for both the Covid and forthcoming Flu vaccination programmes. She commended their diligence in upholding the Trust values of putting patients first and was pleased that a significant number of staff had taken the opportunity during the summer months to have annual leave.	
	LW highlighted from her report the tragic situation in Afghanistan and confirmed the commitment of the Trust to ensure that adequate care provision was in place to meet the needs of refugees who had arrived in North West London. She commended the partnership and system response to health and social care provision and confirmed that it was expected this support would be required in the medium to long term. AD thanked LW for the support and the difference that Chelwest were making to this situation and asked what level of demand the organisation was experiencing and whether adequate translation services were in place. PN responded by confirming that an additional 1,679 Afghan refugees had presented and that many of these had high levels of physical and mental health trauma. She commended the work of the Department of Health and Social Care and the local response to enhance three particular aspects of healthcare provision: - • Mental health • Midwifery and Maternity Care • Paediatric Care PN confirmed that she had been impressed with the level of voluntary support also available and stated that very good translation services were now in place covering the three main languages used in Afghanistan.	
	In addition to the documented detail of her report, LW appraised the public that ongoing meetings had taken place between Chief Executive Officers and Chairs in North West London along with meetings with MPs of North West London to drive forward the integrated care system (ICS). She confirmed that the oversight framework in place echoes that of local governance with a focus on quality of care, timely access to services, wellbeing and development of staff and financial effectiveness. Discussions and developments were already demonstrating the value of shared learning to improve the healthcare offer to our ICS population.	
	LW made reference to the recent national announcement of funding investment in the NHS which was very much welcomed. It was noted that a meeting of NHS Chief Executive Officers would be taking place imminently to explore the details for allocation of this investment. LW confirmed that Chelwest is in 'sector 1' which represents high quality patient care, strong financial performance and use of resources.	

	On the matter of the integrated care system (ICS), LW confirmed that an advertisement had now been placed to seek the interest of high calibre candidates for the position of Chief Executive Officer of the North West London (NWL) ICS. Interviews are planned to take place at the end of October 2021. ML questioned what level of optimism there was in securing a candidate for this complex position. LW advised that she was optimistic given that there are a number of credible individuals who really want to drive improvement through integrated care models. LW confirmed that until an appointment was made, she would continue in her position as Interim NWL ICS Chief Executive Officer.	
	SG made reference to national media reports on 'Mandated Vaccination' of NHS staff. PN confirmed that a national consultation had been launched earlier in the day across the NHS regarding the overall principle of vaccination (which was not limited to Covid). NG recommended that it was important for the Board to form part of this consultation and to put forward a Board view following open Board discussion. This was agreed.	
	Resolution: The Board resolved to: - • Note the content of the report • Hold an open Board discussion to determine a Board View to form part of the response to the national consultation on the principle of vaccination for NHS staff	DC
1.7	**Patient Story**	
	The Board welcomed Olena to the meeting. Olena had sadly become very unwell with Covid during the pandemic and as such was admitted to the ITU at Chelsea where she was ventilated. Olena was heavily pregnant at the time. Olena was joined by two members of the team that had cared for her, Leigh Paxton (LP) who works in ITU and Vicky Cochrane (VC) who leads maternity services.	
	Olena opened her story by thanking the ambulance service and Chelwest for 'saving her life and that of her baby' who is now 7 months old and fit and healthy. The Board were delighted to be introduced to Olena's baby boy via Zoom during the meeting. LP had been involved in the delivery of care to Olena right from the start of her admission and stated that it gave him much pleasure to see how she had recovered from a very unwell position and that her baby was well too. LP spoke of changes that they had made to Olena's ITU room to promote positivity including the placement of photographs of Olena and her family around her room. Olena shared with the Board her experience of hallucinations and vivid dreams during her time in ITU and was immensely grateful for the unfailing kindness and care of the staff. She stated that she could not praise the NHS enough and was in awe of the dedication, strength, kindness, care and skill of the teams. VC spoke of the arrangements that had been put in place to ensure that Olena's family were	

	engaged in her care including the establishment of daily link up calls with her husband and arrangements for him to come into the hospital when Olena's C Section took place. Board members thanked Olena for sharing her experience and asked whether her follow up care post discharge from ITU had been positive. Olena advised that she had a number of follow up appointments and diagnostics and was now able to do all usual daily living activities. It was noted that Olena was also being invited back to the hospital to meet the team that cared for her and to meet other patients in a focus group to talk through their experience of care. NG stated he was grateful to Olena for sharing her experience and reflected that despite the unprecedented demand that Covid placed on our ITU facilities and teams this did not appear to have compromised care delivery. ML asked Olena her views on whether pregnant women should have the Covid vaccine. Olena advised that patients should make an informed choice but in her opinion every woman should have the vaccination. SG thanked Olena for her kind words and for sharing her experience with the Board.	
2.0	**FOR DISCUSSION**	
2.1	**Elective Recovery Plan**	
	RH presented the progress in delivering the elective recovery plan which had been considered in detail at the Quality Committee earlier in the week. He highlighted the following, noting that activity data related to w/e 15th August and waiting list data is w/e 22nd August: - • Priority 2 waiters have decreased across NWL in recent weeks however Chelsea has seen an increase. It was noted that this figure is over-inflated by 60 patients who need to be removed due to validation. • CWFT are reporting the lowest numbers of P2 patients waiting >6 weeks. • Elective IP/DC is at 98% of comparative 19/20 BAU volumes • HVLC is at 104.1% of comparative 19/20 BAU volumes • Elective OP is at 108% of comparative 19/20 BAU volumes • The Trust is ahead of its 52-week waiting trajectory but behind on its 78ww trajectory. There are 2 x 104 week waiting patients reported in the latest period. • Cancer Backlog has increased over the last week with 140 reported. The Trust continues to see significant increases in 2ww referral volumes. • Imaging is at 106.5% of comparative 19/20 BAU volumes, reporting minimal patients waiting over 6 weeks • Endoscopy is at 96.7% of comparative 19/20 BAU volumes, • Echo is at 73.6% of comparative 19/20 BAU volumes and reporting zero patients over 6 weeks ND stated that he was encouraged to see the progress being made and questioned whether we have the staffing capacity and resilience of staff to	

	continue delivery against plan. RH advised that work is taking place to maximise every aspect of capacity and confirmed that some in-sourcing was taking place to build capacity in areas and to respect the wellbeing of staff. NG questioned the implications and rationale for the 200% increase experienced in Dermatology Cancer Referrals. RH confirmed that this appeared to be linked to patient choice and stated that the level of growth seen at Chelwest had not been replicated across North West London.	
	Resolution: - The Board resolved to take assurance of the status of the Elective Recovery plan against planned trajectory.	
2.2	**Medical Revalidation Annual Report**	
	RC presented the above report which provided assurance of controls around medical professionals and their fitness to practice. It was noted that the report covered the pandemic year and that medical appraisals during this period of challenging clinical demand had been voluntary in accordance with national directive. Despite this it was pleasing to see that 350 Medical Professionals took up the opportunity for an appraisal representing 42% of the medical workforce. It was noted that the appraisal format had been adapted to incorporate additional aspects relating to mental health wellbeing. RC confirmed that the report had been considered in detail at the People and OD Committee in July 2021.	
	Resolution: The Board resolved to approve the Medical Revalidation Annual Report for submission to the General Medical Council.	
2.3	**Trust Seasonal Influenza Plan**	
	PN presented the above plan for approval by the Board. It was noted that the targets for 2021-22 had changed to reflect the following: - • 90% vaccination status for frontline clinical staff • 85% vaccination status for all patient facing staff There had been some slippage in the delivery of the vaccine supply due to national logistics and this was now expected to arrive on 23 September 2021. The flu vaccine would be co-administered as part of the Covid booster campaign. LW requested that all Board members are vaccinated in the early stages of the campaign to demonstrate committed leadership from the Board.	
	SG reflected on the totality of the vaccine programme and asked how PN saw the next stage of delivery occurring given the closure of mass vaccination centres. PN confirmed that the physical and human infrastructure was in place across the NWL system to enable delivery of the programme including the current vaccination of 16–17-year-olds, the 12-15-year-old programme (subject to decision by the NHS Chief Medical Officer) and the Covid Booster	

	programme. Infrastructure support included an increase in the number of pharmacies with vaccination status and the work of the NWL vaccination team.	
	Resolution: The Board resolved to approve the Trust Seasonal Influenza Plan	
2.4	**Improvement Programme Update and Quality Priorities**	
	PN and RC introduced the paper and confirmed that there had been good progress in taking forward the improvement programme over the past 6 weeks. SG asked what level of confidence could be given to delivery of the programme and priorities, in particular re Sepsis, by the end of the financial year. Both PN and RC felt that this was achievable as long as we can retain a 'business as usual' status and continue delivery of our elective recovery programme. NG requested a progress update on clinical handover. RC advised that a 'back to basics' approach had been taken and that the subject of handover had been taken into the Medical Leadership Programme to emphasise the importance of good clinical handover of the clinical effectiveness and quality of care to patients. LW stated the need to continue to reiterate accountability for good handover with clinical colleagues.	
	Resolution: The Board resolved to note the content of the report and were assured of progress being made with the improvement programme and quality priorities.	
2.5	**Integrated Performance and Quality Report including Winter Planning**	
	The report was presented by RH. It was noted that July 2021 had been an incredibly challenging month compromised in part by staff absence due to the 'ping-demic'. Despite these challenges the Trust had ended the month as the tenth top national performer against aggregated performance standards and had since improved to 5th position. RH highlighted in particular A&E performance, Cancer Performance and Referral to Treatment Times (RTT). He confirmed that all imaging modalities were compliant. With regard to urgent care demand, RH advised that a number of walk-in centres would be re-opening imminently and that this may have an impact in reducing demand on A&E. NG made reference to new metrics for Emergency Care asking whether these had been confirmed nationally and what impact they will have on the Trust. RH stated that there are potentially 3 new standards for Emergency Care which may be introduced from the end of October. He confirmed that there had been no confirmation nationally as to whether the A&E 4-hour standard would remain. In terms of impact, he felt that these would not change the way in which we run our services and that if required, we will be	

	ready to report on our compliance with these from the end of October. Board members were advised to add caution to the Family and Friends Data contained in the report due to a data quality issue that was now being resolved. RH drew the attention of the Board to a Never Event that had sadly occurred during the month. RC advised that no harm has come to the patient concerned and Duty of Candour was fully enacted immediately upon identification of the event. The Board were advised that a panel meeting would be taking place imminently to review the findings of the Root Cause Analysis report. With regard to Winter Planning, RH advised that regional and local modelling was taking place across North West London to understand the forecast position for Winter in collaboration with key system partners. A total of 73 schemes had been identified as part of Winter Planning for 2021 to date. These would be presented for discussion at the Executive Management Board and the totality of the Winter Plan would be presented to the public meeting of the Board in November 21. ML expressed concern for the wellbeing of staff as we not only continue to respond to Covid, undertake elective recovery but also respond to the challenges that Winter brings. LW stated the Boards commitment to lead the organisation through a difficult period and to work in collaboration with system partners to meet the needs of patients and staff. It was recognised that new funding will be aligned to new ways of working which will drive forward some of the workforce changes that were put on hold during Covid. All Board members confirmed their commitment to staff and their wellbeing and to the need to appreciate and recognise their dedication. SG reminded colleagues that our benchmarked performance continues to be very high and that we are ahead of the Trust's financial plan at the end of month 4.	RH Nov21
	Resolution: The Board resolved to: - • Take assurance from the content of the report on our current performance position • Receive the Winter Plan for 2021 at the public board meeting in November 2021	
3.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**	
3.1	**Learning from Serious Incidents**	
	PN presented the report which had been subject to scrutiny at the Quality Committee meeting earlier in the week. 12 new Serious Incidents had been recorded in July and August as detailed in the report. The associated learning was noted by the Board. SG asked whether the Quality Committee members wished to raise any	

	matters from their consideration of the paper. No matters were raised given the healthy discussion that had taken place at Committee level.	
	Resolution: - The Board resolved to note the content of the report and take assurance that the Trust continues to govern its serious incidents appropriately and that learning is taking place as a result of incident occurrence.	
3.2	**Safe Staffing Annual Report**	
	PN presented the above report and gave thanks to Cathy Hill, Deputy Director of Nursing for all of her hard work in compiling the report. It was noted that despite unprecedented pressure associated with the impact of Covid, improvements had been made against 4 safeguarding measures in the last 12 months resulting in 100% compliance with the 14 national workforce safeguarding measures. Three measures had associated improvement plans to further strengthen any gaps identified during the assessment process which PN confirmed would be governed through the Executive Management Board. SG made reference to the volume of turnover of therapists at West Mid and questioned whether this was an area of concern. PN confirmed that this was an 'artificial raise' due to some contractual changes and should not be of concern to the Board. It was noted that the report had been considered and discussed at the Quality Committee meeting earlier in the week and was recommended for approval.	
	Resolution: - The Board resolved to approve the Safe Staffing Annual Report.	
3.3	**Mortality Surveillance Report Q1, 2021-2022**	
	RC presented the report which had been considered and discussed at the Quality Committee earlier in the week. The Board noted that the mortality indices were some of the lowest in the Country which was a positive clinical effectiveness measure. RC confirmed that Chelwest are working in collaboration with others across North West London to conduct a review of patients who contracted Covid in hospital during the pandemic and succumbed to the virus with the aim of identifying any themes or learning.	
	Resolution: - The Board resolved to note the content of the report and the assurance that low level mortality gave to the clinical effectiveness of care delivery.	
3.4	**People Performance Report**	
	SSm presented the report and highlighted the slight increase in vacancies, turnover and use of temporary staff as a result in part of the 'pingdemic'.	

	She confirmed that there was an ongoing focus on developing and delivering our plans to further recognise and appreciate colleagues and made reference to the Kindness Poster Campaign in place. SG made reference to the underperformance on PDRs and SSm confirmed that she has commissioned a report to go to the People and Organisational Development Committee detailing recovery plans.	
	Resolution: The Board resolved to note the content of the report.	
3.5	**Digital Programme Update**	
	KJ presented the report which was taken as read. It was noted that new national guidance had now been issues which will help inform our future strategic direction around digital technology.	
	Resolution: The Board resolved to note the content of the report.	
4.0	ITEMS FOR INFORMATION	
4.1	**Questions from Members of the Public**	
	SG invited any questions from the public, governors and any other attending the meeting. No questions were raised or posed.	
4.2	**Any Other Business**	
4.2.1	<u>100 Year Anniversary of West Middlesex Hospital</u> LW gave recognition to the forthcoming 100-year anniversary of West Middlesex Hospital which, having been delayed from 2020 by the Covid pandemic, would fall on 17 September 2021 and stated how very proud she and the entire Board were of the staff and services delivered on this site. Details of all celebratory activities to mark the Centenary would be circulated to Board members.	
4.2.3	<u>Blood Vials – Logistics and Supply</u> NG requested an update on the impact of the shortage of Blood Vials due to national logistical challenges and supply issues. PN and VM confirmed that alternative bottles have now been received and a mutual aid process had been established across North West London. RC confirmed that the issue had also been tested through an Emergency Planning approach which confirmed that clinical care had not been compromised.	
4.3	**Date of the Next Meeting**	
	The next meeting will take place on 4 November 2021 at 11.00am until 1.30pm. The meeting closed early at 13.04 hours.	

Glossary of Terms

NHS	National Health Service
MPs	Members of Parliament
ICS	Integrated Care System
NWL	North West London
ITU	Intensive Treatment Unit
P2	Priority 2 Patients (Elective Patients)
IP	In-Patient
DC	Day Case
HVLC	High Volume, Low Complexity
OP	Out Patient
WW	Week wait
BAU	Business as Usual
A&E	Accident and Emergency
RTT	Referral to Treatment Time

Trust Board Public –Action Log

Meeting Date	Minute number	Subject	Action	Current status	Lead
9 Sept 2021	1.2	Board Register of Interests	Update the Board Register of Interests in accordance with the minutes and publish on Trust website	Complete	DC
9 Sept 2021	1.6	National Consultation on Mandated NHS Vaccination Proposal	Hold an open Board discussion to formulate and share the Board view of this national consultation	Staff views sought internally to help deliver a response. Board to share response at Public Meeting in November 2021. On agenda within CEO report.	DC/LW
9 Sept 2021	2.5	Winter Plan 2021-22	Present the totality of the Winter Plan for 2021-22 to the Public Board in November 2021	On agenda	DC/RH

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	1.5
TITLE OF REPORT	**Interim Chair's Report**
AUTHOR NAME AND ROLE	Steve Gill, Interim Chair of the Board of Directors
ACCOUNTABLE EXECUTIVE DIRECTOR	Steve Gill, Interim Chair of the Board of Directors
THE PURPOSE OF THE REPORT Decision/Approval ☐ Assurance ☐ Info Only ☐ Advice ☐ Please tick below and then describe the requirement in the opposite column	To provide a briefing to the Board of Directors and the public on particular aspects of high level Trust affairs
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Nil; Date of Meeting: ; Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• Recognition and thanks to the unfailing commitment of our staff in the continued delivery of safe high quality care during periods of excessive operational pressure • Assurance of action being taken to improve the experience of staff in relation to their health and wellbeing, keeping them safe from violence and aggression and ensuring that we are an inclusive organisation • Assurance of the progression of Council of Governor Elections with voting opening on 1 November 2021 and closing on 24 November 2021 • Confirmation of the appointment of Saxton Bampfylde to lead the recruitment of the singe chair for the four North West London Trusts • Confirmation of the progression of a number of strategic level meetings with London Regional Chairs and Chief Executives and the nature of discussions
KEY RISKS ARISING FROM THIS REPORT	Nil

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

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

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

Strategic discussions relating to the acute provider collaborative aims to ensure an improvement in population health with greater equity across North West London to acute healthcare services

Council of Governor Elections open on 1 November 2021 and the Council of Governor meeting in October 2021 received a full report on proceedings

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

Interim Chair's Report – November 2021 Public Board

1) NHS short / medium term priorities – Thank you to our staff and Executive Team.

The current NHS focus areas continue to be the Vaccination Programme; the Elective Recovery Programme; COVID-19. In addition, Urgent and Emergency care and Ambulance services remain under extraordinary operational pressure with levels of demand normally associated with the busiest periods in Winter.

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

In late September the Trust commenced the vaccination programme for the 2021 winter flu jab and COVID-19 booster jab at both our two main hospital sites for our staff and other health and social care staff.

2) Staff Survey:

The annual Staff Survey launched on 4 October. The Trust continues to invest in the 3 key areas highlighted in last year's survey:

i. Staff health and wellbeing (H&WB).

In 2019/2020 the Trust launched a health and wellbeing (H&WB) plan which was accelerated during the pandemic and in partnership with CW+ the Trust Board approved a multi-year programme which focuses on four pillars of H&WB:

Healthy Mind – enhanced psychological and mental wellbeing support

Healthy Body – programme to support our staff be physically well

Healthy Living – a programme to support our staff live well

Feeling Safe – continued work to ensure our staff feel safe at work

ii. Safety Culture (violence and abuse to staff from patients and visitors).

Trust actions include:

- Focus Groups for staff to raise concerns and share ideas in July 2021
- Learning from peers – working with the national team implementing the violence reduction standards and visiting exemplar sites
- Revised and refreshed policy; Acceptable Behaviour Standards Policy – Violence and Aggression
- Support documents for managers and staff
- Management of abusive telephone calls
- Body worn cameras
- Safe travel hints and tips
- Staff safety guardians (currently 8 identified across the organisation)
- Intranet page and Staff App page dedicated to staff safety
- Kindness campaign
- Strengthening governance processes

iii. Equality, Diversity and Inclusion.

Trust actions include:

- Appointed Gubby Ayida as Board Diversity and Inclusion Advisor
- Launched an LGBT+ staff network; the Trust is a member of the Stonewall Diversity Champions Programme.
- Commenced a Reciprocal Mentoring Programme for Inclusion
- Joined the Timewise Accredited Partnership Programme
- Launched Diversity and Inclusion Champions into the Trust recruitment process for Band 8a+ roles.
- More of our BAME staff are in leadership positions, and 33% of our BAME staff on our new MBA and 45% on the new MSc. programmes both in Leadership
- Introduced a check and challenge process when investigations and disciplinary action is being considered and reduced the number of staff going through formal processes
- Executive led lived experience listening events specifically focusing on career progression and recruitment
- Maintained our Disability Confident Status Level 2 and working towards Level 3
- Ensured all our staff had an individual risk assessment, and achieved 100% compliance to ensure the physical and psychological safety of our people in response to COVID-19

October 2021 was Black History Month (BHM), the Trust ran a range of events under the title 'Proud to be', covering culture, history, career development and food.

3) Council of Governors (COG):

A. COG Elections - September-November 2021.

The COG is a highly valued and important part of our Trust. Our Governors represent different communities, patients, staff and Local Authorities. The COG hold the Trust Board to account and help to ensure that the services we provide reflect the needs and priorities of our patients, staff and local communities.

We opened the 2021 COG election nomination process on Friday 10 September 2021, the deadline for submitting a nomination for one of the vacant seats was Friday 8 October 2021. Voting opened for all nominated candidates on 1 November and will close on 24 November 2021.

The 12 seats available for election are:

- 2 public seats representing the London Borough of Hounslow
- 1 public seat representing the London Borough of Ealing
- 1 public seat representing the London Borough of Wandsworth
- 2 public seats representing the London Borough of Richmond upon Thames
- 5 patient seats
- 1 staff seat representing Nursing and Midwifery

Councillor Atterton has been appointed as the Local Authority Governor representing the London Borough of Hounslow. We are currently liaising with Westminster City Council on their appointed Local Authority Governor.

B. (COG Briefing Sessions – September & December.

The COG briefing session on 23 September was on the Complaints process.

The COG briefing session on 9 December 2021 will be an update on the Trust's Digital programme

4) North West London Integrated Care System (ICS) / Acute Provider Collaborative.

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

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

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

Saxton Bampfylde were appointed in October 2021 to lead the recruitment of the single Chair for the four NWL Acute Trusts.

5) Chair Meetings.

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

As part of the work on the NWL Acute Provider collaborative, I have continued to have weekly meetings with Bob Alexander (Interim Chair of Imperial College Healthcare Trust) and Lord Morse (Chair of Hillingdon Hospital Foundation Trust & London North West University Healthcare Trust). These weekly Acute Provider Chairs meetings will continue throughout November and December.

The NWL Acute Provider Trust Chairs and CEOs met on 25 October to review the current areas of collaboration and explore next steps.

Stephen Gill.

Interim Chair – November 2021.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**1.6**
TITLE OF REPORT	**Chief Executive's Report**
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Lesley Gill, Chief Executive
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: Info Only: X Advice: Please tick below and then describe the requirement in the opposite column	To provide an update to the Board in public on high level Trust affairs and key areas of importance to the delivery of our strategic priorities.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Nil; Date of Meeting: ; Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• Stringent infection control measures remain including the need for patients and visitors to comply with the use of face masks (unless a valid exemption applies) and hand sanitiser. • Work is ongoing to promote the need to value, respect and be kind to staff and to reduce incidents of violence and aggression • Our elective recovery programme continues to be implemented to reduce lengthy waiting times accrued during Covid 19 • Levels of demand, particularly for non-elective patients continues to be high • Planning has taken place at local and system wide levels in readiness for Winter 2021/22
KEY RISKS ARISING FROM THIS REPORT	

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

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

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Chief Executive's Report to the Trust Board, 4 November 2021

1. Thank You

As ever I would like to open this report by expressing my thanks and that of the Board to all of our hardworking colleagues who continue to be committed to excellence in the delivery of patient care. It has been an extremely challenging 18 months and I am pleased to see that many staff took the opportunity to have some annual leave over the Summer months enabling them to be refreshed for the challenges that the Winter poses to us.

2. **Keeping Each Other Safe – Infection Control and Vaccination Update**.

On an important note, I want to reinforce the importance of infection control in my report today. Preventing infection is everyone's responsibility and we must all do our best to remain vigilant. This includes staff, patients and visitors to our hospital sites and community sites. Health Secretary Sajid Javid's warning that restrictions could return if people don't change their behaviour in the days ahead is a stark reminder that COVID-19 has not gone away. We must continue to take steps to protect ourselves and others despite restrictions easing.

Currently, stringent infection control measures remain in place across our sites to ensure we are protecting everyone as much as possible. This includes the continued mandate of wearing facemasks at all times (unless a valid exemption applies) and the use of hand sanitiser. This applies to all patients, visitors and staff including those visiting our Emergency Departments.

In addition for our staff, we have implemented a new system of staff testing, whereby clinical staff are required to use a lateral flow test when starting work. Testing takes place twice a week, but daily on wards with outbreaks.

Our Covid Booster vaccination programme has been in full flow for some weeks now on both the West Middlesex Hospital and Chelsea Hospital sites, along with our flu vaccination programme. We continue to work hard to help broader population health across North West London and are supporting the delivery of the schools vaccination programme through deployment of some of our expert colleagues.

At our last Board meeting we discussed the consultation on whether NHS staff vaccination should be mandated. We have responded to this consultation advising that our own Chelwest local evidence and vaccination levels demonstrate that NHS staff do want to be keep themselves and others safe and are committed to vaccination.

3. Performance and Elective Recovery

September has continued to see many challenges within the month for the Trust, with continued non-elective pressures.

Although non-compliant with a number of key metrics in month, the Trust's performance continues to be strong when compared to the wider NHS and we are ranked 5th on the overall hospital score within Public View, improving from 7th position last month.

Our elective recovery plan continues to be implemented and we are performing strongly with most areas seeing more patients than they typically would have pre-covid. We still have much further to

go and later on the agenda our Deputy Chief Executive and Chief Operating Officer will discuss performance to date and our approach to recovery moving forward.

4. Winter Planning

We and our teams are already going the extra mile to recover from the Covid pandemic and to try to return to 'business as usual'. We can see from our performance report and elective recovery plan progress report on the agenda today that we are making a positive difference, albeit we still have further to go. Winter has always provided additional challenges across the NHS as we see peaks in demand associated with ill health during the Winter season including respiratory complications and influenza. In order to provide the care we all want to provide over winter, we are finalising a winter plan which relies on new ways of working as a system rather than relying on individuals to do even more. Working together to provide equal access to services across North West London is going to be so important to ensuring that all patients are able to receive the care they need as this particularly challenging time. Our Winter Plan is on our agenda today and this sets out a range of initiatives that will be in place to help ensure that we remain responsive to patient needs over the forthcoming months.

5. The Trust and the North West London Integrated Care System (NWL ICS)

The Trust continues to be part of national, regional and sector discussions and the NWL Integrated care system continues to operate as one system whilst legislative changes continue to be progressed.

Meetings continue to be held with:

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

I am delighted that our work to date within the NWL ICS has been externally recognised recently by the Health Service Journal, the British Medical Journal(BMJ) and other awards. These include the 'virtual-ward' which provides remote monitoring of patients, the High intensity User service in the Hillingdon system, the North West London keeping well programme, Westminster community mental Health hub, London North West communication team and Imperial's clinical trial team has been awarded Critical Care Team of the Year by the BMJ

6. Sustainability

In October 2020, the NHS committed itself to becoming the world's first carbon net-zero National Health Service by 2045 with the 'Delivering a Net-Zero NHS' report. Two core objectives were set out:

- To ensure the emissions we control directly (the NHS Carbon Footprint) are net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- To ensure the emissions we can influence (our NHS Carbon Footprint Plus) are net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

As a Trust we are committed to driving sustainable development and later on the agenda today, we will discuss our Sustainable Development Strategy which we will take forward over the next 5 years. The strategy:-

- Sets out our green ambitions and the enablers to achieve these
- Publically sets our commitment to sustainable development
- Shows how we will met our legislative requirements
- Demonstrates how we will evaluate our impact
- Set out how we will monitor and assure against delivery of this strategy

7. Our People

The safety and wellbeing of our staff remains a high priority for me and the whole executive team. Over recent months we have seen an increase in the number of incidents of violence, aggression and abuse to a number of our staff from some patients and visitors. Whilst we appreciate that at times visiting hospital can be stressful for individuals we cannot accept incidents of violence, abuse and aggression to our staff. Our staff safety group is working hard to ensure that we support safety controls for our staff and we have established a number of staff safety champion roles across our sites. I would like to take this opportunity to ask members of the public including patients and visitors to treat our staff with kindness respect and courtesy. Our ongoing 'kindness campaign' is visible across our sites and offers examples of the great work that our colleagues do everyday along with examples of behaviours they have been subjected to. Please do your part to display kindness and respect when visiting our sites.

8. Proud to be' staff stories to celebrate Black History Month

Black History Month (BHM) began in October with a full range of events covering culture, history, career development and food. Celebrating, recognising and valuing the diversity of our staff and our patients is central to our values and to ensuring that we meet the needs of a diverse workforce and community. Black History Month is a time to reflect on and celebrate the richness and strength of our community and we are encouraging all staff to get involved in our celebrations including stories from colleagues across the Trust stories of personal identity and heritage under the title 'Proud to be.'

On the matter of inclusion, we will today discuss our Annual Report on Equality, Diversity and Inclusion. This demonstrates our journey to date towards improving the experiences of our staff and our patients. Inclusion is not a choice, but simply the way we work.

9. Chief People Officer visit

I was pleased to meet Prerana Issar, Chief People Officer last month and share with her our drive to be an 'Employer of Choice'. Prerana met with colleagues from Human Resources and Organisational Development and from our nursing teams to learn more about our successes in recruitment and retention. She was very interested in the pastoral care offered to our international nurses, apprenticeships, the excellent career pathways for our Health Care Assistants and nurses across the Trust, and our health and wellbeing offer.

10. Ghaida Al-Jaddir

Ghaida Al-Jaddir, Service Director of Paediatric Surgical Specialty has won the Chairman's Award at this year's Asian Women of Achievement Awards (AWA) which celebrates multi-culturalism in the UK and the contribution of diverse cultures and talents. The citation describes her as 'a dynamo who has reached the pinnacle of British dentistry… seeking to ensure children can access dental and medical care as a right'. She is the first consultant in paediatric dentistry who is female, of Arabic origin, and educated outside the UK. We are delighted for Ghaida and to have her working at the Trust - huge congratulations Ghaida on your recognition.

11. Allied Health Professionals Day

On 14th October, we marked Allied Health Professions (AHPs) Day, an opportunity to celebrate the fantastic 500+ AHPs in our Trust who play a vital role in patient care. It was a great to be involved in the day. I am sure you would want to join me in recognising the incredible work of our Allied Health Professional and pharmacy colleagues and expressing our thanks for the significant difference that they make to the lives and wellbeing of so many of our patients.

12. Pippa Nightingale appointed Chief Executive for London North West University Healthcare

Pippa Nightingale, Chief Nurse for Chelsea and Westminster Hospital NHS Foundation Trust has been appointed as Chief Executive for London North West University Healthcare NHS Trust.

Pippa has been pivotal to the Trust over the last seven years as Director of Midwifery and Chief Nurse and as Executive Quality Lead for the North West London Integrated Care System, where she led the vaccination roll-out. This is an excellent appointment and a great opportunity for her.

On a personal note, I am very grateful for her leadership and support, working through one of the most challenging periods for our health service. I know she will be missed by many of us and I wish her every success in her next role.

Pippa will not take up her new position until the new year.

13. Our Money

At month 6 we are reporting a year to date surplus of £0.16m, when adjusted for the financial impact of donated assets and profit on disposal. This is £0.16m favourable against the plan that we had set out for the first half of this financial year. The favourable position includes Elective Recovery Funding (ERF) and increased costs to undertake this activity.

END

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**2.1**
TITLE OF REPORT	**Trust Elective Recovery Plan Update**
AUTHOR NAME AND ROLE	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Hodgkiss, Deputy Chief Executive & Chief Operating Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	The purpose of this report is to provide assurance to the Board of the status of our Elective Recovery plan against planned trajectory
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome Executive Management Board / 27/10/21 / Noted NWL Elective Care Board / / Noted
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	Data relates to week ending 10th and 17th October 2021 • Priority 2 waiters have remained stable across NWL in recent weeks. • Elective IP/DC – is 103.3% of Business as Usual 19/20 (w/e 10/10) • HVLC – is at 125.0% of Business as Usual 19/20 (w/e 17/10) • Elective OP – is 113.6% of Business as Usual 19/20 (w/e 10/10) • There has been an increase in the number of patients waiting in excess of 52 weeks in the last week from 468 to 488. Patients waiting over 78 weeks reduced from 86 to 75 and the number of 104 week patients has reduced from 6 patients to 4 week ending 22nd October 2021. • Cancer Backlog 63 days+ has continued to reduce in volume from 96 to 95 w/e 17th Oct 2021 • Imaging – 107.1%% of Business as Usual • Endoscopy – 116.0% of Business as Usual • Echo – 67.0% of Business as Usual (no over 6 week waits)
KEY RISKS ARISING FROM THIS REPORT	There are on-going risks to the achievement of Elective recovery.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		
Equality And Diversity		
Quality	X	There are on-going risks to the achievement of Elective recovery
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance	X	Attainment of the Elective Recovery Fund.
Public Consultation		
Council of Governors		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Chelsea and Westminster Elective Care Recovery

Recovery Update - Summary 25th October 2021

P2 waiting list size across NWL Trusts

Trusts	24.09.21	01.10.21	08.10.21	15.10.21
CWFT	530	511	518	510
ICHT	1,037	1,010	988	1,007
LNWUHT	447	455	412	428
THHT	33	29	44	51
NWL Total	**2,047**	**2,005**	**1,962**	**1,996**

Source: OnePTL

Number of P2s remain steady across all the Trusts.

Prioritisation of admitted patients: Data source and quality

'Null' data across NWL

Dates	Total number of patients on the PTL	Nulls (n)	Nulls (%)
24.09.21	22,514	4,031	18%
01.10.21	22,322	4,038	18%
08.10.21	22,446	4,038	18%
15.10.21	22,430	4,038	18%

'Null' % by Trust

Trusts	24.09.21	01.10.21	08.10.21	15.10.21
CWFT	8%	8%	8%	8%
ICHT	16%	17%	17%	17%
LNWUHT	18%	18%	18%	19%
THHT	38%	40%	40%	22%

Source: OnePTL

This week:

- At CWFT, ICHT and LNW the percentage of Nulls remain steady
- At THHT percentage of Nulls is 22%. Trust had been experiencing issues with Lunar which previously distorted the percentage of Nulls. Positions reported by Trust for previous weeks include 21% (08.10.21), 27% (01.10.21) and 28% (24.09.21).

P2 patients waiting 6 weeks or more

Number of P2 patients waiting 6 weeks or more

Trusts	24.09.21	01.10.21	08.10.21	15.10.21
CWFT	7	16	12	9
ICHT	125	116	106	117
LNWUHT	145	141	128	141
THHT	7	6	15	14
NWL Total	**284**	**279**	**261**	**281**

Source: Exception reporting from Trusts

Undated P2 patients waiting 6 weeks or more

Trust	24.09.21	01.10.21	08.10.21	15.10.21
CWFT	1	0	3	1
ICHT	28	23	28	29
LNWUHT	89	83	87	102
THHT	6	6	10	10
NWL Total	**124**	**112**	**128**	**142**

Source: Exception reporting from Trusts

Two Trusts – in particular LNWUHT - reported an increase in the number of undated P2s waiting 6 wks or more.

Executive summary

	Latest Freeze Position (w/e 10-Oct)					Latest Freeze Position - % BAU by ICS				
	Activity	Var	% BAU (1)	London Regional Rank (2)	Weekly Change In Activity	NWL	NCL	NEL	SEL	SWL
Elective	23,073	▲	84.7%	5	1.0%	86.2%	82.3%	84.7%	81.8%	92.0%
Outpatients	257,733	▲	92.7%	5	3.2%	96.6%	90.1%	95.1%	95.2%	87.3%
Endoscopy	4,387	▼	91.5%	5	-0.2%	82.7%	65.4%	99.4%	113.6%	98.3%
Imaging	61,023	▲	102.4%	3	0.9%	98.7%	103.9%	99.1%	106.4%	104.8%
Echocardiography	6,286	▲	100.0%	3	2.8%	88.7%	109.7%	89.9%	106.7%	105.6%

(1) Prior year baselines from March are based on unadjusted data submitted to SUS by providers for 2019/20

(2) Regional Rank is based on % BAU

Headlines

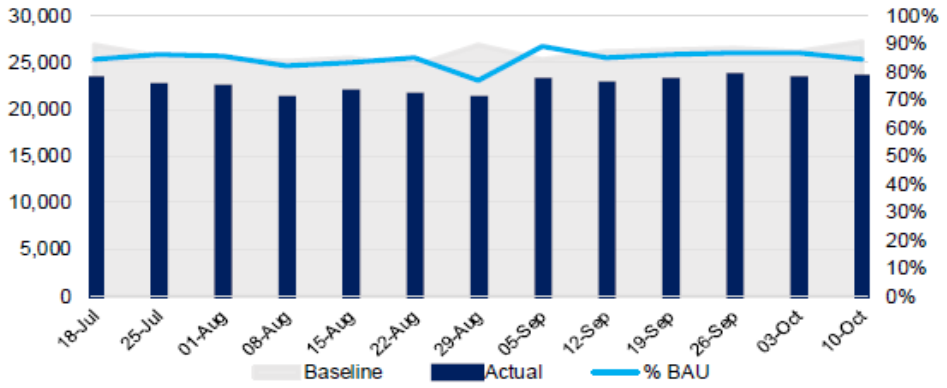
- Activity levels have stabilised.
- Clock starts/stops: Clock starts are at 89.8% of BAU and Clock Stops are at 85.7%, which continues to drive PTL growth. There is wide disparity between systems of BAU clock stops.
- PTL: Increased by c. 1,600; this is an increase of 0.2%. 75% of this growth from non-admitted PTL.
- 104+ ww: London has again seen a small increase of 104+ ww. Royal Free did not report this week and therefore this increase should be treated with caution. There has been a material reduction in the volume of pathways removed from the potential 104 ww breach cohort. Whilst London remains above required run rates, this reduction remains a concern.
- 52ww: This week saw a small reduction of 156 pathways.
- Diagnostics: Activity volumes stable, and at BAU. There is wide disparity in endoscopy and imaging between systems and between trusts and material growth within PTL forecasted to continue into November and December 2021.
- Cancer: Total backlog is beginning to plateau around 3,450 – with a slight reduction this week. As part of H2 planning, backlog targets have been revised, London target has been revised from 2,137 to 2,332 .
- Appendix C: London Theatre Utilisation is updated fortnightly. Last update was 15 October [included in this week's report].
- Please note: Royal Free did not report this week, so this week's activity positions for them is based on their position from w/e 26 September. RF's RTT position this week is based on their position w/e 3 October.

		10-Oct	17-Oct	Var
104 ww	NWL	115	110	*-5*
	NCL	431	421	*-10*
	NEL	644	678	*34*
	SWL	21	15	*-6*
	SEL	163	153	*-10*
	London	**1,374**	**1,377**	*3*
52 ww	NWL	3,998	4,040	*42*
	NCL	12,068	11,968	*-100*
	NEL	10,307	10,215	*-92*
	SWL	1,329	1,338	*9*
	SEL	4,783	4,768	*-15*
	London	**32,485**	**32,329**	***-156***
Waitlist	Admitted PTL	122,492	122,852	*360*
	Non-Admitted PTL	837,358	838,598	*1,240*
	Cancer DTT Backlog	288	294	*6*
	Cancer No DTT Backlog	3,177	3,106	*-71*
	Cancer 104 Day Waits	829	816	*-13*
	Endoscopy Waitlist (3)	21,132	-	*16*
	Imaging Waitlist (3)	148,032	-	*945*

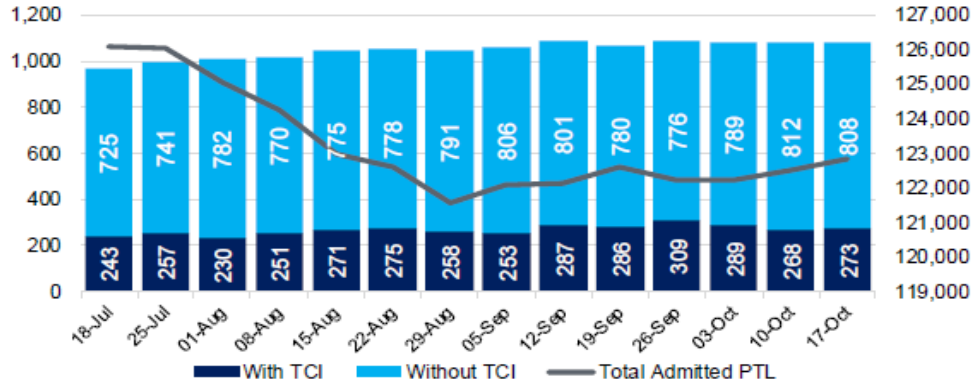
(3) Diagnostic waitlists show latest freeze position and variance on prior week

Elective Activity

Elective Activity Volumes and % of Baseline



Admitted Pathway: 104 ww and Total PTL



Total Electives (Latest Freeze Data: w/e 10-Oct)

Provider	% BAU	Actual Activity	Weekly Var (%)	Latest Data: w/e 17-Oct Admitted PTL Size	Weekly Var (%)	Admitted 104ww	Weekly Var (%)
NEL	**84.7%**	**3,133**	**2.7%**	**21,183**	**-0.3%**	**565**	**2.4%**
Homerton	97.5%	508	6.7%	3,124	4.0%	1	-
BHRUT	90.2%	1,053	5.7%	4,095	-1.0%	4	300.0%
Barts	78.1%	1,572	-0.5%	13,964	-1.0%	560	1.8%
NCL	**82.3%**	**6,017**	**-3.4%**	**30,531**	**0.6%**	**295**	**-2.6%**
GOSH	97.5%	733	14.7%	1,893	-0.1%	7	-
UCLH	91.3%	2,276	-10.5%	8,761	0.5%	53	-19.7%
Whittington	91.1%	428	-2.7%	2,122	2.0%	0	-
NMUH	88.6%	674	-1.5%	1,206	-1.8%	8	33.3%
Moorfields	78.7%	612	-3.8%	5,808	1.9%	0	-
RNOH	74.3%	243	3.0%	2,311	0.3%	6	100.0%
RFL	60.8%	1,051	0.0%	8,430	0.0%	221	-
NWL	**86.2%**	**4,996**	**1.4%**	**22,487**	**0.4%**	**91**	**2.2%**
ChelWest	103.3%	1,088	-1.1%	5,322	0.5%	4	-
Hillingdon	86.6%	459	-3.2%	3,059	-1.9%	26	4.0%
LNW	82.6%	1,413	2.5%	5,131	-1.2%	38	-5.0%
Imperial	81.4%	2,036	3.1%	8,975	2.0%	23	15.0%
SEL	**81.8%**	**5,417**	**3.1%**	**31,674**	**0.5%**	**120**	**-4.8%**
LGT	85.2%	930	13.0%	5,916	-0.2%	61	1.7%
Kings	81.5%	2,087	-1.8%	11,782	1.6%	42	-4.5%
GSTT	80.9%	2,400	4.1%	13,976	-0.1%	17	-22.7%
SWL	**92.0%**	**3,510**	**3.5%**	**16,977**	**0.0%**	**10**	**-**
Croydon	113.2%	644	7.9%	1,870	-1.4%	0	-
Royal Marsden	98.9%	374	-6.5%	218	-1.4%	0	-
Epsom	94.4%	935	9.7%	5,205	0.9%	0	-100.0%
Kingston	84.8%	457	-5.6%	3,538	1.4%	1	-
St George's	82.1%	1,100	4.1%	6,146	-1.1%	9	12.5%
LONDON	**84.7%**	**23,073**	**1.0%**	**122,852**	**0.3%**	**1,081**	**0.1%**

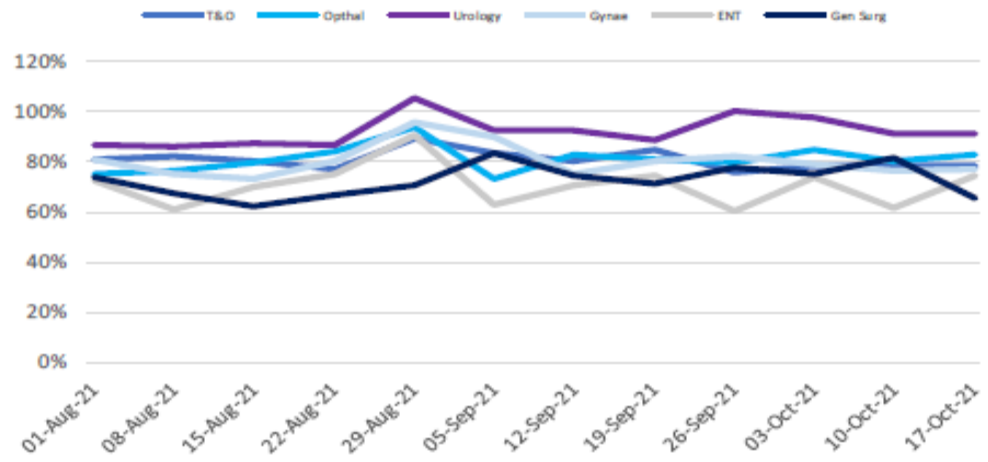
Source: Weekly Activity Return

Source: RTT Weekly PTL

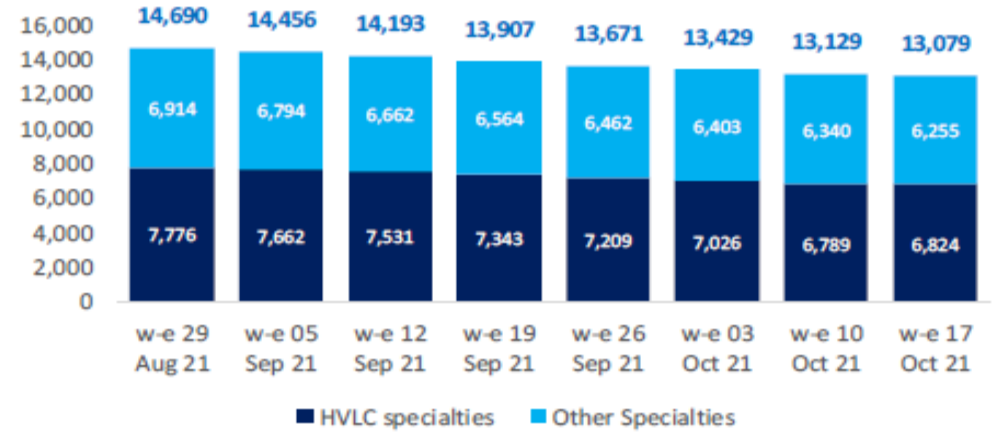
London elective activity in the equivalent baseline period: 27,240.

London Admitted Elective – HVLC Specialties

Elective Activity % BAU - HVLC



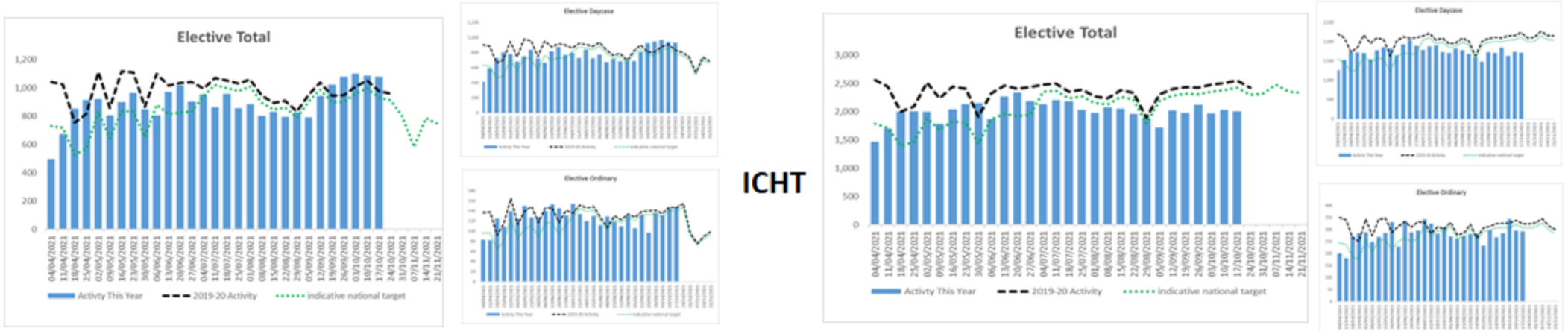
London - 52+ ww - HVLC specialties proportion of Admitted 52 ww



London - HVLC specialties Elective Activity							
Rank	Provider	Flex Week (Current)	Freeze Week (Last)	Freeze Week (Previous)	Change between Freeze Weeks	Current Elective Activity volume	5 week Trend
1	Royal Marsden	161.0%	195.2%	211.0%	▼	124	
2	ChelWest	125.0%	87.4%	95.1%	▼	365	
3	Croydon	121.8%	135.4%	122.7%	▲	218	
4	Kingston	111.7%	79.3%	95.3%	▼	230	
5	BHRUT	95.9%	97.9%	96.0%	▲	439	
6	UCLH	94.7%	81.9%	108.9%	▼	358	
7	RNOH	90.9%	85.7%	78.8%	▲	180	
8	Moorfields	89.4%	79.2%	91.1%	▼	658	
9	Hillingdon	86.8%	102.6%	102.7%	▼	178	
10	Epsom	85.0%	92.9%	92.9%	▼	545	
11	GSTT	84.0%	72.4%	81.8%	▼	336	
12	Homerton	82.1%	104.4%	97.3%	▲	206	
13	St George's	79.7%	89.6%	87.4%	▲	169	
14	Kings	78.9%	76.5%	77.5%	▼	528	
15	Imperial	77.2%	77.6%	77.2%	▲	390	
16	LNW	73.3%	88.7%	83.3%	▲	374	
17	Whittington	72.1%	84.1%	93.1%	▼	93	
18	RFL	68.1%	72.0%	69.2%	▲	299	
19	NMUH	57.9%	79.7%	77.5%	▲	168	
20	Barts	54.1%	67.2%	62.5%	▲	321	
21	LGT	53.6%	70.8%	61.7%	▲	148	
1	SWL	97.8%	101.3%	104.5%	▼	1,286	
2	NWL	86.4%	86.5%	85.8%	▲	1,307	
3	NCL	80.9%	79.3%	86.4%	▼	1,756	
4	SEL	75.2%	74.3%	75.7%	▼	1,012	
5	NEL	74.2%	84.9%	80.5%	▲	966	
	London	**82.8%**	**84.3%**	**86.3%**	▼	**6,327**	

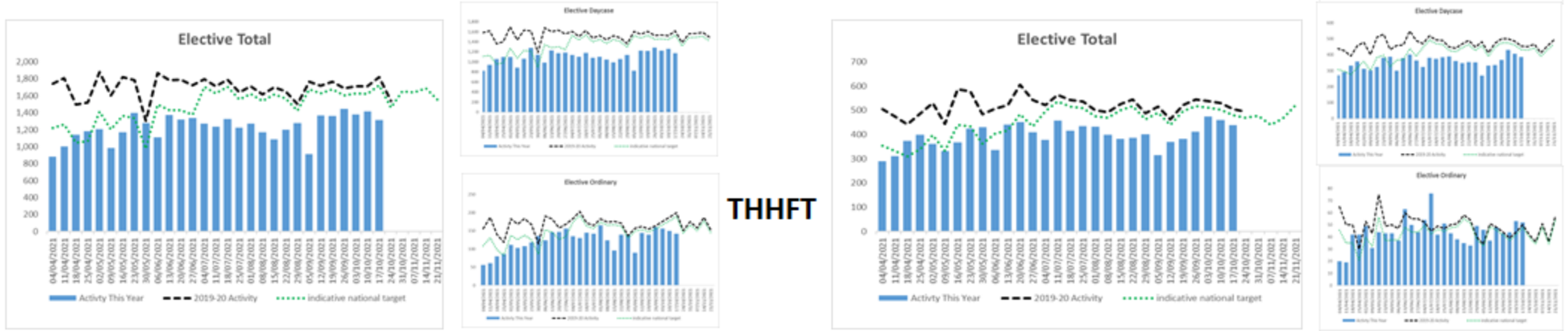
Phase 2: Recovery Plan. Elective Weekly performance by Trust against Plan

CWFT



ICHT

LNWUHT



THHFT

Phase 1: NHS Theatre throughput NHS theatre activity in numbers

NHS activity / capacity

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

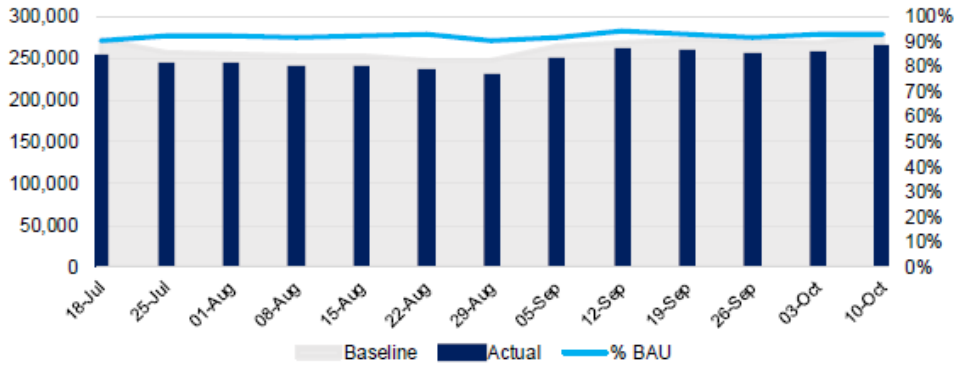
W/E	Peak Recovery 06/12/2020	29/08/2021	05/09/2021	12/09/2021	19/09/2021	26/09/2021	03/10/2021	10/10/2021	17/10/2021
Trust	**Week 49**	**Week 20**	**Week 21**	**Week 22**	**Week 23**	**Week 24**	**Week 25**	**Week 26**	**Week 27**
CWHFT	540	458	431	487	477	549	489	502	568
ICHT	521	450	375	513	457	502	538	536	514
LNWUHT	484	334	265	304	382	384	404	355	357
THHFT	168	145	104	161	177	183	205	209	183
TOTAL	**1,713**	**1387**	**1175**	**1465**	**1493**	**1618**	**1636**	**1602**	**1622**

Highlighted cell indicates BH week where activity is lower.

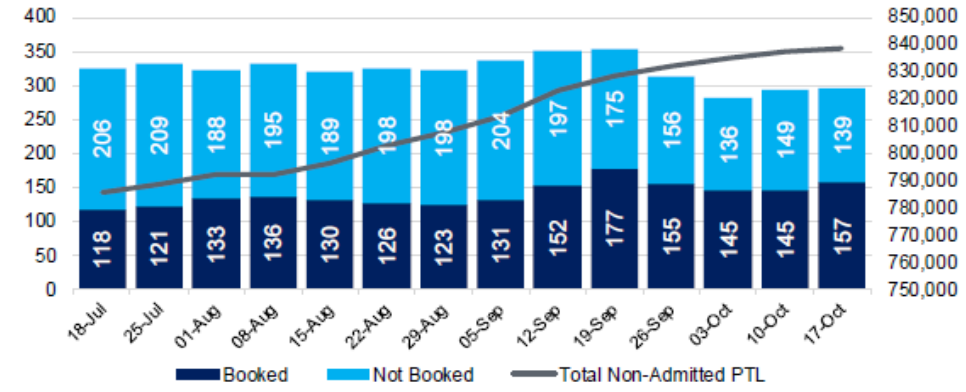
Outpatient activity

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

Outpatient Activity Volumes and % of Baseline



Non-Admitted Pathway: 104 ww and Total PTL



Outpatients (Latest Freeze Data: w/e 10-Oct)

Provider	% BAU	Actual Activity	Weekly Var (%)
NEL	**95.1%**	**35,371**	**2.2%**
Homerton	117.7%	6,290	1.6%
Barts	94.0%	21,710	2.8%
BHRUT	84.4%	7,371	1.1%
NCL	**90.1%**	**72,158**	**7.0%**
NMUH	111.3%	8,549	-0.3%
GOSH	110.8%	3,871	8.6%
UCLH	101.4%	25,952	19.3%
Whittington	93.1%	6,059	0.0%
Moorfields	88.0%	11,028	0.2%
RNOH	84.3%	2,000	12.9%
RFL	67.0%	14,699	0.0%
NWL	**96.6%**	**48,579**	**0.9%**
ChelWest	113.6%	14,979	4.5%
Imperial	91.1%	16,039	2.5%
LNW	90.4%	13,075	-4.5%
Hillingdon	89.3%	4,486	0.6%
SEL	**95.2%**	**61,999**	**3.4%**
Kings	106.5%	24,667	2.5%
LGT	100.1%	10,634	-0.6%
GSTT	85.1%	26,698	5.9%
SWL	**87.3%**	**39,626**	**0.1%**
Croydon	96.7%	7,816	-3.6%
Royal Marsden	95.8%	4,926	0.5%
St George's	91.1%	13,938	5.2%
Kingston	82.5%	6,464	-4.1%
LONDON	**92.7%**	**257,733**	**3.2%**

Source: Weekly Activity Return

Latest Data: w/e 17-Oct

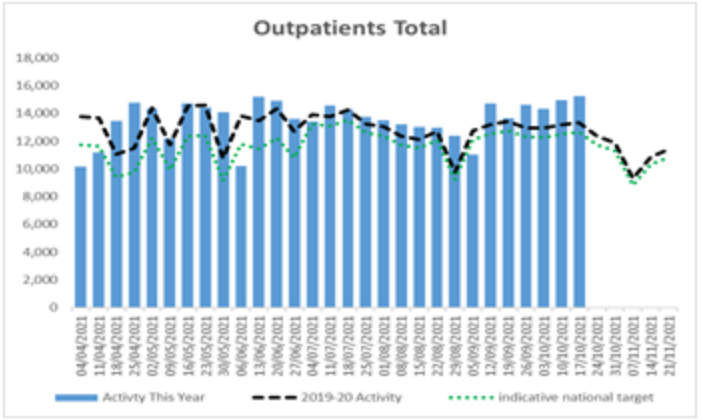
Non-Adm. PTL Size	Weekly Var (%)	Non-Adm. 104ww	Weekly Var (%)
158,674	**0.3%**	**113**	**22.8%**
22,188	-1.9%	0	-
86,400	0.3%	105	25.0%
50,086	1.2%	8	-
203,159	**0.1%**	**126**	**-1.6%**
14,351	-0.7%	1	-
5,203	-1.8%	2	-
47,710	0.3%	8	-
15,673	3.4%	0	-100.0%
29,915	-0.8%	0	-100.0%
4,329	1.6%	1	-
85,978	0.0%	114	-
176,508	**0.2%**	**19**	**-26.9%**
40,155	-0.9%	0	-
72,245	0.4%	4	-20.0%
45,128	0.6%	8	-
18,980	1.1%	7	-46.2%
179,553	**-0.1%**	**33**	**-10.8%**
56,871	-0.6%	5	-
53,326	0.2%	26	-10.3%
69,356	0.1%	2	-33.3%
120,704	**0.2%**	**5**	**-54.5%**
23,289	1.1%	0	-
1,218	-2.2%	0	-
40,917	1.0%	0	-100.0%
20,297	-1.6%	3	-62.5%
838,598	**0.1%**	**296**	**0.7%**

Source: RTT Weekly PTL

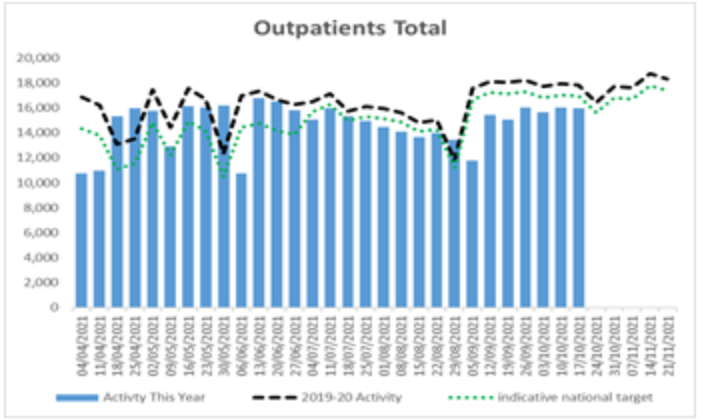
London outpatient activity in equivalent baseline period: 278,074.

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

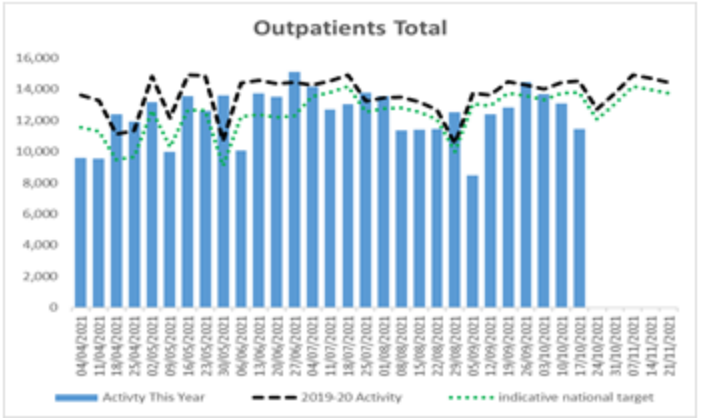
CWFT



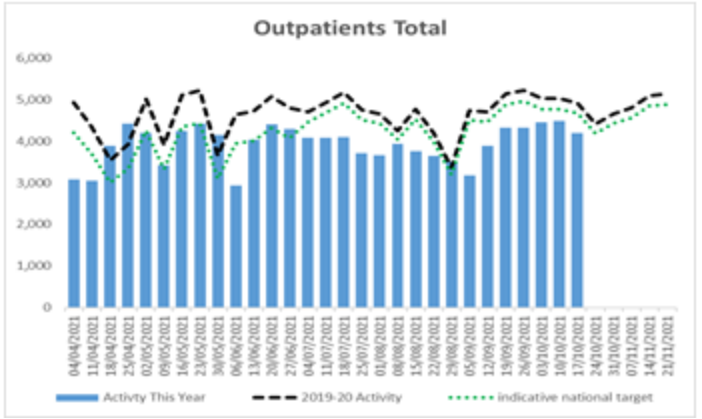
ICHT



LNWUHT

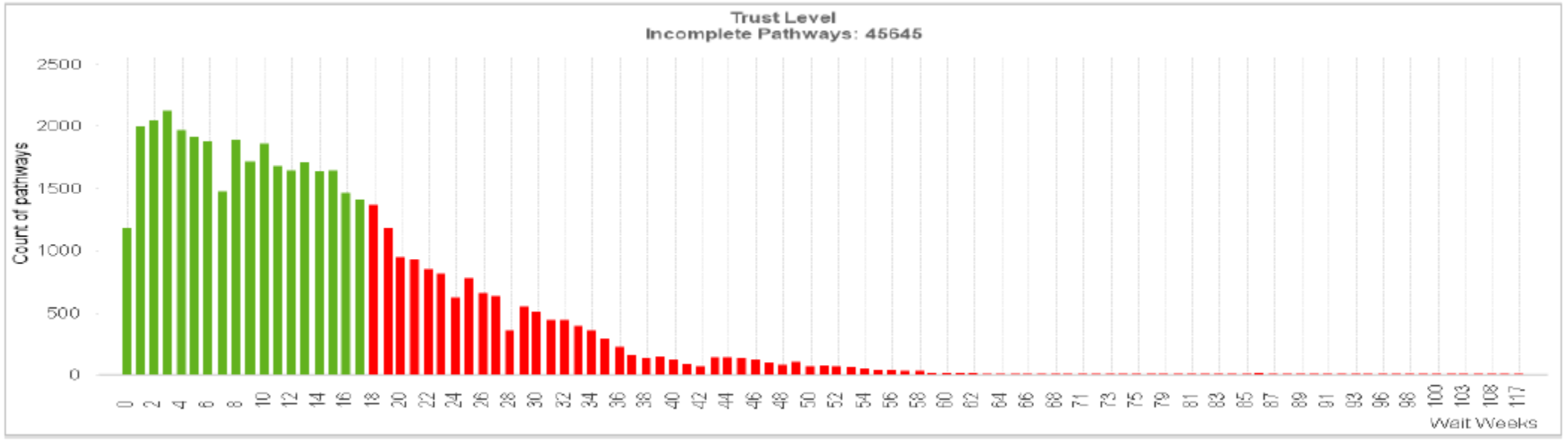


THHFT



Current PTL Position

Performance 68.96% (Last Week 69.19%)



Trust PTL Total: ↓ 45,645 (46,070)
Undated Total: ↓ 16,814 (17,502)
36.84%
Dated Total: ↑ 28,831 (28,570)
63.16%

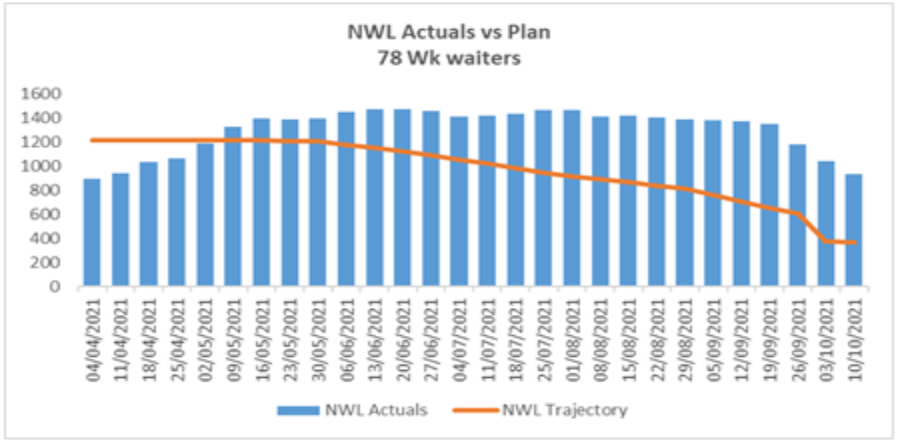
Admitted Pathways: ↑ 5,296 (5,267)
Dated: ↑ 1,553 (1,487)
Undated: ↓ 3,743 (3,780)
52W+: ↑ 219 (202)
78+: ↓ 38 (40)
104+ ↓ 4 (5)

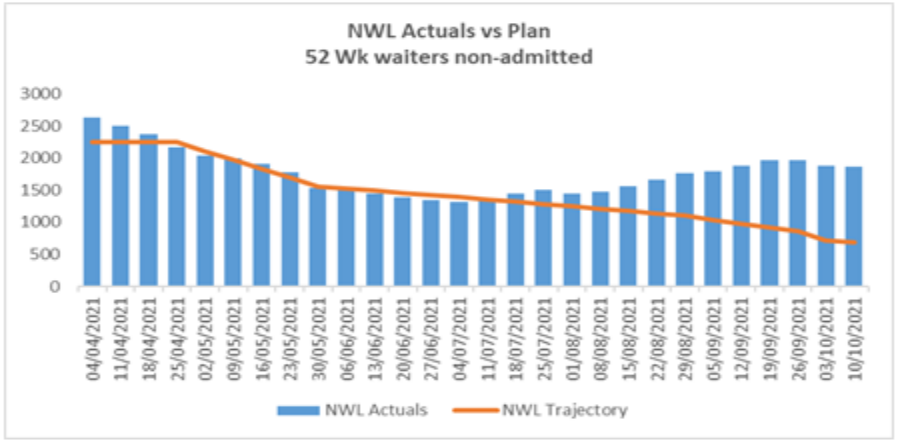
Non-Admitted: ↓ 40,349 (40,805)
Dated: ↑ 27,278 (27,083)
Undated: ↓ 13,071 (13,722)
52w+ : ↑ 269 (264)
78w+ ↓ 37 (46)
104+ ↓ 0 (1)

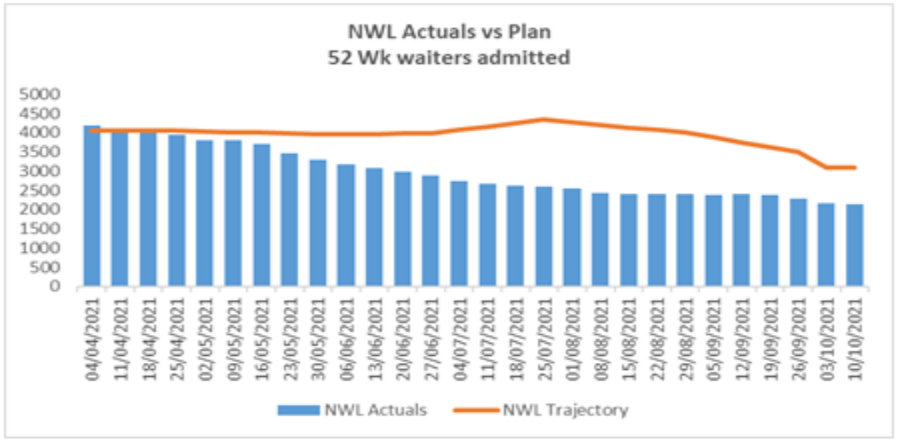
As a 14/10/21

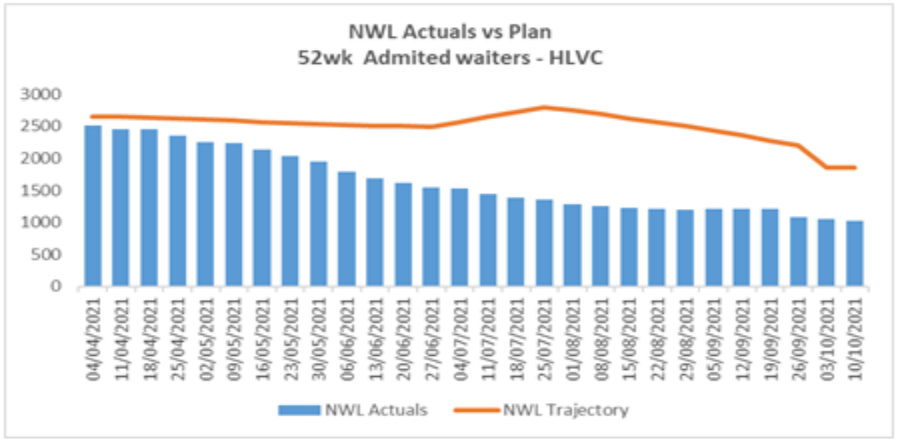
NWL Long Waiters

Actual activity: Un-validated data



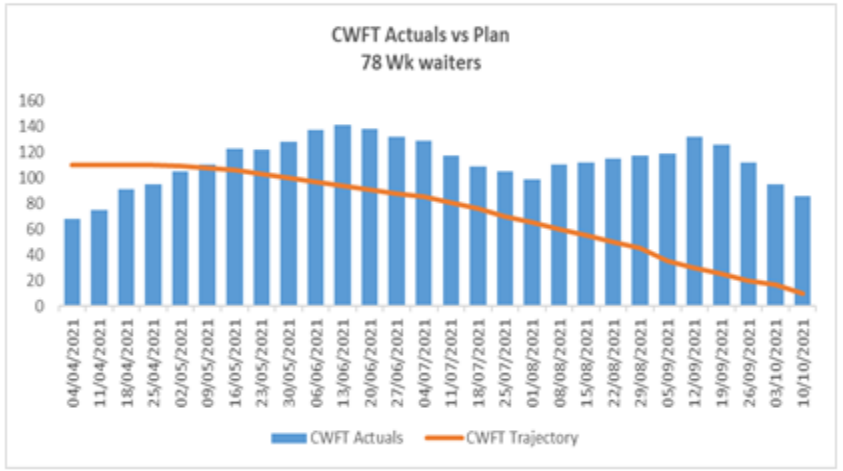


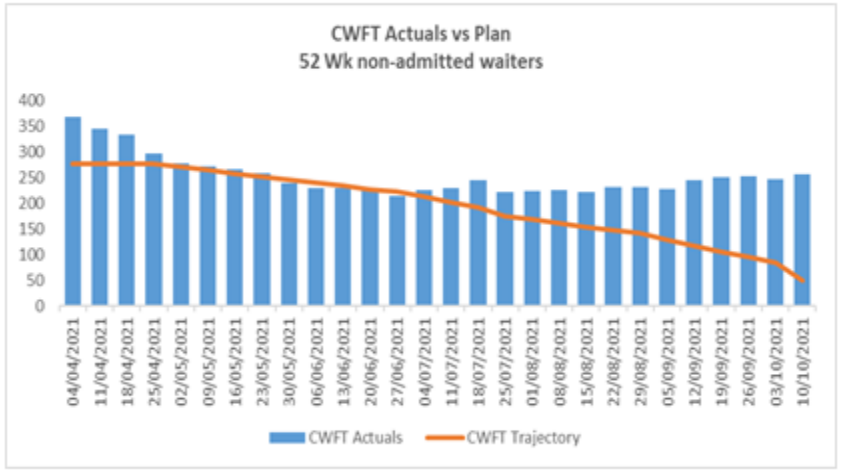


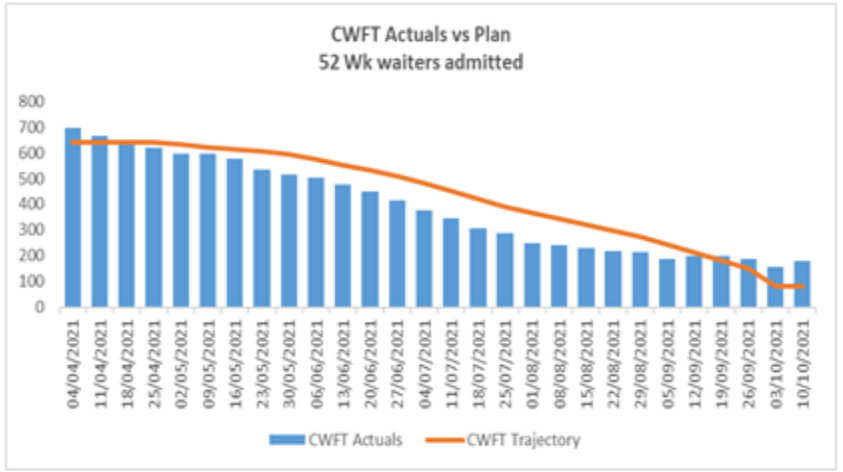


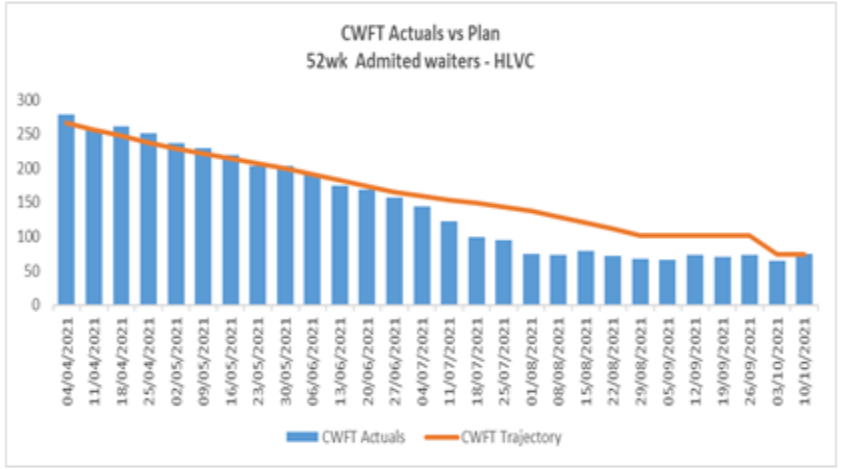
ChelWest Long Waiters

Actual activity: Un-validated data









NWL 104ww

104+ week waiting heatmap

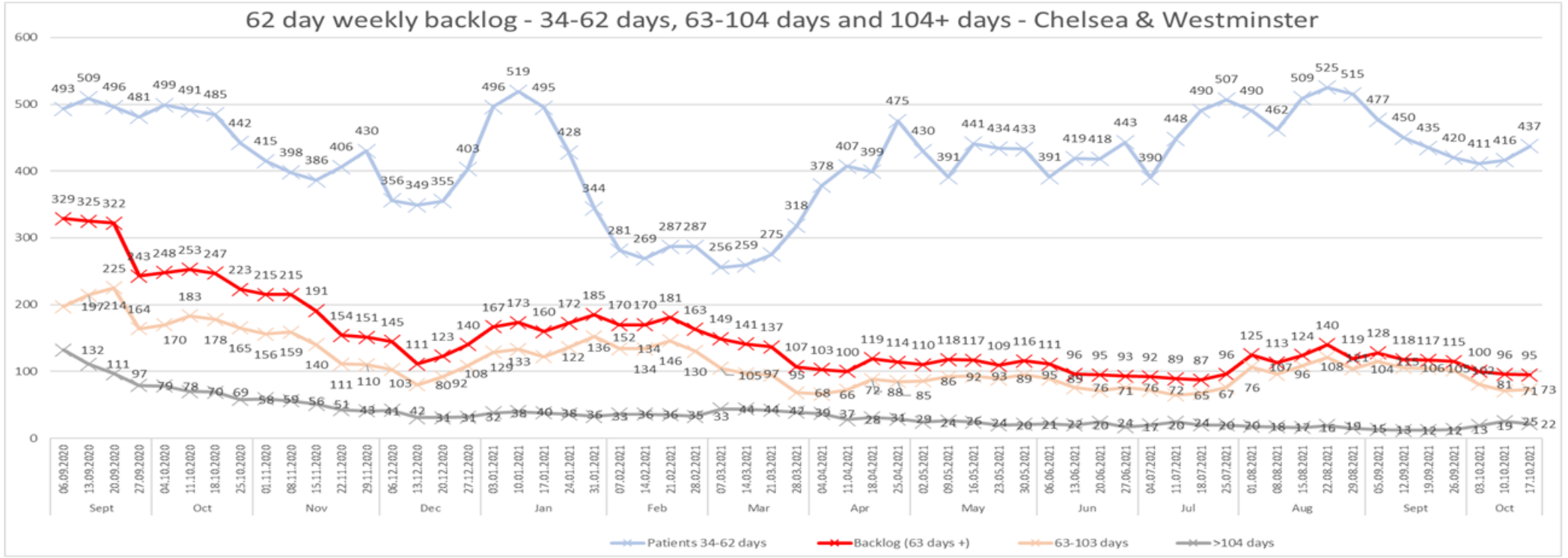
Latest Data: w/e 17-Oct

Specialty	Total	Change	Admitted								Non-Admitted						
			Admitted Total	Change	NCL	NEL	NWL	SEL	SWL		Non-Adm. Total	Change	NCL	NEL	NWL	SEL	SWL
Other	462	▲ 11	387	▲ 10	56 ▶	279 ▲	21 ▲	30 ▼	1 ▶		75	▲ 1	38 ▼	30 ▲	4 ▼	3 ▼	
ENT	246	▲ 5	184	▲ 1	1 ▶	164 ▲	4 ▶	11 ▼	4 ▲		62	▲ 4	1 ▶	52 ▲		9 ▶	
Plastic Surgery	223	▲ 1	195	▲ 1	168 ▶	18 ▲	2 ▶	5 ▶	2 ▶		28	▶ -	28 ▶				
Trauma & Orthopaedics	120	▼ -4	91	▼ -3	28 ▼	30 ▲	16 ▶	17 ▼			29	▼ -1	18 ▲	9 ▲		2 ▼	
Gynaecology	111	▼ -2	89	▼ -4	23 ▼	29 ▲	17 ▼	20 ▼			22	▲ 2	3 ▼	9 ▲	3 ▶	7 ▲	
General Surgery	89	▼ -2	70	▲ 2	6 ▲	10 ▼	25 ▲	28 ▲	1 ▶		19	▼ -4	2 ▶	2 ▼	6 ▶	9 ▼	
Dermatology	36	▼ -5	4	▲ 1	3 ▲		1 ▶				32	▼ -6	26 ▶		6 ▼		
Urology	36	▼ -8	28	▼ -8	8 ▼	19 ▼	1 ▶				8	▶ -	3 ▼	5 ▲			
Oral Surgery	20	▲ 2	16	▲ 1		15 ▲	1 ▶				4	▲ 1		4 ▲			
Ophthalmology	18	▲ 1	8	▼ -1	2 ▶			6 ▼			10	▲ 2	5 ▼			2 ▲	3 ▲
Cardiology	5	▼ -1	4	▶ -			1 ▲	1 ▶	2 ▼		1	▼ -1					1 ▼
Gastroenterology	3	▲ 1	1	▶ -		1 ▶					2	▲ 1				1 ▲	1 ▲
Neurosurgery	3	▲ 2	2	▲ 1			2 ▲				1	▲ 1		1 ▲			
Neurology	2	▲ 2	0	▶ -							2	▲ 2	2 ▲				
Cardiothoracic Surgery	1	▶ -	1	▶ -				1 ▶			0	▶ -					
Rheumatology	1	▶ -	1	▲ 1				1 ▲			0	▼ -1					
Thoracic Medicine	1	▲ 1	0	▶ -							1	▲ 1		1 ▲			
General Medicine	0	▼ -1	0	▼ -1							0	▶ -					
Geriatric Medicine	0	▶ -	0	▶ -							0	▶ -					
Total	**1,377**	**▲ 3**	**1,081**	**▲ 1**	295 ▼	565 ▲	91 ▲	120 ▼	10 ▶		**296**	**▲ 2**	126 ▼	113 ▲	19 ▼	33 ▼	5 ▼

Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust – w/e 17th October 2021

RM Partners
West London Cancer Alliance



Change in last week:

C&W	34-62 days	63-103 days	104+ days	63 days +
% change	5.0%	2.8%	-12.0%	-1.0%
Number of patients	+21	+2	-3	-1

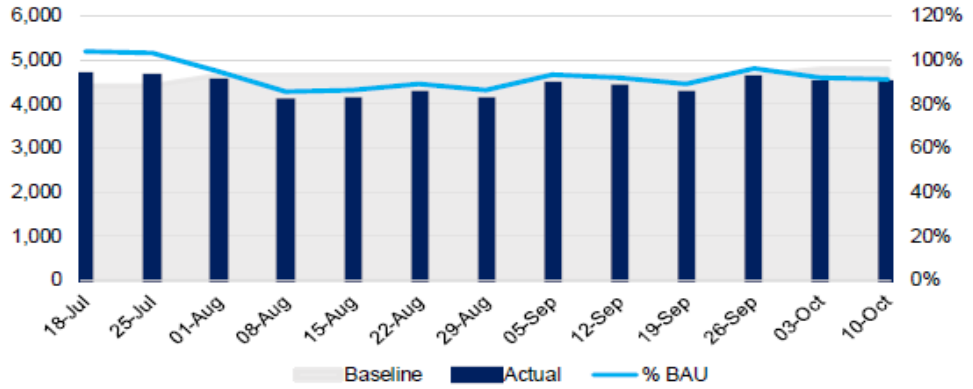
Totals:

NWL	34-62 days	63-103 days	104+ days	63 days +
RMP w/e 17.10.2021	437	73	22	95
Baseline (w/e 01.03.20)	493	189	63	252
Difference to baseline	-56	-116	-41	-157

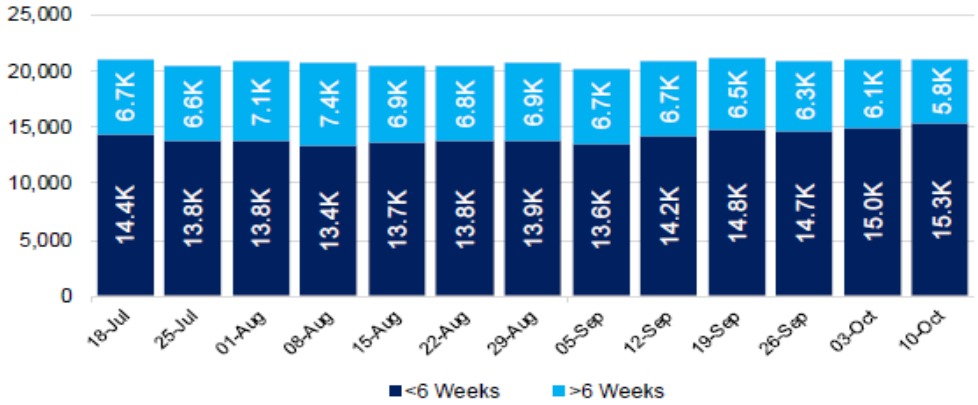
1

Endoscopy activity

Endoscopy Activity Volumes and % of Baseline



Endoscopy: Total Wait List



Endoscopy (Latest Freeze Data: w/e 10-Oct)

Provider	% BAU	Actual Activity	Weekly Var (%)
NEL	**99.4%**	**945**	**-0.5%**
BHRUT	106.2%	270	14.4%
Barts	103.9%	511	-9.6%
Homerton	80.1%	164	10.1%
NCL	**65.4%**	**586**	**2.3%**
Whittington	103.0%	137	3.0%
NMUH	90.1%	140	53.8%
UCLH	82.4%	212	-13.5%
GOSH	70.0%	7	-50.0%
RFL	26.5%	90	0.0%
NWL	**82.7%**	**946**	**1.2%**
ChelWest	116.0%	305	0.7%
Hillingdon	90.2%	137	-6.2%
Imperial	73.0%	213	7.0%
LNW	66.4%	291	1.4%
SEL	**113.6%**	**1,032**	**-9.3%**
GSTT	348.7%	310	-5.8%
LGT	95.5%	304	-17.6%
Kings	83.4%	418	-5.0%
SWL	**98.3%**	**878**	**9.9%**
Croydon	152.3%	192	31.5%
Royal Marsden	120.7%	37	15.6%
Epsom	112.7%	265	10.0%
Kingston	98.4%	176	-7.4%
St George's	64.6%	208	9.5%
LONDON	**91.5%**	**4,387**	**-0.2%**

Source: Weekly Activity Return

Latest Data: w/e 10-Oct

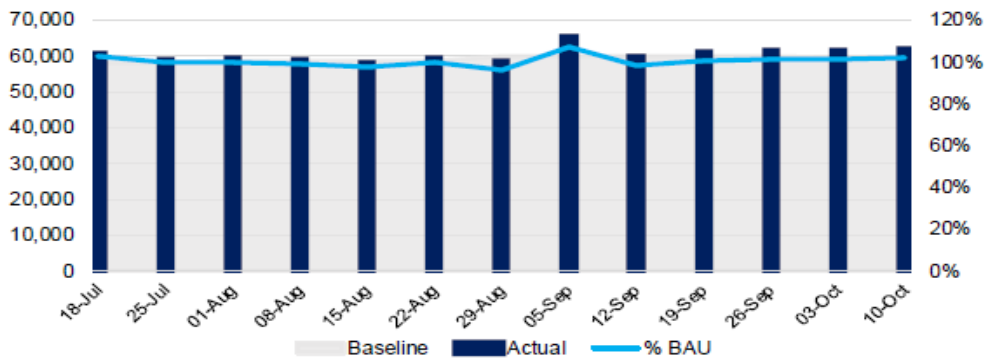
Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
4,136	**2.7%**	**1,254**	**-9.7%**
788	3.1%	29	38.1%
2,718	1.9%	1,206	-10.4%
630	5.7%	19	-13.6%
5,380	**2.2%**	**2,123**	**-1.9%**
346	58.0%	15	-34.8%
1,296	-1.7%	680	-4.4%
2,087	0.4%	1,142	-0.3%
100	4.2%	32	0.0%
1,551	0.0%	254	0.0%
5,660	**-2.5%**	**1,449**	**-7.9%**
1,104	3.5%	92	-15.6%
926	3.7%	282	-13.2%
2,269	-3.3%	972	-2.8%
1,361	-9.3%	103	-26.4%
3,047	**-2.4%**	**631**	**-6.2%**
1,015	4.7%	250	1.2%
828	-3.6%	52	-21.2%
1,204	-7.0%	329	-8.6%
2,909	**0.4%**	**331**	**-4.3%**
929	11.1%	246	-7.2%
121	-6.9%	13	18.2%
790	-0.5%	64	-4.5%
606	-3.7%	6	-
463	-8.9%	2	-33.3%
21,132	**0.1%**	**5,788**	**-5.8%**

Source: Weekly Activity Return

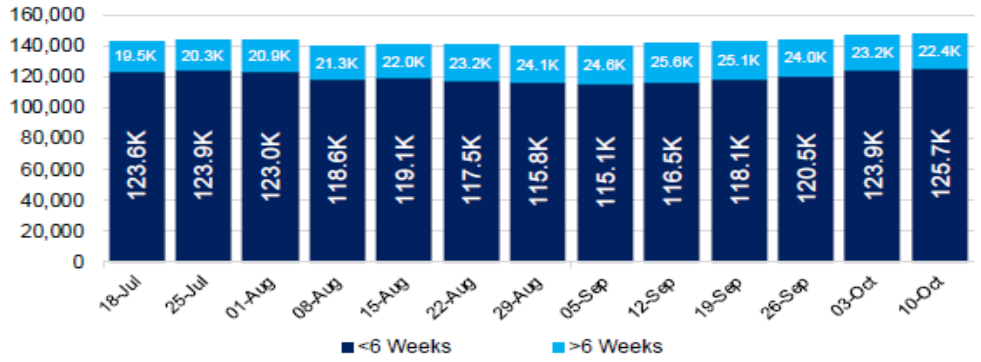
London Endoscopy Activity in equivalent baseline period: 4,792.

Imaging activity

Imaging Activity Volumes and % of Baseline



Imaging: Total Wait List



Imaging (Latest Freeze Data: w/e 10-Oct)

Provider	% BAU	Actual Activity	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
NEL	**99.1%**	**12,514**	**-1.3%**	**50,338**	**-0.3%**	**14,473**	**-4.6%**
Barts	110.3%	6,671	-1.2%	33,836	-1.3%	12,459	-5.6%
Homerton	96.0%	1,788	-8.4%	5,725	3.3%	20	-4.8%
BHRUT	85.9%	4,055	2.1%	10,777	1.0%	1,994	2.3%
NCL	**103.9%**	**12,699**	**3.1%**	**24,389**	**0.2%**	**2,235**	**-1.7%**
Whittington	115.7%	1,582	-1.8%	3,108	-0.7%	91	-21.6%
NMUH	114.7%	1,651	2.9%	2,561	-2.5%	39	18.2%
UCLH	112.0%	3,700	9.2%	7,687	1.5%	1,034	-3.1%
GOSH	105.2%	425	-8.8%	851	3.9%	106	1.9%
RNOH	98.6%	489	23.5%	1,615	0.9%	82	15.5%
RFL	93.1%	4,720	0.0%	8,418	0.0%	882	0.0%
Moorfields	90.9%	132	0.0%	149	-9.1%	1	-
NWL	**98.7%**	**12,535**	**-1.2%**	**23,646**	**4.4%**	**1,308**	**-0.8%**
Imperial	108.3%	5,136	4.6%	8,390	6.8%	26	-7.1%
ChelWest	107.1%	3,007	-4.6%	4,597	7.2%	22	-40.5%
Hillingdon	85.3%	1,237	-10.8%	4,356	0.4%	1,182	-1.7%
LNW	85.2%	3,155	-2.4%	6,303	2.2%	78	52.9%
SEL	**106.4%**	**12,179**	**0.7%**	**22,756**	**0.0%**	**1,990**	**2.4%**
Kings	119.0%	5,170	-0.8%	8,488	0.8%	549	-11.9%
GSTT	99.5%	4,121	7.6%	9,545	1.3%	1,400	7.5%
LGT	97.4%	2,888	-5.2%	4,723	-4.0%	41	127.8%
SWL	**104.8%**	**11,096**	**3.6%**	**26,903**	**0.3%**	**2,372**	**-5.4%**
Epsom	134.2%	2,856	10.0%	6,954	-3.3%	1,267	-0.9%
Croydon	118.2%	2,224	3.5%	8,294	3.2%	746	-17.1%
Royal Marsden	115.0%	1,797	3.2%	605	-0.3%	2	-50.0%
St George's	86.5%	2,763	1.2%	7,262	-3.3%	156	-1.9%
Kingston	80.1%	1,456	-2.7%	3,788	8.6%	201	21.1%
LONDON	**102.4%**	**61,023**	**0.9%**	**148,032**	**0.6%**	**22,378**	**-3.6%**

Source: Weekly Activity Return

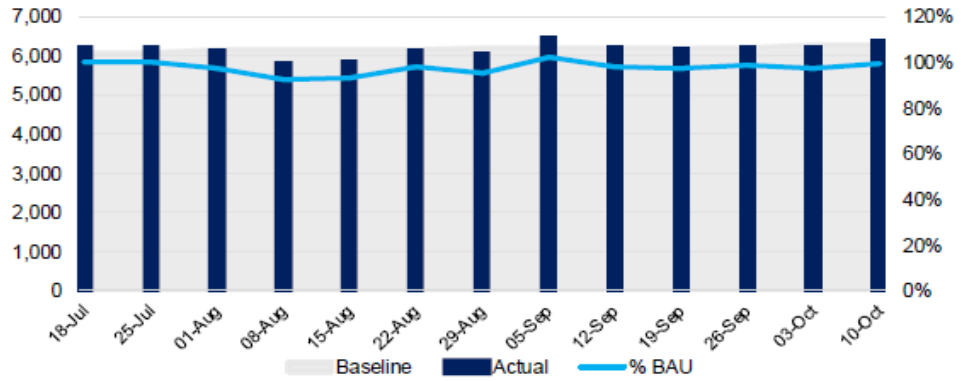
Latest Data: w/e 10-Oct

Source: Weekly Activity Return

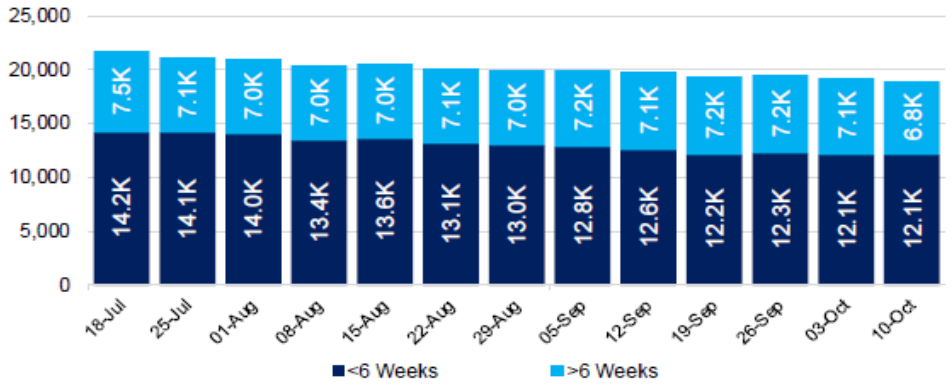
London Imaging Activity in the equivalent baseline period: 59,596.

Echocardiography activity

Echocardiography Activity Volumes and % of Baseline



Echocardiography: Total Wait List



Echocardiography (Latest Freeze Data: w/e 10-Oct)

Provider	% BAU	Actual Activity	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
NEL	**89.9%**	**1,232**	**4.0%**	**8,408**	**0.8%**	**5,106**	**-0.7%**
Homerton	101.9%	167	10.6%	583	5.2%	108	-13.6%
Barts	100.1%	933	3.4%	7,509	0.5%	4,996	-0.1%
BHRUT	48.0%	132	0.0%	316	1.0%	2	-88.2%
NCL	**109.7%**	**975**	**7.9%**	**2,208**	**-5.0%**	**252**	**-29.0%**
GOSH	192.1%	307	3.4%	152	6.3%	44	22.2%
UCLH	135.4%	359	16.9%	610	-2.7%	103	47.1%
NMUH	97.0%	101	2.0%	491	-21.7%	28	-82.8%
Whittington	92.9%	109	6.9%	350	9.0%	0	-100.0%
RFL	40.8%	99	0.0%	605	0.0%	77	0.0%
NWL	**88.7%**	**1,027**	**5.7%**	**2,052**	**-4.6%**	**341**	**-26.0%**
Hillingdon	96.9%	149	3.5%	581	6.8%	209	7.7%
Imperial	96.9%	507	7.4%	334	-4.6%	95	6.7%
LNW	89.4%	195	-8.5%	664	7.1%	37	117.6%
ChelWest	67.0%	176	23.1%	473	-25.7%	0	-100.0%
SEL	**106.7%**	**2,075**	**2.5%**	**3,222**	**-2.9%**	**637**	**-10.3%**
Kings	111.7%	687	-3.9%	1,519	1.7%	160	-11.1%
GSTT	104.7%	1,187	6.6%	1,163	-6.8%	406	-5.8%
LGT	102.1%	201	2.6%	540	-6.3%	71	-28.3%
SWL	**105.6%**	**977**	**-5.1%**	**3,010**	**-1.7%**	**449**	**3.9%**
Epsom	142.2%	246	-7.5%	672	-8.4%	62	-25.3%
St George's	114.9%	442	0.9%	1,103	-2.4%	91	9.6%
Royal Marsden	95.8%	51	6.3%	0	-	0	-
Croydon	87.9%	175	-12.1%	908	5.2%	81	37.3%
LONDON	**100.0%**	**6,286**	**2.8%**	**18,900**	**-1.5%**	**6,785**	**-4.4%**

Source: Weekly Activity Return

Latest Data: w/e 10-Oct

Source: Weekly Activity Return

London Echo Activity in the equivalent baseline period: 6,289.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**2.2**
TITLE OF REPORT	**Integrated Performance and Quality Report**
AUTHOR NAME AND ROLE	Robert Hodgkiss, Chief Operating Officer & Deputy CEO
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Hodgkiss, Chief Operating Officer & Deputy CEO
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	To provide assurance of the combined Trust's performance for Sep 2021 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Executive Management Board; Date of Meeting: 27.10.21; Outcome: Noted Name of Committee: Quality Committee; Date of Meeting: 02.11.21; Outcome: Noted
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	September has continued to see many challenges within the month for the Trust, with continued non-elective pressures. Although non-compliant with a number of key metrics in month, the Trust's performance continues to be strong when compared to the wider NHS and are ranked 5th on the overall hospital score within Public View, improving from 7th position last month. **A&E 4 Hour Standard** 4hr performance in September was 82.44% (Chelsea to 80.94%, West Middlesex to 83.56%). This was the 12th highest performance nationally and 4th in London. Activity in the month surpassed 2019 levels, with daily attendances across the sites 5% higher than the same period previously. Both A&E departments have remained under sustained pressure, particularly in terms of patient acuity, LAS conveyances, UTC attendances and Covid IPC requirements including rapid testing. Flow through the hospital was also a particular challenge on the Chelsea site as a result of closed beds for COVID outbreaks as well as challenges in staffing escalation areas. **Cancer** Unvalidated performance has declined in the month of September to 71.82%. This is predominantly driven by patient initiated delays to diagnostics, and delays in NWLP histology turnaround. **RTT** Performance has declined in the month of September to 73.06% from 74.55% the month before. The overall trust PTL has increased and is now just over 46,000 and work continues to ensure the right capacity is in place to meet the demand.

	RTT 52 Week waits validated position for the month of September has seen another improvement and reduction in patients waiting over 52 week. The numbers have declined from 436 in August to 400 in September. All Divisions are carefully assessing capacity against demand and ensuring appropriate resource is allocated.
KEY RISKS ARISING FROM THIS REPORT	There are significant risks to the achievement of all of the main performance indicators, including A&E, RTT, Cancer & Diagnostics.

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

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

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

TRUST PERFORMANCE & QUALITY REPORT

September 2021

NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	87.65%	85.10%	80.98%	87.55%	87.59%	88.14%	83.56%	88.25%	87.62%	86.84%	82.44%	85.55%	87.94%		!
RTT	18 weeks RTT - Incomplete (Target: >92%)	76.98%	75.60%	74.76%	76.29%	74.89%	73.05%	70.68%	73.33%	76.13%	74.55%	73.06%	74.54%	75.07%		!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	88.98%	93.48%	91.53%	93.68%	91.66%	97.86%	97.56%	96.23%	90.58%	96.08%	94.94%	93.17%	95.15%		-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (Sep-21) in this report	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	98.96%	98.57%	100%	98.81%	98.96%	98.57%	100%	98.80%	98.81%		-
	31 days diagnosis to first treatment (Target: >96%)	100%	83.64%	79.69%	94.72%	98.63%	n/a	92.68%	96.54%	99.17%	83.64%	86.99%	94.29%	95.65%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	n/a	100%	100%	n/a	100%	100%	100%	n/a	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%		-
	62 days GP referral to first treatment (Target: >85%)	76.92%	83.61%	83.58%	85.14%	80.58%	81.03%	64.91%	81.72%	79.35%	81.92%	71.82%	80.72%	83.00%		!
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	100%	66.67%	60.00%	50.00%	80.00%	0.00%	61.11%	50.00%	81.82%	33.33%	60.00%	60.98%		!
Patient Safety	Clostridium difficile infections (Year End Target: 26)	0	2	0	5	2	4	1	11	2	6	1	9	16		!
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 (Sep-21) and are not included in quarterly or yearly totals	

A&E Waiting Times
4hr performance in September was 82.44% (Chelsea to 80.94%, West Middlesex to 83.56%). This was the 12th highest performance nationally and 4th in London. Activity in the month surpassed 2019 levels, with daily attendances across the sites 5% higher than the same period previously.

Both A&E departments have remained under sustained pressure, particularly in terms of patient acuity, LAS conveyances, UTC attendances and Covid IPC requirements including rapid testing. Flow through the hospital was also a particular challenge on the Chelsea site as a result of closed beds for COVID outbreaks as well as challenges in staffing escalation areas.

18 Week RTT – Incomplete
Performance has declined in the month of September to 73.06% from 74.55% the month before. The overall trust PTL has increased and is now just over 46,000 and work continues to ensure the right capacity is in place to meet the demand.

Cancer – 31 Days Diagnosis to First Treatment *
Performance against this metric has improved to 86.99% from 83.64%, although remains non-compliant. This is due to the continued high levels of demand on the skin pathway.

Cancer – 62 Days GP referral to First Treatment *
Performance has declined in the month of September to 71.82%. This is predominantly driven by patient initiated delays to diagnostics, and delays in NWLP histology turnaround (6 whole breaches).

Cancer – 62 Days NHS Screening Service Referral to First Treatment *
Performance for the 62 day Screening pathway has declined in the month of September to 33.33%. This represents 3 patients of which 2 were not treated with the timescale, both colorectal patients at WMUH, both have had harm reviews completed with no adverse outcomes.

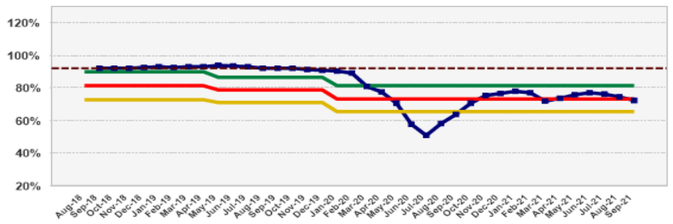
- **All Cancer indicators represent an unvalidated position for the month of September 2021.**

SELECTED BOARD REPORT NHSI INDICATORS

Statistical Process Control Charts for the last 37 months Aug 2018 to Sep 2021

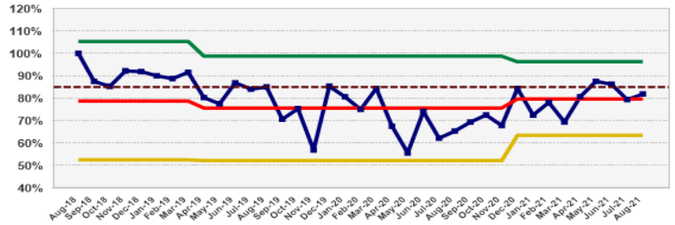
RTT Incomplete pathways

Trust Total

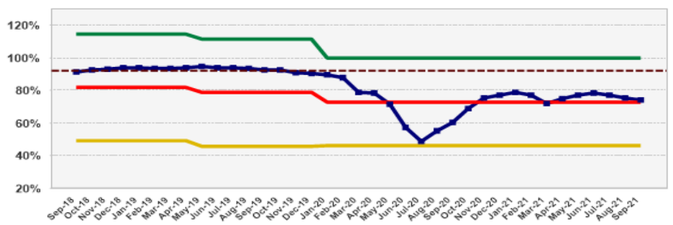


Cancer: 62 day standard

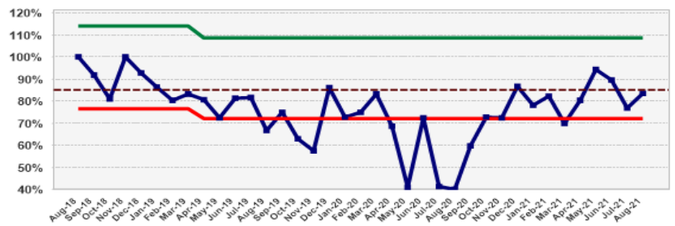
Trust Total



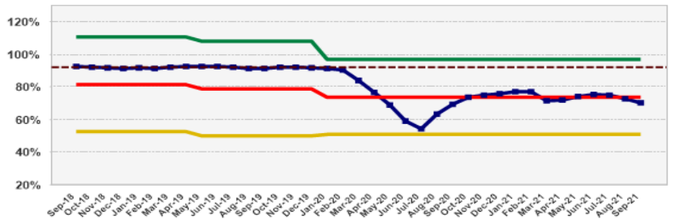
Chelsea and Westminster



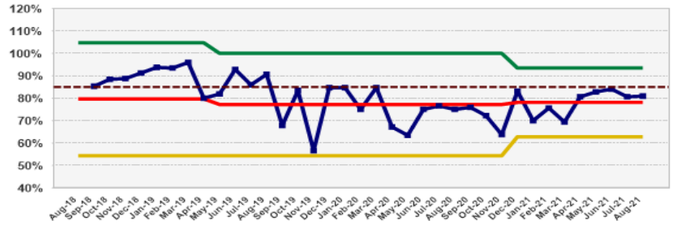
Chelsea and Westminster

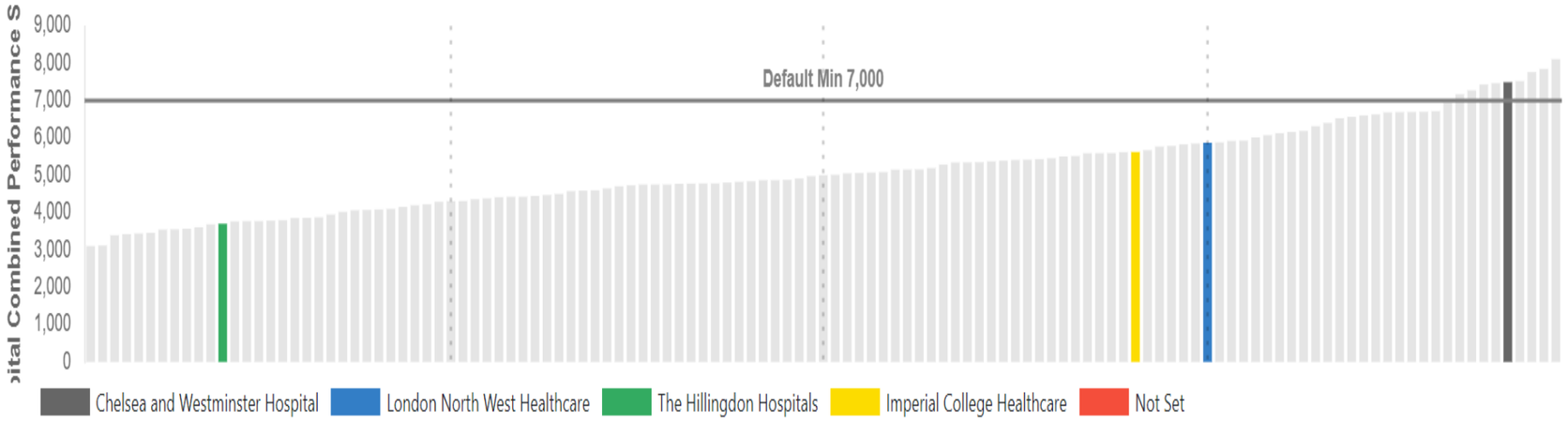


West Middlesex



West Middlesex

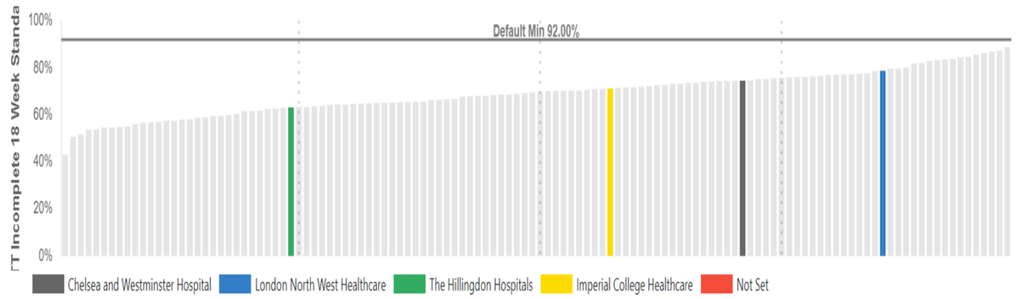




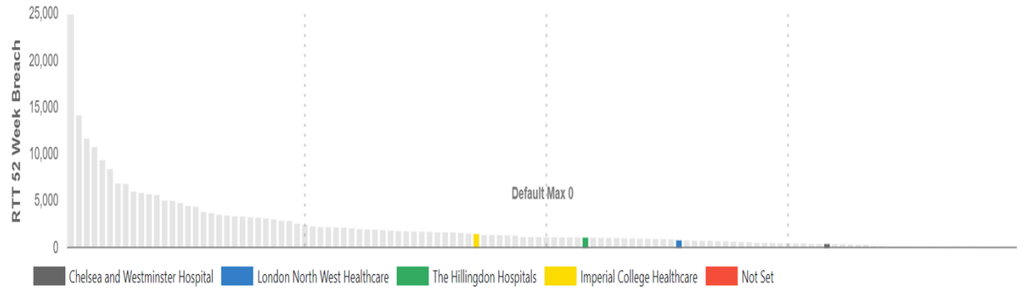
Hospital Combines Performance Score

For the month of September 2021 the Trust is ranked in 5th position. This is an improvement from 7th position the previous month. This positions the Trust as one of the best performing Trusts in the country.

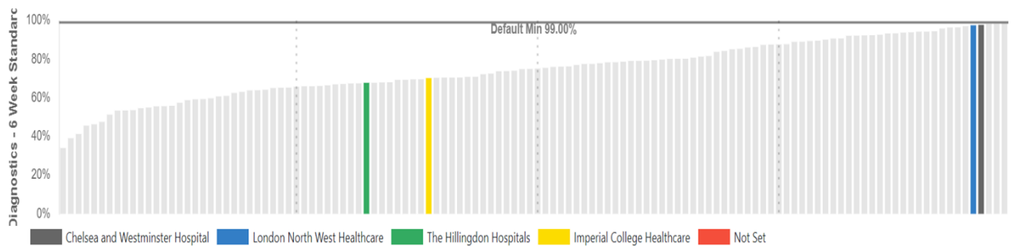
The below reports a one month retrespective and are representitive of August 2021



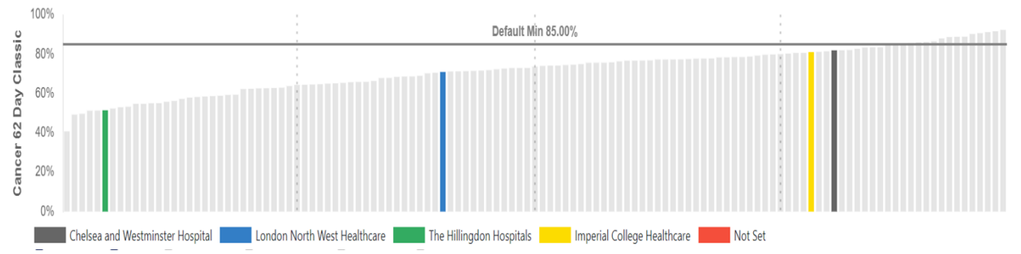
RTT 18 Week Standard: The chart above shows the relative ranking against the RTT 18 Week Standard. The Trust is currently ranked 35th out of 122 Trusts nationally which is a decline in position from 32nd position in July. The chart also demonstrates the position across the ICS.



RTT 52 Week Breaches: The chart above shows the relative ranking against the RTT 52ww standard. The Trust is currently ranked 25th of 123 Trusts nationally. This is an improved position from 28th position in July. The chart also demonstrates the position across the ICS.



6 Week Diagnostic Standard: The chart above shows the relative ranking against the 6 Week Diagnostic Standard. The Trust is currently ranked 4th out of 123 which is an improvement from 9th position in July. The chart also demonstrates the position across the ICS



62 Day Cancer Standard: The chart above shows the relative ranking against the 62 Day Cancer Standard. The Trust is currently ranked 28th of 137 Trusts nationally. The chart also demonstrates the position across the ICS.

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	1	0	0	1	2	0	0	1	1	3	
	Hand hygiene compliance (Target: >90%)	91.4%	90.8%	93.6%	90.9%	91.1%	97.3%	98.2%	91.2%	91.2%	93.5%	95.6%	93.4%	91.1%	
Incidents	Number of serious incidents	2	1	3	19	4	2	8	23	6	3	11	20	42	
	Incident reporting rate per 100 admissions (Target: >8.5)	8.5	8.1	8.5	8.5	10.1	9.4	10.3	10.1	9.3	8.7	9.4	9.1	9.3	
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions	0.02	0.02	0.02	0.02	0.00	0.00	0.03	0.01	0.01	0.01	0.02	0.01	0.02	
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	5.56	2.97	4.48	4.77	3.28	3.48	2.84	3.66	4.37	3.23	3.69	3.75	4.21	
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	0.0%	2.9%	0.0%	0.9%	0.0%	0.0%	0.0%	0.4%	0.0%	1.3%	0.0%	0.3%	0.6%	
Harm	Never Events (Target: 0)	1	0	0	1	0	0	1	1	1	0	1	2	2	
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	0	0	0	1	0	2	0	1	0	1	2	
	Safeguarding adults - number of referrals	19	25	20	119	32	39	31	228	51	64	51	166	347	
	Safeguarding children - number of referrals	22	15	19	158	97	83	92	711	119	98	111	328	869	
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	0.76	0.71	0.72	0.72	0.76	0.71	0.72	0.72	0.76	0.71	0.72	0.73	0.72	
	Number of hospital deaths - Adult	32	40	42	197	55	57	61	316	87	97	103	287	513	
	Number of hospital deaths - Paediatric	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of hospital deaths - Neonatal	0	0	0	0	0	2	2	5	0	2	2	4	5	
	Number of deaths in A&E - Adult	0	0	0	0	1	2	2	13	1	2	2	5	13	
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	0	1	0	0	0	0	1	

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

MRSA Bacteraemia
There was one incident of Hospital acquired MRSA in the month of September at the WMUH site.

Never Events
There was one never event incident reported at WMHU in the month of September

Medication-related safety incidents

A total of 95 medication-related incidents were reported in August 2021. CW site reported 44 incidents, WM site reported 49 incidents and there were 2 incidents reported in community. The number of incidents reported in August has decreased across the Trust since July.

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

The Trust position of medication-related incidents involving patients (NRLS reportable) for August 2021 was 3.09 per 1,000 FCE bed days which is below the Trust target of 4.2 per 1,000 FCE bed days. This will be discussed and reviewed by the Medication Safety Group, with continued monthly monitoring of incident reporting trends.

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

The Trust had 1.3% of medication-related safety incidents with moderate harm and above in August 2021, which is within the Trust target of ≤2%.

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts
Complaints	FFT: Inpatient satisfaction % (Target: >90%)	97.8%	94.9%	95.1%	94.8%	97.3%	97.0%	97.8%	95.1%	97.5%	96.2%	96.8%	96.8%	95.0%	-
	FFT: Inpatient not satisfaction % (Target: <10%)	0.8%	1.9%	1.7%	2.5%	1.3%	0.3%	0.6%	2.2%	1.1%	0.9%	1.0%	1.0%	2.3%	-
	FFT: Inpatient response rate (Target: >30%)	100.0%	100.0%	100.0%	60.5%	100.0%	100.0%	100.0%	76.0%	100.0%	100.0%	100.0%	100.0%	68.8%	-
	FFT: A&E satisfaction % (Target: >90%)	70.8%	87.5%	82.6%	85.0%	90.0%	70.8%	26.3%	85.8%	86.3%	75.0%	57.1%	78.3%	85.2%	!
	FFT: A&E not satisfaction % (Target: <10%)	20.8%	12.5%	13.0%	9.0%	8.0%	12.5%	47.4%	8.9%	10.5%	12.5%	28.6%	14.6%	9.0%	!
	FFT: A&E response rate (Target: >30%)	100.0%	100.0%	100.0%	21.3%	100.0%	100.0%	100.0%	26.3%	100.0%	100.0%	100.0%	100.0%	22.7%	-
	FFT: Maternity satisfaction % (Target: >90%)	55.6%	81.0%	80.0%	86.2%	100.0%	85.7%	85.7%	93.9%	63.6%	82.1%	83.3%	75.8%	86.8%	!
	FFT: Maternity not satisfaction % (Target: <10%)	33.3%	9.5%	20.0%	10.3%	0.0%	0.0%	14.3%	4.1%	27.3%	7.1%	16.7%	16.1%	9.8%	-
	FFT: Maternity response rate (Target: >30%)	100.0%	100.0%	100.0%	27.2%	100.0%	100.0%	100.0%	46.7%	100.0%	100.0%	100.0%	100.0%	28.1%	-
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	111	83	96	489	45	23	27	185	156	106	123	385	674	-
	Complaints formal: Number of complaints received	27	32	27	137	13	8	29	97	40	40	56	136	234	-
	Complaints formal: Number responded to < 25 days	17	16	6	71	9	3	7	40	26	19	13	58	111	-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	1	0	0	0	0	1	-
	Complaints upheld by the Ombudsman (Target: 0)	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
Regarding Friends and Family Tests:	These metrics are currently suspended and will be re-instated it this report when brought back on line		

**Due to the data pipeline being switched off by DW, FFT data only includes online survey results from July.*

PALS & Complaints

The number of complaints received and investigated has increased from 41 in August to 48 in September. Our performance with responding to complaints within the 25 day KPI (95%) was just below the target at 91%.
The number of PALS concerns logged and resolved during September has increased to 121 (from 103 in August) and our performance with responding to the 5-day KPI (90%) during September was 85% - still slightly below the target, due to difficulties in contacting key staff and complexity of issues presented. We aim to resolve as many concerns instantly and for September 2021 this was 64% (225) of the 350 concerns received in total for that month.
We have two open complaints for investigation with the PHSO - one each for CSS and EIC Division.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.21	1.82	3.44	2.51	1.75	2.16	1.73	1.99	2.09	1.91	3.01	2.33	2.40		-
	Average length of stay - non-elective (Target: <3.95)	3.11	3.57	3.99	3.49	2.86	3.12	3.31	3.00	2.97	3.32	3.61	3.30	3.21		-
	Emergency care pathway - average LoS (Target: <4.5)	3.34	3.91	3.53	3.52	3.18	3.51	3.66	3.33	3.24	3.66	3.61	3.50	3.40		-
	Emergency care pathway - discharges	264	240	267	1508	414	374	394	2389	679	614	661	1955	3898		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	6.55%	6.69%	6.06%	6.31%	10.36%	9.84%	10.90%	10.43%	8.43%	8.29%	8.38%	8.37%	8.36%		!
	Non-elective long-stayers	388	352	350	2168	385	383	364	2104	773	735	714	2222	4272		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	83.6%	83.3%	83.8%	81.1%	79.4%	89.0%	81.8%	86.0%	82.6%	85.0%	83.2%	83.5%	82.6%		!
	Operations canc on the day for non-clinical reasons: actuals	0	0	0	1	0	0	0	2	0	0	0	0	3		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.00%	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	0.01%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	0	0	0	1	0	0	0	2	0	0	0	0	3		-
	Theatre Utilisation (Target >85%)	66.2%	64.6%	64.0%	66.2%	72.0%	71.8%	72.3%	72.4%	68.1%	66.9%	66.4%	67.1%	68.1%		!
Outpatients	First to follow-up ratio (Target: <1.5)	2.46	2.49	2.44	2.49	1.78	1.82	1.76	1.87	2.14	2.17	2.12	2.14	2.20		!
	Average wait to first outpatient attendance (Target: <6 wks)	9.0	9.5	10.1	9.3	11.9	11.1	13.4	11.6	10.4	10.3	11.7	10.8	10.3		!
	DNA rate: first appointment	10.6%	10.4%	9.8%	9.8%	8.6%	9.0%	8.5%	8.8%	9.7%	9.7%	9.2%	9.5%	9.3%		-
	DNA rate: follow-up appointment	9.9%	9.8%	9.0%	8.9%	7.9%	6.9%	7.7%	7.6%	9.1%	8.7%	8.5%	8.8%	8.4%		-

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

Average Length of Stay
Average LoS increased from 1.91 to 3.01 for the month of September, this is an increase from 1.91 in the month of August. The average LoS increased significantly due to 1-2 patients who experienced a higher than average LoS. These were complex cancer patients.

Emergency Re-Admissions within 30 days of discharge
The target was reached at CW site however has continued to be breached at WMUH. For the month of September the trust saw a performance of 8.38% against the target of <7.6%

Daycase Rate
Performance for the month of September was just below the target of >85% at 83.2%.

Theatre Utilisation
There has been a small decline in performance against the 85% target at 66,4% utilisation in September from 66.9% in August 2021. Reviews of our dataset for accuracy are being investigated internally, as notable issues have been recognised with emergency activity affecting the elective position.
The roll out of Foundry has highlighted areas of improvement in clinical engagement and scheduling to increase utilisation, whilst sub speciality plans are being developed to improve patient optimisation and cases per session. Plans are being shared across the NWL sector to improve theatre performance, predominantly to support the ICS and standardise practice. .

Outpatients
First to Follow-up Ratio remains above the <1.5 target and is reported at 2.12 for the month of September. This is a slight improvement from 2.17 the previous month. Average wait to first OPA has increased from 10.3 weeks to 11.7. This is being addressed by directorates dedicating efforts to ensure capacity meets demand. DNA rates for both first and follow up appointments have improved in the month of September.

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts
Best Practice	Dementia screening case finding (Target: >90%)	92.7%	83.6%	94.0%	92.6%	96.9%	92.0%	93.1%	95.0%	95.4%	88.7%	93.5%	92.5%	94.1%	-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	93.3%	80.0%	88.2%	88.8%	85.7%	92.3%	92.9%	86.6%	88.9%	88.9%	90.3%	89.3%	87.5%	!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	96.2%	89.5%	86.7%	90.0%	94.1%	93.5%	93.3%	93.5%	93.5%	94.9%	-
VTE	VTE: Hospital acquired	0	0	1	1	0	0	3	4	0	0	4	4	5	-
	VTE risk assessment (Target: >95%)	89.1%	89.1%	87.6%	89.6%	96.0%	95.9%	96.0%	95.8%	92.9%	92.8%	92.1%	92.6%	93.0%	!
TB Care	TB: Number of active cases identified and notified	3	3	1	17	11	2	4	32	14	5	5	24	49	-
Sepsis	ED % of patients with high NEWS score screened for Sepsis	92.5%	92.3%	94.4%	92.2%	85.3%	85.4%	81.6%	87.2%	89.3%	89.4%	89.2%	89.3%	90.0%	
	ED % of patients at risk of developing sepsis receiving antibiotics	58.0%	59.1%	47.1%	60.6%	84.2%	79.4%	87.0%	84.5%	73.0%	69.1%	66.0%	69.4%	73.9%	
	ED % of patients at risk of developing sepsis receiving antibiotics within 1 hour	33.3%	29.5%	22.2%	31.4%	56.4%	52.9%	54.5%	58.2%	46.6%	41.1%	37.5%	41.7%	46.3%	
	AAU/AMU % of patients with high NEWS score screened for Sepsis	84.7%	72.9%	74.5%	82.2%	95.5%	94.2%	93.1%	93.4%	90.2%	83.1%	83.6%	85.5%	87.3%	
	AAU/AMU % of patients at risk of developing sepsis receiving antibiotics	89.2%	91.2%	96.3%	92.8%	97.4%	96.5%	98.1%	96.1%	94.8%	94.7%	97.5%	95.7%	94.9%	
	Inpatient Wards % of patients with high NEWS score screened for Sepsis	90.1%	79.6%	80.7%	84.2%	94.2%	93.3%	91.1%	91.7%	92.2%	86.2%	85.6%	87.9%	87.8%	
Improving outcomes for Inpatient diabetes patients	% of patients identified and triaged as having diabetes														
	Number of inpatient nurses/HCAs that have received 1 0-point training	1	0	0	20	5	0	0	14	6	0	0	6	34	-
	Length of stay for elective (surgical specialties only) patients with recorded diabetes	3.8	4.4	2.9	3.3	3.6	2.9	2.4	3.4	3.7	3.9	2.7	3.4	3.4	-
Improving clinical handover	% staff trained on the principles of safe and effective handover (Target >=50%)	*These indicators are currently unavailable - awaiting services to provide data*													
	% utilisation of handover tool within Cerner (Target >=70%)														

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

VTE Risk Assessment

WMUH site achieved the ≥ 95% target. CW site performance remains below target.

VTE performance is tracked weekly through the TW3 performance meetings to ensure improved compliance. Chelsea site > 95% with the exception of Elective Surgical admissions. Work continues with these areas.

Hospital Associated Thrombosis (HATs)

In September, 1 HAT reported for CW site; and 3 HAT reported for WMUH site.

VTE root cause analysis is performed for HATs to ensure appropriate VTE prevention management with shared learning.

Dementia Screening
For September WM achieved 93.1% and CW achieved 94%, an improvement on August. Safety net to be put in place to avoid dips in compliance when older adults team nurses on leave.

#NOF
CW site – 88% of patients were in theatre within 36 hour - 3 were due to capacity constraints.
WM Site – 93% of patients were in theatre within 36 hours, 1/14 did not achieve time to theatre within 36 hours due to a lack of capacity.

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site Jul-21	Aug-21	Sep-21	2021-2022	West Middlesex University Hospital Site Jul-21	Aug-21	Sep-21	2021-2022	Combined Trust Performance Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trust data 13 months Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	322	244	198	2160	159	192	202	1456	481	436	400	1317	3616		!
	Diagnostic waiting times <6 weeks: % (Target: >99%)	96.94%	96.46%	97.82%	96.08%	97.11%	98.77%	98.31%	97.04%	97.04%	97.76%	98.08%	97.59%	96.62%		!
	Diagnostic waiting times >6 weeks: breach actuals	94	102	65	723	129	45	57	698	223	147	122	492	1421		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.4%	9.0%	8.9%	8.7%	8.6%	8.1%	8.2%	8.2%	9.2%	8.6%	8.7%	8.8%	8.5%		!
	A&E time to treatment - Median (Target: <60')	00:28	00:29	00:29	00:29	01:05	01:05	01:11	01:02	00:47	00:51	00:49	00:49	00:45		!
	London Ambulance Service - patient handover 30' breaches	119	16	22	163	119	66	94	501	238	82	116	436	664		-
	London Ambulance Service - patient handover 60' breaches	3	2	1	6	3	8	4	16	6	10	5	21	22		!

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 Patients
The validated position for the month of September has seen another improvement and reduction in patients waiting over 52 week. The numbers have declined from 436 in August to 400 in September. All Divisions are carefully assessing capacity against demand and ensuring appropriate resource is allocated.

Diagnostics Waiting Times
Have seen a third month of improved performance against the >99% target. September's performance was just below target at 98.08%.

A&E Unplanned Re-Attendances
There was a sharp increase in the number of A&E Attendances for the month of September; the highest number in over a year. The trust has been investigating this increase in attendance and the impact on ED workflows and patient impact. Despite the large increase in attendances for the month the percentage of un-planned re-attendances saw a small increase from 8.6% to 8.7% for the month of September

LAS Handover Breaches
As per the above, the has been an increase in overall A&E attendees, however performance against this indicator saw an improvement from 10 breaches recorded in August to 5 in September.

RTT Positions Dashboard

		Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust Performance		
Domain	Indicator	Jul-21	Aug-21	Sep-21	Jul-21	Aug-21	Sep-21	Jul-21	Aug-21	Sep-21
RTT waiting list positions	Total RTT waiting list	25110	26338	26868	17256	18439	19131	42366	44777	45999
	Total Non-Admitted waiting list	20778	22129	23036	14844	16221	17217	35622	38350	40253
	Non-Admitted with a date	7485	10918	14081	6336	9200	11612	13821	20118	25693
	Non-Admitted without a date	13293	11211	8955	8508	7021	5605	21801	18232	14560
	Total Admitted waiting list	4332	4209	3832	2412	2218	1914	6744	6427	5746
	Admitted with a date	674	850	1064	489	602	722	1163	1452	1786
	Admitted without a date	3658	3359	2768	1923	1616	1192	5581	4975	3960
	Patients waiting >78 weeks	45	64	50	42	60	51	87	124	101
	Patients waiting >104 weeks	0	2	0	2	2	4	2	2	4

RTT 52 week waiters Specialty Dashboard

	Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust position		
Local Specialty	**Jul-21**	**Aug-21**	**Sep-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Jul-21**	**Aug-21**	**Sep-21**
Total	**321**	**244**	**198**	**159**	**189**	**202**	**480**	**433**	**400**
Colorectal Surgery	5	3	3	4	10	6	9	13	9
Community Paediatrics	1						1		
ENT				1	11	14	1	11	14
General Surgery	35	28	21	21	28	24	56	56	45
Gynaecology			1						1
Maxillo-Facial Surgery	2	1					2	1	
Ophthalmology	9	10	16				9	10	16
Oral Surgery				11	10	13	11	10	13
Paediatric Cardiology	1						1		
Paediatric Clinical Immunology	11	8	6				11	8	6
Paediatric Dentistry	97	53	18				97	53	18
Paediatric Dermatology		1						1	
Paediatric Ear Nose and Throat	25	16	11	1			26	16	11
Paediatric Maxillo-Facial Surg	7	6	1				7	6	1
Paediatric Neurology		1						1	
Paediatric Plastic Surgery	13	12	9				13	12	9
Paediatric Surgery	16	9	1	6	7	1	22	16	2
Paediatric Trauma and Orthopae				1	1		1	1	
Paediatric Urology	6	4	4	1			7	4	4
Paediatrics	3	2	1	2	3		5	5	1
Pain Management	1						1		
Plastic Surgery	34	35	40	29	30	38	63	65	78
Podiatric Surgery				3	1		3	1	
Podiatry				5	3	3	5	3	3
Trauma & Orthopaedics	32	26	19	20	17	15	52	43	34
Urology	14	15	31	6	6	8	20	21	39
Vascular Surgery	9	14	16	48	62	80	57	76	96

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	Trend charts	
Workforce	Midwife to birth ratio (Target: 1:30)	1:27	1:27	1:27	1:27	1:28	1:28	1:28	1:28	1:27.5	1:27.5	1:27.5	1:27.50	1:27.5		-
	Hours dedicated consultant presence on labour ward (Target 1:98)	1:77	1:77	1:77	1:77	1:98	1:98	1:98	1:98	1:87.5	1:87.5	1:87.5	1:87.50	1:87.50		-
Birth indicators	Total number of NHS births	507	474	456	2840	428	435	384	2394	935	909	840	2684	5234		-
	Total number of bookings	555	505	601	3423	447	403	432	2579	1002	908	1033	2943	6002		-
	Maternity 1:1 care in established labour (Target: >95%)	97.0%	98.1%	98.8%	98.2%	95.2%	97.4%	96.0%	96.7%	96.1%	97.7%	97.5%	97.1%	97.5%		-
Safety	Admissions >37/40 to NICU/SCBU	16	10	17	94	n/a	n/a	n/a	n/a	16	10	17	43	94		-
	Number of reported Serious Incidents	0	0	1	4	2	2	3	11	2	2	4	8	15		-
	Cases of hypoxic-ischemic encephalopathy (HIE)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Pre-term (gestation <37 weeks) as % of mothers delivered	6.6%	7.2%	8.3%	7.4%	6.4%	6.2%	6.4%	6.2%	6.5%	6.7%	7.4%	6.9%	6.8%		-
	Number of stillbirths	1	0	3	8	2	1	1	8	3	1	4	8	16		-
	Number of Infant deaths	0	3	0	7	0	2	2	5	0	5	2	7	12		-
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Outcomes	% of women on a continuity of care pathway	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	9.5%	n/a	n/a	n/a	0.0%	13.3%		-
	Spontaneous unassisted vaginal births	30.8%	26.4%	33.9%	30.1%	35.6%	38.0%	33.2%	35.7%	33.0%	31.9%	33.5%	32.8%	32.6%		-
	Vaginal Births - spontaneous & induced	58.5%	60.1%	61.7%	60.7%	63.2%	66.5%	61.0%	63.3%	60.7%	63.2%	61.3%	61.7%	61.9%		-
	Instrumental deliveries	14.4%	15.0%	17.3%	15.0%	12.6%	14.3%	13.6%	12.7%	13.5%	14.7%	15.6%	14.6%	13.9%		-
	Pre-labour elective caesarean sections	81	82	69	443	47	55	37	288	128	137	106	371	731		-
	Emergency caesarean sections in labour	57	55	59	339	66	62	72	374	123	117	131	371	713		-

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

Workforce:
Midwifery ratio's calculated on midwifery establishment not those in post. Midwifery workforce has been challenged over the past 8 weeks, with vacancy, sickness and high acuity.

Consultant hours: Successfully recruited 2 Obstetric Consultants to ensure compliance with 98 hours on the Chelsea site.

Birth Indicators:
Compliant with >95% of women receiving 1:1 care in established labour however delays in care have increased due to staffing and capacity over the past 8 weeks.

62 day Cancer referrals by tumour Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance					Trust data 13 months
Domain	Tumour site	Jul-21	Aug-21	Sep-21	2021-2022	YTD breac…	Jul-21	Aug-21	Sep-21	2021-2022	YTD breac…	Jul-21	Aug-21	Sep-21	2021-2022 Q2	2021-2022	YTD breac…	Trend charts
62 day Cancer referrals by site of tumour	Breast	n/a	n/a	n/a	n/a		88.0%	100%	80.0%	96.7%	4	88.0%	100%	80.0%	94.4%	96.7%	4	-
	Colorectal / Lower GI	84.6%	68.8%	80.0%	81.5%	7.5	70.6%	42.9%	0.0%	69.2%	11.5	76.7%	60.9%	54.5%	69.8%	76.1%	19	!
	Gynaecological	57.1%	50.0%	83.3%	70.6%	3	66.7%	n/a	0.0%	80.0%	2.5	61.5%	50.0%	62.5%	58.8%	75.0%	5.5	!
	Haematological	0.0%	100%	60.0%	80.0%	2	100%	100%	100%	90.5%	1	75.0%	100%	71.4%	85.7%	87.1%	3	-
	Head and neck	n/a	n/a	n/a	100%	0	33.3%	100%	100%	66.7%	1	33.3%	100%	100%	50.0%	83.3%	1	-
	Lung	0.0%	100%	100%	80.0%	1.5	100%	100%	71.4%	83.3%	2	66.7%	100%	75.0%	88.9%	81.5%	3.5	-
	Sarcoma	n/a	n/a	n/a	n/a		n/a	100%	0.0%	100%	0.5	n/a	100%	0.0%	100%	100%	0.5	-
	Skin	88.9%	100%	96.0%	97.4%	1.5	85.7%	100%	69.6%	85.5%	7.5	87.5%	100%	83.3%	96.2%	92.4%	9	-
	Upper gastrointestinal	100%	100%	100%	100%	0	n/a	100%	50.0%	73.3%	5.5	100%	100%	58.8%	100%	86.2%	5.5	-
	Urological	92.9%	64.3%	66.7%	75.7%	10.5	74.3%	74.0%	73.0%	73.7%	25	79.6%	71.9%	71.4%	75.2%	74.3%	35.5	!
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a	100%	0	100%	n/a	n/a	100%	100%	0	-
	Site not stated	n/a	n/a	n/a	n/a		100%	25.0%	n/a	63.6%	2	100%	25.0%	n/a	40.0%	63.6%	2	-

Improving personalised cancer care at diagnosis

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

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

Please note the following	n/a	Refers to those indicators where there is no data to report. Such months will not appear in the trend graphs	! Either Site or Trust overall performance red in each of the past three months
		Please note that all indicators show interim, unvalidated positions for the latest month (May-21) and are not included in quarterly or yearly totals	

Trust commentary

No commentary available yet

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

Tumour Site	Chelsea & Westminster		West Middlesex	
	Breaches	Treatments	Breaches	Treatments
Breast			0	14.5
Gynaecology		1.5	1	0.5
Haematology		1	0	2
Head and Neck			0	0.5
Colorectal	2.5	8	2	3.5
Lung	0	2	0	1
Other			1.5	2
Sarcoma			0	1
Skin	0	10	0	8
Upper GI		0.5	0	0.5
Urology	2.5	7	6.5	25
Total	**5**	**30**	**11**	**58.5**

Safe Staffing & Patient Quality Indicator Report – Chelsea Site

September 2021

Ward	Day		Night		CHPPD	CHPPD	CHPPD	National Benchmark		Vacancy Rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents (moderate and severe)		FFT
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA	Total				Qualified	Un-qualified	No harm and mild		Moderate and severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Maternity	99%	78%	91%	95%	7.2	2.6	9.8	14.8		9.5%	10.2%	17.5%		2						2	
Annie Zunz	154%	77%	100%	108%	6.5	2.1	8.6	9.4		-2.9%			1	4						1	98.08%
Apollo	90%	-	87%	-	13.7	-	14.5	10.9													100.00%
Mercury	0.98	0.73	1	-	7.2	0.6	7.9	11		20.9%	24.5%	100.0%									
Neptune	128%	126%	144%	-	17.6	1.8	19.4	15		25.7%	26.5%	100.0%	1	3							88.89%
NICU	0.9	-	0.92	-	13.2	0	13.2	26.7		8.5%	14.9%										100.00%
AAU	105%	65%	107%	90%	7.5	1.9	9.4	9.4		11.8%	9.8%	64.8%	7	41							89.29%
Nell Gwynne	109%	76%	168%	76%	5.3	3.2	8.8	7.9		16.1%	10.6%	43.6%	2	21							100.00%
David Erskine	110%	72%	120%	107%	6.5	3.7	10.5	8. 6		20.2%	38.9%	13.0%									
Edgar Horne	91%	58%	106%	92%	4.7	2.9	8	6.9		20.0%		38.0%	5	43		1					
Lord Wigram	89%	87%	97%	107%	4.1	2.8	6.9	8.2		10.9%	5.1%	4.8%	3	23							95.92%
St Mary Abbots	99%	62%	101%	94%	3.7	2.2	6.3	8.3		23.3%	15.3%		6	16				1			100.00%
David Evans	81%	80%	95%	159%	5.7	2.6	8.2	8.3		10.9%	10.6%	13.0%	3	11							100.00%
Chelsea Wing	0.79	0.99	1.02	0.78	7.7	4.7	12.4	8.3		41.1%	27.3%	25.6%	3	7							100.00%
Burns Unit	0.87	0.57	0.99	0.9	15.4	2.4	17.8	N/A		9.3%	15.3%	15.0%		6							
ICU	98%	-	114%	-	25	0	25.4	27.7		-6.7%	9.7%										
Rainsford Mowlem	66%	38%	66%	66%	4.9	3.2	8.4	7.3		18.3%	17.9%	16.1%	6	30							100.00%

Safe Staffing & Patient Quality Indicator Report – West Middlesex Site

September 2021

Ward	Day		Night		CHPPD	CHPPD	Total	National Benchmark		Vacancy Rate	Turnover		Inpatient fall with harm				Trust acquired pressure ulcer 3,4,unstageable		Medication incidents (moderate & severe)		FFT
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Reg	HCA					Qualified	Un-Qualified	No Harm & Mild		Moderate & Severe						
													Month	YTD	Month	YTD	Month	YTD	Month	YTD	
Lampton	103%	121%	106%	149%	3.2	3.8	7	7.7		6.90%		12.40%	4	21							100.00%
Richmond	40%	11%	75%	30%	8.5	1.2	9.8	7.2		-0.389			1	2							100.00%
Syon 1 cardiology	98%	104%	98%	125%	4.4	2.4	6.8	8.8		13.50%		30.70%	8	25							100.00%
Syon 2	112%	67%	117%	85%	4	2.2	6.5	8.6		16.10%	18.50%	6.75%	2	24							95.60%
Starlight	90%	-	105%	-	7.3	0	7.3	15		22.90%	22.04%		1	1							100.00%
Kew	101%	107%	102%	128%	3.2	3.3	6.6	7.9		-4.20%	4.50%	20.00%	9	51						1	93.70%
Crane	64%	35%	71%	75%	4.5	2.8	7.8	7.7		9.80%	3.50%	5.90%	1	15							100.00%
Osterley 1	100%	68%	101%	106%	3.9	2.4	6.5	7		5.28%	18.80%	6.70%	3	30				1			96.70%
Osterley 2	105%	67%	100%	96%	3.9	1.9	5.9	7.2		-0.62%	3.90%	8.70%	2	23	1	1					95.40%
MAU	117%	134%	123%	131%	6.4	2.5	8.9	9.4		12.20%	14.70%	15.80%	1	27		1		2			98.50%
Maternity	96%	80%	98%	84%	4.7	1.4	6.1	14.8		7.03%	4.95%	4.70%		1							
Special Care Baby Unit	104%	-	98%	-	9.6	0.6	10.2	15		12.70%		11.05%									100.00%
Marble Hill 1	127%	103%	112%	192%	4.2	2.9	7.5	6.9		19.70%	16.00%	14.40%	12	50	1	1					94.70%
Marble Hill 2	98%	97%	100%	158%	3.2	2.8	6.2	6.8		12.53%	26.60%	8.10%	2	26		1		1			9670.00%
ITU	135%	73%	140%	-	33.6	0.6	35.8	26		-4.60%	3.10%					1		2			100.00%

Safe Staffing & Patient Quality Indicator Report

September 2021

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours per Patient Day (CHPPD). This is then benchmarked against the national benchmark and triangulated with associated quality indicators and patient experience for the same month. Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Wards at the Chelsea Site such as Ron Johnson, David Erskine, Edgar Horne, David Evans and Saint Marys Abbots are referred to by their roster name rather than their present physical location.

Following the requirement that numbers of babies as well mothers are submitted for maternity, the number of WM maternity cots has been based on the number of bed days on the top floor of QMMU. Benchmarking data for CHPPD will be updated once this is updated on Model Hospital. The low HCA fill rate for Maternity at WM was due to extra shifts not being filled which were requested to support patients with lack of partner support.

AAU, David Erskine, and Nell Gwynne had a number of HCAs vacancies which are currently being recruited hence the low fill rate but this did not compromise CHPPD when compared to the national benchmark. David Erskine had bed escalation throughout September due to Covid admissions thus requiring more RN's at night. Nell Gwynne also had an increase in Tracheostomy patients requiring additional RN's. Edgar Horne had low HCA fill rates due to long term sickness, though long term sickness on this ward is now improving. Chelsea Wing has high vacancy rates for both qualified and non-qualified staff which accounted for the low HCA day fill rate.

Annie Zunz had high day fill rate for RNs due to the requirement of an extra RN to cover patients admitted through the Surgical Admissions Lounge. On David Evans, the high HCA fill rate at night was due to patient dependency post surgery. Ron Johnson is currently hosted on Rainsford Mowlem therefore staff fill rates are included in Rainsford Mowlem figures, which had low fill rates due to bed closures throughout September the high fill rate for Neptune was due to the number of CAMHS patients and resulting requirement for 1:1 care.

Burns had low activity throughout September and therefore HCA support was not required. The high fill rate on ITU at WM for RN's was due to an increase in numbers of level 3 patients ratio to level 2 patients admitted.

MAU at West Mid extra staff were also booked for high acuity and increased enhanced care capacity. Being the Covid ward at West Mid Crane was only partially open during September with staffing in place for 16-20 beds which accounts for lower staff fill rates. The low fill rates on Richmond are due to the ward not being full to capacity and staffing is reviewed on a daily basis with staff being diverted to mitigate the low daytime HCA fill rates on Osterley 1 and 2. SMA also had low daytime HCA fill rates which was also mitigated by good RN fill rates and cross cover. Kew, Marble Hill 1&2, Lampton and Syon 1had high fill rates were due to a requirement for enhanced monitoring for confused wandering and risk of falls patients. On Syon 2 vacant shifts were covered by staff not required on Crane

Edgar Horne had low HCA fill rates due to long term sickness, though long term sickness on this ward is now improving. Chelsea Wing has high vacancy rates for both qualified and non-qualified staff which accounted for the low HCA day fill rate.

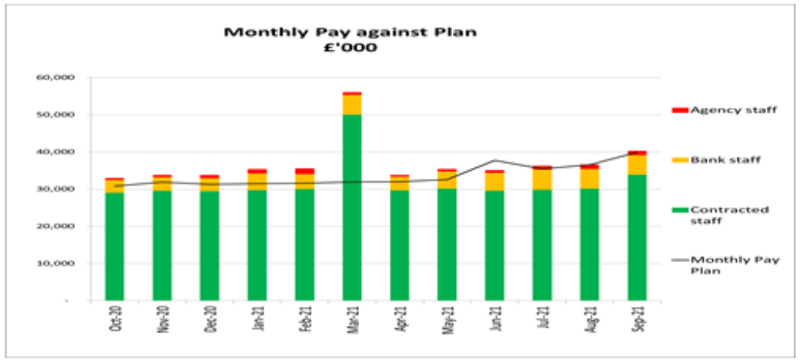
During September the Friends and Family test showed 7 wards at both CW and WM scored 100%. There is an issue with data capture for FFT scores in maternity so these figures have been excluded.

Three falls occurred in September, one on Marble Hill 1 resulting in death which is awaiting review , one on Osterley 2 with severe harm and one on Nightingale with moderate harm which are both waiting for full approval.

Please note all incident figures are correct at time of extraction from Datix

Finance Dashboard M6 2021/22

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	380,525	387,538	7,013
Expenditure			
Pay	(214,224)	(217,450)	(3,227)
Non-Pay	(145,613)	(149,045)	(3,432)
EBITDA	20,689	21,042	354
EBITDA %	5.44%	5.43%	0.0%
Depreciation	(11,828)	(11,828)	(0)
Non-Operational Exp-Inc	(8,682)	(8,859)	(177)
Surplus/Deficit	178	355	177
Control total Adj - Donated asset, Impairment & Other	(178)	(178)	(0)
Disposal of Asset	0	(16)	(16)
Adjusted Surplus/Deficit	0	161	161



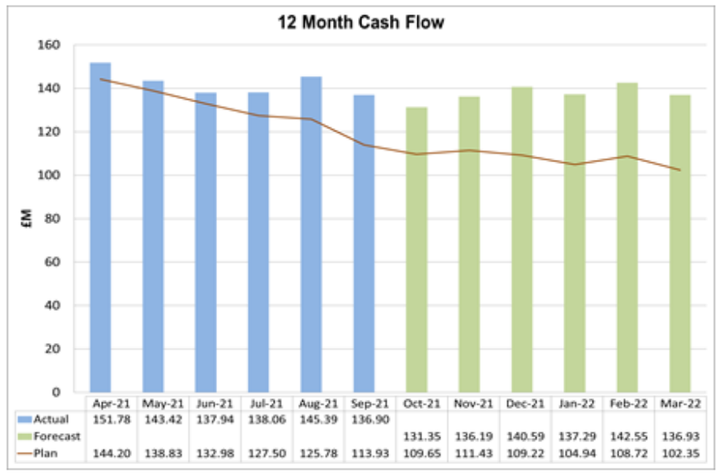
In March 2021 payroll figures include additional spend items for 6.3% Pension contribution (£15.16m a notional figure) and £4.8m movement in holiday accruals (including additional two day accrua for staff R&R/Birthday); these are both matched with equivalent income. Spetember 2021 payroll figures include YTD backdated payawards for AFC staff, Consultants and Career grades.

At month 6 the Trust is reporting a YTD surplus of £0.16m, when adjusted for the financial impact of donated assets and disposal of asset. This is £0.16m favourable against the H1 plan and year to date.

Pay: Pay is overspend by £3.23m YTD. The position includes £3.67m unidentified, red or amber CIP schemes. Pay costs in September include the backdated pay award.

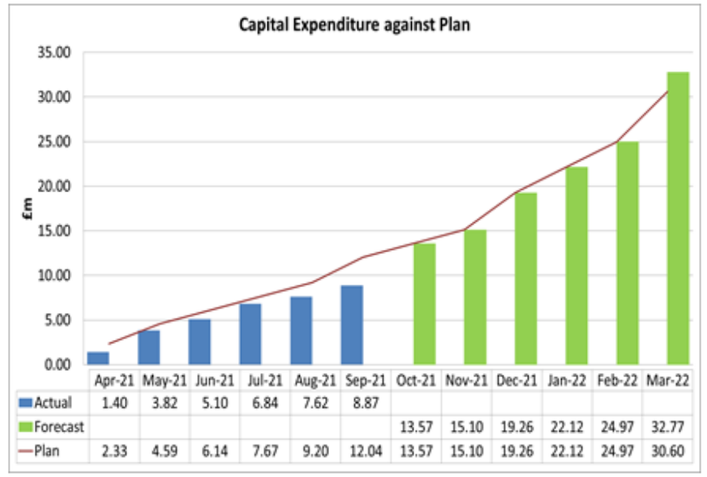
Non-Pay; Excluding pass through drugs, non-pay is £3.43m adverse YTD. The position in month includes an increase in provisions in the central divisions and overspends against CSS and Corporate divisions.

Income: Contractual income from CCGs and NHS England continues on a block at the same level as 2020/21. Sexual health contracted activity is back to cost and volume in 21/22 and PrEP has been included in the baseline. The Elective Recovery Framework (ERF) cumulative performance has improved, driven by Q1 over performance against targets, with additional activity coded prior to freeze dates.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	151.78	143.42	137.94	138.06	145.39	136.90						
Forecast							131.35	136.19	140.59	137.29	142.55	136.93
Plan	144.20	138.83	132.98	127.50	125.78	113.93	109.65	111.43	109.22	104.94	108.72	102.35

The favourable cash variance to plan in M6 of £22.97m is favourable cash variance b/fwd from M5 of £19.61m; Higher receipts to plan of £7.11m (AR £707k, Donations £21k, CCG £3.95m, NHS England £2.75m, PP Income £95k; offset by Local Authority £225k lower, Ft's and Trust -£197k lower), offset by Higher cash outflows to plan £3.75m (Higher Creditor Payments & Higher Payroll).



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Actual	1.40	3.82	5.10	6.84	7.62	8.87						
Forecast							13.57	15.10	19.26	22.12	24.97	32.77
Plan	2.33	4.59	6.14	7.67	9.20	12.04	13.57	15.10	19.26	22.12	24.97	30.60

The Trust has spent £1.25m in period 6 compared to the budget of £2.84m, resulting in an underspend of £1.59m. The YTD variance against plan is an underspend of £3.18m, actual spend of £8.87m compared to budget of £12.04m. The underspend mainly relates to timing differences, with a number of schemes yet to be worked up and business cases prepared. It is envisaged that the capital spend will be incurred in later months as seen in previous years.

CQUIN Dashboard

2021/22 CQUIN Schemes

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**2.3**
TITLE OF REPORT	**Business planning 2021/22**
AUTHOR NAME AND ROLE	Graham Henry, Deputy Director of Finance
ACCOUNTABLE EXECUTIVE DIRECTOR	Virginia Massaro, Chief Financial Officer
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	The Board is asked to approve the H2 2021/22 business/financial plan.

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

Name of Committee	Date of Meeting	Outcome
Executive Board	27.10.21	

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

- NHSE/I have published planning guidance for H2. This includes the 6 priorities for the NHS and details on the revised elective recovery fund.
- H2 financial arrangements remain consistent with H1. Systems will continue to receive a fixed system funding envelope based on the H1 2021/22 envelopes adjusted for additional known pressures e.g. the pay award.
- The Trust is planning to deliver a breakeven position in H2 2021/22 and therefore a breakeven position for 2021/22. This includes keeping the CIP target at £12.7m for the year.
- NWL ICS is also forecasting a breakeven position in 2021/22.
- System submissions are due on 16th November and Trust submissions are due on 25th November. Submissions include aligned activity, workforce and financial plans.

KEY RISKS ARISING FROM THIS REPORT

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	

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

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

Business plans and CIP schemes will be reviewed by the Quality, Equality and Health Inequalities Analysis panel.

Financial impacts relating to risk mitigation actions.

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

H2 Business plan 2021/22

1. Background

NHSE/I published the H2 planning guidance at the beginning of October 2021. The planning guidance outlines 6 priorities for H2, which were originally set out in March 2021:

a) Supporting the health and wellbeing of staff and taking action on recruitment and retention.
b) Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
c) Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
d) Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
e) Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
f) Working collaboratively across systems to deliver on these priorities.

The H2 financial arrangements are broadly consistent with a continuation of the H1 framework. This means that systems will continue to receive a fixed system funding envelope based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of the pay award. H2 envelopes include an increased efficiency requirement from H1.

2. NWL ICS H2 2021/22 financial plan

Overall the H2 allocation for NWL ICS has increased by £25m to £2,182m. The increase is the net of:

- £43m efficiency requirement. This is made up of the 0.82% national efficiency target (£9m) plus additional targeted efficiency requirement of £34m as NWL ICS is above its control total.
- Reduction in national funding for non-NHS income (£2.5m) and reduction in covid funding (£9m)
- Funding the 3% pay uplift for H2 and back pay
- Additional £14m funding for winter capacity to support non-elective activity.

NWL ICS is planning to submit a breakeven plan in H2 2021/22. There is sufficient contingency in the NWL ICS budget that the efficiency requirement will not be passed on to providers in H2. Therefore funding for Trusts will be broadly rolled over from H1, plus funding for the pay award.

3. CWFT H2 2021/22 financial plan

The Trust is planning a breakeven position in H2 and therefore a breakeven position for the full year 2021/22.

The funding allocation in H2 includes funding for the 3% pay award for Agenda for Change and Consultant staff that was paid in September 2021. It also includes non-recurrent funding towards lost non-NHS income of £3.6m in H2.

The CIP target is proposed to remain at £12.7m (c2%) for 2021/22.

The table below outlines the draft plan for H2. The Trust's underlying position remains a deficit of £32m, though this will be reviewed as part of the planning for 2022/23.

	H2 Plan £000
Patient Care income	343,837
Other Operating income	40,946
Total Income	**384,782**
Pay	212,397
Other operating costs	163,269
Non-operating costs	9,117
Total Expenditure	**384,782**
Surplus/ (deficit)	**0**

4. H2 potential upsides and risks

4.1. Potential Upsides

Elective Recovery Fund (ERF) and Target Investment Fund (TIF): No additional income/contribution has been assumed in H2 for surpassing the thresholds set out in the ERF. The national funding for ERF in H2 is £1bn and for TIF is £700m.

The Elective Recovery Fund (ERF) methodology has changed from 1st October 2021. The baseline and activity is now based on RTT clock stops, with the system baseline set at 89% of the 2019/20 clock stops. Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%.

The Target Investment Fund (TIF) is mainly capital funding to support elective recovery. At least 50% is ringfenced for technology that enables elective recovery. NWL ICS has put in bids against this funding and is awaiting the outcome of the business case.

Private Patient income: The PP directorate's recovery trajectory projections are higher than those included in the H2 plan where more prudent assumptions have been made about the speed of income increases in the Private Inpatient and Private ACU services.

3.2 Risks

CIPs: It has been assumed that the full £12.7m CIP savings are achieved in 2021/22, but CIP identification is at 76% as at Month 6. This has been mitigated non-recurrently in H1.

Winter expenditure: Increasing Covid-related admissions and winter pressures could rapidly drive increased expenditure. There is a reserve held in the NWL ICS for winter pressures and there is a process in place to allocate this funding to Trusts.

5. Timetable

The key deadlines for the H2 plans are set out below. The submissions include activity, workforce and financial returns.

Key Milestone	Date - Elective & TIF Submission	Date - Main Submission
2021/22 Operational Planning Guidance (H2) Publication	30-Sep-21	30-Sep-21
Provider Input Submission to ICS	08-Oct-21	
COO Review of Provider Submission	13-Oct-21	
Targeted Investment Fund (TIF) -submission of short form business cases for each proposal	14-Oct-21 (noon)	
Activity and performance (elective recovery/winter capacity submission) (Sign off TBC)	14-Oct-21 (noon)	
Review and sign off of Elective Recovery Narrative Submission - Elective Care Board	15-Oct-21	
Review and sign off of Elective Recovery Narrative Submission - CEO's	19-Oct-21	
Elective Recovery Narrative Submission	21-Oct-21	
CEO Final Submission Sign off of TIF Business Cases	26-Oct-21	
Targeted Investment Fund (TIF)- additional business case information (capital value >£5m)	28-Oct-21 (noon)	
Second (Full) Provider Input Submission to ICS		22-Oct-21
COO's Review		27-Oct-21
HRDs Review		28-Oct-21
Third (Full) Provider Input Submission to ICS		29-Oct-21
COO's Final Review		03-Nov-21
HRDs Final Review		04-Nov-21
CEO Final Submission Sign off		09-Nov-21
H2 Workforce, Activity and Performance (SDCS) submission		16-Nov-2121 (noon)
H2 Finance - System submission		16-Nov-2121 (noon)
Provider Organisations Financial Plan Submission		25-Nov-21

6. Decision/action required

FIC is asked to approve the H2 2021/22 financial plan.

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**3.1**
TITLE OF REPORT	**Annual People, Equality and Diversity Report (including Gender Pay Gap) 2020/2021**
AUTHOR NAME AND ROLE	Harry Sarsah, Equality & Diversity Manager, and Sam Slaytor, Head of Inclusion, Wellbeing and Engagement
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith, Interim Director of People and Organisational Development
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To note approval of the attached report by the People and Organisational Development Committee on 26 October 2021 and subsequent central submission of the report.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome Workforce Development Committee / 18.10.21 / Recommended for publication People and OD Committee / 26.10.21 / Approved
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	We have a duty within the NHS standard contract to report on Public Sector Equality Duty (PSED) and clear responsibilities under the Equality Act 2010. Our Trust is committed to providing fair and inclusive services for our patients and we offer fair and inclusive employment to our staff. Throughout the last year we have continued to focus on embedding equality, diversity and inclusion and have tried to remove barriers to reduce inequities. The COVID-19 pandemic has had a major impact in all NHS organisations and has highlighted inequality, inequity and negative impact across the protected characteristics. Our staff have been challenged by the response to the COVID-19 pandemic and we have learnt many lessons. Our learning will form part of our year 2 and year 3 Equality, Diversity and Inclusion (EDI) plan enabling us to foster a culture of inclusion and belonging and live our PROUD values bringing our EDI ambitions alive. For us to be respondent to our patients and staff we need take into

	account their diverse needs. We need to be open and honest and have brave conversations about diversity and inclusion. We must be unfailingly kind in all of our interactions and determined to develop in this area. We will not just embed equality—we will look at how we value people and how we can encourage others to value people, reflect, and improve our behaviours towards our people and our patients. Our report includes: • An outline of our vision at the Trust to be the employer of choice • An overview of key achievements • The profile of our workforce and key findings • Future plans for 2021/22 based on our priority areas for action We undoubtedly have more work to undertake to ensure that we improve the experience of our people and our patients. The NHS People Plan outlines nine priority areas to support our NHS staff and its imperative we get this right. As staff that have a clear belonging in the NHS have a better line of sight into improving services and also deliver better patient care. Our trust ambition is to ensure all our staff have a great experience working at our Trust. Our Board Diversity and Inclusion Advisor role provides assurance to the Trust to recognise, resolve and address equality gaps and inequities. This report and the EDI plan will map our journey to guarantee we achieve our ambitious plan and improve the experiences of our staff and our patients. Inclusion is not a choice, but simply the way we work.
KEY RISKS ARISING FROM THIS REPORT	NHS standard contract and NHS People Plan in relation to engagement and staff survey.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		Financial implications to recruitment, on boarding and retention.
Equality And Diversity		
Quality		
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance	Y	
Public Consultation		
Council of Governors		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – Not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Chelsea and Westminster Hospital NHS Foundation Trust

Workforce Equality and Diversity Report 2020/21

TABLE OF CONTENTS

SECTION 1

INTRODUCTION

We are happy to present our workforce equality report with details of the actions taken to address our identified gaps. We have a duty within the NHS standard contract to report on Public Sector Equality Duty (PSED) and clear responsibilities under the Equality Act 2010.

Our Trust is committed to providing fair and inclusive services for our patients and we offer fair and inclusive employment to our staff. Throughout the last year we have continued to focus on embedding equality, diversity and inclusion and have tried to remove barriers to reduce inequities.

The COVID-19 pandemic has had a major impact in all NHS organisations and has highlighted inequality, inequity and negative impact across the protected characteristics. Our staff have been challenged by the response to the COVID-19 pandemic and we have learnt many lessons. Our learning will form part of our year 2 and year 3 Equality, Diversity and Inclusion (EDI) plan enabling us to foster a culture of inclusion and belonging and live our PROUD values bringing our EDI ambitions alive.

For us to be respondent to our patients and staff we need take into account their diverse needs. We need to be open and honest and have brave conversations about diversity and inclusion. We must be unfailingly kind in all of our interactions and determined to develop in this area.

We will not just embed equality—we will look at how we value people and how we can encourage others to value people, reflect, and improve our behaviours towards our people and our patients.

Our report includes:

- An outline of our vision at the Trust to be the employer of choice
- An overview of key achievements
- The profile of our workforce and key findings
- Future plans for 2021/22 based on our priority areas for action

We undoubtedly have more work to undertake to ensure that we improve the experience of our people and our patients. The NHS People Plan outlines nine priority areas to support our NHS staff and its imperative we get this right. As staff that have a clear belonging in the NHS have a better line of sight into improving services and also deliver better patient care. Our trust ambition is to ensure all our staff have a great experience working at our Trust.

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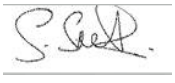


Sue Smith
Interim Director of Human Resources and OD Advisor

Gubby Ayida
Board Diversity and Inclusion

SECTION 2

OUR STRATEGIC PRIORITIES

The Trust has three strategic priorities:

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

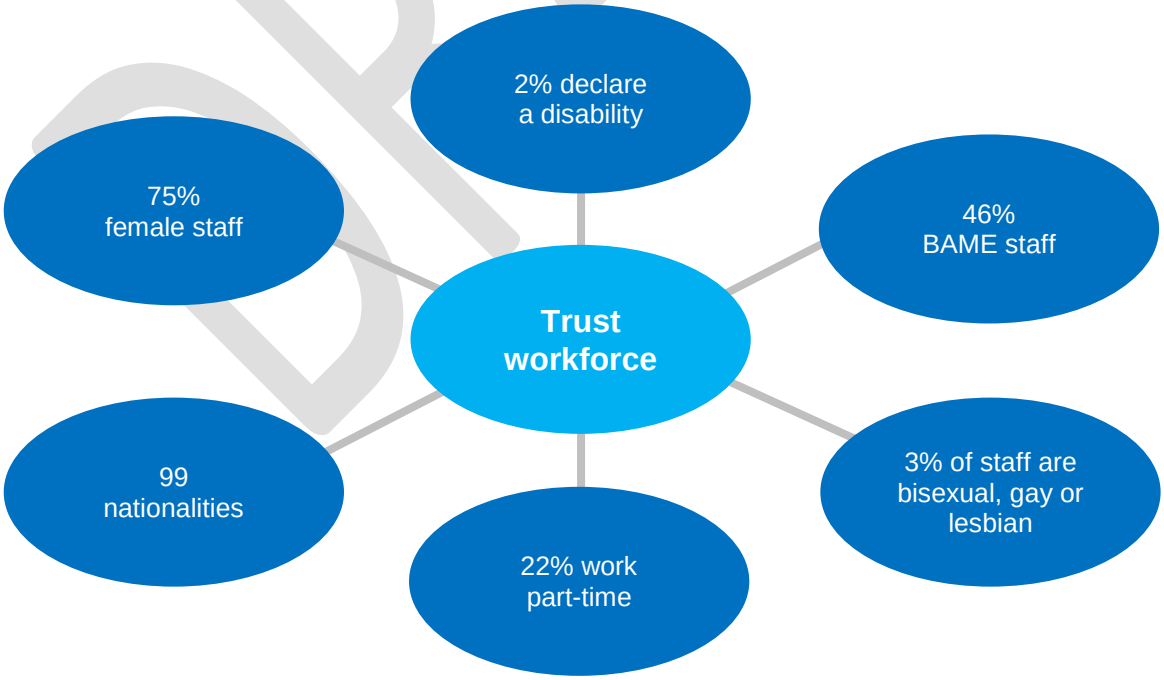
Our staff also work to a strong set of PROUD values which are:

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

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

Key findings

Our workforce remains broadly representative of the population we serve and the workforce data is similar to previous years. The data in the report covers financial year 2020/21 running 1 Apr 2020 to 31 Mar 2021.



- Our 2020 staff survey results highlight that, as a Trust, we score below average at 8.5 for equality, diversity and inclusion compared to other Trusts—the best Trust scored 9.5 and the average was 9.1

- The staff survey highlighted that the percentage of staff experience in positive interest in health and wellbeing from managers improved and the staff looking to leave the organisation fell.

- There has been a continued increase in the overall percentage of BAME that make up the workforce population— BAME staff now make up the majority of the workforce at 46% with Non BAME 44%

- BAME staff report a poorer experience than non-BAME staff—for example, non-BAME staff are 1.6x more likely to be shortlisted than BAME, and BAME staff are 1.9x more likely to enter into formal disciplinary processes than non-BAME staff, which is higher than the expected range of 0.8 - 1.25 for 2021 set out by NHS England and NHS Improvement.

- The gender pay gap report highlighted that female employees earn an hourly mean average pay of 16.4% less than male employees.

- Only 2% of staff have declared a disability yet 12.3% stated in the confidential staff survey that they had a disability, highlighting significant under-reporting.

SECTION 3

KEY ACHIEVEMENTS

We are proud to have achieved the following as at July 2021:

- Launched a disability staff network sponsored by an executive board member and the Trust is participating in the Calibre Programme hosted by Imperial College hosted by Healthcare NHS Trust

- Improvement in closing the Gender Pay Gap between females and males from 17.7% to 16.4%.

- Completed and evaluated a Reciprocal Mentoring for Inclusion programme in which Trust executives and senior leaders were mentees by diverse, under-represented staff members from across the organisation.

- Continued reduction in the overall number of formal employee relations cases

- Improvement in our Workforce Race Equality Standard (WRES) indicators 3 and 4 scores

- Senior level participation in the WRES experts programme

- Improvement in the probation cases percentage affecting BAME

- Membership on the North West London Inclusion Board which focuses on equality, diversity and inclusion across the sector

- Trust participation on NWL Leadership Ladder and Inclusive and Compassionate Pilot programmes

SECTION 4

FUTURE ACTIONS AND PRIORITIES FOR 2021/22

Our future actions and priorities for 2021/22 are to:

- Update the Chelwest People Strategy
- Widen the Reciprocal Mentoring for Inclusion Programme across the organisation
- Review and update the Improving Equality, Diversity and Inclusion Action Plan
- Embed inclusion objectives into senior and middle managers appraisal process
- Continue to improve key metrics for WRES/WDES/Gender Pay Gap and be among the best performing Trust nationally.
- Expand the Diversity and Inclusion champions programme to appointments at Band 7.
- Pilot an innovative form of Equality, Diversity and Inclusion training for staff by using virtual embodiment and Implicit Association Testing (IAT).

SECTION 5

WORKFORCE COMPOSITION

At the end of financial year (FY) 2020/21, the Trust had 6,495 substantive staff, an increase of 101 (1.5%) compared to the end of FY 2019/20. This compares to a 3.5% increase from FY 2018/19 to 2019/20. The section provides a high-level summary of the workforce composition by protected characteristics.

Workforce composition by ethnicity

For the purposes of this report, the Trust has defined staff categories as non-BAME, BAME and 'not stated'. The national electronic staff record does not give the option of 'do not wish to declare' for ethnicity so these are recorded by default as 'not stated'.

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

44.6% of our workforce (2,903 staff) identify as non-BAME compared to 46.9% (3,043 staff) as BAME. This compares with 46% and 46% respectively at the same point last year. 8.5% (549) of our staff are recorded as 'not stated', which whilst a small increase of 20 on the previous year has not changed the percentage of the workforce population.

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

Trust diversity compared to London

	Asian	Black	Mixed	White British	White other	Other
Chelsea and Westminster	25%	13%	4%	31%	13%	13%
London (2020)[1]	18.5%	13.3%	5.0%	44.9%	14.9%	3.4%

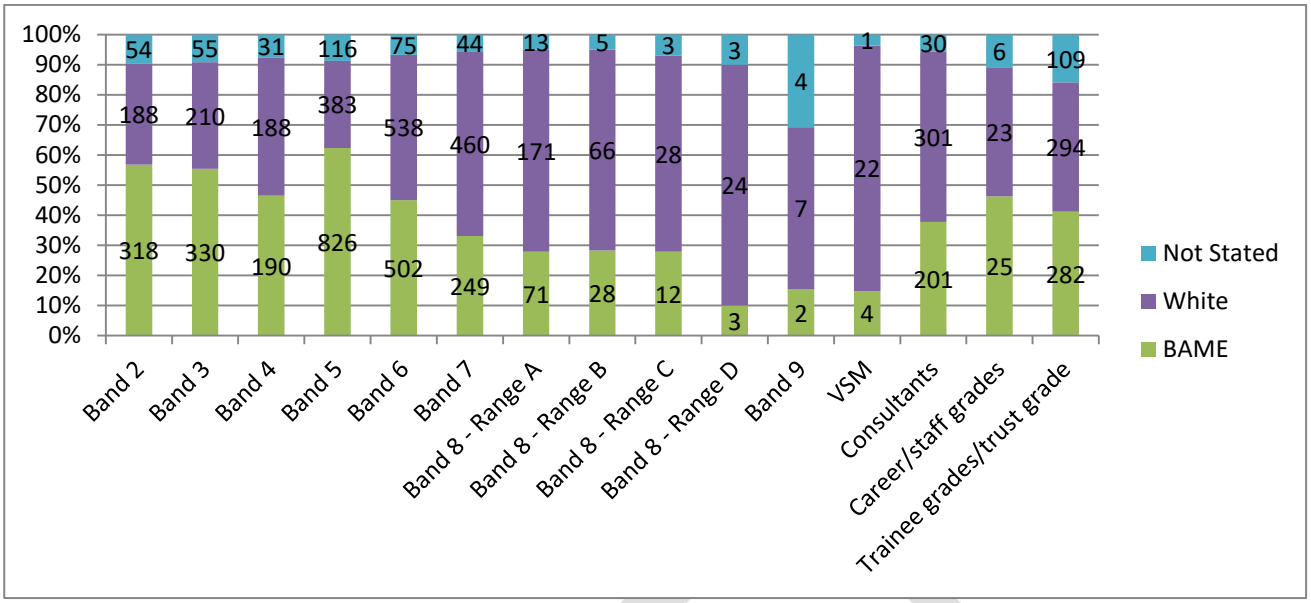
BAME staff remain the majority of staff in Agenda for Change (AfC) bands 2–5, whilst BAME staff now make up the majority of the total workforce there has not been a significant increase in any grade or particular staff group

Non-BAME staff remain the majority of staff from bands 6–VSM (very senior manager).

There have been no significant decreases in non-BAME staff in grades or across staff groups

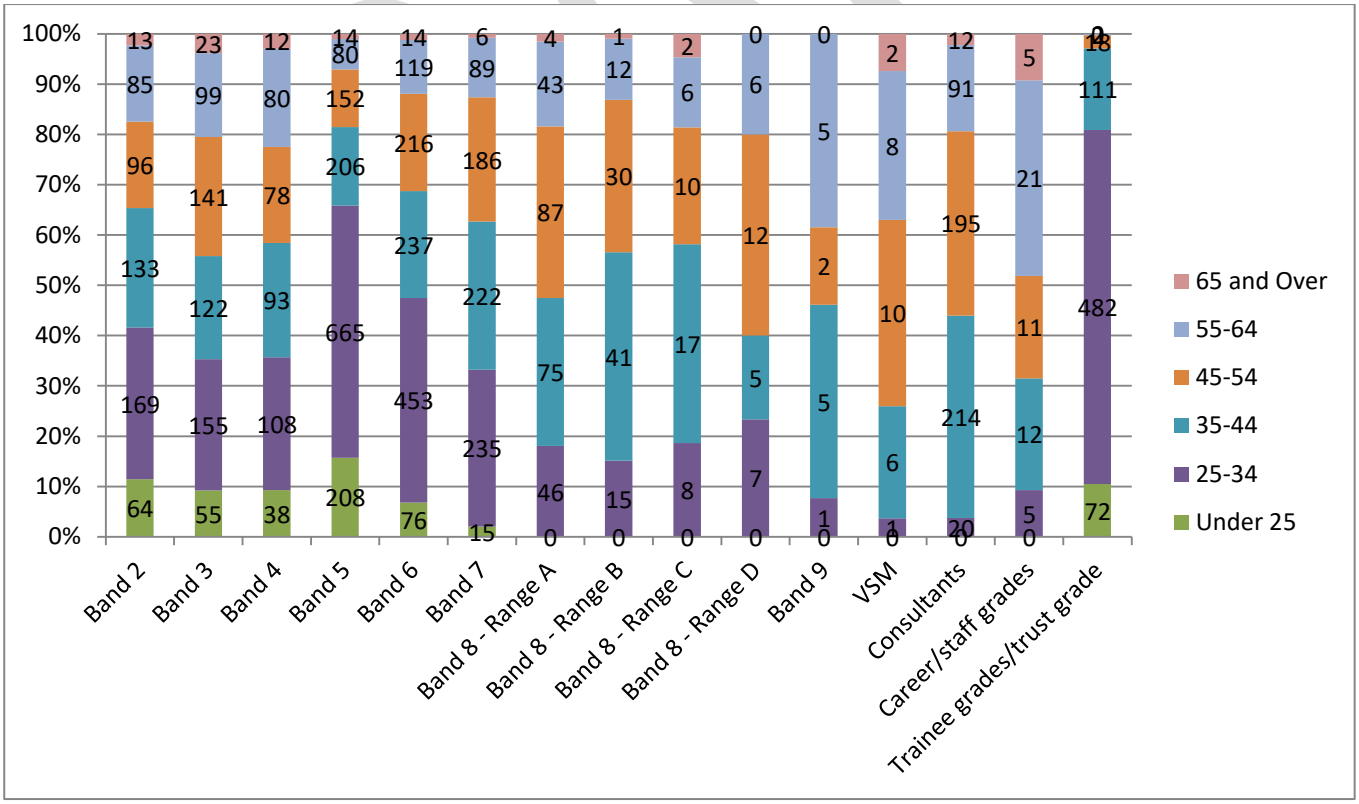
[1] www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest

Pay grade distribution of non-BAME and BAME staff across staff groups



Workforce composition by age

Age profile by pay grade



Age ranges of our workforce

Age range	2020/2021
<25	9%
25–34	36%
35–44	23%
45–54	19%
55–64	11%
65+	2%

The 25–34 age range remains as last year the single largest age group, accounting for 36% of the Trust workforce—a decrease of 2% on the previous year. The 35–44 age range is the second-largest group at 23%.

59% of the Trust workforce is aged between 25 and 44 years old with the 45- 54 age group accounting for 19% with staff aged 55 and over accounting for 13% of workforce.

Workforce composition by Gender

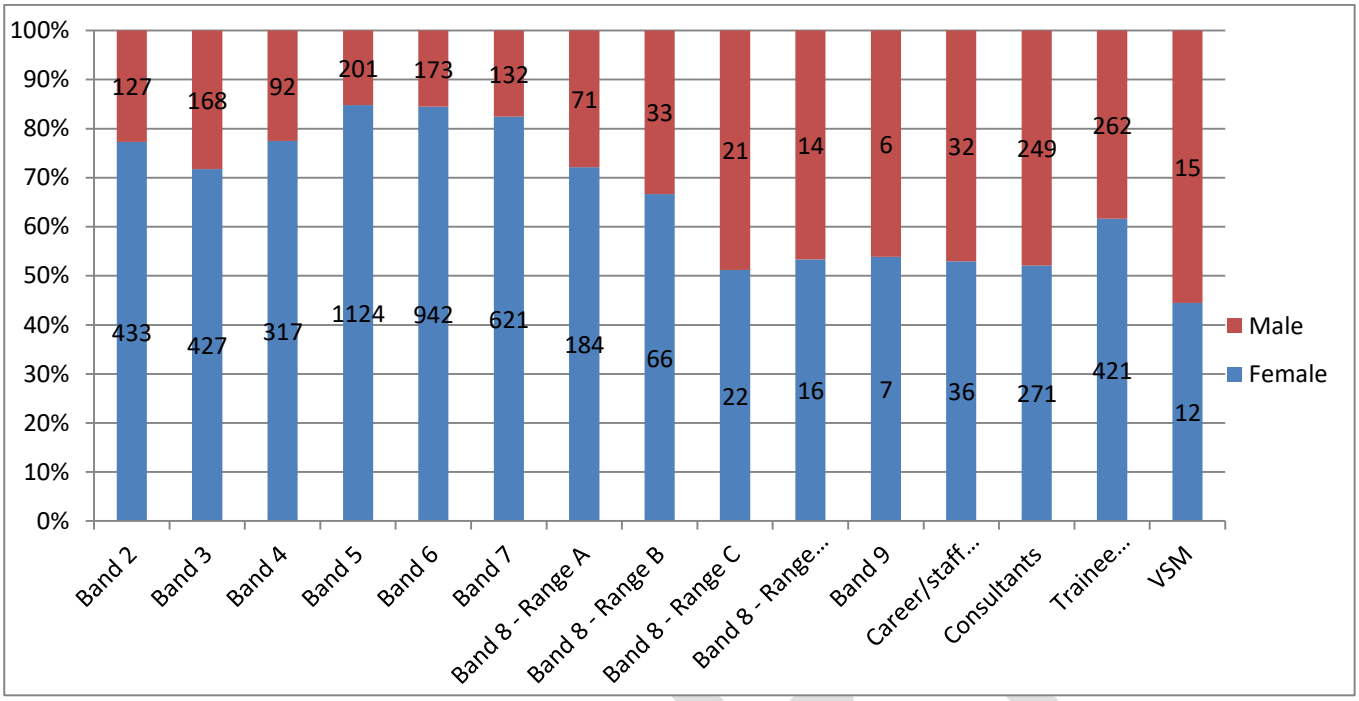
Our workforce consists of 75 % (4,899) female staff and 25% (1,596) male staff this has not changed since last year. In AfC bands 2–8D there are more females than males in each of these grades. NHS Employers indicate there is a binary gender split of 77% females and 23% males so we have an underrepresentation of 2% for female staff. On the Electronic Staff Records (ESR) we are unable to record non-binary gender which is a national NHS issue when reporting on Gender.

At Band 9 the split is just over 50% in favour of females which is a change from last year where the split was 50:50. In the medical grades, including consultant grade, there remain more females than males.

The very senior manager (VSM) grade[2] is the only grade where the gender balance is in favour of males by 55% to 44%. This is a change from 60% to 40% male to female ratio in the previous year.

[2] Across the NHS, 47% of very senior manager roles are held by women—see https://www.nhsemployers.org/articles/gender-nhs-infographic

Gender profile by band



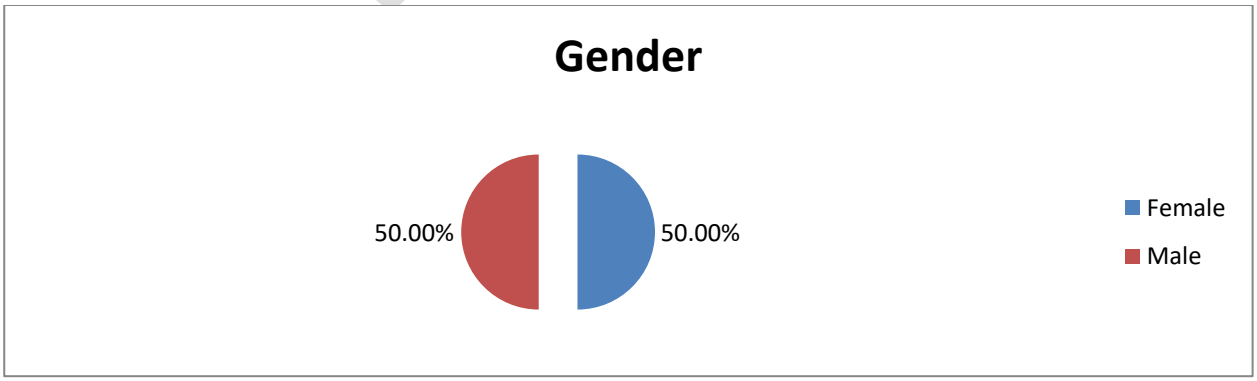
Trust Board of Directors composition by Gender and Ethnicity

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

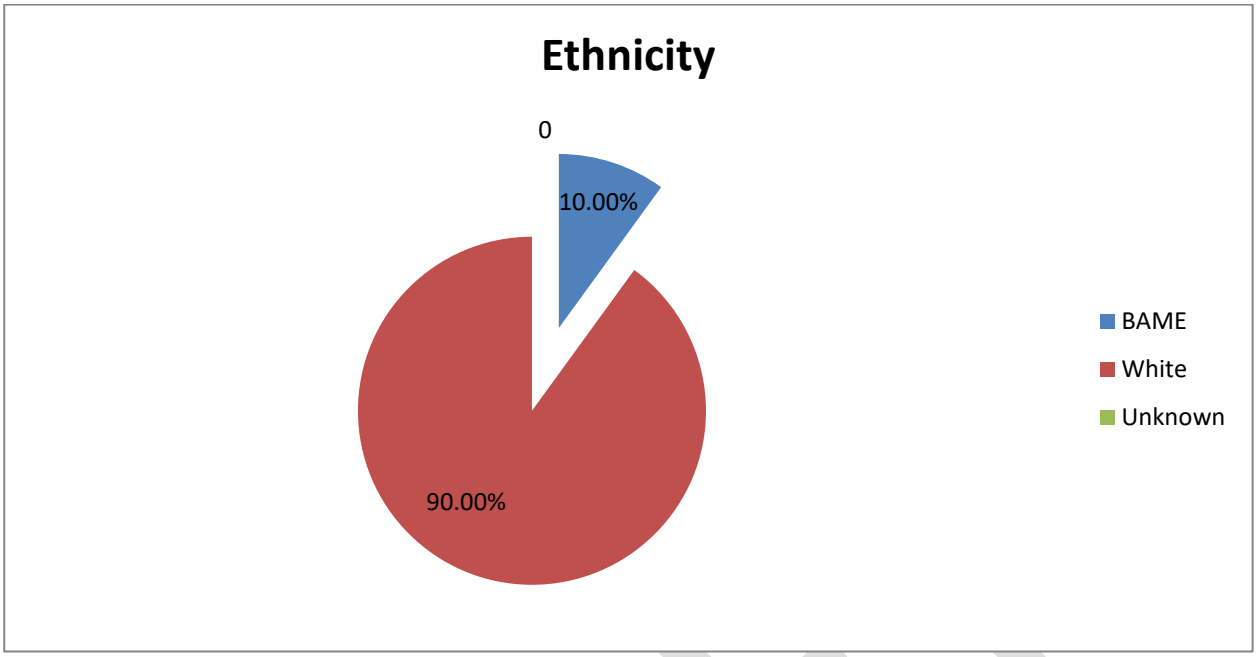
- Deputy Chief Executive and COO
- Medical Director and CCIO
- Chief Financial Officer
- Director of HR and OD
- Chief Nursing Officer
- Chief Information Officer

At 31 Mar 2021, the gender balance at executive director level was 50% female and 50% male compared to the overall workforce profile of 75% female and 25% male, this data has changed from last year as an increase of 7% for Females at board.

Trust Board by Gender



The ethnicity profile of the executive directors including our NEDs is 90% non-BAME with 10% BAME staff at this level within the organisation.



Workforce Composition by Religious Belief

In 2020/21, the majority of staff, who stated a religious belief, identify as Christian (43%), which has remained the same as in 2019/20. There has been a 3% increase in declaration of staff stating Islam as their religious belief 9% in 2020/21 from 6% in 2019/20 (which is a 33% increase in declarations in Islam for electronic staff records). Other religious groups have changed less than 1% since last year.

The percentage of staff recorded as unspecified, meaning no data is recorded on the electronic staff record (ESR) system is 17% a decrease from 18% the previous year.

Religious belief	2019/2020	Number	2020/21
Atheism	10%	675	10%
Buddhism	<1%	64	1%
Christianity	43%	2837	43%
Hinduism	5%	319	5%
Islam	6%	641	9%
Jainism	<1%	427	<1%
Judaism	<1%	13	<1%
Sikhism	2%	27	1%
Did not wish to disclose religion/belief	11%	295	10%
Other	4%	100	4%
Unspecified	18%	1097	17%
Total	**100%**	**6495**	**100%**

Workforce Composition by Sexual Orientation

In 2020/21, the majority of our staff (70%) identify as heterosexual, an increase of 1% from the previous year. 3% of staff declare themselves as gay or lesbian and less than 1% as bisexual.

Declaration rates in other groups have changed by less than 1% from last year. The percentage in the undefined category is 17%, which has reduced from 18% last year.

Sexual Orientation	2019/2020	Number	2020/2021
Bisexual	<1%	72	<1%
Gay or lesbian	3%	180	3%
Heterosexual or straight	69%	4566	70%
Not stated (person asked but declined to provide a response)	10%	601	9%
Other sexual orientation not listed	<1%	4	<1%
Undecided	<1%	3	<1%
Undefined	18%	1094	17%
Total	**6,394**	**6495**	**100%**

Workforce Composition by Disability

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

In 2020/21, 132 staff (2%) have a disability declared on the Trust ESR system. Whilst this is a small increase in the actual number declaring, previously (123) it is not enough to make a change in the declaration percentage.

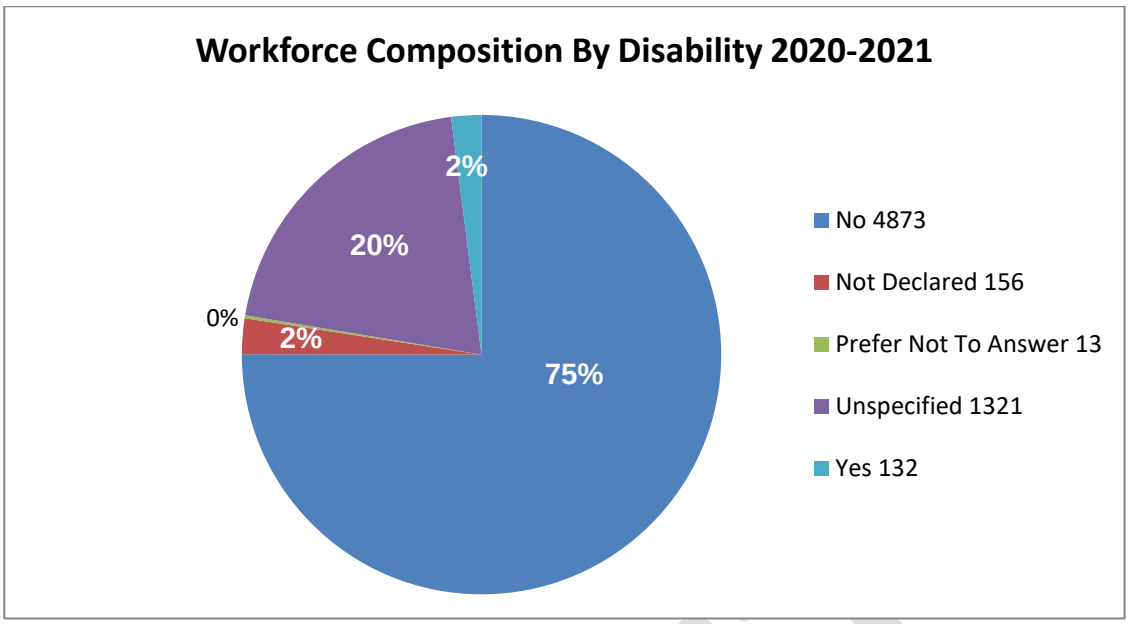
Disability Declaration	2019/2020	2020/2021	Percentage 2020/2021
No	4779	4873	75%
Not Declared	170	156	2%
Prefer Not to Answer	16	13	<1%
Unspecified	1306	1321	20%
Yes	123	132	2%
Total	**6,394**	**6,495**	**100%**

A total of 1,477 staff were in the ‘not declared’ and ‘unspecified’ categories any increase of one on the previous year. 156 staff did not declare if they had a disability and 13 staff preferred not to answer. There has been a 6% reduction in the ‘not declared’ and ‘unspecified’ categories since 2019/20.

The 2020 staff survey shows that 3,500 members of staff responded to the question “*Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?*

Of these respondents 12.3% (403) members of staff stated that they had. This means that 271 members of staff have not declared their disability on ESR

Workforce composition by disability



Workforce Disability Equality Standard (WDES)

Every NHS organisation is required to submit 10 evidenced-based metrics and action plans to NHS England by 31 Aug 2021. The Trust's WDES metrics and action plan can be found at www.chelwest.nhs.uk/equalityinfo.

Disability, sexual orientation and religion data quality

We highlight the importance of completing demographic data by encouraging staff to update their information on our ESR self-service system and by utilising robust data capture processes when new employees join the Trust.

We encourage staff over the course of their employment to declare their disability and ensure that this is recorded on their ESR record.

Protected characteristic	Known status for all staff at 31 Mar 2019	Known status for all staff at 31 Mar 2020	Known status for all staff at 31 Mar 2021
Disability	77%	77%	80%
Sexual orientation	79%	82%	83%
Religion	79%	82%	83%

Staff Networks

The Trust's BAME, Women's, LGBTQ+ and Disability staff networks continue to provide an important way for staff to have a voice, influence ideas and thinking around the organisation and provide opportunities to convey their experiences.
Staff networks also enable staff to feel empowered to help shape workplace culture and the environment in which they work.
In 2021/22, the Trust will continue to develop the staff networks and the roles that they can play in in ensuring the Trust is a fair, inclusive and welcoming environment for all of our staff and those who become our staff in the future

SECTION 6

RECRUITMENT

We are committed to delivering open, transparent and inclusive recruitment processes that do not discriminate against people on the grounds of their protected characteristics. In support of this commitment, we monitor the progress of applicants throughout the selection process.

The Trust uses the NHS Jobs website as its main source for advertising internal and external vacancies and undertakes periodic overseas recruitment, primarily for nursing staff. Our recruitment management system is TRAC which is a system used by the majority of NHS organisations. As a result of the COVID19 pandemic the Trust practices of interviewing shortlisted applicants moved online, however the principles of transparency and openness remained at the forefront.

Recruitment for Leadership Diversity

Diversity and Inclusion Champions

Launched in January 2020 originally as part of the Improving Race Equality through Promoting Fairness Action Plan— Year 1 2019/20 Objective 4: *"Ensure fairness of recruitment processes and progression opportunities for under-represented staff"*

In conjunction with the BAME staff network the key action was to identify and train interview experts from BAME backgrounds to participate in interview panels at Agenda for Change (AfC) band 8a and above. This was expanded as part of the Improving Equality and Diversity Action Plan to include staff from diverse backgrounds and not just BAME.

The intended outcomes were more diverse interview panels for appointments at AfC Band 8a and above which in turn would be to improved scores in:

- Staff Survey question 14 *"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?"*

- *WRES Indicator 2*

During the first and second waves of the pandemic although recruitment activity did not stop it impacted on the ability to provide the face to face training to recruit additional Diversity and Inclusion champions. In 2021/22 the training will be reviewed and revived to increase the number of champions to support this initiative and we plan to extend the champions programme to recruitment for AfC Bands 6–7 and medical appointments during years 2–3 of our Improving Equality, Diversity and Inclusion Action Plan.

5 Year projection of numbers of BAME staff in post

	2019	2020	2021	2022	2023
Band 8a	74	78	82	86	90
Band 8b	25	27	29	31	33
Band 8c	10	11	12	13	14
Band 8d	6	6	7	7	8
Band 9	2	2	3	3	3
VSM	5	6	7	8	9

BAME staff in post 2020

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

BAME staff in post 2021

	2021 ambition	2021 actual	Gap
Band 8a	82	71	-11
Band 8b	29	28	-1
Band 8c	12	12	0
Band 8d	7	3	-4
Band 9	3	2	-1
VSM	7	4	-3

Recruitment by Ethnicity

63% of all non-medical job applications in 2020/21 were by candidates from a BAME background, the previous year this percentage was 67%. For medical posts (excluding junior doctors in training), 85% of all applicants were from a BAME background, which remains consistent with the previous year.

At the application stage, 4.3% of non-medical applicants choose not to disclose their ethnicity, an increase from 3.5% in 2019/2020. For medical applicants, 2.8% chose not to disclose their ethnicity which remained consistent with the previous year.

At the shortlisting stage, 53% of BAME candidates were shortlisted for non-medical posts, compared to 57% in 2019/20. For medical posts, 59% of BAME candidates were shortlisted, compared to 60% the previous year.

At the appointment stage, 37% of BAME applicants were appointed for non-medical posts, a decrease from 40% from the previous year. For medical posts, 44% of BAME applicants were appointed, a decrease from 45% the previous year.

Recruitment analysis by ethnicity (non-medical and medical posts combined)

Ethnic group	% of		
	Applicants	Shortlisted	Appointed
BAME	69%	53%	38%
Non-BAME	27%	40%	44%
Not stated	4%	7%	18%
Total n°	**28,604**	**4,999**	**1,117**

Relative likelihood of being appointed from shortlisting by ethnicity

Descriptor	Non-BAME	BAME
Number of shortlisted applicants	1968	2673
Number appointed from shortlisting	489	428
Relative likelihood of non-BAME candidates being appointed over BAME staff at shortlisting stage	1.5	

The likelihood of non-BAME candidates being appointed from shortlisting in 2020/21 is 1.5 times greater than BAME staff. This likelihood was 1.4 times in 2019/20.

Recruitment by Gender

Recruitment analysis by gender shows that 58% of applications were from female applicants and 40% from male applicants. 2% of applicants chose not to disclose their gender.

Recruitment analysis by gender

Group	% of		
	Applicants	Shortlisted	Appointed
Female	58%	68%	73%
Male	40%	31%	26%
Do not wish to disclose	2%	1%	1%
Total number	**28,604**	**4,999**	**1,117**

Recruitment by age, disability, sexual orientation and religion

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

- The 25–34 age group makes up the largest percentage of applicants and appointees
- 3% of appointees declared a disability, which reflects the percentage of applicants
- 89% of applicants identified as heterosexual
- 41% of applicants identified as Christian

Recruitment analysis by age

Group	% of		
	Applicants	Shortlisted	Appointed
<25	14%	14%	15%
25-34	53%	46%	51%
35-44	20%	23%	21%
45-54	9%	12%	10%
55-64	2%	3%	2%
65+	1%	2%	<1%
Not stated	<1%	0%	0%
Total number	**28,604**	**4,999**	**1,117**

Recruitment analysis by Disability

Group	% of		
	Applicants	Shortlisted	Appointed
No	94%	89%	80%
Not stated	3%	5%	17%
Yes	3%	5%	3%
Total number	**28,604**	**4,999**	**1,117**

Recruitment analysis by sexual orientation

Group	% of		
	Applicants	Shortlisted	Appointed
Bisexual	1%	2%	1%
**Persons of the same sex (gay)	0%	0%	0%
Heterosexual	89%	86%	85%
**Persons of the same sex (Lesbian)	0%	0%	0%
*Other sexual orientation not listed	<1%	<1%	<1%
***Gay or lesbian	4%	6%	6%
*Undecided	<1%	<1%	<1%
I do not wish to describe my sexual orientation	5%	5%	5%
Total number	**28,604**	**4,999**	**1,117**

In 2020/2021 the TRAC recruitment system expanded the number of responses available under sexual orientation.

*Two new categories were added: Other sexual orientation not listed and Undecided
**Persons of the same sex (Lesbian) and Persons of the same sex (gay) were added as additional options
*** Gay or lesbian which had previously been individual options were put together

Recruitment analysis by religion

Group	% of		
	Applicants	Shortlisted	Appointed
Atheism	8%	13%	15%
Buddhism	1%	1%	1%
Christianity	41%	42%	37%
Hinduism	7%	6%	4%
Not disclosed	10%	14%	25%
Islam	25%	14%	10%
Jainism	<1%	<1%	<1%
Judaism	<1%	<1%	<1%
Sikhism	2%	2%	1%
Other	5%	7%	6%
Total number	**28,604**	**4,999**	**1,117**

SECTION 7

NON-MANDATORY TRAINING

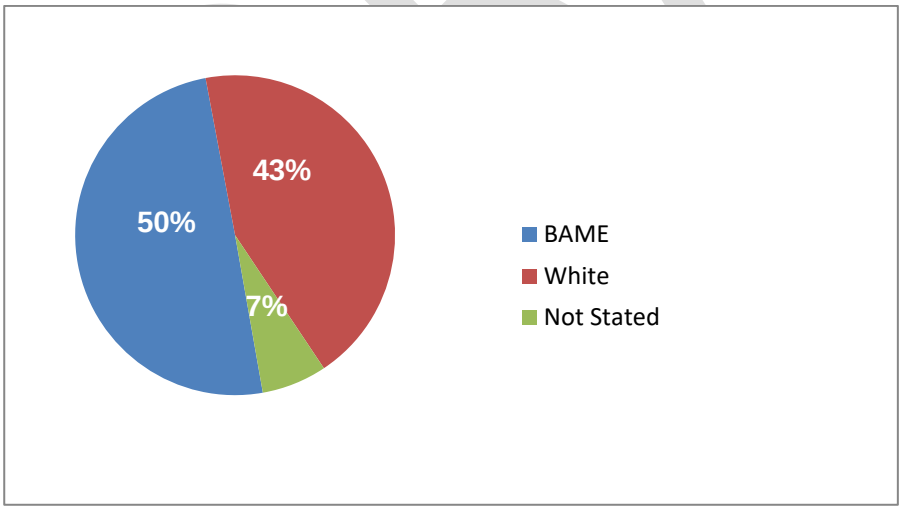
The Trust offers development through a variety of methods—including eLearning, internal courses and access to external courses—across a wide spectrum of topics from clinical specialist courses to personal and management development. We have also increased our use of the apprenticeship levy and offer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

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

The data is based on substantive staff and leavers only throughout the 2020/21 financial year recorded within ESR or the CPPD database. An additional 109 non-substantive staff attended non mandatory training during this period but are not included in the above statistics. (e.g. bank, honorary or secondee staff).

It is important to note during the COVID19 pandemic Health Education England stopped funding as universities and colleges were all closed. All national courses also stopped so we really didn't do much "extra" learning during 2020-2021. The Trust also cancelled all training and provided only COVID skills training,

Staff attending non-mandatory training by ethnicity

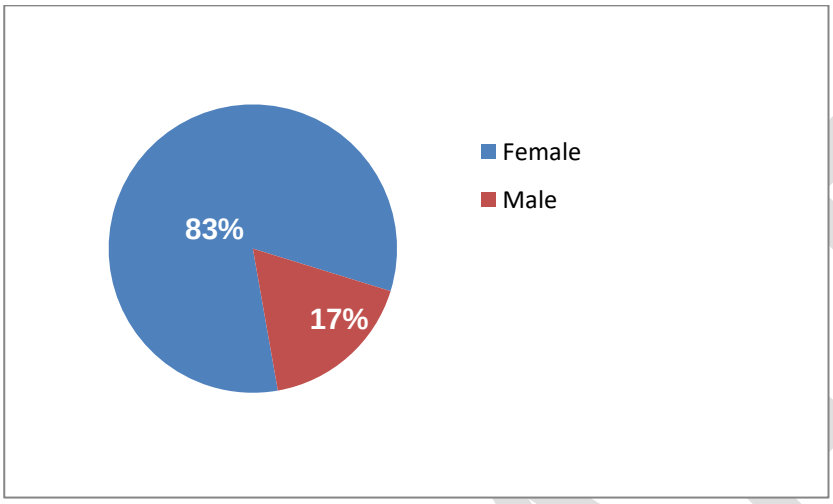


Analysis of non-mandatory training shows that the relative likelihood of non-BAME staff accessing non-mandatory training compared to BAME staff is 0.9. The ratio was 1.1 in the previous year. This reflects that during the reporting period, proportionally more BAME staff have accessed non-mandatory training than non-BAME staff compared to the previous year.

Relative likelihood of accessing non-mandatory training by ethnicity

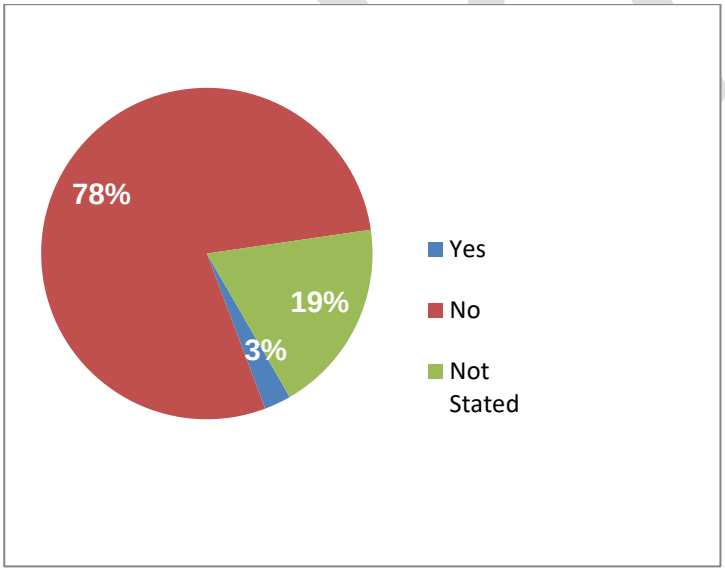
Descriptor	Non-BAME	BAME
Number of staff in organisation	2,903	3,043
Number of staff who have accessed non-mandatory training	1071	1224
Relative likelihood of non-BAME staff accessing non-mandatory training over BAME staff	0.92	

Staff attending non-mandatory training by gender



Female staff accounted for 83% of staff attending non-mandatory training, with males at 17%—the gender composition of the workforce is 75% and 25% male.

Staff attending non-mandatory training by disability



Disabled staff account for 3% of the overall number of staff accessing non-mandatory training courses, which is slightly above the percentage of staff recorded on ESR as having declared a disability.

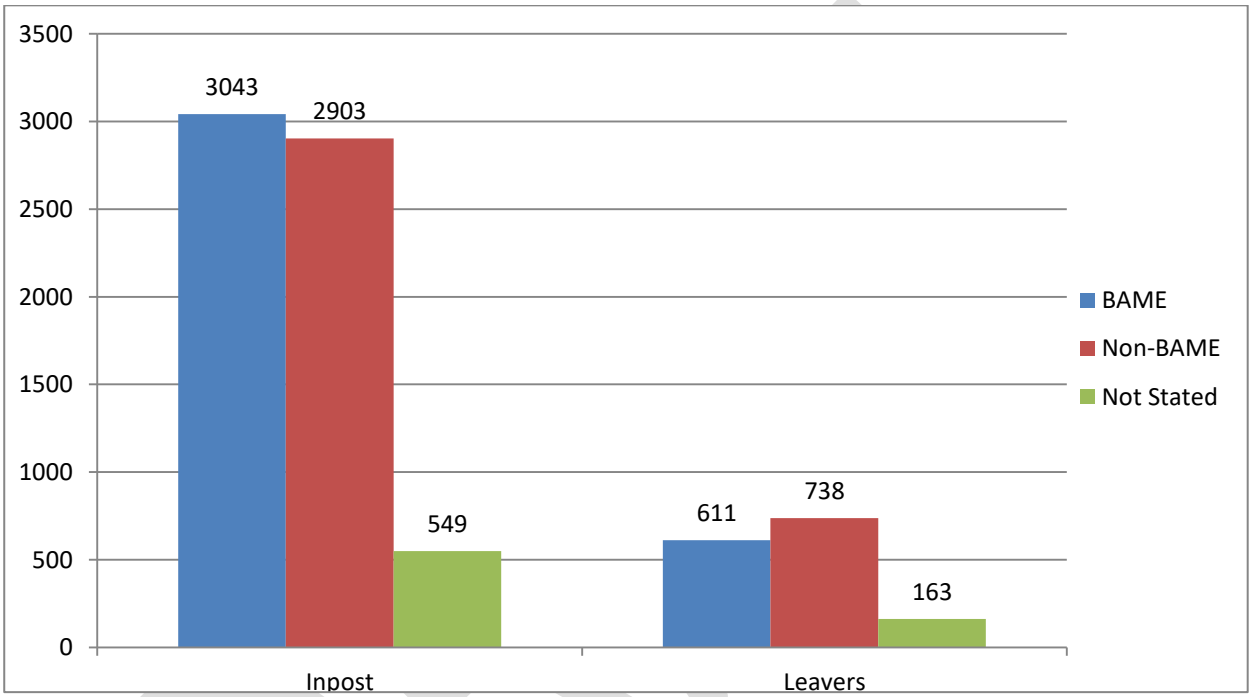
SECTION 8

INPOST AND LEAVERS

Inpost and leavers by ethnicity

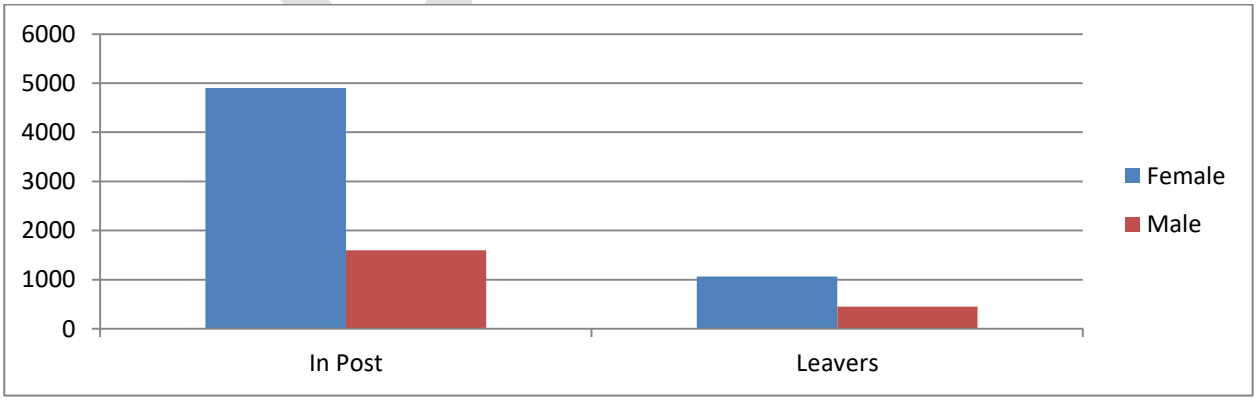
During 2020/21, 738 of the 1,512 staff who left the Trust during the year were non-BAME and 611 were BAME.

Analysis of inpost and leavers by ethnicity



Leavers by gender

1063 of staff who left the Trust were female and 449 were male.

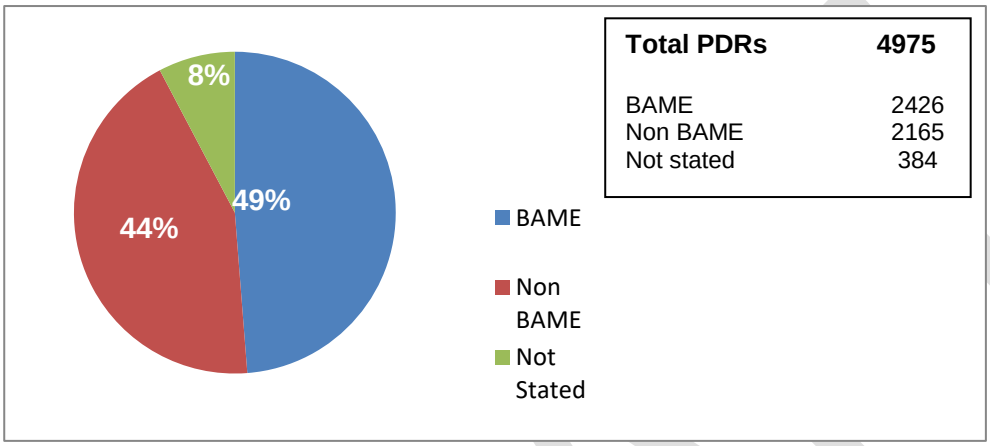


SECTION 9

PERFORMANCE DEVELOPMENT REVIEWS—NON-MEDICAL STAFF

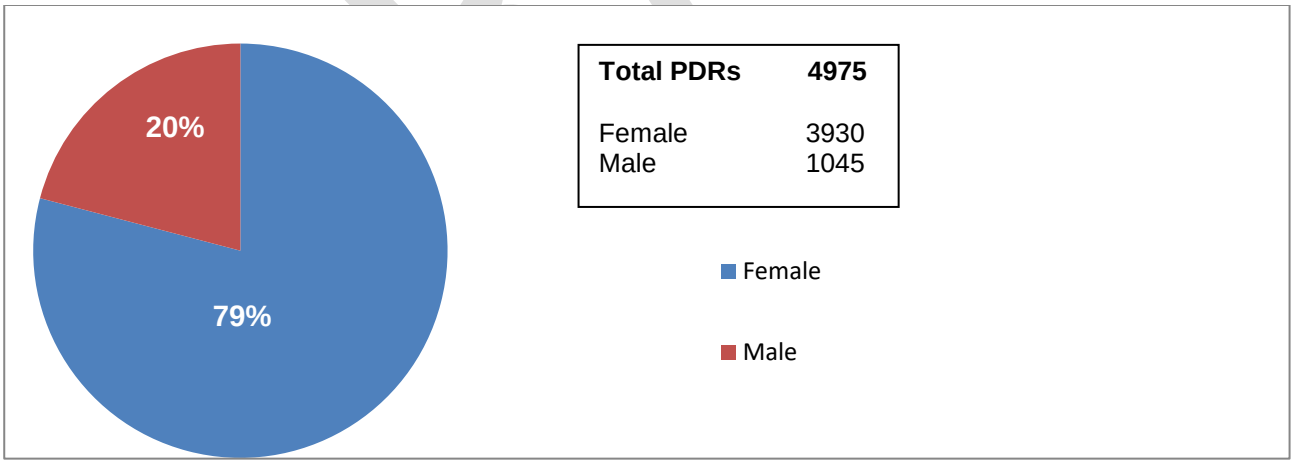
During 2020/21, 4975 performance development reviews (pdrs) were completed. this number excludes medical staff and those on maternity leave or career breaks.

PDRs by Ethnicity



Total PDRs	4975
BAME	2426
Non BAME	2165
Not stated	384

PDRs by Gender



Total PDRs	4975
Female	3930
Male	1045

SECTION 10

APPLICATION OF FORMAL EMPLOYEE RELATIONS PROCEDURES

The COVID19 pandemic through the majority of 2020 and into 2021 and the redeployment of staff across the organisation impacted on the normal operations of the employee relations activities, however during 2020/21 there were 234 formal employee relations cases compared to 327 cases in 2019/20

Employee relations cases are recorded in the following categories:

- Disciplinary
- MHPS (Maintaining High Professional Standards)
- Sickness absence
- Probation
- Performance (capability)
- Grievance including bullying and harassment

Employee Relations Cases

Case Type	2018/19	2019/20	2020/21
Disciplinary	79	48	19
*MHPS	n/a	n/a	15
Sickness absence	265	215	153
Probation	55	39	19
Performance (capability)	20	8	5
Grievance including bullying and harassment	32	17	23
Total	**451**	**327**	**234**

*MHPS cases are those that relate exclusively to all grades of medical staff. MHPS cases are an initial investigative process into either personal or professional conduct and/or performance that once concluded may then lead into a more formal process employee relations case. However these types of cases often result in agreed remedial actions short of a formal employment relations process being instigated.

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

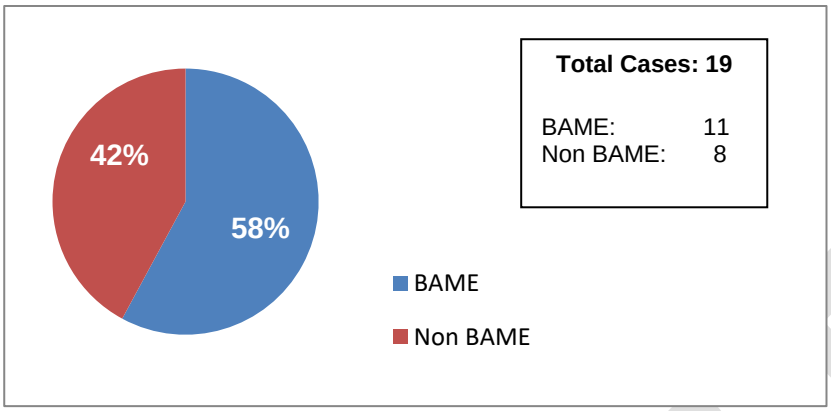
Disciplinary Cases

There were 19 disciplinary cases during 2020/21 compared to 48 cases in 2019/20. BAME staff accounted for 11 of these (58%) while representing 46% of the total workforce. Non BAME staff accounted for 8 cases (42%) while representing 44% of the workforce.

In 2020/21 the overall number of cases has decreased, but the percentage of BAME staff involved in disciplinary proceedings remains disproportionate to the makeup of the workforce.

On initial introduction the percentage of BAME staff involved in disciplinary cases fell from 64% in 2018/2019 to 60% in 2019/20 but still remains higher than the percentage of BAME staff in the workforce.

Disciplinary cases by ethnicity



The relative likelihood of BAME staff entering the formal disciplinary procedure is 1.6x greater than for non-BAME staff. This is an improvement from 2.4x greater in 2019/20.

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

Likelihood of entering the formal disciplinary hearing by ethnicity

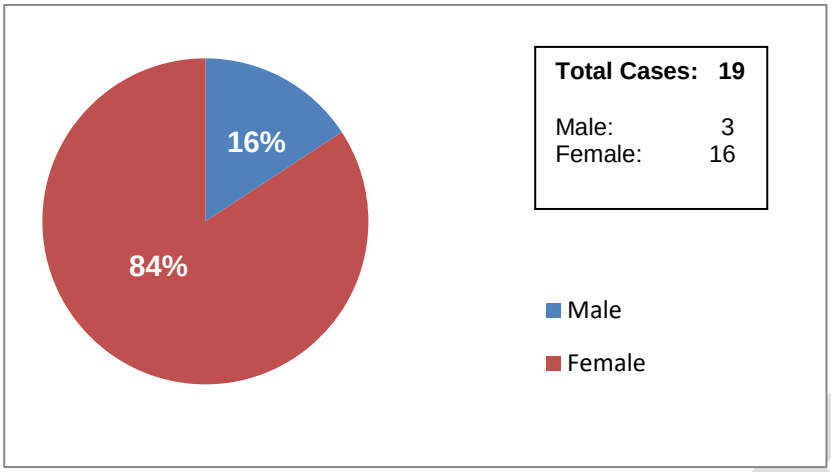
NHS England and NHS Improvement in *"A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce*" published in July 2019 set out an expected rate of improvement in closing the gap in the likelihood of entry into the disciplinary process between BAME staff and Non BAME staff across Trusts, CCGs and national arm's length bodies

2020	2021	2022
51% of NHS organisations within the non-adverse range of 0.8 and 1.25*	76% of NHS organisations within the non-adverse range of 0.8 and 1.25*	90% of NHS organisations within the non-adverse range of 0.8 and 1.25*

*0.8 and 1.25 refers to the relative likelihood of BME staff entering the formal disciplinary process compared to white staff as measured by WRES indicator 3

Descriptor	Non-BAME	BAME
Number of staff in organisation	2903	3043
Number of staff who have entered into disciplinary proceedings	8	11
Relative likelihood of BAME staff entering into disciplinary proceedings compared to non-BAME staff	1.6	

Disciplinary cases by gender

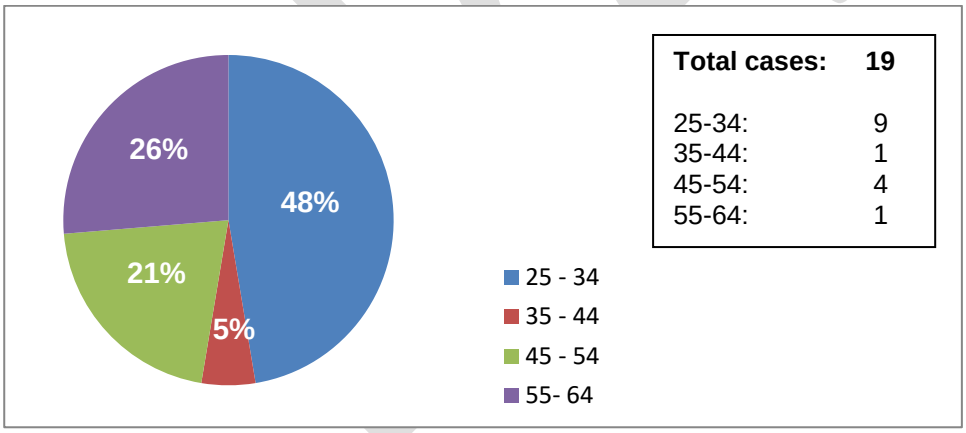


Analysis of disciplinary cases by gender shows that females account for 84% of cases, an increase of 26% from 58% the previous year. Cases involving male staff have decreased by 26% to 16% from 42% the previous year.

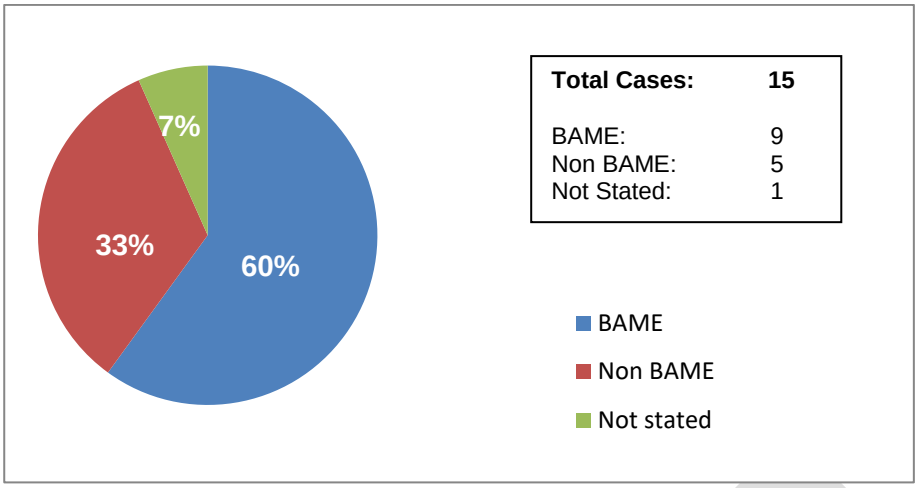
This shows that females are disproportionately impacted as they make up 75% of the workforce.

Disciplinary cases by age ranges show that the 25–34 age group is the single largest age group at 48% of cases an increase of 23% from the previous year. This age group represents 38% of the workforce.

Disciplinary cases by age



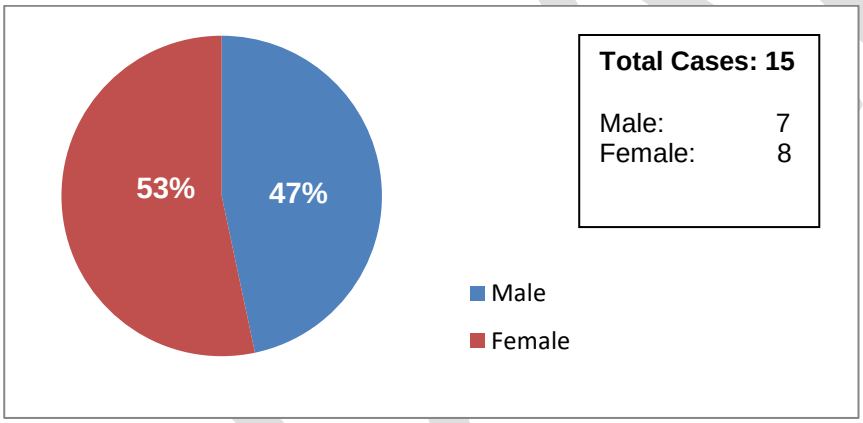
MHPS cases by ethnicity



Staff from BAME backgrounds makes up 39% of the medical workforce which includes consultants, trainee doctors on rotations and career grade doctors yet they account for 60% of MHPS cases.

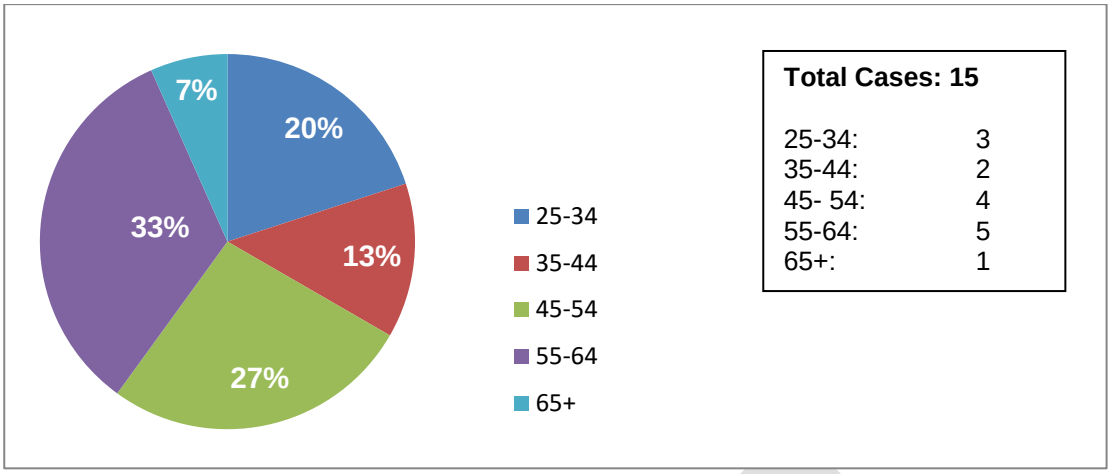
This indicates that BAME medical staff are disproportionately affected in this particular area.

MHPS cases by gender



Within the medical workforce females make up 53% with males at 47%. The percentage split of MHPS cases by gender is broadly similar to that of the workforce population.

MHPS Cases by age

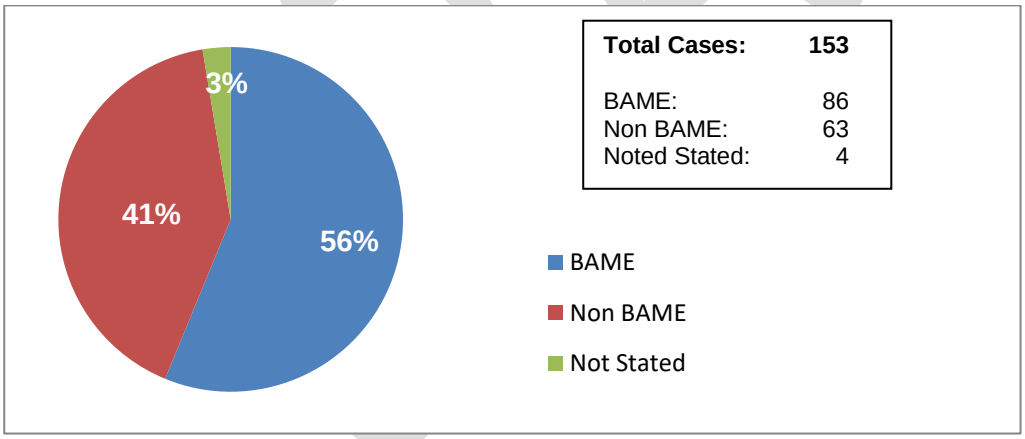


The 55-64 age range account for single largest or the majority of cases at 33%. Together with the 45 – 54 age range at 27% these account for 60% of cases.

Sickness Absence Cases

There were *153 sickness absence cases in 2020/21, compared to 215 in 2019/20 a decrease of 62 which equates to a 28% reduction.

Sickness Cases by ethnicity

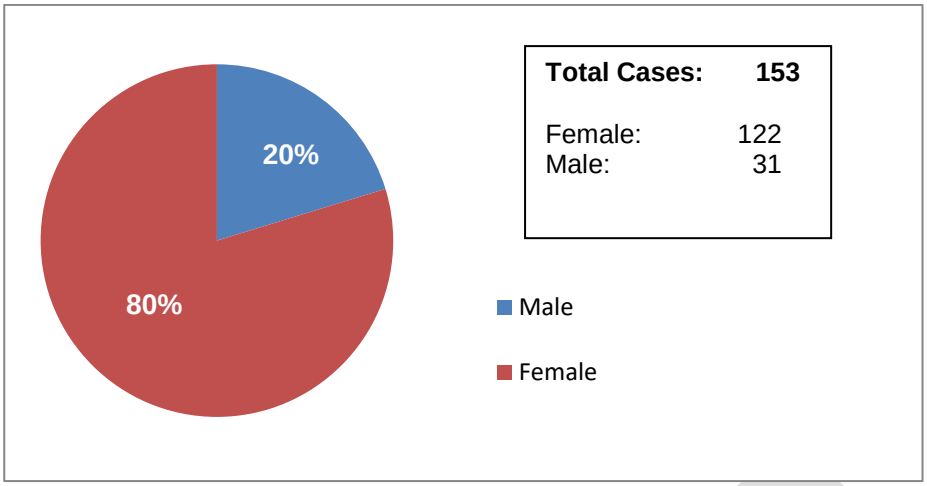


*staff who were absent from work as a result of contracting COVID19 or isolating in line with guidelines are not recorded as being absent for reasons of sickness in these figures.

BAME staff accounted for 56% of cases an increase of 7% from 2019/20 when the figure was 49%. Non BAME staff accounted for 41% of cases which is a 1% reduction from the previous year.

The number of Not Stated reduced by 6% from 9% last year to 3% in 2020/21.

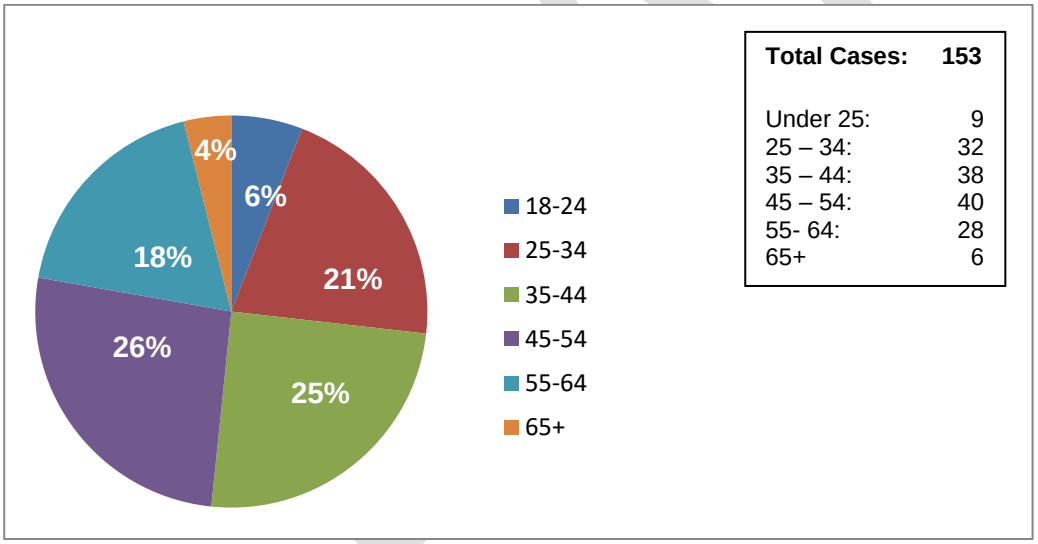
Sickness cases by gender



In 2020/21, sickness absence cases by gender shows that females accounted for 80% of cases, a reduction of 4% from the previous year. The percentage for males has increased by 4% to 20% in 2020/21.

Whilst the percentage rate for females has fallen it is disproportionate to the workforce split of 75% and 25% male.

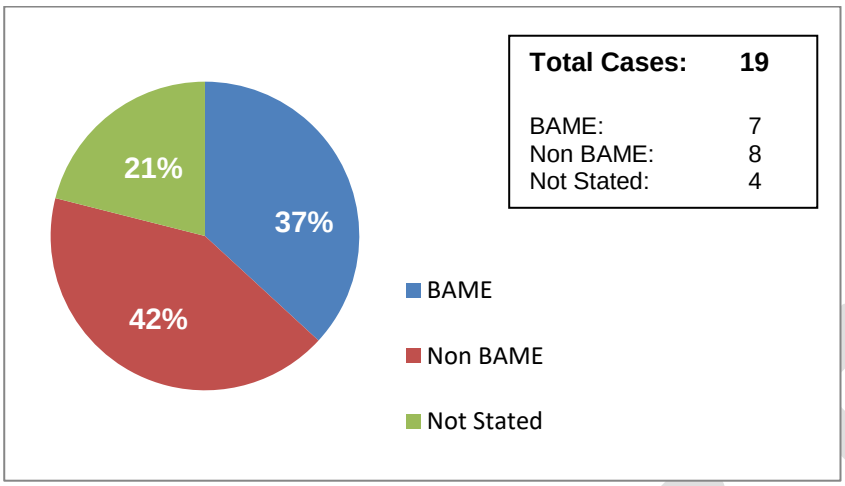
Sickness cases by age



Sickness absence cases by age shows that the 45–54 age group remain the single largest group of cases at 26% up 1% from 2019/20. All categories except the 35-44 age range have reduced from the previous year. The 35-44 age range increased has increased by 2% this year to 25%.

Probationary cases

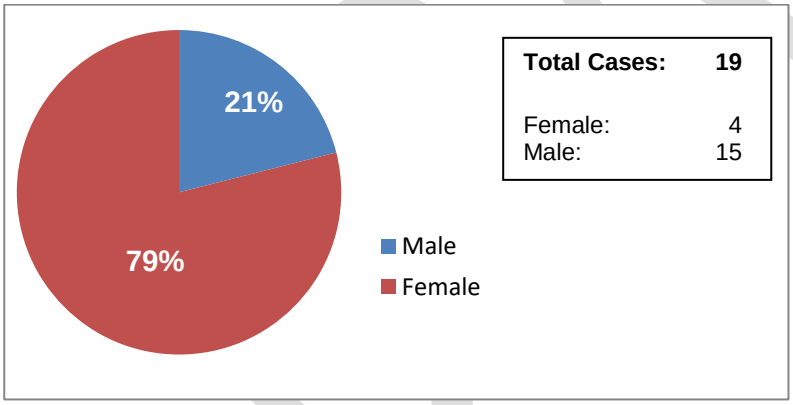
Probationary cases by ethnicity



There were 19 probationary cases in 2020/21 down from a total of 39 in 2019/20. This year is the first year that Non BAME staff accounted for more cases at 42% whereas BAME staff are at 37%.

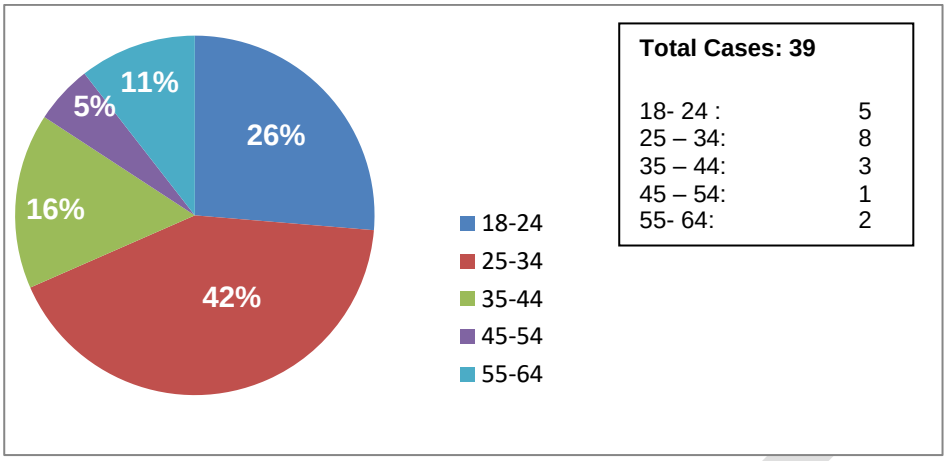
The percentage of Not Stated has not changed from the previous year.

Probationary cases by gender



Female staff accounted for 79% of probation cases, an increase from 72% in 2019/20 The percentage for males has decreased to 21% from 28% the previous year.

Probationary cases by age



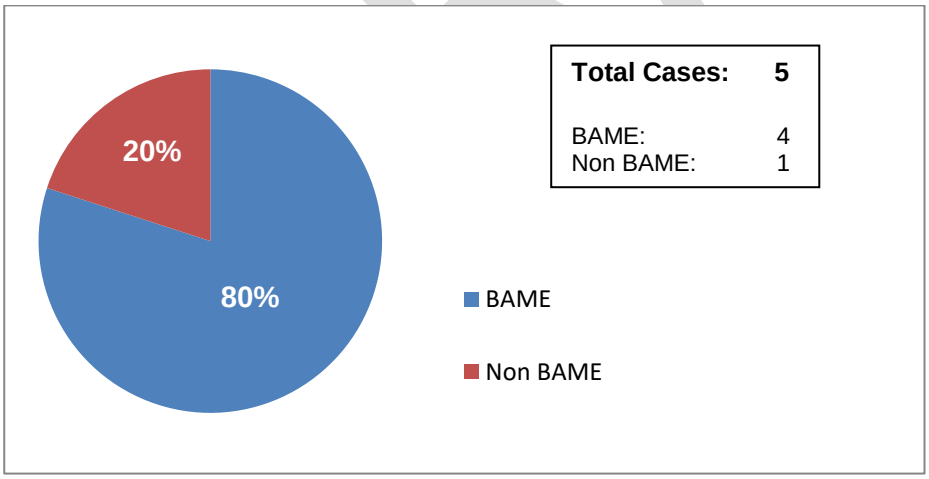
Probation cases by age show that the 25–34 age range remain the majority of cases at 42% of cases, which is a reduction of 2% from last year. The 45-54 age range has seen a reduction of 8% from 13% to 5% this year.

The 35 -44 range has seen the largest increase in any age range of 6% to 16% from 2019/20. The other age ranges have seen increases of between 1% and 3%.

Performance (capability) cases

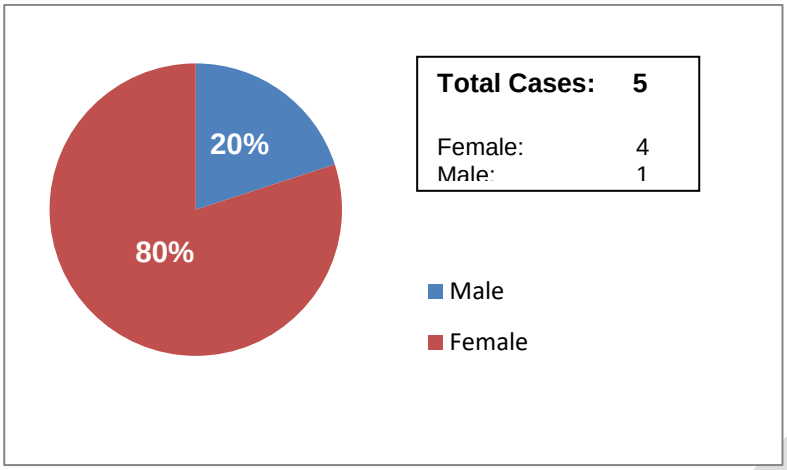
There were 5 performance cases in 2020/21 down from 8 the previous year and 2019/20.

Performance cases by ethnicity



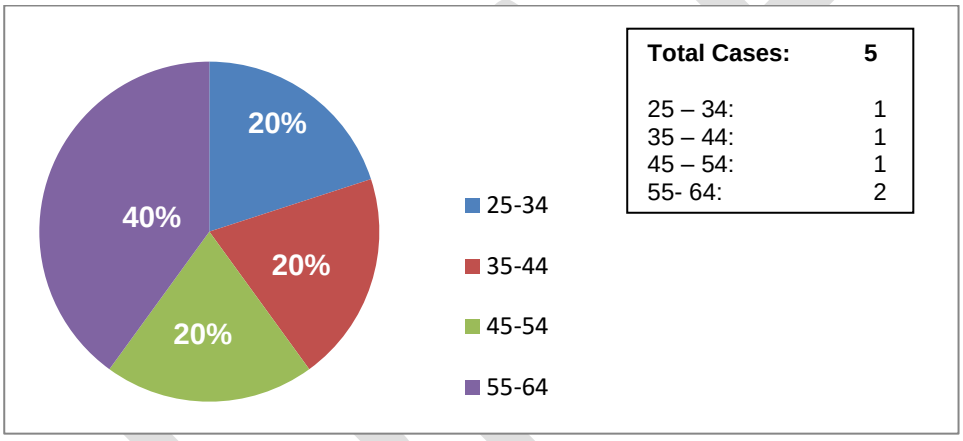
BAME staff accounted for 80% of cases compared to 75% of cases in 2019/20 despite the fewer number of cases overall. A review of these cases will be undertaken as part of the actions in the Improving Equality, Diversity and Inclusion Action Plan.

Performance cases by gender



Performance cases by gender shows that of the 5 cases, 4 (80%) involved female staff, a decrease of 8% from 2019/20 and remains higher than the overall percentage of females in workforce population.

Performance cases by age



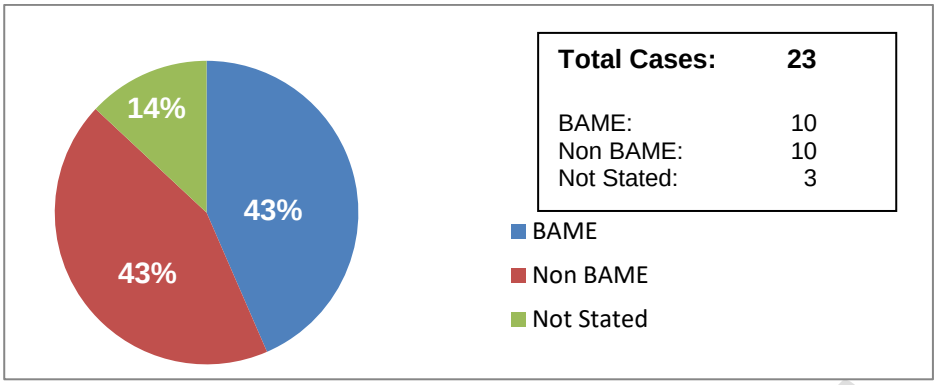
Performance cases by age show that the 55–64 age range account for 40% of cases an increase of 15% on last year as a percentage. In 2019/20 the 45-54 made up 50% of cases.

Grievance cases (including bullying and harassment)

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

There were 23 cases in 2020/21 an increase from the 17 in 2019/20. This is the only area in employment relations cases which saw an increase in numbers on 2019/20.

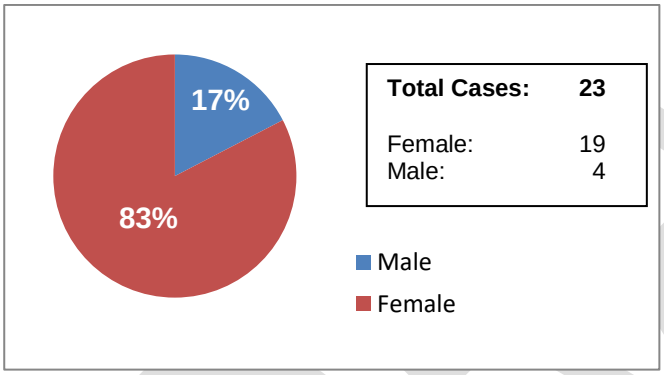
Grievance cases by ethnicity



Of the 23 grievance cases 10 (43%) involved BAME staff, a decrease from 70% of cases in 2019/20.

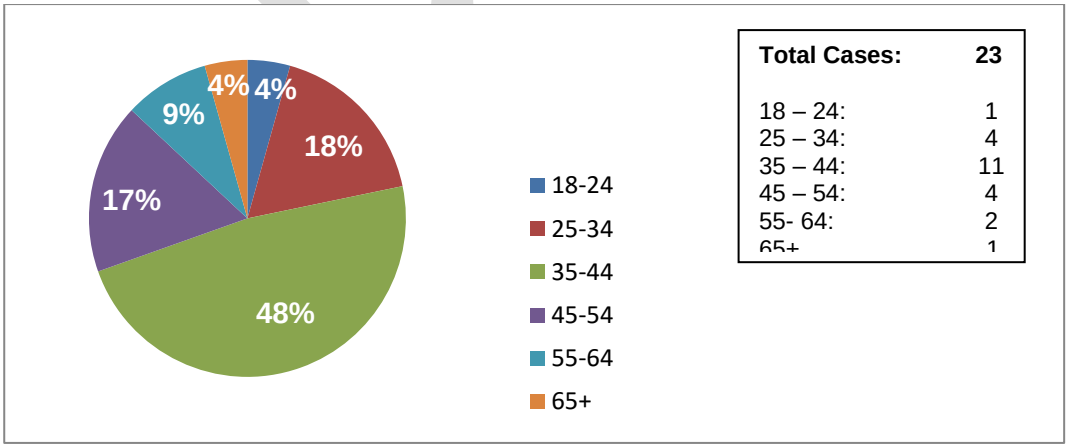
Non-BAME staff also accounted for 10 cases (43%) an increase of 25% from the previous year. The percentage of Not Stated increased by 2% to 14% from 12% the previous year.

Grievance cases by gender



Female staff accounted for 83% of grievance cases an increase of 7% increase from 2019/20. Cases involving male staff decreased to 17% from 24% from the previous year.

Grievance cases by age range



Grievance cases by age range shows that the 35-44 age range were the largest single age range to be involved in the cases at 48%.

SECTION 11

LOCAL CLINICAL EXCELLENCE AWARDS FOR CONSULTANTS

The 2020/21 local clinical excellence round was cancelled and in its place the Trust was asked to pay a one-off payment to all consultants who meet the eligibility criteria 398 consultants met the criteria to receive the payment.

One off payment by ethnicity

Ethnic origin	%
Non-BAME consultants	262 (56%)
BAME consultants	182 (39%)
Unknown	25 (5%)
Total	**469**

One off payment by gender

Gender	%
Female	254 (54%)
Male	215 (46%)
Total	**469**

SECTION 12

STAFF EXPERIENCE—2020
NHS STAFF SURVEY

The 2020 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender. The below tables compare the results for 2019 beside the results for 2020. The full results of the 2020 staff survey can be found at www.nhsstaffsurveyresults.com.

2019 staff survey by gender compared to 2020

Theme	Female 2019	Female 2020	Male 2019	Male 2020
Staff engagement	7.3	7.2	7.4	7.3
Bullying and harassment	7.5	7.5	7.7	7.9
Equality diversity and inclusion	8.5	8.5	8.8	8.6
Morale	6.1	6.1	6.0	6.1
Health and wellbeing	5.7	5.8	6.0	6.4
Immediate managers	7.0	6.9	6.9	7.0
Team Working	6.9	6.6	7.0	6.8
Safety culture	7.0	7.0	7.0	7.0

Disabled staff remain the least likely group to report positive experiences across a range of indicators. Our disabled staff are significantly less engaged than our non-disabled staff and score less positively on the majority of factors.

Staff in the age groups of 21–30 remain the least engaged and still score the lowest in relation to health and wellbeing, whereas staff over 65 score the highest. BAME engagement score and has fallen since 2019 and is now the same as Non BAME staff at 7.2 in 2020.

2019 staff survey by disability compared to 2020

Theme	Disabled 2019	Disabled 2020	Non-disabled 2019	Non-disabled 2020
Staff engagement	6.9	6.8	7.4	7.2
Bullying and harassment	6.7	6.7	7.6	7.6
Equality diversity and inclusion	8.2	8.0	8.6	8.5
Morale	5.7	5.6	6.1	6.1
Health and wellbeing	4.6	4.7	5.9	6.0
Immediate managers	6.9	6.7	6.9	6.9
Team Working	6.6	6.1	6.9	6.6
Safety culture	6.6	6.6	7.0	7.0

2019 staff survey themes by age compared to 2020

Theme	21-30 2019	21–30 2020	31–40 2019	31– 40 2020	41– 50 2019	41–50 2020	51–65 2019	51–65 2020	66+ 2019	66+ 2020
Staff engagement	7.1	6.9	7.3	7.1	7.4	7.4	7.4	7.2	7.9	8.0
Bullying and harassment	7.3	7.4	7.6	7.5	7.6	7.5	7.6	7.6	8.6	8.8

Equality diversity and inclusion	8.6	8.5	8.5	8.4	8.5	8.3	8.6	8.5	9.4	9.8
Morale	5.8	5.7	6.0	6.0	6.0	6.2	6.2	6.2	7.1	7.5
Health and wellbeing	5.4	5.4	5.8	5.9	5.8	6.0	5.8	6.0	7.3	7.6
Immediate managers	7.1	6.9	7.1	6.9	6.9	6.9	6.7	6.7	7.1	7.6
Quality of appraisals	6.8	6.5	7.0	6.6	7.0	6.7	6.8	6.4	7.0	7.4
Safety culture	6.9	6.9	6.9	6.9	7.0	7.1	7.0	6.9	7.3	7.4

2019 staff survey themes by ethnicity compared to 2020

Theme	Non-BAME 2019	Non-BAME 2020	BAME 2019	BAME 2020
Staff engagement	7.2	7.2	7.5	7.2
Bullying and harassment	7.5	7.6	7.6	7.4
Equality diversity and inclusion	8.1	9.2	9.1	7.8
Morale	6.2	6.1	6.1	5.9
Health and wellbeing	5.7	6.0	5.8	5.8
Immediate managers	6.8	6.9	7.1	6.8
Team Working	6.7	6.5	7.1	6.6
Safety culture	6.9	6.9	7.1	7.0

NHS national staff survey questions mandated by the WRES

Under the Workforce Race Equality Standard (WRES), the Trust is required to publish the responses by ethnicity to specific NHS staff survey results as detailed below.

WRES Metric	White staff score	BAME staff score	Compared to 2019
Metric 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	38%	39.6%	↑ BAME ↑ White
Metric 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26.7%	29.1%	↑ BAME ↓ White
Metric 7 - Percentage believing that trust provides equal opportunities for career progression or promotion	86.8%	69.7%	↑BAME ↑ White
Metric 8 - In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	5.7%	16.2%	↓BAME ↓ White

NHS national staff survey questions mandated by the WDES

Under the Workforce Race Disability Standard (WDES), the Trust is required to publish the responses by disability to specific NHS staff survey results as detailed below.

WDES Metric	Non-disabled staff score	disabled staff score	Compared to 2019
Metric 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:			
i. Patients/service users, their relatives or public	38%	45.3%	↑Disabled ↑ Non-disabled
ii. Managers	12.7%	23.7%	↓Disabled ↓ Non-disabled
iii. Other colleagues	21%	31.3%	↑Disabled ↑ Non-disabled
Metric 4b - Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	50.6%	47.4%	↓Disabled ↓ Non-disabled
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	78.%	70.2%	↓Disabled ↓ Non-disabled
Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	24.8%	31.5%	↑ Disabled ↑ Non-disabled
Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	52.8%	40.3%	↓Disabled ↓ Non-disabled
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	75.5%	75.4%	↑Disabled ↑ Non-disabled
Metric 9a - The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	7.2	6.8	↓Disabled ↓ Non-disabled
Metric 9b - Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)	Yes through staff networks and consultation.		

APPENDICES

Appendix 1: Workforce Race Equality Standard (WRES)

The table below summarises the Trust's annual WRES return which will submitted to the national WRES team by Aug 2021.

WRES indicator	Ethnicity	Headcount	Explanatory notes
1. Workforce reporting	Non-BAME	2,903	At 31 Mar 2021
	BAME	3,043	
	Unknown	549	
2. Relative likelihood of staff being appointed from shortlisting across all posts	Non-BAME staff 1.6x more likely		Based on NHS Jobs and TRAC data captured during 2020/21
3. Relative likelihood of staff entering the formal disciplinary process	BAME staff 1.9x more likely		Based on 2019-21 cases (2 yr rolling average)
4. Relative likelihood of staff accessing non-mandatory training and continuing professional development	Non-BAME staff 0.9x more likely		Data should be read with caution, as not all non-mandatory training is captured through the current training databases across both sites
5. Percentage of staff experiencing bullying, harassment or abuse from patients or relatives	Non-BAME	38%	2020 staff survey
	BAME	39%	
6. Percentage of staff experiencing bullying, harassment or abuse from staff	Non-BAME	26.7%	
	BAME	29%	
7. Percentage believing the Trust provides equal opportunities for career progression or promotion	Non-BAME	86%	
	BAME	69%	
8. Percentage of staff experiencing discrimination at work from managers or colleagues	Non-BAME	5%	
	BAME	16%	
9. Percentage difference between BAME Board voting membership and overall BAME workforce	BAME board members	19%	As at 31 Mar 2021
	Overall BAME workforce	46%	

Appendix 2: Gender pay gap 2019/20

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

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

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

The Trust's full gender pay gap report is published at www.chelwest.nhs.uk/genderpaygap and highlights that female employees earn an hourly mean average pay of 16.4% less than men, and the actions the Trust is taking.

Appendix 3: Workforce Disability Equality Standard (WDES) Mar 2021

WDES Indicator	Trust score '21	Trust score '20	Trust score '19
2 – likelihood of appointment following shortlisting (non-disabled staff)	1.29 times greater	1. times greater	0.99 times greater
3 – likelihood of disabled staff entering the formal capability process	3.8 times greater	2.2 times greater	2. times greater
Percentage difference between HPFT's Board voting membership and its overall workforce	-2%	-2%	-2%
Disabled voting board membership	0%	0%	0%

Appendix 4: Improving Equality, Diversity and Inclusion Action Plan years 2–3

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

Our vision and success measures

- Leadership commitment at all levels for the equality, diversity and inclusion agenda
- Influential staff networks for BAME, LGBTQ+, Women and Disability operating and having a voice in the organisation
- Improving our key metrics for WRES/WDES/gender pay gap to be among the best performing Trusts nationally
- Significantly improving our staff survey results for EDI, harassment and bullying

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
Objective 1: Continue to embed the Board's and senior managers' commitment to improving equality, diversity and inclusion				
1. The Board and Executive Cabinet sign-up to, and sign-off, the Year 2 and 3 of the Action Plan and pledge commitment to delivery	End Q2 2020	Staff, are clear of the Board commitment to provide a fair, inclusive and non-discriminatory work environment	Staff experience Q9b, Q9c, Q9d Commitment is published	Board executive
2. All ward/ department managers and heads of services to be able to talk to their staff about the board commitment	End Q4 2020	Improve staff awareness of the commitment to be a fair and inclusive employer	Staff experience Q9b, Q9c, Q9d	Board executive
3. The Board, executive and senior managers participate in development and mandatory training on race equality, and compassionate and inclusive leadership annually	End Q4 each year	Increased awareness amongst senior staff of diversity, inclusion issues and changes in leadership behaviour where appropriate	Staff experience Q9b, Q9c, Q9d Evidence of training CQC well-led domain	Board executive
4. All senior and middle managers to have an objective to embed inclusion as part of the appraisal process	End of Q4 each year	The Board, executive cabinet and senior managers act as role models for equality and inclusion	Staff experience Q9c, Q9d	Board executive

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
5. All executives and senior managers to participate in reciprocal mentoring for inclusion programme	Q2 2020	The executive and senior managers are mentored by a member of staff from an under-represented group to get a deep understanding about the lived experience of staff in the organisation. Create a safe environment to have uncomfortable conversations.	Staff experience Q9, Q9a, Q9d	Board executive
6. Share learning and celebration of staff participating in reciprocal mentoring scheme	Q4 2020	To determine benefits of reciprocal mentoring scheme and positive experiences	Staff experience Q9, Q9a, Q9d	Deputy director of people and OD
7. Ongoing communication programme to facilitate conversations about inclusivity and specific issues on race, LGBTQ+ and disability among senior managers	End Q4 2020	Increased awareness for managers of the BAME/LGBTQ+/Disability/Women's staff experience	Staff survey Q9c, Q9d	Director of HR and OD
8. Trust people strategy to include the key equality, diversity and inclusion outcomes aligned to NWL tackling inequalities and creating inclusive cultures/workstreams	End Q4 2020	Staff and managers understand the work to be undertaken over the next 3–5 years and key measures for improvement over period agreed	Staff experience Q9a, Q9d, Q14 WRES/WDES/GPG	Director of HR and OD
Objective 2: Develop influential staff networks for BAME, LGBTQ+, Women and Disability				
1. Develop regular feedback/listening events for staff attending the networks and undertake 'look forward' surveys to assess how the Trust can support staff using lessons learnt	End Q1 2020 and every quarter	BAME staff share what they want from a BAME network and are involved in its creation	Staff experience Q9c, Q9d	Network chairs
2. Ensure terms of reference and governance arrangements for the networks	End Q1 2020 and annual review	Provides an opportunity for the Board and executive team to engage directly with BAME/LGBTQ+/Disabled/Women about their experience		EDI manager/ network chairs
3. Launch the Disability network	End Q4 2020-21	Provides a voice for disabled staff in the organisation	Staff experience questions WDES score	EDI manager/ network chairs
4. Produce and develop calendar of significant events for BAME/LGBTQ+/Disabled/ Women staff communities	End Q4 every year	Improve staff experience through celebrating difference	Staff experience Q14	EDI manager/ network chairs

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
5. Develop a communication strategy for the staff networks	End Q2 2020 and every quarter	Provides an opportunity for staff to directly influence Trust strategy		EDI manager/ network chairs/ communications staff engagement lead
6. Establish resources (financial and time) required to support network officers to effectively carry out roles	Q3 2021-22	Network officers support chair attending meetings, planning and undertaking network activities, producing network work plan and contributing to EDI plans	Improvement in impact and effectiveness of network and providing personal development opportunities for network officers	Director of HR and OD
7. Network chairs to produce an annual report to update the people and OD committee	Q1–Q4 all scheduled dates	Communicate work and output from staff networks		Network chairs
8. Set meetings/agenda/reporting structures	Q1–Q4	The network has a demonstrable impact on the culture of the Trust		EDI manager/ network chairs
9. Develop annual work plan with detailed action plan	Q1–Q4	Record and evidence work from network and enable visibility of work plan		EDI manager/ network chairs and officers
10. Celebrate success of BAME/LGBTQ+/ Disabled/Women in the organisation	End Q3 2021	Increase awareness of all staff's contribution to the Trust	Staff experience Q9, Q9a, Q9d	
Objective 3: Ensure fairness in Trust disciplinary, grievance and performance management processes				
1. Review the impact of the disciplinary checklist for BAME staff	End Q1 each year	Provides a transparent and structured approach to the disciplinary process and a reduction in the number of staff going through the disciplinary process	WRES indicator 3	Head of employee relations
2. Articulate the lessons learned from the review of 79 disciplinary cases and implement changes in approach as required	End Q2 each year	Themes are understood and guide revisions in process	Staff survey Q15	Head of employee relations
3. Identify and train interview experts from BAME backgrounds staff to support and participate in disciplinary panels contribute and participate in training events	End Q3 2021	A sustained reduction in actual or perceived discrimination against BAME staff	Staff survey Q12, Q13, Q15c WRES indicators 5, 6, 8	Head of employee relations

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
4. Undertake an analysis of the application of use of performance management processes across the Trust by site, staff group and protected characteristics	End Q3 2021	'Hot spots' identified and provide focus for additional support and performance process minimises bias	WRES indicators 3, 7 WDES	Head of employee relations/deputy director of people and OD
5. Develop a process for "check and challenge" for the review of probationary "failures"	Q3 2021	Reduce the number of staff failing the probation process	Reduction in number of all staff and, particularly, BAME staff impacted	Head of employee relations
6. Introduce the resolution framework to approach employee relations issues informally	Q3 2020	Reduction in formal ER cases Reduction in BAME staff entering the formal disciplinary process 'Supportive conversations' handled through mediation Managers have increased cultural awareness	WRES indicators 3, 5 Staff survey questions Reduction in formal cases Staff experience	Deputy director of people and OD
Objective 4: Ensure fairness of recruitment processes and progression opportunities for under-represented staff				
1. Embed new recruitment processes to make sure that they are fair and equitable throughout the pathway from JDs to post-interview processes with new guidance promoted	Q2 2020	Competency-based and non-discriminatory selection practices are used by the Trust	Staff survey Q14 WRES indicator 2	Head of resourcing/deputy director of people and OD
2. Further roll-out of EDI champions from all protected characteristic to participate in panels bands 6–7	Q3 2020	To ensure check and challenge of potential biases within the interview process	Staff engagement score in staff survey	Head of resourcing/deputy director of people and OD
3. Develop a process and associated guidance to ensure that unsuccessful internal candidates for band 8a roles initially and then Band 7 and above receive support when applying for roles and feedback and an associated personal/career development plan	End Q3 2020	Processes in place to track the career progression of BAME and other under-represented groups	WRES indicators 1, 2 Staff survey Q19f WDES indicator 2	Associate director of learning and OD

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
4. Develop a consistent approach and process for providing 'stretch' opportunities for under-represented staff and BAME representation is included on senior leadership development selection panels	End Q2 2020	Opportunities are provided to BAME staff for professional, career development and increase in numbers of BAME staff applying and getting on leadership courses	Staff experience Q4, Q5, Q19f Formal monitoring and reporting to be included as part of evaluation process	Associate director of learning and OD
Objective 5: Address the negative experience that BAME and other groups have of bullying and harassment				
1. In partnership with staffside, networks and FTSU guardian, review and triangulate hard and soft intelligence regarding staff experience of bullying and harassment	End Q2 2020	Understand themes or areas of greater reporting of bullying and harassment	Staff survey Q14 WRES indicator 6 WDES indicator 4a	Deputy director of people and OD
2. Develop a comprehensive set of interventions to address the issues emerging from the review	Q3 2020	A sustained reduction in actual or perceived discrimination against BAME/disability	Staff survey Q12, Q13, Q15c WRES indicators 5, 6, 8	Deputy director of people and OD
3. Develop a zero tolerance to 'racism' reported by staff	End Q3 2020	Reduce impact of aggression from patients to all BAME staff	Staff experience Q4, Q5	Security manager/site director of nursing
4. Hold 6-monthly focus groups with staff who have reported violence and aggression	Q4 2020	Provide support and identify root causes to find practical solutions to reduce incidents of violence and aggression and improve staff experience	WRES indicators 5, 6	Violence and aggression lead
5. Annual report on violence and aggression experienced by staff	Q1 2021	Identify root causes to identify solutions to reduce violence and aggression from patients and staff on staff	WRES indicators 5, 6	Violence and aggression lead
6. Develop and educate managers on how to support staff who have experienced racially motivated violence and aggression	Q4 2020	Improve support of staff who have experienced racial/homophobic/other abuse	Staff experience Q4, Q5 WRES indicator 5	Violence and aggression lead
Objective 6: Embed a culture of inclusion and compassion				
1. Undertake deep dive into EDI metrics/ WRES/WDES/GPG	Q4 2021-22	Develop action to move the needle on cultural indicators	WRES indicators 5–8 WDES/GPG	Deputy director of people and OD

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
2. Identify leaders to support areas which may required to transform workplace cultures	Q4 2021-22	CW leaders who understand the causes of the distress of difficulties staff experience	WRES indicators 5–8	Deputy director of people and OD
3. Raise awareness of responsibility of all managers for the culture of the organisation	Q4 2021-22	Leaders embody compassion in their leadership, and that means for behaviours	Staff Experience	Associate director of learning and OD/deputy director of people and OD
4. Identify areas of focus within the organisation, such as divisions and, where possible, departments/wards	Q4 2021-22	Target areas to focus support and cultural transformation work	WRES indicators 5–8	Deputy director of people and OD
5. Buddy with NELF (organisation with improved WRES metrics)	Q3 2020	Shared replicable good practice models of improvement	WRES indicators 5–8	Deputy director of people and OD
6. Communicate to the public the Trust zero tolerance of violence and aggression to our staff	Q2 2021-22	Reduce abuse and harassment from patients	WRES indicators 5–8	Deputy director of people and OD/chief nurse
7. Introduce better reporting on PSED and Patient data sets to understand the experiences' of people using our services	Q4 2021-22	Form thematic data to reduce inequity	PSED reporting	Director of Nursing
Objective 7: Understand the impact of COVID-19 on specific staff groups and the underlying health inequalities to ensure all staff are kept safe and well at work				
1. Ensure that all risks are mitigated for staff through individual risk assessments/ workplace assessments/access to health and well-being services by ensuring they are culturally sensitive.	Q3 2021	Ensure the health and wellbeing of those disproportionately impacted by COVID-19 Pro-active use of information from risk assessments about the health of our workforce to promote better health Culturally sensitive services Proportionate take up of counselling/EAP/psychological support services by BAME staff and men which are known to be under-represented	Staff survey Q11 Health and wellbeing	Director of HR

Key actions	Due date	Intended impact/outcome	Impact measure	Owner
2. Understand lived experiences of specifically BAME staff adversely affected by COVID 19 pandemic working at the Trust	Q3 2021	Staff are able to have conversations about and participate and contribute to changes needed that they have personally experienced	Staff survey Q11 Health and wellbeing Specific survey—BAME network	BAME network chair/deputy director of people and OD

Chelsea and Westminster Hospital
NHS Foundation Trust

Gender Pay Gap Report

2020/21

proud to care

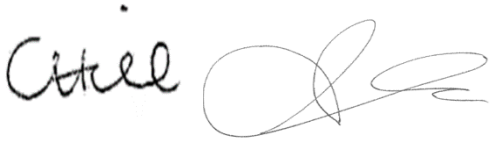
Foreword

Fostering and supporting a diverse and inclusive workforce is at the forefront of our Trust's plans to be the Employer of Choice in order to enable on-going delivery of outstanding patient care.

Our organisation is 75% female and our results show that like the majority of other NHS organisations we continue to have a gender pay gap. This is the fourth gender pay gap report the Trust has published and the report shows a reduction of 1.3% in the mean and an increase in 0.4% in the median pay gap. Our pay gap exists of 16.4% when expressed as a mean average and 11.4% as a median average, therefore there is more work to do. However, progress has been made over the last 4 years reducing our mean gender pay gap from 20.5% in 17/18, 18.6% in 18/19, 17.7% in 19/20 and this year to 16.4%.

The gender balance at Executive Director level is 50% female and 50% male compared to the overall workforce profile of 75% female and 25% male. This is favourable to the typical gender balance of female executive directors at Acute Trusts which is 42% across London (1 NHS Women on Boards 50:50 by 2020).

Having been joint chairs of the Women's Network for the last two years it is pleasing to report progress in reducing the gender pay gap, though there still remains much to do. Trust commitment to improve the flexible working offer through the Timewise accreditation programme and through legislative change should further improve women's career progression. The network is also engaged in contributing to the Trust's talent management strategy. The experience of being a BAME woman at the Trust continues within the Women's Network, with focussed work on improving the buddying and cultural induction of overseas recruits. To this end, the nursing recruitment team and practice development nurses and midwives are registered to attend a cultural readiness and transition masterclass. External funding has been secured to support the career progression and pastoral support of our health care and maternity support worker staff and our overseas nurses, many of which are women. It is hoped that this will gradually have a positive impact upon the number of women in senior posts within the organisation. Work continues to maximise women's well-being at work including the launch of the PEPPY menopause app and sessions on mindfulness and pelvic floor in the last year. The team is involved in the London menopause group which is developing a cross London menopause policy to assist women at work through this challenging life stage, helping to keep them comfortable in the workplace and enhancing ability to apply for more senior posts within the organisation.



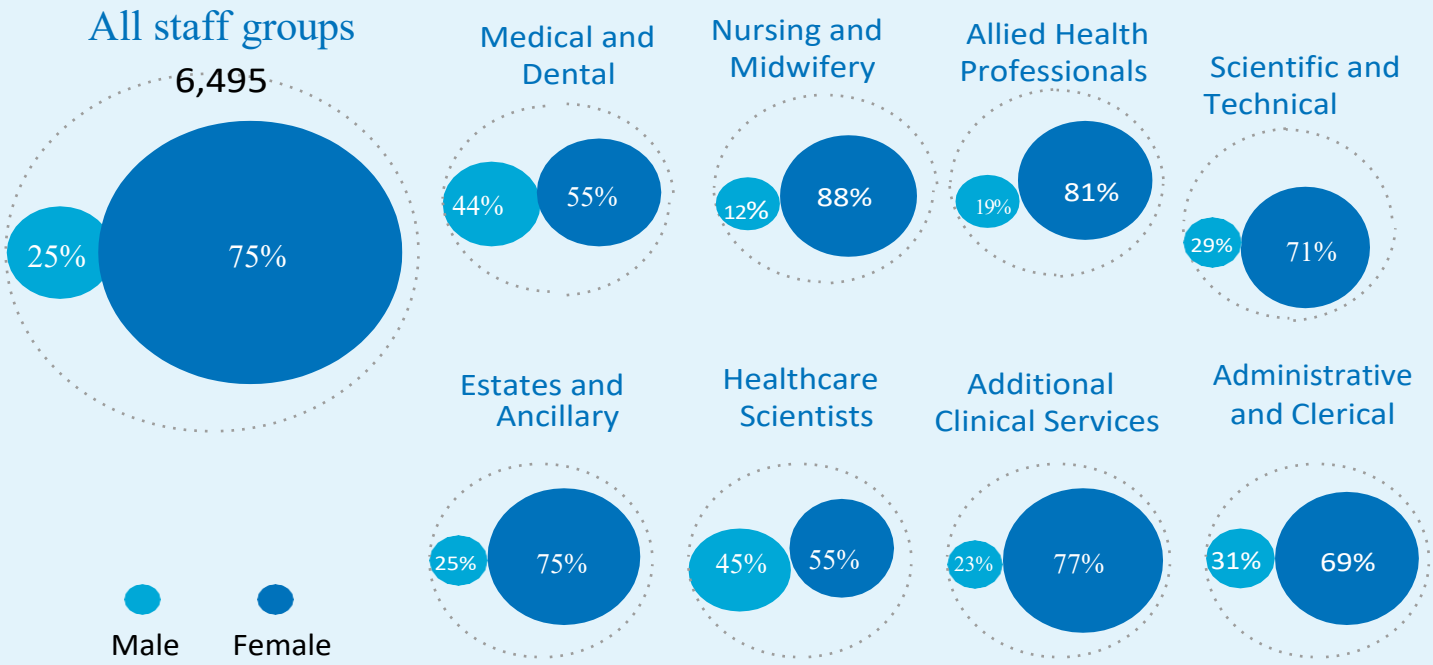
Cathy Hill and Victoria Cochrane
Joint Chairs of the Women's Network

1 Action for equality | NHS Confederation

Gender Pay Gap Report

This report includes the statutory requirements of gender pay gap legislation and includes information about the Chelsea and Westminster Hospital NHS Foundation Trust's commitment to closing this gap. The snapshot date of this report is 31 Mar 2020.

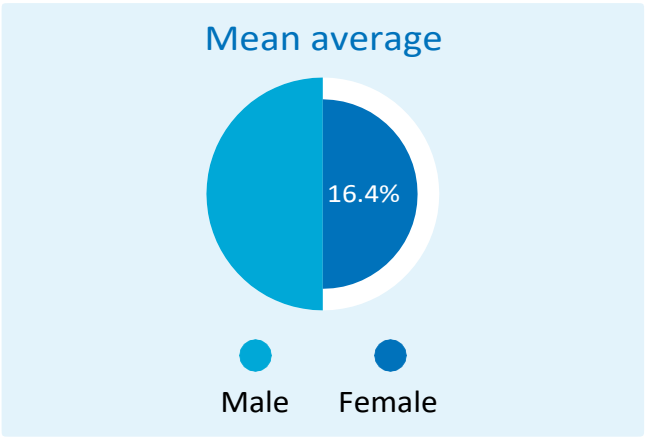
Our Workforce Profile



Gender Pay Gap calculations

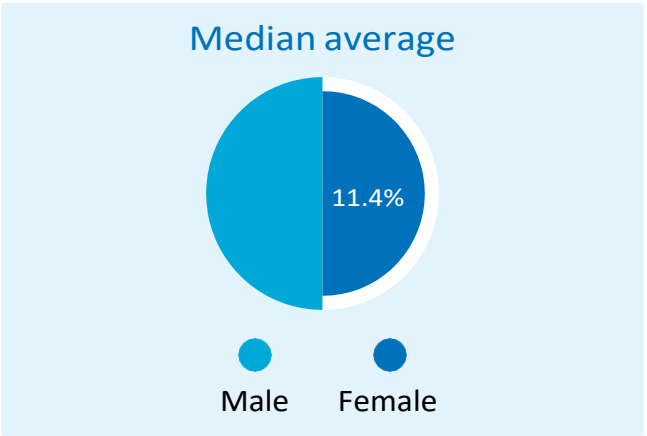
Average gender pay gap as a mean average

The gender pay gap when expressed as a mean average shows that female staff earns 16.4% less than male staff. This equates to a difference of £4.25.



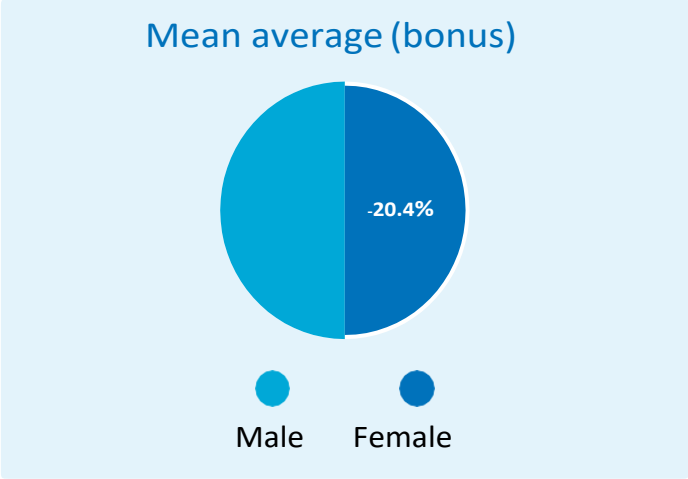
Average gender pay gap as a median average

The gender pay gap when expressed as a median average shows that female staff earns 11.4% less than male staff. This equates to a difference of £2.48.



Average bonus gender pay gap as a mean average*

The gender bonus pay gap when expressed as a mean average shows that female staff earn 20.4% less than male staff. This equates to a difference of £2553 per annum.



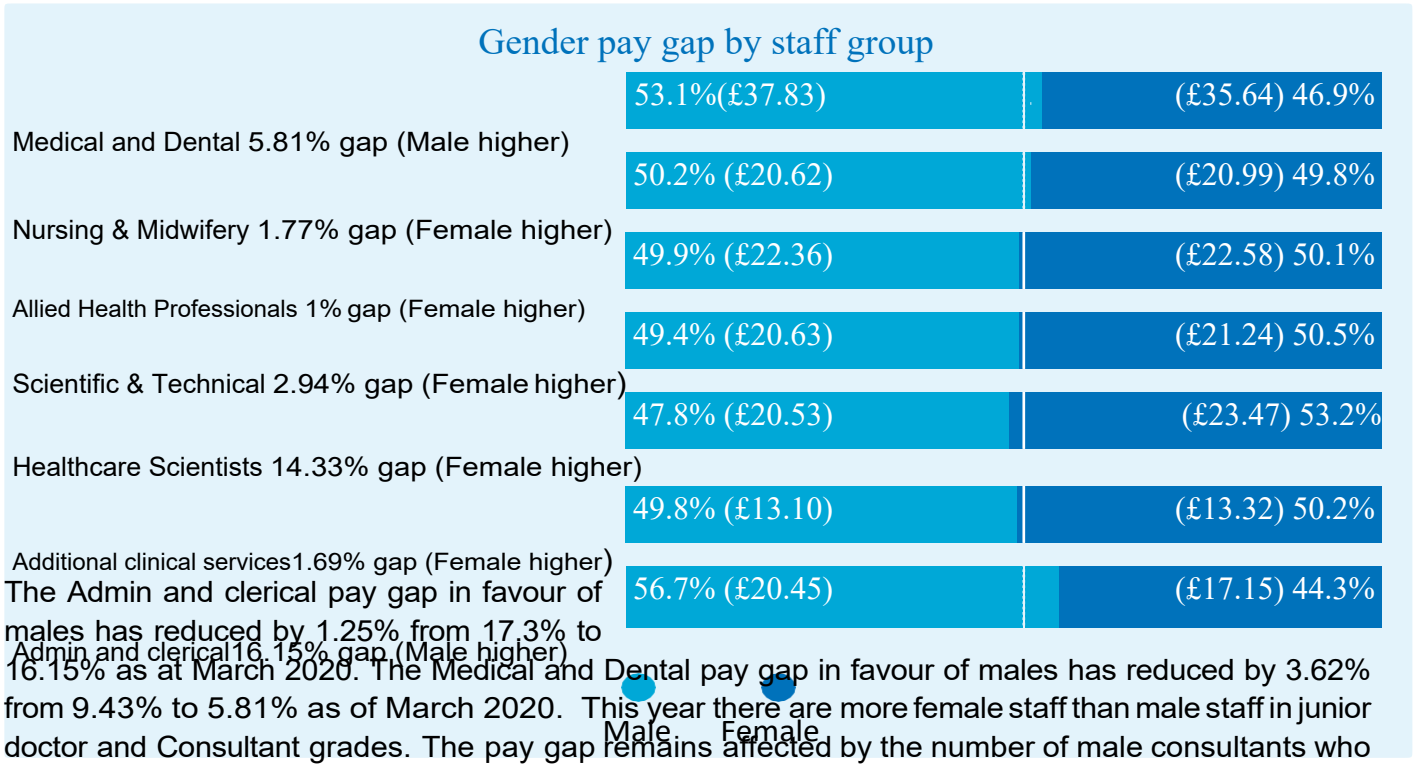
Average bonus gender pay gap as a median average*

In 2020/21 the average bonus pay gap as a median average was £12496 for males and £9943 for females so the bonus gap differentiation between genders is £2553 (20.4%).

* For the purpose of this report the bonus payments referred to are those made to consultants in the form of Clinical Excellence Awards (CEAs)— as at 31 Mar 2020

Gender pay gap calculations by staff group

Beyond gender pay gap legislation reporting requirements, the Trust has looked at the gender pay gap by staff group to identify any areas of concern.

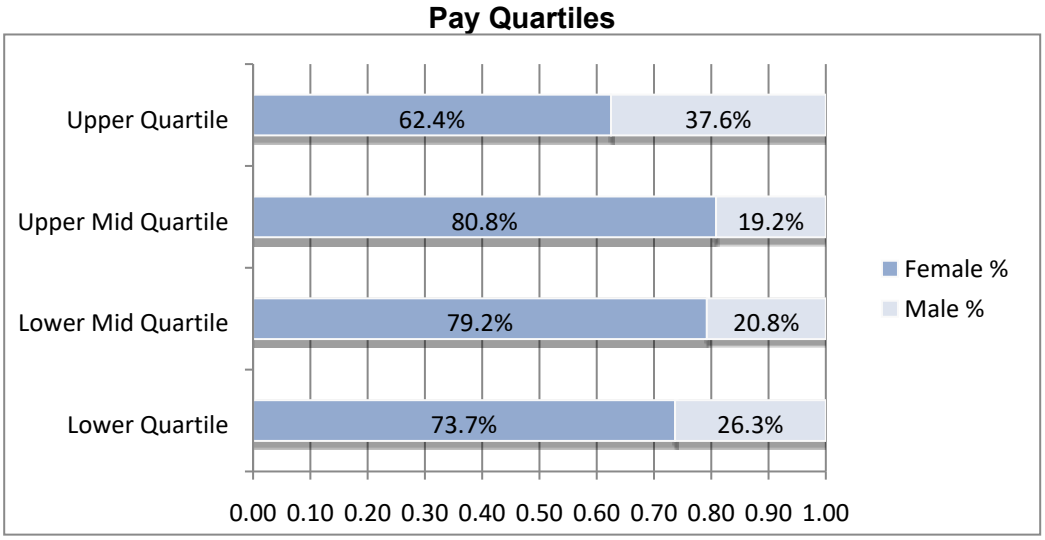


The Admin and clerical pay gap in favour of males has reduced by 1.25% from 17.3% to 16.15% as at March 2020. The Medical and Dental pay gap in favour of males has reduced by 3.62% from 9.43% to 5.81% as of March 2020. This year there are more female staff than male staff in junior doctor and Consultant grades. The pay gap remains affected by the number of male consultants who

are at the top of their pay scales which reflects that we have more male staff with a longer length of service in this grade.

Gender pay gap by Quartiles

Rates of pay are placed into a list in order of value and the list is divided into four equal sections (quartiles) and shows the percentage of males and females in each quartile.



Closing the Gender Pay Gap

We are committed to the continuing the following actions to help to close the gender pay gap:

- Working with the Trust's women's network to explore available options to support female staff across all professions move into leadership roles and are able to access development opportunities both internally and externally.

- In partnership with Timewise deliver our action plan to improve flexible working across the organisation to ensure this adequately supports all staff and achieve our Timewise accreditation to be a flexible employer.

- Delivering on the 6 key high impact areas for recruitment processes to ensure that a fair and consistent approach is taken to enable career progression opportunities for all staff, including women.

- Reviewing the proportions of men and women applying for and obtaining promotions by Division.

- Reviewing the proportion of women still in post a year on from return after maternity leave and ensuring our policies and procedures support women returners and balancing raising a family, through support being available such as the launch in 2020 of our back up care offer in partnership with Bright Horizons.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO	3.2
TITLE OF REPORT	**Annual Safeguarding Report** 3.2.a Safeguarding Adults Annual Report 3.2.b Safeguarding Children's Annual Report 3.2.c Learning Disability Annual Report 3.2.d Domestic Abuse Annual Report
AUTHOR NAME AND ROLE	**Safeguarding Adults Annual Report:** • Nick Hale, Lead Nurse Adult Safeguarding • Paul Morris, Lead Nurse Mental Health **Safeguarding Children's Annual Report:** • Daisy Dholoo, Named Nurse Children's Safeguarding WM • Faye Mitchison, Named Nurse Children's Safeguarding CW • Sarah Green, Consultant Midwife Public Health & Safeguarding • Anne Davies, Named Dr Children's Safeguarding WM • Paul Hargreaves, Named Dr Children's Safeguarding CW **Learning Disability Annual Report:** • Kathryn Mangold, Lead Nurse Learning Disability **Domestic Abuse Annual Report:** • Charlotte Cohen, Domestic Abuse Lead
ACCOUNTABLE EXECUTIVE DIRECTOR	Pippa Nightingale, Chief Nursing Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	The purpose of this report is to provide the Board with both assurance and evidence that the Trust is fulfilling its statutory responsibilities in relation to safeguarding adults, children and young people in line with legislations and associated requirements. Assurance is also given in relation to Learning Disabilities and Domestic Abuse.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Quality Committee — Date of Meeting: September 2021 — Outcome: Approved Name of Committee: Executive Management Board — Date of Meeting: September 2021 — Outcome: Noted
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• To note throughout 20/21 the safeguarding teams were stable in post & were not redeployed in order to continue their support to staff & patients. • The Trust continues to be a high reporter of domestic abuse due to the use of routine questioning. This has led to an increase in our IDVA support • We have expanded our support offered to staff suffering domestic abuse. • Both adult & children's safeguarding services are responding to increasing numbers of referrals as expected post lockdown. • Project Search continues as part of our learning disability work on WM site, & will be starting soon on CW site. • The requirement for Learning Disability Mortality Reviews (LeDeR) is increasing. We have 3 staff trained as reviewers.

KEY RISKS ARISING FROM THIS REPORT	Training remains amber at level 3 for both adults & children, both sessions are 7.5 hours of training requiring the release of staff which has proved difficult. Training has moved to virtual enabling staff to join from wherever they are based.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR: Equality And Diversity: Quality: People (Workforce or Patients/ Families/Carers): Operational Performance: Finance: X Public Consultation: Council of Governors: please mark Y/N – where Y is indicated please explain the implications in the opposite column	To note the planned change from DOLS (Deprivation of Liberty Safeguards) to LPS (Liberty Protection Safeguards) – this will require additional resource but until final national guidance is published it is unclear what this will be. This will be requested through business planning once details are available.

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Year 2020-21 Adult and Children Safeguarding Template						
Standard 1: Leadership and Workforce	**Yes/No**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Nominated Executive Officer for Safeguarding Adults & Children	YES					Vanessa Sloane is Director of Nursing and the Executive lead Safeguarding Lead for the Trust
Nominated Named Professionals/Leads for Safeguarding Adults	YES					Membership of the adult safeguarding Team was stable throughout the year. Leadership ensured that within the Trust's ongoing pandemic arrangements to maintain access of adults of risk of abuse to protective services was maintained. The team responded positively in making adjustments in response to long term sick leave and remote working as conditions changed. **Adult Safeguarding / LD Team and associates.** The Trust Adult Safeguarding team is responsible for the range of duties and responsibilities for safeguarding adults • Nick Hale – Adult Safeguarding Lead • Colette Cashell – Deputy Lead Nurse Adult Safeguarding , Mental Health and Learning Disability • Kathryn Mangold – Lead Nurse, Learning Disability and Transition • Sarah Gallimore- Adult Safeguarding Project Officer **Domestic Abuse** • Charlotte Cohen - Trust Domestic Abuse Lead • Ellie Hepworth – Domestic Abuse Project Coordinator **Mental Health & MCA** • Paul Morris - Lead Nurse – Mental Health, Clinical Lead – Mental Capacity Act and Deprivation of Liberty Safeguards • Lilly Anetseli – Lead Nurse – Mental Health • John Snowden – Lead Nurse – Mental Health

What % of the eligible workforce are compliant within the requirements of Safer Recruitment e.g. Disclosure Barring Service (DBS)						Processes are in place to ensure safe recruitment. Note this reflects earlier report as this narrative describes on-going processes for 2019/20. Pre- Employment Checks Procedures are in accordance with NHS Employment Check Standards January 2013 and in keeping with the Vulnerable Groups Act 2005 and Protection of Freedoms Act 2012. These standards set out the legal and mandated requirements that must be carried out on all candidates prior to NHS employment. These standards apply to permanent staff, staff on fixed term contracts, temporary staff, volunteers, students, trainees, contractors, bank and agency staff. The checks required include: • Identification checks • Disclosure and barring checks • Professional registration • Qualification checks • Right to work • Employment history and reference checks • Occupational health checks • Licence to Practice (medical staff only) **Relevant Trust Policies** • Pre-employment Checks Procedure • Policy on Disclosure and Barring Checks • Recruitment and Selection Policy which includes procedures for Disclosure and Barring Checks and Pre-employment checking procedure **Routine monitoring of staff** The Trust may re-check DBS disclosures on a priority basis, for example where a concern has been raised or where it is required for auditing purposes. Following recent debates of the required frequency of DBS monitoring this is being reviewed. **Monitoring and Audit/ Quality Assurance** Checks in place to ensure compliance with these policies include: • Monthly workforce reports on professional registration for registered staff, work permits and missing NI numbers will be actioned by the Workforce Information Team where the reports identifies due date for renewal of registrations or permits.

Do you have a policy/standard operating procedure to manage agency staff, volunteers						[as above] This Policy forms part of child safeguarding policy

Evidence to demonstrate improved outcomes for Safeguarding Adults & Children in relation to leadership & work force	Plans for improvement/mitigate risks/gaps The Adult Safeguarding Project officer role proved very important in supporting aspects of the fulfilment of safeguarding responsibilities across the Trust through the challenges of the Covid pandemic. Elements of this role included supporting information flow in referrals and on-going liaison with local authorities to support safeguarding alerts and cases. With the support of the project officer the team worked during the rapidly changing circumstances to coordinate information emerging from the data warehouse about use of new EPR safeguarding functionality and information from the referral pathways on both main sites . This work together with managing a Trust wide Quality round demonstrates the commitment to maintaining and seeking opportunities to provide a responsive and effective adult safeguarding service within challenging circumstances. Work was undertaken to maintain standards of service in terms of responding to staff requests for support in supporting adults at risk and collaboration with community protective services. These expectations demanded flexibility and active on-going reflection to provide a level of service within the resources available. The use of real-time monitoring (Qlickview app) and support for safeguarding cases continues to be consolidated during Q4 as it has been throughout the year. On-going support from the Safeguarding team with staff in key departments was delivered. ED at the WMU hospital site were particularly effective during the final quarter of the year. Work was undertaken to embed the use of the safeguarding EPR functionally designed by the Trust Safeguarding teams with the Cerner Transformation team. Safe and secure documentation of safeguarding risk and planning to ensure adults at risk is a core condition of effective safeguards for adults at risk. This presented different challenges across both sites during the year. Differences predominately emerging from each sites previous exposure to EPR based safeguarding standards. This will remain a priority on work into 21/22 as the trust has a plan move to EPR based referrals. Supporting progress, audit and a repeat Quality round the next year will remain a key element of work. The expectation of the referral process will be optimised within the Cerner system together with consolidation of existing functionality will also be carried over. This will be supporting by ongoing audit of standards and a quality round early in 21/22 Continuity of referral processes was a key priority during the 2020/1 with a commitment to support access for adults at risk of abuse to a range of protective services. As indicated mitigation of the risks the go-live of the new EPR system was put in place and EPR records are checked against the separate referral process. This allowed the team to pick up any issues and address them. This process has indicated a significant increase in the use of the safeguarding functionally during the last quarter (Q4) and shows a consolidation of the system. However challenges remain at the end of year and there is a commitment to push ahead to ensure staff are fully compliant with standards set. There remains to be significant progress to be made during 2021/22. An enhanced approach was developed at the end of the year to increase the focus on the EPR system and the initial steps when identifying and reviewing patient safety when managing safeguarding risk in L2 and L3 training.

Year 2020-21 Adult and Children Safeguarding Template						***Organisation Name:***
Standard 2: Training in Adults & Children Safeguarding & Workforce (eligible staff up to date with)	***Level***	***Q1***	***Q2***	***Q3***	***Q4***	***Comments***
Safeguarding Adult Training	*Level 1*	96%	95%	94%	93%	
	Level 2	94%	93%	93%	91%	Work has continued to encourage access to the online training over this challenging period but compliance has fallen overall. It is anticipated that improvement will be evident in 2021/22
	Level 3	85%	86%	84%	88%	The teams and commissioned trainers continue to support access to the course using video technology and gradual improvement towards achieving compliance is demonstrated in some departments but the overall compliance has not improved to the teams expectations. Targeted communications relating to compliance will be pursued during 2021/22
	Level 4	100%	50%	50%		Safeguarding team members regularly attend regional/national conferences and workshops however there is currently formalised attendance recording is being developed. Key members of the team have utilized the virtual conference to achieve L4 training outcomes during Q3 and Q4
Board Level Training (Adults & Children)		30	33	27	26	Chair & NEDS complete the Trust Level 1 Safeguarding training with the same renewal period as all other staff (3 years)
Mental Capacity Act	*Level 1*	26	28			This is incorporated into Learning Disability training and Adult Safeguarding Levels 1 and 2.
	Level 2	26	46	29	5	The rolling training program which offers 1 Zoom session per month (however only 1 session took place during Q4) Total number of staff trained this financial year to date = 109.

Domestic Abuse/Violence (NICE Guidelines)	Level 1 (Nice Guidelines) Level 2 (Nice Guidelines) Level 3 Level 4	388 30 6 0	468 105 7 6	550 139 168	668 19 78	Training Levels defined as: Level 1 – Basic DA awareness (E-Learning/<1hr face to face) Level 2: DA Awareness (1.0 hours – 2.00 hours face to face) Level 3: Enhanced training to become a Domestic Abuse Link/Champion (3.5 – 7.0 hours face to face) Level 4: Domestic Abuse Supervision **Q1:** Training attendance figures across all levels have fallen due to face-to-face training cancellations as a result of Covid-19. Level 1 online voiceover modules were developed to support staff responding to domestic abuse during lockdown. **Q2:** Training attendance numbers have increased. However, level 3 and 4 training numbers remain low as class sizes are limited due to social distancing and there has been a high level of cancellations related to staff shortages. Work is being undertaken to move Level 1 and Level 2 training online. **Q3:** Training attendances at all levels have increased since Q2, with a total 82% increase in training attendance. Although training levels have increased, it is expected that they will once again drop as the Trust responds to the Covid-19 pandemic and steps are being taken to manage this and enable as many staff as possible to continue to attend training. **Q4:** Training attendances at all levels have slightly decreased (-2%) since Q3. Level 1 training levels have increased by 21% which is bringing up the total attendance figures. However, attendance for Level 2-4 have significantly reduced. This is attributed to the cancellation of face-to-face training and staff being unable to attend training as the Trust responds to the Covid-19 pandemic. It is expected that attendance levels will rise as we move into the next financial year and more staff will be able to take the time to attend training. Refer to the DA report for overall analysis.

	Level 2 (Nice Guidelines)	226	643	552		
	Level 3	6				
	Level 4	0				
Female Genital Mutilation (add narrative)		560	1023	903		FGM training is part of mandatory training and is also discussed in the half day Level 3 safeguarding refresher training for staff
PREVENT Basic Awareness		94%	95%	94%	93%	A consistent level of training has been maintained through 2020/21
WRAP (Workshop to Raise Awareness of Prevent)		54%	63%	66%	67%	A rising profile of training compliance is demonstrated through 2020/21 within challenging circumstances. A training plan is in place to achieve compliance during 2021/22 is in place and monitored by the Adult Safeguarding Committee. Staff were encouraged throughout the year to review PREVENT training on eLfH. The series of GRAB guides were made available on the Adult Safeguarding Mini site on the Intranet
Child Sexual Exploitation (add narrative)		504	993	799		Children L1 and L2 e-learning completions from eLFH and
Modern Slavery (add narrative)						Modern Slavery is not included as a discrete competency however, however level 1 introduction to Modern Slavery is included in L2 Adult Safeguarding and explored in case studies within L3 training throughout 2020/21
Pressure Ulcers (add narrative)		1427	163	124	129	Total year trained = 1843. Training includes reference to the Pressure Ulcer Protocol

Evidence to demonstrate improved outcomes for Safeguarding Adults in relation to training & work force	***Plans for improvement/mitigate risks/gaps (incl. timescales)*** The broad range of challenges made by the Covid-Crisis throughout 2020/21 has put particular demands on achieving compliance and reported data on many modules has at best stayed the same and in some reduced. The training team adapted rapidly to the use of zoom and Microsoft teams to deliver L3 and MCA training. The team worked with trainers to work through the particular challenges of safeguarding training. This includes offered support to delegates who may have had unresolved contact with issues such as DV, that can be difficult to identify and respond to appropriately within a video session. The Safeguarding team have worked to maximize the opportunities offered with digital delivery but have had to be mindful of some of the risks. The Safeguarding committee will support and monitor achievement of competencies throughout 2021/22 and aim to improve performance relative to pre-crisis levels. The team has monitored evaluation of the L3 course with video technology and although the course generates overwhelmingly positive evaluations participants do acknowledge the challenges of addressing some particularly difficult and complex sensitive issues addressed. Issues that have been referenced in this report about developing the alignment of referral pathways and EPR standards of documenting safeguarding risk. This led in Q3/Q4 to add an element for more detailed localization within L3 course. This will also opportunities to help staff signpost adults at risk to the widening network of support for complex cases. The team will also review the localization in the L2 e-learning package. Both these initiatives developed in 20/21 will be carried forward to 21/22. This localization will sit alongside the component supporting DA interventions and referral introduced earlier. Performance to achieve the WRAP training target remains resistant to significant improvement and this has been amplified during the pandemic. The Prevent team awaits the promised revised face-to-face Home Office Prevent training session that better reflects the evolving risks and will work with the regional network to explore effective delivery.

Year 2020-21 Adult and Children Safeguarding Template						Organisation Name:
Standard 3: Safeguarding Supervision (Adults & Children) & Workforce	**Yes/No**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Number of staff requiring Safeguarding supervision (Adults & Children) • 1:1 within the organisation • External • Group • Peer						**Adults:** As in previous years, during 2020/21 support has been offered and provided on a case-by-case basis by senior staff and by members of the safeguarding and LD team. As far as possible, staff involved in cases are offered support through existing staff support mechanisms. The adult Safeguarding team continued to meet weekly and a clear section of this of this meeting is devoted to supervision and support emerging from complex cases. Group supervision is provided for DALs by independent Domestic Abuse specialists. The safeguarding team engaged in regional networks in the examination of formal supervision and are committed to implementing systems where there is sufficient evidence to support a particular approach. The team will continue to reflect on the value of the accumulative learning from ongoing peer supervision within the Covid-19 crisis and use it in developing models applicable for trust staff.
Number of staff supervised within timescales in adherence to Supervision Policies • 1:1 within the organisation • External • Group • Peer						**Adults:** Attendance at supervision was not formally recorded. DA supervision is reported in the DA report.

Supervision provided to: • Named Professionals/Leads • MCA/DoLS Leads • Safeguarding Advisors/Specialists • Paediatricians • Maternity • LD Managers • A&E/UCC/WiC * Sexual Health						**Adults**: Currently support is part of PDR framework and with regular team meetings to review challenging and complex cases. Extension support is offered to staff involved in safeguarding cases throughout the year. This normally involves 1:1 engagement with staff leading enquiries and teams as is determined appropriate and helpful. This will often take the form of reviewing cases and identifying learning and development opportunities. **Sexual Health Staff** There are monthly safety nets within sexual health that are supervised with input from the Corporate Safeguarding Team.
Do you have a Safeguarding Supervision Policy Adults Have your staff been trained to carry out Safeguarding supervision						**Adults:** Currently policy specifically for supporting engagement with adult safeguarding is under review. The team has followed the work undertaken regionally in developing a model of supervision and will roll out if appropriate during 21/22
Evidence to demonstrate improved outcomes for Safeguarding Adults & Children in relation to Safeguarding supervision & work force	Plans for improvement/mitigate risks/gaps (incl. timescales) The Safeguarding lead is liaising with colleagues within the London Network to identify priorities for effective process of supervision for adult safeguarding.					

Year 2020-21 Adult and Children Safeguarding Template					Organisation Name:
Standard 4: Partnership Working & Workforce (Adults & Children)	**Yes/No**	**Q1**	**Q2**	**Q4**	**Comments**
Evidence that Nominated Executive Officer for Safeguarding Adults/Children engages with the Local Safeguarding Adult Board/Local Safeguarding Children Board (boroughs covered by NWL CCGs)					**Adult Boards** Trust Exec Safeguarding lead represents at Safeguarding Adults boards and supports designates were required. Responsibly across the 4 key boroughs was reviewed during Q4 and through the year. The team has not the resource to support all subgroups as well as PREVENT and DA regional forums but coordinates within the resources available. Key learning and themes are shared at the Adult Safeguarding Committee where SAEB work plans are a standing item.
Evidence that Named Professionals with Safeguarding responsibility for Safeguarding Adults/Children attend & participate in Safeguarding Boards, LSAB/LSCB sub groups (boroughs covered by NW London CCGs)					Named professionals engage in a range of sub-groups including Training, Best Practice, Quality. Prevent Steering and SAR groups. Limitations of capacity are such that the team members attend as resources permit.

Number of Safeguarding referrals made & category of abuse (in accordance with legislation) if recorded

- Adults
- Children

Adult SG referrals in year = 657
Breakdown per category aggregated numbers

CATEGORY	YTD	Q1	Q2	Q3	Q4
Domestic Abuse	46	7	10	17	12
Physical	114	31	31	27	25
Financial	25	4	8	5	8
Self neglect	205	40	40	59	66
Psychological	46	12	17	9	8
Sexual	25	8	7	6	4
Neglect	160	23	40	55	42
Modern Slavery	3	1	0	1	1
Organisational	28	10	3	7	8
Not known/unsure	5	1	0	1	3
TOTAL	657	137	156	187	177

The numbers of referrals have showed some fluctuation through the year. A level of consistency however does provide an indicator of the resilience of staff and safeguarding adult processes within the context of the COVID-19 pandemic. Questions will remain as to how lock-downs impacted on access to reporting systems more generally and how access to protective services changed through lock downs. The team have worked to identify themes and issues through the year and respond appropriately. For example, the number of admissions of people with LD having complex needs appeared to increase. The available resource within the team to offer support. Key themes within referrals during the crisis and identified in this annual report are summarized below. Challenges around transfer of care to community agencies within changes embedding in the Discharge to assess initiative. Access to IDVA and social care assessments were altered. The surveillance of pressure damage across organizational boundaries and concerns about apparent self-neglect of adults on attendance at ED. Some of these concerns may have been amplified by significant. Issues involving mental health and substance mis use have also became a part of an increasing number of alerts

The reconfiguration of staff and services in response to COVID-19 pandemics. Working practices such as working from home, re-deployment and challenges of cross agency working have not been so amenable to digital technologies for some people at risk and indeed in many case such organization changes carry the risk of transform and disguise forms of abuse. Recovery planning and resilience will be key elements of plans for 2021/22

Evidence of making Safeguarding personal e.g. referral process, data collection (Adults)						**Adults**: The Adult referral form includes a section that requires a record of the person at risk's expectations of the process. Senior staff engage as appropriate with patients and their families who are subject to Section 42 Enquiries. Safeguarding leadership engage in complex cases and Section 44 cases as appropriate.
See LD report for overview of Activity of the LD team						
Number of staff trained as LeDeR reviewers						X 3
Number of LeDeR death notifications completed • Adults • Children (over 4yrs)						X 14 adults X 2 children
Number of LD Mortality Reviews (LeDeR) completed						X 14 completed X 10 awaiting for CDOP review X 9 not allocated by LACs
Engagement with: • CHANNEL Panel • MAPPA • MARAC • MASE	The Sexual Health Consultant at Chelsea and Westminster attends the MASE panel. The safeguarding leads link in and attend MAPPA meetings as required. Adult safeguarding lead attends the Prevent Steering Group and the Channel Panel as required. Staff attend MARAC on a case-by-case basis when required. Maternity have regular representation at local MARACs. Currently in the Trust are developing information sharing pathways to improve our engagement with local MARACs more widely. In April 2019, a 'one-front-door' for all MARAC referrals was created which has streamlined our MARAC referral process and given greater oversight into the amount any quality of MARAC referrals being made.					

Number of referrals made to Domestic Abuse Service: • MARAC • IDVA		MARAC: 39 IDVA: 84	MARAC:35 IDVA: 118	MARAC:64 IDVA: 121	MARAC:47 IDVA: Data unavailable	* *IDVA: Trust IDVA referral data is provided externally by Victim Support. This data is not available until 1 month following the end of each quarter.* **Q1:** MARAC referrals fell by 29% this quarter and IDVA referrals fell by 6.66%. A suggested reason for this decrease could be the reduction in patient contact due to Covid-19. **Q2:** MARAC referrals fell by 10% this quarter but IDVA referrals rose by 40% **Q3:** There was an 83% increase in MARAC referrals this quarter with the highest amount of MARAC referrals being made by the Trust since records began. IDVA referral numbers are not currently available. **Q4:** 47 MARAC referrals were made compared to 64 referrals in Q3 2020/21. This is an 27% decrease from Q3, and a 15% decrease compared to Q4 2019/20 when 55 referrals were made. Despite the decrease, MARAC referrals from the Trust remain high. **SEE DOMESTIC ABUSE REPORT FOR FULL ANALYSIS**

Evidence to demonstrate improved outcomes for Safeguarding Adults relation to leadership & work force	Plans for improvement/mitigate risks/gaps (incl. timescales) There are a significant number of LeDeR cases and leadership of these cases has had to be distributed across the adults' team. This pressure will need to be under continual review by the LD lead to ensure capacity is best utilised.

Year 2020-21 Adult and Children Safeguarding Template						**Organisation Name:**
Standard 5: Responding to Wider Social Issues & Vulnerable Groups (including MCA, DoLS) for Adults & Children	**Yes/ No**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Use of number of Independent Mental Capacity Advocate (IMCA) *(add narrative)*						We don't routinely record this information – As part of the LPS preparation project we are doing we are including this aspect within the scope of the works – We have hired an external LPS expert to do a Gap Analysis, write a recommendations/Resources paper, and write an LPS Policy
Number of DoLS applications		19	30	13	33	95
Number of DoLS applications authorised		0	1	0	1	2
Number of DoLS breaches		0	7	3	8	18
Number of Court Protection applications						*Q3 update outstanding at time of report.* The legal services department does not currently hold centralized records of applications made jointly or by other Trusts. Confirmed by CNWL who we have an SLA with that we had Zero Court of Protection applications.
Number of Court reports completed • Adults • Children						Clarity is needed on what is meant by a court report.
Number of Court attendances • Adults • Children						*Q3 update outstanding at time of report*. As above, the legal services department does not currently hold a centralized record of applications made jointly or by other Trusts.
Number of children/young people missing appointments/was not brought						

Evidence to demonstrate improved outcomes for Safeguarding Adults & Children in relation to leadership & work force	We have engaged with planning for the new LPS regulations with our partner agencies however the postponement of the implementation means changes in time scales. We have also hired an external LPS expert to do all the planning work for us.

<table>
<tr><th colspan="3">Year 2020-21 Adult and Children Safeguarding Template</th><th colspan="4">Organisation Name:</th></tr>
<tr><th>Standard 6: Learning from Serious Incidents to improve Safeguarding (Adults & Children)</th><th>Yes/ No</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Comments</th></tr>
<tr><td>Number of deaths at this organization for Adults
• Expected
• □ Unexpected</td><td></td><td></td><td></td><td></td><td></td><td>Adults:
Trust has review and surveillance process in place that is overseen by WMUH Medical Director.
<table><tr><td>Total Deaths</td><td>1712</td></tr><tr><td>Anticipated</td><td>661</td></tr><tr><td>Not anticipated</td><td>81</td></tr><tr><td>To be reported</td><td>970</td></tr></table></td></tr>
<tr><td>Number of deaths involving LeDeR
• Adults
• Children</td><td></td><td></td><td></td><td></td><td></td><td>X 12 adult deaths

X 2 child deaths</td></tr>
<tr><td>Number of Mortality Review meetings</td><td></td><td></td><td></td><td></td><td></td><td>Adults:
Monthly Trust mortality surveillance group meets monthly chaired by Medical Director at Divisional and Trust level</td></tr>
<tr><td>Number of active:
• Safeguarding Adult Reviews
• Individual Management Reviews
• Serious Case Reviews
• Domestic Homicide Review
- Adults
- Children & Young People</td><td></td><td></td><td></td><td></td><td></td><td>Adults
Member of the Adult Safeguarding team have supported 7 SARs during 2020/21 and contributed to 2 DHRs. Staff work with boards and the Trust committee to share outcomes and learning to Trust services. The Trust committee works to work through learning opportunities that have significant to a number of services and occupational groups. The Safeguarding team hope to set up a library of relevant SAR information in a dedicated section of the trust intranet minisite.</td></tr>
<tr><td>Number of pressure ulcers developed within the healthcare organisation3/4 (Avoidable) & multiple 2</td><td></td><td></td><td></td><td></td><td></td><td>Refer to Reports from Pressure Ulcer Group for full overview
Pressure ulcer incidents are reviewed by Pressure Ulcer Group. During 21/22 there were 0 category 3 & 4 hospital acquired pressure ulcers reported.</td></tr>
</table>

Number of pressure ulcers developed in the community 3/4 (avoidable) & multiple 2						Pressure ulcers incidents are reviewed by Pressure Ulcer Group. During 21/22 there were 155 confirmed category 3/ 4 pressure ulcers on admission reported.

Evidence to demonstrate improved outcomes for Safeguarding Adults & Children in relation to learning from incidents to improve safeguarding for both Adults, Children& Young People	Plans for improvement/mitigate risks/gaps (incl. timescales) The Trust's Adult Safeguarding Committee reviews learning from published SARs where relevant improvement plans are discussed and monitored. The team have been involved in a significantly increased number (7) of SARs during 2020/21. The team works with divisional representatives at the Adult Safeguarding committee to share learning and identify aspect of service developments that emerge from the cases. The 7-minute learning documents have proved an effective tool in sharing information and defining priorities for change. Plans will be made to support staff access to SAR reports and summaries in a way that helps particular teams and departments identify opportunities for local practice improvement

Year 2020-21 Adult and Children Safeguarding Template						Organisation Name:
Standard 7: Adult Issues and Early Help (including reducing restrictive practice)	**Yes/ No**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Provider to monitor trend of restrictive practice to establish appropriateness of intervention. Please provide details of how you monitor trends & details of any care plans, policies & procedures	Yes					We now record all incidents of restraint on datix in order for us to monitor and audit its use. We also datix all episodes of Rapid Tranquilization so are able to pull off reports from Datix when required. We have a cross-site Restraint Policy that has just been updated and approved.
Provider to monitor trends of Restrictive Physical Intervention & Therapeutic Holding for children/young people	Yes					As above regarding recording incidents of restraint on Datix. RCN Guidelines on Physical Intervention and Therapeutic Holding are embedded in our Joint CAMHS Policy
Do you have a policy or guidance to reduce the use of restrictive practice	Yes					No, but our Restraint Policy includes aspects of alternatives to restraint such as de-escalation techniques
Is there a Training Strategy to promote Positive Behavioural Practice that is used to reduce the use of restrictive practice	Yes					Yes – we have been running Adult and Paediatric Simulation Training focusing on communication and de-escalation. Deputy Lead Nurse has run substantial communication and de-escalation training across the Trust to improve staff confidence and reduce physical intervention.
Number of parents/carers attending A&E, UCC, WiC & Maternity with: • Domestic Abuse • Mental Health Issues • Substance misuse • Learning Disabilities						With regard to Parents/Carers attending ED for MH reasons – it is not possible to extract this data currently and there needs to be clearer guidance on what this means.
Number of Antenatal appointments missed						

Safeguarding Children Annual Report 2020/2021

1. BACKGROUND

The Children Act (1989 and 2004) and Working Together to Safeguard Children (2018) specify that the Trust Board has a legal responsibility to safeguard and promote the welfare of children and young people.

The purpose of this paper is to update the Trust Board, Local Safeguarding Children's Partnership and the Clinical Commissioning Groups on the work of the Safeguarding Children and Young People team so that both the Partnership and Commissioners can be assured that processes and procedures remain in place to ensure the safety and welfare of children and young people at Chelsea and Westminster NHS Foundation Trust (Chelsea and Westminster and West Middlesex University Hospital sites).

All staff within the organisation has a statutory responsibility to safeguard and protect all children and families who access our care. Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes
  (Working Together To Safeguard Children, 2018)

2. GOVERNANCE ARRANGEMENTS FOR SAFEGUARDING CHILDREN & YOUNG PEOPLE

2.1 Executive Leadership

Executive Leadership is provided by the Deputy Chief Nurse at Board level.

2.2 Supporting infrastructure:

The Deputy Chief Nurse ensures that:

- All aspects of Safeguarding Children and Young People are reported to the Local Safeguarding Children Partnership (Hounslow)
- Is represented by consistent senior team members at the 3 Local Safeguarding Children's Partnership (LSCP)
- Chairs the multi-professional Safeguarding Children and Young People board within the organisation.

Named Individuals for Safeguarding Children & Young People

The organisation continues to work to a set of protocols governing the safety of children: "Working Together To Safeguard Children" 2018. This guidance clearly outlines the expectations from partner agencies in relation to safeguarding children and as a result the Trust has a well established and dedicated team of clinicians (Named Professionals) on each site:

- Dr Anne Davies Paediatric Consultant (WMH), Dr Paul Hargreaves Paediatric Consultant (C&W) - Named Doctors.
- Daisy Dholoo (WMH) and Faye Mitchison (C&W) -Named Nurses with the remit for strategic development, policy and training, providing support and advice for staff.
- Sarah Green – Consultant Midwife Safeguarding and Public Health (cross site),

- Anna Walther (WMH) and Wendy Allen (CW) – Safeguarding specialist midwives who lead/support midwives with operational case management, have safeguarding oversight of cases and deliver training with a maternity focus.
- Lotus Resol is the Child Death Lead across site. This post is one day per week. Link and key worker for the bereaved families. Supports staff on child death process, training, data keeping and coordinating with the Pan London Child Death Review Team for Joint Agency Response (JAR) and Child Death Review Meetings (CDRM).

The Named Professionals continue to be instrumental in developing and implementing policy at local and strategic level. They are responsible for case management investigations and Case Reviews as determined by the 'Working Together to Safeguard Children (2018)' guidance.

Access to child protection advice for Trust employees is on a 24hr basis ensuring appropriate support and guidance is available via resident, non-resident Paediatric Consultants and 24/7 Senior Paediatric Nurse and Midwifery Cover who cover both acute trusts.

2.3 Organisational Principals:
The Trust's Human Resource Department governs safe recruitment practices. All staff newly employed and those in substantive posts are subject to:

- Pre-employment checks: Disclosure and Barring Service (DBS) checks at enhanced level. This includes contractors and volunteers working on site.
- To provide quality assurance staff files are checked periodically by HR.
- There is a mandatory safeguarding training plan in place for Trust employees with compliance monitored electronically.
- All staff complete online training at level 1, clinical staff complete online training level 2.
- Identified appropriate staff receive face to face level 3 training; this is initially a whole day session then a half day 3 yearly alongside various update sessions for staff.
- Face to face Safeguarding Training was not possible during lockdown. However access to Level 3 zoom and e-learning for health training was available for staff and has continued to be accessed during mandatory training sessions. In addition the named professionals provided bespoke Safeguarding Level 3 face to face training via zoom. This was very well received and is now looking to expand this within the organisation.
  In line with the "Safeguarding Children and Young People: Roles and Competences for Health Care Staff", Intercollegiate Document (2019)The team are looking towards a "Think Family Approach which covers Children and Adults at level 3 Safeguarding.

3. External Scrutiny for Safeguarding Practices.

3.1 Section 11 - Children Act 2004
At previous reviews and self-assessments the Trust has been commended for the emphasis and importance put on multidisciplinary working to support the safeguarding function. The organisation continues to build on these standards and reassure the Board with the measures outlined below.

3.2 Assurance measures to support Trust Board confidence.

Board Assurance Measure Trust Boards have been asked 'as a minimum' to assure themselves that:	Organisation rating against S11 standards.
1. There is senior management commitment to the importance of safeguarding and promoting children's welfare.	• The Chief Nurse is the Trust Board Executive Director for Safeguarding. The Deputy Chief Nurse is the executive lead. • The Board receives an annual safeguarding report. • The Trust Safeguarding board meetings are held across sites face to face and / or using video conference. • Trust wide training compliance is reported and reviewed by the Trust Quality Committee and safeguarding board. • Twice yearly there is a joint adult & children's safeguarding board.
2. A clear statement of the Trusts responsibilities towards children is available to staff	• The Safeguarding children policy is available for all staff via the intranet this is reviewed regularly. • Details of the safeguarding team are available via the intranet • All staff receives level 1 training as part of the induction process. • Safeguarding Training records are monitored via Quikview across both sites. • Audits are presented both internally and externally as part of the annual program. • Commissioning agreements include monitoring of S11 responsibilities. • There is a robust complaints process in place.
3. There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare	• The Chief Nurse is the Trust Board Executive Director for Safeguarding. The Deputy Chief Nurse, reporting to the Chief Nurse, is the executive lead for safeguarding • There is a Named Doctor, Named Nurse on each site. There is a specialist safeguarding midwife who works on each site and the Named Midwife works across site as part of the Consultant Public Health and Safeguarding Midwife role. • Named Professional safeguarding responsibilities are included in the job descriptions. • Details of the named professionals can be accessed by staff via the intranet. • Clear lines of accountability are

	displayed within the safeguarding policy. • Supervision is available for all staff working with vulnerable families on a regular basis.
4. Service Developments take into account the need to safeguard and promote welfare and is informed, where appropriate by the views of children and families.	• All service developments incorporate the appropriate risk assessment for safeguarding. • Play specialists are available to help children communicate their thoughts and concerns to health professionals. • There is a safeguarding/ socially complex midwife within each community midwife team who care for/ have oversight of women and families with socially complex/ safeguarding concerns. There is a peri-natal mental health midwife on each site. • A Perinatal Mental Health Hub is now available in NWL which consists of midwives and psychologists providing additional psychological support for women who have suffered Birth Trauma, pregnancy loss and any on-going mental health concerns during pregnancy/ following birth.
5. Training on safeguarding children is in place for all staff in contact with children.	• There is a training plan in place to ensure that all staff meet the minimum standards required by the intercollegiate guidelines. • In line with the "Safeguarding Children and Young People: Roles and Competences for Health Care Staff", Intercollegiate Document (2019) The team are looking towards a "Think Family Approach which covers Children and Adults at level 3 Safeguarding. • Training is integral to the induction process for all new staff. • All training is recorded electronically and provides a robust audit trail. • Level 1 & 2 training is available via e-learning for staff however, face to face and target training is also available. • Access to Level 3 zoom and e-learning for health training was available for staff and has continued to be accessed during mandatory training sessions. In addition the named professionals provided bespoke Safeguarding Level 3 face to face training via zoom. It is also available to staff through our LSCP'.

	• Diversity is included as part of the training for staff. • Training includes the key competencies from the recommendations in the Intercollegiate document, this includes PREVENT, CSE, FGM, Domestic Abuse, Modern Slavery, Trafficking and Gang Related crime.
6. Safer recruitment procedures including vetting procedures and those for managing allegations are in place.	• Safer recruitment is in line with statutory guidance. • Disclosure & Barring/DBS checks and references are taken up prior to job offer. • A recruitment training programme is in place for all managers. • Quality assurance processes are in place to check staff files. • Named professionals share responsibility for reporting staff allegations to the Local Authority Designated Officer (LADO).
7. Effective interagency working is in place	• Multi-agency working is evident across the trust. • A generic Interagency referral from is used in all departments to make social care and Early Help referrals • Vulnerable children attending ED are referred directly to children's social care (CSC) when a safeguarding risk is identified. • Hounslow Children Social Care, Kensington and Chelsea Children Social Care and the Multi-Agency Safeguarding Hubs (MASH) work in collaboration with the trust as well as the Child Abuse Investigation Team (Police) and other safeguarding partners. • The Trust's internal policies are developed in conjunction with other agencies. • Multi-agency meetings are in place • A monthly multi- agency meeting takes place across both paediatrics and maternity on both sites in order for staff to come and present cases with the Multi-agency partners
8. There is effective information sharing.	• There is a governance protocol in place for sharing information around child protection complying with the GDPR legislation. • Training is given around sharing information and confidentiality. • The Child Protection Information System

	is in place and has recently been embedded into the Electronic system of CERNER • FGM is embedded within the Trust and linked to the NHS Summary Care Record.

Training figures:

	Level 1	Level 2	Level 3	Level 4
Safeguarding children	94%	92%	88%	100%

3.3 Internal & External Audits

The safeguarding team participate in external audits when requested and conduct internal audits as required.

Organisation participates in external partner practice reviews when requested and will attend learning events which in turn improves practice.

There is a Safeguarding internal Audit plan that is updated yearly based on previous learning from any incidents, complaints, surveys, IMR's, SCR's and the audit results shared with the wider team through Clinical Governance forums.

This programme of audits for 2020/21 was agreed by the safeguarding team The team were able to complete a range of audits of areas of safeguarding practice. As well as internal audits the team comply with all audits requested by the LSCP sub groups.

The safeguarding team continue to:

- Evaluate and explore the effectiveness of organisational working to safeguard and promote the welfare of children, young person and adults.
- Identify practical steps for improving outcomes for children and families.
- Ensure Individual provider/professional involvement in the safeguarding process, with particular reference to themes that have emerged from a range of IMR's and Practice Reviews for children.

A clinical governance meeting takes place within the paediatric team which is attended by Consultants and Senior Nurses where clinical/safeguarding issues are raised. This is also a forum where audits and re-audits are presented. The audits are also presented to the internal safeguarding steering group and as requested to the Hounslow Local Safeguarding Children's Partnership Monitoring and Evaluation Sub Group.

There is a monthly morbidity and mortality meeting for general paediatric cases and a combined obstetric and paediatric meeting for cases. This is a forum where cases are discussed, reviewed and critiqued; it ensures that practice is always of a high standard in the Trust and safeguarding concerns have not been missed.

4. Safeguarding Governance Processes

4.1 Psycho-social meetings

Psycho-social meetings chaired by the Named Nurse for paediatrics and the Specialist midwives for maternity continue to take place in the emergency departments, paediatric wards, maternity, NICU/SCBU and sexual health departments across both sites.

These meetings involve members of the multi professional teams including ED staff, paediatric nurses, doctors, ward teachers, liaison health visitors, midwives, CAMHS nurses and children's social workers from neighbouring boroughs.

A member of the safeguarding team also attends the paediatric handover and/or visits the ward and ED each morning to ensure that safeguarding issues are identified and processes are followed.

4.2 Maternity – Socially Complex and Vulnerable Families

There are monthly multi- agency meetings at WMH and CW which are chaired by the Safeguarding Specialist Midwives and include representation from Children's Services, perinatal mental health midwife, team leader of the young mother's group, and safeguarding health visitors, The remit of the group is to review safeguarding/ socially complex cases, provide safeguarding supervison, and act as a safety net to ensure good information sharing and planning is in place.

In addition, the safeguarding midwives and perinatal Mental Health midwife attend the Hounslow social care meeting to discuss new referrals. They also attend the meeting with the Perinatal Mental Health liaison / psych teams to ensure plans have been put in place for women and families. The consultant midwife has been working with the Early Help lead in the different boroughs to try and improve links and therefore referrals into these services.

Consultant Midwife Safeguarding and Public Health is currently Co- chair of the National Maternity Safeguarding Network and is also a safeguarding advisor to the Chief Midwives Office at NHSE.

A new pilot programme- "Supportive Signposting" was launched within maternity in July 20. This was based on the Social Prescribing Model based in Primary care and was one of the recommendations from the consultant Midwife Public Health and Safeguarding Msc research to increase referrals to early intervention and early help services and worked closely with NWL CCG and LMS to bring this to fruition The evidence for use of such a model was positive and linked in well when considering families with inequalities or who had a history of previous or current adversity. Previous or current trauma has been attributed to many mental and physical negative health outcomes and includes Perinatal mental health (which is costing £8.1billion a year) substance misuse, smoking, suicide attempts, smoker, increase in sexual partners, and obesity and all the health implications linked with all of these (Bauer 2014). This has been adopted by the CCG throughout NWL and CW had a dedicated phone line which was managed by a midwife who was shielding during COVID. Posters were put up all around the maternity unit and accepted referrals either directly from women or from midwives.

The CW service to date has received more than 180 referrals and on evaluation follow up phone calls with women and families demonstrated a reported 70% increase in user's emotional and social wellbeing. More than 60% of users were from a BAME background or from an area of deprivation and by far in the whole of NWL the highest areas of referral were from Hounslow geographical area. The Local Maternity System (LMS) approved an extension on this pilot and we now we are coming out of the pandemic will resume initial discussions with NHSE about how to embed this service on a wider level.

4.3 MARAC (Multi Agency Risk Assessment Committee)
This group is led by the Police and has multi- agency representation.

The aim is to:

- Share information to increase the safety, health and well-being of victims/survivors - adults and their children;
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community;
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- Reduce repeat victimisation;
- Improve agency accountability; and
- Improve support for staff involved in high-risk domestic abuse cases.

The Trust, across both sites, have moved to a single point of referral for MARAC. This negates the need to have different forms for different boroughs. All our referrals are sent to the MARAC Team at Standing Together who will in turn forward them on to the respective boroughs.

Four Independent Domestic Violence Advisors (IDVAs) are based within the Trust on both hospital sites. They are based in maternity services and ED and provide advice, support and guidance for staff as well as providing support for victims of Domestic Abuse (patients and staff). This service is provided through Victim Support and Standing Together Against Domestic Violence. The IDVA's work closely with the Safeguarding Team, Domestic Abuse Links and the Trust Domestic Abuse Co- coordinator. Sexual Health Consultant provides medical leadership for the Domestic Abuse service. The Domestic Abuse Coordinator works across all sites which has meant an increase in additional training for staff to become Domestic Abuse Links (DALS) and thereby further increasing awareness, identification and support for staff and their families.

4.4 A quarterly clinical governance meeting takes place within the paediatric and maternity teams which is attended by all the staff where learning is shared from case reviews, incident reviews and any other learning from the LSCP's. These are also incorporated into the training. There is a regular morbidity and mortality meeting for general paediatric cases and a combined obstetric and paediatric/neonatal meeting for cases. This is a forum where complex cases are discussed, reviewed and critiqued; it ensures that practice is always of a high standard in the Trust and safeguarding concerns have not been missed.

4.5 Accident & Emergency Interface
A member of the safeguarding team attends ED on a daily basis to ensure that any issues regarding safeguarding children and families are discussed and referrals are made appropriately, this also includes making contact in the private sectors. In addition to this there is an established Trust wide electronic data base which captures all referrals across made by clinicians to Children's Social Care which are regularly reviewed and the data base up-dated accordingly.

Each child, who attends the organisation is routinely checked to see if they are 'subject to a Child Protection Plan' or Child in Need plan this is completed by the CP-IS IT flagging system.

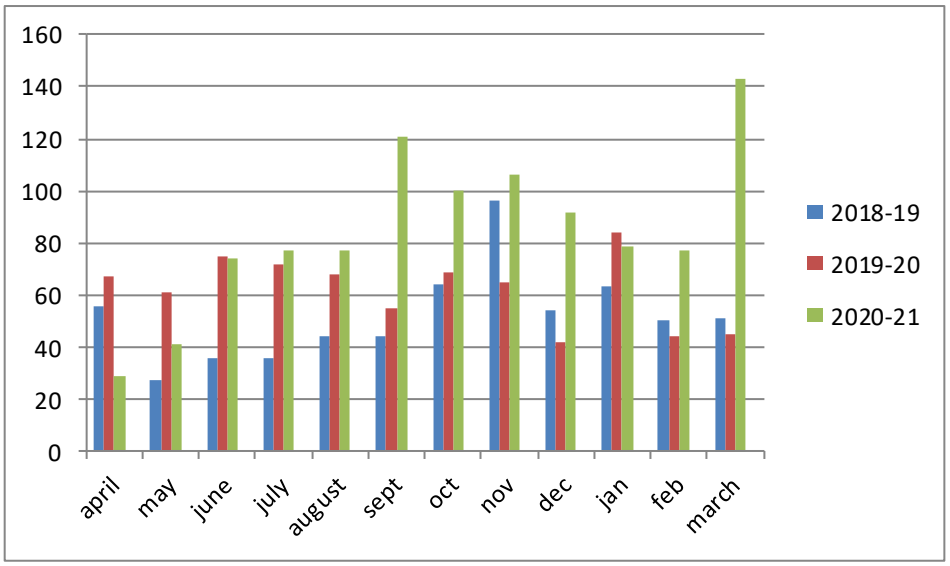
The ED department has dedicated Consultant Paediatricians and a safeguarding nurse link role that are based in both Paediatric EDs. This further ensures that children and young people are safeguarded and processes are followed. Safeguarding Links from the Adult ED department attend the psychosocial meetings and link in with the safeguarding team which has enhanced safeguarding oversight and whilst embedding a Think family approach.

Both sites have an on-site Child and Adolescent Mental Health Services (CAMHS) which is supported by mental health liaison Nurses Mon – Fri 9-5, and also an out of hours psychiatric liaison crisis services. There is also a 7 day service of a Lead Nurse & Deputy Lead Nurse for Mental Health across both sites.

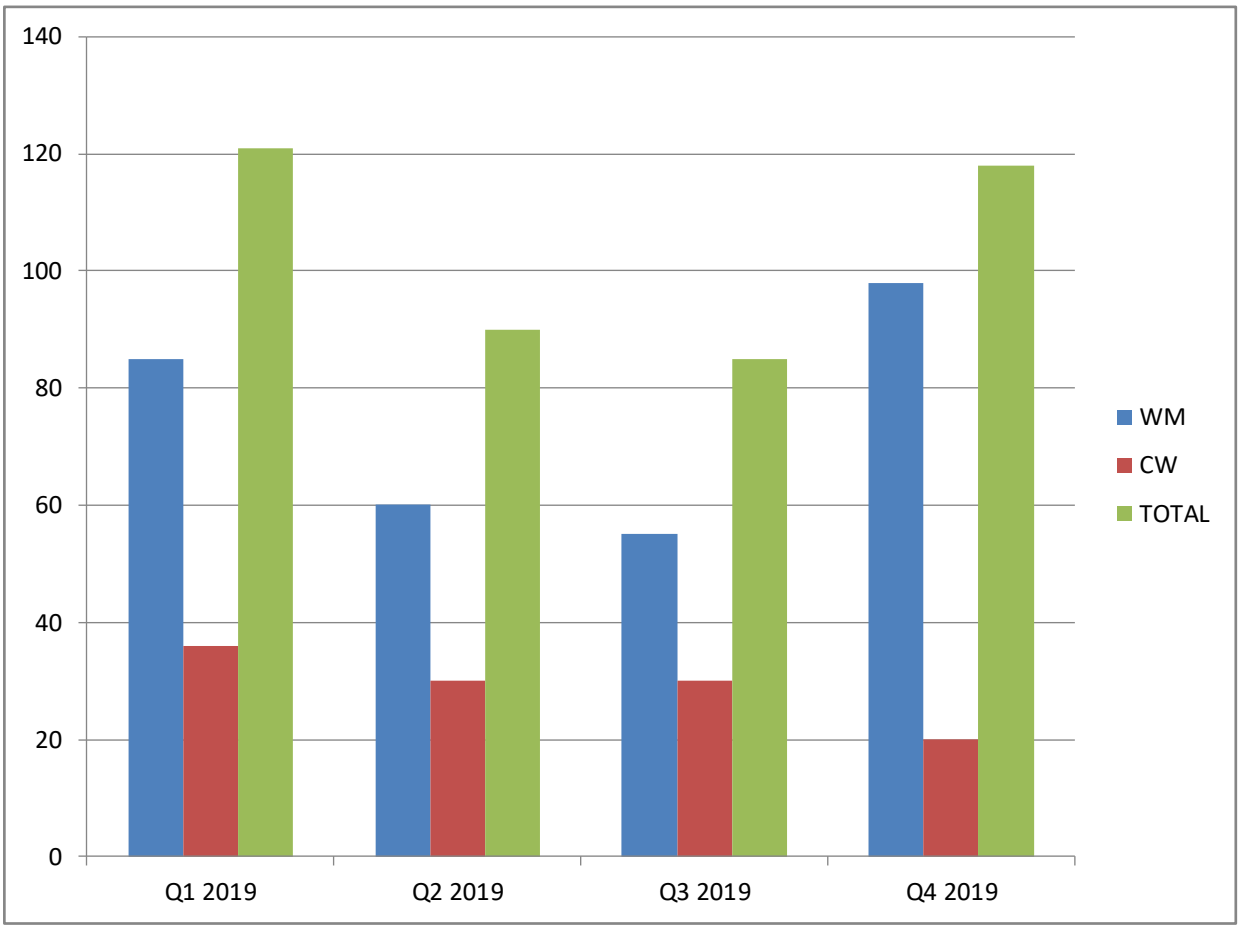
The aim of this service is to:-
Ensure children and young people (0 – 18th birthday) are assessed by a trained and qualified CAMHS professional when presenting to ED with mental health concerns.

4.6 Referrals to Children's Social Care

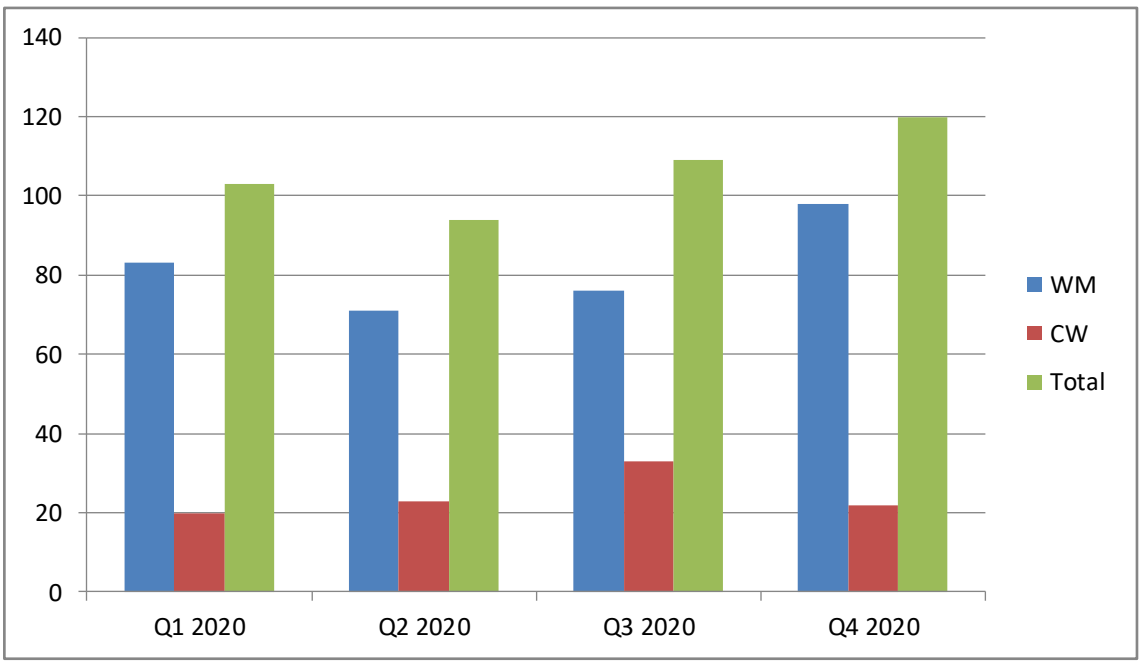
490 717 0971



Maternity Referrals to Children's Social Care Jan 2019-December 2019



Referrals to Children's Social Care Jan 2020-Dec 20



A piece of work was completed to ensure parity with referrals and notifications at both sites and this is now aligned to the NW sector.

The Safeguarding Team are undertaking regular supervision with the teams to ensure all cases are identified as well as reviewing the teams safeguarding lists. In addition staff have been reminded that they need to copy the safeguarding team into all social care referrals via the generic safeguarding inbox. On review of the team lists we found that there are frequently cases with lower level complexities which could be managed with the community teams unless the concerns escalate or a safeguarding concern is identified. The team have taken steps to address this and at time of writing for the updated SHOF in Q2 2021 the number had gone up significantly for CW and 75 referrals had been made to social care.

Two of the teams at CW are going to pilot a "maternity Vulnerability threshold document which is just in the process of commencing. This has been designed jointly by Kings College and REACH Academy with a particular focus on vulnerability within families within the maternity system. It has received very positive feedback on training and is expected to help staff feel increasingly confident in being able to identify those cases that meet safeguarding threshold and those that can be managed within the community teams.

4.7 Child Protection Medicals

The paediatricians undertake child protection medicals across both sites. These medicals are usually requested by a social worker or police due to the child having an injury or the child making a disclosure.

The process involves taking a detailed history from the child, parent/s, social worker and police as required and examining the child. X-rays may also be required as part of the child protection medical. A report is then compiled and submitted to the requesting referrer.

4.8 Urgent Care Centre (UCC)

Hounslow Urgent Care Centre (UCC) is situated adjacent to West Middlesex University Hospital's emergency department. Although the UCC has close working relations with the

hospital, it is managed and run as a separate entity. Hounslow and Richmond Community Healthcare Trust (HRCH) are responsible for the management of the UCC including all processes and procedures in relation to safeguarding children and young people.

The UCC has in place training programmes for all staff at various levels in relation to safeguarding. HRCH works to the same safeguarding policies and procedures as the Trust and the IT systems in use have been developed with alert icons for those children that are subject to a child protection plan.

The UCC at C&W Hospital is integrated within the Paediatric Emergency Department. It is staffed by GPs and Paediatric Emergency Department staff with the appropriate skills. The safeguarding processes for UCC patients are the same as for ED patients.

The Paediatric Liaison Health Visiting Service (PLHV) is based in the UCC at the West Middlesex Hospital. This service is provided by HRCH. The service provides a comprehensive review of all children and young people seen within the emergency department and the UCCs on a daily basis. Those children deemed at risk are followed up with the service liaising with community health visitor's/school nurses, medical staff both in hospital and the community, hospital nursing staff, midwives and social services. The PLHVs also has access to numerous IT databases providing an invaluable source of information that can be shared with the multidisciplinary team when appropriate. This service provides a link between the acute sector with the primary care sector, providing a comprehensive system for the hospital by raising its safeguarding standards even higher and contributing to a reduction in the risk factors some children are exposed to.

The Paediatric Liaison Health Visiting Service (PLHV) at Chelsea & Westminster site is part of the safeguarding team. They have the same function as above and in addition provide role cover the Named Nurse role when required.

4.9 Safeguarding Children committee meetings

This meeting is chaired by the Deputy Chief Nurse and is cross site. The safeguarding team have joint meetings with the adult safeguarding professionals. The group comprises of the named professionals children and adults, safeguarding midwife, sexual health lead, domestic abuse advisor, CAMHS liaison nurses, social workers from the main borough that the organisation covers and senior nurses across both sites.

The meeting reviews all safeguarding issues including complex case discussions, audits, practice reviews, recommendations and training compliance.

The safeguarding team also provide a quarterly SHOF report which is presented to the team and is submitted to the CCG**.**

4.10 Children & Young Persons Committee (West Middlesex Site)

This meeting is chaired by the Consultant Anaesthetist and is attended by the Named Nurse for safeguarding children, the Matron of paediatrics, Orthopaedic, ENT Consultants, Surgeon, and an ED representative. The meeting reviews all complex joint care cases which include young people who have been patients on adult wards. Safeguarding/Child Protection issues are also discussed and outcomes are cascaded to relevant teams.

5.0 Policies and Procedures in place to safeguard Children and young people

There are a number of policies in place that relate directly to safeguarding children and young people and updated through the relevant Clinical Guidelines Committees.

6.0 Staff Training

The Intercollegiate document provides a clear framework which identifies safeguarding competencies for all staff, clinical and non-clinical, who work in any healthcare setting. This has expanded Safeguarding Training Requirements-especially at Level 3 for a significant number of staff which will further increase awareness in this area.

The Safeguarding children/maternity team has developed a joint Level 3 Training package which incorporates both Children and Adults Safeguarding Training on a three year rolling programme. This will be captured using a Safeguarding Training passport and via L&D Teams. The Safeguarding team are compliant at level 4 and above at appropriate levels of training.

Although training was suspended through the COVID-19 pandemic, it has now fully resumed with options of on line and, face to face and training via video conference. This training is regularly evaluated and staff compliance is monitored at Executive board level.
The staff who attend what level is reviewed in line with the Intercollegiate document.

6.1 Prevent
Basic Prevent training (an element of the Government's counter-terrorism strategy) is incorporated into the level 1 and 2 Safeguarding Children's training. The Prevent National Government Strategy – Reducing risk of radicalization and terrorism states that health sector is involved in Objectives 2 and 3:-

- Prevent is part of existing safeguarding responsibilities for the health sector, not an additional job.

- Healthcare workers have the opportunity to refer vulnerable individuals for support in a pre-criminal space.

Given the very high numbers of people who come into contact with health professionals in this country, the health sector is a critical partner in *Prevent*. There are clearly many opportunities for doctors, nurses and other staff to help protect people from radicalisation. The key challenge is to ensure that healthcare workers can identify the signs that someone is vulnerable to radicalisation, interpret those signs correctly and access the relevant support.

The Prevent agenda will continue to be implemented across the organisation led by the Lead Nurse for Adult Safeguarding.

NHSE identified that staff requiring level 3 training for adult or child safeguarding should also receive a higher level of training (WRAP). The Trust is working to deliver this online & through face to face sessions.

The safeguarding team will continue to support the organisation to achieve the 90% compliance required for 2020 /21.

7.0 Supervision for staff in direct contact with Children and Young people
It is a requirement that all staff have access to supervision within the organisation and this must be incorporated into all areas. All staff involved in safeguarding should have appropriate supervision according to their role as set out in the intercollegiate document which is also recommended by the CQC.

7.1 Supervision

The supervision process is inherent within the Trusts safeguarding policy to ensure that there are robust mechanisms in place to support front line staff. This is achieved through:

- Monthly meetings for the safeguarding team
- Monthly steering group meetings
- 1:1 supervision for named professionals
- Weekly safeguarding huddle for the maternity safeguarding team
- Weekly safeguarding zoom surgery for maternity and NNU staff to "drop in" if have any cases they wish to discuss.
- Group supervision for ward staff, specialist staff, sexual health teams
- Peer support programme in place
- Once a month junior paediatricians have access to a clinical psychologist who facilitates reflective practice, at this forum they discuss difficult cases some of which are child protection that they have dealt with on the ward. (WMH)
- Ensuring that there are opportunities for discussion and debriefing with members of the safeguarding team
- Internal case review.
- Feedback from external serious case reviews.
- Implementation of recommendations from lessons learnt

7.2 Supervision Policy

Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

Employers are responsible for ensuring that their staffs are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role. (Working Together To Safeguard Children 2018).

8.0 Partnership Working

Local Safeguarding Children's Partnership (LSCP)

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. For this reason, the Children Act 2004 requires each local authority to establish LSCP. The LSCP is the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

Consistent representatives of the senior nursing team are active member of the 3 LSCP's and the safeguarding named professionals are active members of various sub groups.

9.0 Electronic Record System

An electronic recording system has now gone live on both sites. This will ensure that safeguarding communication is robust within all areas of the Trust and will improve cross site working and information sharing.

The CPIS (child protection information system) has been integrated into this electronic system and will flag a child or mother of an UBB subject to a CP or LAC plan in all unscheduled care settings.

10.0 Safeguarding Practice Reviews and Individual Management Reviews

When a child dies or sustains a potentially life threatening injury, and abuse or neglect is known or suspected to be a factor in the death or injury, partner agencies must undertake a Safeguarding Practice Review. The purpose of this review is to determine what can be

learned from the case about the way local professionals and organisations work together to safeguard children. As part of the review the local authority commissions an overview report and each relevant service is required to complete an individual management review.

Throughout the year a number of cases have been discussed at the Case Review Sub Meetings. The purpose of these discussions is to establish if the internal management reviews met the threshold for a Practice Review.

Past and current internal case reviews are discussed at our safeguarding meetings to establish recommendations and ensure best practice is being implemented. In addition, national case reviews are also reviewed to ensure lessons learnt are embedded locally. The process for following up children who do not attend outpatient appointments is an example of this.

Learnings are shared within the organisation via various team meetings and training.
The safeguarding team also participate in a paediatric newsletter and relevant information is cascaded within the organisation.

10.1 Safeguarding Children Health Network Meeting
The Named Professionals attend this meeting which is also attended by representatives of the wider safeguarding member agencies. This group reports directly to the designated professionals and is chaired by the Designated Nurse for Hounslow/Tri-borough, this group is responsible for strategic development and collaborative working across the health economy.

10.2 NHSE National Maternity Safeguarding Network
The Consultant Midwife for Safeguarding and Public Health is co- chair of the above forum. This is invaluable in being able to network with other safeguarding midwives across the country, share best practice and addressing and escalate safeguarding challenges which appear to have a common theme In April 2020 she was invited to be one of the Chief Midwifery Officer's safeguarding links and will help to ensure that the CMO team are updated of what is happening from a safeguarding perspective both nationally and regionally.

10.3 Serious Case Review Group
The Named Nurse/Consultant Midwife attends the Hounslow LSCP Case Review meeting, relevant cases are discussed with the multi-disciplinary teams and decisions are made as to whether a Practice Case Review is required.
The organisation has participated in a number of Reviews and recommendations and learning has been cascaded to staff.

11.0 Female Genital Mutilation

FGM Information Sharing System (FGM-IS)

The FGM-IS is a national IT system that supports the early intervention and ongoing safeguarding of girls under the age of 18, who have a family history of Female Genital Mutilation (FGM). It allows healthcare professionals and administrative staff to record that a girl has a family history of FGM. FGM-IS has been embedded within the Trust and enables medical professionals to record when a girl under 18 years has a family history of FGM to share that information.


FGM-IS QRG.docx

The FGM log has been added to CERNER

11.1 Modern Day Slavery Act 2015
According to the Home Office Modern slavery is a serious and brutal crime in which people are treated as commodities and exploited for criminal gain.

The true extent of modern slavery in the UK is unknown. Modern slavery, in particular human trafficking, is an international problem and victims (who may be European or non-European nationals) may have entered the UK legally, on forged documentation or clandestinely, or they may be British citizens living in the UK.

Child trafficking is defined as the *"recruitment, transportation, transfer, harbouring or receipt"* of a child for the purpose of exploitation.

The internationally accepted definition of human trafficking comes from the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (2000, 'Palermo Protocol'), which the UK ratified in February 2006.
According to End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT) in 2016, here has been a 30% rise in the number of referrals due to children trafficking to 1,278. The majority of children experienced labour exploitation, including domestic servitude, cannabis cultivation and sexual exploitation including UK as well as non UK nationals. This is the highest figure recorded in the UK. Potentially there are many more children who have not been identified.
Children who are trafficked contain a large proportion of children who are unaccompanied, and children who are missing from care. Thus there is a need to ensure that agencies are able to identify and record children who are at risk of trafficking and exploitation effectively.

The Trust is committed to ensure that all children and young people that present to the organisation are cared for in a safe, secure and caring environment and correct procedures are followed when issues are identified. This is covered in mandatory safeguarding training and staff are also able to access specific LSCP study days.

The Consultant midwife attends the NHSE/I Modern Slavery national forum which will be invaluable to ensure good multiagency working, information sharing and best practice. This group is held on a quarterly basis.

12.0 Work Plan for 2020-21

- To continue to ensure that Safeguarding Children remains a priority within the Organisation
- Continue to review Safeguarding Children's Training in line with the recommendations from the updated Intercollegiate Document Continue to achieve over 90% compliance at level 1,2 & 3. Complete the Safeguarding Training Strategy to incorporate Childrens and Adults Safeguarding and ensure a continued Think Family Approach
- Maintain minimum of 4 audits per year for safeguarding practice
- Increase referrals into Early Intervention and Early Help services and ensure that pregnant women and families and linked into support at the earliest opportunity

3.2.c Learning Disability, Autism or both and Transition

1.0 Introduction

This report will focus on the progress the Trust is making towards recommendations from National Health Service, England(NHSE&I), the annual Learning Disability Mortality Review Programme (LeDeR) report and other National initiatives to enhance the care that we provide to patients with Learning Disabilities, Autism or both and their families/carers.

2.0 Background

The Trust **Learning Disabilities Steering Group**, chaired by the Lead Nurse, ensures appropriate Trust structures, processes and pathways are in place to provide high quality care for patients with learning disabilities.

The remit of the group has been extended to include patients with autism as over 75% of people with autism also have a learning disability.

The group comprises of Trust departmental representation, a Trust Governor, local Mencap, Community Learning Disability teams, Assistant Head at Queensmill School, local charities and carers/parents of patients with a learning disability, autism or both.

These meetings were cancelled during the first phase of the Covid-19 pandemic but recommenced and have continued virtually during the second wave.

3.0 Work in progress

The work is divided into 4 main categories and a brief update of key progress/actions follows:-

3 .1 Patient Experience

3.1.1 Annual activity

- Overall attendance numbers in both the Emergency Departments and in outpatient clinics were more than half the activity due to the lockdowns during the first two waves of the Covid-19 pandemic in March and December 2020. Patients that were seen and/or admitted were often acutely unwell

3.1.2 CERNER IT system

- Work on-going with Cerner /EPR team to record that patients have a learning disability, autism or both- over 2,600 patients' information to be manually added into 3 separate sections of system including High Risk Indicator *Alerts*.
- Community Learning Disability teams sent in individual patient Hospital passports and these have been uploaded onto their electronic medical records.

3.1.3 Support for young people and their families around transition of care to Adult services.

- Increased number of referrals to Lead Nurse received but visits to the Trust were postponed for infection control reasons during the pandemic.

3.1.4 Adult Safe Guarding support

- The team members adjusted/increased their working hours during the last year to support Safe Guarding referrals/ processes and to attend the local Boards and their sub-groups including SARs and Learning from Deaths.

3.2 Measuring Quality

3.2.1 Safe Guarding cases of particular note:

- Hounslow Police/ CPS have closed the case from 2017; four residents with a learning disability from the same residential home were admitted to West Middlesex site within a four day period with aspiration pneumonia. Two of the patients(x 1 Hounslow resident) subsequently died after discharge. Referred back to Hounslow who have completed a Safe Adults Review (SAR) review. The draft report is due for publication shortly and will be submitted to the sub-group of the Hounslow Safe Guarding Board.
- Un-witnessed fracture of a bed -bound care home resident. Missed by GP and physiotherapists. Number of learning points noted for care home staff.
- Patient presented to ED with history of self-neglect and husband had mental health issues, following SG investigation patient discharged to a nursing home
- Patient presented with gastro- interstinal obstruction requiring surgery, caused by incorrect feeding in residential home. Further training from SALT for care home staff.
- Overview of current safeguarding referral trends, more cases of self-neglect, possibly due to less mobility/lack of carers due to isolation or sickness/resources/face to face visits by community teams/availability of external activities e.g. day centres
- Discharge concerns - during acute second phase of Covid pandemic resulted in less efficient communication between hospital and carers/relatives
- To note that in Q4 x6 Safe Guarding alerts raised concerning patients with a learning disability due to abuse/neglect by carers or friends.

3.2.2 Complaints

The Lead Nurse was informed of all complaints concerning a patient with learning disabilities, autism or both but of particular note were the following:

- NHSe Dental services commissioner made the decision this year in a long-standing complaint/legal case that the Trust should arrange for multiple procedures/examinations under GA. NHSe agreed to provide the dentist and ENT will attend from WMUH site.
- Received two complaints about lack of “Changing Place “facility at WMUH site. A suitable location has been identified and plans are being drawn up with the Estates and Facilities team as part of the new Diagnostic Centre to be commenced in 2021

3.2.3 Incidents of key concern

The Lead Nurse was informed and involved in the investigation of all relevant incidents and one externally reported incident (stEIS):-

- stEIS- Patient with myotonic dystrophy attended the Emergency Department at the Chelsea site following a fall at nursing home. Medical assessment and investigations performed- all normal. Returned to nursing home and had a cardiac arrest 3 hours after return, taken to Hammersmith Hospital and died 5 days later. Full investigation was carried in conjunction with the Trust Patient Safety Consultant- no errors/omissions were identified at the Trust.
- Project SEARCH intern developed a progressive allergic reaction to lunch which contained peas. Fast-tracked in the Emergency Department at West Middlesex site. Treated with anti-histamine and steroid, symptoms subsided within an hour. Mother had failed to inform team of a full list of allergies when the intern joined the project prior to the incident and failed to answer her emergency number. Action: - to ensure detailed history of allergies from families and families to provide an emergency number.

3.2.4 Learning Disability Mortality Review programme (LeDeR)

- 17 x deaths were reported in the Trust in 20/21 (x10-11 in previous 4 years)
- 13 x adults and 4 x children between 4- 18 y.o.
- Main causes of death- 10 x Covid-19 & x 4 x sepsis
- Majority resident in Hounslow x 9, 4 from Richmond, 3 from Bi-Borough and 1 from Hammersmith & Fulham
- 13 x reviews completed
- Awaiting Child Death overview panel outcomes

3.3 Training & Development

- Training continues to be a key part of the Lead Nurse and Deputy's roles with 665 Trust staff trained, including 65 junior doctors and mostly delivered virtually.
- Level 2 Learning Disability training included additional information about autism, diagnostic overshadowing and the LeDeR programme
- Level 2 training at WMUH site started in January 2020 together with support from Community Learning Disability team and Richmond Mencap group.
- During second wave cross-site training continued virtually and included videos of the "Treat me well group" from Richmond, Mencap
- Learning disability and autism was included in Clinical update as well as Corporate Welcome/Induction from 2020 across both sites
- Lead Nurse developed an learning disability scenario, with Health Education England and Full of Life, as an e-learning training module for the Care Certificate, which was short-listed for an HSJ award

3.4 Patient & Public involvement

Project SEARCH

- Six interns joined in September 2020 and x3 interns from the previous intake completed their course in December.
- During the lockdowns they worked remotely 3 days a week to obtain their ASDAN(Award Scheme Development and Accreditation Network) qualification and Health & Safety & Office skills with Project SEARCH team.
- Before the interns and the Project SEARCH team returned to site in March 2021 they were fully briefed on Covid-19 safety protocols, were risk assessed and had received their first vaccination
- 5 x interns have achieved paid employment at West Middlesex University Hospital, 2 in the catering department, 2 in medical records and one in Finance.
- 1 x intern from current 3rd intake is working as a volunteer in the first responder role in reception.

4.0 Summary

- The Trust continues to make progress in improving our services for patients with a learning disability, autism or both by developing its approach to inclusion, information, access, support, service provision and partnership working with families and carers, in line with the national agenda.

- A quarterly and an annual Learning Disability report will continue to be provided to the Adult Safe Guarding Board, the Trust Patient & Public Engagement and Experience group, the Mortality Surveillance group and the Trust Learning Disability Steering group.

5.0 Action

The Board is asked to note this information and to provide any comments.

3.2.d Domestic Abuse Annual Report 2020/2021

Due to the implementation of Cerner, DA identification data is not currently accurate as the new tool for recording on Cerner is not being used consistently. Ongoing training on this tool continues to be rolled out within staff inductions, Cerner, and Safeguarding training. This will take time to embed in normal clinical practice.

Table 1: Lilie DA and SA Identification Data 2020/21 – CW sites only

Category	Q1 DA	Q1 SA	Q1 DA + SA	Q2 DA	Q2 SA	Q2 DA + SA	Q3 DA	Q3 SA	Q3 DA + SA	Q4 DA	Q4 SA	Q4 DA + SA	Annual DA	Annual SA	Annual DA+SA
Total no. CSI logs created	43	47	**90**	93	87	**180**	44	79	**123**	34	39	**73**	214	252	**466**

Annually, a total of 214 cases of DA and 252 cases of SA were identified.

IDVA and MARAC Data, 2020/21:

Table 2: IDVA and MARAC Referral Data 2020/21

		Q1	Q2	Q3	Q4	Annual Total
Number of IDVA referrals received by:	CW Victim Support IDVAs	71	81	80	65	297
	WM Victim Support IDVA	13	37	41	40	131
	Total:	**84**	**118**	**121**	**105**	**428**
Number of MARAC referrals made by:	CW staff	20	17	29	21	87
	WM staff	5	10	22	16	53
	CW Victim Support IDVA	6	5	11	4	26
	WM Victim Support IDVA	8	3	2	6	19
	Total:	**39**	**35**	**64**	**47**	**185**

Annual Summary, 2020/21:

MARAC Data:

The MARAC data presented below refers only to MARAC referrals made via the correct Trust process.

185 MARAC referrals were made compared to 146 in 2019/20. This is a 27% increase from 2019/20 and a 176% increase from 2018/19 when 67 MARAC referrals were made.

(A quarterly/annual breakdown of total Trust MARAC referrals is provided in Figure 1 below).

61% (113) of referrals came from CW sites and 39% (72) of referrals came from WM sites in 2020/21.

WM in particular, saw an almost doubling (95%) in MARAC referrals made, from 37 referrals in 2019/20 to 72 in 2020/21. CW referrals rose by 3% from 109 in 2019/20 to 113 in 2020/21.

(An annual breakdown of MARAC referrals by site is provided in Figure 2 below).

A total of 12 different specialities made referrals to MARAC from the Trust. The specialities making the highest number of MARAC referrals were:

1) Adult ED – 95 (51%)
2) Hospital IDVAs – 44 (24%)
3) Maternity – 20 (11%)
4) HIV/GUM – 14 (8%)

WM Adult Emergency Department saw the largest increase (338%) in MARAC referrals made, from 8 in 2019/20 to 35 in 2020/21. CW Adult Emergency Department rose by 46% from 41 in 2019/20 to 60 in 2020/21, with on-going high numbers.

(A full list of annual referrals by speciality is provided in Figure 3 below).

Referrals have been made to 24 different MARAC boroughs. The boroughs most frequently referred to MARAC were:

1) Hounslow – 52 (28%)
2) Hammersmith and Fulham – 31 (17%)
3) RBKC – 26 (14%)

These boroughs have consistently received the highest numbers of MARAC referrals from our Trust.

Notably, over half 105 referrals (57%) were made to non-STADV MARACs and this data would not have been captured had the referral process not changed in 2019.

(A full list of annual referrals by area is provided in Figure 4 below).

IDVA Data:

428 IDVA referrals were made in 2020/21, compared to 373 in 2019/20. This is a 15% increase from 2019/20 and a 23% increase from 2018/19 when 347 IDVA referrals were made.

(A quarterly/annual breakdown of total Trust MARAC referrals is provided in Figure 5 below).

Over two thirds 69% (297) of referrals came from CW sites and 31% (131) of referrals came from WM sites in 2020/21.

In 2020/21, referrals from WM sites rose by 19% from 2019/20, from 110 referrals to 131. CW referrals rose by 13% from 263 to 297.

(An annual breakdown of MARAC referrals by site is provided in Figure 6 below).

A total of 15 (+23 unknown) different specialities made referrals to MARAC from the Trust. The specialities making the highest number of MARAC referrals were:

5) Adult ED – 198 (46%)
6) Maternity – 89 (21%)
7) HIV/GUM – 84 (20%)

(A full list of annual referrals by speciality is provided in Figure 7 below).

Supporting Figures:

Figure 1: Blue 2018/19 Red 2019/20 Green 2020/21

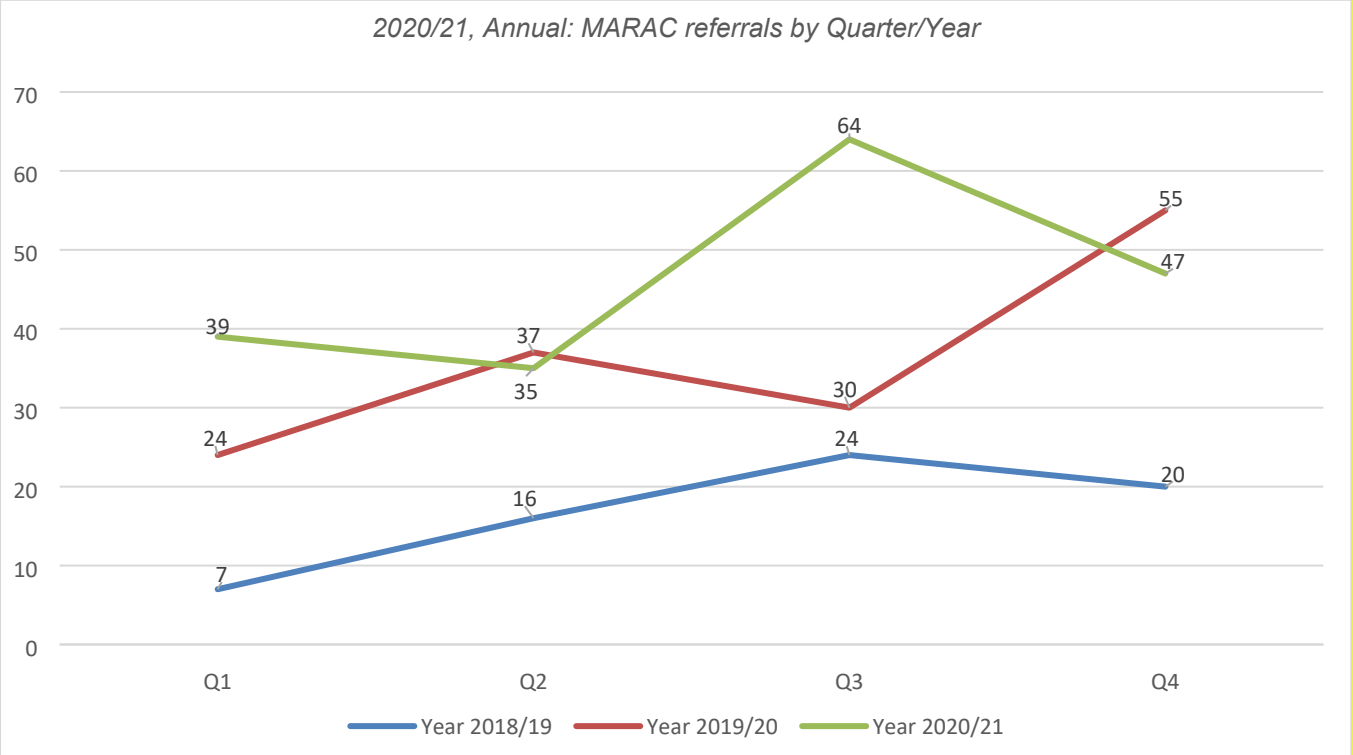


*Figure 2: **Blue CW Red WM***

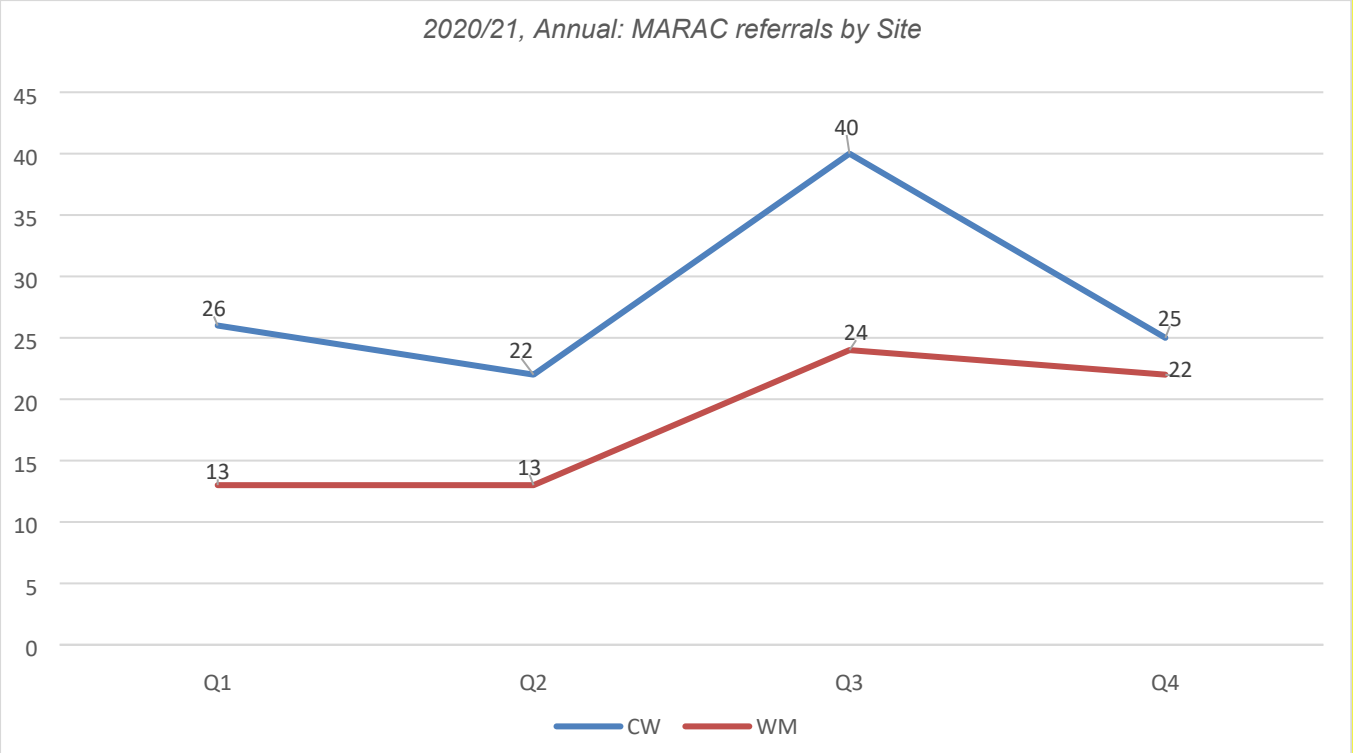
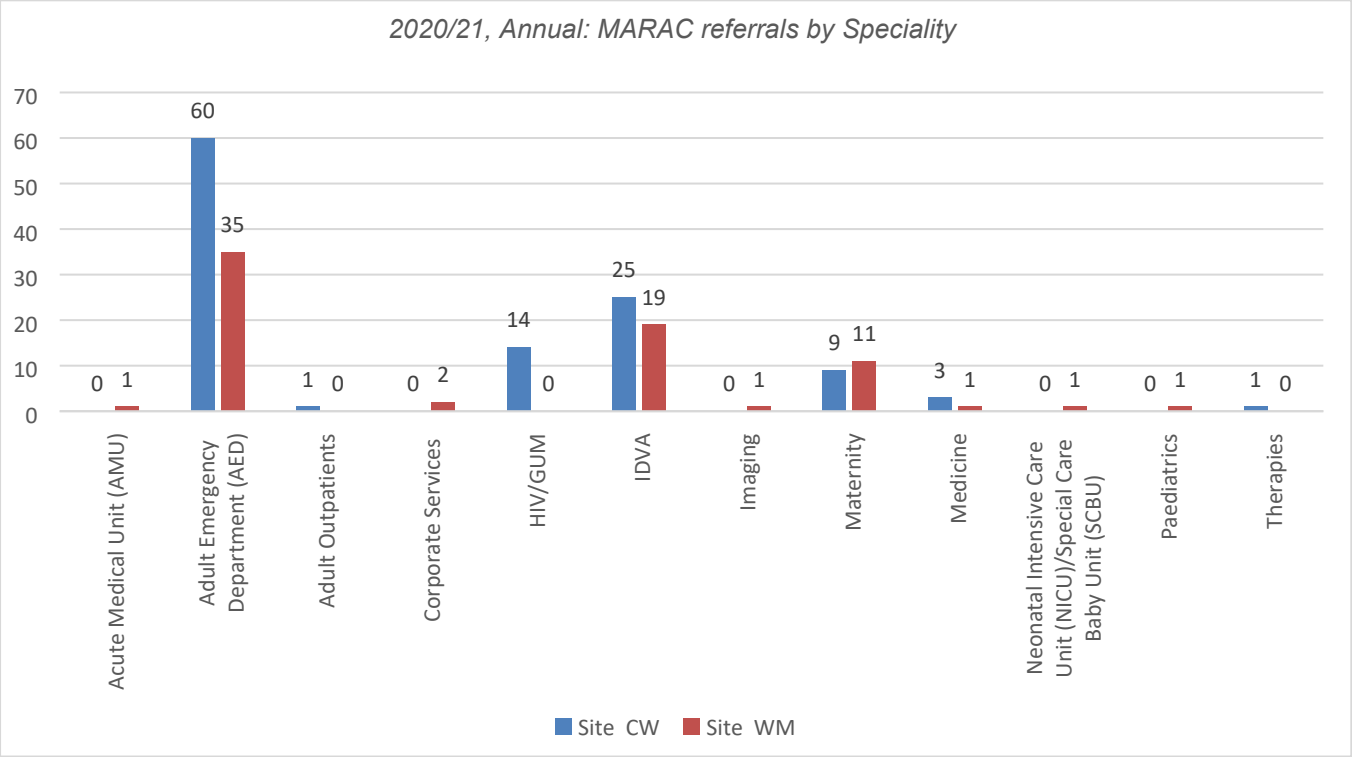


*Figure 3: **Blue** **CW** **Red** **WM***



**Corporate Services referrals refer to referrals from the Deputy Lead for Safeguarding Adults*

Figure 4:

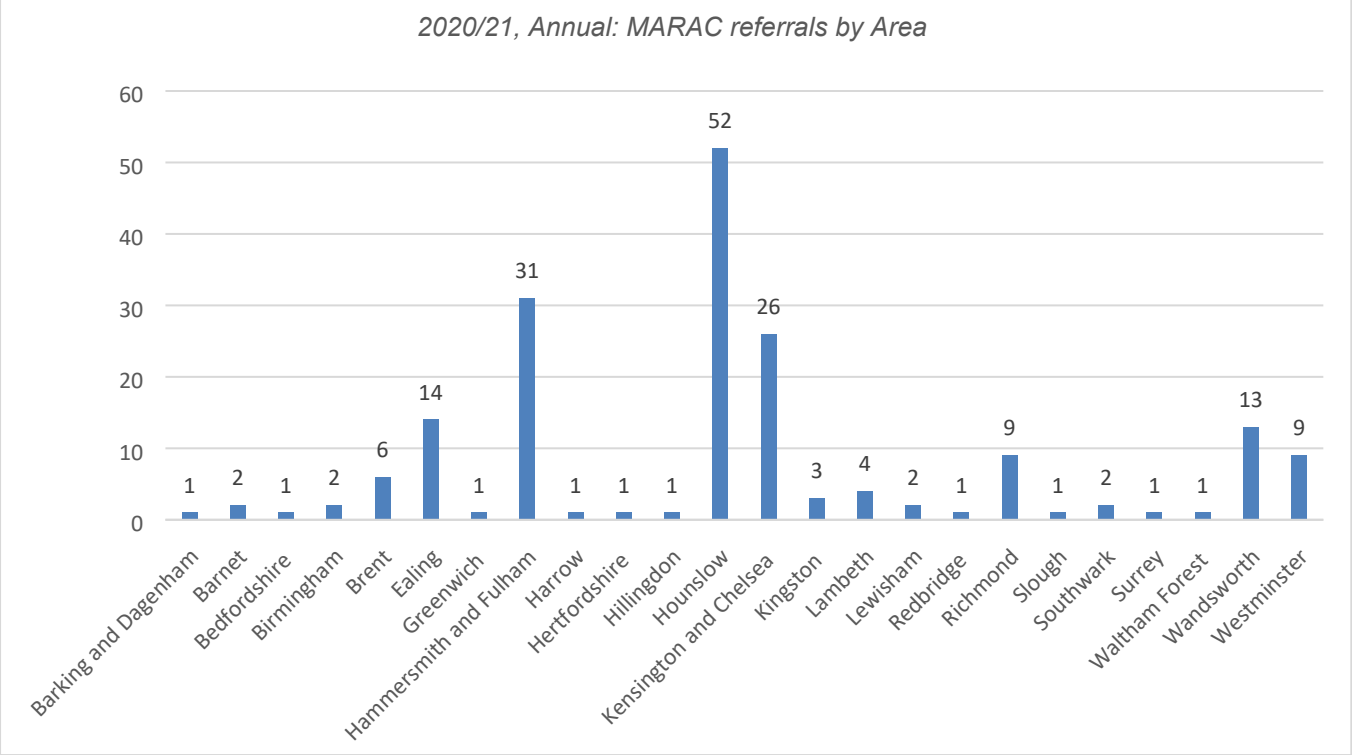


*Figure 5: **Blue 2018/19 Red 2019/20 Green 2020/21***

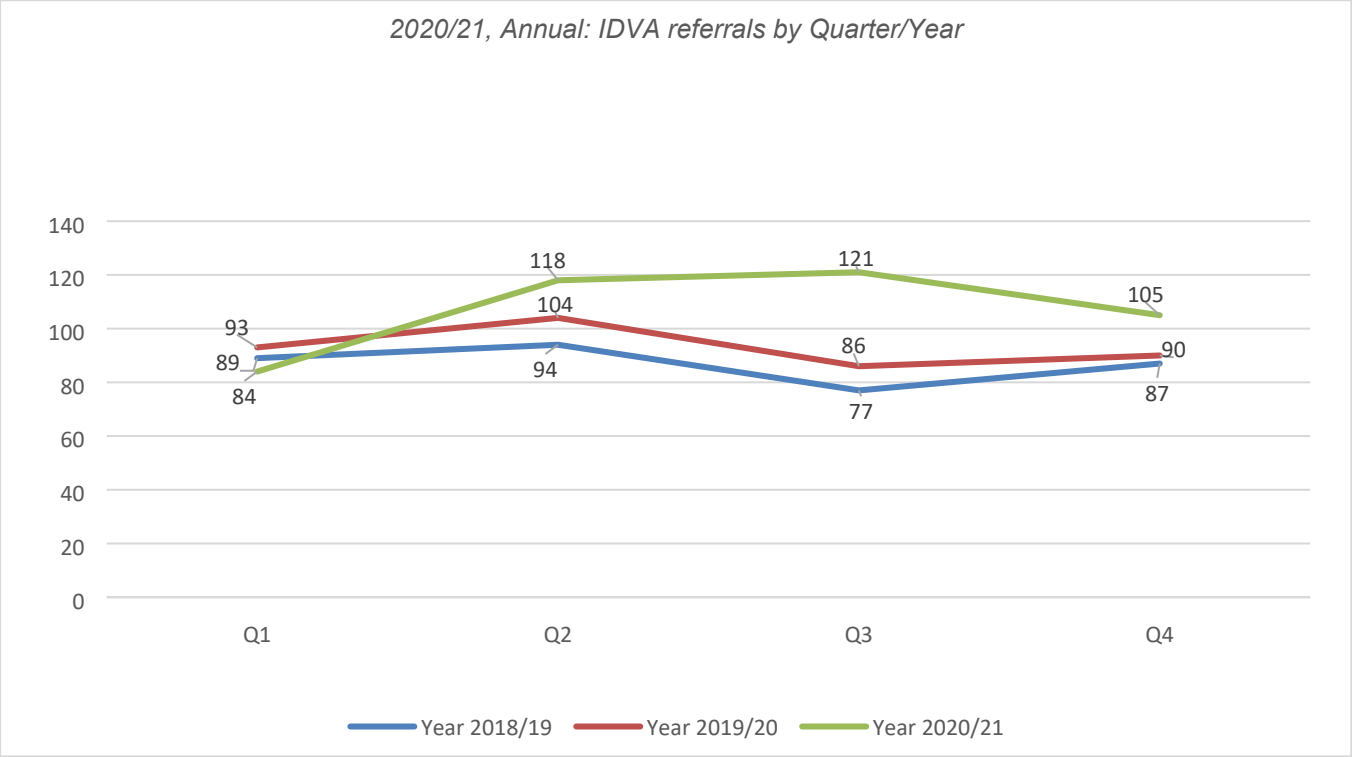


*Figure 6:**Blue CW Red WM***

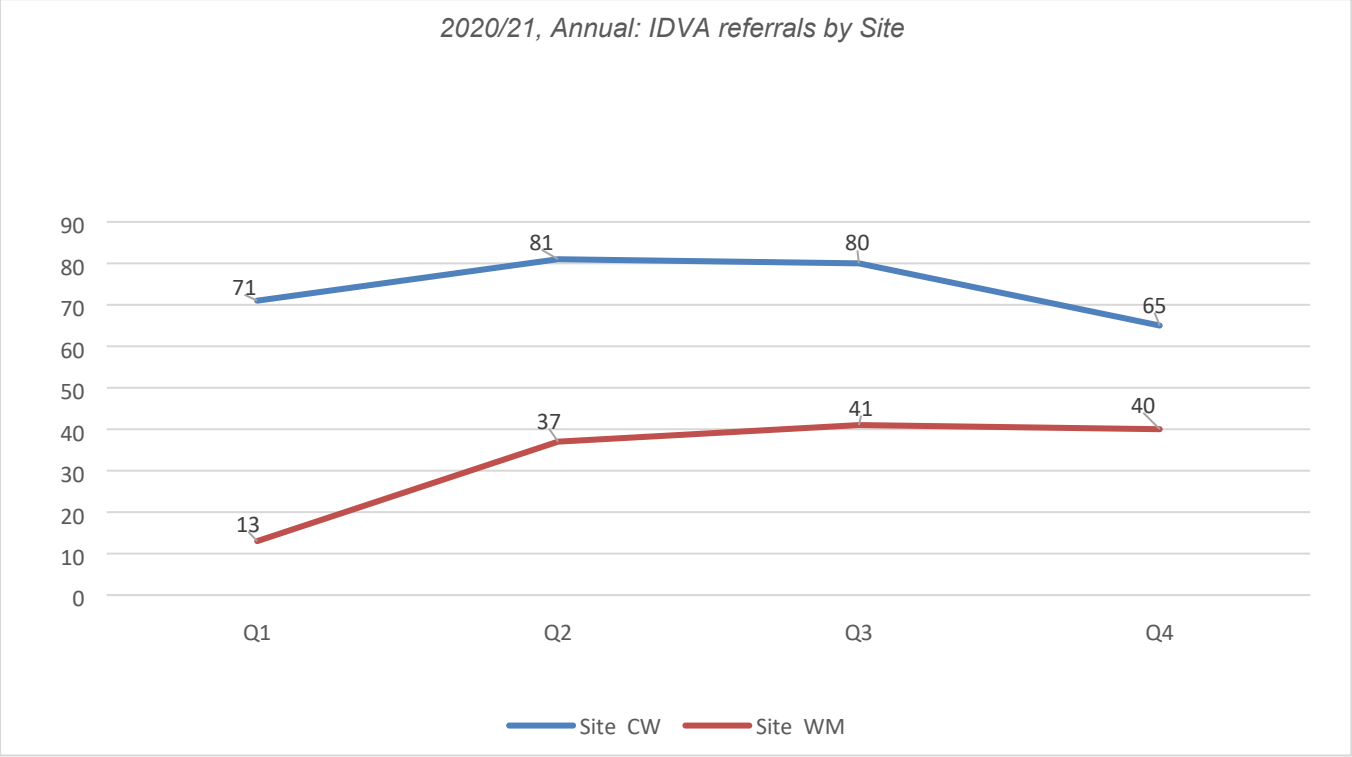
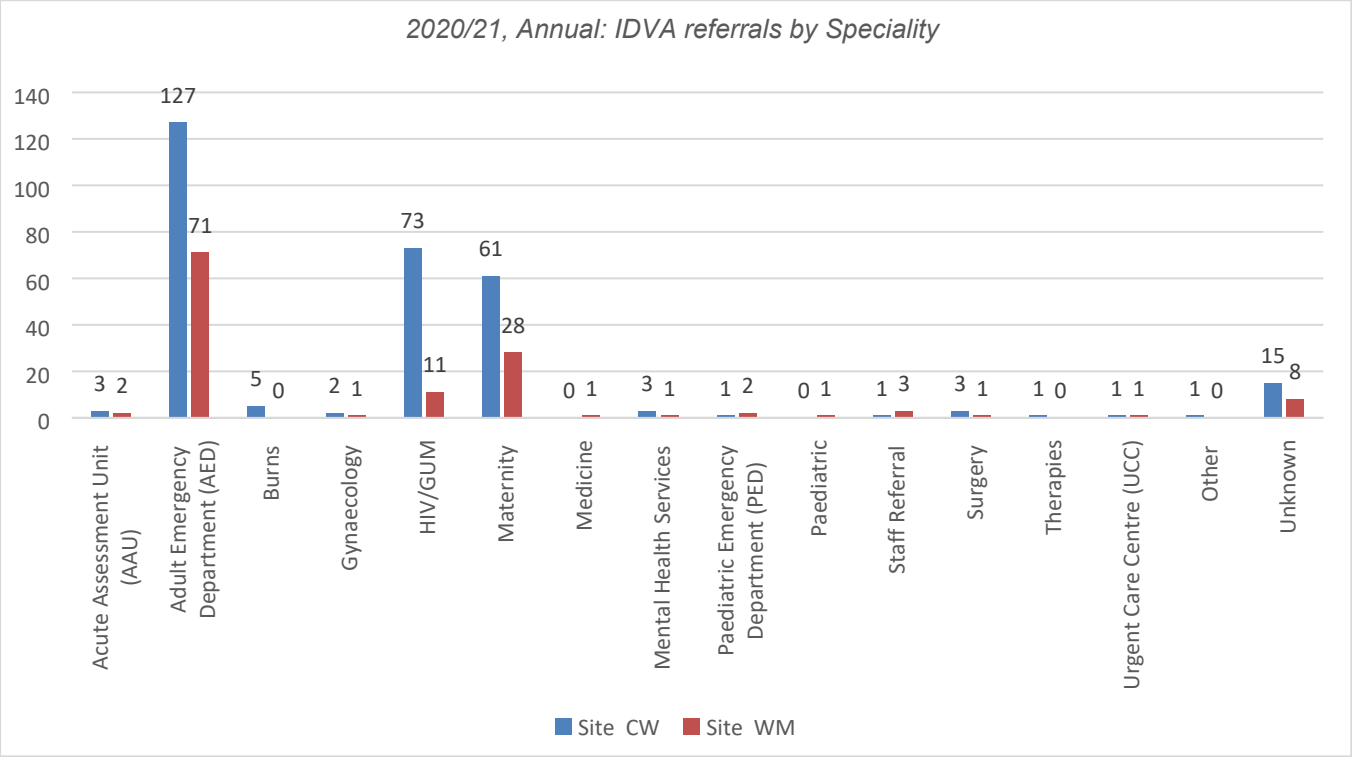


*Figure 7:**Blue** **CW** **Red** **WM***



Other = Adult Social Care (CWFT located)

Table 3: Training Data 2020/21										
Category of training	**Session No. Q1**	**No. trained Q1**	**Session No. Q2**	**No. trained Q2**	**Session No. Q3**	**No. trained Q3**	**Session No. Q4**	**No. trained Q4**	**Session No. 2020/21**	**No. trained 2020/21**
Level 1 (Basic DA Awareness):	4 (+E Learning and voiceover sessions)	388	19 (+E Learning and voiceover sessions)	468	19 (+E Learning and voiceover sessions)	550	15 (+E Learning and voiceover sessions)	668	57 (+E Learning and voiceover sessions)	2074
Level 2 (DA Awareness):	2	30	14	105	15	139	7	19	38	293
Level 3 (DAL Training):	1	6	2	7	4	16	2	7	9	36
Level 4 (DAL Supervision and specialist training):	0	0	2	6	1	8	2	8	5	22
TOTAL:	**7** (+E Learning and voiceover sessions)	**424**	**37** (+E Learning and voiceover sessions)	**586**	**39** (+E Learning and voiceover sessions)	**713**	**26** (+E Learning and voiceover sessions)	**702**	**109** (+E Learning and voiceover sessions)	**2425**

Training Data, 2020/21:

Table 4: Training Data by Level/Year			
Category of training	**Number Trained**		
	2018/19	**2019/20**	**2020/21**
Level 1 (Basic DA Awareness):	4357	2392	2074
Level 2 (DA Awareness):	536	660	293
Level 3 (DAL Training):	54	86	36
Level 4 (DAL Supervision and specialist training):	55	73	22
TOTAL:	**5002**	**3211**	**2425** (-24%)

Annual Summary, 2020/21:

This year, training attendance numbers at all levels have reduced by 24% from 2019/20, which is attributed to training freezes during the Trust response to the Covid-19 pandemic. Significant efforts will need to be made in 2021/22 to increase training attendances back to the levels of previous years, with a recognition of the need for online sessions to be more frequently available.

A total of 36 DALs have been trained this year, which is a 58% decrease on totals DALs trained the year before. The Trust total DAL number remains high, at 324, with the majority 227 (70%) of these at CW, 83 (25%) at WM and the rest Trust-wide.

A key DA training achievement of this year has been obtaining a regular Level 2 training slot on the Trust's Level 3 Safeguarding Children and Adults training, which enables core staff members to receive DA training as part of mandatory training requirements.

Training Feedback:

On average participants rated the Level 2 training as 4.93/5 and Level 3 as 4.97/5. Some feedback from the sessions included:

Level 2:

"[I] feel more confident and can now address domestic abuse concerns. [I] know how to document and escalate my concerns."

"[I will be] more active in asking women about DA and more confident to respond to a disclosure and refer."

"[I have] increased in confidence and pathways of support / policies within the Trust and outside the Trust."

"With my knowledge regarding domestic abuse widened, I can understand the person who is undergoing such a situation. I can identify indicators and can manage the situation better, and/or if needs to be escalated."

Level 3:

"I feel more confident in asking about domestic abuse and how to formulate the question. I feel I can make a management plan, alongside colleagues, with greater confidence now. I will reflect on my language in documentation more."

"[This training has given me] confidence to risk assess appropriately and appropriately refer patients in my care."

"I will be more aware of subtle signs of domestic abuse and know how to ask women about this appropriately."

"[I have] increased confidence and understanding, this will aid me in supporting junior staff."

Training progression plans, 2021/22:

- To increase training attendance numbers at all levels to the high figures of 2019/20.
- To ensure that sufficient DA training is provided to midwives as part of their mandatory safeguarding training:
    - The current plan, formulated with the DA Coordinator and Safeguarding Maternity Lead:
        - All midwives will receive Level 2 DA training and a case study discussion session.
        - Core staff (such as Socially Complex Leads, Clinical site managers and Community midwives) will receive DAL/Level 3 training as part of their core safeguarding training.
        - Level 4 DA training (such as DAL Supervision) will count toward safeguarding hours on staff's safeguarding passport.
    - It is expected that this training plan will begin in September 2021.
- To provide a diverse menu of Level 4 training to enable DALs to improve their professional development:
    - Sessions in on Trauma-Informed Practice and Responding to Perpetrators are planned for May and July 2021, respectively.

- Further sessions will continue to be planned.

- For all Clinical Site Managers to be Level 3/DAL trained by the end of 2021/22.

- For dedicated Level 2 training sessions for HR and Occupational Health staff to take place and to build a network of HR/Occupational Health DALs to enable better support for Trust workers experiencing DA.

    - The first Level 2 HR/Occupational Health training session is booked for May 2021.

- To begin dedicated Level 1 training sessions in WM ED and continue these sessions in CW ED.

Other Updates, 2020/21:

Spotlight on WM:

In October 2018, the Trust's full-time DA Coordinator started in role, with a primary aim of aligning the Trust's DA response across WM and CW sites. Since then, major steps to align working practices have taken place, including:

- Unifying IDVA and MARAC referral forms and pathways
- Introducing regular DA training at WM sites, including DAL training
- Unifying data collection and reporting systems
- Including routine enquiry prompts within WM HIV/GUM

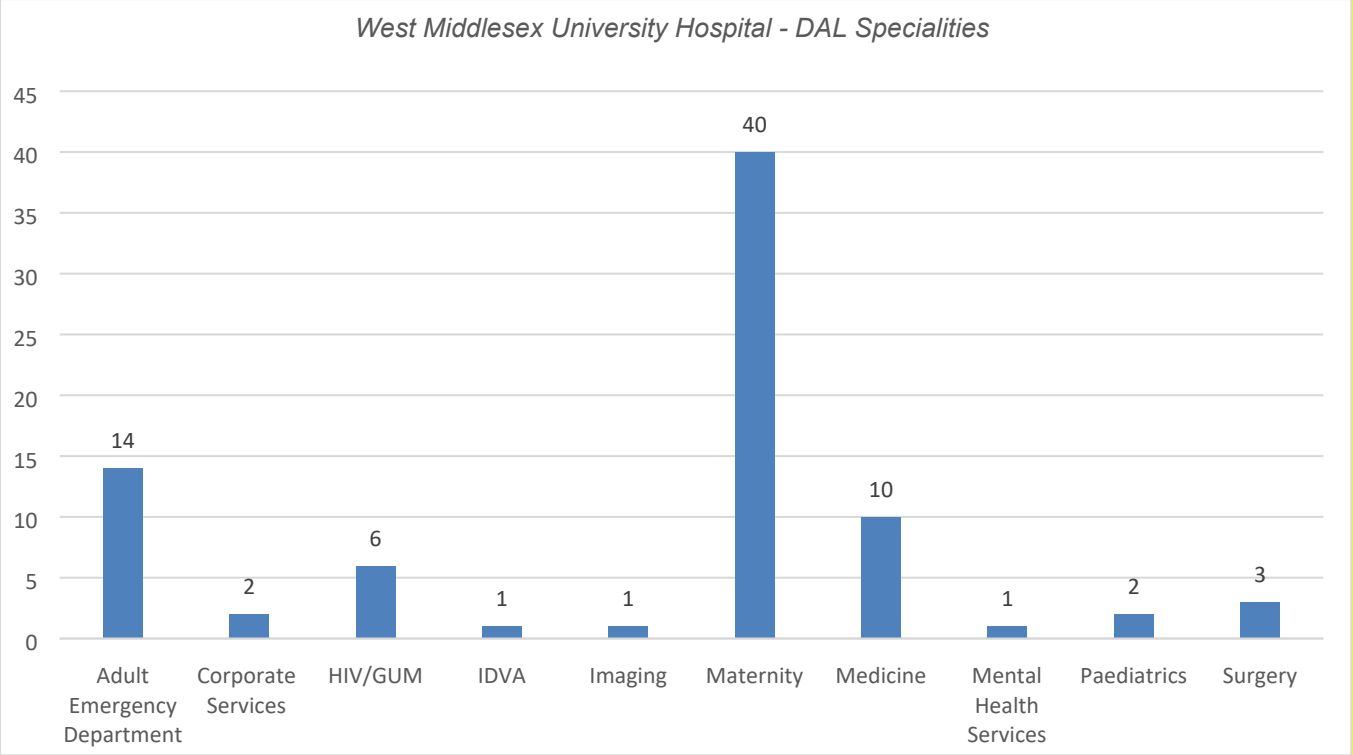
Table 5: West Middlesex University Hospital DA Referrals 2018/19 – 2020/21

IDVA Referrals					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
2018/19	37	32	23	32	124
2019/20	28	33	27	22	110
2020/21	13	37	41	40	131
MARAC Referrals					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
2018/19*	0	1	2	0	3
2019/20	4	11	7	15	37
2020/21	13	13	24	22	72

* Data gathering processes not fully established.

WM has seen huge increases in MARAC referrals being made increasing from 3 in 2018/19 to 72 in 2020/21. IDVA referrals have also increased by 5%..

Dedicated, standalone DA training started on WM sites in October 2018. Sessions have included training at Level 1-4. There are now 80 DALs working within WM sites from 10 different specialities.



Progression plans, 2021/22:

- To work with the wider safeguarding team and Cerner team to tailor Cerner to embed e-referral forms meet data capture needs.

- To develop a new look Safeguarding report from the CIC form in Cerner – now that this has been in use for 18m and adopted across both hospital sites with the new amendments added at the end of Q4 in 2020/21.

- Bid submitted to Ministry of Justice in June 2021 for a specialist LGBT IDVA from GALOP – more information to follow in Q1 or Q2 2021/22 on outcome.

- To produce a standalone staff DA policy to outline the Trust's response to support the safety and emotional wellbeing of its workers.

    - This policy will include the response when both a survivor and perpetrator work within the Trust and will be informed by the staff consultation survey and focus groups with HR, Occupational Health and Legal staff, as well as national best practice and policy guidance.

    - It is aimed that this policy will be published alongside the rolling out of tailored training in supporting staff, targeted at line-managers and HR staff.

- To support an in-depth economic evaluation into the Trust's DA response from 2013-present.

    - This is a piece of work which will be conducted by a researcher from Exeter University, funded by the Pathfinder project.
    - There are seven publications around CWFT DA work planned, the first of which has been submitted in June 2021.

- To create long-term practice and processes to enable the Trust to engage in local MARAC processes, including providing research, attending meetings and feeding back outcomes and actions.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**3.3**
TITLE OF REPORT	**Winter Plan 2021/22**
AUTHOR NAME AND ROLE	Laura Bewick, Divisional Director for Emergency Care
ACCOUNTABLE EXECUTIVE DIRECTOR	Rob Hodgkiss, Deputy Chief Executive Officer & Chief Operating Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To appraise the Board of the Winter Plan for 2021/2022
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Executive Management Board; Date of Meeting: 27.10.21; Outcome: Agreed
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Winter Plan details the key initiatives in place to support the Trust meet an increase in non-elective demand over the winter period, as well as service specific plans for each of the effected service areas. It is assumed that during winter 2021/22 mitigations for increase in non-elective demand cannot impact on the elective recovery programme. Key initiatives are aimed at reducing demand on front door services, and supporting hospital flow through either admission avoidance or earlier discharge. This includes: • UTC redirection • Increased utilisation of SDEC • Discharge Hub arrangements • COVID virtual ward • Increased 7 day working The Winter Plan also sets out the plan for management of non-elective beds on both hospital sites including arrangements for the opening and management of escalation beds. Plans for management of season infections including noravirus, flu and COVID-19 are also included.
KEY RISKS ARISING FROM THIS REPORT	Demand exceeds capacity

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Winter Plan – 2021/22

Chelsea and Westminster Hospital NHS Foundation Trust

1 Introduction

1.1 Aims of the Plan

The Trust-wide Winter Plan sets out the organisations arrangements for ensuring service delivery throughout winter 2021/22. For the purposes of this document 'winter' is defined as November through until March.

Although not an emergency or unexpected event, the winter period sees an increase in emergency and non-elective demand and increased clinical acuity of patients, resulting in increased pressure on patient flow and hospital resources.

The winter period also often brings with it untoward events such as widespread infectious diseases including Norovirus, and there is the risk of the onset of pandemic flu.

During 2020 and 2021, the NHS, and the Trust, has been significantly impacted by COVID-19. Winter planning must therefore also include preparation for managing an increase in covid admissions alongside usual winter pressures; including planning for the necessary surge capacity and Infection Prevention and Control guidance.

The winter plan follows guidance from the NHS England and Improvement in terms of content and approach and recognises key risks to patient care, safety and experience, as well as to the organisation.

In partnership with winter plans across the wider health and social care system, the Trust plan sets out a number of key initiatives to help meet the challenges of winter, as well as service specific plans for each of the effected service areas. Key initiatives include:

Managing Non Elective Demand:

Front Door Schemes

- 111 Direct UTC booking
- UTC redirection to primary care
- Increased Utilisation of Same Day Emergency Care (SDEC)

Inpatient Flow

- Discharge Hub arrangements
- 24/7 Hospital
- COVID Virtual Ward
- Hospital Control Centre
- Management of Escalation Beds
- Phasing of Elective Activity

Capital Works

- CW David Erskine Refurbishment
- Creation of additional bed spaces

Infection Prevention & Control:

- Noravirus
- Flu
- Covid (inc zoning)
- Use of siderooms

Business Continuity:

- Cold Weather Planning

2 Context

2.1 The Trust

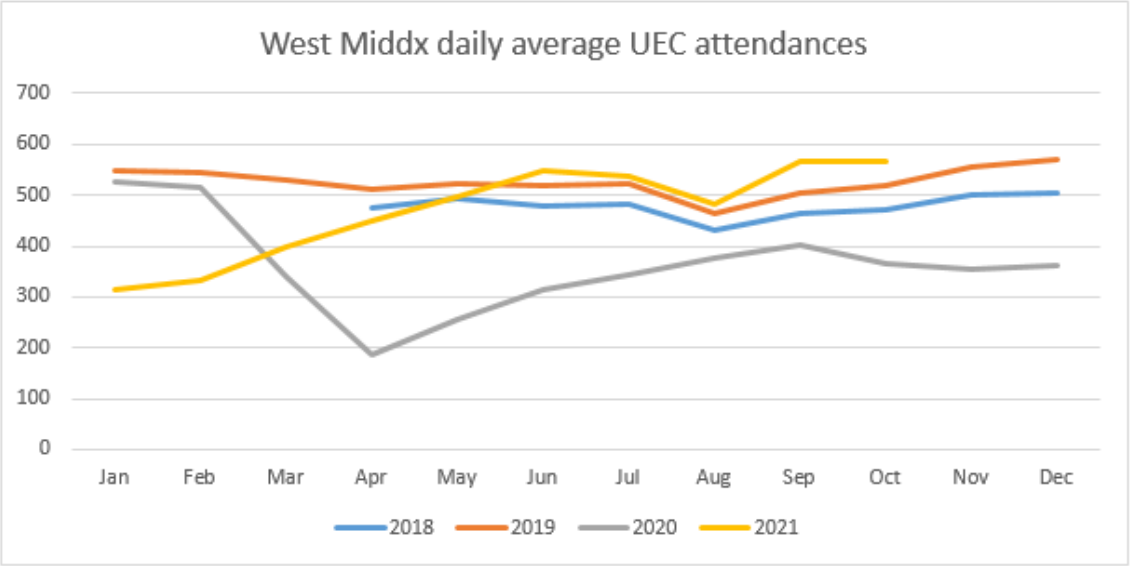
Chelsea and Westminster Hospital NHS Foundation Trust (CWFT, the 'Trust') is a major, multi-site North West London healthcare provider and teaching hospital consisting of Chelsea and Westminster Hospital situated in the borough of Kensington and Chelsea, and West Middlesex University Hospital, situated in Hounslow.

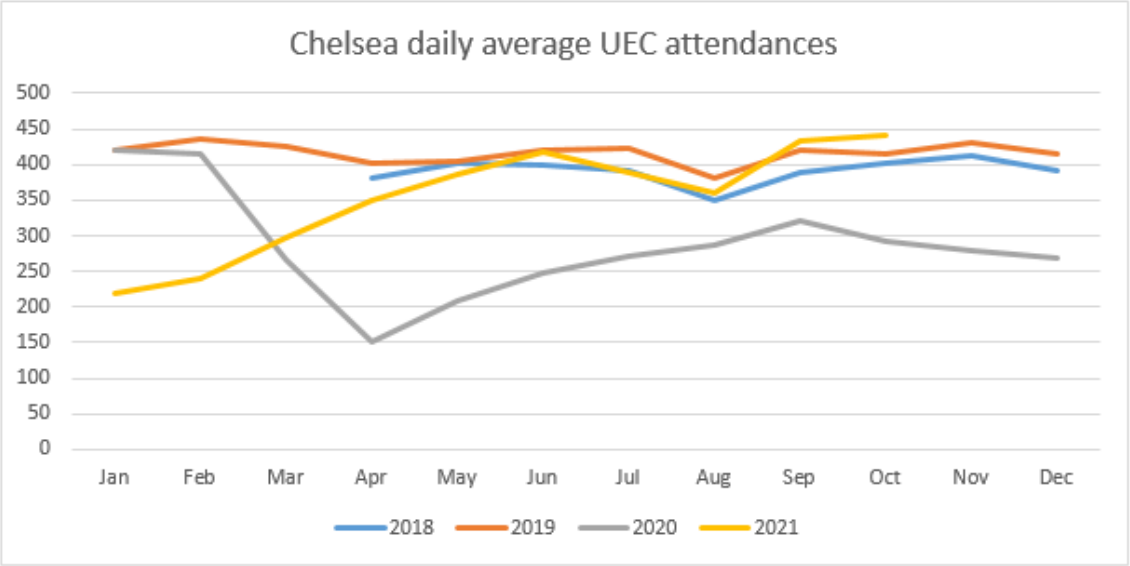
Both hospitals offer core local services including 24/7 adult and paediatric A&E services with co-located Urgent Treatment Centres (UTCs), a full maternity service and a range of medical and surgical specialties.

The Trust has 1,000 beds and serves a local population of 1.1m. In 2019/20 there were over 320,000 attendances to the A&E and Urgent Care Centres across both sites; the 5th highest number of attendances at an acute Trust in England. In 2020/21, although there was a decrease in activity, the front door has been challenged by high patient acuity, a rise in Urgent Care attendances and the requirements of COVID IPC including the need for rapid testing for admission.

2.2 Activity & Performance

In line with previous years, during 2019/20, the Trust saw an increase in A&E and UCC attendances compared to the previous year, with this running at 4.5% growth until the beginning of the covid pandemic. Whilst there has been a reduction in emergency attendances during 2020/21, these have continued to increase month on month and are now at similar levels to 2019/20.





Despite this growth, the Trust has continued to perform well against similar organisations in London. This winter the Trust will begin shadow reporting against the new Urgent and Emergency Care standards from November 2021.

3 Front Door Schemes

Evidence suggests that the longer patients wait in the Emergency Department the greater risk there is to morbidity and mortality, and that 'boarding' (patients remaining in the department whilst waiting for a suitable inpatient bed to become available) is likely to increase length of stay, detract from overall patient experience and risk breakdown in communications because of the number of hand offs/transfers involved. Patients waiting in the Emergency Department for an inpatient bed also reduce the capacity in the department to see and treat patients, resulting in longer waiting times in the department and impacting on the ability of ambulance teams to unload patients. During winter 2021 the pressure on ED and UTC capacity will be further challenged by the requirement to ensure patients are socially distanced in waiting whilst waiting for their treatment.

A number of schemes will therefore be in place for the winter period to maintain patient flow through, and safety in, the Emergency Department.

3.1 111 Direct UTC bookings

During winter 2020 NHS England ran a national pilot encouraging patients to contact 111 before seeking care; 'talk before you walk'. The aim of this initiative is to ensure patients are directed to the most appropriate care setting for their needs, alleviating pressure on Emergency services. To support this initiative Emergency Departments were asked to put in place bookable appointments slots for 111 providers to offer to patients, helping activity to be managed in a more planned way and also encouraging patient use of 111 through the offer of shorter waiting times in the ED.

Chelsea and Westminster ED piloted this initiative for North West London with appointment slots going live at the end of September 2020. These slots were expanded from March 2021, with appointment slots being available 24 hours a day, 7 days a week. This activity model is mirrored on the West Middlesex site, with 4 slots an hour available for booking by 111.

It is anticipated that the department will be able to better manage this activity as a result of notification from 111 that patients are being heralded to the Emergency Department. Over the winter period it is hoped that the national directive for increased use of 111 will result in a larger proportion of patients being directed to ED following a discussion with a 111 GP rather than attending the department directly. If successful this should help manage demand on Emergency Departments as patients are directed to seek care in more appropriate settings, i.e. GP Hot Hubs or Pharmacies.

3.2 Increased Utilisation of Same Day Emergency Care (SDEC)

During 2018/19, a business case for capital and revenue investment in Ambulatory Emergency Care (AEC) was approved, increasing capacity on both hospital sites. During winter 20219/20 further capital was provided by the Department of Health to increase the physical capacity further. There is now 08:00-20:00 service provision Monday – Saturday and 09:00 – 17:00 on Saturdays and Sundays, with a set of standardised pathways in place, and a number of 'hot clinics' established with medical specialty teams to enable patients to be followed up in a more timely way.

Over the winter a number of initiatives will be in place to ensure utilisation of AEC capacity and to divert patients from our Emergency Departments. These are detailed in section 8.2 and include:

- Co-location of the AEC and Acute on-call teams to ensure the default pathway for appropriate patients is seen as AEC, and efficient use of resources.
- Incrementally moving to symptom-based rather than condition-specific pathways, to broaden the opportunity for referral.
- Expansion of Hot Clinics to further specialties
- Agreement of pathway with LAS / 111 to take direct ambulance conveyances

In the winter of 209-20, it was demonstrated that an increased use of AEC capacity greatly alleviated pressure on the Emergency Department and facilitated early discharges from inpatient wards. It is anticipated that the further increase in utilisation will continue to alleviate pressure.

Surgical SDEC

Following changes to the surgical bed base across the two sites due to COVID, benefits were seen in utilising surgical pathways through AEC at both sites.

At the West Middlesex site Planned Care have lost the ability to use Richmond ward as an inpatient surgical space as this is required for ITU surge capacity. While the bed base on the Chelsea site remains the same in total the ability to place non-elective patients on Edgar Horne has been lost due to the COVID protected pathway restrictions.

Pathways in Obstetrics and Gynaecology were successfully piloted at the West Middlesex site, and these are now being replicated at the Chelsea site. In November 2020, the surgical SDEC pathways were launched with a focus on general surgery and urology. These have been successful in supporting admission avoidance schemes and keeping patients out of hospital.

Other learning from the COVID experience involves improved partnership working with our community colleagues to maximise the opportunities for earlier transfer of care to community teams and working with these teams to help prevent admission. The regular OPAT MDT meetings jointly held with the AEC clinicians and Community team ensured safe, early transfer of care to the community for patients requiring on-going IV antibiotics continues to be very effective. In addition, working with the ICRS with clinical support from AEC a pilot was undertaken to provide IV infusion therapy for patients within their own homes who would otherwise have been admitted. The numbers of patient managed in this way was small but significant and the teams are working together to expand the scope of this provision over the winter period.

3.3 UTC redirection

In July 2021, an 8 week joint pilot was conducted between CW Emergency Department and a local GP hub. Patients booking into the department were offered to be redirected to a telephone appointment with a local GP. The slot profile was difficult to match with appropriate patients and daily utilisation did not exceed 60%.

An alternative scheme is being finalised with the former Walk-In Centres at Parsons Green and St Charles, which have re-opened but currently for booked appointments only. A more flexible slot allocation process is envisaged, with patients initially receiving telephone triage by the WIC staff for subsequent phone, video or face-to-face appointments. This will be an ANP rather than GP-led service, which will affect the patients we can redirect. But significantly, Parsons Green may be able to take dressing changes, which currently accounts for a significant number of primary care-appropriate attendances at the UTC.

The increased use of these slots will support in social distancing within the waiting room of the Emergency Department and reduce the volumes of patients waiting to be seen.

4 Inpatient Flow Schemes

4.1 Discharge Hub arrangements

A long stay patient is defined as an adult patient who has been in an acute bed for 21 days or longer. There is strong evidence that long stays in hospital lead to patient deconditioning, harm to patients and unnecessary additional demands on health services. The aim is to therefore discharge patients as soon as they no longer will benefit from acute hospital care, ideally to their original place of residence.

A number of initiatives will be used to ensure that patients who no longer have the right to reside, with proactive management, will achieve a reduced length of stay:

- Daily senior led ward board rounds ensuring accuracy of anticipated discharge date and recording of Red:Green
- Site specific discharge hub with dedicated community appointed discharge hub lead as well as acute specialist discharge nurse support. Operational 7 days a week with daily multi professional meeting to discuss all patients without right to reside
- Clinical Operations Hub will be fully operational and supporting all clinical areas in ensuring timely care and assessment.

4.2 24/7 Hospital

To ensure that robust plans are in place for all inpatients a daily, morning board or ward round is required across all inpatient wards. Through use of Red2Green data it has been identified that there is not consistently a senior medical decision maker at all board rounds, and this can delay decision making and discharge planning.

Over the winter period, outpatient activity will be adjusted to ensure that a consultant or registrar is able to attend daily ward rounds, supporting earlier discharges and patient flow.

A review of A&E attendances and performance over the 24 hour period shows that there is a particular pressure on A&E and subsequent admissions during the ‘twilight’ period from 18:00 – 00:00. Whilst medical and nursing rotas have been adjusted to ensure that staffing models are matched to demand, it is acknowledged that increasing activity will require an increase in staffing in some areas to maintain safety and performance during the winter period.

To support site during these times a number of initiatives will be in place:

- CCOT service is fully recruited
- Additional B7 Senior Site Sister team is in place out of hours supporting the site manager at night on both sites and working in a clinical nurse practitioner role to support the medical teams.

With increased demand over winter, particularly out of hours, on-site cover is required from the senior management team during weekends and evenings.

The ‘Senior Nurse on Site’ model will continue, providing senior nurse cover on each site until 20:00 on week days, and from 09:00 – 17:00 at weekends. This will run separately and in addition to the Senior Manager On Call (SMOC) and Director On Call (DOC) Rotas.

4.3 Covid Virtual Ward

The expansion of the virtual ward will be key in both supporting early discharges and with admission avoidance.

Within the Ambulatory Emergency Care (AEC) units on both sites, patients are currently followed up virtually by the acute medical team following investigations/blood results. This allows flexibility in ensuring that urgent investigations happen but that a patient does not have to remain as an inpatient. It gives the clinical assurance that the patient will still be under review and at any point can be brought in for a face to face review.

Over winter this service will be continue to include patients attending A&E who need urgent investigations. They will be streamed to AEC avoiding the need for admission. The virtual ward will also support the follow up of covid respiratory patients who are discharged but remain under the care of the respiratory team. The medical team in AEC will be able to support in remote monitoring and discharging the patients off the pathway where appropriate.

4.4 Clinical Operations Hub

To further support site operations and patient flow over the winter period and beyond, in September 2020 the Trust launched the 'Clinical Operations Hub'.

Conceptually, an Operations Control Hub is a source of leadership and guidance to ensure that service and order is maintained, rather than an information center or help desk.

Its tasks are achieved by monitoring the environment and reacting to events, from the relatively harmless to a major crisis, using predefined procedures. It enables the real-time visibility and management of an entire service operation, ensuring an organisation functions as designed.

Working together, the Information, Digital and Site Operations teams have developed clinical and non –clinical indicators and using existing data, changed existing roles and responsibilities within divisional and corporate structures to support overall patient flow and patient safety.

The Clinical Operations Hub will run from West Middlesex Hospital and cover both hospital sites. Detail of the work plan and progress is to be monitored via Bed Productivity Programme

4.5 Escalation Beds

As the winter period sees an increased number of non-elective admissions, it is anticipated that escalation beds will need to be opened on both sites to cope with this demand. This will need to be managed around covid surge plans.

On Chelsea site, the current configuration of wards provides Saint Mary Abbott (SMA) ward as escalation to be used over the winter period.

At the time of writing this plan, the ward is being used to allow for the refurbishment of David Erskine Ward which is anticipated to complete in December 2021.

Further escalation beyond SMA ward would impact on elective work as follows:

Gazzard Day Unit, 6 beds (impact on elective chemotherapy)

Edgar Horne Ward, 28 beds (would halt elective surgery)

On West Middlesex site, escalation capacity is limited by a lack of physical space.

During previous winters elective bed capacity on the West Middlesex site was converted non-elective beds. This winter 2021 there can be no escalation into DSU on the WM site due to impact on the COVID protected elective pathway.

The only available escalation capacity will be Richmond ward, 23 beds

A checklist for opening escalation areas safely has been agreed and must be used when opening escalation beds, and can be found on the Trust intranet:

http://connect/EasysiteWeb/getresource.axd?AssetID=28380&type=Full&servicetype=Attachment

4.6 Management of Elective Activity

There is a risk to elective activity on both sites due to the potential of increased emergency admissions.

The risk on the Chelsea site is mitigated by day case elective admissions being managed through the current allocated surgical elective beds which are used exclusively for this cohort of patients only. In severe pressure elective day case patients can be managed through the treatment centre recovery areas.

There is no planned phasing to reduce elective admissions on the west Middlesex site.

The planned HDU/ITU admissions will be scheduled to ensure only one per day on the CW site and will be reviewed the day before surgery, this will support the need for emergency HDU/ITU admissions Monday to Friday.

5 Infection Prevention & Control

5.1 Norovirus

Last winter there were no reported outbreaks of norovirus across the trust. Nationally there was also a substantial reduction in positive norovirus outbreaks reported to PHE since mid-March 2020 compared to the average of the same period during the previous 5 seasons. Many of the interventions implemented to reduce SARS-CoV-2 (COVID-19) transmission, isolation of sick individuals, increased hand washing and enhanced environmental cleaning, are also effective against norovirus. However it is important to remember that alcohol hand gel is ineffective against norovirus.

However, norovirus remains a possible threat to patient safety and disruption of services. It is important that clinical staff remain vigilant and report any increased incidence of diarrhoea and/or vomiting to the IPC team, at the earliest opportunity, to facilitate investigation and optimal management of actual or possible outbreaks. Nationally norovirus laboratory reports have been increasing since week 25 of 2021 and during weeks 35 to 38 the total number of reports was 37% higher than the average of the same period in the previous 5 season's pre-COVID-19.

5.2 Influenza

Last year influenza levels locally, nationally and globally were at a record low which has been attributed to the initiatives implemented in response to COVID-19 such as mask-wearing, physical

and social distancing, and restricted international travel. As social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal influenza virus (and other respiratory viruses) will co-circulate alongside COVID-19 (DH 2021). The Trust has already started to see some cases of both Influenza A and B.

The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2021 to 2022 are currently unknown, but mathematical modeling indicates the 2021 to 2022 influenza season in the UK could be up to 50% larger than typically seen and it is also possible that the 2021 to 2022 influenza season will begin earlier than usual (DH August 2021).

Influenza vaccination is therefore an important priority this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisation during a time when the Trust may also be managing winter outbreaks of COVID-19.

A comprehensive Seasonal influenza plan 2021-2022 has been prepared and approved. The plan includes vaccination, testing, treatment, and prophylaxis as well as IPC precautions.


Seasonal Influenza Plan 2021-22 - FINAL

5.3 COVID-19

In response to COVID-19, a coordinated trust-wide approach to infection prevention and control continues including close collaboration with Public Health England (PHE). PHE guidance is interpreted and implemented by the Trust particularly on the application of Standard Infection Control Precautions (SICPs) and the requirement for physical distancing and extended use of face coverings whilst in hospital settings and the implementation of staff lateral flow testing and a staff vaccination programme. The Trust also has in place a robust rapid testing algorithms for SARS-CoV-2, Influenza and other respiratory viruses.

The appropriate utilisation of side rooms will be essential to appropriately manage and contain COVID-19 and other infections. Requirements and prioritisation for individual infections are listed in the Trust Isolation Policy. Patients admitted with COVID-19 or influenza like symptoms will require a side room until diagnosis is confirmed or excluded. COVID-19 positive patients and patients with the same strain of influenza may be cohorted in a designated bay/ward in collaboration with the IPC team.

Effective communication is a key strategy for disseminating the plethora of policies, standard operating procedures and guidance developed by the IPC team on the management of COVID-19, including guidance on IPC precautions, staff and patient testing, patient transfers etc.

The utilisation of ‘COVID-19 managed’ wards to manage positive patients and patient flow is important way of containing and preventing outbreaks and aided by adherence to step down of IPC precautions guidance for COVID-19 patients.

Between the months of October 2020 and March 2021, the Trust experienced and managed 20 outbreaks of which the lessons learnt inform the continued management of the virus.

New PHE IPC guidance is awaited in October 2021 and will help inform local respiratory pathways and patient placement and rapid testing will be key to the ogoing patient placement and flow.

5.4 Management of Side Rooms

The appropriate utilisation of side rooms will be essential to appropriately manage and contain COVID-19 and other infections. Requirements and prioritisation for individual infections are listed in the Trust Isolation Policy. Patients admitted with COVID-19 or Influenza like symptoms will require a side room until the diagnosis if confirmed or excluded. COVID-19 positive and patients with the same strain of Influenza may be cohorted in a designated bay/ward after discussion with the IPC team.

5.5 Capital builds

1) Redevelopment of David Erskine

The capital programme to re develop the respiratory unit on David Erskine (28 beds) was approved for re-start by Capital Board and Finance & Investment Committee and the programme was formally restarted week beginning 30 September. An accelerated programme has been established (including weekend working and parallel commissioning) which brings forward the planned completion and handover from 22 December **to 6 December**

2) Development of temporary side room capacity

Chelsea site has been exploring the development of additional side room capacity as an alternative to increasing number of bed spaces on the main IP areas. At this stage this is a feasibility proposal and still requires sign off on:

- quality/safety
- staffing

Next step is proposed as Ward Restart template used as checklist to test quality and safety; and Divisional Lead Nurse/Matrons test staffing feasibility

The proposal is to create up to 14 additional beds through use/conversion of side, day and other ambulant rooms. This would provide temporary capacity to mitigate the indicated risks on bed capacity for winter 21/22. This would be established in 2 phases:

Phase 1	5 beds	SMA swap room @ 1 Nightingale D/R @ 2 AAU Investigation Suite @ 2	All areas have bedhead services Beds and stock available Minor conversion works	Available within 48h subject to quality and staffing checks
Phase 2	9 beds	Lord Wigram D/R @ 2 Rainsford Mowlam D/R @ 2 Nell Gwynn D/R @ 2 David Evans D/R @ 2 SMA D/R @ 1 (benching in day room means no space for beds)	No bedhead services in place: Mobile o2 and suction required Curtain rails/screens or P&D requirements Nurse call systems Bed rental (assumed as between3-6 months)	Available within 1 month subject to: Quality and staffing checks Purchase/rental of equipment (*)

(*) Provisional cost of 50k for 6 month period covers cost of suction, trollies, nurse call and bed rental; and all minor conversion works

6 Business Continuity

The Trust has business continuity strategies and plans in place to deal with a range of challenges that might affect services and functions at any time – this includes staff shortages, denial of access, failure in technology and loss of utility. These plans enable a response to a disruptive challenge to take place in a coordinated manner including processes for recovery and restoration of essential functions and services.

Strategic and tactical level business continuity plans have been established. The roles and responsibilities of individuals are detailed and the recovery priorities summarised. The following of these plans will assist recovery, ensuring a return to business as usual in as timely a manner as is possible.

If operational activities were adversely impacted, without appropriate business continuity arrangements in place, the Trust could be considered not to be adequately prepared. This lack of

preparedness could lead to a missed opportunity to mitigate poor resilience. Legislative measures and the main tools linked to business continuity are noted below:

- Civil Contingencies Act 2004. *http://www.legislation.gov.uk/ukpga/2004/36/contents*

- Emergency Preparedness, Resilience and Response (Trust Intranet) (containing multiple documents). *http://connect/departments-and-mini-sites/eprr/*

6.1 Weather

The Trust has a comprehensive Cold Weather Plan which comes into force on 1st Nov annually. The latest version can be found here - http://connect/departments-and-mini-sites/eprr/cold-weather/. Our Cold Weather Plan contains trigger points and associated required actions for all Trust staff, including Estates and PFI partners.

At the time of writing Public Health England have not produced their annual advice. Once this has happened our plans will be modified to reflect such guidance.

7 Service Specific Action Plans

Progress against actions will be monitored fortnightly through the Bed Productivity Programme.

7.1 Emergency Medicine

Action	Lead	Action due date	Risk assessment	Update
Escalation plans to be reviewed and confirmed for both Emergency Departments	Gareth Wright CW – Kris Pillay WM – Max Friedman	31 Oct 21	Green	
Align medical workforce to anticipated demand: • Confirm baseline rota requirements • Issue guidance on Leave, training & CPD • Plan response to escalation plan • Focus additional Consultant cover	James Rowe Lorraine Herbert	31 Oct 21	Amber	

Action	Lead	Action due date	Risk assessment	Update
Front door optimisation: • Confirm Redirection opportunities to GP appointments and community alternatives • Further enhance streaming to AEC • Supplement triage within escalation plan	James Rowe Lorraine Herbert	15 Nov 21	Amber	
Encourage providers to increase use of NHS 111 heralded and booked appointments	Gareth Wright	30 Nov 21	Amber	
Further review patient waiting room experience: layout, capacity options, flow, communication.	James Rowe Lorraine Herbert	31 Oct 21	Amber	

7.2 Ambulatory Emergency Care

Action	Lead	Action due date	Risk assessment	Update

Action	Lead	Action due date	Risk assessment	Update
Encourage increased external referrals to AEC: • Adopt symptom-based SDEC pathways (in place of restrictive condition-based), as soon as clinically approved • Renewed Communication efforts with GPs and NHS 111 providers	Richard Ingrey Sanjay Krishnamoorthy Sofia Cavill	30 Nov 21	Amber	
Enhance internal referrals to AEC: • Within ED front door streaming • ED return safety netting • As a facilitated discharge opportunity from inpatient wards • Promote as the pathway of choice	Gareth Wright Richard Ingrey	31 Oct 21	Amber	

Action	Lead	Action due date	Risk assessment	Update
Expand the AEC offer: • Further develop 'hot pathways' in conjunction with medical specialties • Fully launch the frailty/falls pathways • Facilitate increased Surgical, Ortho and Gynae SDEC on both sites	Richard Ingrey Sanjay Krishnamoorthy Sofia Cavill	30 Nov 21	Amber	

7.3 Medical Specialties

Action	Lead	Action due date	Risk assessment	Update
Review ward cover on medical wards ensuring senior presence (ST3+) at board rounds every day.	Anna Letchworth/Phil Lee/Emma Rowlandson	October 20	Green	Job plans to be reviewed again and clinics reduced in the AM where necessary.
Review out of hours medical cover to support increased weekend discharges	Anna Letchworth/Phil Lee/Emma Rowlandson	October 20	Amber	

Provision of 7 day cardiology service	Anna Letchworth/Emma Rowlandson	October 20	Green	7 day service in place on both sites
Agree configuration of medical beds on both sites to facilitate covid surge and/or winter escalation	Anna Letchworth/Phil Lee/Emma Rowlandson	September 20	Green	Complete

7.4 Discharge Teams

Action	Lead	Action due date	Risk assessment	Update
Discharge Hubs to be fully recruited to as per agreed NWL business case as well as a Trust wide education and awareness programme regarding roles and responsibilities	Richard Turton/Christina Richards/Emily Karugaba	November/December 2021	Amber	This continues to be discussed and monitored at NWL level.
Discharge concerns raised by the community continue to be discussed on a monthly basis and fed into the bimonthly clinical governance meeting	Christina Richards/Emily Karugaba	Throughout winter period	Green	Ongoing and cross site
Time of Day of Discharge – to ensure flow as well as reducing to 20% or fewer the number of discharges after 5pm as well as 2B412	Jacky Sinclair/Richard Turton	Throughout winter period	Red	Requires greater view at all meetings and monitoring on a daily basis.
Long length of stay (14+ and 21+) - to maintain current levels during the winter period	Jacky Sinclair/Richard Turton	Ongoing	Green	Re-engage clinical teams by October 2021 with a focus on ward level clinically led plans to ensure high standards of clinical care in the shortest possible time.

Clinical Operations Hub to incorporate additional functionality - in particular side room usage and infection control	Richard Turton/Bruno Bothelo	Nov-21	Amber	Side room monitoring tool currently being developed
Perfect Week to be undertaken 1st - 7th December 2021 and February 2022	Richard Turton/Charlotte Travill	Dec-21	Amber	To determine dates for Perfect Week in February 2022. GP funding secured for primary care involvement for both weeks.
Resilience of clinical site teams to be reviewed to ensure able to manage within current establishment	Richard Turton	Nov-21	Amber	Consultation paper written and currently with Staff Side for comment

7.5 Emergency Surgery

Action	Lead	Action due date	Risk assessment	Update
Surgical Consultant to decide if patient needs admission or can be supported via SSDEC pathway.	Gareth Teakle	Complete	Green	*Already operational in hours. Plan agreed to enact out of hours, however this would be at times of a site 'black' position.*

Dedicated service manager and nursing lead to manage daily surgical bed capacity and flow. Support with admissions from site and wards with discharges.	Planned Care General Managers	Complete	Green	*Plan ready to enact when needed, there would be an impact on other divisional workflows.*
Extended opening of SSDEC if required.	LN SSDEC	Ongoing	Red	*Adverts onto TRAC, internal movements not possible.*

Planned Care beds

Action	Lead	Action due date	Risk assessment	Update
Close Richmond to inpatients Fri-Tue or Mon-Sun and open an non elective ward.	Trimuverate	Complete	Green	Plans agreed and ready to enact.
Support medical patients in surgical bed base.	Trimuverate	Complete	Green	Enacted and operational.
ICU at WM to remain at 12 beds rather than baseline 9 beds.	Trimuverate	Complete	Green	Enacted and operational

7.6 Elective Surgery

Action	Lead	Action due date	Risk assessment	Update
Increase elective capacity at WM	Gareth Teakle	ongoing	Amber	*Review of potential cost pressure moving to 6 day working.*
				Agreement made to run for supportive specialties only.
Limiting elective ICU admissions, particularly at WM.	Planned Care General Managers	November	Green	*Elective theatre list to be reviewed with site the day before. Potential patients needing cancellation to be discussed and plans agreed.*

7.7 Therapies

Action	Lead	Action due date	Risk assessment	Update
Senior therapy presence in ED to ensure early therapy intervention to support admission avoidance	Amy Carlile (WM) and Michael Shaw (CW)	In place	Green	In place
Daily therapy attendance at cross site bed meeting at 10am as SOP	Helen Stracey	In place	Green	In place

7 day (5+2) service to ED, Respiratory and Orthopaedic cross site	Jeremy Nugent	In place	Green	In place
Recruit to x2 Winter Posts (B6) for each site (OT or PT as required) to support flow, escalation areas, increased weekend capacity. Either short term contracts or longer term bank.	Helen Stracey	For Q3 and Q4	Amber	Part of regular winter planning in Therapies. Fixed term contact or Bank staff to be recruited and / or moved into post. May be affected by staff availability.
Ability to surge staffing in Physio Weekend Cover in Respiratory and Orthopaedics at CW and WM when required.	Helen Stracey / Edel McKeever	In place	Amber	In place, but a Cost Pressure. May be affected by staff availability.

7.8 Maternity and Women's Services

Action	Lead	Action due date	Risk Rating	Update
Monthly maternity demand and capacity meeting cross site – proactive transfer of women where needed	DOM	01/09/20	Green	In place
Maternity team to attend daily bed meetings	Maternity Bleep Holder	01/09/20	Green	Commenced

3 X weekly covid/staffing meetings	DOM	01/08/21	Green	In place
Continuation of Acute Gynae pathways through Elizabeth Suite	GM Womens	01/09/20	Green	In place
Increased Gynaecology SDEC at WM	GM Womens	01/11/20	Green	In place and ongoing

7.9 Paediatrics

Site	Action	Lead	Action due date	Risk assessment	Update
WM	Starlight to open to 24 beds	Mel Guinan	1st Nov	Green	Underway
WM	To have clear surgical pathways- Particularly with transfers through theatres	ShaunD'souza/ MKF	1st Sept	Green	Completed
WM	To Monitor PED flow at both sites for PED	Shaun D'souza	On-going	Green	Underway
WM	Implement 24/7 senior nurse Band 6/ role	Mel Guinan	1st Sept	Green	Completed
WM/CW	Finalise bed reconfiguration plans cross site to maximize cubicle capacity	Shaun D'Souza	1st Oct	Amber	Underway

CW	Open Mercury beds to 24 and increase staffing	Mel Guinan	1st Sep	Amber	Underway
CW	Open 2 PHDU beds for NHS-E winter pressures when needed and ensure a pathway in place for isolating children.	Martin Gray/ Mel Guinan	1st Nov	Amber	Underway
CW	Review Local policies in line with national guidance and infection control team i.e. cohorting, visiting, NIV and SGP	James Ross/ Martin Gray	1st Nov	Amber	Underway
CW	Relocate PAC to maintain/increase capacity	James Ross, Mel Guinan and Shaun D'souza	1st Nov	Amber	Underway
CW	Maintain green elective pathway at CW. Pathway to remain in place in event of 2nd wave in order to provide elective capacity for NWL. Dependant on PC anaesthetic requirements	Shaun D'Souza	1st Sep	Green	Complete

7.10 Pathology

Action	Lead	Action due date	Risk assessment	Update

Monitoring of pathology KPIs by Service Manager and DMD	Eleanor Long	Ongoing	Green	Weekly meetings in place for Blood science & virology between Trust and NWLP Contract managers. Weekly Cancer meetings between DMD and NWLP MD and Ops managers.
Winter Flu Planning	Winter Flu Planning Group	Complete	Blue	Flu testing plans and actions monitored tracked through Flu committee
Rapid molecular diagnostic lab on site	Eleanor Long Panos Panaglotis (NWLP)	Ongoing	Green	The business case to set up rapid molecular diagnostic laboratories at WM & CW has has been approved. To include SARS-Co-V2, FluA, FluB and RSV; as well as other rapid testing. Procurement exercise underway

7.11 Pharmacy

Action	Lead	Action due date	Risk assessment	Update
7 day service to ITU both sites (linked to the PCD ITU Business Case)				

Action	Lead	Action due date	Risk assessment	Update
Extend Pharmacy Service to WM AMU from 6 days to 7 days (£82k - 1 x B7 Pharmacist and 1 x Band 5 Medicines Management Technician)	Chisha McDonald	November 20	Amber	
Extend Out of Hours Service for Pharmacy at WM, from on-call from home to 24/7 service from site (£234k or 5 x Band 6 Pharmacists).	Chisha McDonald	November 20	Amber	

7.12 Radiology

Action	Lead	Action due date	Risk assessment	Update
Additional radiographer to support increased activity (1WTE radiographer between hours 8pm to 8am 7 days per week) due to; • A&E • More inpatients • To cover theatres when additional lists running	Dean Booth Aideen Millar Matt Parks	Complete	Green	- PC to provide business case detailing theatre activity requirements including increased headcount if additional radiographer required. - BC to be completed to support additional staff to be routine.
Rostering: • Additional insourcing from consultants in order to meet reporting demands during periods of leave. Outsourcing in extreme periods of shortage.	Dean Booth Aideen Millar Matt Parks	1. As required 2. 1/11/21 3. 1/12/21	Amber (radiographer staff shortage group)	

• Staff rosters for all grades to be issued at least 6 weeks in advance as opposed to week on week (local/departmental issue). • Business case to be completed so that staffing levels are adequate for increased demand.				
Review of Medica OOH budget to support increased activity and acuity of patients coming through ED. Request for additional budget to be submitted given current budget short of requirements.	Dean Booth Sarah Niazmand	1. 1/12/21	Amber	

7.13 Physiology

Action	Lead	Action due date	Risk assessment	Update
Increase number of staff (in the interim bank or agency) to ensure capacity meets demand to support: 1. Increased overall and inpatient demand (echocardiography and neurophysiology). Business case to be completed. 2. To support Xmas/NYE and annual leave during potentially busy period	Dean Booth Lara Lopes Qaasim Ismail	1. 1/12/21 and as required for bank/agency 2. As required	Amber (staff shortage group)	1. BC has been started for echocardiography staff increase. 2. Recruitment has been completed for all vacancies and regularly chasing recruitment team for updates.
Rostering: 1. Additional reporting sessions provided by EIC bank Consultants during Xmas/NY period, to meet increased IP demand and to cover annual leave. EIC to complete BC to increase PAs to cover. 2. Produce Xmas and New Year rota 2 months in advance to understand/prepare for areas of potential shortage. 3. Optimise cardiology SpR training rota, increasing inpatient echocardiography availability by allowing level 1 echo (quick 10 minutes test) to be performed on suitable patients.	Dean Booth 1. Lara Lopes, Qaasim Ismail, Sadia Khan (EIC). 2. Teresa Rutigliano, Qaasim Ismail, Lara Lopes.	1. As required and job plans to be reviewed by EIC? 2. 1/10/21 3. 30/10/21	Green Amber Green	1. EIC to update on review of job plans to increase stress echocardiography sessions. 2. SpR training rota dependent on EIC review.

	3. Sadia Khan (EIC), Lara Lopes.			
Software: ISCV upgrade works for web based reporting as opposed to station-based, enabling urgent reports to be done by available staff irrespective of location, speeding up discharge process.	Dean Booth Lara Lopes Bruno Botelho	1. November 2021	Green	1. Dependency of OEM (Philips) and CWHFT IT to ensure interface is set up.

7.14 Mortuary

- Funding for rental of pop-up Mortuary tents (£15k/year or to buy £45k)
- Additional temporary Covid surge mortuary capacity is already available at both sites

Action	Lead	Action due date	Risk assessment	Update
Capacity Planning	Sarah Purdy	Complete	Blue	Capacity will be maintained at Covid levels throughout winter and fridge replacement works. Nutwell's at a cost of £1.2k pcm per fridge,
WM Fridge replacement	Eleanor Long	Ongoing	Amber	Engaging with MT to ensure that Bouygues maintain capacity during Fridge replacement works.
Staffing Plan	Eleanor Long	Complete	Blue	Trust staff identified at both sites who can be reassigned to Mortuary to support in the event of staff shortages or surge in demand

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**3.4**
TITLE OF REPORT	**Sustainable Strategy**
AUTHOR NAME AND ROLE	Victoria De La Moriniere, Head of Improvement
ACCOUNTABLE EXECUTIVE DIRECTOR	Virginia Massaro – Chief Financial Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: Info Only: X Advice: Please tick below and then describe the requirement in the opposite column	To outline the Trust's Green Plan to support a net zero health service.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Executive Management Board; Date of Meeting: 21.09.21; Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	In October 2020, the NHS committed itself to becoming the world's first carbon net-zero National Health Service by 2045 with the 'Delivering a Net-Zero NHS' report. Two core objectives were set out: • To ensure the emissions we control directly (the NHS Carbon Footprint) are net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. • To ensure the emissions we can influence (our NHS Carbon Footprint Plus) are net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. As a Trust we are committed to driving sustainable development to deliver our strategic objectives, to enable us to deliver high quality care, to be the employer of choice and to make the best use of our resources. This paper is our Trust's 2021-2026 sustainable development strategy, it acts to: • Set out our green ambitions and the enablers to achieve these • Publically set our commitment to sustainable development • Show how we will met our legislative requirements • Demonstrate how we will evaluate our impact • Set out how we will monitor and assure against delivery of this strategy There are 4 work streams outlined as part of the green plan: • Reduce the carbon impact of NHS- related travel and transport • Improve our Estates and Facilities to meet net-zero

	• Move to a model of sustainable procurement • Co-design new models of care and health delivery innovation To inform our Green plan, we listened and engaged with our staff, patients/ members of the public and our stakeholders.
KEY RISKS ARISING FROM THIS REPORT	As noted above.

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

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

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

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

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

‘Green Plan’

Our Sustainable Development Strategy

Delivering a Net Zero Health Service

Executive Summary

In October 2020, the NHS committed itself to becoming the world's first carbon net-zero National Health Service by 2045 with the '*Delivering a Net-Zero NHS'* report. Two core objectives were set out:

- To ensure the emissions we control directly (the NHS Carbon Footprint) are net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- To ensure the emissions we can influence (our NHS Carbon Footprint Plus) are net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

As a Trust we are committed to driving sustainable development to deliver our strategic objectives, to enable us to deliver high quality care, to be the employer of choice and to make the best use of our resources.

This paper is our Trust's 2021-2026 sustainable development strategy, it acts to:

- Set out our green ambitions and the enablers to achieve these
- Publically set our commitment to sustainable development
- Show how we will met our legislative requirements
- Demonstrate how we will evaluate our impact
- Set out how we will monitor and assure against delivery of this strategy

Contents

1. Who are we?

Chelsea and Westminster Hospital NHS Foundation Trust is one of the top ranked and performing hospital trusts in the UK employing 6,000 staff over our two main hospital sites, Chelsea and Westminster Hospital and West Middlesex University Hospital, and across 12 community-based clinics within North West London; we serve a community of over 1.5 million people.

Both hospitals have major A&E departments, treating more than 300,000 patients each year. The Trust has the second largest maternity service in England, delivering over 11,000 babies every year. Our specialist care includes a world-renowned burns service, which is the leading centre in London and the South East. We also run The Chelsea Children's Hospital with paediatric inpatient and outpatient services, as well as our specialist HIV and award winning sexual health care services.

In partnership with CW+, our hospital charity, we build and enhance clinical facilities to create an outstanding care environment for our patients and for our staff. We are growing our existing portfolio of research, innovation and quality improvement projects, along with our reputation in this field, to become a national leader for innovation within the NHS.

We aspire to provide locally-based and accessible services enhanced by world-class clinical expertise. Our excellent financial and operational performance is a source of great pride to us. It is nationally recognised and sees us simultaneously achieving our financial plan while continuing to be one of the best performing trusts against the national access standards for accident and emergency (A&E), referral to treatment (RTT) and cancer care.

2. Introduction to our Green Plan

The NHS is one of the largest contributors to global heating and air pollution in the UK. The climate crisis and air pollution status is a public health emergency as both have serious consequences for individuals and communities, with disadvantaged and vulnerable populations being disproportionately affected, worsening health inequalities.

The Government, NHS England and Improvement, local authorities and other legislative bodies are now increasingly focusing on this issue and The Climate Change Act of 2008 legally compels us to take action as a Trust.

Our carbon reduction strategy has been developed in response to the need for NHS Healthcare services to take action on climate change and sets out our ambitions to deliver a net zero NHS service in our Trust.

3. ‘Greening the NHS’ - The National Context

Climate change is recognised as a key health crisis facing the world in the 21st century and the UK is committed to becoming carbon neutral by the year 2050, as per the Climate Change Act of 2008.

The NHS has a carbon footprint of 18 million tonnes CO2 per year; this is composed of energy (22%), travel (18%) and procurement (60%). Despite an increase in efficiency, the NHS has increased its carbon footprint by 40% since 1990. This means that meeting the Climate Change Act target of a 26% reduction in carbon footprint by 2020 and 80% reduction by 2050 will be a huge challenge.

The NHS is the largest employer in Britain and is responsible for around 4% of the nation's carbon emissions, if this country is to succeed in its overarching climate goals, the NHS has to be a major part to play in leading a reduction in carbon output whilst maintaining and improving health outcomes both nationally and locally.

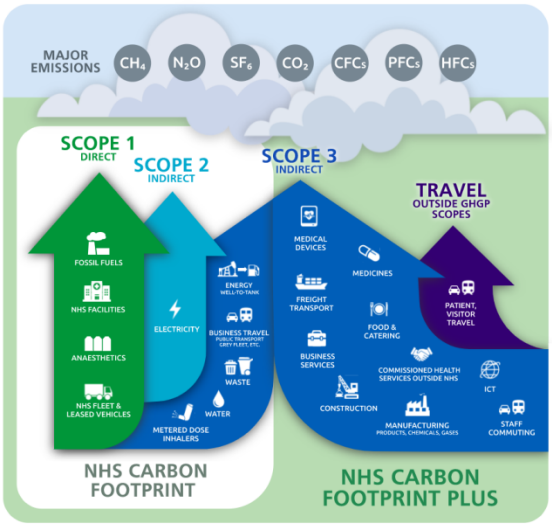
In January 2020, Sir Simon Stevens, The CEO of NHS England, announced the “For a Greener NHS” campaign. This campaign seeks to provide high-level backing for the NHS to adopt sustainability measures in an effort to combat the issue of climate change.

In 2020, as part of the ‘For a Greener NHS Campaign’, an expert panel has been commissioned to review how the NHS can achieve Net Zero as soon as possible. The outputs were published in October in a report called *Delivering a Net-Zero NHS.*

The NHS aims to be the world’s first net zero national health service and has set two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.



4. Drivers for change

The NHS is one of the largest contributors to the carbon footprint in the UK

It is up to us to take action

Drivers

- The NHS is one of the largest contributors to global heating and air pollution in the UK
- The climate crisis and air pollution have serious consequences for individual and population health
- Government, NHSEI are increasingly focusing on the issue
- The Climate Change Act legally compels us to take action
- Our staff are engaged and passionate about this topic
- a desire to be system and national leaders on innovation applied to this area

The NHS Constitution has been updated to include 'a response to climate change'. To enable this, a new national programme 'For a Greener NHS' has been launched, ensuring that every NHS organisation has a board-level net zero lead. This provides clear guidance that creating a greener NHS is a key responsibility for all our staff as part of our aims to provide high quality health care, whilst protecting human health and minimising negative impacts on the environment.

Sustainable healthcare in the NHS is predominantly driven through local and national policy, legislative and mandated requirements and healthcare specific specifications from the Department of Health and NHS England and Improvement, for example:

- The UK Government's commitment to reduce its greenhouse gas emissions to net Zero by 2050 under the terms of a new government plan to tackle climate change, stating that cutting emissions would benefit public health and cut NHS costs
- The National Adaptation Programme (2018) outlines key requirements and associated actions for the NHS to ensure climate change adaptation and mitigation measures are addressed
- The NHS Long Term Plan requirements introduced in 2019 have been incorporated into the contractual obligations of the NHS Standard Contract, substantially increasing the obligations on the NHS for the decade
- Delivering a 'Net Zero' National Health Service sets out the NHS pathway to Net Zero
- For A greener NHS - It utilises resources to form a cohesive board approved plan matched to local requirements whilst supporting national ambition

In addition, one of our Trust's major drivers is the passion and commitment our staff have shown to creating a greener NHS.

5. Our Trust's 'Green Pledge' – Board Commitment Statement

Chelsea & Westminster Hospital NHS Trust with its partners will continue to pursue its ambition to reduce the impact of our activities on the environment whilst providing leading sustainable healthcare. This means that the way we operate today, must meet the needs of the present, whilst collaboratively building on a cleaner healthier environment for future generations.

We understanding the challenging and ambitious goal of being carbon neutral by 2030 and will continue to work in a co-ordinated way to instil a culture which supports our environmental responsibility. We recognise the increasing and urgent need to take action to halt the negative impacts on our environment and improve efficiencies which will support, protect and enhance biodiversity throughout the organisation.

We know taking a sustainable approach will save money and deliver higher quality health services. We will continue to embed this commitment to sustainable development, with a clear strategic focus, ensuring that its national and local sustainability responsibilities are firmly embedded in the overall Trust strategy. We recognise that delivering sustainable healthcare involves working at all levels of healthcare with staff, patients and partner organisations. This will enable us to deliver our ambition to create a health system that supports our social and environmental ambitions which provide value for financial investment.

The PROUD values are at the heart of this commitment and will continue to embed inclusion of sustainability with our staff, service partners, and wider communities and organisations that play important roles in our push towards greater sustainability in the wider NHS.

As we continue to effectively respond in 2021-22 to the extraordinary challenges and demands that the Covid-19 pandemic has created, the additional waste generated has conversely had a beneficial effect on general air quality in London. We will continue to monitor these impacts as they arise and develop efficient approach and resources to manage them sustainably.

Chelsea & Westminster NHS Foundation Trusts' Green plan:

- Sets out our green ambitions and the enablers to achieve these
- Publically sets our commitment to sustainable development
- Shows how we will met our legislative requirements
- Demonstrates how we will evaluate our impact and monitor progress

Chelsea and Westminster NHS Foundation Trust will support the two NHS Green targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Lesley Watts, CEO *Steve Gill, Chairman*

6. Where are we now?

Chelsea and Westminster NHS Foundation Trust have been working on our sustainability performance for a number of years already as part of our Sustainable Development Management Plan.

The below figures illustrate the Trust's year on year reduction against carbon reduction targets and provide a baseline for our Green plan endeavours for the next five years.

Carbon emission location	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Chelsea and Westminster Hospital CO_2 (source: EUETS / ETS UK/ CHPQA submissions)	15,212	15,510	10,930	8,904	9,382	9,286
West Middlesex University Hospital CO_2 (source: CRC/CHP QA submissions)	7,284	6,815	6,525	5,608	3,934	3,501
Trustwide CO_2	**22,496**	**22,325**	**17,455**	**14,512**	**13,316**	**12,787**
Trustwide emissions reduction	-	-170	-5,040	-7,983	-9,180	-9,709
Compared to base year (2015/16)	-	-1%	-22%	-35%	-41%	-43%

7. Green Plan Development

This 2021-2026 green plan strategy updates the existing Trust Sustainable Development Management Plan (expired 2020).

The Green Plan acts to:

- Set out our green ambitions and the enablers to achieve these
- Publically set our commitment to sustainable development
- Show how we will met our legislative requirements
- Demonstrate how we will evaluate our impact
- Set out how we will monitor and assure against delivery of this strategy

Staff and community engagement

To inform our Green plan, we listened and engaged with our staff, patients/ members of the public and our stakeholders. We have:

- Hosted two 'Green committee' co-production sessions where all staff are invited to attend and share their ideas and thoughts on sustainability and how we can improve (see Appendix 3)
- Used our 'RIQI' portal, our single point of access for ideas and projects, to triage enthusiasm and ideas from colleagues on improving sustainability at the Trust
- Engaged our 'emerging leaders' to undertake projects on sustainability as part of their leadership courses and received feedback from this group
- Planned to host a 'green' funding call in partnership with CW+ to generate ideas
- Taken this plan to our patient public engagement group and to our governors to develop ideas with our community

- We have undertaken extensive engagement with our partners at Imperial College Healthcare and our local authority partners
- Used our 'RIQI' bulletin and communications channels, such as the CW staff app, to start a forum for staff to discuss their thoughts on sustainability and feed this into the plan

Mapping against UN 17 Sustainable Development Goals

As part of our 'Green plan' strategy development, we mapped our Trust against the 17 United Nations Sustainable Development goals. We found that our Trust is doing a significant amount against each goal, specifically in the areas of 'health and wellbeing' (goal 3), 'education' (goal 4), 'innovation and infrastructure' (goal 9) and 'affordable and clean energy' (goal 7). But there is more to do across all of these categories. For the full gap analysis, see Appendix 4.

Our values

Our PROUD values underpin everything we do, and will guide development and delivery of our Green plan. Our values are firmly embedded in our organisational culture and continue to demonstrate the standard of care and experience our patients and members of the public should expect from any of our staff and services.

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

8. Our core targets

We are working towards two key targets set out by NHS England:

- To ensure the emissions we control directly (the NHS Carbon Footprint) are net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- To ensure the emissions we can influence (our NHS Carbon Footprint Plus) are net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

We will also supplement these objectives by measuring more specific and detailed metrics associated with each of our four green work streams below.

9. Our Green Ambitions - what we will do?

9.1. Reduce the carbon impact of NHS- related travel and transport

What will we do?

- Engage with our staff and promote and support sustainable travel for our workforce, this includes an increase on flexible working options.
- Take action to reduce air pollution from our NHS fleet & lease vehicles, with a shift to initially ultra-low emission vehicles to zero emission Vehicles by 2032.
- Work with our services to design new models of care which reduce unnecessary patient journeys to our sites.

How will we measure success?

- Reduction in number of business mileages per year
- Increase in % of NHS fleet which have low emission engines
- Increase the % of virtual outpatient appointments
- Increase the % of staff who cycle or walk to work

9.2. Improve our Estates and Facilities to meet net-zero

What will we do?

- Redevelop buildings and estates - we will support sustainable construction and development of our hospitals and community sites in line with the government's Health Infrastructure Plan 'Net Zero Carbon Hospital Standards. This will feed into our Capital development programme. We will adapt our premises to mitigate risks associated with climate change and severe weather.
- Sustainable energy - we will improve the environmental impact of our heating and lighting by completing the LED lighting replacement programme and moving to 100% renewable energy supplies.
- Reducing waste - working with our colleagues and partners to reduce hospital waste through best practice and innovation.

- Reduce water waste - procure, measure and reduce water usage over the whole CWHFT Estate.
- Food, catering and nutrition - we will reduce our carbon impact related to food, this includes reduce food travel miles, reducing food waste, offering more environmentally friendly vegan options.

How will we measure success?

- Reduce our monthly tonnage of waste, and evaluate this based on % of waste which has gone to landfill, been recycled, or incinerated
- Reduce our volume of water waste
- Reduce our carbon emissions from energy consumption and ensure 100% of energy is renewable
- Reduce our volume of food waste

9.3. Move to a model of sustainable procurement

What will we do?

Clinical Divisional Activity – Medicines

- Our medicines and supply chain: By working with our suppliers to ensure that all of them meet or exceed the wider NHS zero emissions targets before the end of the decade.
- Work with Clinical divisions to reduce the use of fluorinated gases used in anaesthetic gases and inhaler propellants by 40%.

Procurement Supply chain

- We will change our procurement processes to secure wider social, economic and environmental benefits for the local community and population through purchase and specification of products and services.
- We will reduce the procurement of single use plastics working with NHS supply chain.

How will we measure success?

- Reduce the % non-salbutamol inhalers prescribed
- Reducing the carbon impact of anaesthetics
- Reduce use of single use plastics
- Increase the number of products bought locally

9.4. Co-design new models of care and health delivery innovation

What will we do?

- Co-design new digital and low carbon models of care with our staff, patients and communities which reduce the carbon impact of healthcare.
- Work with our partners to innovate within healthcare.
- Reduce health inequalities within healthcare.

How will we measure success?

- Reduction in patient travel converted to carbon tonnes
- Reduction in paper

10. How will we do it? Enablers of change

10.1. Leadership and governance

- We will raise the priority of sustainability in the Trust with strong-board level leadership.
- We will create capacity and governance structures within our organisation to deliver the plan.
- We will have 'green champions' who are members of staff who lead the green plan locally, role model behaviours, signpost people who wish to become engage and lead projects.
- We will send a clear signal to our staff, patients and partners of our commitment to reduce impact on the environment with Trust board endorsement and publishing our work transparently on our website.

10.2. Data and measurement

- We will use our Trust 'Improvement Approach' to develop a data and measurement plan that allows us to understand our impact, and undertake data-driven improvements.
- We will embed greener improvement from ward to board and provide measurement to enable tracking of impact.
- We will share our data with the NHS Greener team and with other stakeholders to inform benchmarking and national/ regional data sets.
- We will seek to measure the impact of our work on health outcomes and financial and efficiency indicators.

10.3. Communication and engagement

- We will create a 'Green committee' so that all staff have an opportunity to drive greener changes across the organisation.

- We will work with our staff, patients and partners to co-produce changes and to get them involved with our sustainability agenda.
- We will role model environmentally friendly behaviours and actions.

10.4. Research and innovation

- We will accelerate the delivery of our green plan by using our expertise in research and innovation, applying these skills to the net zero challenge.
- We will take advantage of external bids and funding opportunities which support investment in environmental schemes.

10.5. Partnerships

- We will build partnerships with local universities, local authorities, local specialists, charities and other partners to tackle sustainability together across organisational boundaries.
- We will leverage local partnerships to promote carbon reduction in our local community, acting as an anchor institution to role model behaviours.
- We will lead the North West London ICS on their sustainability development plan and aim to be an exemplar to other sectors and health systems.

10.6. Learning and development

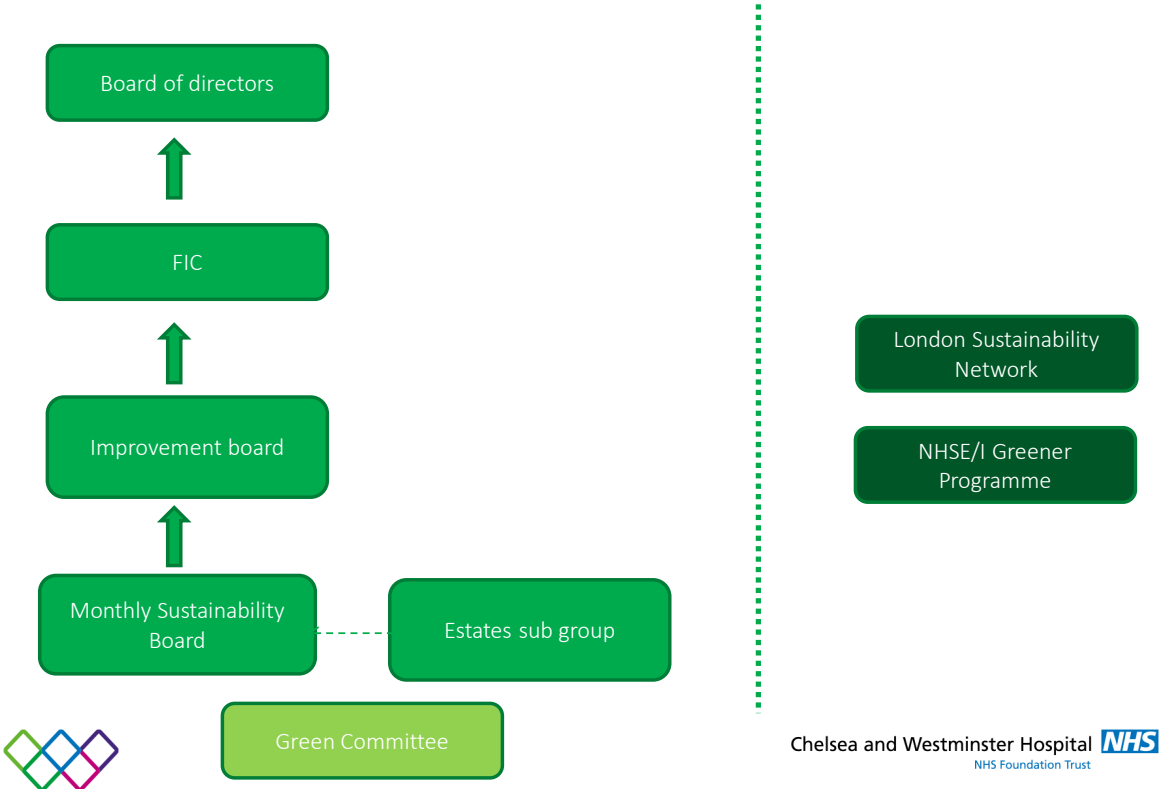
- We will collaborate to deliver formal and informal education and training on sustainability to support local improvements and achieve behaviour change.
- We will use our leadership development programmes to grow future healthcare leaders who care and champion sustainability.
- We will live our value of ‘determined to develop’ to continue to grow skills in this area.

11.Governance

The CWHFT Green Plan governance structure will allow for assurance to the CWHFT Board.

Sustainability is championed by the **Trust's Chief Financial Officer, Virginia Massaro.** Virginia Massaro is also the North West London Integrated Care lead for Sustainability.

Sustainability 'Green' Governance



Sustainability Board
The sustainability board has been established to monitor progress of the sustainability programme. The programmes look to drive forward sustainability improvements across the Trust. Sustainability Board reports through Improvement Board to Finance and Investment Committee and on to Trust Board.

Green Committee
The green committee is staff-led 'network' of colleagues who are passionate about greener improvement and making environmental changes in the NHS. The Green champions lead this forum.

Appendix 1.
Plan on a page

	Workstreams	Scope	Leads	Aims	Measures
Enablers	1. **Travel and transport**	• Patient transport and reducing journeys • Staff travel and shifting modes of transport • Flexible working	HR and E&F	• Reduce air pollution	• No of business mileages p.a • % of NHS fleet low emission engines • % virtual outpatient appointments • % of staff who cycle or walk to work
	2. Estates and facilities	• Re developing buildings and estates • Sustainable Energy & water • Reducing Waste • Food catering and nutrition	E&F	• Reduce waste • Reduce carbon emissions from energy consumption • Reduce water waste	• Tonnage of waste, % landfill, recycle, incinerate • % water waste volume • Carbon emissions from energy consumption
	3. Sustainable procurement	• Medicines procurement and use; including anaesthetics and inhalers • NHS purchasing • Supply chain	Procurement Pharmacy Procurement	• Reduce the carbon impact of anaesthetics • Reduce single use plastics	• % non-salbutamol inhalers prescribed • % single use plastics • Reduce the carbon impact of anaesthetics by at least 40%

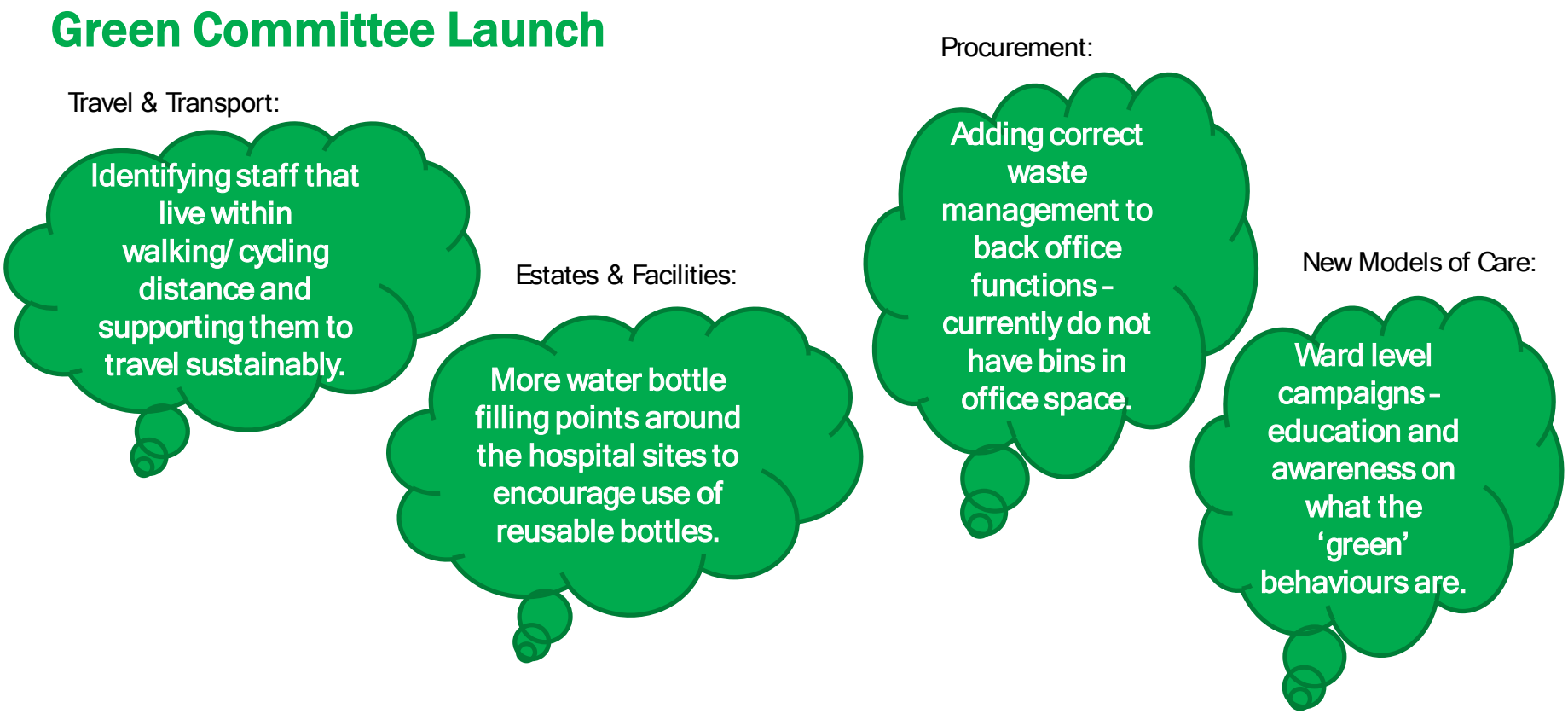
	4. New models of care and health delivery innovation	• Digital and low carbon healthcare delivery • Reducing health inequalities	Clinical/ RIQI	• Reduce use of paper • Reduce carbon	• Reduction in patient travel • Reduction in paper

Appendix 2- Enablers to support the delivery of the Green Plan

Enablers	Goal	Actions; 2021/22
Leadership and governance	*Raise priority of sustainability in Trust with strong board-level leadership, create capacity to deliver plan*	• Executive-level Sustainability lead • Develop sustainability board and reporting structures; incl. articulate links to Anchor work, Health and Wellbeing, Staff Networks • Develop a sustainability team • Embed sustainability as part of 22/23 business planning
Data and measurement	*Develop a data measurement plan that allows us to understand our impact and undertake data-driven improvements*	• Identify metrics which allow us to best understand our environmental impact, financial impact • Collect standardised NHS progress metrics • Embed as part of the IPR to board level • Develop a Qlik or digital sustainability dashboard • Use data to inform future sustainability improvement plan
Communication and engagement	*All staff, patients and partners are aware and opportunity to be involved with sustainability plan*	• Develop communications campaign to support key messages of the programme • Set up 'sustainability' staff network, staff champions and associated work plan • Measurement of attitudes/ whether Trust is recognised as taking sustainability seriously and reducing impact on the environment • Raise awareness and role model across NHS, linked to our work in research and innovation • Engage with public and communities to coproduce sustainability ideas and change
Research and innovation	*Accelerate delivery of sustainability plan with research and innovation*	• Align and embed sustainability as a theme of research and innovation strategy, encourage innovation in this space • Utilise expertise in research and innovation to accelerate improvements in sustainability plan
Partnerships	*Build partnerships to tackle sustainability across organisational boundaries*	• Work with CW+ to forge partnerships with key players in sustainability • We will build partnerships with local authorities, local 'green' organisations • Work with the business support unit/ (new 5th division) to horizon scan for funding opportunities & grants

Learning and development	*Collaborate to deliver education on sustainability to support local improvements, innovation and research in this field*	• Work with OD team to embed as part of Trust L&D curriculum • Increase offer of development opportunities for staff who wish to understand role of sustainability in NHS and anchor institution, e.g. Lunch and Learns, events • Showcase and celebrate best practice

Appendix 3. Example feedback from Green Committee (June 2021)



Appendix 4. Mapping Trust against United Nations 17 Sustainable Development Goals

Themes	Delivered	Activities / Improvement Programmes	What else could we do?
Goal 1: No Poverty	• September 2020; Living Wage Employer accreditation • Employment of local works as part of Vaccine roll-out	• Volunteer programme, and focus on retention and employment programme • Partnership with Hounslow Borough, focus on employment and anchor work in relation to Heathrow and unemployment	• Supporting role to LA • Specific; linked to social determinants of health on living wage • No member of staff living below living standard • Known risk of fragile employment.
Goal 2: Zero Hunger	• Linking with local food banks, especially during Covid19 • Staff meals during Covid19	• Trialling vegan and plant-based foods	• Larger numbers of patients are being admitted with poor nutrition - recognise as signs of risk
Goal 3: Good health and wellbeing	• £oal 3: Good health and wellbeinging admitted with poor • Extensive mental wellbeing support to staff • Extensive work in reducing mortality; SHMI is below 0.8 • Extensive work in fight against AIDS/ HIV	Health and wellbeing programme; • Planned re development of staff wellbeing facilities • Focus on safe and sustainable travel • Investment in rest and recovery post Covid19 • Public health programmes focused on smoking cessation, reducing harmful use of alcohol, substance abuse, MSK service	
Goal 4: Quality Education	• Apprenticeships, L&D programmes • Grants and bursaries for further education • Work experience & wider participation programme, e.g. Project SEARCH • Volunteering • Links with schools	• Increase apprenticeships • Developing and retaining talent ; focused on local population	• Links with schools
Goal 5: Gender Equality	• Back-up care to recognise burden on women for unpaid carer responsibilities (2.6 times more than men) • Domestic violence support • Female leadership at Board level • Women's network • Contraceptive care	Flexible working policy and time wise accreditation Support to staff who return from maternity leave	Significant gender pay gap (men paid >16% more than women in organisation Education and training, talent management
Goal 6: Clean Water and Sanitation	• Increased hand washing facilities during Covid19 response • Reducing water waste by 16.4% since 2014		Respond in new and invest in modernising in sustainable sanitation
Goal 7: Affordable and Clean Energy	• Reductions to carbon footprint • Improvements to infrastructure, including LED lighting, solar reflective films • Waste heat recovery system • Generation of electricity on site	• Improvements to infrastructure; e.g. LED lights project • Upgrades as part of capital programme to supply modern and sustainable energy services	• Converting patient transport vehicles to electric • Re development of estates in sustainable way • Reduce energy waste
Goal 8: Decent Work and Economic Growth	• Existing apprenticeship programme, >150 in place • NWL Vaccination Programme; recruitment of local people to support roll-out	Increase apprenticeships Talent management and retention programme Anchor programme work; includes recruiting locally	

Goal 9: Industry, Innovation and Infrastructure	• Capital programme • Investment in digital infrastructure • Extensive R&D portfolio	• Ideas hub & CW Innovation programme • Development of a single point of access for research, innovation and QI • Ongoing digital infrastructure programme • Partnerships • Fifth division; increasing resource and expertise in IP/ legal / due diligence	
Goal 10: Reduced Inequalities	• CWHFT Equality and Diversity Policy • Active staff networks; BAME, Women, LGBTQ+, Disability and expertise in IP/ • QEHIA framework • Mapping our catchment population • Changing Places facilities	• Patient engagement and experience workstream focused on digital inclusion • Formal launch of Disability network • Clinical programmes, such as continuity of carer in maternity for reducing health inequalities and maternal mortality • Improving Race Equality Plan • Public health programme; reducing health inequalities	• Better outcomes split by protected characteristics • Improving access to care • More structured programmes for staff networks • How we structure access to care
Goal 11: Sustainable Cities and Communities	• Waste management, incl Sterilwave plant • NHS Forest plans • Staff cycling scheme ; work with boroughs on transport strategy	• Capital programme; focused on building infrastructure e.g. water supply, sewage, energy consumption • Biodiversity considerations with new builds, conversation	• Air pollution • Upgrades to on site accommodation • Partnerships with local council • Anchor institution principles • Transport strategy
Goal 12: Responsible Consumption and Production	• NHS Supply Chain • Switch to energy efficient light bulbs	• Waste reduction programme • Procurement practices that are sustainable	• Reducing food waste • Culture of sustainability • Review of travel miles and carbon footprint of products, people and services • Logistics and the way we move resources around the system
Goal 13: Climate Action	Reducing carbon footprint examples Reduced greenhouse gas emissions by 41% against target.	• Digital services programme, reducing patient journeys through virtual outpatient programme and remote monitoring • Work to achieve 80% reduction in greenhouse gas target by 2050	Integrate climate change measures into strategies and planning Improve education and awareness on climate change
Goal 14: Life Below Water	Reducing single use plastics in canteen		Reducing single use plastics
Goal 15: Life on Land	• Implementation of electronic patient record, paper light organisation	Delivering transformational change for people EPR programme	• Managing Covid19 waste • Biodiversity on site • Procuring and working with sustainable partners
Goal 16: Peace, Justice and Strong Institutions	Safeguarding, protecting human rights Theft and bribery, annual account Medical ethics via CRGs	Safety at work Inclusive decision making Ethics of being an anchor institution	Policies for sustainable development Due diligence when working with partners private/ public
Goal 17: Partnerships	NWL ICS	Commercial and partnerships programme	NHS data monitoring and accountability Use of big data

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE OF MEETING	Board of Directors Meeting, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**3.5**
TITLE OF REPORT	**Chelsea and Westminster NHS Foundation Trust People Strategy 2021-2024**
AUTHOR NAME AND ROLE	Karen Adewoyin, Deputy Director of People and OD – Strategy and Change Clare Keogh, Interim Associate Director of HR
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith, Interim Director of Human Resources and Organisational Development
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice:	To seek approval to the People Strategy
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome People and OD Committee / 26.10.21 / Recommended for approval Executive Management Board / 27.10.21 / Recommended for approval
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The People Strategy has been updated following feedback from the Workforce Development Committee, the People and OD Committee and Executive Management Board. The Strategy is aligned with the national People Plan and the NWL People Plan for the ICS. The People Strategy focuses on the 4 key areas: • Looking After Our People; • Belonging in our inclusive organisation; • New Ways of Working and Delivering Care, and • Growing for Our Future, with an underlying theme of innovation and living the PROUD values. The ambition targets have been amended and there is an increased focus on research, development and innovation and the national team have confirmed they will no longer be using the rainbow which was previously used for the NHS People Promise due to feedback nationally from LGBTQ+ colleagues. Therefore, the People Promise has been updated so our strategy reflects the new infographics which will be used across all the NHS material going forward, including staff survey for example. Workforce Development Committee discussed and agreed some key elements of the staff engagement plan, which is being developed for launch in November following the strategy going to Board on 4th November. These

	are included in the slides which accompany the strategy.
KEY RISKS ARISING FROM THIS REPORT	Nil

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		The delivery of the people plan is linked to our staff being able to deliver excellent patient care. Section 2 of the People Strategy outlines specifically the key deliverables in relation to the Trust's commitment to Equality, Diversity and Inclusion.
Equality And Diversity	Y	
Quality	Y	
People (Workforce or Patients/ Families/Carers)	Y	
Operational Performance	Y	
Finance		
Public Consultation		
Council of Governors		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – Not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

Chelsea and Westminster People Strategy 2021 - 2024

Becoming an outstanding place to work

We will provide every member of staff with the support, information, facilities and environment they need to develop in their roles and careers, and we will recruit and retain people we need to deliver high-quality services to our patients and other service users.

The NHS People Plan sets out what our people can expect, from leaders and from each other. We have asked you what is important to you, you have responded through the staff survey, conversations about the People Plan, and listening events.

Our people strategy for 2021-2024 sets out our priorities and is backed up by our clear action plans that will help us deliver this ambition. Here, we set out how we will deliver the NHS people promise at the Trust.

We have experienced a year like no other and I personally have been amazed under such challenging circumstances our staff continue to live our PROUD values every single day.

Things will look very differently from today in terms of how we will deliver healthcare, and our workforce and the way we work with others across North West London needs to reflect this. This year has seen us already adapt in ways we would not have imagined to be possible.

We are one of the highest performing Trusts in the country but we want to continue to improve and develop our services so that we remain at the forefront of providing outstanding and innovative care in today's NHS and can be proud to continue to be an employer of choice.

Lesley Watts
Chief Executive

"I look forward to working with you to build our future and create an outstanding place to work."

Where are we now?

We are on a journey to being an outstanding place to work

Growing our permanent staff

6514

2021

2020 - 6471
2019 - 5478
2018 - 5809
2017 - 5354

Reducing the staff that leave us

16.2%

2021

2020 - 17.93%
2019 - 18.24%
2018 - 19.61%
2017 - 21.61%

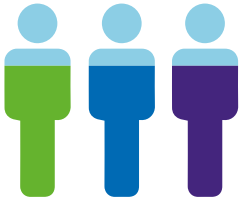
Keeping our vacancy rates low

6.54%

2021

2020 - 6%
2019 - 10%
2018 - 12%
2017 - 14%

An engaged workforce



7.1

2020

2019 - 7.3
2018 - 7.3
2017 - 7.3

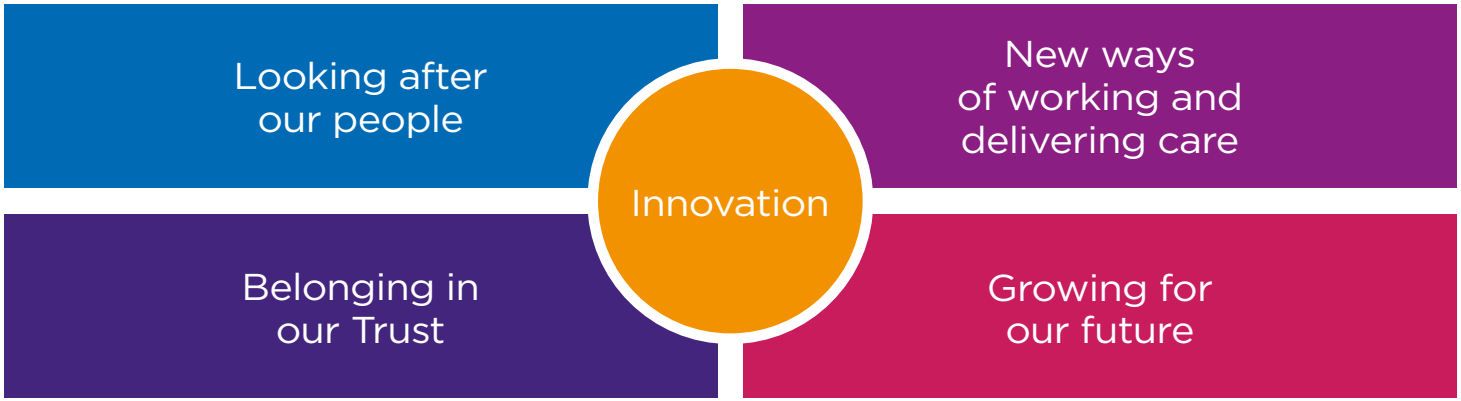
Overall we have one of the best vacancy rates in London at 6% and achieved the 3rd highest engagement score in London last year. However we know that the experience of working for us is not the same for all our staff, all of the time.

We know from our Workforce Race Equality Standard (WRES) and our Workforce Disability Standard (WDES) that people from Black and Ethnic Minority background and those with a disability, do not feel that that are treated equally in the Trust – in terms of appointment to posts and in relation to opportunities for career progression. We have action plans in place to address these disparities and we will be measured year on year on our progress. We are equally committed to continuing to reduce our gender pay gap and ensuring our LGBTQ+ staff feel they are able to bring their full selves to work and treated equally in our Trust. Ultimately we aim to create an inclusive environment where we succeed because of our differences.

Our priorities

Our People, Our Ambition

Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and the environments they work in are inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.



proud to care

P Putting patients first

R Responsive to patients and staff

O Open and honest

U Unfailingly kind

D Determined to develop

Our people

We are an organisation that employs 6,500 staff based over 2 main hospital sites. We are a very diverse organisation and we continually aim to represent the communities we serve.

100 Nationalities

100 nationalities

3% of staff declare they are bisexual, gay or lesbian

3% of staff declare they are bisexual, gay or lesbian

2% ▲

Trust workforce

BAME staff now represent 46%

46% BAME staff

75% female staff

16% work part-time

2% declare a disability

2%

declare a disability

11.5% confidentially declared disability

How we will measure our success

Strategic goal	Key themes of people plan	Performance measure	2020/21 baseline	2023/24 ambition
To be the Employer of Choice	**Looking after our people** ICS Goal 1 – Care *We have a happy, healthy and engaged workforce.*	H&W Staff Survey result	5.9	6.1
		Voluntary turnover of staff	18%	10%
		Sickness (average days)	5.8	5
		% of staff coming in despite being unwell	47.7%	40%
		Uptake of health and wellbeing offers	<2%	>10%
	Belonging in the NHS ICS Goal 2 – Lead ICS Goal 3 - Include *We care and staff report positive experiences and we are inclusive and succeed because of our differences.*	EDI staff survey score	8.5	9.1
		WRES/WDES/Gender Pay Gap Improvements	6 WRES + 10 WDES 3 grades not met target	Positive improvement in all indicators (outlined in Belonging section)
		Increase in numbers of BAME staff in Bands 8a and above	Disproportionate 3 grades not met target	All grades meeting set targets
		Staff Survey engagement score	7.1	7.4
	New ways of working and delivering care ICS Goal 4 – Transform *We have the skills to deliver 21st Century Care.*	Number of staff transitioning to qualified posts	<20	>70
		Increase in new roles (Physician Associate and Nursing Associate)	<1%	>5%
		Flexible working staff survey score	56%	65%
		e-job planning implemented	Not yet implemented	65% of consultants and SAS doctors have e-job plan by March 2022, 100% by 2024
		Number of staff using e-roster	82%	100%
	Growing For the Future ICS Goal 3 – Grow *We have the capacity to deliver great care.*	Utilisation of the apprenticeship levy	39%	70%
		% of volunteers into employment	4.5%	10%
		Increased local employment	Not currently measured	10%
		Reduced vacancy rates in core professions	N&M 5.5%, M&D 3% AHP 6%	N&M 5-8%, M&D <5%, AHP <7%

Looking after our people

Why is this important for us?

Without staff that are supported, well and at work we cannot deliver quality and safe effective care to our patients. Given the events of 2020 and responding to the pandemic, looking after our staff and supporting them to be the best they can be is more vital than ever. Our staff survey shows that staff feel proud to work for us but a prominent and repeated theme is that we have more work to do supporting staff to feel well, healthy and happy at work. We also have higher than average levels of turnover, with staff leaving due to relocation, promotion and work-life balance. Reducing the number of staff leaving us has proved challenging and our retention work is also focusing on staff health and wellbeing.

What we have achieved so far?

In 2019/2020 the Trust launched a one year health and wellbeing plan which was accelerated during the pandemic. As a result the Trust agreed in partnership with CW+ Charity a business case to support our staff's health and wellbeing over the next 3 years. This focuses on four pillars of health and wellbeing:

Healthy Mind – enhanced psychological and mental wellbeing support

Healthy Body – programme to support our staff be physically well

Healthy Living – a programme to support our staff live well

Feeling Safe – continued work to ensure our staff feel safe at work

We also recognise that there are enablers for our health and wellbeing programmes to be successful, ensuring our managers are supported and clear on responsibilities for the wellbeing of the teams they lead, a communications plan to ensure all of our staff understand and can access the offer and evaluation of our programmes.

Proud to care for you
Health and Wellbeing

Occupational Therapist Lina Grohbiel sought the right help in time to Keeping Well.

"In health care we focus so much on everybody else, we need to learn to think about us." Whilst working as an occupational therapist at the Trust, Lina started noticing she was getting a short fuse and not coping well with emotional situations. She didn't so much cry, but felt like it a lot. But before it got too out of hand, she sought help from specialist NHS support and now she's urging others to do the same to avoid Covid burnout. As a health and well-being champion for the NHS she's now urging other staff to seek help with coping with the challenges of the pandemic by using services such as the NHS's Keeping Well resources. Lina says: "Thankfully I did not get burnout but the services really helped me. For me the first thing was to put my mental health and physical health first. I was being more short-fused and at work I did not have the emotional resilience if something was distressing. Everyone has their own way of processing things. I think it's about understanding your flags. If it goes on and on, your body is saying 'I can't handle it,'" she says. Lina turned to talking therapies offered by the Keeping Well Service which is helping 50,000 people working in the NHS, residential homes and care facilities in North West London. The service is run by Central North West London NHS Foundation Trust and West London NHS Trust and has helped more than 550 people since it launched in June to manage conditions such as depression, anxiety, Post Traumatic Stress Disorder and various other mental health and well-being concerns. Now she's looking after herself better, taking more regular breaks. "It's about taking more time for yourself - have a hobby. I've started doing card making and have started running. It is about switching off your mind," says Lina. "There are so many services available with psychological courses and courses that you can download." She stresses that her workplace is "extremely supportive of staff" and colleagues support each other.

Looking after our people

Future plans

- Delivery of the 3 year Health and Wellbeing Strategy and a key focus on yearly evaluation to deliver the key outcomes agreed
- Continued focus on Rest and Recovery programme throughout the pandemic
- Delivery against the staff survey key areas of focus - Health and Wellbeing; Equality, Diversity and Inclusion; Safe Environment; Bullying and Harassment; Violence and Aggression and creating a culture of civility and respect ensuring these themes underpin our leadership development programme to support managers and all staff
- Embedding health and wellbeing conversations for all staff
- Expansion and continued support for Health and Wellbeing Champions and Mental Health First Aiders
- Through regular Pulse and employee experience surveys continue to listen and update support in response to what our staff need

Measures

Performance Measure	Baseline	Ambition	Specific measures
H&W Staff Survey Score	5.9	6.1	• Employer takes positive action on H&W • Increase in the % of staff that feel their manager takes a positive interest in their health and wellbeing
Voluntary Turnover of Staff	18%	10%	• Reduction in the number of staff who leave per year due to work-life balance • Improved feedback from leaver surveys regarding health and wellbeing and work-life balance
Sickness	5.8	5	• Reduction in the % of staff ill with anxiety and depression and reduction in the number of staff reporting in the staff survey they have felt unwell in the last 12 months as a result of work-related stress • Reduction in staff absent due to MSK related sickness
% staff coming to work but unwell	47.7%	40%	• Reduction in the % of staff who also work additional unpaid hours
Uptake of H&W offers	<2%	>10%	• Improved understanding of the H&W offers available, usage of key services and regular feedback and evaluation of what staff value



Belonging at our inclusive organisation

Why is this important to us?

We are committed to providing fair and inclusive services and employment which meet the diverse needs of our patients and staff. Over the last 12 months we have continued to focus on embedding equality, diversity and inclusion in everything we do. Covid-19 shone a real light on inequality and why equality, diversity and inclusion are crucial and important elements to be addressed in all NHS organisations. Our staff have been challenged by the response to COVID-19 and there are many lessons to be learnt and these will form part of our Year 2 and 3 Equality, Diversity and Inclusion plan. Over the next 2 years we want to foster a culture of inclusion and belonging and live our PROUD values which absolutely bring out our ambitions in relation to EDI alive. We can't put patients first or be responsive to patients and our staff if we don't take in to account their diverse needs. We need to be open and honest and have brave conversations about diversity and inclusion, and be unfailingly kind in all of our interactions, and be determined to develop in this area. Our aim is no longer just embed equality but more about how we value people, and how we can encourage others to value people, reflect and improve our behaviours towards our people and our patients.

What we have achieved so far?

- Appointed Board Diversity and Inclusion Advisor
- Launched an LGBT+ staff network and become of member of the Stonewall Diversity Champions Programme.
- Commenced a Reciprocal Mentoring Programme for Inclusion
- Joined the Timewise Accredited Partnership Programme
- Launched Diversity and Inclusion Champions into Trust recruitment process for Band 8a+ roles.
- More of our BAME staff in leadership positions, and 33% of our BAME staff on our new MBA and 45% on the new MSc. programmes both in Leadership
- Introduced a check and challenge process when investigations and disciplinary action is being considered and reduced the number of staff going through formal processes
- Executive led lived experience listening events specifically focusing on career progression and recruitment
- Maintained our Disability Confident Status Level 2 and working towards Level 3
- Ensured all our staff had an individual risk assessment, and achieved 100% compliance to ensure the physical and psychological safety of our people in response to COVID-19

Gubby Ayida

Board Diversity and Inclusion Advisor

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

Belonging at our inclusive organisation

Future plans

- Delivery of Year 2 of our 3 year Equality and Diversity Strategy which includes 7 key areas for action
- Continuing to embed the Board's and senior manager's commitment to improving EDI
- Continue with work to improve our metrics across WRES, WDES, Gender Pay Gap and deliver on our model employer targets
- All health and wellbeing conversations will include themes of equality, diversity and inclusion
- Building confidence to speak up
- Embed our influential Staff Networks for BAME, LGBTQ+, Women and Disability
- Ensure fairness and a Just Culture in Trust disciplinary, grievance and performance management processes and therefore reduce the number of formal procedures
- Ensure fairness of recruitment processes and progression opportunities for under-represented staff
- Address the negative experience that BAME and other groups have of bullying and harassment
- Embed a culture of Inclusion and Compassion
- Understand the impact of COVID-19 on specific staff groups and the underlying health inequalities to ensure all staff are kept safe and well at work

Measures

Performance Measure	Baseline	Ambition – Proportionate representation of BAME staff across all senior roles	Specific measures – 157 of roles at 8a and above to be filled by BAME colleagues by 2023
EDI Staff Survey Score	8.5	9.1	• Increase the number of staff who believe the Trust provides equal opportunities for career progression and reduce the differential across groups • Reduce the number of staff who experience bullying and harassment • Improve the number of staff who agree they feel safe to speak up
WRES/ WDES/GPG	6 WRES and 10 WDES indicators Disproportionate	Positive improvements across all indicators	• WRES improve the likelihood of being shortlisted, likelihood of entering the formal process to 0.8-1.25 range and maintain likelihood of accessing non-mandatory training or CPD within the same range • WDES – Improve declaration rates, improve the likelihood of being appointed, entering formal capability process. • Reduce our GPG by 1% per year
Model Employer Targets – Proportion of staff in senior leadership roles from under-represented groups	Not meeting targets for 3 grades 8a and above	All grades meeting set targets	• Improved WRES, WDES and GPG scores specifically an increased proportion of BAME staff in senior leadership roles and an increased proportion of women in senior leadership roles • Diversity of our FTSU champions
Staff survey engagement score	7.1	7.4	• There will be no difference in the experience of staff across different groups and the Trust will be in the top 20%

Years 2 and 3 of our EDI plan can be found here: Annual-EDI-Report-2019-20.pdf

Summary EDI Report can be found here: linklinklinklinklink linklinklink

3.5a People Strategy 2021_2024.pdf

New ways of working and delivering care

Why is this important to us?

We recognise the importance of enabling staff to develop their careers within the Trust and working in ways that facilitate good quality care for our patients.

We have recognised that established careers in the NHS have developed over time and as an organisation we are looking to broaden the opportunities to deliver care in efficient effective ways.

We have as a Trust embraced the Nursing Associate role and are supporting staff and new employees to undertake this training so they can support the nursing staff in the organisation. We are also now employing Physicians Associates in different departments of the hospital to support the work of the doctors.

The opportunity to work differently will enhance the care we deliver to our patients and enable our staff to utilise the skills they are trained in. Covid has shown how we can use technology to greater use and the Quality Improvement Team has supported a number of projects.

What we have achieved so far?

We have continued to roll out e-rostering within the Trust, refining our processes as we do so. We are starting the process of e-job planning for medical staff and we are looking to roll this out to other healthcare professionals where appropriate. We have enabled the workforce to work in an agile way where this has been possible and we want to build on the opportunities for agile and flexible working. The Trust has continued to develop the apprenticeships that we offer and the opportunities for remote learning. We are at the forefront of research, development and innovation and we have an active Research, Innovation and Quality Improvement (RIQI) department. With the support of our charity CW+, we have also invested in Virtual Reality training as part of our Equality, Diversity and Inclusion work, and created Horizon Fellows, supporting 20 staff to take their first steps into the RIQI world.

RIQI
Research, Innovation and Quality Improvement

Measures

Performance Measure	Baseline	Ambition	Specific measures
Flexible working Staff Survey Score	56%	65%	• Increase in the number of jobs that are advertised as flexible working • Increase in the take up of the digital staff passport • Increase in the number of staff working in an agile way
New roles	<1%	>5%	• Increase in the numbers of staff recruited to new roles • Increase in the number of staff transitioning to qualified posts • Increase in the use of apprenticeships and technology enhanced learning
E-job Planning	Purchasing the system	100% of consultants and SAS doctors using the system	• Roll out e-job planning for medical and other clinical staff
Use of E-Rostering	82%	100%	• Increase in the number of staff using e-roster by training and supporting staff and managers

Edel McKeever
Therapy Lead

timewise
TALENT THROUGH FLEXIBILITY

"Over the years, I have benefitted from working flexibly to support my family responsibilities and work life balance. As a manager, I find the flexible working policy at the Trust a very valuable tool and feel there is almost always a solution that can be arrived at to suit both service and staff member.

I have worked slightly reduced hours with a regular day-off since 2009. My other half also works flexibly with his NHS Employer with a regular day off so as a family our NHS flexible-working arrangements have really helped us both stay near full-time employed but reduce days of paid childcare needed, as well as having individual quality time with our kids at least 1 day per week each.

My managers have been supportive of this work pattern and over the years I have on occasions increased my hours on a temporary basis when the service needed it so it has been a two-way flexibility."

New ways of working and delivering care

Future plans

- Flexible deployment and redeployment of staff as a single system of 4 acute trusts
- Continue to develop policies and processes that support a truly agile workforce by supporting our leaders to understand how they can implement this and support service development
- Continue to implement new roles within the Trust, ie, Physician Associate, Nursing Associate, Advanced Clinical Practitioner, Peri-Operative Practitioners
- Support our staff to transition to qualified career routes
- Developing leaders to enhance and bring about change
- Enabling Talent Management and Succession Planning
- Continue to roll out e-job planning for medical and other clinical staff
- Increase the number of staff who are on e-roster
- Working with Quality Improvement and IT to streamline our processes where possible, without impacting on the quality of service

Hand Therapy' was a staff-led innovation project, funded by the hospital charity CW+. Hand therapy is a free mobile app which provides patients with a bespoke set of hand exercises prescribed by their therapist to aid recovery. The app contains a library of over 80 instructional videos and audio tutorials, making it very simple and easy for patients to follow and replicate at home. Built-in reminders help patients meet their recommended exercise times and frequency.

The Trust was shortlisted in four categories in the BMJ Awards—pictured is the maternity team, shortlisted for Digital Innovation Team of the Year

Growing for the future

Why is this important to us?

As an organisation as we work across the sector and look to provide quality care to our patients it is important that we look to develop our staff and increase their opportunities.

We value our long serving staff and giving them the opportunity for flexible working with retire and return packages has meant we have been able to utilise their skills and knowledge for longer but given them a greater control on their work life balance.

What we have achieved so far?

We have an established leadership development framework from Management Fundamentals up to an MBA for senior managers. We have broadened our offer on apprenticeships to meet the need of the organisation and also our staff development needs, including apprenticeships in Finance, Medical engineering, various nursing roles and pharmacy. We will broaden this offer to utilise more of the levy and enable more staff to develop their careers. As an employer provider we offer apprenticeships at level 2 in HCSW and in the longer term aim to become a main provider enabling us to offer more apprenticeships investing more of the levy back into the organisation and development opportunities for our staff. We will work with the ICS to develop a system wide apprenticeships and entry level opportunities.

We recognise we are stronger as part of the wider integrated healthcare system and are working as part of the North West London ICS and lead employer for the mass vaccination programme, to lead the 'Grow' pillar of the NWL People Plan. Developing an ICS workforce intelligence system to support workforce planning. We will offboard those colleagues on the vaccination programme who wish to, into long term careers in the ICS family whilst working across other London ICS to manage international recruitment, nursing recruitment and the HCSW vacancy reduction programme. This will allow us to improve the availability of workforce information, engage more collaboratively in recruitment, reduce vacancies in core professions and improve retention in the NWL family.

Measures

Performance Measure	Baseline	Ambition	Specific measures
Utilisation of apprenticeship levy	39%	70%	• Broaden participation by attracting new staff to apprenticeship roles • Broaden access to more apprenticeships to support staff development • Support staff on apprenticeships to complete programme
Volunteers into Employment	4.5%	10%	• Develop a clear process for volunteers to be considered for permanent roles
Increased local employment	Not currently measured	10%	• Work with various agencies such as the Prince's Trust to increase the employment of young people, volunteers and local people to support the future of the organisation • Work across the ICS to increase our influence as an anchor organisation
Our international recruitment	International Nurse recruitment 32%	30-40% of all recruitment for registered clinical roles	• Continue to explore opportunities for our international recruitment across all professional groups
Reduced vacancy rates in core professions	N&M – 5.5% M&D – 3% AHP – 6%	N&M 5-8%, M&D <5%, AHP <7%	• Increase the number of cross-organisational initiatives at ICS level • Number of returners to the NHS deployed into frontline roles

Growing for the future

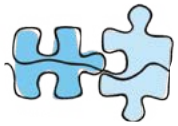
Future plans

- Widening participation and access through work experience shadowing and volunteering
- Identifying posts for apprenticeship and recruiting young people to the roles
- Clear process for volunteers to be considered for permanent roles
- Extending Employer status for apprenticeship delivery to main provider status to broaden apprenticeship offer
- Working with project wingman on redeployment of displaced airline staff especially those who may be from a clinical background and can do return to practice.
- Attracting people to the NHS through strengthening and expanding international recruitment programmes for all staff groups
- Clarify the retire and return process and improve information available to staff around pension flexibilities
- Ensure recruitment and promotion practices reflect the diversity of the community, and regional and national labour markets
- Promoting flexible working opportunities throughout the advertising and talent acquisition processes
- We will work across the system to develop a system wide volunteering programme
- We will explore further models for shared workforce including the digital passport and shared roles across PCN's
- Developing an Employer Value Proposition for the ICS we will develop our offer as an Anchor institution, enhancing social value
- We will offboard those colleagues on the vaccination programme who wish to, into long term careers in the ICS family

The Trust celebrates National Volunteers Week – giving thanks to all of our amazing volunteers that support the hospitals everyday

Working with the Prince's Trust to help young people get into jobs, education and training

The Chelsea and Westminster People Promise

What's in it for you?	What we expect from you
 **We are compassionate and inclusive** Staff networks • We are open and honest • Compassionate and supportive leaders Part of a diverse workforce	You will uphold the values of the Trust in everything you do
 **We are recognised and rewarded** Staff recognition awards • Valued and appreciated	You will always work in the best interests of the patients and staff
 **We each have a voice that counts** Staff partnership • We have a Voice that Counts Freedom to Speak Up Champions	You will raise any concerns you may have in the right way
 **We are safe and healthy** Access to a suite of health and wellbeing benefits via the Vivup app Supportive healthy and safe environment	You will access the range of health and wellbeing offers available and act safely at all times
 **We are always learning** Support for developing your career	You will keep up to date with all your required training
 **We work flexibly** Working towards Timewise accreditation • Agile working	You will embrace new ways of working
 **We are a team** Empowered and accountable teams working for a world class NHS Trust in the heart of London	You will work in a collaborative way with your colleagues

Work with us

Making our Trust an outstanding place to work requires action for each and every one of us and we will only achieve our ambitions if we all take an active role and get involved in various ways. These are some of the ways you can play your part.

How to get involved

- Get involved in quality improvement we need your expertise to continuously improve patient and staff experience
- Have a chat with your manager
- Join a staff network, BAME, LGBTQ+, Women's and Disabilities
- Attend local staff meetings
- Find your trade union or professional body representative and get involved with the hospital staff partnership forum
- Become a Diversity & Inclusion Champion, H&W Champion, a Mental Health First Aider, Sustainability Champion, FTSU Champion
- Fill in the national NHS staff survey, the monthly Pulse survey, joiners and leavers surveys– we need to know what matters to you and we use feedback from the survey to make changes/ improvements
- Speak up about any concerns you have, get to know your FTSU Champions

We welcomed our latest Care Quality Commission (CQC) ratings which show the Trust is well-led and offers safe, caring, responsive and effective services—maternity at the West Middlesex site and Critical Care at the Chelsea site have been rated 'Outstanding'

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**4.1**
TITLE OF REPORT	**Improvement Programme Update Quarter 2 2021/22**
AUTHOR NAME AND ROLE	Dhivya Kesavan, Improvement Manager
ACCOUNTABLE EXECUTIVE DIRECTOR	Virginia Massaro, Chief Financial Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	The purpose of this report is to provide assurance to the Board of the delivery against the 2021/22 Financial Improvement Programme.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome Finance and Investment Committee / 02.11.21 / Noted Executive Management Board / 27.10.21 / Noted
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• The monthly QEHIA panel was held on 21 Oct 2021 and continues to fulfil its delegated responsibilities • The CIP target for each division is set at 2% of their 'addressable' expenditure budget; totalling £12.7m. Recurrent CIP shortfalls, beyond agreed levels, have been added to Division's targets increasing the overall CIP target to £15 m. Currently, £11.4m (76%) has been identified. • Deep dives continue to take place and a schedule for the rest of the year has been agreed A progress update is given on improvement projects to gain financial effectiveness
KEY RISKS ARISING FROM THIS REPORT	Failure to deliver 2021/22 financial improvement and efficiency targets

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		
Equality And Diversity		Major changes to CIP delivery and financial efficiency programme due to Covid19 response. CIP target for 2021/22 is £12.7m. Quality implications have been considered as part of the embedded Quality, Equality and Health Inequality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
Quality	Y	
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance	Y	
Public Consultation		
Council of Governors		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Improvement Programme Q2 2021/22

1. Quality, Equality and Health Inequality Impact Assessment (QEHIA) Programme

The monthly QEHIA panel was held on 21h Oct 2021 and focused on pending cost improvement projects that required assessment. Eight project initiative documents from CSS, and Corporate divisions were reviewed in this meeting and all projects were approved, with two projects having additional actions. The panel also reviewed seven Quality Improvement projects.

Details of this are tabled below:

Details	CSS	Corporate	EIC	PC	W&C	Private Patients
CIPs that require QEHIA process	£332,929	£741,000	-	£2,031,097	£681,160	£63,000
CIPs that has already competed QEHIA process	£1,323,107	£13,000	£2,028,893	-	£1,100,514	-
Exempted CIP list from QEHIA process*	-	£1,589,981	£889,870	£575,000	£231,322	£76,500

**QEHIA is also not required for projects in these categories: Trust Business cases, central non-pay schemes, negotiations of contract for on-going services, over performance of projects or prior year savings.*

The next QEHIA panel will be held on 18th Nov 2021 and invites have been sent to Divisional leads.

2. 2021/22 CIPs and financial improvement programme

Overall financial improvement position

The CIP target for each division is set at 2% of their 'addressable' expenditure budget; totalling £12.7m. Recurrent CIP shortfalls, beyond agreed levels, have been added to Division's targets increasing the overall CIP target to £15 m.

Overall financial improvement position

Currently, £11.4m (76%) has been identified. The breakdown by Division is provided below:

CIP In-year and recurrent identification

Division Name	CIP target	Identified Schemes	Unidentified	% Identified	Recurrent Identified	Recurrent Unidentified	Recurrent % Identified
Clinical Support Services	**£1,703**	£1,656	£47	97%	£1,408	£296	83%
Corporate	**£2,518**	£2,463	£55	98%	£625	£1,893	25%
Emergency & Integrated Care	**£4,211**	£2,919	£1,292	69%	£1,468	£2,744	35%
Planned Care	**£3,028**	£2,261	£767	75%	£2,008	£1,021	66%
W&N C&Yp Hiv & Sh	**£3,573**	£2,152	£1,421	60%	£694	£2,879	19%
Total	**£15,034**	**£11,452**	**£3,582**	**76%**	**£6,202**	**£8,832**	**41%**

M6 2021/22 CIP In-month and YTD performance

M6 CIP delivery was £820k against plan of £1.2m, in-month variance to plan is at £387k. M6 YTD CIP delivery is £6.3m, £1.5m behind plan. The YTD shortfalls are due to the unidentified target (£3.6m full year). CIP shortfall in H1 has been offset non-recurrently by the elective recovery fund (ERF).

CIP In-month and YTD performance

Division Name	M6 Plan	M6 Actual	Variance to Plan	YTD Plan	YTD Actuals	Variance to Plan
Clinical Support Services	£144	£140	(£4)	£838	£814	(£24)
Corporate	£138	£133	(£5)	£1,724	£1,697	(£27)
Emergency & Integrated Care	£341	£291	(£50)	£2,117	£2,486	£369
Planned Care	£291	£103	(£188)	£1,235	£277	(£958)
W&N C&Yp Hiv & Sh	£294	£154	(£140)	£1,817	£987	(£830)
Total	**£1,208**	**£820**	**(£387)**	**£7,731**	**£6,261**	**(£1,470)**

3. Getting It Right First Time (GIRFT) Update

New GIRFT process update:
The GIRFT national programme transferred to NHSEI Improvement Directorate on 1st July 2021 and will sit with the London Development Hub going forward.

GIRFT's approach of driving improvements in patient care by reviewing specialties and producing national reports will continue, and the programme is now also offering additional support to the system-led recovery and restoration of elective care.

Building on the data driven approach, GIRFT has developed new metrics that allow review at both system and trust level in the form of Gateway Reviews; alongside this, specialty-level GIRFT Gateway compartments are being uploaded to the Model Health System so the Trust can see its own data in a more timely and transparent way.

GIRFT national team to also arrange a joint meeting with Trust team every 4-6 weeks involving GIRFT leads across the integrated care system (ICS) to review, discuss, offer potential solutions and share best practice, for both Trust actions and system-wide priorities. The main aim of this is to bridge the gap between Trust level implementations and system level reviews.

Rheumatology - GIRFT rheumatology national report was published in Sep 2021 and this was shared with the Trust rheumatology team. The Trust rheumatology service leads also attended a virtual lunchtime presentation on Friday 1st Oct 2021 to discuss the GIRFT findings and implementing the recommendations. The Trust team are currently reviewing the recommendations with gap analysis and will develop an action plan.

Thrombosis – The result of the GIRFT Thrombosis survey was published in Sep 2021. The National report and action tracker were shared with the EIC team. The GIRFT team has invited Trust leads to attend the launch of the report on World Thrombosis Day on the 13th Oct 2021. A link to register for the event has been shared with the thrombosis' team.

Gastroenterology - GIRFT and the British Society of Gastroenterology (BSG) is holding a webinar to share the findings and recommendations of the GIRFT national report for gastroenterology on 5th Nov 2021 and a link to register for the event has been shared with the Trust team.

4. Deep Dive Update

The Deep Dive Programme is a fluid programme to meet emerging risks in a timely manner. These explore specific challenges that are affecting the delivery of high quality care in line with the Trust's strategic objectives, which may focus on a range of quality, workforce, performance, and/or finance issues. The deep dive schedule is included in appendix 1.

Improvement Programme 'Focus Topics'

a) Bed productivity incl. enhanced recovery

Programme overview – 2021/22
Admission Avoidance - Aim to prevent unnecessary admissions
Flow - Reducing avoidable delays
Discharge – efficiency

£2.2m of bed productivity CIP schemes have been identified in 2021/22 and the schemes have delivered £1.1m of savings (£0.1m ahead of plan) for the year to date. The breakdown of the schemes by division is outlined in the table below.

Division Name	Scheme Name	21/22 Value	In Month Plan	In Month Actuals	Variance	YTD Plan	YTD Actuals	Variance
Emergency & Integrated Care	Bed closures	£1,051,206	£68,082	£93,264	£25,181	£541,180	£639,732	£98,552
Emergency & Integrated Care	Medihome	£316,261	£31,626	£31,626	£0	£126,505	£126,505	£0
W&N C&Yp Hiv & Sh	Bed Closures	£419,666	£19,076	£19,076	£0	£305,212	£305,212	£0
Planned Care	Medihome	£131,403	£18,772	£18,772	£0	£18,772	£18,772	£0
Planned Care	12 bed closures, Richmond/SMA	£253,716	£36,246	£36,246	£0	£36,246	£36,246	£0
Total		**£2,172,252**	**£173,802**	**£198,983**	**£25,181**	**£1,027,914**	**£1,126,467**	**£98,553**

Progress update for the programmes to date

Admission Avoidance –
- Falls SDEC pathway launching at West Middlesex
- Increased use of surgical, medical and gynae SDEC. Pathways now embedded from ED
- ED front door redirection pilot

Flow -
- Quantified bed closure plans, with delivery across the divisions
- Long length of stay review being completed for all patients
- Review of medical/surgical bed base and areas for escalation

Discharge-
- Focus on stranded patients
- End of Life Care
- Discharge checklist in place which starts upon arrival (Paeds)

Risks, issues and dependencies

Admission Avoidance - Increased attendances, and need for opening additional covid/non-covid beds
Flow - Balancing performance targets with bed closure plan

Forward plan – focus for next quarter 2021/22

Admission Avoidance –
- Increase 'hot slot' offers for specialties in AEC
- Continued work on the AEC dashboard (particularly for SSDEC)
- Evaluate front door redirection pilot
- Review what hours is needed from the community services for redirection

Flow –

- Focus on red:green inputting (decreased recently)
- Review quality metrics – VTE, sepsis, swabbing, red:green completion
- Compare other acute trusts red:green completion/any other recording of hospital flow (NWL)
- Ensure right attendance at golden hour/red:green meetings (slight drop off recently)
- Detailed response on why patients are remaining in hospital after being declared medically fit
- Review use of the command and control centre (deep dive in Dec 2021)
- Plan for perfect week (1st – 6th Dec 2021)

Discharge-

- Rainsford Mowlem pilot
- Review stroke therapies and criteria to discharge into stroke rehab (CW site outlying)
- Discharge hub KPIs going through NWL monitoring but to be brought back through bed productivity

b) Sustainability programme

Programme overview – 2021/22

To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.

Case for change - The NHS is one of the largest contributors to the carbon footprint in the UK
Overview of scope - 'Green' focused areas of sustainability, other UN goals mapped through other forums, e.g. wellbeing
Specific aims - For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Progress update for the programmes to date

- Monthly workstream updates from leads at sustainability board
- GreenerNHS data returns submitted in July and October
- Sustainability Strategy (Green Plan) to be presented at EMB for sing-off this month
- Green Committee (staff network) established with monthly meetings, guest speakers, project showcasing and co-production of green plan
- Green Champions role-modelling with sustainability QI projects
- Identification of programme cross-over with Health and Wellbeing

Risks, issues and dependencies

Dependencies - Links to health and wellbeing programme, anchor institution work programme, work of the staff networks on EDI

Risks - There is a risk the programme becomes to broad and does not deliver set priorities
There is a risk that the new programme is not resourced

Forward plan – focus for next quarter 2021/22

- Development of Sustainability Intranet and Web pages to showcase outcomes of the Green Committee work and programme progress
- E&F to investigate retrofit accelerator + other external funding schemes
- Sign off final strategy & plan and publish
- Plans in place to work in partnership with ICHT on 'Tainted Glove' and mask recycling scheme

Appendix 1 – Deep Dive forward plan

	Planned Care	W&C	EIC	CSS	Corporate/Trustwide
Apr 2021	Surgical Wards WM/CW and Assessment Unit (20 Apr)	Early Pregnancy (27 Apr)	Discharge (6 Apr)	-	Research and Development (13 Apr)
May 2021	-	-	Sepsis incl. quality priority summary (11 May)	Cancer Services incl. quality priority (18 May)	Estates and Facilities (25 May) Clinical Handover (28 May)
Jun 2021	Trauma and Orthopaedics (28 Jun)	-	Diabetes incl. quality priority summary (8 Jun)	-	eSR Targeted Deep Dive (15 Jun)
Jul 2021	Theatres Nursing (as requested by DDO) (6Jul) General Surgery (26 Jul)	Obs and Gynae incl. 10 Point Plan (13 Jul)	-	Imaging (20 Jul)	-
Aug 2021	-	-	-	-	Health and Safety (including fit testing update) (31 Aug)
Sep 2021	Opthalmology (2 Sept) Urology (22 Sept)	Dermatology (6 Sept) Paeds Surgery (30 Sept)	Clinical Hub 6 month review (21 Sept)	Outpatients Letter Turnaround (6 Sep) Endoscopy (28 Sept)	HR; Learning and Development (13 Sept)
Oct 2021	Delirium/Dementia (4 Oct) ENT/Audiology (5 Oct)	-	-	Pharmacy (26 Oct)	Finance Service (07 Oct)
Nov 2021	Anaesthetics (2 Nov)	ACU/Fertility (9 Nov)	Sepsis Trust Quality Priority (2 Nov)	Decontamination Services (9 Nov) Phlebotomy (16 Nov)	Procurement (23 Nov) Research, Innovation and Improvement (30 Nov)
Dec 2021	Colorectal (21 Dec)	Private Patients (14 Dec)	VTE (21 Dec)	-	-
Jan 2022	-	HIV (4 Jan)	Acute Medicine including AEC (11 Jan)	Interventional Radiology (18 Jan)	Corporate Nursing; Patient Experience (25 Jan)
Feb 2022	Pain (1 Feb)	GUM (15 Feb)	Frailty (8 Feb)	Phlebotomy (9 Feb)	HR; Staff Health and Wellbeing (22 Feb)
Mar 2022	Podiatry (1 Mar)	Paeds Nursing (8 Mar)	AHP Services (29 Mar)	Patient Access – Appointments (15 Mar)	Fire Safety (22 Mar)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	4.2
TITLE OF REPORT	Learning from Serious Incidents (August/September 2021 data)
AUTHOR NAME AND ROLE	Stacey Humphries, Quality and Clinical Governance Assurance Manager
ACCOUNTABLE EXECUTIVE DIRECTOR	Pippa Nightingale, Chief Nursing Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	This paper provides an update on the process compliance, key metrics and learning opportunities arising from Serious Incident investigations.

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

Name of Committee	Date of Meeting	Outcome
Executive Management Board	27.10.21	Noted
Quality Committee	02.11.21	
Patient Safety Group	03.11.21	

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

During August/September 2021 the Trust declared 14 External Serious Incidents:

- Maternal, fetal, neonatal (6 x External)
- Operations / procedures (1 x External)
- Patient falls (3 x External)
- Diagnosis/Observations (1 x External)
- Provision of care / treatment (1 x External)
- Hospital Acquired Pressure Ulcer (1 x External)
- Assault, abuse and aggression (affecting patients) (1 x External)

There were 20 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the NWL Collaborative (Commissioners).

The organisation has implemented a process designed to measure the effectiveness of actions arising from serious incident investigations. The focus will be on type of control recommended (Hierarchy of controls) and the impact (criticality score 1-5) the control is expected to have at migrating the likelihood and/or consequence.

A Never Event occurred in December 2020 concerning the retention of a guide wire (ref 2020/23436). A second Never Event occurred in July 2021 concerning the use of the wrong implant (ref 2021/14007). A third Never Event occurred in September 2021 concerning wrong site surgery (ref. 2021/18242).

KEY RISKS ARISING FROM THIS REPORT

- Critical external findings linked patient harm
- Reputational risk associated with Never Events.

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		
Equality And Diversity	N	Serious Incident investigation provides clinical teams with a structured approach to care and service delivery evaluation and supports the identification of learning opportunities designed to reduce the risk of harm to patients, staff and the public. Penalties and potential cost of litigation relating to serious incidents and never events
Quality	Y	
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance	Y	
Public Consultation		
Council of Governors		

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

Learning From Serious Incidents Q2

1. Introduction

The Chelsea and Westminster NHS Foundation Trust is committed to the provision of high quality, patient centred care. Responding appropriately when things go wrong is one of the ways the Trust demonstrates its commitment to continually improve the safety of the services it provides.

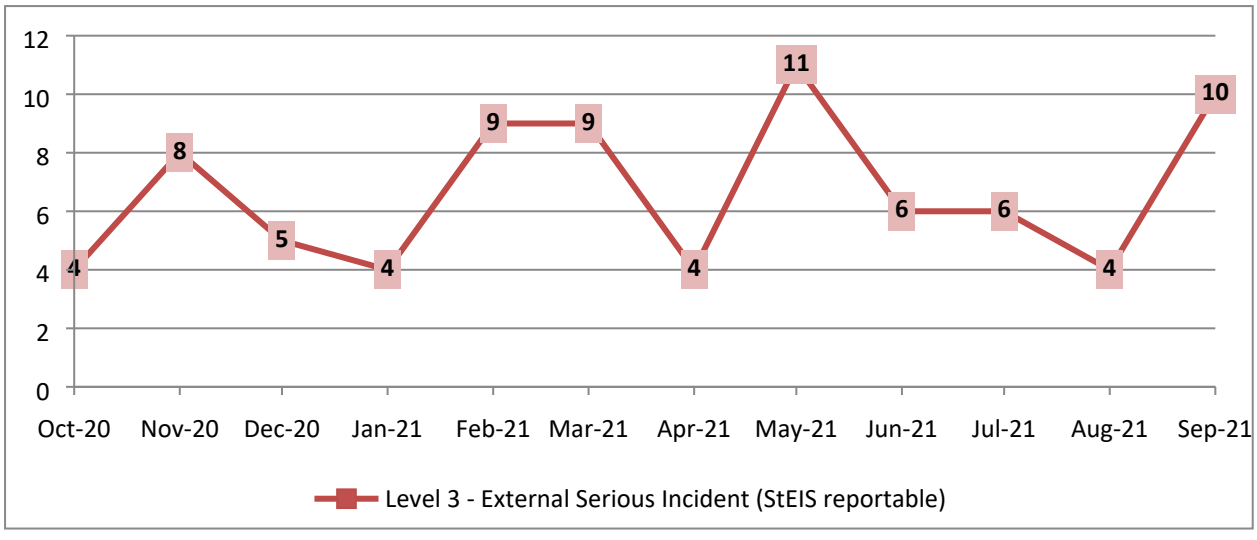
Serious Incidents are adverse events where the consequences to patients, families, staff or the organisations are so significant or the potential for learning so great, that a heightened level of response is justified. When events of this kind occur the organisation undertakes comprehensive investigations using root cause analysis techniques to identify any sub-optimal systems or processes that contributed to the occurrence. The Trust is mandated to report these events on the Strategic Executive Information System (StEIS) and share investigation reports with our commissioners; for this reason these events are referred to as External Serious Incidents within the organisation.

The Trust recognises that some events that do not meet the criteria of an External Serious Incident can also benefit comprehensive RCA investigations; as part of our commitment to improving patient safety the Trust undertakes detailed investigation of these incidents using the same methodology and with the same oversight as Serious Incidents. The Trust is not mandated to report these events on StEIS or share the reports with our commissioners; these events are referred to as Internal Serious Incidents and are part of the Trust's routine incident investigation processes.

Outcomes from both External Serious Incidents and Internal Serious Incidents are considered at Divisional Quality Boards, Patient Safety Group, Executive Management Board, and the Quality Committee so that learning can be shared and improvements enacted.

2. External Serious Incidents activity October 2020 – September 2021

Between October 2020 and September 2021 the Trust reported 80 External Serious Incidents (36 CW/ 44 WM).



Graph 1: External SIs declared by level and month declared, October 2020 – September 2021

A Never Event occurred in December 2020 concerning the retention of a guide wire (ref 2020/23436). A second Never Event occurred in July 2021 concerning the use of the wrong implant (ref 2021/14007). A third Never Event occurred in September 2021 concerning wrong site surgery (ref. 2021/18242).

3. Serious Incidents declared August/September 2021

The Trust started 14 External Serious Incident Investigations:

August 2021				
Division	**Site**	**Specialty**	**Ref**	**Category**
WCHGDPP	CW	Gynaecology	INC83440	Treatment delay
WCHGDPP	WM	Maternity / Obstetrics	INC83101	Maternity/Obstetric incident: baby only.
WCHGDPP	WM	Maternity / Obstetrics	INC83542	Maternity/Obstetric incident: baby only
WCHGDPP	CW	Early Pregnancy	INC74794	Diagnostic incident including delay(including failure to act on test results)
September 2021				
WCHGD	CW	Maternity / Obstetrics	INC84721	Maternity/Obstetric incident: baby only
WCHGD	WM	Maternity / Obstetrics	INC85575	Maternity/Obstetric incident: baby only
WCHGD	WM	Maternity / Obstetrics	INC85965	Maternity/Obstetric incident: baby only
WCHGD	WM	Maternity / Obstetrics	INC86119	Maternity/Obstetric incident: baby only.
EIC	WM	Gastroenterology	INC85705	Slips/trips/falls
EIC	CW	Care Of Elderly	INC86191	Slips/trips/falls
PCD	WM	Trauma / Orthopaedics	INC84475	Pressure Ulcer
PCD	WM	General Surgery	INC84825	Abuse/alleged abuse
PCD	WM	Anaesthetics	INC85126	**NEVER EVENT:** Surgical/invasive procedure incident
PCD	WM	General Surgery	INC85294	Slips/trips/falls

Table 1: External SIs declared in August/September 2021

The investigations into these events will seek to identify any care or service delivery problems that impacted the outcome and establish actions to reduce the risk or consequence of the event recurring.

4. External Serious Incident completed August/September 2021

Following review and agreement by the Divisional Serious Incident Panel and the Chief Nurse / Medical Director 20 Serious Incident reports were submitted to the NWL Collaborative (Commissioners).

August 2021					
Division	**Site**	**StEIS Category**	**Specialty**	**StEIS ref.**	**Degree of harm**
EIC	WM	Slips/trips/falls	Acute Medicine	2021/10747	Severe harm
EIC	CW	Slips/trips/falls	Emergency Department	2021/11353	Severe harm
EIC	CW	Slips/trips/falls	Acute Medicine	2021/12065	Severe harm
WCHGDPP	CW	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/9912	No harm
WCHGDPP	WM	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/12085	Moderate harm
WCHGDPP	WM	Maternity/Obstetric incident: mother only	Maternity / Obstetrics	2021/9904	Moderate harm
EIC	WM	Diagnostic incident	Cardiology	2021/10476	Moderate harm
CSD	WM	Diagnostic incident	Cancer Performance	2021/11227	No harm
CSD	CW	Treatment delay	Clinical Administration	2021/9482	Moderate harm
EIC	CW	Treatment delay	Emergency Department	2021/11256	No harm
EIC	WM	Abuse/alleged abuse of adult patient by staff	Care of the elderly	2021/10638	Low harm

Table 2: External SI reports submitted to the Commissioners in August 2021

September 2021					
Division	**Site**	**StEIS Category**	**Specialty**	**StEIS ref.**	**Degree of harm**
PCD	WM	Pressure ulcer	Trauma / Orthopaedics	2021/14240	Moderate harm
EIC	WM	Pressure ulcer	Acute Medicine	2021/14728	Moderate harm
WCHGD	WM	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/4885 *HSIB*	Moderate harm
WCHGD	WM	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/4238 *HSIB*	Moderate harm
WCHGD	CW	Diagnostic incident	Early Pregnancy	2021/18335	Moderate harm
CSD	CW	Diagnostic incident	Clinical Administration	2021/13554	Severe harm
PCD	CW	Treatment delay	General Surgery	2021/8828	No harm
EIC	CW	Sub-optimal care of the deteriorating patient	Acute Medicine	2021/12075	Low harm
PCD	WM	Surgical/invasive procedure incident	Colorectal	2021/9840	Severe harm

Table 3: External SI reports submitted to the Commissioners in September 2021

5. Learning from Serious Incidents

The Serious Incident investigations are designed to identify weaknesses in our systems and processes that could lead to harm occurring. It is incumbent on the Trust to continually strive to reduce the occurrence of avoidable harm by embedding effective controls and a robust programme of quality improvement.

5.1. Serious Incident action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan is developed to address these factors. Action plan completion is monitored by the Patient Safety Group and the Executive Management Board to ensure barriers to completion are addressed and change is introduced across the organisation (when required). At the time of writing there are 57 SI actions that have passed their expected due date.

In May 2021 the Datix system was updated to record if action due dates are extended. Since implementation 131 action due dates have been extended. At the time of reporting 72 of these actions remain open; 38% (27) are assigned to Women's, Children's, HIV, GUM, Dermatology, 26% (19) are assigned to Planned Care, 22% (16) are assigned to Emergency and Integrated Care and 135 (10) are assigned to Clinical Support .

5.1.1. Measuring the effectiveness of Serious Incident actions

In the majority of cases SI's occur not because there were no controls in place at the time but because the existing controls failed. The organisation is implementing a process designed to measure the effectiveness of actions arising from serious incident investigations. The focus will be on type of control recommended (Hierarchy of controls) and the impact (criticality score 1-5) the control is expected to have at migrating the likelihood and/or consequence.

Since implementing in May 2021, 21 SI action plans have included the actions strength and criticality score. There have been 11 actions recorded as a strong action and with a criticality score of 5, this meaning the action is absolutely critical to the management and reduction of the risk. These actions include:

- The Trust is no longer to use SS heads in surgery
- A project to review pathways in maternity for booking and follow up of DNA's
- A review of the Cerner request order to ensure information meets the needs of all parties involved in booking appointments

- The purchase of a new drugs fridge for Theatres
- A review of the Ophthalmology booking process
- Demand and capacity analysis in the ophthalmology clinic
- Streamlining the process for booking dermatology and maxillofacial patients

Monitoring the effectiveness of SI actions to examine whether highly criticality controls are embedded and effective will provide assurance that the Trust is learning from Serious Incidents.

5.2. Thematic review

Serious Incident investigations explore problem in care (what?), the contributing factors to such problems (how?) and the root cause(s)/fundamental issues (why?). To support understanding a process of theming across these areas has been undertaken to identify commonalities across External Serious Incidents submitted to commissioners since 1st April 2020 (excluding HSIB maternity SIs).

The review did not seek to weight the themes according to their influence on an event but merely to identify their occurrence; this provided increased insight into the more common factors associated with serious incident investigation and increased the opportunity to identify overarching improvement actions.

Since the 1st April 2020, 82 reports have been reviewed and 401 themes were identified. Key themes contributing to the serious incidents include:

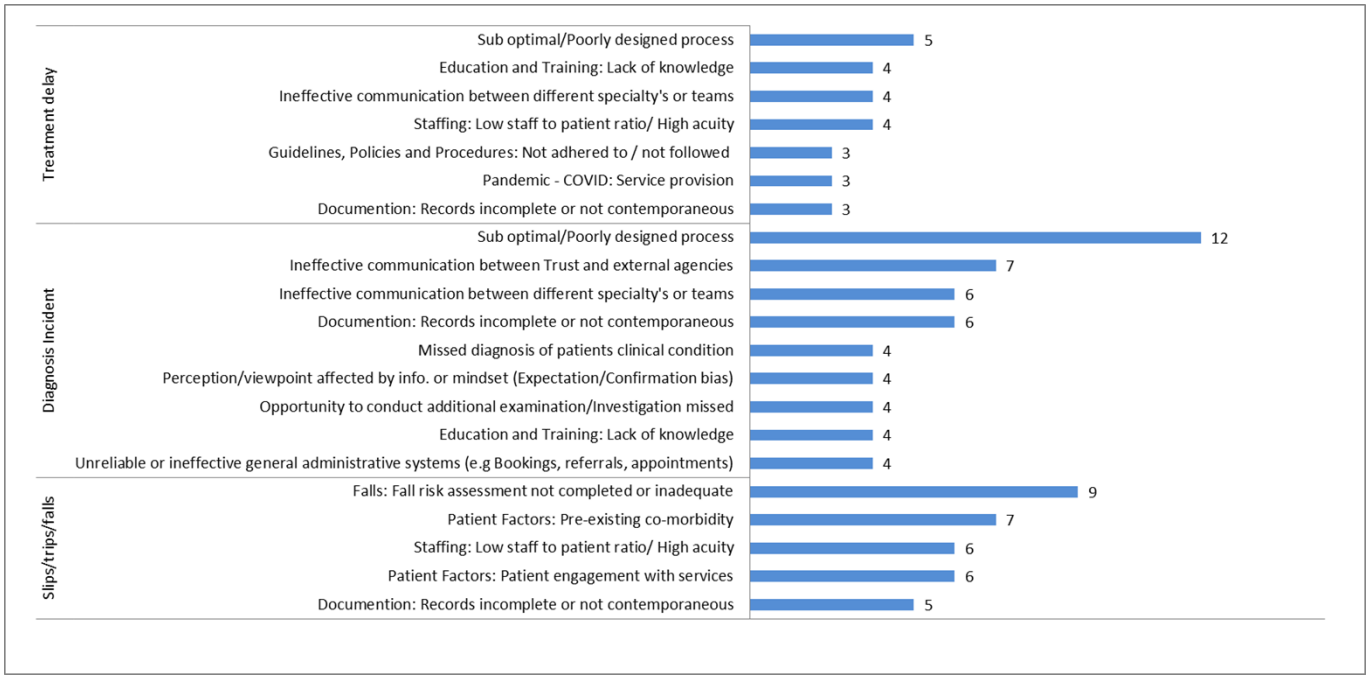
- Documentation: Records incomplete or not contemporaneous– 27 SIs
- Guidelines, Policies and Procedures: Not adhered to / not followed – 25 SIs
- Procedural or Task Design: Sub optimal/Poorly designed process – 22 SIs
- Education: Lack of knowledge/awareness – 20 SIs
- Work Environment: Low staff to patient ratio/ High acuity– 19 SIs

There were a number of Serious Incidents (27) that identified issues with incomplete or missing documentation; the identification of this theme does not mean missing documentation directly led to the event occurring but highlights the issue of poor documentation standards identified by the investigation process.

Non adherence to guidelines/ policies/procedures and sub optimal/poorly designed processes were the second highest themes. These themes appeared most commonly in incidents relating to delays in treatment, missed or delayed diagnosis and medication errors.

The chart below highlights the most common root cause, contributory factor and care/service delivery issue themes for the highest reported SI incident categories:

- Slips/trips/falls
- Diagnostic incident
- Treatment delay



Graph 2: Common themes for the highest reported external SI categories

Key themes will be submitted to the Patient Safety Group and the Executive Management Group for consideration of requirement for further Quality Improvement Projects, deep-dives, or targeted action. Updates on these programmes of work will be reported to the Quality Committee.

6. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Correctable causes and themes are tracked by the Patient Safety Group and the Executive Management Board to ensure change is embedded in practice.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**4.3**
TITLE OF REPORT	Mortality Surveillance Report Q2
AUTHOR NAME AND ROLE	Alex Bolton, Associate Director of Quality Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Roger Chinn, Chief Medical Officer Iain Beveridge, Site Medical Director (WestMid)
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	This paper provides assurance of compliance with the Learning from Deaths approach at Chelwest and provides assurance of the standardised hospital mortality index position for ChelWest.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome Executive Management Board / 27.10.2021 / Noted Quality Committee / 02.11.2021 /
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Trust remains one of the best performing in terms of relative risk of mortality with a Trustwide SHMI of 71.87 recorded for this period. This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality: • WestMid, expected 989.08 deaths, observed 749, SHMI value 75.73 • ChelWest, expected 643.09 deaths, observed 424, SHMI value 65.93 The Trust's approach to mortality review was revised in October 2020 to introduce a new screening step; it is the Trust's target to screen 100% of adult and child deaths and to undertake full mortality review on no less than 30% of cases. During the 12 month period to end of September 2021; 90% of cases have been screened and 35% have been screened & undergone full mortality review COVID-19 has had a significant impact on crude mortality but current trends indicate the rate returning to 5-year mean average. A review of deaths associated with definite or probable nosocomial COVID-19 is in progress to identify overarching learning across the Integrated Care System. A step change (improvement) in the relative risk of mortality has been experienced since March 2017 and has continued within Q2 2021/22; this is an indicator of improving outcomes and safety.
KEY RISKS ARISING FROM THIS REPORT	Delayed review closure could lead to missed opportunities to addresses weakness in service delivery.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:		
Equality And Diversity	N	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery. Limited direct costs but financial implication associated with the allocation of time to undertake reviews, manage governance process, and provide training.
Quality	Y	
People (Workforce or Patients/ Families/Carers)		
Operational Performance		
Finance	Y	
Public Consultation		
Council of Governors		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Mortality Surveillance Report Q2

1. Background

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

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

The Trust's mortality surveillance programme supports overarching service improvement and offers assurance to our patients, stakeholders, and the Board that the causes and contributory factors of patient deaths have been considered and appropriately responded to in an open and transparent manner.

2. Process

All adult and child death are reviewed by consultant teams using the mortality screening tool within Datix; this is used to identify cases that require further review through the full mortality review form. Neonatal deaths, stillbirths, and late fetal losses are reviewed using the perinatal mortality review tool (PMRT); this is a national mandatory monitoring and assurance dataset developed by MBRRACE-UK.

Trust targets:

- 100% of in-hospital adult and child deaths to be screen
- At least 30% of all adult and child death to undergo full mortality review
- 100% of neonatal death and stillbirths to undergo full mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust wide Mortality Surveillance Group (MSG).

3. Medical Examiner's office

On April 1st 2020 an independent Medical Examiner's service was introduced to the Trust to scrutinise all non-coronial deaths and:

- Provide greater safeguards for the public by ensuring robust scrutiny and flagging any potential learning
- Ensure the appropriate direction of deaths to the Coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- Improve the quality of death certification
- Improve the quality of mortality data

The Medical Examiner's Office (MEO) provides assurance that cases are being scrutinised by experienced medical professionals; however the service does not provide the entirety of the Trust's learning from deaths approach. The mortality review process is the focus of this report.

4. Relative risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) to monitor the relative risk of mortality within our hospitals. This tool was developed by NHS Digital to calculate the relative risk of mortality for each patient and then compare the number of observed deaths to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 is lower than expected mortality).

Population demographics, hospital service provision, intermediate / community service provision has a significant effect on the numbers of deaths that individual hospital sites should expect; the SHMI is designed to reduce this impact and enable a comparison of mortality risk across the acute hospital sector. By monitoring relative risk of mortality the Trust is able to make comparisons between our sites and peer organisations and seek to identify improvement areas where there is variance.

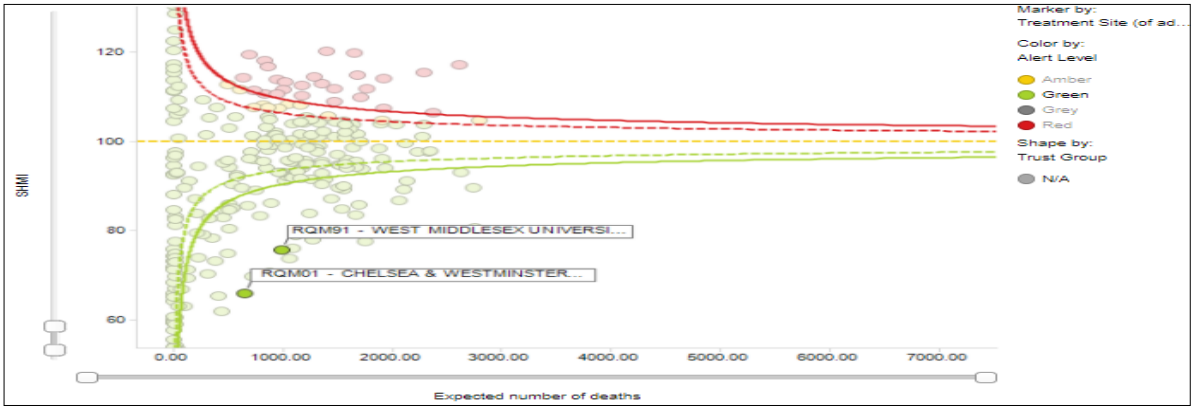


Fig 1 – SHMI comparison of England acute hospital sites based on outcomes between June 2020 and May 2021 (updated 27/09/21)

The Trust remained one of the best performing in terms of relative risk of mortality with a Trustwide SHMI of 71.87 recorded for this period (where average risk of mortality would be 100). This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- WestMid, expected 989.08 deaths, observed 749, SHMI value 75.73
- ChelWest, expected 643.09 deaths, observed 424, SHMI value 65.93

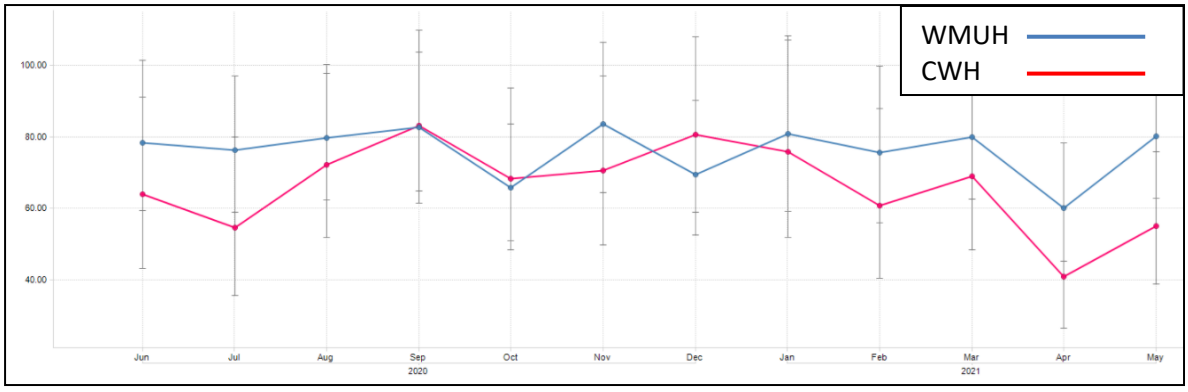


Figure 2: Monthly SHMI trend by site with 95% confidence limits. Updated 27/09/2021

Covid-19 activity is excluded from the SHMI as the tool was not designed for this type of pandemic activity.

Crude mortality

Emergency spells (activity) and the deaths associated with those spells (crude number) can be used to calculate the rate of in-hospital deaths per 1000 patient spells (this calculation excludes elective and obstetric activity).

Crude mortality rates must not be used to make comparisons between sites due to the effect that population demographics, services offered by different hospitals, and services offered by intermediate / community care has on health outcomes (e.g. crude mortality does not take into account the external factors that significantly influence the relative risk of mortality at each site). Crude mortality is useful to inform resource allocation and strategic planning.

The following crude rates only include adult emergency admitted spells by age band. This approach is used as it reduces some of the variation when comparing the two sites and support understanding and trend recognition undertaken by the Mortality Surveillance Group.

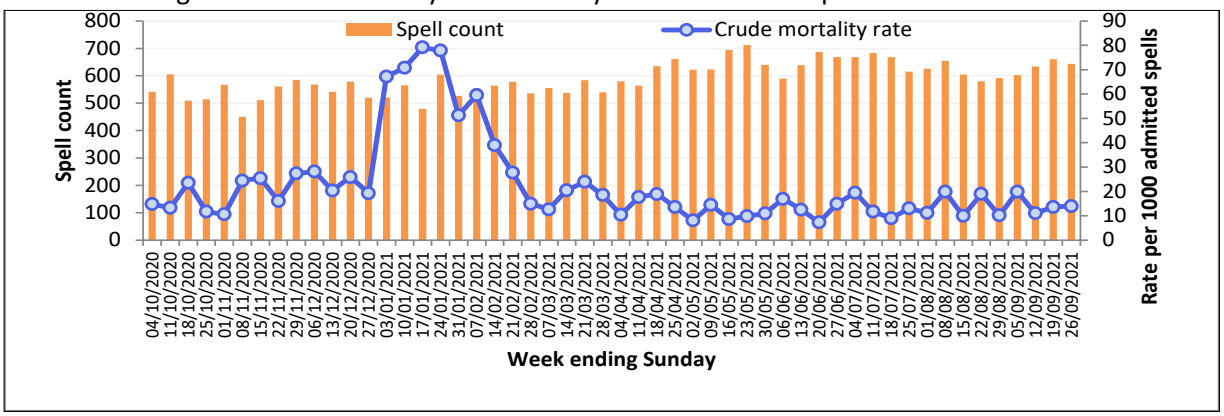


Figure 3: WestMid site, all adult deaths; crude mortality rate per 1000 emergency admissions

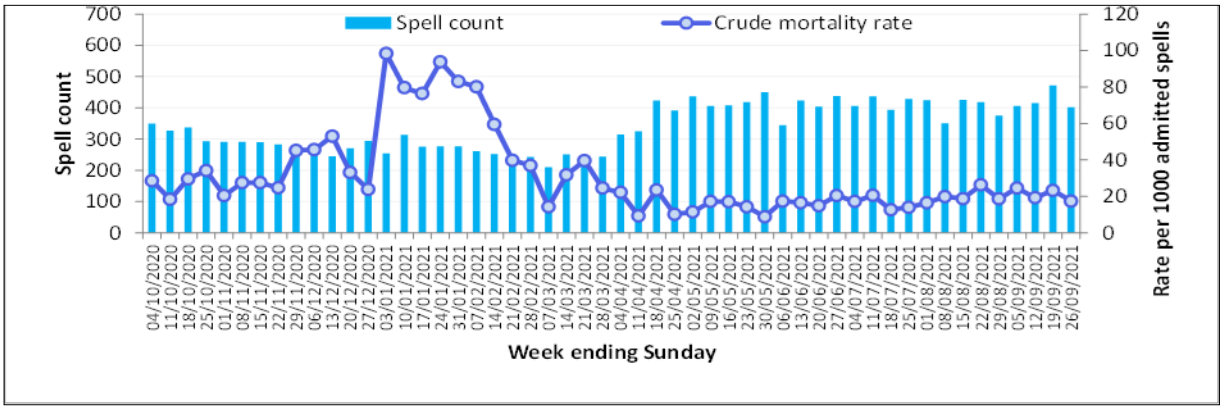


Figure 4: ChelWest site, all adult deaths; crude mortality rate per 1000 emergency admissions

Significant variation in weekly crude mortality rates have been experienced during this 52 week period. A second sharp increase in crude mortality associated with COVID-19 was experienced in January 2021; during this surge activity was maintained to a greater degree than the first COVID-19 surge in April 2020. The crude rate peaked on the week ending 17th January before rapidly reducing in February.

By comparing the actual number of emergency spell mortalities with the same week in the previous 5 year mean (2015-2019) a return to normal rate is demonstrated.

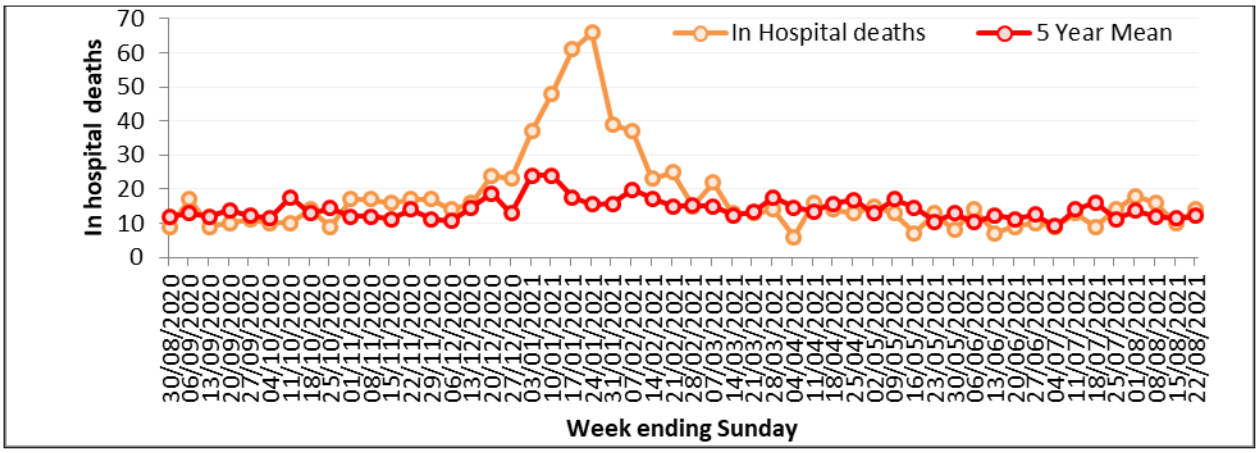


Figure 4: Weekly WestMid in hospital deaths compared to the 5 year average (updated 27/09/2021)

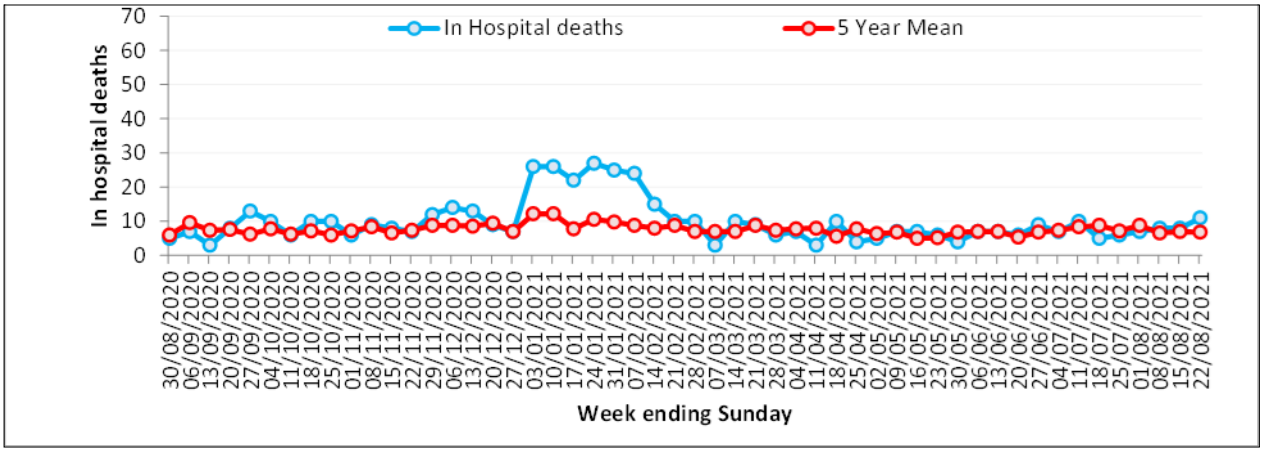


Figure 5: Weekly ChelWest in hospital deaths compared to the 5 year average (updated 27/09/2021)

5. Learning from COVID-19 deaths

Crude rates of death increased significantly above the 5 year mean during surges in patients being admitted with COVID-19. Sadly in some cases patients that were admitted for other reasons during this time were found to have contracted COVID-19 during the course of their admission.

Transmission of COVID-19 within The Trust's hospital sites has significant implications for patient safety, staff safety, and resource allocation. Controls were developed and introduced across the NHS to reduce the risk of nosocomial transmission; where national guidance was issued the Trust responded immediately to amend its local practice.

With all nationally recommended controls in place the risk of in-hospital COVID-19 transmission cannot be entirely mitigated due to; asymptomatic patients and staff, the infections incubation period, the sensitivity level of COVID-19 testing options, and the inability to entirely isolate all patients (within private rooms) throughout their admission. Whilst each occurrence of nosocomial COVID-19 provides the Trust with a learning opportunity the occurrence of in-hospital transmission does not in itself mean there were gaps in the way care or services were provided.

The Trust has robust review processes in place to facilitate learning from nosocomial COVID-19 such as; IPC outbreak reviews, mortality reviews, and incident investigation. The following approach to overarching review of learning from probable and definite nosocomial COVID-19 is in progress.

Definitions

- Hospital-Onset Probable Healthcare-Associated (HO.pHA) - positive specimen date 8-14 days after hospital admission;
- Hospital-Onset Definite Healthcare-Associated (HO.dHA) - positive specimen date 15 or more days after hospital admission.

Outline

Retrospective mortality case review is taking place for patients that died between May 2020 and September 2021; part of this process aims to identify those having Hospital-Onset Probable or Definite Healthcare-Associated COVID-19.

Following initial consultant consideration a secondary review group with membership from the emergency department, medicine, surgery, and infection control; this group will undertake case review of all probable and definitive nosocomial COVID-19 deaths. The following materials will be used to support review.

- Learning from mortality reviews
- Learning from outbreak meetings (IPC)
- Learning from incident investigation
- National guidance (as issued at time of infection)
- Medical case notes

Using this information the secondary review group will seek to confirm:

- If the patient was appropriately isolated on admission to A&E
- If the patient was appropriately tested on admission to A&E
- If the patient was appropriately cohorted following admission
- If the patient was re-tested appropriately post admission
- If the restricted visitor policy was in place
- Is there is evidence that visitors attended
- If the patient was associated with an outbreak area / review
- If there were concerns raised regarding infection control documented
- If the Trust processes at the time of the case were in-line with national guidance
- What the community infection rate (patient home address) was at the time

It should be noted that the national guidelines and recommendation relating to testing, cohorting, PPE, isolating, and infection prevention and control measures developed throughout the pandemic period; cases will be reviewed against national recommendations in place at the time of admission.

Within this audit the secondary reviewers will have regard of the following principles:

- The occurrence of nosocomial COVID-19 does not necessarily mean there has been a failure in Trust processes; even with all nationally recommended controls and precautions in place the risk of in-hospital transmission cannot be completely removed.
- The review is intended to identify gaps in the Trust's approach to reduce the risk of nosocomial COVID-19
- When gaps in control are identified the reviewer will have regard to the patients underlying medical condition when considering CESDI grades, for example:
    - A frail patient with multiple co-morbidities who would likely have died regardless of acquiring nosocomial COVID-19 would be graded as CESDI 0
    - A patient who *may* have lived had they not caught COVID-19 would be a CESDI 1
    - A patient who almost definitely would not have died had they not caught COVID-19 would be graded as CESDI 2.

- A patient who died as a direct result of sub-optimal care and treatment of their underlying medical condition / reason for admission would be graded as CESDI 3.

The outcome of this audit will be reported to the Mortality Surveillance Group, Executive Management Board, and Quality Committee.

Limitations

The cases identified within this review relate to in-hospital deaths; where a patient has died within the community or at another healthcare organisation following discharge or transfer these cases will not have been captured. The Trust is supporting a North West London Integrated Care System review of learning from nosocomial COVID-19 so that sector wide learning can be gained.

6. Learning from all deaths

The Trust's approach to mortality review was revised in October 1st 2020 to introduce a new screening step; it is the Trust's target to screen 100% of adult and child deaths and to undertake full mortality review on no less than 30% of cases.

During this 12 month period 90% of cases have been screened and 35% of cases have been screened & undergone full mortality review.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending	% Screened	% With Full Review	% Pending
Oct-20	383	239	127	17	62%	33%	4%
Nov-20	168	96	64	8	57%	38%	5%
Dec-20	108	43	51	14	40%	47%	13%
Jan-21	84	45	30	9	54%	36%	11%
Feb-21	82	41	35	6	50%	43%	7%
Mar-21	83	51	21	11	61%	25%	13%
Apr-21	95	47	32	16	49%	34%	17%
May-21	103	54	23	26	52%	22%	25%
Jun-21	110	47	22	41	43%	20%	37%
Jul-21	98	53	39	6	54%	40%	6%
Aug-21	129	70	56	3	54%	43%	2%
Sept-21	159	83	68	8	52%	43%	5%
Total	**1602**	**869**	**568**	**165**	**54%**	**35%**	**10%**

During Q2 20/21 308 deaths were recorded within the mortality review system; of these 73% have been screened and 25% have undergone full mortality review.

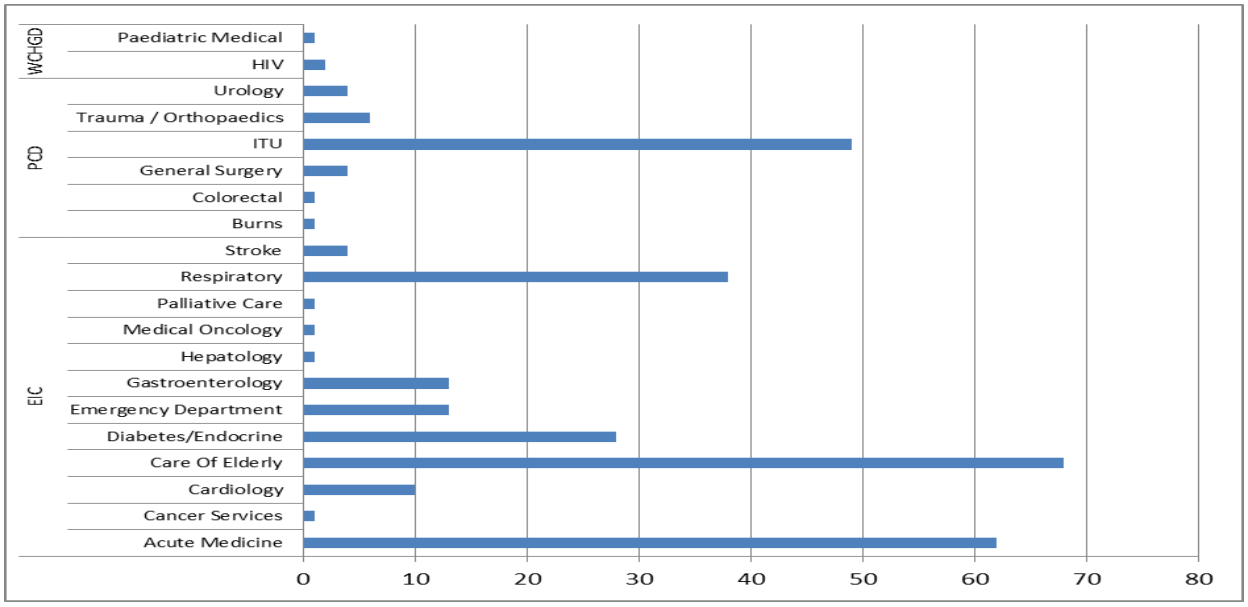


Figure 6: Q2 20/21 adult & child deaths by speciality

Sub-optimal care

Outcome avoidability and / or suboptimal care provision is defined using the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) categories that have been adopted by the Trust for use when assessing all adult and child deaths:

- Grade 0: No suboptimal care or failings identified and the death was unavoidable
- Grade 1: A level of suboptimal care identified during hospital admission, but different care or management would NOT have made a difference to the outcome and the death was unavoidable
- Grade 2: Suboptimal care identified and different care MIGHT have made a difference to the outcome, i.e. the death was possibly avoidable
- Grade 3: Suboptimal care identified and different care WOULD REASONABLY BE EXPECTED to have made a difference to the outcome, i.e. the death was probably avoidable

During Q2 2020/21 five cases with areas of sub-optimal care, treatment or service delivery were identified; these were all graded as CESDI 1 e.g. the sub-optimal issues identified would not have changed outcome. All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning.

The Divisional Mortality Review Groups provide scrutiny to mortality cases so as to; identify themes and escalate any issues of concerns; during this reporting period the following issues / themes have been raised:

- Cerner / documentation: Data accessibility
- Cerner/ documentation: Data quality
- Planning: Completion of Treatment Escalation Plans
- Need for cross divisional involvement in M&M discussion

7. Conclusion

The outcome of mortality review is providing a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality has been experienced since March 2017 and has continued within Q2 2021/22; this is an indicator of improving outcomes and safety.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors Public Meeting, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**4.4**
TITLE OF REPORT	**People Performance Report**
AUTHOR NAME AND ROLE	Karen Adewoyin, Deputy Director of People and OD
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith, Interim Director of Human Resources and Organisational Development
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice:	To provide assurance to the Board of our current performance against key people metrics
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome People and OD Committee / 26.10.21 / Noted Executive Management board / 27.10.21 / Noted
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The dashboard is to provide assurance of workforce activity across eight key performance indicator domains; • Workforce information – establishment and staff numbers • HR Indicators – Sickness and turnover • Employee relations – levels of employee relations activity • Temporary staffing usage – number of bank and agency shifts filled • Vacancy – number of vacant post and use of budgeted WTE • Recruitment Activity – volume of activity, statutory checks and time taken • PDRs – appraisals completed • Core Training Compliance • Volunteering It also includes an update on the key work streams for Workforce and progress made during the month up to end August.
KEY RISKS ARISING FROM THIS REPORT	The majority of KPI's have started to return to pre-COVID-19 levels, vacancies and sickness are increasing and PDR's have started to fall as with all other London Trusts due to the impact of pausing PDR's during the pandemic and automatic pay progression but a recovery and implementation plan is being agreed.

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

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

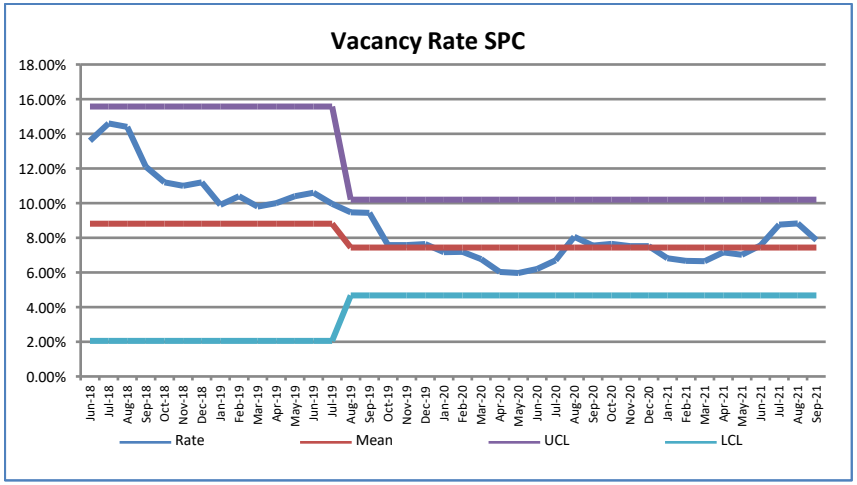
REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

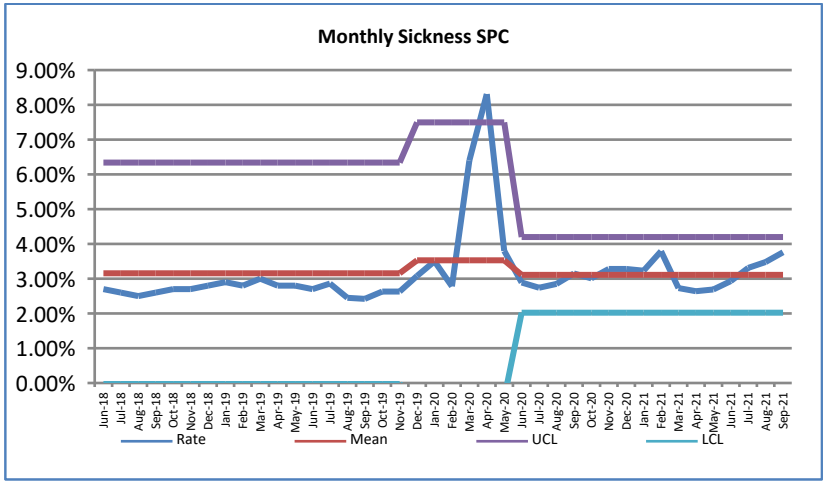
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

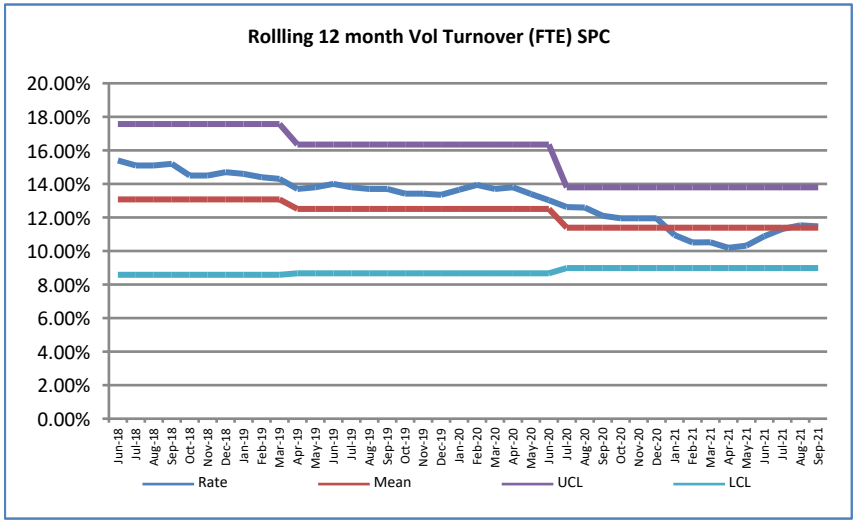
Workforce Performance Report
to the People and Organisational Development Committee

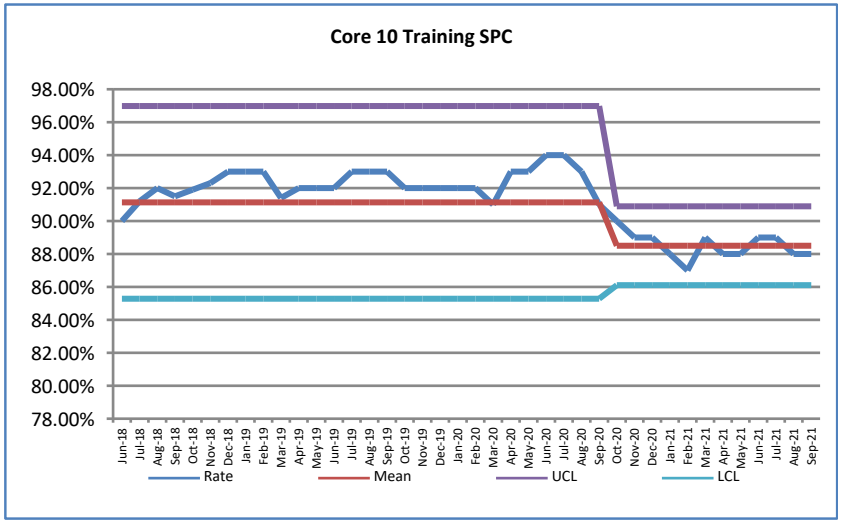
Month 06 – Sep 2021

Statistical Process Control









People and Organisational Development Workforce Performance Report Sep 2021

Key Performance Indicators

Chelsea and Westminster Hospital NHS

Item	Units	This Month Last Year	Last Month	This Month	Target/Ceiling	RAG Status			Trend
						Red	Amber	Green	
1. Workforce Information									
1.1 Establishment	WTE	6399.65	6567.19	6527.55					
1.2 Whole Time Equivalent	WTE	5916.18	5987.07	6014.73					
1.3 Headcount	No.	6392	6464	6484					
1.4 Overpayment Costs (arrears)	No.	59803.25	43074.16	136249.2					
1.5 Overpayment (no) (arrears)	£	26	28	32					
2. HR Indicators									
2.1 Sickness Absence (1 month)	%	3.15%	3.48%	3.76%	3.30%	red			
2.2 Long Term Sickness Absence	%	1.48%	1.73%	1.72%					
2.3 Short Term Sickness Absence	%	1.67%	1.75%	2.04%					
2.4 Gross Turnover	%	17.45%	15.55%	15.04%	17.00%			green	
2.5 Voluntary Turnover (12 month rolling on WTE)*	%	12.10%	11.53%	11.47%	13.00%			green	
3. Employee Relations									
3.1 Live Employment Relations Cases	No.	103	76	67					
3.2 Formal Warnings	No.	2	0	0					
3.3 Dismissals	No.	1	0	0					
4. Temporary Staffing Usage									
4.1 Total Temporary Staffing Shifts Filled	No.	12114	14366	14376					
4.2 Bank Shifts Filled	No.	11118	13049	12399					
4.3 Agency Shifts Filled	No.	996	1317	1977					
5. Vacancy									
5.1 Trust Vacancy Rate	%	7.55%	8.83%	7.86%	10.00%			green	
5.2 Corporate	%	-6.60%	5.07%	1.90%	10.00%			green	
5.3 Clinical support Service	%	12.18%	11.30%	9.80%	10.00%			green	
5.4 Emergency & Integrated Care	%	8.43%	10.23%	9.40%	10.00%			green	
5.5 Planned Care	%	7.28%	3.94%	3.29%	10.00%			green	
5.6 Woman's, Children and Sexual Health	%	8.72%	10.25%	9.02%	10.00%			green	
5.7 Enterprise				15.86%	10.00%	red			
6. Recruitment (non-medical)									
6.1 Offer Made	No.	-	171	165					
6.2 Pre-employment check (days)	No.	-	16.8	16.7	20.00			green	
6.3 Time to recruitment (weeks)	No.	-	6.32	7.11	9.00			green	
7. PDRs Undertaken (Afc Staff)*									
7.1 Trust PDR Rate	%	88.75%	71.65%	76.30%	90.00%	red			
7.2 Corporate	%	86.75%	67.88%	74.73%	90.00%	red			
7.3 Clinical support Service	%	90.73%	72.26%	75.51%	90.00%	red			
7.4 Emergency & Integrated Care	%	90.53%	73.43%	77.13%	90.00%	red			
7.5 Planned Care	%	87.43%	78.28%	84.03%	90.00%		amber		
7.6 Woman's, Children and Sexual Health	%	87.24%	67.60%	72.65%	90.00%	red			
7.7 Enterprise	%			72.03%	90.00%	red			

*The methodologies used for these KPIs is not in line with Sector/National definitions so cannot be used for comparative analysis

**Temp Staffing Excludes the Mass Vaccination and PCN Sites

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

Sep-21	Monthly Sickness (1 month)									
Division	Sickness Absence	RAG Status, Target 3.30%	Available WTE Hours	Absence WTE Hours	Episode	Long Term (WTE Hours Lost)	% Long Term	% Short Term	Previous Month Sickness	% +/-
Corporate	2.37%	green	16624.3	393.65	0	200.8	1.21%	1.16%	2.18%	0.19%
Clinical Support	5.45%	red	30060.3	1636.9	0	795.4	2.65%	2.80%	4.98%	0.46%
Emergency & Integrated Care	2.67%	green	48752.7	1301.4	0	479.2	0.98%	1.69%	2.97%	-0.30%
Planned Care	3.69%	red	32764.5	1209.4	0	485.73	1.48%	2.21%	2.91%	0.79%
Women's, Childrens and Sexual health	4.52%	red	46734.7	2111.2	0	1074.8	2.30%	2.22%	3.94%	0.57%
Trust	3.76%	red	180134	6779.6	0	3098.9	1.72%	2.04%	3.48%	0.28%

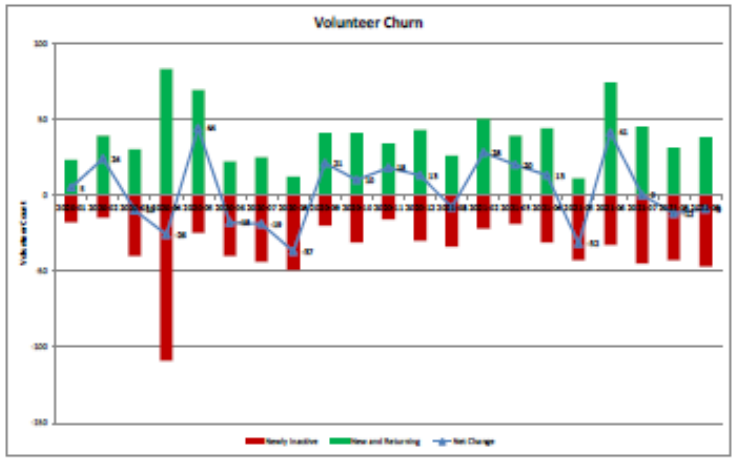
Sep-21	Core Training				
Course	Last month	Thir Month	Target	RAG Stat	Trend
Core Training Rate	88%	88%	90%	amber	⇨
Theory Adult BLS	74%	74%	90%	red	⇨
Practical Adult BLS	77%	77%	90%	red	⇨
Conflict Resolution - Level 1	94%	94%	90%	green	⇨
Equality & Diversity	91%	91%	90%	green	⇨
Fire	87%	87%	90%	amber	⇨
Health & Safety	92%	92%	90%	green	⇨
Infection Control (Hand Hygiene)	91%	91%	90%	green	⇨
Infection Control - Level 2	89%	89%	90%	amber	⇨
Information Governance	89%	89%	95%	amber	⇨
Moving & Handling - Level 1	86%	86%	90%	amber	⇨
Moving & Handling - Level 2 Theory	88%	88%	90%	amber	⇨
Moving & Handling - Level 2 Patient	80%	80%	90%	red	⇨
Safeguarding Adults Level 1	89%	89%	90%	amber	⇨
Safeguarding Adults Level 2	87%	87%	90%	amber	⇨
Safeguarding Adults Level 3	82%	82%	90%	amber	⇨
Safeguarding Children Level 1	91%	91%	90%	green	⇨
Safeguarding Children Level 2	89%	89%	90%	amber	⇨
Safeguarding Children Level 3	83%	83%	90%	amber	⇨

Sep-21	ntary Turnover (12 month ro		
Division	Turnover	Previous Month	% +/-
Corporate	8.81%	11.31%	-2.49%
Clinical Support	12.03%	12.10%	-0.07%
Emergency & Integrated Care	13.69%	14.17%	-0.48%
Planned Care	7.87%	7.56%	0.32%
Women's, Childrens and Sexual health	9.84%	11.19%	-1.34%
Trust	11.47%	11.53%	-0.06%

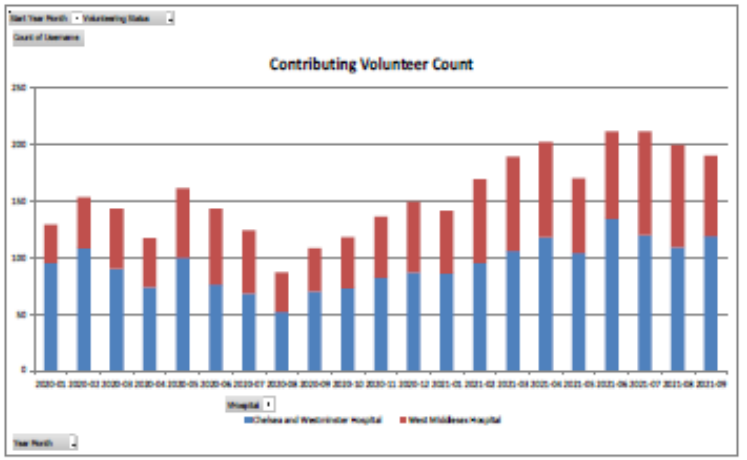
Employee Relations Activity		
Category	Metric	Number / %
No of Disciplinary cases opened in month	Number	0
No of current, live disciplinary cases	Number	6
Average length of current disciplinary cases	Days <60	60.17
Average length of disciplinary Investigation	Days<30	34.30
Total Disciplinary cases opened in year (from April 21) - these numbers include current score card month	Number	12
% BAME Disciplinary Cases in year (from April 21) - these numbers include current score card month	12	100%
% BAME Disciplinary Cases in month - new cases for score card month	6	100%
No of current, live MHPS cases – include all live cases	Number	1
Average length of current MHPS cases	Days<60	121.50
Average length of MHPS investigation	Days<30	36
% BAME – current MHPS Cases -	0	0%
Exclusions - No. of live in month – this includes all exclusions	Number	1
Grievance - No. of live cases in month	Number	1
Grievance – Average length of case	Days <60	111.00
Grievances - % that are BAME	0%	0%
B&H cases - included in grievance numbers	Number	1
Sickness - No. of cases in month	Number	51
Long Term - sickness cases in month	Number	32
Short Term - sickness cases in month	Number	19
No. of Employment Tribunals (ET)	Number	14
Staff attending ER training sessions	Number	92

People and Organisation Development Workforce Performance Report
Volunteer Staff Activity Profile – Sept 2021

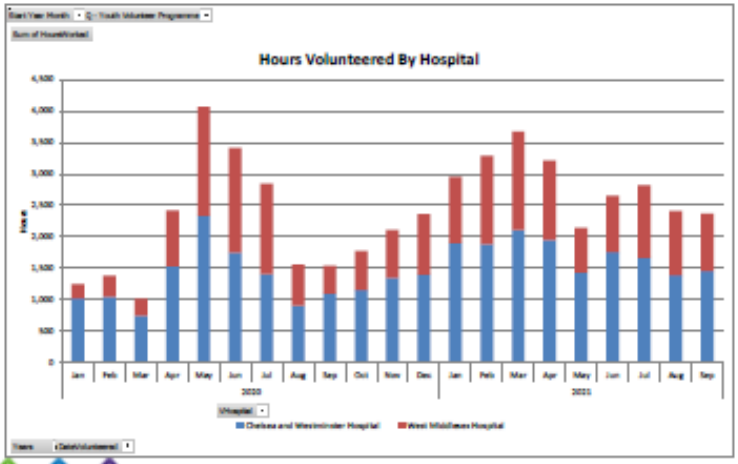
Change on Last Month -9



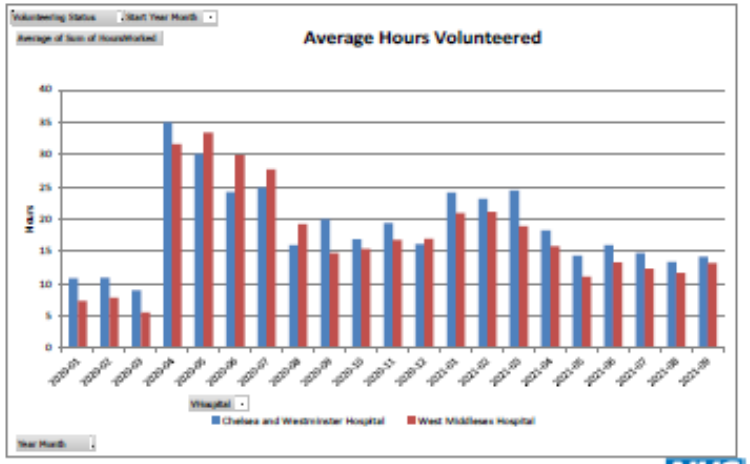
Change on Last Month -5%



Change on Last Month -2%



Change on Last Month +9%



Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People and Organisation Development Workforce Performance Report September 2021

Establishment, Staff in Post and Vacancies:

There has been an material decrease in the vacancy rate for September from last month of 0.98% to 7.86% against the Trust target of 10%. SPC analysis shows that this is with expected levels of variance within historic performance.

The driver for the reduction is two fold, a reduction in establishment of 39.64 FTE and an increase in In post FTE of 27.66 FTE. Only the newly formed Enterprise Division is outside of the target rate of 10% at a starting position of 15.88%

Temporary Staffing:

Our temporary staffing requirements remain under pressure with unusually high levels of demand stretching our existing numbers of bank staff. Nursing and Midwifery demand fell compared to August (5.1%) however remains up 25% year on year. The increased demand impacts our shift fill, with bank fill 17% lower than last year, whereas agency is up 7%. Medical and Dental demand fell in September, for the second month in a row and so continues and downward trend, however overall requirements still remain up 26% compared to September 2020. Our Drs bank fill was aided by a record number of shifts (95) worked by bank Drs on the collaborative bank from other Trusts. We continue to work towards replicating this success for a Nursing collaborative bank (go live planned for November). Our contractual arrangement with our agency master vendor is due to expire in January 2022 and so we continue to progress with the tender exercise to procure a new supplier in partnership with other Trusts in the NWL ICS. Initially this will include ChelWest, Hillingdon and Royal Marsden.

Core Training Compliance:

Overall compliance has held at 88% from last month. We have seen an overall 2.3% decline in both Practical and Theory BLS. The Senior L&OD Information Analyst has been working with the Resus leads and identified a number of staff who are mapped as needing to complete training where it actually may not be necessary or relevant. Work will start in the next couple of weeks with service leads and managers to identify if any other staff can be removed. Moving and Handling is continuing to improve, it is currently 80%, improving between 1-2% every two weeks. This is due to the additional sessions that have been added by the team. The aim is to reach the 90% compliance by the end of the year. The change in capacity for room across the Trust should also help push compliance back up to the Trust target of 90%. IG is currently at 89% (national target 95%). Work has gone in to capture new starters to make sure they are complaint within the first week of employment. All other SME's are continuing to send emails to non-compliant staff for most topics which continues to have an impact as we are seeing clinicians complete their training following a reminder from the CMO of their responsibilities to undertake training.

Sickness Absence:

The Trust's sickness rate is currently 3.76% in month which is outside the target rate of 3.30% and 3.25% 12 months rolling, which remain under the sickness target. The rate is still within SPC statistical natural variance but is the 6th monthly rise consecutively indicating an upwards trend. Overleaf you can also note that the peak over the last 24 months was during the height of the 1st wave. Long-term and short-term sickness rates are 1.72% and 2.04% respectively. The three most common reasons for sickness were Cold/Cough/Flu, Gastrointestinal problems and Chest & Respiratory problems. In terms of impact and FTE days lost, the most common causes are Anxiety/Stress/Depression and other psychiatric illnesses, Chest & respiratory Problems and Other Known Causes. Sickness absence is particularly high in Clinical Support Division at 5.45%. Further analysis will be conducted on reasons for sickness absence and ensuring appropriate case management is in place. The ER team continues to support managers with sickness management including on line training, the case count is 7 less compared to last month. In September there has been a reduction of 5 long term and 2 short term absences. The Trust Sickness Policy is under review with the aim to simplify and promote a more proactive approach to wellbeing, utilizing the growing wellbeing offer available.

Staff Turnover Rate: Voluntary:

12 month rolling Voluntary Turnover (on FTE) has decreased in September by 0.06% to 11.46%. EIC remain the only division outside of the 13% target rate (Enterprise will need to be recalculated over a 12 month period to assess its starting 12 month rolling position). Continued work to code staff/career grades and training/deanery medics on budgets and ESR may increase Medical and Dental rates as well as overall rates but the initial work has had a limited impact this far.

PDRs:

The PDR rate for staff in non Medical roles has been adversely effected by Covid Pressures and the national suspension of appraisal performance tracking as well as confusion caused by the change locally of the way appraisals have been reported. Linking appraisals to increment points has caused confusion as to when staff are actually due their appraisals within a 12 month period and aligned to the AfC pay progression rules. The Workforce Development Committee has agreed to change the metric but have asked that the new methodology is phased in over the next 6 months. Operational reports show both and aid in prioritisation of those that should be appraised to ensure an improved position by the end of March.

People and Organisation Development Workforce Performance Report September 2021

Diversity & Inclusion:

Key highlights in the last month included submitting our Gender Pay Gap data collection. We reviewed the data collections for the years 2019-20 and 2020-21 as the Equality and Human Rights Commission (EHRC) requested that both data collections were submitted this year by the 5th October and we submitted on 30th September. Our final GPG report will be ratified at People and OD Committee in October so we can publish at the end of October on our public facing website and our intranet. The staff networks are meeting regularly with more support needed for our LGBTQ+ network for it to really flourish and thrive and we are looking to appoint a chair in November. We completed and submitted our application for the Stonewall Work Equality Index 2022 which will gives us a benchmark on areas we can improve to better understand the differential experiences of staff. We had one member of our Disability Staff Network start the Calibre Programme hosted by Imperial College London and the founder Dr Ossie Stuart will begin some work with our Disabled Staff Network. Participants on the NWL Inclusive and Compassionate Leadership pilot programme finished and attendees have been asked to engage in some focus groups to look at pertinent themes. Since reviewing the D&I champions programme we have strengthened areas and will begin to recruit more D&I champions from November to be in place for interviews from band 7 and above. The reciprocal mentoring programme work with NHS elect has been shortlisted for publication in the British journal of healthcare management. The reciprocal mentoring programme is in the process of being updated and in Q3 so we can begin the next cohort in Q4. We will also be focusing on learning and resources for managers as a quality improvement initiative supporting with understanding how to address a need across the protected characteristics and support managers to signpost and have supportive conversations.

Leadership and Development:

The Management Fundaments programme was launched in January 2019. Since its launch over 200 staff have a attended a variety of the courses offered. The course with the highest number of attendances are Management vs. Leadership, PDR and Time Management. The programme has also been launched at Hillingdon meaning staff are learning together across the two Trusts, feedback has been positive. We have received 22 applications for Emerging Leaders programme Cohort 18. Applications were received from across both sites and from a variety of staff roles, including consultants, clinical fellows, researchers as-well as ward based staff. To support the Trust OT team in its recruitment and retention challenges, tailored developmental support is currently being explored to enable a robust talent pipeline.

Organisational Change

The Divisional HR BPs continue to support a number of organisational change programmes across the Trust. Currently, there are 6 live formal consultations affecting 43 staff members. There are further consultations due to launch formally in October. There is an increasing level of change ahead particularly in relation to collaboration and sector wide working, with significant formal change projects being supported such as the Pharmacy Wholly Owned Subsidiary. Activity is also significantly increasing regarding the West London's Children's Hospital programme of work. In addition, the Business Partnering team are supporting a number of smaller scale, informal changes.

Health and Wellbeing:

Online courses for staff and physical activity classes are proving great engagement tools for staff. A fast track Physiotherapy service will be going to tender shortly. New showering facilities are now in situ across our sites, 3 at ChelWest and 4 at WestMid. There are 79 trained mental health first aiders in place. Counselling provision as part of our PTS offer has been gaining great feedback. The flowchart developed so that staff are aware of what mental wellbeing support will be available next month. We have continued with our contract management review meetings with our subcontractors and have agreed we will hold these either monthly or bi-monthly with each provider. For Nursery provision for staff across our sites we launched a survey to all staff to capture much needed feedback and will analyse next month . The Peppy (menopause) service for staff is being well accessed and obtained good feedback from staff. We re-established a Schwartz round planning group and will be re-launching Schwartz rounds across the trust in October. The Trust continues to have issues regarding storage of bikes and bikes being stolen and an amended business case is going to capital programme board in October. We have been supporting staff to embed the Wellbeing conversations across the Trust and there are tools/templates to support this. Provision to benefits such as will writing, financial wellbeing services and alcohol and smoking support remain in place. The H&W champions programme is being reviewed through a QI lens as part of the PDSA cycle. We undertook crucial work for the National Staff Survey before the launch on 4th October 2021 . This will also be tracked via our team H&W annual plan which will be matched to the priorities in our ChelWest People Strategy streamlining work and pulling in information from our HRBPs across the divisions which should result in connected priorities ,more engagement and enhanced communication.

Volunteers:

We have seen a reduction in the number of volunteers as people are returning to work. There was a 5% reduction in volunteering numbers from August to September, but only a 2% fall in volunteering hours. In August, there were 190 volunteers across both sites, who contributed 2368 hours of volunteering. However overall Chelsea's volunteer activity was up whereas West Middlesex experienced a significant drop and some activities have been delayed due to the Volunteering Manager at West Middlesex off on long-term sick leave. Recruitment is now underway on both sites with 26 new volunteers recruited to either the youth pathway which West Middx is heavily reliant on or the standard pathway. Turnover in September of the youth pathway is normal as students move on in their studies. The team is bidding for NHSE funding for a recruitment coordinator at West Middlesex to add capacity there. The service continues to provide as much as it can of the requests made but occasionally some requests cannot be met as priority is given to clinical areas.

People and Organisation Development Workforce Performance Report September 2021

Transactional Plan:

In September recruitment time to hire (non-medical) was 7.1 weeks on average. The N&M Qualified vacancy rate has decreased from 8.62% to 7.6% this month. Focus has remained on finalising the on boarding process for over 75 WTE newly qualified midwives and newly qualified paediatric nurses in the recruitment pipeline whilst supporting the overseas recruitment process for over 60 overseas nurses due to be deployed imminently. The unqualified N&M vacancy rate has increased in September. In addition to the national Healthcare Support Worker programme in collaboration with NHSE/I, the Trust is involved in a number of local recruitment programmes for HCSW roles including mass recruitment campaigns, NWL vaccination workforce redeployment programme and Apprenticeships as an immediate approach to increasing staffing levels in this area. In line with the revised HR work plan, there will be focus over the upcoming months on integrating and streamlining the on boarding process to further improve recruitment lead times and candidate experience, collaborative working across North West London and the ICS to improve NHS to NHS staff transfer processes and seamless movement of staff across North West London and pan London. As part of Growing the Workforce and attracting talent, work is on-going with regards to international recruitment in line with the Capital Nurse Consortium and more recently successful international recruitment for AHPs specifically Occupational Therapists as these roles have been difficult to fill previously and retention of the mass vaccination workforce.

Apprenticeships:

The NHS Chief People Officer and her team visited the Chelsea site and met with representative Nursing Apprentices, the Nursing team and members of the Apprenticeship team and she was very interested to hear about the successes of our apprenticeships offering, the care and support that apprentices receive and she was impressed with the work being done . The invitation to apply for the Register of Apprenticeship Training Provider (RoATP) is not expected until February 2022 at the earliest. The Trust will be applying to become a main provider once its invitation is received in order to deliver Apprenticeships Programme to other organisations primary to NHS Northwest London organisations including Hillingdon hospital. The Trust currently has 214 Apprentices; delivering 18 non Clinical Apprenticeship programmes to 90 staff members and 20 Clinical; Apprenticeship programmes to 127 staff members of which we're currently using 32% of the levy, this downfall this month is due to a provider changing their invoicing process and so they will double invoice next month. We have had several completions this year with 3 apprentices who completed a Business Admin programme, 1 apprentice completing the Team Leader and 14 apprentices completing the Nursing Associate programme.

Medical Workforce:

The HEE Junior Doctors rotations of September 2021 saw 50 new starters, 41 internal rotations and 47 leavers processed by the team in terms of on boarding, work schedules and payroll. The overall vacancy rate for M&D staff group is 0.36% with reflecting a busy month for medical recruitment. M&D appraisal rates for consultant workforce is 90.11% . For the non-consultant workforce this is 87.55% just below the 90% target rate. Implementation of E-Job Planning has begun under the Interim E-Job Planning Manager with work being undertaken to merge the site based Chelsea Hospital & West Middlesex Allocate E-Job Planning and e-Appraisal systems. A working group has been set up as a part of the implementation plan however, to date there has been limited engagement from the divisions which has been escalated to Dr Gary Davies and Dr Roger Chinn. Work is on-going to improve this engagement.

Employee Relations:

Disciplinary and MHPS cases

The average length of case is now presented as two separate lines: the average length of investigation shows the time from when the investigation is started to when concluded (measured from when the report is sent to the commissioning manager). The overall average length for the entire disciplinary process is 60 days allowing 30 days for investigations. The length of process this month has taken 60.17 days - very close to the target of 60 days. The average length of investigations is 34.3 slightly above the target of 30 days.

The average timeframe for live MHPS case in September 2021 was higher in comparison to non-medical cases with the overall process taking 121.5 days. For these cases the same target timeframes have been applied; although it is noted that MHPS cases and investigations may take longer due to their complexity and staff group involved. The average length of MHPS investigations is currently 36 days just over the target of 30.

Grievance and Bullying & Harassment cases

The ER team are supporting managers in concluding these cases and the average length of case is 111.0 days (this is for the entire process) 51 days outside the 60 day target, this target was not reached due complainant's sickness. Of the one live grievance cases, this relates to Bullying & Harassment. The ER team meets on a monthly basis with the FTSU guardian and the Divisional HRBPs to triangulate the data with concerns raised and with the staff survey data.

Framework for early resolution of ER cases

Work has resumed in developing a new for conflict resolution framework. The Trust is procuring a provider to train approximately 10 internal mediators in support of this approach waiting for final sign off in October 2021. This will allow the Trust to run an internal, independent mediation service which can be used to resolve issues prior to formal processes. 100% of disciplinary cases since April 2021 have involved BAME Colleagues. This is a worrying statistic and in addition to the work in support of the WRES data, focussed work is planned to address in collaboration with EDI colleagues and our BAME Staff forum.

NWL Workstreams

Phase 3 of the mass vaccination is proving extremely challenging. The roving operational model is different to deliver the children and young peoples vaccination programme in schools. The RHCP workforce requirement is significantly increased and the workforce team have recruited over 60 RGCPs to support phase 3 in the last 3 weeks. C250 agencies have been contacted and other avenues including medic bank exhausted. The team are booking c 150 vaccinator shifts per day with a similar volume of administrators. Phase 3 delivery is proving a challenge across London and NHSE are actively reviewing. Payroll issues continue to be a challenge due to the volume of new starters, complications cross charging. New payroll experts have been recruited to the workforce hub and are already making progress. The wellbeing of both workforce and operations teams is a concern. The retention programme continues with some great success stories, we are a leader in this area of work, although timeframes need to shift in light of the need to deploy existing mass vaccination staff to phase 3 rather than offboard as had originally been planned.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 2 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	4.5
TITLE OF REPORT	**Digital Programme update**
AUTHOR NAME AND ROLE	Bruno Botelho, Deputy COO & Director Digital Operations
ACCOUNTABLE EXECUTIVE DIRECTOR	Rob Hodgkiss, Deputy CEO, COO
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: Info Only: X Advice:	To update the committee about progress made within Digital and Innovation and cover 3 relevant projects. - DrDoctor - Endoscopy solution - Improving Care Coordination for Patients (ICCP)

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

Name of Committee	Date of Meeting	Outcome
Executive Board Management	27/10/2021	Endorsed
Digital Programme Board	04/10/2021	Noted

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

To update the committee about progress made within Digital and Innovation projects:

- DrDoctor usage continue to be a success. 80% of our patients can reschedule appointments online, 22% of these go directly to Cerner without admin input. 71% of our patients open their letter online and for patients that decide not to use the option, an automated process prints and posts the letter to their address within 3 days of receiving the link.
- DrDoctor Endoscopy solution being recommended by Cancer network as best practice and for implementation across the sector
- Improving Care Coordination for Patients (ICCP) pathway tool, formerly known as End to End Pathway continues to be well adopted within Chelsea And Westminster Foundation NHS Trust and is also being deployed across 7 Integrated Care Systems (totalling 36 Trusts), including all of the acute trusts within North West London.

KEY RISKS ARISING FROM THIS REPORT: None

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:

Equality And Diversity	N
Quality	Y

We anticipate the projects mentioned in this report to:
- support the delivery of patient care,
- equip our staff with better tools to manage the patient pathway
- improve use of resources

People (Workforce or Patients/ Families/Carers)	Y	- be part of several actions in place to support the delivery of activity outlined in our operational plan.
Operational Performance	Y	
Finance	Y	
Public Consultation	N	
Council of Governors	N	
please mark Y/N – where Y is indicated please explain the implications in the opposite column		

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Digital Operations & Innovation

October 2021

DrDoctor continues to be a success

Rescheduling Online

8 of 10 patients
Are able to reschedule online – no need to call

22%
Of online requests go **direct** into Cerner. 0% Admin time taken

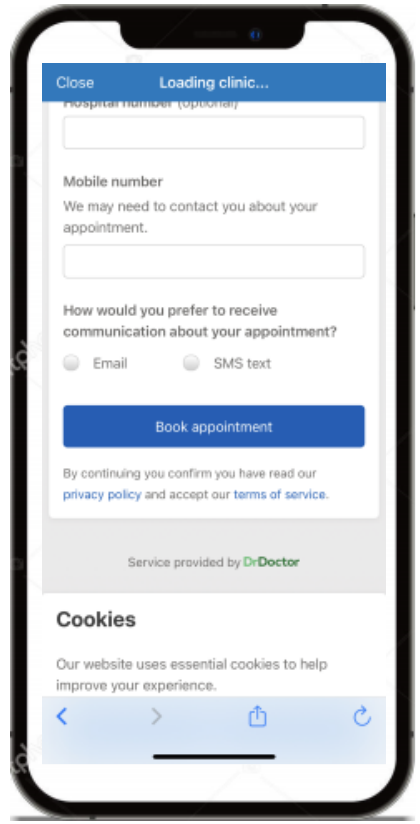
73%
Of online requests are successful

Video Consultation

78%
Of patients think a Video Consultation is as good or better than F2F (25% prefer it)

Direct Access
Clinicians can join Video Consult direct from Cerner (M-Page)

Staff Vaccination Booking



Text reminders

+ 3%
Of patients have opted to receive reminders via email – saving further costs

Digital Letters

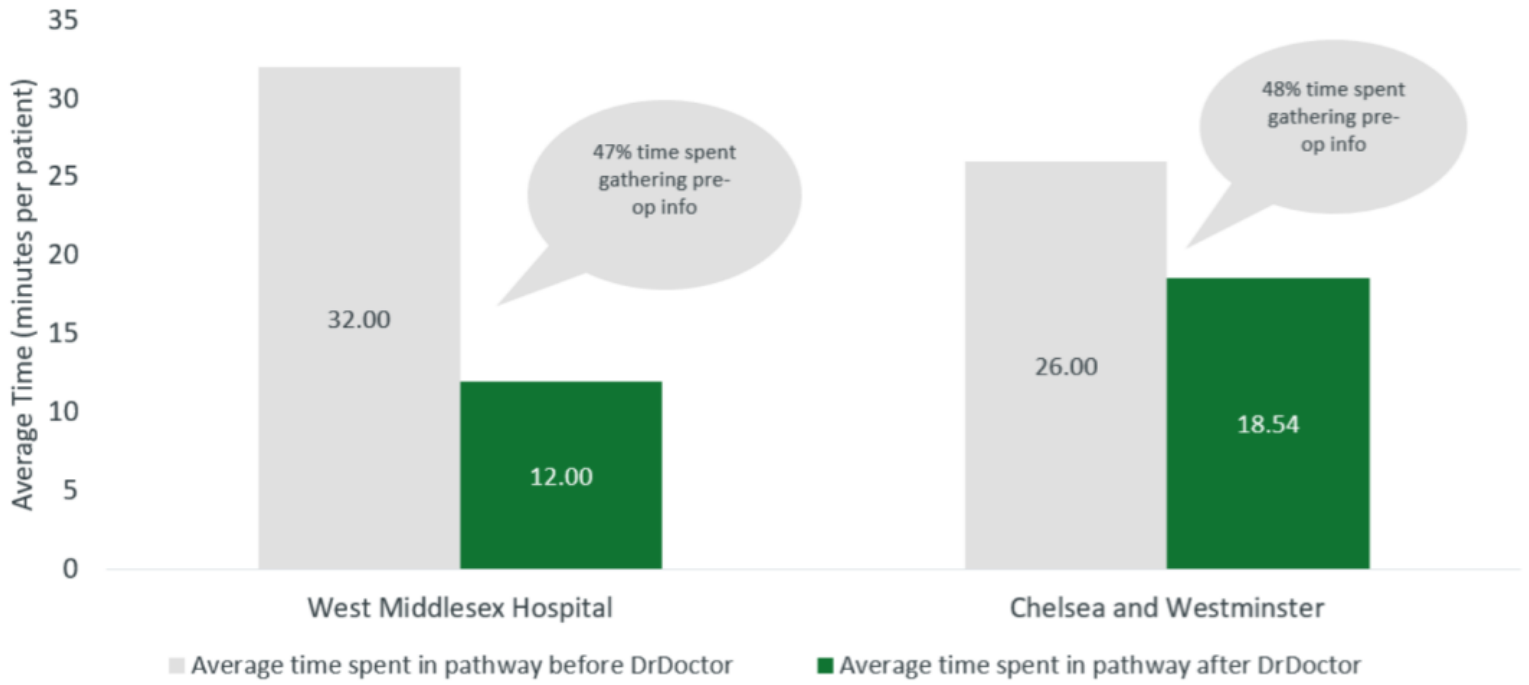
+ 2%
Patients view their letter online due to a change in wording of the notification (T: 71%)

Image submissions (Isla)

95%
Of patients have submitted their image after a clinician request

The implementation of multiple DrDoctor solutions throughout the Endoscopy pathway allowed administrative time savings

Processes were monitored and data captured before and after implementation



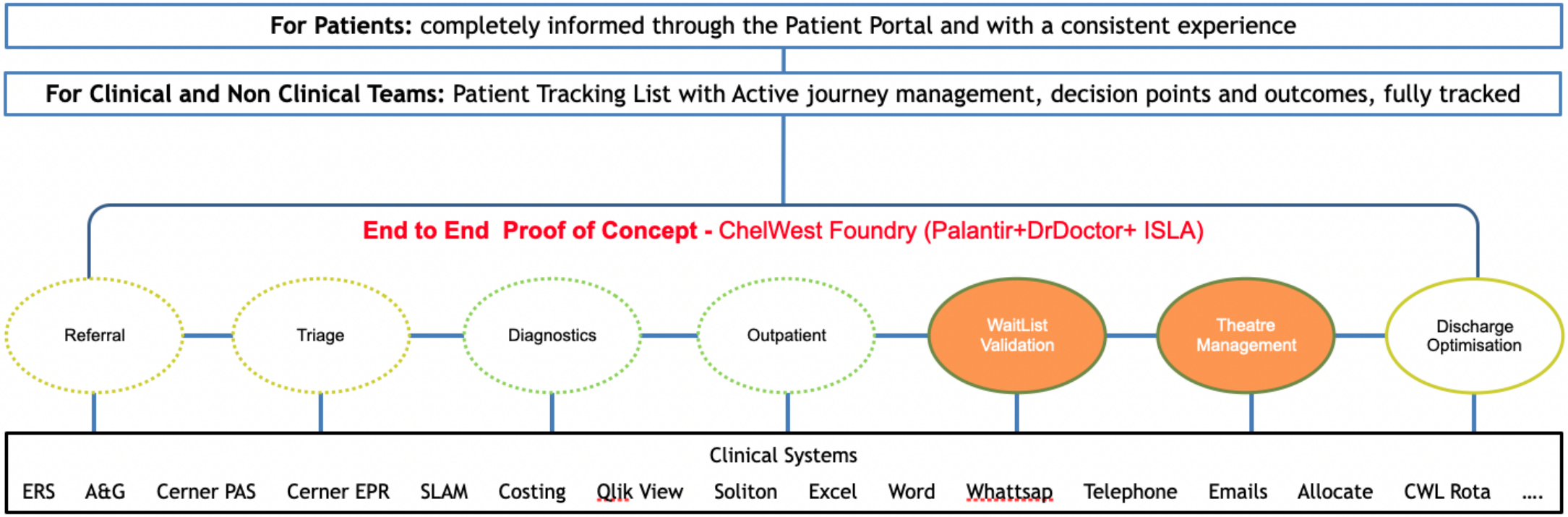
Total time calculated based on average number of patients seen per day and potential time saved per patient's pathway at each hospital site (7 mins for CW and 20 mins for WM).

29% (~133 min)*
Average time reduction per day after Endoscopy Pathway Implementation at Chelsea and Westminster (CW)

63% (~360 min)*
Average time reduction per day after Endoscopy Pathway Implementation at West Middlesex Hospital (WM)

Pre-op assessment
Highest time savings seen after implementing digital pre-op assessment survey

Support Recovery and Restore NHS Services
Improving Care Coordination for Patients (Known as End to End Pathway Management Tool)



Ambition

Better, faster, information-based decisions

- Operational tools for waiting list management, patient prioritisation and theatre scheduling workflows are in one place, optimising the elective care pathway
- Clinicians, operational staff, schedulers and data quality specialists have high-quality waiting list data to treat as many patients as possible, as fast as possible, in the right order

Simpler processes for improving elective waiting list data

- Data Quality teams can clean and correct data as they use the solution, and implement consultants' changes back to source
- Implementing changes back to source systems improves information for all system users

Better care co-ordination at all levels

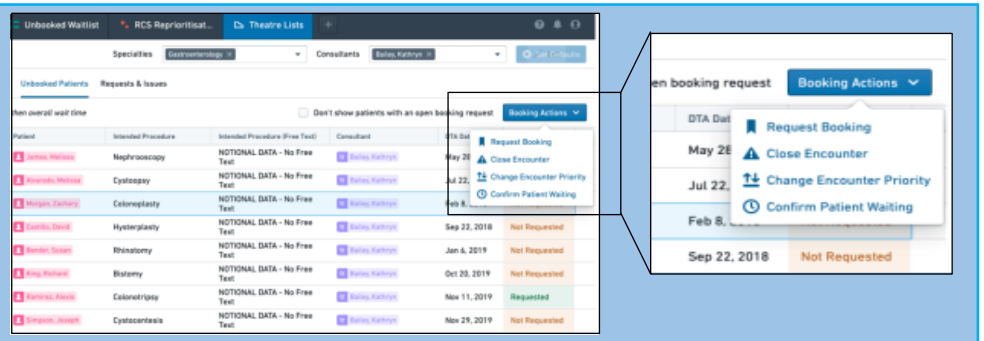
- Trusts can securely share pseudonymised data within one platform, reducing administrative effort
- Leaders at System, Regional and National levels can make better-informed operational decisions, improving the co-ordination of care across Trusts

End users

- Single view of all patients on waiting list
- Surgical reprioritisation through systemic tracking
- Visibility of anaesthetist assignment
- More control over usage of theatre facilities
- A fuller picture of patient information
- Time saving reduction of manual tasks

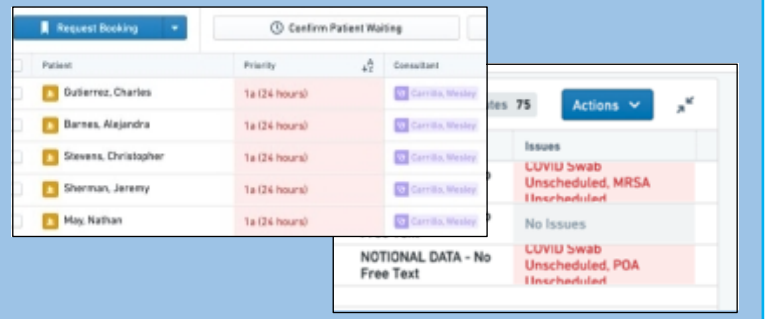
Clinicians

- Live access to their current elective waiting list and upcoming schedule.
- Easily prioritise their patients using RCS surgical codes.
- Directly request a specific patient to be booked into a surgery slot based on their RCS code and time on waitlist.



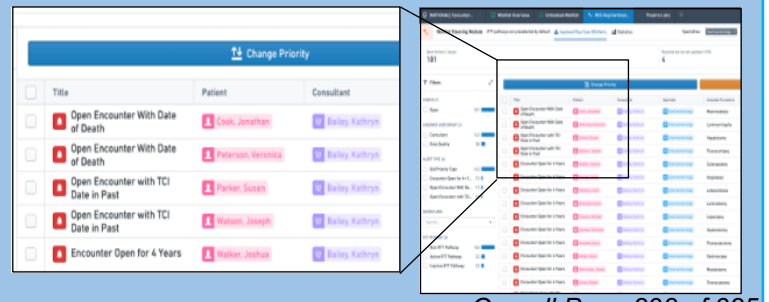
Theatre Scheduling Staff

- See the prioritised elective waiting list and book the highest priority patients into available theatre slots.
- Directly receive standardised requests from clinicians.
- Proactively manage issues which might prevent surgery (e.g., lack of pre-operative assessment or COVID-19 test).



Data Quality Teams

- View the same information as clinical colleagues as a single point of truth.
- Receive automated notifications that clinicians want to remove a patient from the elective waiting list, to action in the EPR.
- Actively clean records (duplicate entries, patients on long term follow up plans or alternative pathways) and immediately see the change in the waiting list.



TITLE AND DATE	Board of Directors Public Meeting, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	**4.6**
TITLE OF REPORT	**Board Assurance Framework – Half Yearly Report**
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: x Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To present the latest version of the Strategic Risks on the Board Assurance Framework and to seek assurance that the Board is satisfied of the adequacy of controls and assurances in managing risks associated with the achievement of the organisations strategic objectives.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome Audit and Risk Committee / 25.10.21 / Approved People and OD Committee / 26.10.21 / Approved Quality Committee / Sept 21 02.11.21 / Approved Finance and Investment Committee / 02.11.21 /
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Trust Board has overall responsibility for ensuring systems and controls are in place to mitigate any significant risks which may threaten achievement of its strategic objectives. The Board Assurance Framework (BAF) provides a structure and process which enables the organisation to focus on those risks which might compromise achieving the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks, and also enable the Board to gain assurance about the effectiveness of these controls. The BAF is monitored through the Board sub-committees on a quarterly basis, and the full Board on a bi-annual basis. Assurance is gained through a wide range of sources and the most recent update of the Board Assurance Framework was validated and verified through the latest round of Board Committee meetings.

	As part of this validation the following should be noted:- • Strategic Risk 9 was closed as management of Covid 19 is now considered part of business as usual and is an operational risk as opposed to a Strategic Risk. • BAF Risk 2 'Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards' was reviewed and it was agreed that this risk score increases from 2x4 to 3x4 (12 high) to reflect the challenges associated with sustained increased demand impacting on access standards and patient experience Given the pace at which strategic developments are taking place across the Health and Social Care System and the ongoing need to recover from the impact of Covid 19, all Board Committees support the need for the Board to revisit the Strategic Priorities and Risks detailed on the Board Assurance Framework to ensure they reflect the future environment in which we will be operating. We are therefore dedicating a Board Development Session to this on 2 December 2021.
KEY RISKS ARISING FROM THIS REPORT	Key risks are detailed in the attached framework

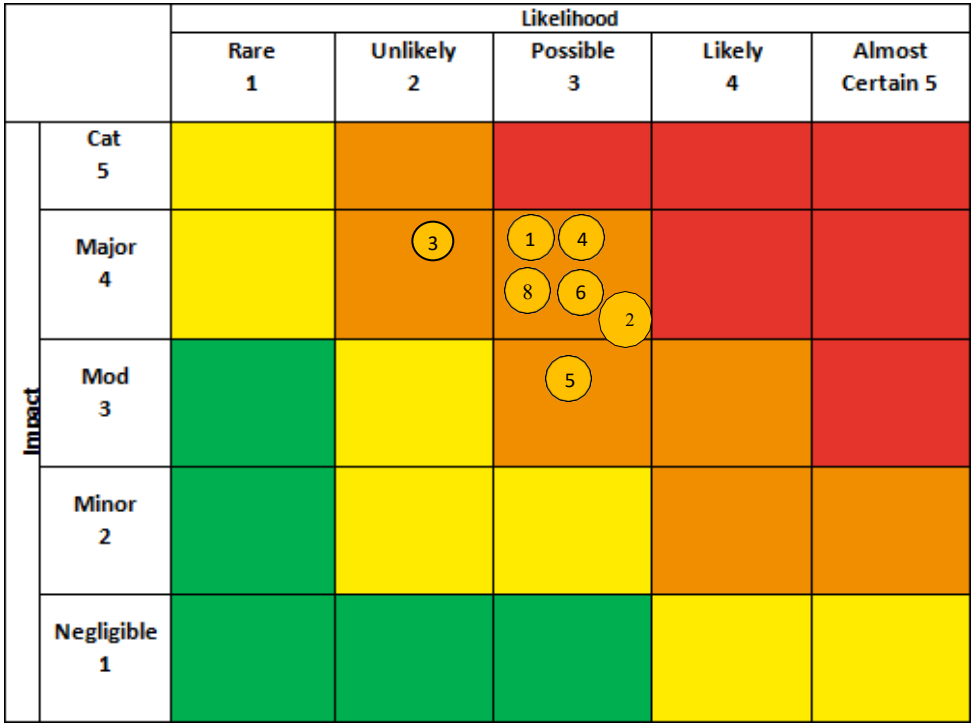
STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)

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

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Board Assurance Framework – Summary Matrix, October 2021



Key Risks

No.	Title	Assurance
1	Sustainability	Amber
2	Quality	Amber
3	Culture Values and Leadership	Amber
4	Use of Resources	Amber
5	Innovation & Improvement	Amber
6	Estates & Environment	Amber
7	EPR Programme – Closed September 2020	Green
8	Digital Programme	Amber
9	Covid-19 – Closed September 2021 via Quality Committee (BAU)	Amber

Key: Control Assurance levels

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

Board Assurance Framework – Controls and Assurance

BAF Risk 1: Failure to deliver the NWL Health & Care Partnership (HCP) System Recovery Plan and build a sustainable portfolio of outstanding acute and specialised services; consolidated across NWL (and beyond); leading to improved care and patient experience. **Cause(s):** • **No/partial delivery in NWL Provider Board back office support programmes** • **No/partial delivery in NWL Provider Board clinical standardisation programmes** • **Insufficient progress with ICHT Joint Transformation Programme** • **Failure of CCG consolidation and fragmentation of Commissioning Intentions** • **The system does not have appropriate management or governance arrangements in place to support the delivery of joined up, effective and efficient services across NWL.** **Impacting on:** • **The Trust's ability to support growth in activity, with the impact on performance and quality of care** • **The Trust's ability to implement new models of care and the resulting impact on the availability and quality of services** • **The Trust's freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance** • **The pace of the Trust's Recovery Programme with a collaborative system approach to recovery of elective care during Covid-19 pandemic** ***NB Extreme risk on Trust Risk Register is the continued growth in Non Elective activity impacting quality, safety and performance.***	**Executive Owner:** **Chief Executive**

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

Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action due
1.1 A NWL Integrated Care System (ICS) Chair and Chief Financial Officer have been appointed. Delivery against NWL System Recovery Plan is overseen by NWL Provider Board. Progress is also monitored through the weekly ICS Executive meeting and the NWL CEO Group forum. Both are chaired by the CWFT CEO as the SRO for the NWL ICS. The CWFT Deputy CEO and CNO are members of the ICS Executive Team	Programme Reports Deep Dive Reports NWL ICS System Recovery programmes 1) Programme of Care 2) Contract and Operating Plan			
1.2 Revised ICS Governance Structure now in place to support delivery of the key the NWL Health & Care Partnership programmes and strategy. CW Directors have lead operational and relational roles for many of these programmes.	NWL Clinical and Care Strategy Programme Reports Deep Dive Reports	Ensure resources deployed to support CW Executive Directors leadership on major work programmes and aligned with Divisional business plans	CEO	On-going
1.3 Joint programme of work with Imperial College Healthcare Trust in place underpinned by Memorandum of Understanding and overseen by Joint Executive Board.	Joint Service Transformation Plan (high level) Joint Programme update reports NWL Clinical Reference Groups	Ensure trust recovery plans build on NWL CRG Leadership Ensure ICHT and CWFT lead on deploying full capacity to support NWL recovery	CEO	On-going
1.4 A comprehensive series of Provider Oversight meetings have been re-introduced as a result of the Covid pandemic, to ensure system-wide oversight and ownership of provider performance in workforce, quality and use of resources.	Provider Oversight meetings reports			

BAF Risk 2: Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to support high quality care and consistent achievement of all relevant national and local quality, performance and regulatory standards **Cause(s):** • **Governance structures not in place or ineffective** • **Lack of alignment on priorities and plans across the organisation** • **Poor adherence to policies and guidelines** • **Quality of information does not support effective decision making** • **Emergence of Covid-19 pandemic** **Impacting on:** • **The ability to deliver the best patient experience and clinical outcomes** • **The Trust is subject to regulatory action and possible fines because it is not able to demonstrate compliance with relevant standards e.g. CQC, Health & Safety, GDPR** • **The Trust is unable to demonstrate compliance with Single Operating Framework and falls below the standards set by our commissioners, regulators and those we set for ourselves including 4h A&E access, 18w RTT and Cancer standards** • **The Trust does not make the most effective use of its resources** • **The loss of reputation as a result of the above** • **The ability to deliver safe elective and non-elective care due to Covid-19 virus**			**Executive Owner:** **Deputy Chief Executive / Chief Nurse**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Quality	3 x 5 = 15 (Extreme)	3x4= 12 (Moderate)	1x4 = 4 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**		
Deliver high quality patient centred care	Well-Led	Quality Committee / Audit & Risk Committee last reviewed October 21		
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action due date
2.1 Covid-19 Risk recorded within register (infection control, PPE and FIT testing)	Risk Assurance reporting to Committees of the Board Covid-19 related risk to be reviewed by Gold			
2.2 Embedded top down and bottom up annual business planning process ensures alignment across strategic objectives and quality, financial and operational plans. Plans are signed off through Executive Management Board, the relevant Board Committee and Trust Board.	Annual Quality Priorities and Plans Annual Operating and Financial Plans	Business planning process in place aligning to national timetables.	Chief Financial Officer	On-going
2.3 Maintain Quality Impact Assessment (QIA) process to ensure any quality risks associated with proposed service changes and financial improvement plans are effectively mitigated, and a Equality Impact Assessment is integral to this.	Risk matrix and mitigation output	QIA process applied to all Improvement opportunities and approved by Chief nursing Officer and Chief Medical Officer	Chief Nursing Officer / Chief Medical Officer	On-going
2.4 Maintain and monitor medical staff appraisal and revalidation process	Annual Medical revalidation report and annual NMC revalidation reports to POD	Quarterly meeting with GMC and NMC Liaison officer, and quarterly GMC returns completed. Annual report on NMC and GMC revalidations made POD.	Chief Medical Officer/ Chief Nursing Officer	On-going

2.5 Completion of CQC Board Assurance Framework for Covid-19 Infection Control	Assurance report to Quality Committee and Trust Board		Chief Nursing Officer	
2.6 Re-established Recovery Board for the Trust, and lead and engage with NWL Recovery Groups to ensure partnership working	Monthly Recovery Board reports to Executive Management Board, sub committees and Trust Board. NWL Recovery reports to Trust Board			
2.7 Established Board Governance structures and processed in place to monitor all relevant national and local quality, performance and regulatory standards including: • Integrated Quality &Performance report incorporating national quality, performance and financial standards monitored through Quality Committee and Trust Board • CQC registration requirements monitored through Clinical Effectiveness Committee. CQC action plan monitored through Quality Committee • Legal function, compliance and outcomes monitored at Executive Management Board and reported to Quality Committee including evidence of learning • Annual internal audit programme agreed and monitored through Audit and Risk Committee • National patient experience surveys and in house PREMS patient feedback.	Patient experience, serious Incident, complaints and mortality surveillance reports Integrated Quality &Performance report National survey reports and action plans Annual legal report Clinical audit reports Internal and external audit reports NHSE/I Provider Oversight Meetings CQC self-assessment and Inspection reports Embedded quality assurance system Ward accreditation Deep Dives Benchmarking information CQC inspection due in Q3 2019/20 Annual self-evaluation of Board Committee effectiveness (Jan 2020) National patient survey results			
2.8 Divisional oversight and governance structures in place to monitor all relevant national and local quality, performance and regulatory standards reporting to the Trust's Executive Management Board (EMB)	Divisional Update Reports to EMB Divisional Performance and Improvement Reports Divisional Finance Reports	Ensure Integrated Performance report is kept relevant and aligned to internal and national reporting requirements	Deputy CEO	Ongoing
2.9 Mandatory training programme in place and compliance monitored through Divisional Performance & Improvement meetings, Executive Management Board, People & OD Committee and Quality Committee and Workforce Development Committee	Divisional Performance Reports Integrated Quality & Performance Report Workforce Report			
2.10 Harm Reviews introduced for all long waiting patients to be completed regularly to ensure appropriate clinical prioritisation is in place.	Cerner System has in-built Harm Review Cancer Board Elective Access Board Weekly 'P2' clinical prioritisation meetings			

BAF Risk 3: Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Employer of choice' in a competitive labour market. **Cause(s):** • **Requirement to re-deploy large numbers of staff at pace to expand key service provisions. e.g. ICU during Covid-19 pandemic** • **Failure to manage and mitigate the impact of COVID virus on our workforce and specific 'at risk' groups** • **Psychological impact of dealing with the COVID incident across our key services** • **Communication with our workforce may not sufficient to ensure understanding and commitment to our future outcomes** • **Failure to respond to the staff survey (and other indicators)** • **Failure to build an engaged, responsive, and inclusive workforce** • **Staff do not feel valued, listened to and supported** **Impacting on:** • **The health and wellbeing of our people. e.g. absence rates** • **Expectations of staff around the 'give and get' between staff and the trust** • **Retention of 'hard to recruit' staff across key services** • **The approach to training our staff to increase their versatility to be deployed** • **Where staff will work, the way in which they deliver care to our patients and in some cases the role they undertake** • **The extension of our culture and values outside of the organization and for the benefit of the wider population** • **The Trust's reputation with partners, commissioners, regulators, the NHS and the public**			**Executive Owner: Interim Director of Human Resources and Organisation Development**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Human Resources	4 x 4 = 16 (Extreme)	2x4= 8 (High)	2 x 3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**		
Be the employer of choice	Well-Led	People & OD Committee last reviewed October 21		
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action due date
3.1 People programme in place and delivery monitored through Workforce Development Committee and People and OD committee	People programme Staff survey report HR KPI dashboard (incl. voluntary turnover rate) People reset and recovery programme Establishment of Retention Steering Group to consolidate plans and identify further actions to retain staff particularly after a period of intense work and flight risk of those close to retirement and younger workforce to travel etc.	People reset and recovery programme actions (including mandatory training recovery plan) Reset the People Programme to deliver against the agreed 4 key sections of the newly developed People Strategy.	Interim Director of Human Resources & Organisational Development	October 2021
3.2 EDI plan in place and delivery monitored through Workforce Development Committee and People & OD Committee	New EDI 3-year plan agreed with key actions including harassment and bullying action plan. Staff survey report Staff networks updates quarterly to committees Listening events with executive team NWL Inclusion Board and 4 associated workstreams NWL BAME Network EDI metrics in section 3.6	Bringing together the work of the Networks and more formal establishment of the role of the Executive Sponsor to champion and support the growing staff networks, BAME, LGTBQ+, Women's and Disability. Delivery of the NWL Leadership Ladder programme and agreed deliverables across the sector.	Interim Director of Human Resources & Organisational Development	July 2021 onwards Key deliverables in EDI plan have specific delivery dates

		Evaluation of the reverse mentoring programme and further roll-out.		
3.3 Health and Wellbeing plan in place and delivery monitored through Workforce Development Committee, People & OD Committee and Health and Wellbeing Steering Committee	Health and Wellbeing business case and associated two-year work programme – approved at EMB, PODC, FIC in July 2020 Staff survey report COVID related work-streams for workplace risk assessments, individual risk assessments, support to clinically extremely vulnerable staff, psychological support offers, welfare check ins, support of staff with Long-Covid and stress, burnout, vaccination uptake and testing. Re-set and recovery programme in place including supporting staff to take annual leave, re-set with teams and team building, approach to PDRs for 2021-22 to change to focus on health and wellbeing conversations.	Consolidation of OH services across NWL, to give greater stability and service breadth. Business case agreed and monthly OH Partnership Board in place and working towards July 2022. Year 1 evaluation of health and wellbeing programme to review measures in place over Year 1.	Interim Director of Human Resources & Organisational Development	July 2022 October 2021
3.4 Systems in place to listen to and respond to staff feedback including listening events, staff networks, team brief, senior link leads and perfect day	Trust and Divisional Staff Survey Action Plans Senior link survey report Fortnightly CEO Webinar Monthly Starter and leaver feedback Quarterly FTSU report to People and OD Committee and updates at webinar Monthly Staff Network meetings Staff survey engagement events to discuss and agree results of the 2020 staff survey results Monthly national Pulse survey launched from April 2021 to ensure more regular feedback from staff which will be incorporated into the heatmaps. Updated at webinars. 59 staff Survey pledges developed and 5 recognised an awarded as best in Division	Review of Corporate Welcome and new starters group with Execs to be reviewed. Delivery of staff survey pledges, presentations of delivery against pledges happening w/c 30th August 2021 Introduction of coffee cup conversations by health and wellbeing team for direct local feedback	Interim Director of Human Resources & Organisational Development	October 2021 Ongoing, September reviewing progress October 2021 onwards
3.5 External systems in place for staff feedback monitored through Divisional Boards, Executive Management Board and People & OD Committee	National staff survey report Quarterly Pulse survey GMC survey Freedom to Speak Up report Senior Link Partner Programme			
3.6 Systems in place to monitor key workforce metrics including Divisional Boards, Executive Management Board, Workforce Development Committee and the People & OD Committee	Workforce KPI dashboard (incl. voluntary turnover rate) HR Transactional Services KPI dashboard			

	Annual review of WRES, WDES, Gender Pay Gap reporting, Model Employer Targets Workforce information improvement plan to develop reporting arrangements including introduction of workforce heatmap to review at committees quarterly, now embedded.			
3.7 Partnership Forum and LNC reviews formal and informal staff feedback	Internal and National staff survey scores Pulse survey results Leaver surveys Union feedback GOSW Staff Networks Formal Partnership and LNC meetings restarted from March 2021.	Monthly Deep Dives on core issues	Interim Director of Human Resources & Organisational Development	March 2021 onwards
3.8 Development of a full people strategy for CW with alignment with ICS and national people plan (released July 2020).	People programme NWL People programme with NWL People Board Agreed CW people strategy Review of the 4 key themes of the People Plan at People and OD Committee each quarter: Looking After Our People – April 21 Belonging in the NHS – July 21 New Ways of Working & Delivering Care – October 21 Growing for our Future – January 2022	Approval of final draft of CW People Strategy for exec cabinet, EMB, WDC and PODC in September for Board in November 2021.	Interim Director of Human Resources & Organisational Development	November 2021

BAF Risk 4: Failure to maintain the financial sustainability of the Trust and the services it provides Cause(s): • NWL Sector affordability impacting on Trust income • Costs to deliver the elective recovery programme • Impact of inflationary costs and price changes, including CNST premium costs • Loss of transaction funding not fully mitigated • Lack of robust financial management across operational and corporate teams to ensure the cumulative impact of all decisions is understood • Non-Delivery of financial efficiency targets and impact of reduced efficiency due to infection control requirements during covid-19 and back-log of elective patients • Pathway changes and service redesign across the sector • Digital and other innovations are not fully exploited Impacting on: • Capacity to support growth in activity, with the impact on performance • Ability to continue to invest in the workforce and infrastructure required to maintain and improve the quality of services • Loss of freedom to make investment and other decisions within the relevant regulatory frameworks, policies and guidance			Executive Owner: Chief Financial Officer	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Use of Resources	4 x 5 = 20 (Extreme)	3x4 = 12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Last Reviewed**	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	November 21	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action Due
4.1 Long term financial strategy and position is reviewed quarterly by the Finance and Investment Committee	LTFM report	H1 2021/22 financial plan completed and signed off. H2 2021/22 planning to take place in Oct/ Nov	Chief Financial Officer	Nov 2021
4.2 Delivery against the Trust's financial improvement plan (CIP) is monitored through Divisional Finance Review meetings, the Improvement Board, and Finance and Investment Committee	Improvement Programme Reports Monthly CIP Delivery Report Divisional and Financial Performance Reports Divisional CIP plans for 2021/22 are in place and monitored through Divisional Finance meetings, Improvement Board & FIC.			
4.3 The effectiveness of the Trust's financial control systems are monitored through the Audit and Risk Committee as part of the internal audit programme	Internal Audit Reports			
4.4 Capital plans are reviewed regularly and monitored through Capital Programme Board, Executive Management Board and Finance & Investment Committee. Large capital projects (e.g. ADC) have separate	Capital programme report NICU/ICU programme update report EPR programme update report			

programme boards where progress is monitored and reported through to Capital Programme Board and Finance & Investment Committee				
4.5 NWL sector financial recovery plan and financial governance for sector decisions are reviewed and monitored through the NWL CFO group, then to NWL CEOs & Partnership Group.	NWL CFOs group NWL Partnership group NWL Financial Governance Framework			
4.6 Changes in commissioner contract terms are reviewed and signed off by the Executive Management Board, Finance and Investment Committee and Trust Board. Performance against the contract is monitored as part of the delivery against the Trust's overall financial plan.	Annual Financial Plan Divisional and Trust level monthly Financial Performance Reports			
4.7 Annual financial plan signed off through Executive Management Board, Finance and Investment Committee and Trust Board	Annual Financial Plan			
4.8 Annual financial improvement plan (CIP) signed off through Improvement Board, Executive Management Board and Finance and Investment Committee	Cost Improvement Plan Improvement Programme Plans Project Initiation Documents			
4.9 Delivery against the Trust's overall financial plan is monitored on a monthly basis through Divisional Finance Review meetings, the Executive Management Board, Finance and Investment Committee and Trust Board	Divisional and Trust level monthly Financial Performance Reports			
4.10 The effective use of resources is monitored against external benchmarks through the Improvement Board and individual programme boards (e.g. theatre productivity, bed productivity, outpatient transformation, diagnostic demand management), as well as external visits and assessments (GIRFT, NHSI)	Programme Board Reports Reference Costs & Model Hospital GIRFT Reports Use or Resources Assessment	NWL ICS-wide benchmarking metrics are being developed as part of the NWL financial recovery programme	Chief Financial Officer	On-going

BAF Risk 5: Failure to embed innovation and improvement in our culture and deliver innovative, patient centered services at scale **Cause(s):** • **Staff not encouraged and enabled to drive innovation and improvement** • **Lack of capability and capacity to support idea generation, testing and scaling** • **Failure to build partnerships to access innovative ideas and technology** • **Failure to spread innovative practice** • **Lack of funding to support innovation programme** • **Capital limits and capital prioritisation set at NWL ICS level may limit ability to invest in innovation** **Impacting on:** • **Transformative models of care, required to deliver wide ranging service improvement, are not adopted** • **Research & Development agenda fails to grow and deliver** • **Lost revenue opportunities from failure to commercialise innovations** • **Ability to deliver world class care aspiration** • **Profile and reputation for innovation is negatively impacted**			**Executive Owner:** **Chief Nurse/Deputy CEO**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Innovation	4 x 4 = 12 (Extreme)	3x3 = 9 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	November 21	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
5.1 Innovation Strategy Group in place to oversee the implementation of the Trust's Innovation Strategy	Innovation strategy Research Strategy Improvement and Innovation Framework Innovation Project tracker Media footprint for innovation Staff survey results			
5.2 Improvement and Innovation Framework in place setting out clear approach to developing the Trust's improvement and innovation culture, and building the Trust's capability and capacity to support this		Innovation and Improvement Champions in place across all departments. Support with case studies inc ROI Build capacity in business intelligence to support digital maturity	Deputy CEO	Complete
5.3 CW Innovation Programme in place as vehicle for attracting new partners and funding. • Overseen by an Innovation Advisory Board that brings together a broad set of third party skill sets and experience to provide guidance, challenge and support • Supported by dedicated Innovation Business Partners	Feedback from Advisory Board members Innovation project tracker Innovation fund growth Media footprint for innovation	Explore the creation of an innovation fund with corporate funders and partners	Deputy CEO	Ongoing
5.4 Innovation Operations Group in place to oversee delivery of Trust's portfolio of innovation projects and support diffusion of innovative practice	Innovation Project tracker Projects plan and update reports against agreed project milestones and KPIs. Improvement Board monitoring and reporting structure			
5.5	Innovation Project tracker			

Strict alignment of innovation grant awards with Trust strategy supported through Improvement and Innovation Team and overseen by Executive Management Board and CW Grants Committee	Grant applications CW+ Impact Report			
5.6 Agreed capital prioritization criteria across NWL, with regular review through NWL CFOs group and reviewed through Capital Programme Board	Annual and 5 year capital programme Review through Capital Programme Board			
5.7 Development of a new division which encompasses Research, Innovation and Digital teams 'the Enterprise Divison'to provide a streamlined and coordinated infrastructure and approach.	Governance and reporting structures will be established for this new division in line with current divisional structures. Executive Management Board monthly reports			
5.8 Commercial Assurance Board established to govern all commercial partnerships	Reports into Audit and Risk Committee			

BAF Risk 6: Failure to develop our estate in a sustainable way to support the delivery of high quality, effective and efficient care **Cause(s):** • **Commercial and cost improvement plans not delivered** • **Capital development programme not delivered (including ITU/NICU development)** • **Long term development plan for WMUH is not realised** **Impacting on:** • **Capacity to support growth in activity, with the impact on performance** • **Ability to transform models of care and improve the quality of services** • **Environmental impact of how we deliver services**			**Executive Owner:** **Deputy Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Estate & Environment	4 x 4 = 16 (Extreme)	3x4 =12 (High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver high quality patient centered care	Well-Led	Finance & Investment Committee	November 21	
Current controls and assurance	Actions to further enhance risk management			
Key controls in place to address risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
6.1 Capital Development Programme, aligned to Estates Strategy, signed off and regularly reviewed through Capital Programme Board, Finance and Investment Committee and Trust Board.	Capital Development Programme Report ERIC report Targeted Deep Dive – Estates Capital Strategy Senior Link Partner Programme Ward Accreditation	Establish rolling ward refurbishment programme led by the Hospital Directors Consider impact of London ICP guidelines and establish 'Silver Site' status and COVID-19 protected pathways to support all priority services	Deputy Chief Executive	Complete
6.2 Annual Operating Plan and budgets aligned with Capital Development Programme with clear scheme of delegation with regular updates to Executive Management Board	Estates and Facilities Monthly Report	Review Capital requirements in light of NWL ICS development programmes; Critical Care expansion, Endoscopy, SDEC	Deputy Chief Executive	Complete
6.3 ITU/NICU development overseen by dedicated Programme Board reporting to Finance and Investment Committee	ITU/NICU Programme Report Internal Audit	Apply learning from the NICU/ICU project and ensure that the contingency for unknown risks in future major developments is adequate	Deputy Chief Executive	Ongoing
6.4 Estates Strategy approved by Trust Board and reviewed through Finance and Investment Committee and Trust Board Strategy sessions	Estates Strategy WMUH Site Master Plan			
6.5 Rolling maintenance programme in place aligned to Annual Operating Plan	Estates and Facilities Monthly Report Targeted Deep Dive – Estates Capital Strategy Sub-group reviews of capital expenditure on each site			
6.6 Establishment of a new sub-group of Finance and Investment Committee to oversee capital developments			Deputy Chief Executive/Chief Finance Officer	September 2021

BAF Risk 8 (opened September 2020): Risk that the implementation of work programmes within Digital and Innovation Strategy may not be delivered due to costs associated with purchase of software and hardware, costs of transformation, and sustainability of resources. **Cause(s):** • Workforce capability • Clinician, Executive and other staff engagement (including training) • Risks associated with system collaboration across NWL and decision making processes potentially delaying CWFT progress • Budget constraints due to the need for recurrent investment in to both hardware and software • Change management does not ensure adoption of best practice and / or benefits realization **Impacting on:** • The running of the hospitals to deliver normal services and contractual responsibilities during periods of significant disruption • The need to maintain and improve cyber security • Adequately respond to the digital requirements of local communities • The need to modernize and upskill the workforce • Ability to respond to major incidents as well as the current global pandemic			**Executive Owner:** **Deputy Chief Executive**	
Risk Domain	**Gross risk score**	**Net (Current) risk score:**	**Target risk score (risk appetite)**	
Digital and Innovation Programme	4 x 4 = 16 (Extreme)	3x4 = 12(High)	2x3 = 6 (Moderate)	
Strategic objective	**CQC Domain**	**Assurance Committee**	**Date of last review by Committee:**	
Deliver better care at lower cost	Well-Led	Finance and Investment Committee	November 21	
Current controls and assurance	Actions to further enhance risk management			
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
8.1 Review of IT Infrastructure upgrade costs in preparation of capital spend	Capital Programme for IT Infrastructure 21/22	Development of rolling IT Infrastructure Capital Investment Programme	Chief Financial Officer/Chief Clinical Information Officer	December 2021
8.2 Review current Digital and Innovation projects and align with Trust / ICS objectives	Monthly Digital and Innovation Programme Board			
8.3 Joint EPR change board governance process with Imperial College Healthcare Trust in place	Monthly EPR Board Report	Continued monthly EPR/Digital Steering Group	Deputy Chief Executive	Ongoing
8.4 Development of Digital Strategy in concert with NWL partners	EPR Board Report	Complete NWL Digital and Innovation Strategy	Deputy Chief Executive/Chief Clinical Information Officer	April 2022

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	4.7
TITLE OF REPORT	Half year report on use of the Company Seal 2021/22
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Company Seal has been used on 1 occasion during the period 1 April 2021–30 September 2021.
KEY RISKS ARISING FROM THIS REPORT	None.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:	Nil

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) – not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Report on use of the Company Seal 2021/22

1. The Constitution, at Annex 7 (Standing Orders), Section 11 refers to the sealing of documents. This section states:

Custody of Seal and Sealing of Documents

11.1. **Custody of Seal** – the common seal of the Trust shall be kept by the Company Secretary in a secure place.

11.2. **Sealing of documents** - where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.

11.3. **Register of sealing** - an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.

11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

2. The Company Seal has been used on one occasion during the period 1 April 2021–30 September 2021. This was on 9 August 2021 under seal reference 211. The seal was affixed to a supplemental agreement and deed of variation to the Project Agreement between Chelsea and Westminster Hospitals NHS Foundation Trust and ByWest Limited relating to the Ambulatory Emergency Care Department at West Middlesex Hospital. The seal was affixed by the Chief Executive Lesley Watts and the Chief Financial Officer Virginia Massaro.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE	Board of Directors, 4 November 2021	PUBLIC SESSION

AGENDA ITEM NO.	4.8
TITLE OF REPORT	**Committee Effectiveness Review 2021-22**
AUTHOR NAME AND ROLE	Dawn Clift, Interim Director of Corporate Governance and Compliance
ACCOUNTABLE EXECUTIVE DIRECTOR	Dawn Clift, Interim Director of Corporate Governance and Compliance
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To provide assurance to the Trust Board of the process and timeframe for undertaking Board Committee Effectiveness Reviews as approved by the Audit and Risk Committee.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Audit and Risk Committee; Date of Meeting: 25.10.21; Outcome: Approved
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The NHS Foundation Trust Code of Governance recommends that there should be a formal and rigorous annual evaluation of the performance of the board, its committees, the chair and individual directors. These provisions are echoed in the UK Corporate Governance Code (CGC) (July 2018), with both recommending a three-year (three-five year UK CGC) externally facilitated evaluation of the Board. In 2016, the Board agreed a rigorous process for undertaking all three elements of Board evaluation. In 2020, the Audit and Risk Committee approved a refresh of the element concerned with Committee evaluation. This refresh serves to also support KLOE 4 of the CQC well led framework and will form part of a broader well led self assessment prior to the Commissioning of an external well led review later in the year. During November each Committee will undertake a self-evaluation and report the outcomes to the Audit and Risk Committee to inform an assurance report to the Board. This requires each Committee member to answer a series of questions about the effectiveness of each Committee of which they are a member and the opportunity to offer reflections, as a Board member, on the effectiveness of Committees of which they are not a member. Responses relevant to each Committee will be collated by the Director of Corporate Governance & Compliance and shared with the Committee Chair for reporting back to the Committee for discussion before onward submission to the Audit and Risk Committee to allow for a collated report to be presented to the Board.

KEY RISKS ARISING FROM THIS REPORT	Failure to undertake effective evaluation could result in opportunities for improvement to be missed.

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

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

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

REASON FOR SUBMISSION TO THE BOARD IN PRIVATE ONLY (WHERE RELEVANT) Not applicable	
Commercial Confidentiality	**Y/N**
Patient Confidentiality	**Y/N**
Staff Confidentiality	**Y/N**
Other Exceptional Circumstances (please describe)	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Committee Effectiveness Review 2021/22

Introduction

1. Board committee evaluation is an important feature of good governance and supports compliance with the principles of the UK Corporate Governance Code and the NHS Foundation Trust Code of Governance. It also features as part of the CQC well led framework particularly in relation to KLOE 4 'Are there clear responsibilities, roles and systems of accountability to support good governance and management'.

2. Effective evaluation allows the Board, and individual committees, to obtain assurance on how well each committee is performing against its remit, delivering its objectives and in turn contributing to the effective performance of the Trust as a whole. A common framework is proposed which will allow for consistency of approach in evaluation which further underpins that element of its remit to assure the Board on the effectiveness of its systems of internal control.

3. The Committees which would be subject to this process are:
    a. Audit and Risk Committee (ARC)
    b. Quality Committee (QC)
    c. Finance and Investment Committee (FIC)
    d. People and Organisation Development Committee (PODC)
    e. Board Nominations and Remuneration Committee (NRC)

4. The process is similar to that used in 2020. Each Committee member will be asked to complete a survey about the effectiveness of each Committee of which he/she is a Member. The draft survey, at **Annex A**, is built around five themes and a number of statements in each for scoring:
    a. Composition, establishment and duties
    b. Administrative arrangements
    c. Governance, scrutiny and assurance
    d. Scope of work
    e. Committee engagement

5. There are five questions where narrative responses are requested:
    a. Committee focus
    b. Committee effectiveness
    c. Committee leadership
    d. Committee values

Action: The Committee is asked to review the proposed surveys and agree to their use.

6. Each Board member will also be provided with the opportunity to provide feedback on any Committee of which he/she is not a member. This will provide Committees with a degree of 'external' perception of effectiveness. We will look to review formatting to see if a number of Committees can be assessed on a single grid. See **Annex B.**

7. Completed surveys will be collated by the Director of Corporate Governance & Compliance and reported to each Committee Chair, for onward discussion within Committees. Each Committee Chair

would then be asked to provide a summary report to the Audit and Risk Committee, so that an assurance report on Committee effectiveness, and any recommended actions, can be reported to the Board.

8. The survey will be conducted on Survey Monkey to ease completion and evaluation of responses.

9. It is suggested that the substantive survey at Annex A is completed by those who were members up until end October 2020, not new Committee members, as shown in the grid below.

Audit and Risk	**Quality**	**Finance and Investment**	**People and OD**	**Nominations and Remuneration**
Nick Gash	Eliza Hermann	Nilkunj Dodhia	Ajay Mehta	Steve Gill
Aman Dalvi	Nilkunj Dodhia	Aman Dalvi	Nick Gash	Aman Dalvi
Eliza Hermann	Ajay Mehta	Steve Gill	Martin Lupton	Nilkunj Dodhia
Plus attendees:	Lesley Watts	Lesley Watts	Lesley Watts	Nick Gash
Lesley Watts	Roger Chinn	Rob Hodgkiss	Roger Chinn	Eliza Hermann
Virginia Massaro	Rob Hodgkiss	Virginia Massaro	Rob Hodgkiss	Ajay Mehta
Dawn Clift	Pippa Nightingale		Pippa Nightingale	
Head of Internal Audit	Dawn Clift		Vanessa Sloane	
Head of External Audit	Alex Bolton		Karen Adewoyin	
Counter-fraud lead			Lindsey Stafford-Scott	
			Dawn Clift	

10. The timescale proposed is:

- October 2021 – ARC approves process and survey - complete
- End October 2021 – survey issued to all Board members (NOTE: last year's outcomes will be circulated to each Committee at this point for information) - complete
- Mid November 2021 – completed surveys returned
- End November/early December 2021 – FIC/PODC/QC review responses
- Early January 2022 – FIC/PODC/QC Chairs provide summary report to ARC
- January 2022 – ARC reviews its own responses and FIC/PODC/QC reports
- March 2022 – Board receives assurance report from ARC

Action: The Board is asked to note the above timescale.

Annex A: Committee Member Survey

Statement	Strongly agree	Agree	Disagree	Strongly disagree	Unable to answer	Comments / ideas for improvement
Composition, effectiveness and duties						
The Committee has written terms of reference that adequately define the Committee's role						
The Committee has the membership, authority and resources it needs to perform is role effectively						
The Committee provides timely, clear and transparent assurance to the Board						
Committee members have sufficient knowledge to identify key risks areas and challenge the executive when required						
The Committee receives the appropriate level of input from Executive members						
Administrative arrangements						
Agendas and papers are circulated in good time to allow for due consideration						
Minutes and actions are circulated in good time to allow for due consideration						
The timing, location and meeting room facilities are appropriate						
Committee attendance is in line with the quorum						
Governance, scrutiny and assurance						
The Committee can demonstrate that it provides the Board with assurance in respect of all matters within its agreed remit						
The Committee can demonstrate the assurance it provides in respect of the Board Assurance Framework and on identification and management of risks within its remit						

Statement	Strongly	Agree	Disagree	Strongly	Unable to	Comments / ideas for improvement

	agree			disagree	answer	
The frequency and duration of Committee meetings is sufficient to give appropriate consideration and scrutiny to the matters within its remit						
The reports presented to the Committee are of an appropriate quality and level of detail to allow for scrutiny and challenge and assurance to be provided						
The Committee understands the risks and issues within its remit and the decisions and assurances it is required to provide						
The Committee is alert to conflicts of interests and reports and manages these appropriately						
Work plan						
The Committee has established a work plan for the year ahead						
The Committee reviews its work plan at least quarterly						
The Committee has achieved its work plan						
The work plan reflects the agreed Terms of Reference of the Committee						
The Committee has sufficient flexibility within its work plan to address newly emerging risks and issues						
Committee Engagement						
To what extent do you feel Committee members contribute regularly and evenly across the range of issues discussed?						
Committee Focus						
To what extent are agenda item 'closed off' appropriately so that the committee is clear what the conclusion is; who is doing what, when and how, etc. and how it is being monitored?						
Statement	**Strongly**	**Agree**	**Disagree**	**Strongly**	**Unable to**	**Comments / ideas for improvement**

	agree			disagree	answer	
Committee Effectiveness						
To what extend do you feel the Committee actively challenges the executive during the year to gain a clear understanding of their findings?						
Committee Leadership						
Does the Committee Chair have a positive impact on the performance of the Committee, including the encouragement of views and allows for free-flowing debate?						
Committee Values						
To what extent do you feel the Committee considers the PROUD values of the Trust in its work?						

Annex B – Non-Committee member survey
Optional for completion – any Board member may complete for any Committee of which he/she is not a member/regular attendee

ARC / PODC / FIC / QC [delete as appropriate]						
Statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**Unable to answer**	**Comments / ideas for improvement**
The Committee provides assurance to the Board on the areas that fall under its Terms of Reference						
The outputs of the Committee are understood by and considered at the Board						
The Board is assisted through its ability to delegate key areas of scrutiny to the Committee						
General comments						