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

7 July 2022 11:00 - 7 July 2022 13:30

AGENDA

#	Description	Owner	Time
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1.3	Minutes of the previous meeting held on 5 May 2022 Paper 1.3 Draft Public Board minutes 05.05.22.docx 15	Chairman	11.02
1.4	Matters arising and Board action log Paper 1.4 Board Action Log PUBLIC.doc 27	Chairman	11.04
1.5	Patient Story: Maternity Patient Story Verbal	Director of Midwifery	11.05
1.6	Chairman’s Report Paper 1.6 Chair's report July 2022.docx 29	Chairman	11.10
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#	Description	Owner	Time
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2.3	Maternity Services Improvement Programme Report Paper 2.3 Maternity Improvement Plan_updated version 2... 75	Chief Nursing Officer	12.10
3	FOR APPROVAL		
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4	FOR NOTING – HIGHLIGHTS BY EXCEPTION		
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#	Description	Owner	Time
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4.5	Freedom to Speak Up Report 4.5a Freedom to Speak Up Q4 Report.docx 231 4.5 Freedom to Speak Up Q4 Report.doc 233	Director of Human Resources & Organisational Development	
4.6	Learning from Deaths Report Q1 2022/23 Paper 4.6a Mortality_Surveillance Q1 2022 PUBLIC BOA... 239 4.6b Review of deaths associated with nosocomial... 249	Chief Medical Officer	
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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Date: 7 July 2022
Time: 11.00 – 13.30
Location: Virtual via Microsoft Teams

Agenda

	1.0	**GENERAL BUSINESS**		
11.00	1.1	Welcome and apologies for absence	Verbal	Chairman
11.01	1.2	Declarations of Interest, including register of interests	Paper	Chairman
11.02	1.3	Minutes of the previous meeting held on 5 May 2022	Paper	Chairman
11.04	1.4	Matters arising and Board action log	Paper	Chairman
11.05	1.5	Patient Story: Maternity Patient Story	Verbal	Director of Midwifery
11.10	1.6	Chairman's Report	Paper	Chairman
11.25	1.7	Chief Executive's Report	Verbal	Chief Executive Officer
	2.0	**FOR DISCUSSION**		
11.40	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
12.10	2.3	Maternity Services Improvement Programme Report	Paper	Chief Nursing Officer
	3.0	**FOR APPROVAL**		
12.25	3.1	Board Business Cycle 2022/23	Paper	Interim Deputy Director of Corporate Governance
	4.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**		
	4.1	Learning from Serious Incidents	Paper	Chief Nursing Officer
	4.2	Complaints Annual Report	Paper	Chief Nursing Officer
	4.3	Infection Prevention and Control Annual Report	Paper	Chief Nursing Officer
	4.4	People Performance Report	Paper	Director of Human Resources & Organisational Development
	4.5	Freedom to Speak Up Report		Director of Human Resources & Organisational

				Development
	4.6	Learning from Deaths Report Q1 2022/23	Paper	Chief Medical Officer
	4.7	Guardian of Safe Working Report	Paper	Chief Medical Officer
	5.0	**ITEMS FOR INFORMATION**		
13.25	5.1	Questions from members of the public	Verbal	Chairman
13.25	5.2	Any other business	Verbal	Chairman
13.30		Date of next meeting – 8 September 2022, 11.00am – 13.30pm		

Chelsea and Westminster Hospital NHS
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Chelsea and Westminster Hospital NHS Foundation Trust
Register of Interests of Board of Directors – 1 June, 2022

Name	Role	Description of interest	Relevant dates		Comments
			From	To	
Matthew Swindells	Chair	MJS Healthcare Consulting (Founder / Owner) Clients: - Senior Advisor to Global Council Policy and Strategy Consultancy whose clients include a number of pharma companies and Palantir, whose Health Advisory Panel I chair - Internal Advisor to Accenture Global consultancy firm - Internal Advisor to Carnall-Farrar Healthcare strategy consultancy Board Member for Prism Improvement Limited - Small healthcare improvement consultancy	Aug 2019 Sept 2019 Sept 2019 Feb 2022 Apr 2022	Present Present Present Present Present	To be excluded from any decision making in relation to Palantir with whom Chelwest work.
		Shareholder of Written Medicine			Written Medicine are a supplier to LNW Trust. MS is in the process of transferring his shares to the LNW Charitable Trustees as a gift.
Stephen Gill	Vice Chair and Senior Independent Director	Owner of S&PG Consulting	May 2014	Ongoing	
		Chair of Trustees, Age Concern Windsor	Jan 2018	Ongoing	
		Shareholder in HP Inc	April 2002	Ongoing	
		Shareholder in HP Enterprise	Nov 2015	Ongoing	
		Shareholder in DXC Services	April 2017	Ongoing	
		Shareholder in Microfocus Plc	Sep 2017	Ongoing	

		Member of the Finance and Audit Committee (FAC), Phyllis Court Members Club	Aug 2019	Ongoing	
Aman Dalvi	Non-executive Director	Aman Dalvi Ltd (Housing & Planning Consultancy)	2017	Ongoing	
		Non-Executive Director of Fairplace Homes	2018	Ongoing	
		Non-Executive Chair of Goram Homes (Bristol)	2019	Ongoing	
		Non-Executive Chair of Kensington & Chelsea TMO Residuary Body	2019	Ongoing	
		Non-Executive Chair of Aspire Housing (Staffordshire)	Jan 2021	Ongoing	
		Non-Executive Chair of Newlon HT	Jan 2021	Ongoing	
		Board Member of Old Oak Development Corporation	March 2022	Ongoing	
Nilkunj Dodhia	Non-executive Director	Directorships held in the following:			
		Macusoft Ltd	May 2017	Ongoing	
		Independent examiner of St. John the Baptist Parish Church, Old Malden	April 2016	Ongoing	
		Cerner Limited as Director and GM for London Oracle Cerner Limited as Director and GM for London	27 September 2021 7 June 2022	Ceased Ongoing	To be excluded from any decision making relating to Oracle Cerner Limited with whom Chelwest work
		Spouse – Assistant Chief Nurse at University College London Hospitals NHS FT	Jan 2019	Ongoing	
Nick Gash	Non-executive Director	Trustee of CW + Charity	Jan 2017	Ongoing	
		Chair North West London Advisory Panel for National Clinical Excellence Awards	Oct 2018	Ongoing	Lay Member of the Panel throughout my time as NED
		Spouse - Member of Parliament for the Brentford and Isleworth Constituency	Nov 2015	Ongoing	
		Associate, Westbrook Strategy	Feb 2020	Ongoing	
		Chair of the Audit and Risk Committee for the Royal Society of Medicine.	October 2021	Ongoing	
Eliza Hermann	Non-executive Director – Ceased 30 June 2022	Former Board Trustee and current Marketing Committee Chairman, Campaign to Protect Rural England, Hertfordshire Branch	2013	Ongoing	
		Committee Member, Friends of the Hertfordshire Way	2013	Ongoing	
		Close personal friend – Chairman of Central & North West London NHS Foundation Trust	Ongoing	Ongoing	
Ajay Mehta	Non-executive Director	Director and Co-Founder at em4 Ltd	2019	Ongoing	Social Enterprise works with international funders and investors to build the

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

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

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

Non-Voting Directors

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

Martin Lupton	Honorary NED, Imperial College London	Employee, Imperial College London	01/01/2016	Ongoing	
Chris Chaney	Chief Executive Officer CW+	Trustee of Newlife Charity	Jun 2017	Ongoing	
Susan Smith	Interim Director of HR & OD	Joint Chief People Officer /Interim Director of HR & OD The Hillingdon Hospitals NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust	13/10/2020	Ongoing	
Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to Board	Director, Women's Wellness Centre private healthcare facility	2005	Ongoing	
		Board of Governors, Latymer Upper School, London Audit and Risk Sub-Committee of Board	2015	Ongoing	
		Interim Medical Director, The Hillingdon Hospitals NHS Foundation Trust	14/10/2020	Ongoing	
Serena Stirling	Director of Corporate Governance and Compliance	Local Authority Governor at Special Educational Needs School (Birmingham)	2019	Ongoing	
		Mentor on University of Birmingham Healthcare Careers Programme	2018	Ongoing	
		Leadership Mentor for Council of Deans for Health	2017	Ongoing	
		Partner is Princess Royal University Hospital site CEO at King's College Hospital NHS Foundation Trust	Feb 2020	Ongoing	
		CW+ Fundraising Governance Committee Trust representative	Jul 2020	Ongoing	

Minutes of the Board of Directors (Public Session)

Held at 11.00am on 5 May 2022 via Zoom

Present	Matthew Swindells	North West London Chair in Common	(MS)
	Stephen Gill	Senior Independent Director and Vice Chair	(SG)
	Aman Dalvi	Non-executive Director	(AD)
	Nick Gash	Deputy Chair (Interim)	(NG)
	Eliza Hermann	Senior Independent Director (Interim)	(EH)
	Ajay Mehta	Non-executive Director	(AM)
	Lesley Watts	Chief Executive Officer	(LW)
	Roger Chinn	Chief Medical Officer	(RC)
	Rob Hodgkiss	Deputy Chief Executive and Chief Operating Officer	(RH)
	Virginia Massaro	Chief Financial Officer	(VM)
In Attendance	Dawn Clift	Interim Director of Corporate Governance and Compliance	(DC)
	Vanessa Sloane	Deputy Chief Nursing Officer	(VS)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Martin Lupton	Honorary Non-Executive Director	(ML)
	Gubby Ayida	Equality, Diversity and Inclusion Specialist Advisor to the Board	(GA)
	Emer Delaney	Director of Communications	(ED)
	Chris Chaney	Chief Executive Officer CW+	(CC)
	Victoria Cochrane	Director of Midwifery (item 2.3)	(VC)
	Harry Sarsha	Head of Inclusion (item 1.5)	(HS)
	Olivia Dawson-Annan	Senior Administrator Radiology (item 1.5)	(ODA)
Members of the Public/Observers	Caroline Boulliat	Governor	(CB)
	Dr Paul Kitchener	Governor	(PK)
	Richard Ballerand	Governor	(RB)
	Dr Des Walsh	Governor	(DW)
	Prof Mark Nelson	Staff Governor	(MN)
	Laura Jane Wareing	Governor	(LJW)
	Parvinder Singh	Governor	(PS)
	Anouchka Goldman	Member of Public	(AG)
	Nick Kituno	Media	(NK)
	Janet Adeyemi	Interim Board Governance Manager Chelwest	(JA)
Apologies for Absence	Serena Stirling	Director of Corporate Governance and Compliance	(SS)
	Vida Djelic	Board Governance Manager	(VD)
	Robert Bleasdale	Chief Nursing Officer	(RB)
	Nilkunj Dodhia	Non-executive Director	(ND)

Minute Reference		Action
1.0	**GENERAL BUSINESS**	
1.1	**Welcome and Apologies for Absence**	
	MS welcomed members, attendees and observers to the meeting. Apologies for absence were noted as above. MS expressed his thanks to SG (former interim Chair) for his support to him as he has transitioned into the role of Chair in Common. MS requested that questions from the public be held until item 5.1 on the agenda.	
1.2	**Declarations of Interest including the Board Register of Interest**	
	DC presented the opening Board Register of Interests which had been amended to reflect the following:- •Appointment of Matthew Swindells as NWL Chair in Common from 1 April 2022 •Appointment of Robert Bleasdale as Chief Nursing Officer from 4 April 2022 •Closure of the appointment of Vanessa Sloane as interim Chief Nursing Officer from February 2022 – 3 April 2022 •Additional interest of Aman Dalvi as Board member of Old Oak Development Corporation from 24 March 2022 <u>Resolution:-</u> The Board resolved to approve the Board Register of Interests.	
1.3	**Minutes of the Previous Meeting held on 3 March 2022**	
	The minutes of the previous Board meeting held in public on 3 March 2022 were agreed as a correct record.	
1.4	**Matters Arising and Board Action Log**	
	The action log was reviewed and noted. All actions were complete and matter 3.1 (Guardian of Safe Working) had been formally referred to the People and OD Committee for their consideration at their meeting in late May 2022.	
1.5	**Staff Story**	
	MS welcomed Olivia Dawson-Annan to the meeting. Olivia was introduced by GA, the Board Inclusion Advisor and Chair of the BAME Network. Olivia advised that she had worked at Chelwest for 19 years as a senior administrator in the Radiology Department. In September 2021, she encountered an incident whereby a patient presented at the main reception of the hospital stating that she had an appointment. Olivia went to the reception to meet the patient and explained that her appointment had been the day before and offered to arrange an alternative appointment for her. The patient called Olivia 'a stupid woman' and left the building. The patient returned to reception again and said to Olivia 'you are stupid. I don't want to see you. You are black' She then continued	

	to racially abuse Olivia to significant levels. The patient threatened to pull Olivia's hair out. Olivia was shocked by this abuse but remained calm, composed and endured the pain and insult and instead prayed for the patient. Olivia advised the Board that she recognised that this was an extreme case and that the vast majority of patients very much appreciate the care given to them by staff in the organisation. She stated that she is proud to work for the Trust and is an Ambassador for the Trust living its values everyday. Olivia expressed concern that despite this aggressively and unacceptable racial incident, an alternative appointment was still given to the patient and that this had caused her to be frightened and upset – recognising that she would come face to face with the patient again. The matter was escalated by her consultant colleagues to the Chief Medical Officer and Chief Executive who immediately visited Olivia to provide her with support and to express their sincere apologies that this had happened to her. The Chief Executive was very clear that a no tolerance approach to discrimination should be applied and the patient was given a red card, meaning that they could not access the hospital unless in the case of a medical emergency. Olivia expressed her thanks and appreciation for the support that the organisation had given to her including the direct engagement of members of the Executive Team, her immediate colleagues and the ongoing support of the BAME Network Chair. She stated that the response given to her helped her to feel safe, listened to and cared for. GA stated that the organisational approach to racial abuse must be taken as seriously by all staff as that of physical abuse and asked the Board for their support in ensuring that a zero tolerance approach to any form of discrimination is understood and owned at all levels of the Trust. GA reminded Board members of the People Promise and the key pillars of our people strategy relating to inclusion and mental and physical health and wellbeing of staff. MS thanked Olivia for her bravery in sharing her story with the Board. He stated that he was extremely sorry that she had encountered this experience and that he fully supported a zero tolerance approach to discrimination. This was echoed by SG who was shocked at the outrageous behaviour that had been displayed to Olivia. He stated that he was immensely proud of the way in which Olivia had responded to this very difficult and inappropriate situation. AM stated he was very sorry that Olivia had lived this experience and stated his commitment as Health and Wellbeing Guardian for the Trust to understand more about these experiences and to actively help to develop a zero tolerance approach to all aspects of discrimination. LW commended Olivia for her bravery. She stated that racial discrimination and discrimination and abuse of all protected characteristics has to be a number one priority for the Trust. AD stated that he was very moved by Olivia's story and agreed that internal scars are often more hurtful and more difficult to heal. He was pleased that Olivia had received positive support from the Trust.	

	GA closed the session that she valued the Board's commitment to a zero tolerance approach and would take this back to the BAME network. It was agreed that further transparency and education was needed within the organisation to expose discrimination and that this was a focus for 2022. Olivia expressed her heartfelt thanks to the Board for their support.	
1.6	**Chair's Report**	
	MS presented the report and stated that he was privileged to have been appointed as the North West London Chair in Common with effect from 1 April 2022. He delivered an overview of the benefits and aims of the Acute Provider Collaborative and stated that he was engaging with as many people as possible to understand their wants and needs of the collaborative. He had also been speaking with lead Governors and local authority leaders. MS gave a commitment to support Chelwest to be the very best that it can be. ML asked how the physical estate infrastructure needs would be balanced across the collaborative given that some sites had deteriorated significantly over the years. MS confirmed that he recognised that there was variation and that a collaborative approach to local allocation of capital and also sourcing of additional funds from any regional and national support which becomes available from time to time would support the direction of travel. <u>Resolution:-</u> With there being no further questions, the Board resolved to note the content of the report.	
1.7	**Chief Executive's Report**	
	LW gave a warm welcome to all attending the Board meeting including MS. LW opened her report by paying tribute to all staff for their professionalism and commitment in 2021/22 despite the constraints that they had faced. She expressed optimism in the year ahead to deliver further improvements and referenced learning from a national piece of work she was leading on hospital flow and timely discharge which would seek to ensure that systems and processes are as effective and efficient as possible. LW reinforced the collaborative approach to treat patients in turn across the collaborative to start to reduce inequalities in healthcare access and outcomes. She stressed the challenging financial position for the NHS and confirmed that this was replicated at local levels further reinforcing the need to deliver clinically effective and efficient care to our patients, thereby meeting the standards in place before the Covid pandemic. LW expressed her significant thanks to Steve Gill former interim Chair, for his compassionate leadership and looked forward to continuing to work with him in his role as Vice Chair and Senior Independent Director. She	

	expressed her thanks to Eliza Hermann, Non-executive Director who would be reaching the end of her term of office in June 2022. Eliza's commitment, tenacity and rigorous approach to assuring patient safety and high quality care was commended and would be sorely missed. Thanks were also expressed to Dawn Clift, Interim Director of Corporate Governance and Compliance who were nearing the end of her time at Chelwest. Dawn was noted to have held the Board to account over the last 10 months and would be greatly missed. SG put on record his own thanks and that of the Non-executive Directors to Eliza and Dawn for their leadership and dedication to the Trust and its patients. EH expressed her thanks, noting the very positive team spirit and culture at the Trust. On the matter of the CEO report, she commented that future reports could benefit from a more balanced description of successes and challenges. This was noted and agreed.	
	Resolution:- The Board resolved to note the content of the report.	
2.0	**FOR DISCUSSION**	
2.1	**Elective Recovery Plan Update**	
	RH presented the progress in delivering the elective recovery plan. It was noted that this report had been considered in detail at the Quality Committee the previous week. He highlighted the following:- • March had been an incredibly challenging month for the Trust with Covid impacting on staffing levels • The Trust had eradicated any waiting times for surgery of 104 weeks or more and was working hard to reduce waits in excess of 52 weeks • A number of long waiting patients from within the NWL Collaborative had been treated at Chelwest in the spirit of mutual aid – overall 4,000 patients had been moved across NWL hospitals to help reduce health inequalities AM requested clarity on the date that patients are calculated as being on the Patient Tracking List under the collaborative model. RH confirmed that there was no adjustment made to the waiting times of patients seen within the collaborative system. ML sought assurance on our approach to productivity measures and assurance. RH confirmed that a range of productivity indicators were under development. He advised that some aspects of care were demonstrating opportunities for improvement such as a reduction in out patient follow up appointments. He referenced the need to ensure that alternative pathways are established both within and outside the hospital setting to assure timely flow and receipt of the right care at the right time in the right place. With regard to productivity of people, RH stated that	

	this is work in progress with the aim of supporting people to work smarter rather than harder.	
	Resolution: - The Board resolved to take assurance of the status of the Elective Recovery plan against planned trajectory.	
2.2	**Integrated Performance and Quality Report**	
	RH presented the Integrated Performance Report which had been subject to scrutiny at the Quality Committee during the previous week. He highlighted the following aspects:- • The Cancer 2-week Urgent Referrals, 2-week Breast Symptomatic, 31-Day (Drug) standards and 62-Day (NHS Screening Service) Referral to First Treatment were all reporting compliance in March. The 6-Week Diagnostic standards was marginally below the 99% target in M12, however it was noted that Nationally the Trust continues to retain its position as one of the best performing Trusts. • A&E March saw 30,214 urgent and emergency care attendances; higher than pre-pandemic levels of activity. This level of activity, coupled with the staffing challenges saw compliance against the 4-hour standard deliver 78%. Although this was a non-compliant position, CWHFT remained as one of the top performing organisations in the country in a very challenging urgent and emergency care environment. Reduced performance was driven by a number of factors including COVID-19 staff absences and a further deterioration in performance at the West Middlesex Urgent Treatment Centre. Work continued to ensure there is sufficient staffing to cope with additional demand, as well as to redirect patients to community partners where possible. • Cancer 14-Day (All Urgent): The 2-Week wait target continued to be compliant, with 95% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received 14-Day (Breast Symptomatic): The 2-Week wait target continued to be compliant, with 99.08% of patients having their first outpatient appointment within 14 days of their suspected cancer GP referral being received 28-Day FDS: The 28-Day Faster Diagnostic Standard had returned to compliance in February 2022, it was forecast that this measure will remain compliant in March 2022 once full validation is complete. 62-Day GP Referral to First Treatment: 62-Day target was non-compliant, showing an unvalidated position of 78.84%. This was largely due to the impact of COVID on the diagnostic part of the pathway and increased patient initiated delays.	

	31 day: 31-Day target was non-compliant at 92% in Mar 2022, however this was forecast to improve following final validation. The target was met in Feb 2022 reflecting the focused work on the skin pathway to improve the overall performance • Diagnostic Waits <6 weeks There had been a marginal decrease in performance as the Trust was reporting non-compliance against the 99% diagnostic standard in M12 due to underperformance on the West Middlesex site. The Trust retained its standing as the best performing Nationally in this area NG referred to the pressures on the Urgent Care Centre at West Middlesex Hospital and asked for an update on management arrangements for the centre. RH advised that there had been a significant number of staffing challenges which has impacted on service delivery. He advised that the entirety of the contract for the centre was not going out to procurement and that the Trust would be playing a lead role in shaping the future model.	
	Resolution: As there were no further questions, the Board resolved to take assurance from the report on the current performance of the organisation.	
2.3	**Maternity Services Improvement Programme Report**	
	Vicky Cochrane (VC) Director of Midwifery attended to present this item. An update was presented on the following matters:- • The final Ockenden report and its proposed actions nationally to ensure the failings of Shewsbury and Telford are not replicated • Latest guidance on the maternity continuity of carer standard nationally and the proposed actions • Planned assurance visits based on the 7 Immediate and essential actions from the Interim Ockenden report • Interim Ockenden compliance, assurance visit, next steps for the final Ockenden report and staff engagement events VC confirmed that the final Ockenden report was published on the 30th March 2022 and had been defined as the biggest scandal in NHS history and as such must be taken very seriously. The report included 1,592 clinical incidents involving 1,486 families over a 10 year period (2009-2019. The report included 15 additional immediate and essential actions sitting within 4 key pillars: 1. Safe staffing levels 2. A well-trained workforce 3. Learning from incidents 4. Listening to families Assurance was given that the maternity service had already commenced a full gap analysis against all recommendations and that the findings would be presented at the June quality committee and July public board. 18 engagement events were being held with staff and these commenced in	

	April 2022. These gave an opportunity for the report findings to be fully explored and time for staff to be able to share their views. VC confirmed that over 200 staff had attended to date and that they had been very balanced and were contributing to improvement opportunities. With regard to the Interim Ockenden report, 100% compliance was confirmed by June 2022. VC advised that with regard to the maternity continuity of carer teams standard, the service were in the final stage of revisiting and risk assessing the plans approved by Board in January 2022. At this stage, it was recommended that the Trust continues with its previously approved plan of achieving compliance with this standard by 2026. Board were advised that during the period May to September 2022, all maternity services across the Country would receive an independent assurance visit to understand their level of compliance with recommendations and the strength of their improvement actions/plans. VC reminded colleagues that this was a positive opportunity to showcase the good work that Chelwest have and continue to take forward. ML made reference to the philosophical dissonance between different professional staff groups referred to in the report and asked whether sufficient reflection had been given to ensure we have the right mindset to make services work/improve in a multi professional and multi disciplinary environment. VC stated that there was a positive culture of multi disciplinary learning and working within the maternity service at Chelwest, driven by the civility saves lives approach and co-production. LW stated that there must be equity of patient, family and professional voice and that centralised decision making around the mother is core. AD thanked VC for the paper and questioned whether additional changes are being made in response to the theme of failing to listen to families. VC referred to the improvement work required in this area to ensure that adequate translation facilities are in place to meet the needs of diverse patient groups which constitute 44% of our maternity community. It was noted that 2 midwives were actively leading this work. SG advised the Board that he holds six weekly meetings with VC in his role as Board Maternity Champion and that the Quality Committee also gives considerable scrutiny to the Maternity Improvement Programme. He reflected that progress was being made locally and felt assured that the Trust will be fully compliant with the first Ockenden report by June 2022, with a further report then coming to Board in July on the benchmarking assessment of the final Ockenden report. <u>Resolution</u>: The Board resolved to :- • Note and receive the report and took assurance of the continued work to support Maternity Improvement. • **Receive a further report in July 2022**	**RB**

2.4	**Staff Survey Results and Improvement Plan**	
	SSM presented the paper clarifying that the results of the staff survey provided feedback from a proportion of staff about their experience of working in the Trust. It was noted that the plan had been scrutinised in detail by the People and OD Committee of the Trust. She highlighted the following aspects:- • 47% of staff completed the survey which is 3025 members of staff having their say about working with us • The report provided benchmarking to 126 other Acute and Acute and Community Trusts across the country, where the median response rate was 46% and 444,326 staff responded in total. • A number of the questions in the NHS Staff Survey were aligned to the NHS People Promise and included a completely new section on burnout, • The Trust scored above average for learning, safety culture and staff engagement • A score of average was given for Compassionate and inclusive, Recognised and Rewarded, having a voice, safe and healthy, team working and morale • The Trust scored below average for one area which was flexible working. • 56.4% of staff responding had worked on a COVID ward and 25.1% had worked remotely compared to 20.6% average. SSm gave an overview of key aspects of improvement work being taken forward to improve the staff experience further. She confirmed that these aspects of improvement would be governed through the Workforce Development Committee and the People and OD Committee. Particular workstreams of note were:- • We are Compassionate and Inclusive – delivering our EDI and leadership plans • We are recognised and rewarded - rolling out our new people recognition programme and team events • We are safe and healthy – delivery of our Year 2 H&W programme and our focus on staff safety in terms of violence and aggression • We work flexibly – delivering our Timewise Action Plan AM made reference to the need for the Trust to continue to listen to staff and highlighted that the discrimination in the workplace score was slightly below average. GA felt that the matter of discrimination was somewhat clouded in the results and needed greater transparency and action as this was not moving at the pace required. SG triangulated the themes of workload, staffing, long hours and stress and expressed the need to ensure that our actions make a meaningful difference. SSM stated that there was a need to get the basic fundamentals right and to keep vacancy levels below 5%, meaning a focus on retention as well as recruitment. LW stressed the need to develop good leadership at all levels of the Trust.	

	MS stated the aim was to have a plan of improvement that would see Chelwest in the upper quartile of Trusts nationally in 2023. Resolution:- The Board resolved to note and receive the report.	
3.0	**FOR APPROVAL**	
3.1	**Board Assurance Framework 2022/23**	
	DC presented the Board Assurance Framework for approval. It was noted that the framework and content had been refreshed to take account of the latest strategic risks to the organisation. Board Committees had considered and discussed the strategic risks within their oversight during Committee meetings in March, April and early May 2022 and recommended approval of the Framework to the Board, subject to the addition of Research and Development updates on the forward plan for the Quality Committee. EH thanked DC for her guidance and leadership in the development of the refreshed Assurance Framework, commenting that this was much improved from previous versions.	
	Resolution / Action**:** The Board resolved to:- • Approve the Board Assurance Framework	
3.2	**Board and Committee Governance inc Terms of Reference 2022/23**	
	DC presented the Board and Committee Governance Handbook for 2022 which included the templates for Board Covernotes and Minutes, along with the Terms of Reference of each Board Committee and its associated Business Cycle. SG commended the document and felt it helpful to have all information in one document.	
	Resolution: The Board resolved to the content of the handbook.	
3.3	**Board Business Cycle 2022-23**	
	DC presented the Business Cycle for the public board meetings for 2022/23 and confirmed that his had been developed to ensure the Board could meet its statutory responsibilities. DC advised that the business cycle may need to be refreshed as the Acute Provider Collaborative governance model evolves. Resolution:- The Board resolved to approve the business cycle.	

3.4	**Standing financial Instructions and Scheme of Delegation**	
	VM presented the standing financial instructions and scheme of delegation which had been reviewed by the Audit and Risk Committee. Resolution:- The Board approved the standing financial instructions and scheme of delegation.	
4.0	**FOR NOTING – HIGHLIGHTS BY EXCEPTION**	
4.1	**Learning from Serious Incidents**	
	VS presented the report, highlighting that falls remains a significant theme within serious incidents. EH reminded the Board of the importance of learning from serious incidents and gave assurance that the Quality Committee spend a significant amount of time on the learning aspect. As Chair of the Quality Committee, she had requested that a focussed effort be given to reduce the number of overdue actions associated with serious incidents.	
	Resolution:- The Board resolved to receive and note the content of the report.	
4.2	**People Performance Report and Quarterly Heatmap**	
	SSm presented the report which had been considered in detail at the People and OD Committee. She expressed thanks to Karen Adeyowin for her hard work in developing the revised report. SG commended the report.	
	Resolution: The Board resolved to note the content of the report.	
4.3	**Learning From Deaths Quarterly Report**	
	RC presented the report which had been considered in detail at the Quality Committee. It was noted that the mortality indices remained some of the best in the Country. RC gave examples of how learning from mortality case note reviews had resulted in the development of Quality Priorities for the Trust. Resolution:- The Board resolved to note and receive the report.	
4.4	**Use of the Company Seal**	
	DCL presented the report, confirming that the seal had not be used during the last six months of 21-22. It was noted that the seal had been affixed in April 2022in relation to the lease between Chelsea and Westminster Hospital NHS Foundation Trust and CW Medicines Limited for the use of	

	facilities on the ground floor of the Chelsea site as an out patient pharmacy.	
	Resolution:- The Board noted and received the report.	
5.0	**ITEMS FOR INFORMATION**	
5.1	**Questions from Members of the Public**	
	There were no questions from members of the public.	
5.2	**Any Other Business**	
5.2.1	Top 50 CEOs in the NHS LW was applauded for being confirmed as one of the top 50 CEOs in the NHS.	
5.2.2	End of Life Care EH noted that it is the national week for raising awareness that death matters. RC said that the institution of the Medical Examiner role over the past year had been instrumental in developing end of life care. LW commented that the pre-covid personalised interventions given to individuals at the end of their life were important to re-introduce now that the pandemic had eased.	
4.3	**Date of the Next Meeting**	
	The next meeting will take place on 7 July 2022 at 11.00am until 1.30pm. The meeting closed at 1304 hours.	

Glossary of Terms

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

Trust Board Public –Action Log 5 May 2022

Meeting Date	Minute number	Subject	Action	Current status	Lead
06.01.22	3.4	People Performance Report	Arrange a meeting between NG and SSM regarding the Maintaining High Professional Standards (MHPS) Service.	Complete	SSM
03.03.22	2.2	Integrated Performance and Quality Report	Make two amendments to the report – the first related to SHMI where the actual reported position needed amending to read 71. The second amendment related to the number of patients waiting over 104 weeks which would be adjusted to read 10.	Complete	RH
03.03.22	3.1	Guardian of Safe Working Report	Request that the People and OD Committee receive and consider a report on the impact of the national reduction in training numbers	Formally referred to POD Chair and Exec Lead via email on 22 April 2022. To be scheduled for POD in May 2022	RC/AM
05.05.22	2.3	Maternity Services Improvement Programme Report	A further report would be presented at the July meeting. Please refer to agenda item 2.3	To be closed	RB

TRUST BOARD (PUBLIC)

Paper Title: Chair in Common Report - North West London Acute Trusts
(Incorporating Chelsea and Westminster Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals Foundation Trust)

Agenda item:

Author: Matthew Swindells – Chair in Common

Purpose: For noting

Meeting: Trust Board (Public)

Meeting Date:

1.	**Meeting Staff**
	In my report back in May I said that top of my priorities would be to get out around our hospitals and meet the staff who are doing such a brilliant job for local people. I am pleased to say that I now have a programme in place which enables me to get out into the service and do just that. Over the past few weeks, I have made a number of visits and met hundreds of staff, and I intend to continue to do this every month going forwards. My thanks to the people who organised my visits and to the people who were so generous with their time in showing me their services. At **St Mary's** I had a full tour of the estate to see the desperate need for major capital investment and met ward managers and their teams who were delivering great care in Victorian conditions. At **Charing Cross** I visited the physiology departments where we talked about the accreditation programmes that they have been going through, the challenge of recovering waiting times post COVID with high levels of sickness and vacancies and the difficulty in getting needed equipment with the global shortage of microchips and the need to finish the roll-out of the Cerner system and connect up other IT to give a full end-to-end view of the patient pathway. At **Hillingdon Hospital** I visited teams from catering, security, maternity, the respiratory unit and care of the elderly to discuss their experience of working in the hospital and their pride in working in a hospital that is a real part of its local community. At **Northwick Park,** I was delighted to be part of the opening of new Clinical Research Facility and walk around it with Christiana Dinah, Director of Research, and Dame Kate Bingham.

	At **Central Middlesex**, Pippa Nightingale, chief executive of London North West NHS Trust, took me for a walk around to including meeting staff that have been part of the transfer of St Mark's Hospital and see the great job they are doing to settle their patients into the new surroundings. At **Chelsea and Westminster** I had the guided tour of the hospital from end to end by Lesley Watts, chief executive, seeing the exceptional facilities and care delivered to local people. I haven't visited every site yet, including my local hospital at Ealing, and I'm a long way from getting to know every department - which will take me years. So, please, if you'd like me to visit your department and tell me what works and what could be better, please contact my office.
2.	**Meeting Stakeholders**
	I have met with a range of our critical stakeholders including Sean Harris - the outgoing CEO of Harrow Council, Cllr Ketan Sheth - the Chair of Community & Wellbeing Scrutiny Committee at Brent Council, and Cllrs Cowan and Coleman - the Leader and Chair of Health & Wellbeing respectively at Hammersmith and Fulham Council. I also chaired the Hillingdon Redevelopment Partnership Board which expressed its whole-hearted support for the outline business case for the new Hillingdon Hospital, developed by the hospital team. We wait anxiously now for the decision of the Department of Health and Ministers before moving on to the next phase of planning. I have worked closely with our two Councils of Governors, chairing four meetings for Hillingdon Hospitals – Noms and Rems, a redevelopment briefing, a briefing on the acute collaborative and the full Council of Governors; and two for Chelsea and Wesminster – Noms and Rems and their awayday as well as a number of meetings with individual governors. I also met with Trish Longdon, the lead lay partner for Imperial's Lay Strategy Forum. I look forward to further developing our governor and lay member engagement in the coming months. Lastly, I spoke at the Australia – British Health Catalyst Event at the Royal College of Physicians on "Adopting change for effective and efficient healthcare" and chaired a panel session on "Putting data to work; tackling the elective care backlog" at the NHS Confederation conference in Liverpool which our own Kate Wilson from Hillingdon and Bruno Botelho from Chelsea and Westminster were excellent contributors.
3.	**The Acute Collaborative**
	During the past month we have been developing the forward vision and structures for the acute collaborative. You will remember that the acute collaborative is driven out of the experience of COVID when the four acute hospitals in North West London demonstrated how working in partnership delivered a fantastic response

	for the benefit of our local population. The acute collaborative aims to continue that tightly integrated working as we recover our services after COVID and focus on improving the health of the population and reducing health inequalities, and avoid drifting back into sterile competition between our institutions. As the first steps towards that joint working we have been moving forward on four fronts in the past few weeks. Firstly, with the support of the two FT Councils of Governors, I have confirmed Vice Chairs into post with enhanced roles to reflect their new responsibilities in tying together the work of the Boards across the Acute Collaborative. Thankyou to: Steve Gill (Chelsea and Westminster), Catherine Jervis (Hillingdon), Bob Alexander (Imperial) and Janet Rubin (London North West). Secondly, each of the four Trust Chief Executives has taken cross-system leadership for a major strategic area and is now working with the appropriate senior leadership in each of the four Trusts to implement improvements in: i) Operational performance (Lesley Watts, Chelsea and Westminster); ii) Clinical Quality and Care (Tim Orchard, Imperial); iii) People management (Pippa Nightingale, London North West); and iv) Information and data (Patricia Wright, Hillingdon). Thirdly, we have launched a programme to bring our information across the acute collaborative onto a common data platform and to align the way we count and measure things, so that we identify excellence and risks across the four Trusts and align around best practice so that everyone in North West London receives an equally high quality of services. Fourthly, we have been consulting widely to design the governance structures that will enable ourselves to come together around a single Board in Common for the four Trusts in the autumn whilst, at the same time, enhancing engagement with local communities.
4.	**Recovering Our Services**
	The Chief Executives will talk more about this, but perhaps the most important thing that we have done in the last couple of months is agree and start to implement our plans for the coming year. All of our hospitals have signed up to challenging plans for the coming year that will show us returning to levels of activity higher than they were pre-COVID whilst maintaining financial control. If we can achieve this, we will see reductions in A&E waiting time, reductions in the number of patients waiting a very long time for outpatients and surgery and a reduction in the total number of people on the waiting lists. This will be tremendously challenging for all of our staff, and we know that even if we achieve what we have set out to do, we will still be a long way short of what any

	of us would consider to be our ambition for waiting time. The journey back from the impact of COVID on our services will be a long one.
5.	**Our staff**
	By the time you read this we may know the recommendations of the pay review bodies and the government response to them. Staff will know whether the gratitude of the public expressed by people clapping on their doorsteps is being turned into a pay offer that reflects the cost of living increases our people face and supports the hospitals in recruiting and retaining staff. Whatever happens, the Board and I remain hugely grateful to all our staff, clinical and non-clinical, for the tremendous work they do every day to care for our patients.
6.	**London Bridges Walk 2022**
	And lastly, I'd like to thank Ian Tate and the collective efforts of the Griffin Institute, Hillingdon Hospitals Charity, London North West Healthcare Charity, The Red Lion Group and the St Mark's Hospital Foundation in organising the London Bridges Walk to raise funds for their important causes. Victoria and I had a great time meeting the other walkers on our way through central London and are now proud owners of the official t-shirt. Well done and thankyou to the other walkers.

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors (Pubic) 7 July 2022

AGENDA ITEM NO.	1.7
TITLE OF REPORT	Chief Executive's Report
AUTHOR NAME AND ROLE	Daryl Lutchmaya, Interim Deputy Director of Corporate Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Lesley Watts, Chief Executive Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To assure the Board of high level affairs pertinent to the period since the last Public Board meeting in May.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: N/A Date of Meeting: Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• The largest rail and tube strike in 30 years initiated a major operational response to ensure service continuity for our patients. • Thank you and farewell to Eliza Hermann who has served as a Non-Executive Director on the CWFT Board for eight years and whose term ended at the end of June 2022. • Health & Care Act 2022: Integrated Care Systems (ICS) put onto a statutory footing from 1 July 2022. • Our elective recovery programme continues to deliver activity levels above those seen before the Covid pandemic. • Our staff continue to be the fundamental core of our Trust and we thank them for their continued hard work, resilience and commitment to patient care.

KEY RISKS ARISING FROM THIS REPORT	

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR:

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

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

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

Chief Executive's Report

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

We continue to observe and practise best infection control across the Trust. Masks are still mandatory for staff, visitors and patients. We are seeing a rise in COVID-19 cases and hospital admissions, and it is our duty to do everything that we can to protect ourselves and each other. Good care is about putting patients first, remembering that they can be vulnerable too. Other than those individuals who are medically exempt, we are asking everyone to wear face masks at all times, maintain social distancing and practice good hand hygiene.

2. Rail and Tube strike

Colleagues worked tirelessly in the week leading up to the largest rail and tube strike in 30 years. The major operational response was led by the Emergency Response team, under the direction of Rob Hodgkiss, Deputy CEO and Chief Operating Officer, with support from Estates and Facilities. It was a tremendous effort by everyone. Planning transport and accommodation requests to support staff ensured an effective response to the strike action for our staff and equally importantly, our patients. Many staff shared cars, cycled, sat on long bus journeys, rearranged shifts and walked to work. I would like to thank our Head of Emergency Planning, Catherine Sands, who ensured that we were fully prepared. I would also like to thank our staff who whose commitment and hard work is exemplary.

3. Thank you to Eliza Hermann

On behalf of the Trust Board and the Council of Governors I would like to thank Eliza Hermann, Non-Executive Director, whose term came to an end in June 2022 after eight years; for her outstanding personal contribution to CWFT. During that period the Trust has seen incredible change, and Eliza has played a critical role in many aspects that were fundamental to the 'journey to outstanding'.

Eliza's professional scrutiny and challenge and constructive style has set an extremely high standard for patient focus, GRIP and performance across the Trust, but particularly in Quality Committee, where after an almost unbelievable 74 meetings she will be sorely missed. We wish Eliza the very best in her future endeavours.

4. Annual Members Meeting

The Trust will be holding its Annual Members Meeting on 21st July 2022 to receive and Annual Report and Accounts. I look forward to seeing our members, patients, Governors and staff at the virtual event.

5. Health & Care Act 2022

The 2022 Health and Care Act introduced new legislative measures that aim to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple different services. The Act establishes integrated care systems (ICSs) as statutory bodies. Chelwest is a member of the North West London Integrated Care System and will as part of this geographically based partnership, work with others, to bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services.

6. Optimising Patient Flow

Whilst we are proud of the achievements we have made in sustaining the delivery of our elective recovery programme, it is fair to say that the NHS is under considerable pressure to meet the ongoing demands for care. Across different points of delivery, the Trust continues to experience capacity challenges, due to staff sickness, coupled with increases in demand across the system. We are working incredibly hard both within Chelwest and across the Acute Provider Collaborative and Integrated Care System to explore all opportunities to streamline our ways of working, remove barriers and reduce health inequalities. Ensuring that patients receive the right care in the right place at the right time is critical to the clinical effectiveness and safety of care we provide

7. NHS Parliamentary Award

To mark the 74th birthday of the NHS, the NHS Parliamentary Awards shortlist was released and we are very proud to announce that Dr Sadia Khan and her team were nominated in the *Excellence in Healthcare* category for the work done to improve pathways for cardiovascular care in hospital and in the community. This work has included new pathways and the use of technology, digital apps and wearables. It has enabled earlier diagnosis, treatment, and for care to be delivered closer to home improving outcomes, choice and patient experience. The team was nominated by Seema Malhotra MP.

8. Windrush Day

We celebrated the Windrush generation and their enormous role to the NHS in June. The Empire Windrush arrived at Tilbury docks on 22 June 1948 from the Caribbean, in response to a call from the Government to assist with the labour shortages after World War II. I would like to acknowledge and recognise the huge contribution that the Windrush generation has made to the NHS. Nurses from the Caribbean have played a significant role in the NHS and to our organisation, and have paved the way for the second and third generation of nurses and midwifes in the NHS today.

9. Valuing and Recognising our Staff

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

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

10. Concluding Remarks

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

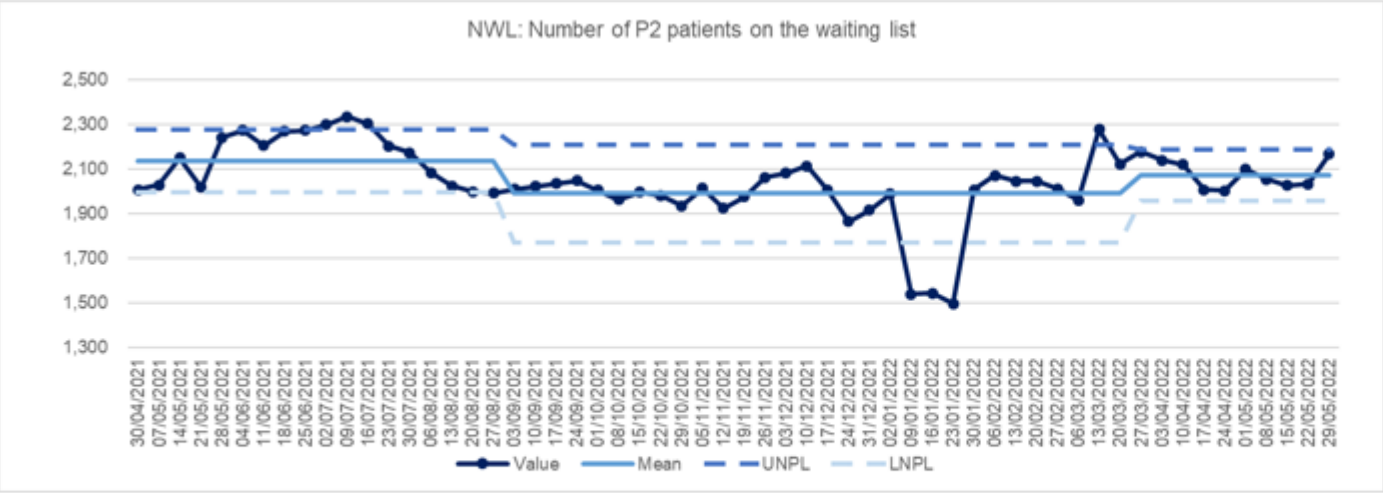
Chelsea and Westminster Elective Care Recovery

Recovery Update - Summary

13th June 2022

P2 waiting list size across NWL Trusts

Trusts	08/05/2022	15/05/2022	22/05/2022	29/05/2022
CWFT	459	451	463	490
ICHT	937	918	932	1016
LNWUHT	501	512	496	488
THHT	158	146	143	173
NWL Total	**2,055**	**2,027**	**2,034**	**2,167**



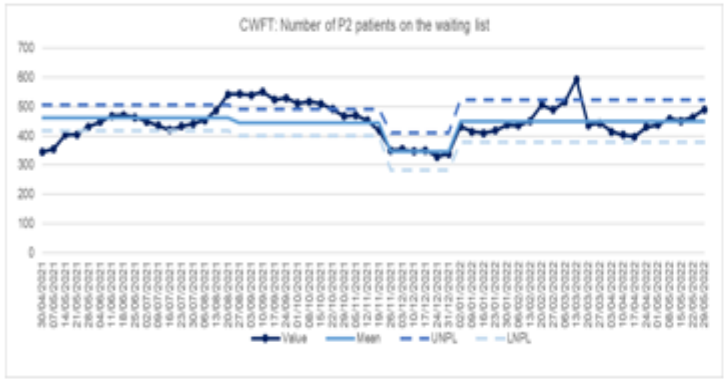
Source: OnePTL prior to 02.01.22 and WLMDs from 02.01.22
Note: Upper natural process limit (UNPL) and Lower natural process limit (LNPL)
Note: ICHT in January 2022 utilised a new supplier for PTL extraction which impacted on reporting of PTL numbers.

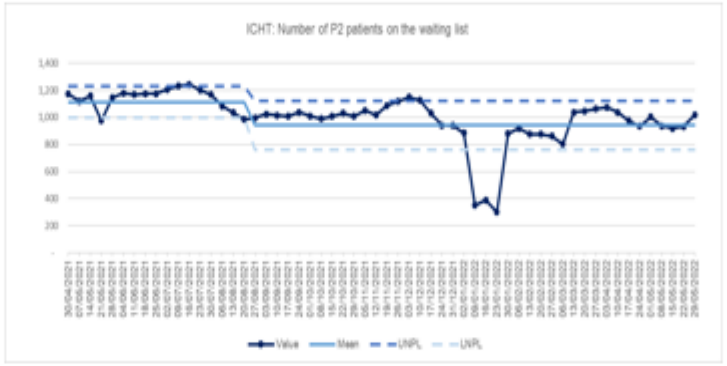
Statistical Process Control charts demonstrate trend of P2 numbers over the last 57 wks.

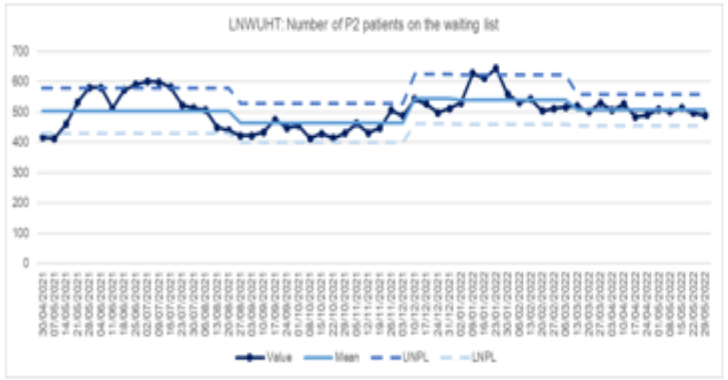
Aggregated NWL position shows variation over time of P2 patients on waiting lists. This week, variation remains within statistical control limits.

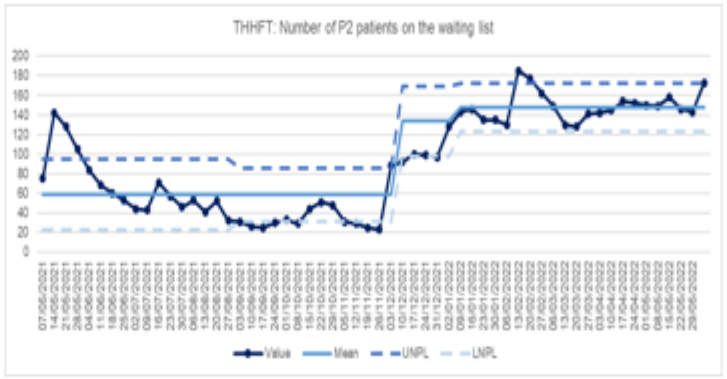
Trust level SPC charts can be found on the next slide.

P2 waiting list size at each Trust: SPC charts









Statistical Process Control charts demonstrate variation of P2 numbers over the last 57 wks and any trends.

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

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

Note: Source of the data has changed from OnePTL to WLMDS for week ending 02.01.22

P2 Patients Waiting 6 Weeks Or More

Number of P2 patients waiting 6 weeks or more

Trust	08/05/2022	15/05/2022	22/05/2022	29/05/2022
CWFT	20	20	TBC	27
ICHT	193	122	106	138
LNWUHT	118	128	105	114
THHFT	49	51	44	38
NWL Total	380	321	N/a	317

Undated P2 patients waiting 6 weeks or more

	08/05/2022		15/05/2022		22/05/2022		29/05/2022	
Trust	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL	N	% of total P2 WL
CWFT	2	0.4%	7	2%	TBC		10	2%
ICHT	30	3%	29	3%	33	4%	54	5%
LNWUHT	68	14%	81	16%	68	14%	68	14%
THHFT	32	20%	31	21%	26	18%	18	10%
NWL Total	**132**	**6%**	**148**	**7%**			**150**	**7%**

Source: Exception reporting from Trusts.

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

Executive summary

- **PTL:** The total PTL (admitted and non-admitted) stands at **1,077,726** - an increase of c.4, 800 (0.4%) from the previous week.
- **104ww:** An increase of 23 pathways.
  Please note: 104ww position is influenced by 3 day work week last week, and Barts data quality issues being worked through.
- **52ww:** 52ww have increased by 943 pathways to a total position of **30,137**.
- **Diagnostics:**
  Waiting List: Endo up 304 (1.7%), Imaging up by 774 (0.5%), with Echo up 1.3% to 24,620.
  >6 week positions decreased in Endoscopy (-13.8%), Imaging (-6.9%), and Echocardiography (-3.4%).
  Activity: Endo (-5.0%), and Echo (-2.1%) had volume decreases, Imaging's activity was up 0.8% on the previous week.
- **Activity:** Activity positions were stable in Electives overall (0.0% at c. 92% of BAU baseline), decreasing overall in Outpatients -0.4% (c. 106% of BAU).
  Please note: Available data suggests total electives continue to be at their highest activity volumes seen over the last 12 months
- **OPA First:** 104.5% of BAU with an downtick of -0.4% in activity this week
- **OPA Follow Up:** Activity decreased in week (-0.2%), %BAU at 107.1%.
- **OP Transformation:** The PIFU rate for March 22 is 0.8%, which is below the national target of 5%. A&G utilisation sits at 12.8%, below the national target of 16%. The cancellation rate was at 25.0% and DNA's at 10.3% for March 2022.

	Latest Week (w/e 05-Jun)		
	Volume	% Change	Volume Change
Total PTL	**1,077,726**	**0.4%**	**4,823**
52ww	30,137	3.2%	943
78ww	3,915	5.8%	216
104ww	315	7.9%	23
Cancer Backlog	-	-	-

Latest Week by ICS				
NCL	NEL	NWL	SEL	SWL
254,089	**197,602**	**228,059**	**240,584**	**157,392**
8,911	8,857	5,772	5,237	1,360
1,282	1,486	491	572	84
65	203	6	39	2
-	-	-	-	-

	Freeze Week (w/e 29-May)		
	Volume	% Change	Volume Change
Endoscopy Waitlist	18,139	1.7%	304
Imaging Waitlist	146,581	0.5%	774
Echo Waitlist	24,620	1.3%	327

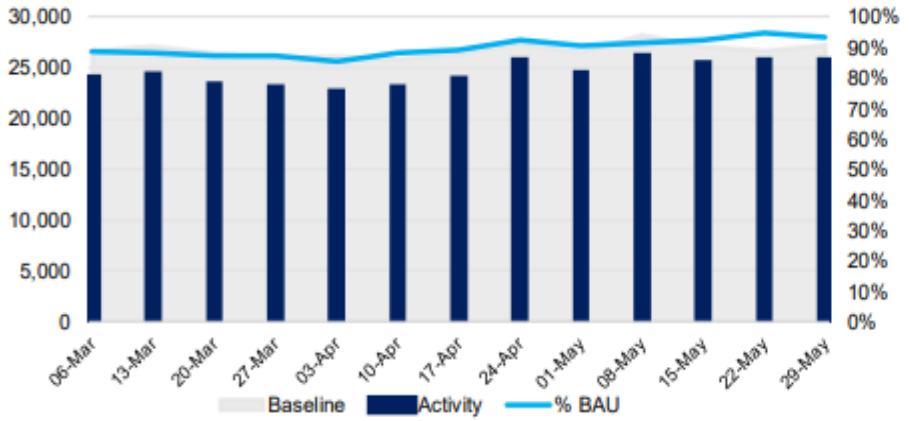
Latest Freeze Position by ICS				
NCL	NEL	NWL	SEL	SWL
4,728	2,663	4,675	3,156	2,917
28,433	41,730	26,661	23,640	26,117
3,190	9,175	2,639	4,396	5,220

	Latest Freeze Position (w/e 29-May)				Latest Freeze Position - % BAU by ICS				
	Activity	Weekly Change	% BAU (1)	Regional Rank (2) (4)	NCL	NEL	NWL	SEL	SWL
Total Electives	**25,363**	**0.0%**	**93.3%**	**2**	**100.4%**	**85.9%**	**98.0%**	**84.5%**	**96.2%**
Elective Day Case	21,186	-0.8%	93.9%	2	101.7%	84.3%	97.9%	85.8%	96.8%
Elective Ordinary	4,177	4.4%	90.3%	4	94.3%	94.2%	98.1%	79.9%	93.8%
Total Outpatients	**275,246**	**-0.4%**	**106.3%**	**3**	**113.4%**	**103.2%**	**107.0%**	**105.1%**	**97.1%**
Outpatients - First	85,127	-0.9%	104.5%	2	116.9%	96.0%	103.4%	99.3%	101.3%
Outpatients - Follow-Up (3)	190,119	-0.2%	107.1%	5	112.0%	106.7%	109.0%	107.3%	94.7%
Diagnostics									
Endoscopy	4,667	-5.0%	99.3%	2	79.0%	105.4%	88.9%	125.3%	95.0%
Imaging	67,418	0.8%	110.5%	1	130.7%	104.6%	96.9%	115.7%	110.3%
Echocardiography	6,854	-2.1%	107.8%	1	132.8%	92.7%	124.1%	96.0%	110.6%

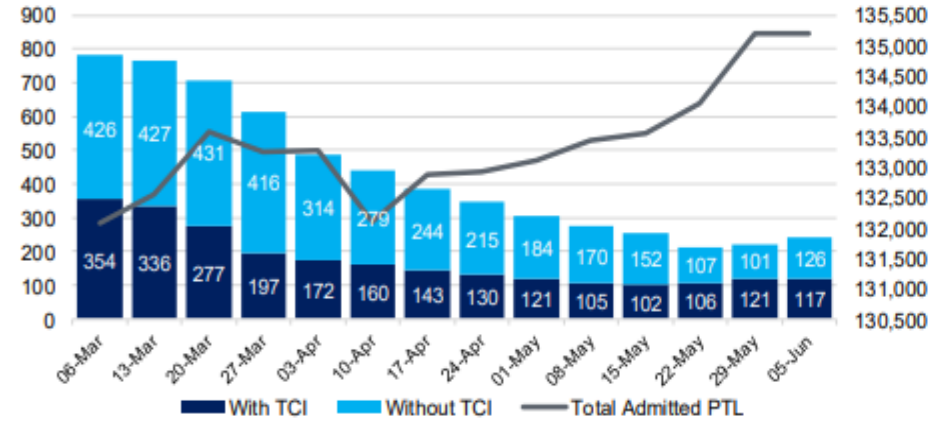
(1) Prior year baselines from March are based on unadjusted data submitted to SUS by providers for 2019/20
(2) Regional Rank is based on % BAU
(3) Colour coding modified to reflect reduction as positive, due to National target of reducing follow-ups by 25%
(4) London Regional Ranking for Outpatient Follow-ups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

Elective Activity: Total Overall

Elective Activity Volumes and % of Baseline



Admitted Pathway: 104 ww and Total PTL



Total Electives (Latest Freeze Data: w/e 29-May)

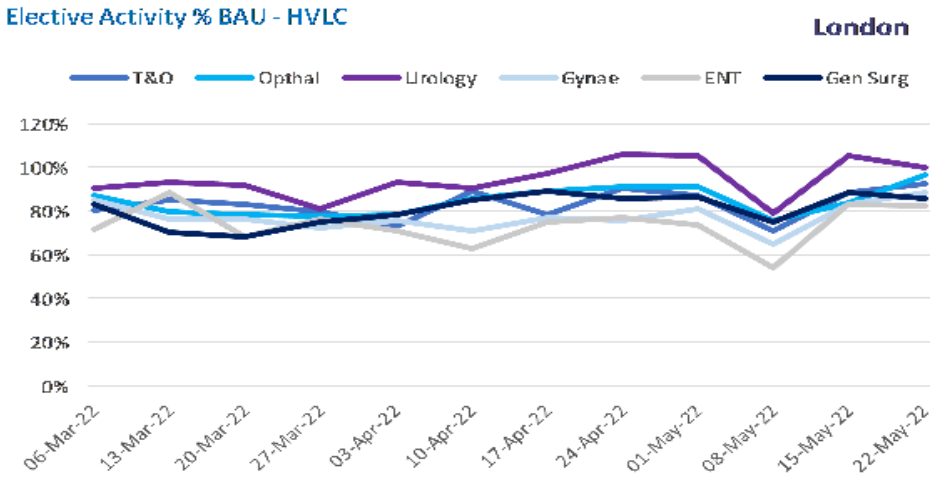
Provider	% BAU	Activity Volume	Weekly Var (%)	Admitted PTL Size	Weekly Var (%)	Admitted 104ww	Weekly Var (%)
LONDON	**93.3%**	**25,363**	**0.0%**	**135,207**	**0.0%**	**243**	**9.5%**
NCL	**100.4%**	**7,146**	**-0.1%**	**33,115**	**-0.3%**	**50**	**-7.4%**
RFL	91.0%	1,574	0.4%	7,595	0.8%	27	-
UCLH	113.0%	2,610	2.8%	10,207	-0.9%	15	-28.6%
GOSH	92.9%	756	-4.8%	2,121	0.4%	4	33.3%
NMUH	93.7%	678	-5.4%	1,220	-4.2%	3	50.0%
Moorfields	99.0%	766	-1.8%	7,405	-0.5%	1	-
RNOH	109.3%	295	-0.7%	2,205	0.9%	-	-
Whittington	94.1%	467	2.2%	2,362	-0.4%	-	-
NEL	**85.9%**	**3,344**	**2.1%**	**21,191**	**0.7%**	**158**	**15.3%**
Barts	83.6%	1,798	2.4%	13,672	1.1%	153	17.7%
BHRUT	85.6%	1,003	3.5%	4,145	-0.2%	5	-28.6%
Homerton	95.3%	543	-1.3%	3,374	0.1%	-	-
NWL	**98.0%**	**5,582**	**4.1%**	**25,441**	**-1.1%**	**3**	**-25.0%**
LNW	90.4%	1,471	-7.8%	5,089	-0.5%	2	-33.3%
Imperial	90.8%	2,166	-2.6%	10,868	-1.3%	1	-
ChelWest	134.5%	1,456	37.5%	6,471	-0.5%	-	-
Hillingdon	81.0%	489	1.0%	3,013	-2.1%	-	-
SEL	**84.5%**	**5,701**	**-4.4%**	**36,322**	**0.4%**	**30**	**15.4%**
LGT	90.8%	937	-10.3%	6,742	0.9%	19	11.8%
GSTT	85.3%	2,587	-1.3%	15,711	-0.4%	8	-
Kings	81.3%	2,177	-5.2%	13,869	1.0%	3	200.0%
SWL	**96.2%**	**3,590**	**-0.6%**	**19,138**	**0.6%**	**2**	**100.0%**
Epsom	103.3%	928	-1.7%	5,651	0.9%	1	-
St George's	90.7%	1,191	5.9%	6,611	0.7%	1	-
Croydon	91.5%	607	4.8%	2,708	0.4%	-	-
Kingston	97.7%	508	-11.7%	3,932	0.3%	-	-
Royal Marsden	105.9%	356	-8.5%	236	-4.1%	-	-

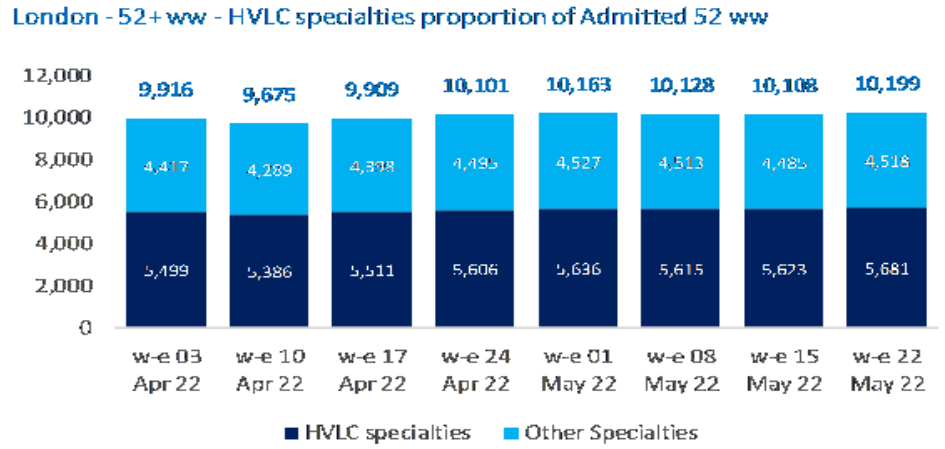
Source: Weekly Activity Return

Latest Data: w/e 05-Jun

Source: RTT Weekly PTL

Elective – high volume low complexity specialties

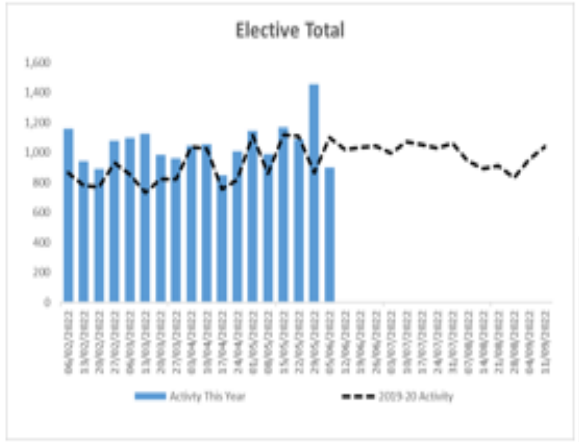




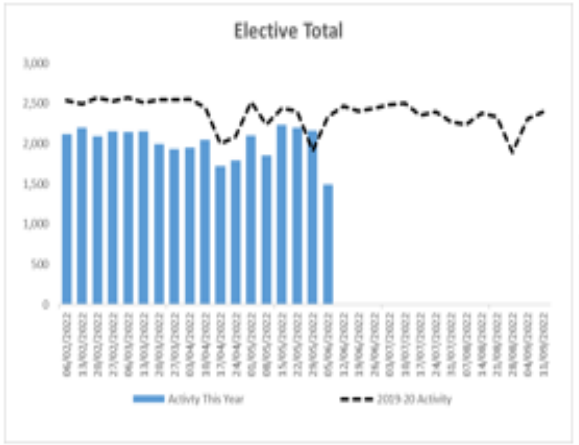
London - HVLC specialties Elective Activity							
Rank	Provider	Flex Week (Current)	Freeze Week (Last)	Freeze Week (Previous)	Change between Freeze Weeks	Current Elective Activity volume	5 week Trend
1	Homerton	119.0%	105.6%	86.3%	π	232	
2	BHRUT	111.2%	112.7%	94.6%	π	465	
3	Kingston	107.8%	87.0%	70.7%	π	221	
4	Moorfields	103.6%	89.3%	74.9%	π	777	
5	LNW	102.9%	85.5%	61.0%	π	496	
6	RFL	100.2%	111.8%	69.9%	π	405	
7	ChelWest	97.1%	103.3%	96.1%	π	299	
8	Epsom	96.4%	91.7%	81.4%	π	587	
9	Kings	95.4%	91.3%	79.6%	π	750	
10	RNOH	91.8%	104.2%	91.2%	π	234	
11	Royal Marsden	87.7%	94.7%	78.5%	π	71	
12	Hillingdon	87.4%	66.0%	64.9%	π	187	
13	Whittington	85.0%	89.5%	68.6%	π	102	
14	Croydon	84.8%	108.5%	72.7%	π	179	
15	Imperial	84.6%	79.1%	64.5%	π	397	
16	St George's	82.7%	94.6%	64.1%	π	191	
17	GSTT	82.7%	80.9%	65.4%	π	372	
18	UCLH	80.0%	94.7%	64.0%	π	308	
19	Barts	76.3%	66.4%	52.9%	π	444	
20	LGT	69.6%	67.3%	56.8%	π	174	
21	NMUH	66.0%	68.7%	72.1%	0	190	
1	NEL	95.5%	88.2%	72.2%	π	1,141	
2	NWL	93.6%	83.8%	68.9%	π	1,379	
3	SWL	93.4%	94.0%	75.1%	π	1,249	
4	NCL	91.6%	93.3%	72.8%	π	2,016	
5	SEL	87.2%	83.7%	71.3%	π	1,296	
	London	**92.0%**	**88.9%**	**72.0%**	π	**7,081**	

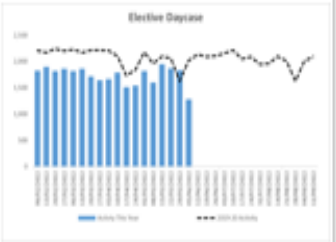
Elective Weekly performance by Trust

CWFHT

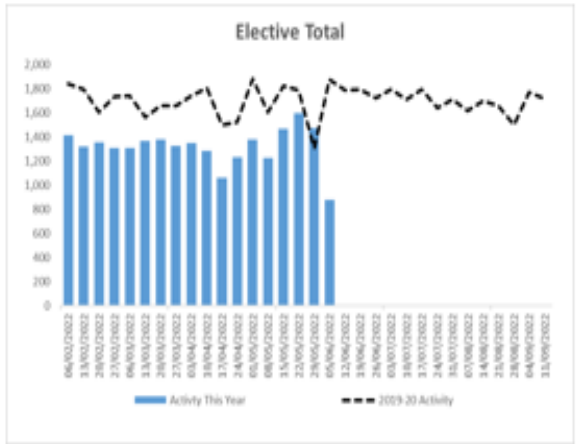


ICHT





LNWUHT



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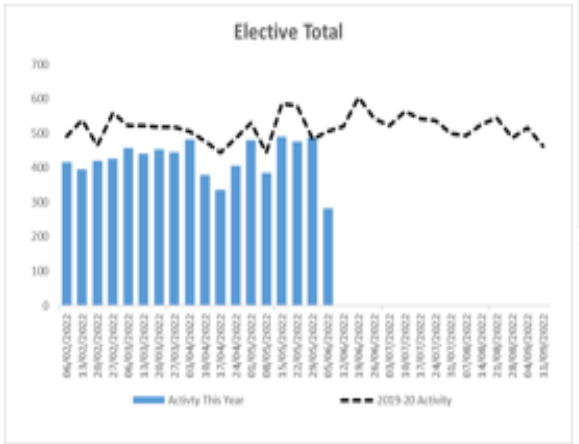
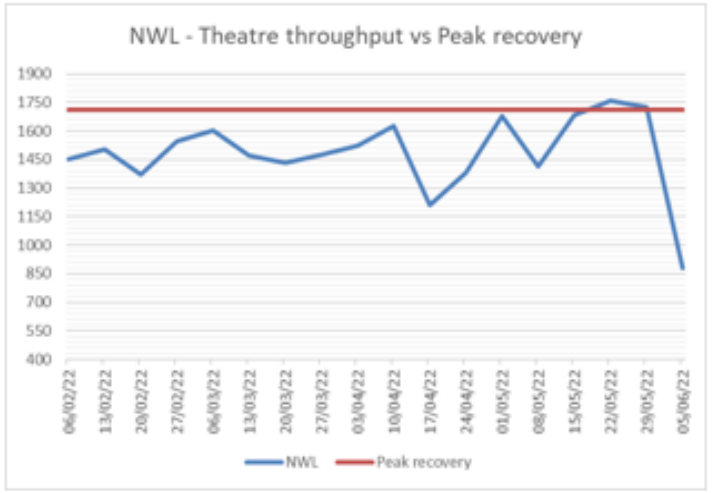
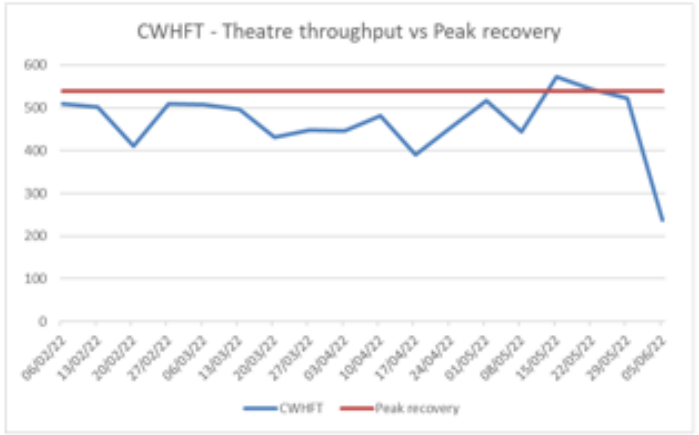
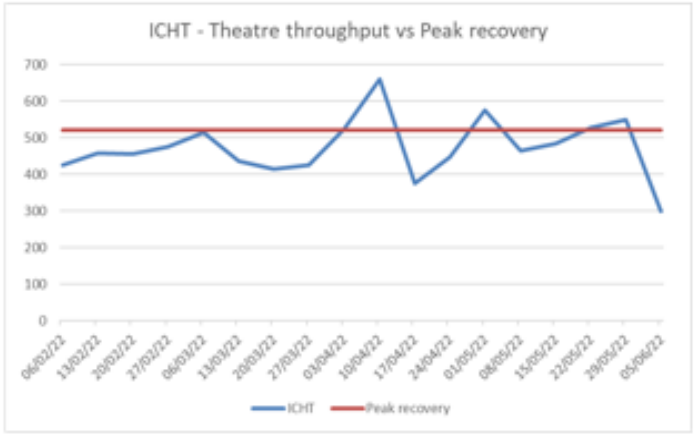


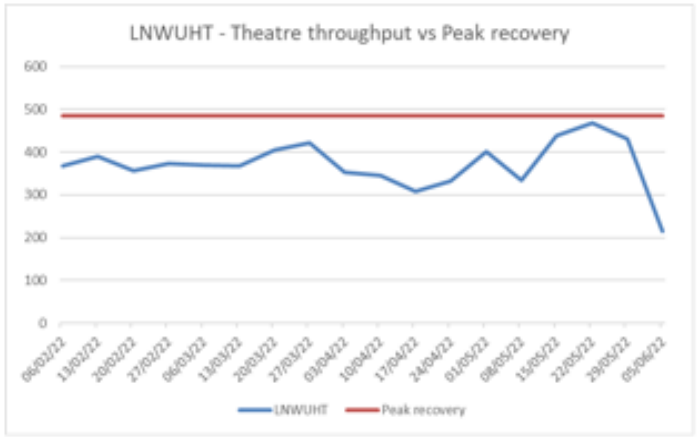
Phase 1: NHS Theatre throughput NHS theatre activity in numbers

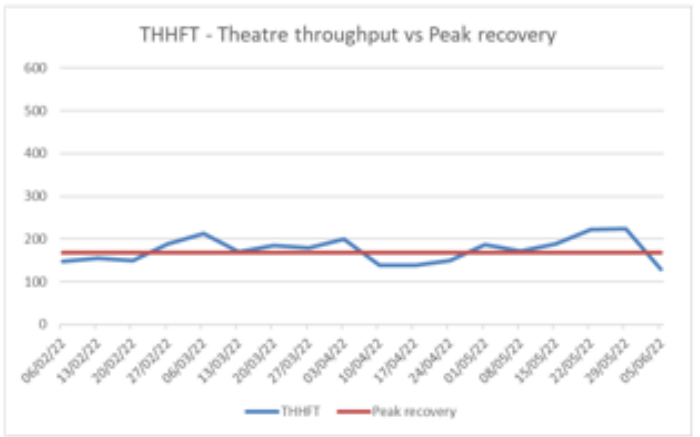
Theatre throughput – 878 elective patients received surgery in NWL theatres last week. This is 51.3% of peak recovery activity across the system.





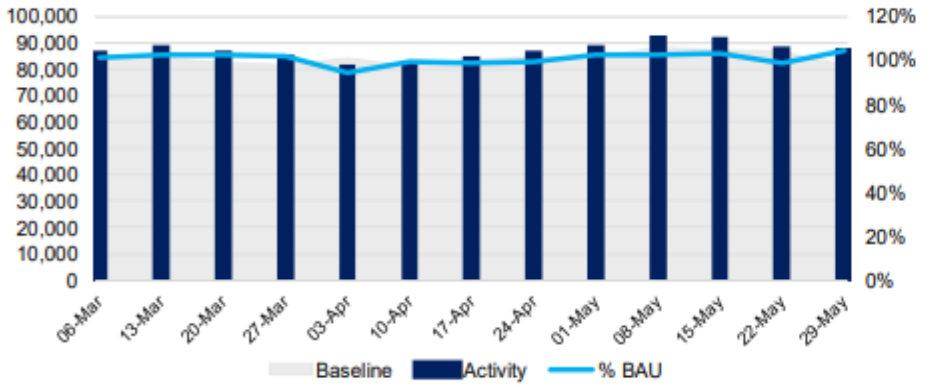




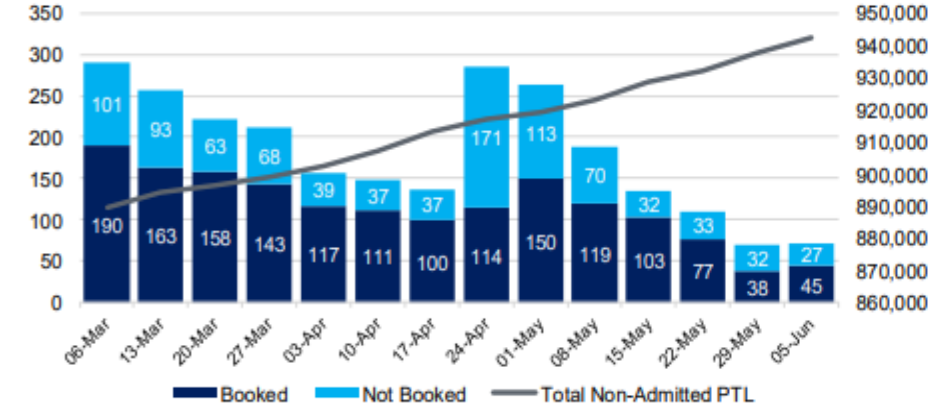


Outpatient Activity: 1st Appointment

OP - 1st Appt Activity Volumes and % of Baseline



Non-Admitted Pathway: 104 ww and Total PTL



OP - 1st Appt (Latest Freeze Data: w/e 29-May)

Provider	% BAU	Activity Volume	Weekly Var (%)	Latest Data: w/e 05-Jun Non-Adm. PTL Size	Weekly Var (%)	Non-Adm. 104ww	Weekly Var (%)
LONDON	**104.5%**	**85,127**	**-0.9%**	**942,519**	**0.5%**	**72**	**2.9%**
NCL	**116.9%**	**23,971**	**0.2%**	**220,974**	**0.7%**	**15**	**-16.7%**
RFL	106.0%	8,004	-3.9%	85,504	0.6%	8	-20.0%
UCLH	132.2%	5,753	7.2%	56,518	0.8%	6	20.0%
Whittington	108.2%	3,278	-1.4%	18,127	1.3%	1	-
GOSH	144.6%	714	-1.9%	4,920	-0.7%	-	-100.0%
Moorfields	103.6%	2,889	-1.3%	33,189	-0.1%	-	-
NMUH	149.9%	2,852	2.9%	17,905	1.7%	-	-100.0%
RNOH	124.1%	481	0.2%	4,811	0.6%	-	-
NEL	**96.0%**	**11,491**	**5.9%**	**176,411**	**-0.2%**	**45**	**4.7%**
BHRUT	87.1%	3,098	4.5%	60,460	-0.4%	26	-7.1%
Barts	95.9%	6,360	11.0%	94,295	0.0%	19	26.7%
Homerton	114.3%	2,033	-5.7%	21,656	-0.9%	-	-
NWL	**103.4%**	**17,428**	**-2.5%**	**202,618**	**1.0%**	**3**	**50.0%**
Hillingdon	104.1%	1,730	-7.7%	23,741	0.7%	3	50.0%
ChelWest	103.4%	4,699	-2.4%	42,062	1.2%	-	-
Imperial	103.4%	5,751	-3.0%	79,866	0.5%	-	-
LNW	103.3%	5,248	-0.2%	56,949	1.5%	-	-
SEL	**99.3%**	**16,691**	**-2.5%**	**204,262**	**0.4%**	**9**	**28.6%**
LGT	74.1%	3,576	-5.1%	57,041	0.1%	6	50.0%
Kings	127.6%	6,473	-2.0%	66,095	0.2%	2	100.0%
GSTT	96.1%	6,642	-1.5%	81,126	0.9%	1	-50.0%
SWL	**101.3%**	**15,546**	**-3.6%**	**138,254**	**0.7%**	**0**	**-**
Croydon	149.3%	2,921	-3.2%	25,109	1.5%	-	-
Epsom	106.3%	2,430	-7.5%	42,226	0.2%	-	-
Kingston	89.1%	3,489	1.1%	23,740	-1.0%	-	-
Royal Marsden	114.5%	405	-6.5%	1,014	2.1%	-	-
St George's	92.2%	6,301	-4.4%	46,165	1.5%	-	-

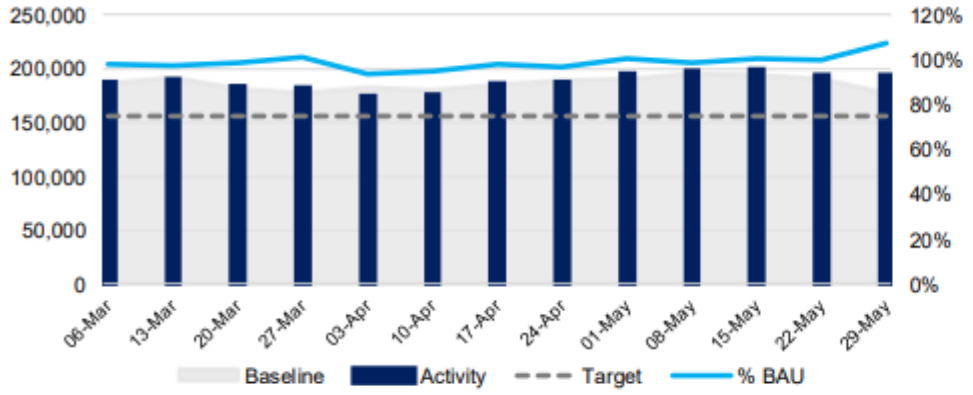
Source: Weekly Activity Return

Source: RTT Weekly PTL

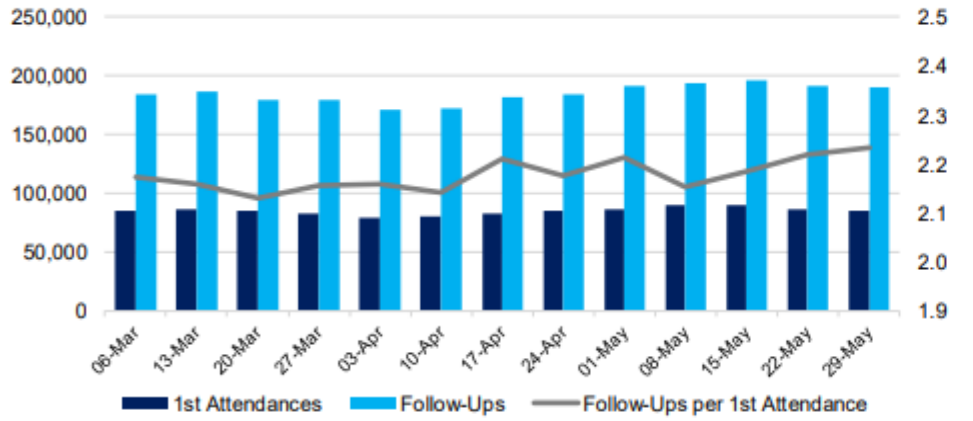
London 1st outpatient activity in equivalent baseline period: 81,480.

Outpatient Activity: Follow-Ups

OP - Follow-Up Activity Volumes and % of Baseline



Number of Follow-Ups per 1st Attendance



OP - Follow-Up (Latest Freeze Data: w/e 29-May)

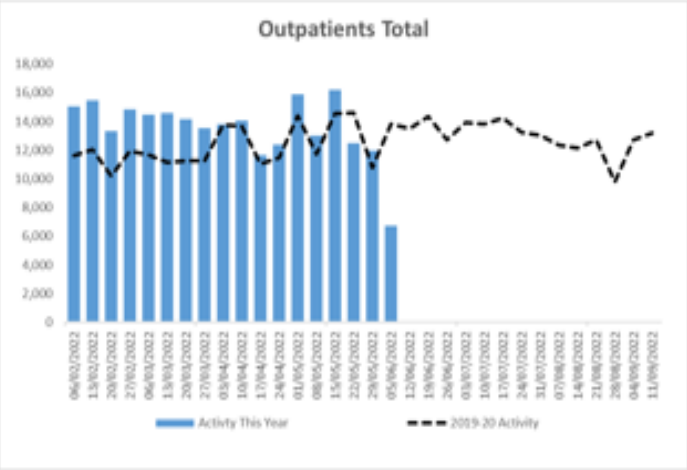
Provider	% BAU	Activity Volume	Weekly Var (%)	Ratio of 1st to FUP
LONDON	**107.1%**	**190,119**	**-0.2%**	**1: 2.2**
NCL	**112.0%**	**60,265**	**-0.4%**	**1: 2.5**
RFL	101.1%	13,537	-2.4%	1: 1.7
UCLH	124.8%	23,648	4.0%	1: 4.1
Whittington	93.2%	2,910	-1.9%	1: 0.9
GOSH	124.2%	3,236	-4.8%	1: 4.5
Moorfields	103.9%	9,537	-0.3%	1: 3.3
NMUH	117.4%	5,891	-7.2%	1: 2.1
RNOH	98.1%	1,506	-8.4%	1: 3.1
NEL	**106.7%**	**25,818**	**3.0%**	**1: 2.2**
BHRUT	89.0%	4,924	0.5%	1: 1.6
Barts	110.9%	17,020	6.4%	1: 2.7
Homerton	117.1%	3,874	-6.9%	1: 1.9
NWL	**109.0%**	**32,406**	**2.7%**	**1: 1.9**
Hillingdon	100.2%	2,918	-2.9%	1: 1.7
ChelWest	81.6%	7,283	-5.4%	1: 1.5
Imperial	127.3%	12,206	-0.4%	1: 2.1
LNW	120.4%	9,999	16.2%	1: 1.9
SEL	**107.3%**	**46,710**	**-2.8%**	**1: 2.8**
LGT	133.7%	6,143	-6.7%	1: 1.7
Kings	122.9%	20,429	0.1%	1: 3.2
GSTT	90.3%	20,138	-4.4%	1: 3.0
SWL	**94.7%**	**24,920**	**-1.4%**	**1: 1.6**
Croydon	88.7%	4,646	3.9%	1: 1.6
Epsom	74.8%	4,289	-3.2%	1: 1.8
Kingston	121.4%	3,759	1.7%	1: 1.1
Royal Marsden	96.5%	4,566	-1.9%	1: 11.3
St George's	101.9%	7,660	-4.4%	1: 1.2

Source: Weekly Activity Return

London follow-up outpatient activity in equivalent baseline period: 177,566.

Outpatients Weekly performance by Trust

CWFHT



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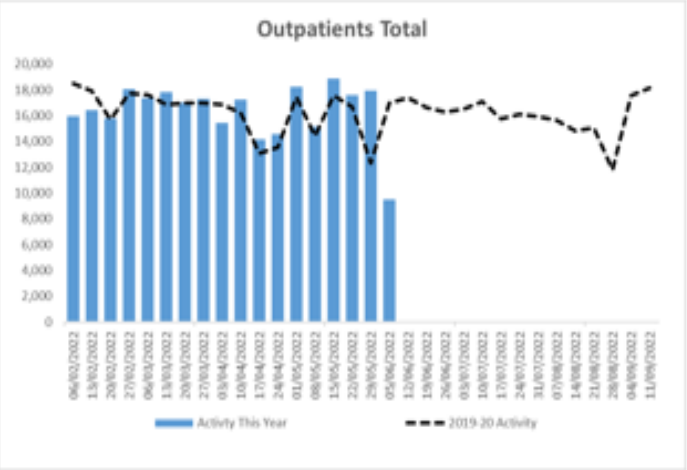
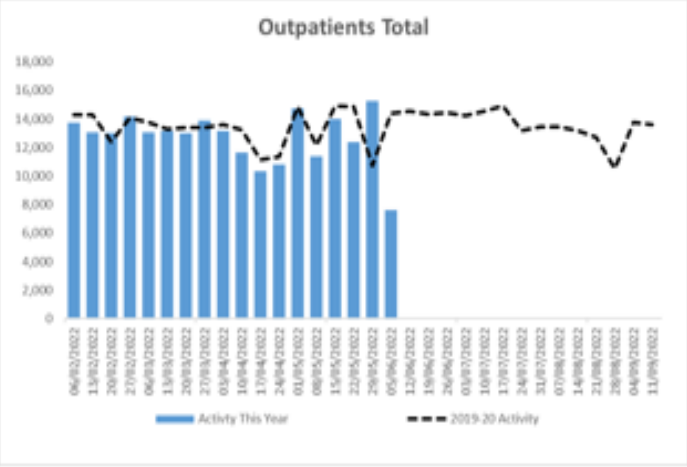
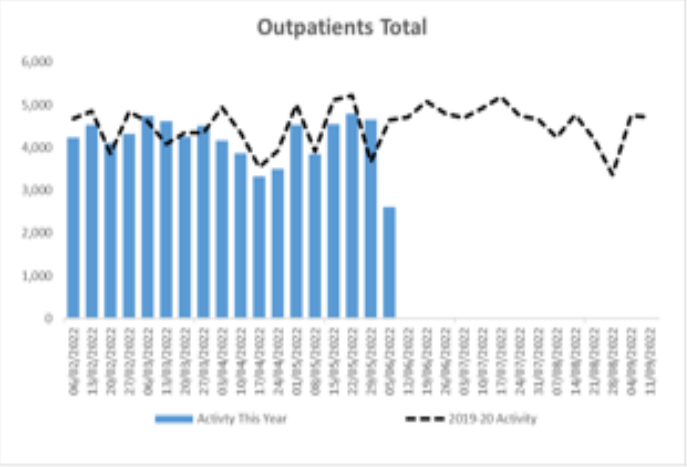


LNWUHT

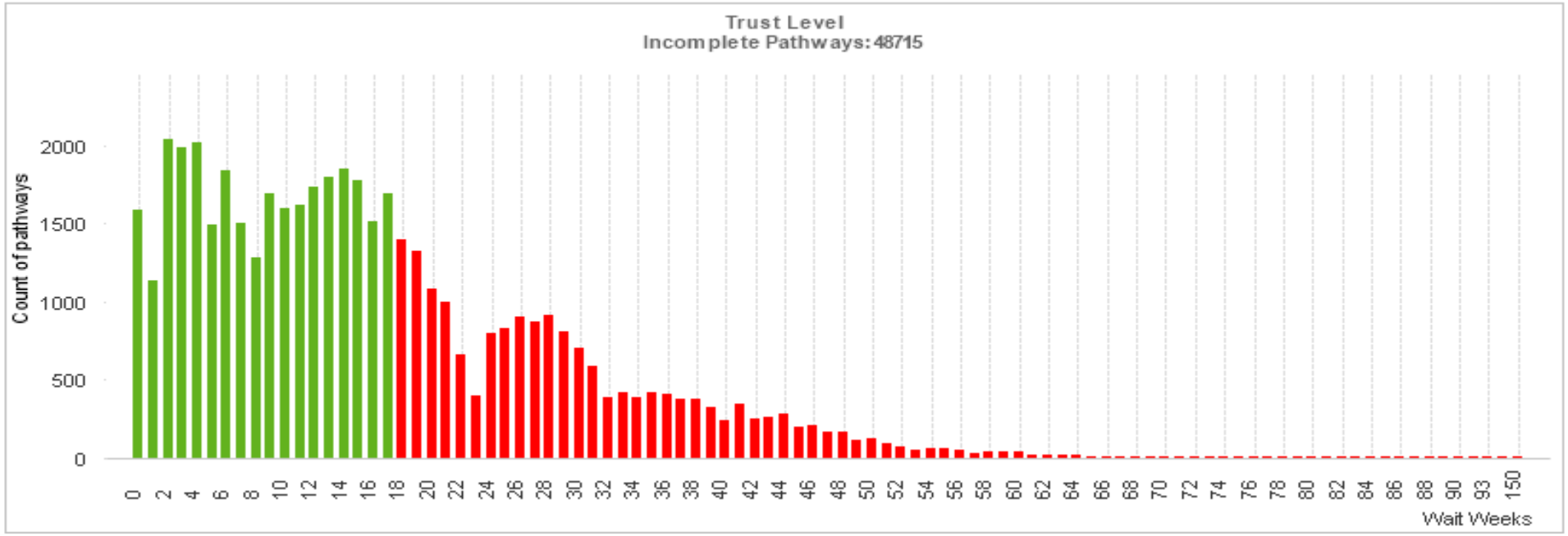


THHFT



Current PTL Position

Trust PTL Total: ↑48,715 (47,833)
52w+ ↑ 683 (665)
104w+ 0 (0)



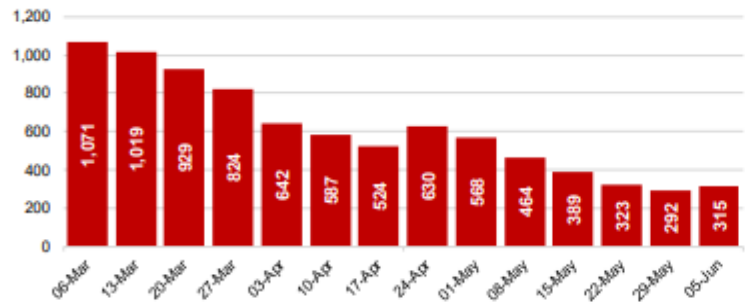
Specialty Name	14 to 18 Weeks	<18 Weeks	>18 Weeks	>26 Weeks	>40 Weeks	>52 Weeks	>78 Weeks	>104 Weeks	Total Waiters
Total	6858	30176	18539	11052	3159	683	47	1	48715

100+ week patient is a Data Quality issue which has now been updated on Cerner but will be reflected the next day

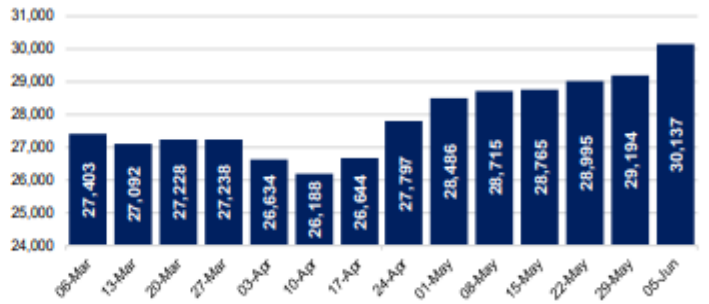
Regional Headlines

London PTL Overview	03-Apr	10-Apr	17-Apr	24-Apr	01-May	08-May	15-May	22-May	29-May	05-Jun
Total PTL	1,035,879	1,039,267	1,045,909	1,049,753	1,052,439	1,056,491	1,061,956	1,066,030	1,072,903	1,077,726
Weekly PTL Change (%)	0.3%	0.3%	0.6%	0.4%	0.3%	0.4%	0.5%	0.4%	0.6%	0.4%
Admitted PTL	133,269	132,093	132,865	132,928	133,107	133,425	133,550	134,058	135,194	135,207
Non-Admitted PTL	902,610	907,174	913,044	916,825	919,332	923,066	928,406	931,972	937,709	942,519
52 Week Waits	26,634	26,188	26,644	27,797	28,486	28,715	28,765	28,995	29,194	30,137
52ww Change (%)	-2.2%	-1.7%	1.7%	4.3%	2.5%	0.8%	0.2%	0.8%	0.7%	3.2%
104 Week Waits	**642**	**587**	**524**	**630**	**568**	**464**	**389**	**323**	**292**	**315**
104ww Change	-182	-55	-63	106	-62	-104	-75	-66	-31	23
104ww Change (%)	-22.1%	-8.6%	-10.7%	20.2%	-9.8%	-18.3%	-16.2%	-17.0%	-9.6%	7.9%

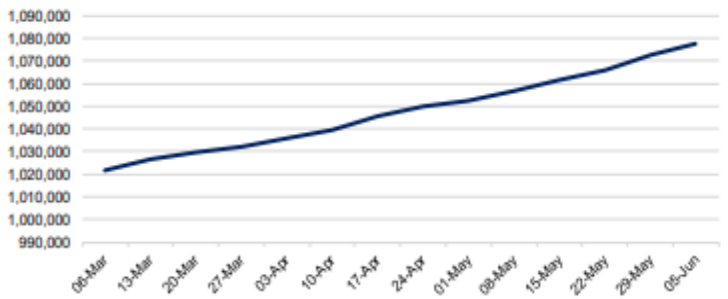
London Total 104+ Week Waits



London Total 52+ Week Waits

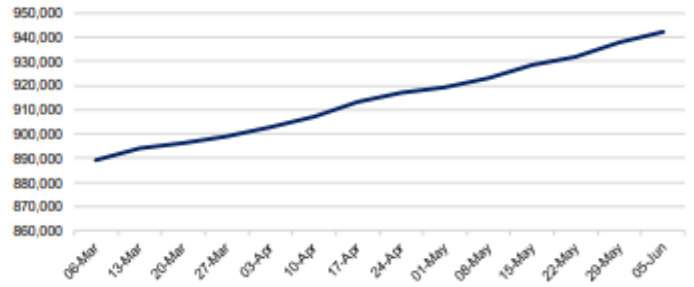


London Total PTL



London Total Admitted PTL

London Total Non-Admitted PTL



104+ week waiting Patient System Heatmaps

Latest Data: w/e 05-Jun

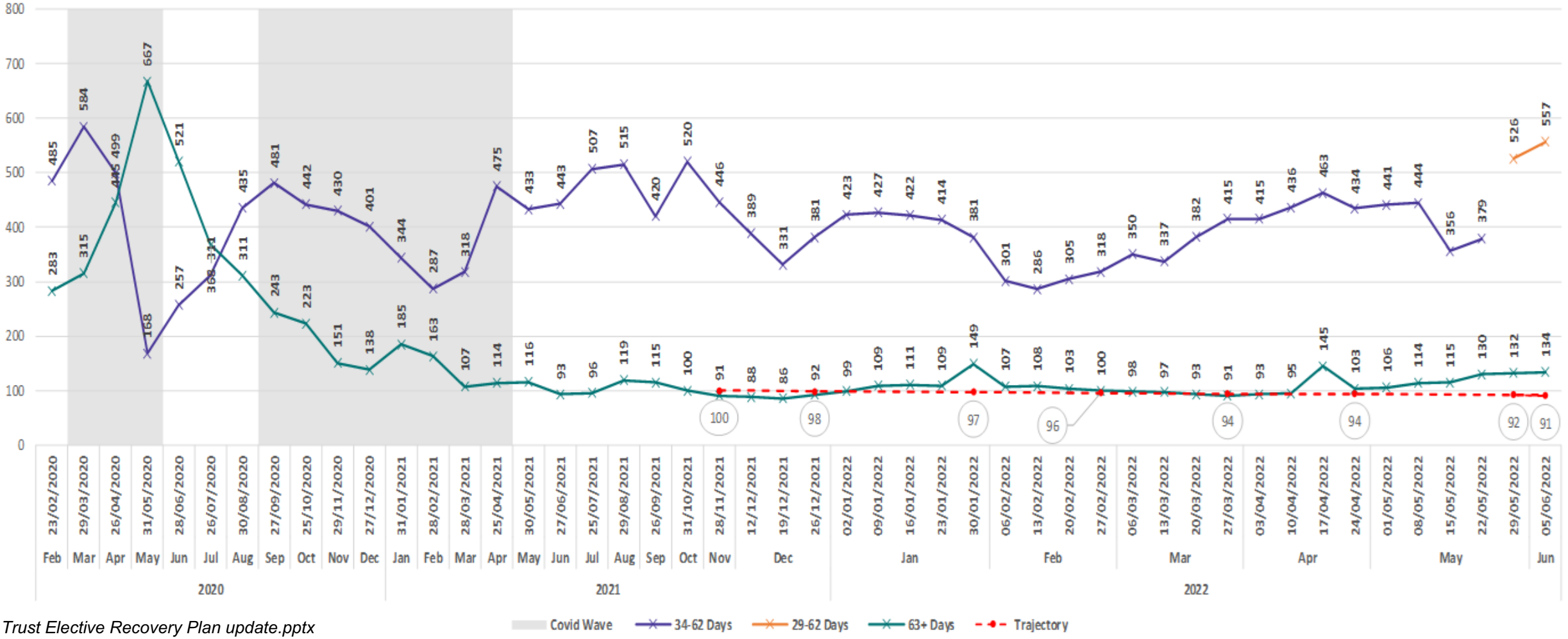
Specialty	Total	Change	Admitted Total	Change	NCL	NEL	NWL	SEL	SWL	Non-Adm. Total	Change	NCL	NEL	NWL	SEL	SWL
			Admitted							Non-Admitted						
Other	80	▲ 11	61	▲ 8	11 ▶	49 ▲		1 ▶		19	▲ 3	4 ▲	13 ▲		2 ▼	
Gynaecology	58	▲ 10	34	▲ 6	5 ▼	17 ▲		12 ▲		24	▲ 4	2 ▲	19 ▶	1 ▲	2 ▲	
ENT	50	▼ -7	46	▼ -4	2 ▼	39 ▼		5 ▼		4	▼ -3	1 ▼	2 ▼		1 ▶	
Trauma & Orthopaedics	50	▲ 11	34	▲ 8	6 ▲	22 ▲		6 ▲		16	▲ 3	8 ▼	4 ▲	1 ▶	3 ▲	
Plastic Surgery	26	▲ 1	26	▲ 1	16 ▼	7 ▲		2 ▶	1 ▲	0	▶ -					
Urology	17	▶ -	17	▲ 1	9 ▼	7 ▲		1 ▶		0	▼ -1					
General Surgery	11	▼ -2	11	▼ -1		6 ▶	3 ▼	1 ▶	1 ▶	0	▼ -1					
Neurosurgery	4	▶ -	4	▶ -		4 ▶				0	▶ -					
Ophthalmology	4	▲ 1	2	▲ 1	1 ▶			1 ▲		2	▶ -		1 ▼		1 ▲	
Oral Surgery	4	▼ -1	3	▶ -		3 ▶				1	▼ -1		1 ▶			
Cardiothoracic Surgery	3	▶ -	3	▶ -		2 ▶		1 ▶		0	▶ -					
Thoracic Medicine	3	▲ 2	2	▲ 2		2 ▲				1	▶ -		1 ▶			
Cardiology	2	▲ 1	0	▶ -						2	▲ 1		1 ▶	1 ▲		
Neurology	2	▼ -3	0	▼ -1						2	▼ -2		2 ▼			
Gastroenterology	1	▶ -	0	▶ -						1	▶ -		1 ▲			
Dermatology	0	▶ -	0	▶ -						0	▶ -					
General Medicine	0	▶ -	0	▶ -						0	▶ -					
Geriatric Medicine	0	▶ -	0	▶ -						0	▶ -					
Rheumatology	0	▼ -1	0	▶ -						0	▼ -1					
Total	**315**	**▲ 23**	**243**	**▲ 21**	**50 ▼**	**158 ▲**	**3 ▼**	**30 ▲**	**2 ▲**	**72**	**▲ 2**	**15 ▼**	**45 ▲**	**3 ▲**	**9 ▲**	**0 ▶**

Chelsea and Westminster Hospital NHS Foundation Trust

W/E 05/06/2022

RM Partners
West London Cancer Alliance
Hosted by The Royal Marsden NHS Foundation Trust

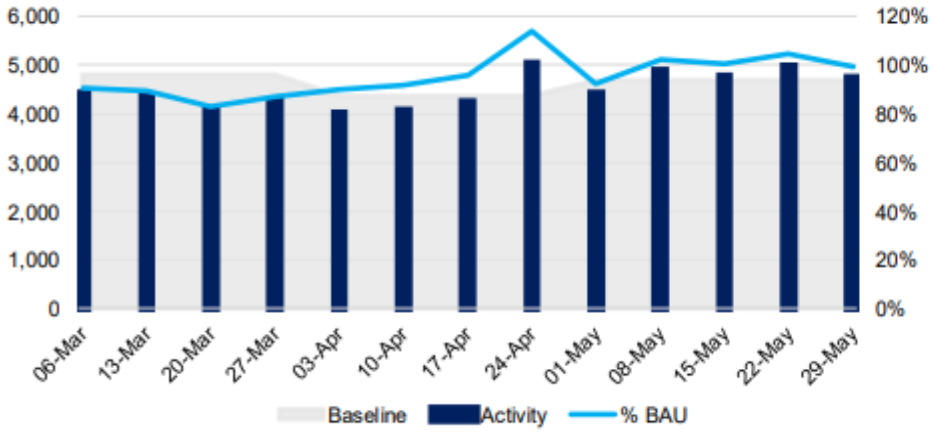
62 Day Weekly Backlog



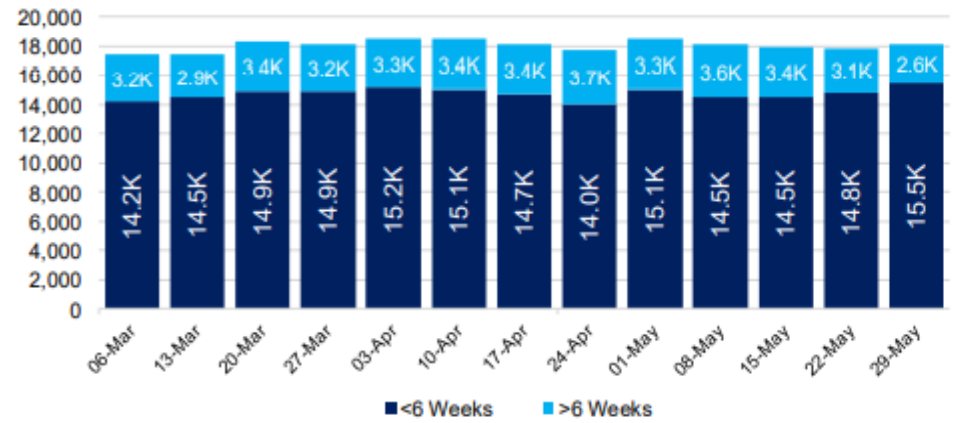
Endoscopy Activity

Below table note: Royal Free has returned to data reporting, currently working through data submission to ensure quality.

Endoscopy Activity Volumes and % of Baseline



Endoscopy: Total Wait List



Endoscopy (Latest Freeze Data: w/e 29-May)

Provider	% BAU	Activity Volume	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
LONDON	**99.3%**	**4,667**	**-5.0%**	**18,139**	**1.7%**	**2,642**	**-13.8%**
NCL	**79.0%**	**689**	**-0.7%**	**4,728**	**2.4%**	**1,186**	**-8.4%**
RFL	40.6%	133	-20.4%	1,815	-0.4%	409	-9.5%
UCLH	118.3%	297	30.3%	1,199	2.0%	270	-15.4%
NMUH	123.5%	152	7.0%	787	1.0%	233	-2.1%
Whittington	66.5%	107	-30.5%	784	10.4%	217	-10.7%
GOSH	0.0%	0	-100.0%	143	10.9%	57	32.6%
NEL	**105.4%**	**937**	**-5.4%**	**2,663**	**5.4%**	**33**	**-10.8%**
Barts	108.3%	490	-9.3%	1,425	4.1%	22	-18.5%
Homerton	100.8%	196	-8.8%	556	13.2%	9	12.5%
BHRUT	103.9%	251	6.4%	682	2.4%	2	0.0%
NWL	**88.9%**	**890**	**-4.3%**	**4,675**	**-0.1%**	**569**	**-27.7%**
Hillingdon	296.8%	147	25.6%	1,020	9.0%	347	-1.7%
ChelWest	111.0%	281	-10.5%	1,174	2.3%	121	-27.1%
LNW	56.7%	238	-10.5%	946	7.7%	67	-1.5%
Imperial	80.1%	224	-3.9%	1,535	-10.7%	34	-83.0%
SEL	**125.3%**	**1,290**	**-6.0%**	**3,156**	**3.6%**	**599**	**-9.4%**
GSTT	182.5%	391	-1.3%	1,189	0.8%	347	-9.2%
Kings	89.1%	411	-13.7%	1,102	12.3%	191	-6.4%
LGT	137.9%	488	-2.4%	865	-2.5%	61	-18.7%
SWL	**95.0%**	**861**	**-7.2%**	**2,917**	**-1.6%**	**255**	**-10.8%**
Croydon	131.8%	192	6.7%	974	-2.9%	193	-9.0%
Epsom	107.9%	274	-16.7%	675	-6.3%	45	-23.7%
St George's	65.2%	195	0.0%	568	0.0%	8	0.0%
Kingston	95.4%	173	-11.3%	587	1.0%	7	133.3%
Royal Marsden	103.1%	27	-6.9%	113	22.8%	2	-50.0%

Source: Weekly Activity Return

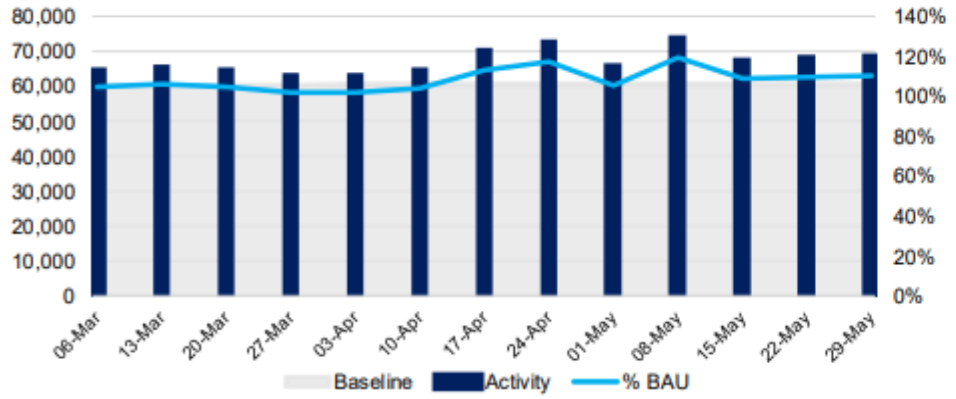
Latest Data: w/e 29-May

Source: Weekly Activity Return

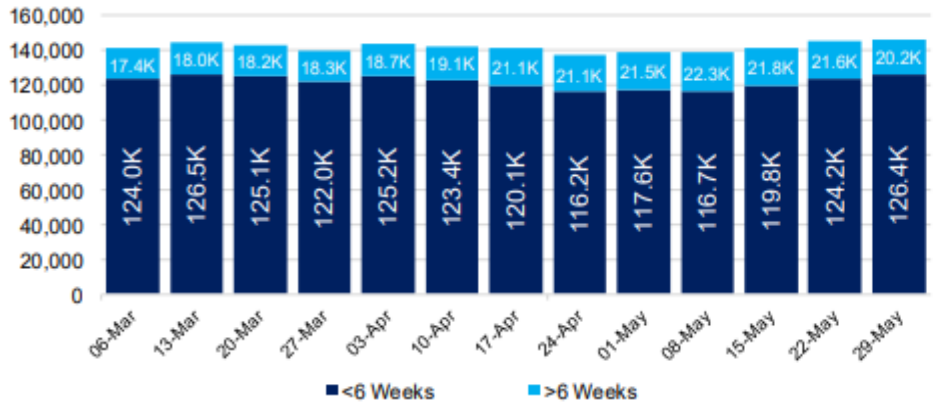
London Endoscopy Activity in equivalent baseline period: 4,698.

Imaging Activity

Imaging Activity Volumes and % of Baseline



Imaging: Total Wait List



Imaging (Latest Freeze Data: w/e 29-May)

Provider	% BAU	Activity Volume	Weekly Var (%)	Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
LONDON	**110.5%**	**67,418**	**0.8%**	**146,581**	**0.5%**	**20,156**	**-6.9%**
NCL	**130.7%**	**13,990**	**2.4%**	**28,433**	**1.5%**	**4,003**	**-6.1%**
UCLH	157.3%	3,984	8.6%	8,179	3.5%	1,805	-3.8%
RFL	107.6%	5,464	3.0%	10,295	1.3%	1,510	-9.0%
Whittington	153.5%	1,683	-0.4%	3,429	3.5%	215	21.5%
GOSH	112.1%	454	-4.0%	1,120	2.2%	202	6.9%
NMUH	177.4%	1,694	-6.1%	3,449	-3.1%	191	-26.3%
RNOH	100.8%	493	-7.5%	1,790	-1.2%	78	-22.8%
Moorfields	142.2%	218	17.2%	171	-0.6%	2	0.0%
NEL	**104.6%**	**13,892**	**-1.6%**	**41,730**	**2.0%**	**11,473**	**-5.8%**
Barts	118.3%	7,760	0.5%	28,814	2.2%	9,100	-4.0%
BHRUT	87.6%	4,123	-2.8%	6,807	0.8%	2,343	-9.3%
Homerton	99.8%	2,009	-6.9%	6,109	2.4%	30	-75.0%
NWL	**96.9%**	**13,862**	**-1.2%**	**26,661**	**1.4%**	**1,394**	**-8.7%**
Hillingdon	84.0%	1,488	8.5%	4,661	3.3%	846	-2.4%
Imperial	106.8%	5,229	-2.6%	10,298	0.9%	365	-17.2%
LNW	91.9%	3,695	-1.2%	5,363	-1.4%	174	-15.1%
ChelWest	95.2%	3,450	-2.6%	6,339	3.1%	9	-35.7%
SEL	**115.7%**	**13,561**	**3.0%**	**23,640**	**-3.6%**	**1,333**	**-11.7%**
GSTT	108.2%	4,499	-2.7%	8,257	-5.2%	945	-2.5%
Kings	128.3%	5,688	3.2%	7,494	2.6%	303	-36.9%
LGT	107.8%	3,374	11.2%	7,889	-7.2%	85	39.3%
SWL	**110.3%**	**12,113**	**1.7%**	**26,117**	**0.2%**	**1,953**	**-9.5%**
Kingston	108.8%	1,829	13.0%	4,815	2.3%	1,161	-1.0%
Epsom	129.9%	3,022	2.0%	8,264	-0.9%	598	-24.3%
St George's	92.2%	3,057	0.0%	6,441	0.0%	144	0.0%
Croydon	120.9%	2,460	3.7%	6,025	0.5%	48	6.7%
Royal Marsden	107.4%	1,745	-8.2%	572	-2.2%	2	-60.0%

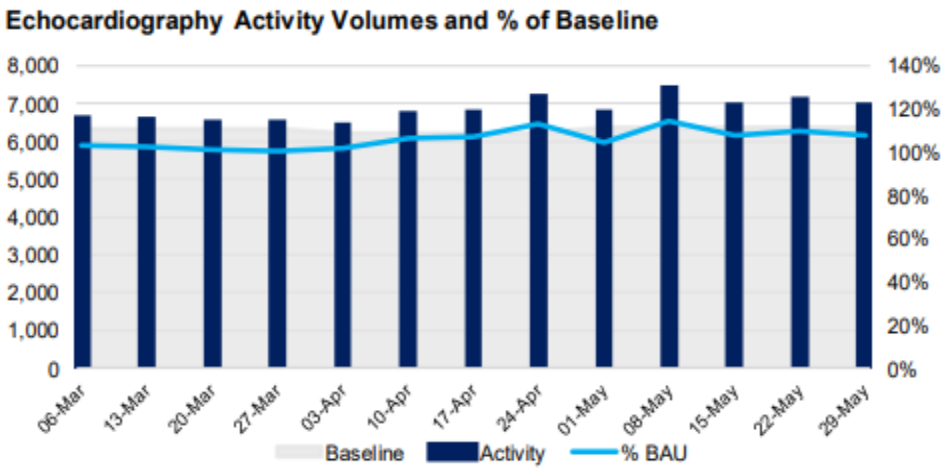
Source: Weekly Activity Return

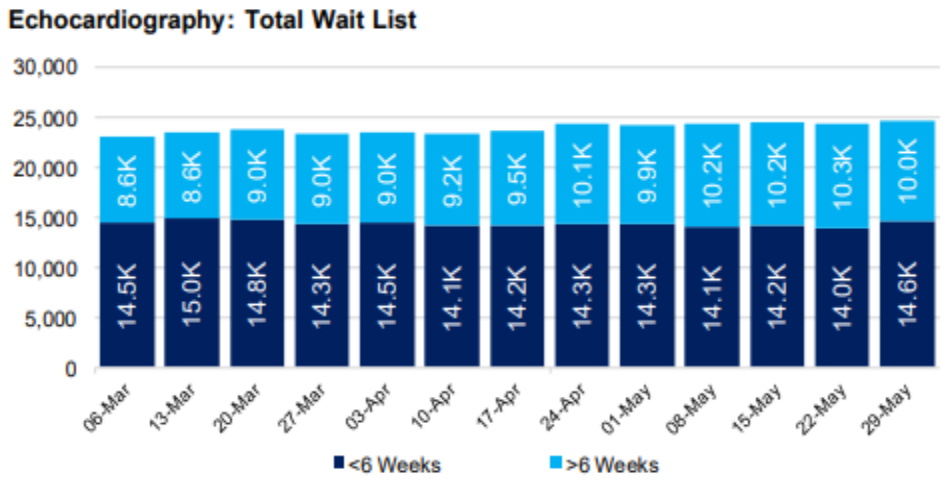
Latest Data: w/e 29-May

Source: Weekly Activity Return

London Imaging Activity in the equivalent baseline period: 61,000.

Echocardiography Activity





Echocardiography (Latest Freeze Data: w/e 29-May)

Provider	% BAU	Activity Volume	Weekly Var (%)
LONDON	**107.8%**	**6,854**	**-2.1%**
NCL	**132.8%**	**1,192**	**-0.7%**
RFL	147.7%	327	-7.4%
Whittington	99.7%	113	-13.1%
UCLH	129.0%	306	6.3%
GOSH	250.9%	356	15.6%
NMUH	49.0%	90	-25.6%
NEL	**92.7%**	**1,289**	**-10.7%**
Barts	100.3%	937	-7.3%
Homerton	117.8%	177	-16.5%
BHRUT	57.2%	175	-20.8%
NWL	**124.1%**	**1,350**	**2.2%**
Hillingdon	96.5%	153	-5.0%
Imperial	103.9%	572	-1.2%
LNW	96.6%	259	-13.7%
ChelWest	329.9%	366	30.2%
SEL	**96.0%**	**1,819**	**-2.6%**
GSTT	97.6%	1,052	3.0%
Kings	104.5%	640	-2.9%
LGT	62.1%	127	-32.4%
SWL	**110.6%**	**1,204**	**3.3%**
Croydon	110.4%	234	17.6%
Kingston	96.6%	143	44.4%
Epsom	138.8%	238	-12.2%
Royal Marsden		52	-13.3%
St George's	96.3%	537	0.0%

Source: Weekly Activity Return

Latest Data: w/e 29-May

Waitlist	Weekly Var (%)	>6 Weeks	Weekly Var (%)
24,620	**1.3%**	**9,977**	**-3.4%**
3,190	**2.4%**	**419**	**-12.7%**
1,384	-4.3%	263	-3.0%
627	3.0%	78	-22.0%
439	-2.0%	41	-48.1%
125	0.0%	35	25.0%
615	26.3%	2	0.0%
9,175	**2.3%**	**5,580**	**-0.3%**
8,013	2.5%	5,486	0.4%
631	-1.7%	86	-25.2%
531	3.5%	8	-50.0%
2,639	**-1.3%**	**944**	**-8.4%**
1,184	1.9%	603	-3.7%
347	0.9%	187	-7.0%
948	-7.2%	99	-41.4%
160	9.6%	55	57.1%
4,396	**2.5%**	**747**	**-15.1%**
1,343	-2.9%	402	7.2%
2,399	1.1%	343	-32.1%
654	22.5%	2	-
5,220	**-0.4%**	**2,287**	**-2.6%**
2,095	-1.0%	1,111	0.6%
1,426	-4.4%	1,013	-5.5%
743	9.1%	161	-5.3%
2	100.0%	1	-
954	0.0%	1	0.0%

Source: Weekly Activity Return

London Echo Activity in the equivalent baseline period: 6,360.

TRUST PERFORMANCE & QUALITY REPORT

May 2022

NHSI Reporting

NHSI Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	78.08%	82.86%	77.24%	79.88%	78.60%	77.77%	80.17%	79.04%	78.37%	80.00%	78.88%	79.41%	79.41%	!
RTT	18 weeks RTT - Incomplete (Target: >92%)	65.72%	66.61%	70.91%	68.75%	60.96%	58.95%	60.33%	59.65%	63.66%	63.29%	66.25%	64.77%	64.77%	!
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	90.01%	92.84%	94.44%	92.84%	97.96%	98.12%	97.08%	98.12%	94.69%	95.83%	95.98%	95.83%	95.83%	-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	99.08%	100%	100%	100%	99.08%	100%	100%	100%	100%	-
(Please note that all Cancer indicators show interim, unvalidated positions for the latest month (May-22) in this report	31 days diagnosis to first treatment (Target: >96%)	95.52%	89.47%	95.92%	89.47%	92.86%	94.20%	97.70%	94.20%	94.16%	92.52%	97.06%	92.52%	92.52%	!
	31 days subsequent cancer treatment - Drug (Target: >98%)	n/a	n/a	100%	n/a	100%	n/a	100%	n/a	100%	n/a	100%	n/a	n/a	-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	n/a	100%	n/a	100%	n/a	100%	n/a	100%	n/a	100%	n/a	100%	100%	-
	62 days GP referral to first treatment (Target: >85%)	78.82%	93.75%	71.15%	93.75%	78.00%	81.52%	63.28%	81.52%	78.38%	85.71%	65.56%	85.71%	85.71%	!
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	50.00%	33.33%	44.44%	41.67%	50.00%	33.33%	44.44%	41.67%	41.67%	!
Cancer - FDS	Faster Diagnosis Standard (Target: >= 75%)	79.52%	76.61%	79.62%	78.16%	73.07%	66.92%	71.60%	69.46%	75.58%	71.00%	74.79%	73.02%	73.02%	!
Patient Safety	Clostridium difficile infections (Year End Target: 26)	3	1	1	2	2	2	1	3	5	3	2	5	5	!

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 (May-22) and are not included in quarterly or yearly totals	

A&E: A&E 4hr performance remains uncompliant with performance of 78.88% in Month 2. This was the 3rd highest performance in London and 14th highest nationally. Both departments continue to be strong performers with ambulance handover times. The departments remain pressured by increasing type 3 activity, with overall activity in month 6% higher than May 2019. Challenges continue with staffing levels within the UTC at West Middlesex with deterioration in the department's performance impacting performance in A&E. Work continues to redirect patients to primary care as well as SDEC services, and changes in COVID-19 testing have been made during June which should help to support improved flow through the Emergency Departments.

RTT 18 Week Incomplete: The teams continue to book patients in priority and chronological order to address the longest waiting. Plans to reduce outpatient waits, see patients on different pathways and improve theatre efficiency will result in improved RTT performance. The Trust continues its work to ensure data quality challenges are minimised, the patient tracker lists are accurate and reported performance is as expected.

Cancer (*Unvalidated)*
2WW: This measure is compliant for May 2022. Compliance is maintained despite the sustained increased in GP suspected cancer referrals, particularly in skin, lower GI and gynaecology pathways.
***28-Day FDS*:** The 28-day Faster Diagnosis Standard (FDS) target is marginally non-compliant for May 2022, currently at 74.79%. The expectation is that following final validation this will achieve compliance.
***62-Day*:** 62-Day *GP Treatment* for May 2022 is currently non-compliant at 65.56%. This is expected to improve as patients treatment status are confirmed but is projected to be non-compliant for the month. Complex patients as well as delays in histology have broadly driven this position, increasing the length of patient's pathways.
62-Day Screening- Screening is reporting a non-compliant position currently. This represents 1.5 patient pathways against 1.5 patient breaches. It is noted that this is an unvalidated position.

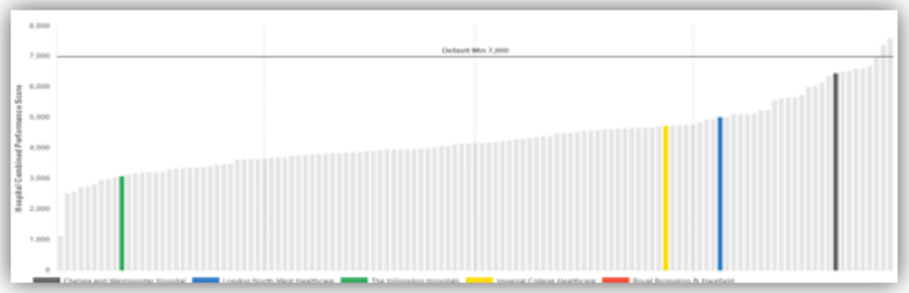
Patient Safety
There were two Trust attributed CDI cases in May 2020. 1 HOHA occurred at the CW site and 1 COHA occurred at the WM site. The first case was attributed to Lord Wigram ward, the patient tested positive on day nine of their admission following orthopaedic surgery post fall. The second case was attributed to Starlight ward, the child was positive on admission but had a recent inpatient stay and antibiotic therapy for suspected meningitis in April 2022. RCA meetings to review these cases are pending.

National Benchmarking Against Select Indicators

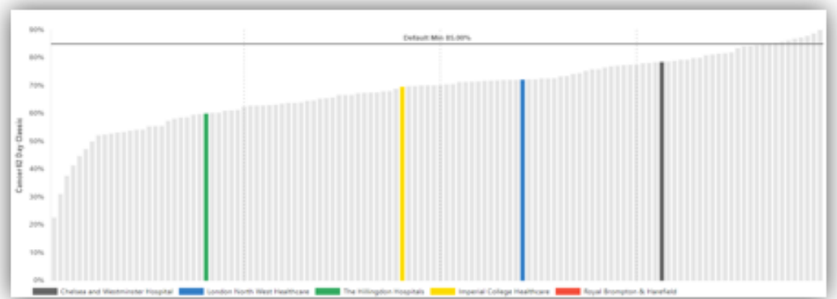
The below has been sourced from PublicView and represents the Trust Performance for Mar 22, except for the ***Hospital Combined Score (HCS)*** which is displaying Apr 22 data. The Ranking is based on peers in the same group as the Trust

The Trust ranked 9th nationally on the HCS in April 2022

Hospital Combined Score -9TH *Nationally*

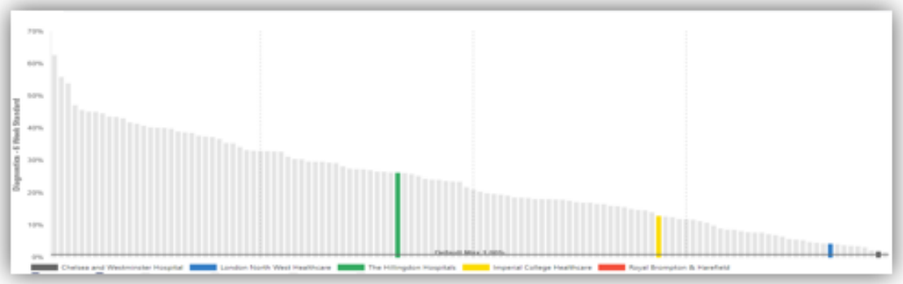


Cancer 62 Days 26th OF *122*



62 Day Cancer Standard: The Trust is currently ranked 26th out of 122 trusts, an improvement in performance when compared to the previous month.

6 -wk Diagnostic – 2nd OF *122*

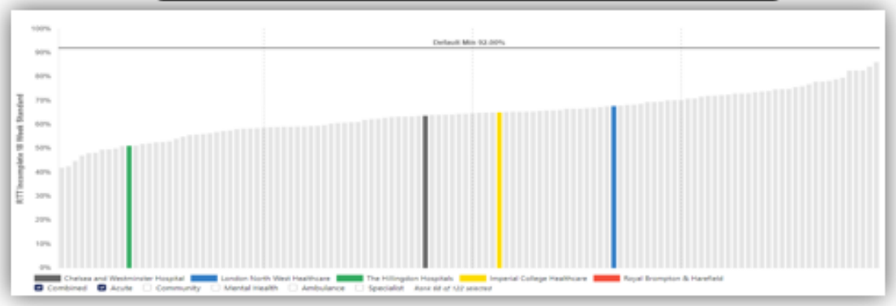


6 Week Diagnostic Standard: The Trust as one of the top two nationally for diagnostic waits.

RTT 52 wks- 29TH OF 122

RTT 52 Week Breaches: The Trust is currently ranked 29th of 122 Trusts.

RTT 18-wk Incomplete Pathway 68th OF *122*



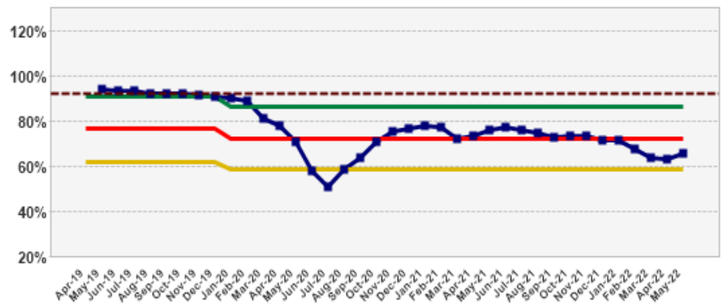
RTT 18 Week Standard: This position is a decrease in ranking compared to the previous month.

SELECTED BOARD REPORT NHSI INDICATORS

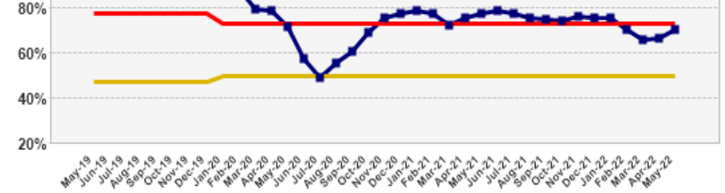
Statistical Process Control Charts for the last 37 months Mar 2019 to May 2022

RTT Incomplete pathways

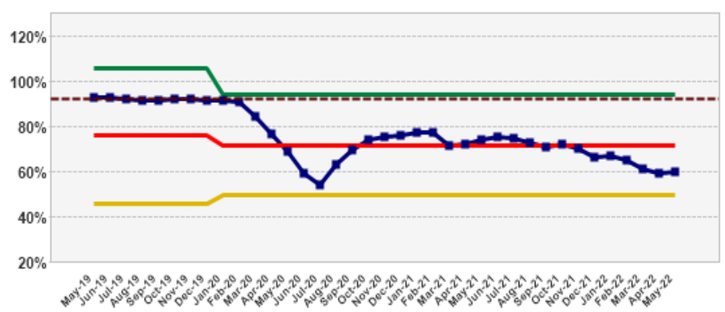
Trust Total



Chelsea and Westminster

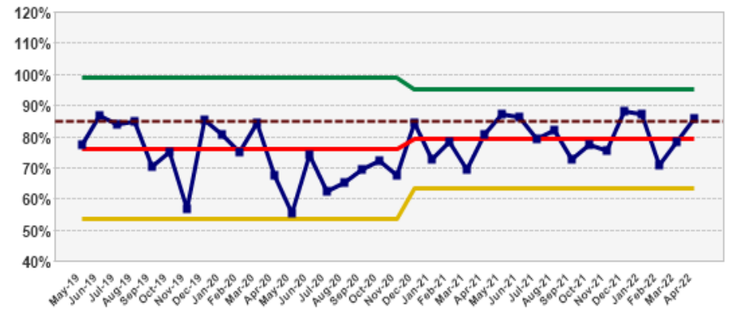


West Middlesex

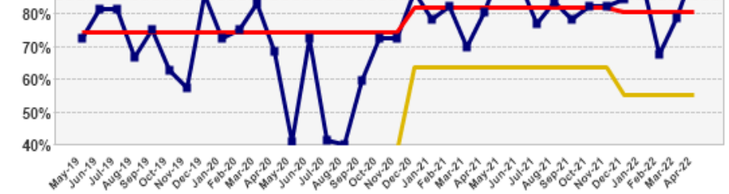


Cancer: 62 day standard

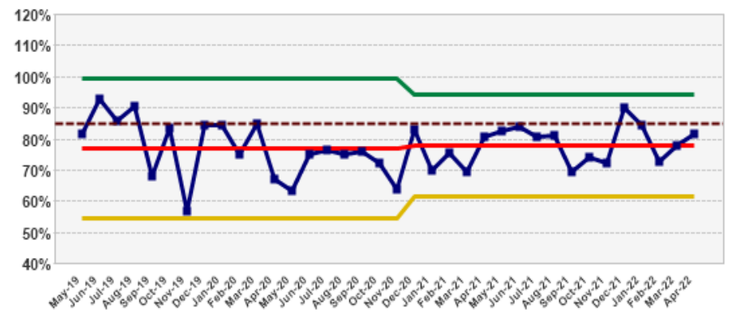
Trust Total



Chelsea and Westminster



West Middlesex



Safety Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	1	0	1	0	0	1	1	0	1	1	2	2	
	Hand hygiene compliance (Target: >90%)	92.1%	94.1%	94.5%	94.3%	96.3%	96.9%	98.9%	97.9%	93.8%	95.4%	96.4%	95.9%	95.9%	
Incidents	Number of serious incidents	1	1	4	5	2	0	5	5	3	1	9	10	10	
	Incident reporting rate per 100 admissions (Target: >8.5)	8.4	8.6	8.4	8.5	9.9	10.5	8.1	9.2	9.1	9.5	8.2	8.8	8.8	
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions	0.03	0.00	0.00	0.01	0.04	0.04	0.02	0.03	0.03	0.02	0.01	0.01	0.01	
	Medication-related (NRLS reportable) safety incidents per 1,000 FCE bed days (Target: >=4.2)	4.25	4.35	5.02	4.68	1.67	2.48	2.88	2.71	2.61	3.43	3.83	3.64	3.64	
	Medication-related (NRLS reportable) safety incidents % with moderate harm & above (Target: <=2%)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Harm	Never Events (Target: 0)	0	0	1	1	0	0	0	0	0	0	1	1	1	
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	0	0	1	1	0	0	0	0	0	0	1	1	1	
	Safeguarding adults - number of referrals	20	25	11	36	47	36	42	78	67	61	53	114	114	
	Safeguarding children - number of referrals	20	17	28	45	112	89	118	207	132	106	146	252	252	
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	67	67	65	65	75	74	75	75	72	71	71	71	71	
	Number of hospital deaths - Adult	46	37	47	84	52	72	63	135	98	109	110	219	219	
	Number of hospital deaths - Paediatric	1	0	0	0	0	0	0	0	1	0	0	0	0	
	Number of hospital deaths - Neonatal	1	2	0	2	0	1	0	1	1	3	0	3	3	
	Number of deaths in A&E - Adult	0	0	0	0	2	3	3	6	2	3	3	6	6	
	Number of deaths in A&E - Paediatric	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of deaths in A&E - Neonatal	0	0	0	0	0	0	0	0	0	0	0	0	0	

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

MRSA
There was one trust attributed MRSA bacteraemia in May 2022, which occurred at the WM site on Lampton ward. MRSA was not detected on the patient's admission screen on but subsequently detected from a blood culture. The Root Cause Analysis meeting was held which identified it was likely not a clinically significant isolated issue.

Medication Related Safety Incidents
A total of 132 medication-related incidents were reported in May 2022. CW site reported 72 incidents, WM site reported 59 incidents and there was 1 incident reported in community. The number of incidents reported in May has increased across the Trust since April (109), with an increase in reporting at both sites.

Medication-related (NRLS reportable) safety incidents per 1000 FCE bed days
The Trust position of medication-related incidents involving patients (NRLS reportable) for May 2022 was 3.83 per 1,000 FCE bed days which although falls below the Trust target of 4.2 per 1,000 FCE bed days, is an increase from the previous month. Teaching on the benefits of incident reporting will continue to be delivered to different healthcare professional groups.

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

Incidents
There were nine serious incident declared in May 2022; One was a ***Never Event*** *(*Wrong site surgery), three were delayed diagnosis of cancer, two patient falls, one treatment delay, one sub-optimal care of the deteriorating patient and one maternity incident affecting the baby. The investigations into these events will seek to identify any care or service delivery challenges that impacted the outcome and establish actions to reduce the risk or consequence of the event recurring.

Overall the number of patient safety incident per 100 admissions is lower at CW compared to WM. It is anticipated that reporting rates will increase following the implementation of the new Patient Safety Incident Response Framework (PSIRF); staff training will be an integral part of the roll out.

Patient Experience

Patient Experience Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts
Friends & Family Test	FFT: Inpatient satisfaction % (Target: >90%)	95.3%	96.0%	94.4%	95.0%	95.7%	95.5%	97.1%	96.4%	95.6%	95.6%	96.1%	95.9%	95.9%	-
	FFT: Inpatient not satisfaction % (Target: <10%)	2.5%	2.7%	3.5%	3.2%	1.6%	0.5%	1.7%	1.2%	1.9%	1.2%	2.3%	1.8%	1.8%	-
	FFT: Inpatient response rate (Target: >30%)	16.9%	14.5%	22.9%	18.9%	49.9%	46.1%	47.4%	46.8%	31.1%	28.4%	34.1%	31.4%	31.4%	!
	FFT: A&E satisfaction % (Target: >90%)	79.1%	81.5%	78.5%	79.9%	75.5%	78.7%	76.6%	77.6%	78.1%	80.7%	77.9%	79.3%	79.3%	!
	FFT: A&E not satisfaction % (Target: <10%)	14.0%	11.4%	15.1%	13.3%	18.0%	15.1%	14.3%	14.7%	15.1%	12.5%	14.9%	13.7%	13.7%	!
	FFT: A&E response rate (Target: >30%)	20.6%	21.4%	20.4%	20.9%	20.2%	20.9%	20.0%	20.4%	20.5%	21.2%	20.3%	20.7%	20.7%	!
	FFT: Maternity satisfaction % (Target: >90%)	86.1%	87.4%	93.3%	90.6%	90.9%	80.0%	100.0%	90.9%	86.6%	86.9%	93.8%	90.6%	90.6%	-
	FFT: Maternity not satisfaction % (Target: <10%)	9.7%	9.8%	6.1%	7.8%	9.1%	10.0%	0.0%	4.5%	9.6%	9.8%	5.7%	7.6%	7.6%	-
	FFT: Maternity response rate (Target: >30%)	30.2%	27.3%	30.5%	29.0%	40.0%	30.3%	21.1%	24.4%	31.1%	27.5%	29.6%	28.6%	28.6%	-
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	19	14	19	33	19	14	19	33	33	!
Complaints	Complaints (informal) through PALS	134	91	78	169	41	50	60	110	175	141	138	279	279	-
	Complaints formal: No of complaints due for response	33	21	21	42	19	6	14	20	52	27	35	62	62	-
	Complaints formal: Number responded to < 25 days	33	19	20	39	18	5	14	19	51	24	34	58	58	-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	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		

PALS and Complaints
The Trust is reporting 97% of complaints responded to within the 25 day KPI (target 95%) during May 2022. Full compliance was achieved in both Chelsea and West Middlesex sites. Compliance with responding to PALS concerns within 5 working days was 93% (KPI 90%). It is noted that there is one complaint awaiting an outcome from the PHSO.

Friends & Family Test
Inpatient wards at the Trust have maintained a satisfaction rate >90% for both sites. Inpatient ward response rates for the Chelsea site has improved slightly for the month of May. The Patient Experience team are working closely with the Ward Managers and Matrons and continue to offer support in order to improve the response rate.

ED at both sites remains <90% satisfaction for the month of April and the submitted FFT free-text notes continue to attribute this to long waiting times; despite this, there has been improvement in the overall negative satisfaction rate. The reported positive feedback for ED exhibits that patients are overall happy with the care received and staff attitude. A recovery plan started last month led by the Divisional Director of Nursing for EIC and the Lead Nurse for ED to assist with the reported negative feedback related to wait times and poor communication. This is an on-going project and the FFT data shows a drop in negative satisfaction rate.

Maternity services at Chelsea & Westminster and West Middlesex Hospital positive satisfaction rate is >90% for the month of May. Maternity services continue to maintain <10% not satisfied rate.
The Patient Experience Team are continuously working with staff across the Trust to ensure an improvement in the FFT response rate.

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

Efficiency and Productivity

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <2.9)	2.76	2.99	2.04	2.45	2.19	2.03	2.50	2.30	2.62	2.76	2.15	2.41	2.41		-
	Average length of stay - non-elective (Target: <3.95)	3.91	3.94	3.66	3.80	5.99	3.81	4.07	3.94	5.04	3.87	3.88	3.88	3.88		-
	Emergency care pathway - average LoS (Target: <4.5)	4.36	4.15	4.16	4.16	3.76	4.51	4.81	4.67	4.01	4.35	4.55	4.45	4.45		-
	Emergency care pathway - discharges	275	266	270	537	389	349	384	734	664	616	655	1271	1271		-
	Emergency re-admissions within 30 days of discharge (Target: <7.6%)	5.88%	6.12%	5.51%	5.80%	7.10%	8.36%	6.81%	7.53%	6.44%	7.15%	6.11%	6.60%	6.60%		!
	Non-elective long-stayers	394	401	239	640	403	351	337	688	797	752	576	1328	1328		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	87.2%	81.0%	87.8%	85.0%	85.9%	78.8%	83.8%	81.6%	86.9%	80.4%	86.7%	84.0%	84.0%		-
	Operations canc on the day for non-clinical reasons: actuals	6	8	7	15	4	16	18	34	10	24	25	49	49		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.20%	0.31%	0.22%	0.26%	0.25%	1.10%	0.96%	1.02%	0.22%	0.59%	0.49%	0.54%	0.54%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	5	8	2	10	0	1	1	2	5	9	3	12	12		!
	Theatre Utilisation Model Hospital (Target > 85%)									80.3%	80.0%	81.3%				-
Outpatients	First to follow-up ratio (Target: <1.5)	2.07	2.20	2.18	2.19	1.84	1.88	1.72	1.79	1.98	2.07	1.98	2.03	2.03		!
	Average wait to first outpatient attendance (Target: <6 wks)	9.0	9.1	9.7	9.4	8.4	8.7	10.5	9.7	8.8	8.9	10.1	9.6	9.6		!
	DNA rate: first appointment	11.0%	10.2%	9.7%	9.9%	9.9%	10.3%	10.2%	10.3%	10.6%	10.3%	9.9%	10.1%	10.1%		-
	DNA rate: follow-up appointment	9.9%	9.0%	8.9%	8.9%	8.5%	8.0%	8.1%	8.0%	9.4%	8.6%	8.6%	8.6%	8.6%		-

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

DNA and Wait to 1st attendance: DNA rate has continued to improve across the Trust for both new and follow up appointments between April and May**.** Wait to 1st Appointment has increased, in line with the expectation previously outlined that as more new appointments are booked this metric will rise initially before dropping, as un-booked patients waiting are scheduled more quickly after triage.

New to Follow Up: Divisional plans continue to be developed to be in line with the 2022-23 Operating Plan and are being tracked via Elective Access and Outpatient Board. As noted in previous month, focus has shifted to reduction of follow up activity with patient's care being managed via new pathways, for example, patient initiated follow up and virtual appointments. The data suggests that these plans are yet to be implemented. The Cerner PIFU functionality has now been completed and there are services being set up to use the functionality, which should show improvement in the coming months.

Theatre Utilisation: There has been a noted slight improvement in Theatre Utilisation, however performance is still not at the expected 85% target. There are specific specialties with delays in starting the list and inter-case delays. The action plans to address these are taken through the theatre productivity meeting and addressed at divisional level.

Operations Cancelled same Day: As reflected in the performance reporting, a failing C-Arm (Mobile x-ray) machine in theatres at WM has impacted a number of lists with patients requiring cancellation on the day. Replacement devices have been procured and are expected in the Trust in June 22. All patients cancelled on the day with the exception of one were rebooked within the national target of 28 days.

Emergency Care Pathway (ALOS): A review of the noncompliance of this target has shown that this is due to outliers that require data amendment on the system. It is anticipated that following this correction the metric will return to compliance. A weekly review of all long stay patients continues and the number of patients staying in hospital >21 days has reduced in month.

Clinical Effectiveness

Clinical Effectiveness Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts
Best Practice	Dementia screening case finding (Target: >90%)	90.2%	97.6%	95.5%	96.5%	92.5%	95.0%	90.8%	92.9%	91.5%	96.2%	92.9%	94.5%	94.5%	
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	71.4%	47.4%	80.0%	61.8%	63.6%	83.3%	25.0%	47.8%	67.4%	64.9%	44.2%	53.8%	53.8%	
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	91.7%	100.0%	100.0%	100.0%	93.3%	94.4%	89.5%	91.9%	92.6%	97.5%	93.1%	95.7%	95.7%	
VTE	VTE: Hospital acquired	0	0	1	1	4	5	6	11	4	5	7	12	12	
	VTE risk assessment (Target: >95%)	89.2%	90.3%	91.9%	91.1%	96.3%	95.7%	96.6%	96.1%	92.9%	93.1%	94.4%	93.8%	93.8%	
TB Care	TB: Number of active cases identified and notified	4	5	3	8	9	8	13	21	13	13	16	29	29	
Sepsis	ED % of patients with high NEWS score screened for Sepsis	88.8%	92.4%	90.8%	91.5%	79.0%	82.0%	78.2%	80.0%	84.9%	88.0%	85.9%	86.9%	86.9%	
	ED % of patients at risk of developing sepsis receiving antibiotics	42.9%	44.9%	40.5%	42.3%	81.7%	82.8%	80.2%	81.4%	58.8%	63.6%	57.5%	60.2%	60.2%	
	ED % of patients at risk of developing sepsis receiving antibiotics within 1 hour	19.6%	21.0%	19.4%	20.1%	52.4%	56.5%	50.0%	53.1%	33.0%	38.5%	32.5%	35.2%	35.2%	
	AAU/AMU % of patients with high NEWS score screened for Sepsis	91.0%	95.4%	94.3%	94.8%	92.3%	95.4%	95.4%	95.4%	91.6%	95.4%	94.8%	95.1%	95.1%	
	AAU/AMU % of patients at risk of developing sepsis receiving antibiotics	94.0%	87.9%	93.7%	90.9%	96.3%	98.0%	95.7%	96.9%	95.1%	93.6%	94.8%	94.2%	94.2%	
	Inpatient Wards % of patients with high NEWS score screened for Sepsis	84.0%	87.9%	86.6%	87.2%	93.5%	94.9%	95.1%	95.0%	88.4%	91.4%	90.8%	91.1%	91.1%	
Improving outcomes for Inpatient diabetes patients	% of patients identified and triaged as having diabetes														
	Number of inpatient nurses/HCAs that have received 10-point training	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Length of stay for elective (surgical specialties only) patients with recorded diabetes	4.9	7.8	2.6	5.3	2.0	2.1	4.2	3.6	3.4	6.5	3.3	4.8	4.8	
Improving clinical handover	% staff trained on the principles of safe and effective handover (Target >=50%)	-	45.0%	-	45.0%	-	-	-	-	-	45.0%	-	45.0%	45.0%	
	% of handover meetings-medical downstream ward (Target >=95%)	-	95.0%	95.0%	95.0%	-	-	-	-	-	95.0%	95.0%	95.0%	95.0%	

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

Dementia screening: Compliance is noted across both sites which remain above the 90% target for the month of May.

VTE Risk Assessments: WMUH site continues to achieve the ≥ 95% target for VTE risk assessment. VTE root cause analysis is performed for HATs to ensure appropriate VTE prevention management with shared learning.

NoF Time to Theatre: Although the Trust has seen a marginal decrease in performance since the previous month, there has been significant improvement noted in the West Middlesex site. Of the patients who did not achieve surgery within the set timeframe in the Chelsea site, there were 9 medically unfit patients for surgery and 12 medically fit. For the medically fit patients these were due to pre-operative Echos (2), lack of specialist surgery availability for hip replacements (3), patient presenting having eaten (1) where this should have been *nil by mouth* and scheduling challenges/high volume trauma (6). In the West Middlesex site there were 7 patients breaching the timeframe. Four were medically unfit whilst three were due to list overrunning.

Clinical Handover: Junior doctor teaching in the principles of handover continues. Relaunch meeting scheduled for third week in July with excellent nursing representation as well as west Middlesex and surgical representation identified. A baseline audit is underway to identified areas of focus within current handovers in all MDT settings.

Access Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts	
RTT waits	RTT Incompletes 52 week Patients at month end	246	243	253	496	246	338	330	668	492	581	583	1164	1164		!
	Diagnostic waiting times <6 weeks: % (Target: >99%)	96.68%	96.39%	97.13%	96.76%	99.31%	99.56%	99.55%	99.55%	98.05%	98.03%	98.48%	98.27%	98.27%		!
	Diagnostic waiting times >6 weeks: breach actuals	124	135	107	242	28	18	21	39	152	153	128	281	281		-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	9.0%	8.7%	9.3%	9.0%	8.2%	7.5%	8.4%	8.0%	8.7%	8.3%	9.0%	8.7%	8.7%		!
	A&E time to treatment - Median (Target: <60')	00:32	00:29	00:33	00:31	01:06	01:06	01:08	01:07	00:46	00:45	00:47	00:46	00:46		!
	London Ambulance Service - patient handover 30' breaches	74	23	28	51	174	138	112	250	248	161	140	301	301		-
	London Ambulance Service - patient handover 60' breaches	10	0	3	3	30	7	5	12	40	7	8	15	15		!

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

RTT Incomplete: The teams continue to book patients in priority and chronological order to address the longest waiting. Plans to reduce outpatient waits, see patients on different pathways and improve theatre efficiency will result in improved RTT performance. The Trust continues its work to ensure data quality issues are minimised, the patient tracker lists are accurate and reported performance is as expected,

Diagnostic Waits < 6 weeks: May performance was marginally below the 99% target. The Trust remains committed to delivering the target with working groups in sub specialities set up to support improvements. May 2022 noted the majority of breaches in Cystoscopy and Echocardiography. Both services have increased capacity in June 2022 by utilising outsourcing provision, it is likely with this resource that breaches in these specialities will be mitigated in June 2022. Endoscopy across the Trust has seen improvements in its breach numbers in May 2022, this reflects the management support in ensuring the booking process is delivered and maintained.

LAS: The Trust continues to be amongst the highest performing in London in terms of ambulance handover times. We have continued to see a reduction in 30 minute handover breaches during the year with a focus on eliminating all 60 minute breaches.

RTT Positions Dashboard

		Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust Performance		
Domain	Indicator	Mar-22	Apr-22	May-22	Mar-22	Apr-22	May-22	Mar-22	Apr-22	May-22
RTT waiting list positions	Total RTT waiting list	26942	27453	27188	20525	21067	21447	47467	48520	48635
	Total Non-Admitted waiting list	21490	22211	22577	18026	18659	19302	39516	40870	41879
	Non-Admitted with a date	7035	10570	12978	8365	10951	12914	15400	21521	25892
	Non-Admitted without a date	14455	11641	9599	9661	7708	6388	24116	19349	15987
	Total Admitted waiting list	5452	5242	4611	2499	2408	2145	7951	7650	6756
	Admitted with a date	807	997	1119	540	655	797	1347	1652	1916
	Admitted without a date	4645	4245	3492	1959	1753	1348	6604	5998	4840
	Patients waiting >78 weeks	8	5	9	18	27	31	26	32	40
	Patients waiting >104 weeks	0	0	0	0	0	0	0	0	0

RTT 52 week waiters Specialty Dashboard

	Chelsea & Westminster Hospital Site			West Middlesex University Hospital Site			Combined Trust position		
Specialty Name	Mar-22	Apr-22	May-22	Mar-22	Apr-22	May-22	Mar-22	Apr-22	May-22
Total	**246**	**243**	**253**	**246**	**338**	**331**	**492**	**581**	**584**
Burns Care	1	2	3				1	2	3
Colorectal Surgery	3	2	1	3	14	20	6	16	21
Community Paediatrics		5	7					5	7
Dermatology	1	1	2	1	2	1	2	3	3
ENT	1		1	42	81	61	43	81	62
General Surgery	19	22	29	28	32	38	47	54	67
Gynaecology	3	2		1			4	2	
Maxillo-Facial Surgery	1	1					1	1	
Medical Endoscopy			1						1
Not Stated						1			1
Ophthalmology	10	12	10				10	12	10
Oral Surgery				6	8	3	6	8	3
Orthodontics		1						1	
Paediatric Clinical Immunology		1	4					1	4
Paediatric Dentistry	35	28	16				35	28	16
Paediatric Dermatology	2	2	5		3		2	5	5
Paediatric Ear Nose and Throat	4	5	3	3	7	13	7	12	16
Paediatric Gastroenterology			1						1
Paediatric Maxillo-Facial Surg	1	2	1			1	1	2	2
Paediatric Plastic Surgery	10	3	4				10	3	4
Paediatric Surgery	3	3	7		1	1	3	4	8
Paediatric Trauma and Orthopae			1		1	1		1	2
Paediatric Urology	2	1	2				2	1	2
Paediatrics		2	2					2	2
Pain Management	1	3	3				1	3	3
Plastic Surgery	35	41	39	21	20	33	56	61	72
Podiatric Surgery				1	2	2	1	2	2
Podiatry				1			1		
Trauma & Orthopaedics	27	20	21	6	5	5	33	25	26
Urology	71	64	63	15	17	26	86	81	89
Vascular Surgery	16	20	27	118	145	125	134	165	152

Maternity

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	Trend charts	
Workforce	Midwife to birth ratio (Target: 1:30)	1:28	1:28	1:28	1:27	1:29	1:29	1:29	1:28	1:28.5	1:28.5	1:28.5	1:28.50	1:27.5		-
	Hours dedicated consultant presence on labour ward (Target 1:98)	1:98	1:98	1:98	1:77	1:98	1:98	1:98	1:98	1:98	1:98	1:98	1:98.00	1:98.00		-
Birth indicators	Total number of NHS births	451	444	452	896	359	363	355	718	810	807	807	1614	1614		-
	Total number of bookings	508	551	557	1108	509	495	361	856	1017	1046	918	1964	1964		-
	Maternity 1:1 care in established labour (Target: >95%)	97.9%	97.5%	98.9%	98.2%	95.1%	96.3%	95.1%	95.7%	96.5%	96.9%	97.1%	97.0%	97.0%		-
Safety	Admissions >37/40 to NICU/SCBU	12	17	13	30	n/a	n/a	n/a	n/a	12	17	13	30	30		-
	Number of reported Serious Incidents	0	0	0	0	0	0	1	1	0	0	1	1	1		-
	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	4.9%	7.4%	7.5%	7.4%	8.4%	8.8%	7.2%	8.0%	6.5%	8.0%	7.4%	7.7%	7.7%		-
	Number of stillbirths	1	2	0	2	2	2	1	3	3	4	1	5	5		-
	Number of Infant deaths	0	1	0	1	0	1	0	1	0	2	0	2	2		-
	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%	0.0%	0.0%	0.0%	0.0%	0.0%	n/a	n/a	n/a	0.0%	0.0%		-
	Spontaneous unassisted vaginal births	30.3%	24.3%	24.9%	24.6%	30.7%	30.2%	32.5%	31.4%	30.5%	26.9%	28.3%	27.6%	27.6%		-
	Vaginal Births - spontaneous & induced	60.6%	56.4%	59.2%	57.8%	59.1%	58.9%	60.6%	59.8%	59.9%	57.6%	59.8%	58.7%	58.7%		-
	Instrumental deliveries	16.1%	19.5%	14.1%	16.8%	14.8%	15.5%	11.6%	13.6%	15.5%	17.7%	13.0%	15.4%	15.4%		-
	Pre-labour elective caesarean sections	75	75	71	146	48	38	47	85	123	113	118	231	231		-
	Emergency caesarean sections in labour	51	66	63	129	63	72	62	134	114	138	125	263	263		-

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

The above dashboard metrics covers: workforce, birth indicators, safety and clinical outcomes.

Workforce
The current midwifery ratios on each site are 1:28 at Chelsea and 1:29 at West Middlesex. We have now received the outcome of a recently commissioned birth rate plus analysis of the midwifery workforce and the recommended ratios are 1:24.9 Chelsea and 1:21.7 West Middlesex. Both sites are now compliant for the 98 hours dedicated consultant labour ward presence and twice a day ward rounds. The MIS year 4, safety action 4 indicates that we have to demonstrate an effective clinical workforce and acknowledge and incorporate the principles outlined in the RCOG 'Roles and responsibilities of the consultant in providing acute care in obstetrics and gynaecology' (appendix attached). This document will be embedded by 29th July and compliance monitored monthly from then.
Our attrition rate is still fluctuating widely since the pandemic. In May there were 452 births at the Chelsea site and 355 at the West Mid site, acuity and complexity of the women continue to be high. Demand/capacity planning strategy in place to ensure our activity does not vary widely compared to plan.

Safety
Our safety outcomes remain stable and we are not an outlier for stillbirth or infant deaths across the sector.
SIs: At the WMUH site there was 1 Si in May of a full term baby born by caesarean section who was transferred out for cooling and of note there was an early notification of concern in April that was received due to neonatal care received by the baby on the special care baby unit. A full response has been shared with HSIB and a detailed action plan is in place. For the Chelsea site there were no SI's in May.

Avoidable term admissions to NICU: At the WMUH site, there were a number of admissions in May. There is ongoing work with regards to hypothermia and transitional care on the postnatal ward to reduce admissions for these causes.
Stillbirths and neonatal deaths: PMRT (MIS SA1 and Ockenden There have been a backlog of review of cases due staffing pressures but the team have now allocated a midwife who will work closely alongside the two consultants (currently each 1PA per week). There was 1 late fetal loss (22-24 weeks) and one antenatal stillbirth (24-27weeks). There were early or late neonatal deaths.

Outcomes
Preterm birth: The national target is to reduce the PTB rate to 6% by 2025 and Ockenden SA9. At the Chelsea site the PTB rate was 7.5% (30 women affected). Of these14 were spontaneous, 16 iatrogenic). 8 women had a PTB <34 weeks and 4 of these were IUTs from other units. 5 births were <30 weeks and 80% were given magnesium sulphate (one was not given as birth was imminent and unavoidable). A preterm birth debrief service is now embedded for these women and their families and provides preconception care to address risk factors such as smoking, preconception folic acid and early use of aspirin. We now have a lead midwife and obstetrician cross site for this service. The WMUH site does not have a dedicated service and service redesign is in progress.

The service in preparing for its Ockenden assurance visit that will take place in July in relation to full compliance against the 7 IEA's from the interim report. From June additional metrics will be reported on from the perinatal quality surveillance model.

62 day Cancer referrals by tumour site Dashboard
Target of 85%

Domain	Tumour site	Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance					Trust data 13 months	
		Mar-22	Apr-22	May-22	2022-2023	YTD breaches	Mar-22	Apr-22	May-22	2022-2023	YTD breaches	Mar-22	Apr-22	May-22	2022-2023 Q1	2022-2023	YTD breaches	Trend charts
62 day Cancer referrals by site of tumour	Breast	100%	n/a	n/a	n/a		89.5%	75.0%	91.7%	75.0%	2	90.0%	75.0%	91.7%	75.0%	75.0%	2	-
	Colorectal / Lower GI	53.8%	100%	83.3%	100%	0.5	77.3%	83.3%	40.9%	83.3%	7.5	68.6%	87.5%	50.0%	87.5%	87.5%	8	!
	Gynaecological	50.0%	n/a	80.0%	n/a	0.5	66.7%	87.5%	80.0%	87.5%	1	57.1%	87.5%	80.0%	87.5%	87.5%	1.5	-
	Haematological	80.0%	50.0%	50.0%	50.0%	1.5	85.7%	50.0%	33.3%	50.0%	2.5	83.3%	50.0%	40.0%	50.0%	50.0%	4	!
	Head and neck	100%	100%	n/a	100%	0	n/a	n/a	0.0%		1.5	100%	100%	0.0%	100%	100%	1.5	-
	Lung	80.0%	n/a	n/a	n/a		50.0%	n/a	100%		0	66.7%	n/a	100%	n/a	n/a	0	-
	Sarcoma	n/a	n/a	n/a	n/a		n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a		-
	Skin	91.3%	100%	92.3%	100%	0.5	73.3%	50.0%	66.7%	50.0%	6.5	84.2%	77.8%	78.6%	77.8%	77.8%	7	!
	Upper gastrointestinal	100%	0.0%	n/a	0.0%	0.5	80.0%	100%	80.0%	100%	1	81.8%	50.0%	80.0%	50.0%	50.0%	1.5	!
	Urological	89.5%	93.8%	58.3%	93.8%	5.5	82.4%	92.5%	58.5%	92.5%	10	86.1%	92.9%	58.5%	92.9%	92.9%	15.5	-
	Urological (Testicular)	n/a	n/a	n/a	n/a		n/a	n/a	n/a			n/a	n/a	n/a	n/a	n/a		-
	Site not stated	n/a	n/a	n/a	n/a		100%	100%	n/a	100%	0	100%	100%	n/a	100%	100%	0	-

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-22) and are not included in quarterly or yearly totals	

Trust Commentary

62-Day for May 2022 is currently non-compliant. This is expected to improve as patients treatment status are confirmed but is projected to be non-compliant for the month. Complex patients as well as delays in histology have broadly driven this position, increasing the length of patient's pathways.

Tumour Site	Chelsea & Westminster		West Middlesex	
	Breaches	Treatments	Breaches	Treatments
Breast			1	4
Gynaecology			0.5	4
Haematology	0.5	1	0.5	1
Head and Neck		2.5	0	0
Colorectal	0	2	1	6
Other			0	2
Skin		10	4	8
Upper GI	0.5	0.5	0	0.5
Urology	0.5	8	1.5	20
Brain			0	0.5
Total:	1.5	24	8.5	46

Safer Staffing

Chelsea and Westminster Site (May 22)

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	108%	69%	98%	97%	8.6	2.9	11.4	12.5		10.22%	14.14%	19.48%									89.34%
Annie Zunz	131%	97%	102%	100%	7.2	3	10.2	7.5		9.79%	19.12%	0%	1	1							100%
Apollo	95%	-	88%	-	14.7	0	14.7	N/A		12.70%	39.01%	50%									
Mercury	98%	-	97%	-	7.6	0	7.6	10.1		19.84%	15.01%	50%		1							95.83%
Neptune	120%	-	122%	-	10.3	0	10.3	12.5		47.15%	44.21%	0%		1							81.69%
NICU	92%	-	91%	-	14.2	0	14.4	26.8		15.34%	16.70%	0%									100%
AAU	107%	53%	105%	78%	8.2	1.7	10	7.8		6.57%	11.13%	40.47%	5	11							96.29%
Nell Gwynne	100%	70%	117%	78%	4.5	3.6	8	6.9		23.12%	11.96%	33.95%	3	9							98%
David Erskine	97%	79%	100%	91%	4.8	3.3	8.5	7.2		3.05%	37.21%	10.46%									1
Edgar Horne	98%	76%	100%	103%	3.3	2.6	6	6.6		28.86%	11.43%	41.41%	4	11			1	1			98%
Lord Wigram	89%	90%	102%	104%	4.1	2.9	7	7.1		20.31%	20.98%	8.80%		1			1	1			96%
St Mary Abbots	98%	85%	127%	103%	4	2.5	6.6	7.1		25.02%	17.23%	19.96%	1	3							93.33%
David Evans	84%	88%	93%	105%	6.4	2	8.9	7.1		-5.74%	13.20%	12.24%		1	1	1					95%
Chelsea Wing	105%	88%	105%	74%	8.2	4.2	12.4	7.1		15.92%	21.43%	13.43%	1	4							
Burns Unit	79%	97%	125%	148%	16.9	4.3	21.2	N/A		7.60%	4.27%	0%	3	5							
Ron Johnson	92%	140%	101%	153%	4.6	3.8	8.4	7.4		14.92%	16.55%	25.00%	3	5		1					100%
ICU	108%	33%	110%	37%	29.7	2.6	32.4	26.8		-5.47%	9.74%	0%									1
Rainsford Mowlem	75%	68%	94%	83%	3	3.1	6.6	6.8		13.54%	18.74%	9.93%	5	10							100%

West Middlesex Site (May 22)

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	102%	124%	104%	150%	3.2	3.7	7.1	6.8		3.33%	18.84%	6.30%	3	6							100.00%
Richmond	54%	0.46	92%	151%	5.1	2.5	7.6	7.1		8.92%	0%	28.57%	2	7							100.00%
Syon 1 cardiology	101%	91%	99%	132%	4.2	2.2	6.4	9.5		8.84%	3.77%	30.12%	3	7	1	1					100%
Syon 2	103%	92%	101%	107%	3.6	3.2	7	7.2		13.87%	16.56%	6.67%	7	4							96.92%
Starlight	91%	-	114%	-	7.5	0	7.5	12.5		15.93%	25.41%	100%									77.27%
Kew	97%	120%	100%	130%	3.1	3.6	6.9	6.9		16.51%	19.51%	19.86%	3	8							100.00%
Crane	80%	44%	87%	76%	4.5	2.7	7.3	7.3		12.49%	12%	12.27%	4	10							100.00%
Osterley 1	98%	83%	103%	122%	3.8	3.1	7.1	7.1		3.14%	9.35%	26.02%	4	5		1					100.00%
Osterley 2	90%	76%	100%	144%	3.9	2.6	6.6	7.1		3.25%	3.92%	4.55%	2	6							100.00%
MAU	84%	85%	98%	102%	5.8	2.5	8.4	7.8		21.14%	14.80%	21.58%	6	15							99%
Maternity	85%	80%	89%	88%	8.1	2.6	10.6	12.5		12.96%	11.06%	14.63%	1	1							88.27%
Special Care Baby Unit	94%	100%	98%	100%	8.6	2	10.6	12.5		8.16%	7.88%	0.00%									100%
Marble Hill 1	116%	95%	97%	201%	3.8	3.3	7.2	6.6		18.32%	15.62%	7.46%	2	10							97.44%
Marble Hill 2	103%	101%	104%	172%	3.7	3.6	7.5	6.1		5.17%	28.16%	5%	3	5							100.00%
ICU	103%	1.2	107%	0.87	27.8	2.5	30.3	26.8		-12.98%	10%	0%									

Safe Staffing & Patient Quality Indicator Report

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & Midwifery staffing fill rates and Care Hours per Patient Day (CHPPD). This is then benchmarked against the national benchmark and triangulated with associated quality indicators and patient experience for the same month. Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience. Vacancy and turnover data is taken from April 2022.

There were high fill rates on Lampton due to additional HCAs being booked for frail confused patients at high risk of falls for both days and nights. On Syon 1, Kew, Marble Hill 1 and Marble Hill 2 extra HCAs were booked for patients requiring one to one for various reasons including mental health issues, high risk of falls, and confused wandering patients. Crane staffing was adjusted according to bed occupancy. Osterley 1 & 2 had high fill rates on nights due to confused wandering patients who needed close observation. On Osterley 2 during the day and on the medical wards at the Chelsea Site HCA fill rate was low due to vacancies which were not filled by bank or agency staff.

On St Mary Abbots staffing was increased from 3 to 4 RNs at night due to high acuity. On David Evans the numbers of RNs on days was increased due to high activity.
On Burns staffing fill rates low during the day but supplemented by Ward Manager and Matron. Fill rates increased at night for RNs and HCAs due to the volume of specials required to ensure close observation of patients. At the Chelsea site there were fill rates of HCAs on days on ICU and on nights on ICU and Chelsea Wing as HCAs were deployed to other wards to assist. On Ron Johnson two patients on the ward required close observation by HCAs. High fill rate on Annie Zunz was due to the Surgical Admissions Lounge being based on there.
Low fill rates on the West Mid maternity unit was supplemented by specialist and practice development midwives (PDMs) working clinically. Nine Maternity Support Workers (MSWs) vacancies have now been filled and expected to start by the end of July. 3.5wte newly qualified midwives started in May, but the vacancy gap will not be closed until the Internationally Recruited midwives arrive and pass their OSCE (over the next 6 months), and there will be a significant number of newly qualified midwives in October. At the Chelsea Site maternity unit, 6 new MSWs are due to start in the next six weeks which will support an increase in fill rate for the non-qualified workforce. Maternity nursing posts are currently out to advert to support inpatient staffing. Temporary staffing and redeployment of specialist midwives and PDMs were used to maintain safe staffing. Action plan in place to improve FFT satisfaction rates.
High fill rates on Neptune are due to the high number of patients requiring RMNS. The establishments between Jupiter and Neptune have still not amalgamated yet and therefore are showing a higher vacancy rates than is the case.

In terms of incidents with harm: a patient was admitted with a stage 2 pressure ulcer on Lord Wigram that deteriorated, a patient on Syon 1 had a fall with severe harm and sadly died and a patient on David Evans fell and sustained a fractured neck of femur.
Friends and Family test showed 5 wards at CW and 7 wards at WM scored 100%, with Maternity & Paediatrics showing the lowest satisfaction rates, a number of the issues raised on Starlight relate to long wait in ED.

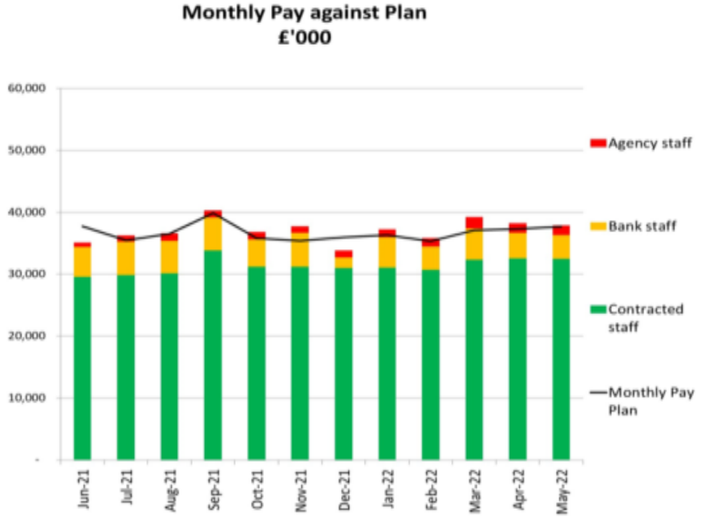
Please note all incident figures are correct at time of extraction from Datix. Red flags are now being reported and for April 20 flags were raised, 8 for CW & 12 for West Mid, mainly related to staffing shortfalls.

Finance M2 (May 2022) 2022/2023

£'000	Plan to Date	Actual to Date	Variance to Date
Income	133,541	130,770	(2,771)
Expenditure			
Pay	(71,147)	(76,086)	(4,940)
Non-Pay	(54,873)	(50,272)	4,600
EBITDA	7,522	4,412	(3,110)
EBITDA %	5.63%	3.37%	-2.3%
Depreciation	(5,324)	(4,670)	654
Non-Operational Exp-Inc	(2,759)	(2,589)	170
Surplus/Deficit	(561)	(2,846)	(2,286)
Control total Adjs	169	131	(38)
Adjusted Surplus/Deficit	(392)	(2,716)	(2,324)

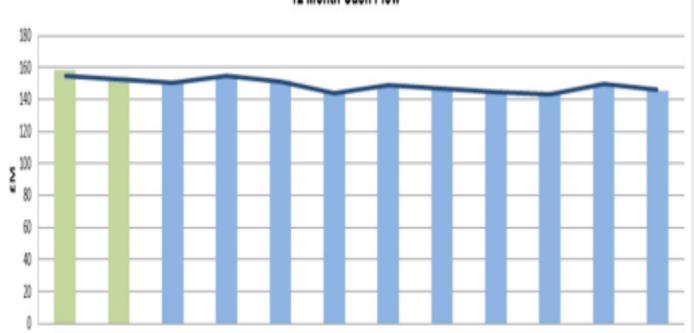
The adjusted financial position at month 2 is a £2.7m deficit, which against the revised plan is a £2.3m adverse variance. This is primarily driven by slippage on CIP schemes and underperformance on ERF.
Pay is £4.9m adverse against plan at month 2. Material variances include CIP slippage, premium cover for sickness, vacancies and other staff absences.
Income is £2.8m adverse YTD against the plan. Patient Care Income £0.2m adverse position is predominantly driven by ERF underperformance, Sexual health income £0.2m favourable to plan, Private Patient income £0.3m favourable to plan, Overseas patient income £0.1m adverse to plan. The position includes ERF income at just 25% minimum levels due to under recovery on targets, this is driven by high levels of staff sickness and Covid pressures in the first 2 months of 2022/23.

Monthly Pay against Plan
£'000



Comment: The exceptional March 2022 payroll figures which included the 6.3% Pension contribution (£16.1m - a notional figure) hflas been stripped out for better comparison. September 2021 payroll figures include YTD backdated pay awards for AFC staff, Consultants and Career grade doctors. An estimate for the 2022/21 pay uplift has been included from April 2022.

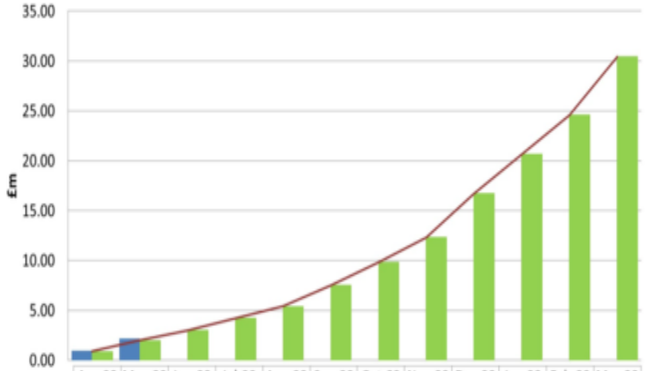
12 Month Cash Flow



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Forecast		-	150.41	155.06	151.96	144.82	149.29	147.25	145.11	143.05	149.61	145.71
Actual	158.42	154.00										
Plan	154.63	152.66	150.42	155.06	151.18	144.21	148.85	146.98	145.00	143.11	149.85	146.11

Comment:
The favourable cash variance to plan in M2 of £1.3m is favourable cash variance b/fwd from M1 of £0.6m, Higher receipts to plan of £1.2m (CCG £0.3m Higher, Local Authority-£0.2m Lower, Donations -£0.1m Lower, NHS England £0.2m Higher , AR £0.3m Higher, PP Income £0.3mHigher, FT's -£0.5m Lower, Health Education £0.9m Higher) offset by Higher cash outflows to plan £0.5m (Higher creditor payments).

Capital Expenditure against Plan



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Actual	0.96	2.15										
Forecast	0.90	2.00	3.00	4.21	5.40	7.53	9.83	12.33	16.71	20.66	24.59	30.44
Plan	0.90	2.00	3.00	4.21	5.40	7.53	9.83	12.33	16.71	20.66	24.59	30.42

Comment:
The Trust has spent £1.2m in month2 2022/23 compared to the original budget of £1.1m, resulting in an overspend of £0.1m. The spend year to date is £2.2mcompared to the planned position of £2.0m, resulting in an overspend of £0.2m. The capital forecast for the year is £30.4m which is apportioned between the areas as follows; Estates £20.3m; Medical Equipment £3.9m; IT £6.0m; Non-Medical Equipment £0.2m and Central Contingency £0.1m. Each area has prepared individual project budgets for their areas.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Maternity improvement plan (service users voices)

July 2022

Quality committee

Victoria Cochrane (Director of Midwifery & Gynaecology) & Amy Dignam (Maternity Voices Partnership Chair)

Maternity improvement programme: 2022/23

The maternity department is working to achieve recommendations outlined in multiple national and local reports. The aim of this paper is to summarise these recommendations into a single comprehensive improvement plan for the directorate and update on our progress. Each time the paper is presented there will be a focus topic.

This paper is to provide report provides assurance to quality committee on how we are progressing the recommendations that will make the greatest impact on quality, safety and patient experience.

This papers focus topic is on service user experience (survey on ethnicity & maternity experience and cultural safety programme of work, CQC survey and action plan and the maternity voices partnership and work plan).

Drivers of the maternity improvement programme

Focus areas	Key drivers
Quality & Safety	• Ockenden report • 10 point maternity safety plan (MIS yr 4) • MBBRACE recommendations • Better Births continuity of carer • Maternity transformation programme
Patient Experience	• Family and friends test feedback • Healthwatch reports • Survey of BAME women's experience • CQC survey • Complaints and compliments
Staff experience & wellbeing	• Staff survey
Effective & efficient	• Covid-19 recovery • CIP target

In addition, a programme of locally owned research, innovation and QI projects

Maternity improvement programme

Delivering high-quality, patient-centred care

Workstream 1 Quality & safety

Priority 4:
Ockenden
Aim: To improve the safety and outcomes of maternal and neonatal care
KPIs: delivery of 7 IEAs (interim report) and 15 IEAs (final report)
Lead: HOM, DOM, CD, MQAS
Reports to: WIG, Women's services Directorate Board, Quality Committee

Priority 2:
MMBRACE-UK
Aim: Ensure compliance with published reports
-Implement recommendations on MBRRACE: Stillbirths and neonatal deaths in twin pregnancies
- delivery against 8 themes
Lead: Maternity safety champions & MQAS
KPIs: *GAP analysis against recommendations*
Reports to*:* Cross-site MQAS, WIG, Divisional Quality Committee

Priority 3:
Compliance with the 10 measures of the NHSR incentive scheme for CNST *Aim*:
Achieve 10 requirements of the incentive scheme by August
KPIs: delivery against 10 safety action
Lead: HOM, DOM, CD
Reports to: WIG, Women's services Directorate Board

Patient Experience

Workstream 2 patient experience

Priority 1:
Increase continuity of carer
Aim: increase no. of women booked onto a Continuity of carer (MCoC) pathway to >50% by March 2023
KPIs: No of women booked onto CoC pathway
Lead: DOM/Consultant midwife
Reports to: WIG, Improvement Board, LMS

Priority 5..
Saving babies lives care bundle v2
Aim: To improve the safety and outcomes of maternal and neonatal care
KPI: 5 Elements with specific measures
Lead: HOM, DOM, Service Leads
Reports to: WIG, Maternity Forum, Service Quality Meeting CW

Other work :
- BFI re-accreditation
- Service user surveys and MVP work plan
- QA assurance – screening, CQC
- Guideline
- PMRT (M & M)
- VTE compliance
- Reducing inequalities/ E&E strategy and

Be the employer of choice

Workstream 3 Workforce

Priority 6:
Improving staff retention & staff survey results
Aim: Create Staff development opportunities and cultural safety
KPIs: 90% mandatory training and appraisals Maternity staff survey

Leads: HOMs, PDMs and PMA's
Reports to: WIG

Priority 7:
Improve staff wellbeing
- Health and wellbeing
- Diversity and inclusion
- Recovery post-Covid

Leads: HoMs, SDs
KPIs: Staff survey metrics, sickness
Reports to: Divisional Board, POD

Priority 8:
Grip
- Skill mix
- Roster management
- Recruitment/Vacancy/ turnover
- Temporary staffing
- Job planning
- Leave management

Reports to: P&I
Leads: DOM, HR Partners, service leads
KPIs: turnover, vacancy, safer staffing

Deliver better care at lower cost

Workstream 4 Efficient and effective

Priority 9:
Improving flow and reducing LOS. focused on three pathways
- IOL
- Elective section
- Postnatal

Aim: CW: reduce average LOS to 2.6
WM: maintain LOS at 1.9 days
KPIs*:* LOS, numbers of readmissions
Leads: HOM, DOM, Matrons, Clinical Lead
Reports to: MCIG, Bed Productivity

Priority 10:
NWL Maternity helpline project
Aim: Implementation of sector-wide maternity helpline
Lead: HOMs & service director
Reports to: Local Maternity System

Priority 11:
Maternity digital solution (K2)
Aim: Implementation of electronic patient record
Lead: Clare Baker, Lyndsey Smith, Francesca Hanks
Reports to: Maternity planning meeting: WIG, Directorate Board
KPIs: : MSDS , coding, tarif

Other work:
Demand and capacity planning

Surveying women's experiences in maternity services – Ethnicity & Maternity Care

The survey was locally designed by the maternity voices partnership in collaboration with the senior team to understand the experiences of women from Black, Asian and minority ethnic background from between 6/8/20 – 7/2/21 with 373 responses

176 of responses equating to 47% of respondents were from a Black, Asian or minority ethnic background and the majority felt this made a difference to the care they received.

Generally the scores were middle to high in satisfaction across all questions – where scores were lowest in satisfaction these related to:

- Not feeling like they received personalised care & not always feeling listened to and heard.
- Accurate recording of medical history is very important to women and they didn't always feel we did this well and lacked continuity in terms of having to repeat their history often.
- 50% of women did not feel they had been given a choice of place of birth.
- They were more likely to have difficulty understanding and speaking English.

Listening event held virtually in March 21 where women invited to give further feedback – 16 in attendance

Surveying women's experiences in maternity services – Ethnicity & Maternity Care

Suggestions for improvement from women:

- More diverse staff group
- Better resources for language and support
- Listen and hear
- More checks/scans
- Better organisation and communication
- Training on bias – improve staff attitude
- Better pain relief options and support
- Continuity of midwifery care
- Peer support groups
- Hear women the first time – shouldn't have to raise concerns multiple times
- Provide all information and options
- More compassion and kindness – being too busy no longer good enough

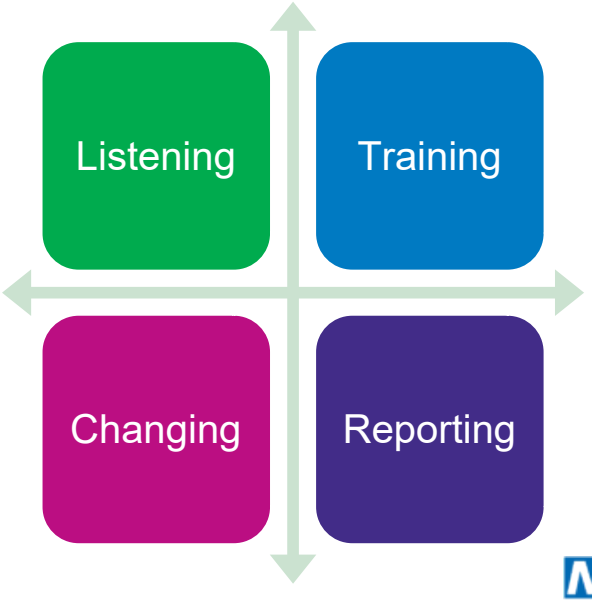
- A detailed action plan was taken through the directorate and division and is monitored via the Trust Patient experience group
- Report of the survey was provided to the cultural safety group to inform their improvement plans and actions.
- The survey is planned to be repeated in December 2022

Showcase: Maternity Cultural safety and inclusion

Segment from Maternity's EDI Statement:
We are committed to improving equality, diversity and inclusion to ensure that our Maternity Services delivers high quality care to all women and birthing peoples and optimises career progression opportunities for all members of staff. We intend to bring about the real organisational change required, within our maternity service, to reflect these values.
We aim to achieve these changes by:
Embedding a culture of compassion, where speaking out against witnessed or experienced discrimination, racism or abuse is supported and encouraged.

CAPITAL midwife

THE QUEER BIRTH CLUB

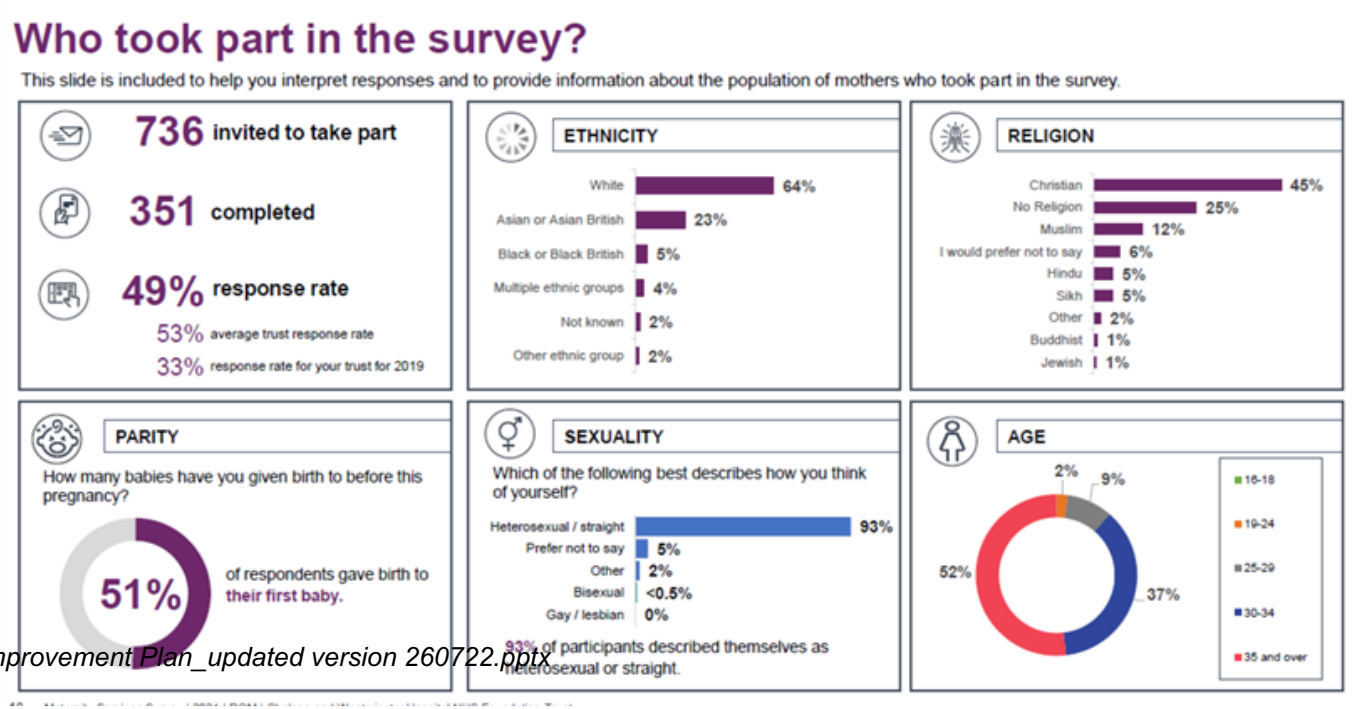


Maternity Cultural safety and inclusion- action plan

What	Detail	By when /completed	By whom
Launch Cultural safety champions across maternity	Who the team are, email inbox and work plan	Completed – March 2021	CSC
Staff cultural safety survey	Understand staff views of inclusion and development opportunities	Ongoing (delayed due to omicron crisis)	JH & CSC
Cultural safety champion boards	Photo and Bio of all CSC visible for service users and staff	Completed – May 2021	CSC & DOM
Training	Select and deliver external training to CSC on antiracism, LGBTQ+ and disability issues	Completed- November 2021	CSC & DOM
Cultural safety champions to attend- anti-racism, cultural safety and well-being training	Develop competence and skill-set	Completed- November 2021	DOM/HOMs
Book club	Knowledge translation of EDI issues	Started September 2021- on-going	CSC
Review of the website	To include EDI, CSC and email inbox for service users to contact	Completed- February 2021	CSC
Anti-racism framework- bronze award	Capital midwife accreditation scheme	September 2022	CSC
Development and delivery of sector wide in house training	Focusing on anti-racism, LGBTQ+ and disability issues	September 2022	JH
Evaluation of the work	Evaluation of the success of the project	December 2022	JH
Support the development and implementation of MCoC teams	Work with the senior team to support the implementation of MCoC teams that focus on women from Black, Asian and Minority Ethnic backgrounds	On-going (October 2025 full implementation)	CSC/DOM
Support capital midwife fellows who are also CSC focused project on interpreting on wheels	Each capital midwife fellow has a project and based on the survey our 2 will focus on a QI project related to interpreting	March 2022	CSC

Introduction to the CQC survey

- The CQC maternity survey sent in November to all users of maternity services that birthed in the prior February. Results are released in May.
- This lag in time must be considered as QI projects may have already been enacted to address the concerns raised.
- Results are provided both as base scores (out of ten) and as comparisons with comparable and local units. It is made clear if trusts score in the top or bottom five of an area within their region.

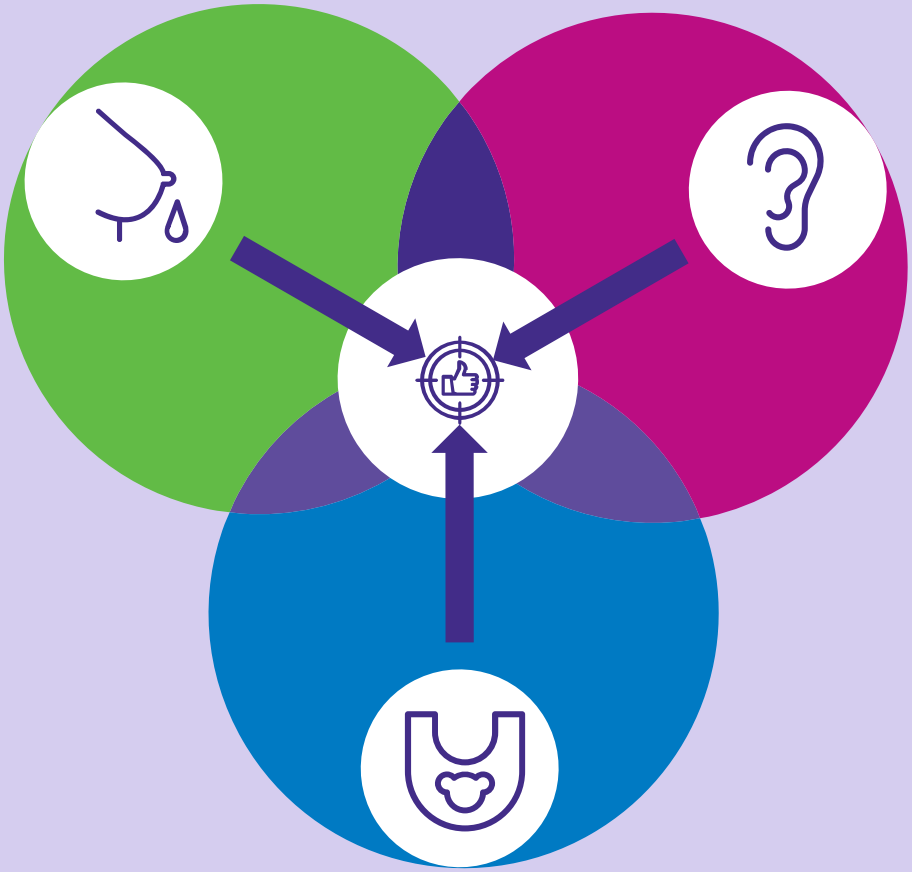


CQC survey

Area	Chelsea & Westminster	Imperial	UCLH	St Georges	Hillingdon	LNW	GSTT
Start of care during your pregnancy	5.5	5.4	4.4	5.7	4.8	4.9	4.7
Antenatal check ups	7.9	7.7	7.5	8.2	7.9	8.3	7.2
During your pregnancy	8.0	8.0	7.6	8.3	8.0	8.2	7.7
Your labour and birth	8.3	8.7	7.8	8.5	7.8	8.2	8.0
Staff caring for you	8.4	8.5	8.2	8.4	7.8	8.1	8.1
Care in hospital after birth	6.6	7.0	6.4	6.6	7.4	6.8	6.1
Feeding your baby	8.0	8.1	7.9	8.1	8.5	8.5	8.0
Care at home after birth	7.4	7.2	No score given	7.0	7.6	7.3	7.2

Highlighted scores top five in London

2022/23 Action plan



A - Listening

A – Parent Reported Experience Measures

B – Listening rounds

B - Feeding support

A – Review pathway

B – Expand infant feeding team on WM site

C - Postnatal care

A – Expand nursery and staff nurses

B – Discharge pathway QI project

C – Healthwatch Richmond action plan

MVP – Who We Are

Chelsea and Westminster Maternity Voices

What We Do

- Build Trust and create safe space for ALL service users
- Consistent and regular communication with the trust and with our service users
- Feedback - collection, acknowledgement and action
- Presence and participation
- Co-production of services

What we achieved last year

- Working with the senior team to support services users in the pandemic- attend the Covid calls, reviewing the pathways, facebook lives and continuous update of the website
- Ethnicity survey & MVP chair as co-chair for CSC group
- Represented Trust QI at external conferences

MVP work plan 2022-23

Ongoing MVP Meetings and regular lay member only meetings	Hold listening events of specific areas	Walk the Patch and 15 Steps	Ongoing feedback collection
Develop & implement plan to increase service user involvement, especially amongst underrepresented groups	Attending and working together with the Cultural Safety Champions	Co-production of improvements of IoL pathway, CoC and postnatal area	Review and co-design service changes related to LGBTQ+ community
LMNS MVP Chairs' meeting	London MVP meetings	Meetings with Project Managers	LMNS MTP Pillar meetings (1,2 and 3)

Appendix 1: CQC survey – results, actions and deliverables

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of mothers who took part in the survey.

736 invited to take part

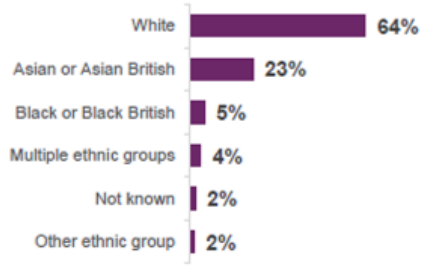
351 completed

49% response rate

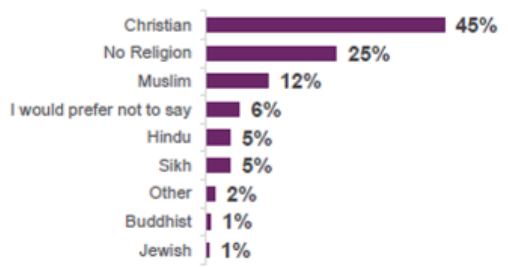
53% average trust response rate

33% response rate for your trust for 2019

ETHNICITY



RELIGION



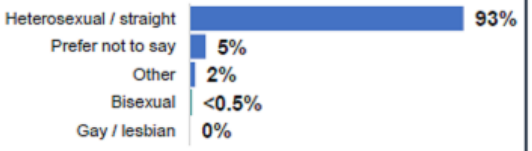
PARITY

How many babies have you given birth to before this pregnancy?

of respondents gave birth to **their first baby.**

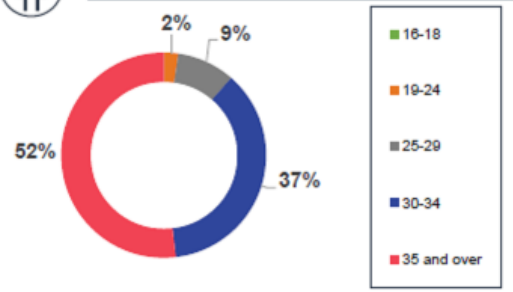
SEXUALITY

Which of the following best describes how you think of yourself?



93% of participants described themselves as heterosexual or straight.

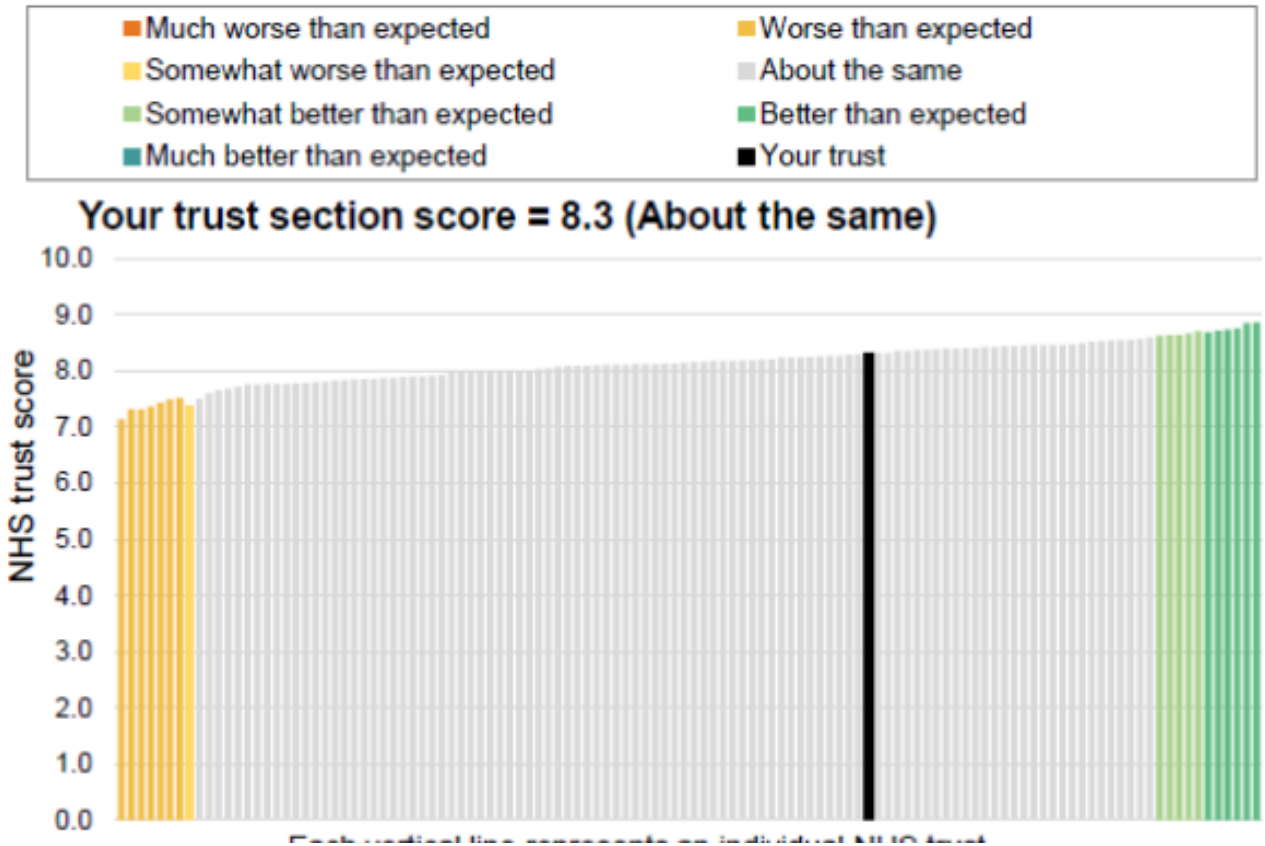
AGE



Changes over time – labour and birth

Question	2021 result	2019 result	
At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.0	8.9	
*If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	8.5	9.7	
*Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	2.3 *NB covid impact	7.5	
If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.2	9.0	
On the day you left hospital, was your discharge delayed for any reason?	6.6	4.9	
Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.8	8.4	

No significant differences in antenatal or postnatal care over time


Much worse than expected
Worse than expected
Somewhat worse than expected
About the same
Somewhat better than expected
Better than expected
Much better than expected
Your trust
Your trust section score = 8.3 (About the same)
NHS trust score
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0

Comparisons

Area	Chelsea & Westminster	Imperial	UCLH	St Georges	Hillingdon	LNW	GSTT
Start of care during your pregnancy	5.5	5.4	4.4	5.7	4.8	4.9	4.7
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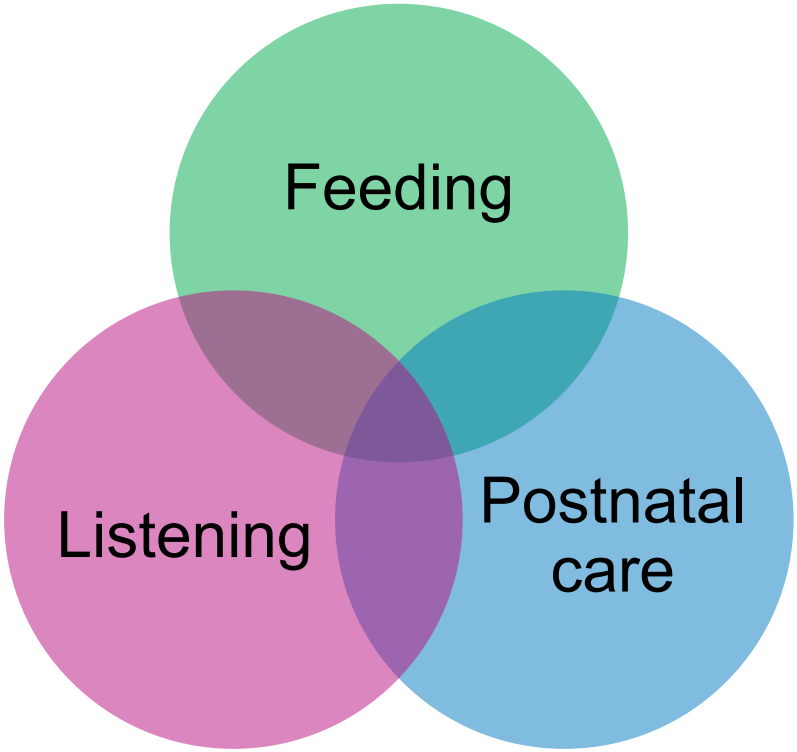
Your labour and birth	8.3	8.7	7.8	8.5	7.8	8.2	8.0
Staff caring for you	8.4	8.5	8.2	8.4	7.8	8.1	8.1
Care in hospital after birth	6.6	7.0	6.4	6.6	7.4	6.8	6.1
Feeding your baby	8.0	8.1	7.9	8.1	8.5	8.5	8.0
Care at home after birth	7.4	7.2	No score given	7.0	7.6	7.3	7.2

Yellow highlighted scores for CW indicate top five in London
Red highlighted scores for Hillingdon indicate bottom five for London

Themes for action



Feeding

Only area that we performed ‘worse than expected’

Scored low on out of hours support, antenatal information and somewhat low on active support for feeding

Action: review of feeding support throughout pathway

Person responsible: James Harris

Key deliverable: summary ‘mini CQC survey’ in October showing improved outcomes

Listening

Scored low on being able to get a member of staff to help when they needed, being left alone at a time that worried them and having an opportunity to ask questions about the labor and birth, asking about mental health during pregnancy and speaking to a midwife as much as wanted

Significant decrease in raised concerns being taken seriously

Theme that is linked to Ockenden report, and therefore actions from that to be incorporated into this theme

Postnatal care

Compared to others in the sector, this is the area we are performing least well in.

Women highlight not being able to talk to staff as much as they would like, and not receiving information about physical recovery or mental health issues

Action: review of postnatal pathway, staffing and information giving

Person responsible: Ally Downey/Marina Wingham, matrons

Sunita Sharma/Susan Barnes/Philippe De Rosnay Obstetric Leads

Key deliverable: summary ‘mini CQC survey’ in October showing improved outcomes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public Meeting, 7th June 2022

AGENDA ITEM NO.	3.1
TITLE OF REPORT	Board Business Cycle 2022-23
AUTHOR NAME AND ROLE	Daryl Lutchmaya, Interim Deputy Director of Corporate Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Daryl Lutchmaya, Interim Deputy Director of Corporate Governance
THE PURPOSE OF THE REPORT Decision/Approval: X Assurance: Info Only: Advice: Please tick below and then describe the requirement in the opposite column	To present the Board Business Cycle for 22-23 in accordance with best practice governance. To note that this may evolve during the course of the year as our approach to collaborative working develops within the acute provider collaborative.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee / Date of Meeting / Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	Best practice governance recommends that Boards hold a business cycle/forward plan which demonstrates how they will fulfil their duties and statutory responsibilities throughout the course of the year. The attached business cycle is proposed for the Public Board meetings of Chelsea and Westminster Hospital NHS Foundation Trust. As we develop our acute provider collaborative model, the business cycle may change and evolve.
KEY RISKS ARISING FROM THIS REPORT	
STRATEGIC PRIORITIES THAT THIS PAPER SUPPORTS (please confirm Y/N)	

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

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

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

BOARD OF DIRECTORS CYCLE OF BUSINESS 2022-2023 – PUBLIC BOARD

Item	May	July	Sept	Nov	Jan	March	Lead	Assuring Committee
Apologies for Absence	X	X	X	X	X	X		
Minutes of the Last Meeting	X	X	X	X	X	X		
Declarations of Interest	X	X	X	X	X	X		
Action Log and Matters Arising	X	X	X	X	X	X		
Chair's Report	X	X	X	X	X	X	Chair	
Chief Executive's Report	X	X	X	X	X	X	Chief Executive	
Patient Story/Staff Story/Service Presentation	X	X	X	X	X	X	Chief Nurse	
Integrated Performance and Quality Report	X	X	X	X	X	X	Deputy CEO/Chief Operating Officer	QC
Elective Recovery Plan Report	X	X	X	X	X	X	Deputy CEO/Chief Operating Officer	QC
Learning from Serious Incidents Report	X	X	X	X	X	X	Chief Nurse	QC
People Performance Report	X	X	X	X	X	X	Director of People and OD	POD
Quarterly Items								
	May	July	Sept	Nov	Jan	March	Lead	Assuring Committee
Board Assurance Framework	X		X		X		Director of Corp Gov and Compliance	ARC
Risk Assurance Framework							Chief Nurse	ARC

Maternity Improvement Report	X	X	X	X	X	X	Chief Nurse	QC
Learning from Deaths/Mortality Report	X		X		X	X	Chief Medical Officer	QC
Improvement programme and Quality Priorities Progress Report			X	X		X	Chief Nurse	QC
Guardian of Safe Working Report	~~X~~	X		X		X	Chief Medical Officer	POD
Freedom to Speak Up Report (as defined in national NHSE/I FTSU guidance)		X			X		Direc of HR and OD	POD
Annual Items								
Complaints Annual Report		X					Chief Nurse	QC
Health and Safety Annual Report			X				Chief Nurse	FIC
Safeguarding Annual Report			X				Chief Nurse	QC
Infection Prevention and Control Annual Report		X					Chief Nurse	QC
National Inpatient Survey Results and Improvement Plan							Chief Nurse	QC
Bi-Annual Safer Staffing Report			X			X	Chief Nurse	QC
GMC Results and Improvement Plan				X			Chief Medical Officer	POD
Staff Survey Results and Improvement Plan	X						Dir of HR and OD	POD
Medical Appraisal and Revalidation Annual Report			X				Chief Medical Officer	POD
NMC Annual Report			X				Chief Nurse	POD
Equalities & Diversity (EDI) Annual Report inc WRES,WDES and Gender Pay Gap	~~X~~	X		X			Dir of HR and OD	POD
Annual Patient Equality Report			X				Chief Nurse	QC
Winter Plan				X			COO	
Seasonal Flu Plan				X			COO	
Annual Report and Accounts		X					Chief Finance Officer	ARC
Annual Governance Statement		X					Director of Corp Governance and Compliance	ARC

Emergency Planning Core Standards Annual Report (EPRR)	X						Deputy CEO/Chief Operating Officer	FIC
Review of Risk Management Strategy			X				Chief Nurse/Dir of Corp Gov and Compliance	ARC
Standing Financial Instructions, Standing Orders and Scheme of Delegation	X						Chief Finance Officer/Dir of Corp Gov and Compliance	ARC
Research Strategy and associated governance- Annual Update			X				Chief Medical Officer	QC
Board Self Certification Declarations		X					Dir of Corp Gov and Compliance	ARC
Report on Board Committee and Board Effectiveness and Terms of Reference						X	Dir of Corp Gov and Compliance	ARC
Board Committee Terms of Reference approval: Quality Committee; Finance and Investment Committee; People and Organisational Development Committee; Audit and Risk Committee	X						Dir of Corp Gov and Compliance	ALL
Guardian of Safe Working Report Q4 2021/22		X					Chief Medical Officer	
As and When Required								
Sustainability Strategy (for approval)							Chief Financial Officer	FIC
Estates Strategy							Dep CEO/Chief Operating Officer	FIC
Digital Strategy and IT and Innovation Strategy							Dep CEO/CCIO	FIC
Research and Innovation Strategy							Chief Medical Officer	QC
People Strategy							Dir of HR and	POD

Patient and Public Engagement and Experience Strategy 2019-2024 – progress update (Board action)								
Quality Strategy							Chief Nurse	QC
Financial Strategy							Chief Finance Officer	FIC
Externally facilitated developmental review of leadership and governance using the NHSI well-led framework (every three – five years)							Dir of Corp Gov and Compliance	ARC
Outline/Full Business Cases							As approp	FIC
CQC and Other Relevant Regulatory Reports							Chief Nurse/Dir of Corp Gov and Comp	QC
Appointment of the Senior Independent Director							Chair	CoG
Amendments to the Foundation Trust Constitution							Dir of Corp Gov and Compliance	CoG
Review of Transactions Policy							Chief Finance Officer	FIC and CoG
Award of Legal Contracts							Chief Nurse	
Application of the Trust Seal	X			X			Dir of Corp Gov and Compliance	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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TITLE AND DATE (of meeting at which the report is to be presented)	*Public Board* *7th July 2022*

AGENDA ITEM NO.	
TITLE OF REPORT	Learning from Serious Incidents (April and May 2022 data)
AUTHOR NAME AND ROLE	Stacey Humphries, Quality and Clinical Governance Assurance Manager
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Bleasdale, Chief Nursing Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	This paper provides an update on the process compliance, key metrics and learning opportunities arising from Serious Incident investigations.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Patient Safety Group — Date of Meeting: 25/05/2022 & 22/06/2022 — Outcome: Name of Committee: Quality Committee — Date of Meeting: 05/07/2022 — Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	During the 12 month period ending in May 2022 the Trust reported 78 serious incidents (SIs). In April/May 2022 the Trust declared 10 SIs (CW 5, WM 5). A never-event concerning patient identification (wrong site surgery) occurred during this reporting period. There were 10 SI reports approved by the Divisional Serious Incident panel and the Chief Nurse/Medical Director and submitted to the NWL Collaborative (Commissioners). Common causal factors contributing to serious incidents include: • Ineffective communication (Inc. handover) • Complexity of patients clinical condition • Documentation incomplete or not contemporaneous • Staffing: Low staff to patient ratio/ High acuity • Procedural or Task Design: Sub optimal/Poorly designed process Thematic review of causal factors supports the identification and delivery of the organisations Divisional and Trust-wide Quality Priorities.
KEY RISKS ARISING FROM THIS REPORT	• Critical external findings linked patient harm • Reputational risk associated with Never Events.

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

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

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

1. Introduction

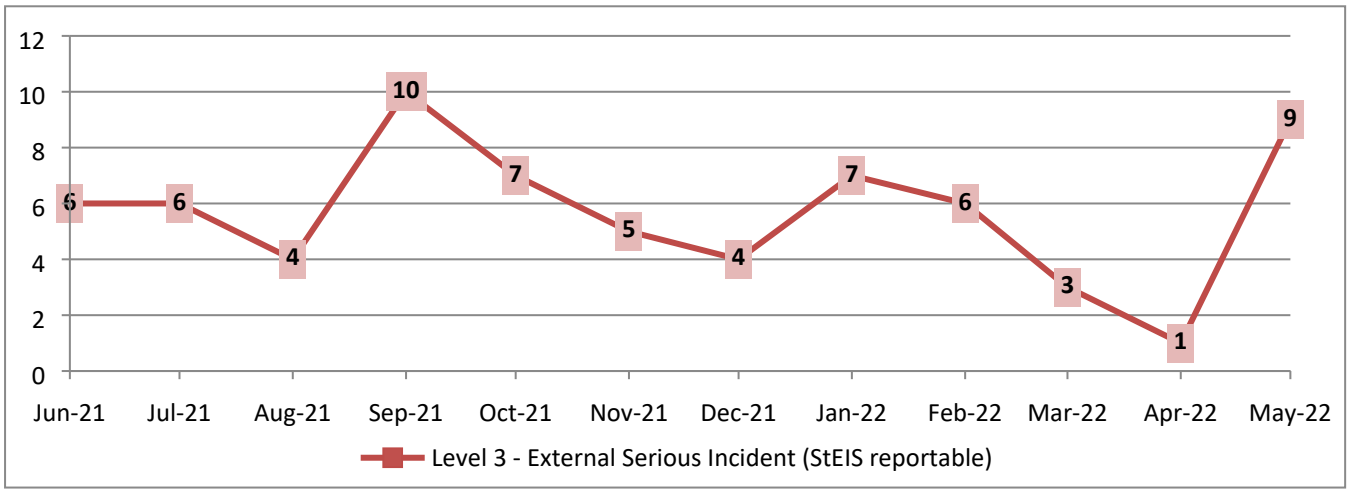
The Chelsea and Westminster Hospital NHS Foundation Trust is committed to the provision of high quality, patient centred care. Responding appropriately when things go wrong is one of the ways the Trust demonstrates its commitment to continually improve the safety of the services it provides.

Serious Incidents are adverse events where the consequences to patients, families, staff or the organisations are so significant or the potential for learning so great, that a heightened level of response is justified. When events of this kind occur the organisation undertakes comprehensive investigations using root cause analysis (RCA) techniques to identify any sub-optimal systems or processes that contributed to the occurrence. The Trust is mandated to report these events on the Strategic Executive Information System (StEIS) and share investigation reports with our commissioners.

Outcomes from both External Serious Incidents are considered at Divisional Quality Boards, Patient Safety Group, Executive Management Board, and the Quality Committee so that learning can be shared and improvements enacted.

2. Serious Incidents activity last 12 months

Between June 2021 and May 2022 the Trust declared 68 External Serious Incidents (30 CW/ 38 WM)



Graph 1: SIs declared by month declared between June 2021 and May 2022

A Never Event, wrong implant, occurred in July 2021 (ref 2021/14007). A second Never Event, wrong site surgery, occurred in September 2021 (ref. 2021/18242). A third Never Event, wrong site surgery, occurred in May 2022 (ref. 2022/10537).

3. Serious Incidents reported April/May 2022

The Trust declared 10 External Serious Incident Investigation:

Division	Site	Ward or Specialty	Ref	Brief description
April 2022				
WCHGD	CW	Paediatric ED	INC94450	Delayed diagnosis of menigo-enchephalitis.
May 2022				
CSD	CW	Imaging	INC96631	Never event. Incorrect patient underwent an interventional radiology procedure
CSD	CW	Outpatients	INC95910	Delayed diagnosis of cancer
CSD	CW	Imaging	INC95565	Delayed diagnosis of cancer
CSD	WM	Gynaecology	INC96262	Delayed diagnosis of cancer
EIC	WM	Outpatients	INC91969	Treatment delay (medication)
EIC	WM	Syon 1 Ward	INC96031	Patient fall resulting in acute subdural haematoma
PCD	CW	Intensive Care Unit	INC94605	Sub-optimal response to a deteriorating patient
PCD	WM	Osterley 1 Ward	INC95775	Patient fall resulting in fracture
WCHGD	WM	Maternity	INC95766	HSIB case. Baby transferred to tertiary unit for cooling

Table 1: External SIs declared in April/May 2022

The investigations into these events will seek to identify any care or service delivery problems that impacted the outcome and establish actions to reduce the risk or consequence of the event recurring.

4. External Serious Incident completed April & May 2022

Following review and agreement by the Divisional Serious Incident Panel and the Chief Nursing Officer 10 Serious Incident reports were submitted to the NWL Collaborative (Commissioners).

Division	Site	StEIS Category	Specialty	StEIS ref.	Degree of harm
April 2022					
CORP	WM	Major incident - Power outage	Estates Operations	2022/2216	No harm
PCD	WM	Patient fall	General Surgery	2022/1089	No harm
EIC	CW	Patient fall	Acute Medicine	2022/122	Severe harm
EIC	WM	Patient fall	Diabetes/Endocrine	2021/25090	Death
WCHGD	CW	Maternity/Obstetric incident: baby only	Maternity / Obstetrics	2021/24410	Moderate harm
WCHGD	WM	Maternity/Obstetric incident: mother and baby	Maternity / Obstetrics	2022/1899	No harm
May 2022					
EIC	WM	Patient fall	Kew ward	2022/3283	Severe
CSD	WM	Diagnostic incident	Imaging	2021/25811	Low
WCHGD	CW	Maternity/Obstetric incident: mother only	Labour ward	2021/20904	No harm
WCHGD	WM	Maternity/Obstetric incident: mother only	Labour Ward	2021/23573	Moderate

Table 3: External SI reports submitted to the Commissioners in April/May2022

5. Learning from Serious Incidents

The Serious Incident investigations are designed to identify weaknesses in our systems and processes that could lead to harm occurring. It is incumbent on the Trust to continually strive to reduce the occurrence of avoidable harm by embedding effective controls and a robust programme of quality improvement.

Lessons learned are shared at multiple forums including specialty MDT meetings, Clinical Governance half days and divisional quality boards. Departmental newsletters and the monthly serious incident report also highlight findings from SI investigations.

5.1. Serious Incident action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan is developed to address these factors. Action plan completion is monitored by the Patient Safety Group and the Executive Management Board to ensure barriers to completion are addressed and change is introduced across the organisation (when required).

5.1.1. Measuring the effectiveness of Serious Incident actions

In the majority of cases serious incidents occur not because there were no controls in place at the time but because the existing controls failed. The organisation has implemented a process designed to measure the effectiveness of actions arising from serious incident investigations. The focus is on type of control recommended (hierarchy of controls) and the impact the control is expected to have at mitigating the likelihood and/or consequence (criticality score).

There are 15 actions recorded as a strong action and with a criticality score of 5 thus meaning the action is deemed essential to the management and reduction of the risk.

14 of these actions have been completed and include the following:

- Cease using stainless steel heads within hip replacement surgery
- Amend maternity appointment pathway relating to patient not attending (next appointment made for non-English speaking patients before they leave current appointment, no patients discharged from the clinic system until a next appointment is booked).
- Demand and capacity analysis in the ophthalmology clinic undertaken September 2021 (deficit of 63 slots a week).
- Patient Access Process maps and roles and responsibilities of admin staff involved in ophthalmology booking process developed to ensure standardisation and clarify functions
- Mini pilot; spycra dressing introduced to prevent shearing and friction to patients with neck injuries. Colleagues have attended training and will roll-out to teams.

Monitoring the effectiveness of SI actions to examine whether highly criticality controls are embedded and effective will provide assurance that the Trust is learning from Serious Incidents.

5.2. Causal factors

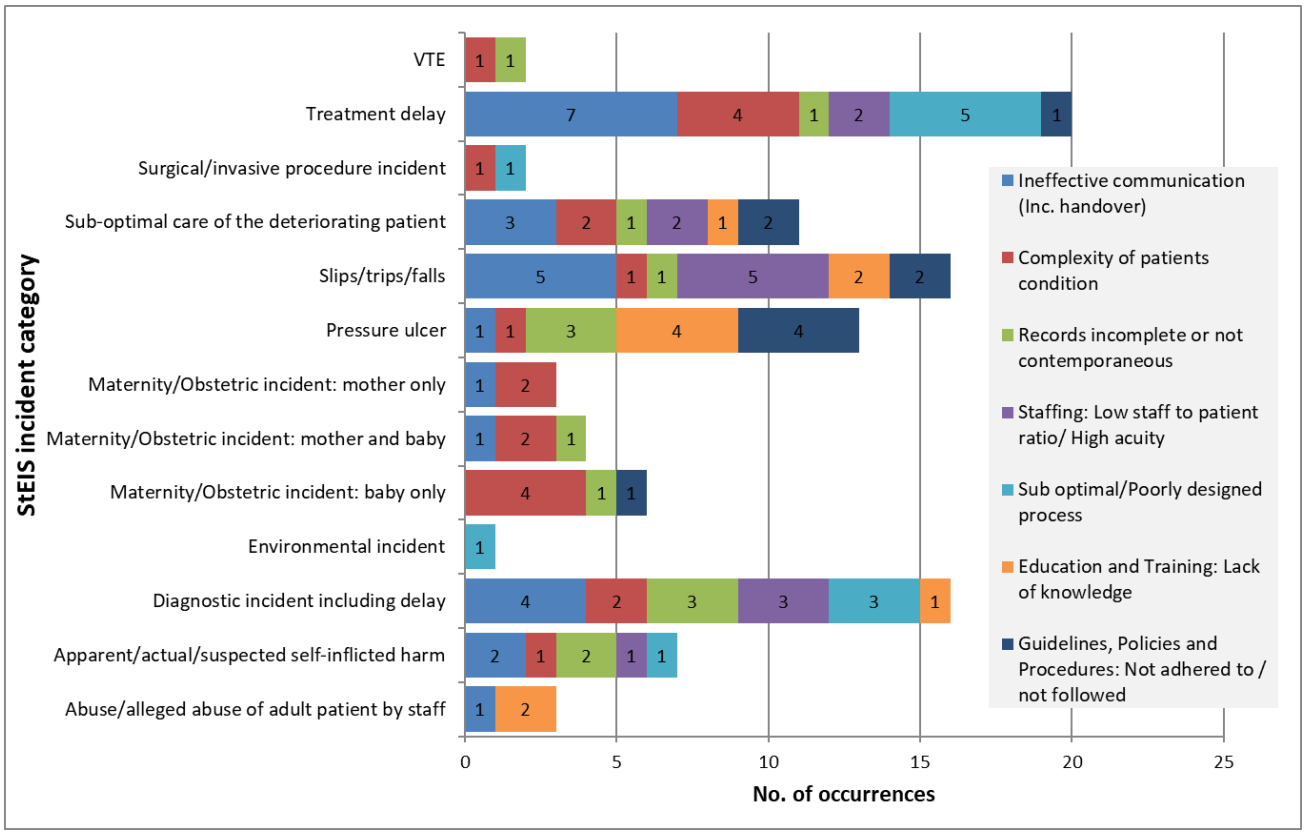
Serious Incident investigations explore problems in care, the contributing factors to such problems and the root causes (i.e the underlying/fundamental issues). To support understanding, a process of reviewing the causal factors has been implemented to identify commonalities across External Serious Incidents submitted to Commissioners (excluding HSIB maternity SIs).

This process does not seek to weight the occurrence of a causal factor according to their influence on an event, but merely to identify their occurrence; this provides increased insight into the more common factors associated with serious incident investigation and increases the opportunity to identify overarching improvement actions.

In the past 12 months to May 2022, 55 external SI reports have been reviewed. Common causal factors contributing to serious incidents include:

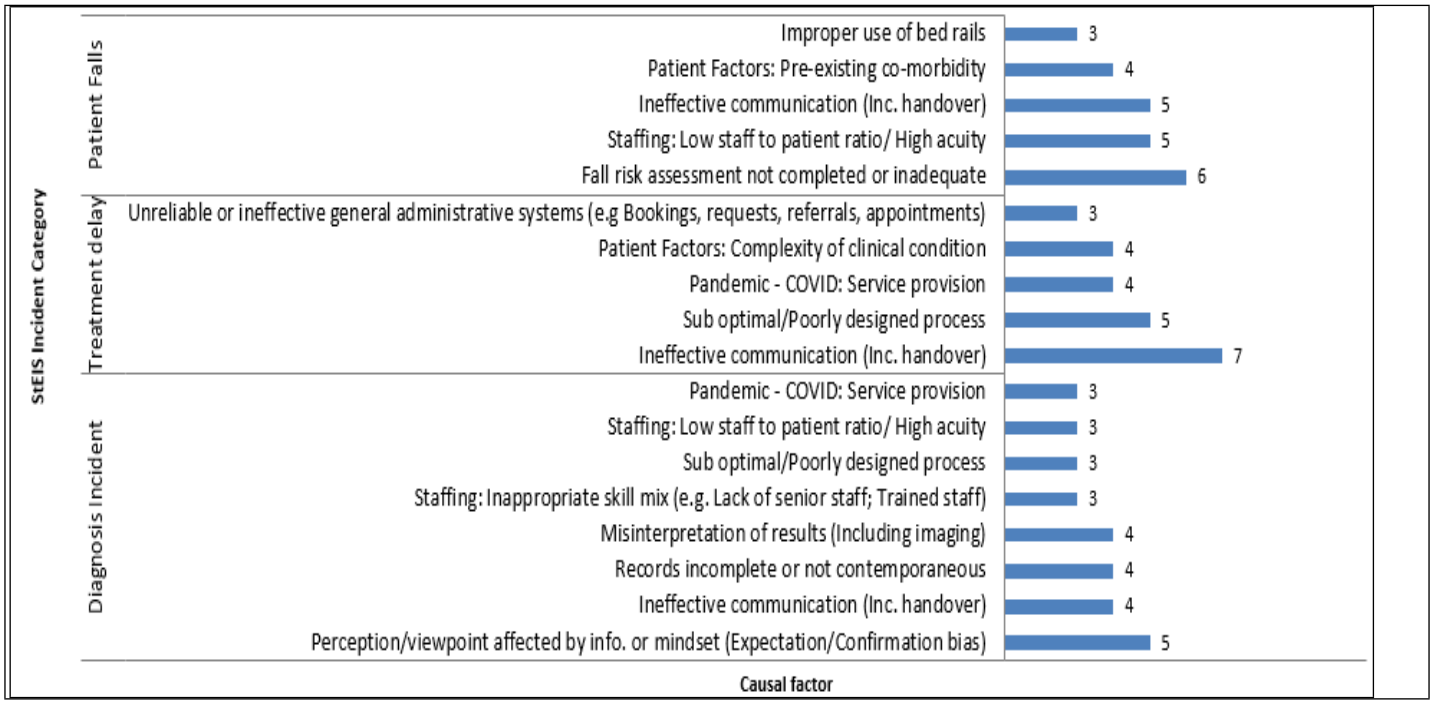
- Ineffective communication (Inc. handover)- 25 SIs
- Complexity of patients clinical condition – 21 SIs
- Documentation incomplete or not contemporaneous – 14 SIs
- Staffing: Low staff to patient ratio/ High acuity – 13 SIs
- Procedural or Task Design: Sub optimal/Poorly designed process – 11 SIs

The chart below highlights the most commonly occurring causal factors and the StEIS incident category they are attributed to.



Graph 2: Top occurring causal factors (External SI reports submitted between June 2021 and May 2022)

The chart below highlights the most common root cause, contributory factor or care/service delivery issues for the three highest reported external SI incident categories:



Graph 3: Common causal factors for the highest reported external SI categories

The Trust invests in an integrated governance approach that regularly considers learning from Incidents, Patient Feedback (complaints, concerns, and patient experience), mortality review, outcomes of claims and inquests. The triangulation of causal factors is used to inform both the establishment and delivery of our quality priorities.

Our 2022/23 quality priorities are to:

- Improve patient safety—reducing the risk of inpatient falls with harm
- Improve effectiveness and outcomes—improving clinical handover
- Improve patient experience—timeliness and quality of communication with patients and primary care
- Responsiveness—improving end-of-life care

6. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Key themes will be submitted to the Patient Safety Group and the Executive Management Group for consideration of requirement for further Quality Improvement Projects, deep-dives, or targeted action. Updates on these programmes of work will be reported to the Quality Committee.

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TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Public 7th July 2022

AGENDA ITEM NO.	4.2
TITLE OF REPORT	**PALS and Complaints Annual Report**
AUTHOR NAME AND ROLE	Lee Watson, Director of Nursing
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Bleasdale, Chief Nurse
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: X Advice: Please tick below and then describe the requirement in the opposite column	Annual PALS and Complaints report for financial year 2021-22
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: EMB — Date of Meeting: 22/06/22 — Outcome: Approved Name of Committee: Quality Committee — Date of Meeting: 05/07/22 — Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	• During 2021-22, the Trust received a total of 449 complaints which equates to an average of 9 complaints per week. This is an increase of 15% against the number of complaints received during 2020-21 (390). • The PALS and Complaints Team has not consistently met the target of 95% of responses being sent within 25 working days of receipt of the complaint. However, we recovered the position in March 2022 and we are back on track to meet this target going forward. • 443 out of the 449 complaints received and investigated during 2021-22 were completed at the time of this report. • During the year, we received contact from the PHSO regarding four complaints they assessed during 2021-22. We received a decision on four cases they have investigated, two for EIC Division were partly upheld and one for EIC was not upheld and one for WCH Division was not upheld. As at 1st April 2022, there was one open complaint with them for investigation for CSS Division. • During 2021-22, the PALS team resolved 1412 concerns, this is an increase of 58% from 2020-21 (896). • The PALS team logged a total of 614 compliments on Datix during the year 2021-22, an increase from 499 the previous year.
KEY RISKS ARISING FROM THIS REPORT	Reputational risk associated with not meeting the Quality priorities and the trust targets.

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

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

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

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

Annual Report

Patient Advice and Liaison Service (PALS) and Complaints Team

2021-2022

1. Introduction

Chelsea & Westminster NHS Foundation Trust comprise two acute hospital sites; West Middlesex University Hospital and Chelsea and Westminster Hospital. Both sites deliver specialist and general hospital care to our patients, have major A&E departments and the Trust also provides the second largest maternity service in England.

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

The Trust serves a catchment area in excess of one million people an employs over 6,000 staff. The Trust's main health commissioning and social care partnership is the North West London Integrated Care System which covers the following areas:

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

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

They are:

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

This report summarises the activity in relation to informal concerns and formal complaints for Chelsea and Westminster NHS Foundation Trust during 2021/22.

2. Definitions

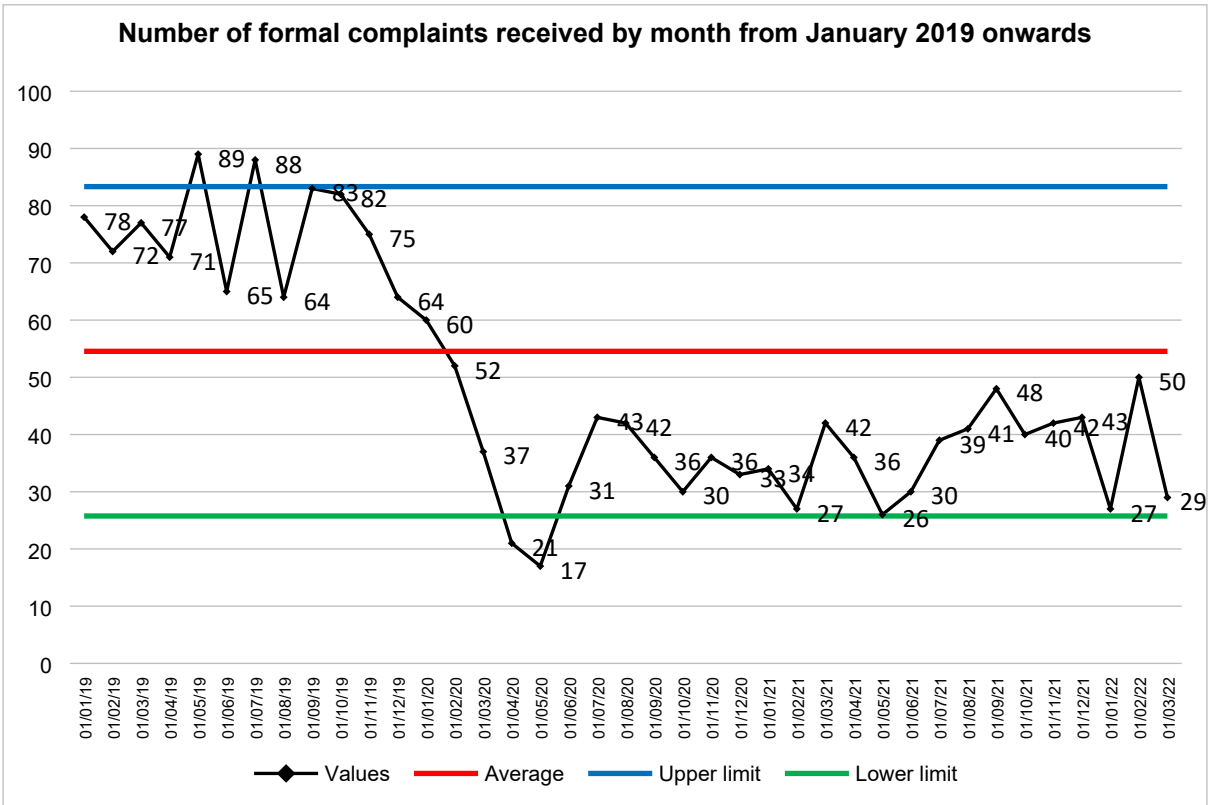
Informal concerns relate to those issues raised to the Patient Advice and Liaison Service (PALS) which aims to resolve issues quickly and at source and where this is not possible to resolve the issue within 5 working days.

Formal complaints relate to concerns raised through the formal Trust process. Complaints are acknowledged within 2 working days, assigned to the appropriate division and investigated and repsonded to within 25 working days.

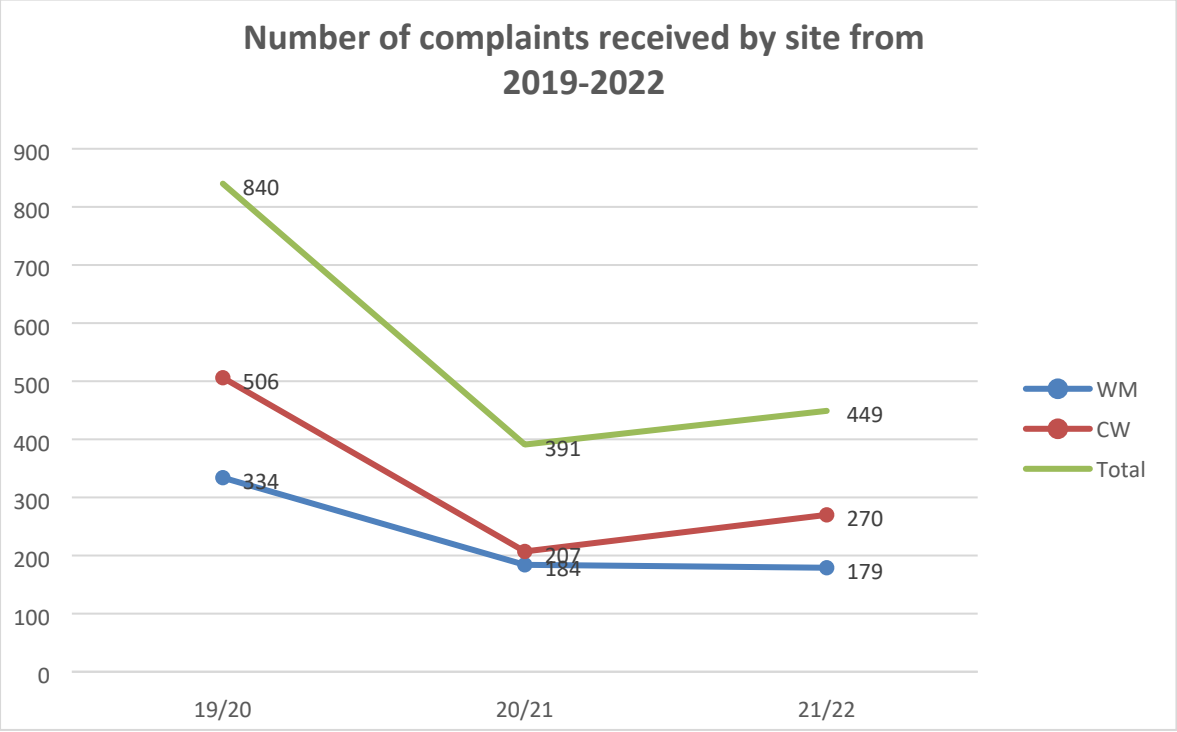
3. Complaints received during 2021/22

During 2021-22, the Trust received a total of **449** complaints which equates to an average of 9 complaints per week. This is an increase of 15% against the number of complaints received during 2020-21 (390).

The SPC chart below demonstrates the number of complaints received in each month during 2021-22 compared to the previous year.



Broken down by site:



The graph below shows the number of complaints received by Division and site during 21-22:

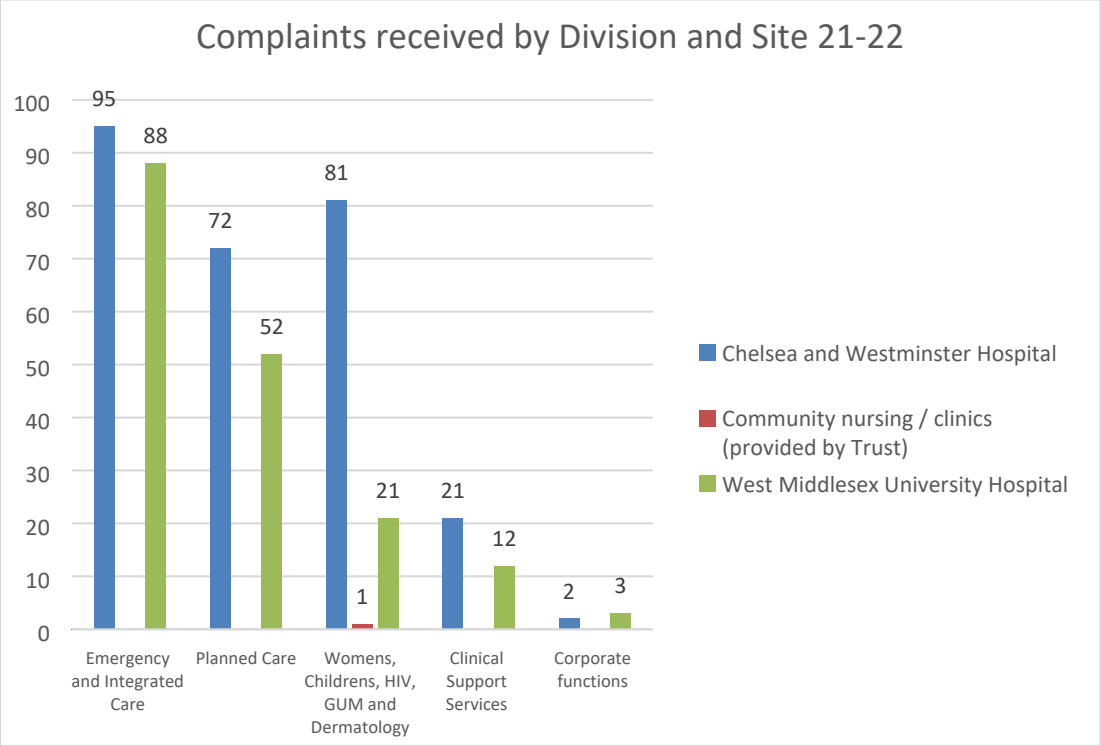
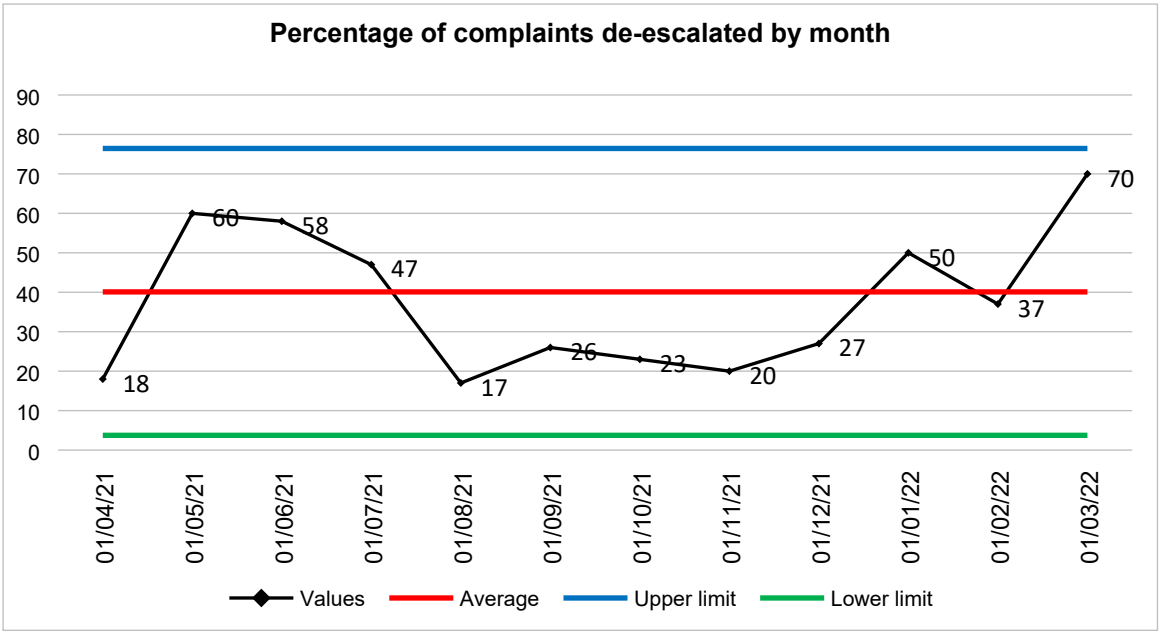


Table 1 below shows the number of logged complaints and concerns received by Division compared with the previous year.

Division	Complaints 2021/22	Concerns 2021/22	Divisional Total 2021/22	Complaints 2020/21	Concerns 2020/21	Divisional Total 2020/21
Corporate	5	12	17	5	17	22
Emergency and Integrated Care	183	270	453	160	222	383
Planned Care	124	354	478	84	209	293
Clinical Support Service	33	490	523	33	263	296
Womens Division	104	287	391	108	185	293
TOTAL	**449**	**1413**	**1,862**	**390**	**896**	**1,286**

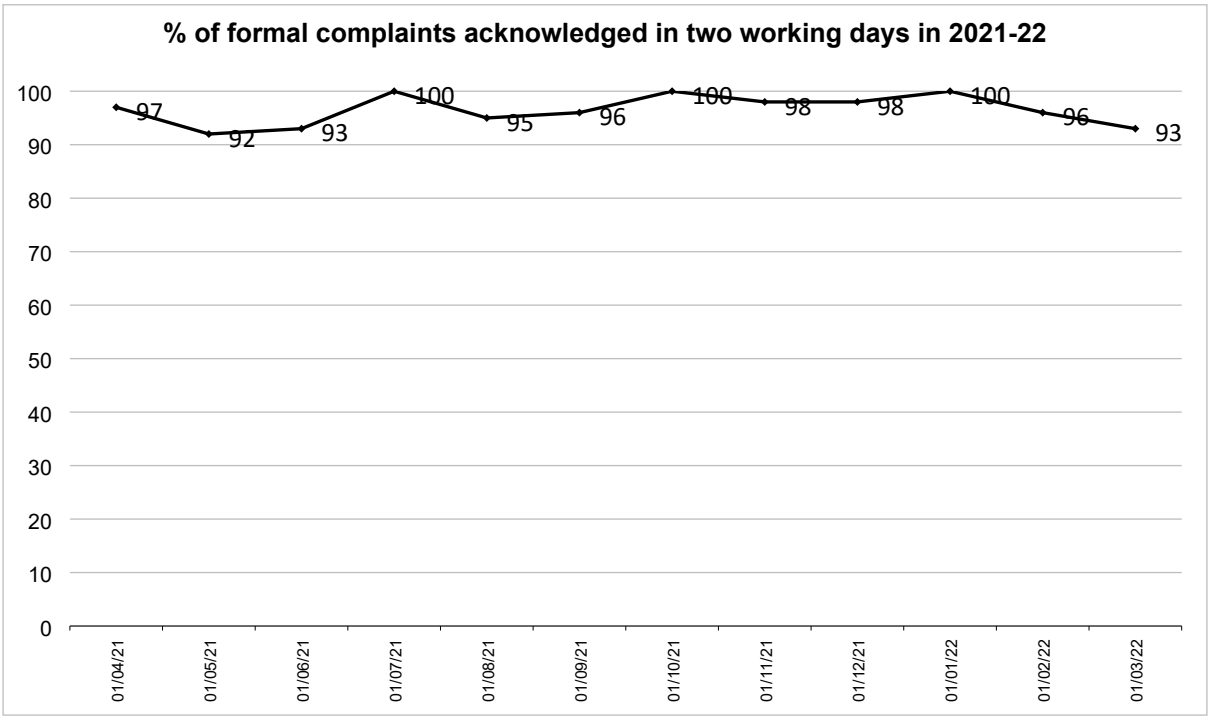
There has been an increase in complaints and PALS concerns received across the board on last year after the COVID-19 pandemic. The PALS and Complaints Team have actively de-escalated complaints where possible in order to provide instant resolution for the patient and their representative. Below is a chart showing percentages of complaints de-escalated and/or resolved on the spot.



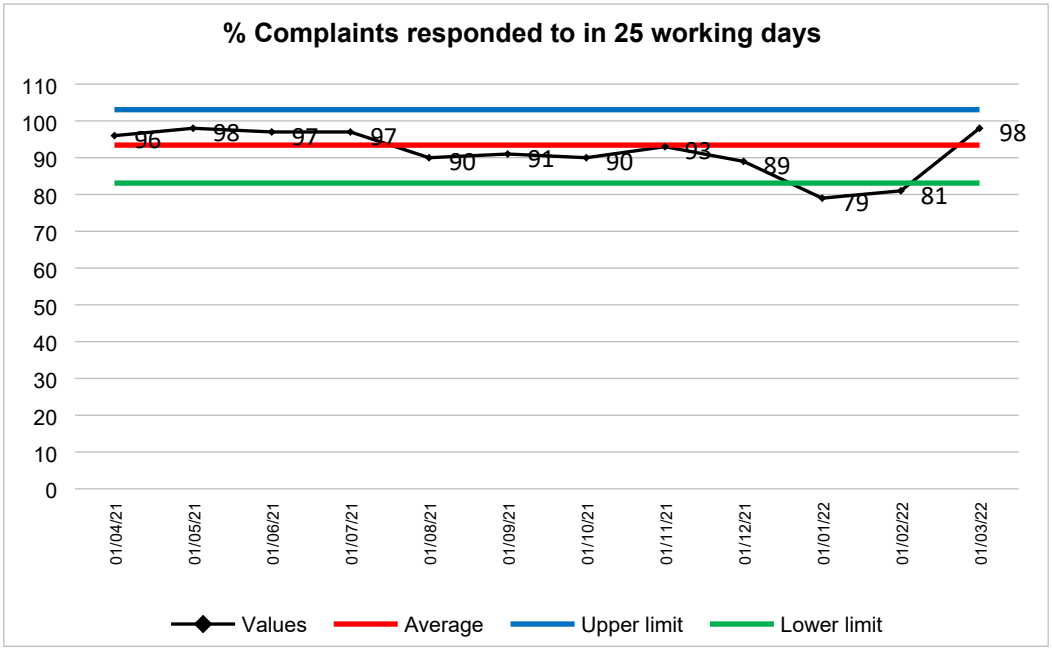
5. Performance in responding to complaints

In addition to monitoring the number of complaints received by our Trust we also monitor our performance against locally set timescales. These are to ensure that we acknowledge all complaints within two working days and that we respond to 95% of complaints within 25 working days.

The chart below shows the percentage of complaints acknowledged within two working days:

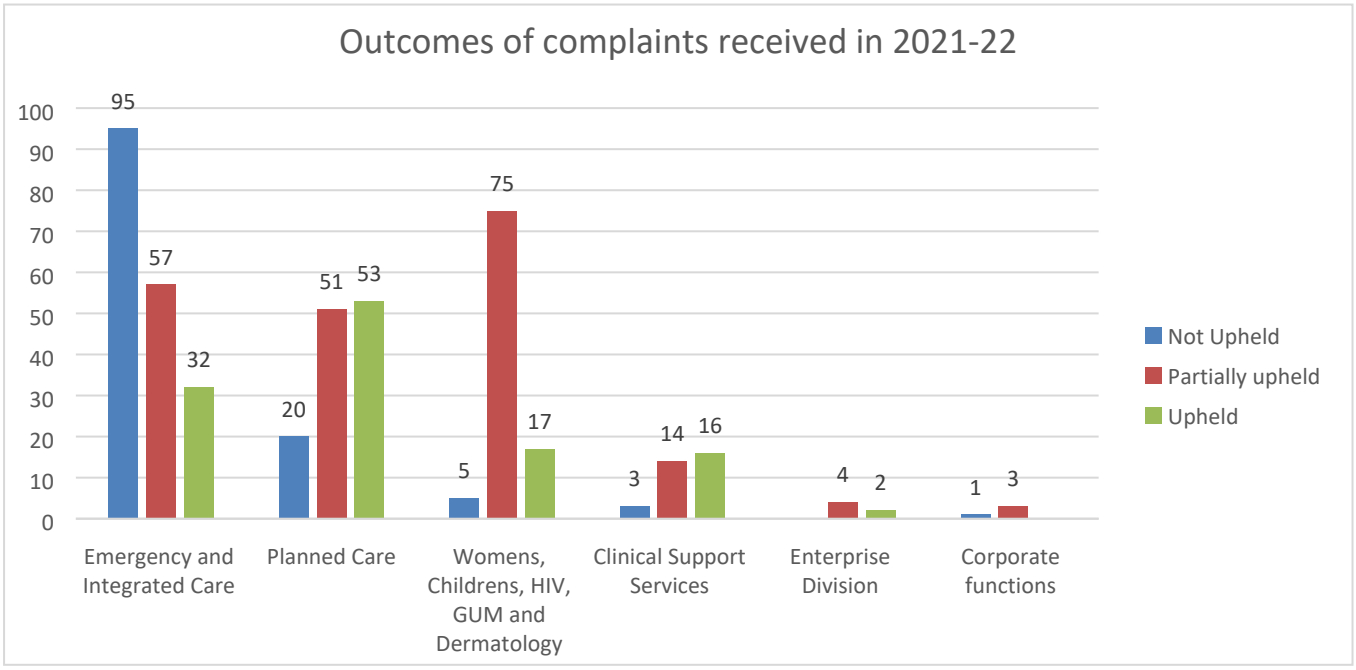


The chart below tracks our progress with achieving the 25 day response rate for the past year.



The PALS and Complaints Team has not consistently met the target of 95% of responses being sent within 25 working days of receipt of the complaint. However, we recovered the position in March 2022 by implementing training of investigators and a more robust approach to monitoring and escalating issues and we are back on track to meet this target going forward.

The chart below shows the outcomes from each of the complaints completed by Division, 72% of complaints investigated were either fully or partially upheld, where we provided an explanation and apology for a shortfall in care. This outcome is determined by the investigator and recorded in Datix:



5. Complaint themes

The Trust catagorises complaints using K041 criteria set by the Department of Health for reporting purposes. A complaint may involve more than one issue, however the main issue of the complaint will determine the subject it is logged under.

The table below identifies the themes and trends from complaints and highlights whether there has been an increase or decrease.

Complaint theme	Total complaints 2019/20	Total complaints 2020/21	Total complaints 2021-22
Access to treatment or drugs	20	3	15
Admissions, discharges and transfers	45	25	18
Appointments	77	13	10
Clinical treatment (across all specialties)	215	119	137
Communication	121	121	132
Consent to treatment	0	2	0
End of life care	2	0	1
Patient care	187	49	79
Prescribing errors	10	1	2
Privacy, dignity and wellbeing	4	5	5
Trust administration	20	5	4
Values and behaviours	120	43	40
Waiting times	7	0	1
Other	11	4	2

The top three themes for complaints that have recurred during the past three years have been about communication, patient care (nursing care) and clinical treatment (across all specialties). Breaking this down further, communication with the patient about their care and treatment, a patient's care needs not being adequately met, communication with families and carers and a delay or failure to diagnose a condition are the top five sub-themes logged for complaints. Looking at this by site, similar numbers of complaints by theme are received by both hospitals apart from communication where there are more complaints logged for Chelsea and Westminster Hospital.

There has been a significant decrease in the number of complaints about values and behaviours and also for a decrease in the numbers of complaints about appointments – as we are trying to resolve as many of these informally as possible. Numbers of complaints received for other themes remain low.

6. Learning from complaints

To address the themes above, here are some examples of changes to our services arising from the complaints we have received:

- Patient Access Team at WM auditing calls monthly to ensure quality of service is maintained.
- Emergency Department consultant available to prescribe stronger medication at triage for patients who need it.
- Neurophysiology team have devised a patient information leaflet to explain the process of nerve conduction tests to prepare patients in the future.
- Barcodes applied to medicines loaded into the pharmacy robot to check expiry dates are helping to avoid human error when dispensing medicines.
- Staff to ensure they communicate clearly with families to advise them of a fall by a patient whilst on the ward.

- Posters advertising Visiting Times to be kept updated, as this has caused confusion.
- Senior nurse to support student nurse with discharges from the ward and not to be left solely responsible for this.
- Food charts for inpatients to be completed correctly.
- Chaperone awareness posters to be reinstated in the therapy department.

7. Parliamentary and Health Service Ombudsman

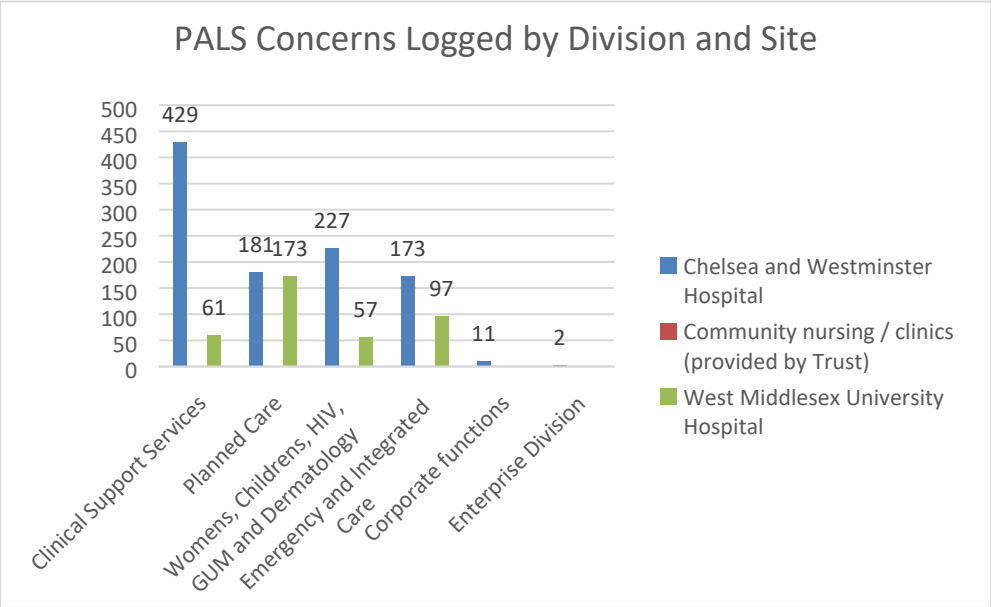
During the year, we received contact from the PHSO regarding four new complaints they assessed during 2021-22. We received a decision on four cases they have investigated, two for EIC Division were partly upheld, one for EIC was not upheld and one for WCH Division was not upheld.

	2019/20	2020/21	2021/22
Contacts from PHSO	N/A	11	13
Complaints formally investigated	5	3	4
Complaints fully or partially upheld	1	5	2
Complaints not upheld	2	0	2

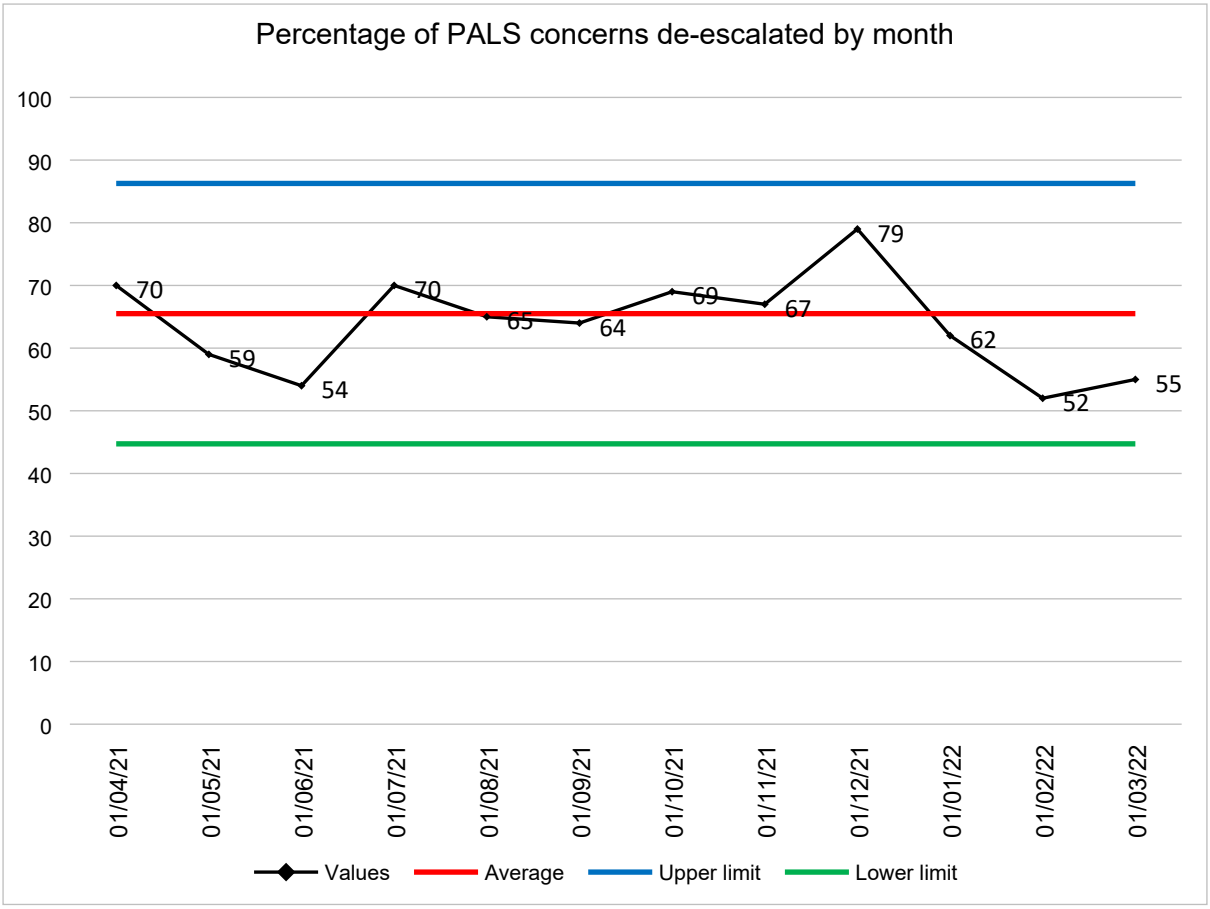
As at 1st April 2022, there was one open complaint for investigation for CSS Division.

8. Informal concerns (Patient Advice and Liaison Service)

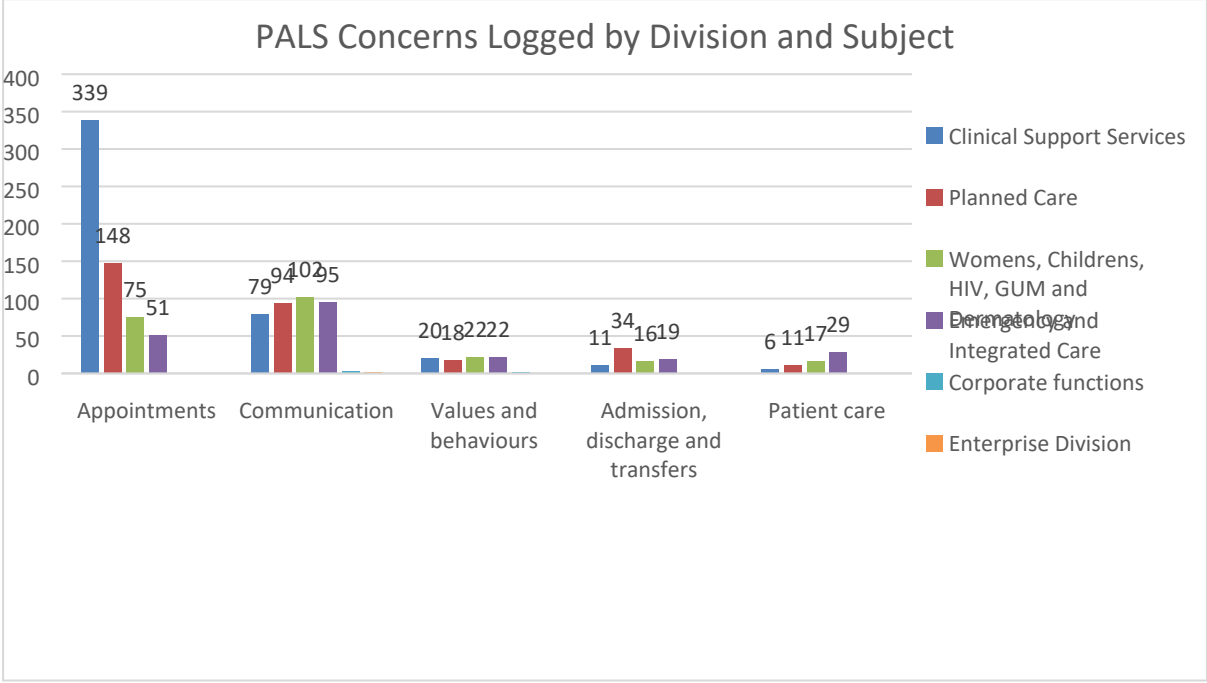
During 2021-22, the PALS team resolved **1412** concerns, this is an increase of 58% from 2020-21 (896).



These figures do not include any concerns raised at ward or service level that were immediately resolved or concerns received by the PALS and Complaints team that were immediately resolved. We continue to see a trend for 50% or more concerns received being de-escalated and resolved immediately:



The top five subject from concerns are demonstrated in the chart below.



As you will see, the principle reason for contacting PALS is in relation to concerns about appointments – cancellations, bookings and changes. The PALS team continue to work with colleagues within Patient Access to resolve appointment queries as quickly as possible.

9. Compliments

The PALS team logged a total of **632** compliments on Datix during the year 2021-22, an increase from 499 the previous year. Please see the table below for a breakdown of the compliments received by Division and site:

10. Service Improvements

The PALS and Complaints team has worked hard to respond to concerns and complaints that they receive and are reliant on good working relationships with their operational and clinical colleagues to achieve this.

The following objectives have been achieved in the past year:

- There has been a consistent focus on de-escalation and instant resolution of concerns and complaints where possible.
- We now have embedded systems and processes in place to ensure that learning and improvements from complaints and concerns is captured for all complaints on Datix

and followed up during our weekly tracker meetings and actions and learning are also discussed in divisional quality governance meetings.

- We have worked to improve compliance with our KPIs to ensure patients receive a timely response from the team.
- We have continued to work with colleagues in the Patient Access Directorate to support with reducing the number of appointment based concerns received by PALS.
- We continue to support our investigators by providing training on the complaints investigation process.

CONFIDENTIAL

TITLE AND DATE *(of meeting at which report to be presented)*	Board of Directors Public 7th July 2022

AGENDA ITEM NO.	4.3
TITLE OF REPORT	Infection Prevention and Control Annual Report 2021/22
AUTHOR NAME AND ROLE	Dr Nabeela Mughal; Consultant Microbiologist, Director of Infection Prevention and Control (DIPC) Jane Callaway; Lead Nurse Infection Prevention and Control Martyn Case; Deputy Lead Nurse Specialist Infection Prevention and Control Magno Castillo; IPC Surveillance Officer Elizabeth Cunningham; Infection prevention and Control Nurse Avinash Dhillon; Sterile Services Department Manager Maria Dineen; Clinical Nurse Specialist Infection Prevention and Control Dr Hugo Donaldson; Microbiology Consultant/Infection Control Doctor Kirsty Eyles: Hard FM facilities CW Stephen Hughes; Lead Antibiotic Pharmacist AnnaMarie Mitchell; Occupational Health Lead Advisor Joanne Nevison; IPC Surveillance Officer Mario Olivar; Clinical Nurse Specialist Infection Prevention and Control Margaret Outaleb: Estates and Facilities; Soft Services Sheeba Pothen, Infection Prevention and Control Nurse Jaysun Tuffin: Hard FM facilities WM Zara Tzouros; Infection Prevention and Control Data Manager
ACCOUNTABLE EXECUTIVE DIRECTOR	Robert Bleasdale - Chief Nursing Officer
PURPOSE OF REPORT Decision/Approval: ; Assurance: ✓ ; Info Only: ; Advice: Please tick above and then describe the requirement in the opposite column	DIPC / Infection Prevention and Control Team (IPCT) Annual Report 2021/22 as an assurance to the Board
REPORT HISTORY Committees/Meetings where this item has been considered	Committee / Date of //Meeting / Outcome: IPCG / 18/05/22 / No comments received. EMB / 08/06/22 / Approved Quality / 05/07/22 /
SUMMARY OF REPORT AND KEY MESSAGES THE MEETING NEEDS TO UNDERSTAND	The provision of an annual report on infection prevention and control is the duty of the Director of Infection Prevention and Control. The IPCT implements the annual

	programme and policies; makes clinical decisions on the prevention and control of infection and advises staff. The IPCT ensures that there are processes to manage risks associated with IPC by demonstrating compliance with the Code of Practice for the prevention and control of infection and associated guidance (2015) the Care Quality Commission core standards. This paper outlines the assurance measures related to infection prevention and control, performance against these and mandatory targets and sets the strategy plan for the year ahead. This paper reflects the COVID-19 pandemic and the IPC activities that supported the Trust during the pandemic and through the recovery and restart programme.
KEY RISKS ARISING FROM REPORT	Key risks include : COVID-19 Pandemic The continuing rise of antimicrobial resistance and resistant organisms Recognised IPC risks are included on the Trust risk register. Live risks • MRSA trajectory • Increase in multi-drug resistant infections • Gram negative bloodstream infections • Viral haemorrhagic fever preparedness • Legionella in water outlets • Pseudomonas aeruginosa in water outlets Accepted risks •Lack of compliance with IPC policies, work underway to improve •Clostridium difficile trajectory •COVID-19 pandemic • Emerging infections

STRATEGIC PRIORITIES 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:

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

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

To protect patients and staff against hospital acquisition and provide assurance to the Trust in relation to compliance with the Health Act 2008 and the Code of Infection Prevention and control guidance 2015.

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)	

Infection Prevention and Control

Annual Report

2021-2022

1. Introduction

This is the report of the Director of Infection Prevention and Control (DIPC) and summarises the work undertaken in Chelsea and Westminster NHS Foundation Trust (CWFT) for the period 1 April 2021 to 31 March 2022.

The report summarises the measures taken to protect patients and staff against infections, and provides assurance in relation to the Trust's compliance with the requirements of the Health Act 2008 and the Code of Practice on the prevention and control of infection and related guidance (2015).

The paper outlines the developments undertaken by the Infection Prevention and Control Team (IPCT) and summarises the following:

- Infection Prevention and Control (IPC) Management of COVID-19
- Mandatory surveillance reporting and progress against targets
- Decontamination and cleaning
- Incidents and outbreaks
- Hand hygiene and infection prevention audit and surveillance programme
- Education and training
- IPC link professionals
- Antibiotic stewardship
- Body fluid exposure
- Seasonal influenza
- Hard services
- The IPCT annual programme.

2. Executive summary

2.1. There were 6 cases of Trust apportioned MRSA bacteraemia against a trajectory of 0. A targeted deep dive of Trust attributed MRSA bacteraemias was conducted at the end of the year, see Appendix 3.

2.2. There were 36 cases of Trust apportioned *Clostridium difficile* infection (CDI) during this period, against a target of 23 for this financial year. The Trust (February 22 data) is ranked 21st of 138 Acute Trusts and below the national average rate of 13.00 with a rate of 10.36, (Public View Ltd data).

2.3. There were 77 Trust apportioned *E.coli* bacteraemias reported during 2020-21 which is a reduction on last year's figure of 79. A reduction in non-apportioned cases was also reported; 227 cases for 2021-22 in comparison to 230.

2.4. The average hand hygiene compliance score was 93% and overall completion of reporting was 98%. An increase of 1% in compliance from the previous year and a 7% increase in completion.

2.5. Surveillance of surgical site infection (SSI) was undertaken for total hip replacement and knee surgery for all quarters on each site, participation for 1 quarter is mandated by the Department of

Health. The number of elective procedures increased considerably during this period due to the establishment of COVID-19 recovery plans.

2.6. Enhanced monitoring for *Pseudomonas aeruginosa* in water outlets continues in augmented care units. Mitigations on positive outlets are agreed by the DIPC, the Infection Prevention and Control Team, authorised water engineer and the hard FM providers in conjunction with Estates and Facilities. The Water Safety Group meets monthly and reports into HSERG and Estates Performance and Governance Group.

2.7. There were no influenza outbreaks identified at CWFT.

2.8. NHS England set a CQUIN of >90% of frontline healthcare workers to receive influenza immunization; 55% of frontline staff were vaccinated. This is consistent with most of the NWL sector due to the focus on mandatory COVID-19 vaccination which was prioritised over influenza. Low prevalence of flu may have impacted staff perception of the value of flu vaccination and the Influenza Strategy group met to identify actions to improve performance for the coming season.

2.9. The Infection Prevention and Control Team supported the Trust in their response to the COVID-19 pandemic with a focus on returning to business as usual through restart and recovery plans and site visits to ensure that all areas of the Trust have in place the required IPC precautions to keep patients, staff and visitors safe.

2.10. There were a number COVID-19 ward outbreaks during 2020– 21.

2.11. Cleaning audits conducted across the Trust exceeded the minimum targets set out in the National Specification of Cleanliness as a result of the pandemic.

2.12. All NHS England sponsored CQUINs have been suspended for the financial year due to the pandemic. The CWFT AMS team have continued to optimise historic AMS targets from previous CQUINs in line with NHS England and Improvement criteria.

2.13. The decontamination department successfully passed the annual three day External Audit during this year to confirm compliance with the requirements of the European Directive MDD/93/42/EEC and the ISO 13485:2016 Standard. From 2020/21 the service is registered with NQA and will no longer be accredited against European Directive MDD/93/42/EEC.

2.14. 89% of Trust staff were compliant with mandatory infection prevention and control training.

3. Infection Prevention and Control Team Annual Programme

Under the leadership of the DIPC, the IPCT in conjunction with a range of colleagues across the Trust have contributed to the annual programme of work described in this report.

In the forthcoming year, the IPCT will continue to focus on the harmonisation of IPC practices, policies and processes. Key objectives for the coming year also include; continuing to minimise the

risk of healthcare associated infections, infection audit and surveillance, further developing the skills and knowledge of staff, ensuring evidence based clinical guidance on IPC practices and improving accessible patient information. The overarching IPC objectives for 2022/23 can be found in Appendix 6.

The DIPC and IPC Lead Nurse are actively involved in advising on Trust new and refurbishments projects e.g. respiratory ward David Erskine refurbishment at Chelsea and Westminster hospital, new children's department on the CW site and the new build of an Ambulatory Diagnostic Centre on the West Middlesex site. The IPCT will also continue to provide reactive IPC advice to Estates and Facilities and support the divisions with COVID-19 restart programmes as well as ensuring that the Trust are always in line with the latest UKHSA respiratory guidance and all other IPC guidance as relevant.

4. Infection Prevention and Control Background

The Trust is required to demonstrate compliance with the Health and Social Act 2008 and the Code of Practice on the prevention and control of infection and related guidance (2015). In addition there is a requirement to demonstrate compliance with NICE and best practice guidance. The Infection Prevention and Control Team aims to ensure there are processes in place to manage risks associated with infection prevention and control.

The IPCT covers all sites of the Trust. The funded establishment for the nursing team is currently 6 WTE infection prevention and control nurses, 1 WTE data manager and 1 WTE administrative support and 2 WTE infection surveillance officers.

Other members of the wider IPC team include the DIPC, infection control doctors, medical microbiologists, infectious diseases physicians, antimicrobial pharmacists and the decontamination lead.

The core infection control service includes an infection control advisory service, proactive infection prevention work and education and training throughout the organisation. The IPC team also undertake audit and surveillance, policy revision, report generation and outbreak management. Another aspect of their work is advising on the planning of new builds and refurbishments.

The team meet regularly to review clinical cases, infection control issues and mandatory data. A cross site team meeting is also held weekly and ad hoc team huddles as necessary.

The Trust IPC group is chaired by the DIPC and meets monthly with representatives from all divisions and key service areas. Quarterly reports are provided by the Occupational Health Department, the Decontamination Lead, the infection control surveillance officers, Pharmacy and UK Health Secretary Agency (UKHSA) (formerly Public Health England). The IPC group notes are made available on the Trust intranet. This group reports to the Quality Committee and the Terms of Reference for the group are available at Appendix 1. The IPC Lead Nurse maintains the IPC elements of the corporate risk register.

5. Mandatory reporting

The Trust is required to report the following healthcare associated infections to Public Health England.

In July 2020 a new apportionment algorithm was introduced by PHE and applies to all blood stream infections reported. The 3 categories are:

Hospital-onset healthcare-associated (HOHA): cases that are detected in the hospital two or more days after admission.

Community-onset healthcare-associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been a recent discharge from the reporting organisation with 28 days of their positive blood culture.

Community-Onset Community-associated (COCA): cases that occur in the community with no patient history of a recent admission.

Due to the algorithm and definition changes, the Trust attributed blood stream infection rates have risen.

Further analysis has been conducted to review all Trust attributed cases.

5.1. Meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA)

Chelsea and Westminster NHS Foundation Trust had six Trust apportioned MRSA bacteraemia against our target of zero for the year 2021/2022, 4 occurred at the WM site and 2 at the CW site. See Appendix 3 for a summary report of the MRSA bacteraemia cases.

5.2. *Clostridium difficile* infection (CDI)

From April 2019, a new PHE apportionment algorithm was introduced. Trust apportioned cases now include:

- **Hospital-onset healthcare-associated (HOHA):** cases that are detected in the hospital two or more days after admission.
- **Community-onset healthcare-associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

There were 36 Trust apportioned CDI cases against a Target of 23 in comparison to 25 Trust apportioned cases for the year 2020/21.

There were also 11 cases of non-Trust apportioned cases of CDI.

A root cause analysis (RCA) of each Trust apportioned case was undertaken by the IPCT and senior medical and nursing staff caring for each patient. Action plans were subsequently developed to address lessons learnt which are monitored at the quality and risk meetings.

The following lapse in care was identified in one case of Trust attributed CDI:

- Inappropriate antibiotic prescribing.

The lapse in care identified was due to inappropriate antibiotic prescribing/review and occurred at the WM site.

Analysis of the RCAs concluded that the following lessons were important in preventing CDI:

- Appropriate clinical assessment and pathology request (not MC&S) by educating ward staff.
- Antibiotic stewardship-ongoing active stewardship programme in place.
- The importance of maintaining high levels of hand hygiene compliance. Compliance is measured monthly via IPC audits and data is reported at the monthly IPC group.
- The importance of maintaining high standards of environmental cleanliness.
- The importance of appropriate glove use - Trust wide gloves off campaign has been launched.
- Isolation of infectious patients – continue to ensure prompt recognition of CDI cases and prompt isolation of all patients when an infection is suspected.
- Completion of stool charts.

The antimicrobial stewardship programme with antimicrobial pharmacists and ID/microbiology continues on both sites to optimise antimicrobial prescribing.

A *Clostridium difficile* Deep Dive was conducted for 2021/22, see Appendix 4.

5.3. Meticillin sensitive *Staphylococcus aureus* bacteraemia (MSSA)

There were 26 cases of Trust apportioned MSSA bacteraemias compared to 41 community apportioned cases (see Appendix 2 for summary data). No upper limit is currently set by the Department of Health.

This is an increase from 24 Trust apportioned cases in 2020/21.

5.4. *E.coli* bacteraemia

There were 77 cases of Trust apportioned *E.coli* bacteraemias, against a target of 80 and 227 community apportioned cases. This is a decrease of 2.53% in Trust Attributed Cases and a 1.3% decrease in Community Attributed Cases from the previous year (see Appendix 2 for summary data).

5.5. *Klebsiella spp.* bacteraemia

There were 37 cases of Trust apportioned *Klebsiella spp.* bacteraemias and 65 community apportioned cases (see Appendix 2 for summary data).

This compares to 26 and 62 cases respectively for 2020 – 21.

5.6. *Pseudomonas aeruginosa* bacteraemia

There were 24 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemias and 17 community apportioned cases (see Appendix 2 for summary data).

This compares to 16 and 8 cases respectively for 2020 – 21.

5.7. Orthopaedic Surgical Site Infection (SSI) Surveillance

The IPC Surveillance Officers carried out Total Hip Replacement (THR) and Total Knee Replacement (TKR) surveillance continuously throughout the year using criteria set by UK Health Security Agency (UKHSA).

Cross site, 4 hip infections were identified from 300 procedures (2 infections per site) and 3 knee infections from 320 procedures (3 on the Chelsea site). See tables below for detail per site.

RCA meetings were conducted for each case and no lapses in care were identified however it was observed that theatre etiquette required improvement i.e. reducing staff numbers in operating theatres, keeping theatre doors closed and harmonising theatre products cross site.

For the first three quarters of this year the trust is classified as an outlier as infection rates are above the national average. One of the reasons for this is due to the low number of procedures being undertaken.

We did also note that there were no additional cases of infection that were treated in the community (with 100% completion of the patient questionnaire), which is reassuring when compared to the benchmark. A quarterly report generated by UKHSA is shared with the orthopaedic surgeons for their information and action if necessary.

The SSI officers monitor patients for up to a year post op hence the above data is subject to change.

Total Hip Replacement Data

Table 1: CW Site Data

Total Hip Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Infections rate %**	**National Average**
Apr – Jun 2021	59	1	1.69%	**0.3%**
Jul – Sep 2021	44	1	2.20%	
Oct – Dec 2021	54	0	0.0%	
Jan – March 2022	63	0	0.0%	
Total	**220**	**2**	**0.90%**	

Table 2: WM Site Data

Total Hip Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Hospital % Infections**	**National Average**
Apr – Jun 2021	15	2	13.33%	**0.3%**
Jul – Sep 2021	24	0	0.0%	
Oct – Dec 2021	24	0	0.0%	
Jan – March 2022	17	0	0.0%	
Total	**80**	**2**	**2.5%**	

Table 3: Chelsea and Westminster NHS Foundation Trust Joint Data

Total Hip Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Hospital % Infections**	**National Average**
Apr – Jun 2021	74	3	4.05%	**0.3%**
Jul – Sep 2021	68	1	1.47%	
Oct – Dec 2021	78	0	0.0%	
Jan – March 2022	80	0	0.0%	
Total	**300**	**4**	**1.33%**	

Knee Replacement Data

Table 4: CW Site Data

Knee Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Infections rate %**	**National Average**
Apr – Jun 2021	58	1	1.72%	**0.3%**
Jul – Sep 2021	46	1	2.17%	
Oct – Dec 2012	40	1	2.50%	
Jan – March 2022	41	0	0.0%	
Total	**185**	**3**	**2.40%**	

Table 5: WM Site Data

Knee Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Infections rate %**	**National Average**
Apr – Jun 2021	39	0	0.0%	**0.3%**
Jul – Sep 2021	37	0	0.0%	
Oct – Dec 2021	40	0	0.0%	
Jan – March 2022	19	0	0.0%	
Total	**135**	**0**	**0.0%**	

Table 6: Chelsea and Westminster NHS Foundation Trust Joint Data

Knee Replacement				
Surveillance Period	**Number of Procedures**	**Number of Infections**	**Infections rate %**	**National Average**
Apr – Jun 2021	97	1	1.03%	**0.3%**
Jul – Sep 2012	83	1	1.20%	
Oct – Dec 2021	80	1	1.25%	
Jan – March 2022	60	0	0.0%	
Total	**320**	**3**	**0.93%**	

6. Screening for Carbapenemase-producing *Enterobacterales* (CPE)

A Carbapenem Resistant Organism (CRO) risk assessment is carried out on all patients on admission to the Trust; this identifies patients that require screening for CRO. There were 31 cases of CPE at the CW site and 48 cases at the WM site from April 2021 - March 2022.

7. COVID-19 Pandemic

The COVID-19 pandemic was again a large focus of the work alongside the usual work carried out by the IPC team in 2021/2022. The IPC team was responsive and actively involved in implementing the newly formed UK Health Security Agency (UKHSA) and pan-London guidance as it was published to keep patients, visitors and staff safe. This was delivered actively through review of and writing of guidelines, patient pathways, education of both nurses, doctors and allied health care workers, Trust wide webinars, updated communication bulletins and divisional training days. The team supported ward and other training as the pandemic continued.

Throughout the pandemic the IPC team led on the development of staff and patient testing pathways including regular liaison with the UKHSA and the NWLP IPC ICS. The team were also involved in the daily sitreps of cases and attendance at the bed and site meetings to help with patient management and flow whilst providing ongoing data management with a review of case definitions for purposes of reporting.

The IPC team played an active role at Gold and governance meetings and led on the management of outbreaks, continually feeding back any lessons learnt and learning in order to help improve patient care and safety and ensured cross site harmonization of polices and practice. Outbreak management formed the bulk of IPC work with both internal and external reporting, ward management and high visibility and presence of IPC nursing and medical staff on the wards to help support and monitor practice.

A regular and engaged liaison with the NWLP IPC ICS sector continues to help harmonize IPC practice across the sector and helps provide peer support and aid. In addition ongoing advice on PPE both locally and in working groups across the sector has been important along with establishing safe patient pathways for the hospital, with review in line with evolving national guidance with clear and effective communication and signage for all visitors and staff.

The IPC team has supported the COVID-19 vaccination programme and continues to play a pivotal role in reviewing restart pathways for the safe and effective opening of services in the restart and recovery of the hospital and elective programmes. This has included the development of an assessment tool and screening questionnaires and additional support for new ward refurbishments or configurations to ensure that the patient and staff environment provides the appropriate level of IPC assurance. This has also included a cross site review of the Trusts meeting and training rooms to ensure safe and effective working and capacity for all staff.

A coordinated hospital-wide approach was taken to infection prevention and control. UKHSA guidance was 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 continuation of staff lateral flow testing and the staff vaccination programme.

An effective communication strategy disseminated 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, isolation etc. A range of training sessions were also delivered by the IPC team including participation in Grand Rounds and Quality Rounds, workplace training and Trust wide webinars to help disseminate and implement new guidance.

'COVID-19 managed' wards were again utilised to manage positive patients and patient flow was aided by adherence to step down guidance of IPC precautions for COVID-19 patients. The Delta variant was classified as a variant of concern by PHE on 06 May 2021 due to evidence that it was at least as transmissible as the Alpha variant, which was dominant at the time. Evidence has since emerged that Delta was significantly more transmissible and it became the dominant strain. However in December 2021 the Omicron variant started to replace Delta to become the dominant strain, being highly contagious but generally causing less severe disease. The introduction of the Omicron variant has meant the Trust has identified large numbers of positive patients via routine screening, although the vast majority were not unwell due to COVID-19. This resulted in significant bed pressures for the Trust and ward outbreaks of COVID-19. See Appendix 5 for an outbreak summary.

Finally the IPC team continues to keep the Trust updated on the requirements for managing emerging COVID-19 variants to ensure all required precautions are in place for patient flow and the safety of patients, visitors and staff.

8. Seasonal Influenza

Chelsea and Westminster NHS Foundation Trust began flu planning in July 2021. A detailed operational plan was developed, finalised in September 2021, and its implementation was overseen by the Flu Strategy Group. This steering group met weekly throughout the flu season and had representation from infection control, microbiology, nursing and clinical divisional representatives, maternity, pharmacy and communications. The group was chaired by the Director for Infection Prevention and Control.

Influenza incidence nationally and locally was at a record low this year as can be seen from the NWL respiratory pathogens report up to 21st March 2022 UKHSA surveillance data table below.

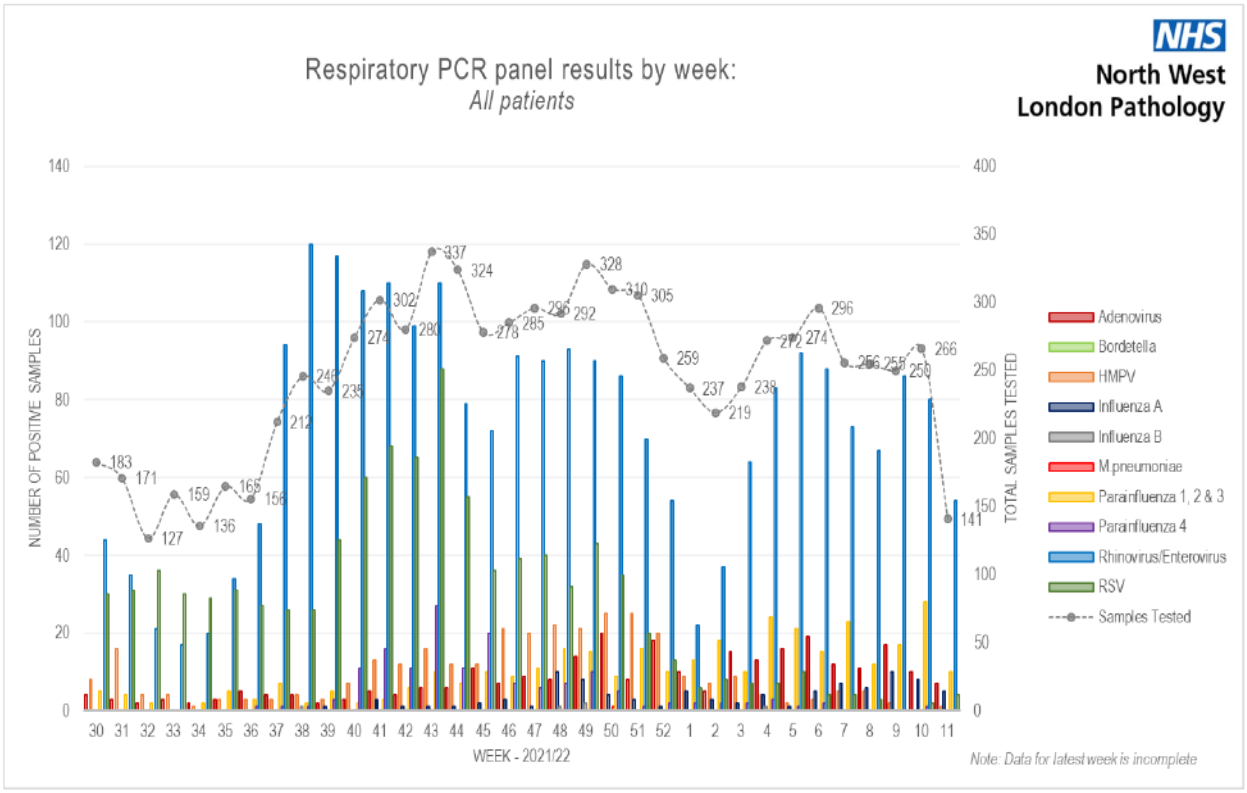


Figure 1. NWLP Respiratory Pathogens Report – up to 21st March 2022

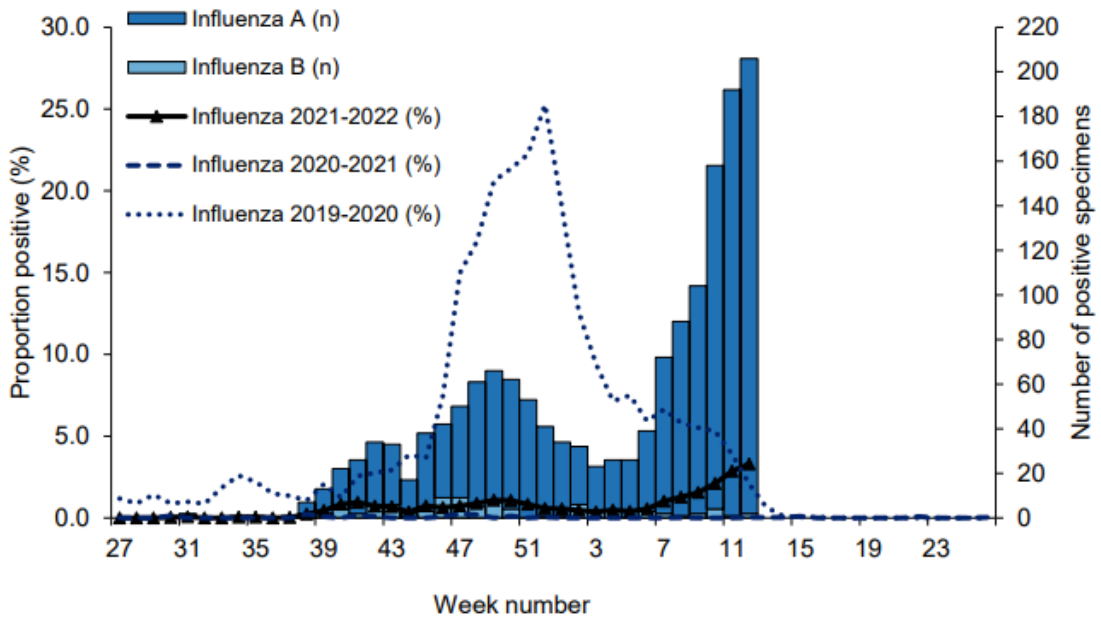


Figure 2. UKHSA DataMart- Samples positive for influenza and weekly positive % for influenza, England (up to week 12 data)

8.1. Staff Vaccination

In 2020/21, Chelsea and Westminster NHS Foundation Trust achieved a 93% staff immunisation uptake. This year, there was a commissioning aspiration of the Trust achieving 100% offer of vaccination with an uptake of >85%.

The Trust achieved a 55% vaccination rate of front line staff. This was disappointing in comparison to the 93% achieved last year. However, this is in keeping with other Trusts across London and NWL sector. A number of factors influenced the staff decision and availability to receive the vaccine including:-

- National and Trust prioritisation of COVID-19 over Flu vaccination (91% of staff double vaccinated against COVID-19)
- Personal choice of staff to choose COVID-19 vaccination over Flu
- Vaccination as a condition of deployment and the fall out of staff feeling forced to have vaccinations
- COVID-19 sickness and staff not being eligible at the times vaccines offered as they were unwell

This year very few cases of influenza were recorded nationally and locally and this may have been due to the precautions in place for COVID-19 and SARS-CoV-2 becoming the dominant respiratory virus. There were no outbreaks or incidents in relation to influenza reported.

Breakdown by Divisions

Table 7: Divisional Staff Influenza Vaccination Rates

	All Staff Flu Moving Baseline	Flu Immunised	Flu Rate
Corporate	607	300	49.42
Clinical Support	1001	468	46.375
Emergency & Integrated Medicine	1644	1036	63.02
Enterprise	180	97	53.89
Planned Care	1114	667	59.87
Women, Children, Dermatology, HIV and GUM	1622	818	50.43
Grand Total	6168	**3386**	**54.90**

9. Incidents, Outbreaks and Clusters (excluding COVID-19)

9.1. Chelsea and Westminster Hospital (CWH):

***Legionella* positive patient on Rainsford Mowlem ward (July 2021)**
A patient tested positive for *Legionella pneumophilia* serogroup 1 from a urine sample sent on 04/07/2021 and a sputum sample sent on 07/07/2021. Patient was transferred from Leicester Royal Infirmary (LRI) on 16/06/2021 with a history of a dry non-productive cough, headache and feeling generally unwell.

Due to the possibility of nosocomial infection, incident meetings were held to investigate the case, which included PHE representation. Water sampling of the ward was undertaken, whilst awaiting results the ward was closed and all existing patients moved to another area. All water outlets were later found to be negative for *Legionella pneumophilia* and following UK Health Security Agency (UKHSA - previously Public Health England) consultation the environment was deemed safe and the ward reopened. There were no further patient positives isolated nor any clinical concerns and ongoing clinical vigilance and testing was in place.
UKHSA concluded that this patient's acquisition of *Legionella* likely predates admission to CWH. The patient lives in Leicester and UKHSA Leicester is investigating at LRI, as well as the patient's home and work settings.

***Acinetobacter baumannii* detected on the Neonatal Unit (July 2021)**
A fully sensitive *Acinetobacter baumannii* following routine screening on the Neonatal Unit between 12/07/2021 - 31/03/2022 was found in the screening isolates of ten babies.
Investigation prompted further testing by UKHSA laboratories and the initiation of a detailed review of the incident.
Infection control and containment measures included screening all babies on the unit in addition to routine screening, multiple infectious cleans of the unit, thorough cleaning of shared equipment, de-cluttering of the entire unit and reiteration of the importance of stringent hand hygiene and changing of personal protective equipment between babies.
The neonatal unit carried out an independent route cause analysis for the positive babies to identify any aspects of the unit requiring improvement, as well as being in regular communication with the Infection Prevention and Control team.
Fortunately, UKHSA testing identified that eight of the ten results were returned and all isolates were unique, suggesting cross-transmission had not occurred.
The Infection Prevention and Control team continue to monitor this organism and work closely with the unit.

Norovirus/COVID-19 outbreak on Rainsford Mowlem ward (January 2022)
Twenty two patients and two members of staff were identified with diarrhoea and/or vomiting between 24/01/2022 – 03/02/2022; two patients tested norovirus positive. On 25/01/2022, two patients were also identified as COVID-19 positive; given the nature of the outbreak which required respiratory and enteric precautions, the decision was made not to move these patients onto a COVID-19 managed ward as there was a risk of transferring norovirus to other areas of the hospital. In total seven patients and four staff became COVID-19 positive.
The ward was immediately closed to admissions and monitored closely by the IPC team. Eight outbreak meetings were held as managing a dual-virus on a ward was a delicate balance of effective control and containment measures alongside appropriate utilisation of side rooms/cohort bays.
The ward reopened fully again on 02/02/2022.
UKHSA attended outbreak meetings and supported decision making.

Increased incidence of diarrhoea and vomiting on Nell Gwynne ward (February 2022)
Twelve patients and four staff reported symptoms of diarrhoea and/or vomiting on Nell Gwynne ward from the 18/02/2022 – 25/02/2022. Although norovirus was not formally identified, the increased incidence was declared a likely norovirus outbreak as norovirus outbreaks in the community are largely managed based on clinical suspicion and rarely with laboratory confirmation, this decision was supported by UKHSA. Faecal pathogen samples and norovirus specimens were

advised for all symptomatic patients. This identified one case of rotavirus and one *Clostridium difficile* case. Nell Gwynne ward was temporarily closed to admissions on 21/02/2022 and IPC control and containment measures put in place. The ward subsequently reopened on the 25/02/2022 following stool sample results and resolutions of patient's symptoms.

9.2. West Middlesex Hospital

Smear Positive TB Exposure on Syon 2 (May 2021)

A patient was identified smear positive for TB in May 2021 on Syon 2. The identified patients and staff contacts were risk assessed, and offered TB screening. An incident meeting was conducted and managed by the Tb service and the ward staff were given further education regarding IPC measures and precautions required in the management of TB patients.

Chicken pox patient on SCBU (May 2021)

SCBU received a premature baby on the 24/05/2021, whose mother developed a rash on the 29/05/2021 of which the clinical team suspected chicken pox.
Varicella-zoster immunoglobulin (VZIG) was administered to the baby since the mother's diagnosis could not be confirmed. No other patient, staff or visitor contacts were identified as the IPC COVID-19 precautions in place mitigated the risk of transmission. The baby and father were advised to isolate for 21 days from exposure. The mother re-presented to WM ED in June due to worsening rash and was referred to Dermatology which diagnosed a likely Pemphigoid gestationis excluding chicken pox. Based on this information and the fact that mothers' result was consistent with previous varicella infection, SCBU was advised that the baby could be de-isolated.
UKHSA were involved in the incident and supported decision making.

Carbapenem Resistant Organism (CRO) outbreak on Syon 1 (July 2021)

Six patients were identified on Syon 1 with *Klebsiella pneumoniae*, OXA 48 gene positive, between 13/07/2021 to 21/07/2021. The index case was previously positive from another hospital and was not identified by the clinical team as CRO positive although an alert was documented in the electronic patient record.
The following IPC control and containment measures were initiated immediately- outbreak meeting convened, ward closure, enhanced cleaning of equipment and the environment, reiteration of the importance of compliance with hand hygiene and PPE and twice weekly CRO screening of the ward until assurance of no further cross transmission.
The incident emphasised the importance of checking IPC alerts for all patients and management was supported by UKHSA colleagues.

***Pseudomonas aeruginosa* cluster on AICU/HDU (September 2021)**

A cluster of four patients were identified with *Pseudomonas aeruginosa* on AICU/HDU, over a 16 day period; sample typing revealed that 2 of the 4 identified cases were possibly linked. This was against a background of three positive water outlets on AICU/HDU/Richmond from water samples sent on the 01/09/2021 as part of routine testing every 6 months.
An incident meeting was held and emphasised the importance of appropriate use of PPE, hand hygiene compliance, clinical environment cleaning and water re-sampling. Bed spacing in HDU was also identified as an issue resulting in bed capacity being reduced from four beds to three allowing

for adequate space for staff to don/doff PPE and perform hand hygiene effectively between patients. Intravenous line and hand hygiene audits and practices were reviewed as well as cleaning of water outlets. It was reiterated that clinical hand wash basins are to be solely used for hand hygiene and not for disposing fluids.
No further cases were reported following the implementation of the above actions.
UKHSA were involved in the incident and supported decision making.

Carbapenem Resistant Organism (CRO) outbreak on Marble Hill 2 (October 2021)
Six patients were identified on Marble Hill 2 with *Klebsiella pneumoniae*, OXA 48 between 27/10/2021 to 15/11/2021.
The following IPC control and containment measures were initiated immediately- outbreak meeting convened, ward closure, enhanced cleaning of equipment and the environment, weekly commode steam cleaning, reiteration of the importance of compliance with hand hygiene and PPE and weekly CRO screening of the ward until the end of November when no further cases were identified. The ward gradually opened to admissions after isolating the positive cases and the direct contacts.
UKHSA were involved in the incident and supported decision making.

RSV cluster on SCBU (October 2021)
Seven babies were identified as RSV positive on SCBU between 26/10/2021 to 28/10/2021.
The unit was closed by the clinical team and IPC control and containment measures included supporting closure of the unit to admissions unless clinically indicated and all babies on the unit were screened using a full respiratory panel. An outbreak meeting was conducted and emphasised the importance of appropriate isolation precautions, increased vigilance for clinical cases, appropriate use of PPE, importance of hand hygiene, and enhanced cleaning to continue.
The unit reopened on the 05/11/2021 once a final round of screening identified no further positive babies. An infectious clean was carried out on the unit prior to opening and the remaining positive babies cohorted in one bay.
UKHSA were involved in the incident and supported decision making.

10. Hand hygiene

Hand hygiene is a key priority within the organisation. Monthly audits of hand hygiene compliance take place and are reported to the Infection Prevention and Control Group (IPCG).

From April 2020 – March 2021, 98% of hand hygiene audits have been completed for the Trust and the mean hand hygiene compliance rate was 99% (see summary data in Appendix 2).

11. Infection prevention and control audits:

Infection Control Link Professionals (ICLPS) continue to audit peripheral venous catheters, urinary catheters and central venous catheters on a monthly basis using a care bundle process.

This process is an evidence based approach to clinical interventions which when implemented consistently, reduce variation and the risk of infection. Both sites audit electronically, via Survey Monkey.

Below are the average compliance scores for each site for 2020/2021.
CW

- PVC: 70%
- CVC: 85%
- Paediatrics CVC: 94%
- UC: 86%

WM

- PVC: 89%
- UC: 90%
- CVC: 96%

From April 2022, divisional triumvirates are sent an infection dashboard to allow them oversight of their audit data in order to improve on the above performance figures, with presentation at the monthly IPCG.

12. Education and Training

The IPC team provide training for staff across the organisation. This includes mandatory training for all staff along with mandatory updates for clinical staff. The team also provided a wide range of additional education and training. The team provide induction training for all new clinical staff, including junior doctors and medical students. During 2021 a new updated eLearning module was developed and will be available in the spring of 2022.

Table 8: Staff mandatory training compliance (including IPC) April 2021 - March 2022

Division	Total	Infection Control (Hand Hygiene)
Overall %	90%	88%
Change from previous month	?	?
Clinical Support Division	91%	87%
Corporate Division	89%	90%
Emergency & Integrated Care Division	90%	86%
Enterprise Division	91%	83%
Planned Care Division	91%	89%
Women's, Children's and Sexual Health Division	88%	83%

13. Infection Control Link Professionals (ICLP)

The ICLPs are responsible for instigating and monitoring the Trust's infection control priorities at ward/unit level. This includes the completion of local hand hygiene and High Impact Intervention audits, consisting of the on-going care of peripheral vascular devices, central venous catheters and urinary catheters. The IPC team held nine ICLP study days this year in which 49 staff were trained. The divisional breakdown of this is; 10 from Emergency and Integrated Care, 17 from Planned Care and Surgery, 15 from Women's and Children's, HIV, GUM, Private Patients and 7 from Clinical

Support. The ICLP study days continue to be popular and are always oversubscribed with a long waiting list of interested staff keen to be supported in improving IPC practice across the Trust.

14. Antimicrobial Stewardship

Report written by a Trust Antimicrobial Pharmacist

14.1. Antimicrobial Pharmacist Stewardship Activities

The Trust has a dedicated specialist pharmacy team working with medical microbiology/infectious diseases, infection control and clinicians cross site, to form the Antimicrobial Stewardship Group (ASG), which reports to the Medicines Committee. The antimicrobial pharmacists and infectious diseases and microbiology team work closely to ensure appropriate antimicrobial stewardship guidance is practiced in the clinical setting. Regular ward rounds, MDTs, and surveillance help support this.

Key developments and achievements of the antimicrobial pharmacists during 2021/22 include:

14.1.1. Specialist Advice / Support / Ward Rounds

The West Middlesex (WM) site has rolled out the use of computer decision support system (CDSS), ICNET, in June 2021. This software enables ward-based reviews of patients with revision of antimicrobial prescribing prospectively. There is immediate and real time feedback on AMS performance to clinical teams, allowing for continued AMS education to users. This has been implemented successfully at the Chelsea & Westminster (CW) site since April 2021.

14.1.2. AMS service provision during COVID-19 pandemic

The Trust AMS service has been repurposed from March 2021 to manage the infective complications of SARS-CoV-2. The service has lead on the introduction of novel evidence based therapies, controlling the use of non-evidence based interventions and supporting the work of the ward-based and research teams. COVID-19 anti-infective guidelines have been produced to reflect the emerging evidence base and rapidly disseminated to ward-based clinicians through the traditional AMS structure. The infectious disease (ID) & Microbiology consultants have worked closely with the Trust's COVID-19 response team to ensure evidence-based management of these patients. The ID & Microbiology specialists working with the antimicrobial pharmacists have continued to provide the full AMS service in adjacent to the COVID-19 response. Ward-based patient consults with clinicians has continued and antimicrobial usage, including antifungals and antivirals, have been stewarded throughout the pandemic. Real-time feedback on prescribing was provided to promote timely evidence based interventions throughout the pandemic. Novel therapies including sarilumab, Ronapreve, sotrovimab, molnupiravir and Paxlovid have been introduced for COVID-19 and used widely in line with national guidance.

The team has also supported with the COVID Medicines Delivery Unit (CMDU) from December 2021, helping to deliver timely anti-COVID-19 therapy to patients from across the NWL integrated care systems (ICS).

14.2. Key Performance Indications

14.2.1. NHSE *National Contract / CQUIN*

All NHS England sponsored CQUINs have been suspended for the financial year due to the pandemic. The CWFT AMS team have continued to optimise historic AMS targets from previous CQUINs in line with NHS England and Improvement criteria.

14.2.1.1. Reducing total antibacterial usage across the Trust

Total antimicrobial usage (in DDD/1,000 trust beds) has reduced marginally (1.3%) over the last financial year from baseline 2018. This shows continued improvement in the AMS strategy to minimise unnecessary antimicrobial prescribing at a Trust level. This has been implemented by using shorter total durations of therapies (strategy for AMS at CWFT 'shorter is better') whilst introducing higher dosing in light of EUCAST recommendations (2020). Emergency admissions and sexual health clinic account for 20% and 35% of total antibacterial usage at the CWFT site, respectively. Antibacterial usage with local peers within London has increased by 1.6% during this period [Figure 3].

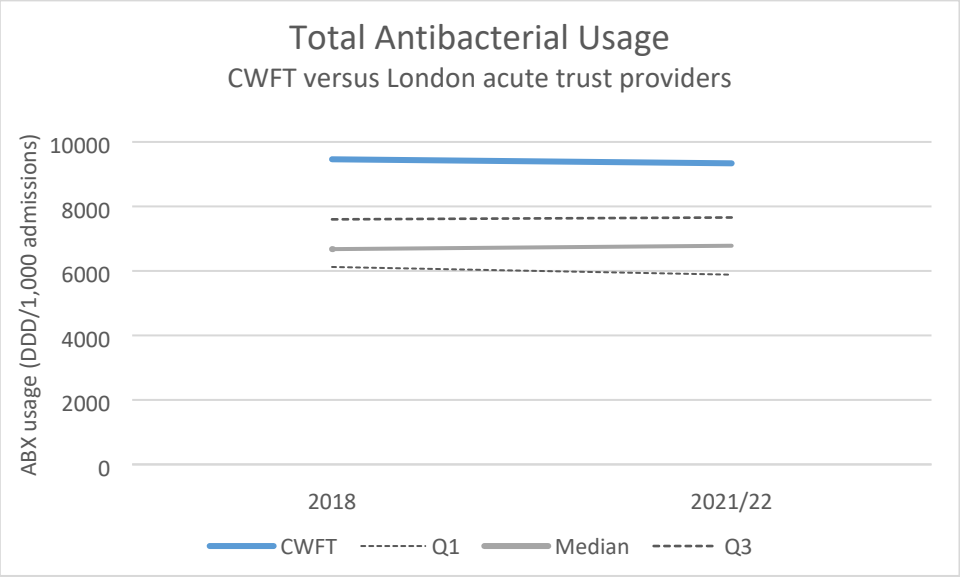


Figure 3. Total antibacterial usage at CWFT compared to London peer NHS hospitals (2018 (baseline) – 2021/22)

The new NHSE targets for reducing broad-spectrum antimicrobial usage by 6.5% over the next 5 years has been introduced during Q4 of 2021/22. The CWFT AMS team have been working to this target internally since 2019 and in 2021/22, demonstrates a 19.3% reduction in total broad-spectrum antimicrobials from baseline (2018). This is against a baseline reduction of 3% seen by peer London NHS hospitals [Figure 4]

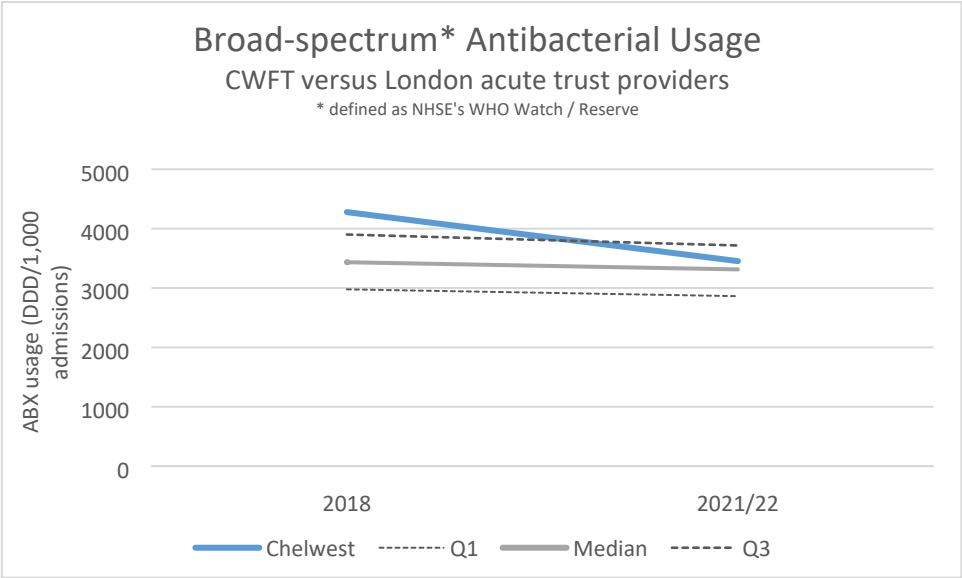


Figure 4. Broad-spectrum antibacterial usage at CWFT compared to London peer NHS hospitals (2018 (baseline) - 2021/22)

14.2.1.2. Reducing quinolones and carbapenem usage

Broad-spectrum antimicrobials, including quinolones (e.g. ciprofloxacin) and carbapenem, are continually monitored to ensure all use in clinically appropriate. CWFT has continued to reduce total usage of these broad-spectrum therapies in response to the MHRA alert on quinolone safety and to reduce selective pressure on carbapenemase producing organisms (CPO), for quinolones and carbapenems respectively. Despite the COVID-19 pandemic pressure, carbapenems remain low and are reducing despite increasing trends with NHS London peers; 19% overall reduction at CWFT versus a 12% increase with London peers.

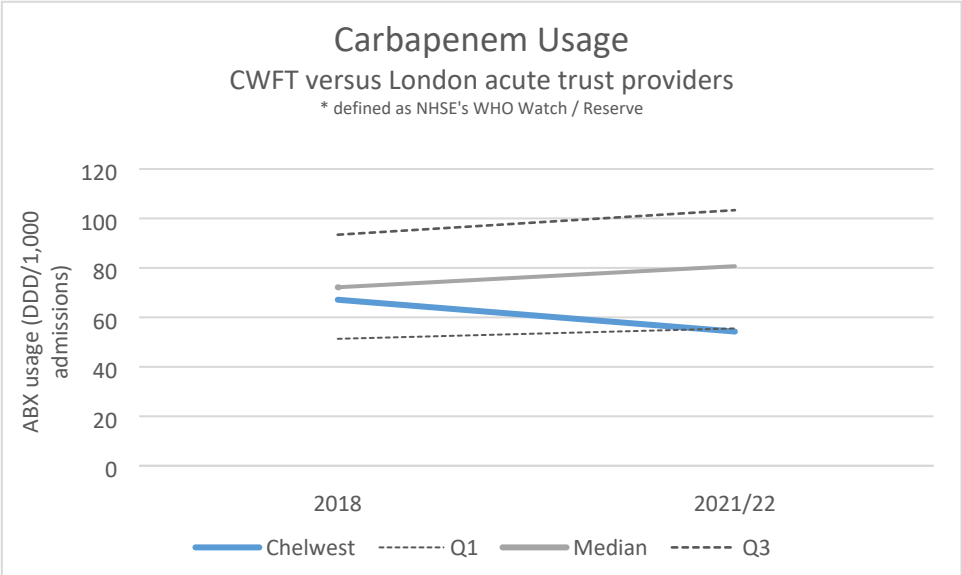


Figure 5. Carbapenem usage at CWFT overtime and compared to NHS London peers

The overall quinolone usage has increased by 21% at CWFT trust over this period compared to a 50% median increased by NHS London peers [Figure 6]. Local increases have been primary driven by

increased use of moxifloxacin in adult TB patients (West Middlesex respiratory team) and out-patient sexual health clinics.

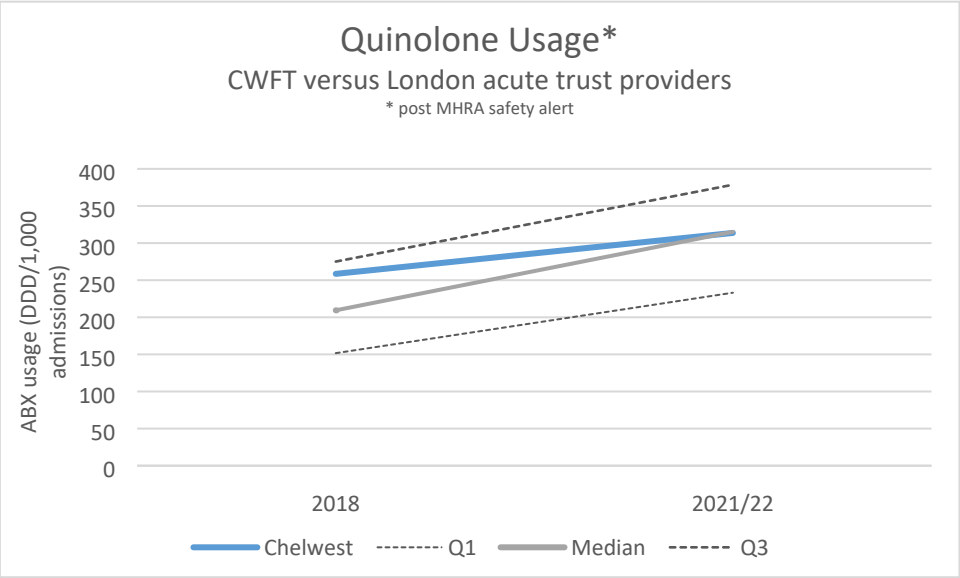


Figure 6. Quinolone usage at CWFT overtime and compared to NHS London peers

14.2.1.3. Optimising antifungal usage

Systemic antifungal stewardship has continued at the CWFT throughout the pandemic with a focus on minimising unnecessary antifungal usage. Total systemic antifungals (under specialist commissioning) has reduced by 21% at the CWFT from baseline in 2018 despite overall increase of antifungal usage by 54% across NHS London peers [Figure 7]. Daily antifungal reviews by the AMS pharmacy team as well as the introduction of biomarkers (e.g. serum beta D-glucan) have likely contributed to this improvement.

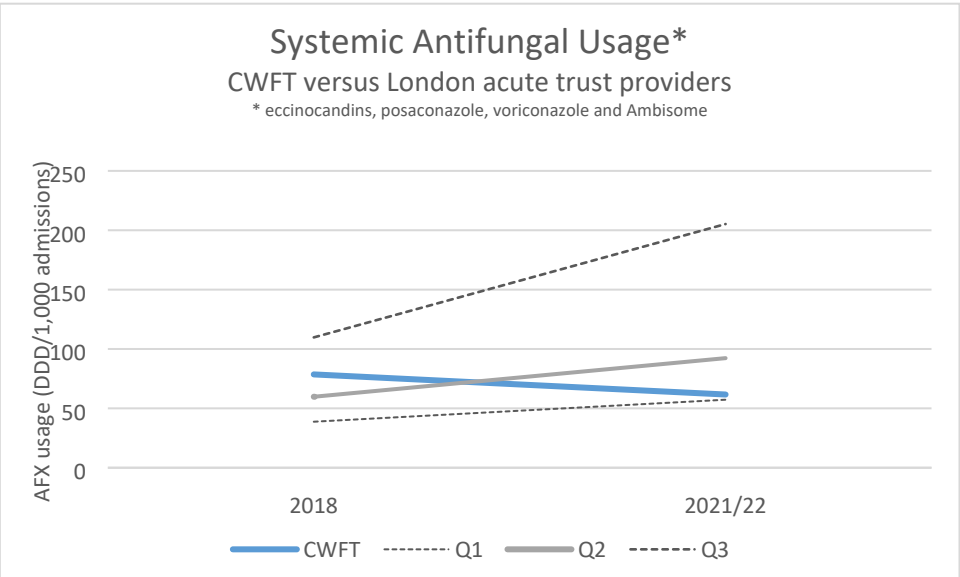


Figure 7. Systemic antifungal usage at the CWFT

14.2.2. C.*difficile* Infections

The definitions for hospital acquired *C. difficile* infection (CDI) have expanded from April 2019 to include healthcare associated infections. Thus comparisons of CDI rates over time is challenging due to definition differences. Rates have increased locally but this is a trend replicated nationally and reassuringly the CWFT has the lowest rates of CDI across England (versus peer NHS acute teaching hospitals). The AMS team is continuing to identify high-risk practice to further mitigate the risk of CDI with ward rounds focusing on all broad-spectrum antibacterial prescribing.

Area	Count	Value
England	5,952	18.7
Teaching trust	2,694	20.1
Lancashire Teaching Hospitals	109	40.3
University College London Hospitals	77	37.1
Blackpool Teaching Hospitals	81	37.0
The Newcastle Upon Tyne Hospitals	137	32.0
Sheffield Teaching Hospitals	122	28.4
Cambridge University Hospitals	90	27.8
Wirral University Teaching Hospital	60	26.4
University Hospitals Bristol and Weston	85	26.2*
York Teaching Hospital	69	23.7
Manchester University NHS Foundation Trust	158	23.5*
Leeds Teaching Hospitals	127	22.2
University Hospital Birmingham	189	21.0*
Imperial College Healthcare	66	20.8
North Cumbria Integrated Care NHS Foundation Trust	37	20.7*
Bradford Teaching Hospitals	40	20.7
Royal Free London	61	20.3
Oxford University Hospitals	69	20.3
Salford Royal	90	18.2
Liverpool University Hospitals	90	17.3*
Nottingham University Hospitals	85	17.1
Derby and Burton Foundation Trust	70	16.4
Southampton University Hospitals	58	16.2
Kings College Hospital	71	15.2
Norfolk and Norwich University Hospitals	46	14.6
Barts Health NHS Trust	86	14.5
University Hospitals Of Leicester	74	14.0
Hull and East Yorkshire Hospitals	41	13.3
St Georges Healthcare	34	12.0
University Hospitals Coventry and Warwickshire	41	11.6
Guys and St Thomas	39	11.3
Chelsea and Westminster Hospital	25	10.4*
Royal Liverpool and Broadgreen	-	-
South Manchester University Hospital	-	-

Source: HCAI Mandatory Surveillance Data

Figure 8. Chelsea & Westminster NHS Trust vs NHS peers for hospital acquired CDI rates

14.2.3. COVID-19 related activity

The antimicrobial stewardship pharmacy team have lead on the Trusts response to COVID-19 treatments from March 2020. Over 2021/22, the team has introduced novel therapies including sarilumab, Ronapreve®, sotrovimab, molnupiravir and Paxlovid® into clinical practice for both out- and in-patient population. All prescribing is overseen by the antimicrobial team to ensure safe and effective use of these novel therapies. A guideline and prescriber information guideline has been created by the antimicrobial stewardship team with the Microbiology / ID team. The team has also supervised the COVID-19 medicines delivery unit (CMDU) introduction since December 2021 and provides 7 day prescribing support for this complex patient group.

14.2.4. In-patient bed-days saving through Out-patient antimicrobial therapy (OPAT) saving efficiency

The Antimicrobial stewardship team have continued to develop and support the OPAT service. Guidelines written by the AMS pharmacy team have been implemented cross-site to facilitate earlier discharge with the use of new agents (e.g. Cefazolin, thrice weekly Teicoplanin and elastomeric filled benzylpenicillin) and through delivery of multi-daily doses through 24 hour elastomeric infusion devices. This has been further improved with the introduction of pharmacy-lead self-administration training programme. Total numbers of OPAT have reduced as the team has targeted early oral de-escalation of therapy; this ensures overall greater bed-day saving but improves patient quality of life through more favourable oral treatments

14.2.5. Patient outcome measures

Due to the unavailability of ICNET for parts of 2021/22, the team have been unable to analyse trends in patient related outcomes secondary to infection. 30-day mortality, re-admission rates and length of stay trends are not available for comparison with previous years.

The prospective study, *Impact of early patient engagement on the outcome of their antimicrobial 48-72 hour review: an interrupted time-series intervention study*, is currently recruiting patients for involvement in a time-interrupted study to determine impact of patient involvement in Antimicrobial Stewardship. A total of 180 patients have been recruited to date. This work seeks to improve patient engagement in the decision making in clinical practice. Further work to collect patient outcome data via electronic device is being explored through NHS Entrepreneurship Fellowship.

14.3. Guidelines

- Updated cross-site A&E/UCC guidelines
- Updated cross-site paediatric empirical and surgical guidelines
- Updated cross-site adult empirical guidelines
- Updated cross-site adult dosing guidelines (now includes dosing in line with EUCAST)
- Updated obstetric and gynae empiric guidelines
- Updated COVID-19 treatment guidelines

14.4. Audit

- Management of invasive *S. aureus* infections (cross-site)
- Antibacterial prescribing in paediatric community acquired pneumonia (cross-site)
- Management of spontaneous bacterial peritonitis (cross-site)
- Audit of ITU vancomycin dosing and administration in adults (cross-site)

- Audit of non-ITU vancomycin dosing and administration in adults (cross-site)
- Audit of vancomycin and gentamicin dosing and administration in NICU (CW site)
- Antimicrobial prophylaxis prescribing in adult general surgery (cross-site)
- Ambisome prescribing (appropriateness and safety) in adult ITU patients (cross-site)
- Audit of paediatric appendectomy antibacterial prophylaxis prescribing

14.5. ***Antimicrobial Sensitivities Monitoring***

Yearly review of Trust sensitivity / resistance data to support guideline writing and to aid monitoring of resistance patterns. Bespoke antibiograms have also been created for clinical departments to improve local prescribing.

14.6. Teaching

- Junior Doctors: F1, F2 & CMT teaching sessions on prudent antibiotic prescribing
- Pharmacists: In house teaching sessions on a variety of antibiotic topics, including penicillin allergy, basic microbiology, antimicrobial resistance, OPAT management and the treatment of common infections
- Pre-registration pharmacists: Teaching session on antimicrobials for pre-registration pharmacists from Chelsea and Westminster Healthcare NHS Foundation Trust, Royal Marsden Hospital & Royal Brompton Hospital
- Induction training for new junior doctors and pharmacists
- Educational supervision for JPB Diploma for General Pharmacy Practice
- Junior Doctor new antimicrobial therapies and OPAT teaching
- Antimicrobial teaching for Imperial Medical Students
- ECCMID, FIS, CPC and IPC oral presentations
- UKCPA & RPS webinar teaching
- Research tutor for Imperial Medical Students

14.7. Publications and Presentations

- **Hughes S**. Chair of RPS and UKCPA COVID-19 and AMS webinars 2021/22; seventeen webinars completed to date
- **Hughes S**. Present of Pharmacy Congress (May & September 2021) on Antimicrobial Resistance
- **Hughes S**. Present of ECCMID Lisbon (April 2021) on AMS in A&E
- **Hughes S**, Mughal N, & Moore LSP. Procalcitonin to Guide Antibacterial Prescribing in Patients Hospitalised with COVID-19 **Antibiotics** (2021)10(9):1119
- **Valenti M**, Rangantathan N, Moore LSPM, **Hughes S**. *Listeria monocytogenes* infections: presentation, diagnosis and treatment. British Journal of Hospital Medicine (2021)
- **Mistry R, Hughes S**. *C. difficile* infection management. Pharmaceutical Journal (2021)

15. Body Fluid Exposure – Occupational Health

Report written by Head of Occupational Health

The Occupational Health and Wellbeing Department along with key stakeholders support staff following body fluid exposures at work.

Data submitted to the Trust's DATIX reporting system between 1st April 2021 and 31st March 2022 indicates that there were 166 body fluid exposures during the period.

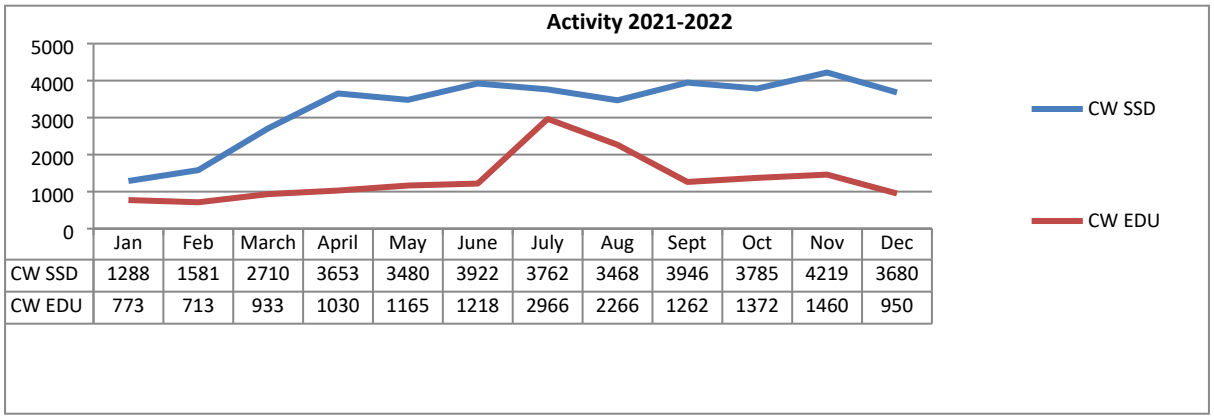
Table 9: Body fluid exposure reported via DATIX

Sub category	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Grand Total
Contact with sharps - Clean	1	2	1	1	1				3	2	1	1	13
Contact with sharps - Dirty	13	6	7	8	6	10	18	9	10	19	11	11	128
Exposure to biological hazard (inc splash / spill)	1	4	1	2	4	2	1	2	1	2	2		22
Exposure to chemical hazard (inc splash / spill)		1			1			1					3
CW site Total	**7**	**7**	**4**	**5**	**7**	**7**	**11**	**8**	**7**	**13**	**8**	**5**	**89**
Contact with sharps - Clean	1	1							3		1		6
Contact with sharps - Dirty	5	2	3	4	3	5	10	7	4	11	6	5	6
Exposure to biological hazard (inc splash / spill)	1	3	1	1	3	2	1	1	0	2	1		6
Exposure to chemical hazard (inc splash / spill)		1			1								6
WM site Total	**5**	**5**	**4**	**4**	**4**	**5**	**7**	**4**	**6**	**10**	**3**	**7**	**64**
Contact with sharps - Clean		1	1							2		1	6
Contact with sharps - Dirty	5	3	3	3	3	5	7	2	5	8	2	6	6
Exposure to biological hazard (inc splash / spill)		1		1	1			1	1		1		6
Exposure to chemical hazard (inc splash / spill)								1					6
Community clinics Total	**3**	**1**	**1**	**2**	**1**	**0**	**1**	**0**	**1**	**0**	**3**	**0**	**13**
Contact with sharps - Clean				1	1								6
Contact with sharps - Dirty	3	1	1	1			1		1		3		6
Grand Total	**15**	**13**	**9**	**11**	**12**	**12**	**19**	**12**	**14**	**23**	**14**	**12**	**166**

- 166 Body Fluid Exposures were reported among healthcare workers. This compares to 164 reported for 2020-2021. Healthcare workers across all occupational groups continue to be at risk of injury.
- There were no seroconversions to blood borne viruses (Hepatitis B; Hepatitis C; and/or HIV) during this reporting period.

16. Decontamination

Report written by Deputy Manager Decontamination Services



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
CW SSD	1288	1581	2710	3653	3480	3922	3762	3468	3946	3785	4219	3680
CW EDU	773	713	933	1030	1165	1218	2966	2266	1262	1372	1460	950

Figure 9. Activity 2021-22

The department successfully passed the annual three day External Audit during this year to confirm compliance with the requirements of the European Directive MDD/93/42/EEC and the ISO 13485:2016 Standard. From 2020/21 the service is registered with NQA and will no longer be accredited against European Directive MDD/93/42/EEC.

EDU JAG Accreditation Audit will take place on the 31st May 2022.

Chelsea & Westminster Hospital Update:

- The Project replacing all autoclaves and all the washers was successfully completed in November 2021, resulting in a more efficient and reliable operations.
- The RO system upgrade has also been completed.
- The new traceability system (Fingerprint) will be implemented by the end of May 2022.
- The new Quality Management System is under constant review with a full training programme to ensure full compliance.
- Loan equipment process is now operating successfully following implementation of a new procedure agreed by all parties.

West Middlesex Hospital Update:

- Ventilation system rebalanced and adjusted in December 2020. Airflows now in correct direction. Air changes are 14.4 in the Clean Side and 10.8 ACH via extract in the Dirty side.
- Clean room positive pressure at +16Pa to surrounding areas. Washroom -2Pa to surrounding. Whilst this falls short of the -5Pa recommendation, the difference to the clean room is well in excess of 10Pa. Further plans are also being considered to install an additional window extract in the wash room to achieve -5Pa.
- Particle counts show class 8 clean room standard.
- The Supplier Lubron installed the new RO water system and was upgraded on 19th and 20th September 2020.
- Sterile Services: I HSS provide Decontamination service for surgical instruments for West Middlesex site. IHSS are compliance with standards.

Departmental Improvement

New management has improved staff morale with the adoption of an open door policy with regular updates, encouraging two-way communication.

Staff structure was realigned and recruitment process reviewed accordingly.

Staff absenteeism has reduced over the year.

Communication has improved with all the stakeholders.

17. Trust's Estates & Facilities

Report written by the Contract Monitoring Manager, Estates & Facilities Directorate

The role of Estates and Facilities is to oversee all aspects of managing trust buildings and facilities services within them, this includes Soft FM (traditional services provided by ISS including cleaning and catering), Hard FM (JCA at Chelsea and Bouygues at West Middlesex, which includes building maintenance and ventilation), and NEPTS (Non-Emergency Patient Transport provided by HATS). Other services include Space management and Staff Accommodation across the Trust.

The E&F Team and our service partners work closely with both the Site Operations Teams and IPC to ensure compliance to all Trust Policies.

During the period April 2021 to March 2022 a number of services were affected by both local and national guidance e.g. national guidance was issued from UKHSA on cleaning, social distancing (which affected NEPTS as well as the way we use office space) and waste services. These were the most impactful to our services.

In addition with local IPC guidance other services were impacted, most notably cleaning services across the Trust with the decision to use Chlor-Clean routinely for daily cleaning significantly increase cleaning in clinical areas due to COVID-19. There has also been a significant increase in the number of hand gel dispensers made available around the trust and a corresponding increase in use of alcohol gel.

It should be noted that contractual KPI's for our service partners were suspended for the majority of the COVID-19 period, restarting in March 2022. This was to allow them to be flexible to the changing demands of the Trust without worrying about financial penalties in other areas for doing so.

17.1. Cleanliness

The second and third waves of the COVID-19 pandemic impacted a number of the Facilities Services provided across the Trust, namely waste, patient catering and most obviously cleaning. Over the course of the year, increased cleaning continued to be implemented in all areas across the Trust, including staff-only and public facing areas. Routine cleaning of all areas with Chlor Clean became standard practice during the pandemic.

The cleaning workforce, in particular on the COVID-19 managed wards was significantly increased in order to prevent the spread of the virus. All cleaning staff as well as other staff groups were fit tested for FFP3 masks, and the requirement for all subcontractors to maintain a level of fit tested staff within their teams continued to be made mandatory.

The use and cost of consumables also significantly increased over this period, notably curtain changes as part of "infectious" cleans required with every COVID-19 case.

Mask changing stations consisting of a large mask dispenser, with offensive waste bin and alcohol gel dispenser were positioned at the entrance/exit of every ward, and smaller mask holders were designed and put up with every apron and glove dispenser in the inpatient wards to ensure PPE was available in the correct place.

Additional manpower was recruited to man every entrance of the Trust's buildings for temperature checking with the use of Thermofy machines. This was in addition to mask and hand gel dispensers in position at the entrances.

Given the challenges of the second year of the pandemic, it has been acknowledged that the support from ISS and our Service Partners has been exemplary in both hospitals.

At the beginning of 2021, a notification was received from NHS England that the new National Standards of Healthcare Cleanliness (NSoC 2021) would be rolled out as from April 2022. Work started immediately after the announcement to be ready for the official implementation date.

All Trust's areas were reviewed to allocate them to the new risk categories from FR1 to FR6 according to the new guidance, these replaced the very high, high, significant and low risk categories according to NSoC 2007.

At West Middlesex Hospital which is run by a PFI management company, a request for a variation to the cleaning contract was issued in order to comply with the mandatory requirement to follow the new NSoC 2021, which means a delay in implementing the new standards is still ongoing.

17.1.1. Cleanliness: Chelsea and Westminster Hospital

During the year a total of 1793 cleaning audits were undertaken in accordance with NSoC. Only 11 cleaning audits were cancelled due to COVID-19 ward closures or restricted access during periods of the pandemic, however regular inspections of the areas by service managers continued.

In October 2021 The National Standards of Healthcare Cleanliness were implemented ahead of the national launch in April 2022 and risk categories were allocated to all areas according to the new guidance.

Within the Very High-Risk/FR1 category, all functional areas were inspected weekly except for closed areas or restricted access areas, resulting in a total of 960 audits. All audits achieved the minimum target score of 98%. The overall average score achieved for this category was 98.68% showing consistency with the previous year's score of 98.4%.

In the High Risk/FR2 category, all functional areas were inspected monthly resulting in a total of 590 audits for the year, except for closed areas or restricted access areas due to COVID-19. All audits achieved the minimum target score of 95%. The overall average score achieved for this category was 97.6%.

Functional areas within the FR3 Risk category have all been audited accordingly making it a total of 24 audits for the year. The average score achieved for this risk category was 96.90% against a KPI target of 90%.

Compliance with cleaning audits being carried out jointly with a member of clinical staff was 100% in all risk categories reported above.

Where access was permitted, the below areas were deep cleaned and/or enhanced cleaned between April 2021 and March 2022 as part of the deep cleaning programme. A full deep cleaning programme for 2021 was shared with Estates and Facilities Department:

- Mars
- Apollo Ward
- Birthing Centre
- ED OBS
- Intensive Care Unit & High Dependency Unit
- Burns Unit
- Burns Operating Theatre
- Ron Johnson - HIV centre
- Labour Ward
- Labour Theatre
- Josephine Barnes Ward / HDU

- Neonatal Unit (NICU)
- Treatment Centre Day Surgery
- Operating Theatres (Main) & Recovery
- Children Theatres & Recovery
- Dermatology Theatre (Daniel Turner Theatre)
- ED Resus
- ED Paediatric
- ED Majors
- Gazzard Unit
- Endoscopy Unit/Theatres
- ECG/Cardiology & Lung Function

In addition to the standard discharge cleans carried out between April 2021 and March 2022, the cleaning teams completed 9,758 infectious cleans which is an increase of 38% compared to the previous year. Of the 9,758 infectious cleans, 5,232 (46.38%) were related to COVID-19.

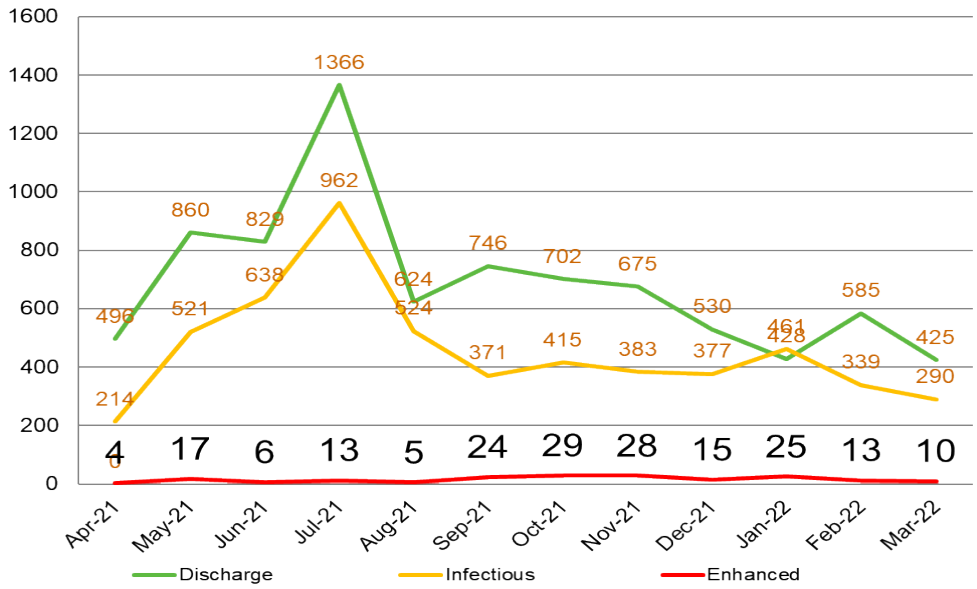


Figure 10. Cleans – Chelsea & Westminster hospital

17.1.2. Cleanliness: West Middlesex Hospital

During the year a total of 1,264 cleaning audits were undertaken in accordance with National Specification of Cleanliness 2007. Within the Very High-risk category, all functional areas were inspected weekly making it a total of 432 audits for the year April 2021 to March 2022. All audits achieved the minimum target score of 95%. The overall average score achieved for this category was 98.8% showing a slight increase compared with last previous year's score of 98.6%.

In the High-risk category, all functional areas were inspected monthly making it a total of 516 audits for the year April 2021 to March 2022. All audits achieved the minimum target score of 90%. The overall average score achieved for this category was 96.7% showing a slight increase compared with the previous year's score of 96.4%.

Functional areas within the Significant risk category, which includes mainly OPD clinics, had all been audited monthly rather than quarterly making it a total of 144 audits for the year. The average score achieved for this risk category for was 96% against a KPI target of 85% which is similar to last year's score, which was 96.1%.

Compliance in respect of cleaning audits being carried out jointly with a member of clinical staff reached 100% in Very High-risk category similar with previous year. Within the High-risk category joint auditing compliance achieved 100%, showing an improvement from last year.

Between April 2021 to March 2022, the ISS special projects team have completed a total of 78 deep cleans which include the annual deep clean of Main Theatres and the quarterly deep clean of Aseptic Suite in Pharmacy.

In addition to the "standard" discharge cleans carried out between April 2021 and March 2022, the cleaning teams completed 4646 "infectious" cleans which is a decrease of 35% compared to previous year and 20% of the total volume of discharge cleans for previous year. 43% of Infectious cleans were related to COVID-19 cleans.

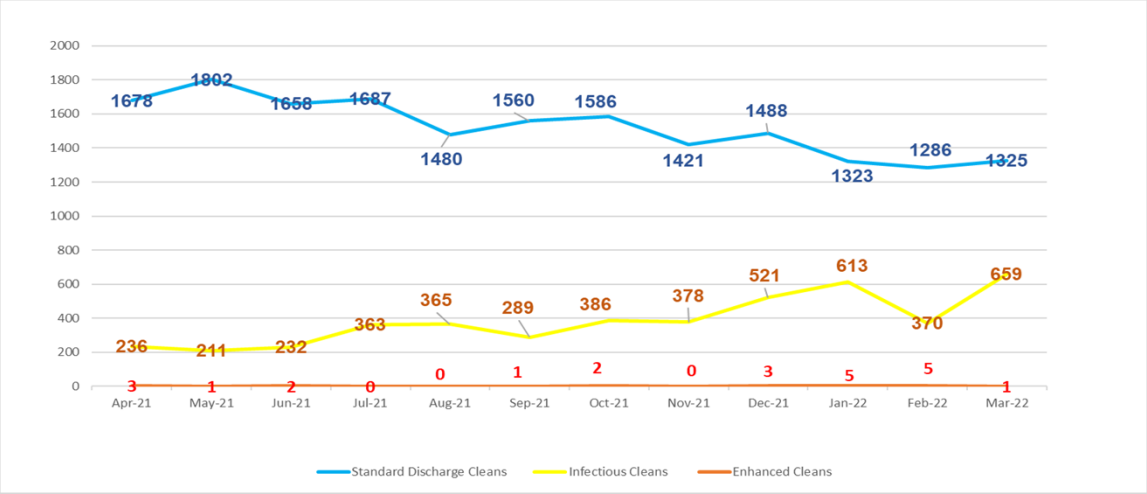


Figure 11. Cleans – West Middlesex Hospital

17.2. Estates and Facilities Cross-site Coronavirus Update

17.2.1. Mask Fit Testing

In October 2020, due to the change of the FFP3 mask type, ISS commenced re-testing of ISS staff working in high-risk areas. During 2021-22 ISS fit tested a total of 69 members of staff at West Middlesex Hospital and 95 members of staff at Chelsea and Westminster Hospital who worked in COVID managed areas. ISS have 3 trained Fit Testers on each site.

17.2.2. Lateral Flow Devices

Throughout 2021/2022, ISS distributed COVID-19 lateral flow devices (home testing kits) to patient facing staff. Staff were provided with a demonstration and briefing on how to use the kit and test

results are recorded manually on a 'Statutory Report Form' which is checked by Supervisors on a weekly basis to ensure compliance.

17.2.3. Cleaning after Aerosol Generating Procedures (AGPs)

Updated guidance from Infection Prevention and Control stated that where 'AGP' procedures were carried out, staff had to wait 30 minutes before entering negative pressure rooms and 45 minutes for neutral pressure rooms after the AGP had finished. These instructions were put in place with the ISS dispatch desk and domestic staff were briefed before undertaking cleaning.

17.2.4. Risk Assessments

COVID-19 workplace, BAME and individual risk assessments were carried out for ISS staff returning to work following shielding or recovery from COVID-19.

17.2.5. Vaccination

Roll out of staff vaccinations commenced late December 2020. To date 95% of ISS staff & sub-contractors received their first vaccination. 90% of BAME staff have received their vaccination at West Middlesex Hospital and 90% of BAME staff have been vaccinated at Chelsea and Westminster Hospital.

17.3. JCA – Chelsea and Westminster Hospital

Report written by JCA Stock Control and Senior Water Supervisor

JCA continue to contribute to the monthly Water Safety Group (WSG). ZetaSafe is constantly reviewed by the team on site and when necessary additional outlets are added. The red readings on Zeta temperatures outside of the required parameters have been reported at the WSG monthly meetings. Identified infection risks readings have been subject to regulatory guidance, in non-clinical areas and under the guidance of the IPCT, risk assessments have been undertaken to identify where samples need to be retaken.

JCA have Responsible and Deputy Responsible persons on site also a lead water technician who have all completed responsible person training in Practical Water Safety for Healthcare Premises courses. In addition, there is a water technician who has completed water safety for healthcare technicians.

The main control measures around both *Legionella* and *Pseudomonas aeruginosa* are based on maintaining the correct temperatures, flushing little used water outlets, and minimising dead legs. Where positive counts have occurred in clinical areas, remedial actions were immediately taken along with resamples. All microbiological samples are analysed by UKHSA. Positive results usually have a local identifiable cause, such as low use of the outlet. All outbreaks are thoroughly investigated to ascertain the root cause of the problem.

The *Legionella* risk assessment was carried out in May 2020, a review is due in 2022. JCA have completed the remedials from the risk assessment in 2020.

The hydrotherapy pool has been closed for the past 24 months.

The monitoring of the negative pressure rooms continues a monthly basis. Where rooms were outside of the accepted parameters remedial actions were taken.

17.4. Bouygues Energies and Services – West Middlesex Hospital

Report written by Bouygues Contract Manager

Bouygues have continued to use Zetasafe to monitor water hygiene and to observe trends across the West Middlesex Site.

A flow issue was identified affecting the time it takes to get to temperature in Richmond Ward and AEC. This issue has been discussed in the Water Safety Group and there is an action plan in place to rebalance the system, with a contingency design of splitting off the area to have its own dedicated hot water circuit. To mitigate risk, there is a control scheme in place which includes daily flushing of outlets in the affected area, along with enhanced monthly biological testing.
Microbiological testing is also undertaken by UKHSA at the request of the Trust. Positive results usually have a local identifiable cause, such as low use of the outlet. Following the introduction of replacing shower heads and hoses, Bouygues are continuing to see a reduction in *Legionella* and *Pseudomonas aeruginosa* levels at WM.

The monitoring of negative pressure rooms on site have all been satisfactory throughout the year and clinical staff within the areas carry out daily monitoring checks – this includes the two new rooms in the Richmond ward that were built as part of the surge project at the end of 2020.

Ventilation validation has been carried out in all designed procedure rooms and theatres across site, and there is a current project moving forward looking at all ventilation flow rates where mechanical ventilation exists.

All other HTM03 AND HTM04/L8 compliance has been adhered to and the site is well maintained.

Appendix 1: Terms of Reference - Infection Prevention and Control Group

1. Constitution

The Infection Prevention and Control (IPC) Group is established as a formal sub-committee of the Patient Safety Group, which in turn reports to the Quality Committee, a formal Committee of the Trust Board.

The group will

- Work to an annual plan
- Monitor performance against targets/objectives and against policy standards
- Report on the incidence and prevalence of 'alert organisms'
- Report on the nature of any outbreak of infection
- Develop & maintain IPC policies
- Report into & provide assurance to the Patient Safety Group on all aspects of IPC.

The Patient Safety Group will review and approve these Terms of Reference on a yearly basis.

2. Authority

The IPC Group is directly accountable to the Patient Safety Group, and will provide a summarised report of activity on a quarterly basis, with more frequent reporting by exception as required or at the request of the Director of Infection Prevention and Control.

3. Aim

The IPC Group will focus on all aspects of IPC for employees, patients and visitors to the Trust and will operate in accordance with the requirements of the Health and Social Care Act 2008 and CQC Regulation 12 Guidance.

4. Objectives

- To approve and review progress against the annual plan for IPC.
- To approve the annual report for IPC prior to presentation to the Patient Safety Group/Quality Committee.
- To advise the Chief Executive Officer of any serious problems or hazards relating to IPC.
- To monitor Trust performance against the healthcare acquired infections explicated in the Health and Social Care Act 2008 including externally set objectives.
- To monitor performance against hand hygiene and care bundles and associated internally set targets.
- To approve Trust policies in relation to IPC and monitor the relevance of and compliance with them.
- To advise on the planning and development of services and facilities in the Trust on issues relating to IPC.
- To be provided with assurance by the hard and soft facilities management in conjunction with Trust Estates team who have overarching responsibility, including water safety, on both sites on a monthly basis.

- Monitor and report on Trust responsiveness to outbreaks of infection from ward to executive levels.
- Examine and provide feedback on IPC audits on a regular basis.
- The Group will consider any other reports relevant to IPC in the Trust.
- The Group will be kept up to date with new or revised international, national or local guidance and legislation.
- Receive quarterly reports from:
    - Decontamination Lead
    - Head of Occupational Health
    - Public Health England/Health Protection Units.
    - Antimicrobial Stewardship Team
    - Surgical Site Surveillance Officers
    - Receive the following annually:
    - Sharps and inoculation incidents and audits

5. Method of working

The IPC Group will have a monthly standard agenda with additional quarterly and annual reports.

6. Membership

The Members of the IPC Group shall comprise of:-

- Director of Infection Prevention and Control (Chair)
- Director of Nursing
- Consultant Microbiologists
- Infection Prevention and Control Specialist Nurses
- Antimicrobial Pharmacists
- Consultant in Communicable Disease Control / Health Protection Team Nurse
- Health and Safety Manager
- Occupational Health Manager
- Trust Decontamination Lead
- Deputy Director for Facilities and Estates
- ISS Soft FM General Manager
- Bouygues Energies and Services General Manager
- JCA General Manager
- Divisional Nurses
- Senior Divisional Doctors
- Divisional Directors
- Infection Prevention and Control Team Administrator
- Matrons

Core members are expected to send deputies in their absence

Meetings of IPC Group shall not be held in public.

Only the Group Chair and members shall be entitled to be present. In addition, other members may be invited to attend some meetings depending on the agenda items to be discussed at the invitation of the Group.

7. Quorum

The quorum shall be 8 members, of whom one shall be either the chair or nominated deputy.

8. Frequency of Meetings

The Infection Prevention and Control Group will meet monthly using video/teleconferencing facilities to enable across site attendance.

Members are expected to attend a minimum of 80% of the meetings. If members cannot attend, they should expect to send a well briefed deputy.

9. Secretariat

Papers, action logs, minutes and agenda to be circulated by the IPC Team.

The meeting slides will be uploaded onto the intranet within 72 hours of the meeting. The notes of the meeting will be uploaded onto the intranet once approved. Both will be stored by the IPC Team.

10. Review

The IPC Group will review these Terms of Reference on a yearly basis. Any recommended changes to the Terms of Reference will require the approval of the Patient Safety Group. TOR are next due for review July 2022.

Appendix 2: Infection Prevention and Control Data

MRSA bacteraemias

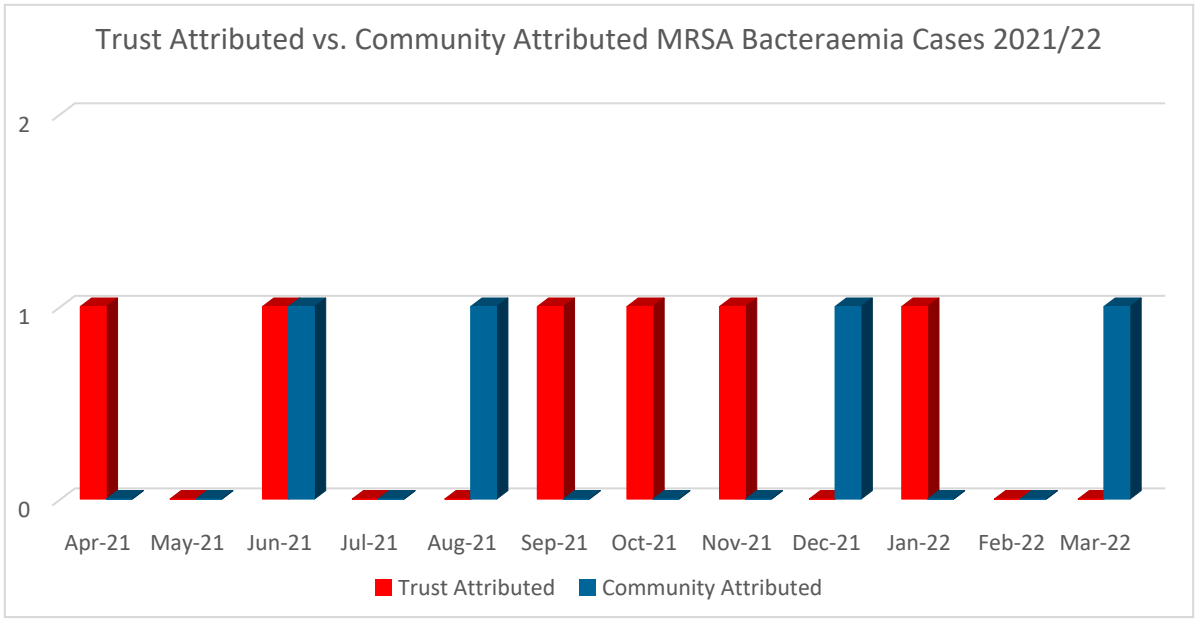


Figure 12: Hospital onset vs. community onset MRSA bacteraemias April 2021 – March 2022

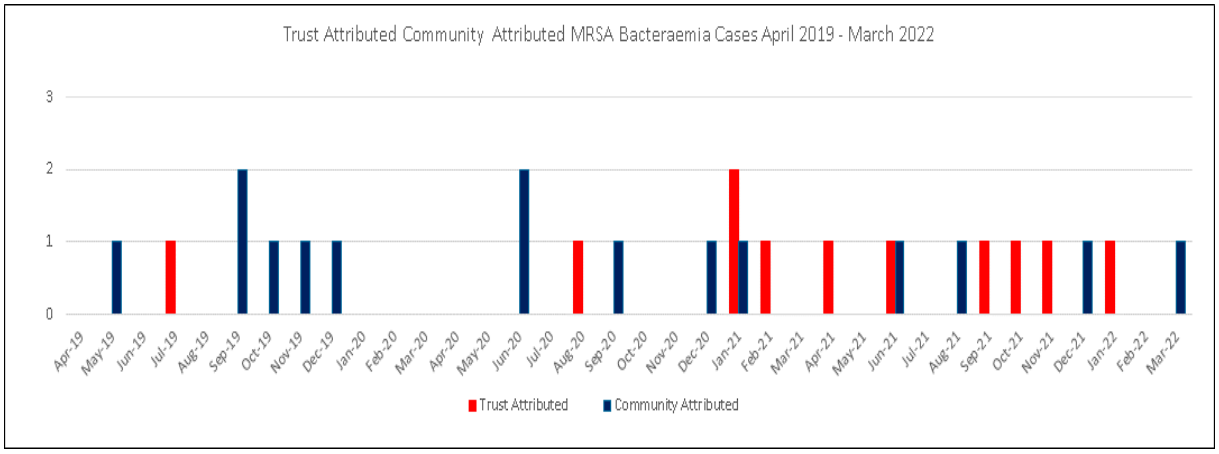


Figure 13: Hospital onset cases April 2019 – March 2022

***Clostridium difficile* infections**

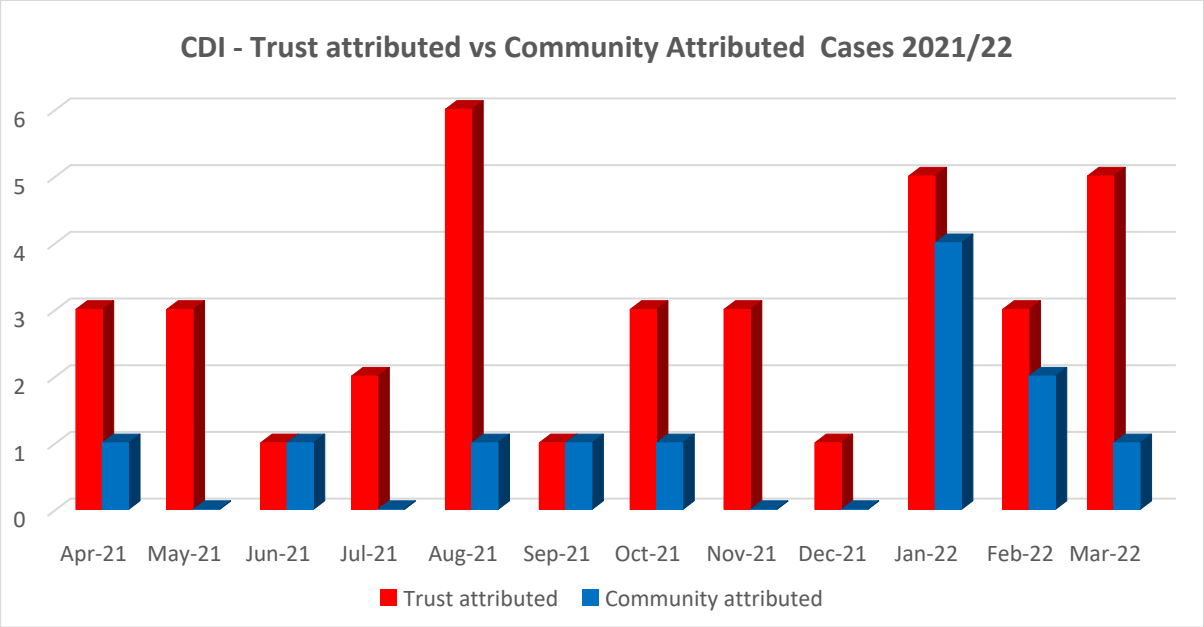


Figure 14*: Clostridium difficile* cases per month and attribution April 2021 – March 2022

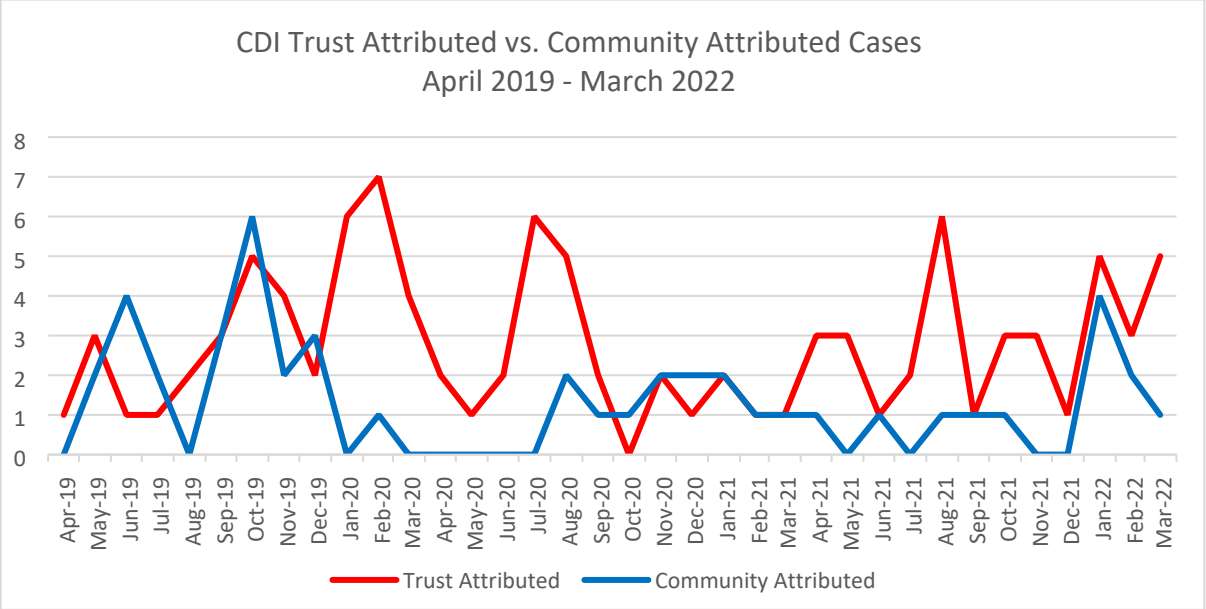


Figure 15: Trust attributed *Clostridium difficile* vs Community Attributed Cases April 2019 – March 2022

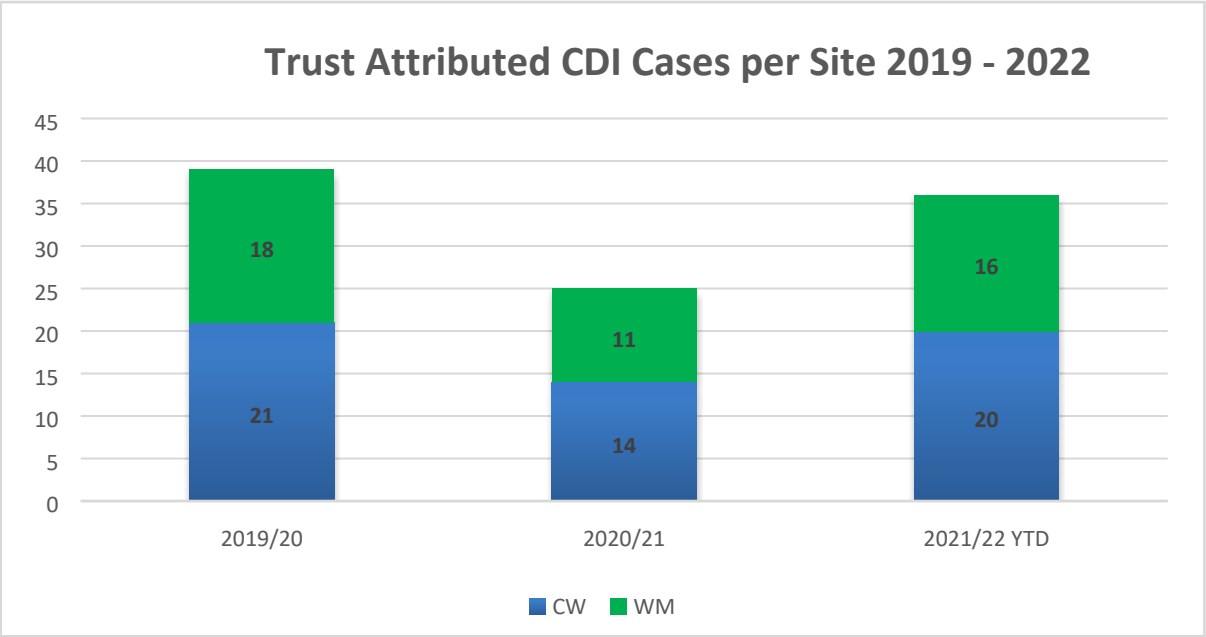


Figure 16: Trust Attributed CDI Cases per Site April 2019 – March 2022

MSSA bacteraemias

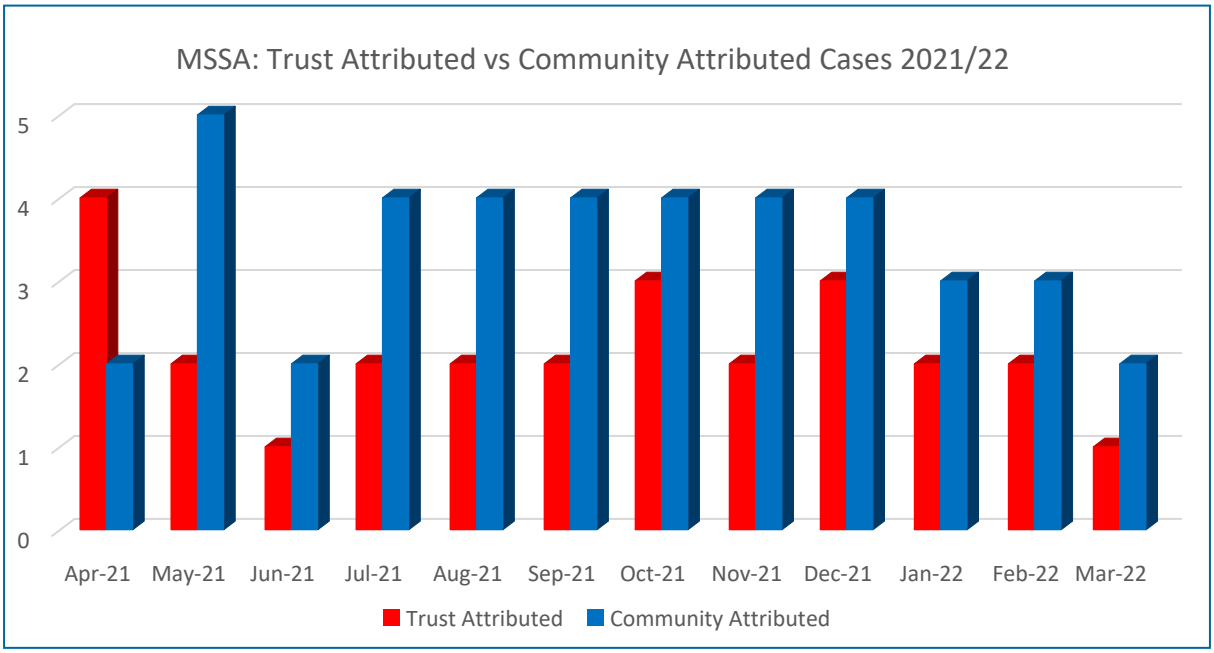


Figure 17: Trust Attributed vs. Community Attributed MSSA bacteraemias April 2021 – March 2022

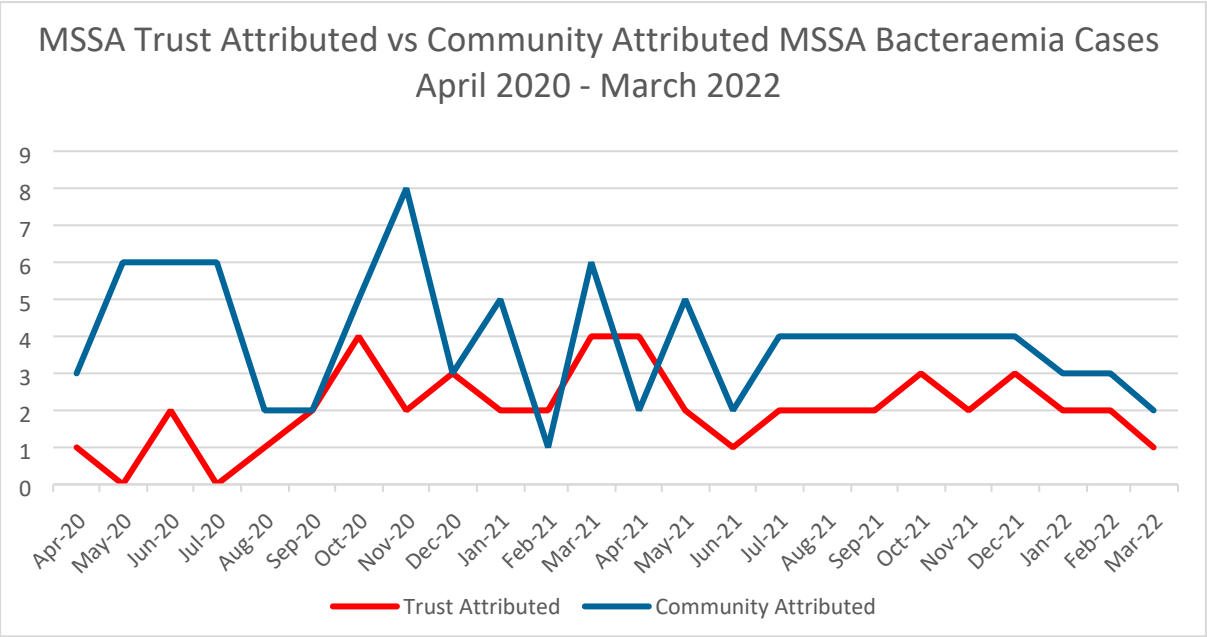


Figure 18: MSSA Trust Attributed vs. Community Attributed MSSA Bacteraemia Cases April 2020 – March 2022.

***E.coli* bacteraemias**

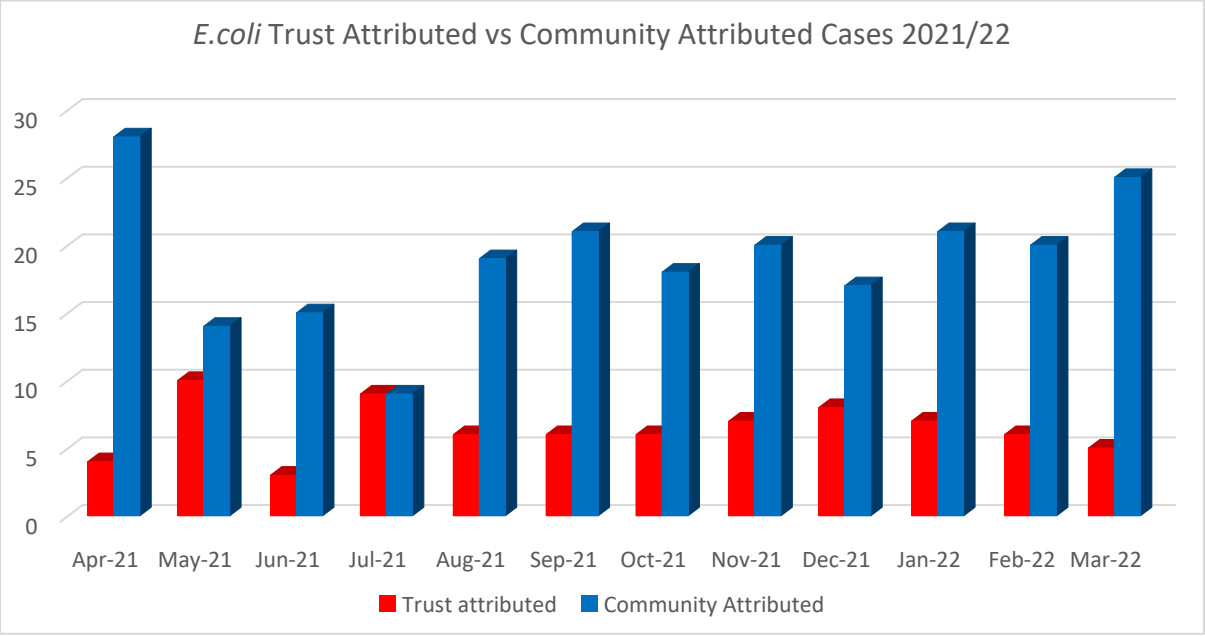


Figure 19: Trust Attributed vs. Community Attributed *E.coli* bacteraemias April 2021 – March 2022.

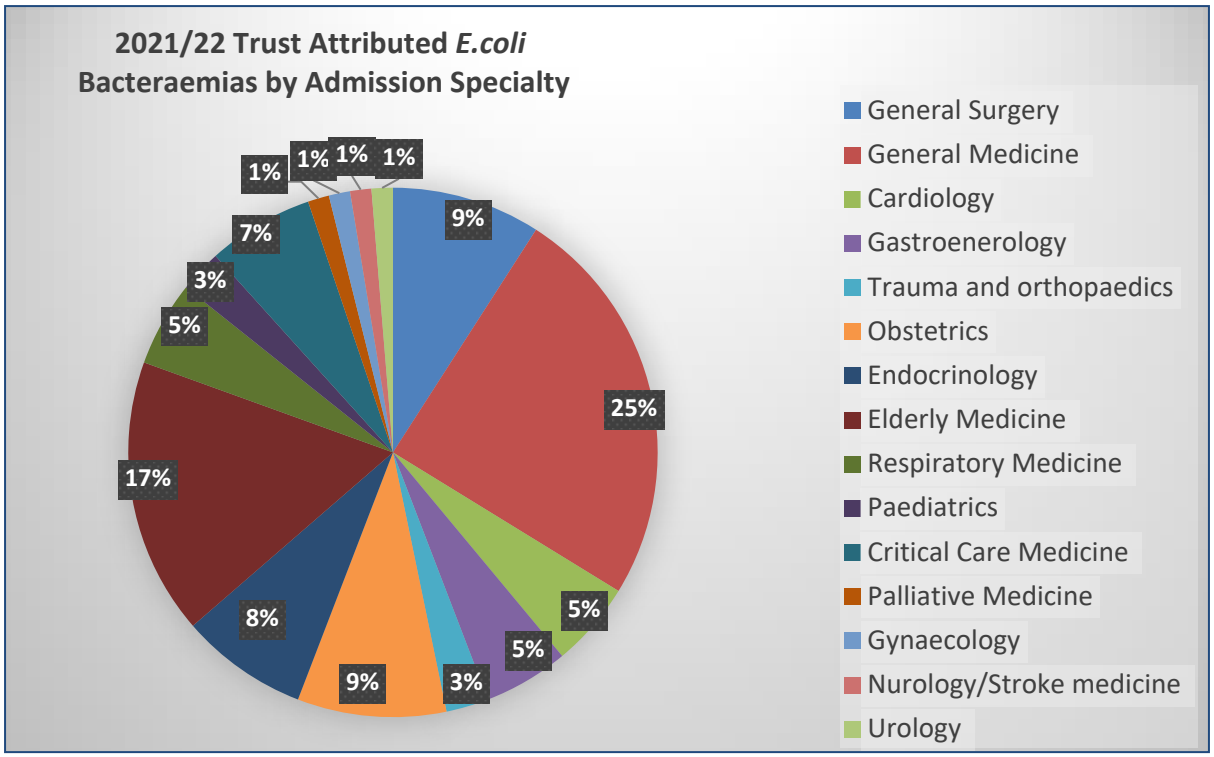


Figure 20: *E.coli* deep dive data: Admission Specialty of Trust attributed bacteraemias identified from April 2021 – March 2022.

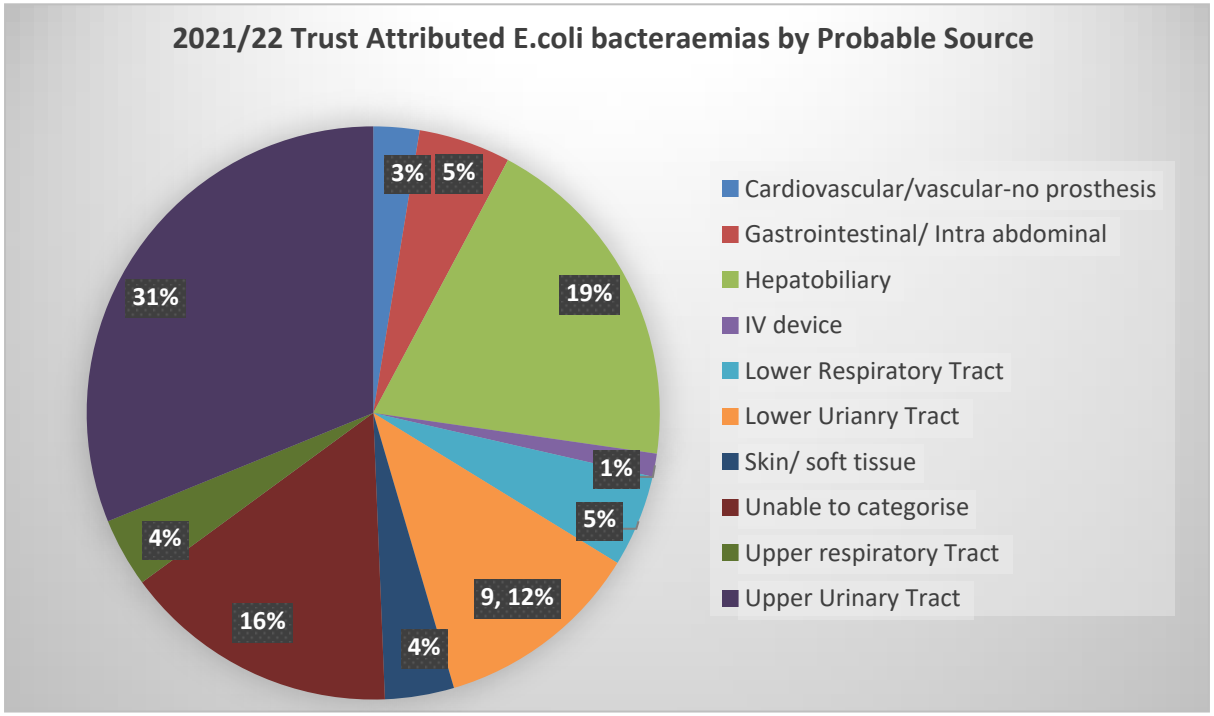


Figure 21: *E.coli* deep dive data: 2021/22 Trust attributed bacteraemias by Probable Source

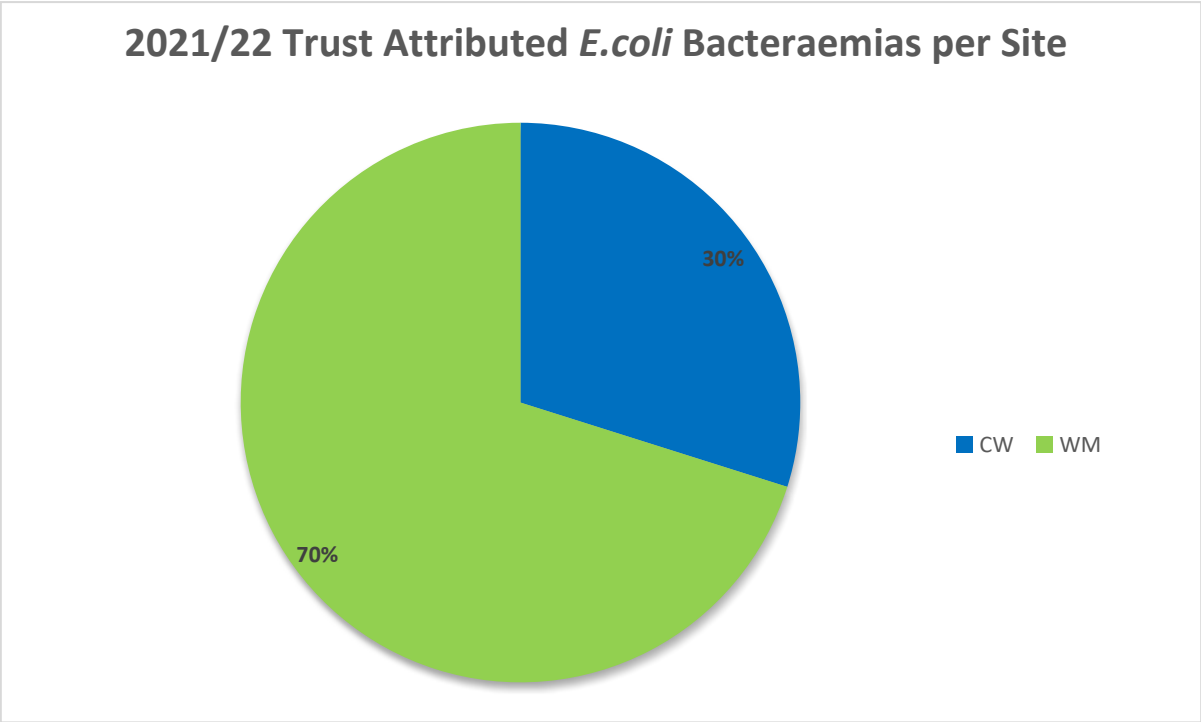


Figure 22: *E.coli* deep dive data: Trust Attributed *E.coli* Bacteraemias per Site.

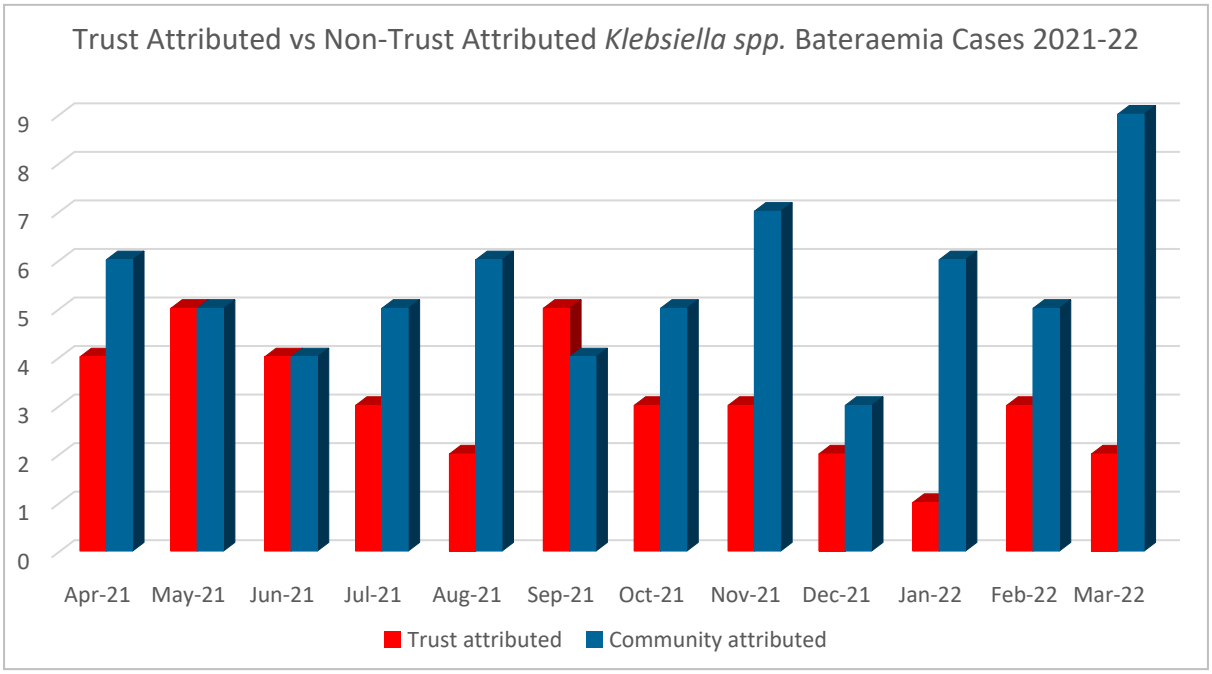


Figure 23: Hospital vs. Community onset *Klebsiella spp*. Blood stream Infections 2021/22.

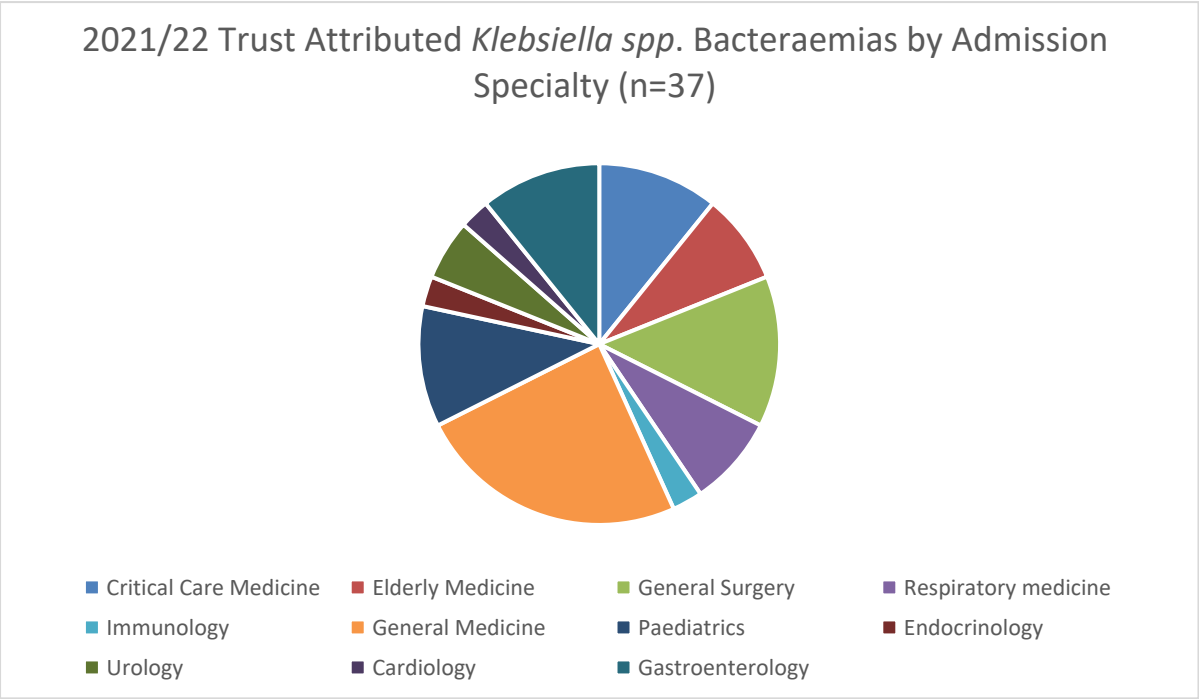


Figure 24: 2021 Trust Attributed *Klebsiella Spp*. Bacteraemias by Admission Specialties.

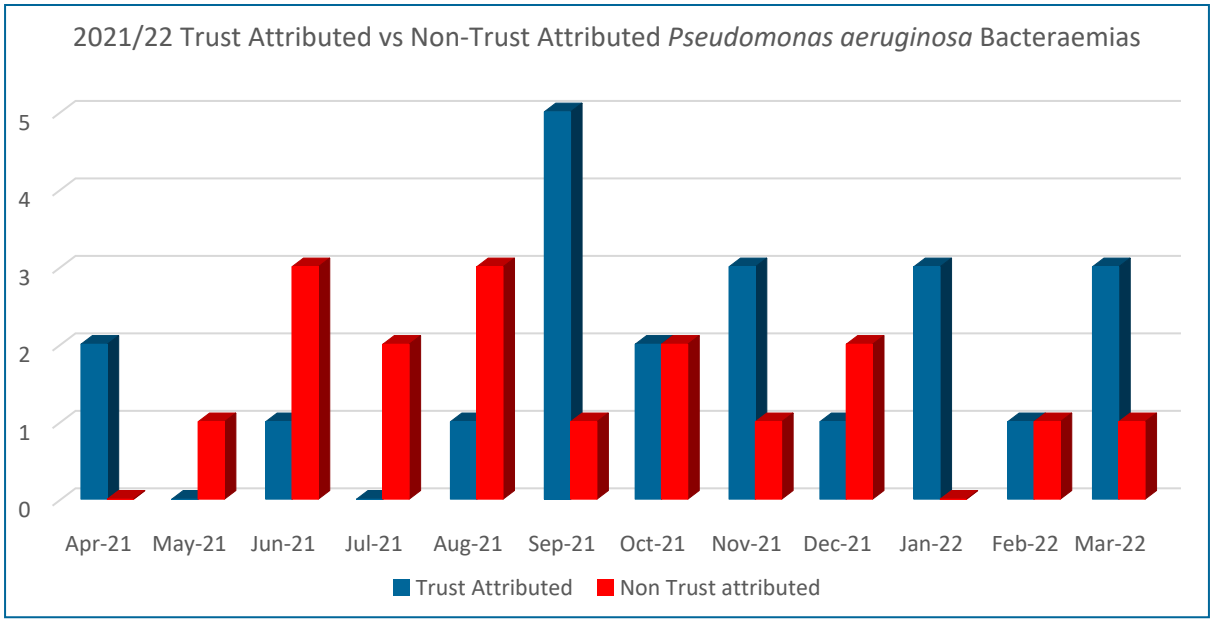


Figure 25: Hospital onset vs. Community Onset *Pseudomonas aeruginosa* Blood Stream Infections 2020/21.

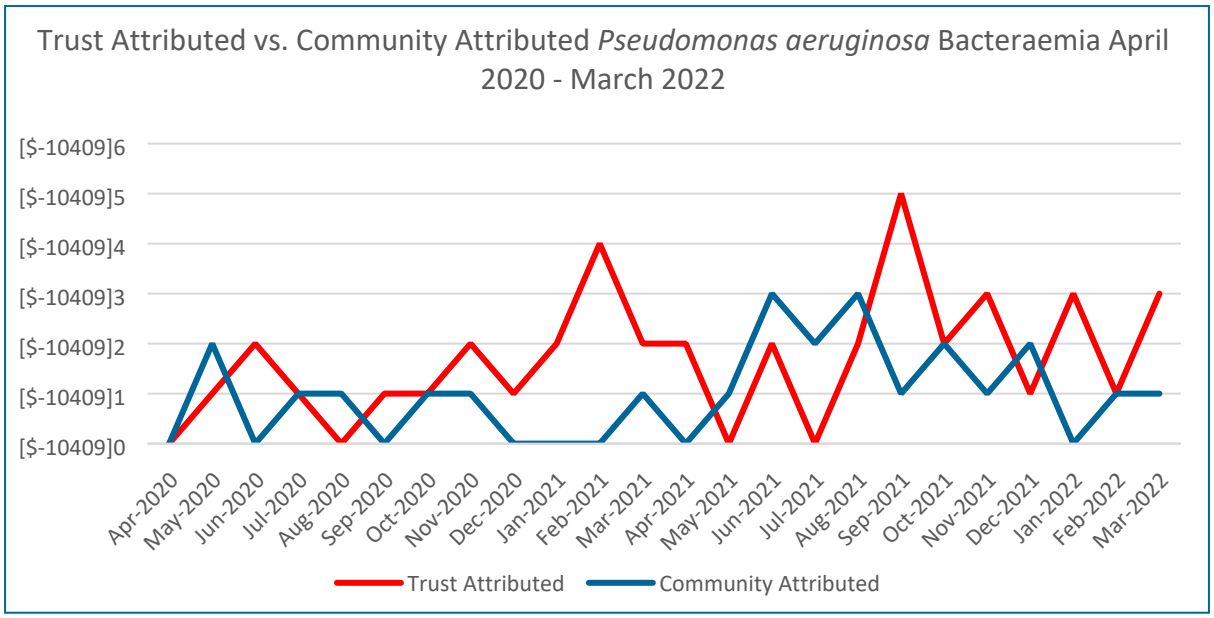


Figure 26: Trust Attributed Pseudomonas aeruginosa bacteraemias April 2020 – March 2022

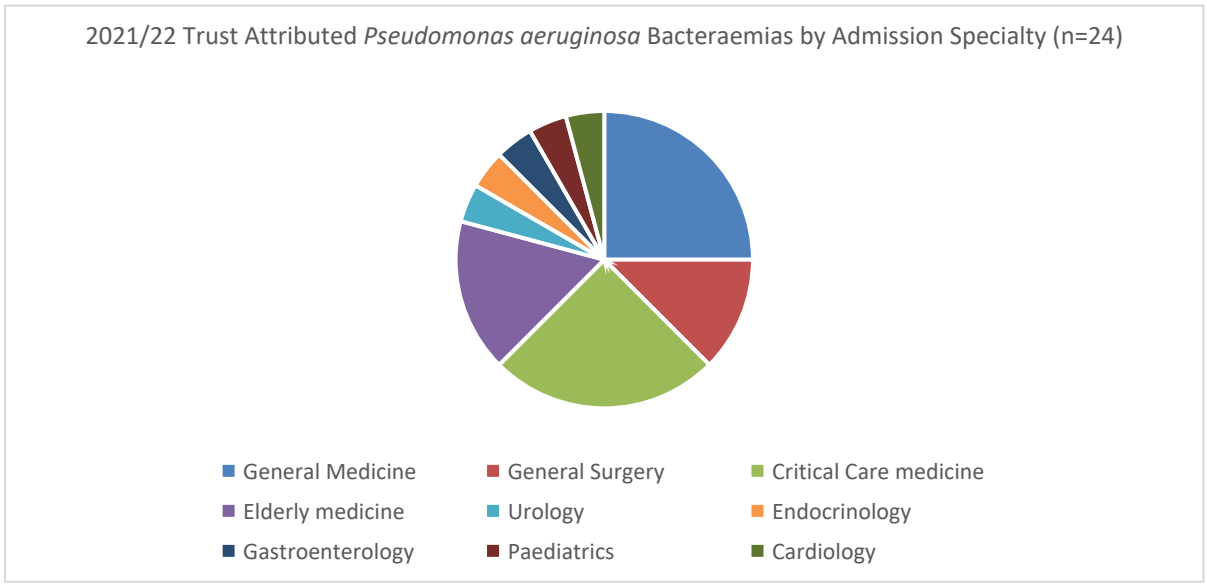


Figure 27: Trust attributed *Pseudomonas aeruginosa* bacteraemias by Admission Specialty.

Hand Hygiene Audit Data

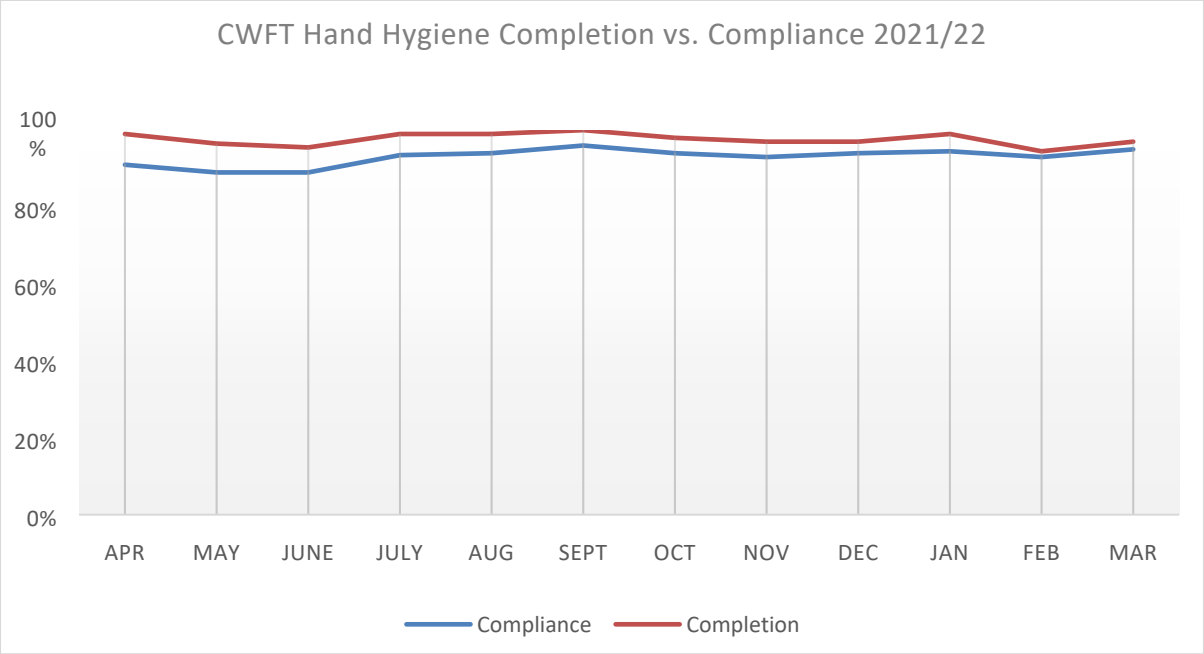


Figure 28: Trust Average hand hygiene completion and compliance

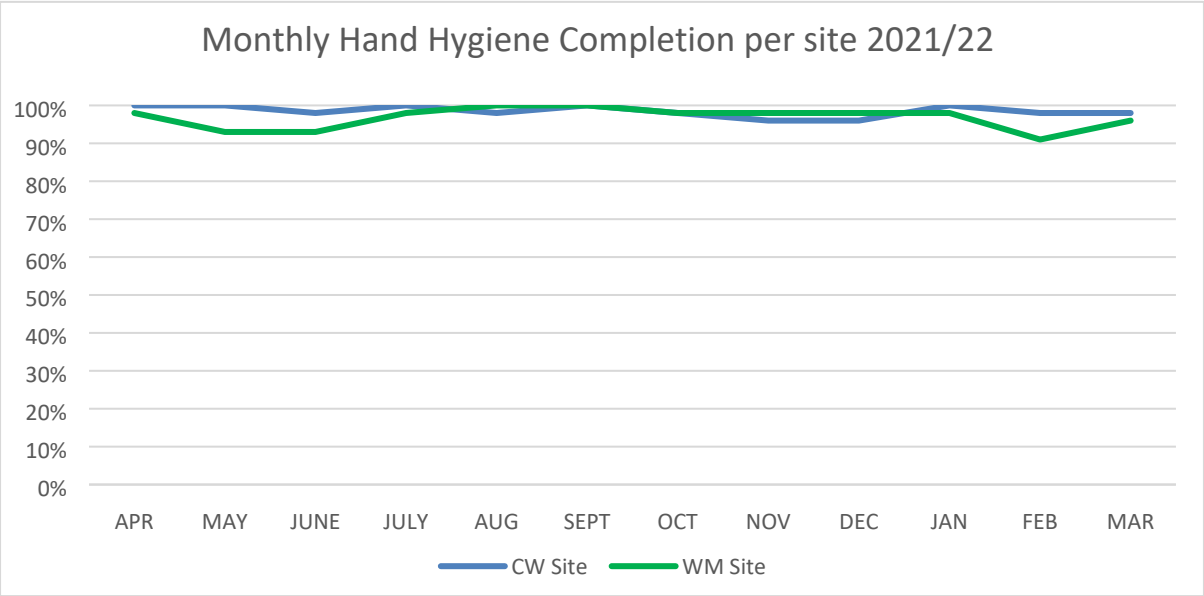


Figure 29: Average Hand hygiene audit Completion per site

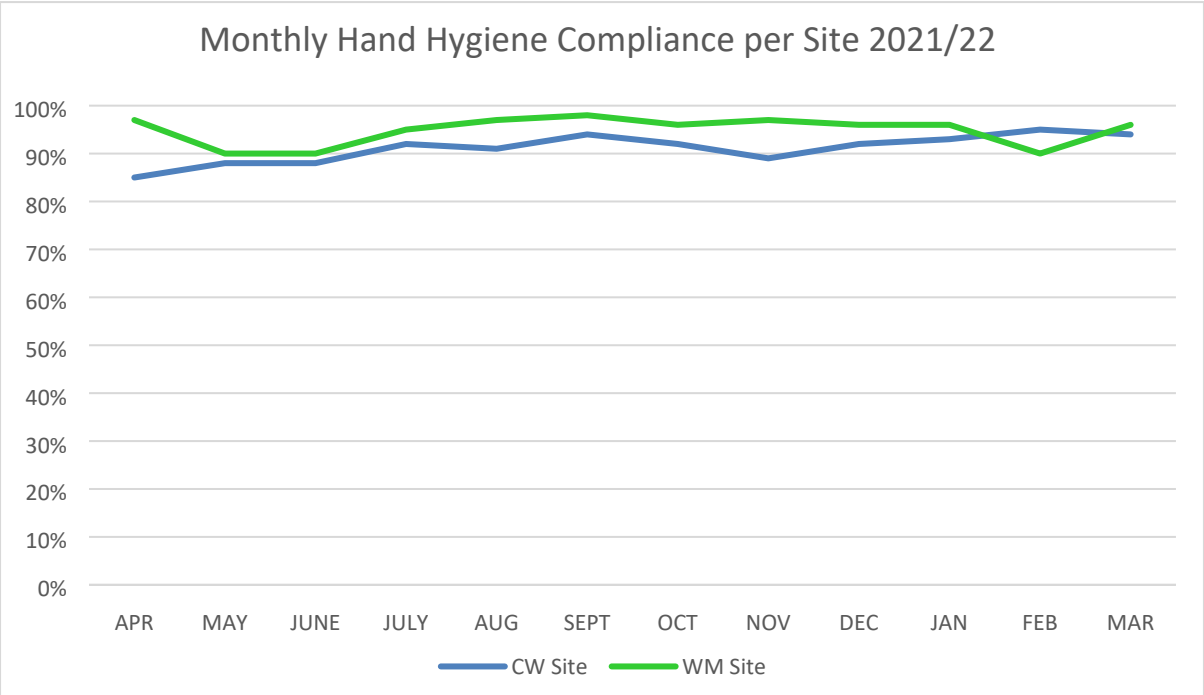


Figure 30: Hand Hygiene compliance Site

Infection Prevention and Control Audit Data

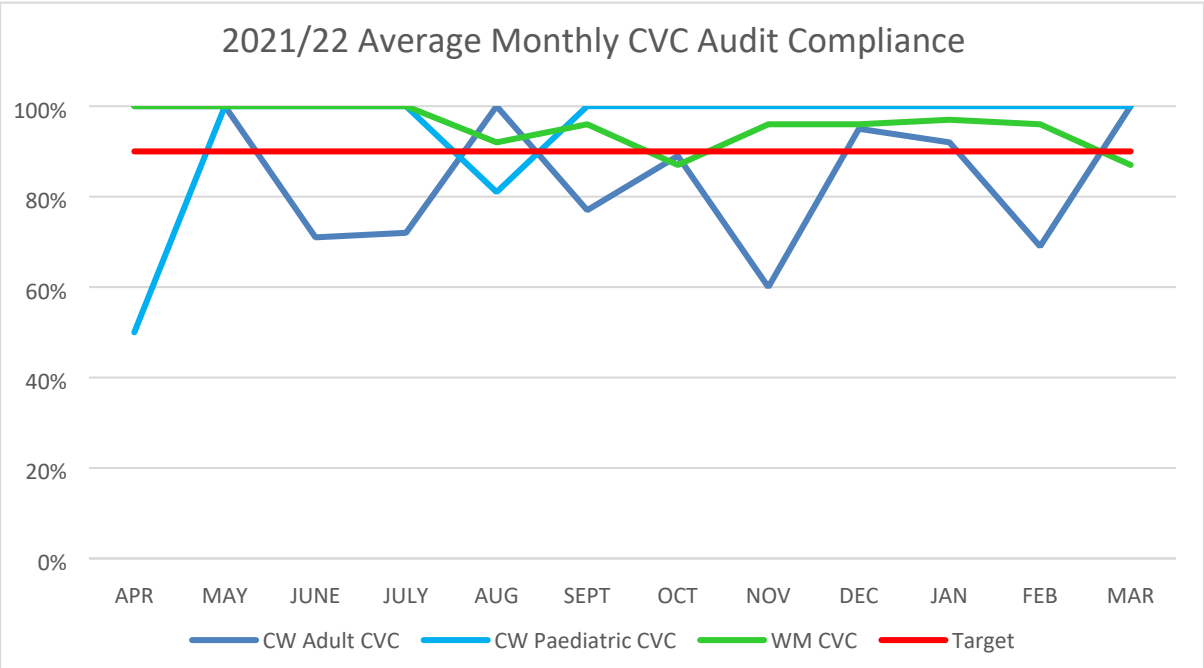


Figure 31: High Impact intervention Central Venous Catheter (CVC) audit results 2021 – 22

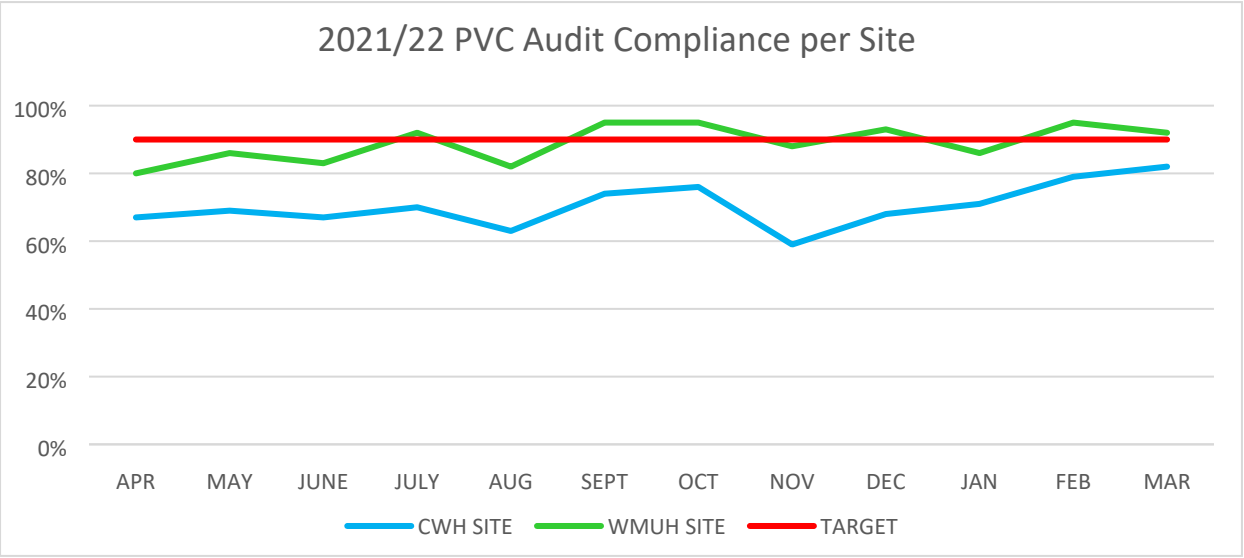


Figure 32: High impact interventions Peripheral Venous Catheter (PVC) Audit results 2020 – 21

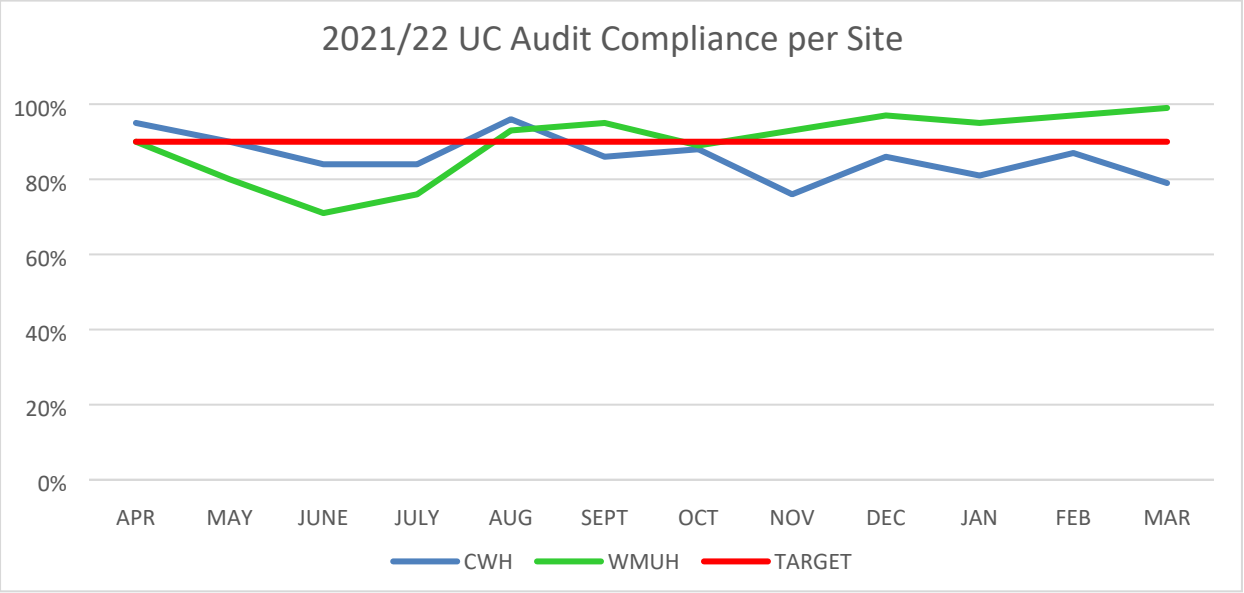


Figure 33: High Impact Intervention Urinary Catheter Audit results 2020-21

Divisional Audit Data – Hand Hygiene

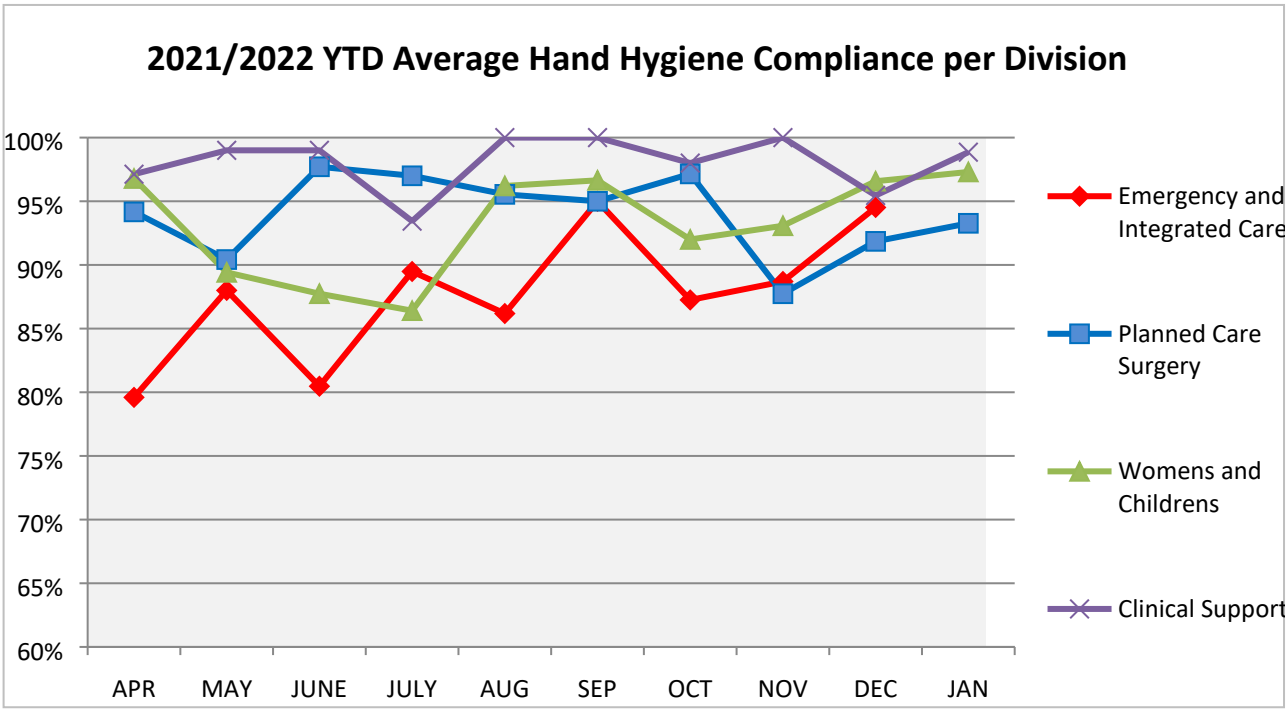


Figure 34: Hand hygiene audit result per Division

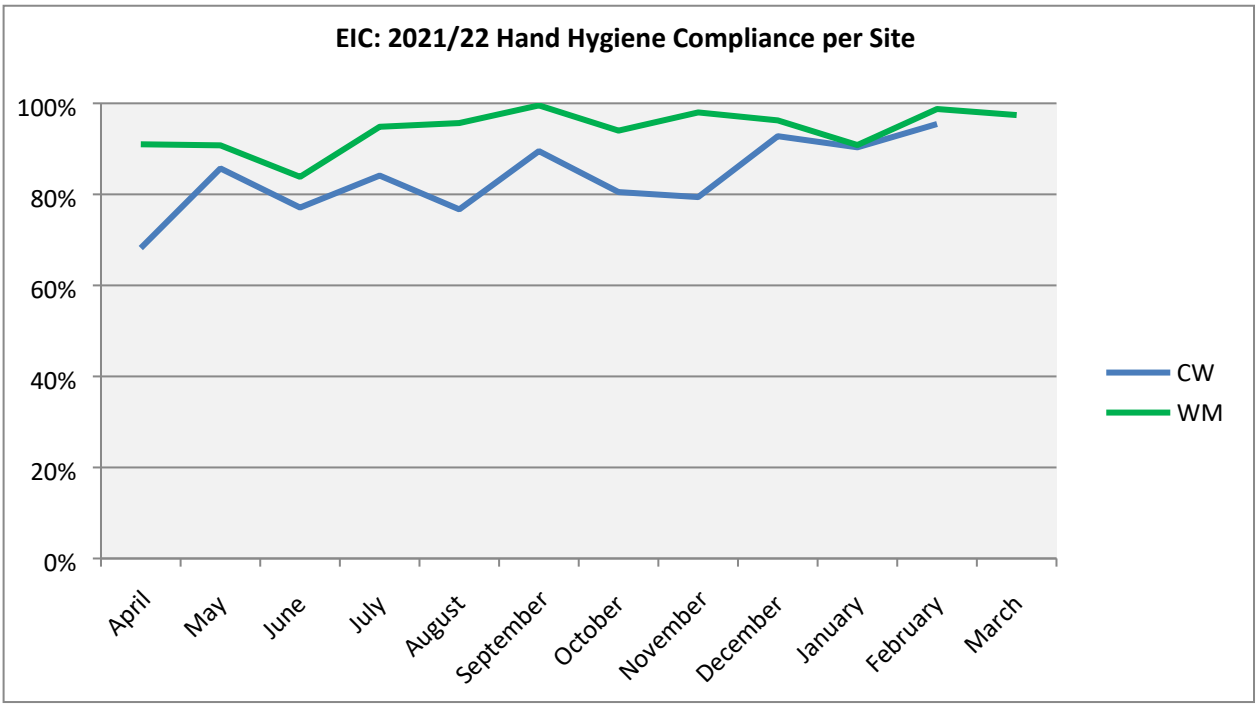


Figure 35: Emergency and Integrated Care (EIC) division Hand hygiene audit result 2020/21

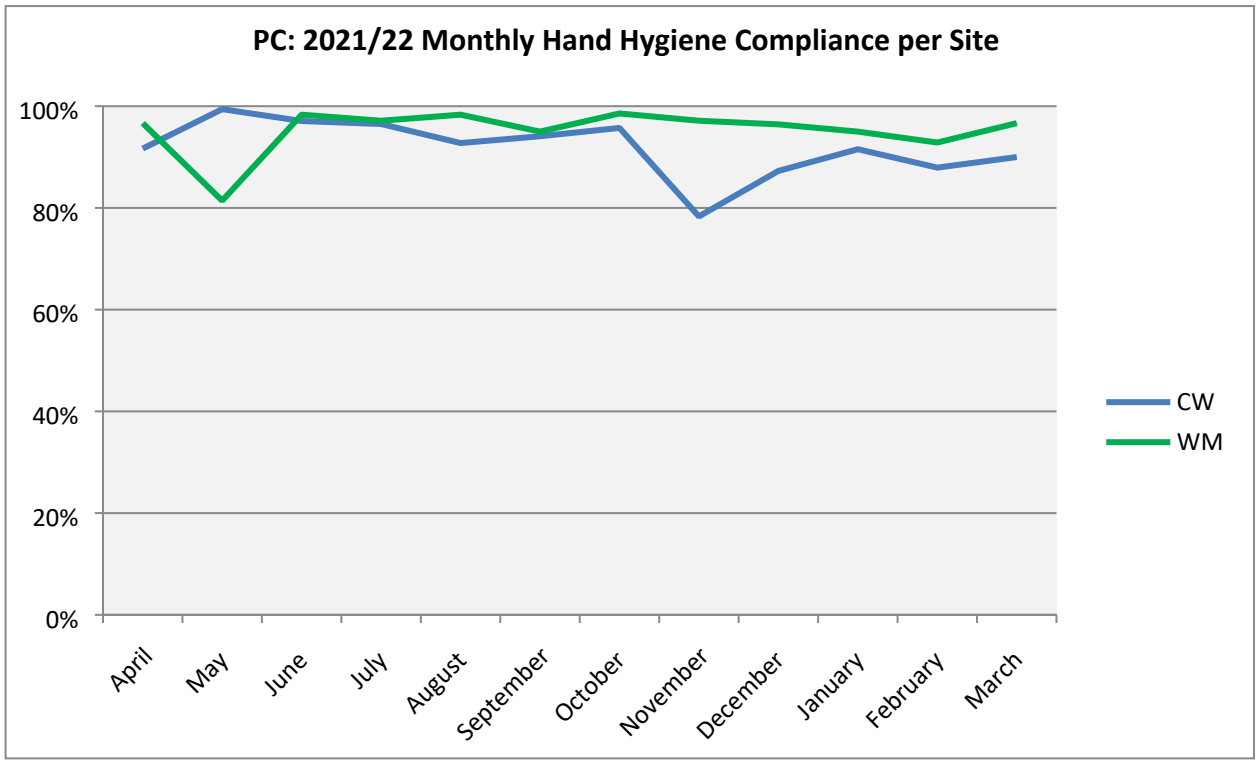


Figure 36: Planned Care division 2020/21 hand average hand hygiene audit results per site

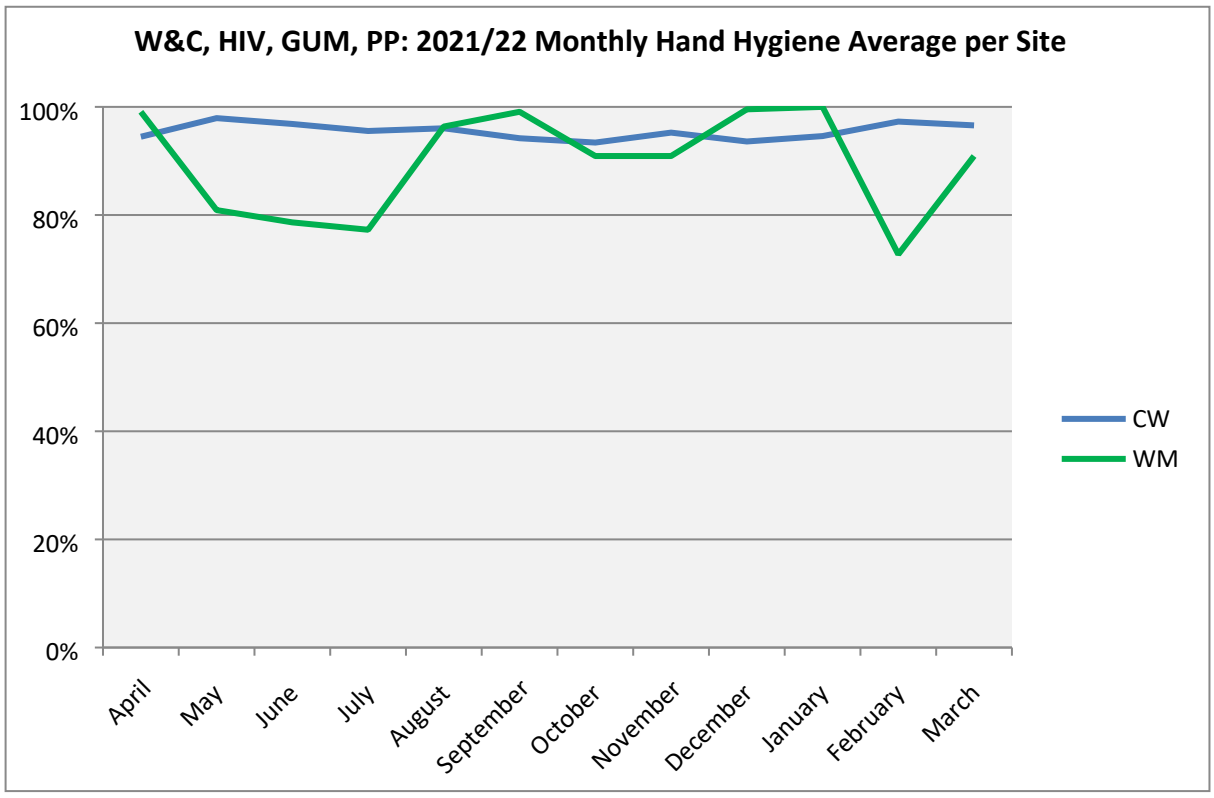


Figure 37: Women's and Children's HIV, GUM and Private Patient's (W&C, HIV, GUM, and PP) division hand hygiene audit results 2020/21.

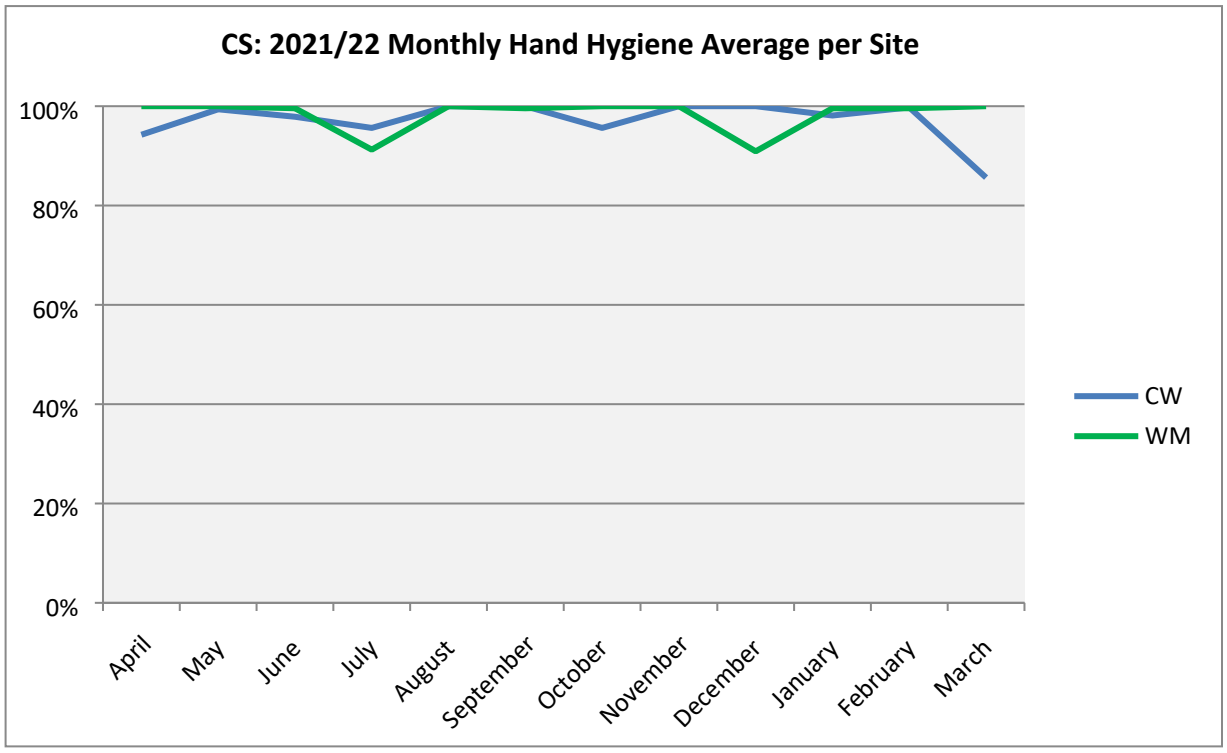


Figure 38: Clinical Support (CS) division hand hygiene audit results 2020/21

Divisional Audit Results: High Impact Interventions

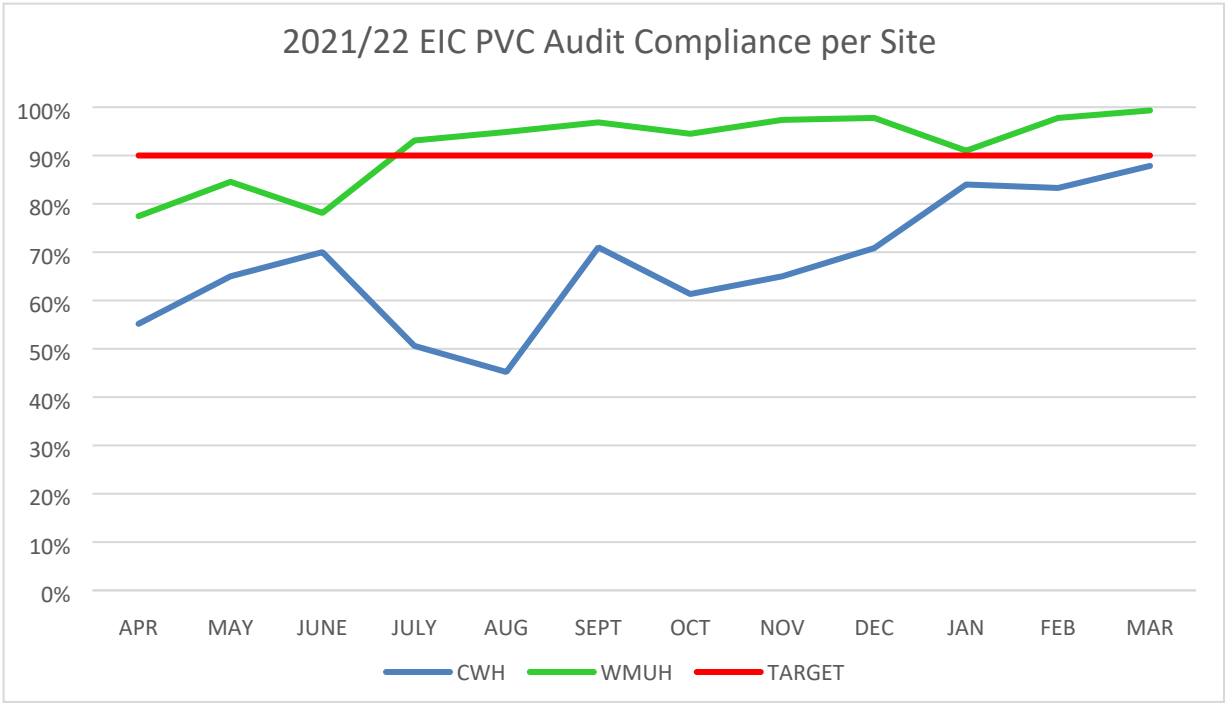


Figure 39: Emergency and Integrated Care (EIC) 2020/21 Average PVC results per site

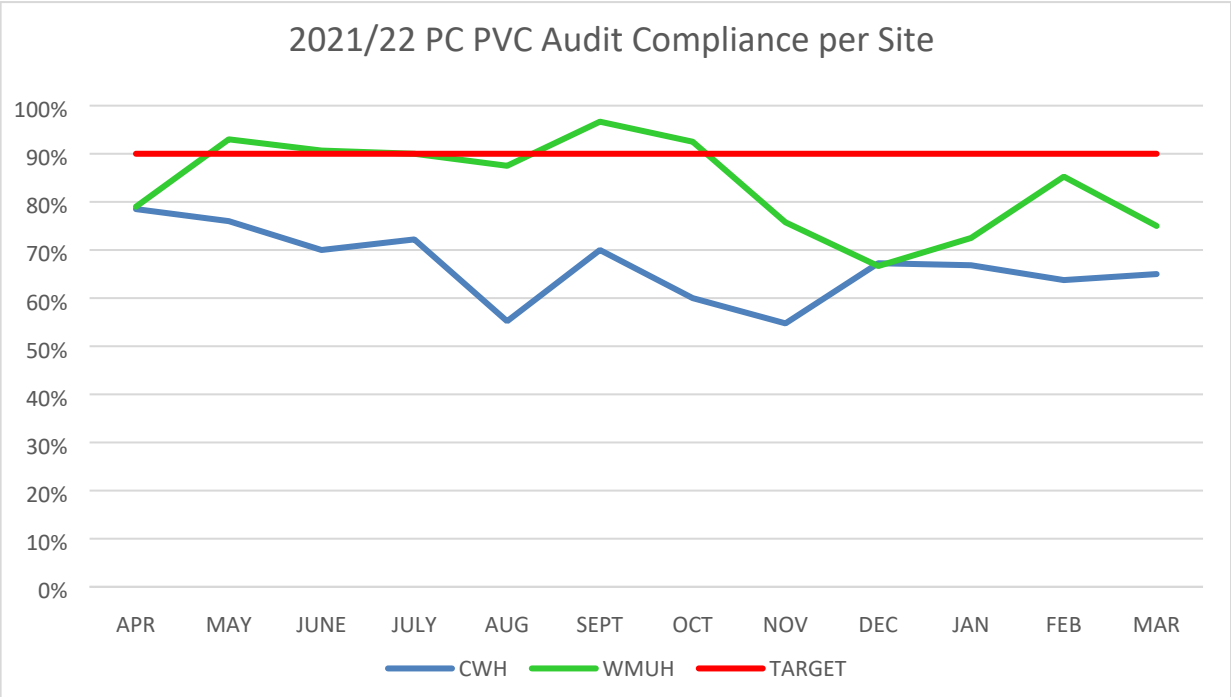


Figure 40: Planned Care (PC) 2020/21 Average PVC Results per Site

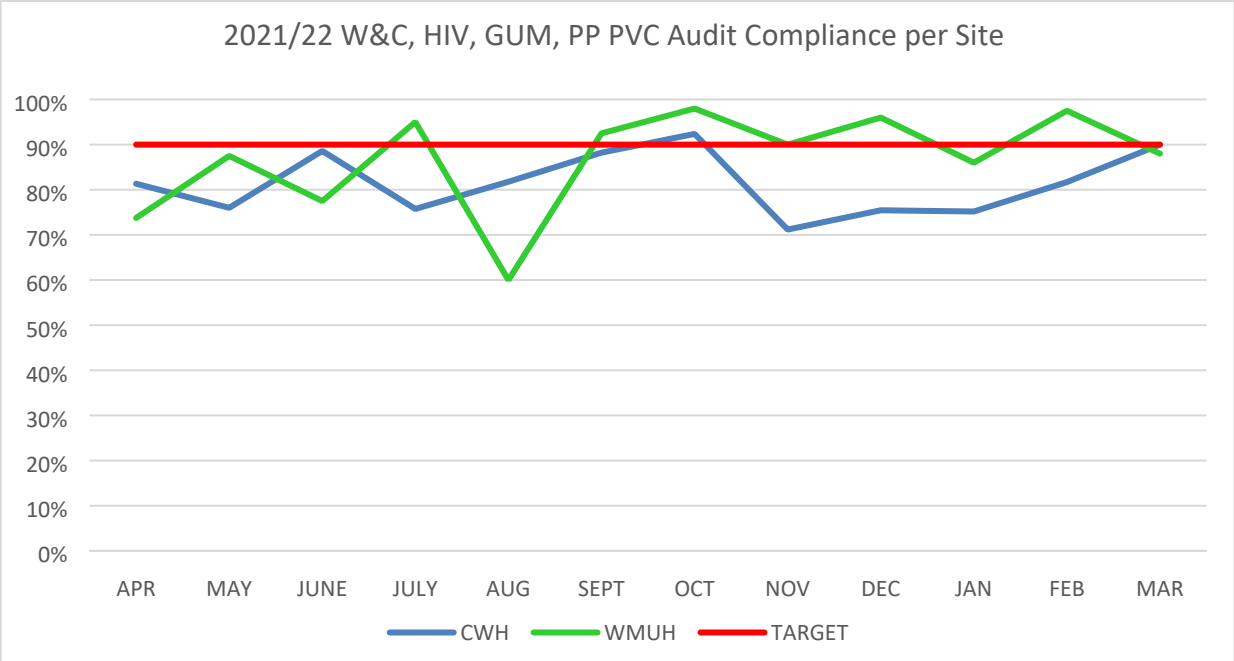


Figure 41: Women's and Children's, HIV, GUM & Private Patient's Division, Average PVC audit results per site.

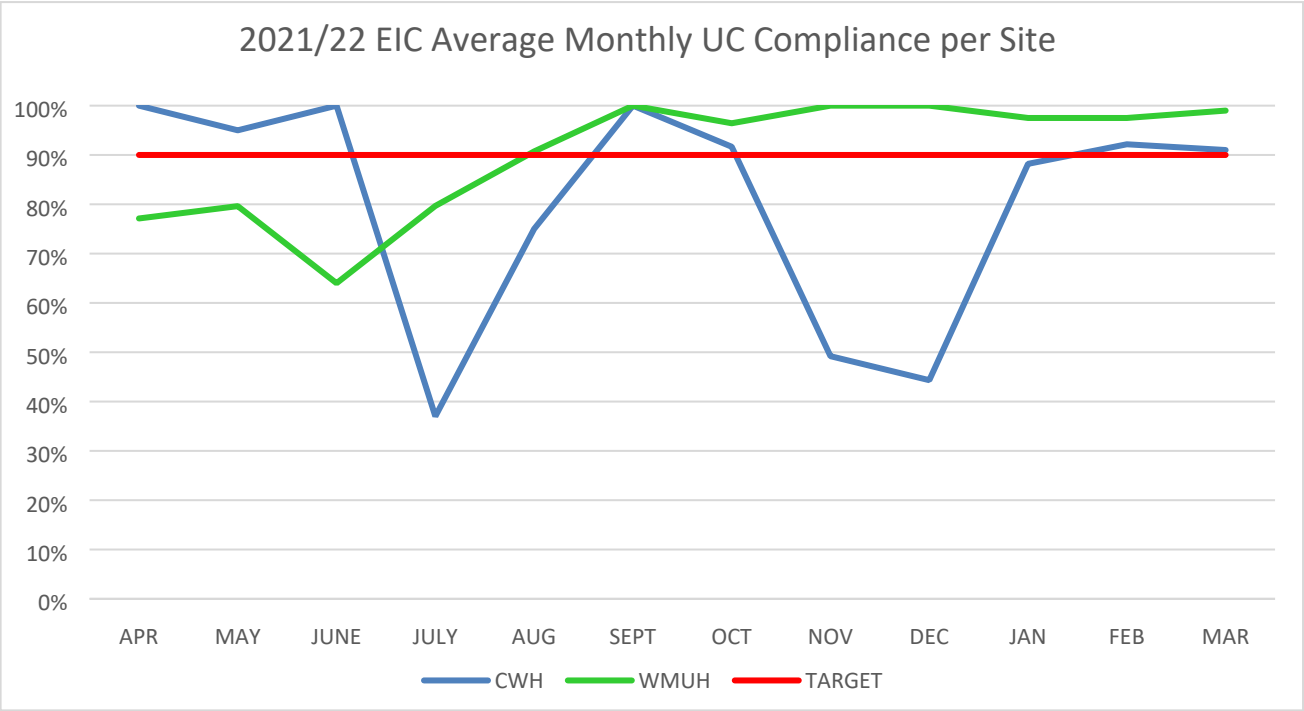


Figure 42: Emergency and Integrated Care Division, Average Urinary Catheter Audit results per site.

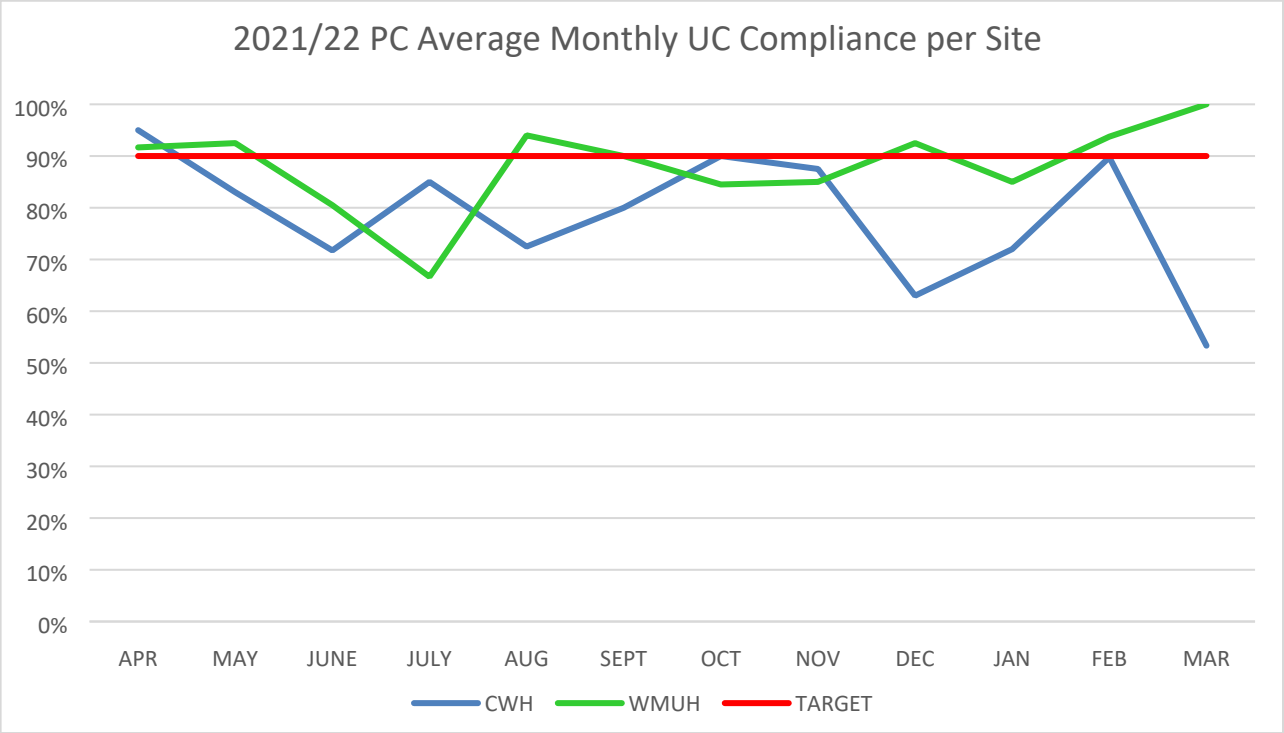


Figure 43: Planned Care Division Urinary Catheter Audit Results 2020/21 per Site

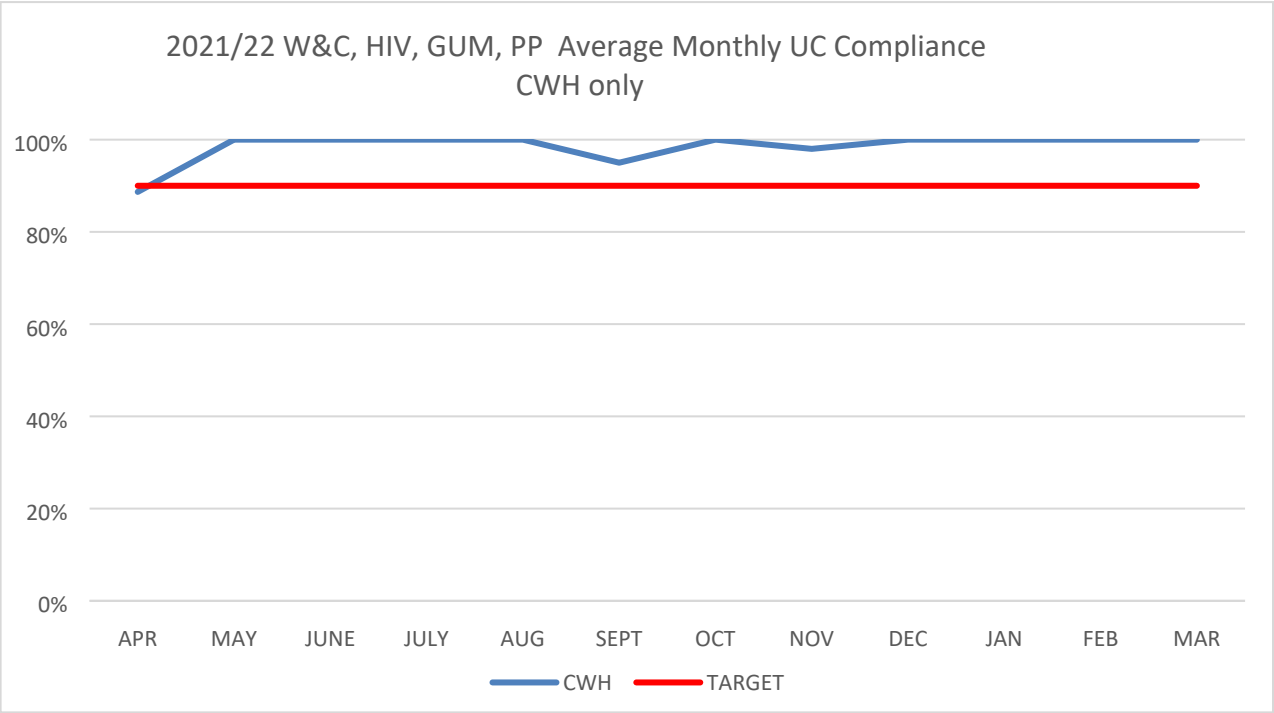


Figure 44: Women's and Children's, HIV, GUM & Private Patient's Division, Average Urinary Catheter audit results.

N.B: WM Women's and Children's, HIV, GUM & Private Patient's Division do not currently audit Urinary Catheters.

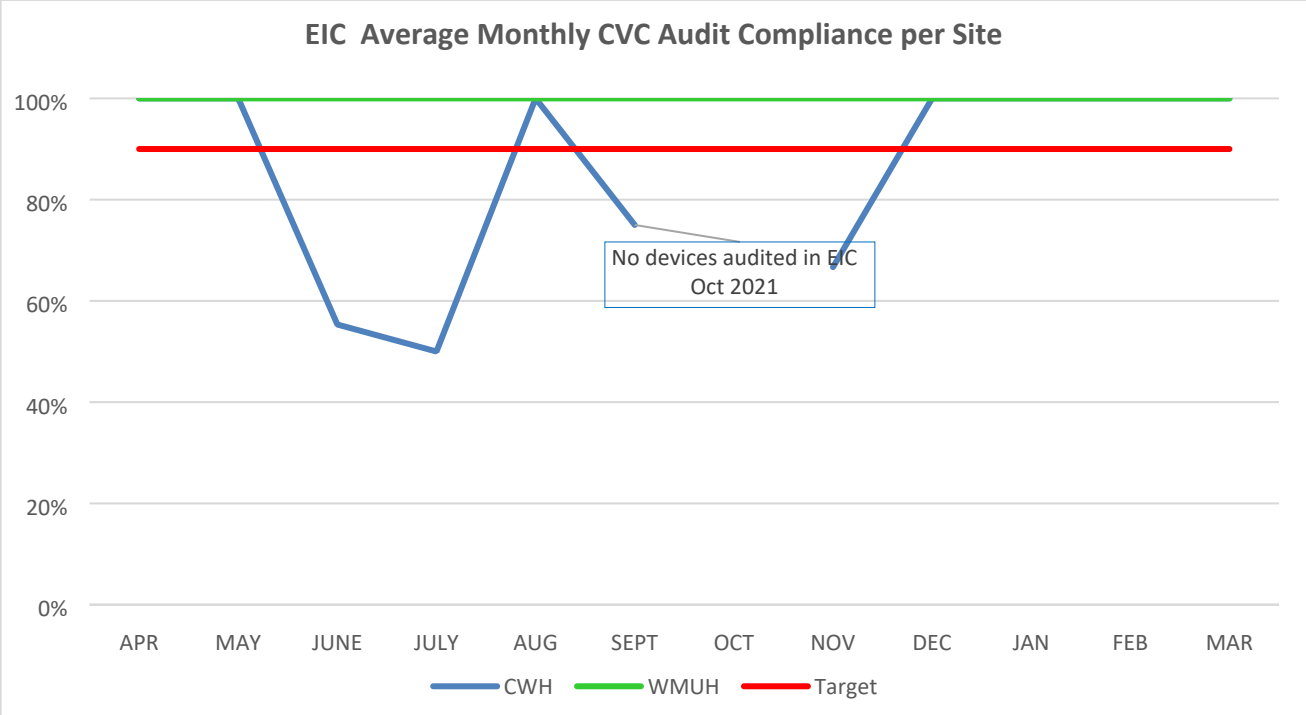


Figure 45: Emergency and Integrated Care 2020/21 Joint Average CVC Results.

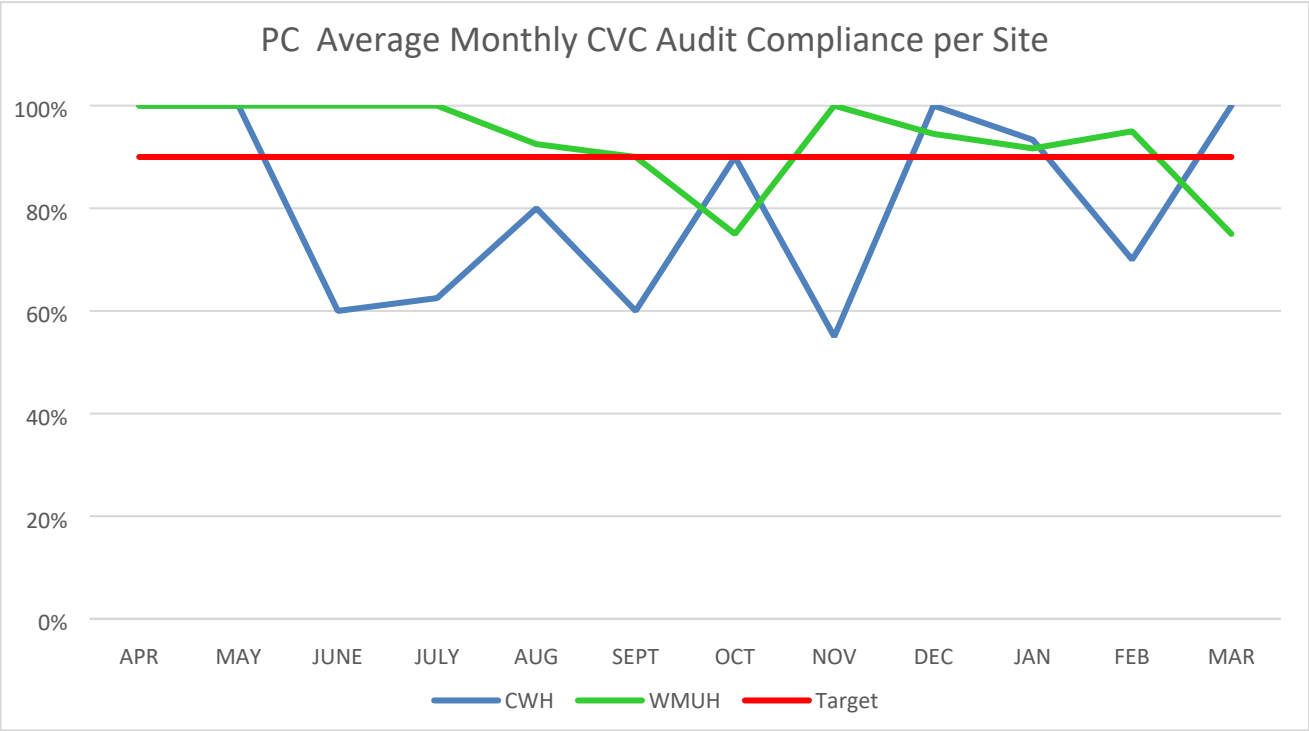


Figure 46: Planned Care division 2020/21 Joint Average CVC Audit Compliance

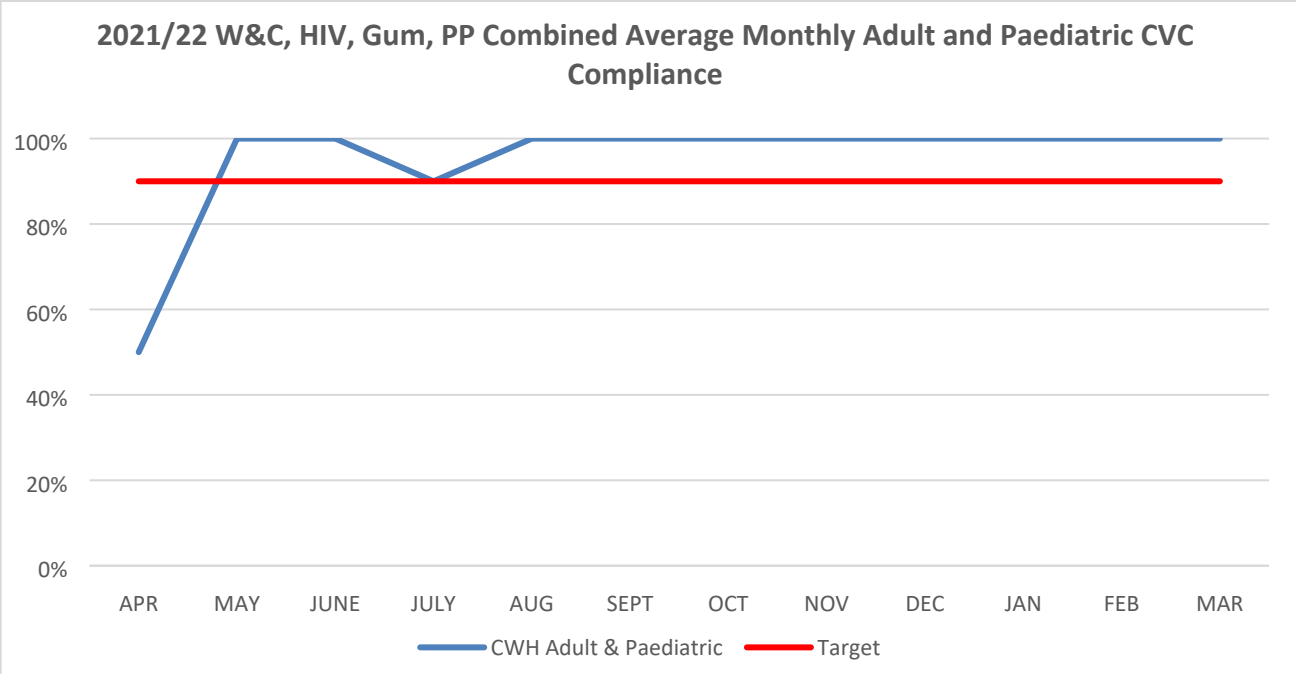


Figure 47: Women's and Children's, HIV, GUM & Private Patient's Division, 2020/21 Joint Average CVC Audit Compliance (combined adult and paediatric).

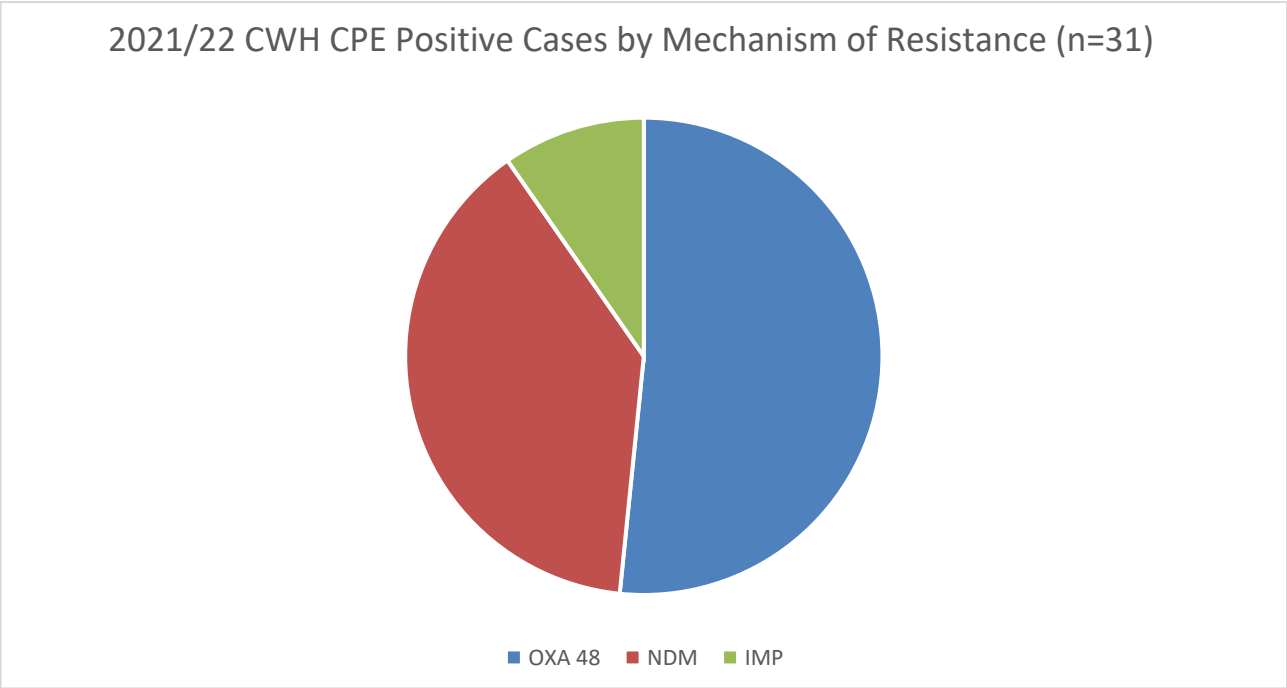


Figure 48: CWH Carbapenemase-Producing *Enterobacterales* (CPE) Surveillance 2021/22

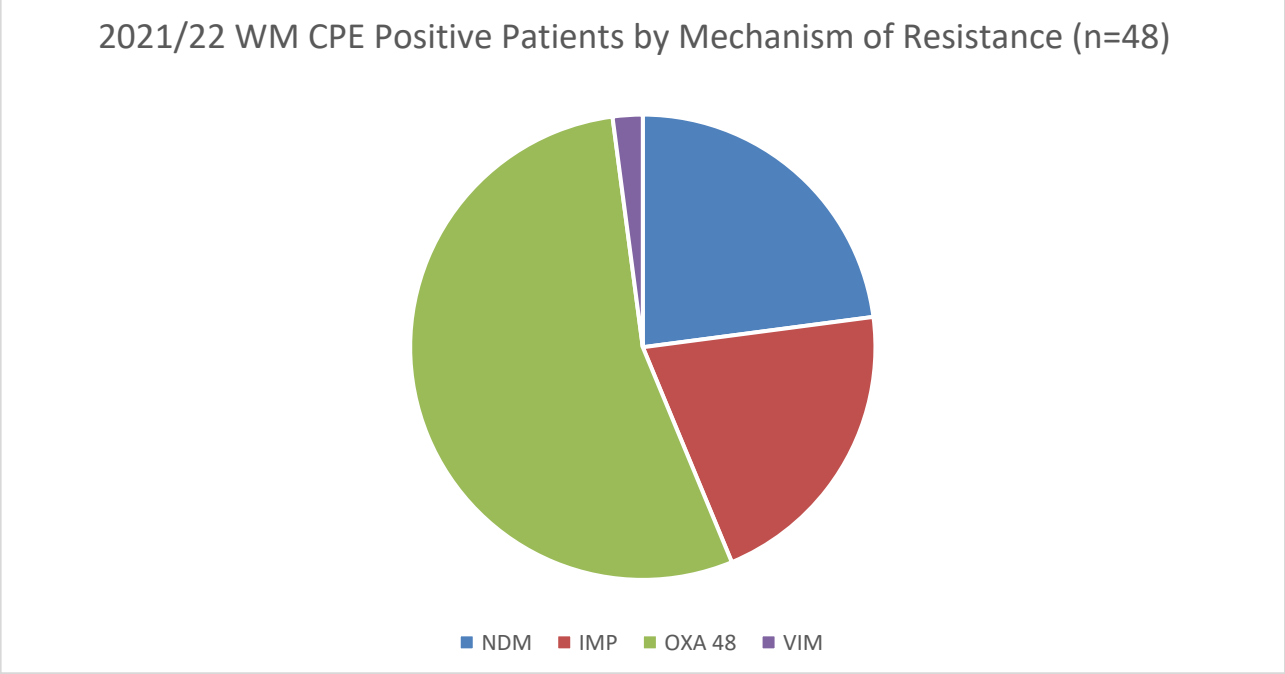


Figure 49: CW Carbapenemase-Producing *Enterobacterales* (CPE) Surveillance 2021/22

Appendix 3 – Targeted Deep Dive of Trust Attributed MRSA Bacteraemias - April 2021 - March 2022

The Trust has been set a target of 0 Trust attributed MRSA blood stream infection cases this financial year. From April 2021- March 2022 there have been 6 cases of Trust attributed MRSA, RCAs have been held for all 6 cases. 4 cases occurred at the WM site and 2 at the CW site.

The changes to the DCS algorithm and definitions– detailed below when introduced (FY2020/21) guaranteed an increase in Trust attributed *MRSA bacteraemia* cases, therefore the Trust's previous performances (pre 2020/21) are not directly comparable.

From April 2020 Trust attributed cases include:

Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission (day 1 = day of admission regardless of time).

Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days (previously classified as a community attributed case).

The DCS algorithm that attributes the cases does not factor if patients have attended another organisation/ their GP in the past 28 days, therefore cases are sometimes assigned unfairly based solely on admission and discharge dates.

These cases are referred to the CCG for review but the DCS algorithm is inflexible and no resolution has been offered.

The expected increase in Trust attributed cases was only realised once CWFT returned to pre-pandemic admission levels.

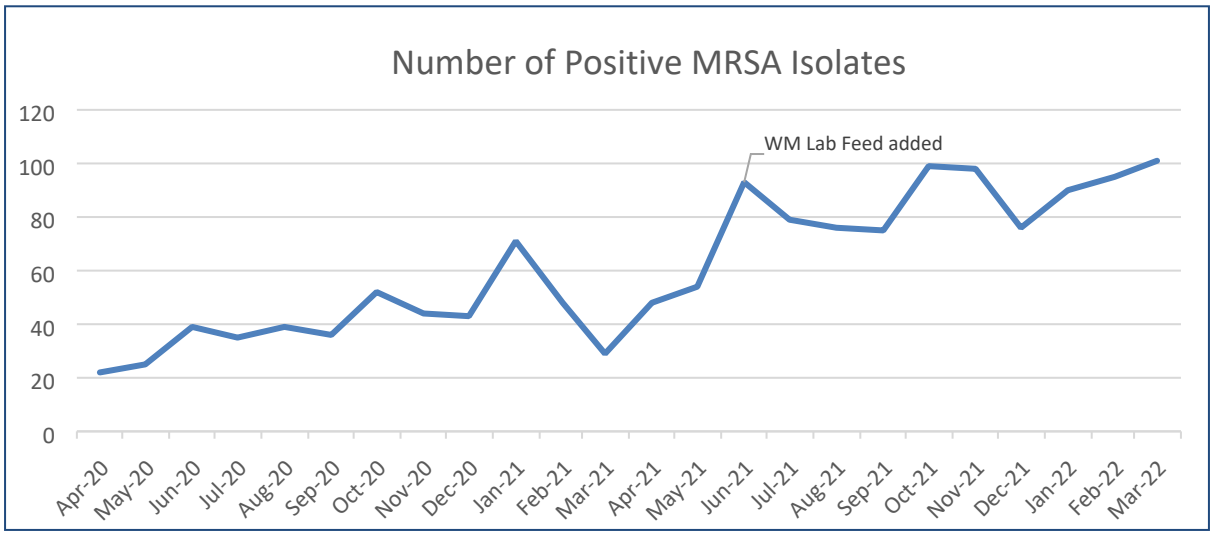


Figure 50: MRSA Prevalence at CWFT

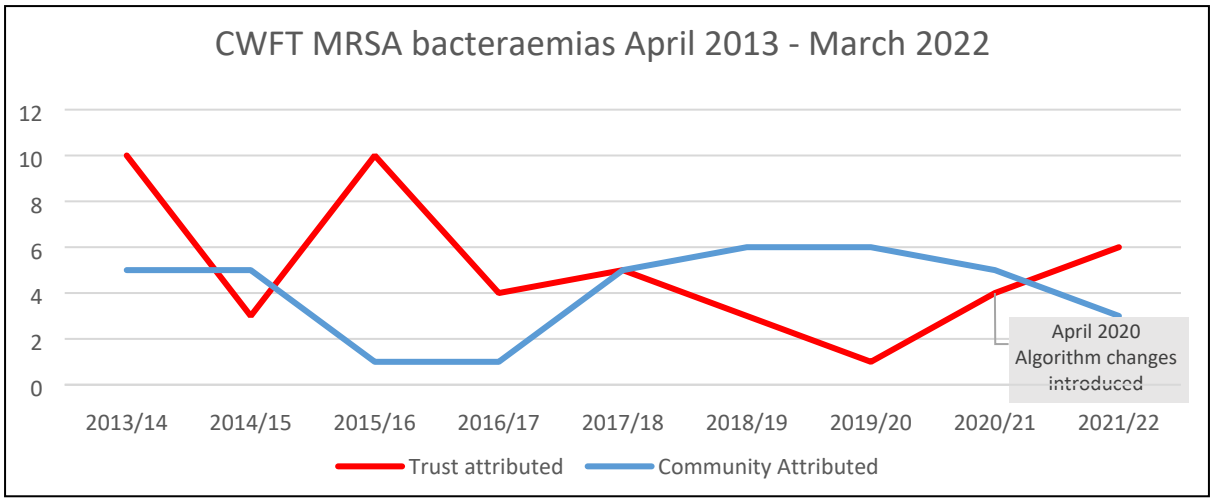


Figure 51: MRSA Bacteraemias April 2013 – March 2022.

MRSA bacteraemia cases:

April 2021 – March 2022: 6
April 2020 – March 2021: 4
April 2019 – March 2020: 1

Table 10: Trust Attributed MRSA Rates Benchmarking against other Organisations:

MRSA cases 2021/22 - April 2021 – February 2022	
Chelsea and Westminster NHS Foundation Trust	**6**
Imperial College Healthcare NHS Trust	**11**
North Middlesex University Hospital NHS Trust	**1**
The Hillingdon Hospitals NHS Foundation Trust	**0**
University College London Hospitals NHS Trust	**3**

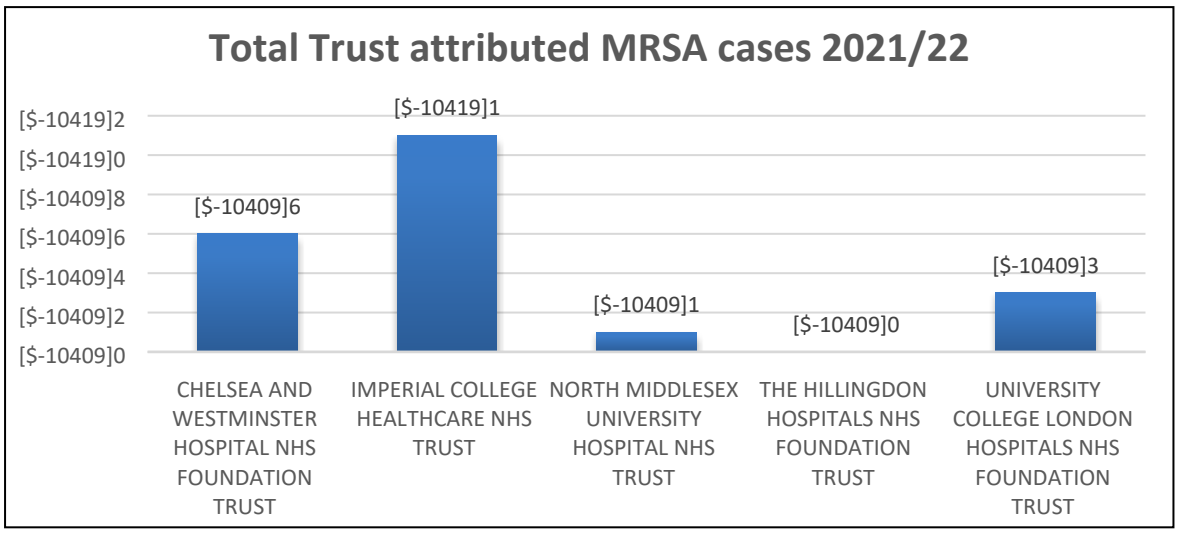


Figure 52: Total Trust Attributed MRSA Bacteraemias Cases 2021/22 (April 2021 – February 2022)

Analysis of Attributed Wards

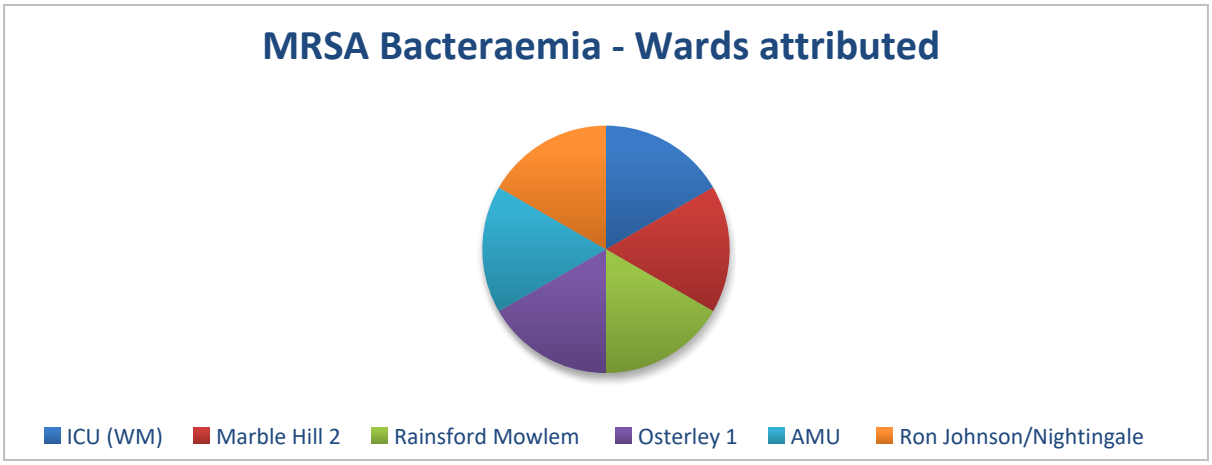


Figure 53. MRSA Bacteraemia – Wards Attributed

Month	Ward	HH Audit score	PVC Audit score	UC Audit Score	CVC Audit Score
April 2021	ICU (WM)	100%	100%	100%	100%
June 2021	RNM (CW)	50%	20%	100%	100%
Sept 2021	OST 1 (WM)	75%	71%	100%	No CVCs.
Oct 2021	MH2 (WM)	90%	86%	75%	No CVCs
Nov 2021 (inpatient stay Oct)	AMU (WM)	100%	90%	100%	No CVCs
Jan 2022 (inpatient stay Nov/Dec)	RJ/Night (CW)	95% / 85%	100% / 20%	100% / DNS	No CVCs

Table 11: Summary of IPC Audit Scores Associated with MRSA Bacteraemias

Source of bacteraemia and Admission Specialty:

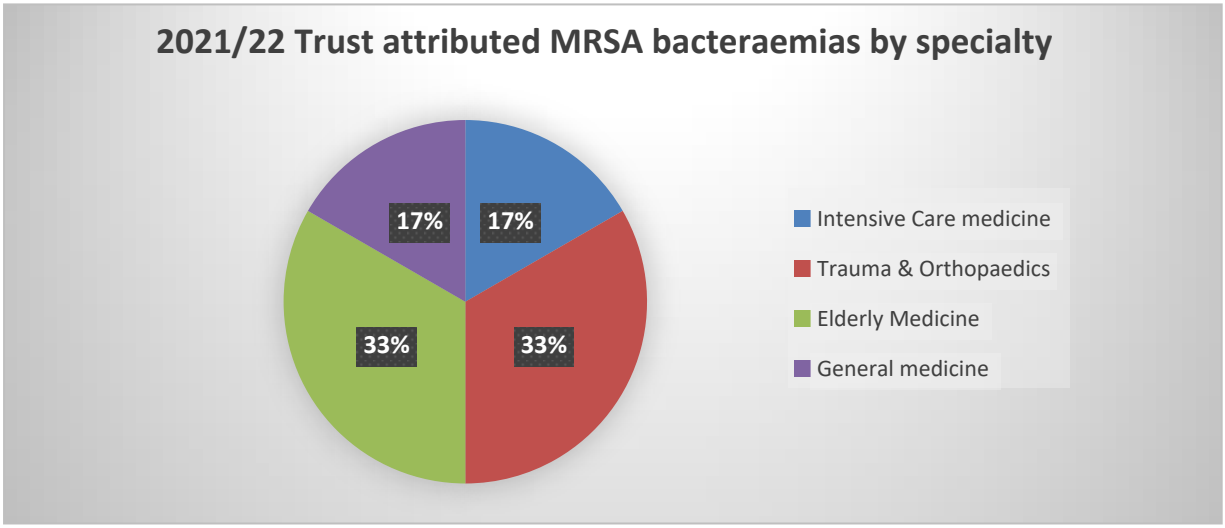


Figure 54. 2021/22 Trust attributed MRSA bacteraemias by specialty

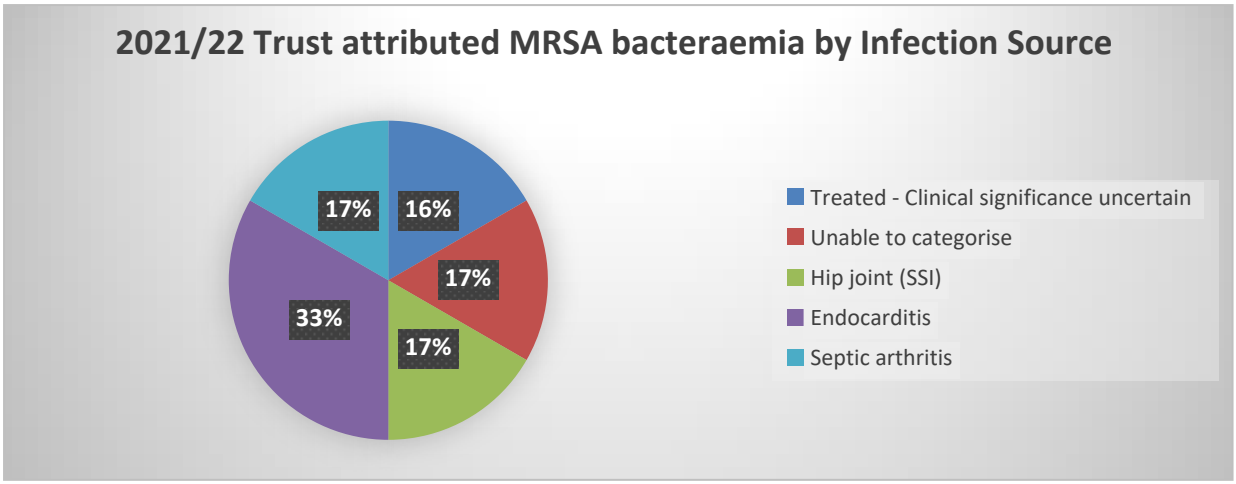


Figure 55. 2021/22 Trust attributed MRSA bacteraemia by infection source

Case Review

Hospital-onset, healthcare associated (HOHA) cases

Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)

Case 1:
Ward Attributed: WM ITU
Admission date: 29/03/2021
Positive Blood culture date: 05/04/2021
Specialty: Critical Care Medicine
Probable Source: Treated, clinical significance uncertain
Comments: Colonised with MRSA long term. Sepsis with multi-organ failure
NAG + on admission – no decolonisation

Case 2
Ward Attributed: CW Rainsford Mowlem
Admission date: 24/05/2021
Positive Blood culture date: 07/06/2021
Specialty: General Medicine
Probable Source: Unable to categorise
Comments: NAG + 31/05/21 – Decolonisation from 5/06 not always given as prescribed
Patient colonised with MRSA, had multiple indwelling devices inserted and compromised skin integrity.

Case 3
Ward Attributed: WM Marble Hill 1
Admission date: 30/09/21
Positive Blood culture date: 03/10/21
Specialty: General Medicine
Probable Source: Endocarditis
Comments: NAG + 01/10/21 – decolonisation commenced after BC taken.
Unclear history, possible MRSA previously other hospital. Endocarditis judged to have developed prior to admission

Community-onset healthcare-associated cases

Community-onset healthcare-associated (COHA) - the patient was recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date).

These cases (prior to April 2020) would have been assigned at Community Attributed Cases.

Case 4
Ward Attributed: AMU
Admission date: 09/11/21
Positive Blood culture date: 09/11/2021
Specialty: General Medicine
Probable Source: Endocarditis
Comments: Was in AMU less than 24 hours before transfer to SMH 22/10/21
MRSA NAG positive on admission 21/10/21
Cellulitis cannula site 29/10/21 whilst at SMH

Case 5
Ward Attributed: Ron Johnson/ Nightingale
Admission date: 07/01/22
Positive Blood culture date: 07/01/22
Specialty: General Medicine
Probable Source: R elbow joint – septic arthritis
Comments: Complex medical history including diabetic foot ulcer. Was inpatient CWH 6/11 – 14/12/21

Case 6
Ward Attributed: Osterley 1
Admission date: 09/09/21
Positive Blood culture date: 09/09/2021
Specialty: Trauma and orthopaedics
Probable Source Comments: Surgical procedure: Date: 26/06/2021 OPCS Code: W94.1 Reason for surgery: Failure of metalwork and chronic pain (Sept 2020: Left hip femoral IM nail) Description: Left hip removal of IM nail and total hip replacement Subsequent surgical procedures: Date: 01/09/2021; 09/09/2021

Full RCA completed – Failure to decolonisation or give appropriate antibiotic prophylaxis – MRSA alert not recognised

Improvement Opportunities:

- Prudent antibiotic stewardship – Ensuring appropriate therapy
- Hand hygiene - maintain high levels of hand hygiene compliance measured by monthly IPC audits. Data reported at the IPC Group. Action plans for areas failing to meet targets over seen by divisions.
- Line care – Improve care levels of CVC, PVC & UC care through monthly audits.
- Data reported at the IPC Group. Action plans for areas failing to meet targets overseen by divisions.
- Environmental decontamination - maintain high standards of environmental hygiene. Reviewed monthly at the IPC Group.

- Personal protective equipment - reduce inappropriate use of gloves.
- Isolation/cohort nursing – isolation of MRSA

Key Themes Identified at RCA Meetings:

- Decolonisation not prescribed for known MRSA positive patients-actioned by pharmacy
- Decolonisation poorly administered-actioned by pharmacy
- Orthopaedic Prophylaxis for MRSA positive patients- actioned by pharmacy and highlighted to orthopaedic teams
- PPE – Inappropriate glove usage-Trust wide campaign in place
- Line Care-actions plans in place by divisions

Actions Generated:

- Intravenous line care: Revised ICLP course focused on line care and auditing.
- Tainted glove campaign
- Monthly PPE compliance audit to be introduced from April 2022.
- Hand hygiene – Areas of low compliance have produced divisional action plans, compliance is monitored at the IPCG.

Appendix 4 - *Clostridium difficile* Deep Dive – 2021/22

The Trust was set a target of 23 Trust attributed CDI cases for this period. From April 2021 – March 2022 there were a total of 36 cases of trust attributed *Clostridium difficile,* RCA's were held for all cases and only 1 lapse in care related to anti-biotic prescribing was identified that contributed to the development of *Clostridium difficile*. All other 35 cases were deemed unavoidable, as all treatment was appropriate and required for patient's care.

This is an increase of 44% from the 25 cases in 2020/21 but the increase was expected due to the increase in admissions to pre-pandemic levels.

The target of 23 was generated using the 2019/20 'calendar' year cases to ensure targets were not affected by the COVID-19 pandemic. However this was not favourable to our Trust as the increase in CDI Trust attributed cases seen in January – March 2020 was excluded and our target was set significantly lower than the total number of Trust attributed cases seen in 2019/2020 (39).

The changes to the DCS algorithm – detailed below when introduced (FY2019/20) guaranteed an increase in Trust attributed *Clostridium difficile* cases, therefore the Trusts previous performances (pre 2019/20) are not directly comparable.

From 2019 /20 Trust attributed cases include:

- **Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission** (previously 3 days).

- **Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 28 days** (previously classified as a community attributed case).

The DCS algorithm that attributes the cases does not factor if patients have attended another organisation/ their GP in the past 28 days, therefore cases are sometimes assigned unfairly based solely on admission and discharge dates. Several CDI cases with admissions at other hospitals in the 28 days leading to a CWFT admission have been challenged by the DIPC however no resolution has been offered by the CCG.

Trust Attributed cases from 2019-2022

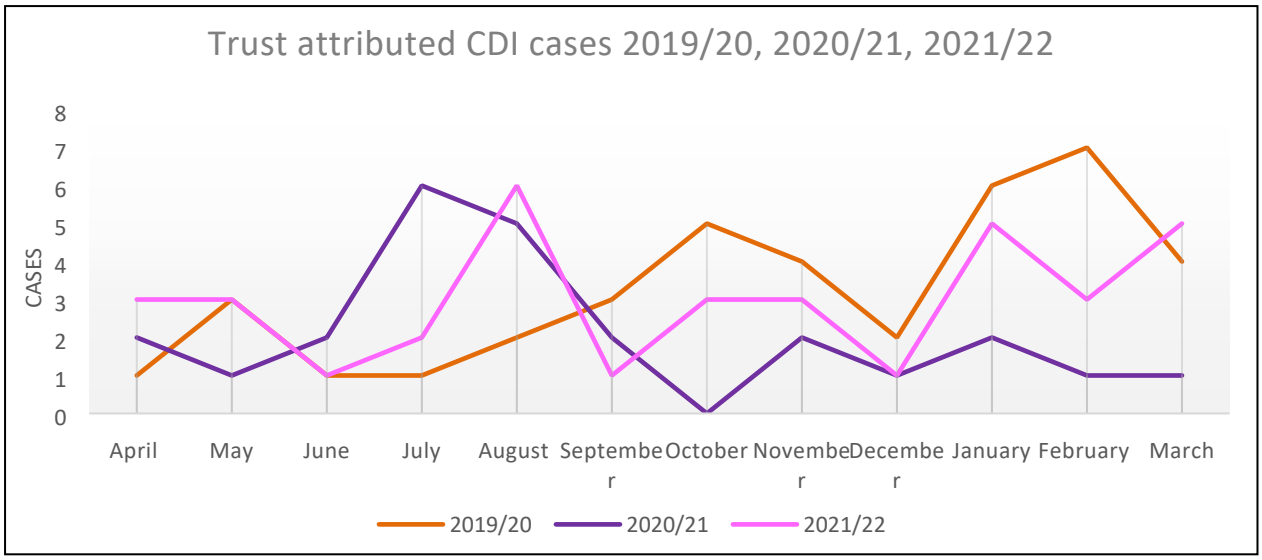


Figure 56: Trust attributed CDI cases per month 2019/20, 2020/21, 2021/22

CWFT *Clostridium difficile* infection (CDI) cases:

- April 2019 – March 2020 = 39
- April 2020 – March 2021 = 25
- April 2021 – March 2022 = 36

Trust Attributed CDI rates benchmarking against other organisations

Despite the increase in CDI at CWFT, the Trust continues to score well when benchmarked against local organisations.

Average Rates per 100,000 bed days + Day admissions:

- Chelsea and Westminster NHS Foundation Trust: 378.57
- Imperial College Healthcare NHS Trust: 378.30
- North Middlesex University Hospital NHS Trust: 395.21
- The Hillingdon Hospitals NHS Foundation Trust: 522.35
- University College London Hospitals NHS Trust: 681.38

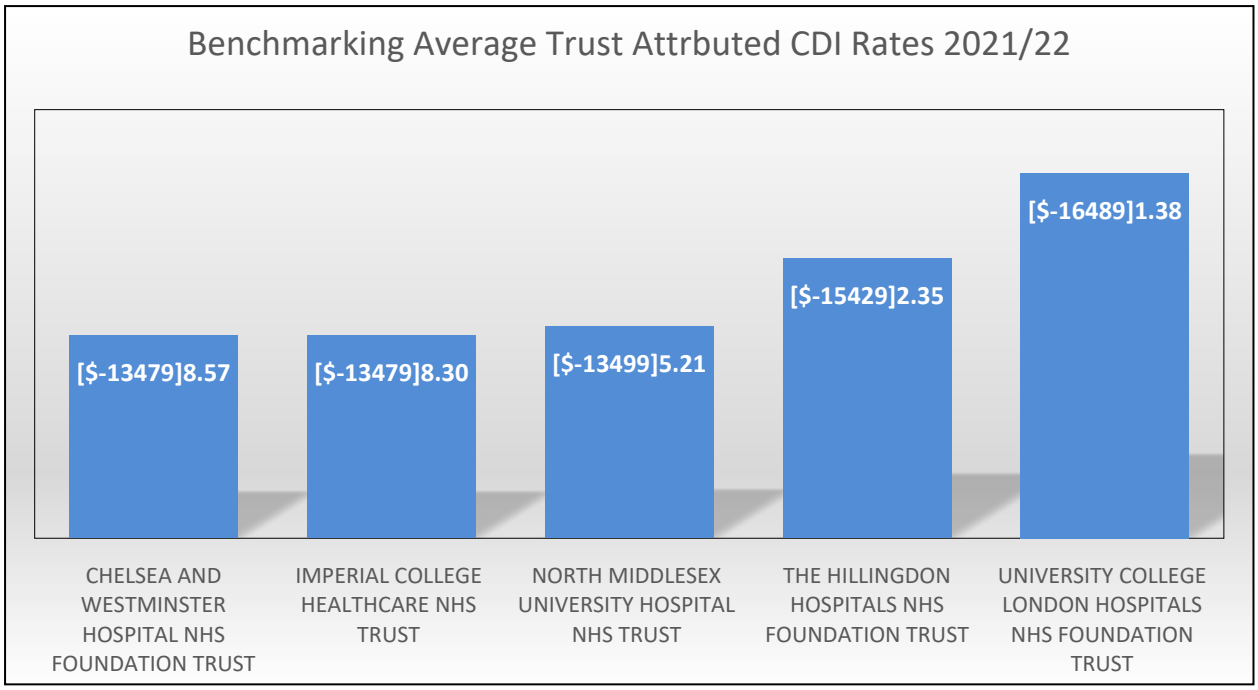


Figure 57: Benchmarking Average Trust Attributed CDI rates per 100,000 bed days + days admissions.

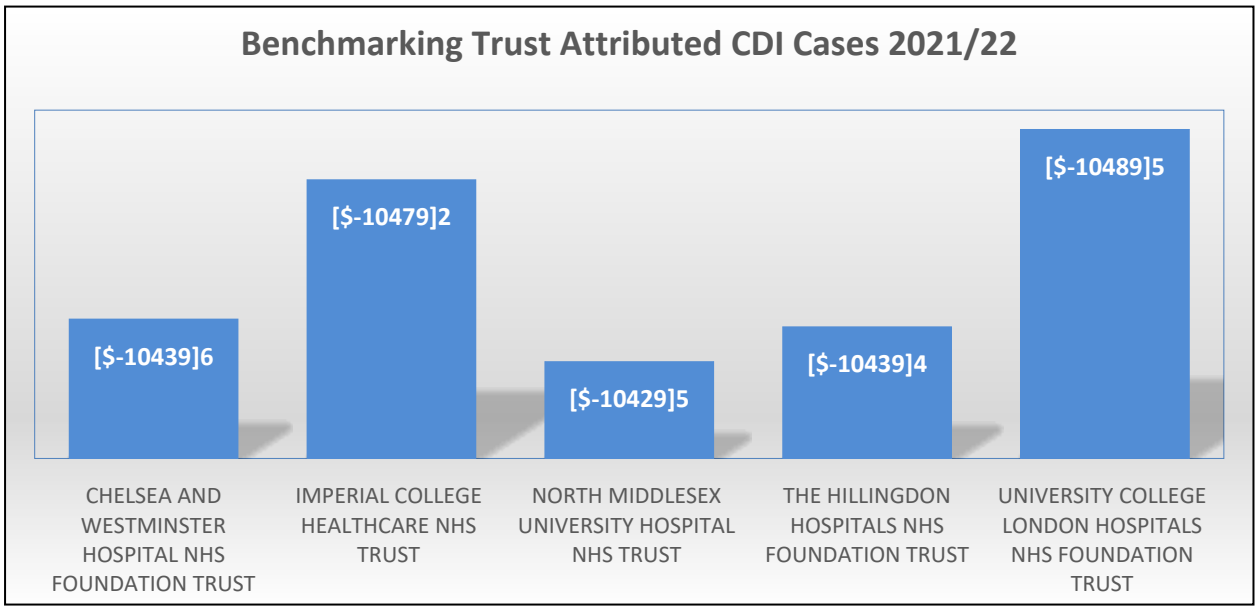


Figure 58: Benchmarking by Count of Trust Attributed CDI cases.

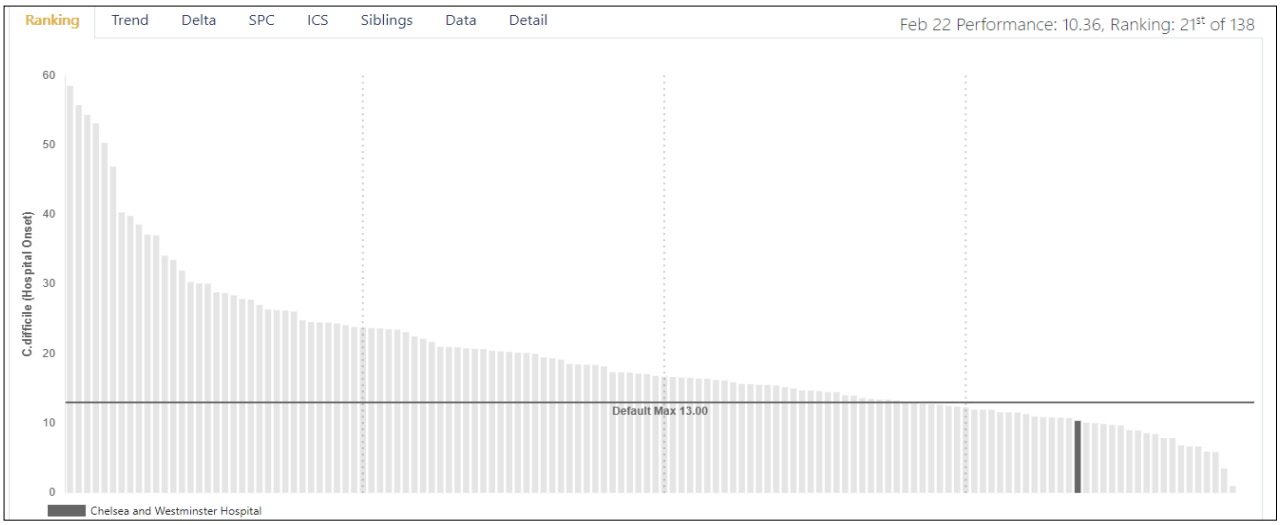


Figure 59: CWFT February 2022: 21st of 138 Acute Trusts - Public View Ltd

CDI Breakdown per Site

Of the 36 cases that occurred, 20 were at the CW site and 16 at the WM site, from 2019 – 2022 the cases per site have remained relatively stable.

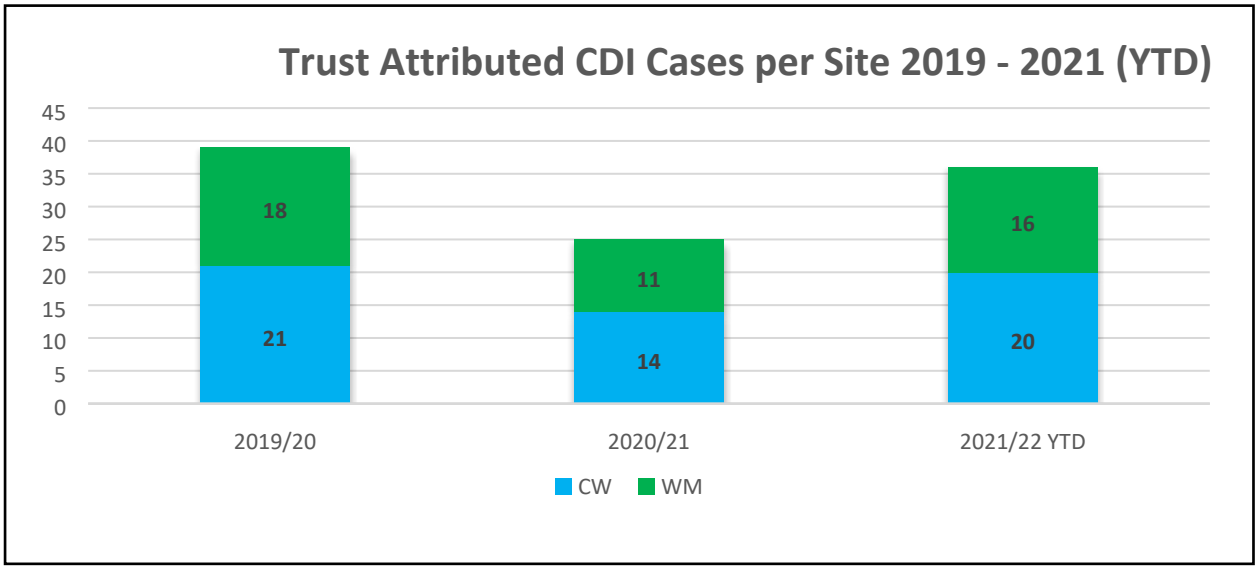


Figure 60: CDI occurrence per site 2019/20, 2020/21, 2021/22

Attributed Wards

Wards are attributed by reviewing the patient's location prior to diagnoses either during the patient's current admission if a HOHA or their previous admission if a COHA.

Any cases that have occurred on the same ward have been reviewed and typing/ contact tracing has confirmed that cross transmission did not occur.

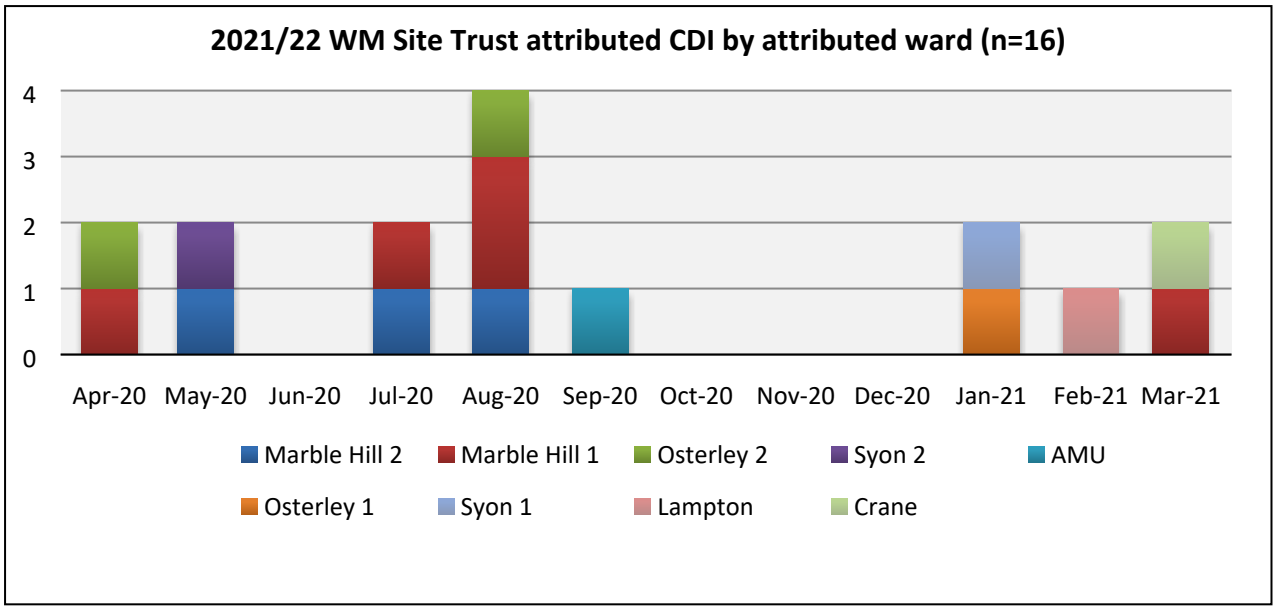


Figure 61: WMH Attributed Wards

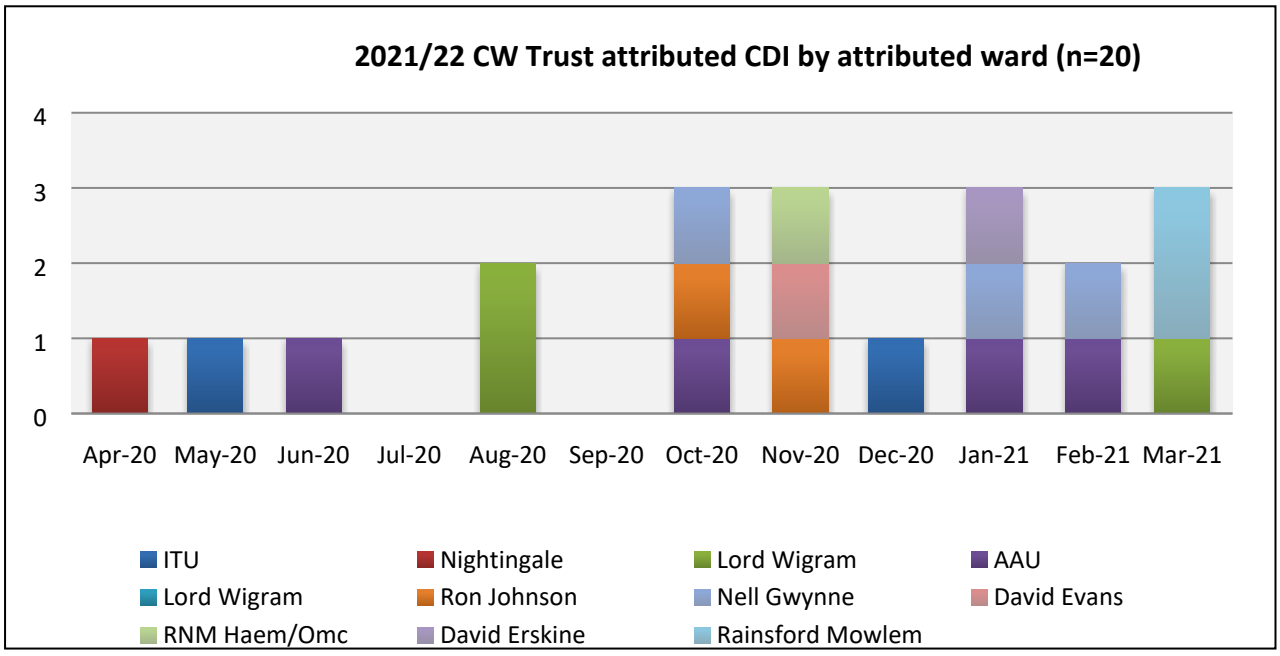


Figure 62: CWH Attributed ward

Improvement Opportunities

- **Testing -** Ensure appropriate clinical assessment and pathology request (not MC&S).
- **Clinical engagement -** Escalation of *Clostridium difficile* symptoms and RCA attendance.
- **Prudent antibiotic stewardship -** facilitated by the rollout of ICNet to WM to improve antimicrobial prescribing and monitoring.
- **Hand hygiene -** maintain high levels of hand hygiene compliance measured by monthly IPC audits. Data reported to the IPC Group.
- **Environmental decontamination -** maintain high standards of environmental hygiene. Reviewed monthly at the IPC Group.
- **Personal protective equipment -** reduce inappropriate use of gloves. From April 2022 PPE compliance will be measured by monthly audits and reported to the IPC Group.
- **Isolation/cohort nursing -** continue to ensure prompt recognition of patients with suspected infectious diarrhoea/CDI and prompt isolation.

Key themes identified from RCA meetings:

Issues identified:

- Stool charts incomplete.
- Testing for *Clostridium difficile* – time /appropriateness/ retesting.
- Laxative usage in patients with diarrhoea.
- Delay in isolation of patients with diarrhoea due to a suspected infectious cause.

Actions generated:

- Stool charts –made more accessible on Cerner & educating ward staff on its location.
- CDI checklist usage – made available electronically on Cerner rather than paper versions to facilitate completion and better monitoring.
- PPE usage – Tainted glove campaign launched
- Hand hygiene – Areas of low compliance have produced divisional action plans, compliance is monitored at the IPCG.

Appendix 5: COVID-19 Outbreak Summaries 2021/2022

COVID-19 definitions:

HO.iHA: - Indeterminate as to whether acquired in hospital or community (diagnosed 3-7 days)

HO.pHA: - Probable hospital acquired (diagnosed 8-14 days after admission)

HO.dHA: - Definite hospital acquired (diagnosed 15+ days after admission)

General control and containment measures:

- Enhanced cleaning instigated across the ward
- Visiting restricted, essential visitors only
- Ward closed to admissions
- Increased vigilance of PPE use and hand hygiene compliance
- Outbreak signage displayed
- Compliance with routine and contact patient screening
- Increased patient testing as soon as outbreak apparent
- Testing of staff
- External reporting of outbreaks to the CCG

Table 12: COVID-19 Outbreak Summaries

	Site	Ward	Date of first positive case	Date of last positive case	Total Number of positive patients	Total Number of positive staff
1	WM	MH2	16/08/21	23/08/21	4	1
2	CW	Rainsford Mowlem	03/09/21	13/09/21	13	2
3	CW	Nell Gwynne	16/09/21	27/09/21	10	6
4	WM	MH2	03/10/21	15/10/21	11	1
5	WM	MH2	13/11/21	17/12/21	9	0
6	CW	Nell Gwynne	10/11/21	13/11/21	3	0
7	WM	MH1	13/11/21	30/11/21	8	0
8	WM	Lampton	15/11/21	25/11/21	7	0
9	WM	MH2	16/12/21	21/12/21	5	0
10	WM	Osterley 1	26/12/21	02/01/22	7	0
11	CW	Nell Gwynne	15/12/21	04/01/22	9	10
12	CW	Rainsford Mowlem	15/12/22	04/01/22	9	2
13	WM	Syon 2	26/12/22	17/01/22	13	2
14	WM	Kew	31/12/21	18/01/22	28	3
15	WM	MH1	09/01/22	27/01/22	14	6
16	CW	Nell Gwynne	01/02/22	06/02/22	7	3
17	WM	Syon 1	26/02/22	28/03/22	39	10
18	WM	Syon 2	21/02/22	29/03/22	30	2

Appendix 6: Overarching IPC Objectives 2022 - 2023

Table 13: IPC Objectives

Overarching IPC Objectives 2022 - 2023	
Objective	Rationale
Work with the CCG (evolving to ICS) and local health and social care organisations to reduce Gram negative bloodstream infections.	The Government has an ambition to halve healthcare associated Gram negative blood stream infections by delivering a 25% reduction by 2021 – 2022 with the full 50% reduction by 2023 – 2024.
Continue to provide assurance that the Trust complies with the criteria in the Code of Practice for the control of infection and related guidance (2015)	The Code of Practice sets out the 10 criteria against which the Trust will be judged on how it complies with the registration requirements related to infection prevention by the Care Quality Commission.
Continue to update and implement IPC policies, procedures and documentation across the organisation.	Implementation of policies, procedures and documentation will ensure a standardised approach to IPC cross the organisation.
Continue to monitor multi-drug resistant micro-organisms and ensure processes are in place to minimise their transmission.	The increase in antimicrobial resistance is recognised both nationally and internationally as a major threat to public health.
Continue to optimise historic AMS targets from previous CQUINs in line with NHS England and Improvement criteria.	Antimicrobial stewardship is an important element of the strategy to minimise the development of antimicrobial resistance.
Actively contribute to the management of seasonal respiratory viral infection focussing on influenza, SARS-CoV-2 and respiratory syncytial virus (RSV) while continuing to support the recovery of Trust services.	Supporting the Trust in the management of respiratory viral infections and continuing to play a proactive role in the recovery of Trust services to ensure the safety of their patients and staff.
Upskilling and education of the IPC team.	Ensure the IPC team are developing specialist IPC skills and knowledge to better support and educate healthcare workers.

Work collaboratively with departments across the Trust to improve IPC practices and to disseminate IPC guidance agreed at IPC meetings. Also to work collaboratively with Trusts across the sector and to continue leading across the sector at ICS level.	Improving and maintaining IPC practices across the Trust. Supporting other Trusts across the sector and learning from others experiences.
Continue to work with and support the Estates and Facilities team.	To ensure compliance with national standards in relation to Estates and Facilities and providing a safe estate for users.

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Chelsea and Westminster Hospital NHS
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TITLE AND DATE (of meeting at which the report is to be presented)	*Board of Directors, 7th July 2022*

AGENDA ITEM NO.	4.4/July/ 2022
TITLE OF REPORT	Workforce Performance report May 2022
AUTHOR NAME AND ROLE	Karen Adewoyin- Deputy Chief People Officer Lindsey Stafford-Scott - Deputy Chief People Officer
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith- Interim Chief People Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: x Info Only: x Advice: Please tick below and then describe the requirement in the opposite column	The attached performance report provides an update to the Board against key themes and deliverables in the Trust's People Strategy. It provides an update on key performance metrics, trends and themes and narrative to provide assurance that the members of the committee are aware of the risks and challenges associated with workforce and has the necessary plans in place to address them. Workforce Development Committee and People and OD Committee were not scheduled for June and therefore the report was discussed at Executive Management Board and also circulated via e-governance to members of Workforce Development Committee.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: EMB; Date of Meeting: 6th July 22; Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The monthly report provides a summary of key progress against our People Strategy as at the end of May 2022. **Sickness rates** have seen a significant drop from 4.11% in April to 3.29% in May. The highest reason for absence remains chest and respiratory problems followed by anxiety, stress and depression. **Turnover** has continued to rise from 14.39% in April to 14.58% in May and although mobility has now returned to pre-pandemic levels, we are slightly higher than the NWL sector position. Relocation continues to be the highest reason for leaving, with Scientific & Technical (Qualified) staff group seeing the most churn. A focus on staff retention remains a clear priority. **Appraisal** completion has gone up from 65.54% to 67.18% in month. Recovery efforts continue in order to achieve the 90% target, with trajectories in place for each Division. We will monitor the impact of the revised PDR paperwork intended to focus on supportive conversations. **Mandatory training continues** on target at (90%) with a clear focus needed on BLS, Moving and Handling, Safeguarding, Infection Control and Conflict Resolution. Mandatory training performance is below that of the NWL sector. **ER cases** have varied slightly with the number of disciplinary and ET cases having dropped, grievance cases remaining steady and sickness absence seeing a slight increase. A further 19 managers were trained in May bringing the total to 59 managers trained in ER since April 22

	EDI targets for 22/23 show a deficit total of -11 and focus is needed on 4 out of the 6 grades from Band 8a – VSM. The team continue to work on the relaunch of the Diversity Champion scheme. This should increase both capacity and new capabilities to support our staff selection processes. **Flexible Working** We see a spike in applications from 4 in April to 20 in May, with 75% of these accepted. The majority applications are from female employees with 70% from BAME members of staff. 66% of vacancies advertised in May promoted flexible working. There is a Trust focus on the Timewise flexible working action plan given this is an area for improvement from this year's staff survey results. **Local employment** The number of staff employed locally has risen slightly from 20% in April to 21 % in May and continues to significantly surpass our target of 10%. The success of the ICS healthcare support worker recruitment has seen us progressing 27 candidates through pre-employment so far, with more expected over coming months. The Trust is leading an NHS reservists programme on behalf of the ICS with 202 staff retained into employment from our mass vaccination workforce. **Volunteering** went up by 5% in May consistent with predictions following the end of Easter and Ramadan in April. There will be increased efforts in youth engagement driven by the planned introduction of a Youth Coordinator at Chelsea. **Vacancy** rates have dropped from 8.81% to 7.95% in month, remaining well within target and against a backdrop of both a reduction in establishment and an increase in staff in post. Nursing (unqualified) continues to carry the highest vacancy factor. 20 internationally experienced nurses joined us whilst a total of 187 employment offers were made in May. Time to hire however crept up to 9.38 weeks, just over the 9-week target, due to staffing challenges. **Temporary staffing** is a continued focus to support the Trust achieve its financial objectives, with a clear focus on weekly reporting and defined approval processes in place to ensure grip and control. There has been a positive increase of candidates on the NWL collaborative bank helping to support shifts filled through bank and minimising agency expenditure. The report also highlights key programmes of work against our People Plan, including an update on health and wellbeing, Diversity and Inclusion, Leadership and Development, Organisational Change, E-Rostering, Medical Transformation Programme, Growing our workforce, NWL collaboration and COVID specific work, mass vaccination.
KEY RISKS ARISING FROM THIS REPORT	Risk are as set out within the report. Key are: • Vacancy rates for support to nursing for which specific plans are in place, • Rising turnover which should see more concerted effort in retention plans and practices and • EDI requiring efforts to close the -11 deficit within Band 8a to VSM against the model employer targets.

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:		The key risks are highlighted above and throughout the report.
Equality And Diversity	X	
Quality		
People (Workforce or Patients/ Families/Carers)	X	
Operational Performance		
Finance		
Public Consultation		
Council of Governors		
please mark Y/N – where Y is indicated please explain the implications in the opposite column		

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People Plan & Workforce Performance Report

to the Workforce Development Committee and People and Organisational Development Committee

Month 2 – May 2022

Our People, Our Ambition

Our people are able to provide great care for our patients and communities because they have the skills, tools and capacity to do their job and people are able to provide the environments they work in are inclusive and supportive. Staff are motivated and engaged and have opportunities to grow, develop and innovate.

How we will measure our success

Strategic goal	Key themes of people plan	Performance measure	2020/21 baseline	2023/24 ambition
To be the Employer of Choice	**Looking after our people** ICS Goal 1 – Care *We have a happy, healthy and engaged workforce.*	H&W Staff Survey result	5.9	6.1
		Voluntary turnover of staff	18%	10%
		Sickness (average days)	5.8	5
		% of staff coming in despite being unwell	47.7%	40%
		Uptake of health and wellbeing offers	<2%	>10%
	Belonging in the NHS ICS Goal 2 – Lead ICS Goal 3 - Include *We care and staff report positive experiences and we are inclusive and succeed because of our differences.*	EDI staff survey score	8.5	9.1
		WRES/WDES/Gender Pay Gap Improvements	6 WRES + 10 WDES 3 grades not met target	Positive improvement in all indicators (outlined in Belonging section)
		Increase in numbers of BAME staff in Bands 8a and above	Disproportionate 3 grades not met target	All grades meeting set targets
		Staff Survey engagement score	7.1	7.4
	New ways of working and delivering care ICS Goal 4 – Transform *We have the skills to deliver 21st Century Care.*	Number of staff transitioning to qualified posts	<20	>70
		Increase in new roles (Physician Associate and Nursing Associate)	<1%	>5%
		Flexible working staff survey score	56%	65%
		e-job planning implemented	Not yet implemented	65% of consultants and SAS doctors have e-job plan by March 2022, 100% by 2024
		Number of staff using e-roster	82%	100%
	Growing For the Future ICS Goal 3 – Grow *We have the capacity to deliver great care.*	Utilisation of the apprenticeship levy	39%	70%
		% of volunteers into employment	4.5%	10%
		Increased local employment	Not currently measured	10%
		Reduced vacancy rates in core professions	N&M 5.5%, M&D 3% AHP 6%	N&M 5-8%, M&D <5%, AHP <7%

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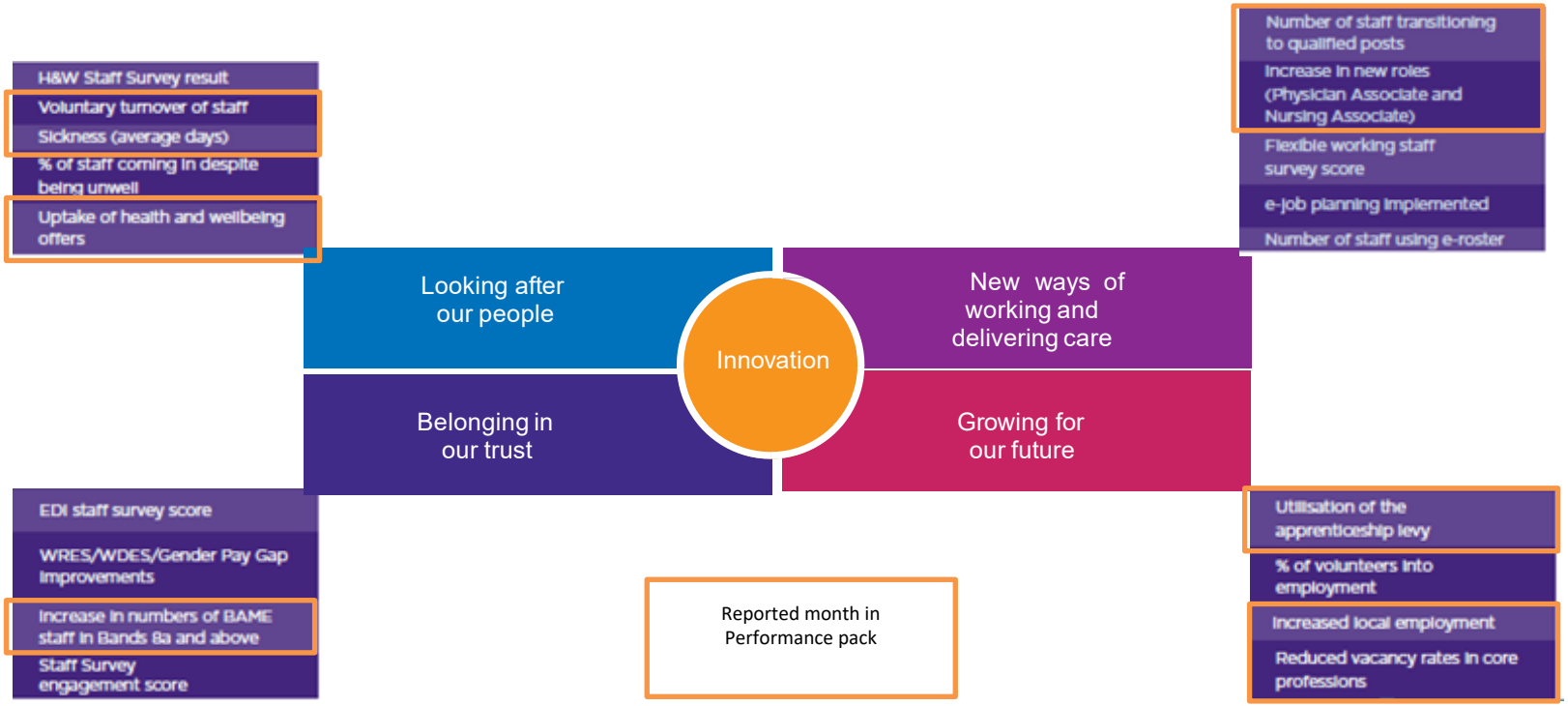
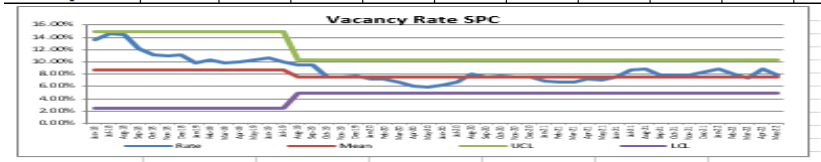
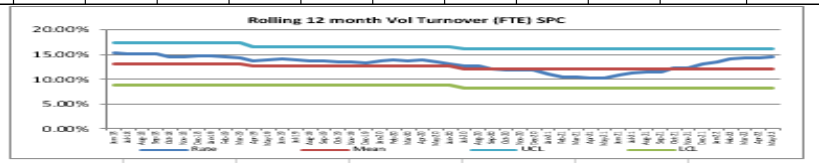


Key Indicators Over time and Coverage Triangulation

KPI	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Vacancy Rate	8.06%	7.55%	7.63%	7.52%	6.89%	6.82%	6.67%	6.54%	7.16%	7.02%	7.56%	8.76%	8.83%	7.86%	7.94%	7.89%	8.35%	8.80%	8.01%	7.36%	8.81%	7.95%
Voluntary Turnover	12.59%	12.10%	11.95%	11.95%	11.53%	10.95%	10.52%	10.50%	10.19%	10.32%	10.66%	11.20%	11.53%	11.47%	12.19%	12.32%	13.00%	13.50%	14.16%	14.24%	14.39%	14.58%
Sickness (1 month)	2.85%	3.15%	3.01%	3.28%	4.16%	3.23%	3.79%	2.73%	2.64%	2.69%	2.93%	3.31%	3.48%	3.76%	3.66%	3.90%	5.29%	5.69%	4.36%	4.17%	4.11%	3.29%
PDR Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	46.42%	50.01%	56.96%	57.30%	58.54%	57.44%	58.50%	61.95%	64.31%	65.56%	67.18%
Medical Appraisal Rate											90.19%	89.76%	89.20%	88.28%	85.47%	86.64%	89.10%	89.89%	89.89%	87.08%	83.99%	87.42%
Core Training Rate	93.00%	91.00%	90.00%	89.00%	89.00%	89.00%	87.00%	89.00%	88.00%	88.00%	89.00%	89.00%	88.00%	88.00%	87.00%	88.00%	88.00%	89.00%	89.00%	90.00%	90.00%	90.00%



Movement in Month	⬌
Movement Year to Date	⬌
Movement over Last 12 months	⬌



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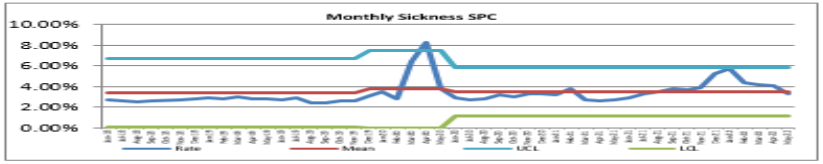
Movement Year to Date	⬌
Movement over Last 12 months	⬌



Movement in Month	⬌
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Movement over Last 12 months	⬌

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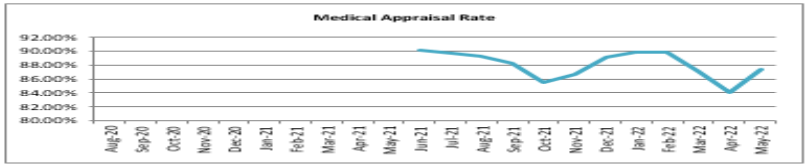
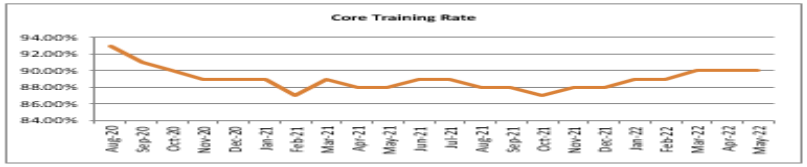


Movement in Month	⬌
Movement Year to Date	
Movement over Last 12 months	



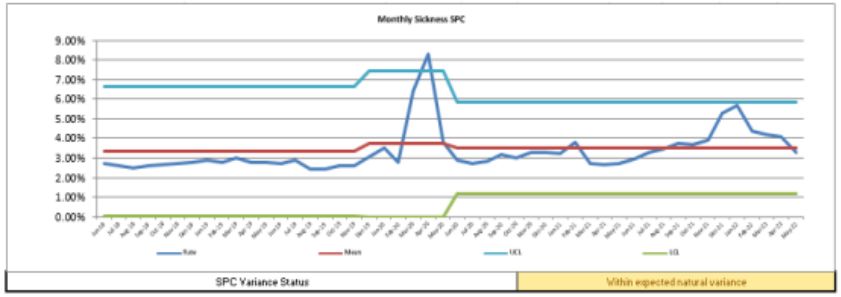
Movement in Month	⬌
Movement Year to Date	⬌
Movement over Last 12 months	

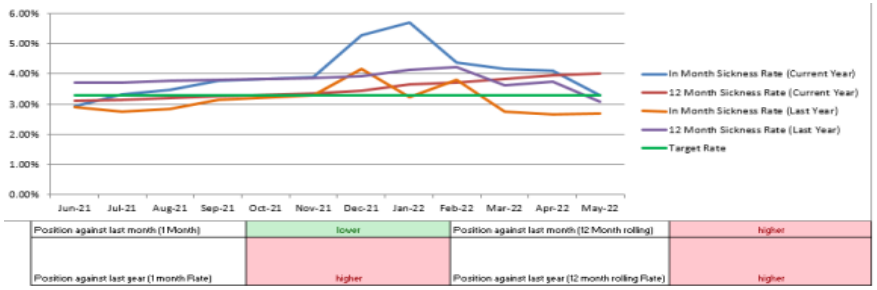
Division	Budget WTE	In Post WTE	Vacancy Rate	Agency WTE	Bank WTE	In Month Sickness	FTE Lost to Sickness Estimate	Sum of Vacant FTE + Sickness FTE less Sub, bank and agency deployed	Sum of coverage % (B&A + In post) against Budget and Sickness
COR	612.03	573.09	6.36%	7.53	46.95	1.27%	7.25	-8.28	101.34%
CSD	1063.53	960.10	9.72%	1.18	98.97	3.80%	36.46	39.74	96.39%
EIC	1810.10	1649.57	8.87%	80.31	236.38	2.84%	46.81	-109.35	105.89%
PDC	1214.83	1152.36	5.14%	45.24	126.51	3.51%	40.44	-68.84	105.48%
WCH	1710.92	1555.35	9.09%	20.66	154.94	3.85%	59.87	39.84	97.75%
ENT	201.21	196.70	2.24%	5.43	16.22	4.86%	9.56	-7.58	103.60%
Trust	**6612.62**	**6087.16**	**7.95%**	**160.35**	**679.97**	**3.29%**	**200.35**	**-114.52**	**101.68%**

People Plan - Looking after our people

ICS Goal 1 - Care

Performance Measure	2020/21 baseline	2023/24 ambition
Sickness (average days)	5.8 days	5 days





Divisional	Trust	COR	CSD	EIC	ENT	PCD	WCH
FTE Days Lost to Sickness (In month)	6210.45	224.40	1128.94	1453.28	280.01	1254.34	1859.48
FTE Days Available	180686.51	17728.10	29730.16	51218.19	5966.96	35740.00	48303.09
Staff Headcount	6545	594	1040	1743	211	1224	1733
In Month Sickness Rate	3.29%	1.27%	3.80%	2.84%	4.86%	3.51%	3.85%
of which Short Term	1.84%	0.69%	2.02%	1.88%	2.61%	2.03%	1.88%
of which Long Term	1.45%	0.58%	1.77%	0.96%	2.25%	1.48%	1.97%
No of Episodes in Month	1280	48	225	330	44	244	389
New Active Sickness Triggers	186	8	38	49	5	37	49
Triggers Downgraded	99	6	15	23	2	21	32
Previous Months 1 Month Sickness Rate	4.11%	2.18%	4.92%	3.42%	4.81%	4.06%	5.01%
In Month Movement	-0.82%	-0.91%	-1.12%	-0.59%	0.05%	-0.55%	-1.16%
12 Month Sickness Rate	4.00%	2.04%	5.15%	3.33%	4.98%	3.80%	4.76%
Number of Active Sickness Triggers	2670	116	497	714	83	494	766

Staff Groups**	Administrative & Clerical	Allied Health Professionals	Medical & Dental	Nursing & Midwifery (Qualified)	Nursing & Midwifery (Unqualified)	Other Additional Clinical Staff	Scientific & Technical (Qualified)
FTE Days Lost to Sickness (In month)	1298.35	284.36	196.18	2852.61	1106.86	168.88	303.21
FTE Days Available	36451.87	10246.88	38376.02	71673.5	18456.11	4882.13	8600
Staff Headcount	1232	364	543	2493	638	177	305
In Month Sickness Rate	3.56%	2.78%	0.51%	3.98%	6.00%	3.46%	3.53%
of which Short Term	1.66%	2.25%	0.29%	2.40%	2.93%	1.04%	2.59%
of which Long Term	1.90%	0.53%	0.23%	1.58%	3.07%	2.42%	0.94%
12 Month Sickness Rate	4.21%	3.45%	0.94%	4.89%	6.35%	4.93%	4.49%
Previous Months 1 Month Sickness Rate	4.41%	3.69%	0.52%	5.31%	6.71%	4.74%	3.68%
In Month Movement	-0.85%	-0.92%	-0.01%	-1.33%	-0.71%	-1.29%	-0.16%

Highest Sickness Reason	In Month Episode %	Highest Sickness Reason	In Month FTE Lost %
S25 Gastrointestinal problems	17.55%	S15 Chest & respiratory problems	17.99%
S13 Cold, Cough, Flu - Influenza	12.25%	S10 Anxiety/stress/depression/other psychiatric illnesses	13.24%
S15 Chest & respiratory problems	11.93%	S12 Other musculoskeletal problems	8.89%
S16 Headache / migraine	8.35%	S25 Gastrointestinal problems	7.84%
S12 Other musculoskeletal problems	7.96%	S98 Other known causes - not elsewhere classified	7.60%

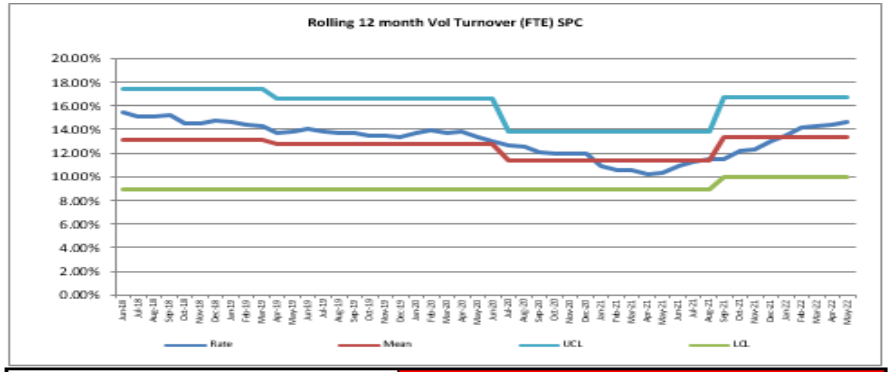
The sickness rate has continued its downwards trajectory from the 12 month high in December 2021. The rate does remain within expected statistical variances. Material improvement has been seen in COR (down 0.91% to 1.27%), CSD (down 1.12% to 3.80%), PCD (down 0.56% to 3.51%), EIC (down 0.58% to 2.84%) and WCH (down 1.16% to 3.85%).

The highest reason for sickness both FTE days lost remains Chest & Respiratory issues which includes Covid19 but its fallen to the 3rd reason by number of episodes. The second highest reason by FTE days lost for absence in month by impact was Anxiety/stress/depression/other psychiatric illnesses and the Trust is proactively trying to manage health and wellbeing during a period where staff will be susceptible to burn out after the last 2 years of pandemic response. By episode the 2nd highest reason is influenza.

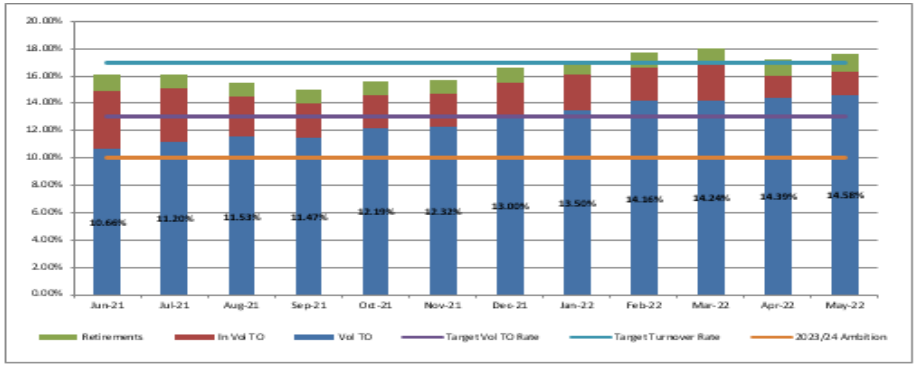
People Plan - Looking after our people

ICS Goal 1 - Care

Performance Measure	2020/21 baseline	2023/24 ambition
Voluntary Turnover of Staff	18%	10%



SPC Variance Status	Increasing Shift Change (8 data points)



Position against last month (1 Month)	higher
Position against last year (1 month Rate)	higher

Divisional	Trust	COR	CSD	EIC	ENT	PCD	WCH
Voluntary Leaves (FTE) in last 12 months	791.90	83.00	162.00	214.00	45.00	103.00	252.00
Voluntary Leaves (HC) in last 12 months	859	38.94	103.43	160.53	4.51	62.47	155.57
Voluntary Turnover Rate	14.58%	14.49%	15.30%	14.45%	23.12%	9.98%	15.79%
Retirement Rate	1.19%	1.52%	1.48%	0.78%	0.00%	1.12%	1.41%
Gross Turnover Rate	17.85%	18.78%	19.98%	16.30%	25.42%	13.00%	19.17%
Previous Vol TO Months Rate	14.39%	13.75%	15.41%	14.18%	23.32%	10.34%	15.15%
Movement	0.18%	0.74%	-0.11%	0.27%	-0.21%	-0.36%	0.63%
Last Years Vol TO Rate	10.32%	11.22%	10.38%	13.22%	#DIV/0!	7.47%	8.92%
Movement	4.26%	3.27%	4.92%	1.22%	#DIV/0!	2.50%	6.87%

Staff Groups	Administrative & Clerical	Allied Health Professionals	Medical & Dental	Nursing & Midwifery (Qualified)	Nursing & Midwifery (Unqualified)	Other Additional Clinical Staff	Scientific & Technical (Qualified)
Voluntary Leaves (FTE) in last 12 months	183.11	66.69	13.68	334.25	106.63	25.43	62.11
Voluntary Leaves (HC) in last 12 months	188	71	17	365	115	34	69
Voluntary Turnover Rate	15.59%	20.66%	2.21%	14.60%	18.22%	16.31%	21.85%
Retirement Rate	1.40%	0.31%	0.56%	1.41%	1.34%	2.57%	1.71%
Gross Turnover Rate	19.24%	23.33%	6.06%	16.44%	20.69%	28.20%	26.58%
Previous Vol TO Months Rate	14.95%	21.16%	2.08%	14.85%	17.45%	14.85%	21.49%
Movement	0.64%	-0.50%	0.13%	-0.25%	0.77%	1.46%	0.35%

Top 5 Vol Leaver Reasons	WTE Leavers in 12 Months	%
Voluntary Resignation - Relocation	443.56	30.49%
Voluntary Resignation - Other/Not Known	224.06	15.40%
Voluntary Resignation - Promotion	206.98	14.23%
Voluntary Resignation - Work Life Balance	120.00	8.25%
Voluntary Resignation - To undertake further education or training	134.63	9.25%

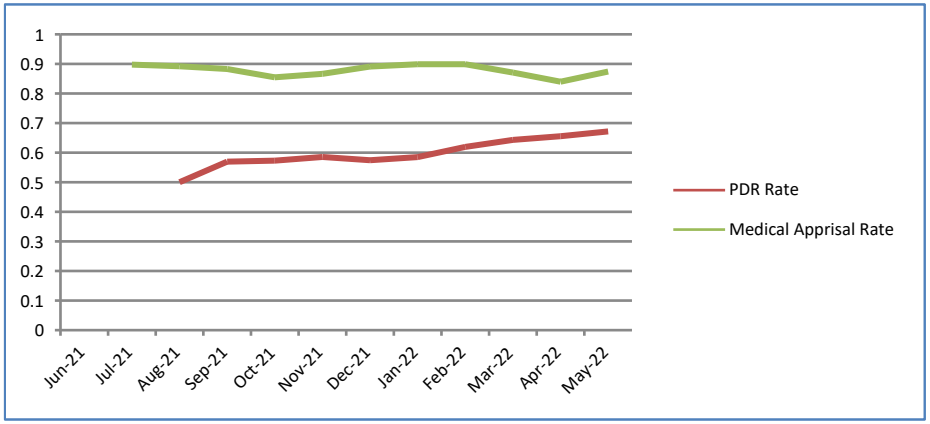
Voluntary turnover has increased to 14.58% in month on a rolling basis, this is higher compared to last year and although the rate of progression is slow, and is in line with the sector position this does represent a negative shift change indicating a material change. Mobility of staff has returned to pre-pandemic levels. Divisional improvement programmes focused on retention are a focus for business planning and the Trust is investing heavily in Health and wellbeing programmes to support staff.

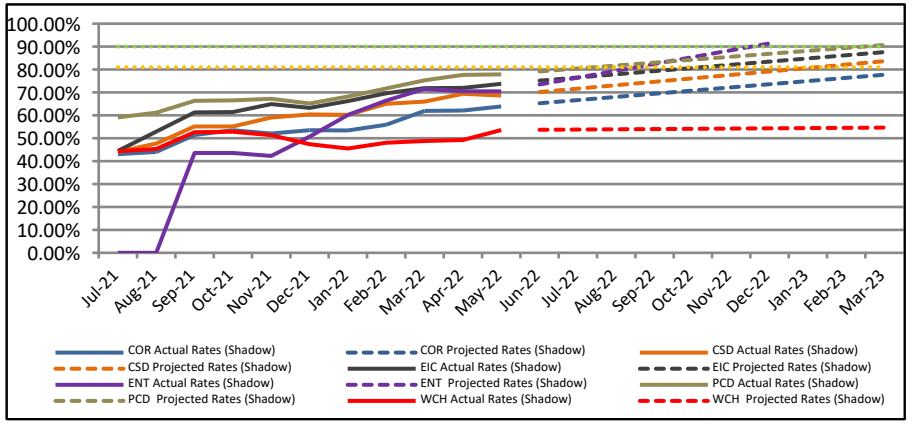
Relocation remains the most significant reason for leaving. The nature of that reason itself are complicated and may be impacted by rates of pay, cost of living, family dependencies and burn out.

People Plan - Looking after our people

ICS Goal 1 - Care

Appraisal Rates	Target – 90%





Month	Feb-22	Mar-22	Apr-22	May-22
Trust PDR Rate	61.95%	64.31%	65.56%	67.18%
COR PDR Rate	55.88%	61.93%	62.09%	63.88%
CSD PDR Rate	65.03%	65.99%	69.38%	68.64%
EIC PDR Rate	69.60%	71.85%	72.03%	73.74%
ENT PDR Rate	66.43%	71.53%	70.47%	70.47%
PCD PDR Rate	71.72%	75.24%	77.64%	77.87%
WCH PDR Rate	48.04%	48.79%	49.22%	53.58%

Month	Feb-22	Mar-22	Apr-22	May-22
Trust PDR Rate	61.95%	64.31%	65.56%	67.18%
A&C PDR Rate	51.78%	54.60%	57.08%	59.57%
AHP PDR Rate	58.15%	65.33%	69.06%	69.31%
Nursing (Q) PDR Rate	65.17%	66.60%	67.58%	69.38%
Nursing (UQ) PDR Rate	65.53%	68.04%	67.80%	69.47%
OACS PDR Rate	60.84%	63.23%	65.56%	65.54%
STT(Q) PDR Rate	75.81%	78.97%	77.11%	75.00%

Month	Feb-22	Mar-22	Apr-22	May-22
Trust Med App Rate	89.89%	87.08%	83.99%	87.42%
CSD Med App Rate	89.58%	85.42%	91.49%	93.62%
EIC Med App Rate	88.80%	84.03%	76.86%	84.77%
PCD Med App Rate	[illegible]	[illegible]	87.14%	90.85%
WCH Med App Rate	91.67%	91.32%	85.49%	85.49%

The rate of improvement in the appraisal rates slowed materially in May leading to CSD and EIC moving to being forecast to close in the amber range at year end.

The projection predicts that ENT and PCD will all achieve the target rate by the close of 22/23, EIC and CSD will make the amber range with WCH and COR finishing outside of the targeted tolerances.

For medical staff, the overall Trust appraisal rates as increased in month to 87.42% remaining within acceptable tolerances but a material drop. Divisionally no area is outside the amber ranges with CSD and PCD at the target rates . Appraisals overdue but these are being followed up by the Medical Workforce Team in line with Trust processes.

Targeted reports have been sent out to divisions this month in order to assist in increasing compliance. Furthermore, there has been a change to recording PDRs at 6 months which means a number of staff are automatically out of date. This is being addressed by the divisions and compliance should improve over the next few months.

People Plan - Looking after our people

ICS Goal 1 - Care

Statutory and Mandatory Training Rates

Target – 90% (IG 95%)

Core Training Compliance Totals / Overall	Core Training			
	Last Month	This Month	Target	Trend
Theory Adult BLS	90%	90%	90%	→
Practical Adult BLS	87%	86%	90%	↓
Conflict Resolution - Level 1	81%	81%	90%	→
Equality & Diversity	95%	95%	90%	→
Fire	91%	92%	90%	↑
Health & Safety	90%	89%	90%	↓
Infection Control (Hand Hygiene)	92%	93%	90%	↑
Infection Control - Level 2	88%	89%	90%	↑
Information Governance	90%	90%	90%	→
Moving & Handling - Level 1	90%	90%	95%	→
Moving & Handling - Level 2 Theory	89%	90%	90%	↑
Moving & Handling - Level 2 Patient	89%	89%	90%	→
Safeguarding Adults Level 1	85%	85%	90%	→
Safeguarding Adults Level 2	90%	91%	90%	↑
Safeguarding Adults Level 3	90%	89%	90%	↓
Safeguarding Children Level 1	75%	71%	90%	↓
Safeguarding Children Level 2	92%	92%	90%	→
Safeguarding Children Level 3	91%	91%	90%	→
	74%	74%	90%	→

	Last Month	This Month	Trend
TRUST	90%	90%	→
Clinical Support Division	91%	92%	↑
Corporate Division	89%	91%	↑
Emergency & Integrated Care Division	90%	91%	↑
Enterprise Division	91%	91%	→
Planned Care Division	91%	91%	→
Womens, Childrens and Sexual Health Division	88%	87%	↓

Overall compliance is **90%**

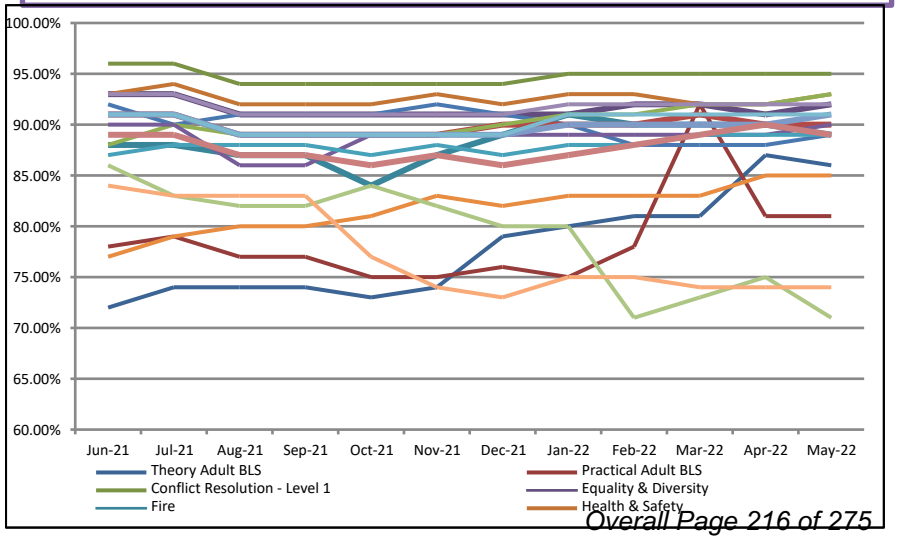
Information Governance: is currently at **93%** (national target 95%), IG sees a 1% increase every 2 weeks, we are hoping that we reach the national target by the end of June mid-July

Moving and Handling: Has remained at **85%,** the team have had to cancel sessions due to low numbers on sessions. The team delivered 40 sessions (these include Induction, Updates, OSCEs and ward targeted sessions), training 132 staff within the month of May.

Basic Life Support – Practical: Has also remained at 81% - The team delivered 11 sessions with a total of 138 staff attending

Safeguarding Children & Adults Level 3 - As stated last month, the Senior L&OD Information Analyst has had meeting with SMEs and will start looking into key areas in the Trust that need some support.

WCH Division: WCH is currently at 87% overall, the Senior L&OD Information Analyst has created a report on areas that the division should focus on to get back track, key areas being E&D, Fire, Infection Control L2. Safeguarding L3 is a key area within the division but these have been addressed with the SMEs and directorate leads, we are waiting for lists of staff who have completed, this should see compliance percentages go up.

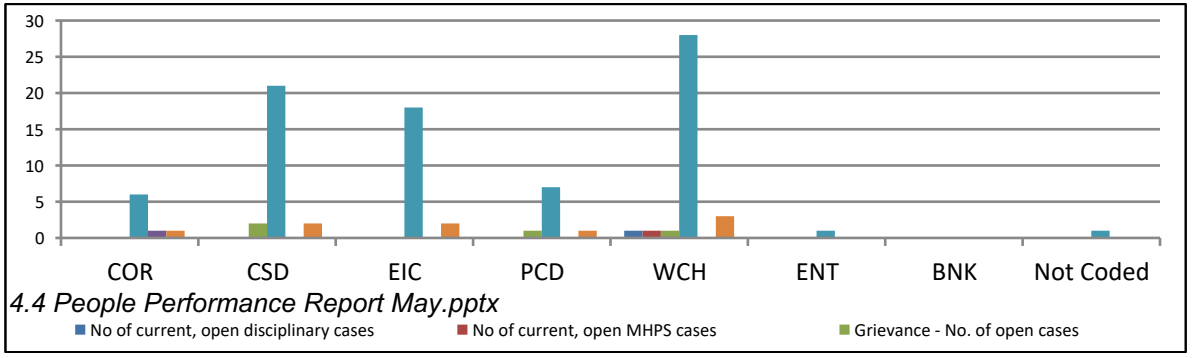


People Plan - Looking after our people

ICS Goal 1 - Care

Employee Relations

Category	Metric		
Non Medical Disciplinary		Apr-22	May-22
No of Disciplinary cases opened in month	Number	0	0
No of current, open disciplinary cases	Number	2	1
Average length of closed disciplinary cases (closed in the last 24 months)	Days <60	70.38	70.38
Average length of disciplinary Investigation	Days<30	37.50	35.00
Total Disciplinary cases opened in year (from April 22)	Number	0	0
% BAME Disciplinary Cases in year (from April 2022)	%	100.00%	100.00%
% BAME Disciplinary Cases opened in month	%	0.00%	0.00%
Exclusions - No. of live in month	Number	1	1
Medical Disciplinary		Apr-22	May-22
No of MHPS cases opened in month	Number	0	0
No of current, open MHPS cases	Number	1	1
Average length of closed MHPS cases (closed in the last 24 months)	Days <60	136.76	136.76
Average length of MHPS Investigation	Days<30	28.00	28.00
Total MHPS cases opened in year (from April 22)	Number	0	0
% BAME MHPS Cases in year (from April 2022)	%		0.00%
% BAME MHPS Cases opened in month	%		-
Exclusions - No. of live in month	Number	0	0
Grievance		Apr-22	May-22
Grievance - No. of opened cases in month	Number	1	1
Grievance - No. of opened cases in year	Number	1	2
Grievance - No. of open cases	Number	4	4
Average length of closed grievance cases	Days	130.43	132.29
Grievances - % that are BAME Cases opened in month	%	0.00%	0.00%
Grievances - % that are BAME Cases opened in year	%	0.00%	0.00%
B&H cases - included in grievance numbers (of those opened in year)	Number	0	0
Sickness		Apr-22	May-22
Sickness - No. of cases opened in month	Number	22	13
Sickness - No. of open cases	Number	79	82
Long Term - sickness cases in month	Number	10	11
Short Term - sickness cases in month	Number	11	2
Ancilary		Apr-22	May-22
No. of Employment Tribunals (ET) active	Number	8	7
Staff attending ER training sessions in month aggregate	Number	40	59



4.4 People Performance Report May.pptx

We currently have 1 live disciplinary case with 1 case closed since April 2022 . The average length of disciplinary investigation has decreased from 37.50 to 35 days, getting closer to the target of 30 days.

There is one live MHPS case which met the investigation KPI. The MHPS hearing has taken place but the decision was delayed due to the requirement for further evidence which has been received. Whilst, the outcome has now been issued, a sanction hearing must follow and the delays have meant that this open MHPS case is 132 days which is significantly above the current KPI of 60 days.

There are currently 4 open grievances. 1 new case was opened and 1 was closed in the month of May 2022. The general themes still remain the same, around bullying, race discrimination, leadership and breakdown in relationships. The ER team continues to work closely with managers to identify resolutions and schedule appropriate interventions for example mediation.

There are currently 82 active sickness cases under management. 13 new cases were opened in the month of May 2022 and 14 sickness cases closed since last month.

The number of Employment Tribunal (ET) cases has reduced to 7. These claims relate specifically to issues pertaining to race discrimination, disability discrimination, unfair dismissal and whistleblowing. The outcomes to date remain positive by way of strong case management and early resolution where appropriate.

The number of managers attending training remains positive, increasing from 40 to 59 since the beginning of April 2022.

The team has taken a proactive approach in supporting managers so most of the employee relations cases are managed at the informal stage.

People Plan - Belonging

ICS Goal 2- Lead/ Include

Performance Measure	2020/21 baseline	2023/24 ambition
Increase in the number of BAME staff 8a and above	Disproportionate – 3 grades not met	All grades meeting set targets

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

2022/22 Performance	2021/2 ambition	2021/2 current	Gap
Band 8a	86	84	-2
Band 8b	31	26	-5
Band 8c	13	16	+3
Band 8d	7	4	-3
Band 9	3	3	-
VSM	8	7	-1

Slide 11 Belonging

Divirsn	BAME Staff in Band 8A+ (Afc)	Staff in Band 8A+ (Afc)	Band 8A+ (Afc) BAME %	BAME Staff in Medical	Staff in Medical	Medical BAME %	Overall Staff Population BAME %
289 PDC Planned Care Divirsn	10	44	22.73%	138	358	38.55%	56.13%
289 EIC Emergency & Integrated Care Divirsn	27	103	26.21%	200	445	44.94%	55.08%
289 Enterprise Divirsn	5	23	21.74%	1	11	9.09%	41.23%
289 CSD Clinical Support Divirsn	43	91	47.25%	33	65	50.77%	52.12%
289 COR Corporate Divirsn	39	144	27.08%	12	30	40.00%	44.61%
289 WCH Women, Children and Sexual Health Divirsn	8	65	12.31%	180	409	44.01%	40.10%
Trust	132	470	28.09%	564	1318	42.79%	49.44%

Factor	Current Month	Last Month	Start of Year
% of Diversity Champions on Band 8A+ Interview Panels	0.00%	8.33%	8.33%

During the last month we have had a slight improvement on our projected model employer targets for 2022/23 . An increase in the number of 8a roles from 83 to 84 and we are now 2 away from the 2022 target of 86 . Our band 8c roles have also increased during May from 15 to 16 but we have already surpassed the target set for 22/23 13 and for 23/24 of 14. For the 8b roles this has remained static this month at 26 with our 22/23 target of 31 and we need to understand the narrative behind this. The number of 8d roles and VSM have also remained static during May. Our Band 9 roles have been achieved.

Our number of BAME staff in Senior Leader positions is currently 140 and our target is for 22/23 is 148. The charts highlight our nationally set targets and how this is reflected across Divisions and by Agenda for Change and medical staff groups. During the month of May have embedded our two new associates from the leadership ladder programme into their areas of work and have clear set achievable targets in place.

The Diversity Champions on panels is under review and the new programme increase availability of diversity champions by including patient representatives and non-executive directors and aid us in achieving the cultural shift needed and ensure diverse representation on all senior appointments across the Trust.

People Plan - New Ways of Working

ICS Goal 4- Transform

Performance Measure	2020/21 baseline	2023/24 ambition
Increase in the number of staff transitioning to qualified posts	<20	>70

Division	Number in Qualified Roles that were in unqualified roles 12 months before
289 PDC Planned Care Division	0
289 EIC Emergency & Integrated Care Division	0
289 WCH Women's, Children's and Sexual Health Division	0
289 CSD Clinical Support Division	0
289 COR Corporate Division	0
289 WCH Womens, Childrens and Sexual Health Division	0

Roles (Coded as per below)	Established (Mar 22)	Established Current	In Post (Mar 22)	In Post Current
Apprentice Nurse Associate	5.00	5.00	27.07	20.67
Nurse Associate (Qualified)	14.00	32.85	15.00	23.00
Advanced Clinical Practitioner (NMC)	0.00	0.00	0.00	0.00
Advanced Clinical Practitioner (HPC)	0.00	0.00	0.00	0.00
Physicians Assistant	4.00	4.00	3.00	5.00

Work continues to identify areas where ACP and PA's can bolster workforce and fill medical workforce gaps. There are currently 7 Advanced Clinical Practitioner Level 7 Apprentices at the moment, 4 from EIC and 3 from PCD, all due to finish April 2024. There is also one other ACP being trained through HEE funding from WCH who will complete in January 2023.

People Plan - New Ways of Working

ICS Goal 4- Transform

Performance Measure	2020/21 baseline	2023/24 ambition
Flexible Working Staff Survey Score	56%	65%

Category	Metric	Number/%
Number of flexible working requests received since April 22	Number	20
Disabilities	%	0%
%BAME - requested flexible working	%	70.00%
Average length arranging meeting	Days <28	TBC
Requests accepted	%	75.00%
Requests pending	Number	2
Requests rejected	%	15.00%
Number of appeals received in total	Number	0
Appeals accepted	Number	0
Appeals rejected	Number	0

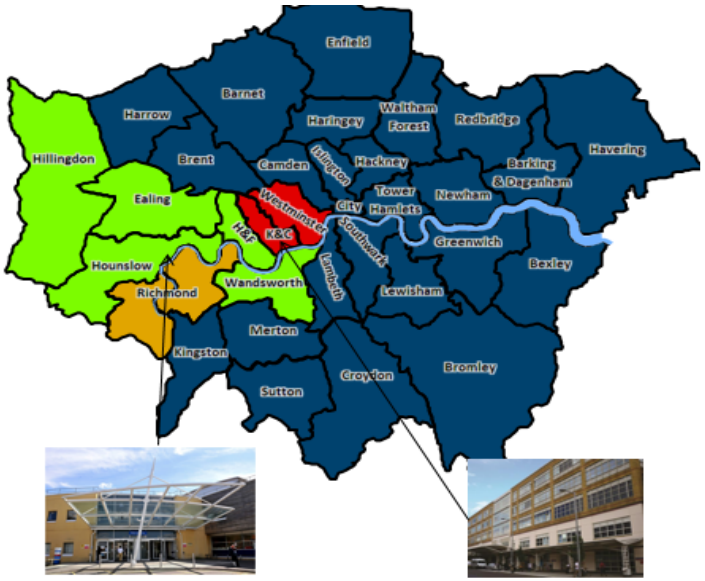
There are 20 flexible working applications from April 2022, this was an increase due to a recent restructure. The total number of applications accepted overall is 75% at the end of May 2022. The majority of the applications continue to be made by female employees. The total number of applications made by Black and Ethnic Minority (BME) employees from April is 70%.

So far 3 applications have been rejected and 2 applications are pending. We continue to advise and support managers on flexible working applications. NHS employers have recently released some new toolkits to

People Plan - **Growing for our future**

ICS Goal 3- Grow

Performance Measure	2020/21 baseline	2023/24 ambition
Increased local employment	Not currently measured	10%
Utilisation of the apprenticeship levy	39%	70%



HCA London Collaborative Event

Following the success of the event , currently we have 19 candidates cleared to start (8 from the NWL HCA event and 11 from additional activity) – these candidates are currently being allocated start dates

There are a further 126 applicants being progressed through recruitment checks and a further cohort that are in the process of being reviewed and allocated. There are a small number of applicants that have requested an alternative Trust due to distance from home.

Apprentices and Levy Update

Total Number of Apprentices:	206
EIC:	66
Planned Care:	37
WCH, HIV/GUM:	49
Clinical Support:	27
Corporate:	29

Levy Utilisation: 46%
As of: April 2022

Staffing % (substantive by Headcount on primary assignment by home addresses)

SLIDE 14 Grouing

Divisran	Ealing	Hammersmith and Fulham	Hillingdon	Hounslau	Kensington and Chelsea	Richmond upon Thames	Wandsworth	Westminster	Not local	Hounslau and K&C
289 PDC Planned Care Divirian	11.52%	11.44%	5.64%	20.34%	4.25%	4.82%	8.82%	1.96%	31.21%	24.59%
289 EIC Emergency & Integrated Care Divirian	11.24%	12.10%	6.54%	21.04%	4.13%	6.02%	8.83%	1.72%	28.38%	25.17%
289 Enterprire Divirian	9.48%	13.74%	0.47%	6.64%	6.16%	4.74%	15.64%	0.47%	42.65%	12.80%
289 CSD Clinical Support Divirian	15.10%	9.33%	7.21%	19.04%	3.75%	3.75%	7.69%	1.54%	32.60%	22.79%
289 C[illegible] Divirian	6.39%	7.39%		10.92%	3.03%	2.86%	5.21%	1.01%	50.08%	13.95%
289 WCH Womens, Childrens and Sexual Health Divirian	11.36%	8.48%	5.13%	11.65%	3.92%	5.59%	9.80%	2.08%	41.98%	15.57%
Trust	12.05%	10.11%	5.99%	16.72%	4.00%	4.99%	8.80%	1.73%	[illegible]	[illegible]

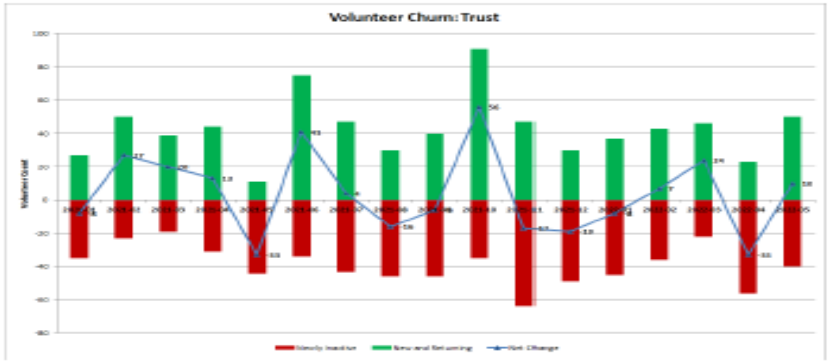
People Plan - **Growing for our future**

ICS Goal 3- Grow

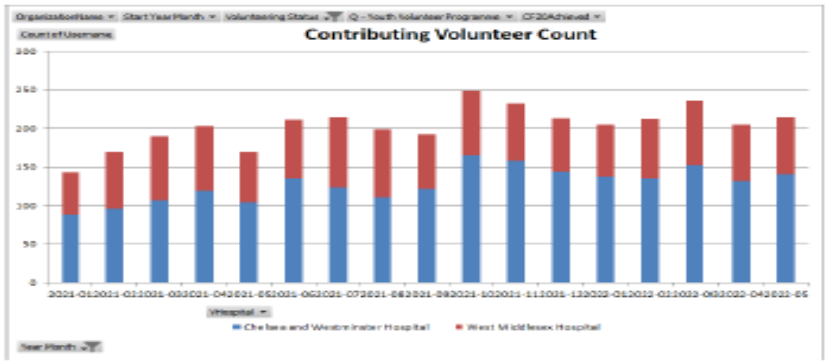
Volunteers	There was an increase in volunteering activity from April to May. This was driven by an increase in active volunteers, volunteers doing more hours, and a notable increase in ward helper engagement at Chelsea. Also, April's numbers were depressed by the Easter and Ramadan holidays. It is expected that we could see another decrease in hours in June due to half term and the long Jubilee weekend. The team is recruiting a Youth Coordinator based at Chelsea to assist with the Best for You project and with more youth engagement. This is a 12 month fixed-term post funded through CW+ by DCMS.

Trust Summary

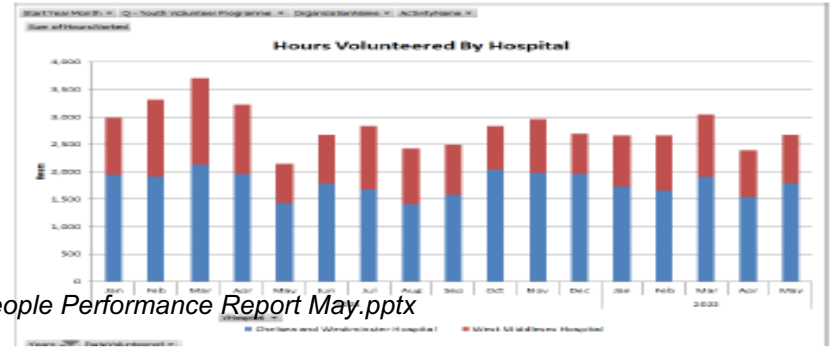
Change on Last Month +10

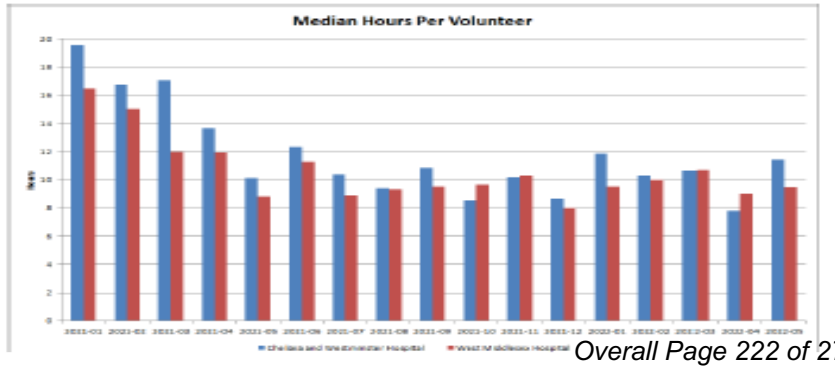


Change on Last Month +5%



Change on Last Month +12%

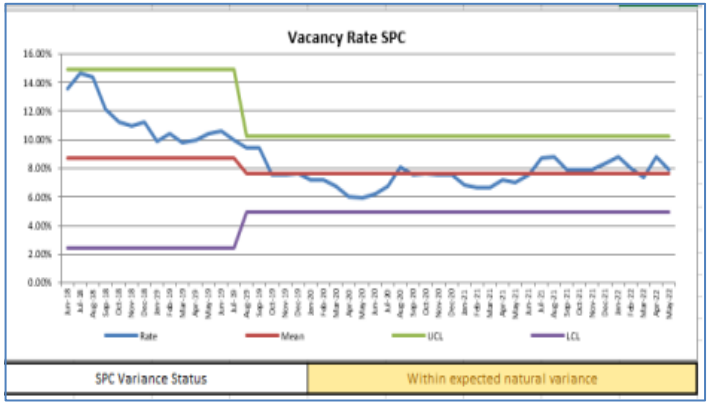


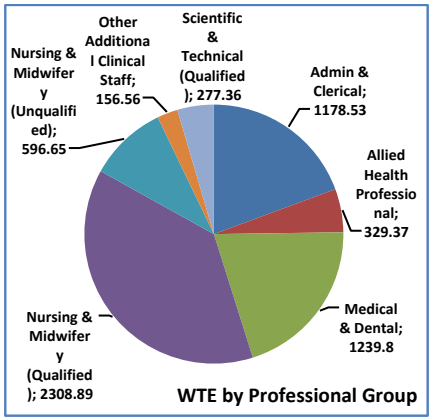


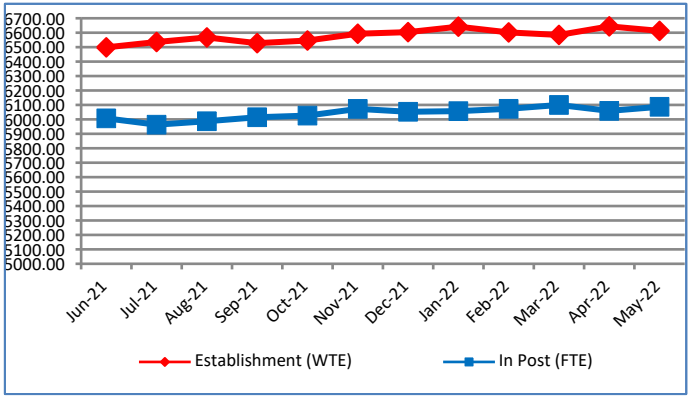
People Plan - **Growing for our future**

ICS Goal 3- Grow

Performance Measure	2020/21 baseline	2023/24 ambition
Reduced vacancy rates by Core Professions	N&M 5.5% M&D 3.5% AHPs 6%	N&M 5-8% M&D <5% AHPs <7%







Although the Trust vacancy rates remain within expected statistical variances there was a material decrease in the vacancy rate down to 7.95% driven by a combination of a reduction in establishments (-31.25FET) and an increase in the staffing levels (+28.37FTE).

The Qualified nursing rates fallen driven by a combination of -32.30FTE establishment decrease and 18.71 FTE increase in the in post. The nursing forecast shows that at current projections the band 5 nursing vacancy rate should fall under 5% in the next 3 months

Unqualified nursing remains high at 21.06% but has improvement over the previous periods was reversed with the established roles being increased materially last month which will mean a lag as the posts are recruited to. There was a significant number of candidates assigned to the Trust at the NWL event and the rate will reduce in line with their on boarding. With supply pool at band 2 level, either a grow our own or skill mix reviews linked to safer staffing models maybe required. Other clinical support levels also remain high but have seen a 2nd material improvement of circa 5% within the last 3 months. This may be due to the establishment issue so needs to be monitored carefully.

Month	Feb-22	Mar-22	Apr-22	May-22	Target Rate
Trust Rate	8.01%	7.36%	8.81%	7.95%	
COR Rate	4.11%	3.74%	5.46%	6.36%	
CSD Rate	10.26%	9.31%	10.23%	9.73%	
EIC Rate	7.70%	6.39%	8.86%	8.87%	10.00%
ENT Rate	7.56%	7.87%	8.00%	2.24%	
PCD Rate	6.66%	6.50%	8.48%	5.14%	
WCH Rate	9.31%	8.98%	9.38%	9.09%	

Month	Feb-22	Mar-22	Apr-22	May-22	Target Rate
A&CRate	8.16%	7.77%	9.44%	8.84%	10.00%
AHP Rate	7.04%	7.36%	5.89%	5.62%	5.00%
Med Rate	-1.42%	-2.43%	-1.85%	-1.58%	5.00%
Nursing (Q) Rate	8.48%	8.06%	9.29%	7.36%	5.00%
Nursing (UQ) Rate	17.99%	17.60%	21.94%	21.06%	8.00%
OACS Rate	19.13%	15.63%	15.97%	17.27%	10.00%
STT(Q) Rate	12.14%	10.07%	11.09%	[illegible]	10.00%

People Plan - **Growing for our future**

ICS Goal 3- Grow

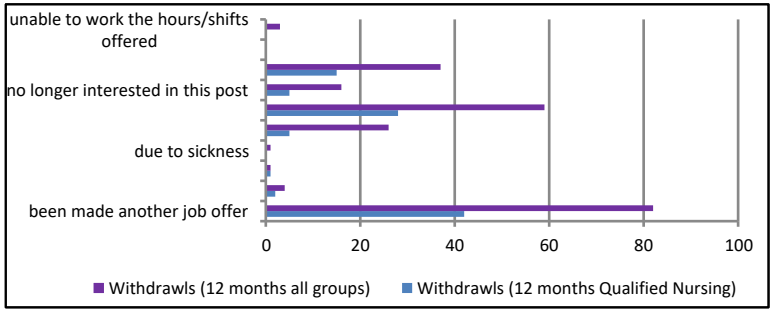
Recruitment Data for non-medical

Performance

Metric	Units	Status	Avge YTD	Last mth	This mth
Advert published		target > 2 days			
Corporate	avge.	days	0.6	0.7	1.0
CSS	avge.	days	0.4	0.3	0.3
EIC	avge.	days	0.3	0.0	0.6
PCD	avge.	days	1.2	0.3	0.3
WCH	avge.	days	0.6	0.2	0.6
Total	avge.	days	**0.6**	**0.2**	**0.6**
Shortlisting sent		target > 1 day			
Corporate	avge.	days	1.4	1.0	2.0
CSS	avge.	days	1.0	1.0	1.0
EIC	avge.	days	1.1	1.0	2.3
PCD	avge.	days	1.1	1.3	1.1
WCH	avge.	days	1.2	1.1	2.6
Total	avge.	days	**1.2**	**1.1**	**1.9**
Arrange interview		target > 2 days			
Corporate	avge.	days	0.2	0.1	0.5
CSS	avge.	days	0.3	0.8	0.2
EIC	avge.	days	0.2	0.1	0.0
PCD	avge.	days	0.5	0.2	1.2
WCH	avge.	days	0.3	0.3	0.2
Total	avge.	days	0.3	**0.3**	**0.3**
Offer issued		target > 2 days			
Corporate	avge.	days	0.9	0.3	2.9
CSS	avge.	days	1.4	2.2	3.9
EIC	avge.	days	1.1	3.6	2.4
PCD	avge.	days	0.8	1.8	0.3
WCH	avge.	days	1.1	0.8	1.1
Total	avge.	days	**1.1**	**1.5**	**2.2**
Pre-employment checks		target > 20 days			
Corporate	avge.	days	13.2	17.8	15.0
CSS	avge.	days	20.4	23.7	20.1
EIC	avge.	days	14.9	19.8	14.0
PCD	avge.	days	27.0	13.7	29.0
WCH	avge.	days	20.7	22.8	21.3
Total	avge.	days	**17.8**	**19.6**	**19.8**
Time to hire		target > 9 wks			
Corporate	avge.	weeks	7.3	8.7	9.1
CSS	avge.	weeks	9.0	10.5	9.9
EIC	avge.	weeks	7.2	8.2	7.9
PCD	avge.	weeks	9.5	8.3	10.0
WCH	avge.	weeks	8.9	9.5	8.9
Total	avge.	weeks	**8.14**	**8.96**	**9.38**

Process times

Metric	Units	Status	Avge YTD	Last mth	This mth
Authorisation start to final approval					
Corporate	avge.	days	25.0	17.0	24.7
CSS	avge.	days	29.5	16.2	58.7
EIC	avge.	days	24.9	62.7	5.0
PCD	avge.	days	25.2	4.8	10.2
WCH	avge.	days	33.2	44.2	16.0
Total	avge.	days	28.8	38.0	27.3
Time taken to shortlist					
Corporate	avge.	days	8.1	7.0	4.5
CSS	avge.	days	6.7	5.9	6.4
EIC	avge.	days	5.4	4.8	5.3
PCD	avge.	days	5.3	7.1	6.1
WCH	avge.	days	5.7	6.1	8.3
Total	avge.	days	**6.2**	**6.1**	**6.5**
Interview date to informing recruitment team					
Corporate	avge.	days	2.7	3.4	3.8
CSS	avge.	days	3.0	7.7	3.5
EIC	avge.	days	1.5	4.1	2.9
PCD	avge.	days	1.1	1.5	3.4
WCH	avge.	days	2.4	4.0	4.5
Total	avge.	days	**2.3**	**4.6**	**3.8**

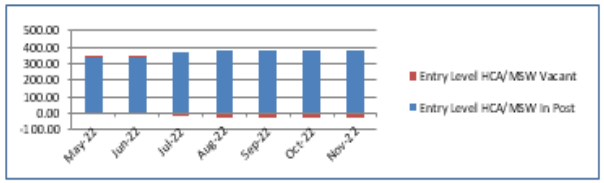


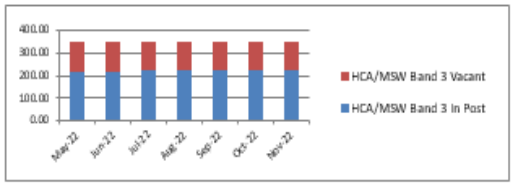
Metric	Units	Avg 12mth	Last mth	This mth
Vacancy created				
Corporate	no.	30	24	39
CSS	no.	38	34	38
EIC	no.	31	30	28
PCD	no.	24	21	27
WCH	no.	48	47	57
Mass recruitment	no.	5	10	5
Total	no.	176	166	194
Advertised vacancies				
Corporate	no.	30	21	32
CSS	no.	38	33	39
EIC	no.	31	31	26
PCD	no.	24	25	22
WCH	no.	48	51	58
Mass recruitment	no.	5	10	5
Total	no.	176	171	182
Offers made				
Corporate	no.	22	27	22
CSS	no.	38	42	57
EIC	no.	35	37	27
PCD	no.	23	19	26
WCH	no.	47	54	49
Mass recruitment	no.	7	22	6
Total	no.	172	201	187

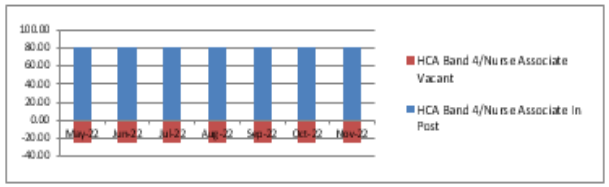
May's activity continued to see a rise in the number of vacancies created and advertised. The number of offers made decreased slightly from 201 to 187. The reduced number of working days in addition to a long term sickness episode within the team contributed to our Time to Hire slipping beyond our target, achieving 9.38 (.38 above target). We had 20 international nurses arriving in May with similar arrival numbers forecasted again by month over the summer. We are currently working on producing a weekly pipeline report which will be broken down by division and cost centre to provide visibility on WTE vacancy V's Budgeted Establishment. The report will also detail the number of candidates that are actively being recruited.
In May the total number of external vacancies advertised with reference to flexible working was 92 (66%).

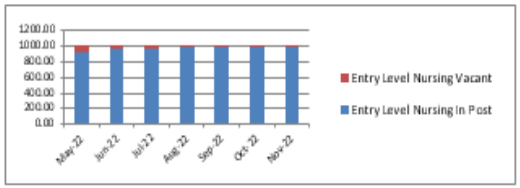
Nursing Pipeline Forecast

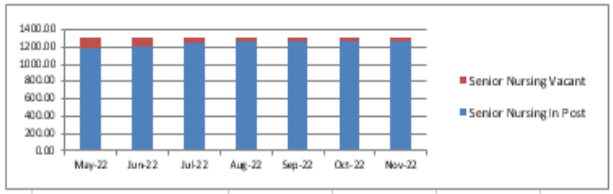
Band	Budget	In Post	Vacant FTE	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Apprentice	20.60	34.93	-14.33	35.93	47.93	55.93	55.93	55.93	55.93
Band 2	330.15	299.01	31.14	302.01	318.01	328.01	328.01	328.01	328.01
Band 3	348.92	216.42	132.50	220.42	224.92	226.58	226.58	226.58	226.58
Band 4	56.19	82.29	-26.10	82.29	82.29	82.29	82.29	82.29	82.29
Band 5	1022.56	925.22	97.34	969.22	973.22	997.22	997.22	997.22	997.22
Band 6	860.68	730.58	130.10	739.58	767.08	781.41	781.41	781.41	781.41
Band 7	449.15	459.70	-10.55	461.70	476.20	486.86	486.86	486.86	486.86











Unqualified Nursing

As can be seen in the close of May and continued forecast, although the Trust is carrying significant vacancies at Band 3 level, we will be over established in the band 2/Apprenticeships and band 4 level. It has been identified under the new ways of working work stream that longer term planning of clinical models and establishments is required both to support the current pathways for ANAs is needed. The band 2 level will not account for the closure of current apprentices so is not a cause for concern however the need to establish the band 4 Nurse Associate roles within service line budgets is more pressing. The latest recruitment fair appointments for HCA roles at entry level (band 2) are being processed will place further pressure on the need to conduct skill mix/safer staffing reviews.

Qualified Nursing

The Trust has currently has over 136 band 5 nurses in the recruitment pipeline and a further 60 in the international nursing pipeline. Accounting for a steady turnover rate ,internal appointments to band 6s and a nominal withdrawal factor from the pipeline we should be able to hit target vacancy rate of 5%. The focus in this area must be on retention efforts.

The picture on the band 6/7 Senior nursing posts differs with the projection of more leavers than starters due in the recruitment pipeline. The overall vacancy rate for Qualified Nursing is likely to over the next 3 months remain outside the 5% stretch target.

Entry Level HCA/MSW – Band 2 and Apprentices
HCA/MSW Band 3s – Band 3
HCA Band 4/Nurse Associate – Band 4
Entry Level Nursing – Band 5
Senior Nursing – Bands 6 and 7

Methodology:
Close of Month base position for In post and establishment, assume the establishment remains stable
Inflows:-
International Nursing Pipeline- Assumes all successful with arrival dates are deployable at 1.0 FTE per capita
Recruitment Pipeline:- Assumes not withdrawals from current pipeline, those with set start dates coded to the forecast month, those without start dates in place split between M2-M3 of the forecast
Outflows:- Assumes the average monthly leavers from last rolling quarter project forward to M1-3

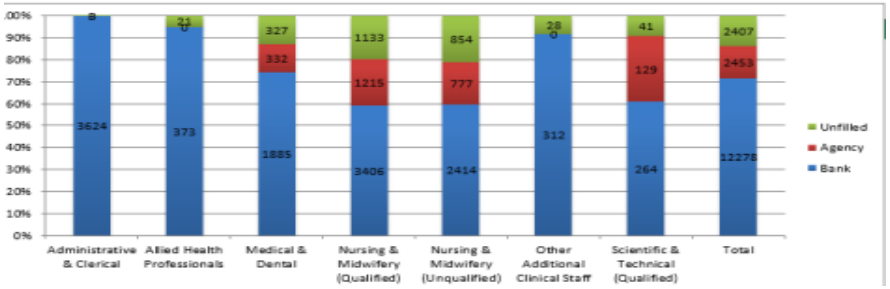
People Plan - **Growing for our future**

ICS Goal 3- Grow

Bank and Agency

Division	Bank	Agency	Unfilled	Total Requested	Bank Fill Rate	Overall Fille Rate
COR	1085	108	41	1234	87.93%	96.68%
CSD	2561	27	89	2677	95.67%	96.68%
EIC	3557	1223	1079	5859	60.71%	81.58%
ENT	150	15	6	171	87.72%	96.49%
PDC	2614	798	446	3858	67.76%	88.44%
WCH	2032	220	669	2921	69.57%	77.10%
Total	12278	2453	2407	17138	71.64%	85.96%

Group	Bank	Agency	Unfilled	Total Requested	Bank Fill Rate	Agency Fill Rate	Unfilled rate	Overall Fille Rate
Administrative & Clerical	3624	0	3	3627	99.92%	0.00%	0.08%	99.92%
Allied Health Professionals	373	0	21	394	94.67%	0.00%	5.33%	94.67%
Medical & Dental	1885	332	327	2544	74.10%	13.05%	12.85%	87.15%
Nursing & Midwifery (Qualified)	3406	1215	1133	5754	59.19%	21.12%	19.69%	80.31%
Nursing & Midwifery (Unqualified)	2414	777	854	4045	59.68%	19.21%	21.11%	78.89%
Other Additional Clinical Staff	312	0	28	340	91.76%	0.00%	8.24%	91.76%
Scientific & Technical (Qualified)	264	129	41	434	60.83%	29.72%	9.45%	90.55%
Total	12278	2453	2407	17138	71.64%	14.31%	14.04%	85.96%



Bank shifts filled increased by 533 in May with agency shifts seeing a reduction of 168 shifts worked.

The Temporary staffing team are continuing to work with clinical areas to identify longer lines of work, with the focus to fill with bank / Framework agency offering consistency in addition to minimising cost. A defined approval has been agreed for high risk when requesting off-framework to ensure tighter grip and control.

The Theatres incentive scheme was successfully delivered ensuring no cancellation of lists to support the elective care pathway recovery work for patients affected by delays as a result of COVID19.

The number of candidates registered on the Nursing Collaborative Bank has seen an increase this month reaching 924 candidates. To date CW have 167 bank workers registered.

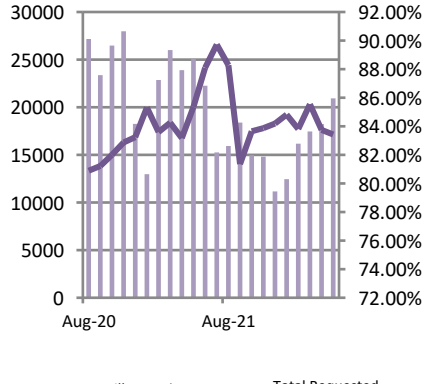
CW have seen the most shifts filled by the Collaborative Bank, with 52 shifts filled (64% of total shifts booked which is currently at 81). 23 shifts were booked in May and 34 have already been booked in June. The increase in numbers is steadily rising and there are a number of onsite engagement events scheduled to continue to push the benefits. Bank rates across the acute collaborative are currently being aligned to ensure agency workers continue to migrate to bank. In addition to this a proposal to restrict those registered on the collaborative bank being able to work on any of the sites via agency is something being reviewed.

Monthly shifts requested on Healthroster and Patchwork (Bank/Agency/Unfilled) by lead time (when the shift was booked in relation to start date).

Lead Time	Bank	Agency	Total Filled	Shifts %	Unfilled	Type
Minus 30 and Over	0	0	0	0.00%	0	Retro
Minus 15-29	11	0	11	0.08%	1	
Minus 8-14	51	0	51	0.35%	3	
Minus 7	54	0	54	0.37%	4	
Minus 6	71	0	71	0.49%	1	
Minus 5	81	0	81	0.56%	1	
Minus 4	98	1	99	0.68%	2	
Minus 3	112	1	113	0.78%	1	
Minus 2	119	1	120	0.83%	2	
Minus 1	339	1	340	2.35%	5	
Same Day	314	2	316	2.19%	6	Same Day
1-3 Days Notice	473	4	477	3.30%	6	Very Short Notice
4-7 Days Notice	280	5	285	1.97%	26	
8-14 Days Notice	237	7	244	1.69%	15	Short Notice
15-28 Days Notice	240	5	245	1.69%	8	Medium Notice
Over 30 Days Notice	81	0	81	0.56%	8	Long Notice
Total	2561	27	2588	17.90%	89	

*immaterial variance in place for Covid Sickness Backfill which is not in this dataset

REQUEST REASON	BANK	AGENCY	TOTAL FILLED	SHIFTS %	Unfilled
Annual Leave	1	0	1	0.0%	0
Covid Operational	1	0	1	0.0%	0
Covid Sickness/Isolation Cover	26	0	26	0.8%	1
Mat Leave	0	0	0	0.0%	0
Other	0	0	0	0.0%	0
Other Leave	0	0	0	0.0%	0
Private Patients	0	0	0	0.0%	0
Sickness Cover	21	4	25	0.8%	1
Specialling	28	0	28	0.9%	3
Study Leave	8	0	8	0.3%	0
Vacancies	447	0	447	14.3%	6
Workload	404	0	404	12.9%	9
Total	**936**	**4**	**940**	**100%**	20



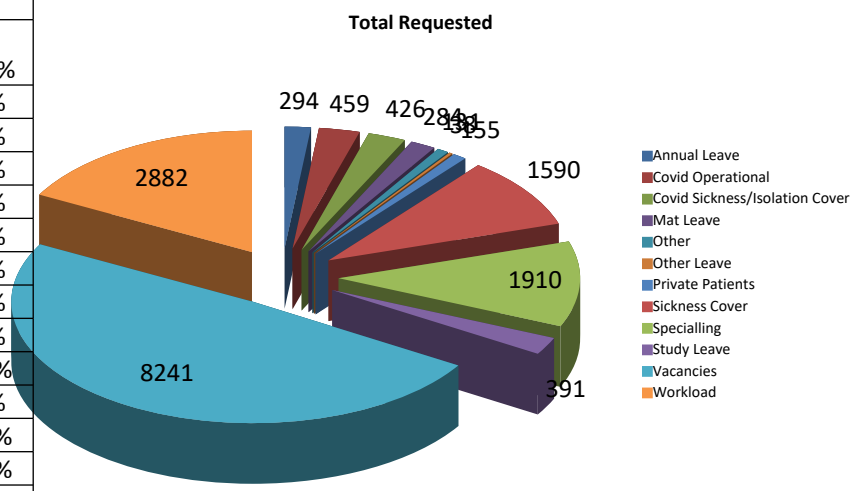
Bank and Agency – Reasons for Requests

Total							
Division	COR	CSD	EIC	ENT	PDC	WCH	Total
Annual Leave	4	2	234	0	46	8	294
Covid Operational	77	76	253	0	40	13	459
Covid Sickness/Isolation Cove	22	46	174	31	61	92	426
Mat Leave	0	0	150	0	46	88	284
Other	0	0	89	0	24	18	131
Other Leave	1	0	20	0	10	7	38
Private Patients	0	0	0	149	5	1	155
Sickness Cover	36	108	693	112	409	232	1590
Specialling	15	58	872	4	504	457	1910
Study Leave	4	103	87	0	181	16	391
Vacancies	734	1397	2819	234	1811	1246	8241
Workload	341	887	470	59	721	404	2882

The highest request reason continues to be as a result of vacancies which accounts for 49.05% of all shifts sent to bank. Workload accounts for 17.15% of shifts sent to bank.

We are still continuing to see requests as a result of Covid related cover (sickness – 2.54% and Covid Operational – 2.73%).

	Trust				
Request Reason	Bank	Agency	Unfilled	Total Requested	Shifts %
Annual Leave	198	32	64	294	1.75%
Covid Operational	359	59	41	459	2.73%
Covid Sickness/Isolation Cover	242	93	91	426	2.54%
Mat Leave	208	17	59	284	1.69%
Other	87	26	18	131	0.78%
Other Leave	20	8	10	38	0.23%
Private Patients	118	16	21	155	0.92%
Sickness Cover	771	378	441	1590	9.46%
Specialling	1005	504	401	1910	11.37%
Study Leave	290	59	42	391	2.33%
Vacancies	6141	1115	985	8241	49.05%
Workload	2635	80	167	2882	17.15%
Total	12074	2387	2340	16801	100.00%



HR Programme Updates

Looking After Our People

Health & Wellbeing

During May the team reviewed budgets and contracts for key services, and will continue to work on the procurement schedule, to ensure all of our essential support offers continue and offer value for money for the Trust. The first cohort of 8 staff had the opportunity to go on the CW+ Scottish Island retreat and engaged in reflective practice sessions, Island activities, team building to unpack issues, decompress and build their psychological safety and the progression and growth of staff over the 5 days was invaluable. Cohort 2 plans are being worked through and the team will be hosting meetings with staff over the next month. The team have continued to use the National Health and Wellbeing diagnostic tool which was first used as part of the Trailblazer pilot to measure our Health and Wellbeing Programme offer and improve our offer based on the insights. The team have continued to promote awareness days during the month including international HR day, Mental Health Awareness Week. The team continued to visit areas and this month engaged with all key sites so that there is continued engagement with staff. The first cohort of Mental Health First Aiders for 22/23 took place taking our total number to 120. There are 79 wellbeing champions also now in place. Three more staff are undertaking their training to become Schwartz Facilitators. To date 5,753 offers have been engaged with by our staff since the launch of the new Health and Wellbeing Programme. This includes the delivery of 47 wellbeing sessions reaching over 1,450 staff. 1,922 have accessed psychological support, 466 staff have accessed back up care to support childcare and elder care arrangements, 406 staff have used bike doctors. Monthly wellbeing sessions with doctors induction, excellence in care programme and preceptorship programme are also now in place reaching 209 staff to date.

Belonging

Diversity & Inclusion

Key highlights in the month include some awareness raising events across the month including International Day Against Homophobia, Biphobia and Transphobia (IDAHOBIT) and Equality and Human Rights Week. The team have been working on plans for Pride month. Our staff network leads met to discuss their shared work across the networks. The team have sought expressions of interest for the vice chair and secretary of the LGBTQ+ staff network. The team also met with the specialist advisor of the Board to review the 2022/23 EDI work plan and also to discuss the need to look at the core group for our BAME staff network. The team will also now be advertising expressions of interest for the chair, vice chair and secretary of the BAME staff network during the month of June. The Trust renewed our Stonewall account for another year to 2023. The team have been supporting a review of policies and have scoped a just culture working group with the Head of ER which will meet in June. The team have also set up regular engagement meeting with the comms team so that we can increase the way in which we engage with all staff.

Leadership & Development

Emerging Leaders cohort 19 have their final presentations mid-June and project groups have been established and working towards their chosen improvement.

Management Fundamentals virtual training is available to staff at both Hillingdon and Chelsea and the most popular sessions to date are: Management vs Leadership, Listening, Communicating and Dealing with Difficult Conversations.

The NHS Leadership Academy have launched a new self-paced 6 week eLearning programme on Inclusive Leadership. The content of this will be reviewed and aligned to the current offer and promoted to all colleagues.

New Ways of Working

Organisational Change

The Trust currently has four live consultations with no anticipated redundancies. There are two more consultations in the pipeline which are due to launch in July 2022. The Trust has two live TUPE transfers affecting 36 total staff.

Work continues with the formation of the West London Children's Hospital with work continuing with developing the Clinical Leadership Structure across Chelwest and Imperial.

E- Rostering

Junior and Trainee Grades – On track for end of August
Consultant Rota data – In progress across 8 Specialtys, but awaiting Consultant on-call/rota data for the majority of other areas. - Next Project Board 27th July.

Medical Transformation Programme:

We continue to work with the Divisions and DMEs to recruit Medical Support Workers. We also want to ramp up our efforts to engage with the Divisions on where CESR posts might add value.

Junior Doctors Deep dive:

As reported previously, rota compliance will be achieved when recruitment is completed, in August, to the Paediatric and ED rotas. A review of the established for all Junior Doctors is ongoing.

Implementation of E-Job Planning:

The team continues for focus on optimising the e-job planning system. The aim is that all SAS/Consultants will be able to upload their own job plans and manage the sign-off process in a transparent manner. Arrangements are being made to ensure that staff have access to the relevant training and guidance.

Talent Acquisition:

We continue to engage with Divisions to support them to identify gaps in medical workforce and progress recruitment accordingly. In particular, we are working with colleagues in CSD and EIC to fill middle grade gaps.

HR Programmes Updates

Growing For Our Future

NWL Reservists

NWL Reservist programme underway and utilising a different way of recruitment

- Programme plan developed
- C 90 candidates identified via NHSE pipeline
- Model to recruit 254 across NWL
- The reservist roles will be Ward Helper, Administrator, Vaccinator, Band 5 Nurse
- The proof of concept will be delivered in the 4 Acute Trusts

NWL Skills academy

Significant work has been progressed by new programme lead – headlines include:

- Completed Baseline Project Plan
- Project Plan was submitted on the GLA-OPS
- Key contacts identified
- Signed grant agreement
- PID developed
- Signed MOU
- Engaged with London's Mayors office to develop relationship
- One to one meetings with the training providers to seek data from quarter 4 2021/2022 and understand data requirements and gaps
- Project Team developed Data sharing agreement drafted and with CCG for sign off
- Steering Group TOR agreed

NWL Collaboration

There are various work-streams across NWL to collaborate.

NWL OH service

The NWL OH Service has focused in the month of May on the integration of the COHORT systems to the new version with the system being merged during the week of 27th June 2022. The NWL team have surveyed all OH staff across the organisations and are currently working on recruitment to all posts across the sector. The overall business case for full integration is planned to go to the host (CNWL's) committees in October and will therefore go through Chelwest and Hillingdon's committees in November 22.

Payroll services:

The monthly payroll run continues to be successful and the team is working closely with Imperial on the harmonization and optimization phase post transition. Extension of deadline for payroll input has improved the team's turnaround to processing requests from Epay.

The feedback remain positive and ICHT continues to maintain the standard around turnaround to queries. Issues around manual payment has been identify given the high volume in May but steps are now in place to rectify these to reduce the numbers for June payroll.

COVID Specific

Mass vaccination

COVID-19 – Phase 4 continues with significant work undertaken to identify the future workforce and operational model. This includes a broader remit for the Mass Vaccination team in immunisations and Making Every Contact Count (MECC).

Recruitment events have taken place to select the future workforce from the current mass vaccination pool – work continues to identify the potential for creating fixed term posts to provide greater stability and more attractive job opportunities. A report was shared with the Executive Cabinet for consideration.

The necessary funding decisions are yet to be made with NHSE advising that each ICS will be given a budget imminently which will replace the current recharge arrangements

Mass Vaccination Retention

The retention programme continues towards its target of retaining 25% of the Mass vaccination workforce who have opted in to the Retention programme. We have 959 workforce members opt in to the Retention Programme with a target of 240 to retain.

Of the almost 700 mass vac staff matched to vacancies 205 colleagues have been placed to date - (22%) of those who opted into the programme.

Of those retained, 83 have joined a bank and the remainder have secured employment within the ICS

The team is focussing on the NWL careers festival 16th July 2022

The quieter summer period is being utilised to provide support and training including offering all vaccinators the opportunity to undertake the Care Certificate to aid redeployment

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TITLE AND DATE (of meeting at which the report is to be presented)	Public Board Meeting 7 July 2022

AGENDA ITEM NO.	4.5
TITLE OF REPORT	Freedom To Speak Up Report Quarter 4 2021 -2022
AUTHOR NAME AND ROLE	Sue Smith, Director of Human Resources & Organisational Development Robert Bleasdale, Chief Nurse
ACCOUNTABLE EXECUTIVE DIRECTOR	Sue Smith, Interim Chief People 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 summarize the concerns raised to FTSU in quarter 4 of 2021 - 2022 and provide the WDC committee with the overarching themes and actions taken.

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

Name of Committee	Date of Meeting	Outcome
WDC	16/05/2022	
POD	23/05/2022	

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

The report outlines the concerns raised during Q4 of 2021 - 2022 and outlines them in terms of themes, areas and diversity. A recurrent theme this quarter is one of racism and the way staff feel that career development is being hindered.

KEY RISKS ARISING FROM THIS REPORT

Poor outcomes in staff survey if issues are not addressed.

Staff affected may seek to work elsewhere, if issues are not resolved.

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	Y
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

The Trust is seen as a centre of good practice and supporting our staff to continue that is key to helping the continued success of the organisation. This impacts on our retention and also on external inspections when they occur who want to see we are supporting our staff.

EQUALITY & DIVERSITY IMPLICATIONS
Of the concerns raised 55% were raised by BAME staff, which is higher than normal but good that staff from BAME backgrounds feel able to speak up.

FINANCIAL IMPLICATIONS
Cost of recruiting new staff if staff leave.

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

Freedom to Speak Up Report – Public Board 7 July 2022

Q4 January – March 2022

1. Purpose

The purpose of this paper is to provide a quarterly report to the Public Board in respect of our Freedom to Speak up (FTSU) arrangements and actions in Q4 of 2021-2022 and a summary of the years reports and national changes.

2. Background

The FTSU Guardian for the Trust is supported by 13 champions.

The report covers the period January – March 2022, in this quarter we have had 11 concerns raised which is two less than the same quarter as last year (15 concerns). Last quarter 2021-2022 we had 13 concerns raised.

In total for 2021 – 2022 we have had 51 concerns raised and in 2020 – 2021 we had 52 concerns raised.

April – June 2020	20 concerns
July – September 2020	9 concerns
October – December 2020	8 concerns
January 2021 – March 2021	15 concerns
Total	**52 concerns**

April 2021 – June 2021	12 concerns
July 2021 – September 2021	15 concerns
October – December 2021	13 concerns
January 2022 – March 2022	11 concerns
Total	**51 concerns**

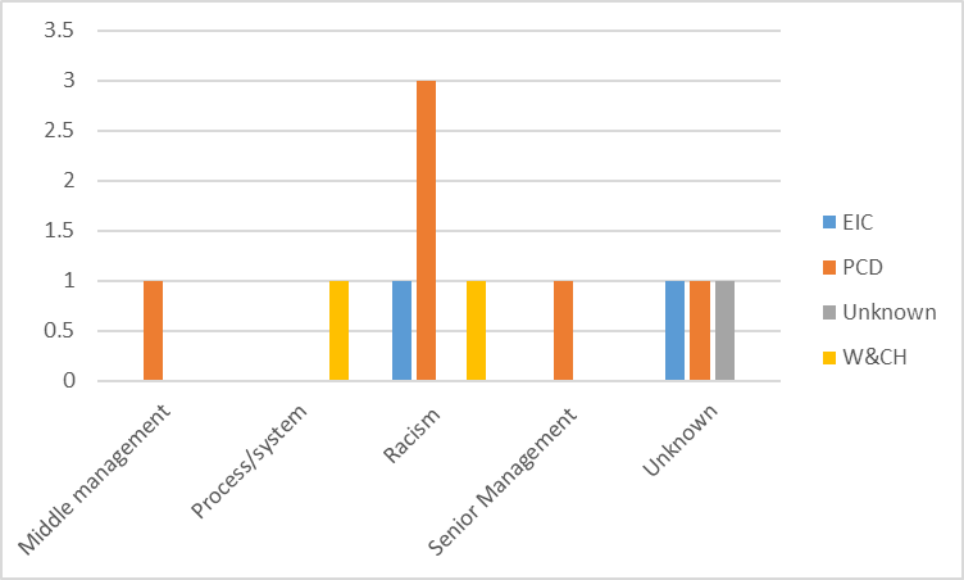
Number of cases per year (April - March)

Year	Total	Corp	PCD	WCH	E&IC	CSD	Unknown
2017	12	4	3	3	1		1 (contractor)
2018	16	5	2	2	3	2	2
2019	23	4	2	8	1	8	0
2020	52	15	13	11	4	8	1
2021	51	4	12	17	11	6	1

3. Concerns Raised January – March 2022

During Q4 11 concerns were raised by 11 people through FTSU, however one was an anonymous letter which raised concerns in an area and said that several people were concerned but nobody came forward when followed up.

The following graph demonstrates the concerns raised by division.



Five of the concerns raised were regarding racism and staff feeling disadvantaged due to their cultural background. (See Appendix 1) This is a relatively new trend with only 9 concerns raised in the whole year relating to this topic however these 5 form part of the 9, but more have occurred in the year 2022-2023. The previous trend around senior and middle management behaviours has dropped to only 2 this quarter from 9 last quarter.

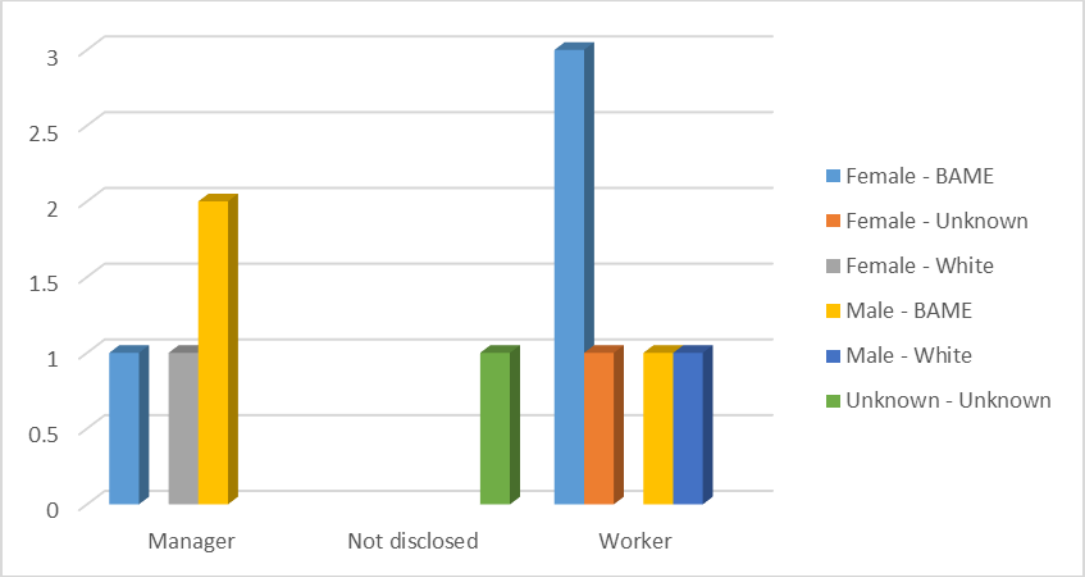
Of the 11 concerns raised

1. Only one remains open but actions from others are still in progress.
2. The average length of a concern being raised to it being closed is 33 days an increase from the last quarter of 10 days. The longest was 57 days and the quickest was 1 day.

The monthly meeting with the HRBP's and employee relations is on-going to triangulate the issues and is helpful in supporting the HRBP's and their divisions to be aware of particular key issues . The HRBP's and Employee relations are aware of the issues regarding racism and the particular cases.

Of the concerns raised in the past twelve months twelve have moved to a formal stage with employee relations. I cannot comment on outcomes of the concerns raised as the FTSU needs to remain independent and is not involved.

The following graph shows the breakdown by ethnicity, gender, professional level of the individuals raising concerns all of which are required in the national report that is submitted.



The following table shows the cases raised per category for this year from April 2021 – March 2022

Concern	Number of cases April – Sept
B&H	6
Covid-19	1
Cultural	3
Leadership	3
Middle management	5
Process/system	7
Racism	6
Senior Management	15
Unknown	5
Grand Total	**51**

4. Evaluation

Surveys were sent to 14 staff but only 4 responses were received. One person of the four felt the service is tokenistic and that issues were not resolved however there is very positive feedback as well.

5. National Update

A new national guardian has been appointed Dr Jayne Chidgley-Clark and she is bringing changes to the Guardian role. They will soon be launching a new Freedom to Speak Up Guardian Foundation Training programme. All existing guardians will be expected to complete the e-learning as refresher training.
The Guardians office has released training for all staff about FTSU and there are three levels

- Speak up for all workers
- Listen up for all managers
- Follow up for all senior leaders.

This will be considered at the next Education Strategy Board and then recommendations made to the organisation about the opportunity to do the training. This is a positive move and will enable awareness of the Freedom to Speak Up service.

6. Actions for this Quarter

- On-going support of individuals
- Review Service Provision in light of increased FTSU issues.
- Launch the eLearning to the organisation
- Guardian to undertake training as required by Guardians office when it becomes available.

Appendix 1 Concerns raised January – March 2022

Date raised	Division	Category	Summary	Status	Lessons learnt and Implementation
07/01/2022	Unknown	Unknown	Despite attempts to contact no response	closed	
07/03/2022	EIC	Unknown	Staff member was struggling on ward and wanted someone to speak to. Newly qualified nurse and needing support directed to senior nursing colleagues for support.	closed	Directed to other nursing colleagues for support.
08/03/2022	EIC	Racism	Staff member reported to manager that she had been in discussion with a ward sister who specifically asked her not to employ any staff from a particular continent as she had had problems with staff from that area.	closed	Staff to be aware that if they hold a position of responsibility making comments like this is offensive and does not link to PROUD values.
17/01/2022	W&CH	Racism	Problems with manager and lack of support for career progression and believes other staff are being able to progress more than her.	closed	Awareness of necessity to be transparent with opportunities for staff and clear development opportunities.
08/03/2022	PCD	Racism	Staff member raised concerns about process for advertising new posts in the division and how staff from BAME background are not being supported.	closed	Awareness of necessity to be transparent with opportunities for staff and clear recruitment processes.
08/03/2022	PCD	Racism	Concerned about the recruitment processes in the division and how staff appear to being earmarked for jobs and slotted in. Also appointed staff who do not have skills or knowledge for their role.	closed	Awareness of necessity to be transparent with opportunities for staff and clear recruitment processes.
10/03/2022	PCD	Racism	Lack of opportunity to develop and support from manager. Also concern about a new role being created specifically for a person and the JD being amended to ensure the individual met the person specification.	closed	Awareness of necessity to be transparent with opportunities for staff and clear recruitment processes.
21/03/2022	PCD	Senior Management	Concerned at process to recruit new staff member and apparent bias being given to a particular staff member. Also inappropriate use of social media.	closed	Open communication in recruitment process necessary and managers and staff need to be aware of this.
15/03/2022	PCD	Unknown	various concerns	closed	No lessons learnt due no follow up by complainant.
24/03/2022	PCD	Middle management	Feels insulted and had derogatory comments made to her by work colleagues but specifically one person. Also comments about her appearance and failure to meet her competencies and failing her probation.	closed	Manager made aware of issue and has spoken to staff member and supporting her.

30/03/2022	W&Ch	Process/system	Individual believes he is owed his Band 2 role despite being recruited as an apprentice and has not completed his excellence in care work yet. Has asked to be moved to band 2 with immediate effect and back pay for Christmas duties worked.		

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TITLE AND DATE (of meeting at which the report is to be presented)	*Public Board* *7th July 2022*

AGENDA ITEM NO.	4.6
TITLE OF REPORT	**Learning from deaths: mortality report Q1 2022-23**
AUTHOR NAME AND ROLE	Alex Bolton, Associate Director of Quality Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Roger Chinn, Chief Medical Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	This report provides a Trust level quarterly review of mortality learning for quarter 1 2022/23 (1st April 2022 – 27th June 2022).

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

Name of Committee	Date of Meeting	Outcome
Mortality Surveillance Group	01/07/2022	Discussed
Quality Committee	05/07/2022	

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

The Trust is the best performing acute (non-specialist) provider in England in terms of relative risk of mortality with a Trustwide SHMI of 0.7123 (where a number below 100 is lower than expected mortality) for period February 2021 – January 2022. This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality.

It is the Trust's target to screen 100% of all in-hospital adult and child deaths and to undertake full mortality review on no less than 30% of cases within the Emergency and Integrated care Division and 80% of cases within Planned Care Division and the Division of Women's, Children's, HIV/GUM, Dermatology.

During the last 12 months 80% of in-hospital adult and child deaths have been screened and 31% have undergone full mortality review. Divisional compliance target for full review completion have not been met (EIC 24%, PCD 62%, WCHGD 10%)

Process barriers are escalated to the Mortality Surveillance Group, Patient Safety Group, and Quality Committee; compliance gaps are primarily identified within surgical specialties (colorectal, general surgery, trauma and orthopaedics).

	During Q1 2022/23 (QTD) 64% of in-hospital adult and child deaths have been screened and 12% have undergone full mortality review. During this period 5 cases with areas of sub-optimal care, treatment or service delivery were identified, 2 of which were assessed as maybe leading to a different outcome (CESDI 2) and are being investigated via the serious incident process. Where the potential for improvement is identified learning is shared at Divisional review groups and presented to the Trust-wide Mortality Surveillance Group; this ensures outcomes are acted upon and learning is cascaded.
KEY RISKS ARISING FROM THIS REPORT	Delayed mortality review closure could lead to missed opportunities to addresses weakness in service delivery. The Mortality Surveillance Group oversees process compliance.

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

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

IMPLICATIONS ASSOCIATED WITH THIS REPORT FOR: Equality And Diversity: Quality: Y People (Workforce or Patients/ Families/Carers): Operational Performance: Finance: Public Consultation: Council of Governors: please mark Y/N – where Y is indicated please explain the implications in the opposite column	Mortality case review following in-hospital death provides clinical teams with the opportunity to review expectations, outcomes and learning in an open manner. Effective use of mortality learning from internal and external sources provides enhanced opportunities to reduce in-hospital mortality and improve clinical outcomes / service delivery.

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

Learning from deaths

1. Background

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed.

The Summary Hospital Level Mortality Indicator (SHMI) is used to compare the Trust's relative risk of mortality with other acute (non-specialist) providers in England. The SHMI is not a measure of quality care but it does flag variation, and therefore, potential problems that may require further investigation.

The Medical Examiner (ME) system was introduced across England and Wales from April 2020 to provide greater scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns. Learning from the medical examiner process is embedded within the Trust's mortality review process.

Mortality case review is undertaken by the clinical teams involved in a patients care; it provides clinicians with the opportunity to review expectations, outcomes and potential improvements. All adult and child in-hospital deaths are initially screened to identify triggers for full retrospective case record review. It is the trust's target to screen 100% of in-hospital adult and child deaths and undertake full mortality case review of no less than 30% those cases aligned to Emergency and Integrated Care and 80% of those aligned to Planned Care Division and the Division of Women's, Children's, HIV/GUM, Dermatology.

The Mortality Surveillance Group (MSG) provides leadership to this programme of work; it is supported by monthly updates on relative risk of mortality, potential learning from medical examiners, and divisional learning from case record screening / review. The MSG is a sub-group of the Patient Safety Group and is aligned to the remit of the Quality Committee.

This report provides a Trust-level quarterly review of mortality learning for Q1 2022/23 (1st April 2022 – 27th June 2022).

2. Relative risk of mortality

The Trust uses the Summary Hospital-level Mortality Indicator (SHMI) to monitor the relative risk of mortality. 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 (in-hospital and within 30 days of discharge) to the number of expected deaths; this provides a relative risk of mortality ratio (where a number below 100 represents a lower than expected risk of 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 peer organisations and seek to identify improvement areas where there is variance.

2.1. Summary Hospital-level Mortality Indicator: Trust wide

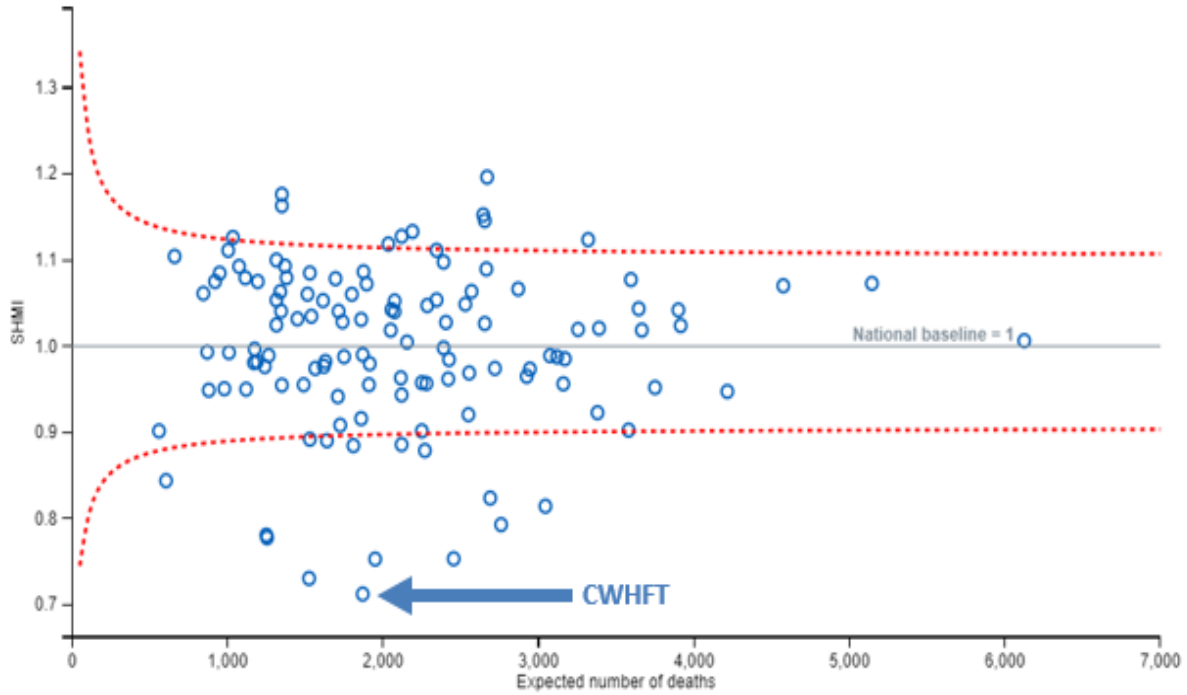

Fig 1 – SHMI comparison of England acute hospital Trusts based on outcomes, published 09/06/2022

The Trust is the best performing acute provider in England in relation to the SHMI relative risk of mortality indicator. The Trust wide SHMI for the period February 2021 – January 2022 is 0.7123 (where a number below 100 represents lower than expected risk of mortality).

Top performing acute (non-specialist) providers in England:

	SHMI	Observed Deaths	Expected Deaths	Provider Spells
Chelsea and Westminster Hospital NHS FT	0.7123	1,330	1,870	86,480
Royal Surrey County Hospital NHS FT	0.7305	1,115	1,525	48,970
Guys and St. Thomas' NHS FT	0.7529	1,470	1,950	97,770
Imperial College Healthcare NHS Trust	0.7533	1,850	2,455	94,840
University College London Hospitals NHS FT	0.7777	975	1,255	94,840*

*Data quality issue relating to provider spells is noted

This positive assurance is reflected across the Trust as both sites continue to operate significantly below the expected relative risk of mortality:

- West Middlesex University Hospital:
  SHMI value 0.7509 (830 observed deaths, 1,105 expected deaths, 46,000 spells)

- Chelsea and Westminster Hospital:
  SHMI value 0.6566 (500 observed deaths, 765 expected deaths, 40,480 spells)

2.2. Summary Hospital-level Mortality Indicator: Diagnostic Groups

The SHMI is made up of 142 different diagnostic groups which are then aggregated to calculate the Trust's overall relative risk of mortality. The Mortality Surveillance Group monitors expected and observed deaths across diagnostic groups to identify areas that would benefit from further investigation.

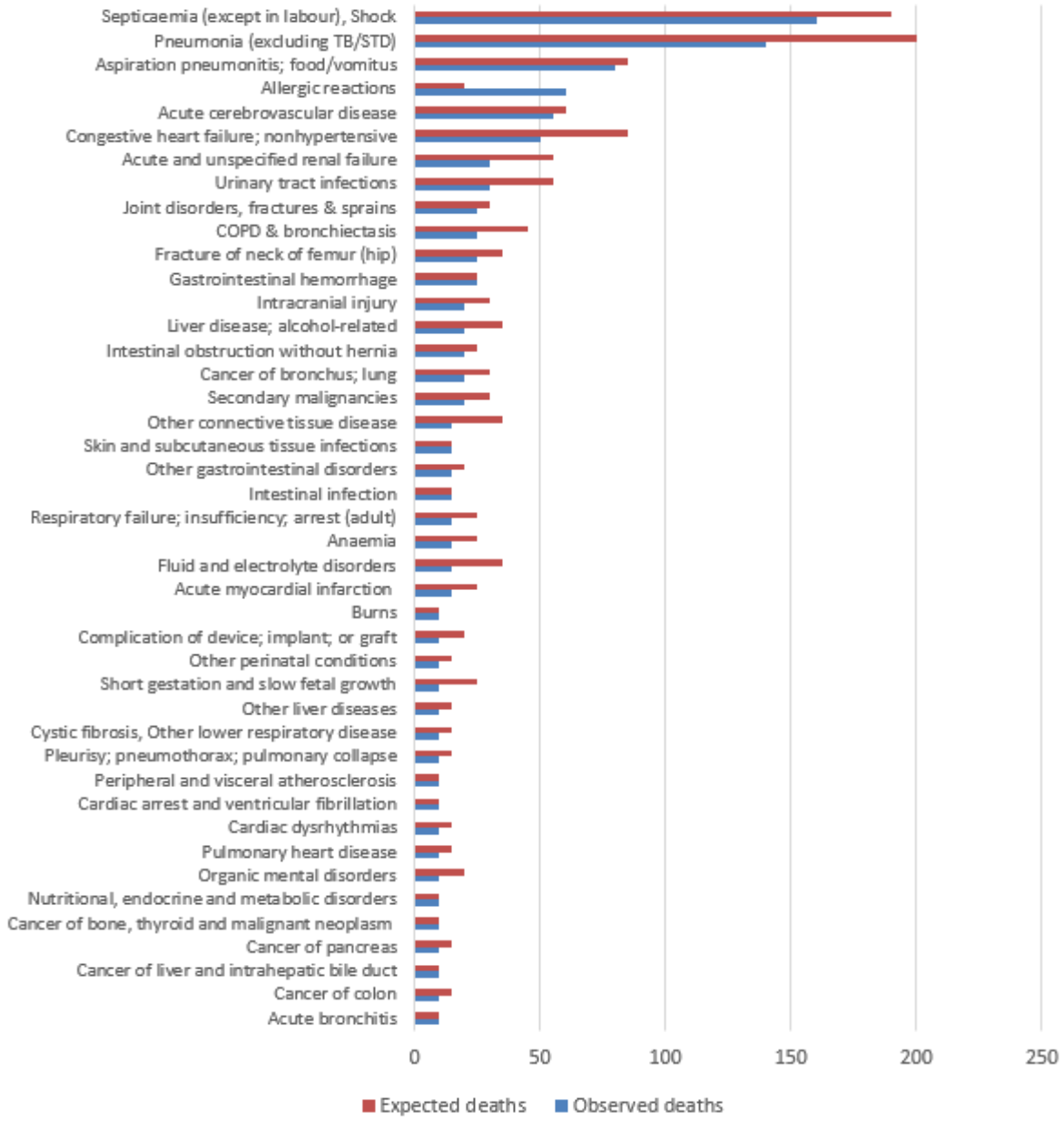

Fig 2 – Expected and observed deaths by diagnostic group (null values omitted), February 2021 – January 2022, published 09/06/2022

During Q1 2022/23 one diagnostic group was flagged within the summary hospital-level mortality indicator; allergic reactions (60 observed deaths, 20 expected deaths). This is not an indication of lower quality care but is a trigger for the Mortality Surveillance Group (MSG) to oversee a coding review and/or retrospective case record review for this cohort of patients.

3. Medical Examiner's office

An independent Medical Examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- 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

During 2021/22 the medical examiners service scrutinised 99.6% of all in-hospital deaths. Potential learning identified during medical examiner scrutiny is shared with the patients named consultant, divisional mortality review group and the Trust-wide Mortality Surveillance Group.

During Q1 2022/23 the medical examiner's office identified 60 cases with potential learning for the Trust; a full mortality review will be undertaken for each case identified.

4. Mortality case review

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

- Identifying sub-optimal or excellent care
- Identifying service delivery problems
- Developing approaches to improve safety and quality
- Sharing concerns and learning with colleagues

All in-hospital adult and child deaths are screened by consultant teams using the screening tool within Datix; this supports the identification of cases that would benefit from full mortality review.

Trust targets:

- 100% of in-hospital adult and child deaths to be screen
- At least 30% of all adult and child death aligned to the Emergency and Integrated Care (EIC) Division to undergo full mortality review
- At least 80% of all adult and child deaths aligned to Planned Care Division (PCD) and the Division of Women's Children's HIV/GUY, Dermatology (WCHGD) to undergo mortality review
- 100% of cases aligned to a Coroner inquest to undergo full mortality review
- 100% of cases where potential learning identified by Medical Examiner to undergo full mortality review

Learning from review is shared at specialty mortality review groups (M&Ms / MDTs); where issues in care, trends or notable learning is identified action is steered through Divisional Mortality Review Groups and the trust-wide Mortality Surveillance Group (MSG).

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. Learning from PMRT review is reported to the Mortality Surveillance Group.

4.1. Process compliance

The Trust's learning from deaths policy describes the responsibility of consultants to use the Datix mortality screening tool to identify cases that require further consideration through the full mortality review process. All cases should be screened, reviewed (where indicated) and outcomes presented to the specialty team within 45 days of death; where potentially suboptimal care has been identified cases should be escalated to the Divisional Mortality Review Group for agreement and closure the following month. Therefore deaths occurring during May and June 2022/23 are not expected to have been closed at the time this report was written.

During this 12 month period 1357 in-hospital adult and child deaths were recorded within the Trust's mortality review system (Datix); of these 80% have been screened and 31% have had full mortality case review closed following speciality discussion.

	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
Jul	94	47	42	5	95%	45%	5%
Aug	103	62	36	5	95%	35%	5%
Sep	110	56	48	6	95%	44%	5%
Oct	132	74	48	10	92%	36%	8%
Nov	117	66	39	12	90%	33%	10%
Dec	124	53	52	19	85%	42%	15%
Jan	117	54	48	15	87%	41%	13%
Feb	102	54	29	19	81%	28%	19%
Mar	109	49	29	31	72%	27%	28%
Apr	119	56	30	33	72%	25%	28%
May	124	49	18	57	54%	15%	46%
Jun	106	41	3	62	42%	3%	58%
Total	1357	661	422	274	80%	31%	20%

- Emergency and Integrated Care - Target to review >30% of cases, not met
  84% screened, 24% reviewed, 16% pending

- Planned Care Division - Target to review >80% of cases, not met
  62% screened, 62% reviewed, 38% pending

- Women's, Children's, HIV/GUM, Dermatology - Target to review >80% of cases, not met
  40% screened, 10% reviewed, 60% pending

The Trust has currently not met its targets to undertake consultant led mortality case review, however it is noted that the deaths occurring during May and June 2022 are not expected to be closed at the time of report writing.

The Trust's learning from deaths policy describes the Divisional Medical Directors, and Clinical Directors, responsibility to ensure the learning from death process is embedded across the specialties within their remit. Process compliance is monitored by the Mortality Surveillance Board and overseen by the Patient Safety Group, Executive Management Board, and Quality Committee. Significant variation in process compliance is noted across the specialties.

	No. of deaths	No. of cases screened and closed	No. of cases with full mortality review	No. of cases pending screening	% Screened	% with Full Review	% Pending
Acute Medicine	332	241	71	20	94%	21%	6%
Anaesthetics	2	0	2	0	100%	100%	0%
Burns	6	0	2	4	33%	33%	67%
Cancer Services	1	1	0	0	100%	0%	0%
Cardiology	43	10	26	7	84%	60%	16%
Care Of Elderly	283	183	56	44	84%	20%	16%
Colorectal	14	0	0	14	0%	0%	100%
Diabetes	102	77	12	13	87%	12%	13%
Dietetics	1	0	0	1	0%	0%	100%
Emergency Dept.	78	0	61	17	78%	78%	22%
Gastroenterology	65	31	15	19	71%	23%	29%
General Surgery	25	0	1	24	4%	4%	96%
Haematology	3	0	0	3	0%	0%	100%
Hepatology	7	0	0	7	0%	0%	100%
HIV	3	3	0	0	100%	0%	0%
ICU	167	0	144	23	86%	86%	14%
Medical Oncology	11	4	0	7	36%	0%	64%
Paed. Medical	7	0	1	6	14%	14%	86%
Palliative Care	2	0	1	1	50%	50%	50%
Respiratory	128	90	17	21	84%	13%	16%
Rheumatology	3	3	0	0	100%	0%	0%
Stroke	35	18	4	13	63%	11%	37%
Trauma / Ortho	32	0	8	24	25%	25%	75%
Urology	7	0	1	6	14%	14%	86%
Grand Total	1357	661	422	274	80%	31%	20%

There are currently seven specialties with 75% or more of their aligned cases pending / overdue. Four of these specialties have low total case numbers and as such are less familiar with the process (haematology, hepatology, paediatric medical) support is provided by Clinical Governance and the Division. Four of the specialties appear to be experiencing barriers to completion of mortality review (urology, colorectal, general surgery, trauma / orthopaedics); compliance concerns have been escalated by the Planned care Division to the Mortality Surveillance Group and Patient Safety Group.

During Q1 2022/23 (QTD) 64% of in-hospital adult and child deaths have been screened and 12% have undergone full mortality review. Divisional plans to achieve to achieve required compliance to be reported to the Mortality Surveillance Group.

4.2. 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

CESDI grades – last 12 months:

Period	CESDI 0	CESDI 1	CESDI 2	CESDI 3
Q2 21/22	114	10	2	0
Q3 21/22	115	24	0	0
Q4 21/22	92	13	1	0
Q1 22/23	46	3	2	0
Total	367	50	5	0

During this 12 month period five cases of sub-optimal care that might have made a difference to the patients outcome have been identified via the mortality review process; each of these cases has been escalated to the Executive and declared as serious incidents. The organisation publishes a Learning from Serious Incidents report on a quarterly basis and outcomes / learning is received by the Patient Safety Group on a monthly basis.

The Divisional Mortality Review Groups provide scrutiny to mortality cases so as to; identify themes and escalate any issues of concerns; during this 12 month period the following issues have been escalated:

- Documentation: Data accessibility & quality – *Each Division has an aligned Digital Clinical Information Officer supporting quality improvement in this area; work is overseen by the EProg Group.*
- Communication: Unreliable response to bleep – *A bleep replacement programme is planned to move the organisation to a digital solution and improve functionality.*
- Communication: Handover between teams – *Clinical handover is a trust Quality Priority; the programme is overseen by the Improvement Board and Executive Management Board.*
- Communication: Feedback from external organisations – *The Trust is working within the North West London Integrated Care System and Acute Collaborative to support coordination and communication between provider organisations.*
- Staffing: Lower numbers of substantive staff on wards may impact quality – *Staffing levels, recruitment and retention are monitored by the People and Organisational Development Committee. The trust is engaged in significant recruitment activities to ensure clinical staffing levels are maintained.*
- Planning: Escalation Plans (to be recorded on Cerner and communicated with families) – *Support, guidance, and advice regarding the completion of treatment escalation plans is provided via the Trust's end of life group.*
- End of life care: Need to reduce invasive monitoring at end of life – *Care at the end of life is a trust Quality Priority; the programme is overseen by the Improvement Board and Executive Management Board.*

- Services: Lack of out of hours echo availability within critical care – *In-house training is being provided to enable ITU consultants to provide ECHO's within the department.*

All cases of suboptimal care are presented to the Mortality Surveillance Group to ensure shared learning.

5. Conclusion

The outcome of the Trust's mortality surveillance programme continues to provide a rich source of learning that is supporting the organisations improvement objectives. A step change in the relative risk of mortality was experienced in March 2017 and has continued into Q1 2022/23; which the trust now being recognised as having the lowest relative risk of mortality (SHMI) across NHS England.

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TITLE AND DATE (of meeting at which the report is to be presented)	*Public Board* *7th July 2022*

AGENDA ITEM NO.	4.6b
TITLE OF REPORT	**Hospital Mortality associated with COVID-19**
AUTHOR NAME AND ROLE	Alex Bolton, Associate Director of Quality Governance
ACCOUNTABLE EXECUTIVE DIRECTOR	Roger Chinn, Chief Medical Officer
THE PURPOSE OF THE REPORT Decision/Approval: Assurance: X Info Only: Advice: Please tick below and then describe the requirement in the opposite column	This report describes learning outcomes from the review of mortality associated in in-hospital transmission of COVID-19 between April 2020 and March 2021.
REPORT HISTORY Committees/Meetings where this item has been considered)	Name of Committee: Mortality Surveillance Group — Date of Meeting: 01/07/2022 — Outcome: Discussed Name of Committee: Quality Committee — Date of Meeting: 05/07/2022 — Outcome:
SUMMARY OF THE REPORT AND KEY MESSAGES THAT THE MEETING NEED TO UNDERSTAND	The Trust provides services to our community from Chelsea and Westminster Hospital, West Middlesex University Hospital and a number of community-based clinics within North West London. The Trust is one of the top ranked and top performing hospital Trusts in the UK and we pride ourselves on providing outstanding care to a community of more than 1.5 million people. An outbreak of a novel coronavirus was first reported in January 2020 and by March 2020 the World Health Organisation had declared a global pandemic. The initial lack of population immunity, testing infrastructure, or effective vaccine meant this new virus (COVID-19) was able to spread rapidly and widely. The Trust responded quickly to the significant challenges posed by the pandemic and established the strategic and operational leadership arrangements required to preserve care quality, protect our staff, and reduce the risk of infection. The transmission of COVID-19 within hospital sites has significant implications for patient safety, staff safety, and resource allocation. Controls were rapidly developed and introduced across the NHS to reduce the risk of in-hospital transmission; where national guidance was issued the Trust responded rapidly to amend its local practice. The Trust's primary systems of control related to: • Enhanced infection prevention and control measures • Enhanced cleaning and environmental management • Provision of information and guidance for patients and staff • Provision of testing arrangements for patients and staff • Enhanced occupation health and well-being support for staff

	• Redesigned pathways, processes and estate • Introduction of patient cohorting • Restricted access to hospital premises The risk of in-hospital COVID-19 transmission could not 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 throughout their admission. It was however incumbent upon the Trust to review the provision of care and treatment to ensure all potential learning opportunities were exploited. Between 1st April 2020 and 31st March 2021 there were: • 183 patients with probable hospital acquired COVID-19 were identified (where a positive result was recorded 8-14 days after hospital admission); of these cases 28 patients sadly died in hospital. • 158 definite hospital acquired COVID-19 cases were identified (where a positive result was recorded 15 or more days after hospital admission); of these cases 35 patients sadly died in hospital. The Trust has robust mortality review processes in place; this was used to ensure every death associated with probable or definite hospital acquired COVID-19 was critically reviewed by a team of experience clinicians in an open and transparent environment. This learning was combined with outcomes from outbreak meetings, risk assessments, incident investigations, and site inspections to support identification of potential sub-optimal care. When undertaking retrospective case review of the 62 deaths associated with probable or definite hospital acquired COVID-19 the following outcome avoidability / sub-optimal care conclusions were reached: • 36 cases related to frail patients with multiple co-morbidities who would likely have died regardless of acquiring COVID19 • 20 cases related to patients who may have lived had they not caught COVID-19 • 6 cases related to patients who almost definitely would not have died had they not caught COVID-19 Cases of sub-optimal care were reviewed by specialty, divisional, and Trust wide scrutiny groups to ensure all learning opportunities were considered. No themes or routes of infection were identified by the review groups therefore further risk mitigation activity is limited allowing for the iterative learning that occurred at the time. The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. Review of nosocomial associated death will continue to be supported through medical examiner scrutiny and clinical team mortality review. Further learning opportunity identified will be reported within the quarterly learning from deaths report submitted to the Board.
KEY RISKS ARISING FROM THIS REPORT	Delayed mortality review closure could lead to missed opportunities to addresses weakness in service delivery. The Mortality Surveillance Group oversees process compliance.

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

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

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)	

Hospital Mortality associated with COVID-19

1. Introduction

The COVID-19 pandemic has been recognised as the greatest public health emergency since the formation of the National Health Service; it resulted in a large number of lives lost in patients who have been admitted to NHS care establishments, during this period.

The Trusts' within North West London Integrated Care System (NWL ICS) acknowledge the huge impact that these losses have had on bereaved relatives and are committed to ensuring that lessons learnt from their response to the pandemic are put in place, where possible, to improve the future care of our patients.

For that reason, in keeping with each organisation's guidance on learning from deaths [(1)], the decision was made to undertake retrospective mortality reviews for all deaths attributed to COVID-19 from 1st April 2020- 31st March 2021 for hospital inpatients; this approach was not nationally mandated.

This report encompasses information from all the multidisciplinary reviews that have been undertaken.

2. National context (in relation to reporting period - i.e. which wave)

The first cases of COVID-19 in the UK were confirmed on 31 January 2020 and the first death reported on 5 February 2020. By 7 March 2020, there were 316 confirmed cases of COVID-19 in the UK and a further four people had died.

On 11 March 2020, the World Health Organization (WHO) declared a pandemic. The pandemic continued to progress rapidly and on 23 March 2020 the Prime Minister announced full lockdown across England [(2).]

Initially, London was the most severely affected, where the confirmed number of cases accounted for almost one-third of the total in England by 31 March 2020. The death toll increased along with the number of cases, resulting in the UK overtaking Italy as the country with the highest death toll in Europe and the second highest in the world on 5 May 2020. As of 24 June 2020, there had been over 306,000 confirmed cases of COVID-19 and almost 43,000 deaths in the UK. [(4)]

The overall death toll from COVID-19 from the start of the pandemic in March 2020 to 9 April 2021 was 137,000, one in five of all deaths in England and Wales during this period. The first wave from about March to August 2020 resulted in 52,000 COVID-19 deaths and the second wave from September 2020 to 9 April 2021 caused an additional 85,000 COVID-19 deaths. [(2)]

A summary report published by HSIB highlighted a number of challenges faced by hospital trusts at the height of the pandemic [(4)]:

- There had been a need to constantly develop national guidance to respond to the emerging risks of COVID-19 infection. This posed a significant challenge in how guidance was developed and disseminated. It was noted that there were 21 separate updates to the COVID-19 infection prevention and control guidance between 1st January and 7th May 2020 (6). Local teams had challenges in interpreting guidance and identifying resources to implement this rapidly evolving guidance.
- Community testing was introduced in early April 2020 which meant that hospital trusts had no way of confirming whether an individual was infected with COVID-19 unless they were unwell enough to be admitted to hospital
- The timeliness of test results being returned impacted on a hospitals ability to respond effectively to the pandemic. When rapid testing was introduced, these were in limited supply and supplies had reduced further during the course of the pandemic. Patients awaiting a test result were sometimes required to be moved into the hospital system prior to test results being returned, either due to the demand on COVID-19 related admission areas or based on the clinical needs of the patient. This provided a further challenge should any patient subsequently return a positive COVID-19 test following admission to a non-COVID-19 area.
- Transmission of COVID-19 by asymptomatic individuals was not well understood. There was limited evidence on the rate of asymptomatic transmission; estimates suggested the rate could be as low as 16% or as high as 41% (5).
- Trusts reported frequent problems in receiving a consistent supply of FFP3 respirator masks. With each change in supplier, the regulatory requirement to 'fit test' staff with masks arose which had an impact on the numbers of staff who could undertake duties with patients.
- Estates- In some old builds there were a small number of side rooms which further complicated by the fact that there are no ensuite facilities so patients would have to share facilities. In addition, ventilation systems of some trusts could not be easily repurposed as they were not designed to be filtered to capture a high proportion of airborne particulates.
- Concerns about patients becoming infected with COVID-19 during hospital admission began to emerge into the public domain in mid-May 2020. A report which collated clinical data from hospital admissions suggested that approximately 20% of patients were reporting symptoms of COVID-19 seven days following admission indicating possible nosocomial transmission.
- Trusts had to make rapid adaptations to enable them to respond to the pandemic. This had seen a trade-off in levels of consultation, assurance and governance systems usually in place to embed systems.

3. ICS GOLD decisions

All Trusts within NWL ICS were involved in key decision making during the height of the pandemic so that the approach was sector wide. Below is a summary of these decisions taken to support the sector at the height of the first wave of the pandemic.

March 2020

- Noted NHSE letter to free up critical care beds
- Mutual aid agreed to decant pressurised sites
- Surge protocol agreed by CEO's- to ensure that blue light patients and COVID-19 patients could be diverted rapidly at high pressure sites.

April 2020

- COVID patient ambulance distribution-distributing ambulance conveyances of COVID patients to different A&Es, concentrating them to potentially 3 areas to reduce pressures.
- Working with London Ambulances on divert arrangements to give a better distribution of patients to inner NWL acute Trusts
- Patients transferred between Trusts to support with capacity issues and some to the Nightingale Hospital
- Pembridge unit opened with 20 bed capacity(CLCH)
- Reinforce message about appropriate use of PPE by staff to ensure no under use to ensure staff safety
- CNWL - Mental health patients to be re-directed to St Charles, Northwick Park Hospital and Hillingdon hospital from emergency departments when attending with mental health issues only to special units.
- Principle that urgent patients to Independent Sector should go ahead with retrospective approval
- Endorsed proposal, including prioritisation equipment to support ECMO patients.

4. Definitions used for Hospital acquired COVID-19

In line with the NHSE guidance [3] the following definitions have been used in completing the investigations into COVID related deaths.

COVID-19 hospital death:

The NHS defines a COVID-19 hospital death as the death of a patient in hospital who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).

A Hospital-Onset Probable Healthcare-Associated infection

- is defined as an infection where the first positive specimen was taken 8-14 days after hospital admission with day of admission counted as day 1.

A Hospital-Onset Definite Healthcare-Associated infection

- is defined as an infection where the first positive specimen was taken 15 or more days after hospital admission with day of admission counted as day 1.

5. Challenges associated with community acquired COVID-19 infections.

The focus for the NWL ICS group was in investigating definite or probable inpatient COVID deaths attributed to the relevant Trust. For patients who died in the community, it is noted that it would be very difficult to accurately ascertain how the individual contracted the infection.

6. ICS approach to Mortality and Nosocomial infections including assigning harm ratings.

The ICS approach has been agreed by all the mortality leads across Acute, Mental Health and Community Trusts in NWL and is aligned to the guidance set out by NHSE [3]

- Trusts to use existing processes in place to review mortality.
- Building on the statutory reporting requirements for COVID deaths, each Trust is to ensure that robust processes exist to report probable and definite COVID related deaths.
- The approach is designed to support system wide learning. There must be an agreement that if patients have been transferred between sectors, there should not be any hindrance in obtaining relevant information to complete the review from the organisations involved in the patient's care.
- The system has agreed that although a retrospective review was not mandated nationally, this will be the NWL ICS approach of all cases involving "probable" and "definite "COVID Related mortality from April 2020 to March 2021. Any new or emerging themes that are arising from the new infections are analysed as appropriate.
  Those that meet the definitions of a serious incident should be recorded and managed as such.
- Thematic analysis of learning to be shared with the system including any rapid learning identified for new cases of COVID related mortality.
- Sector wide agreement on assigning harm ratings. If the individual Trust, via its internal MDT panel have not identified any lapses in care, taking into consideration guidance in place at the time of the infection, the final harm rating will be recorded as low /no harm.

7. Total number of COVID-19 positive deaths and deaths with COVID-19 on the Medical Certificate of Cause of Death (MCCD)

Between 1st April 2020 and 31st March 2021:

183 patients with probable hospital acquired COVID-19 were identified (where a positive result was recorded 8-14 days after hospital admission);

- 28 patients with probable hospital acquired COVID-19 sadly died in hospital

- The death certificate for 19 of these patients included COVID-19 within part1a (this part of the certificate records the disease or condition leading directly to the death).

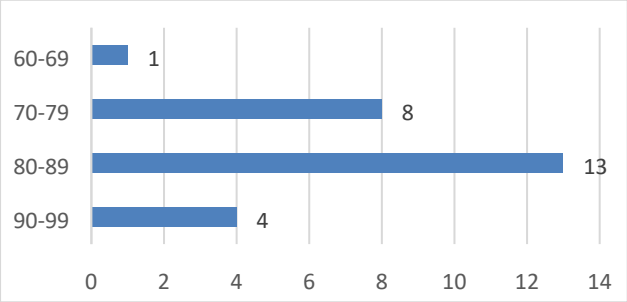
158 patients with definite hospital acquired COVID-19 were identified (where a positive result was recorded 15 or more days after hospital admission);

- 35 patients with definite hospital acquired COVID-19 sadly died in hospital
- The death certificate for 19 of these patients included COVID-19 within part1a (this part of the certificate records the disease or condition leading directly to the death).

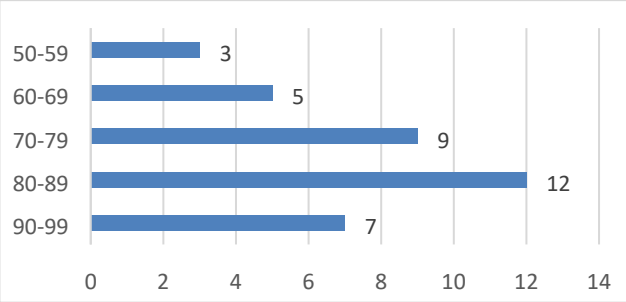
8. Number of the completed reviews (trajectory if not complete) that have resulted in confirmed nosocomial COVID cases

During this period a total of 62 in-hospital deaths have been linked to probable or definite hospital acquired COVID-19.

Female patient deaths by age band



Male patient deaths by age band



26 cases (42%) relate to female patients and 36 (58%) relate to male patients; the majority of in-hospital deaths affected patients aged between 80-89 years old (40% of all cases identified).

Retrospective case review identified the high co-morbidity of patients within this cohort; the most frequently identified significant diseases, conditions or illness contributing to the death (recorded on part 2 of the medical certificate of death) were: frailty, hypertension, COVID-19, atrial fibrillation, Ischaemic heart disease, dementia, Chronic obstructive pulmonary disease, chronic kidney disease, and Diabetes.

Cross divisional and specialty support has been provided to ensure retrospective case review was undertaken for all 62 deaths linked to probable and definite hospital acquired COVID-19 infections between 1st April 2020 and 31st March 2021.

9. Number of cases where a lapse in care has been identified and investigated as a serious incident. (note caveat that these should not be compared to other Trusts due to different methodologies used)

When reviewing deaths the Trust makes use of a grading system first developed as part of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI); this grading system enables the organisation to classify outcome avoidability and / or suboptimal care provision.

CESDI grades:

- 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

When undertaking retrospective case review the Trust considered the following guidance to support CESDI grading:

- A frail patient with multiple co-morbidities who would likely have died regardless of acquiring nosocomial COVID19 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

Whilst the Trust's normal mortality review process seeks to identify potential suboptimal care across the patients admission this focused review of deaths associated with in-hospital COVID-19 sought to establish a CESDI grade relating solely to the control, management, and risk mitigation regarding COVID-19.

CESDI grade assessments:

- CESDI 0 – 36 cases
- CESDI 1 – 20 cases
- CESDI 2 – 6 cases
- CESDI 3 – 0 cases

During this 12 month period 6 cases of sub-optimal care were identified where on the balance of probabilities the patient would not have been expected to die during that admission were it not for contracting COVID-19. Cases of sub-optimal care were reviewed by specialty, divisional, and Trust wide scrutiny groups to ensure all learning opportunities were considered. No themes or routes of infection were identified by the review groups therefore further risk mitigation activity is limited, allowing for any iterative learning that occurred at the time.

The mortality review process was employed to learn from these events rather than the serious incident framework.

10. Key Challenges

In-Hospital transmission

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 throughout their admission. It was incumbent upon the Trust to review the provision of care and treatment to ensure all potential learning opportunities were explored; this was achieved via the mortality review process.

Duty of Candour

An independent Medical Examiner's service was introduced to the Trust in April 2020 to provide enhanced scrutiny to deaths and to offer a point of contact for bereaved families wishing to raise concerns.

The purpose of this service is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- 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 Trust takes significant assurance that all deaths associated with COVID-19 were carefully and contemporaneously scrutinised by the medical examiner's service and the bereaved were supported to understand the reasons for the outcome and implications of in-hospital COVID-19 transmission.

The work of the medical examiner office supported clinical teams who also played a significant role in explaining and apologising to patient and the bereaved when in hospital COVID-19 transmission was suspected. Supportive guidance was provided to clinicians to help them have these difficult conversations.

Patient testing arrangements

The Trust, and the wider NHS, has ceased routine use of PCR testing for the majority of our patients. Lateral flow tests are now used to help identify those patient who could be spreading the disease without knowing they have it. Lateral flow test results are recorded within our electronic patient record but cannot be extracted and reported on in the same was as laboratory PCR results were; this reduces the trust's oversight of in-hospital acquired COVID-19.

11. Key learning and action points

Principle controls to in-hospital COVID-19 transmission considered as part of the review:

Leadership response: The Trust rapidly developed its strategic and operational leadership approach in response to the pandemic with the aims to coordinate with our peer organisations, preserve care quality, protect staff, and reduce the risk of infection. Existing command and control structures were expanded to manage the unprecedented levels of demand, cascade guidance, and co-ordinate actions.

Enhanced infection prevention and control measures: The Trust's Infection Prevention and Control team maintained a strong working relationship with Clinical Commissioning Groups, Integrated Care Systems, Public Health England, and NHS England/Improvement to ensure measures taken within the Trust were consistent with the evolving national guidance and best practice. The IPC team also continued to support the established processes and procedures in place to identify and manage outbreaks of infection with feedback and learning shared immediately with the areas involved and Trust gold.

Environmental management: The Trust conducted COVID-19 workplace risk assessments for all wards and common areas and oversaw both risks and actions at the organisation's Health Safety and Environmental Risk Group and Trust gold. This process was further enhanced through routine site inspections designed to tested each areas approach to; hand hygiene, decontamination / cleaning, social distancing, correct use of personal protective equipment, and patient / staff testing arrangements.

Enhanced cleaning schedules: The Trust significantly enhanced its approach to cleaning and decontamination with both increased frequency and intensiveness of cleaning and decontamination activities.

Provision of information and guidance: A significant feature of the developing approach to COVID-19 management was the frequency with which new guidance and recommendations were cascaded nationally and locally. Trust gold oversaw all recommendations and requirements and were supported by the communications team to share learning across a variety of formats (including intranet, emails, apps, safety huddles, safety groups, webinars). The Trust's weekly all staff webinar provided excellent opportunity for staff to engage with these changing needs and communicate their concerns.

Staff welfare: Staff were supported by a comprehensive range of measures to protect their health safety and welfare. Individual risk assessments were undertaken and enhanced staff support was provided in recognition of both the immediate and longer-term impact that the pandemic may have on individual and collective wellbeing. Enhanced staff welfare arrangements also helped reduce the risk of in-hospital COVID-19 transmission.

Staff testing: Routine staff testing was introduced and enhanced support was provided via occupation health. This had the effect of prompting staff welfare but also reducing the risk of in-hospital transmission between staff and patients.

Patient testing: During the second wave, a more advanced COVID-19 antibody test that allowed the detection of an immune response to vaccines as well as to previous infection was introduced for patient testing on admission 24/7. This approach helped reduce the risk of nosocomial infection and supported patient flow through both hospital sites.

Redesigned pathways, processes and estate: There were measures in place to separate admission areas for patients with COVID-19 so as to minimise contact between patients. A COVID-19 triage assessment was conducted at all points of direct admission to the hospital

and patients were not moved until COVID-19 test results were available. Green areas were designated for patients who were unlikely to have COVID-19 and Red pathways for those at high risk of having COVID-19.

Restricted access to hospital premises / areas: The Trust adopted a number of measures to reduce the amount of movement within the hospital; this included the implementation of restrictions on visiting in accordance with national guidance. However, the review identified factors such as staff sickness and the requirement to provide specialist input, resulted in movement of staff to maintain patient care.

Vaccination process: The Trust's operated a highly successful COVID-19 vaccination programme to nationally agreed priority and eligible groups. The Trust acted as lead for the NW London vaccination programme and provided vaccination resource to staff, public, patients, and peer organisations.

Social / physical distancing: The Trust reduced bed capacity within key admission areas to support social distancing and reduce COVID-19 transmission within the highest risk areas. This approach was complimented by the installation of physical barriers in ward areas.

Multi-disciplinary team learning: The Trust's mortality case review process provided clinical teams with the opportunity to review expectations, outcomes and potential improvements in an open, supportive and transparent environment. Clinical teams were well engaged in this learning opportunity and were able to meaningfully reflect on the pandemic, high crude death rates, and threats posed by in hospital transmission. The ability to share concerns and develop safety approaches with colleagues provided a rich source of learning for individuals and the Trust.

12. Processes in place to reduce the risk of Nosocomial infections

a. The Trust's patient testing programme continues
b. Supply and support for staff to use the required PPE is embedded
c. Learning from outbreak meetings operating as business as usual

13. Recommendations for Trust board

The Trust's Mortality Surveillance programme offers assurance to our patients, stakeholders, and the Board that high standards of care are being provided and that any gaps in service delivery are being effectively identified, escalated, and addressed. Review of nosocomial associated death will continue to be supported through medical examiner scrutiny and clinical team mortality review. Further learning opportunity identified will be reported within the quarterly learning from deaths report submitted to the Board.

References:

1. National Guidance on Learning from Deaths. National Quality Board 2017.
2. Deaths from Covid-19 (coronavirus): how are they counted and what do they show? https://www.kingsfund.org.uk/publications/deaths-covid-19

3. NHSE Guidance - Learning from Hospital onset COVID-19. July 2021
4. HSIB- COVID-19 transmission in hospitals: management of the risk – a prospective safety investigation(Oct 2020) https://www.hsib.org.uk/investigations-and-reports/covid-19-transmission-in-hospitals-management-of-the-risk/
5. Transmission dynamics of the COVID-19 epidemic in England. Yang Liu, Julian W. Tang, Tommy T.Y. Lam Int J Infect Dis. 2021 Mar; 104: 132–138.
6. https://www.hcsa.com/media/154216/HCSA-Report-Covid19-Learning-from-the-First-Wave.pdf

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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TITLE AND DATE (of meeting at which the report is to be presented)	Board of Directors Meeting (Public Session) – 7 July 2022

AGENDA ITEM NO.	4.7
TITLE OF REPORT	Guardian of Safe Working Q4 Report
AUTHOR NAME AND ROLE	Emma Barrett, Medical Workforce Manager & Dr Julian Collinson, Guardian of Safe Working
ACCOUNTABLE EXECUTIVE DIRECTOR	Dr Roger Chinn, Chief Medical Officer & Sue Smith, Interim Chief People 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	Provide assurance of the safe working hours and working conditions for all junior doctors and dentists employed by the Trust.
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	Senior Trust management and HR have continued to provide support and ensure the safe working of the junior doctor workforce in Q4. A total of 88 exception reports have been submitted for this quarter.
KEY RISKS ARISING FROM THIS REPORT	Financially, the majority of exception reports submitted were resolved by additional payment to the junior doctors concerned and by fines allocated to the departments concerned in accordance with the 2016 Junior Doctors TCS.

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:		Finance implications: the majority of exception reports submitted were resolved by additional payment to the junior doctors concerned and by fines allocated to the departments concerned in accordance with the 2016 Junior Doctors TCS.
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		

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

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Guardian of Safe Working Hours Q4 2021/2022

1. Executive Summary

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

As in previous quarters (2021-2022) the trust continues to navigate its way through recovery from the COVID-19 Pandemic, most junior doctors rotas have now returned to BAU. Rotas are now being reviewed for the August 2022 rotation.

A total of 88 exception reports have been submitted for this quarter – 78 (89%) of which were submitted by junior grade (F1/F2/ST1/ST2) doctors across the trust. This is a marked reduction in the number of exceptions submitted in Q3.

The Junior Medicine rotas (F1/F2/ST1-2) at CW account for 38% of the total exception reports – the main reason submitted is overtime due to workload

There have been 3 fines (2 in January / 1 in February) levied for this quarter. All fines have been due to a breach of the maximum 13 hour rule – Please see breakdown of fines below.

2. Trainee Vacancies

Rota gaps continue to remain a national problem. The trust continues to ensure that existing gaps are recruited to as soon as the gap is confirmed by HEE in order to ensure patient safety and maintain desired standards of clinical care. Trainee gaps are outlined below. Once all doctors are using the e-rostering system rota gaps will be able to be reported in more detail.

Site	Department / Grade	Trainee Gaps for Q3 2021
Core Surgical CT1/2	WM	2 (1 General, 1 T&O)
Anaesthetics Core	CW	1
Anaesthetics ST3+	CW	2
Internal Medicine (IMT3)	CW	7 (5 Acute Med, 1 Geri, 1 Endo)
Internal Medicine (IMT3)	WM	2 (1 Gastro, 1 Endo)

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Paediatrics ST6-8	CW	3
Paediatrics ST1-5	CW	1
Paediatrics ST1-5	WM	1
Emergency Medicine ACCS	CW	1
Emergency Medicine ST3+	CW	1

3. The Junior Doctor Forum

The Junior Doctor forum continues to be held virtually on a monthly basis. Meetings are hosted by each site on alternate months and take place on the third Wednesday of each month from 1200-1300 hrs. The Education fellows at both sites take the minutes for these meetings and circulate them to relevant members within the forum. There are plans in place to strengthen the structure of these meetings going forward and to encourage more junior doctors to attend, including plans for face to face meetings with a virtual option, to allow juniors from both sites to attend going forward. Trainee attendance continues to be poor.

4. Exception Reporting

A total of 88 exception reports were submitted for the quarter. 58 at CW and 30 at WM.

January 2022: A total of 34 exception reports were submitted. 2 fine levied.

Division	C & W: 17 + 5 + 3 = 25	WMUH: 3 + 1 + 5 = 9
EIC – 20 (17 @ CW / 3 @ WM)	F1 (General 11 / Acute 1) F2 /ST1-2 (General 3 / Acute 2)	F1 (General 2) ST3+ (Respiratory 1)
Planned Care – 6 (5 @ CW / 1 @ WM)	F1s (General 3) ST3+ (Anaesthetics 2)	F1s (General 1)
W&C / HIV / Derm – 8 (3 @ CW / 5 @ WM)	F2/ST1-3 (Paediatrics 3)	F2/ST1-3 (Paediatrics 5)

February 2022: A Total of 14 exception reports were submitted. 1 fine levied.

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Division	C & W: 8 + 2 + 2 = 12	WMUH: 0 + 0 + 2 = 2
EIC – 8 (8 @ CW / 0 @ WM)	F1 (General 2) F2/ST1-2 (General 4 / Acute 1) ST3+ (Acute 1)	0
Planned Care – 2 (2 @ CW / 0 @ WM)	F1 (General 2)	0
W&C / HIV / Derm – 4 (2 @ CW / 2 @ WM)	F2/ST1-3 (Obs & Gynae 2)	F2/ST1-3 (Paediatrics 2)

March 2022: A total of 40 exception reports were submitted. 0 fines levied.

Division	C & W: 13 + 2 + 6 = 21	WMUH: 7 + 6 + 6 = 19
EIC – 20 (13 @ CW / 7 @ WM)	F1 (General 2 / Acute 3) F2/ST1-2 (General 2 / Acute 3 / ED 1) ST3+ (Neurology 2)	F1 (General Med 3) F2/ST1-2 (Gastro 3) ST3+ (Acute 1)
Planned Care – 8 (2 @ CW / 6 @ WM	F1 (General Surgery 1) ST3+ (Anaesthetics 1)	F1 (General Surgery 6)
W&C / HIV / Derm – 12 (6 @ CW / 6 @ WM)	F2/ST1-2 (Obs & Gynae 5) ST3+ (GUM 1)	F2/ST1-3 (Paediatrics 5 / Obs & Gynae 1)

Of the exception reports received in Q4 39 have been paid for the additional hours worked, 27 have payments for the additional hours pending, 7 have had TOIL recommended, 2 are being further investigated, 6 were closed

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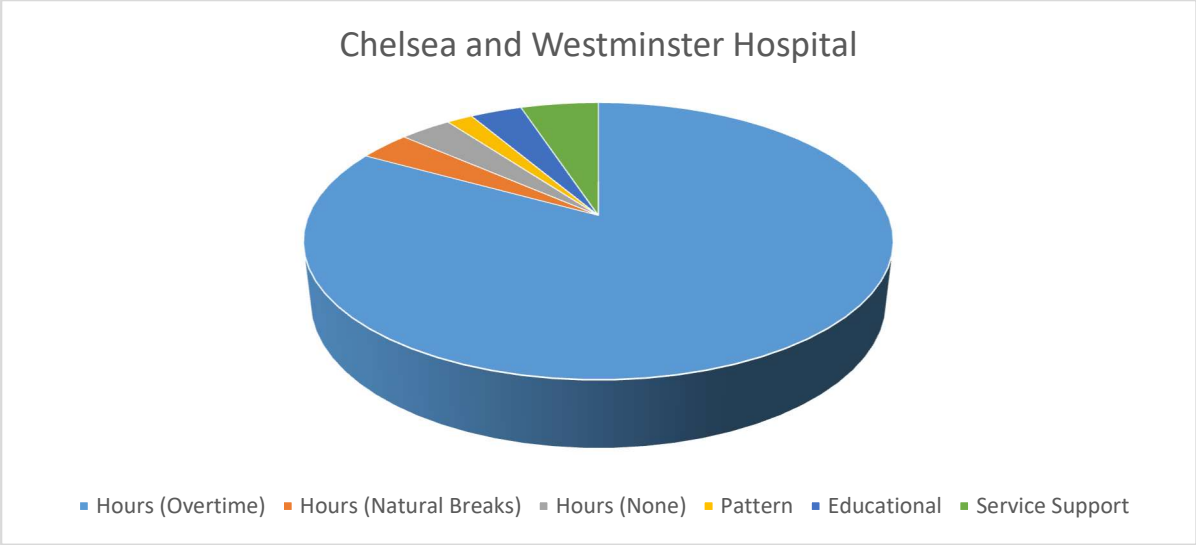
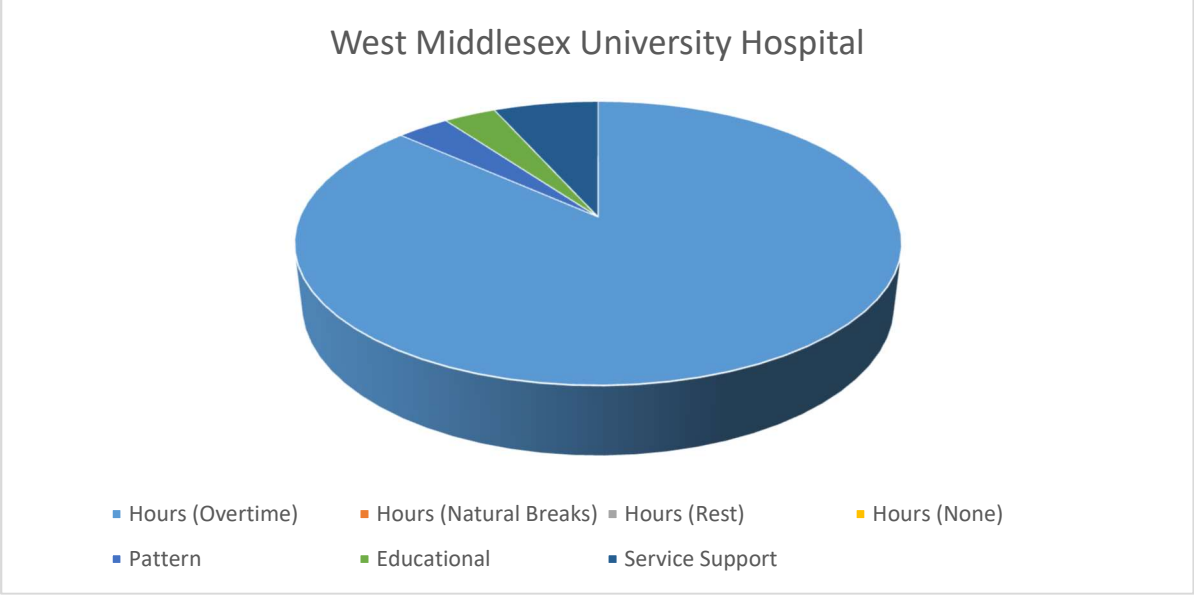
with concerns noted and escalated where required, 7 were submitted passed the 7 day window and were rejected. The exception reporting process will be streamlined in order to ensure that TOIL is the preferred option and that a timely review of exception reports is adhered to, in line with the contract. It has also been raised again at the JDF the importance of submitting exception reports in a timely manner and within the 7 day window.

The the reasons for the exception reports that were submitted in Q4, are illustrated in the pie charts below, the main reason for both sites and all rotas was working longer hours due to workload.





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5. Breakdown of Fines

Specialty	Grade	Site	Reason	Paid to doctor	Paid to GoSW	Total fine
Paediatrics	GPST1	WM	Over 13 hrs	£44.72	£74.53	£119.25
Paediatrics	ST1	WM	Over 13 hrs	£22.36	£37.27	£59.63
Paediatrics	ST1	WM	Over 13 hrs	£22.36	£37.27	£59.63
Total						£238.51

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Acronyms

The following document explains some acronyms and terms which Staff and Governors may come across in their role.

A			
A&E	Accident & Emergency	AHSN	Academic Health Science Network
ARC	Audit & Governance Risk Committee	ALOS	Average Length of Stay
AGM	Annual General Meeting	AMM	Annual Members Meeting
AGS	Annual Governance Statement	AO	Accountable Officer
AHP	Allied Health Professionals	ALB(s)	Arms Length Bodies
AHSC	Academic Health Science Centre		
B			
BAF	Board Assurance Framework	BAME	Black Asian Minority Ethnic
BCF	Better Care Fund	BoD	Board of Directors
BMA	British Medical Association		
C			
CAMHS	Child and Adolescent Mental Health Services	CFO	Chief Financial Officer
CapEx		CMO	Chief Medical Officer
CBA	Cost Benefit Analysis	CNO	Chief Nursing Officer
CBT	Cognitive Behavioural Therapy	CoG	Council of Governors
CCG	Clinical Commissioning Group	COO	Chief Operating Officer
CDiff	Clostridium difficile	CPD	Continuing Professional Development
CE / CEO	Chief Executive Officer	CQC	Care Quality Commission
CF	Cash Flow	CQUIN	Commissioning for Quality and Innovation
CFR	Community First Responders	CSR	Corporate Social Responsibility
CHC	Continuing Healthcare	CT	Computed Tomography
CIP	Cost Improvement Plan		

D			
DBS	Disclosure and barring service	DoF	Director of Finance
DGH	District General Hospital	DPA	Data Protection Act
DHSC	Department of Health and Social Care	DPH	Director of Public Health
DNA	Did Not Attend	DTOCs	Delayed Transfers of waiting Care
DNAR	Do Not Attempt Resuscitation	DTC	Diagnostic and Treatment Centre
E			
E&D	Equality and Diversity	EOLC	End of Life Care
ED(s)	Executive Directors or Emergency Department	EPR	Electronic Patient Record
EHR	Electronic Health Record	ESR	Electronic staff record
F			
FFT	Friends and Family Test	FT	Foundation Trust
FIC	Finance and Investment Committee	FTE	Full Time Equivalent
FOI	Freedom of Information	FTSU	Freedom to speak up
G			
GMC	General Medical Council	GDP	Gross Domestic Product
GDPR	General Data Protection Regulations		
H			
HCAI	Healthcare Associated Infection	HRA	Health Research Authority
HCA	Health Care Assistant	HSCA 2012	Health & Social Care Act 2012
HDU	High Dependency Unit	HSCIC	Health and Social Care Information Centre
HEE	Health Education England	HTA	Human Tissue Authority
HR	Human Resources	HWB / HWBB	Health & Wellbeing Board
I			
IG	Information Governance	ICU or ITU	Intensive Care Unit Intensive therapy unit
ICP	Integrated Care Pathway	IP	Inpatient
ICS	Integrated Care system	IT	Information Technology

ICT	Information Communications Technology	IV	Intravenous
K			
KLOE(s)	Key Line of Enquiries	KPIs	Key Performance Indicators
L			
LD	Learning Disability	LOS	Length of Stay
M			
M&A	Mergers & Acquisitions	MRI	Magnetic Resonance Imaging
MHPRA	Medicines and Healthcare Products Regulatory Agency	MRSA	Methicillin-Resistant Staphylococcus Aureus
MIU	Minor Injuries Unit	MSA	Mixed Sex Accommodation
MoU	Memorandum of Understanding		
N			
NAO	National Audit Office	NHSI	NHS Improvement
NED	Non Executive Director	NHSLA	NHS Leadership Academy
NHS	National Health Service	NHSP	NHS Professionals
NHS111	NHS nonemergency number	NHSX	
NHSBSA	NHS Business Services Authority	NICE	National Institute for Health and Care Excellence
NHSBT	NHS Blood and Transplant	NIHR	National Institution for Health Research
NHSE	NHS England	NMC	Nursing and Midwifery Council
O			
OD	Organisational Development or Outpatients Department	OSCs	Overview and Scrutiny Committees
OOH	Out of Hours	OT	Occupational Therapy
OP	Outpatients		
P			
PALS	Patient Advice & Liaison Service	PHSO	Parliamentary and Health Service Ombudsman
PAS	Patient	PICU	Psychiatric Intensive

	Administration System		Care Unit or Paediatric Intensive Care Unit
PbR	Payment by Results or 'tariff'	PLACE	Patient-Led Assessments of the Care Environment
PCN	Primary care network	POD	People and Organisational Development Committee
PDSA	Plan, do, study, act	PPI	Patient and Public Involvement
PFI	Private Finance Initiative	PTS	Patient Transport Services
PHE	Public Health England		
Q			
QA	Quality assurance	QIA	Quality Impact Assessment
QC	Quality Committee	QOF	Qualities and Outcomes Framework
QI	Quality improvement		
R			
R&D	Research & Development	RoI	Return on Investment
RAG	Red, Amber, Green classifications	RTT	Referral to Treatment Time
RGN	Registered General Nurse		
S			
SALT	Speech and Language Therapist	SLA	Service Level Agreement
SFI	Standing Financial Instructions	SoS	Secretary of State
SHMI	Summary Hospital Level Mortality Indicator	SRO	Senior Responsible officer
SID	Senior independent Director	STP	Sustainability and Transformation Partnership
SIRO	Senior Information Risk Officer	SUI	Series Untoward Incident / Serious Incident
SITREP	Situation Report	SWOT	Strengths, Weaknesses, Opportunities, Threats
T			
TTO	To Take Out		
V			
VTE	Venous Thromboembolism	VfM	Value for Money

W			
WLF	Well Led Framework	WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	WTE	Whole-time equivalent
Y			
YTD	Year to Date		